

# vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. JUNE / JULY 2018

## Preparing for a medical career

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CERVICAL CANCER**

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FRONT COVER: AMA Victoria's Medical Careers Expo assisted over 900 delegates. See page 16.



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# Welcome from the editor



Associate Professor Julian Rait (left) is the new President of AMA Victoria and Dr Tony Bartone (right) is the new AMA Federal President. See page 7.

We're always keen to share the news on great achievements and discoveries in medicine made by our members and also shine the spotlight on some interesting stories and careers. This edition of Vicdoc features both.

Professor Suzanne Garland is a world-leading clinical microbiologist working hard towards the eradication of cervical cancer. It's hoped that Australia will be the first country to effectively eliminate the disease, thanks to the impact of the HPV vaccine.

Dr Graeme Killer has more than enough stories about his medical career to fill a book. He believes the most important work was undertaken during his time as Principal Medical Adviser to the Department of Veterans' Affairs, but there is also plenty of interesting reading about his role as the personal physician to five sitting Australian Prime Ministers.

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

A medical tragedy in the United Kingdom which resulted in the death of a six year-old boy has raised many questions. While one doctor has borne the brunt of the responsibility, many believe the case reflects systematic failures in the healthcare system and could discourage other doctors from admitting to mistakes. What are the implications for Australian doctors? The case is analysed on page 14.

This Vicdoc also includes news on changes to medical treatment decision-making laws, a key appointment to AMA Victoria's Workplace Relations team, and a closer look at the new Enterprise Bargaining Agreement for Doctors in Training.

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



**Barry Levinson**

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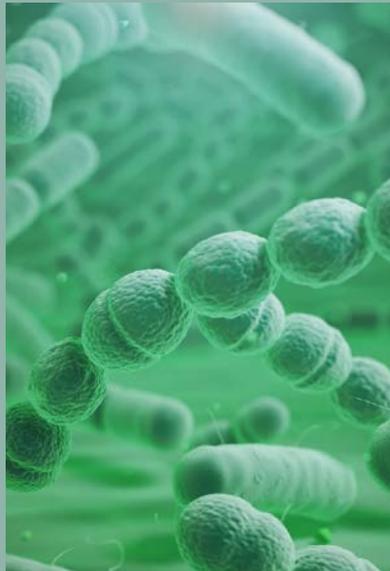
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BY  
P C  
& E

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# President's message



Throughout my career I have been confronted by many social issues which have had a direct and detrimental impact on the health of communities. This is true in the developing world and in a prosperous country such as Australia.

It is why, as well as driving health policy, the AMA must also engage in social advocacy. By investing in prevention and the way we look after the most vulnerable people in our community, we can improve social wellbeing while saving money in our health system.

Health ministers at state and federal levels are most effective when they listen to doctors. The AMA is at its best when it works in partnership with politicians to improve patient outcomes. Thus, AMA Victoria needs to have positive working relationships across the political spectrum. We should share a common aim to improve health outcomes for the community.

Underlying the advocacy of any state AMA must be a suite of highly researched policies and position statements, developed in discussions with our Council, subdivisions and peer groups. The AMA is the only organisation in Australia that can take the opinions of trainees, GPs, psychiatrists, surgeons, physicians - and put them all together. Consultation with people who work in our state public system, in private practice, in health agencies and in our community is necessary to prepare thoughtful policies. Careful preparation can provide a sound policy book which must stand behind every state President. In my opinion, the leadership of AMA Victoria is tasked with the prosecution of arguments based on work that's been undertaken by our many colleagues throughout the subdivisions and peer groups, by the Federal AMA and by those doctors who have served as our state Councillors. AMA Victoria updates its policies and statements every few years; and I will ensure that we continue this routine of broad consultation.

At this point, I warmly congratulate Dr Tony Bartone, a former AMA Victoria President who was elected our new National AMA President on 27 May. I also acknowledge our outgoing AMA Victoria President, Dr Lorraine Baker who has worked tirelessly these past two years to engage with all sides of politics. She has endeavoured to obtain the right outcomes for our members and for our community of patients.

In addition, I thank our outgoing Board members and Councillors for their commitment to our organisation and for being measured in the face of many debates about the operations of AMA Victoria. Their long hours of work and deliberation have been much appreciated. I also extend many thanks to our staff and to our Chief Executive Officer, Dianne Angus, who has been an organisational tower of strength over the past five months.

I also want to pay particular tribute to Geoff O'Kearney who finished in his role as Director of Workplace Relations in March. In addition to a number of our Board members, the leaders of ASMOF, and a resolute Workplace Relations team, Geoff was pivotal to the recently successful Enterprise Bargaining Agreement for Doctors in Training and Senior Salaried Staff across the Victorian public health system. This historic agreement, once certified by the Fair Work Commission, promises significant improvements in the terms and conditions of doctors working in our public hospitals. This includes substantial increases in salaries, shift penalty payments and greater clarity on leave entitlements. AMA Victoria is very pleased with the outcome of these bargaining negotiations, and with a sound agreement in place, we are now focused on ensuring that these conditions are fully implemented by the State Government and by public hospitals.

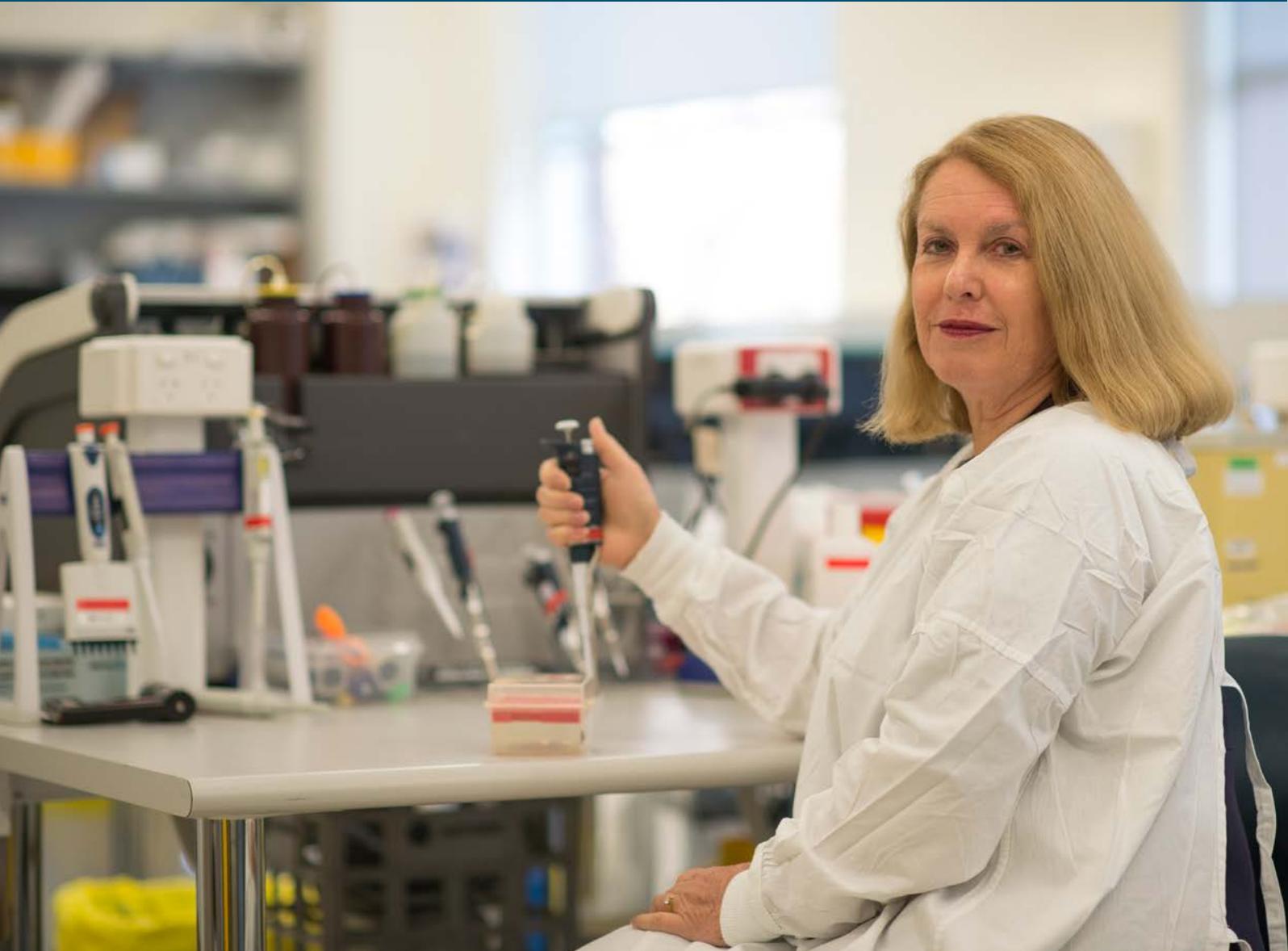
Members might be surprised to know that I have followed the AMA with interest since 1968. In May of that year, my GP father took me to an AMA national conference in Sydney. Despite being a shy nine year-old, I was introduced to Dr Christian Barnard, the tall South African cardiac surgeon who had performed the world's first human-to-human heart transplant six months earlier.

I realised then how scientific research and technology would soon transform the medical profession.

I also much admired the AMA as an organisation that would continue to encourage grand ideas and have a positive influence on the health of Australians. I hope to live up to this tradition as your President.

**Associate Professor Julian Rait  
President**

# Elimination of cervical cancer in sight



AMA Victoria member, Professor Suzanne Garland, is the Director of the Centre for Women's Infectious Diseases at the Royal Women's Hospital.

## Cervical cancer could be effectively eliminated within the next 40 years, with Australia set to be the first country, according to the world's leading cervical cancer experts.

In a statement published in the *Journal Papillomavirus Research* on International HPV Awareness Day (4 March), the International Papillomavirus Society (IPVS) has for the first time outlined that cervical cancer could soon be eliminated as a public health problem.

The IPVS is made up of the world's leading cervical cancer and Human

Papillomavirus (HPV) researchers, including Professor Suzanne Garland from the Royal Women's Hospital and University of Melbourne. It advises the WHO and global policy makers on cervical cancer prevention and screening.

The statement comes as new research is published showing a dramatic decline in the rates of HPV, the infection that causes about 99.9 per

cent of cervical cancer cases, the majority of anal cancer cases, and a proportion of vulvar, vaginal, penile, tonsillar and back of tongue cancers.\*

Professor Garland, who is the Director of the Centre for Women's Infectious Diseases at the Royal Women's Hospital, said Australia would likely be the first country to effectively eliminate the disease. "We are

forecasting that over the next 30-40 years, rates of cervical cancer will drop from around the current 1000 cases a year in Australia to just a few," she said. "Our national HPV immunisation program for both boys and girls, combined with our cervical cancer population screening, means we are well positioned to be the first country to effectively end this deadly cancer."

The latest research from Professor Garland's team, published in the *Journal of Infectious Diseases*, is showing that rates of HPV in women has dramatically dropped due to the effectiveness of the vaccination program. Researchers found that among women aged 18 to 24, the HPV rate had dropped from 22.7 per cent to just 1.1 per cent over the last 10 years. While only 53 per cent of women were vaccinated, the 'herd effect' had helped deliver a better than anticipated decline. Recent research has also shown a decline in HPV among males.

Prior to the vaccination program, almost all sexually active people had contracted HPV.

"If we continue with a successful vaccination program for boys and girls and our population screening for HPV, then we can effectively eradicate this cancer. The research is showing a decline in rates of the cancer causing HPV; however due to the delay between contracting HPV and cervical cancer developing, we expect it to be a few more years before we see a steep decline in rates of cervical cancer," Professor Garland added.

The majority of cervical cancers globally happen in the developing world where there are no population screening programs. Around 430,000 women each year are diagnosed with cervical cancer. The cost-effective vaccine is slowly being rolled out in many countries.

The IPVS has highlighted that eliminating the disease globally depends on high uptake of the vaccine in countries across the world. "The effectiveness of the vaccine and a lower cost is likely to make it possible for us to eliminate the disease in low socioeconomic countries too," Professor Garland said.

## Background

*Very low prevalence of vaccine human papillomavirus (HPV) types among 18 to 35 year old Australian women, nine years following implementation of vaccination*, was published in the *Journal of Infectious Diseases*, February 2018. The study was led by the Royal Women's Hospital, University of Melbourne and the Murdoch Children's Research Institute.

## International Papillomavirus Society' statement: Moving towards Elimination of Cervical Cancer as a Public Health Problem

IPVS has released a 'Call to Action' to health authorities to adhere to international standards developed by WHO to develop national, regional and local plans to ultimately achieve the goal of cervical cancer elimination as a public health problem. A markedly reduced incidence of cervical cancer is possible in the near term, with elimination thereafter, if high rates of HPV vaccination and cervical screening are achieved.

## The facts

Every 2 minutes a woman dies of cervical cancer around the world.

- Cervical cancer is a cancer caused by human papillomavirus (HPV) infection, which can be effectively prevented as a public health problem by vaccination and screening.
- Highly safe and effective vaccines that can prevent the majority of HPV infections that cause cervical and other HPV-associated cancers are available.
- Tests to screen for, and methods to treat, cervical pre-cancerous lesions are available and are proven to reduce cervical cancer incidence.
- Combining HPV vaccination at

high coverage for adolescents and high coverage of cervical screening, with appropriate treatment of all women, can eliminate cervical cancer as a public health problem.

- Recent modelling suggests that, with the tools available, elimination of cervical cancer in local populations is achievable within our lifetime. To achieve this, these effective and cost-effective prevention methods will need to be expanded, to include those not currently vaccinated or screened.
- Broad dissemination of HPV vaccines has been achieved in some low and high resource countries, but needs to be scaled up globally, to reach the majority of age eligible individuals.
- \*HPV is linked to 99.9 per cent of cervical cancer, 90 per cent of anal cancers, 65 per cent of vaginal cancers, 50 per cent of vulva cancers, 35 per cent of penile cancers and 60 per cent of oropharyngeal cancers (cancers of the back of the throat, including the base of the tongue and tonsils).

Today we are poised to markedly reduce the incidence of cervical cancer, with the vision of eventually eliminating it as a public health problem, using the combination of sustained high coverage HPV vaccination and sustained high coverage screening with treatment.

**Please help spread the message that we can markedly reduce cervical cancer. We have the science and the tools. We now urgently need the policy, the resources, political will and the public's determination to move forward to implement these actions.**



the women's  
the royal women's hospital  
victoria australia

# Member profile: From war zones to the White House

It's 50 years since Dr Graeme Killer AO graduated from the University of Queensland and began his unique medical journey.

As the personal doctor to five sitting Australian Prime Ministers, Dr Killer has met many world leaders during his distinguished career. Nelson Mandela, Bill Clinton, George W. Bush, and Queen Elizabeth II are among a rather impressive list of VIPs. Over dinner he's also discussed the major world health challenge of obesity with Chinese President Xi Jinping.

But aside from looking after the health of our nation's chief decision-maker, Dr Killer has also served his country with distinction as a doctor in the Royal Australian Air Force (RAAF) for 24 years. He then went on to use these important insights to look after the welfare of our returned servicemen and women as the long-time Principal Medical Adviser for the Department of Veterans' Affairs.

When Dr Killer sat down with Vicdoc Editor Barry Levinson to reflect on his career, there was certainly no shortage of stories to recall.



## Prime Ministers

### How did you become the Prime Minister's doctor?

In 1988, Prince Andrew and Sarah, Duchess of York (Fergie) came to Australia and I was invited to accompany them on their official visit as their medical practitioner. At the time I was a Senior RAAF Medical Officer. It went well but I never thought much more about it and life returned to normal. Shortly after I retired from the Air Force, I was offered the job in Canberra as the Principal Medical Adviser to the Department of Veterans' Affairs.

This was around the time Paul Keating became Prime Minister (1991). On his first overseas trip in Indonesia, he became unwell and the doctor who went on the trip decided not to continue in the role. I was asked if I wanted to be the personal physician to Prime Minister Keating.

I met with Paul Keating and then stayed on as doctor to the Prime Minister all the way through to Tony

Abbott. Shortly after, Sir William Deane became Governor-General and I was asked to fulfil a similar role at Government House. These arrangements continued until the appointment of Sir Peter Cosgrove.

**I imagine the Prime Minister is generally sleep deprived, overworked and highly stressed - all potentially triggers for poor health. Is it difficult to be healthy making the most important decisions in the country?**

When I took the job I really didn't understand totally what was involved and after a few weeks it occurred to me, 'What if I have a Prime Minister with a serious health problem? What would I do? Who do you go to? The implications of this situation go well beyond medical decision-making and have a far wider impact than the individual's health problem. If you are tired or have a mental health

issue there is always the possibility something untoward could happen. When you come from outside, you expect the PM to be healthy and well and then you realise their routine has gone from nine to five to 24/7.

### How did they cope with these pressures?

In this 24/7 nature of politics, the health and wellbeing of politicians and their families is easily forgotten. It is not an easy journey for either. Over the years that I was the Prime Minister's doctor, I could see the demands of the office increase. There was a far greater number of visits overseas. A far greater number of international meetings like APEC, ASEAN, G20, G12 and it's incredibly demanding, physically and mentally. The PM not only has to deal with issues overseas, they still have to deal with issues and crises at home at the same time. The role of the doctor in dealing with this is extremely important. It's important for the doctor to have a really close relationship with the PM, but equally important that the



Dr Graeme Killer receiving the AMA President's Award in 2016 from then Federal President Dr Michael Gannon.

doctor treats the PM as they would any other patient. The real risk is of under treatment, or even over treatment, if you do see them differently. It's crucial to find the right balance.

In addition, I think being in the military held me in good stead. It gave me a good understanding of government and dealing with prominent and important people. There's no doubt that over the years, the role of Prime Minister's doctor did give me a few challenges, but in medicine we need to expect challenges and they often occur when they're least expected.

## Brush with terrorism

**You've counted 191 overseas trips in 20 years working with veterans, Prime Ministers and Governors-General. Any particular ones stand out?**

There are two trips to the United States that really stand out - both for

completely different reasons.

The first was my brush with terrorism. I was in Washington DC with John Howard at the time of 9/11. I still remember it so clearly. I was sitting in the Prime Minister's office at the Willard Hotel, which is very close to the White House, and we all looked incredulously at the television as the two planes crashed into the World Trade Centre in New York. It was almost impossible to comprehend and I and others didn't really know at the time if it was real. Within a space of time, Prime Minister Howard gathered staff and the Australian media together to do a press conference and as he was doing so his US security asked him to stand away from the window as a plane crashed into the Pentagon. If we had looked out the window at the time, we would have seen it happen. We'd been in the Pentagon the day before. Following this, Mr Howard was rushed to the Australian Embassy and a bus was sent for the rest of us. We were all put in the bunker under the Embassy and at that stage we were able to ring our families.

After this, all civil airline flights in the US were cancelled and we couldn't get home. The President provided John Howard with Air Force Two, which was the aircraft of the Vice President. We flew in Air Force Two to Hawaii and then from there a Qantas flight took us back to Australia.

The overseas visit that was the most enjoyable was John Howard's last trip as PM to the US. He and George W. Bush were very good friends. He used to refer to John Howard as the 'Man of Steel'.

At the end of a big dinner at the White House, all the guests lined up to meet the President, Mrs Bush and Mr and Mrs Howard. When I was introduced to the President as the Prime Minister's doctor, Mr Bush came up and threw his arms around me and said, 'Hey doc, what's his prostate like?' And I said, 'Mr President, it's in good shape, but I can't tell you any more because it's medical in confidence'. It brought the

**Continued on page 13**

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house down. On that trip, every bit of hospitality was afforded to us. It was a great recognition of the strong links between Australia and the US and the strong personal links between John Howard and George Bush.

On a trip to Beijing with Dame Quentin Bryce I discussed obesity and health promotion over dinner with the then heir apparent, Xi Jinping, who is now the President.

I met Nelson Mandela in Pretoria, South Africa. He was being given an honorary Order of Australia at the Australian High Commissioner's residence. I just had to meet him! Of all the people in the world I've met, Bill Clinton was the most charismatic. He'd come into a room and it was like the lights were turned on. No one else has come close to Bill Clinton for sheer charisma. I can see why the ladies liked him!

## Veterans' Affairs

### Can you tell us about your work with the Department of Veterans' Affairs (DVA) and the challenges veterans face?

Leaving the Air Force and joining Veterans' Affairs was almost a natural transition. All of a sudden the issues of mental health and post-traumatic stress were very real to me. I'd actually seen them when I was in uniform but never understood them. Then I was confronted with them in those early days at Veterans' Affairs. Some were very angry men and women, because of their health problems and because they weren't treated well.

They weren't given proper recognition. In the past, when soldiers came home, they were given a ticker tape parade and their neighbours and friends knew what they had done serving their country and how important it was. There was none of that for the Vietnam veterans. A lot had problems.

### You retired as Principal Medical Adviser three years ago, but what are you doing for the DVA now as a part-time consultant?

While looking after VIPs has been interesting, my real journey has been providing care to the veteran community - veterans and their families. In semi-retirement I'm still involved in the care of veterans with complex problems, particularly around mental health and chronic pain, along with supporting families through the RSL and Legacy. It's very hard

to rehabilitate someone with mental health issues if they suffer from chronic pain. Until you sort the pain out, you can't sort the head out.

I now provide advice to people who manage difficult cases. There's issues with mental health, chronic pain, substance abuse, family dislocation and sometimes homelessness. These people need help getting back on their feet. They're not all like that, but there's a number. It creates so much tragedy for whole families and it feeds into the community around them.

I think the biggest challenge is when they leave defence because the ones who are made medically unfit are leaving all their mates and often moving to different locations. They often have financial problems, their partners might be looking for a job - there's too much change. We've got to pick them up as they come out and give them all the support they need. If you miss them and they are in the community for too long without support, it's a very long road back.

### Are you happy in (semi) retirement?

I guess I'm not really happy, but I find I'm actually doing something that's quite meaningful and I think in a way, feeling you are useful is more important to me than being happy.

### Dr Killer hopes to continue consulting to DVA for at least another year. He also works with Legacy and is on the board of PainAustralia. He was made an Officer of the Order of Australia in 1999 for services to the veteran community and in 2016 was presented with the AMA President's Award for his 'outstanding contribution towards fostering the objectives of the AMA.'

I'm very proud to be a member of the Australian Medical Association. The links between the AMA (or the BMA, as it was) go back to the end of World War One. The doctors, with the government, have been a very strong part of providing the best of care for the servicemen and women and the veteran community. While I was the Principal Medical Adviser in Canberra we would never have achieved all the things we did without the great support of the AMA and the doctors from the cities to the most rural settings in Australia providing veteran-centric care.



# Dr Bawa-Garba: Who's to blame when a medical tragedy occurs?

In 2011, Jack Adcock - a six-year-old boy with Down's syndrome, a congenital heart disease and heart failure - was admitted to Leicester Royal Infirmary in the United Kingdom. He'd been sick overnight, with diarrhoea and vomiting. His breathing was shallow and he looked unwell.

The registrar on duty in the emergency paediatrics ward that day was Dr Hadiza Bawa-Garba. Her consultant, (senior doctor) Dr Stephen O'Riordan, was teaching in another town that morning and Dr Bawa-Garba was doing the work of at least one other paediatric registrar, who was on leave. So Dr Bawa-Garba was covering various wards of the hospital, including maternity, taking calls from GPs, and dealing with other emergencies. It was also her first day on duty for emergencies involving sick children, in an unfamiliar hospital and having recently returned from 14 months of maternity leave.

It was mid-morning when Dr Bawa-Garba first saw Jack Adcock. She put him on intravenous fluids and ordered blood tests and a chest X-ray. One blood test showed his blood was too acidic - a sign of severe illness - but that improved later in the morning after Jack was given fluids.

It was another two hours before Jack's chest X-ray was done, and it took Dr Bawa-Garba longer to see it - but once she did, she realised the boy had pneumonia and that was the cause of his illness. What she did not realise, and what no-one else realised, was that the infection had caused Jack to go into septic shock - he was having trouble maintaining enough output from the heart to stay alive.

Dr Bawa-Garba prescribed Jack antibiotics for his pneumonia, but he didn't get them for another hour. Around this time, the doctor's consultant returned to the hospital. He saw Jack's blood test results but didn't see the child. Jack was already

on a drug called enalapril for his heart condition. This drug takes the stress off the heart and lowers blood pressure and therefore shouldn't be used when someone is in shock. Dr Bawa-Garba knew this, and deliberately didn't write him up for the drug. But despite there being no continuing prescription for it, someone later gave Jack enalapril - and he went into cardiac arrest.

When she arrived at the resuscitation she mistook Jack for another child in the ward who had a 'do-not-resuscitate' order on his notes and called off the resuscitation. Another junior doctor present corrected the misunderstanding and efforts were resumed a minute later but they failed to revive Jack. He died less than 12 hours after being admitted to the hospital.

## Mistakes made: But who's to blame?

Dr Bawa-Garba was convicted of manslaughter on the grounds of gross negligence in November 2015. She was then suspended from practice for 12 months by an independent tribunal. But Britain's regulator of doctors, the General Medical Council, appealed that decision. They wanted her permanently struck off the medical register, arguing the doctor failed to act on signs Jack was seriously ill and therefore contributed to his death.

In January, the High Court of England and Wales found in favour of the GMC and struck off Dr Bawa-Garba for life. In its decision, the High Court found that the tribunal had failed to adequately sanction Dr Bawa-Garba - given that a jury had decided her conduct was "truly exceptionally bad".

"This misconduct by manslaughter by gross negligence involved a particularly serious departure from the principles of "Good Medical Practice," and the behaviour was fundamentally incompatible with being a doctor," Justice Ouseley wrote in his High Court decision.

Among the failings of Dr Bawa-Garba listed by the court were that she ignored key signs Jack was critically ill (like the high amount of acid and lactate in his blood, warning signs of septic shock) and didn't raise concerns about Jack's health with the consultant when he arrived at the hospital at about 4:30pm. But the ruling sparked outcry from doctors in Britain and around the world, who say the case reflects systemic failures at the hospital and in the broader healthcare system, and that it could have happened to any one of them.

"I've worked for 10 years in the UK, including some of the most intensive hospital environments in the UK, and I've never faced a day such as reported as her having faced that day," said Dr Moosa Qureshi, a haematology trainee and cancer researcher at the University of Cambridge. "The situation she was in was a situation which really was going to produce mistakes, and it wasn't only herself who was making those mistakes, though most of the blame seems to have been pinned on her."

Dr Qureshi is one of three doctors calling themselves 'Team Hadiza' - they've fundraised over 300,000 pounds (\$530,000) to pay for legal fees towards Dr Bawa-Garba's appeal of the High Court's decision. Doctors are fearful



Doctors in the UK hold up signs in support of Dr Hadiza Bawa-Garba (Photo: Twitter @drcmday).

the case could discourage medical professionals from owning up to their mistakes, and the cultural change it could effect within the British medical system.

“Mistakes happen in medicine, but the way we stop those mistakes is we have a culture of open learning, we share our mistakes, we reflect on them and we learn from them,” Dr Qureshi said. “One of the particularly alarming features of this case is that it seems that Dr Hadiza Bawa-Garba’s reflections on her mistakes were used against her in court ... in the long term that’s going to be damaging to patient safety across the UK.”

The GMC denies it used notes taken by Dr Bawa-Garba about that day, though accepts they may have been used in the Medical Practitioners Tribunal. Nurse Isabel Amaro, who also treated Jack Adcock, was also convicted of manslaughter and struck off the nursing register. Dr Bawa-Garba’s consultant, Dr O’Riordan, was not charged over the boy’s death.

### Could it happen here?

South-west Sydney paediatrician Andrew McDonald said most Australian consultant doctors would have had an experience like that of Dr Bawa-Garba’s. “Twice a week in Australia there is a serious adverse event in healthcare, child or adult. This already happens here.” Dr McDonald said the key difference was that the Australian system is better at recognising “system error”.

While a similar analysis as to what went wrong would happen in Australia as in the UK, he said Australia’s medical bodies are less likely to attribute blame to a particular doctor. “It would be done by the same people, but the outcome I expect would be different. The New South Wales Medical Board or the Australian Health Practitioner Regulation Agency (AHPRA) are not perfect but I’ve never seen anything as vindictive and poorly informed as this.”

Dr McDonald also criticised the consultant at the hospital for not going to see Jack Adcock when presented with his blood tests by Dr Bawa-Garba. “I have no idea why he wasn’t brought before the court. Before the court of his peers, consultants, to not go and see a child with a pH of 7.08 with an unexplained illness is just hopeless ... this consultant has failed in his duty of care to provide safe care to this child,” he said.

Chair of the Medical Board of Australia (the nearest equivalent of the UK’s GMC) Dr Joanna Flynn, said a conviction of manslaughter for a doctor in Australia was incredibly rare - only “a handful of cases over perhaps 50 years”. She said it was even rarer for a conviction to be recorded against an Australian doctor.

“There is a process of open disclosure in Australia, and in fact in Victoria there is a proposal to introduce candour as a legislative requirement, which means that patients must be told

if something bad has happened, why it happened, what has been learned from it, how it can be prevented,” she said. “There are protections so that explanation about what happened, and even acknowledgement that something went wrong, can’t be used in litigation against the doctor in the context of an apology.”

### A needless death

While debate continues over the personal and systemic errors in the case, Dr Moosa Qureshi said the focus needed to be on preventing similar deaths in the future. “This is a tragic, avoidable death of a young six-year-old boy, and really our hearts go out to the family of the young boy who has died needlessly,” he said.

“But I fear that this is actually a trend rather than a glitch ... these things happen all the time in medical practice and if we respond to them in this way we are really, really going to actually make things much worse because doctors are going to start feeling fearful of actually admitting mistakes. If that happens, then mistakes cannot be corrected and avoided in future.”

**James Bullen**  
ABC Health Report

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# Medical Careers Expo

On Saturday 28 April, over 900 delegates gathered at the Melbourne Convention & Exhibition Centre, excited to gain some insight into their future medical careers.

The delegates had access to over 40 exhibitors consisting of potential future employers and health providers across the day. While the exhibit alone proved very helpful, AMA Victoria also treated the delegates to short presentations from over 30 speakers representing organisations able to provide students with unique insights into what they can do specifically to find an edge, as they begin their medical careers.

Students were particularly keen to hear from the likes of the Austin, Eastern, St Vincent's and Ballarat health services. A double-length presentation from Mardi O'Keefe, AMA Victoria's own Careers and Pathways Coordinator, was highly beneficial for students looking for current insider tips on how to get ahead of the competition when it comes to your career.

AMA Victoria would particularly like to thank major sponsor's MDA National and Melbourne BMW for their support of the event, and also all of the students and delegates that came along to the day. We hope that you feel more prepared for your busy year ahead!

We'd also like to thank the sponsors who provided prizes and giveaways for our delegates - Wine Direct; Laithwaite's Wine People; Little Real Estate; MDA National and MedX.





# Introducing new Workplace Relations Advisor John Ryan



**AMA Victoria is pleased to welcome John Ryan to our Workplace Relations team. John brings 38 years of experience to his new role as Workplace Relations Advisor, joining the team in late March.**

John was a Commissioner for the Fair Work Commission (FWC) for the last eight years, where his key functions included conciliation and arbitration of industrial disputes, unfair dismissal claims, conciliation of bargaining disputes and bullying claims, and approval or rejection of enterprise agreement applications. He has previously held senior industrial relations positions in a number of organisations, including the Shop, Distributive and Allied Employees' Association, Federated Ironworkers' Association and the Pharmacy Guild.

John has seen industrial relations issues from all sides and says he's looking forward to helping and servicing members on the ground.

"I've always been passionate about worker rights. I think you can best assist worker rights, either by helping employers get it right or you can assist workers directly by ensuring they get what they're entitled to. If you get that fairness going then you will have improved the relationship between employers and employees and that should be at the heart of a membership organisation like the AMA. I can add value and bring a set of skills that have taken me 38 years to acquire and I want to put back in, by helping members.

"If you spend all your time becoming a doctor, you don't have time to become an IR expert. At some point you need to ask, 'Where is my IR expert so that I can deal at an equal level with an employer's IR expert?' That's why you have an organisation like the AMA. It provides this level of expertise and I'm part of this."

John's philosophy is relatively simple - a happy workplace is good for the employee and the employer. "With my experience, I'm far more able to see the merits of both sides of an argument and far better placed to promote the concept that we're dealing with relationships. Every industrial problem is a relationship

problem and the main thing is how you improve relationships. Workers want to work in happy workplaces and employers want workers who want to come to work. You only get that by working on relationships.

"The more I've learnt about the law, I've learnt that it's more important to focus on the relationship than it is on the legal question. The health industry needs to get its relationships right. Having an EBA is not about the words on the paper, it's about the relationships you have with your employees. If you aren't doing something right, it shouldn't be a case of being told off for doing something wrong. Instead, can we point out the better way of doing it and improving relationships?"

AMA Victoria CEO Dianne Angus says the appointment of John Ryan, enhances the service available to members and is a further boost to the Workplace Relations team, following the successful negotiation of the new enterprise bargaining agreement for public hospital doctors.

"We are very fortunate to secure someone with the depth, breadth and seniority of experience to join our Workplace Relations team," Ms Angus says. "No other associations, employers or hospitals have ex-Commissioners working for them and we know John will be a great asset and a strong advocate for the rights of our members."

If you would like to contact John about an employment issue, please contact the Workplace Relations team on (03) 9280 8722.



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# Diabetes doubles risk of sudden cardiac death

## Report reveals new aspects of the chilling link between type 2 diabetes and CVD

One and a half million Australians living with type 2 diabetes (T2D) are twice as likely to suffer a sudden cardiac death compared to those without the condition, according to a new report that provides a national snapshot of T2D and cardiovascular disease (CVD).

The report, *The Dark Heart of Type 2 Diabetes*, launched in January by Baker Heart and Diabetes Institute, shines a light on the sinister interplay between T2D and CVD. It reveals that CVD is the number one cause of death among Australians with T2D and is a major contributor to the shortening of life expectancy by up to a decade (8.2 years for men and 9.1 years for women) for people with T2D. It is responsible for one-in-three deaths in people with T2D.

The report also highlights that developing T2D early in life is one of the greatest contributors to an early death. Age of diagnosis was also the focus of a recent paper by Baker Institute researchers published in *Diabetologia*, showing that the younger the age at diagnosis of T2D, the greater the effect of diabetes on mortality from CVD, ischaemic heart disease and stroke.

Head of Clinical Diabetes and Population Health at the Baker Institute and co-author of the Dark Heart report, Professor Jonathan Shaw, says that while great strides had been made in controlling blood glucose levels and thereby reducing the associated risk of kidney disease, loss of sight and limb complications, CVD remains a threat for people with T2D.

"The reality is that Australians with T2D are much more likely to die from heart disease, and at a younger age, than those without the condition – regardless of whether their blood sugar levels are elevated or under control," Prof Shaw says.

"Perhaps the greatest concern is

the risk of sudden cardiac death which happens without warning, even among people with no history of heart disease. The importance of regular check-ups cannot be understated."

The report also identifies heart failure as a major driver of the cardiovascular burden among Australians with T2D, saying the likelihood of death from heart failure is elevated to the same level as from myocardial infarction. Indeed, heart failure is now often the initial CVD presentation, coming before myocardial infarction, and some studies have indicated that even as the first manifestation of CVD in people with diabetes, heart failure is more common than myocardial infarction.

"While glucose-lowering medicines can protect against some of the consequences of diabetes, such as blindness and kidney damage, the effect of good glycaemic control on reducing cardiovascular risk is much weaker. It remains vitally important to ensure that therapies with proven cardiovascular benefits (e.g. statins and blood pressure lowering agents) are used by those at increased CVD risk," Prof Shaw says.

The Baker Institute report, supported by an unrestricted educational grant from Boehringer Ingelheim and Eli Lilly, notes that the number of people diagnosed with diabetes early in life is increasing rapidly.

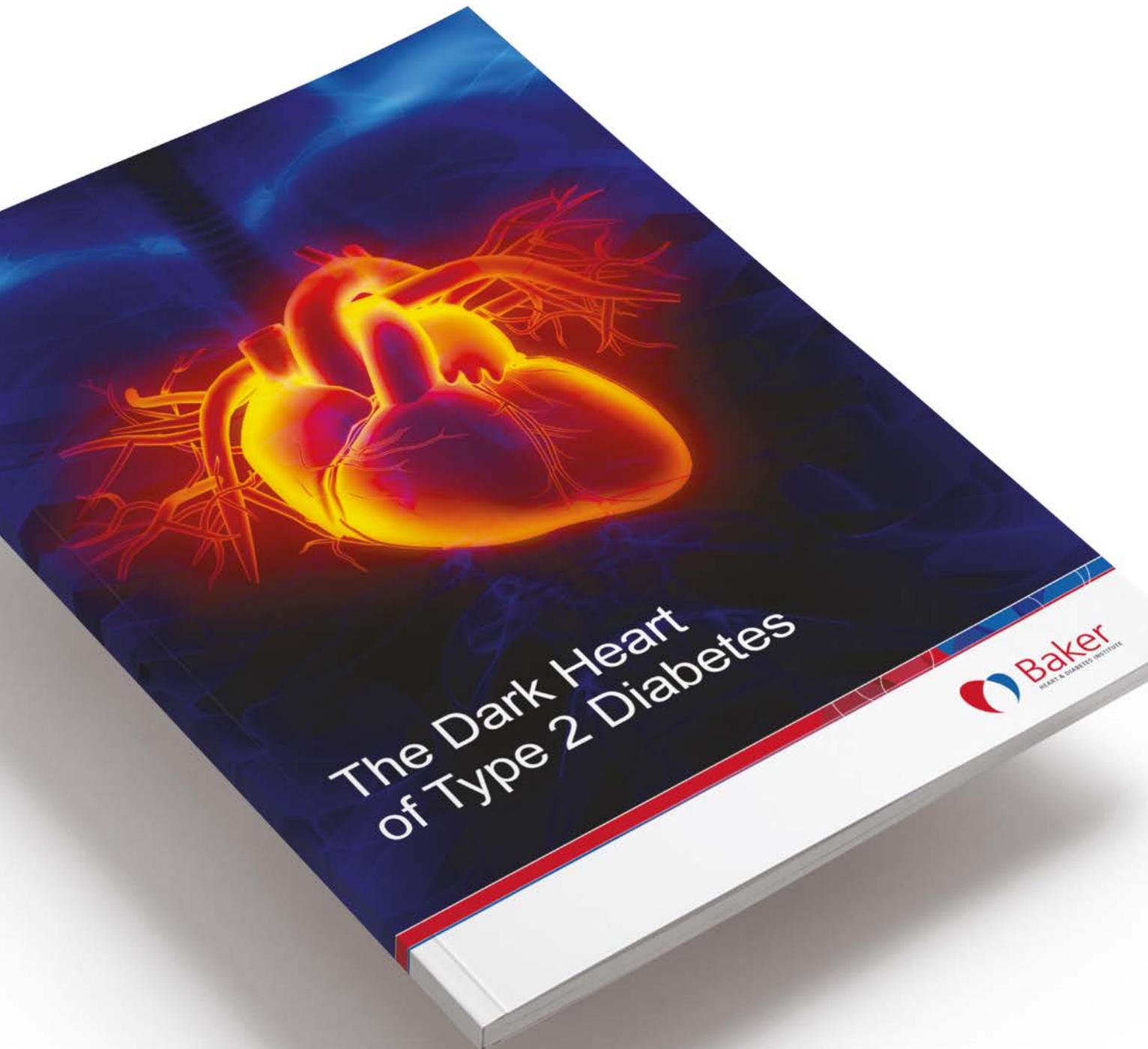
"Over the last decade, we have seen reductions in heart disease deaths in older Australians with diabetes, yet we have not seen the same improvements in those under the age of 40."

Professor Shaw says having T2D has a greater effect on the risk of dying due to cardiovascular disease in women than it does in men. "It appears that the gender-associated protection against cardiovascular disease is lost in women with T2D."

The report recommends that Australians living with T2D adopt a healthy diet, moderate weight reduction, increase physical activity and take appropriate action to keep blood pressure and cholesterol, not just blood sugar, at healthy levels.

The *Dark Heart of Type 2 Diabetes* report also found:

- Diabetes is the fourth most common condition managed in general practice.
- Hypoglycaemia is a potential risk factor for sudden death and arrhythmia.
- An estimated two-thirds of Australians with T2D also have cardiovascular disease.
- Approximately 1-3 per cent of individuals with T2D experience a



coronary heart disease event per year. This is approximately twice the rate of people without diabetes.

- Weight loss of 5-10 per cent is worthwhile as over 95 per cent of those with T2D are overweight or obese.
- Co-morbid psychological stress, anxiety and depression are significantly associated with

coronary heart disease and its outcomes.

- Aboriginal and Torres Strait Islander people with T2D have a higher incidence of CVD and death from CVD.
- The annual cost of diabetes for medical care and government subsidies in Australia exceeds \$10 billion.

For more on this report, visit [www.baker.edu.au/impact/advocacy/dark-heart-diabetes](http://www.baker.edu.au/impact/advocacy/dark-heart-diabetes)



References available from the Editor on request.

# If codeine is passé and opioids are ineffective for long-term pain, what next?



Since beginning my role as CEO of PainAustralia, I have become aware of the thin divide between an individual who has become dependent on drugs and someone with chronic pain who is reliant on opioids. Both depend on drugs for their perceived survival. The drug dependent person is more likely to prioritise drug seeking behaviour over every other aspect of their lives, but will be all too aware of what they are doing and why. Many who use opioids prescribed by their doctor for pain, do not realise how dependent they have become.

According to the Australian Bureau of Statistics, the person most likely to die from a drug-induced death in Australia today is a middle-aged male living outside of a capital city who has misused prescription drugs, such as oxycodone, usually by accident because they used other drugs at the same time that multiplied the effect of the opioid.

In research associated with our recent 'Real Relief' consumer education campaign - part of our information campaign around codeine upscheduling - we found most people were unaware that codeine is a potentially harmful opioid. When people understood the serious potential harms associated with codeine - addiction, poisoning and death - they became more supportive of the decision to make it a prescription-only product.

Opioids are very effective in relieving acute pain and cancer pain, and in palliative care, however, numerous studies have shown use of opioids for long-term chronic pain is fraught with risk and danger, with minimal or no benefit. Despite this growing body of research, chronic pain is the main reason cited for increasing rates of opioid prescribing.

The 2015 *Australian Atlas of Healthcare Variation* found the number of opioid prescriptions dispensed in Australia is more than 10 times greater in the areas with the highest rate of chronic non-cancer pain. The variation was also associated with socioeconomic disadvantage as well as poor access to effective pain management services including non-pharmacological approaches.

Chronic ongoing or recurrent non-cancer pain affects one in five Australian adults and children and one in three aged over 65. It costs Australia at least \$34 billion per year - our third most costly health burden and the leading cause of early retirement and absenteeism.

The opioid issue is not just an addiction problem or a prescribing problem in need of some consumer education and accredited doctor training. We have a pain epidemic that needs strategic, focused, nationwide action. Not the kind being touted in the US, where the administration has called for the death penalty for drug traffickers dealing in prescription drugs and believes punitive action is an effective solution. If the opioid crisis is largely a result of our inability to appropriately manage pain, a strategy to better manage pain is the most sensible place to create a momentum for change.

As a nation we have no more excuses for inaction on pain. While restriction of codeine and other opioids is in keeping with our evolving understanding of best-practice pain management, if codeine up-scheduling

showed us anything, it is that too many Australians are relying on potentially harmful pain medication because there are too few alternatives.

In most cases chronic pain can be successfully managed with a multidisciplinary approach. This addresses the bio-psycho-social nature of the pain experience, with input from doctors and a range of allied health professionals - most commonly psychologists and physiotherapists with specialised training - who help develop individualised management plans.

The problem is that patients face long wait times to access multidisciplinary pain clinics - frequently more than a year - resulting in deterioration of their pain condition. In some cases significant travel is required and in the case of specialised paediatric care, the clinic may be interstate. There is insufficient assistance through Medicare for allied health services for people with chronic conditions, and poor rebate structures for those who have private health insurance.

These issues highlight the urgent need for a national and holistic strategy to better prevent, treat and manage pain as an emerging national health emergency. It requires a cross-portfolio and multi-level response by the Federal and State Governments.

We already have a national strategy for pain. Our goal is for the Australian Government to endorse and coordinate implementation of this strategy to ensure a consistent approach to pain health services Australia-wide. This is likely to be the safest and most effective path to address the opioid issue in Australia. We can and must do better at managing pain.



**Carol Bennett**  
CEO  
PainAustralia

References available from the Editor on request.

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# Keeping the mouth in mind

Results released from the most recent Royal Children's Hospital National Child Health Poll suggest parents lack the basic information required to adequately care for their children's teeth, with few parents of young children receiving the advice they need from healthcare professionals.

Despite recommendations, a third of pre-schoolers have never seen a dentist and more than half of toddlers are not brushing their teeth often enough.

Rates of tooth decay are on the rise in Australia, particularly among young children. Dental caries is the highest cause of acute, preventable hospital stays in Australian children, with more than 26,000 children under 15 years of age being admitted to hospital for treatment of decay every year. The most common age for preventable hospitalisations is five to nine years.

Untreated dental disease can cause chronic infection and pain. This can affect a child's ability to eat, play and learn, and so impact their growth, development and quality of life. It is also linked to long-term health outcomes like heart disease, stroke and diabetes in adults.

## RCH NATIONAL Child Health POLL

**1 in 3** preschoolers have never seen a dentist

To help keep teeth healthy children should visit the dentist for a checkup from age one

[rchpoll.org.au](http://rchpoll.org.au)



Multiple factors are at play in the alarming rate of growth of dental disease among Australian children including problematic diet, inadequate brushing and a lack of equitable and accessible professional dental care. The RCH National Child Health Poll shows that many parents, despite meaning well, lack the basic knowledge to prevent tooth decay in their children. Others are confused when it comes to recommendations about brushing teeth, diet and when to see the dentist for a check-up.

### Visiting the dentist

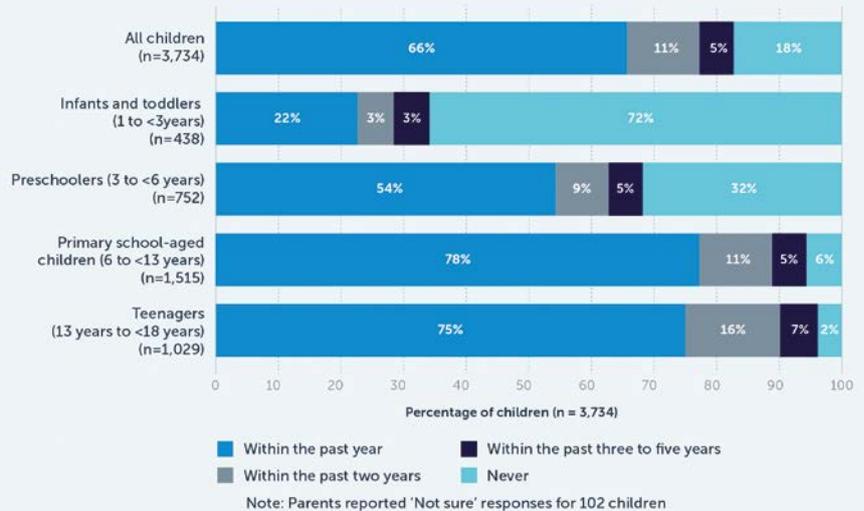
Recommendations arising from the National Oral Health Plan suggest that all children should have an oral health assessment by the age of two years. The Australian Dental Association recommends a visit to a dental health professional at around 12 months of age. Our poll found that only 17% of children had seen a dentist by the

age of two and a third of children had not visited the dentist by the time they started school (see Figure 1). Yet one-quarter of Australian children have tooth decay that requires filling by early primary school and one in ten require an extraction.

Improved availability and accessibility of dental services to Australian families is warranted, particularly for those families living in regional areas and those of relative socioeconomic disadvantage. Importantly though, this poll found that half of all parents were not aware of the free or low-cost government funded dental services that may be available in their local area. One in four families who were eligible for the Child Dental Benefits Scheme, were not aware of the scheme's existence, suggesting a need to better educate and support families in how to access affordable dental care where it is available to them.

Figure 1

## Timing of last dental checkup



## Tooth brushing

In order to prevent tooth decay, it is recommended that children's teeth are cleaned or brushed twice a day, from the time the first tooth erupts. A pea-sized amount of children's strength fluoride toothpaste is recommended from 18 months of age. Our study found that a third of children do not have their teeth cleaned twice a day, with younger children being less likely to have their teeth cleaned often enough than older children (see Figure 2). Of concern, a third of parents think that babies don't need their teeth cleaned every day and one in five parents indicated that it didn't matter if baby (primary) teeth developed decay since they fall out anyway.

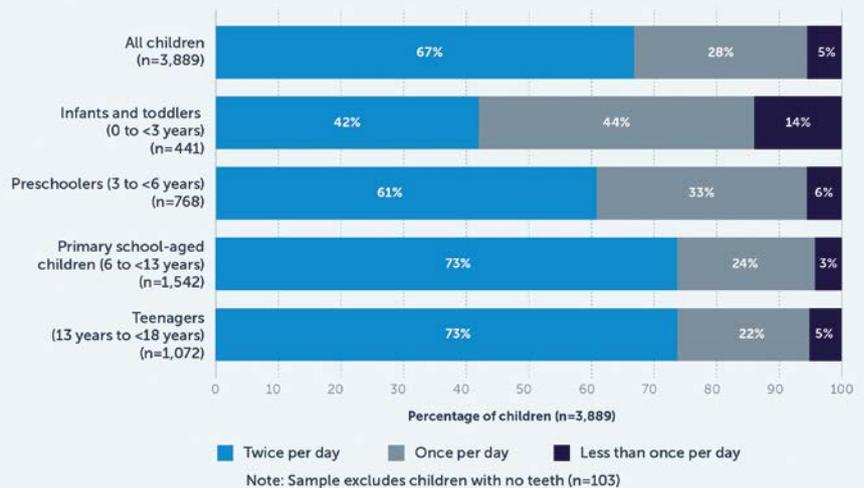
## Diet and drinks

Most parents know that consuming sugary food and drinks can contribute to tooth decay, but more than 70% of Australian children and adolescents exceed World Health Organisation recommendations for sugar intake. Many parents report finding it hard to know how much sugar is in food. According to parents polled, one-third of Australian kids have sugar-sweetened drinks most days of the week, including one in five pre-schoolers. A 375mL can of soft drink contains around nine teaspoons of sugar, well over the recommended maximum daily intake of added sugar.

The vast majority of Australians have access to high quality fluoridated tap water, which helps to strengthen teeth and prevent decay. Yet our poll found that half of parents thought bottled water may be better for their children's teeth than tap water, suggesting a lack of awareness of the benefits of fluoridated tap water for teeth.

Figure 2

## Frequency of teeth brushing in Australian children



## Towards solutions: the doctor's role in oral health

This study suggests there is a big knowledge gap to fill among Australian parents when it comes to caring for their children's teeth. In the first two years of life, children have many encounters with the healthcare system, including visits to the child health nurse, general practitioner, paediatricians and even the emergency department. Each of these care episodes is an opportunity for oral health advice, education and risk assessment.

Historically, medicine and dentistry have always been distinct practises, meaning that oral health is treated differently by the healthcare system, health insurance funds, public

health professionals, policy makers and even patients themselves. If we are to improve the state of oral health in Australia, and in turn overall health, we must bridge this artificial 'body and mouth divide'. Medical professionals must explore ways to better partner with their dental colleagues in delivering oral healthcare, and seize the many opportunities available to them for oral health risk assessment, anticipatory guidance and health promotion in children and families.



**Dr Anthea Rhodes**  
 Director, RCH National Child Health Poll  
 Paediatrician  
 Royal Children's Hospital Melbourne

# Career Conversation

An emerging pattern in recent years has seen some doctors looking to explore alternate and non-traditional careers both within and outside of clinical medicine. In this Career Conversation series, we are profiling a range of doctors who have transitioned to non-traditional paths - either instead of, or in parallel to a traditional clinical path. These stories are not only very interesting but can help other doctors understand that medicine can present diverse, often untapped career options.

**Dr Melanie Tan**  
*Doctor, lawyer,  
medico-legal  
consultant*

## **How would you summarise your career path in medicine?**

A process of elimination - having intermittently and concurrently been a doctor, medical negligence lawyer, medical indemnity claims handler, and medico-legal adviser. I'm now a Lawyer and Medico-legal Consultant at Rankin & Co. (Business Lawyers) on a part-time basis. In my own time I remain an independent educator, writer, media presenter and PhD student (in law).

## **Why did you choose to study medicine?**

I wanted to be an actor! Once sense prevailed, I aimed for law - I loved writing, analysis and expression. However I started questioning if I was tough enough to be a lawyer - little did I know how 'tough' I would need to be as a doctor, at times.

My father being a surgeon, I have often been asked whether I felt pressure to become a doctor. The short answer is no - other than the influence of his infectious enthusiasm and passion, as a pioneer and innovator - and like him, I have always believed in believing in what you do. Wanting to help people, and being intrigued by the mind, I decided to become a psychiatrist.

## **Who or what have been the main influences on your career pathway choices?**

I struggled to engage with medicine - I have a creative streak which it didn't fulfil. Nevertheless, I jumped on the treadmill and didn't get off until my fifth year, when I decided against psychiatry after rotating through it. I thereafter considered everything in medicine from surgery to paediatrics to geriatrics. I felt a bit lost - until my interest in law was reignited by lectures in medical law - and thought, why not? Combining the two disciplines could be my niche! Finally I felt excited, and after my internship, completed a law degree at Cambridge University. It was the most inspiring period of my life.

I qualified as a solicitor in London before returning to Melbourne. I wanted to combine law with medicine, however without much real-life experience I didn't know exactly how. Having trained for two years in a law firm, I wasn't attracted by the corporate world. So I picked up where I'd left off as a junior doctor five years earlier to refresh my clinical skills, while at the same time exploring options.

In the ensuing years I transitioned through various roles in health law - I lectured at Flinders and Deakin

Universities, worked in the health law team at the Victorian Department of Health and Human Services, and ultimately landed at Phillips Fox (now DLA Piper) as a medical defence solicitor (also providing general advice to healthcare clients).

I later returned to London for almost five years, continuing to work as a defendant solicitor until deciding medical negligence litigation was too demoralising. I returned to clinical medicine as a locum medical officer in the NHS, and serendipitously found myself working at a Lloyd's insurance syndicate, managing claims against Italian public hospitals - something different!

In 2013 I returned home to Melbourne and since then I have managed claims against public hospitals, and subsequently worked as a medico-legal and medical advisor for medical defence organisations, before taking time out to focus on my PhD and explore opportunities in consulting and education, and in legal practice outside of medical defence.

### What inspired the career pathway choices you

### have made?

I have always tried to stay true to myself. One day I had an epiphany, which explained everything: "I have the heart of a doctor, the mind of a lawyer, and the soul of an artist".

As I've matured, I've grown into medicine. I have learnt its art, beyond its science. I enjoy being a doctor and helping people. However my background in claims means that I live in fear - and write excessive notes!

Intellectually I love the law, especially where it intersects with medicine. Thinking in medicine is algorithmic which doesn't excite me, whereas legal thinking can be creative. I still want to help people, and can.

My attraction to media probably stems from my childhood acting aspirations!

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

I have no regrets despite my divergent paths, and am grateful for all the opportunities and experiences that have presented themselves to me.

### Do you foresee any other changes in career paths in the future?

My role with Rankin & Co. is a recent addition. In conjunction with supporting the firm in providing a wide range of commercial legal services to healthcare providers, I also offer general medico-legal advice to its healthcare clients.

My independent pathway in the education sphere is also likely to develop in parallel with the PhD.

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

Be true to yourself. Know there are always alternatives to the 'norm'. Life is too short to be unhappy at work - or worse, uninspired.

**We would love to hear from you if you have a career story you would like to share. Alternatively, if we can assist you in exploring your career options, please book a free 15-minute career call or a career coaching session via our website [amavic.com.au/careers-advice](http://amavic.com.au/careers-advice)**



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# Plea to reverse declining vaccination rates against fatal lung infection

**Lung Foundation Australia is teaming with researchers, doctors and patients to call for proactive community action to address the declining vaccination rates against pneumococcal pneumonia - an infection responsible for more than 15,000 GP visits, 8,000 hospitalisations, and 2,000 deaths among those aged over 65 each year.**



Streptococcus pneumoniae

The call coincides with an article recently published in *MJA Insight* by UNSW Vaccine and Infection Research Lab (VIRL) researchers, urging governments and doctors to work harder to reinforce the public health message regarding the seriousness of the potentially life-threatening, but preventable infection, pneumococcal pneumonia.

The article reveals pneumonia ends lives prematurely, even in wealthy countries with access to the best healthcare. It also reinforces that the main tools to prevent the most common cause of pneumonia - streptococcus pneumoniae, responsible for an estimated 20 per cent of pneumonia cases in Australia - are vaccines.

According to article co-author and infectious diseases researcher, Dr Rob Menzies from UNSW

VIRL, a healthcare professional's recommendation to vaccinate, or otherwise, is the most influential factor determining whether a person chooses to protect against vaccine preventable infections.

"We're achieving a 93 per cent pneumococcal vaccination rate among Australian children. Yet we're failing to achieve even a 50 per cent pneumococcal vaccination rate among equally vulnerable seniors, despite the publicly-funded immunisation program - a simple preventative health measure that could prevent serious disease or premature death.

"The most recent data suggests pneumococcal vaccination coverage has actually declined to 47 per cent in NSW, with more than half of these vaccinations occurring after 70 years of age," Dr Menzies said.

"This decline must be urgently reversed. Doctors should be looking to opportunistically vaccinate those at risk of pneumococcal pneumonia (including people aged 65 and over, the immunocompromised and Indigenous Australians) in the same way they do for other population-based programs.

"It is also important for individuals to take the initiative for their own health. Anyone who smokes, has a chronic disease, immunocompromising condition, or is aged 65 years or over should talk to their GP about whether they should have a pneumococcal vaccination, or a re-vaccination against the infection," Dr Menzies said.

Dr Michelle Caldecott, a respiratory and sleep disorders physician at Austin Health and Epworth Healthcare, says all adults aged 65 years and over are at increased risk of contracting



pneumococcal pneumonia due to their age alone, and many more have existing chronic medical conditions or lifestyle factors, such as current or past smoking, that places them at heightened risk of infection.

“Importantly, the *MJA Insight* article reinforces the importance of vaccination against pneumococcal pneumonia as a preventative health strategy from the age of 65, rather than delaying vaccination for a number of years. Given pneumonia is a potentially life-threatening respiratory infection, should an individual develop a cough, fever, shortness of breath, and feel generally tired and unwell, they should head to their doctor without delay,” Dr Caldecott said.

The pneumococcal vaccine is provided free under the National Immunisation Program (NIP) Schedule for all Australians aged 65 and above,

Indigenous Australians aged 50 years and over, Indigenous Australians aged 15 to 49 years who are medically at risk, and infants under 12 months. A second dose of vaccine is also available to Australians with immunocompromising conditions or chronic disease, or smokers, a minimum of five years following their first dose.

The vaccine is also available on the Pharmaceutical Benefits Scheme (PBS), and the NIP in some states, for all adults aged 18 years or over, who are smokers or medically at risk, such as those with chronic lung, heart or liver disease or diabetes.



References available from the Editor on request.

## About Lung Foundation Australia

Lung Foundation Australia is the only national charity supporting anyone with a lung disease. Since 1990, the charity has been the national first point-of-call for patients and their families, carers, health professionals and the general community. Their mission is to improve lung health and reduce the impact of lung disease for all Australians by driving world class research; promoting lung health and timely diagnosis of lung disease, providing clinical support and education, and promoting equitable access to evidence-based care.

[www.lungfoundation.com.au](http://www.lungfoundation.com.au)

# Guess the Whisky Evening

On 16 April, AMA Victoria hosted a night for whisky lovers with the support of the Scotch Malt Whisky Society, McLaren Melbourne, FIIG Securities and Clinic to Cloud. The event took place in the beautiful McLaren Melbourne showroom. Guests enjoyed their chance to network among impressive automobiles, as they were challenged to identify various whiskies on taste alone.



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# Helping couples get their timing right



Studies have found that a considerable proportion of people have poor understanding of the menstrual cycle and when a woman is most likely to conceive. Your Fertility, a government funded public education program to improve knowledge about modifiable factors that affect fertility, sees evidence of this in the behaviour of visitors to its website. Of the three million annual visitors to the Your Fertility website, more than 70 per cent of traffic goes to pages with information about when to have sex for conception.

Commonly, sexual and reproductive health education in school focuses on how to avoid pregnancy and sexually transmitted infections (STIs). Less time is spent developing a general understanding of fertility and the factors that can affect the ability to have a healthy baby - including, the best time to have sex in order to become pregnant.

Educating people about this can reduce the time they take to conceive and perhaps save them a trip to a fertility clinic. For GPs and other

primary care health providers, it is worth checking with patients who are trying to have a baby, whether they are sufficiently informed about the basic facts of conception.

Many people are not aware that ovulation happens about 14 days before a period starts, but knowing this allows a woman with regular cycles to calculate when she is likely to ovulate and therefore, when to have sex in order to conceive. The Your Fertility website - [www.yourfertility.org.au](http://www.yourfertility.org.au) - has an interactive ovulation calculator that helps people pinpoint when in the menstrual cycle they are most likely to conceive.

Some patients may not realise that a woman's menstrual cycle is counted from the first day of one period to the first day of the next period - or that women's cycles can vary in length. As a result, the day on which an individual woman's ovulation occurs will depend on the length of her cycle. For example, women who have a period every 28 days will ovulate around day 14 and their best chance of conceiving is between days 11 and 14.

For a woman whose cycle is 24 days, ovulation happens around day 10 and her most fertile days are between days seven and 10, while someone who has a 35 day cycle will be most fertile between days 18 and 21.

Not everyone knows that pregnancy is technically only possible during the five days before ovulation through to the day of ovulation. These six days are the 'fertile window' in a woman's cycle, and reflect the lifespan of sperm (five days) and the lifespan of the egg (24 hours). The likelihood of becoming pregnant is dramatically increased if intercourse takes place in the three days leading up to and including ovulation.

For women who have irregular cycles, it may be better to recommend that they have sex every two to three days to cover all bases and optimise their chance of conceiving. It is also helpful for women trying to conceive to be aware of how the vaginal mucus changes when ovulation approaches. A few days before ovulation, vaginal mucus becomes clear and slippery and this is the best time to have sex if they are trying for a baby.

Just as there is a lack of awareness about when to have sex to have a baby, many people also have gaps in their understanding of other factors that can impact on their ability to conceive, including their age, weight, whether they drink heavily, smoke or have had an STI. With this in mind, Your Fertility's new website ensures that people visiting pages with information about timing of intercourse, also find useful information about other factors that affect their chance of pregnancy in the hope that this will help them on their way to becoming parents.

Your Fertility has an extensive range of fact sheets for health professionals and the public available for download. Visit [www.yourfertility.org.au](http://www.yourfertility.org.au) to learn more.



**Louise Johnson**

CEO

Victorian Assisted  
Reproductive Treatment  
Authority (VARTA)

# EBA wins for Victorian Doctors in Training

The beginning of 2018 has seen an exciting update of the Victorian Doctors in Training (DiT) Enterprise Bargaining Agreement (EBA), yet a significant proportion of us are unfamiliar with the agreement or how it is relevant to our daily lives.

Enterprise agreements are governed by the Australian Fair Work Commission and are minimum entitlements to be provided to employees. Our DiT EBA is negotiated by the Australian Medical Association (AMA) and the Australian Salaried Medical Officers' Federation (ASMOF) on behalf of public sector trainee doctors. The new DiT EBA followed 58 bargaining meetings since November 2016 with hospital representatives and the Department of Health and Human Services. DiT subdivision members attended many of these meetings to ensure a DiT voice at the negotiating table. March 2018 saw the new version approved by 99.75% of the DiTs who voted. The next EBA will be negotiated in 2021.

The new agreement is a 100-page document covering several different aspects of our work, and applicable to interns through to advanced trainees. Consultants in the public sector are covered by a separate EBA, which has also been updated this year.

## Some key changes and wins for DiTs in 2018

### Clause 33 - Hours of work

Maximum rostered shift length for registrars reduced to 16 hours.

Mandatory 48 hours off duty when transitioning from night shift to another shift arrangement.

Doctors must be free from duty for at least 10 hours between rostered ordinary shifts.

### Clause 34 - Training time for registrars (in addition to the pre-existing clause of five hours of protected mandatory training per week)

On commencement of employment or rotations, the employer must discuss forms of training and its rostering with registrars.

Any changes to rostered training time

must be recorded in writing by the employer, which must be accessible to registrars.

Training allocation must be published on a document for all clinical and non-clinical staff.

### Clause 41 - Workload management and review

There is to be regular consultation about a doctor's workload, the capacity for workload to be reviewed and the ability for disputes about whether a workload is safe.

### Clause 42 - Remuneration

Scheduled pay increases of 3% per annum to occur from January 2018, 2019, 2020 and 2021, plus a one-off lump sum payment of \$2,000 (or pro-rata for part-time doctors) as part of an additional 6% increase from January 2018.

### Clause 48 - Internal training

DiT must be provided with reasonable time within paid working hours to complete compulsory training.

### Clause 63 - Public holidays

Trainees to be paid for public holidays even if rostered off.

### Clause 49 - Examination leave

A minimum of 3 days of examination leave immediately before each examination.

## Become well-versed in your DiT EBA

Obtain a copy of the current DiT EBA, skim through the list of contents and familiarise yourself with sections that interest you. AMA members can download a PDF copy of the document from [www.amavic.com.au/files/DITEBA.pdf](http://www.amavic.com.au/files/DITEBA.pdf)

Discuss the DiT EBA entitlements with fellow trainees, and assess whether there are issues requiring attention in your workplace.

## What if your employer breaches the EBA?

AMA Victoria Workplace Relations recommendations:

- Contact your health service in writing. Outline concerns and specify a deadline for their response.
- Serious breaches, or failure to respond as requested, should be flagged to the AMA promptly.
- Raising issues as a group prevents an individual from being singled out, and allows the issue to be referred to Fair Work directly, bypassing the need to be escalated through the disputes procedures in the workplace.

## Feel empowered to improve the system

As a DiT, it is likely that you are already busy juggling work with other aspects of life. The EBA is enforceable and exists to protect your wellbeing as a trainee. By discussing and speaking up about our rights under the EBA you can help to bring about necessary change to ensure a safe (and more enjoyable) working environment for ourselves, our colleagues and our patients.

All AMA DiT members are welcome to attend AMA DiT subdivision meetings, which are held on the second Wednesday of each month. To RSVP or for more information about the DiT subdivision please contact Grant Forsyth, AMA Workplace Relations Advisor, [GrantF@amavic.com.au](mailto:GrantF@amavic.com.au)



**Dr Karla Villafana-Soto**  
Doctor in Training

# Legal guide for doctors on medical treatment decision-making laws

This article outlines the obligations of health practitioners caring for people who do not have decision-making capacity.

Medical treatment decision making laws changed on 12 March 2018 when the *Medical Treatment Planning and Decisions Act 2016* (Vic) ('the MTPD Act') came into effect. The MTPD Act repeals the *Medical Treatment Act 1988* (Vic).

## Appointing a medical treatment decision-maker from 12 March 2018

An enduring power of attorney (medical treatment) appointment made before 12 March 2018 will continue to be recognised under the MTPD Act. This means there is no need to appoint someone as a medical treatment decision-maker from 12 March 2018 if they have already been appointed as an enduring power of attorney (medical treatment) prior to this date.

From 12 March 2018, a person will no longer be able to make an enduring power of attorney (medical treatment). Instead, a person can appoint a medical treatment decision-maker with authority to make medical treatment decisions on their behalf when they no longer have decision-making capacity.

A person appointing a medical treatment decision-maker also has the option to appoint a support person. A support person's role is to assist the person to make decisions by collecting and interpreting information, or assisting the person to communicate and give effect to their medical treatment decisions.



## Who can be an appointed medical treatment decision-maker?

A medical treatment decision-maker cannot be the person's usual treating doctor.

A person is able to appoint multiple medical treatment decision-makers. However, there can only be one medical treatment decision-maker for a particular decision. This will be the first person listed in the appointment who is willing and able to make the decision.

An adult may appoint a medical treatment decision-maker when they have decision-making capacity to do so.

## What does it mean to have a decision-making capacity?

An adult is presumed to have decision-making capacity. A person is deemed to have decision-making capacity if the person:

- understands the information relevant to the decision and the effect of the decision

- retains information to the extent necessary to make the decision
- uses or weighs that information as part of the process of making a decision
- communicates (either verbally or non-verbally) the decision and their views and needs as to the decision.

## What if an adult lacks decision-making capacity?

If an adult does not have decision-making capacity, the medical treatment decision-maker will be the first person who is willing and available of:

- an appointed medical treatment decision-maker
- a guardian appointed by the Victorian Civil and Administrative Tribunal (VCAT), or
- the first of the following with a close and continuing relationship with the person:
  - a spouse or domestic partner

- the primary carer of the person or an adult child of the person
- a parent of the person, or
- an adult sibling of the person.

### What if a child lacks decision-making capacity?

If a child does not have decision-making capacity, their medical treatment decision-maker will be a parent, guardian or other person with parental responsibility.

### Creation of Advance Care Directives and deciding on future medical treatment

The new law will also allow for the creation of Advance Care Directives which document a person's preferences for future medical treatment, including refusal of treatment.

Advance Care Directives are legal documents that may include:

- an instructional directive - which will provide legally binding consent to or refusal of medical treatment, and/or
- a values directive - which will outline a person's values and preferences to help guide future medical treatment.

A medical treatment decision-maker and health practitioner will be required to give effect to a values directive. The MTPD Act requires a medical treatment decision-maker to make decisions that they reasonably believe the person would have made.

In making a decision, the medical treatment decision-maker must consider:

- any valid and relevant values directive
- any other relevant preferences that the person has expressed and the circumstances in which the preferences were expressed
- if the medical treatment decision-maker is unable to identify any relevant preferences, consideration should be given to the person's values, as expressed in a values directive (if they have made one) or otherwise inferred from the person's life.

The medical treatment decision-maker must also consider the likely effects and consequences of the medical treatment including:

- the likely effectiveness
- whether treatment is consistent with

the person's preferences and values.

The medical treatment decision-maker is also obligated to consider alternative treatment options, including not providing treatment.

### What if no medical treatment decision-maker is available?

Doctors are obliged to make reasonable efforts in the circumstances to locate an Advance Care Directive and medical treatment decision-maker.

If there is no relevant instructional directive and the doctor cannot locate a medical treatment decision-maker, then the doctor must:

- if providing significant treatment - obtain consent from the Public Advocate, or
- if providing routine treatment - proceed without consent but record this in clinical notes.

Significant treatment is any medical treatment that involves a significant degree of bodily intrusion, a significant risk to the person, significant side effects or significant distress to that person.

Routine treatment is any treatment that is not significant treatment.

### Witnessing an Advance Care Directive

An Advance Care Directive is a legal document that must be signed and witnessed by a medical practitioner and another adult witness.

The medical practitioner must certify that, at the time of signing, the person:

- appeared to have decision-making capacity in relation to each statement in their Advance Care Directive
- appeared to understand the nature and effect of each statement.

To assess whether a patient understands the nature and effect of each statement, a doctor must discuss these statements with the patient and ensure they understand their implications. This is particularly important if the patient has included broad statements and the patient may not have considered how these statements could be applied in particular instances. For example, the statement 'I refuse cardiopulmonary resuscitation in all circumstances' should be discussed and a medical practitioner must ensure the person is aware that this could be applied in a broader range of circumstances than

chest compression.

A medical practitioner is under no obligation to witness an Advance Care Directive if they do not believe the person meets the above requirements. In these circumstances, the medical practitioner must not sign the document.

### Exceptions to provision of future medical treatment under directive

Doctors are not obliged to provide futile or non-beneficial treatment, regardless of any directives that exist. People cannot refuse palliative care in an Advance Care Directive and a medical treatment decision-maker cannot refuse palliative care. Doctors however, should consider the person's preferences and values when providing palliative care.

An exception applies to emergency situations. In a medical emergency, a health practitioner may make decisions on urgent medical treatment without obtaining consent from a medical treatment decision-maker, and there is no requirement to make reasonable efforts to locate an Advance Care Directive. However, this exception will not apply if the doctor is already aware of an instructional directive and acts in contravention of an existing directive.

### Can a person nominate voluntary assisted dying as a preferred treatment option?

It is important to note that the MTPD Act does not allow voluntary assisted dying. The *Voluntary Assisted Dying Act 2017* explicitly states that a person cannot include voluntary assisted dying in an Advance Care Directive and a medical treatment decision-maker is not authorised to make a decision about voluntary assisted dying.

Template consumer Advance Care Directives can be accessed here:

[www2.health.vic.gov.au/about/publications/formsandtemplates/advance-care-plan-template](http://www2.health.vic.gov.au/about/publications/formsandtemplates/advance-care-plan-template)



Last reviewed March 2018

*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.*

# Confidentiality versus risk of harm



**A key element to the doctor-patient relationship is the patient's expectation that the doctor will hold their information in confidence. But there are times when doctors are not required to maintain patient confidentiality, and these exceptions are set out in both state and federal privacy legislation.**

However, under privacy legislation, there is no mandatory duty for doctors to disclose confidential information to third parties. Against this background, a recent finding by a Victorian Coroner suggests there are those who consider that doctors should make disclosures when exceptions apply.

## Case history

Ms Adriana Donato was murdered by her ex-boyfriend, James Stoneham, on 23 August 2012 in Essendon. The focus of the inquest into Ms Donato's death centred on the extent of Mr Stoneham's disclosure to his case manager, clinical psychologist Dr Caroline Gregory, of any threat to Ms Donato's safety, either implied or explicit.

Ms Donato ended her relationship with Mr Stoneham for the second time in December 2011. By early to mid-February 2012, there was a change in Mr Stoneham who struggled to deal with the break-up. From this time, Mr Stoneham was drinking excessively

and taking illicit drugs. He was attending Dr Gregory for treatment. Dr Gregory last saw Mr Stoneham on 22 August 2012, the day before Ms Donato's death.

## Medico-legal issues

The Victorian Coroner explored Dr Gregory's obligations of confidentiality in the therapeutic relationship and the exemption to that confidentiality as set out in the Health Privacy Principles contained in the *Health Records Act 2001* (Vic). The Coroner also examined whether the threshold for breaching confidentiality under the Health Privacy Principles - that the patient must present a "serious and imminent threat to an individual" - was too high.

Dr Gregory was shocked to learn about Ms Donato's death. She stated that while Mr Stoneham had discussed feelings of anger, there was a vast difference between those feelings and what had happened. In her assessment of Mr Stoneham on 22

August 2012, Dr Gregory saw no risk of harm to anyone. At a consultation on 13 August 2012, Mr Stoneham had expressed aggression towards an unnamed individual and had thoughts of violence, but refused to disclose any details. There were earlier consultations where Mr Stoneham had expressed anger towards Ms Donato.

As a result of expert evidence, the Coroner concluded that Dr Gregory should have questioned Mr Stoneham on 13 August 2012 about his thoughts of violence and she should have made specific reference to Ms Donato. The Coroner considered that if this had occurred, it may have led to a notification by Dr Gregory to the police.

The Coroner commented that while the reporting of such matters is not mandatory, the spirit of the Health Privacy Principles demands that such matters must be addressed and that the reporting of above threshold cases should occur. In arriving at this view, the Coroner considered that the threshold under the Health Privacy Principles was too high and acknowledged that, at a federal level, there is no requirement that the threat needs to be "imminent". The Coroner recommended that the Department of Health and Human Services give consideration to the removal of the requirement that a "serious risk of harm" be also one which is "imminent".

## Medico-legal advice

Under the Australian Privacy Principles (APPs), health information can be disclosed if it is a "permitted general situation" - this includes if you reasonably believe that the disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual.



*References available from the Editor on request.*

*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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BY ZAHA HADID



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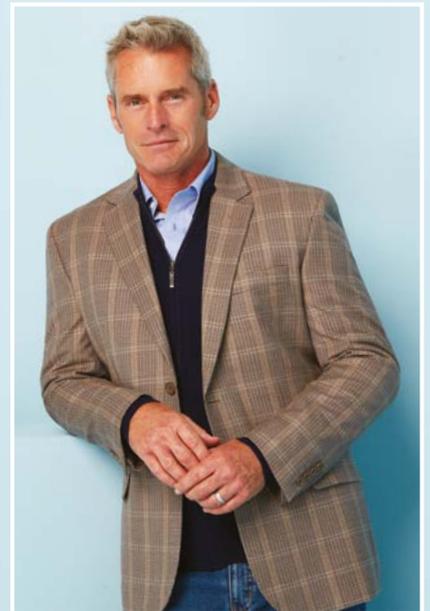
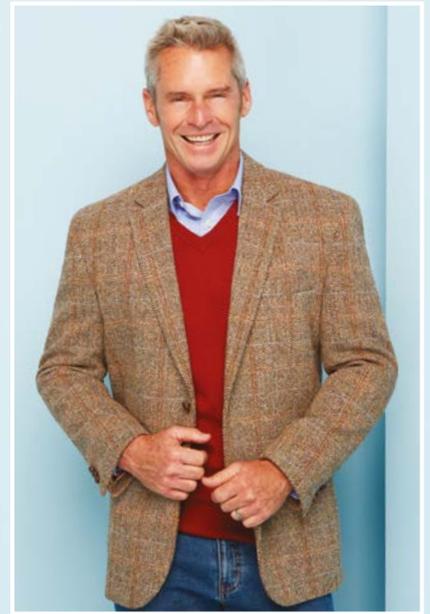
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AUSTRALIA

# Preparing for SafeScript – Information for Victorian doctors

The Victorian Government is implementing SafeScript, a real-time prescription monitoring system, to reduce the growing harms from high-risk prescription medicines.



SafeScript is computer software that will provide prescribers and pharmacists with access to their patients' prescription records for high-risk medicines, during a consultation, to enable safer clinical decisions.

The implementation of SafeScript is scheduled to start in October 2018. Roll-out will initially be focused in a specific geographical location before being extended to the rest of Victoria in early 2019. After an 18-month introductory period it will be mandatory for doctors and pharmacists to check SafeScript when writing or dispensing a prescription for a high-risk medicine.

Prescription records for medicines that are causing the greatest harm to our community will be captured in SafeScript. These are all Schedule 8 medicines and Schedule 4 benzodiazepines, z-drugs and quetiapine, as per recommendations of the project's External Advisory Group – for more details visit the SafeScript website. Prescription records will be automatically transmitted through the Prescription Exchange Services (PES) to SafeScript when a prescription is issued or dispensed at a medical clinic or pharmacy. Integration with PES is already supported by the majority of medical and pharmacy software.

Connection to a PES will enable more complete patient information to be

available to clinicians and provide a superior experience when using SafeScript. If clinicians are connected to a PES, they will receive pop-up notifications from desktops within seconds when a monitored medicine has been prescribed, to inform them whether it is necessary to review a patient's history in SafeScript and, by clicking on the notification, they will be taken directly to the relevant record in SafeScript. Without connection to a PES, clinicians will need to log on to a separate web portal and search for the patient, which will be more time consuming.

Some regulatory changes are necessary to enable the collection of accurate and complete patient data in advance of implementation of SafeScript. Proposed regulatory changes were open for public consultation from 8 February to 7 March and will take effect from 1 July 2018 - more details are available on the SafeScript website.

These regulatory changes will require medical practitioners to include the patient's date of birth on all prescriptions for medicines to be monitored through SafeScript. Clinical software should prompt prescribers to include this information for computer generated scripts.

In preparation for SafeScript, medical practitioners are also strongly encouraged to:

- Activate their connection to a Prescription Exchange Services (PES) through their prescribing software vendor. This is easy, free and most medical clinics in Victoria are already connected. Medical clinics can contact their software vendor to ensure they are connected.
- Ensure their registration details with the Australian Health Practitioner Regulation Agency (AHPRA) are up-to-date, especially primary place of practice and email address. This will allow an easy and automated online registration for access to SafeScript which will open later in the year, closer to implementation.

More information about the project can be found on the SafeScript page of the Department of Health and Human Services website:

[www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript](http://www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript)



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[property.littlerealestate.com.au/amavic](http://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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# Dental considerations for patients on prescription medications

Commonly prescribed medications may have adverse effects on oral health, and have the potential to cause complications during invasive dental procedures. Patients should be educated about the potential oral health complications that these medications can create, and given assistance to develop appropriate management strategies.



There are three classes of drugs which notably pose significant downstream effects. Patients who are on anticoagulants, bisphosphonates and chemotherapy are at an increased risk of detrimental oral health consequences.

Many prescription medications are associated with adverse effects in the oral cavity. One of the most common adverse effects is xerostomia, or the perception of a dry mouth. More than 500 medications are known to potentially induce xerostomia, although the exact mechanism is not understood. Saliva plays an important protective role, and patients with reduced salivary flow are at higher risk of developing tooth decay. In addition, patients often mitigate the symptoms of a dry mouth by consuming sweet and /or acidic foods and drinks, which also increases the risk of tooth decay.

Oral lichenoid reactions and gingival hypertrophy may also occur and can often be reversed with cessation of the causative drug. Other effects like intrinsic teeth discolouration, however, are irreversible once the chemical pigments are incorporated into the tooth matrix (i.e. prior to the eruption of the tooth). Prolonged use of antibiotics and corticosteroids can also precipitate opportunistic infections in the oral cavity. Examples of other adverse dental effects which are linked with commonly prescribed drugs are listed in Table 1.

Adverse dental effects linked with commonly prescribed drugs

DRY MOUTH	GINGIVAL HYPERTROPHY	ORAL CANDIDIASIS
Anticholinergics	Phenytoin	Antibiotics
Antimuscarinics	Sodium valproate	Corticosteroids
Antidepressants	Cyclosporine	Immunosuppressants
Antipsychotics	Calcium channel blocker	Chemotherapy
Antihistamines		
TEETH DISCOLOURATION	ORAL LICHENOID REACTION	JAW CLENCHING
Tetracycline	NSAIDs	Metoclopramide
	Barbiturates	
	Methotrexate	

Table 1

Anticoagulants are generally indicated in patients with a history of venous thromboembolic events. Inhibition of the coagulation factors within the cascade can prolong clotting time which increases the risk of post-operative bleeding after invasive dental procedures, especially tooth extractions and oral surgery. Warfarin has historically been the drug of choice, but this is no longer the case with the advent of novel oral anticoagulants (NOACs) such as apixaban, dabigatran and rivaroxaban.

The safety and efficacy of warfarin is reliant on maintaining the INR (International Normalised Ratio)

within the target range. Generally, it is possible for dental practitioners to work within a patient's target range without the need to reverse the effect of warfarin, but good dentist-doctor communication is essential. During oral surgical procedures, local haemostatic measures with primary closure and tranexamic acid application may be sufficient to achieve a stable clot. Dose adjustment or heparin bridging may sometimes be required if INR is found to be supratherapeutic. The significance of irreversible binding of some coagulation factors by NOACs on dental procedures is still under investigation.



Bisphosphonates are widely used to down-regulate bone turnover in patients with metastatic cancer, multiple myeloma, Paget's disease, osteopenia and osteoporosis. A small number of patients, predominantly those taking IV bisphosphonates, have developed osteonecrosis of the jaws following invasive dental treatment like extractions. Bisphosphonate-related osteonecrosis of the jaws (BRONJ) is an area of exposed bone in the jaws persisting for more than eight weeks in a patient treated with a bisphosphonate. The reported incidence of BRONJ is from 1 in 1500, to as high as 1 in 500 in patients treated with oral bisphosphonates, and from 1 in 15, to as

high as 1 in 10 in patients treated with IV bisphosphonates (following tooth extractions).

Prior to placing patients on long-term oral or IV bisphosphonates, it is advisable for doctors to refer to dentists to undertake a comprehensive oral examination. This is vital to ensure that the patient is dentally fit and unlikely to require any removal of teeth in the foreseeable future.

Prescription medication use in general is expected to increase with our ageing population, and it is important for doctors to be aware of the potential

for adverse oral health effects and complications that can arise during dental care. Check that your patient has a regular dentist that can provide pre-assessment, dental check-ups and any necessary dental treatment. If you have any questions regarding your patients' dental health, contact their dentist or find a local dentist at [www.ada.org.au/Find-a-Dentist](http://www.ada.org.au/Find-a-Dentist)



**Dr Mark Tsai**  
Oral Health Committee  
Australian Dental  
Association Victorian  
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# How parents can help their children into property

First-home buyers are back in the property market at a scale we haven't seen for half a decade. They now represent 18 per cent of monthly housing finance commitments, according to the ABS - just shy of the long-term average of 19 per cent, but much higher than the 13 per cent or so we have seen in recent times.

Despite tough affordability challenges, the cohort has been coaxed back by improved stamp duty exemptions in most states. First-home buyers (FHBs) also have a new 'bestie' in the unlikely form of APRA, the prudential regulator, which has handicapped investors, one of their key competitors, with tougher borrowing requirements.

While it is encouraging to see more FHBs succeeding, we clearly have a backlog of young people with thwarted ambition to put their feet on the first rung of the property ladder. The biggest challenge for this group is saving a sufficient deposit to enter the market. Sure, low interest rates mean they often have sufficient cash flow to afford the monthly mortgage repayments of their target property. But with \$80,000 required to fund a 20 per cent deposit on a modest \$400,000 entry-level home in many of our CBDs, it is a herculean task to achieve.

Unsurprisingly, around half of first-home buyers resort to obtaining



Photo: Kathy Alys

financial help - be it a gift or loan - from parents to fund the deposit, according to 2017 research from Digital Finance Analytics. Naturally, many parents don't have the wherewithal to provide such support without experiencing financial stress themselves, which still leaves a lot of young people on the sidelines of the market.

There is a way more parents can assist their children without having to find thousands of dollars of cash. It's called a limited security guarantee. In short, parents use the equity in their own home to guarantee the difference between what their child has saved and the bank's usual requirement for a deposit. Essentially, the parents are lending a portion of their credit worthiness. To illustrate, if a bank usually requires a deposit of \$80,000 and the child has saved \$50,000, the bank will accept just the \$50,000 as a deposit on the basis that the parents guarantee to pay the bank \$30,000 in the worst case scenario where the child defaulted on the loan and the value of the property fell by \$80,000 in a repossession sale.

One of the immediate advantages of this approach is that it usually enables adult children to avoid lenders mortgage insurance - which often costs north of \$10,000 even for a modest loan - when the deposit is less than 20 per cent of the target property's value.

Of course, as outlined above, providing a limited security guarantee is not riskless, although the amount is capped at the defined amount that represents

the difference between the notional deposit and the child's contribution (or \$30,000 in the example above). The best way to mitigate this risk is to choose property that has a track record of and propensity for capital growth. Not only is that self-evidently a good thing, but also the parents' limited security guarantee typically can be removed once the child's equity in the property reaches 20 per cent of its value.

This might require the first-home buyers to think more like a return-focused investor when they are looking for the right home, rather than just a single-minded home buyer. But that might well be a reasonable stipulation for a parent to place on their offspring in return for the limited security guarantee. However, do obtain independent financial advice before proceeding.



**Richard Wakelin**  
Director  
Wakelin Property  
Advisory

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# Tax treatment tips for starting in private practice

For members looking to commence private practice either as a contracting doctor, specialist, buying into a practice or starting a group practice, Belinda Hudson from William Buck provides some tips for tax treatment on your income.



## Business structure - get it right from the start

Your business structure impacts on the tax treatments such as income tax, capital gains tax, stamp duties, legal liability and the ability to add new investors. It can be costly to unwind a structure, so it's best to get it right from the start.

Setting up a practice or service entity using a company caps the tax rate (27.5% - 30%) and allows you to define clear interests held in the business, however, this doesn't have good outcomes for capital gains tax. A discretionary or family trust, on the other hand, is good for capital gains tax and flexible distributions. However, if you are a high income earner with no family members to distribute to, it doesn't give you the flexibility you need or ability to cap the tax rate.

## You don't need a company to practice

When starting in private practice, a company can add unnecessary compliance costs and offers you no additional protection from claims in

relation to medical practice issues. You don't require a company in order to employ your spouse to assist with ad hoc/administration tasks. If the circumstances are right, you can still do this as an individual.

The ATO will look through any structure that is in place to see how the income is derived. This is the key focus of the personal services income (PSI) legislation. If income is derived by the medical practitioner as a result of his or her personal work or exertion, this income is PSI and must be attributed to the individual performing the work.

It is sometimes mistakenly assumed that if you meet the requirements to be classified as what is called a Personal Services Business (PSB), you can split your income between yourself and your family members. This is not the case. Where personal exertion income is split inappropriately with associates, the ATO is likely to consider this tax avoidance and ignore any tax benefits obtained. You should seek advice in order to determine what structure is right for you.

## Spouse and family members can be active participants in the practice

A medical practitioner can employ a spouse or family member in their PSB provided the employment is bona fide and wages are at a reasonable level. A spouse working for the medical practitioner can receive a superannuation contribution as part of their salary. Excessive amounts paid to spouse and family members will be deemed as non-deductible.

Should you wish to discuss any aspects of the above please contact Belinda Hudson of William Buck on (03) 9824 8555 or by email [Belinda.Hudson@williambuck.com](mailto:Belinda.Hudson@williambuck.com)



**Belinda Hudson**

Director, Health Services

William Buck

 **William Buck**

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

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**Contact William Buck to find out more and see what difference one hour could make to your practice. It's free and there's no obligation.**

Please contact:

**Belinda Hudson**

Health Services Director

William Buck Chartered Accountants

Melbourne

**T: 03 9824 8555**

E: [belinda.hudson@williambuck.com](mailto:belinda.hudson@williambuck.com)



*Changing  
Lives.*

# Retired doctors trip to Castlemaine

On the morning of Thursday 15 March, the retired doctors group met early at Southern Cross Station. One V/Line and a short bus trip later, the doctors made their first stop at Castlemaine Art Gallery. The group spent a couple of hours with exclusive access to the gallery, exploring its beautiful offerings. A special treat included guided tours hearing about the history behind the artwork at the volunteer-run gallery.

Lunch was provided by the amazing Lela at the Buda Historic Home and Garden. Almost 50 members were treated to a local wine supplier providing some tastings over a two-course lunch. In the afternoon, the group split into two for concurrent guided tours of both the historic house and gardens. There are so many historic sites around regional Victoria and the retired doctors in attendance are already excited about the next tour being organised.





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# Travel: Ethiopia



**A young boy, barefoot in an old Arsenal shirt and grubby, dusty shorts stands with his goat. He has walked over the hills and across the high plains for many days, hoping to sell his companion for a good price so he can make his family proud. Behind him is the shell of a giant football stadium, being constructed by the Chinese. It will house 60,000 fans and cost over US\$100m.**

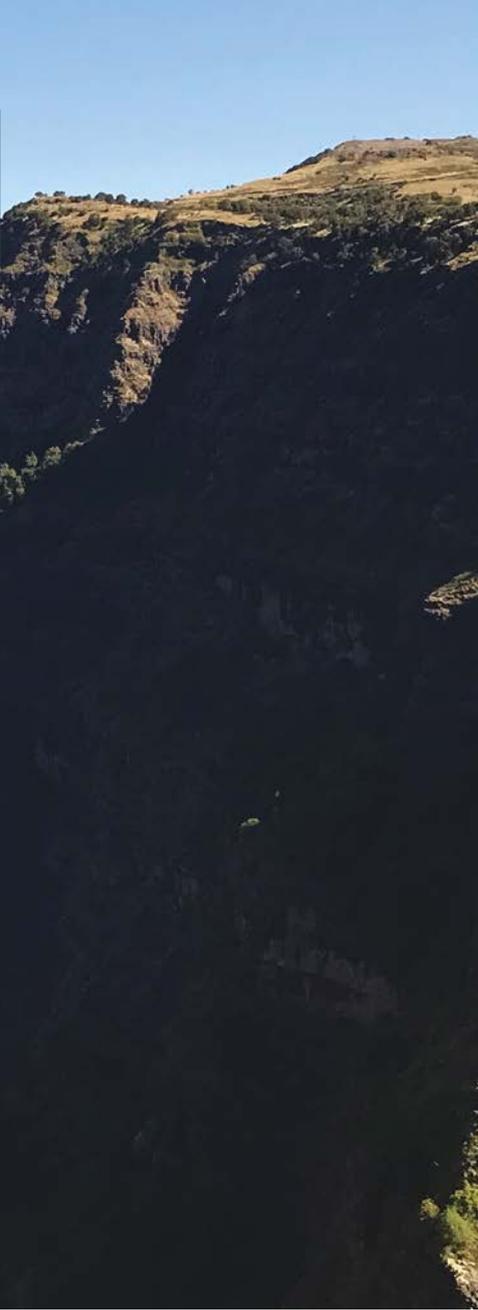
In the shadow of the giant dome, goat herders huddle together not prepared for the unseasonal cold snap. A few months ago, a giant gas explosion rocked the construction site, and a dozen were killed, however, it never made the press. Not that the goat herders were able to read anyway.

We weaved our way through the goat market, waved to the herders and received enthusiastic waves and big smiles in response. Further along the road the contrast of old and new

evaporated and the hustle and bustle and chaos of one of Africa's largest cities soon engulfed us. Blue and white rusty Peugeot taxis that were at least 50 years old, competed for space with trucks, minibuses and pedestrians with no apparent right of way. Aiming for a renowned coffee shop, we attempted to cross the busy road just as a kid grabbed my arm and yelled something incoherent in my ear. Annoyed, I pushed him away and continued to the other side. Instinctively I felt for my iPhone in my pocket and it was gone. Last I saw

of it was the kid and his accomplice merging into the crowd. Welcome to Addis Ababa, the capital of Ethiopia.

Addis Ababa is a big city with all the usual big city issues, however, other than pick pockets in several districts, crime is virtually non-existent. This is evidenced by the lack of police on the streets - even their HQ was an unmarked non-descript building with around half a dozen officers. Their only ammunition, an antique broken typewriter and a pile of carbon paper.



You soon learn in Ethiopia that their history runs deep, and Addis has its fair share of impressive museums, so when you are standing in the bowels of the National Museum staring at “Lucy”, a 3.2 million year-old fossil, suddenly many aspects of the city start to look decidedly modern. The Ethnological Museum, which is in the grounds of the university, is one of the best I have ever seen. Initially you are welcomed by a tortoise who has been there through the fall of the kingdom, the rise of communism and the move to democracy. As you enter the building you are reminded by the young student guide that this is the former palace of Emperor Haile Selassie.

Throughout Ethiopia we came across the legend of Haile Selassie - we stood in his bathroom, showed respect at his grave, accidentally showed a lack of respect by sitting on his throne in a church and ran around practising the Rastafarian greeting, “Jah Haile

Selassie”. Haile Selassie was Emperor of Ethiopia from 1930-1974, known globally as both an extraordinary and controversial leader who ensured that Ethiopia was the only African nation not to be colonised. His life ended ingloriously - murdered by the communists in 1975 and buried beneath a toilet block in his own palace.

The Rastafarian movement revere Haile Selassie as the messiah who “will lead a future golden age of eternal peace, righteousness, and prosperity”. It is believed that he was a descendant of King Solomon and the Queen of Sheba, a dynasty that lasted over 3,000 years.

Arriving in the town of Harar in Eastern Ethiopia is like stepping back into biblical times. It is a world heritage listed walled city that dates back to the 14th century. It has over 100 mosques and is considered the fourth Holy City of Islam. Harar is also famous for the hyenas who come in at night and clean the streets, and given the overall cleanliness around us, this system seemed to be pretty effective.

Several gates mark the entrance to the ancient city and at each gate traders compete to sell fruits, vegetables, coffee and the ubiquitous khat. Virtually the entire population of Harar is on khat, a plant with stem tips that are chewed for their stimulating effect. Subsequently the locals are on a sustained high and are very friendly, constantly laughing and really keen to be photographed. Very few tourists venture out this way, so the women are keen to show off their amazing brightly coloured wraps, while the boys just want a selfie. Once inside the old city the chaos subsides, replaced by steep, narrow cobbled streets, each house painted brighter than its neighbour.

Ethiopia is known as “The Roof of Africa” as most of the country is above

2400m. This makes for a comfortable temperate climate throughout the year. It is only once you are in the Simeon Mountains that you really appreciate how high you are. The peaks rise up to 4500m, however, the mountains are dramatic in that you are not surrounded by them, you are on top of them, looking down into the gorges, gullies and rock formations. For several hours we walked along the cliff edges, stopping to watch the gelato monkeys cavorting all around us. These majestic creatures were pretty much oblivious to our presence, although I suspect the younger monkeys were showing off.

Outside the national park we came across a group of children who were waiting patiently for us. They greeted Sue, our tour leader like she was a rock star. We had no idea what the excitement was about until Sue reached into her backpack and pulled out an envelope containing photos of the children that she had taken several weeks earlier. For many of these children it is the only picture they will ever have of themselves. On a recent stop a young mother accompanied the children, desperate to collect a photo of her only child who had died a few days prior. Sue, an Englishwoman who has lived in Ethiopia for 17 years, is an incredible individual who spreads her love of the people of Ethiopia in so many ways. At every village, roadblock, restaurant or local shop Sue would motivate, enthuse, respect and provide hope to individuals.

To read more about traveling in Ethiopia and other interesting locations you may not have considered for your next trip, visit [www.reho.com](http://www.reho.com)



**Karsten Horne**

CEO

Reho Travel

# AMA Victoria 2018/19 Council Ballot Results

## Affiliated Professional Organisations

Organisation name	Votes received
Alfred Hospital Senior Medical Staff Association	33
AMA Victoria Section of General Practice	47
Austin Hospital Senior Medical Staff Association	27
Australasian Integrative Medicine Association	1
Australian Association of Consultant Physicians	20
Australian Association of Surgeons	3
Australian Chinese Medical Association (Victoria)	15
Australian Salaried Medical Officers Federation	43
Australian and New Zealand Society for Geriatric Medicine (Victorian Division)	11
Australian Society of Anaesthetists (Victorian Section)	48
Australian Society of Orthopaedic Surgeons (Victorian Branch)	11
Australian Society of Plastic Surgeons (Victoria)	7
Greater Eastern Primary Health	4
Health Education Australia Ltd	3
Hellenic Medical Society of Australia	8
Italian Medical Society of Victoria	7
Monash Senior Medical Staff Association	36
National Association of Specialist Obstetricians and Gynaecologists	13
North East Valley Division of General Practice	3
Overseas Medical Graduates Association	11
Peninsula Health Senior Medical Staff Association	8
Royal Children's Hospital Senior Medical Staff Association	17
Rural Doctors Association of Victoria	42
Skin & Cancer Foundation of Victoria	22
St Vincent's Hospital Senior Medical Staff Association	25
Thoracic Society of Australia and New Zealand (Victorian Branch)	4
Urological Society of Australia and New Zealand (Victorian Branch)	3
Medical Association for the Prevention of War (Victorian Branch)	23
Victorian Medical Benevolent Association Inc	8
Victorian Medical Women's Society	41
Western Health Senior Medical Staff Association	29
Australian Orthopaedic Association (Victorian Region)	10

# The AMA Victoria 2018/2019 Council ballot opened Friday 20 April 2018 at 3pm and closed Friday 11 May 2018 at 5pm. A total of 814 members voted in the election.

Scrutiny of the Ballot was conducted on Tuesday 15 May. The result of the scrutiny, showing the total votes recorded for Affiliated Organisations and Independent Representatives, is displayed here.

One Independent Representative, Dr Lorraine Baker, received more than 100 votes and was elected to Council for 2018/2019.

The votes received by each Affiliated Organisation/Independent Representative are the number of votes

that were cast by that Organisation's Representative/Independent Representative in the election of the 2018/2019 AMA Victoria Board of Directors, which took place at the annual election meeting on 22 May 2018.

Five candidates submitted nominations for the five Fellows positions on Council. Each candidate was elected unopposed.



## Affiliated Academic Organisations

Organisation name	Votes received
Australasian College for Emergency Medicine (Victoria Faculty)	51
Australasian College of Dermatologists (Victorian Faculty)	21
Australasian Faculty of Occupational & Environmental Medicine (Victorian Division)	6
Australasian Faculty of Rehabilitation Medicine	8
Australian Medical Acupuncture College (Victoria)	6
Australian & New Zealand College of Anaesthetists (Victorian Regional Committee)	71
Royal Australasian College of Physicians Division of Paediatrics	15
Royal Australasian College of Medical Administrators	15
Royal Australasian College of Physicians (Victorian Committee)	79
Royal Australasian College of Surgeons (Victorian State Committee)	58
Royal Australian & New Zealand College of Obstetricians & Gynaecologists (Victorian State Committee)	29
Royal Australian & New Zealand College of Ophthalmologists	22
Royal Australian & New Zealand College of Psychiatrists (Vic Branch)	54
Royal Australian & New Zealand College of Radiologists (Victorian Branch)	24
Royal Australian College of General Practitioners (Victorian Faculty)	110
Royal College of Pathologists of Australasia (Victorian State Committee)	23

## Independent Representatives

Organisation name	Votes received
Dr Lorraine Baker	189
Dr John Mathew	97

## Fellows Representatives

Organisation name	Votes received
Dr Sandra Hacker	Elected unopposed
Dr Harry Hemley	Elected unopposed
Dr Gerald Segal	Elected unopposed
Dr Michael Troy	Elected unopposed
A/Prof Mark Yates	Elected unopposed

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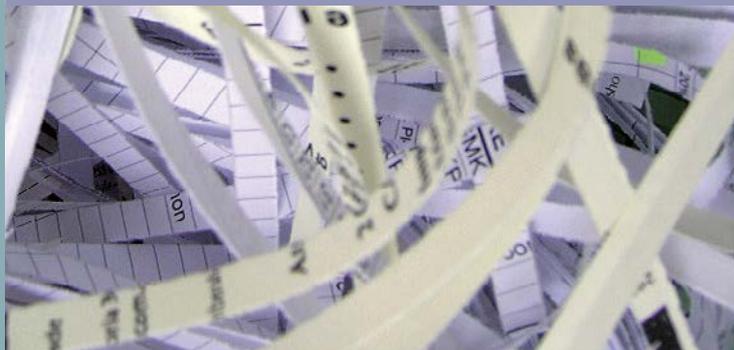
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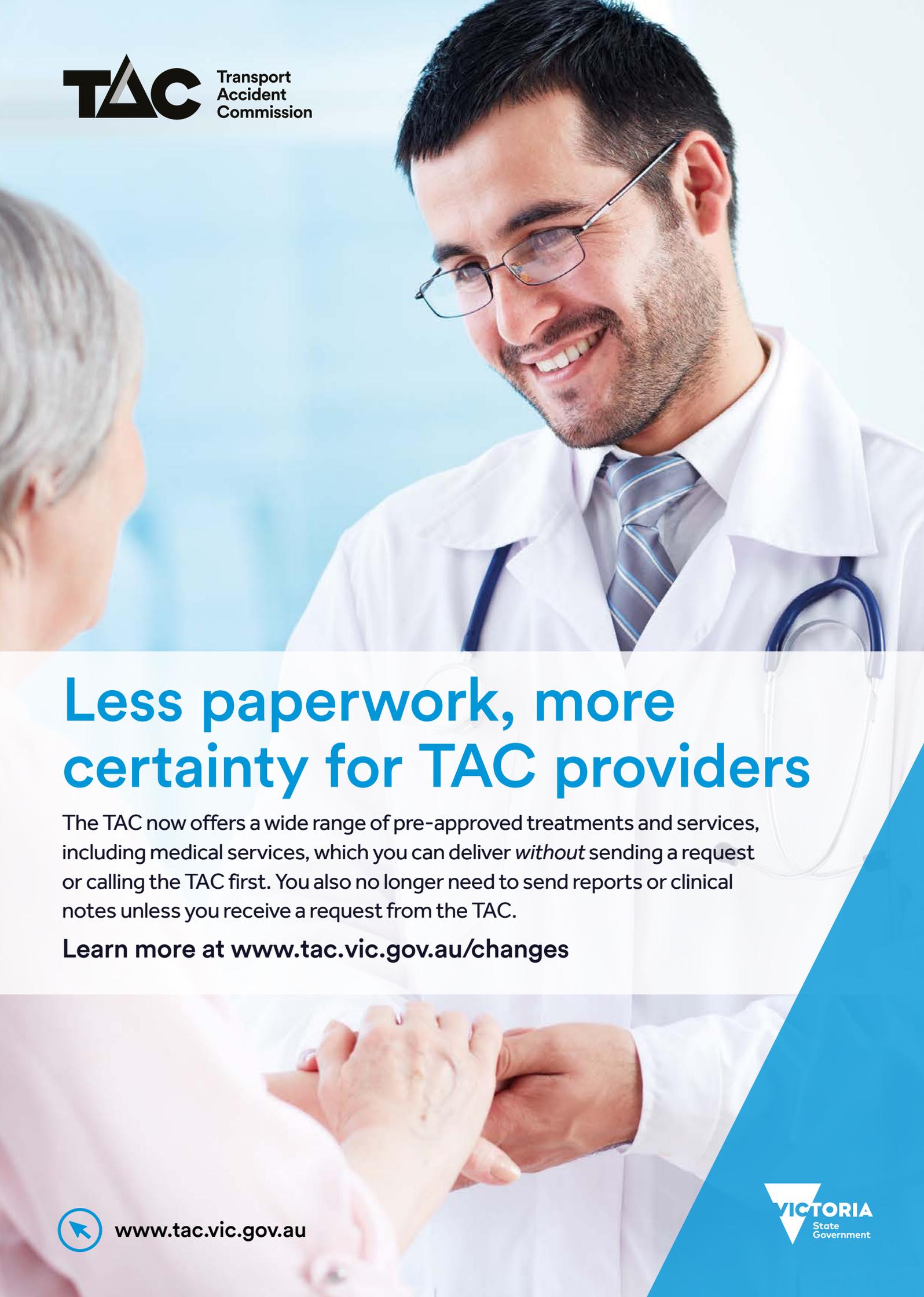
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\* Prices are for AMA Victoria Members or for Practice staff referred by an AMA Victoria Member. AMA RTO offers 6, 8 and 12 month payment plans for all courses. Visit [amarto.com.au](http://amarto.com.au) for more info.



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\* Terms and Conditions To be eligible for the offer, applications to join Doctors' Health Fund must be received by 11.59 PM (AEST) 30 June 2018. Offer is only available to those who are eligible to join Doctors' Health Fund restricted access group and who do not currently hold private health insurance with Doctors' Health Fund. The new member must take out combined Hospital and Extras cover to be eligible for the gift. Cover start date and join entry date must commence within the campaign period of 7 May 2018 to 30 June 2018. Only one gift card will be provided per policy as follows: a) a \$200 Westfield XS Eftpos Gift Card when purchasing a single Smart Starter hospital cover policy in conjunction with an extras cover policy; b) a \$400 Westfield XS Eftpos Gift Card when purchasing a couples Smart Starter hospital cover policy in conjunction with an extras cover policy; c) a \$300 Westfield XS Eftpos Gift Card when purchasing a single Prime Choice hospital cover policy in conjunction with an extras cover policy; d) a \$600 Westfield XS Eftpos Gift Card when purchasing a couples/family/single-parent Prime Choice hospital cover policy in conjunction with an extras cover policy; e) a \$400 Westfield XS Eftpos Gift Card when purchasing a single Top Cover hospital cover policy in conjunction with an extras cover policy; or f) an \$800 Westfield XS Eftpos Gift Card when purchasing a couples/family/single-parent Top Cover hospital cover policy in conjunction with an extras cover policy. Member needs to be active and financial for 12 continuous weeks of joining the fund before the gift card is issued; If the level of cover changes within the 12 week period, the value of the gift card will be determined by the lowest level of hospital cover held in the period. The offer does not apply to policy upgrades, or when a spouse, or dependant is added to an existing Doctors' Health Fund policy. This offer is not available to those who have held an active health insurance membership with Doctors' Health Fund in the last one year (either in their own right or under a Couple/Family/Single Parent health insurance membership). Policy holder must be over 18 years old to be eligible for the offer. This offer is not available with other offers. Doctors' Health Fund is not responsible for any lost, stolen or damaged gifts. Gift colour may vary from image shown. Each new member should look to the product issuer for all warranties, terms and conditions, which are subject to change without notice. Westfield XS Eftpos Gift Card is valid for redemption 3 years from when the gift card is purchased. Westfield XS Eftpos Gift Cards are not redeemable for cash. Some retailers may choose not to accept Westfield Gift Cards. Westfield Gift Card terms and conditions apply. Issued by Westfield Gift Cards Pty Ltd ACN 113171663. For more terms and conditions, visit <https://www.westfieldgiftcards.com.au>. The promoter shall not be liable for any loss or damage whatsoever which is suffered (including but not limited to direct or consequential loss) or for any personal injury suffered or sustained in connection with any prize/s, except for any liability which cannot be excluded by law. Private health insurance products are issued by The Doctors' Health Fund Pty Limited, ABN 68 001 417 527 (Doctors' Health Fund), a member of the Avant Mutual Group. Cover is subject to the terms and conditions (including waiting periods, limitations and exclusions) of the individual policy. DHF238\_5/18