# vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. **SUMMER 2019/20**

## Reducing prescription drug-related harms

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# Welcome from the editor

*A/Prof Julian Rait (right) with President's Award recipient, Prof John Wilson. Check out the winners and the photos from the inaugural AMA Victoria Awards night. See page 12.*

In our final edition of Vicdoc for the year, we have comprehensive coverage of the issues surrounding prescription drug-related harms and the positive work being done to assist doctors and save lives.

The most recent figures tell us more Victorians are dying from drug overdose deaths involving pharmaceutical medicines than illicit drugs. The death toll is significantly higher than the state's road toll. While Penington Institute's analysis of its Annual Overdose Report provides sombre reading, fresh data from the Department of Health and Human Services outlines the encouraging impact of the introduction of SafeScript.

While it is important to provide members with information about SafeScript, we also recognise doctors in public hospitals and private specialists are experiencing issues with the system. AMA Victoria is advocating to the State Government that public hospital doctors and private specialists be exempted from the mandatory requirement to check SafeScript until such time as digital health infrastructure improvements deliver seamless, integrated SafeScript use for the vast majority of these medical practitioners. The Government is considering this and we will inform you as soon as we hear a response.

This Vicdoc also features an introduction to 'The Change Program' – a resource to assist patients living with obesity; thought-provoking research into challenging cognitive bias in medical diagnoses; a deep dive into the work of our leading psychiatrists and their hopes for mental health system reforms; plus more on flexible workplace arrangements.

Finally, a reminder to all of our members that Vicdoc will be 'going digital' in 2020, with the first of our new-look editions to be available via email for viewing on your computer screens, smartphones and tablets in March. For those who would still prefer a hard copy of the magazine, please review the opt-in option in your membership renewal or communication package.

**Barry Levinson**

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# President's message

The recent release of international hospital rankings by London-based digital healthcare start-up Medbelle has got me thinking. Medbelle has created a ranking of cities from across the world that offer the best overall medical care, as well as creating a benchmark for the rest of the world to understand how to better develop their medical education, accessibility and infrastructure for a healthier future.

So I would like to congratulate all those who have contributed to Melbourne's hospital system - ranked by Medbelle as 7th in the world, and the best in Australia (with Sydney ranked 11th). However, behind these ratings, it is actually not such 'a golden time' in the Victorian public health system.

If we don't maintain pressure on our governments to continue to invest in and prioritise the public health system, their attention will drift elsewhere. And while the Federal Government is obsessed with achieving and maintaining a budget surplus, other things like tunnels, roads and bridges have attracted the fond attention of our state Premier and Treasurer.

Inevitably the public health system suffers from these policy decisions. We're seeing evidence of this lately in Victoria. Despite claims from the State Government of record investment, this past year we have seen an operational funding crisis in many of our public hospitals.

Consequently, it's a tale of two cities; it is the best of times, and it is the worst of times. On the one hand, the State Government has announced that our health funding is at record levels. On the other hand, our members tell us that the system is more constrained than ever, and under enormous pressure from ever increasing demand for hospital care.

Public hospitals continue to call on staff to work smarter and find savings - which staff have done, year on year for nearly a decade. Meanwhile we're hearing from many of our members in our hospital wards and in our emergency departments that there is simply no more to give.

For a decade, we have had increasing demands to improve throughput, improve performance and improve efficiency – but is there really more that we can do with our current infrastructure and resources? There comes a point when to work smarter, the system needs more investment, more beds, more staff - not the application of more stress through cost cutting and high-handed rhetoric.

In many respects, a perfect storm is brewing in Victoria – booming and ageing population pressures, an exodus from the private health sector and insufficient support for GPs to better manage chronic disease.

Equally, there has been no new investment to address the Victorian mental health crisis into which the State Government called a Royal Commission during the last state election campaign, while access to effective treatment for patients and their carers worsens.

The pressures are being felt in other areas as well. Whilst the Victorian State Government has gained a great deal of kudos with its focused investment on transport infrastructure, it has taken its eye off our public hospital infrastructure needs across the state.

The state's public hospital infrastructure is ageing - with no clear strategy in place for upgrading, improvement or renewal. Health requires complex buildings. They need to be flexible and need to be built to evolve as technology develops, the delivery of care changes, and the community's expectations shift. Many of the state's older public hospital buildings are at end-of-life and are severely constrained in their ability to meet the standards expected in the delivery of healthcare in 2020 and beyond.

Similarly, the management of public hospital assets and equipment requires huge investment to ensure end-of-life infrastructure does not fail; nor should hospitals have to draw on operational funding to pay for the replacement and upgrading of equipment. As we have seen this year at both the Alfred and Austin Hospitals, when critical public hospital infrastructure fails, quality and safety can be compromised and public confidence in the system is undermined.

The AMA agenda for 2020 is to urgently advocate on these issues in a way that pressures the Victorian State Government to prioritise public healthcare; to reappraise its priorities and review its spending. We will endeavour to ensure that the operational and infrastructure needs of the public health system are maintained at a level that will meet Victoria's current and future needs. We will also do this in a way that engages the broader public, for it is their health and equitable access to care that we are most concerned about.

And finally, thank you for working with the AMA during 2019. Powerful advocacy relies on high-level and meaningful engagement with the medical profession and our members. Your insights and ideas have shaped our policy platform and have informed our conversations with government; your shared stories and experiences have helped build our media campaigns. We will build on this work and continue to work with our members to advocate strongly to government throughout 2020 to achieve better outcomes for the Victorian health system and for the healthcare of our community.

I have thoroughly enjoyed engaging with you all and wish our members and staff a pleasant and relaxing festive season along with an exciting and productive New Year.

**A/Prof Julian Rait OAM**
**President**

# General practice – an under-used resource for patients living with obesity

## Community GPs can make a difference to the health and wellbeing of patients living with obesity – they just need the right resources and support. Obesity is a condition that affects all body systems, is influenced by social and community factors and has multiple, complex causes. These factors mean that generalist, ongoing care, from a trusted GP is an effective option for patients living with obesity.

For nearly the past decade, Dr Liz Sturgiss, a clinical GP and Monash University academic, has been exploring ways of making life easier for GPs wanting to address obesity with their patients. During her PhD training at the Australian National University (ANU), Liz and Prof Kirsty Douglas led a team of researchers at the ANU Medical School to develop The Change Program.

The Change Program is designed to improve overall health through long-term, sustainable changes in nutrition and physical activity. Initially aided by the RACGP-IPN Foundation grant, The Change Program development team included GPs, consumer representatives, dietitians, psychologists and a graphic designer who produced the program materials. The toolkit comprises of a GP handbook (about 40 pages) and a patient workbook (about 80 pages) that uses psychological behavioural strategies within worksheets and fact sheets to promote self-management, improve nutrition and increase physical activity. The program also includes a clinical software template to assist with appointment planning and recording of progress.

The Program provides the 'how' to translating the National Health and Medical Research Council's (NHMRC) guidelines on weight loss into action. The core tenets of The Change Program are patient-centredness and therapeutic alliance with the GP. No additional training is required to use the program as it draws on the existing skillset of GPs and the strength of the GP-patient relationship.

While the ideal consultation schedule is fortnightly for the first three months and reducing to monthly sometime during the following three months, the reality is that patients tend to come monthly for the first six months. Consultations can be billed as Level B, C or chronic disease items as appropriate. This ensures sustainability and scalability of the program.

Through an additional grant from the Australian Primary Health Care Research Institute (APHCRI), a feasibility trial of The Change Program showed that it was feasible and acceptable for use by urban and rural GPs for weight management and further, that the therapeutic alliance between the patient and the GP was one of the key aspects of success. (To learn more about the trial, watch the video at www.youtube.com/watch?v=GhWOaoW03TI)

Through a further RACGP Foundation Chris Silagy Grant, Dr Sturgiss explored the GP-patient relationship and when applying it to The Change Program, found that, "A robust therapeutic alliance was strongly associated with patient engagement in the weight management program indicated by number of appointments … also associated with some general health and quality of life outcomes."

Using both quantitative and qualitative data, Dr Sturgiss found that The Change Program, a structured weight management program for adults in Australian general practice, improved GP's confidence and self-efficacy in working with patients living with obesity.

Patients who have used The Change Program found the education fact sheets about obesity and weight gain very helpful. They learned why people gain weight and found the focus on the biology of obesity made them feel less guilty about living with obesity. Reducing shame and guilt is an important part of The Change Program.

In 2018, the Commonwealth Department of Health invited the team to present The Change Program to Primary Health Networks as an option for improving health and wellbeing for patients in their area. To date, five PHNs across Australia have adopted The Change Program and discussions are underway with other PHNs. There is no cost to the PHNs to adopt the program, apart from the printing of the GP handbook and the patient workbook. Once a simple agreement – usually via email – is reached between the PHN and the program owners, the ANU, we provide the PHN with the PDF material and they manage the process as best suits them.

The Change Program is administered through the Academic Unit of General Practice, an affiliate of the ANU Medical School. We have had numerous enquiries from GPs and the public around Australia asking how they can access the program. On behalf of the GPs, we have approached the relevant PHN and commenced discussions towards making it available to them. Until now, no Victorian PHNs have adopted the program, but we would be keen to assist their involvement.

We have received strong positive feedback from GPs who are implementing The Change Program in their clinics. It is great to see primary care research making a real impact in the daily work of GPs across Australia.

Visit www.changeprogram.com.au for more information. Enquiries can be made through either change.program@anu.edu.au or dagmar.ceramidas@anu.edu.au

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*References available from the Editor on request.*

# Challenging cognitive bias in medical diagnoses

Consider this scenario: A woman comes into a hospital clutching the right side of her abdomen and complaining of pain. What happens next? As a doctor, even before you have had time to think consciously about a diagnosis, your brain will have started scanning its storehouse of similar situations, filtering, cross referencing. Before you know it, you may have arrived at a possible explanation for the patient's symptoms.


Doctors at Box Hill Hospital's emergency department used the RaDD tool to review the diagnoses of 155 patients with abdominal pain over four weeks.

It's one of our great skills. Instead of starting from scratch each time we encounter a familiar situation, our brains use mental shortcuts – known as heuristics – to help interpret events and make decisions. These shortcuts allow us to brush our teeth, shower, drive to work – all the small routines that underpin the average day – while freeing us up to think about other things.

In a hospital setting they also serve us well, at least most of the time. It's what tells a doctor that a person with slurred speech and one side of their body not working properly may have had a stroke. But sometimes, it can lead us astray – predisposing us to jump to conclusions or rely too heavily on 'rules of thumb'. This is known as cognitive bias.

Now, in a new study, researchers are examining how cognitive bias may be reduced in medical diagnoses. In a trial funded by the Victorian Government's insurer and risk adviser, Victorian Managed Insurance Authority (VMIA), researchers from BehaviourWorks Australia at the Monash Sustainable Development Institute developed and tested the Rapid Diagnosis Discussion (RaDD) tool to challenge these often unconscious habits.

The tool was trialled in an emergency department, where, as lead researcher Associate Professor Peter Bragge explains, diagnosis can be difficult. "Because doctors are under time pressure, they don't know the history of the patient and sometimes they can lock themselves into a diagnosis too early and not consider some of the alternatives."

For the study, the team chose to focus on abdominal pain presentations. Abdominal and pelvic pain is the most common principal diagnosis reported in Victorian emergency departments, accounting for approximately 80,000 patients a year, or 1 in 20 of all patients presenting to Victorian emergency departments. It can be a challenge to diagnose, as there are many possible causes.

The RaDD tool was designed as a 'circuit breaker' to give emergency doctors a chance to reassess their initial diagnosis in parallel with a second independent emergency doctor. In the trial, doctors at Eastern Health's Box Hill emergency department used the intervention to review the diagnoses of 155 patients with abdominal pain over four weeks last year. Two other emergency departments acted as controls.

The intervention was shown to change doctors' behaviour. Patients were less likely to be discharged and more likely to be admitted to short-stay units and to have blood tests ordered. Doctors' confidence in diagnosing abdominal pain increased somewhat, particularly for high risk cases and particularly for more junior doctors.

After doctors used the tool, their initial diagnoses also changed in nearly a quarter of cases. This increased to 35 per cent when the first clinician was a junior doctor and the second a senior.

The study had limitations. For one, there is no way of knowing whether doctors would have revised their initial diagnoses anyway. Nor did the study design enable measurement of the ultimate outcome for the patients – meaning it was unable to determine whether the changes in diagnosis were ultimately beneficial for the patient. And while RaDD appears useful in encouraging more cautious behaviour in doctors, it also comes with potential costs.

"Increased caution might reduce missed diagnoses, but at the expense of efficiency, over investigation and patient flow," says A/Prof Bragge.

The findings may be important in helping doctors detect and challenge their own hidden biases. Australian and international studies show that errors occur in one in 10 diagnoses – and that while many don't end up harming patients, diagnostic error is one of the top 10 causes of death in first world health services.

According to VMIA, misdiagnosis is a factor in approximately 21 per cent of medical indemnity claims. Maria Mota, VMIA's head of Insights and Analytics, says the aim of the project is to work with the health sector to better understand the drivers of claims and explore opportunities to improve patient safety. "I think the beauty of this pilot is in trying to drill down into the human behaviour that we are all subject to and seeing if, with the help of behavioural science, we can develop tools to help doctors navigate and mitigate some of the healthcare challenges."

Dr Paul Buntine, an emergency physician at Eastern Health who helped design and run the trial, says RaDD raises interesting possibilities. While he says Victoria already has a first-class health system, he hopes the tool might help encourage doctors to take more accurate histories from their patients before they settle on their early diagnosis.

"One of the big areas of medicine that I'm very interested in is actually over-diagnosis, where people are not taking a nice, accurate history from the start and instead are casting the net too widely or going in the wrong direction and missing something obvious because they were searching for something less obvious," Dr Buntine says.

Ms Mota adds the initial results from the trial are promising but that further work is needed to understand the outcomes more fully and to assess possible future applications of the tool. "Are there specific environments or conditions for which it is best suited? Is it more beneficial for junior than senior doctors? How might it be used in small or remote health settings?

"Working in partnership with researchers and health services, we're aiming to support practical interventions and tools that can help to reduce preventable harm."

The RaDD trial is one of six VMIA-funded research projects that will be conducted by BehaviourWorks Australia as part of a three-year Research and Innovation program. For more information, visit: www.behaviourworksaustralia.org/victorian-managed-insurance-authority/

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*References available from the Editor on request.*

# AMA Victoria Awards Night

Health professionals from across Victoria were honoured at the inaugural AMA Victoria Awards on 23 November. Sixteen finalists gathered at Park Hyatt Melbourne to recognise their commitment to medical practice, education or research, preventative health or patient advocacy. Congratulations to our winners:

**President's Award - Prof John Wilson AM**

Prof Wilson heads Monash Alliance, which aims to implement eHealth initiatives in clinical care. He has contributed to the AMA and Victorian Senior Medical Staff in providing analysis of the public hospital performance, supporting the EBA and development of the health check tool for public hospital medical staff.

**Patrick Pritzwald-Stegmann Award - Dr Helen Schultz**

Dr Schultz is a psychiatrist who specialises in the mental health and wellbeing care of medical students, doctors-in-training and practising doctors.

**Care Super Junior Doctor of the Year Award - Dr Nardine Elzahaby**

Dr Elzahaby is passionate about promoting a positive culture in medicine, improving doctors' health and promoting a high standard of patient care.

**Priscilla Kincaid-Smith Award – Prof Tissa Wijeratne**

Prof Wijeratne is a leading neurologist and Chief of the Neurology Department, University of Melbourne and Western Health's Sunshine Hospital.

**Stawell Memorial Prize - RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities**

Lead Author: Juanita L Westbury. Co-Authors: Peter Gee, Tristan Ling, Donnamay T Brown, Katherine H Franks, Ivan Bindoff, Aidan Bindoff, Gregory M Peterson.

AMA Victoria thanks all of our sponsors who supported the evening, in particular, major sponsor Care Super. We hope all of our guests enjoyed the evening as much as we did hosting it!



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# Flexible workplace arrangements enhance an employer's appeal

In the last edition of Vicdoc we spoke to general surgical trainees Dr Stephen Kunz and Dr Jasmina Kevric who will be undertaking flexible surgical training in 2020 at the Austin/ Northern Training Hub. In this edition we look at the hospital changes that are making flexible training a reality.

## A supportive supervisor plays an important role

Part-time surgical training has the full support of the Austin/Northern Training Hub's general surgical supervisor, A/Prof Vijayaragavan Muralidharan, who has been instrumental in facilitating the arrangement.

"The flexible training option was discussed at the General Surgery Board long before the program commenced," A/Prof Muralidharan explained to Vicdoc. "The increase in number of trainees, particularly trainees who wanted to pursue flexible training, lead to the formation of a formal program at Austin Health. The Austin worked well because we have a large number of trainees who already did week-on, week-off arrangements, for example night shifts and subspecialty rotation. We thought that if we can make it work at a subspecialty tertiary hospital then it can work anywhere."

With such a supportive supervisor, trainees at the Austin/Northern Training Hub have found the application process straightforward.

"Murali (A/Prof Muralidharan) has been very supportive of any trainee wishing to undertake the flexible training," Dr Kevric said. "The process was very easy; Murali wrote a support letter to General Surgeons Australia... the flexible training was approved and I was allocated to my preferred training rotation. This arrangement was encouraged and recommended to me by the previous candidates who stated that their social lives improved drastically whilst still being able to achieve training requirements and a balanced lifestyle."

Dr Kunz also acknowledged the important role that a supportive supervisor plays. "Given our supervisor's keen interest in flexible training and research into the area, we feel well supported to ask for and achieve it," Dr Kunz said.

## The negative impact of inflexible training options

A lack of flexible training has negative impacts on doctors and hospitals, according to Dr Kevric. "It leaves doctors who are looking for flexibility in the workforce without a choice. It also forces the doctors to choose between work and other life or personal factors, which can negatively impact their wellbeing and work performance. There is also a significant financial impact if a doctor has to cease work because of a lack of flexible workplace arrangements."

## Barriers to flexible training

Efforts to introduce flexible training need to consider barriers at the individual, hospital, college, specialty society and supervisor levels. Dr Kevric believes these barriers will reduce over time, particularly as trainees gain access to information about available options. "The main barriers are access to the information and lack of awareness of the positions and availability," she said. "Also, training supervisors are required to write a support letter and unless they understand the value of flexible training, flexible training will probably not be as encouraged. I think with time this will improve and I hope talking about it now will open doors to other trainees wishing and needing to pursue this pathway."

## Cultural shifts are underway

Dr Kevric acknowledges that cultural shifts are increasing the demand for flexible work, noting a positive change in attitudes from interns through to consultants in recent years. "I think it is much more accepted to want to be a well, rested doctor than it has been in the past," she said. "I was pleasantly surprised how interns' attitudes towards flexible training has changed over the years. Consultants have also jumped on board with the concept and this practice of job sharing has now almost been normalised at Austin Health among the general surgery departments."

A/Prof Muralidharan agrees. "Every program has critics. I would say that we have shown it to work. The benefit for the unit is that it will have two accredited trainees for an entire year. The hospital is financially better off due to reduced overtime and there is always an extra trainee who can potentially cover sick leave on their weeks off if they choose to do so."

## An employer of choice

Offering flexible working arrangements is making the Austin/Northern Training Hub an employer of choice, as trainees seek alternatives to the traditional 'full-time only' training model. "If I were in the situation of picking my training network again, access to


*Surgical registrars Dr Stephen Kunz (left) and Dr Jasmina Kevric pictured with A/Prof Vijayaragavan Muralidharan at the annual Austin Surgical Trainees Education Committee's Gratias Cena dinner. The event is organised by trainees to thank their mentors.*

part-time choices would certainly be an important factor," Dr Kunz said.

Research demonstrates that doctor fatigue compromises patient care and that fatigue hampers learning. This, coupled with a desire to improve trainee wellbeing and work-life balance led the AMA to develop a National Code of Practice for hours of work, shift work and rostering for hospital doctors in 2005. In line with this, Dr Kunz believes that the Austin/Northern Training Hub's flexible working initiative may improve both doctor health and patient care. "It's a positive initiative and acknowledges that the next generation of doctors require flexible solutions to maintain the best care for themselves and their patients."

Dr Kevric concurs. "The hospital that offers flexible training has really thought about the wellbeing of their staff. If circumstances arise which preclude doctors from continuing full-time work, the option of flexible working will still allow for clinical practise and maintenance of skills whilst pursuing other interests – rather than quitting."

## Part-time stand-alone or job share?

While there are pros and cons when comparing the job share model of flexible training to that of the part-time stand-alone option, the Austin/Northern Training Hub favours the job share model. "The general feedback from interns and residents is that they wanted a flexible way to train," A/Prof Muralidharan explained. "The stand-alone part-time option for some seemed not to work because they were not able to leave on time for commitments, such as childcare. The week-on, week-off options worked better for those reasons."

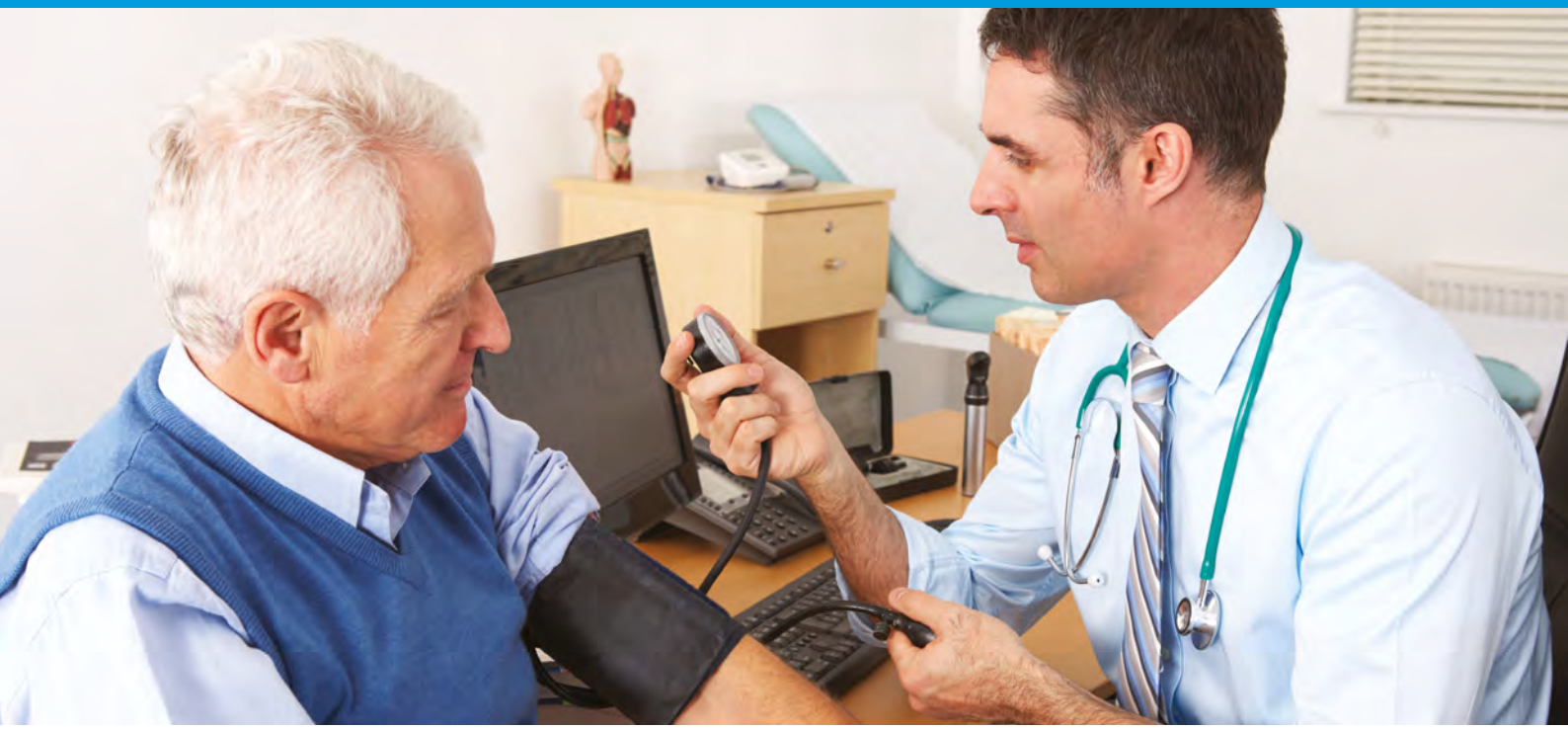
## Looking towards the future

AMA Victoria applauds the Austin/Northern Training Hub's move to offer flexible working arrangements and the work of A/Prof Muralidharan in setting-up and supporting surgical trainees. We look forward to a future when it is the norm for doctors to have access to flexible working arrangements – whether that is full-time flexible, part-time job share or part-time stand-alone – from internship through to retirement.

If you are having difficulty accessing part-time or flexible working or training arrangements, please contact the AMA Victoria Workplace Relations team on (03) 9280 8722 to discuss your concerns, your rights and your options.

**Dr Jill Tomlinson**
Plastic surgeon
AMA Victoria Board Member

# It's time for the fourth wave of general practice



**GPs are uniquely well-placed to help treat an Australian health system beset by rising costs, soaring rates of chronic disease, an aging population, rising inequity and access problems. GPs are the first point of contact for the vast majority of interactions with the health system; and demand is only growing.**

GP visits were up 18 per cent in the 10 years to 2017, while in 2017-2018 some 88 per cent of Australians – 9 in 10 of us – visited a GP, with the average Australian going to their GP seven times per year.

Within their general practice team, GPs treat and manage more than 90 percent of all the problems with which patients present. The decisions we make and the type of care we provide are fundamental to achieving the best outcomes for both the patient and the system.

However, at the risk of stating the obvious, as GPs we can't, by ourselves, manage every problem of every patient. With increasing complexity and chronicity of problems and therapeutic interventions, we require other practitioners and systems to work with us collaboratively around a patient, carer and family to achieve the best health outcomes.

To take one of many examples, a key priority in Australian healthcare right now is reducing avoidable hospital admissions. The Australian Institute of Health and Welfare found that in 2016-17 there were more than 700,000 preventable hospitalisations – in other words, around six per cent of admissions could have been avoided by, "Timely and appropriate provision of primary or community-based healthcare".

Each of these preventable hospitalisations represents a significant cost. There is not just the expense of inpatient treatment, which is many times higher than community care, but the days and hours of lost productivity, the strain on hospital capacity and the unnecessarily prolonged pain and suffering for the patient themselves and their family. Better primary care, whether that is improved management of chronic conditions or timely treatment of acute illness, would be an enormous benefit for us all.

So what do we need to do to make it happen? Australian medical training is already first-class and our GPs do not want for ability, care or commitment. What they lack is the opportunity to do their jobs in the best way possible. To spend the time they need listening to their patients and reading between the lines, looking for and managing the underlying causes of their condition and getting to know them as people, not as a collection of diseases. Giving patients that opportunity calls for a rethink of how we structure, fund and support primary care. To do that, I believe it is time to embrace a model that I call the 'fourth wave of general practice'.

As I see it, the first wave was the traditional doctor, a generalist who

often worked in isolation treating a wide range of ailments that were usually acute. The second wave started in the 1970s, with the family medical program that led to general practice becoming a specialty in its own right, and this led to the third wave of larger practices and multidisciplinary teams. Now it is time to take this to the next level, with the fourth wave – the patient-centred medical home becoming the bedrock of the provision of healthcare.

The evidence-based medical home model puts the patient in a partnership with a nominated GP in the middle of a connected suite of services that expand and enhance what a GP alone can offer. Several Primary Health Networks (PHNs) are already helping practices that want to move in this direction, with initiatives such as supporting quality improvement and the use of actionable data, embedding non-dispensing pharmacists in clinics or the Strengthening Care for Children pilot conducted by the North Western Melbourne PHN. This project looked at the impact on child health and the ability to care for children in the community by general practice by providing GPs with dedicated and timely specialist support from Royal Children's Hospital paediatricians. Results showed a greater confidence in GPs in treating children, improved trust from families and a reduction in hospital outpatient and emergency referrals.

It is important to understand that moving to this 'fourth wave' is an urgent need and not an abstract one. At a time when the complex care needs of the community mean the need for GPs is greater than ever, and the demographics of the profession means we are facing an imminent wave of retirements, fewer and fewer medical students are opting to specialise in general practice. Since 2015, there has been a 20 per cent drop in students applying to study general practice and in 2019 there were 63 first-year GP training places left unfilled, despite multiple recruitment rounds.

The reasons for this range from the perceived lower status of general practice compared with other specialties to the very real gap in remuneration and conditions, which is only likely to grow under the current Medicare model. We need to be able to offer general practice registrars a more financially and professionally rewarding environment, where they are not forced to churn through patients, are supported to achieve outcomes and are properly compensated for the non-face-to-face time they invest in patient care. We need to be able to remove these negatives in order to showcase that general practice really is the most interesting, rewarding and valuable of all the specialities.

What we must do is preserve and build upon the historical privilege that GPs have enjoyed – the capacity to have a three-dimensional view of the person they are treating, to deliver all-important comprehensive, coordinated continuity of care. The cost of getting it wrong will be high, both to the budget bottom line and the health of all Australians.

**Dr Ines Rio**

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# Section of Psychiatry update

## The Royal Commission will continue to be a priority

It has been a very busy 2019 for the Section of Psychiatry, with a particular focus on the Royal Commission into Victoria's Mental Health System.

Addressing the Royal Commission has taken up the bulk of the committee's time this year. AMA Victoria established a taskforce to specifically deal with the response with representation from psychiatrists, general practitioners, emergency physicians and trainees, as well as members of the AMA executive.

Committee members also attended meetings held by external organisations responding to the commission, including attending Mental Health Victoria and regular RANZCP committee meetings. AMA doctors and policy staff also participated in almost all of the scheduled state-wide Royal Commission community consultation sessions and the Section of General Practice also held meetings to discuss the Royal Commission.

In July, AMA Victoria provided a substantial formal submission to the Royal Commission (a copy can be downloaded from AMA Victoria's website). We received a range of contributions from the broader membership addressing mental health challenges from the perspective of various subspecialties and craft groups.

After the formal hearings concluded, the AMA was invited to round table meetings with the Royal Commission on matters of workforce and priorities for the sector.

AMA Victoria also requested and recently had a very constructive additional meeting with Royal Commission CEO Ms Jodie Geissler and Commissioner A/Prof Alex Cockram. We explored a range of important themes, including supporting the development of the psychiatric workforce, medical staffing challenges at all levels, system architecture, the importance of community-based care and supporting general practitioners in their work, as well as approaches to managing the newly coined 'missing middle'.

We are pleased that the Interim Royal Commission Report, provided to the Victorian Government in late November, contains several recommendations to be acted upon quickly, including 170 new acute inpatient beds and immediate plans to support and expand the mental health care workforce. The Productivity Commission has also just produced its Draft Report (available on the Commission's website – www.pc.gov.au) with responses due by 23 January 2020. The proposals suggested in this report are likely to impact on private psychiatry. I would encourage everyone to read the two reports and think how the respective themes may apply to their workplace.

At the start of this year, the Section of Psychiatry had a very successful meeting involving the broader section membership. Psychiatrists and registrars from various backgrounds raised a range of priorities and insights that helped to develop the AMA response and navigate potential challenges. We are hoping to undertake a similar event again in early 2020 to drive our approach through the next phase.

Finally, I would like to thank all those on the Section of Psychiatry committee, the AMA Victoria executive, taskforce, secretariat and those who have generously given their time and energy to contribute to the AMA response. It has been a year of constant discussions, meetings and emails and I wish everyone a safe and very well deserved break going into the festive season.

**Dr Ajit Selvendra**
Chair
AMAV Section of Psychiatry
AMA Taskforce on the Royal Commission into Victoria's Mental Health System

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# Member profile: Seeking a better mental health system

Dr Vinay Lakra has been an AMA member for over a decade, after beginning his medical journey in India. He has been a valued contributor to the AMA Victoria Council and Section of Psychiatry. Dr Lakra sat down with Vicdoc Editor Barry Levinson to chat about his medical career as a psychiatrist, transition into leadership roles and his hopes for the Royal Commission.

## Why did you want to study medicine?

Medicine was a career that was almost chosen for me. Quite a few members on the maternal side of my family are doctors. One of my uncles is a physician and growing up I always looked up to him. I saw the work he was doing and how he contributed to society. There was also a lot of respect for the profession and that drove me towards choosing medicine as a career.

## Why did you choose to specialise in psychiatry?

I always found it interesting to hear people's stories. And I think psychiatry is one field which pays attention to the person, not just the illness. We're looking at the person behind the illness and they come with their story. That was interesting for me.

## What brought you to Australia?

Quite a few of my colleagues came to Australia and I thought it'd be good to look at how psychiatry is practised in a different system. Initially, I wanted to finish my training and go into private practice in my hometown. But then I thought of the opportunity and I thought I'll go and work in Australia for one year and that was 15 years ago and I'm still here!

## What was it that made you want to stay here?

I liked quite a few different things. I liked the flexibility of what you could do in terms of professional opportunities. Once I finished my college exams I got an opportunity to be in a leadership position as a deputy clinical director, due to a colleague going on long service leave. I liked working on a slightly different level, having a chance to look at systems and influence more than just the patient in front of me. That opportunity then led to subsequent opportunities and here I am, having been the clinical director of the service, worked for the Victorian health department as the Deputy Chief Psychiatrist for three years, being on the board of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and now the President-elect of the college. I'm also on the AMA Victoria Council and have been a member of the Section of Psychiatry. So all in all it has been a very rewarding journey that has contributed to me staying longer than a year, as intended initially.

## You are currently serving a two-year term

## as President-elect of RANZCP, becoming President in 2021. What does this involve?

The lead-in period of a couple of years is important; working with someone who's already in the position and trying to understand how the system works and how we can be more effective. It does two things; firstly, it allows you to learn things about how you can upskill yourself in some ways and secondly, it also gives you time to prepare for when you will be in more of the spotlight. I am looking forward to the next two years as President-elect and then being in the President's role. The model is very useful, in my view, for us to be more effective and allows us to be more sustainable in our efforts.

## What motivates you to go from treating individual patients to wanting to have a bigger influence beyond your own patients? Does it start with frustration over the system?

It never really started with frustration, fortunately. For me, it has always been about opportunities. Sometimes I have looked for opportunities and something has come my way and sometimes opportunities have come my way while I was not even looking for them. Many times opportunity comes from understanding a system which is not working well and a drive to improve things. That's why I wanted to be more involved with the RANZCP. After I became an AMA member, I saw that I could have a better influence being on the Section of Psychiatry, because the section influences state-level policy.

I've always looked at doing different things every few years to expand my expertise, to expand my thinking and to bring diversity into the way I do my work. I sincerely think that diversity of thinking is what will help us address the challenges we are facing. If we just keep doing the same thing, we are not going to get a different outcome. So if you want a different outcome, we need to do things differently. If we want to do things differently, we need to have experiences in a range of things. This process has enriched me over the years to be able to better contribute at this level.

## Do you feel like contributing to influencing the system makes you a better doctor to your patients?

Absolutely, I think it allows you to think about not just what is in front of you, but what is likely to happen in future and what has been happening elsewhere. It certainly gives you that perspective. Being at the systems level, you cannot get that perspective unless you've been at the coalface with a patient in front of you and knowing what the problems and challenges are. One of the things I'm very mindful about in my roles, is how I stay connected with what happens at a clinical level. There's a real risk that we get disconnected from what's happening on the ground. It's important to stay connected.

## While doctors generally are required to be good communicators and show empathy for their patients, I imagine psychiatrists must need to go to an extra level.

Absolutely. We all have different strengths and come with a different perspective, but there are skills which are learnt during the training program. That helps us understand those issues better and provide the necessary care and treatment to the patient. These skill sets are developed over a long period of time, including interviewing skills, how you are empathic towards the individual, the ability to asses who else you need to seek information from... this is part of the training program.

## Everyone agrees the mental health system is broken. How realistic do you think it will be for meaningful change to be implemented quickly?

From the day that the Royal Commission into Victoria's Mental Health System (RC) was first announced, I have been cautiously optimistic. I think that word 'cautiously' is very important because if there were quick solutions, they would have already been implemented. For a long time things have slowly gone downhill, including a lack of investment. There are certain things which can be achieved quickly but there are also things which will take a longer time to materialise. I've been fortunate enough to be part of quite a few submissions, including the submissions from AMA Victoria, the RANZCP and other groups of colleagues and we've made quite a few recommendations, with a mix of things which can be done rather quickly and others which can be done over a longer period of time. I think there is a lot of optimism around the RC but time is ticking.

I attended an event recently, where someone talked about how mental health needs to be approached from a campaign point of view, if we really want to make a difference. It's not about short wins, or necessarily about episodic things, it's about a sustained long-term campaign. The RC gives us that opportunity to look at mental health from a campaign perspective. For example, it could be treated similarly to the campaign to reduce rates of smoking. This resonated with me.

With campaigns, multiple stakeholders are involved; they are not necessarily driven by one group of people. So if you look at the anti-smoking campaign, a lot of things contributed to that downward trend in smoking rates – the role of health professionals and healthcare organisations, cessation of funding from cigarette

***Continued on page 22***

companies for sport organisations, government policy, the banning of smoking in workplaces and plain packaging. All of these individually might not have made a huge difference, but collectively, they made a significant impact in terms of the culture shift with smoking; but these could only be successful as long as the focus remained on health benefits due to smoking cessation. A far-reaching campaign can do this.

It is really important for us to be able to have sustained investment and have a vision and a strategy which is monitored over a period of time. So I'm assuming, and I'm hoping, that the RC will come out with some of those things to help us.

## It must be a frustrating, or challenging, aspect of healthcare that there's never going to be enough money for everything. How do you see it?

Having a lot of money is not necessarily the only answer, although it is helpful to have well-funded services. A lot of things we do in terms of clinical service provision can be done better, but it is very difficult and challenging to continue to provide service in a system which has lacked sustained investment over a long period of time. Even if we were provided the funding immediately, we might not be able to achieve the change we want given lack of skilled workforce. Most of such things take time and that is why a good strategy is important.

Besides lack of investment, the problem also includes stigma, models of care, the support systems and infrastructure, and how we address issues for those who have a chronic and recurring illness. How do we ensure that issues like housing support systems are addressed? They are all things which require a whole of system approach.

## Have you thought about what a mental health campaign would look like?

There are a few elements. First it's about increasing awareness. We want people to have better awareness of mental illnesses, so that they can seek treatment at an early stage of the illness. If you are not aware, you cannot seek treatment and delayed treatment means poor recovery. Second, we need to address the issue of stigma, which permeates all aspects of mental illnesses - delay in access to treatment, discrimination faced by our patients and colleagues, difficulties in attracting a suitable workforce to name a few.

The third element of the campaign is providing good evidence-based strategies, both for prevention as well as treatment. That requires not only good clinical service provision, but also funding for research so that there are more effective treatments. We wouldn't have made such progress in terms of cancer treatment or HIV-AIDS by increasing awareness and reducing stigma alone, if there wasn't also the development of new and effective treatments. Having evidence-based effective treatment and prevention strategies is very important. So investment into awareness, reducing stigma and evidence-based strategies are the three things which need to be part of a campaign.

All of us have a role to play. We've talked about rates of mental illness in society. None of us would be untouched by it. There will always be somebody in our family, workplace or in our social circles who will be touched by a mental illness which requires treatment and support. Professional organisations like the AMA and RANZCP have a role because of the expertise they have within their memberships. We need to work with other organisations including people with lived experience to take it forward. The RC could be a starting point for this campaign.

*This interview was conducted prior to the release of the Royal Commission into Victoria's Mental Health System Interim Report.*

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# Australia's overdose toll

**Australians are experiencing greater harms from drugs. That's the main conclusion of *Australia's Annual Overdose Report 2019*, published by Penington Institute in August.**

In 2017, the year covered by the report, 2,162 Australians died of an overdose, with 1,612 of those deaths unintentional..

The overdose crisis is affecting Australians of all ages, from all economic classes and in our rural and regional towns, as well as our major cities.

More than half of those deaths – 904, to be exact – involved opioids. Fifty-three per cent of those 904 opioid-induced deaths involved the pharmaceutical opioids that virtually every GP in Australia would have prescribed to a patient. By way of comparison, 358 unintentional overdose deaths involved heroin.

Looking past the headlines, the *Annual Overdose Report 2019* also reveals that overdose risks in Australia are changing. Our report showed that, for the first time on record, there were more unintentional drug-induced deaths involving four or more substances (which could include alcohol) than death where only a single drug was detected (445 compared to 411).

Consider someone suffering from significant pain, which has been unresponsive to non-medical treatments. They may well be prescribed opioids to alleviate their pain. That patient might also be prescribed a benzodiazepine drug to help them sleep. Or something to mitigate the symptoms of a prior mental health condition or an anti-depressant to assist with the effects of chronic pain.

Then imagine what might happen if a person with two or more of these pharmaceutical drugs also consumes an illicit drug – or happens to drink some alcohol, as they try to relax or sleep. They're at significantly greater risk of a fatal overdose than the average Australian. And, as the *Annual Overdose Report 2019* shows, this isn't just a hypothetical.

Of immediate concern is the dangerous combination of opioids and benzodiazepine drugs, which was detected in 497 unintentional overdose deaths in 2017. In the United States, the Centres for Disease Control and Prevention (CDC) has recommended that clinicians not prescribe opioids concurrently with benzos where possible. Concomitant prescribing does occur in Australia, although studies have found that its prevalence has declined since 2012.

Overall, unintentional deaths involving benzodiazepines are continuing to increase, with 583 deaths in 2017 – more than any group except opioids. However, it's not only benzos we should be concerned about.

Since 2013, there's been a big rise in unintentional deaths involving opioids and other pharmaceuticals including anti-psychotics and anticonvulsants such as pregabalin. Unintentional deaths involving antipsychotics increased from 15 to 192 between 2013 and 2017, while unintentional deaths involving anticonvulsants increased from fewer than five in 2014 to 67 in 2017.

We've also seen a stark rise in deaths involving stimulants including methamphetamine. Unintentional deaths involving stimulants have increased from 156 in 2013 to 417 in 2017.

The *Annual Overdose Report* shows that we are making some progress in stemming the sustained increase in unintentional overdose deaths, particularly in relation to pharmaceutical opioids. But the trend is still pointing in the wrong direction – and only thinking about this issue in terms of curbing supply or reducing demand is inadequate.

Curbing supply is not without risks. Discontinuing chronic opioid therapy in pain patients was recently shown to have increased, not decreased, their risks of overdose mortality. A recent article published in the *International Journal of Drug Policy* found, "A consistent, positive association between state PDMP (prescription drug monitoring program) adoption and heroin poisoning mortality." There is also evidence to suggest that reducing supply of pharmaceutical opioids can result in increased harms from illicit opioids such as heroin.

Efforts to reduce demand won't succeed without sustained efforts to educate the Australian public. We need interventions that focus on the context in which overdose deaths occur and on improving and integrating pain management services. This could include improving access to naloxone in primary care, for all patients prescribed opioids – a strategy that has been found effective internationally. It could also include population-level interventions, such as overdose recognition and first aid.

For our part, Penington Institute recently launched Life Savers – www.lifesavers.global – a resource on opioids and opioid dependence for medical practitioners to share with patients. This website aims to educate and empower people who use opioids while providing a brief guide to treatment for people concerned about their usage of opioid drugs, or their family members and friends.

As new drugs become available, and Australians use them in different ways, we must continue to treat the conditions that afflict thousands of patients, while understanding and reducing the risks. As Australia's *Annual Overdose Report 2019* makes clear, we face many challenges – but, with the right effort, they can be met.

**John Ryan**
Chief Executive Officer
Penington Institute

*References available from the Editor on request.*

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# SafeScript reducing overdose risk in Victoria

Six months after state-wide implementation, SafeScript is already making a difference and proving its worth in clinical practice. Over 15,000 doctors and pharmacists are now registered for SafeScript, with more than 1,600 clinicians using the system each day. Early data shows the program is helping doctors make safer decisions when prescribing high-risk medicines including opioids and benzodiazepines.

Overall, there has been a 25 per cent reduction in the proportion of patients taking high-risk doses of opioids (over 100mg MED) during the past six months in Victoria and a 12 per cent reduction in the number of alerts the system generates for particular high-risk circumstances. The data shows that while patients are still receiving opioids as part of their pain management plans (i.e. there has not been a significant decrease in the number of prescriptions), many are now being prescribed safer doses that will reduce their risk of overdose. There is evidence that patients who are prescribed doses of opioids over 100mg MED may have an 11-fold greater risk of opioid overdose death compared with those prescribed lower doses.

From July to September 2019, just over 1 in 10 Victorians received a high-risk SafeScript monitored medicine in Victoria. Of these patients, 5.8 per cent had a clinical alert appear in their SafeScript history to signal to clinicians that the dose or combination of medicines prescribed could be placing the patient at risk and should be reviewed.

It will be mandatory for Victorian doctors to check SafeScript before prescribing a monitored medicine from April 2020. With over 40 per cent of clinicians (including over 56 per cent of GPs) already registered and using the system, these early results are extremely encouraging.

It is crucial doctors continue to ensure that appropriate ongoing care is provided for patients when a clinical risk alert appears in SafeScript. Services available to support doctors in Victoria in the safer management of patients taking high-risk medicines include the SafeScript GP Clinical Advisory Service, a peer-to-peer service helping GPs to support patients with prescription medicine concerns and complex needs (1800 812 804). (You can read more about this service on page 28 of this Vicdoc.) Secondary consultation services are also available through Reconnexion (1300 273 266), specialising in anxiety disorders, depression and benzodiazepine dependency. (You can read more about this service on page 30.)

SafeScript training is available, covering best practice prescribing of high-risk medicines and how to respond to the needs of patients who may be at risk of harm due to prescription medicine dependency. Visit www.vtphna.org.au/safescript-training-hub for more information.

A four-part podcast series has been created for SafeScript featuring clinicians and patients with lived experience of prescription medicine dependency discussing the clinical risks associated with long-term opioid and benzodiazepine use. The series includes interviews with AMA Victoria President, A/Prof Julian Rait, as well as Victorian GPs, Dr Ferghal Armstrong and Dr Nick Carr. Visit www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript/safescript-podcasts to listen.

If you need any assistance setting up SafeScript in your practice you can call the SafeScript technical support line on 1800 723 379 or visit www.safescript.vic.gov.au.

SAFE SCRIPT

*References available from the Editor on request.*


Overseas model shown.

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# SafeScript and the GP Clinical Advisory Service

In 2017, drug overdose deaths in Victoria involving pharmaceutical medicines (414) exceeded the number of overdose deaths involving illicit drugs (271) and, tragically, were also higher than the road toll (258). These deaths typically involve a combination of drug classes, most commonly opioids and benzodiazepines, however until recently, there has been limited visibility of a patient's prescription history across different medical clinics and pharmacies.

A key Victorian Government response to the growing rates of prescription-related harms is the introduction of the real-time prescription monitoring program, SafeScript, a clinical tool that will help doctors and pharmacists to make safer decisions about the prescribing or dispensing of high-risk medicines. In this article, we discuss common questions related to SafeScript and highlight the support options available, including a state-wide GP Clinical Advisory Service.

## What is SafeScript?

SafeScript is computer software that records in real-time the prescribing or dispensing of certain medicines and stores the record in a centralised database which can then be accessed by doctors and pharmacists during a consultation. Most practice-based prescribing software will automatically send records of scripts to an exchange service and therefore to this database.

SafeScript implementation commenced across Victoria in April 2019, and from April 2020 it will be mandatory to check SafeScript prior to writing or dispensing a prescription for medicines monitored through the system.

## What medicines will be monitored by the system?

The system will monitor prescription medicines that are causing the greatest harm to the Victorian community. Currently this will include all Schedule 8 medicines (opiates, benzodiazepines, Z-drugs and stimulants), as well as the anti-psychotic medication quetiapine.

SafeScript monitors all prescriptions for these medicines regardless of whether they receive a PBS subsidy or are private, non-PBS prescriptions. Other medications may be added in the future.

## Why is SafeScript necessary?

The introduction of SafeScript is a response to the increased harms and significant number of deaths related to prescription medications over recent years. It will be most useful in identifying those patients who may have been accessing more than one prescriber or pharmacy to obtain extra medication.

## How do I connect to SafeScript?

There is a registration process available on the SafeScript website. Once registered, the database can be accessed each day by a relatively simple login process. From there it is possible to look up relevant patient files manually. Alternatively, you can activate the connection between SafeScript and your prescribing software and the SafeScript file can be accessed from within your patient record.

## What happens when I prescribe?

When a doctor prescribes the medications listed earlier using prescribing software, either for the first time or as a continuing script, SafeScript will check the database to see if there are issues of concern. If the doctor has activated the connection between the prescribing software and SafeScript, the system will then send a message in a 'traffic light format':

1. Green - there are no issues of concern detected.

2. Amber/red - When use of SafeScript becomes mandatory, prescribers/pharmacists will be required to click on the notification to review the patient history to assess whether it is safe or appropriate to prescribe/dispense a medicine.

Once in the SafeScript file, the doctor will then be able to see the previous prescriptions written, and usually by whom, and when the medication has been dispensed by pharmacies.

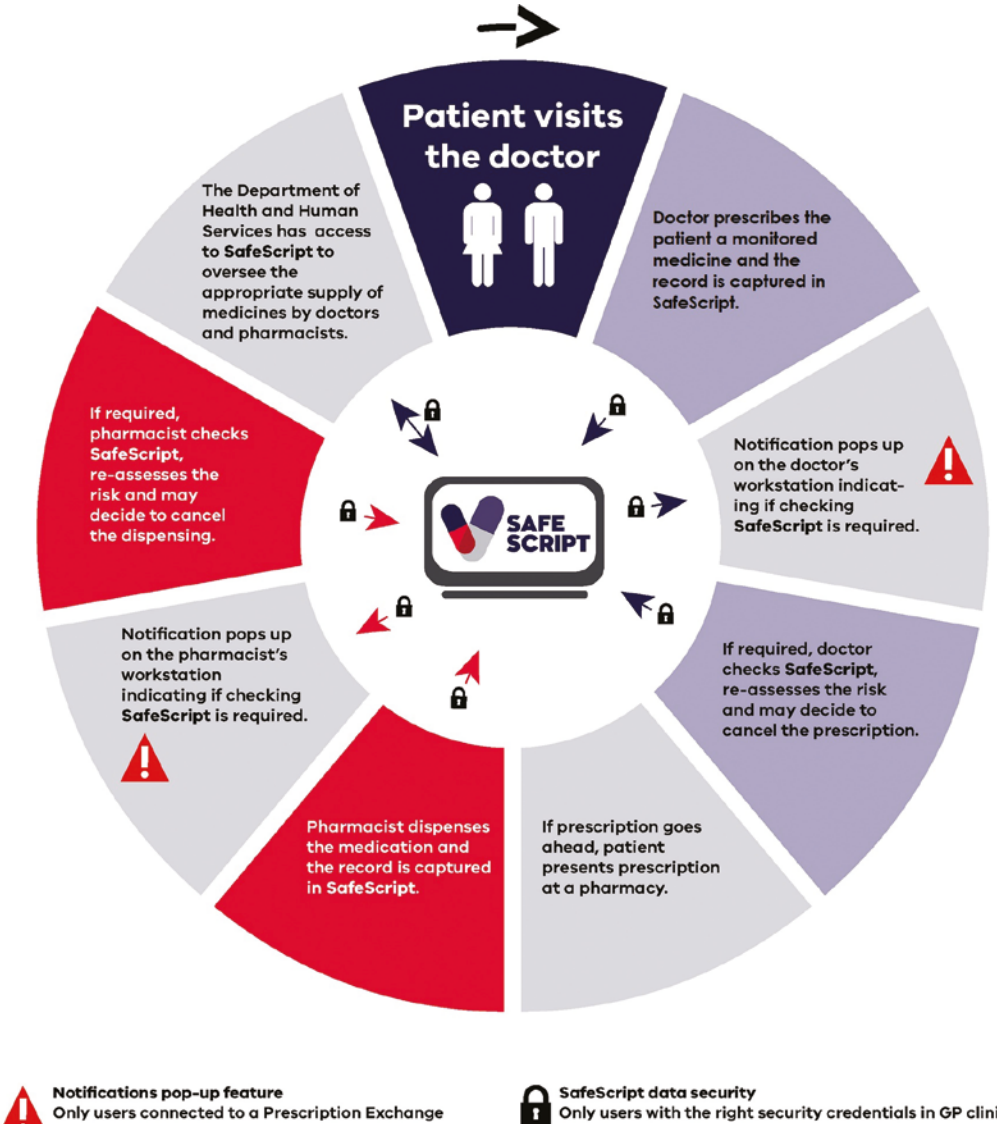
## Can I prescribe if there is an alert?

An alert does not mean that you are not allowed to prescribe or dispense a medicine, but it indicates that some clinical risk has been identified which you need to review and manage appropriately. SafeScript does not instruct you on what to do or decide whether a medicine should or should not be prescribed to your patient. It remains your clinical decision whether the medicines prescribed continue to be the safest and best option for your patient's medical needs.

There will be occasions where doctors are surprised to find a patient has been seeing other practitioners. It is important on these occasions to respond in the patient's best interests rather than feeling offended and automatically refusing to treat. There are many potential reasons and explanations for these situations. It is also possible that your patient has inadvertently developed a dependence on a certain medication. Remember that it is possible for anyone to become dependent on prescription medications and that no-one obtains medications with the intent of becoming dependent.

An unexpected alert creates an opportunity to discuss with your patient what has been happening in their lives, to review or develop a pain management plan, to refer for specialist support in relation to pain, insomnia, anxiety or addiction management. It may be necessary to contact the other doctors who have been prescribing to coordinate care. Contacting the pharmacy to discuss more controlled dispensing regimes might also help to manage the situation.

If you feel uncomfortable managing this situation without additional support, you can call the GP Clinical Advisory Service (GPCAS) on 1800




812 804. This is a service that has been set up specifically to assist doctors in dealing with issues related to SafeScript. GPCAS will connect you with a trained GP who can offer suggestions on management, guide you to further services and even provide some mentoring regarding management of ongoing prescribing and medication-assisted treatment of opiate dependence.

## What can I say to the patient when there is an unexpected alert?

The most important thing is to remain non-judgemental. Point out that there is now a system which requires us to review what medicines have been prescribed or dispensed and that the system shows that a prescription for a particular medication was collected from a pharmacy on the specified date. Give patients an opportunity to explain the situation. There may be a valid reason, such as there being no appointments available at your clinic or that the patient was travelling at the time. Patients may at this time express to you that they have indeed been struggling and not wanted to upset you by asking for more medication. Explaining that it is good to have things in the open, that support is available, and you would like to be given an opportunity to help them will be important for patients to hear.

## What if I don't want to continue prescribing?

There may be a situation where you are not comfortable continuing to prescribe. It is important in this circumstance to remember that good clinical practice involves ensuring that appropriate continuity of care is provided for your patient. Abruptly discharging the patient from your care or abruptly stopping treatment in patients who have been taking high-risk medicines over a long period of time may be contrary to patient safety. This is another opportunity to contact GPCAS for advice about the best way to proceed. An option at this time could be to write a limited prescription to pick-up from a nominated pharmacy for a day or two until other supports can be arranged.

## Where can I learn more?

There is excellent and comprehensive training provided as part of the SafeScript implementation and it is available at www2.health.vic.gov.au/safescript

To access support from the GP Clinical Advisory Service (GPCAS) call 1800 812 804


**Dr Paul MacCartney**

GP Clinical Advisor

**Prof Dan I Lubman**

Turning Point

Monash University

# Why doctors must think again before prescribing benzodiazepines

**The introduction of prescription monitoring program, SafeScript, into Victoria has focused attention on the prescribing of opioids and the psychotropic drugs, benzodiazepines (benzos) and their associated harms. Clinical guidelines state that benzos and Z-drugs (zolpidem and zopiclone) should only be prescribed on an intermittent basis, or for no longer than two to four weeks, in order to prevent development of tolerance and iatrogenic dependency.**

Despite recommended guidelines, there is a widely held view that benzos are inappropriately prescribed and dispensed and PBS and RPBS data reveal that 6.3 million prescriptions for benzodiazepines were dispensed in Australia in 2015, not including inpatient prescriptions or private prescription items.

Evidence of a broad range of harms associated with long-term benzo use now exists. These harms include cognitive deficits, reductions in quality of life, depression, risk for road accidents and, more specifically in older adults – increased risk of falls, developing dementia and mortality. Short-term, paradoxical effects such as increased anxiety, agitation, disinhibition and aggression have also been observed. Often both patients and prescribers are unaware of the dangers of taking benzos or Z-drugs long-term and fail to recognise their adverse effects and withdrawal symptoms, or the challenges of how to taper slowly and safely.

## Reasons some doctors keep prescribing benzos and find it difficult to have the conversation with patients

- Some GPs are not convinced of the harms of prolonged benzo use.
- Some GPs feel it may present a threat to the therapeutic relationship.
- Failure to recognise the symptoms of dependency or breakthrough withdrawal.
- Lack of confidence about how to withdraw patients safely and offer support.
- Lack of access to alternative treatment.
- Suggestions about reducing or stopping are met with strong rejection from the patient.

## Using the SafeScript notifications

SafeScript is designed for prescribers and dispensers to monitor a patient's high risk prescription medication history and provide notifications and alerts as to any potentially harmful drug combinations. It provides a decision-making tool which can signal a reminder to the prescriber that a conversation about use of benzos may be indicated. Given that guidelines for benzodiazepine prescriptions recommend no longer than four weeks use, all notifications, including 'green', should act as a trigger for doctors to initiate a conversation.

An 'amber' or 'red' notification may not necessarily indicate misuse. As the majority of patients receive their medications from a single prescriber, they are more likely to have developed iatrogenic dependence. There is no way of predicting who will become dependent but studies indicate that 50-80 per cent of people using benzodiazepines continuously for 6-12 months will become dependent.

When a SafeScript notification appears, it is important that prescribers don't abruptly stop treatment in patients who have been taking benzos over a long period as it is contrary to patient safety. Patients need to be informed about how benzos work on the brain, how tolerance develops and that taking benzos is no longer effective and may in fact be causing further harm or exacerbation of the original condition. The conversation about how to safely withdraw from benzos needs to inform the patient that it is a slow, tapered process which needs to be carefully monitored and that they are likely to experience a range of withdrawal symptoms.

## Managing a reduction

Support is available for patients, doctors and health workers through Reconnexion, a service of EACH, a state-wide program funded by the DHHS. Reconnexion provides a range of services including face-to-face and phone counselling treatment, information and withdrawal support for patients and secondary consultations for prescribers who seek advice to support a patient through a taper.

Whenever possible, the patient should be transitioned to a long acting benzodiazepine, typically diazepam and then stabilised. Varying reduction schedules exist as to how quickly a

taper should be managed but, based on the Ashton Manual (2002) and informed by many years of experience, Reconnexion recommends a reduction of 10 per cent of the total dose every two to three weeks as the most effective for long-term success and in preventing relapse.

The patient needs to be closely monitored for a range of physical and psychological withdrawal symptoms. These can be quite severe and may vary each time a reduction occurs. Most patients find it very helpful to have these symptoms acknowledged. To assist medical practitioners with their management of the taper, patients can call the Reconnexion Telephone Support Line 1300 273 266 (during business hours) for ongoing support during withdrawal. The patient needs to be stabilised before commencing each subsequent reduction and ideally they should be developing alternative strategies for managing their anxiety or insomnia.

It is well documented that psychological treatments such as cognitive behaviour therapy (CBT) for anxiety and CBT-I for insomnia have much more effective long-term therapeutic outcomes than medications, so non-drug interventions such as referral to psychological counselling is an alternative treatment pathway, including for older patients. The Reconnexion website www.reconnexion.org.au contains information for patients on reducing from benzos and Z-drugs, including some e-modules developed by Federation University with alternative management strategies.

## Summary

- Use SafeScript as a tool to start the benzo conversation – including the 'green' notification.
- Keep revisiting the 'deprescribing' conversation.
- Don't abruptly stop prescribing.
- Stabilise the patient's dose and transition to a long acting benzodiazepine such as diazepam.
- Taper slowly – 10 per cent of the total dose every two to three weeks – and monitor progress.
- Believe your patient when they describe withdrawal symptoms and validate their journey. It is often a 'rocky road' but reassure them support is available.

The introduction of SafeScript prescription monitoring in Victoria provides an opportunity for GPs to address the issue of long-term benzodiazepine prescribing as it can be a catalyst for having the conversation with all patients about their use of benzos. Raising the issue of benzodiazepine dependence can be confronting for some patients and challenging for doctors but support is available.

## Resources for you and your patients

**Reconnexion** www.reconnexion.org.au

**Reconnexion Telephone Support Line**
1300 273 266 / (03) 9809 8200

**SafeScript Victoria**
www2.health.vic.gov.au/public-health/drugs-and-poisons/SafeScript/health-professionals

**SafeScript GP Clinical Advisory Service (GPCAS)**www.dacas.org.au / 1800 812 804

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*References available from the Editor on request.*

# Is clinical medicine for you?

We established the Medical Careers Service at AMA Victoria seven years ago due to increased demand by our members for a safe, non-judgemental and objective space to discuss their careers. Since then we have supported hundreds of doctors in the role of advisor and coach to develop and manage their medical careers. Over this time there is not much we haven't heard about the highs and lows of a career in medicine. Questioning a career in clinical medicine comes up often; reasons for this are many and varied. A few we hear often include:

- Issues of fit for chosen pathway and role.
- Imposter syndrome and non-identification with peers and superiors.
- Burnout and the challenge of inflexible work and training models.
- Inability to progress career and achieve professional goals.
- Incongruence between personal and professional demands.
- Boredom and a desire to diversify (re-energise) career.
- A keenness to transition away from medicine – what else is out there?

## What support is available to explore non-clinical/ alternate pathways?

This final theme of 'transition' away from clinical medicine to non-clinical or alternate pathways is an area we have experienced considerable growth in over recent years. There is a misconception within the profession that these doctors are either 'not cut out for clinical medicine' or that they are 'under-performing' as clinicians. However, it is important to understand that in the majority of cases this is untrue and it's the doctor's decision to leave medicine or diversify their career. They do this on their own terms; it is their choice.

Despite this, there is often a negative stigma attached to such a decision and whether this is real or perceived is irrelevant. The sense of shame, betrayal, distress and embarrassment these doctors often bring into the coaching session is considerable and very real. However, there is also a great sense of relief in having made this declaration – sometimes it is the first time they have admitted publicly to anyone, even themselves, that the career trajectory that they are on is incongruent with their needs and wants.

## Why the shift away from clinical medicine?

Our insights on why doctors are exploring pathways outside of clinical medicine come from our interactions with hundreds of doctors, as well as through our extensive engagement with the profession, our members, wellbeing forums and partners. Some of the reasons doctors give for wanting to leave clinical medicine include:

- The realisation that a doctor's personal and professional strengths, interests and needs do not align with the pathway they have chosen. This often manifests in burnout, boredom and a lack of identification and engagement with the role and their peers.
- Rejection of the traditional career trajectory rewarded by the profession – i.e. specialisation.
- Issues of access to accredited training roles and constantly changing goal posts leaves doctors-in-training trapped in a professional bottleneck, unable to progress their career forward, even if they do what is asked. Many find this excruciating and opt to leave.
- The traditional structure of the profession does not support flexible work models and changing workforce dynamics. They are forced to choose what is most important, so they do.
- They don't think clinical medicine is a sustainable career pathway for them – in terms of work demands, structure and tasks of the role.
- The profession is deemed as demanding too much of them and they are not prepared to sacrifice their personal aspirations and family.
- Changing life goals and priorities.
- Bored – looking for a new challenge and to learn new skills.
- The health system and patients – too many demands, too many decisions, limited support and an inability to influence change.
- Other interests and passions they want time to pursue.
- Illness and changes in life circumstance.
- More flexibility, standard hours, weekends off.

## The steps to take if you believe clinical medicine is not for you

### Reflect on your professional role and understand yourself better

- We strongly advocate that doctors and medical students increase their awareness and understanding of their natural style, strengths and interests. We encourage them to take time to reflect on what insights these provide in taking up their medical role and assessing pathways. We believe in bringing a strengths-based approach to navigating your career. Move towards professional roles that interest you, come naturally to you and leverage your strengths.
- Doctors also need to understand what work environments, demands, culture and values align with their needs. By needs we mean the fundamental things a doctor requires from their work, the people around them and the work culture to thrive. Many doctors don't understand what these are, how they translate to a work role and how to educate others around them on what they need. If your needs are met, you have the opportunity to thrive and reach your potential.
- Become more aware of environments, rotations and areas of your work that you find interesting and enjoy and those

that don't. Reflect on why this is the case and what it means. Consider if you can move towards doing more of what you enjoy in your role.

- Be mindful of identifying peers and seniors who are like you, or you aspire to be like – this can provide insights as to how you might want to shape and adopt your approach in your role. It also might help you find pockets of clinical or non-clinical work where people 'like you' excel.
- Ask yourself whether your mix of work is right – sometimes it just needs to be realigned or tweaked.

### Don't do it on your own – connect and seek support

- Obtain a mentor and build your network with people you admire or aspire to be, to gain advice and support.
- Seek assistance in the form of professional career coaching to support you to think about and manage your career. AMA Victoria offers 'Professional career coaching programs' for doctors.
- Talk to your boss about broadening the scope of your role.
- Join professional interest groups (medical and non-medical) and engage with your professional association, AMA Victoria, to broaden your network and connections.
- Socialise with people outside of medicine.

### Build capability – gain experience

- Get involved in projects and programs that align with your interests and build capability.
- Upskill – obtain a new credential that builds new skills, engage in a short course.
- Further education – explore formal postgraduate education opportunities that align with your interests and build knowledge and networks.
- Say 'no' to things that no longer interest you and 'yes' to things that do.

In summary, we are not convinced that the shift away from clinical medicine is a new phenomenon. However, there is a movement within the profession to provide a voice for doctors who want to look beyond a clinical role, which has helped to normalise it and in fact to celebrate doctors experiencing success in other fields, besides medicine.

This is evidenced by the rapid growth in recent times of communities such as the Facebook group 'Creative Careers in Medicine' founded by GP and digital health leader, Dr Amandeep Hansra, who has worked tirelessly to raise awareness, support and networking opportunities for doctors exploring pathways out of medicine. We recommend joining these communities as well as engaging with our coaching team to better understand why you might want to leave clinical medicine and what this might look like.

AMA Victoria's Medical Career Service is designed to support doctors at all stages of their career. For more information, visit www.amavic.com.au/careers-advice or please contact us on (03) 9280 8722 or careersadvisor@amavic.com.au



**Mardi O'Keefe**
Manager, Medical Career Service

# 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 with their decision-making.

**Dr Greg Young**
**Forensic pathologist**
**Victorian Institute of Forensic Medicine**

## Why and how did you choose your specialty?

I actually fell into forensic pathology rather serendipitously. Through medical school, internship and residency years I was quite unsure about what I was actually interested in, and what would use my skills best. I was in the middle of an early career break and went travelling through Europe. When I was lying on a beach in Spain, I was contacted by a friend who was training in anatomical pathology. She suggested that I consider it as a career choice, so I applied for the anatomical pathology training scheme in Victoria and got a job as an anatomical pathology registrar. On my first day at work, I was introduced to coronial autopsies, which really piqued my interest. Through my training in anatomical pathology I became more and more interested in autopsy pathology, so I decided to make a change and finish my pathology training in forensic pathology. For someone who was so unsure about what they wanted to do, I think forensic pathology has provided me with the best opportunity to use a varied set of skills, engage with different people and use a broad array of knowledge to solve problems.

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

As a forensic pathologist, I think it is essential to have an inquisitive mind, to relish solving problems and be confident in your abilities. Forensic pathologists are diagnosticians and need to be able to turn their minds to many different possibilities. Some of what we see is not very nice, thus it is important to have resilience and know your limitations. The forensic pathologist is a generalist, so having had experience in a wide variety of other medical specialties is always useful. Most importantly, it is useful to be able to separate work from home life. Having interests outside of work is a fundamental way of being able to cope with what you may encounter at work.

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

As a forensic pathologist, I feel honoured knowing that I may be any given person's last doctor, providing their final medical examination. It makes me feel great knowing that I am helping to provide closure to grieving families, discover

information about people which may have not been known about in life, and facilitate the judicial and coronial processes to ensure we have a safer and fairer society.

However, on the flipside, I always find it a challenge knowing that the deceased person in front of me is someone's husband, wife, partner, son, daughter, mother, father, cousin or friend, etc. This is especially the case in some high profile cases, paediatric autopsies, or people who have suffered from a violent death. It is so important to accord the same respect to a person in death as you would if they were alive, and to remember that person was important to someone else.

## Describe your typical day as a forensic pathologist.

On any given day, you would probably find me in the mortuary performing a few autopsies. The first stage requires reviewing the police information about circumstances of death, medical notes from the deceased's GP or hospital, any extra information from the deceased's family, a post mortem full body CT scan of the deceased and any preliminary toxicology results. The second stage involves doing an external examination of the deceased then, with the help of a forensic technician, performing an internal examination of the deceased, with dissection of the internal organs. Later, I would review histology from the autopsy and complete an autopsy report for the Coroner with the results of all other ancillary tests including toxicology, biochemistry, microbiology and radiology. When I am not doing routine autopsy cases, I may be the on-call forensic pathologist for suspicious cases (including homicides); the duty forensic pathologist who reviews and triages all the reportable deaths that are coming through the system; giving evidence in court; or providing training, lectures, presentations or tutorials to students, other health professionals or police.

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

Forensic pathology is a relatively little known specialty. As such, many medical students and junior doctors are not aware of it as a career path. If someone is interested in it as their chosen specialty, it would be useful to enquire with their local forensic institute to see if they can discuss career options with a pathologist, or spend some time viewing autopsies. The Royal College of Pathologists of Australasia (RCPA) also has some great information on their website, and is happy to engage with people who have an interest in pathology.

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

# The other gender bias in medicine

**Although steadily shortening, the list of gender-based discriminations in the medical sphere is long. From gender pay gaps and unequal representation in leadership, to fewer women in surgical positions, we are no strangers to dealing with inequality in medicine. However, I would like to highlight a lesser known gender bias in medicine; a bias against female rats.**

Historically, the rats used in clinical trials were male. It was believed that hormones like oestrogen could distort how a rat would respond to experimental treatments and result in misleading and difficult to interpret findings. Females were considered more of a 'hassle,' plagued by the inconveniences of menses and pregnancy. In her paper published in *Science*, Associate Professor Rebecca Shansky chronicled a long history of researchers relying on male mice for pharmacological studies, citing a deep-seated misconception that women are more biologically complex than men.

Unfortunately, many female humans suffer the same fate as female mice in the research sphere. In its 2014 report, the Brigham and Women's Hospital in Boston highlighted the frequent exclusion of women from medical trials. "Once clinical trials begin, researchers frequently do not enrol adequate numbers of women or, when they do, fail to analyse or report data separately by sex. This hampers our ability to identify important differences that could benefit the health of all."

When women are not included in clinical trials, we cannot be sure that the advice we are giving to female patients regarding drug dosing, side effect profiles and efficacy, is entirely reliable. We are forced to make the assumption that women will have the exact same metabolic and biochemical response to treatments as their male counterparts. However, this is not always the case.

Males and females have important biological differences. We differ in size and weight, which means that dosing may need to be considered differently. Moreover, we experience illness differently with respect to age of onset, severity, symptom burden and prevalence, particularly in the case of autoimmune diseases such as lupus or psychological conditions such as anxiety and depression.

In paediatric medicine, we are careful to titrate doses and classes of medication to a child's height, weight and age. There is no assumption that a one-year-old, 10kg child will tolerate the same dose of medication as a 10-year-old, 25kg child. Paediatric doses are often carefully titrated to the individual characteristics of the patient, particularly when a drug has a low therapeutic index. However, for many adult drugs we do not know the specifications to determine the lowest effective dose. An elderly, 50kg woman and a fit, 80kg male may have the same recommended dose of a particular drug. Many doctors will lower a dose of particular medications for a small, female patient, however the exact dosing modification is often an estimation, influenced by clinical experience rather than the ability to access evidence-based guidelines.

Many of us will remember the case of the sleeping tablet zolpidem (Ambien). The pre-clinical and clinical trials recommended a specific treatment dose, based on the results from their trial populations. Once used in a real-world population, it was found that women had a lower apparent rate of clearance of the drug. The US Food and Drug Administration (FDA) has subsequently released a black box (strict labelling) warning for the drug and advised that women take 50 per cent of the dose recommended to men.

Of course, this bias is not always intended sinisterly, particularly when we consider the difficulty of conducting clinical trials in a pregnant population. Following the thalidomide tragedy in the 1950s, the US FDA recommended in 1977 that women with 'childbearing potential' should refrain from participating in phase 1 and early phase 2 clinical trials until toxicity studies are conducted. As an old lecturer of mine so eloquently put, "Sperm regenerates. An egg doesn't".

Naturally, many doctors are fearful of prescribing any new medication to a pregnant woman if the toxicity is not known. Yet, it is difficult to ascertain teratogenicity without trialling the drugs in pregnancy. As a result of this insoluble dilemma, our medical system often fails these pregnant patients.

During a recent few weeks spent working in the obstetric medicine department of a major London hospital, I witnessed all too poignantly what happens when specialists who are inexperienced in women's health are faced with a suddenly pregnant patient. In the birth suite, I met a young woman who waited an unnecessary six months between being diagnosed with cancer and the birth of her son, before starting life-saving chemotherapy. The emerging evidence now demonstrates that the drug is safe to use during pregnancy and poses no known risk to a fetus. She now has metastatic disease and a child suffering from complications relating to him being delivered six-weeks early so his mother could start chemotherapy.

Pregnancy is a catch-22. We don't want to test potentially toxic drugs on pregnant women, but we want to advise pregnant women on which drugs are potentially toxic. Yet this exception aside, there are very few justifiable reasons to exclude or minimise the percentage of women enrolled in clinical trials for drugs which are being marketed to women. We do not want the data pertaining to treatment metabolism, excretion, side effect profiles, safety and efficacy to be less applicable to women than to men.

I'd be remiss not to acknowledge the significant progress in this sphere and the increasing representation of women in clinical trials. The United States' National Institute of Health (NIH) Revitalisation Act of 1993 mandated that the appropriate inclusion of all minorities in any NIH funded research included the world's largest 'minority' group; women. In 2017, the FDA was able to announce that 43 per cent of their clinical trial participants were women. Yet as is the case with so many facets of medicine, despite heading in the right direction, we still have significant ground to cover before we can safely say that we are providing women with the best advice about their suitability for the most cutting-edge pharmacological treatments.

We're pushing for equal representation of women in the boardroom; in STEM fields; in surgery; as academics; in parliament; and as Prime Ministers. Equal representation of women in clinical trials should be on the agenda too.

**Yael Lefkovits**
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# How to save the environment while saving lives

**If you have been following any form of media in the past few months, you will be aware that climate change is again at the forefront of conversations. With climate strikes occurring internationally, including 100,000 people gathering in Melbourne in the lead-up to the United Nations Climate Action Summit, the conversation regarding climate action has never been more prominent.**

The AMA recently acknowledged that climate change is a health emergency. *The Lancet* in 2015 described climate change as the biggest global health threat, potentially undermining the last 50 years of gains in public health. It also stated, "Tackling climate change could very well be our greatest global health opportunity". Trends in average global temperature since 2015 are on track to make this the warmest of any equivalent period on record; carbon emissions grew globally by 2 per cent and have reached a record high of 37 billion tonnes of carbon dioxide in the atmosphere. There are both direct and indirect health consequences of this - from morbidity and mortality related to increasingly prevalent heat waves, floods, fires, droughts and severe storms, to the indirect consequences of increased transmission of vector borne disease, air pollution on respiratory and cardiovascular health, mental illness, and impaired access to clean air and water, leading to food insecurity and malnutrition.

Our immediate action is required. While making changes as one individual may seem futile when contemplating the systemic and global barriers to achieving the drastic change required on an industrial level, they should not! As a medical community we have the ability to introspect and make changes within the health system to positively impact this health crisis. In 2014-15, healthcare contributed to 7 per cent of the Australian carbon footprint, with two-thirds attributable to hospitals and pharmaceuticals. Single-use plastics, anaesthetics, food waste and energy consumption are some of the biggest contributors. However, simple solutions implemented by all of us can make an immense difference and also be a cost benefit to health services.

Across the country we are already seeing leadership on the issue and examples of how to make small but effective changes - namely at Princess Alexandra Hospital (PAH) in Brisbane and Western Health here in Victoria. In 2018 alone, PAH managed to reduce its waste by 600,000kg and Western Health successfully recycles 35 per cent of its annual waste, diverting 570 tonnes of waste from landfill.

Unsurprisingly, the most bang for your buck in waste reduction is in the theatre suite. Polyvinyl chloride products (a lightweight plastic commonly referred to as PVC) alone account for 25 per cent of single-use waste in hospitals, including oxygen tubing, face masks, IV fluid bags and diathermy wires. At PAH, 400kg of PVC is recycled every month. A similar project was commenced at Western Health several years ago, removing the metal nose clips and plastic inlet nozzles off masks, to recycle these products in partnership with a company that turns them into agricultural hoses. This program is now in approximately 130 hospitals across the country, making a huge difference to our environmental footprint. A 300-bed hospital can recycle 2.5 tonnes of PVC in a year.

There have also been efforts to reduce the use of plastics from the outset, such as replacing the annual use of 700,000 plastic kidney dishes at PAH with biodegradable products. It is also important to understand that recycling efforts are very important and reusing where possible is always preferential; Western Health reuses kidney dishes, laryngoscopes, breathing circuits and facemasks, saving over $100,000 annually.

Single-use metal equipment, also predominantly used in theatre, contributes to a large burden of waste when incinerated following use. PAH and Western Health have both set up metal recycling and sterilisation equipment, leading to an 80 per cent reduction in sharps bin waste disposal at Western Health. Recycling and laundering the single-use towels for surgical scrubbing to sell and raise funds for breast cancer in a program dubbed the 'Little Blue Towel' project has also been a winner.


Beyond the surgical equipment in theatre, another significant contributor to carbon emissions is the use of volatile anaesthetic gases. Desflurane, sevoflurane and nitrous oxide are more potent greenhouse gases than carbon dioxide. Replacing these with intravenous anaesthetics has a significant environmental benefit without an overbearing cost burden or patient disadvantage.

Disposing of clinical waste and infection control is understandably a predominant concern when discussing recycling of material in hospitals. The World Health Organization (WHO) has found that in high income countries like Australia, hospitals produce 3 to 5kg of waste per patient per day. Eighty-five per cent of this waste is classified as non-hazardous and non-infectious. The evidence within Victoria shows that approximately 45 per cent of hospital waste produced is general waste, 30 per cent infectious and 25 per cent recycling. The cost of general waste and recycling disposal are similar, but the cost of disposing clinical waste is approximately $1 per kg, which is ten times the cost of non-clinical waste disposal.

Studies have shown that a recycling rate of 20 to 25 per cent in operating theatres and wards is achievable without compromising infection control or financial constraints.

Clearly, there is a strong financial incentive for separating waste streams as well as the clear environmental benefit. The Royal Melbourne Hospital implemented waste streams in 2013 with separate recycling bins for cardboard and paper, co-mingled glass and plastic, aluminium, batteries, PVC and sterile hand towels. This has had a clear environmental and financial benefit, with a reduction of 187 tonnes of clinical waste and a cost saving of $230,000 in that year.

Moving outside the realm of hospital equipment, there are many other areas in which sustainable changes can make a significant difference, as enormous institutions servicing hundreds of people. Upwards of 40 per cent of hospital food is not consumed by patients and many items are wrapped in plastic as single item servings.

Strategies to minimise food waste are occurring more frequently across the country. Sunshine Hospital has large food dehydrator systems and then sells dehydrated food as compost to local farmers. Similar composting efforts are happening at Ballarat Health and at PAH, with PAH having several gardens fertilised by composted food waste, coffee grounds and dead flowers and the fruit grown in the garden is served to patients as either fresh produce or in jams.

Beyond food waste management, many other simple and effective strategies exist. Sunshine Hospital and Ballarat Health have implemented solar panels which deliver 440mwH per year, or the equivalent of the energy required to power approximately 60 four-person houses in a year. This has been coupled with the implementation of LED lighting, which saves the equivalent of powering 165 houses annually; with the installation costs repaid within two years with the reduction of power used. Other simple measures include reducing general waste bin sizes and a higher frequency of recycling bins in office departments, increasing telehealth utilisation to minimise long haul commuting where possible whilst still providing adequate care and even implementing water fountains and encouraging the use of recyclable coffee cups.

Our environment and health outcomes are inextricably linked; it's why public health policies such as those surrounding water usage and air pollution exist. The impact that climate change will have on health is already significant and threatens to become catastrophic if we continue on our current trajectory. The delivery of healthcare in our hospitals is inadvertently contributing to a global problem, and yet there is so much potential for changes that we can make.

While international and local political change is necessary to achieve the emission and global temperature targets of the Paris agreement, as health services we have a moral obligation to initiate and sustain efforts to reduce the carbon footprint of healthcare. Attempting to reduce the impact of climate change is a cost-effective endeavour. Reducing waste and energy consumption and recycling have a direct cost benefit and can even be a profitable exercise. The long-term cost benefits of investing in this as a health prevention strategy are abundant. So if you haven't done so already, it's time to consider what you and your health service can implement in order to simultaneously save money while saving lives and protecting our environment.

**Dr Jessica Redmond**
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*References available from the Editor on request.*

# Oral cancer: Risk factors and what to look for

**Oral cancer rates continue to rise in Victoria, with over 15 new cases diagnosed each week on average. Despite declining rates of smoking and advances in treatment, the number of non-smoking oral cancer patients is increasing and the five-year survival rate remains at only 50-60 per cent.**

Responding to this low survival rate, the Victorian Government's 2016-20 Cancer Plan identified a need to increase early detection and established the Victorian Oral Cancer Screening and Prevention Program. Stage one of the program is currently being piloted with oral health professionals. Stage two plans to offer oral cancer screening and referral training to doctors in the future.

One of the key factors leading to low survival rates is that cancer of the lips, oral cavity or salivary glands is commonly diagnosed at a late stage. By that time, these cancers are already advanced and have spread into adjacent tissue and local lymph nodes. Most early stage oral cancer is painless, presenting as innocuous lesions that are difficult to recognise during limited examination.

It is not possible to predict if or when there will be a malignant change in a pre-existing oral lesion. These lesions are relatively common, occurring in around two per cent of the population and often appear as flat white areas in the mouth, termed 'leukoplakia'. The presence of dysplasia observed histopathologically in biopsies of tissue remains the best predictor for developing oral cancer. However, the grade of dysplasia does not always correlate with the potential for malignant transformation.

## Risk factors

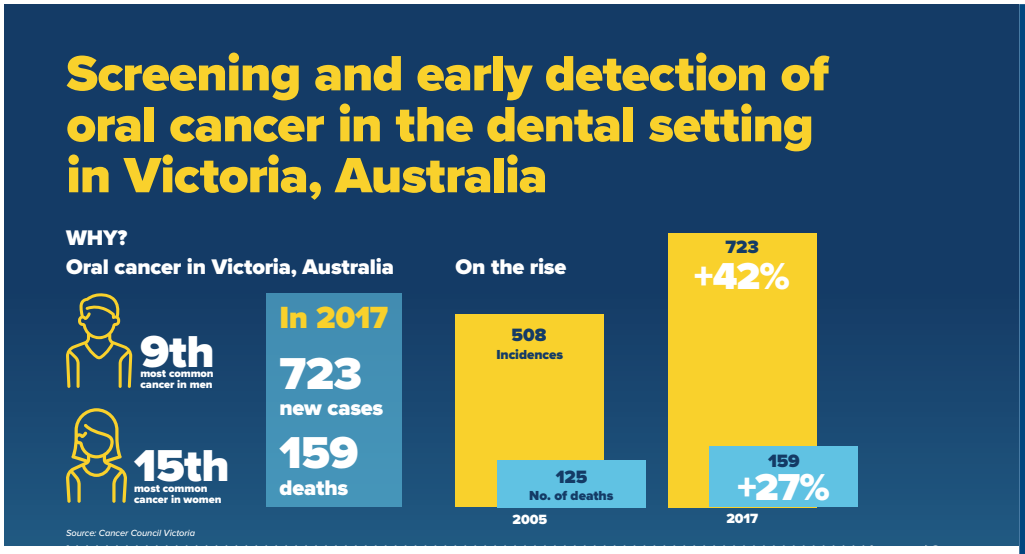
Modifiable risk factors play a major causative role in oral cancer pathogenesis. The greatest risk factor for oral cancer continues to be tobacco use, which results in a tenfold increase in risk when compared to non-smokers. Regular alcohol consumption greater than three standard drinks per day also increases risk by threefold. The combination of these two risk factors is greater than either one in isolation and approximately 75 per cent of all oral cancers are associated with consumption of tobacco and alcohol. Other risk factors for oral cancer include regular use of betel nut, paan, snuff and smokeless tobacco. Rising age (over 50 – 60 years), being immunocompromised and a history of a previous oral squamous cell carcinoma are important risk factors for oral cancer.

Prolonged exposure to the sun without proper protection is a significant risk factor for lip cancer. Viruses, in particular the human papillomavirus (HPV) subtypes 16 and 18, have been strongly linked to oropharyngeal cancer with an increasing number of these cancers occurring over the past 10 years. However, HPV is involved in only a small number of oral cavity cancers; around 2 per cent. While it has been postulated that genetic predisposition may increase susceptibility to oral cancer, no specific genetic component has been clearly established as a risk factor. Hence, in many instances the risk factors for oral cancer are modifiable.

## Signs and symptoms

Oral cancer can present in a variety of ways and in any area of the oral cavity. The most obvious clinical presentations of oral cancer are a non-healing ulcer or an exophytic, indurated swelling with or without fixation, as well as palpable neck lymph nodes. The most common sites for oral cancer are on the lateral margins of the tongue, the buccal mucosa (lining of the cheeks) and the floor of mouth. Less obvious clinical presentations include white, red, or mixed red and white patches that cannot be removed during clinical examination. In the early stages, most presentations of oral cancer are painless. In the later stages patients have pain, numbness or altered sensation, as well as difficulty swallowing, chewing or moving the tongue.

The most effective screening method doctors or dentists can undertake is a thorough oral examination using good lighting to visually examine the entire oral mucosa. Any lesion that has persisted for more than two weeks without a definite cause should be referred for immediate biopsy. It should be recognised that the major cause for oral mucosal changes is trauma and such things as sharp cusps of teeth, broken fillings and ill-fitting dentures. These causes need treatment and should be reassessed for healing two weeks later. Failure to improve within two weeks requires referral for further management.




## Assessment

Patients suspected of having oral cancer should be referred to an oral medicine specialist or oral and maxillofacial surgeon for further assessment. Assessment includes a comprehensive oral examination involving extra-oral examination and palpation of the lymph nodes in the head and neck region. A full intra-oral examination using white dental light is conducted. The need for adjunctive tests including blood tests, selective imaging, use of diagnostic aids, cytology and histopathological assessment will be determined at the clinician's discretion at the time of examination. For definitive diagnosis, histopathological assessment of biopsy material is required.

## Management

Definitive diagnosis of oral cancer necessitates referral to a tertiary hospital for multidisciplinary treatment planning and management. In the first instance, the patient would undergo extensive imaging including CT, MRI and often ultrasound examination so that accurate staging can occur to guide treatment. Multidisciplinary management usually consists of multiple treatment modalities including a combination of surgery, radiotherapy and/or chemotherapy. The team involved in managing a patient with oral cancer usually consists of oral and maxillofacial, plastic, ENT and head and neck surgeons, radiation oncologists, speech pathologists, radiologists, dieticians and other dental specialists. The best management outcome for the patient is surgical eradication of the cancer at an early stage. For Aboriginal and Torres Strait Islander patients, it is fitting to involve a culturally appropriate healthcare professional in that person's treatment.

## Prevention and early detection

Counselling by healthcare professionals is key to reducing risk factors, particularly smoking and drinking alcohol. Those with oral mucosal changes that have potential malignant change should be reviewed regularly by either an oral medicine specialist or an oral and maxillofacial surgeon. Self-monitoring for changes in appearance and consistency of a lesion between review appointments should also be encouraged so that patients can represent earlier if they are concerned. Support of patients at greater risk by their healthcare team, as well as patients' ability to change modifiable factors, can play an important role in avoiding adverse outcomes.

**Dr Lara M DeAngelis**
Oral Medicine Registrar
Victorian Oral Cancer Screening and Prevention Program

**Prof Michael J McCullough**
Oral Medicine Specialist
Victorian Oral Cancer Screening and Prevention Program

*References available from the Editor on request.*

# New guidelines could significantly reduce dementia rates

**Dementia is now the leading cause of death for Australian women and is highly prevalent at older ages, with approximately 30 per cent of adults aged over 85 being diagnosed with the condition and a total of 6-8 per cent of adults over the age of 65.**

Currently there are no effective treatments or cures for the diseases that cause neurodegenerative changes leading to dementia syndromes. In late-life it is recognised that most dementias are 'mixed'. This means that vascular and Alzheimer's pathology are likely to be present and possibly other causes of neurodegeneration.

Risk reduction has been recognised by the World Health Organization as a key strategy in reducing future incident dementia, given the number of modifiable risk factors for which there is accumulating observational and clinical trial evidence. While significant gaps remain in our knowledge, the public health benefits of dementia risk reduction are incontrovertible, because several modifiable risk factors overlap with other key chronic disease areas such as heart disease, stroke, diabetes and cancer. Risk reduction for dementia is likely to also promote healthier ageing and reduce risk of frailty.

Whilst the mantra of 'what's good for the heart is good for the brain' is largely true, there are some nuances in the evidence regarding cardiovascular risk factors and brain health that distinguish dementia risk reduction from cardiovascular risk reduction. For example, long-term studies show that having high cholesterol, hypertension or being overweight in midlife increase the risk of dementia in late-life. However, the association between these risk same factors and risk of dementia when they are present in older adults, is less clear.

Obesity in old age, for example, does not appear to increase risk of dementia. Some of the complexity in interpreting the evidence stems from 'reverse causation' – that is changes that occur in the risk factors due to accumulation of neuropathology and brain changes that are prodromal to dementia. Weight loss may precede Alzheimer's disease by up to eight years which confounds observations in cohort studies. This two-way interaction between neurodegenerative disease and vascular risk factors is an area of current investigation.

With the burgeoning of evidence on dementia being published, and some of it being inconsistent or from populations with different characteristics, it can be at times difficult to know where to focus, which studies to pay attention to and which evidence is applicable here in Australia. Our team has therefore focused on establishing the quality of the evidence base and risk factors for which there are solid systematic reviews that show replication of the risk factors in different populations.

We examined factors such as the source of the evidence, the age at which the populations were first examined for risk factors and the length of time over which they were followed for dementia outcomes. We also consider factors such as potential reverse causation and related guidelines for risk factors for multiple chronic disease areas.

The recent publication of guidelines on dementia risk reduction in primary care was based largely on our review of the observational evidence published in

2019. We also took into account clinical trial evidence for medications.

In summary, the guidelines recommend the following lifestyle advice:

- smoking cessation
- advise consumption of alcohol according to NHMRC guidelines
- increase physical activity according to national guidelines
- healthy diet following the national guidelines with nutrient pattern similar to the Mediterranean diet
- increase social engagement and cognitively stimulating activities, if these are low.

The guidelines recommend the following medical advice for reducing medical risk factors for dementia:

- treat sleep disorders as appropriate
- treat depression
- advise maintaining weight in the normal BMI range, particularly in middle age
- treat diabetes, hypertension, atrial fibrillation as per clinical recommendations as these all increase risk of late-life dementia
- apart from antihypertensives, no other medicines have RCT evidence to show they reduce risk of cognitive decline or dementia
- these medicines are not indicated for cognitive symptoms (HRT, statins, anti-inflammatories)
- benzodiazepines and anticholinergic medicines have been shown to increase risk of late-life cognitive decline or dementia and should be deprescribed where possible.

Finally, this is an area of active research and we expect the guidelines to be refined regularly. For more information visit https://cdpc.sydney.edu.au/wp-content/uploads/2019/09/Dementia-Prevention-FINAL-20-Sep-19.pdf


**Prof Kaarin Anstey**
Dementia Centre for Research Collaboration University of New South Wales and Neuroscience Research Australia

**Dr Ruth Peters**
Dementia Centre for Research Collaboration University of New South Wales and Neuroscience Research Australia

# Fact sheet: Conscientious objection to termination of pregnancy

## Victorian legislation supports the right of every woman to make her own health decisions.

Under the *Abortion Law Reform Act 2008* ('the Act') medical practitioners who have a conscientious objection to termination of pregnancy are legally entitled to decline to provide advice and assistance. It is recommended that medical practitioners treat a conscientious objection as they would a conflict of interest, and act to avoid the conflict where possible. Placing signs in your waiting room and on your practice website stating that you are not available to provide advice or assistance with termination of pregnancy should assist to avoid a conflict situation occurring.

If the consultation is in progress and it becomes apparent that a patient is seeking advice regarding termination of pregnancy, the Act requires a medical practitioner who has a conscientious objection to (a) advise that s/he has a conscientious objection to termination of pregnancy, and b) provide a referral to a registered medical practitioner who the medical practitioner knows does not have a conscientious objection.

Medical practitioners troubled by the obligation to refer should remember that with a referral, the patient will be discussing her pregnancy and her options with another medical practitioner who can provide her with all the information and advice available. It is not a certainty that she will proceed with a termination.

While it is good medical practice to provide a written referral, there is no legal requirement to do so. Informing the patient where they can seek assistance and recording this in your notes would likely suffice.

If providing a written referral, you do not need to write a request for a pregnancy termination if it is against your beliefs. It is reasonable to ask the doctor to whom you are referring to, "Assist the patient with management of her pregnancy".

## Frequently raised concerns

***I have a conscientious objection to abortion and cannot in good faith refer to a service provider.***
The law does not require you to refer the patient to an abortion service provider - just someone who does not hold a conscientious objection.

***I do not know any doctors who aren't conscientious objectors.***
The Victorian Government funds the 1800 My Options service to provide you with up to date information on available pregnancy counselling services provided by doctors who do not have a conscientious objection to pregnancy termination. Phone 1800 696 784 for assistance.

***I feel uncomfortable putting a sign in my waiting room saying I am a conscientious objector; patients may not like it.***
A sign in the waiting room is to save you and the patient from an uncomfortable consultation because you are required to inform the patient of your objection.

## Notice template

A notice template is provided below to assist members of AMA Victoria who have a conscientious objection to providing termination of pregnancy services. You may amend this template as you deem appropriate. Legal advice should be sought regarding any amendments.

## Termination of pregnancy information

Because of Dr [INSERT NAME]'s personal beliefs, s/he is not able to offer you advice or assistance regarding termination of pregnancy, including medical and surgical abortion.

If you require advice or assistance regarding termination of pregnancy, please ask for an appointment with [INSERT DETAILS OF LOCAL FAMILY PLANNING CLINIC] or refer to Victoria's 1800 My Options phone line (1800 696 784) and website (www.1800myoptions.org.au).

## Abortion Law Reform Act 2008 - Sect 8

Obligations of registered health practitioner who has conscientious objection

(1) If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must:

(a) inform the woman that the practitioner has a conscientious objection to abortion; and

(b) refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.

(2) Subsection (1) does not apply to a practitioner who is under a duty set out in subsection (3) or (4).

(3) Despite any conscientious objection to abortion, a registered medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.

(4) Despite any conscientious objection to abortion, a registered nurse is under a duty to assist a registered medical practitioner in performing an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.

*(Last reviewed November 2019.)*

The members-only section of the AMA Victoria website includes fact sheets on many other important topics.

AMA VICTORIA

*This article is intended to provide general advice only. The contents do not constitute legal advice and should not be relied upon as such. Readers should seek specific expert and legal advice in relation to the information provided in this article.*

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# A question of faith

**Few cases are so ethically vexed as when the offer of life-saving treatment is pitted against a patient's religious beliefs. In the case of a 17-year-old woman of the Jehovah's Witness faith, her decision to refuse human blood products risked harming both herself and her unborn child.**

## Case study

The patient was 38 weeks pregnant when she consented to delivery of her baby via induction of labour and, if necessary, a caesarean section. She was assessed to be at significant risk of a post-partum haemorrhage and was advised of the possibility that a life-saving blood transfusion might be required. Adhering to her faith, the woman refused to consent to the hospital administering human blood products. Her mother, also of the Jehovah's Witness faith, refused to consent to the treatment on behalf of her daughter.

On 31 August 2018, the hospital made an urgent application in the Supreme Court of Victoria, seeking a declaration to authorise the administration of blood and/or blood products as considered reasonably necessary by the patient's treating medical practitioners to save her life, or to prevent serious injury during the course of induction of labour, labour, caesarean section and related procedures, and the postnatal period in regard to her pregnancy. The application was opposed by the patient.

Exercising the Court's 'parens patriae' (parent of the state) jurisdiction, the judge considered all the welfare interests of the 17-year-old patient – medical, spiritual, personal autonomy and identity – when deciding what was in the patient's best interests. Some of the factors impacting on that evaluation included:

- opinion from a child psychiatrist who, following his assessment of the patient, was not confident that the patient understood the complexity and full implications of her decision to refuse human blood products should they be medically necessary
- opinion from the medical director of maternity who felt that the patient's decision was partly motivated by her desire to please her mother and the support person from their faith community
- several factors (including an earlier transgression of one of the principles of the Jehovah's Witness faith) that cast some doubt on the patient's maturity and the extent of her personal adherence to the tenets of her faith.

## Outcome

After weighing the evidence, the judge was not satisfied that the patient had sufficient understanding of the consequences of her choice.

He remained unconvinced that, "... Overriding (the patient's) expressed choice would so rob her of her essential self as to outweigh the loss she would suffer through losing her life or sustaining a catastrophic injury. In summary, I do not consider that allowing her, in effect, to choose to die or only survive with serious injury is in her best interests taking into account a holistic view of her welfare (physical, spiritual and otherwise)".

After accepting the hospital's undertaking to only administer blood products as a last resort, the judge made the declaration sought by the hospital.

**Alice Cran**
Claims Manager
(Solicitor)
MDA National

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

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# Goulburn Valley Health Wellness Day

**AMA Victoria was pleased to support and participate in the recent Goulburn Valley Health wellness day for hospital staff, alongside representatives from the Victorian Doctors' Health Program (VDHP), the Victorian Medical Benevolent Association (VMBA), the Pharmacists' Support Service (PSS) and the Nursing and Midwifery Health Program Victoria (NMHPV).**

Across the day there were several presentations to different staff groups, including three separate presentations to medical students, doctors-in-training and consultants. AMA Victoria Senior Workplace Relations Advisor, John Ryan, described how we support medical student and doctor wellbeing. He explained how enterprise agreements are designed to support wellness through a holistic approach to employment, considering the many aspects of being an employee at the same time as being an individual, a family member, a health professional and a member of society.

Dr Tim Dewhurst from VDHP focused on health issues for doctors and medical students, including stress, burnout, mental health issues and self-care. Dr Dominic Barbaro provided an overview of the compassionate assistance offered by the VMBA to doctors and medical students over many years.

Each presentation to the health professional staff was accompanied by some mindful meditation activities lead by Ben Norden of Deepest Dish. Other activities organised by the hospital included massage, yoga, meditation and fruit smoothies, as well blood pressure and healthy weight checks.

The take home message from the day was that the wellbeing of health professionals is multifactorial and requires both good systems and attention to self-care. Medical students and doctors have profession-specific support services available through AMA Victoria, VDHP and VMBA.

**Kay Dunkley**
Doctor Wellbeing Program

*Ben Norden of Deepest Dish leading some mindful meditation activities.*

*AMA Victoria Senior Workplace Relations Advisor, John Ryan.*

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# Retiring well: Dr Rosalind Terry

**Retirement is emerging as one of the big issues for which our senior members are seeking support. In response, our Medical Career Service has expanded its coaching offering to deliver a targeted retirement solution designed to support senior doctors to retire well. This program assists doctors to navigate the retirement process and can be tailored to each doctor's individual needs. In this regular series, doctors share their retirement stories.**

## Can you tell us about your career?

My career didn't start in medicine because even though I had wanted to do medicine, my father took me aside in year 12 and told me no-one in the family had been to university and a girl's not going to be the first one! After a change of heart I was encouraged to look at three-year courses, so I did a degree in biochemistry and microbiology at Melbourne University, thinking if I ever got a chance to go back and do medicine it would give me the best background.

I went to America and worked in Chicago and then Wisconsin and then came back and worked in Tasmania as the first full-time worker in a new hydatid eradication program. Hydatid had become a nasty disease and quite a lot of Australians were dying from it at that stage, in the late 60s. After two years of this, I got into medicine and came back to Melbourne University, with a few exemptions from my earlier studies. I studied medicine during the day and worked in biochemistry at the Royal Melbourne Hospital (RMH) at night and on weekends.

After two years residency at the RMH, I decided that I quite liked surgery, even though it wasn't a field for women in those days. I got a job at St Vincent's in Sydney as the first female surgical registrar there. In the final half of my second year, I had to go to New Guinea for six months. I loved all of the work, met somebody and ended up staying there for 10 years! I did all sorts of things, beyond surgery. I didn't ever finish my surgical training, so I wasn't officially recognised as a surgeon in Australia, despite 10 years of all sorts of experiences (Editor's note: with plenty of good stories for another time).

I was worried about the idea of coming back to Australia because I'd been in New Guinea for so long and it was all so different, so through some diverse connections I got offered a job on Norfolk Island, which I thought was the perfect way back into the Australian system. Being in an isolated area still required me to be ready for a variety of experiences and it was the perfect stepping stone to a return to the mainland.

Back in Melbourne, I did a lot of surgical assisting work and I think I saw an ad in the paper for someone to assist in the emergency department at the Alfred which was appealing because it was walking distance from home. I then began my career in emergency medicine, which I did all the way through until I retired.

I was the Director of Emergency Medicine at the Mercy Hospital in Werribee in the mid-90s and enjoyed the job of establishing all of the protocols for their new emergency department.

After four years of long hours, I was planning on taking six to 12 months off work for a break, but I received a persuasive offer to be a consultant back at the Alfred and I

ended up working there until I retired at the age of 74. I asked my boss if there was a rule about doctors having to retire at the hospital when they turned 70 and he said, "I haven't got a clue and we're not going to ask!" so I worked for another four years and retired in 2014.

### What resources or support did you utilise in implementing your retirement?

Whenever I made noises about thinking I should retire, I was regularly encouraged not to and instead the Alfred suggested I just tell them what shifts I wanted to keep working and they would work around me. So I reduced my hours down to about half-time for the last little while. I was very lucky that they were happy for me to nominate my own shifts in the roster.

### Were there any challenges or surprises for you during or after the transition process?

I did a lot of thinking about it and I think I planned it fairly well in cutting down my hours in the two or three years before I retired, so it wasn't like I'd been going hell for leather, non-stop for 48 hours a week and then 'bang', stop. I think that helped very much.

### Do you have any advice for others considering retirement?

I think it depends on what your interests are. I had a farm that I was looking forward to spending more time at. I think they certainly need to have one or two things in their lives that are really important to them and that they're interested in, or that they would like to have more time for. If they have this, then retirement is going to be a really good, positive thing.

**If you are interested in sharing your story as part of this Retiring Well series or if you would like assistance with planning your path to retirement, please contact the AMA Victoria Medical Career Service on careersadvisor@amavic.com.au or (03) 9280 8722.**

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**Wakelin Property Advisory** (03) 9859 9595

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**HWL Ebsworth** (03) 8644 3718

**Member benefits:** As a member of AMA Victoria, this partnership provides you with legal assistance and support, both individually, for your business and for your staff. HWL Ebsworth will provide AMA Victoria members with an initial consultation by phone or in person at no cost (up to 30 minutes).

**Little Real Estate** (03) 9514 8992

**property.littlerealestate.com.au/amavic**

**Member benefits:** Little Real Estate has partnered with AMA Victoria to offer you 6 months of free professional property management services. Based on weekly rental payments of $450, this will equate to approximately $900 in savings for the first year. To arrange, speak with our dedicated account manager, Lida Roshan on (03) 9514 8992.

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# Rising market complicates the buy first or sell first switching dilemma

**"Should I buy first or sell first?" is a question often asked by owner-occupiers planning to move. In a simple world, the order wouldn't matter too much. Whichever transaction came first would be contracted on a long settlement period, whilst the second transaction would be agreed on a shorter settlement timeframe such that both properties settled at the same time.**

That degree of coordination is hard to achieve in practice. Switchers often either end up with two properties for a period (if they buy first) or no property at all for a time (if they sell first).

The conventional wisdom is to play it safe and sell first and buy second as holding two assets with very high debt for a prolonged period is considered a bigger danger to finances and nerves than the potential inconvenience of renting for a while. But there is a case for the less risk-adverse approach of buying first and selling second, particularly in a rising market like we see in parts of Australia today.

Judge correctly that prices are moving up and the participant can be tens of thousands of dollars better off by buying in the cheaper current market and selling in the more expensive future one compared to the net outcome of a sell first, buy second strategy.

Unusually low stock levels and mounting demand – a common feature around Australia presently – is lengthening the typical buying timeframe and shortening sales campaigns, so amplifying the potential upside of the buy-first approach.

Moreover, there are tried-and-tested ways to minimise the risks associated with holding two properties. Bridging finance priced at interest rates comparable to standard home loans can be locked in for a period of up to 12 months typically and banks often offer to capitalise the interest on the bridging loan to avoid a cashflow squeeze. Finally, it is also possible to lease out one of the two properties, earning rent to offset most if not all the holding costs until market conditions improve sufficiently to offload the property on more favourable terms.

Price trends are not the only factor to consider when deciding transaction order. How similar are the asset types that are being switched? If quite different, then the rule of thumb is to buy or sell the more unusual property first as this transaction will probably take longer. This approach reduces the likelihood and length of time of either holding two properties and extra debt or holding no properties and having to rent an interim home.

For example, it is usually easier to buy or sell a well-maintained three-bedroom suburban house (where the market is liquid), than a large country mansion of a very particular architectural style with several bedrooms and living rooms and a tennis court (where the market is illiquid). If the homeowner was switching between these types of properties, then the focus should be on transacting the country mansion first.

Putting aside the order of transactions, prospective homeowner switchers should make contingency plans to either rent for a while or take out bridging finance. Hopefully, they are the fortunate ones who can coordinate transaction settlement timings perfectly. But having an artificial must-buy or must-sell deadline just to achieve this end risks delivering various panicky outcomes: buying the wrong replacement property, paying too much or selling too cheaply.

**Richard Wakelin**
Founder
Wakelin Property Advisory

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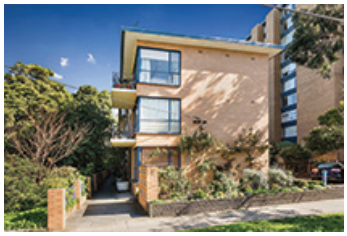

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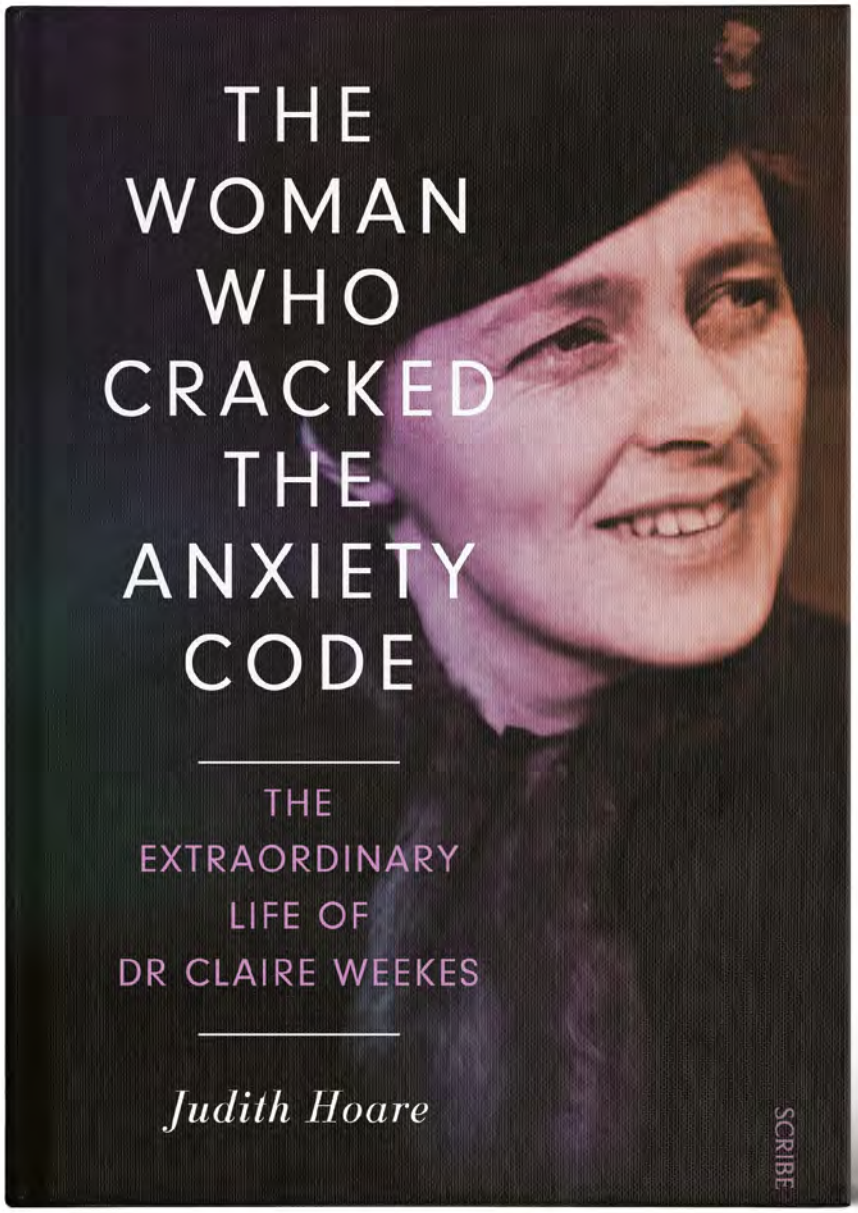
# The woman who cracked the anxiety code: The extraordinary life of Dr Claire Weekes

## The true story of the little-known mental-health pioneer who revolutionised how we see the defining problem of our era: anxiety.

Panic, depression, sorrow, guilt, disgrace, obsession, sleeplessness, low confidence, loneliness, agoraphobia … Dr Claire Weekes knew how to treat them, but was dismissed as underqualified and overly populist by the psychiatric establishment. In a radical move, she had gone directly to the people. Her international bestseller *Self Help for Your Nerves*, first published in 1962 and still in print, helped tens of millions of people to overcome all of these and continues to do so.

Dr Weekes pioneered an anxiety treatment that is now at the cutting edge of modern psychotherapies. Her early explanation of fear and its effect on the nervous system, is state of the art. Psychologists use her method, neuroscientists study the interaction between different fear circuits in the brain and many psychiatrists are revisiting the mind–body connection that was the hallmark of her unique work. *Face, accept, float, let time pass*: hers was the invisible hand that rewrote the therapeutic manual.

This understanding of the biology of fear could not be more contemporary – 'acceptance' is the treatment du jour and most mental-health professionals explain the phenomenon of fear in the same way she did so many years ago. However, most of them are unaware of the debt they have to a woman whose work has found such a huge public audience. This book is the first to tell that story, and to tell Weekes' own remarkable tale, of how a mistaken diagnosis of tuberculosis led to heart palpitations, beginning her fascinating journey to a practical treatment for anxiety that put power back in the hands of the individual.



## From the author

I was in my early 20s when I joined the small, mainly male contingent of journalists covering politics in Australia's national capital, Canberra. It was an exciting time to be a political reporter and I had recently completed a degree, specialising in government, at the University of Sydney. Now I had the opportunity to watch and cover politics first-hand.

The hours were long and the work fascinating, but intense. Then a small medical issue lead to minor surgery. I was run down and out of the blue developed heart palpitations which alarmed me. A trip to the cardiologist was reassuring and yet the palpitations were unceasing. Something had to be wrong. I became distressed by the state I was in.

It was a story that had parallels with Claire Weekes, whose heart palpitations as a young student had distressed and alarmed her back in the 1920s. Unlike me however, she had no helpful book to explain the baffling symptoms of 'nerves'.

As it happened, my mother had been lent *Self Help for Your Nerves* by a friend of the family and she passed it onto me. Suddenly light was thrown into darkness and I was struck by the sheer power of an intelligent, yet simple explanation of the mind/body connection.

The palpitations disappeared and I forgot about them. However, I never forgot the gift of Dr Claire Weekes. Over the years as a journalist I was witness to the footprints left by powerful people, across all areas of public life. I noticed how few people really contributed, individually, unequivocally, to the public good, and sadly, how many did just the opposite. I understood very personally the scale of the achievement of Dr Claire Weekes. She changed lives, saved lives, and changed history. Yet her monumental accomplishment and huge global footprint was invisible.

I was also struck by her powers of communication. It is one thing to be right and it is another to have the power to wield words to change the world for the better. How did she do this?

Decades after I came across her work I knew the chase for the story of Dr Claire Weekes would be utterly fascinating and so it has been. Her story spans a century of ideas and the biggest battles in science and medicine, covering Darwin, Freud, two World Wars, evolution, genetics, the brain, the mind and the body. And one woman battling it out against an entire profession. It has been a wonderful, thrilling journey of discovery.

Judith Hoare


*The Woman Who Cracked the Anxiety Code: the extraordinary life of Dr Claire Weekes* is published by Scribe and available to purchase as an eBook or paperback, wherever you buy your books. www.scribepublications.com.au

ADVERTORIAL

# Top five questions you should ask your private health insurer

## As the rollout of the Federal Government's Private Health Insurance reforms continues, here are some questions you should be asking your fund to ensure you are still getting the cover you need for the best value.

### 1. What tier is my hospital policy in?

Health funds are now required to classify all their hospital policies into four tiers. These tiers are labelled Gold, Silver, Bronze or Basic based on the number of clinical categories included. Gold is the highest tier and covers all 38 clinical categories. Conversely, Basic policies are only required to include a minimum of three categories (rehabilitation, psychiatric services and palliative care).

These new tiers are designed to make it easy for you to identify your level of cover. There are also 'Plus' policies, which offer coverage above the minimum requirement for a specific tier. Doctors' Health Fund's Smart Starter Bronze Plus, covers all Bronze-level inclusions as well as some Silver level inclusions like plastic and reconstructive surgery, and dental surgery. Sleep studies, which is a Gold category, is also included.

### 2. What excess options do you offer?

Health insurers can offer a higher excess of $750 per year on their hospital policies ($1,500 for couples and families). It is worthwhile asking your fund whether they have a cap on excess payments for couples and family policies. While some health funds require you to pay excess per admission, per person, Doctors' Health Fund caps excess payments to one payment per person per year, so the same person will never pay more than one excess payment per year, regardless of the number of hospital admissions.

### 3. Am I likely to pay an out-of-pocket cost?

Even with Gold-level cover, you may still need to pay out-of-pocket medical costs. You should ask about the proportion of services that the fund pays with no out-of-pocket costs. This will indicate the quality of the fund's medical schedule.

Doctors' Health Fund's Top Cover Gold uniquely pays up to the AMA list of medical fees; this means members on this cover will have fewer out-of-pocket expenses.

### 4. Do you have a preferred provider network?

Some funds operate preferred provider networks for their Extras policies; this means some of their policy benefits are only available at providers either owned or contracted by the fund. Always ask whether the benefits offered will be the same at your chosen allied health provider as they are at the fund's preferred network.

Doctors' Health Fund advocates for clinical independence and freedom of choice. With no restrictive preferred provider networks, you are free to choose who treats you.

### 5. Do you offer discounts for 18 to 29-year-olds?

Insurers can now offer discounts to people aged between 18 and 29 on their hospital policy. This new initiative is designed to make private health insurance more affordable for young people.

This discount is voluntary and not all health funds will be participating. Doctors' Health Fund recognises the importance of young people within the private health system and has chosen to support this new initiative. If you are under 30, ask your current fund if they are offering this discount.

If you are not completely satisfied with the responses from your fund, consider getting comparisons for more suitable cover. At Doctors' Health Fund we can provide a comprehensive comparison over the phone and making the switch is easy because we take care of everything for you.

For more information about our products and services, please email us at info@doctorshealthfund.com.au or call us on 1800 226 126.

**Peter Aroney**
CEO
Doctors' Health Fund

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