

# vicdoc



MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. OCTOBER/NOVEMBER 2019

## Flexible training for surgical registrars

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ELECTRONIC MEDICAL  
RECORDS**

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OF PROSTATE CANCER  
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FRONT COVER: Surgical registrar Dr. Jasmina Kevric is looking forward to a new job share program in 2020.



**Magazine of the Australian Medical Association Victoria**

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# Welcome from the editor



The Women's: Carers, advocates and reformers exhibition is on display at the Medical History Museum. See page 52.

The aim of Vicdoc is to keep doctors informed about AMA Victoria's advocacy work to enhance the careers of our members and improve the health system for patients. We also like to highlight important developments in medicine, such as the surgical breakthrough by Prof Chris Coombs and Mr David Dangerfield. The pair has developed a procedure to enhance the lives of the many men who experience erectile dysfunction after surviving prostate cancer.

This edition also features a GP's perspective on how to improve Victoria's mental health system, suggestions on how to support patients struggling to maintain a healthy weight and a detailed look at the sensitivities around diagnosing and supporting autistic people.

AMA Victoria is a strong supporter of more flexible working opportunities for doctors. Medicine trails many other industries in this space, but a new arrangement at two Melbourne health services has been warmly received by surgical trainees.

We also pay tribute to a former AMA Victoria President who passed away in July. Professor Vernon Plueckhahn was a highly-respected forensic pathologist who was a driving force behind the establishment of the Victorian Institute of Forensic Medicine. He was also more publically known as an expert witness who devoted many hours towards overturning the murder conviction of Lindy Chamberlain. Prof Plueckhahn's life story makes fascinating reading.

This edition of Vicdoc has been sent to all Victorian doctors. If you are not currently a member, this magazine highlights some of the invaluable services you are missing out on. You can also read the thoughts of AMA Victoria President, A/Prof Julian Rait, on the link between electronic medical records and physician burnout.



**Barry Levinson**

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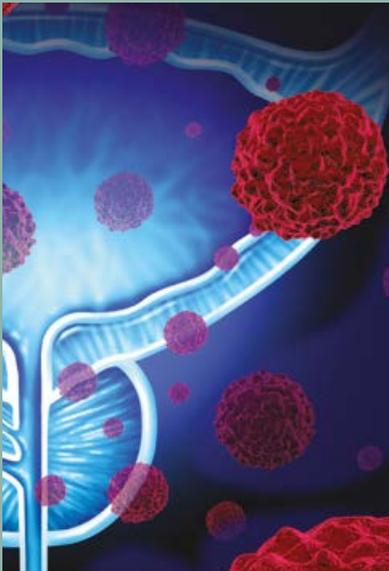
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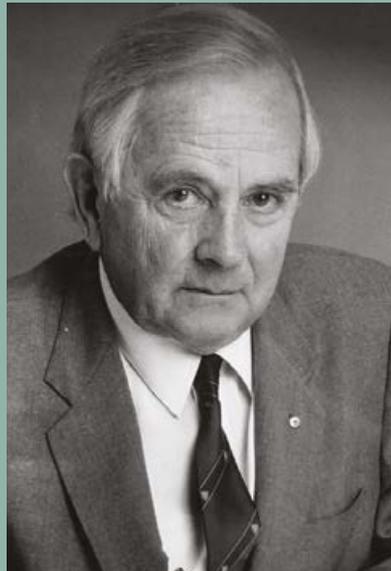
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# President's message



## The trouble with electronic medical records

A few months ago, an amusing but disconcerting observation was made in the American online journal *Politico*. Referring to the popular electronic health record system 'Epic' in an article entitled 'Lost in translation: Epic goes to Denmark', the authors mused that the United States of America had successfully exported physician burnout to Scandinavia via this system. Sadly, the introduction of Epic to Copenhagen hospitals had become a disaster characterised by a pervasive culture shock that was described as "immense" and "demoralising".

This publication was almost immediately followed by an insightful article in the *New York Times* by a physician, Danielle Ofri of the Bellevue Hospital in New York. In her piece entitled 'The business of health care depends on exploiting doctors and nurses', Dr Ofri explained that while resource constraints in medicine have become more frequent and profound, one resource remains infinite and free: the professionalism of caregivers.

The term 'physician burnout' is ubiquitous and now widely used to describe a state of emotional, physical and mental exhaustion caused by excessive and prolonged stress. It occurs when one feels overwhelmed, emotionally drained and unable to meet the constant demands of the workplace. It often means escalating workloads superimposed on heightened anxiety about poor outcomes which are out of your control - but will likely be blamed on you.

Earlier this year, the World Health Organization recognised the serious effects of burnout from chronic workplace stress. Burnout levels among doctors are estimated to be at an all-time high and are increasing relentlessly. Doctors and medical students commit suicide at higher rates than in almost any other professional group. Moreover, these higher levels of burnout are associated with more medical errors and compromised patient safety.

Of course, the introduction of electronic medical records (EMRs) has become a major contributor to burnout. And while there are many salutary aspects of the EMR - with no-one wanting to go back to the old days of chasing down lost charts and indecipherable handwriting - sadly much of the data entry has become mind-numbing and voluminous.

EMRs have also been a profound disappointment

for many who could see their potential for quality improvement and greater continuity of care. However, it has been estimated that many doctors spend two to three hours beyond their normal 10-hour shifts typing and 'documenting' things into the EMR.

The EMR is now "conveniently available" to log into from home. Many of our colleagues devote their weekends and evenings to this spill-over work. They feel they can't sign off until they've documented all the critical details of their patients' complex medical histories, followed up on all the test results, sorted out any potential medication errors and responded to all the calls from other staff, patients and their families. This does not even include the hours of compliance modules, annual mandates and administrative requirements that they are expected to complete between patients, and for which hospitals seldom provide and remunerate the necessary clinical support time. Consequently, many clinicians are now putting in ever greater hours of time each day for the same number of patients and the same remuneration.

But in my opinion, the biggest failure of electronic health was not to take advantage of the opportunity to have a truly useful, portable EMR that crossed all boundaries: public and private hospitals, community health clinics, states, private practices etc. Unfortunately, our existing systems are unbelievably cumbersome and time-sucking for doctors but lacking in the promise of widespread utility. What is less apparent and sinister is that there are multiple companies selling and maintaining such software at extraordinary profit, while the systems remain independent and rarely communicate with each other - primarily for the anti-competitive benefit of those same companies.

As many clinicians now work in multiple systems, we must learn each one separately. And, as others have noted, the biggest benefits of EMRs to hospitals and clinics is that they facilitate the capture of all possible diagnostic codes for a given patient's care, so that activity-based billing and revenue can be maximised. This has become the primary purpose of many EMRs and all other benefits including clinical utility seem to have become minimised or lost.

These complex and expensive electronic record programs have been designed by non-clinicians to

collect data on numbers and outcomes while not freely allowing communication with peers. For example, in Victoria there is no hospital based EMR which freely communicates directly with general practitioners unless GPs go through hoops and install special software on their desktops outside their own practice software systems. Furthermore, electronic communication of information to GPs and between hospitals is just limited to a few sites in the Parkville precinct.

Therefore, the demands on medical professionals have escalated relentlessly in the past few decades, without a commensurate expansion of time and resources. The medical complexity per patient (i.e.

the number and severity of chronic conditions) has steadily increased, meaning that medical consultations are becoming ever more involved. They typically include more illnesses to treat, more medications to administer, more complications to handle - all in the same-length office or hospital visit.

Doctors are not opposed to working hard or for long hours. But when we become demoralised and burnout through ever escalating demands and frustrating record keeping systems, it can only lead to worse patient care.

Thus it seems that things are rotten in more places than just Denmark.

## New digital Vicdoc in 2020

Vicdoc magazine is highly valued by AMA Victoria members and we greatly enjoy bringing together a publication that is interesting, engaging and relevant for our doctors and medical students.

Over the last five years, the increasing costs of printing and distributing Vicdoc have been unrelenting with only further increases predicted for the future.

This has required us to re-examine the way we produce the magazine and look for a more financially sustainable and efficient way to deliver this popular product to members.

We have concluded that the most logical and responsible way forward is to 'go digital' in 2020. This decision is a more responsible use of members' funds as well as being more environmentally thoughtful - a step which aligns with the values of many of our members.

We are also particularly excited by the opportunities provided by 'going digital'. Members will receive the same high-level content but there is great potential to improve the user-experience over time - making it more dynamic and engaging.

The digital launch in March 2020 will be the first step and then we will continue to enhance digital Vicdoc over time, based on your feedback and input and of course, through the insights provided by digital products.

We know this change might not suit everyone and that some of our members will be disappointed. We are offering to provide a printed Vicdoc for members who might prefer it for a small charge (\$36 in 2020) to cover the cost of the print and mail run for five editions. We hope that over time these members will also join us on our digital journey. \*

As always, we welcome your feedback to this change - please email Vicdoc Editor, Barry Levinson, at BarryL@amavic.com.au. As a membership organisation, we're here to represent and serve you and we will strive to adapt to your needs and expectations as much as possible.

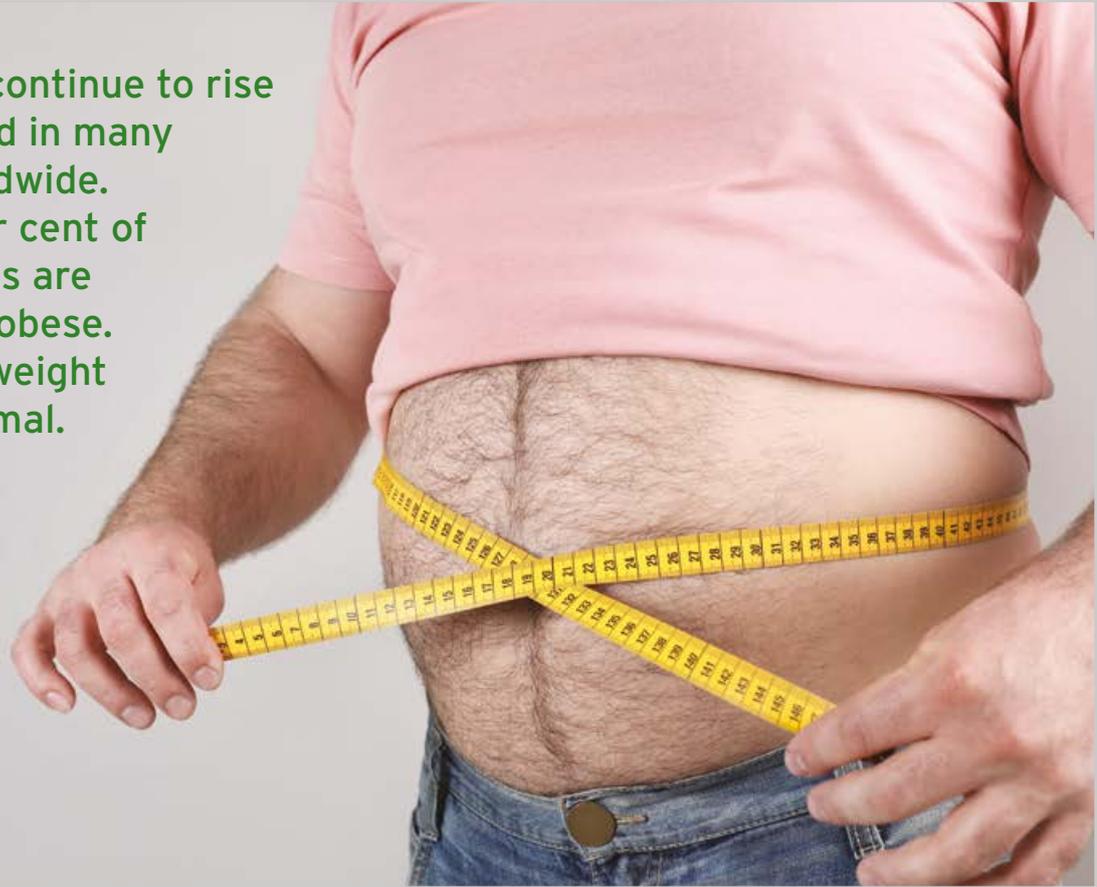
**A/Prof Julian Rait OAM  
President**

*\*Please note: a viable print-run of Vicdoc is dependent on at least 10 per cent of members opting-in for print. Members will be provided with the option to select a print version at membership renewal time but will not be charged until March 2020 when a decision can be made about the viability of a print-run.*

*References available from the Editor on request.*

# The weight of the consultation

Obesity rates continue to rise in Australia and in many countries worldwide. Sixty-three per cent of Victorian adults are overweight or obese. An unhealthy weight is the new normal.



Measuring weight is one of the first medical assessments conducted on a newborn. As babies and infants, our growth is assessed in the My Health and Development Record (the 'green folder') in Victoria. However, the frequency of this simple check often diminishes over time until it totally disappears.

Preventing increased weight decreases the risk of many chronic diseases. Prevention begins in childhood. Children with obesity are twice as likely to have obesity as adults. This tracking is higher in adolescents; it can be as high as 90 per cent. Obesity is not only a risk factor for chronic diseases but also a complex chronic condition itself. Why has a simple weight status assessment become so difficult?

The word 'obesity' is loaded with stigma, blame and shame. Weight stigma arises from the misunderstanding of obesity drivers. Weight stigma can trigger physiological and behavioural changes linked to poor metabolic health,

increased weight gain and exercise avoidance. Using compassionate terms and discussing weight from a health perspective can help alleviate these negative effects. Using words like, "being well above a healthy weight" is preferred rather than "extremely obese" or "fat". However, not discussing weight has equally detrimental outcomes.

Is having the conversation about weight as difficult as we perceive it to be?

A major international study conducted in 11 countries, including Australia, investigated perceptions, attitudes, behaviours and barriers to effective care in 14,502 adults with obesity and 2,785 healthcare professionals. The survey results identified a dichotomy between patients and healthcare professionals.

More than two-thirds (65 per cent) of patients wanted their healthcare professional to talk about their weight. However, on average, they had to wait six years between starting to struggle

with their weight and having the conversation. The top reason (71 per cent) given by healthcare providers why weight was not discussed was the perception that the patient was not interested in losing weight. In contrast, only 7 per cent of patients reported not being interested. Most patients are interested and want their healthcare professional to discuss their weight and the sooner this conversation takes place, the better.

The majority (80 per cent) of healthcare professionals acknowledged they have a responsibility to actively contribute to their patients' weight loss efforts but relatively few were comfortable in bringing it up. Patients felt totally differently. They felt weight loss was their responsibility (81 per cent) with only a quarter (26 per cent) acknowledging that their healthcare provider had a role.

This study shows us that we need to take affirmative action. You may feel starting the conversation is difficult

as you don't want to embarrass or upset your patient. The data from this study demonstrated the vast majority of patients (77 per cent) liked the fact that their healthcare professional had brought up weight during their appointment. More than half (65 per cent) of patients reported they felt positive about talking to their doctor; and only 3 per cent were offended.

- Initiating the conversation is important. Patients want their healthcare professional to have the conversation. Obesity is a chronic condition, although not recognised as a disease in Australia, and weight loss is important for our patients when overweight or obese and even if they are in good health. This needs to be communicated to our patients. Relating their increased weight with their family history or any associated comorbidities can be a good starting point.
- It is also important to investigate previous serious weight loss attempts by your patients. Many have tried; 81 per cent reported having made at least one serious attempt and 29 per cent said they had made five or more attempts. In contrast, the perception of healthcare professionals was that

only about a third (35 per cent) of their patients had made a serious weight loss effort. Patients are trying and need support.

- Talking about their weight is just the beginning; it also needs to be followed up. It was reported only a fifth (21 per cent) of discussions relating to weight management were followed up. Time constraints, lack of incentives and lack of strong guidelines for continuing care need to be addressed. Governments need to realise that money spent here will save orders of magnitude of the increased costs incurred during treatment of obesity-related diseases such as diabetes, cardiovascular disease and cancer.

Managing obesity is not simple. Obesity is a complex chronic condition and needs long-term management. It begins with discussing weight.



**Kyra Sim**  
Boden Collaboration,  
Charles Perkins  
Centre  
The University of  
Sydney

*References available from the Editor on request.*

For information about weight management services and resources for your patients, go to:

[www.lifeprogram.org.au](http://www.lifeprogram.org.au)

The Life! program is a free lifestyle modification program that helps people reduce their risk of type 2 diabetes and cardiovascular disease

[www.betterhealth.vic.gov.au/healthyliving/weight-management](http://www.betterhealth.vic.gov.au/healthyliving/weight-management)

The Victorian Government's Better Health Channel

[www.livelighter.com.au/Health-Professionals/](http://www.livelighter.com.au/Health-Professionals/)

The LiveLighter program encourages Victorian adults to lead healthier lifestyles

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# Surgical breakthrough improves the lives of prostate cancer survivors

Prostate cancer is the most common cancer in men in the first world. It is predicted that almost 1.3 million cases are diagnosed around the world every year. In recent times, there has been a shift in focus to survivorship when managing patients with early stage prostate cancer. This has been brought about by the high survival rates seen in these men, combined with an emphasis on quality of life issues.



One of the most significant factors impacting the quality of life of prostate cancer survivors is erectile dysfunction. Erectile dysfunction is experienced in up to 70 per cent of patients following treatments for prostate cancer, including radical prostatectomy. The impact of erectile dysfunction on quality of life has been under-recognised, particularly in terms of rates of depression and relationship breakdowns. This common side effect occurs despite modern surgical techniques and the use of rehabilitation programmes involving medications such as Viagra, vacuum devices and intracorporal injections.

Having seen first-hand the impact erectile dysfunction had on this population of men who live long lives following treatment, we wanted to help give them back their quality of life.

Over a five-year period, we developed a new surgical approach which has been shown to have the potential to restore erectile function and return quality of life, following prostate cancer treatment.

The procedure involves harvesting sural nerves from the lower limbs via small incisions. These are then grafted into the femoral nerves bilaterally in an end-to-side fashion via 4cm incisions in the groin, before being passed subcutaneously into the corpora cavernosum.

New nerves regenerate from the donor femoral nerve and are guided to grow into the corporal penile bodies via the sural nerve grafts. The new nerves grow at 1mm per day, restoring erectile function, on average, between six and 12 months after the procedure.



It is thought that the nerve fibres release a new source of acetylcholine (the chemical released by motor neurons to activate muscles) into the corpora cavernosa, restoring the original neurotransmitter that was produced via the cavernosal nerves before they were damaged at the time of radical prostatectomy.

Patients have tolerated the procedure well; the only long-term side effect being a predictable area of paraesthesia on the lateral feet from mobilising the sural nerves in both legs. The procedure takes approximately three and a half hours and patients are discharged the next day.

Currently, we have been able to restore sexual function in 71 per cent of cases, with significant improvements in terms of quality of

life in 94 per cent of patients. The technique has been peer reviewed in *European Urology* earlier this year and presented at the American Urological Association, Urological Society of Australia and New Zealand and the Asia-Pacific Prostate Cancer Conference meetings.

Better outcomes have been recognised in patients with strong erectile function before radical prostatectomy, who have not undergone radiotherapy and who have undergone sural nerve grafting early in their recovery. After recovering from the surgery, many patients reported having a new outlook on life.

Our aim now is to gain a better understanding of why the procedure hasn't worked for all patients, to hopefully improve upon the current

success rates. The procedure is now being applied to other cases of iatrogenic erectile dysfunction, including transurethral resection of the prostate (TURP), cystectomy and abdominal perineal resection (APR).



**Prof Chris Coombs**  
Microsurgeon  
Cabrini Health



**Mr David Dangerfield**  
Urologist  
Cabrini Health

# Digital health partnership to improve the lives of men with prostate cancer

Men diagnosed with prostate cancer are set to benefit from a new digital health collaboration that will empower them, their clinicians and hospitals to improve prostate cancer treatment and care.

The Movember Foundation, the world's largest men's health charity, and practice management software provider Genie Solutions, have announced a partnership to integrate Movember's True North digital health products with Genie Solutions software.

Through the partnership, men living with prostate cancer can fill out online questionnaires to:

- regularly track and follow-up on changes to physical and mental health over time
- receive personalised and tailored insights on managing treatment side effects
- understand the experiences of other men receiving similar treatment
- share responses with treating clinicians for care management and follow-up.

For clinicians and hospitals, the partnership will also fast-track the provision of clinical and patient data to the National Prostate Cancer Outcomes Registry - enabling them to better monitor treatments and outcomes, with the potential to improve effectiveness, reliability and cost efficiency.

Genie Solutions' specialist software is used in more than 4,000 medical practices around the country, reaching



the majority of Australia's privately registered urologists.

Movember Foundation Executive Director of Programs, Paul Villanti, said men often experienced ongoing side effects as a result of prostate cancer treatment, but didn't know how to take action for their health. "Many clinicians are currently working in a vacuum. They don't have access to the data that enables them to understand whether men diagnosed and treated for prostate cancer have got back to living a normal life, or are doing it tough," Mr Villanti said.

"By joining forces with Genie Solutions, we will be able to better support men living with prostate cancer by ensuring that the right resources and information from True North reaches patients and clinicians at the right time, when they need it most."

Genie Solutions CEO, James Scollay, said the partnership with Movember connects directly to their purpose of helping medical professionals

deliver better health outcomes. "The integration with Movember's True North program will deliver our urologist customers with practice efficiency benefits whilst contributing to the broader fight against prostate cancer," Mr Scollay said.

In 2019, it is estimated more than 19,500 men will be diagnosed with prostate cancer in Australia and there are approximately 200,000 men living with or beyond the disease.

While the initiative will initially focus on prostate cancer, Movember and Genie Solutions envision resources for other types of cancer will also be integrated into the platform in the future.





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# President's Reception

This year's President's Reception was hosted at St Andrews Conservatory in Fitzroy in September. The cocktail event offered key stakeholders the opportunity to network with AMA Victoria and hear from President, A/Prof Julian Rait, about the achievements we have accomplished together over the past year.



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# Mental health: A GP's perspective

## As any GP would know, mental health in Australia is in crisis.

It's shown in the statistics. In any given year, around one million Australian adults will experience depression and 45 per cent will have some form of mental health problem during their life. The cost of poor mental health is estimated at more than \$60 billion a year. And it's shown at our clinic door, where more and more people are turning to GPs for help.

This is by no means a hidden epidemic. Awareness of mental health is at an all-time high, thanks to the dedicated work of many individuals and organisations. Federal and State Government spending is increasing year on year, but still, the problem is growing and outcomes aren't improving. The Royal Commission into Victoria's Mental Health System will deliver its much-anticipated interim report in November and in my roles as a GP, the Chair of AMA Victoria's Section of General Practice and the Chair of North Western Melbourne PHN, I contributed to multiple submissions.

## So, how do we make mental health care better?

Typically, the answer to this question is more money for more services or infrastructure. Funding is part of the equation and resourcing is crucial. However, resourcing has already been increased with little to show for it. As such, in order to create a better system and achieve the best outcomes, it has never been more important to critically analyse the ways we are spending that money.

In an ideal world, there would be many paths to the destination needed – a single, integrated system offering multiple levels of services and care that communicate and coordinate with each other and the patient. This is the 'no wrong door'

principle, which ensures the patient ends up where they need to be, regardless of where they start. It would be a system for all ages and all stages; one that wraps around the patient and responds to their whole person needs, whether that is for acute inpatient services, drug and alcohol rehabilitation, housing or subsidised counselling sessions with a psychologist.

The services are available right now. What's missing is an integrated, coordinated approach. What happens, for instance, to someone who experiences an acute episode but is then discharged with no follow-up plan and support? Do they have a safe place to go back to? Are there untreated substance-abuse issues? Can they successfully navigate the complexities of securing their own treatment, dealing with waiting lists for psychologists and psychiatrists and facing significant out-of-pocket costs (even for those with a mental health plan from their GP)? Vulnerable people do not need – and are often in no position – to be negotiating these issues. The system needs to flex around them to meet their care and service needs.

The pressing need right now is not for infrastructure as much as it is for equitable and easy access, coordination and whole of person care. Mental health problems don't exist in isolation. They are often an effect of, but can also lead to, factors including trauma, homelessness, social isolation, substance abuse, family conflict and unemployment. Poor mental health is also linked strongly to poor physical health, higher risk factors and lower preventative activities. Those with serious mental health issues do need specialised services; but that is not all they need.

The best international evidence tells us that the system we should be supporting, resourcing and developing to get the best outcomes in the most cost effective way is the patient-centred 'medical home'. It's a model that assembles a multidisciplinary team and services around the individualised care and service needs of a patient, bringing together GPs, psychologists, nurse practitioners, psychiatrists and others, in a timely, accessible,

coordinated, comprehensive manner.

What would that look like for a GP on a day-to-day basis? It would mean that in collaboration with the patient they would use their broad expertise to provide comprehensive care and continuity of care for both mental and physical health. Where the GP needs more expertise they would have access to timely secondary advice on medication, diagnosis and management plans. If they need to refer onwards for specialised mental health help, there would be a single point of entry for their patients.

This single entry point would link to the range of services required; from acute assessment in 48 hours by a psychiatrist, a CATT team to the patient's home within 24 hours, drug and alcohol assessment, care coordination by a mental health nurse or a psychologist appointment within a month. There would be accountability and clear lines of communication to the GP, patient and family and other clinicians. The GP would coordinate ongoing care. The patient is at the centre, in their 'medical home', surrounded by the services they need.

Many Primary Health Networks (PHNs) are already working to improve the capacity of general practice and working in collaboration with them to support the 'medical home'. PHNs also commission mental health services to fill gaps identified in their community. They now provide a suite of services to whom GPs can refer their patients. Originally, PHN-funded mental health services only provided the ability for GPs to refer patients to psychologists and social workers. This has now been expanded so that they fund:

- specialised suicidal risk assessments within 72 hours by a subset of trained psychologists
- mental health nurses that can work with GPs, patients and carers to coordinate medication and care for people with more chronic and severe mental health problems
- access to timely services for perinatal depression
- drug and alcohol services.

With the right resourcing and relationships, PHNs would jump at any chance to better coordinate with state-run bodies so that everyone's specialised services, support and knowledge worked together to meet the needs of patients. HealthPathways are one way PHNs are bringing together referral service details and advice for GPs in one place. Coordination between state, federal and private services could significantly unlock capacity and improve accountability by eliminating duplication.

Mental health needs to be treated holistically. We have a great general practice system that should be, and could be, enhanced. We don't need to spend money on bricks and mortar. This may well exacerbate fragmentation of care and pull us further away from the patient-centred medical home model. We need those resources to fund something far more meaningful: supporting general practice to access and harmonise the services we already largely have to meet all the care needs of the patient.

Right now, the problem is not that there is nowhere to turn for someone in distress. The issue is what happens after they do. Turning that initial call for help into a seamless journey in a fully integrated system will determine the success or failure of future efforts. This is a key moment for mental health services in this country.



**Dr Ines Rio**

Chair, AMAV Section of GP and North Western Melbourne PHN

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AMA Victoria's submission to the Royal Commission into Victoria's Mental Health System was produced by a number of highly-experienced clinicians with many years of expertise in their specialisation, along with extensive consultation from our membership. The submission represented the views of doctors of vast experience across medicine, but did not denote the entire views of any specific individual. Our Section of General Practice Chair, Dr Ines Rio, has outlined some of her ideas. We hope to bring you more thoughts from other contributors in the future.

— AMA VICTORIA —

# AWARDS

23.11.2019

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AMA Victoria Awards Night is a celebration of excellence, dedication and leadership in healthcare.

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## MC – SAMI SHAH

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# Flexible options for surgical trainees providing better work-life balance

Almost a decade ago a survey of Australian surgical trainees found a 100-fold disparity between the number of surgical trainees who were undertaking part-time training (0.3 per cent) and the number of trainees expressing an interest in undertaking less than full-time training (33.8 per cent). Surgical training has certainly not led the way with flexible training, but positive change is underway.



Training inflexibility has traditionally meant that some doctors leave the workforce before completing postgraduate training because of the impossibility of balancing professional and personal commitments. This comes at considerable cost to the individual doctor and also our community. Access to flexible training and work opportunities are also an increasingly important determinant of career choice.

## Austin/Northern Training Hub offers flexible training positions

Pleasingly, Victoria's Austin/Northern Training Hub is now offering flexible working arrangements to general surgical trainees from across Australia, allowing trainees to continue Surgical Education and Training (SET) during periods when it is not feasible to undertake full-time training and allowing the opportunity to combine training with research, additional study, hobbies, carer roles, sporting roles and more. In this edition of Vicdoc, we explore

how the Austin/Northern Training Hub's initiative works and speak with general surgical trainees Dr Jasmina Kevric and Dr Stephen Kunz about their attitudes and experiences with flexible training. In the next edition of Vicdoc we will explore how flexible training works from a supervisor and employer's perspective.

## Flexible training models

Flexible surgical training is generally offered either through a job share arrangement, or a part-time stand-alone position. A job share arrangement requires two trainees to be matched for specialty, geography and training level. A part-time stand-alone position, such as that offered at the Royal Adelaide Hospital in 2009, offers flexible training without requiring two matched, like-minded trainees. However, as with the job share model, it does require approval from the employing hospital, supervisor and specialty board.

In 2020, Dr Kunz and Dr Kevric will undertake a job share arrangement

at the Austin/Northern Training Hub. "The Austin/Northern network offers (and encourages) flexible training within the accredited registrar sphere," Dr Kunz explains. "The set-up is of a week-on, week-off schedule, allowing continuity of care with patients while allowing time away from work."

While the initiative was initially solely at the Austin, and only for general surgery SET registrars, Dr Kevric says the initiative is expanding and additional options may be introduced. "This is primarily aimed at SET registrars but also may become optional for non-SET registrars who are interested in week-on, week-off work arrangements, particularly if a SET trainee is unmatched. In 2020 the program is expanding to the Northern Hospital and will consist of 16 positions for eight trainees."

## Reasons to pursue flexible training

Dr Kunz's desire to improve his work-life balance has been a key factor in his decision to pursue a flexible



training position in 2020. “The clinical workload of surgery can make you weary and personally I find it easy to fall into the habit of staying back late at work; there’s always an extra patient to see, an extra case that could use a pair of hands, an extra research project to complete.

“As a result, now eight years out of medical school, having run the gauntlet of a year of cardiothoracic surgery, being accepted onto the general surgical training program and completing 18 months in rural Australia, I’ve found it has taken its toll. I’ve lost touch with friends, I’ve lost healthy habits and the interests that once sustained me have fallen by the wayside.”

Dr Kevric has witnessed the benefits her colleagues have found from flexible training. “My observation of my colleagues who have undertaken it this year is that they seem much happier, more balanced, with numerous research projects under their belts and able to attend to family commitments. Over the years I have spent a lot of energy on training and research,

looking after patients, fully committing to my work, whilst still trying to have a healthy relationship and social life.

“I spent two of my last four years of training interstate or in rural regions, away from my partner, which can take a real toll. I found that adding exam study to everything else would mean I’d have to sacrifice something in my life. We talk a lot about sacrifice in surgery but I think there is a better way if we can work more flexibly.”

### **Flexible training is not a gender specific issue**

A common misconception about flexible surgical training is that it is a gender specific issue, but in fact trainees of all genders are increasingly requesting flexible training. Dr Kevric notes that gendered misconceptions around flexible work can be harmful for all trainees. “People may think that flexible work is only suited to mothers who have child care commitments or that men are not as ambitious if they seek part-time training.

“There is a misconception that unless you are 100 per cent committed to full-time work and operating constantly you are not ambitious or interested. But the truth is that surgery has many competencies, technical and non-technical and part-time work gives us the opportunity to focus on other aspects of surgery that we may not see in clinical practice. It gives us the opportunity to be human, to enjoy family time and to feel happy within ourselves. This certainly can only make us better doctors.”

We wish Dr Kunz, Dr Kevric and their colleagues at the Austin and Northern the very best for their rotations.



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

*References available from the Editor on request.*

# A medical career with a profound legacy

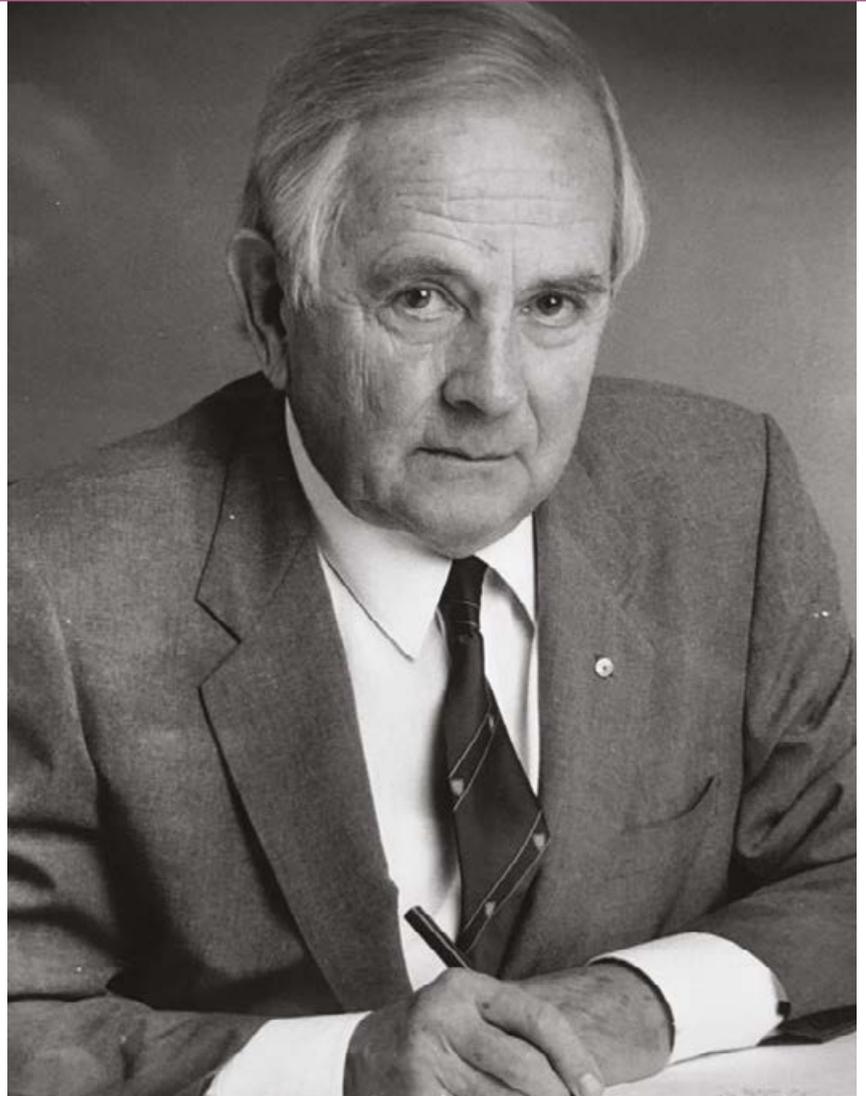
Victoria has lost one of its most respected citizens with the passing of Professor Vernon Plueckhahn, who died in July 2019 at the age of 98.

Born in Riverton in rural South Australia in March 1921, and descended from German Lutheran migrants who arrived in Adelaide in the 1840s, Vern was raised on his parent's farm. After a serious accident to his father, the family moved to Adelaide where Vern spent his teenage years. He attended Adelaide High School and did well. When he was 14 his mother became very ill, dying at home of breast cancer during Vern's last year at school. Within a year, his father remarried and moved back to the country, leaving Vern to fend for himself.

Harboring thoughts of becoming a doctor but knowing that he could not afford to study full-time, he worked as a laboratory technician at Adelaide's Institute of Medical and Veterinary Science (IMVS). At the same time, he became a part-time science student at the University of Adelaide. His first job at the Institute in 1937 was to be the 'lab boy' for the new director, Dr Weston Hurst, who had recently arrived from the UK. Later Vern acknowledged how much Dr Hurst had taught him about attention to detail and precision in laboratory medicine. He remained at the IMVS until 1941, by which time he had completed two and a half years of his science degree.

## Military service

The direction of his career was strongly influenced by the outbreak of World War II. In 1940, he had sought to enlist in the airforce but was not accepted because he was working in an essential service. He tried again in 1941 and joined the army. Because of his five years of laboratory experience and his university



Prof Vernon D. Plueckhahn OBE, AM

studies, he was soon made a sergeant and allocated to the hospital ship 'Wanganella', a converted passenger liner. He was placed in charge of the pathology laboratory on the ship which he ran single-handedly for four years.

This was not an entirely safe place to be. Despite international conventions, the ship was attacked twice as were two other Australian hospital ships, one of which was sunk with the loss of over 200 lives. Duty on the Wanganella took him to Singapore, South Asia, the Middle East, the Mediterranean and the South Pacific. He was discharged from the army in 1945 as the war was

coming to a close. However, this did not represent a complete break from the armed forces as he then joined the Citizens Military Force (renamed the Army Reserve in 1980) where he served for 18 years, rising to the level of Colonel at the age of 38.

## Entering medicine

Benefitting from government assistance for returned military personnel, Vern enrolled in medicine at the University of Adelaide. He was exempted from the first year of the course so he graduated in 1949, winning prizes in clinical medicine,

obstetrics and public health, and being ranked third in his year overall. After a year as an intern at the Royal Adelaide Hospital and six months at the Adelaide Children's Hospital, he became assistant pathologist at the Royal Melbourne Hospital (RMH) to Dr Douglas Hicks. His thinking was that this would give him the time to study for his specialist physician exams and he was indeed successful at these.

Towards the end of two years at RMH, he was invited by Dr John Lindell, who had recently been appointed head of the Hospitals and Charities Commission, to take on the challenge of heading an expanded regional pathology service at Geelong Hospital. In 1954 at the age of 32, he assumed this role and remained as head until compulsory retirement in 1986. In the intervening years he built a pathology department that was the pride of Geelong Hospital and its medical staff and arguably the centre of the hospital's intellectual life. It became a popular place for training laboratory technicians, in whom Vern took special interest and for training doctors to become pathologists.

The level of innovation he promoted and the scale of its service activity soon placed it in the leading rank of pathology departments nationally. During a two-year period, when he also served as Acting Director of Medical Services of the hospital, he was instrumental in it becoming a clinical school for medical students from Monash University, a development that had lasting benefits for the hospital and the people of Geelong.

## **A highly-respected forensic pathologist**

At the time of his appointment to Geelong Hospital, its mortuary served also the Geelong Coroner, thus providing the unexpected opportunity for Vern to develop into one of Australia's best known and highly-respected forensic pathologists. He grasped the opportunity to undertake groundbreaking research, including studies to validate blood alcohol measurements made at autopsy and documentation of the critical role of alcohol misuse in deaths by drowning in boating and swimming accidents.

Working closely with his microbiologist Joan Banks, he undertook a study of 'golden staph' infection and its prevention with Phiso-hex emulsion in newborn babies at the Geelong Hospital Maternity Wing, a study that eventually involved over 80,000 babies and their mothers. He became internationally recognised for this work and when questions arose about the possible toxicity of Phiso-hex, he was invited to testify to the Food and Drug Administration (FDA) in the USA. He also gave expert evidence in four trials in the French courts relating to a tragic accident, when baby talcum powder was inadvertently contaminated with hexachlorophene (the ingredient of Phiso-hex) and 30 babies died.

## **The trial of Lindy Chamberlain**

Vern was frequently asked to give expert forensic evidence in courts around Australia. Most notably he appeared for the defence in the 1982 trial of Lindy Chamberlain in the Darwin Supreme Court for the murder of her infant daughter, Azaria. At the trial, the jury preferred the evidence of a UK forensic pathologist over his. Vern regarded the conviction of Lindy Chamberlain as the gravest miscarriage of justice in Australian legal history and offered his services pro bono to assist in the subsequent appeals and the Royal Commission into the conviction. His views were finally heeded, as the Royal Commissioner was highly critical of the UK pathologist and accepted the evidence given by Prof Plueckhahn.

He taught pathology and forensic medicine at the University of Melbourne, served as President of the Victorian Branch of the Australian Medical Association and as President of the Royal College of Pathologists of Australasia. He was a prolific writer contributing over 90 articles to the medical literature, authoring two editions of a textbook on forensic pathology and co-authoring three editions of a textbook on medical ethics, law and professionalism. In 1979, he was made an Officer of the British Empire and in 1989 a Member of the Order of Australia.

**Continued on page 22**

## **Professor Plueckhahn's contribution to the AMA**

Vernon Plueckhahn was first elected to the Council of AMA Victoria in 1959, representing the Geelong subdivision. He represented Victoria on the Federal Assembly of the AMA every year from 1962 to 1971. In 1967 he was elected Vice President of AMA Victoria and was elevated to President in 1969; then a one-year position.

There were a number of key issues of concern at the time. Abortion was a subject of intense debate among AMA members, with the branch lobbying the government to conduct a legislative inquiry. The Menhennitt ruling on 22 May 1969 clarified the existing law and gave doctors good guidance. In addition, at around this time the honorary system of staffing public hospitals was beginning to be dismantled. The provisional registration 'intern' year for new medical graduates was also being discussed. It was introduced with strong AMA support in 1970. There was lobbying for a new Wages Board for senior hospital doctors and equal pay for women doctors. Members debated hotly the issue of whether a specialist surgeon was entitled to a higher fee for those operations that were also done by general practitioners. And they argued vigorously against a government proposal to register chiropractors and osteopaths.

On 3 December 1969, at the end of his Presidential year, Vernon addressed AMA Victoria's AGM. It was the first such address in the new Parkville premises at 293 Royal Parade. His talk was subsequently published in the *MJA* with the title, 'The Doctor and his Machines'.

He briefly outlined the history of the Medical Society of Victoria (the forerunner of AMA Victoria) and the Medical Society of Geelong. He described medical practice in Geelong in the 1850s and 1860s, noting the absence then of machines to help doctors. He followed this with the recent enormous growth in pathology testing and emphasised the problems that were emerging through the overuse and misuse of testing. He told his audience, "There are profound ethical, clinical and financial problems involved and we as a profession have a responsibility to assure our colleagues, our patients and our government of the value and standard of our professional services". In many ways, this summed up the foundation of his many contributions to medicine, pathology and forensic medicine over the course of a remarkable career.

## Establishing the Victorian Institute of Forensic Medicine

Prof Vern Plueckhan gave a lasting legacy to the people of Victoria in the form of the Victorian Institute of Forensic Medicine, which recently celebrated 30 years of existence. Vern had railed against the appalling conditions at the morgue and Coroner's Court in Flinders Street Extension. He spent 15 years campaigning for his compelling vision and eventually convinced the Victorian Attorney-General, Jim Kennan, and Premier, John Cain, to take action. The result was a state of the art mortuary and laboratory complex co-located with a new Coroner's Court in Southbank, which was opened in 1988.

Vern's vision included the concept that the institute would (against government policy) be a statutory authority and also be active in training and research. He successfully negotiated for the institute to be a part of the Faculty of Medicine at Monash University with the director of the institute also being the Professor

of Forensic Medicine at Monash. (He would be also the first to acknowledge the crucial roles of The Hon. John Phillips, Prof Graeme Schofield and Dr Gad Trevaks in these developments). Vern was acting director of the institute for several months, pending Prof Stephen Cordner's arrival to take-up this position in May 1987.

## Family life

In 1953, just before his move to Geelong, Vern married Ann Roark at Trinity College Chapel in Parkville. This was to be a long, happy and successful partnership. They soon built a family home in Geelong where they raised four children and where friends were generously entertained. Despite a heavy workload and much travel, Vern made his family his first priority, perhaps a reflection of missing something in his own family life in his later teenage years. Not an overtly religious man, but a highly moral one, Vern continued a Lutheran practice of reading the Bible every evening. Sadly his wife Ann predeceased him in 2012, as did his sister Edna who died in Canada in 1998. He is survived by

his younger brother Glen and his four children, Debra, Sally, David and Rick.

## Tribute compiled by Prof Kerry Breen AM and Prof Stephen Cordner AM

Editor's note: AMA Victoria extends its condolences to the family and friends of Prof Plueckhahn. He made a truly remarkable contribution to the health and wellbeing of Victorians. We are grateful to the Victorian Institute of Forensic Medicine (VIFM) for permission to publish this obituary, which was written by Prof Kerry Breen and Prof Stephen Cordner for the VIFM's annual report. The first author is Prof Plueckhahn's biographer and *A Passion for Justice: The life and times of Vernon Plueckhahn* has been very recently published by Australian Scholarly Publishing. Copies are available by email to enquiry@scholarly.info or at the publisher's website: www.scholarly.info

Prof Cordner delivered the eulogy at Prof Plueckhahn's funeral and it can be read in full on the VIFM website - www.vifm.org

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# Diagnosing and supporting autistic people

Recent studies in Australia have found that one in 100 people are autistic and diagnosis rates indicate this prevalence is increasing. It's likely you have come across autistic patients of all ages, but the subtleties and differences in autistic people means that many go undiagnosed.

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition that affects the way people communicate and interact with the world. Characteristics generally appear in early childhood and will be present, in some form, for life.

The autism spectrum incorporates previous diagnosis categories of Autistic Disorder, Asperger's Syndrome and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS).

Autistic people can present in many different ways. No two people with the condition are alike. Some may have an intellectual disability, others have average or above average intelligence. Some people may never develop spoken language, others may acquire language at the same rate as their typically-developing peers.

## Diagnosis

When you're detecting autism in a patient, consider if they show differences in the following areas.



## Social interaction and communication

Autistic people often have a different interpretation and expression of social behaviours and communication. This may present as difficulty with social relationships, for example, appearing aloof and indifferent to other people, difficulty understanding others' viewpoints and intentions and difficulty with verbal and non-verbal communication. Autistic people can be as sensitive and empathetic as anyone else. You may observe an autistic person as aloof and disinterested. Keep in mind that this isn't a reflection of what the person's feeling or thinking. Similarly, an autistic child may not give you eye contact, however, this doesn't mean that they don't want to communicate with you.

## Restricted, repetitive patterns of behaviour, interests or activities

Autistic people can display repetitive behaviour patterns, for example, resistance to changes in routine, difficulty with transitions, a preference for sameness, lining up objects or doing things in a certain order. These behaviours can be subtle; some people may just have a deep interest in a particular thing, or be prone to becoming intensely focused on a task for a period of time.

## Sensory processing

Autistic people may be hypo- or hyper- sensitive to sound, touch, pain, light, smell, etc. If your patient shows any signs of sensory processing differences, physical examinations could be very stressful to them. It's essential to warn them before touching them, explain what you are doing and why you need to do it that way. Some autistic people are extremely sensitive to light and can even discern the flashing of fluorescent lights. Pen lights can trigger seizures in susceptible people. This is important to know as 20-30 per cent of autistic people also experience seizures.

## Women and girls

Within the three categories above, the signs of autism are wide-ranging, with some signs very obvious and some very subtle or nuanced. Also, it's important to note that historically, studies have focused predominantly on autistic males. There is little research focused on autistic women and girls, however, in the studies we do have (on women and girls with typical speech development), we can see important differences in the characteristics of autistic boys/men and autistic girls/women.



Some autistic people may avoid eye contact, but this does not mean they do not want to engage.

They may find waiting for an appointment stressful. Many autistic people like order and routine, so an update on how long they may need to wait during unexpected busy times could alleviate some anxiety.

- Some autistic people require extra time to process information, so be patient. They may require a longer appointment because of this.

Explain that there are many things autistic people and their families can do to learn more about autism, connect with people who have shared experiences and receive support to live healthy, happy and fulfilling lives. There is a growing worldwide culture of autism positive identity and if patients do receive a diagnosis, they and their families should be encouraged to visit the Amaze website - [www.amaze.org.au](http://www.amaze.org.au) - or get in touch with the Amaze Autism Advisors. Amaze is the peak body for autistic people and their families in Victoria and has a wealth of evidence-based information that will help a patient or their carer feel informed, empowered and accepted.

For example:

- Autistic girls and women often camouflage their autism by imitating social skills or suppressing some of their autistic characteristics.
- Autistic girls and women can appear to have stronger language and social communication skills.
- Special interests and atypical play in autistic girls can differ to autistic boys and be much more subtle.
- Autistic girls and women are often more likely to talk about their emotions than autistic boys and men, resulting in them being less likely to resort to physically aggressive behaviours. This can lead to them being labelled simply as passive or shy.

The best way to ensure people are correctly diagnosed is to leave stereotypes at the door. Autism is described as a spectrum because the way it affects each individual is many and varied.

#### Talking to your patient

Informing someone that they or their child may be autistic can be a

very sensitive conversation, so be gentle and compassionate. Use clear, simple language and short sentences. Outline a clear process for receiving a formal diagnosis (for example, the specialists they will be referred to or what the assessment will entail) so they understand what will come next. It's in the individual's interest to raise it as early as possible and not delay a potential diagnosis.

If you suspect someone is autistic, there are a few simple things you can do to communicate better with them.

- Ask for the information you need. An autistic person may not volunteer vital information without being asked directly.
- Avoid using body language, gestures or facial expressions without the assistance of verbal instructions as autistic people often have difficulties with non-verbal communication.
- Some autistic people take what you say literally. If you say, "It will only hurt for a minute", they will expect the pain to be over in exactly one minute.
- Offering the first or last appointment of the day can be helpful for autistic people.

#### Mental health

If you suspect or know that a patient is autistic, make sure you monitor their mental health closely. Approximately 50-70 per cent of autistic people experience co-occurring mental health conditions, most commonly depression and anxiety disorders.

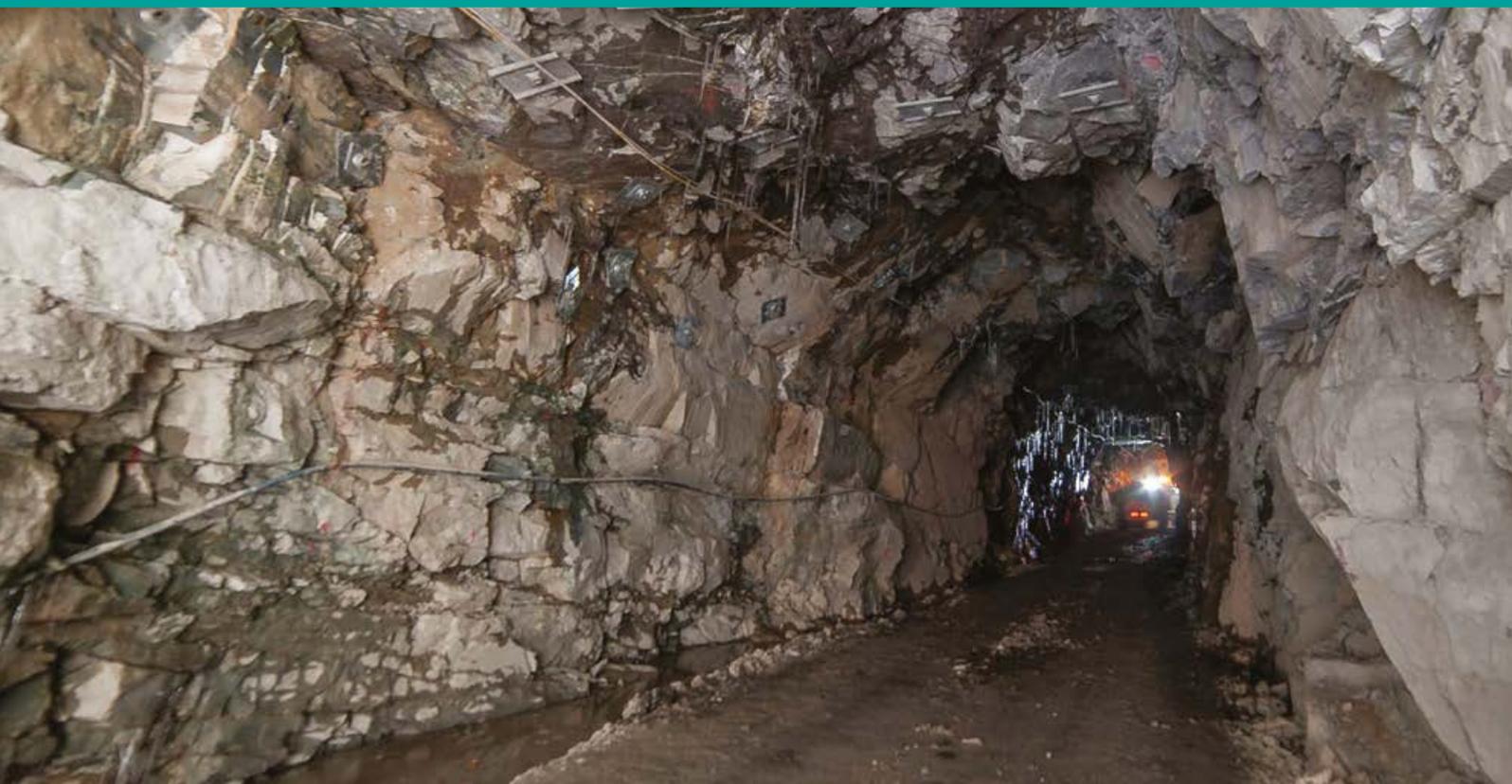
Mental health conditions are not an implicit part of autism and autistic patients should be treated with as much concern as anyone else with mental health conditions.

For more information about autism and how you can support autistic patients, contact Amaze's Autism Advisors on 1300 308 699, email [info@amaze.org.au](mailto:info@amaze.org.au) or use the webchat on the website. This service is available from 8am to 7pm, Monday to Friday (excluding public holidays).



References available from the Editor on request.

# The human impact of silicosis



On Saturday 31 August, more than 200 medical professionals and specialists from across Australia and New Zealand joined WorkSafe Victoria at a summit on silicosis. The event was an outcome of the action plan announced in May this year by the Victorian Government to better identify, treat and eradicate silicosis across the state.

## The truth about crystalline silica

Although not a new disease, silicosis is an emerging lung disease Australia-wide. Crystalline silica (quartz) is a natural mineral. It's found in stone products such as reconstituted stone, granite and sandstone and is released to the worker when cutting, grinding or polishing the material. It is also in other building materials such as concrete, bricks and mortar.

How much crystalline silica is present depends on the material. Reconstituted stone can have very high crystalline silica content, sometimes up to 95 per cent.

Exposure to silica dust can result in a silicosis diagnosis. It is very concentrated within the stonemasonry industries in particular, but not limited to these workers. Typical presentation is also often in young people and in severe cases, workers may require a lung transplant.

It is classified in three types:

1. **Acute silicosis** - associated with extremely high intensity silica dust exposure. It can develop after a matter of weeks, up to a few years of exposure.
2. **Accelerated silicosis** - although historically very rare, it develops

after a high level of exposure, over less than 10 years.

3. **Chronic silicosis** - typically occurring after long-term exposure to low amounts of silica dust. Often seen in the mining sector or relating to quarry work.

## The action plan

The Victorian Government's comprehensive action plan to address and prevent unsafe silica exposure includes the following initiatives:

- a state-wide ban on uncontrolled dry cutting of engineered stone



- a tough new compliance code for businesses working with silica
- a compliance and enforcement blitz with WorkSafe inspectors targeting over 300 high-risk workplaces focusing on stonemasonry workshops to prevent the disease
- free health screening for Victoria's 1,400 stonemasons
- an awareness campaign to highlight the risks of working with engineered stone
- a silicosis summit for GPs and medical specialists as well as education seminars for those in the stonemasonry industry and health sector.

"Silicosis has had a debilitating effect on too many tradies in their prime - our ban on dry cutting and an unprecedented enforcement blitz will help protect Victorian workers," said Minister for Workplace Safety, Jill Hennessy.

The Victorian Government is also advocating to reduce the Australian

silica workplace exposure standard from 0.1mg per cubic metre over an eight-hour day to 0.02mg. The states are in discussion to agree on the standard going forward - notwithstanding the outcome, Victoria will continue to advocate a limit of 0.02mg/m<sup>3</sup>.

### Diagnosis and health assessment

Diagnosing silicosis can be difficult, so it's important that the health assessment your patient receives is in-line with the recommended process. WorkSafe has developed a Crystalline Silica Health Assessment in partnership with medical experts and Monash University. It is available on their website and includes what a respiratory health assessment for individuals exposed to crystalline silica should involve.

You can read more here:  
[www.worksafe.vic.gov.au/resources/crystalline-silica-health-assessments](http://www.worksafe.vic.gov.au/resources/crystalline-silica-health-assessments)

Less rigorous testing may lead to an increased risk of false-negative diagnosis. If your patient has completed a health assessment that does not meet these guidelines, it's recommended they repeat the process.

Symptoms may include:

- shortness of breath
- coughing
- fatigue
- weight loss.

Screening will help identify workers who have early stage silicosis or associated diseases, such as lung cancer and autoimmune diseases.

The free WorkSafe health assessment involves:

1. A specialist occupational health provider assessment and review.
2. Chest x-ray and, if clinically indicated, a CT scan; both conducted by a radiologist competent in applying the ILO classification by successfully completing the National Institute

for Occupational Safety and Health (NIOSH) B Reader examination.

3. Lung function testing at an accredited Thoracic Society of Australia and New Zealand (TSANZ) laboratory.
4. Respiratory physician appointment and pathology, where clinically indicated.

Emotional and wellbeing support is also available to the patient and their family.

### Free health assessment eligibility

WorkSafe's free health assessment program has been developed for people working within the stonemasonry industry in Victoria. All past and present workers in the stonemasonry industry are eligible for a free health assessment. Eligible patients can be referred for a free health assessment directly through WorkSafe Victoria.

To start the process or for queries about eligibility, refer patients directly to the WorkSafe Advisory Service:

- Phone: 1800 136 089 and select option 1, 7:30am to 6:30pm (Monday to Friday)
- Email: [healthscreening@worksafe.vic.gov.au](mailto:healthscreening@worksafe.vic.gov.au)

### A commitment to research

WorkSafe has funded Monash University to undertake research into the assessment of silica associated lung disease. Screening and disease registries will be developed and the analysis of health assessment data will be undertaken to inform the prevalence, prevention and appropriate health screening requirements.



# Eight tips for everyday positive psychology

Disease. It wasn't until recently that it was pointed out to me that the actual Middle English root of this word is 'lack of ease'. We spend the vast majority of our time as medical students and doctors learning about what can go wrong with the human body and mind. How to fix something that is broken, or near-broken. How to look for problems. We imagine worst-case scenarios and can reel off lists of differential diagnoses (all problems) for a set of symptoms. We are trained over years to look for and diagnose what is wrong in a person and how to bring that state of 'disease' back to normality.

I didn't realise until recently that there is a completely different way of looking at things. It is, in a sense, the 'flip side' of the way we learn how to be doctors. And it can be incorporated into our everyday lives, both within our medical work and personal lives (which, at the very least, is just as important!).

I'm talking about the field of positive psychology. It is, in essence, identifying what makes people flourish and prosper and developing strategies to cultivate this in our own and others' lives. For me, it feels like the polar opposite of the way I was taught to be a doctor. Instead of bringing people from a 'diseased' to a 'normal' state, positive psychology works by identifying the best qualities in flourishing, successful,

happy individuals and then developing strategies about how to actually work towards this. You may see this as a significant shifting of the goal posts, but in my opinion, the two perspectives can actually be synergistic.

Elements of positive psychology have, of course, been around for a long time. Meditation, one of the key elements, is centuries-old. The formal science of positive psychology, as a researched discipline, is only a few decades old. I had not heard of it until searching around on the internet for some kind of course to help me navigate my way through some tough times - both work-wise and also personal - and decided to enroll in a diploma of positive psychology. I also felt that this would complement my work in oncology and in medical education; to bring a sense of positive momentum to my patients and students as well as myself.

A diploma does not make me an expert and many of you reading this will know more about positive psychology than me. These days in many medical schools, elements of positive psychology are covered, but I graduated nearly 20 years ago now and do not have any personal recollection of being taught these kinds of concepts and skills, ever. I had to discover this world myself. I also think some aspects of positive psychology sometimes risk

being 'overprescribed' and, in doing so, lose their appeal, significance and worth. I sincerely hope this does not belittle their potential effectiveness.

We also need to be aware (and proud) that, as doctors, we are a unique and special breed; we work hard and we are often very hard on ourselves. I am also fully aware that many (most) of the challenges in medicine lay well beyond the individual and within the system itself. I, too, have felt broken by it at times throughout my career. Despite now having a diploma in positive psychology, I don't walk around feeling enlightened and ethereal! I don't meditate. I simply can't do yoga without my mind ruminating over whether I've checked all the blood tests I need to. I still get anxious and worried about the same old things and I still set near-impossibly high standards for myself. However, I did come away feeling enthusiastic that there were ways I could actually train myself to turn a bad day into a better one and with respect for a relatively new science that is fascinating to me.

So, for those of you in a similar boat to me, here are my eight simple take-away tips related to positive psychology - specifically in the context of being a busy doctor. I still need to remind myself about these regularly, but it helps to know they are there.

## 1. You have permission to look after yourself.

This is perhaps one of the hardest things for us to do, in the context of medical work, where arguably working 24 hours a day would still not get you through everything there is to do. For me, a sense of 'permission' to think about myself and my own health is really important. I do often need to hear this from someone else though, as my mind is rarely this kind to itself! So, if you're similar to me, ask someone you care about to reassure you that it's absolutely essential to look after yourself.

## 2. Don't put conditions on your happiness.

I often find myself thinking that when I have finished writing the next paper, passed the next exam, completed the next course, or even got through the next clinic, then I'll be happy. This is flawed thinking, as there will only be the next hurdle, the next exam, the next thing to do. It is an endless pursuit. There should never be conditions placed on happiness. We have the right to feel fine right now! It shouldn't be an elusive goal of the future. What is stopping positive emotion from happening right now?

## 3. Don't put all of your sense of personal self-worth and self-value in your work.

If you do, a bad day at work (which is inevitable for every single one of us) will mean that it feels like your whole world is crashing down. There needs to be other things in life to feel a sense of achievement from, that are not solely related to work.

## 4. Know and leverage your strengths.

Strengths are things that you do well and which give you energy. We all have a different set of key strengths; you may know some of your own, otherwise there are several validated strengths questionnaires that can give you (and explain) a list of your 'signature' strengths. It actually helps to get insight from a validated tool about where you are likely to derive energy from and to then use those skills and strengths knowing these are helping you in life.

## 5. 'I get to...' versus 'I have to...'

Try it out. It's amazing the difference it makes to frame your activities differently. 'I get to...' is way more powerful in how it helps you to feel about what you're talking and thinking about and it usually reminds me that what I do most days is a privilege.

## 6. You can be mindful even when you're too busy for mindfulness.

I will never be one to meditate for hours; it's just not me. However, mindfulness - being in the present moment - is so precious. And you don't need to meditate for hours to be mindful! It can be as simple as putting the phone down when ordering a takeaway coffee; taking in the smells, sights and sounds while you wait. Instead of checking your emails, I suggest you try this next time you order a drink. This simple act of mindfulness is a wonderful little 'refresh' button in your everyday that does not take any extra time whatsoever!

## 7. Make a do-able 'to-do' list.

I am a list-writer like many of us are and often feel compelled to look at my ever-growing to-do list in despair. I was given great advice once: while it is ok to have a big master list, each day you should write down two things you HAVE to do and one thing you WANT to do. Crossing out those three things gives the psychological sense of achievement and additionally prioritises something you actually want to do. It's a great strategy. Now, if I could only remember to practice what I preach each day...

## 8. Gratitude helps.

Bad days happen to us all. Gratitude, though, is easy to find. For me, it can switch my mindset very quickly from one spiraling into negativity, back to being positive. All of us can think of three things we are grateful for. It might be our children, our families, our health, or more simple things like good coffee, a holiday we've had, or the blue of the sky. It sounds simple but it really works for me to remind my mind there are really good things in life that can (usually, at least temporarily) override the less good times.

Maybe one of these will resonate with you. If so, think about it today and the next day. If it makes even a little difference in your day, hold onto it!



**Dr Kathryn Field**  
Medical oncologist  
AMA Victoria  
Women in Medicine  
Committee



# Health experts call for stronger national air pollution standards

Leading health groups across Australia have united to call for stronger national air pollution standards to limit dangerous pollutants that include nitrogen dioxide (NO<sub>2</sub>), sulfur dioxide (SO<sub>2</sub>) and ozone (O<sub>3</sub>), to save lives and reduce illness.

The health groups involved in the joint position statement include Doctors for the Environment Australia (DEA), the Royal Australasian College of Physicians, the Lung Foundation of Australia, the Thoracic Society of Australia and New Zealand, the Lung Health Research Centre and the Climate and Health Alliance.

The call comes in response to the long-awaited revision of Australia's ambient air quality standards, known as National Environment Protection Measures (NEPM), which will be finalised by the end of 2019. The full regulatory impact statement can be found on the EPA Victoria website - [www.epa.vic.gov.au](http://www.epa.vic.gov.au).

Australian medical practitioners are concerned with the negative impacts of air pollution on human health. Air pollution in Australia is attributed to over 3000 premature and preventable deaths per year, as well as poor lung and cognitive development in children, asthma, heart disease, lung disease and cancer, especially when living in close proximity to a major source of pollution.

Many people who live, work or attend schools near major roadways are exposed to higher levels of pollutants, not only SO<sub>2</sub>, NO<sub>2</sub> and O<sub>3</sub>, but also other air pollutants such as particulate matters PM2.5 and PM10, carbon monoxide, diesel particulates and volatile organic compounds. When combined, all these pollutants impact human health and potentially affect every organ in the body. In line with international studies, Australian research demonstrates there is no safe level of air pollutants; even well below the threshold standards.

Australia's air quality standards which were set in 1998 do not meet

international best practice and lag behind developed countries such as the US and those in the EU. The purpose of the NEPM is to minimise the risk of adverse health impacts from exposure to air pollutants and needs to be based on up-to-date research.

Coal-fired power stations and motor vehicles are the main sources of sulfur dioxide and nitrogen dioxide respectively in Australia. Diesel powered vehicles emit higher amounts of nitrogen dioxide compared to petrol vehicles.

There are a number of EPA monitors to measure ambient levels of these pollutants in major cities in Australia, but hot spots, such as along or near major roads and industry are often excluded from monitoring. Roadside exposure can be many times higher than urban background, especially for NO<sub>2</sub>. In urban areas, vehicle emissions contribute up to 80 per cent of nitrogen dioxide emissions.

Over the last 10 years, the prevalence of asthma increased in the Australian population from 9.9 per cent in 2007-08 to 11.2 per cent in 2017-18. Australia's current annual NO<sub>2</sub> standard is set at the upper limit of 30 ppb. Recent research by the Australian Child Health and Air Pollution Study (ACHAPS) of children (7-11 years) across 12 Australian cities found small increases in NO<sub>2</sub> exposure are significantly associated with increased risk of asthma and reduced lung function, with mean NO<sub>2</sub> at exposure of 8.8 ppb.

Asthma is multifactorial, but recommendations to reduce the new annual standard of NO<sub>2</sub> to 9 ppb in line with the science will have substantial benefits for children's health and help reduce asthma prevalence. A recent

study in California found lowering NO<sub>2</sub> levels by improving vehicle emissions can significantly reduce the incidence of asthma in children.

However, the levels proposed by the NEPM for NO<sub>2</sub>, SO<sub>2</sub> and O<sub>3</sub> do not go far enough to protect the health of the community.

Key recommendations in the joint position statement by Australia's health groups include:

- Adopting world's best NO<sub>2</sub> standard of 9 ppb in line with current research.
- Adopting the World Health Organization's one-day SO<sub>2</sub> standard of 8 ppb. Australia's current one-day SO<sub>2</sub> standard of 80 ppb is 10 times higher than the recommended WHO standard.
- Making air quality monitoring data publicly available through a coordinated national website, allowing access to real-time and historical data will help enforce state and territory standards of the air pollutants.
- Vehicle emission control and electricity generation are areas of technological change where low or zero pollution options are rapidly entering the market. Strong pollution reduction policies based on good standards will assist Australia in reaching the best outcome during this period of change.
- Exposure to vehicle pollution is reduced by better vehicle emission standards, situating schools and childcare centres away from busy major roads, improving public

transport, reducing the use of diesel fuel and by encouraging a shift to tighter Euro 6 vehicle emission standards, or electric or hybrid vehicles to reduce air pollution.

- Coal-fired power station pollution can be reduced by post-combustion treatment of flue gases, however, wind and solar-based electricity avoids air pollution completely.
- A network of NEPM air monitors should be expanded near hotspots such as major roads to closely monitor air pollutants and better enforce air quality standards to meet tighter guidelines.

So what can you do to help Australia meet these recommendations and reduce the health burden from air pollution? Write to your state and federal Ministers of Environment calling on these recommendations. See the Doctors for the Environment Australia website - [www.dea.org.au](http://www.dea.org.au) - for more details.



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*References available from the Editor on request.*

# Time for action on long-term health policy vision



Dr Tony Bartone with National Press Club President, Sabra Lane. Photos supplied by the National Press Club of Australia. Photographer: Lyn Mills.

AMA Federal President, Dr Tony Bartone, addressed the National Press Club in late July. The following excerpt focuses on two of the key issues raised in his speech.

## Primary care and general practice

We know primary care is the most cost-effective part of the health system. But our GPs are working under increasingly enormous pressure. Genuine, targeted investment in this area can and will reduce downstream health costs by improving access to high quality GP-led primary care services. We know that people in communities with more GPs live longer than those with access to fewer GPs.

Currently, general practice services represent around just seven per cent of total health expenditure from all levels of government. This translates to \$382 per person annually. For comparison, \$2606 is spent per person on public hospitals. This disparity exists even though, every year, around 88 per cent of Australians see a GP. And 90 per cent of the health problems that are encountered in general practice are managed in general practice.

We must start planning for the new primary care environment now. The

Federal Government has asked the AMA to help develop and implement a 10-year plan for primary healthcare and general practice.

As a start, the Federal Government has finally lifted the Medicare indexation freeze. It has also made a down-payment with new policies and funding to improve continuity of care for patients over 70. There is also new investment for quality improvement within general practices through the Practice Incentive Program. But we need to build on these measures and this must include additional funding models.

Fee-for-service funding is the predominant funding model for general practice. It works well for most patients. It provides autonomy and choice, but it is more suited for treating acute health issues. The AMA believes that a more blended funding model is needed. Such a model would support general practices to continue to deliver safe, innovative, high-quality, accessible care in a more complex and more demanding primary care world.

The Federal Government's proposed 10-year plan must be about:

- improving access to high-quality, GP-led primary care services
- ensuring adequate spending on general practice, correcting Medicare rebates
- improving the confidence of medical professionals in general practice, thus encouraging more doctors-in-training to pursue a career as a GP.

It has been argued that the Federal Government should increase the proportion of its health budget spend on general practice. Other jurisdictions are already legislating targets. More investment would equip general practice for seamless care-coordination - genuine holistic care. It's about, as I often have said, improving the infrastructure, the capacity and the capability of general practice.

To correct the fee-for-service model

that underpins GP funding, general practice needs more investment, not a redistribution of existing resources. Current remuneration structures do not value GPs' time or the significant complexity of their work. Instead, they reward volume over value.

The introduction of an extended Level-B, the most common GP consultation, would be the first step. This would support GPs to spend more time with their patients.

Expanded funding for coordinated primary healthcare through general practice would be next. Carefully working with the profession to design the new system of coordinated care payments to recognise the significant amount of non-face-to-face work that GPs undertake.

It is essential that all payments for these programs are indexed to keep up with the cost of running a practice. This should also include the introduction of specific Medicare rebates for nominated GP telehealth consultations.

The same applies to the Workforce Incentive Program. The goal to support the employment of nurses, pharmacists and allied health professionals in general practice will fail if the payments remain capped at current levels, which have not changed since 2012.

These reforms can only succeed with a highly-trained GP workforce in enough numbers to meet future need. This will involve improving GP-registrar working conditions and making general practice a viable career path for Australian-trained doctors.

GP training has been undersubscribed for two consecutive years. This is concerning, particularly as we are graduating doctors at the highest rate in the OECD. GP registrars are paid significantly less than their non-GP registrar counterparts. They are unable to transfer leave and other entitlements as they progress through training. These are major issues.

We want a review of employment arrangements for the GP training program, including the consideration of a single employer model for GP registrars.

The AMA also wants maternity care, mental health and rural health to be core considerations of the 10-year primary care plan.

## Private health insurance

The unique balance between the public and private sectors makes the Australian health system one of the best in the world. This balance and harmony allows universal access to healthcare. This is a key and vital feature of our world-class health system.

Just as we need to ensure our public hospitals are funded and supported appropriately, the Federal Government must ensure that the private health sector remains efficient, robust and productive.

The private health insurance industry, which facilitates access to private health care, has been under the microscope. In fact, private health insurance is currently in trouble - real trouble. There have been 15 successive quarters of decreasing coverage despite a comprehensive Government review and the transition to the new policy structure. But the situation is even worse than these figures portray.

There is a reality that we must all face here right in front of us. We see increases in premiums averaging three to five per cent a year, when wages growth is firmly stuck at around two per cent. But premiums are going up because an ever-increasing number of younger and healthy Australians are opting out of insurance. This is leaving a higher proportion of older, less healthy, expensive-to-insure patients in the system, and there are more of these joining every day. This, in turn, causes fund outlays to go up and round we go again. This is clearly unsustainable.

**Continued on page 34**

Sooner or later, the number of people with private health insurance will fall further and dramatically. This would mean the option of private hospital access would be unaffordable for many Australians. The burden would then fall calamitously on the already stressed public system.

We are truly on the precipice of the possible demise of a system that provides for the majority of elective surgery in Australia. The notion of free and affordable universal access in this country will simply evaporate overnight.

We need a private health insurance system that continues to offer affordable, transparent and appropriate cover. Reform of private health insurance needs to also address indexation of rebates, variation in rebates and insurer contracts. This reform needs to start now. We can't wait for another dozen quarters of decline. The death spiral is already underway.

We need to look at all the reform options, including the Federal Government's current private health insurance settings and investment. Whenever private health affordability is debated, it is inevitable that the issue of out-of-pocket costs will arise.

Let us be crystal clear about why we have out-of-pocket costs in the first place. The three contributors to out-of-pocket costs are the doctor's fee; the Medicare rebate; and what the health fund will pay. Let's also be clear that 87 per cent of services are billed under a no-gap arrangement. But the proportion of our health expenditure paid as out-of-pockets by individuals is not growing.

Australian Institute of Health and Welfare figures show that the proportion of health expenditure funded by individuals - not by government or insurers - has remained at around 16 or 17 per cent for the last 10 years. Importantly, of that 17 per cent, only 10 per cent is spent on non-hospital referred medical services. Most individual expenditure is on dental services and pharmaceutical products and other medications; 20 per cent and 37 per cent respectively.

So, what are the reasons behind out-of-pocket costs? Gaps can be caused by:

- the very wide variation of rebates from funds
- or a lack of appropriate insurance coverage
- or whether a hospital has a contract with a specific insurer.

MBS fees, and therefore insurers'



rebates, have fallen well behind the true cost of providing quality health services to the Australian community. Each insurer sets the rebate amount that they are willing to pay. If the insurer's rebate is low, the out-of-pocket cost to their customer can be high.

Out-of-pocket costs can vary by thousands of dollars because of the variation in what the insurer chooses to pay as a rebate. And yet we have only seen a 0.6 per cent decrease in the number of services provided at the no gap or known gap rates in the last 12 months. This is testament to the restraint of doctors.

The Federal Government was saving money through the Medicare rebate freeze, but in doing so passed the growing gap between the rebate and the doctor's fee directly on to the patient. Let me be clear; the AMA supports and actively encourages full transparency of doctors' fees. We unreservedly condemn egregious billing, which occurs in a very small percentage of cases. In fact, the AMA is taking extra steps to help patients understand medical fees.

In July 2019, Federal Health Minister, Greg Hunt, launched an Informed Financial Consent (IFC) information guide produced by the AMA with more than a dozen other medical organisations. The guide explains to patients that the same doctor performing the same procedure can

be paid significantly different rates by each fund.

This is often the untold story behind patient out-of-pocket costs and one that is hidden by high levels of no gap and known gap billing statistics. This is another important step in improving health financing literacy.

We want to provide patients with more information to give them the confidence to ask questions about their fees. We want to empower patients to be equal partners in fee conversations with their doctors.

The guide is available from [ama.com.au/article/ama-informed-financial-consent](http://ama.com.au/article/ama-informed-financial-consent)

The Federal Government's proposed fees website needs to also list what patients can expect back from Medicare and their private health insurance fund. Patients want to know what their out-of-pocket cost will be for a health procedure. A website that only shows doctors' fees cannot deliver this outcome.

We remain in discussions with the Minister's office about this issue. We need transparency all round.

**Visit [ama.com.au/media/national-press-club-address](http://ama.com.au/media/national-press-club-address) to read the full address, which includes Dr Bartone's thoughts on aged care, Indigenous health, mental health and prevention.**



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# Mentoring refugee doctors from the Middle East

AMA Victoria has partnered with AMES Australia to offer a group of Syrian and Iraqi refugee doctors the benefits of AMA Victoria membership, career coaching and the chance to be matched with a mentor. The opportunity resulted from an AMES (Adult Multicultural Education Services) Career Pathways Pilot, a one-year federally funded initiative. We meet one of the mentee-mentor pairs.



*Dr Jurstine Daruwalla (left) with mentee Dr Marwa Al-Bana.*

Dr Marwa Al-Bana comes from a medical family. Her father practised as a paediatrician in Iraq and both Marwa and her brother, Marwan, studied medicine and worked as hospital medical officers in Northern Iraq before they had to leave, arriving in Australia as refugees. Marwa recalls as a child going to the clinic with her father and seeing him care for his patients. Her hero is Sir Magdi Yacoub,

Professor of Cardiothoracic Surgery at the Imperial College London, who in 1980 carried out the first British live lobe lung transplant, as well as being involved in the restart of British heart transplantation at that time. Marwa's philosophy is that when someone is sick they are at their weakest and a doctor can relieve this by providing empathic support as well as medication and surgery.

At present, Marwa's main aim is to restart her medical career with an HMO2 position. Longer term, some of the specialties which appeal to her include general practice, obstetrics and gynaecology, plus surgery including plastics or ophthalmology. When Marwa was studying English through AMES Australia she took up the opportunity to join AMA Victoria.

Dr Jurstine Daruwalla is the first in her family to pursue a medical career. Initially she studied biomedical science and pursued research and a PhD. It was during her PhD research on selective vascular targeting therapies for colorectal liver metastases that she became interested in a surgical career and decided to pursue medicine. She then completed her PhD alongside a MBBS at the University of Melbourne, graduating in 2010.

Jurstine has recently completed her Fellowship in General Surgery with the Royal Australasian College of Surgeons (RACS) and is working at Northern Health on the Acute General Surgery Unit, which handles all emergency surgical presentations. She is enjoying her work and post-exam life. Her long-term goals include working as a global surgeon with specialisation in trauma surgery.

Jurstine has a long history of being a mentor, starting out while she was at university mentoring biomedical students and also Sudanese refugees through AMES. Jurstine believes

that if you have the knowledge and experience, why not help someone else? In addition, she believes it is important to be involved in activities beyond her own career.

Jurstine has experience as a volunteer surgeon with RACS in Fiji and has also volunteered in India and South Africa. As soon as she gains the necessary breadth of experience, she is keen to volunteer as a surgeon with Médecins Sans Frontières (MSF). Jurstine notes that MSF surgical placements are for nine weeks to reduce the risk of burnout and to allow them to be combined with ongoing roles elsewhere.

When Jurstine saw a callout from AMA Victoria for mentors to assist a group of Syrian and Iraqi refugee doctors, it seemed like a good fit based on her previous experience. The match with Marwa has worked really well, as Jurstine was able to introduce her mentee to the Northern Hospital observership program. This has provided Marwa with exposure to the Australian healthcare system, along with some practical experience at Northern

Health. She did so well in her placement that she was invited to undertake additional time as an observer.

Marwa has applied to a number of hospitals, seeking an HMO2 position and Jurstine has been able to use her experience to assist with advice about CV and cover letter preparation and to provide practice interview skills. Marwa would love to stay at Northern Hospital with its diverse, multicultural patient group which includes many young families.

There are currently six mentee and mentor pairs as part of this program with AMES Australia, with the doctors from Iraq and Syria all matched with AMA Victoria members. We're keen to be involved again, if there is funding for the program to be renewed in the future.



**Kay Dunkley**  
Doctor Wellbeing  
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# Retired doctors' tour

On Thursday 19 September, our Retired Doctors group visited Melbourne's inner-north for a guided tour of the Islamic Museum of Australia in Thornbury, followed by a three course lunch at Free to Feed in Northcote.

The not-for-profit restaurant is staffed by refugees, asylum seekers and new migrants, who are provided with training and professional development to help them connect into their new community.





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# Super gonorrhoea exposed on social media

Most medical professionals are familiar with social media and believe they know the potential pitfalls, both privately and professionally. But every so often we come across a cautionary tale which demonstrates how far reaching social media can be and how even the best consent process can fall at the last hurdle.

A young man presented to ED with severe burning during urination and penile discharge. He advised the ED registrar that he had recently returned from Southeast Asia and was worried he had picked up a sexually transmitted infection after having unprotected sex. His symptoms were getting worse and he was running out of excuses with his fiancée - who was unaware of the unwanted souvenir he had brought back from his holiday.

The ED registrar suspected 'super gonorrhoea' after reading about a recent case in the UK, so he called in the infectious disease team. The diagnosis of multi-drug resistant gonorrhoea was later confirmed and alternative antibiotic treatment eventually cured the patient. The registrar asked the patient if he could write up the case for a medical journal. The patient, feeling grateful and relieved, signed an authority for the registrar to publish the case on the proviso he wasn't identifiable.

The registrar wrote an article with some of the infectious disease doctors and was really pleased when the paper was published in a well-respected medical journal eight months later. The patient signed an additional authority at the request of the medical journal and also gave consent for the registrar to be interviewed by a media outlet who showed interest in the story - as long as he (the patient) remained anonymous.

The registrar gave the interview. Although he referred to the patient as a backpacker, he felt he had protected the patient's anonymity and hadn't released any information that would identify him. The media outlet promoted the upcoming interview on their Facebook and Instagram pages.

However, the patient had also told some of his mates that he had super gonorrhoea, which they all thought was hilarious. So when the media outlet publicised the interview with the tagline, "Young Aussie goes backpacking in Southeast Asia and returns with super gonorrhoea", his mates couldn't resist and started tagging him in the comments on Facebook.

**"Hey Johnno - is this what you had?"**  
**"I think they are talking about you bro!"**

By the time he became aware of the comments, his fiancée had seen the posts. She put two and two together and gave 'Johnno' his marching orders. The patient's workmates saw the posts, as did members of his immediate family.

The patient contacted the registrar saying, "You told me I would be anonymous - this article has ruined my life. Everyone knows it was me!" The registrar was understandably shocked, never having intended for the patient's identity to become public. The registrar apologised and contacted the media outlet who agreed to remove both the interview and the promo - but it was too late, the damage had been done.

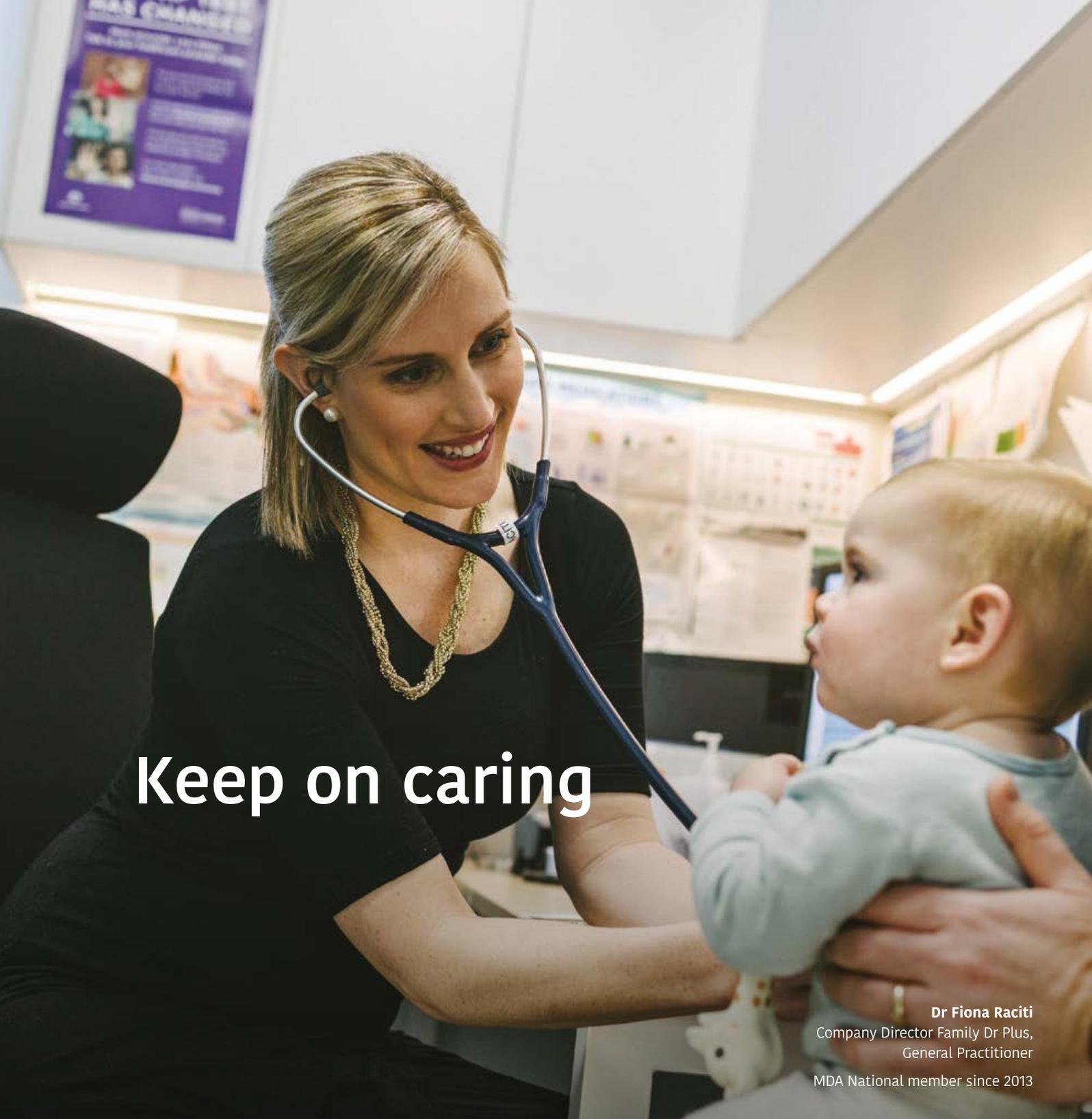
In this case, it was the patient's friends who effectively 'outed' him - not the registrar. But the registrar felt terrible nonetheless and quickly realised that in the age of social media, information can take on a life of its own.

Anonymity cannot always be guaranteed, because if a third party holds information disclosed by the patient, the de-identified information may be enough to complete the whole picture and disclose the patient's identity.



*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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# Copyright licensing – Are you entitled to play that music in your waiting room?

A recent court decision serves as a timely reminder to all businesses of the obligation to obtain appropriate copyright licences for any uses of commercial music (or video) recordings as part of their business. This includes, for example, radios played at employee workstations, music played over phone hold systems and background music or television broadcasts at reception and waiting areas, as well as soundtracks in the use of internally produced training videos.

## Copyright in sound recordings

Recorded songs incorporate two separate works which are protected by copyright and typically owned by different parties. Recordings are comprised of copyright in the musical work, being the composition itself (i.e. the tune and the lyrics which in and of themselves can be owned by different parties), which is owned by the composers/publishers of a song and copyright in the sound recording (i.e. the recorded performance of a particular artist performing the song), which is typically owned by record companies. When a party wishes to use a recorded song, for example a track which is commercially released, it needs to obtain permission from the owners of both of the copyright works, in order to be fully authorised to use the song.

## Copyright collection societies

The Australasian Performing Rights Association and the Australasian Mechanical Copyright Owners Society (APRA AMCOS) represents the rights of composers/publishers of musical works and collects and distributes licence fees for the public performance and communication (including broadcast) of its members' musical works. The performance and communication rights in sound recordings are administered by the Phonographic Performance Company

of Australia (PPCA). The PPCA performs functions similar to those of APRA AMCOS and represents the owners of copyright in sound recordings (typically record labels).

## The Federal Circuit Court case

The case of *PPCA v Hairy Little Sista Pty Ltd* involved two unlicensed restaurants and bars in Melbourne, one called Hairy Little Sista and the second called Hairy Canary. Both venues played recorded music owned or controlled by the record companies and were operational since August 2012. Since that date, the PPCA had been trying, without success, to negotiate appropriate licences with the respondents for the performance of recorded music at the venues. The Court found that the respondents had infringed copyright by not obtaining a licence to play music and acted either, "In a flagrant disregard of copyright, or at least... turned a blind eye or put their heads in the sand". In total, the financial penalties imposed by the Court amounted to almost \$200,000.

## Summary

The case is notable for the significant financial penalties that can be applied if businesses ignore their copyright licensing obligations. Licences can be obtained directly from copyright owners but for mainstream businesses,

both APRA AMCOS and the PPCA offer a range of blanket licences to allow the use of sound recordings and music videos in the workplace and as part of business. This is the most efficient and effective way to comply with copyright licensing obligations.

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References available from the Editor on request.

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# Recurrent swellings in a teenager - could this be HAE?



**Marianne is a 16-year-old teenager who presents with increasingly frequent swellings that can involve face, hands, feet and on one occasion, her neck was very swollen.**

There is no accompanying urticaria and no cardiovascular or respiratory compromise at these times of swelling. She does not notice improvement after antihistamines and on one occasion when she presented with marked facial and neck swelling, she was given an injection of adrenaline but the swelling persisted for over 24 hours despite this.

## What is the diagnosis?

This girl has angioedema without urticaria. Angioedema is defined as a vascular reaction of deep dermal / subcutaneous tissues or mucosal / subcutaneous tissues with localised permeability of blood vessels resulting in tissue swelling.

## What are the possible mechanisms causing these swellings?

Angioedema may be classified into several subtypes differentiated by the clinical presentation and underlying

pathophysiology. There are two major types - histaminergic or mast cell - mediated, and bradykinin-mediated. A third category of idiopathic angioedema is included when no underlying mechanism is demonstrated.

Histaminergic or allergic angioedema is a result of mast cell degranulation and release of histamine and other inflammatory mediators. This may be IgE dependant or IgE independent and these episodes are often accompanied by urticaria. Triggers include foods, medications and stings. Angioedema and urticaria may be part of a systemic reaction involving respiratory, cardiac and gastrointestinal symptoms characteristic of anaphylaxis. This form of angioedema will respond to antihistamines, adrenaline and corticosteroids.

A second major subtype of angioedema is that mediated by bradykinin. This can occur either on a hereditary or acquired

basis due to a deficiency or defect of the inhibitor of the first component of complement (C1 inhibitor) or other mechanisms. Swellings occur as a result of impaired regulation of bradykinin synthesis. Different forms of hereditary angioedema (HAE) are recognised depending on the biochemical abnormality:

- Type 1 HAE (HAE-1) has low antigenic and functional C1 inhibitor levels (85 per cent of cases).
- Type 2 HAE (HAE-2) is due to C1 inhibitor dysfunction with normal antigenic levels of C1 inhibitor.
- HAE with normal C1 inhibitor levels (nC1-INH) is a much rarer form-mutations in the factor 12, angiotensin I and plasminogen genes identified so far.
- Bradykinin-mediated angioedema may be acquired due to underlying malignancy or use of ACE inhibitors.

## What other history is useful to assist in arriving at a diagnosis?

### Has there ever been any accompanying urticaria?

Urticaria is not associated with HAE.

### Has there ever been any other rash associated with swellings?

Erythema marginatum is a lacy non-pruritic rash that often appears before or with angioedema swellings due to HAE.

### How quickly do the swellings evolve and how long do they take to disappear?

Angioedema of a histaminergic type comes on rapidly and may last for one to two days. Bradykinin-mediated angioedema usually has a much slower onset and offset and may last anywhere from two to five days.

### Have there been any episodes of abdominal pain lasting many hours?

Abdominal attacks are very typical of patients with all forms of HAE.

### Has there been any swelling compromising the upper airway?

HAE is a potentially life-threatening condition because it can be associated with laryngeal swelling causing asphyxiation if not managed appropriately. With effective therapies and recognition of the urgency to treat these attacks, death from asphyxiation is now a rare event in HAE patients.

### Is there any family history of angioedema?

HAE is an autosomal dominant disease due to mutations in the Serping 1 gene; a negative family history does not exclude the possibility that a patient has HAE, as 25 per cent of cases are caused by de novo genetic variants.

## What investigations are useful in assisting with diagnosis?

In cases of histaminergic angioedema, the clinical history aids in determining

what further diagnostic tests are required. Measurements of specific IgE and oral challenges with foods or medications may be useful in confirming the culprit agent.

For bradykinin-mediated angioedema, assessment of complement components is necessary. Diagnosis of HAE-1/2 is made by measuring plasma levels of C4, and if abnormal, C1-INH level and function. If a diagnosis of HAE is confirmed, all family members should be screened as early as possible.

## How would you manage this patient?

For the patient with a new diagnosis of HAE, referral to an immunologist for assessment, in depth education and provision of a management plan is recommended.

Management includes:

- Referral to the patient support organisation.
- Therapy for managing acute attacks. In Australia, two therapies are available:
  - Icatibant (Firazyr) as a subcutaneous injection for prompt self-administration at the onset of a significant attack. Two syringes should be on hand at all times.
  - Intravenous plasma-derived C1-INH (Berinert). It is usually administered in a medical facility but some patients are trained for home use. It is used for children, pregnant women or where Icatibant is contra indicated.
- Monitor HAE attacks for assessment of frequency.
- Consider prophylactic therapy when frequency and severity of attacks becomes burdensome to the individual.
- Appropriate prophylactic treatment is necessary for certain surgical and dental procedures.
- For young women such as Marianne, avoidance of oestrogen containing oral contraceptive pills



is important as this may worsen attacks and increase frequency. Progesterone only pills may be prescribed safely.

- Family member screening.
- Provision of a letter / management plan for the benefit of other medical personnel is highly desirable.

Refer to the HAE document and a standardised management plan on the Australasian Society of Clinical Immunology and Allergy website for more information: [www.allergy.org.au/hp/papers/hereditary-angioedema](http://www.allergy.org.au/hp/papers/hereditary-angioedema)

Patients and their carers seeking support and information can contact HAE Australasia via [www.haeaustralasia.org.au](http://www.haeaustralasia.org.au)



**Prof Connie Katelaris AM**  
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# Retiring well: Dr Jean Douglas

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



## Can you tell us about your career and what you are doing now?

I have worked in various places in my early career - Papua New Guinea, Broken Hill, Sydney, Auckland and Warrnambool, before settling in Bendigo in country Victoria. Each place I worked gave me great memories and a wide range of medical experiences. There is no question that when you are young and free, working and travelling is beneficial to your life and work experience.

In 1977, my husband, Dr Moli Tamanika (also a GP), and I settled in Bendigo. I worked as a GP at Eaglehawk Community Health Centre until 1990 when we bought the small family practice in Mclvor Road, Bendigo and remained there for 25 years! Once you start a family you are tethered!

In the late 1980s, I came to Melbourne University once a week to do the Master of Medicine (Community Health) post-graduate course under the supervision of Dr Ross Webster. I also enjoyed being involved in the medical community through a variety of groups: AMA Victoria subdivision, Breast Screen, Community Abuse and Sexual Assault

Unit, Medication Committees in Nursing Homes, Loddon Mallee Integrated Cancer Service and as the General Practice Representative on the St John of God Medical Advisory Committee.

Our practice was a true family practice, caring for families through their whole life; doing GP obstetrics in the early days, surgical assisting, hospital admissions, palliative care and nursing home care, as well as our normal day-to-day patients. In 2013, I became a life member of the RACGP.

We sold our practice in 2015 and moved to Melbourne in 2016; a 'tree change' in reverse!

We saw the AMA had a retired doctors group and we decided to join. Four times a year there is an event; going to a theatre show, museum or art gallery, or a guest speaker with lunch. Meeting other doctors and their partners has been fantastic. AMA Victoria is to be praised for organising this and it is recommended to all retired doctors.

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

Changing your routine as you get older is often a challenge. Stopping practice is difficult in a caring profession where you have developed many wonderful relationships of trust and loyalty. Particularly in general practice, over the years you become part of people's families. Even after retirement, when meeting old patients they still like to share details about their present medical conditions. Returning to Bendigo and bumping into old patients in the street, I get asked opinions about their medication and recent tests! You have to develop appropriate answers without offending. It is indeed nice to know your opinion is valued.

Retiring from the professional part of your life is a form of grieving. You have to go through the phases. It takes time.

Prof Leon Piterman has written a wonderful little book, *"There's a lot of it going around"* - *A GP's Odyssey*. Chapter 19, 'It's Time' is succinct. This little book should be mandatory reading for all doctors. He calls it relevance depletion syndrome!

I think one should retire before one makes mistakes or looks silly. Leon outlined a case of an 82-year-old GP whose slurred speech and difficulty

writing a prescription frightened the patient so much he raced to report to the reception. They thought the doctor was having a stroke but the GP claimed he was only having a TIA and would get better in an hour or so!

In country areas where young doctors often choose not to go to live and work, older doctors maintain their dedication to the community by working past their retirement age. Over the years I have heard many reasons why doctors do not want to go to the country and I find most excuses are not entirely true. It depends on what you want out of your working career. Country practice is very rewarding!

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

We did not receive any resources or support to retire. I diversified my 'out of medicine' interests over the years. I have always enjoyed the arts, reading and writing. I wrote a few medical

papers pertaining to general practice and did two presentations at WONCA (World Organisation of Family Doctors).

In first-year medicine we were encouraged to diversify our knowledge and 'The History of Western Civilisation' was a compulsory subject. This stimulated my continuing interest in history. I have a particular interest in medical history and I am fortunate to be on the Heritage and Archives Committee for AMA Victoria. We are a group of volunteer doctors who are preserving historic records and memorabilia, researching and recording the history of the medical profession. There are many heroic stories of doctors who created the foundations of our profession here in Victoria.

When my husband retired he continued playing golf. He loves the sand belt courses of Melbourne.

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

You do not have to plan your retirement to the finite degree early in your working career but at least think about it. Ensure you think about your finances for your retirement and have an interest outside medicine.

The challenge is to accept your mortality. Daniel Klein has written a book *Travels with Epicurus* in which he focuses on getting life fulfillment out of old age. Old age is a privilege; savour it.

Give yourself advice as you would do to your patients, but seek advice from others if you think you need it. The new AMA Victoria Retirement Support Programs offered to all members will be very helpful.

My husband Moli says, "If your patients ask when you are going to retire, the bells should start to ring. When your colleagues ask you when are you are going to retire, the bells should be loudly ringing. But when your partner asks when you are retiring, that is a different story!"

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

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# Are you paying too much land tax?

Paying land tax is an inevitable side effect of successful property investment and arguably a nice problem to have. Rates and tax-free thresholds vary across states but are always structured in a progressive way. And with the tax only applicable to the unimproved portion of a holding - which is typically less than 70 per cent of the total value even for houses - little if any tax is paid by those owning a single investment property worth under a million dollars.

It is a different story if the owner has built a portfolio of say two or three houses that might be worth \$3m in total and comprise \$2m in land value. In some states, the annual land tax bill in those circumstances would be over \$20,000 a year. And once unimproved values move north of \$4m, the marginal land tax rate can sit between 2 and 2.25 cents in the dollar of unimproved value and annual land tax bills of \$50,000 are not uncommon.

Although land tax is a relatively modest portion of total state government receipts (for instance, it represents around 4 per cent of total government revenue in NSW), the amount raised has swelled in Victoria and NSW since the start of the decade off the back of strong property price growth. In Victoria alone, land tax receipts in 2019/20 are expected to be \$3.7b, over three times higher than the \$1.2b raised in 2009/10.

Now it is both unremarkable and unobjectionable that higher land values lead to higher land tax. But there is a likelihood that some investors will be over-taxed in the current environment due to the manner in which properties are valued for the purposes of land tax.

In many states, the government relies on councils to manage the valuation process, adopting the same valuation data used by local government to calculate rates. In NSW, the valuation process is run by the state's valuer general (an approach Victoria is slowly transitioning to). Generally, the assessment's land value is an estimate on a prescribed date, typically 1 January or 1 July in the previous year.

Fresh valuations of properties are undertaken intermittently, generally on a two-to-three year cycle, although some states flag that desktop-based adjustments are made more often to reflect market movements. Overall, this is a reasonable approach that balances a need for accuracy without being onerously expensive to operate.

However, the methodology leaves landowners vulnerable when prices are volatile. For instance, in Sydney and Melbourne, prices are now down 15 and 11 per cent respectively from their 2017 peaks, according to CoreLogic. But falls aren't uniform within cities. CoreLogic reports that the top quartile of properties in Sydney and Melbourne are down 17 and 16 per cent respectively and there will be properties that are down over 20 per cent in value from their peak.

An out-of-date council valuation that doesn't capture a 20 per cent price drop on a portfolio comprising \$4m in land holdings subject to a 2-cents-in-the-dollar land tax rate could see the investor overcharged \$16,000.

Fortunately, there is always a mechanism to challenge the land tax bill. It varies across states but usually involves filling in a comparatively short form. The key to success is two-fold: one, providing evidence of comparable sales from around the time of the assessment's valuation date that supports a lower valuation; and two, speed. In most instances, objections need to be lodged within 60 days of receipt of the land tax assessment notice.

With assessment notices usually issued in the first quarter of the year, it is now generally too late to challenge a 2019 land tax bill. But when your 2020 bill arrives next autumn, be sure to check that the valuation genuinely reflects prices from the state's official 2019 assessment date rather than from the peak of the market in 2017.



**Richard Wakelin**  
Founder  
Wakelin Property  
Advisory

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# The Women's: Carers, advocates and reformers

*"The colony was in the midst of a gold rush that would bring half a million people in the decade. Women were abandoned - pregnant and destitute - while their husbands and erstwhile lovers tried their luck on the goldfields. The need for a charity lying-in hospital for women without homes was urgent." - Professor Janet McCalman AC, Historian*



*Women's Hospital, ambulance for transporting premature baby, 1949.*

The Victorian gold rush, in the mid-19th century, represented a period of immense wealth and population growth that helped establish Melbourne as one of the wealthiest and most thriving settlements in the colonies. The surge of population brought with it social and economic upheaval, not least for women at the time. This was an era that vilified women who, through no fault of their own, fell afoul of contemporary social mores. Women on the periphery of society: those in poverty, left widowed or deserted by partners or pregnant out of wedlock, were all but excluded from access to adequate health services. Mortality rates of infants and women dying in childbirth climbed and the need for providing healthcare to these, and all women, became imperative.

Dr Richard Tracy and Dr John Maund with a committee, led by Mrs Frances Perry, were determined to enact a change and set to work to establish a facility that would provide universal healthcare and treatment for women. In August 1856, the Melbourne Lying-In Hospital and Infirmary for the Diseases Peculiar to Women and Children opened to the public in an East Melbourne terrace house. Since its establishment, what's now known as the Royal Women's Hospital has seen many iterations up to its present-day home in Parkville, but has remained committed to its focus on the underprivileged.

The University of Melbourne's Medical History Museum in collaboration with The Royal Women's Hospital's History, Archives and Alumni Committee has produced a major exhibition *The Women's: Carers, advocates and reformers*. The exhibition is accompanied by a catalogue tracing the history of women's health in Victoria generally - and at the Royal Women's Hospital in particular - through our combined collections. Importantly, the rich history of Indigenous peoples' knowledge and practises for pregnancy and

Ovariotomy instruments, c. 1864, presented to the Royal Women's Hospital by Dr Tracy descendant Robert Tracy-Ingليس 1963.



childbirth is acknowledged through contributions by senior Victorian Indigenous women.

Among the Medical History Museum's rich collections is the first Annual Report of the Melbourne Lying-In Hospital and Infirmary for Diseases of Women and Children, dated 13 December 1856. It states that one of the hospital's distinguishing characteristics would be, "The admission ... of poor women during their confinements, with provision to ensure proper medical attendance, with judicious and kind nursing during their stay". The hospital would, the report predicts, "Supply a want that has long been felt to exist and which could not be satisfactorily met by any of the previously existing Charitable Institutions in Melbourne".

From its beginnings in 1862, Melbourne Medical School has had strong connections with the Melbourne Lying-In Hospital and Infirmary for the Diseases Peculiar to Women and Children. One of the founders of the hospital, Dr Richard Tracy, was the University's first lecturer in obstetric medicine and diseases of women and children. The Royal Women's Hospital and The University of Melbourne continue to collaborate through teaching and research, with both institutions leading the field in women's health.

The exhibition includes ovariotomy instruments owned by Dr Tracy (pictured above). Sent to him from England by his mentor, Sir Thomas Spencer Wells, who was surgeon to Queen Victoria and a leader in obstetrics.

One of the eye-opening items on show is a midwifery nurse's case that belonged to Florence Green (pictured right), who trained as a midwifery nurse at the Women's Hospital in a two-year scheme designed for women without prior qualifications in nursing (for general nurses, the course was one year). Those enrolled in midwifery

training at the Women's were referred to as 'midwifery pupil nurses', yet their certificates bore the title 'obstetrical nurse'. This term was adopted in 1898 after the pupils requested replacement of the longstanding title 'ladies monthly nurse'.

The rapid advancements in medical science during the mid-20th century is highlighted by the display of an incubator, constructed in 1949 by chief engineer of the Women's Hospital, Mr Jack Murphy and used for transporting newborn infants within the hospital. Paediatrician, Dr Neil Roy, describes for the exhibition the construction of the incubator, which was suspended on springs, warmed by hot water bottles. Oxygen came from an externally placed cylinder, the gas passing through the walls of the incubator, warming it before consumption by the infant.

Public health movements in modern women's healthcare are explored in the exhibition, detailing changing focuses in women's nutrition, contraception, substance abuse and mental health. The hospital's long history treating gynaecological conditions, abortion and childbirth complications are also chronicled, including the often-tragic consequences of backyard abortions before the procedure was legalised.

The health needs of women on the fringes of society remain a priority for the hospital and the exhibition and catalogue detail this continued commitment. "Today it is the homeless, those with substance abuse issues, those from the lowest socioeconomic groups, refugees and others," said Associate Professor Leslie Reti, head of gynaecology at the Women's.

*The Women's: Carers, advocates and reformers* provides the public unprecedented access to the collections of The Royal Women's Hospital Archive and Historical Collection and the University of Melbourne's Medical

History Museum. Together they take the viewer through the history of women's health in Victoria and explore the figures, technology and the social challenges that weave together a formidable portrait of the historical, scientific and social impact of The Women's Hospital in Melbourne.



**Dr Jacqueline Healy PhD**  
Senior Curator  
Medical History Museum and Henry Forman Atkinson Dental Museum

Florence Green's midwifery case, 1916, gift of Margaret and Eric Smith (great-nephew of Florence Green) 2018.



#### Exhibition details:

*The Women's: Carers, advocates and reformers* runs until 2 November 2019 at The Medical History Museum, University of Melbourne, 2nd Floor Brownless Biomedical Library.

Opening Hours: 10am to 5pm Monday to Friday, 1pm to 5pm Saturday.

[www.medicalhistorymuseum.mdhs.unimelb.edu.au](http://www.medicalhistorymuseum.mdhs.unimelb.edu.au)

# Beware of junk health insurance policies

So-called 'junk policies' are private health insurance policies that only provide cover for a handful of in-patient services; this can often be just the minimum required to qualify as a 'compliant health insurance policy'. These policies allow the consumer to avoid paying the Medicare Levy Surcharge and Lifetime Health Cover loading. That's why they are also referred to as 'tax-avoidance' policies.

The list of exclusions is long and junk policies are better defined by their limited inclusions. In addition, even for the few services that are covered, they usually only provide benefits at public hospital rates. This means the patient either chooses a public hospital (with no out-of-pocket costs), or a private hospital with potentially high out-of-pocket costs.

As part of the last round of private health insurance reforms, health insurers are required to categorise their policies as either Gold, Silver, Bronze or Basic. These tiers are determined by the clinical categories they cover; junk policies are defined as Basic covers. Establishing this Basic tier means these junk policies have been officially endorsed and while the tiers will assist consumers in understanding the level of cover they hold, we still consider these policies problematic.

## Addressing affordability

Affordability continues to be a prevalent issue in private health; especially for young people who are at a much lower risk of encountering health incidents. However, we disagree that the solution to affordability is junk policies. These types of policies will likely leave those consumers disillusioned with their health insurer, should they need to make a claim only to find they may not be covered.

Moreover, these policies do not assist in reducing the burden on the public hospital system, which is an

essential function of private health insurance. It is also questionable if consumers who hold these policies fully understand the limitations of their cover until it's too late.

## Our stance on junk policies

At Doctors' Health Fund, we don't offer Basic policies because it's important to us that our members have adequate cover. Our entry-level Smart Starter Bronze Plus policy strikes the right balance between affordability and value. It is well-priced, but, at the same time, offers cover for multiple services. In fact, it provides cover for 25 out of the total 38 clinical categories defined under the new system.

Our Smart Starter Bronze Plus cover provides better value for money when compared to the junk policies available from other health funds, it covers services above the minimum required in the Bronze tier for an affordable price and offers something that junk policies don't; peace of mind.



**Peter Aroney**  
CEO  
Doctors' Health Fund



Doctors' Health Fund is an AMA Victoria Member Benefits Partner. Visit [doctorshealthfund.com.au](http://doctorshealthfund.com.au) for more information.



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