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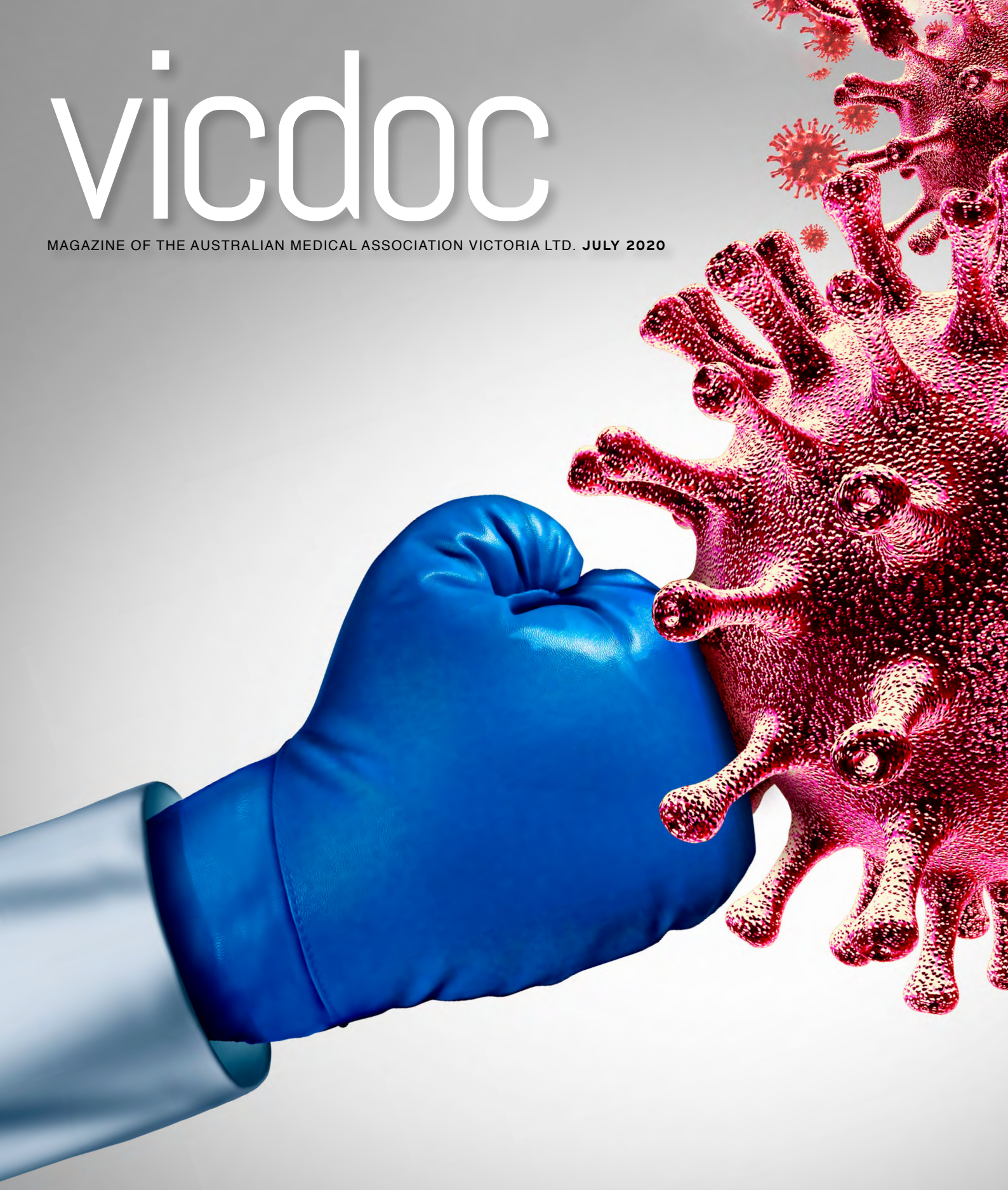

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President's message

Is managing Victorian hospitals via devolved governance working?

Earlier this year, an expert panel from *Newsweek* magazine ranked our own Royal Melbourne Hospital as the best hospital in Australia and 28th best in the world, while the Alfred Hospital was second in Australia and ranked 36th in the world. *Newsweek* partnered with global data research company Statista to establish these rankings and had the judgements overseen by a board of six global experts in hospital management, quality and safety.

Critics might argue that this is just another opinion-based list, a bit like judging the world's top golf courses. However, Melbourne also rated highly in another study published late last year by London-based digital healthcare company, Medbelle, which listed the 100 best cities in the world for hospital services. After evaluating numerous parameters including the number of beds, staff-patient ratios, the quality of medical education, the cancer survival rate and ease of access to hospital care, nearly every Australian capital city made it into the top 100, with Melbourne again being the highest ranked in Australia at No.7, while Sydney was in 11th place.

Consequently Australia, and Victoria in particular, must be doing something right to be independently ranked in this way using accepted statistical measures. Perhaps this excellence has been driven by open and at times aggressive competition between our metropolitan hospitals, particularly exemplified by the inter-generational Royal Melbourne and Alfred rivalry. However, it begs the question, how can we create a climate within which all our hospitals, including our regional ones can do better and even excel when compared to their global metropolitan peers?

Of course, on many other measures, AMA Victoria argues that Victorian hospitals could improve. Our own Hospital Health Check survey conducted late last year revealed that even before the COVID-19 pandemic, many early career doctors had observed declining hospital cultures and an indifference to their pay and conditions. Equally, AMA Victoria has encountered an extremely combative industrial culture with widespread reluctance of hospital managers to fully implement the 2018 Enterprise Agreement for many senior staff, including variable hostility to the concept of clinical support time, despite the fact that budgetary support has been received from the Department of Health and Human Services (DHHS) for this staff benefit for almost a decade.

Moreover, the role of general practitioners often appears devalued by public hospitals despite the fact that more integrated care and less emphasis on hospital management will be necessary to improve the prognosis for chronic diseases and moderate the demand for hospital-based care.

One possible reason for this bizarre paradox is our devolved hospital governance arrangements. Significant flaws in this structure have also been exposed by the extreme challenge and extra strain experienced this year as we prepared the system for COVID-19. There is a conversation to be had around whether the devolved system really serves us well in a pandemic and whether the DHHS (and especially Safer Care Victoria) should have a more active role to play so that, for example, we might have more transparency from public hospitals, a fairer and more equitable distribution of PPE between various public hospitals and more consistent application of processes and guidelines – such as for PPE use and training.

President's message

In 2015, an independent charity working to improve health and healthcare in the UK (called the King's Fund) was asked to review the model of Victoria's devolved governance of health services. Like the above mentioned studies of hospital quality, the King's Fund found that Victoria delivered superior results compared to other parts of Australia underpinned by the considerable autonomy exercised by our hospitals within a state-wide framework of priorities.

Ideas proposed by the report from the King's Fund included:

1. Assessing how the health department, in partnership with health services could become more involved in planning and monitoring of the quality of clinical services (including staff engagement) both within Melbourne and in regional/rural Victoria.

2. Encouraging boards to share their innovations in care and to support each other when they encounter performance challenges, including strengthening their leadership and clinical capabilities.

3. Reducing the number of separate boards (from the current 85) while encouraging greater collaboration between them, especially with respect to the delivery of regional and rural services.

4. Allocating oversight of hospital board appointments to an independent authority so that appropriate candidates could be selected based on their skills and experience, so as to avoid the perception of politically based appointments.

5. Reviewing how decisions on the use of capital might be made to ensure greater transparency and consistency of these decisions.

6. Measuring the performance of hospital executives via an expanded number of key performance indicators (beyond finance and access) to include many more related to staff satisfaction and system morale.

So, without destroying the (usually) healthy competition that has arisen via our devolved governance of Victorian hospitals, there is perhaps a case for a system re-think. We'd love to know members' thoughts on this topic. Please email AMA Victoria's Director of Communications and Advocacy, Taryn Sheehy at TarynS@amavic.com.au

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A/Prof Julian Rait OAM
President

COVID-19 highlights the crucial role of general practice

It's hard to comprehend how much has changed since my last article for Vicdoc. We have all seen our lives upended by a global health crisis worse than any in living memory and we are all struggling to find our way forward in a world where many of the old rules simply do not apply.

The COVID-19 pandemic has presented enormous challenges for every level of the health system. While Australia's early lockdown and strict physical (social) distancing measures have so far spared us the terrible scenes witnessed in Europe and the United States, preliminary modelling suggested that tens of thousands of Australians could lose their lives to the coronavirus. With that spectre looming over us, the focus was on preparing hospitals for the expected

wave of patients: cancelling elective surgery, setting up isolation wards and increasing intensive care capacity.

Unfortunately, it felt as if the role of general practice and primary healthcare was overlooked in the rush to boost critical capacity. In the first stages of the pandemic, GPs found themselves dealing with mixed messages, a lack of personal protective equipment (PPE) and confusion about where we fitted in to the national COVID-19 strategy.

Our response, however, was eloquent testimony to the flexibility of general practice. We showed how nimble practices, big and small, could be in adapting to unprecedented challenges. Within weeks or even days, we had identified the issues and acted on them. Clinics completely overhauled their operations, instituting triage methods to ensure separation of infectious patients, redesigning service delivery to ensure the safety of doctors and staff, setting up drive-through COVID-19 testing and embracing remote consultations. GPs also reached out to Primary Health Networks and Local Hospital Networks to discuss opportunities for an integrated care response. The result was a model of care that allowed clinics to maintain and even expand their offering.

One of the game-changers that made that response possible was, of course, the temporary addition of telehealth consultations to the Medicare Benefits Schedule. Remote consultations are undoubtedly an important tool in a pandemic environment that has been embraced by both patients and GPs. I foresee telehealth becoming an integral part of the patient-centred medical home, the evidence-based model that puts the patient and the GP together at the heart of an interconnected web of services. While nothing can, or should, replace the face-to-face appointment, we should urge the Federal Government in the strongest possible terms to retain the telehealth benefit. However, this should be in an enhanced version that is clearly linked to a patient's usual general practice and provided as one part of the suite of services that quality and comprehensive general practice provides to its patients.

While we have so far succeeded as both a nation and a health system, we don't yet know where the pandemic will eventually lead. We know, however, that we are heading into a very different world. Until an effective vaccine or treatments are available, the potential for further COVID-19 outbreaks remain. So the welcome fact that we have not yet seen a wave of infections in Australia does not mean we never will. If we do, how does general practice fit into that world?

My answer is that in the era of COVID-19, general practice has never been more important. Not only will we continue doing what we've always done, we can play a crucial role in making sure our hospitals can cope with whatever is thrown at them. To do this, GPs will increasingly be dealing with people who would otherwise have gone to the emergency department and continue caring for these people in the community. In the event of future outbreaks, it is likely we will be managing many of the less serious cases of COVID-19, perhaps over 80 per cent of total infections. With the right support and advice, that is not only possible, but desirable.

So what do we need to play our part? We need clarity and recognition for our role and timely support. To achieve this, general practice needs to have a seat at the big table in planning responses. We need full PPE to keep doctors, their staff and patients safe. We need ready access to specialist opinion to help us manage cases that are more complex but don't necessarily require inpatient treatment or referral. Tools such as the HealthPathways website are invaluable. We need clarity of healthcare system roles and efficient interfaces for patient flows, communication and shared care arrangements.

So much has changed, but some things remain the same. Along with the COVID-19 crisis, Australia still faces the creeping burden of chronic, lifestyle and mental health illness, many of which will have been exacerbated by our time in lockdown. There has been a worrying drop-off in the number of people presenting for routine care for conditions including cancer and heart disease. We need to get the message out that GPs are still there to help, that it is safe to come to us; that prevention and early diagnosis is important and that the coronavirus is not the only disease that needs management.

General practitioners have always been on the frontlines of medical care and nothing about this pandemic should change that. We have shown how quickly we can adapt and that's a lesson that must be taken forward as we plan for the future. With the right support, planning and communication, general practice can be our first and best line of defence and response.

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AMA Victoria wants to know about your experiences using telehealth. Please email Director of Communications and Advocacy, Taryn Sheehy at TarynS@amavic.com.au and let us know your views on retaining the telehealth benefit.

The Royal Melbourne Hospital implements virtual monitoring

Innovation and adaption have been critical in dealing with the current COVID-19 crisis and in a quick thinking move, Emergency Department staff at the Royal Melbourne Hospital (RMH) have created a platform to monitor patients for COVID symptoms outside of the hospital.

The program was set up to assist with anticipated pandemic numbers of COVID patients expected at the RMH. The idea was to use pulse oximeters, a small device that typically clips on to your finger, toe, or earlobe to measure oxygen levels in the blood.

RMH staff use the device to effectively monitor patients from their homes, allowing for a reduction in people using beds while still maintaining peace of mind.

The program, which is now available free for other hospitals to use, was designed to be able to safely send patients who do not currently require hospital treatment back home to self-quarantine, whilst still being able to rapidly identify a subset of patients who subsequently become significantly unwell and need to return to hospital.

RMH staff created a novel software solution which assists patients to manage their own health, by monitoring their oxygen levels at home and reporting back into the hospital using their own smartphone twice a day.

Every few hours the patient is asked to record vital signs and record the data, which is fed back into the hospital system. If there is a reason for concern the software will trigger a 'met call' - notifying the supervising clinician of a potential deterioration in the patient.

A pulse oximeter is a small electronic device that estimates the saturation of oxygen in your blood. According to the World Health Organization, a healthy person should have a reading between 95- 100 per cent. There is reason for concern if the number drops below 92 per cent.

Emergency Department consultant and AMA Victoria member, Dr Martin Dutch (pictured), developed the program which has capacity to monitor 1000 patients. "This is a cheap and effective way of monitoring patients and giving them peace of mind, knowing the hospital is keeping an eye on them when they aren't physically onsite," Dr Dutch said.

In the treatment of COVID-19 it's become more apparent that patient's symptoms often worsen during the second week of the illness. Monitoring from home means staff will be alerted immediately if there is any change to vital signs and, importantly, oxygen levels.

"COVID-19 provides some unique challenges for the health system. It is now clear that a subset of patients may have a very significant deterioration in their health in their second week of illness," Dr Dutch said.

"This deterioration can often begin to occur silently, without a significant worsening of symptoms. A number of international centres are now recommending the early identification of this subgroup of patients, through use of pulse oximeters in the community."

However, many health systems do not have processes setup to remotely manage large numbers of at-risk individuals in the community.

The program uses a novel adaptation of REDCap™, a commonly used piece of hospital software, found in over 300 health institutions in Australia, and over 4,000 internationally. By linking this software to an SMS service, staff at the RMH have developed a comprehensive system to reach out to patients in the community via text message and allow them to reply with the oxygen level measurements and other important health information.

This system has been built with pandemics in mind and is designed to handle large numbers of patients, with the integration of automated advice to patients on their self-care and the promotion of important public health messages.

"The costs of setting up a system are particularly affordable," Dr Dutch said. "The underpinning software is free to use for all health institutions and our adaption can be downloaded for free."

The RMH COVID-19 Home Monitoring technology is available to **other hospitals via this link**. All the hospitals need to do is purchase the oximeters and install the technology onto their REDCap.

The Royal Melbourne Hospital

AMA Victoria expresses its appreciation to all of the doctors who have contributed to the effort fighting COVID-19 and we'd like to highlight more of this great work in Vicdoc. If you have a story to share, or want to nominate a colleague, please contact Vicdoc Editor, Barry Levinson at BarryL@amavic.com.au

The COVID-19 treatment trials that 'learn as they go'

Innovative COVID-19 treatment trials enable us to quickly hone in on the most promising treatments, saving time and potentially saving lives.

At the time of writing, there is no known effective treatment for COVID-19, a serious and highly contagious respiratory disease that has caused a global pandemic, mass hospitalisations, and sadly, many deaths. Quickly finding an effective treatment is paramount, but comes with many challenges.

COVID-19 is caused by a novel coronavirus, named SARS-CoV-2, which was first detected in December 2019 in Wuhan, China. Being novel means the virus is completely new to science, so there is a limited understanding of how COVID-19 might best be treated and what the treatment outcomes might be. But we have seen similar diseases this century that might hold some clues.

The novel coronavirus is similar to two other recently emerged coronaviruses: namely, severe acute respiratory syndrome (SARS-CoV), which first circulated in 2002-2003 and Middle East respiratory syndrome (MERS-CoV), which appeared in 2015.

Drugs that have been investigated as treatments for SARS or MERS include lopinavir and ritonavir, both used to treat human immunodeficiency virus (HIV) infection, and hydroxychloroquine, mainly used to treat arthritis or malaria.

The same drugs may be able to treat COVID-19 and have demonstrated some activity against SARS-CoV-2 in laboratory experiments and in humans outside of the rigours of a clinical trial.

A/Prof Justin Denholm (left) and A/Prof Steven Tong. Photo: Doherty Institute.

While lab experiments are a key step in assessing whether a drug has the potential to be an effective treatment, the real proof will come from rigorous studies in humans.

To date, there has been one commendable, yet ultimately small and inconclusive, human trial of lopinavir and ritonavir from Wuhan in early 2020, although several other human trials are now underway.

Challenges for COVID-19 trials

The traditional approach to discovering how a new treatment works when given to humans is to cycle through several, often lengthy, phases of clinical trials.

First, the study must assess safety of the proposed treatment (Phase 1) and then demonstrate that the new treatment is likely to be effective using a small number of people (Phase 2). Finally, it must confirm that the treatment is effective in a much larger number of people (Phase 3). This process may take many years. Even then, it may fail to show that the new treatment is effective.

Fortunately, the safety of the candidate treatments that we have described is well-understood as they have

already undergone these early trial phases for other diseases. But Phase 3 COVID-19 trials are now required to generate evidence to support effective treatment(s) of COVID-19.

Given the rapid spread and increase in detected case numbers across the globe, the challenge is to design trials so that we can identify effective treatments and start providing them to patients as quickly as possible. All in the face of uncertainty.

Meeting the challenges

Researchers at the Peter Doherty Institute for Infection and Immunity are leading a trial, currently underway, that steps up to the unique challenges posed by the current pandemic: the Australasian COVID-19 Trial, or 'ASCOT' for short.

The main aim of ASCOT is to assess whether lopinavir/ritonavir, hydroxychloroquine, or a combination of both treatments, will lead to improved outcomes for COVID-19 patients compared to the current standard of care.

In contrast to most traditional randomised trials, as ASCOT generates evidence for, or against, any particular treatment, the likelihood an individual is randomised to a particular treatment can be updated while the trial is underway. This ensures that most patients entering the trial receive what appears to be an effective treatment, while still generating sufficient evidence to prove that the treatment is effective.

This unique aspect of ASCOT also means that we are able to stop the trial if one of the treatments gives us enough evidence that it will work, or drop any treatment that looks like it will not work before the trial would typically finish.

Further, as evidence is generated from other trials around the world about other promising treatments, we are able to seamlessly introduce these new treatments into our study.

The ASCOT study joins a growing cohort of trials that are taking a similarly 'adaptive' approach to finding effective COVID-19 treatments, including the WHO Solidarity, REMAP-CAP and RECOVERY trials.

Benefits of being Bayesian

The flexibility of ASCOT and similar trials to adapt is possible using Bayesian statistical methods, which allow evidence about treatments to be continually updated with new information as it becomes available, while at the same time maintaining trial integrity. In other words, Bayesian methods allow trials to 'learn as they go'.

The new information doesn't have to be raw data, it could be expert opinion or results from other trials. This level of flexibility is difficult with classical, non-Bayesian approaches. Bayesian statistical methods are useful in almost all medical research, but particularly so in clinical trials, where they can be used to design what are known as 'Bayesian adaptive trials'.

Although classical statistical methods, like the ones many people learn in high school and university, can be used to design adaptive trials, the mechanics of the Bayesian approach allows information to be combined much more naturally and better resemble how we think in the real world.

A key strength of the Bayesian approach tends to be on the probability that a treatment works, rather than a less informative focus on what 'works' or 'doesn't work' according to a statistical test.

Why be Bayesian in a pandemic?

In the event of an outbreak of an infectious disease, such as the current COVID-19 pandemic, we often know very little but are required to act very fast. Designing a non-Bayesian trial to confirm whether a treatment works under uncertainty is difficult because the sample size and design features of the trial rely on assumptions about how the treatment will work.

The design cannot be modified easily and so, if those assumptions are ultimately incorrect, the trial may finish without providing any useful evidence about what treatments are effective.

An outcome like this in the midst of a rapidly evolving pandemic is, unfortunately, not unlikely. A key flaw of some early clinical studies of treatments for COVID-19 is that they were underpowered and did not provide sufficient evidence to inform treatment decisions.

If many people have the pandemic disease and it progresses quickly, a Bayesian adaptive trial can swiftly learn about existing treatments, abandon any that prove futile and expand to include new and promising candidates.

Facing a disease that in just over five months to the start of June had resulted in more than 400,000 deaths reported globally, it goes without saying that these are crucial design features.

In a pandemic, as the medical community scrambles to learn more about the disease, using Bayesian adaptive trial designs can ensure that we quickly hone in on the most promising treatments.

In turn, an effective treatment may be found much sooner than otherwise possible which saves time, but most importantly, has the potential to save lives.

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This article was first published on *Pursuit*. Read the original article.

Biobanking on the future: Project to unravel the effects of COVID-19

When the COVID-19 pandemic first hit, there were big questions being asked in medical science about immunity. Why do the effects of this destructive new virus differ so much in people? Why do some escape the virus relatively easily, while others suffer greatly and potentially die?

Monash University's Dr James McMahon is an infectious diseases expert and hospital clinician at Alfred Health and Monash Health. He leads The Alfred's Clinical Research Unit in Infectious Diseases, which examines a wide range of infections such as HIV, hepatitis and bacterial infections, but also respiratory infections such as influenza. And now, of course, COVID-19, the newest mutant offspring from the coronavirus family of respiratory infections.

"It became pretty clear pretty quickly that individuals were having different responses to this virus," he says. "Much of that was to do with age and also people with other medical conditions and compromised immune systems. But we were seeing severe cases alongside mild cases. We were very interested in finding out more about why that was happening."

Aiming to crack the immunity code

Dr McMahon is now leading aspects of a Monash-Alfred project aimed at cracking the immunity code by collecting blood and respiratory swabs from COVID-19 patients in Melbourne to thoroughly test what the virus does and how it behaves in different people.

"We connected with different research groups – many within Monash and also at the Burnet Institute (where Dr McMahon is a Research Fellow), from immunologists, virologists to other clinicians – to establish a biobank. Essentially, you get people who are infected and collect repeated samples of their blood and respiratory swabs, then you can study all these facts of the virus and individual immune systems to understand why some patients do well and others don't do well."

The samples are frozen in the 'bank', allowing a series of repeated tests. Patients' clinical information from hospital data is also collected. The aim is to predict who gets hit hardest.

"This gives us clues as to what drugs might be effective," says Dr McMahon. "At the moment there are no proven therapies for COVID-19."

The biobank project – with Dr McMahon as principal investigator – is funded by a $250,000 grant from the Lord Mayor's Charitable Foundation (LMFC) in Melbourne.

LMFC Chief Executive Officer, Dr Catherine Brown OAM, says the foundation recognised the "urgent need" to pay for medical research with a treatment focus "at this crucial time".

"The research will have a positive impact upon the treatment of patients from groups such as older people living in residential care and the wider community, people with HIV, people with heart and lung conditions, as well as other serious health issues," Dr Brown said.

Extending influenza research

The grant also funds an extension of clinical studies underway for influenza research and has enabled new studies such as the biobank to be implemented quickly. The work in the flu season this winter is important, as the concern is that COVID-19 and influenza will overlap to some degree.

"It's inevitable," says Dr McMahon. "If COVID is still circulating, you'll see some people with both viruses and if people have both, it could increase the overall mortality or worsen outcomes. But we don't really know. If a person's immune system is OK, you tend to get only one infection at once. But we don't know until we go through a flu season. The assumption at this stage is, yes, having two respiratory infections at once will make things worse, but we need the data to support this."

Findings from the study will be immediately applied clinically at The Alfred and will be shared nationally and internationally so that other health organisations can increase their capacity to respond to COVID-19.

"The Alfred's Department of Infectious Diseases is one of the largest and most comprehensive infectious disease clinical services in Australia," says Dr Brown. "They're in an excellent position to translate medical research into clinical practice and we're very pleased to support Alfred Health during this health crisis."

MONASH University

This article was first published on *Monash Lens*. Read the original article.

Forced annual leave is not on

AMA Victoria has become aware that a number of health services have been requesting or directing that doctors take a period of annual leave during the COVID-19 pandemic. In some instances the health services have communicated that the doctor has an 'excessive leave balance' and that the health service can direct a doctor to take leave.

No health service has a right under the AMA Specialist or Doctors-in-Training Agreements 2018-2021 to direct a doctor to take leave. No health service has a right under the *Fair Work Act* to direct a doctor to take leave. The agreements are very clear: "Paid annual leave may be taken for a period agreed between the doctor and the health service".

The AMA accepts that health services and doctors should proactively and appropriately manage employees' leave. It is not, however appropriate to raise these issues during a pandemic in the way some health services have been doing; and especially when there has been very limited opportunities for the doctor to make best use of any period of annual leave. We are also concerned that when the pandemic first began, doctors' leave requests were being declined or cancelled by health services.

Where a health service implies or states that it has the right to direct a doctor to take a period of annual leave, the health service is breaching the *Fair Work Act* because to state or imply this is a misrepresentation of the workplace rights of doctors.

AMA Victoria believes that it is important for a doctor's wellbeing to be able to take their annual leave at the time of their choosing.

If you are contacted by your health service about your excess annual leave, you should agree to discuss the issue, but be advised that you are entitled to take leave at a time when it is beneficial to you.

If you are being pressured to take annual leave, or if you have already been pressured into taking annual leave at a time when you did not want to do so, please contact the AMA Victoria Workplace Relations team on (03) 9280 8722 or by email amavic@amavic.com.au

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Grant Forsyth
Director Workplace Relations

Mentoring a key to successful flexible surgical training positions

Eastern Health's Director of Urology, Dr Caroline Dowling (left) has been the ideal mentor for urology trainee, Dr Marni Basto.

Following on from last year's story about the success of flexible workplace arrangements at the Austin/Northern Training Hub, two doctors from Eastern Health are sharing their experience as healthcare pioneers. As just the second female Director of Urology anywhere in Australia, Dr Caroline Dowling has championed the first stand-alone part-time urology training position in Australia and New Zealand for Dr Marni Basto.

Progress for the next generation

A surgical training graduate almost 20 years ago, Dr Dowling said having her first of four children long before flexibility was on the radar made for quite the struggle to find balance between family and career. "It was a very real battle and not one I wish for any of our surgical trainees today," she said.

So when Dr Dowling found out that Dr Basto was hoping to return to surgical training from an extended period of maternity leave, it presented an obvious opportunity to start the flexible conversation.

Dr Basto said the urology training board has been very supportive

of her maternity leave and return to work in a flexible capacity. However, there is a practical reality in implementing these positions at the hospital level and this is where it requires a champion on the unit who is prepared to push it across the line. "Eastern Health and our unit VMOs in particular were receptive to her proposal," Dr Dowling said. "We want to be leaders in this progressive way of working in surgery."

In 2019, Dr Basto returned to surgical training in Melbourne juggling her two and three-year-old children, while her husband, Dr Matthew Liava'a, worked as a paediatric heart surgeon in Sydney. "Prior to this, we had been living in New York for my husband's Fellowship when our second child was born," Dr Basto explained. Ironically their son was diagnosed with a fatal heart condition requiring the very same surgery her husband was practising.

"Our son, Sebastien, was born with transposition of the great arteries (TGA) and his surgery was performed by my husband's mentors in New York." The twist of events that was a little too close to home meant Dr Basto required further time away from surgical training to support her son through his recovery.

Stand-alone part time options are essential

The Urology Unit at Eastern Health set up a stand-alone part time position for Dr Basto, where she worked three days a week, Tuesday to Thursday. This included three operating lists, two outpatient clinics, a morning for administration and a radiology meeting, a multidisciplinary cancer meeting and teaching time.

The on-call requirement was 1:4 which was similar to the other registrars. "Marni's role was an additional role to the unit. We were able to accommodate this by ensuring that all leave for the unit would be covered internally rather than another registrar provided to cover leave," Dr Dowling said.

As the number of female surgical trainees approaches 30 per cent - most in their prime child-rearing years - flexibility in the surgical workforce is essential to prevent trainees from leaving altogether and to improve workforce diversity.

"Female surgeons should not be faced with the choice of having a child on their six weeks of annual leave or alternatively taking a whole year away from training if that is not their preference," Dr Basto said.

"My position this year has really shown that you can work part-time and progress your skill and knowledge set, albeit at a slightly slower rate." She also said that while people commonly acknowledge the difficulty of working in a surgical profession with a newborn, it's important to remember that the pressures of child-rearing extend well beyond the first year of life.

Dr Dowling said a more flexible approach will assist more than just new parents. "Although our research has shown that nearly 40 per cent request flexible training for child-rearing reasons, these arrangements should not only be for parents, but for those needing flexibility for a variety of reasons," she said. "This includes men in our surgical workforce who juggle childcare responsibilities, trainees with sick children or family members and individual trainee health issues."

"I've seen highly-skilled doctors leave the profession because the job demands can't accommodate their personal needs. Traditionally people are very hesitant to ask for flexible options, because they feel it will be poorly looked upon."

Dr Dowling and Dr Basto feel strongly that the time has come for all in surgery to show that they are leaders and actively encourage trainees to request these roles when required.

Embrace change or risk losing our best future surgeons

Dr Dowling, Dr Basto and several other colleagues in the surgical and surgical education fields conducted an evaluation of prior flexible training positions within the Royal Australasian College of Surgeons. Importantly they found that 25 per cent of respondents would have withdrawn from surgical training had their position not been available.

"I suspect this is an underestimate too, as we know that some trainees who defer do not come back and those who continue in a full-time capacity under significant stressors may not be able to continue surgical training," Dr Dowling said.

Respondents from this research were from general surgery, urology, paediatric surgery, cardiothoracic surgery, otolaryngology and orthopaedic surgery training programs.

"While the majority of trainees were satisfied with their flexible training experience and their ability to manage other life commitments, over 50 per cent had encountered negative perceptions of the role, or bullying and discrimination, so there is still a lot of work to be done in reinforcing positive perceptions of these roles," Dr Basto added.

Dr Dowling is a firm supporter of the notion from American civil rights activist Marian Wright Edelman who stated, "You can't be what you can't see" and hopes the discussion about flexible training and a visibly diverse surgical workforce will have an impact on choice for future surgeons.

easternhealth

Acknowledgements: Dr Dowling and Dr Basto thank their colleagues Christine Lai, Carolyn Vasey, Debra Nestel and Shomik Sengupta for their contribution to the research of flexible training positions. They would also like to thank Eastern Health (EH) for leading the charge and their colleagues at the EH media team for their oversight of this article and images.

Career spotlight: The diverse opportunities in general practice

GPs play a crucial role in the Australian healthcare system. Their important role on the frontline is evident as the world comes to terms with the impact of COVID-19. However, general practice is often a career path initially overlooked by medical students and junior doctors as they begin training in the hospital system, exposed to hospital specialties. In this series, we are introducing you to a range of GPs, highlighting the diverse and rewarding career possibilities.

Dr Steve Dunn

My father was a rural GP and though he rarely spoke about his work (and probably because he was never home), I grew up vaguely aware that being a country doctor was a profession worth pursuing. He removed unhappy appendices, performed autopsies, delivered babies, dispatched the local unwanted pets and tended to the victims of major road trauma. As a child I sensed the high community esteem that his work engendered.

After graduating from Adelaide with a traditional medical education, I was perceptive enough to be aware of multiple clinical inadequacies and so, like many of my peers, went to the NHS 'to practise on the Poms'. After two years in the UK, I returned to South Australia in the early 1980s with an anaesthetic diploma, some experience in geriatrics and a Liverpudlian wife.

Back in the region of my childhood, in the southeast of SA, I joined a large practice in Mount Gambier and spent the next 10 years in a blur, doing anaesthetics and obstetrics as well as busy general practice.

I worked alongside vastly skilled colleagues from all corners of the globe. We managed kids with meningitis, neonates requiring pyloromyotomies (two from one evening clinic, believe it or not), obstructed labours and major trauma.

The clinic had the foresight to offer internally-funded long service leave. This was to enable a break from the relentless day-to-day demands, as well as an opportunity to upskill. And so our young family spent six months in Dunedin in New Zealand while I completed a Diploma in Industrial Health.

Consequently, when I saw the job advertisement in the *Weekend Australian* for a procedural GP to work with an international oil company in Brunei, I felt confident that this was an opportunity to practise newly-acquired skills.

The family spent five eventful years in Brunei before schooling demands brought us back. I was nominal head of the medical side of the Department of Health, Safety and Environment, gave lots of anaesthetics, delivered many Bruneian and Ghurkha infants and learnt the important Bahasa difference between kepala (head) and kelapa (coconut) while palpating pregnant abdomens. Spare time in those years enabled me to explore the nascent field of distance education and I was able to complete a Diploma in Asian Studies, together with Masters degrees in Family Medicine and GP Psychiatry, from Monash. Communicating via fax seemed very exciting!

I was offered a job with the Australian Embassy in Dili but a flare in the civil war in East Timor dissuaded me from pursuing it, to the undisguised relief of the family.

Instead, I returned once more to my former general practice in Mount Gambier. The academic basis of the masters degree strengthened an interest in medical education, which led to a role with the local GP training organisation as the regional medical educator. This was an interesting balance to ongoing general practice and procedural obstetrics.

An opportunity to improve governance skills via the Australian Institute of Company Directors supported subsequent leadership roles in the Divisions of General Practice, as well as many other associated boards and workforce associations. This continues in present times with a committee role with the Professional Services Review Board.

When the local fly-in botox service to our town ceased, I saw this as another opportunity to supplement my medical practice. My Thursday night practice at

a local beauty salon offered a valuable insight into the cosmetic interests of my patients and after volunteering as a guinea pig during one of our training sessions, my earlier prejudices about the effect of facial fillers was challenged!

I have now ceased clinical medicine, apart from a role as medical support for a private charter travel company. The long-standing interest in medical education is satisfied by a part-time role with a GP training organisation, as well as continuing a 15-year role as an examiner with RANZCOG.

Opportunities still tantalisingly beckon. A grant has enabled me to complete a medical editing course from the University of Chicago. This is a new direction, yet to be developed!

Broad-based general practice has given me a varied and fulfilling professional life. Taking some opportunities to develop new skills has offered me new and interesting activities, often with unforeseen results. For those who are currently unable to 'feel the passion', I would say, "Don't worry". Grab any opportunity to upskill and see where that leads. It is a wonderful profession.

Dr Steve Dunn
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Disinfecting mobile phones daily could help stop diseases spreading

We reviewed the research on how mobile phones carry infectious pathogens such as bacteria and viruses and we believe they are likely to be 'Trojan horses' that contribute to community transmission in epidemics and pandemics.

This transfer of pathogens on mobile phones poses a serious health concern. The risk is that infectious pathogens may be spreading via phones within the community, in workplaces including medical and food-handling settings, and in public transport, cruise ships and aeroplanes.

Currently mobile phones are largely neglected from a biosecurity perspective, but they are likely to assist the spread of viruses such as influenza and SARS-CoV-2, the novel coronavirus responsible for the COVID-19 pandemic.

What the research shows

We reviewed all the studies we could find in peer-reviewed journals that analysed microbes found on mobile phones. Our conclusions are published in the Journal of Travel Medicine and Infectious Disease.

There were 56 studies that met our criteria, conducted in 24 countries around the world between 2005 and 2019.

Most of the studies looked at bacteria found on phones and several also looked at fungi. Overall, the studies found an average of 68 per cent of mobile phones were contaminated. This number is likely to be lower than the real value, as most of the studies aimed to identify only bacteria and, in many cases, only specific types of bacteria.

The studies were all completed before the advent of SARS-CoV-2, so none of them could test for it. Testing for viruses is laborious and we could find only one study that did test for them (specifically for RNA viruses, a group that includes SARS-CoV-2 and other coronaviruses).

Some studies compared the phones of healthcare workers and those of the general public. They found no significant differences between levels of contamination.

What this means for health and biosecurity

Contaminated mobile phones pose a real biosecurity risk, allowing pathogens to cross borders easily.

Viruses can live on surfaces from hours to days to weeks. If a person is infected with SARS-CoV-2, it is very likely their mobile phone will be contaminated. The virus may then spread from the phone to further individuals by direct or indirect contact.

Mobile phones and other touchscreen systems – such as at airport check-in counters and in-flight entertainment screens – may have contributed to the rapid spread of COVID-19 around the globe.

Why phones are so often contaminated

Phones are almost ideal carriers of disease. We speak into them regularly, depositing microbes via droplets. We often have them with us while we eat, leading to the deposit of nutrients that help microbes thrive. Many people use them in bathrooms and on the toilet, leading to faecal contamination via the plume effect.

And although phones are exposed to microbes, most of us carry them almost everywhere: at home, at work,

while shopping, on holidays. They often provide a temperature-controlled environment that helps pathogens survive, as they are carried in pockets or handbags and are rarely switched off.

On top of this, we rarely clean or disinfect them. Our (unpublished) data suggests almost three-quarters of people have never cleaned their phone at all.

What this means: clean your phone

While government agencies are providing guidelines on the core practices for effective hand hygiene, there is little focus on practices associated with the use of mobile phones or other touch screen devices.

People touch their mobile phones on average for three hours every day, with super-users touching phones more than 5,000 times a day. Unlike hands, mobile devices are not regularly washed.

We advise public health authorities to implement public awareness campaigns and other appropriate measures to encourage disinfection for mobile phones and other touch screen devices. Without this effort, the global public health campaign for hand washing could be less effective.

Our recommendation is that mobile phones and other touch screen devices should be decontaminated daily, using a 70 per cent isopropyl alcohol spray or other disinfection method.

These decontamination processes should be enforced especially in key servicing industries, such as in food-handling businesses, schools, bars, cafes, aged-care facilities, cruise ships, airlines and airports and healthcare. We should do this all the time, but particularly during a serious disease outbreak like the current COVID-19 pandemic.

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This article was first published on The Conversation. Read the original article.

Member profile: Saving lives and politics

Dr Marcus Kennedy is a long-time AMA member who was the Director of Adult Retrieval Victoria, before retiring from his career as an emergency physician and medical administrator in 2018. Recently he has been honing his skills as a fiction writer, publishing his first novel, *The Cut*. Dr Kennedy spoke to Vicdoc about calling on his experience in medicine to create an engaging story set in a troubled health system.

Can you give us a brief overview of your medical career?

As a junior doctor in Melbourne I had a really broad start with usual intern rotations, then paediatrics, ED and obstetrics in a rural setting, and a year doing NETS (Newborn Emergency Transport Service) which presumably was the origin of my interest in retrieval medicine. After that I travelled and had five years as a GP before moving back to emergency medicine training. This included a stint at The Alfred and a year doing anaesthetics in the UK; then another couple of years at The Alfred in ED and trauma.

Afterwards came three years in regional Queensland in ED and retrieval (road and air). In the 90s, I worked back at The Alfred then moved into ED Director roles at Eastern Health and later at the Royal Melbourne. The last decade of my career was in establishing Adult Retrieval Victoria – which provides critical care outreach, advice and retrieval right across Victoria.

When did your interest in writing start?

As a younger person I read a lot of fiction. During the management phase of my career I wrote a lot – all technical, clinical, teaching, research or business; but I enjoyed writing and language and expression.

I think I appreciated the impact of a well-presented story and the persuasiveness of clear language. Four years ago, I was part of a small group that wrote and edited a retrieval textbook in the Oxford Handbook series and I think that increased my interest in the process of writing and publishing.

I also subscribe to the maxim that most people have a book in them! The trick seems to be taking a good story and turning it into a good book - that part I needed to learn and get lots of help with!

You have just released your first non-medical book, *The Cut*. Was it an easy topic for you to write about?

Reasonably easy, but sometimes the topic got a bit close to home. The early thinking was to write a more 'serious' philosophical book, but a sensible friend talked me out of this! The novel was a way to present some meaningful themes in an entertaining way. The writing has been absorbing and required new skills and discipline. It was really challenging!

It is a work of medico-political drama which wanders into the thriller/crime space as well as having interesting philosophical threads. In a way, a heavily dramatised version of a realistic workplace felt like a natural place to start a first novel.

Tell us about the plot in one paragraph.

Harvey Pearce is a committed emergency physician (and sometime podcaster). He uncovers politically orchestrated activities that kill patients, harm staff and hide deficiencies in the system and he is determined to find a solution. He's confronted with desperate and ruthless players who turn his efforts at reform into a perilous game with critical stakes. There are some philosophical moments, the odd dilemma to navigate and quite a bit of pressure.

Although it's a fictional story, how much have you drawn upon real personal experiences?

I think most authors must draw on their own experiences to a degree, depending on genre. Having said that, I didn't want to just do a thinly disguised memoire – there's much more to *The Cut* than my anecdote library!

Yes, this story is set in what was my professional world so it is inevitable that I would draw on my own experiences, however it is based in

fiction. The events and people are all made up, so no-one needs to be too sensitive about it! Having said that there are themes that confront many of the real challenges of health systems and our lives as professionals; that was crucial so that the struggles of our hero are plausible and relatable.

Among the themes covered in your story are the challenges for health systems and all the considerations that come before patient outcomes. There's a fair amount of synergy with the current COVID-19 crisis...

Yes, I agree. The story picks up on many aspects of challenge in healthcare and life. The concept of limited resources and overwhelming demand is featured as is the concept of political influence – a reality in all health systems. The human impacts for people working in these systems is confronted, as is the way we work with our own limitations and imperfections to do the best we can.

Through the hero's podcasts, the book also challenges us to look for simpler and better ways. In the cover blurb, as well as spruiking the drama and fictional plot, it says: "This is an absorbing novel about damage and death, safety and survival, evil and ethics and the ever-present hope for a better way". These themes are very relevant at a time when world health systems are stretched beyond imagination and government and personal agendas abound. The book's catch line says that, "Saving lives is meant to be above politics" which is a topical and rational aphorism.

How would you describe the experience of retiring from medicine? Have you found any unexpected challenges?

I have found moving into retirement a mixed experience but one with an overall positivity. I was very much looking forward to it. Extracting myself from routine and structure has been a bit of a challenge, so the process of a project like writing has helped that transition.

It has also required me to learn new things about writing, editing, publishing and book production, marketing, social media, web page construction, blogging and so on – that has been pretty full-on, not to mention the months and months of actual writing!

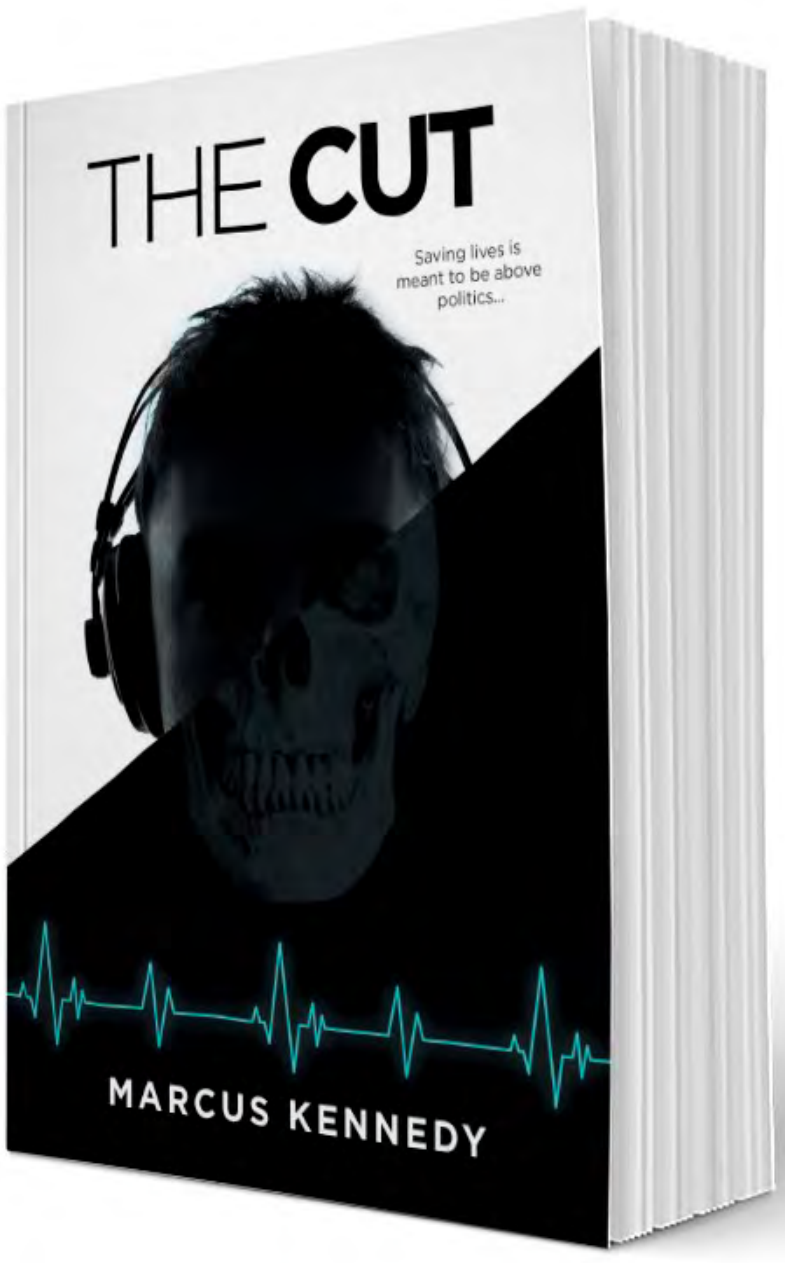
I find no trouble in filling my time; I am teaching myself the piano slowly and fairly poorly. I have a great interest in travel and in Paris especially. I enjoy reading and music and walking... and even bought a bicycle. Most importantly, I have a wife and children I need to repay for decades of semi-neglect.

Where can you buy the book?

The Cut by Marcus Kennedy is available at:

Direct order: marcuskennedy.net
Online: Booktopia, Amazon, Angus & Robertson, Book Depository.
In Dymocks bookstores (post COVID-19).

Direct orders from Dr Kennedy's website receive a 15 per cent discount on the retail price and free postage within Australia.



Vale Dr Geoff Pearce

AMA Victoria pays tribute to long-time member and Chair of our Retired Doctors Group, Dr Geoff Pearce, who passed away from cancer in April, aged 83.

Dr Pearce was an active member for 59 years, joining AMA Victoria the year after he graduated from medicine at Melbourne University in 1960.

Featured in our Vicdoc series 'Retiring Well' as recently as June last year, Dr Pearce did two years residency at Footscray Hospital, followed by one year at the Repatriation Hospital in Heidelberg. He then worked as a GP for 43 years in a group practice, principally in West Preston, but for some of that time had a branch in Reservoir. He retired from his practice in 2007.

Dr Pearce had a very active retirement, travelling extensively abroad and throughout Australia with his wife Rosemary. He enjoyed a weekly lunch with a group of doctor friends, playing tennis, looking after his grandson and was a past president of the Heidelberg Probus Club.

He was a regular at AMA Victoria subdivision meetings and, together with Dr Kevin McDonald and the late Dr Tony Sahhar, played an integral role in the formation of our Retired Doctors Group around 2007. He was a member of the group's committee since its inception.

AMA Victoria and the Retired Doctors Group extends its condolences to Geoff's wife Rosemary, their family and friends.

Supporting MDA National members through COVID-19

MDA National recognises you may be facing challenges as a result of COVID-19.

Our priority is to support our members in the moments that matter. To ease some of the financial pressure, we have frozen premium increases for 99 per cent* of members for 2020-21.

As always, our medico-legal experts are here 24/7 to guide you through any issue you encounter during this difficult time.

We've also launched a COVID-19 information hub online, so you can stay updated with our latest learning resources. Here you will find helpful FAQs, blog posts, guides, and podcasts https://www.mdanational.com.au/mda-national-coronavirus-advice.

MDA National experts recently discussed a case of COVID-19 in a rural town, where the issues of privacy and patient confidentiality featured prominently.

A patient, Jack, was self-isolating at home following his return from a trip to the USA when he received a call from a teammate from the local football team. "Hey! Just checking you're still alive mate. I heard you've got coronavirus," his friend said. "Facebook has gone right off!"

Jack was shocked. He hadn't told anyone he had tested positive to coronavirus. Having seen some backlash on local social media about selfish travellers bringing COVID-19 back to Australia, he had decided to lay low until he recovered. As he lived in a small town in country Victoria, he was worried about his work prospects following his recovery if anyone knew about his diagnosis.

Jack told his friend he was fine and that he was self-isolating at home after his return from overseas. But Jack was concerned about how his friend knew about his diagnosis. Jack had avoided testing at his local practice and instead gone to a large multi-disciplinary clinic over 30km away, where he felt he would have greater anonymity.

As the Facebook posts escalated, Jack became increasingly concerned about how his results were made public. Jack contacted the doctor who had performed the test to explain how his privacy had been breached.

Click here to read more about why this breach occurred and how to prevent this from happening in the future.

*A very small number of MDA National members will receive a premium increase due to their claims experience, nature of practice, level of billings or risk profile. We have communicated with these members separately.

Phone: 1800 011 255
Email: peaceofmind@mdanational.com.au
Website: mdanational.com.au

MDA National
Support Protect Promote

Why COVID-19 could be a rare opportunity for savvy investors

National Investment Advisory exists for time poor professionals looking to increase wealth and destroy their mortgage in less than 10 years, who are dissatisfied with their massive tax bill.

Our service delivers a system to smash tax and grow net worth. Unlike typical advisors, NIA is client focused and strategy driven. We give you a secure formula that turns your high income into wealth so you can live life by design.

At NIA, we are professionals in wealth creation and property wealth planning. Our business allows us to handle flexible and convenient client engagement as part of our commitment to your financial certainty.

These are unprecedented times that require a positive approach in the face of adversity. We are not downplaying the severity of what we are facing now and going forward, but it's times like these that present an opportunity. The important aspects here are to look at the facts and explore the remarkable investment opportunities that are being presented right now. Are you ready? Below are the real figures and facts that handle many of those 'What if' questions.

Fast Facts

Property has consistently increased in value and performed over the long term, 40+ years, despite all of these and similar major health and economic events. In some cases, there's been 27 per cent to over 60 per cent increases in value within 12 months of the crisis.

- Stock Market Crash, 1987
- Airline Pilots Strike, 1988
- Interest rates of 17 per cent and unemployment at 11 per cent, 1989
- Gulf War, 1990
- Australian recession, 1991
- Asian Financial Crisis, 1997
- Dotcom Tech Wreck, early 2000s
- September 11, 2001
- SARS Virus, 2003
- US Subprime GFC, 2008
- Bird Flu, 2013

Property and the stimulus opportunity

- Interest rates dropping below 3 per cent and forecast to remain low for the next five to six years.
- The Federal Government has underpinned the most important industries, being property, construction and banks.
- Government schemes and packages worth $214 billion plus the RBA package of $90 billion.
- The increasing population growth in Australia and a flight to a safer country.
- Capital funds move to safer more stable fixed assets – transfer into property.
- Government expenditure on infrastructure increased and brought forward – jobs.
- Around 65 per cent of residential property in Australia is owner-occupied, with around 1 in 3 debt free.
- Positive cash flow opportunities combined with major capital growth.
- Potentially able to borrow on a mortgage of $1 million and pay $400 per week in interest. Some property strategies could produce $150-$200 per week in positive cash flow.
- Government packages to protect tenants and support landlords on rent payments and mortgage payments. No defaults and repayment holidays.
- The need for some 1200 houses in Australia to be built per week. Thus, an increase in demand with decreasing supply.
- The new Government incentive 'HomeBuilder' grant worth $25,000.

Your financial wellbeing is our priority

Now more than ever is the right time to focus on your finances. The NIA team and its specialist affiliate partners are all experts in their fields and are here to help with your specific circumstances.

Contact us and setup a meeting to discuss your portfolio and finance position. We will review:

- Your loan and repayment options.
- The current equity in your property and how to access it, safely.
- Your options to reduce interest rates - including repricing rate reviews and refinances.
- Your position regarding investment properties, tenants, rental income and cash flow.
- How to use the NIA LEAP Roadmap to your advantage.

We encourage you to become educated, informed of the facts and act based on how these principles relate to your situation.

What you can do is take immediate action and secure a free Property, Wealth & Finance Strategy Session valued at $495. Let us review your scenario and design a blueprint for the future.

Call 1300 565 888 or email contact@mynia.com.au

NATIONAL **INVESTMENT** ADVISORY

Arthritis Australia launches rheumatoid arthritis patient-support website

Arthritis Australia, in partnership with the Australian Rheumatology Association, has launched a new online rheumatoid arthritis patient-support website. The free MyRA website provides individually tailored information designed to help people seize control and become active participants in their journey with the disease.

Rheumatologist, Prof Susanna Proudman, said the holistic approach is a game-changer for people with rheumatoid arthritis (RA) and is encouraging other doctors to explore the new website and recommend it to their patients.

"Patients may only have face-to-face time with their rheumatologist for a few hours each year and GPs can't be expected to cover everything outside of that," Prof Proudman explained. "The MyRA website provides a holistic resource and trusted support for people with RA that can be confidently recommended by specialists and GPs."

"It will save people a lot of time going down rabbit holes that they don't need to that may offer unproven or even unsafe advice. People with RA can benefit from the wisdom of others who have already been down the same path."

More than 450,000 Australians live with RA, an autoimmune disease that causes pain and swelling of the joints. The disease can strike at any age, including during childhood, and can greatly impact on a person's wellbeing.

However, with early diagnosis and the right treatment, most people with RA can lead full and active lives.

"Everyone's journey with RA is different. Some people are at the starting point, while others have been living with arthritis for decades," said CEO of Arthritis Australia, Andrew Mills. "Prior to this program, we found many people were either using 'doctor google' to make important decisions based on incorrect, irrelevant or alarming information, joining online forums without independent and trusted moderation, or joining programs that may only be suitable at a particular point in time due to the medication they are using."

"Responding to what people living with RA were telling us, Arthritis Australia wanted to develop a national, gold standard patient-support website that was open to everyone with RA is and that people and clinicians could trust. Through thorough consultation, we learnt that people wanted a support website that could meet each person where they are at on their journey, providing them with relevant, tailored, evidence-based information regardless of what drug they are currently on or how long they have been diagnosed with RA."

"Understandably, due to funding, most patient-support programs are linked to a specific drug the person is taking. However, with RA, medication is likely to modify over time and changing patient programs can get complicated. That's why it is important that this website is 'medication agnostic'. There are also many people with RA that don't have access to a patient-support program at all."

The MyRA website provides the full spectrum of trusted information with input from respected arthritis organisations from around the globe. The website also links through to the National Arthritis Infoline - 1800 011 041 - and state and territory arthritis organisations to provide a holistic patient-support system. It covers topics such as symptoms, risks, treatment options, diet, exercise, day-to-day tips, support services and how to manage pain, mental health and fatigue. It also looks at how to build good relationships with healthcare teams and provides updates about COVID-19.

"A fantastic feature is the way the online patient-support website then links people with arthritis organisations nationwide and relevant local information, educational events, fitness

activities, webinars and other support services, including trained health educators," Mr Mills said.

The project was independently developed by Arthritis Australia for Australian users with unrestricted, educational grants from sponsors. This required an ambitious whole-of-health-sector approach, meaning people living with RA, clinicians, health workers, companies and affiliated state and territory arthritis organisations all came together to create a centralised tool. The website uses algorithms to get to know participants over time, routinely checking in with how they are feeling. The intent is for this longitudinal information to help identify how health services can be improved to achieve better outcomes for people living with RA.

"A coordinated approach, thorough consultation with consumers and pooled funding delivers what people living with RA have told us they need," Mr Mills said. "Information is independent and people will still receive relevant medication information, but that information will change if they change medication. To our knowledge, this approach is the first of its kind – the combination of a centralised program and funding, created with support from multiple countries, to provide information that is indexed to a patient's point in their disease journey and integrates drug-specific support."

President of the Australian Rheumatology Association, Prof Catherine Hill, said, "We are proud to endorse this ground-breaking initiative that has been achieved by our two trusted organisations working together to address gaps in the RA patient experience. By providing people with quality information about RA, some simple management skills and the opportunity to share the experience of others, we can help everyone live a better life with RA."

More information can be found at myra.org.au

National Arthritis Infoline: 1800 011 041

myRA RHEUMATOID ARTHRITIS SUPPORT PROGRAM | Arthritis AUSTRALIA 1800 011 041

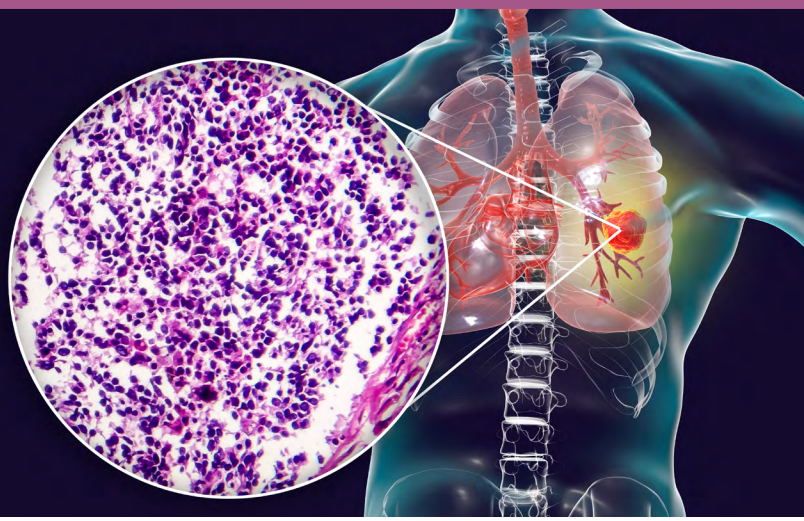
Key arthritis stats and facts

- About 458,000 Australians (1.9% of the total population) have rheumatoid arthritis
- In Australia, rheumatoid arthritis accounted for 15% of the total burden of disease due to musculoskeletal conditions in 2015.
- In 2016–17, there were 13,213 hospitalisations for rheumatoid arthritis, a rate of 54 per 100,000 population
- Additionally, there is an economic impact of rheumatoid arthritis. In 2015–16, rheumatoid arthritis cost the Australian health system an estimated $1.2 billion, representing 9.6% of disease expenditure on musculoskeletal conditions and 1% of total disease expenditure.
- Rates of rheumatoid arthritis are slightly higher for women (2.3%) than men (1.5%).
- Rheumatoid arthritis is a significant cause of physical disability. Functional limitations arrive soon after the onset of the disease and worsen with time. Joint damage in the wrist is reported as the cause of most severe limitation even in the early stages of rheumatoid arthritis.
- In 2017–18, more than 2 in 3 people with rheumatoid arthritis aged 45 and over (68%) experienced 'moderate' to 'very severe' pain in the last 4 weeks. People with rheumatoid arthritis were 3.1 times as likely to have severe or very severe bodily pain in the last 4 weeks (30%) compared with those without the condition (10%).
- People with rheumatoid arthritis are more likely to suffer from anxiety, depression and low self-esteem. Rheumatoid arthritis can affect a person's ability to participate in work, hobbies and social and daily activities. Combined with the chronic pain associated with rheumatoid arthritis, this can lead to mental health issues including depression, anxiety, feelings of helplessness and poor self-esteem.
- People aged 45 and over with rheumatoid arthritis were 2.5 times as likely to describe very high levels of psychological distress (11%) compared with those without the condition (4.3%)—according to the 2017–18 NHS.
- People with rheumatoid arthritis often have other chronic conditions, or 'comorbidities. According to self-reported data from the ABS NHS 2017–18, among people aged 45 and over with rheumatoid arthritis:
    - 36% also had back problems compared with 25% of people without rheumatoid arthritis
    - 33% also had mental and behavioural conditions compared with 21% of people without rheumatoid arthritis
    - 22% also had heart, stroke and vascular disease compared with 11% of people without rheumatoid arthritis.

Source: Australian Institute of Health and Welfare

Immunotherapy in small cell lung cancer

Small Cell Lung Cancer (SCLC) is an extremely aggressive and widely metastatic form of lung cancer that affects roughly 2,000 Australians each year.



Most patients do not survive beyond 12 months, making it one of the deadliest cancer diagnoses. Moreover, SCLC typically affects heavy current or former smokers, who are often of lower socioeconomic status and afflicted with multiple comorbidities.

While the incidence of SCLC is declining in most developed countries, largely due to smoking cessation programs, its incidence is increasing in low to middle-income countries, ensuring that the global incidence will continue to rise.

The rapid proliferation rate of SCLC also renders it susceptible to DNA damaging agents such as platinum and etoposide chemotherapy, which has remained the standard chemotherapy regimen since 1985. Despite many trials and several novel agents, no changes in the therapeutic landscape have emerged until now.

Immunotherapy has greatly impacted oncological therapeutic paradigms, especially for melanoma and non-small cell lung cancers (NSCLCs). Building on this, a trial recently published in the *New England Journal of Medicine*, IMpower133, demonstrated that adding the immunotherapy atezolizumab, which targets the programmed death receptor ligand 1 (PD-L1), to chemotherapy (carboplatin + etoposide [CP/ET]) helped people with extensive stage SCLC live longer compared to treatment with CP/ET alone,[†] with minimal toxicity. Atezolizumab was given with CP/ET every three weeks for 12 weeks, after which treatment with Atezolizumab continued every three weeks without CP/ET, if patients remained well without disease progression.

Although the absolute survival benefit of two months could be considered modest, some patients experienced much longer improvements, suggesting that a subset of patients derive significant benefit. Unfortunately, despite testing several biomarkers, it is impossible to predict which patients will achieve these longer survival outcomes. However, given that at 12 months only 38 per cent of the placebo + CP/ET arm were alive compared to 52 per cent of the atezolizumab + CP/ET arm, a new standard of care for a recalcitrant malignancy has been identified.

Interestingly, the similarly designed trial CASPIAN, mirrored the IMpower133 results using the immunotherapy durvalumab, demonstrating that the benefit from immunotherapy was real regardless of agent.

The results of the IMpower133 trial lead to the Pharmaceutical Benefits Advisory Committee (PBAC) approving atezolizumab for reimbursement for patients with previously untreated extensive-stage SCLC on the Pharmaceutical Benefits Scheme (PBS) from March 1, 2020. This heralds the first change in management for this lethal malignancy in over three decades. Importantly, it provides impetus to build on this and other studies showing that immunotherapy when combined with chemotherapy or with other immunotherapies can be effective.

Traditionally, cigarette associated-NSCLC and ultraviolet-associated melanomas are considered to be immunogenic cancers because the number of mutations within the tumour enables novel epitopes to be presented to the immune system, enabling immune recognition and subsequent tumour killing. The PD-L1 pathway is a common mechanism that tumours utilise to evade immunological surveillance that when blocked by PD-L1 inhibitors such as atezolizumab, renders them sensitive to immune cell killing. SCLCs that are usually the result of heavy carcinogen exposure also have very high mutational loads, but surprisingly do not respond as well to immunotherapies as NSCLC or melanoma. Exploring the reasons behind this and the mechanisms of immunoevasion in this disease promises to alter the therapeutic landscape.

While it is a significant development that we can finally offer something more effective to our patients with SCLC, there is still much work to be done to improve on our therapies that result in changing the near-universal lethality of this disease. Understanding the biology of SCLC and the interaction between the tumour and the immune system promises to uncover other strategies likely to impact SCLCs dismal survival rate and hopefully within a much shorter time frame than three decades.

A/Prof Tom John
Medical oncologist
Translational researcher
Peter MacCallum Centre, Melbourne

[†] Median overall survival [mOS] Hazard ratio =0.76, 95% CI: 0.60–0.95; p=0.0154.

References available from the Editor on request.

Heart Foundation app puts Australian cardiology guidelines at your fingertips

Doctors, nurses and pharmacists can now carry around Australian cardiology guidelines in the palm of their hand, via a new Heart Foundation app that aims to bridge gaps in patient care.

The Smart Heart Guidelines app, exclusively for health professionals, provides access to Heart Foundation clinical guidelines for heart failure, atrial fibrillation (AF) and acute coronary syndromes.

Heart Foundation Clinical Evidence Manager, Cia Connell, said the Smart Heart Guidelines app is a valuable clinical decision aid for health professionals across the country.

The Heart Foundation's clinical practice guidelines are developed in partnership with Australia's peak cardiology body, the Cardiac Society of Australia and New Zealand.

"By using the Smart Heart Guidelines app to access our guidelines, you can be sure you are providing the best evidence-based care for every patient with heart failure, atrial fibrillation and acute coronary syndromes," Ms Connell said.

"It's ideal for time-poor health professionals to use in their daily work because you can refer to the information you need quickly and easily on your mobile phone or tablet."

"We know gaps exist between guideline recommendations and current practice in hospital and community settings, so this is a tool to help close those practice gaps and, ultimately, improve patient outcomes."

The free medical app features interactive algorithms and calculators to guide decision-making and is designed for easy navigation to specific sections of the guidelines.

More than half a million Australians are living with AF, while an estimated 110,000 people are living with heart failure. The latest figures show an estimated 375,000 Australians have had a heart attack and 230,000 have experienced angina.

"The widespread impact of heart disease highlights the importance of ensuring patient care is in line with current recommendations, whether that be during a visit to hospital or a GP clinic," Ms Connell said.

"The Smart Heart Guidelines app can help achieve this by improving access to our guidelines, which are nationally recognised as best practice in the diagnosis and management of heart diseases."

Health professionals can download the Smart Heart Guidelines app for free via the Apple App Store and Google Play. Visit the Heart Foundation website or phone the helpline on 13 11 12 to learn more.

Heart Foundation®

A change to income protection insurance you may have missed

There's been a fair bit of news to digest of late, so we don't blame you if you missed a recent change in the life insurance industry.

If you've been thinking about taking out income protection insurance, it's a change you'll want to know about because as of 31 March 2020, Australian insurers are no longer offering 'Agreed Value Income Protection' policies.

The adjustment was first proposed by the Australian Prudential Regulation Authority (APRA) back in December 2019 as one of a number of measures put forward to attempt to address the ongoing losses being made by insurers on income protection insurance products.

As a result, insurers will now only be able to offer 'Indemnity based Income Protection' going forward. What's the difference you ask?

"Agreed Value Income Protection uses your income at the time of application as the basis to assess the amount payable for any claim you may make in the future," said Anthony Brown, CEO of NobleOak Life.

"The other, more sustainable type of income protection is 'indemnity based income protection, which uses your income (usually the last 12 months immediately before claim) to assess how much you will get paid at the time of claim."

That means the change is likely to largely affect self-employed workers whose incomes fluctuate from year-to-year.

Will the new measures impact existing policies?

In short, no. The change only applies to new policies, so existing policies will be unaffected. In fact, depending on your insurer, you may have only been able to take out indemnity based income protection insurance anyway.

For example, NobleOak has always offered indemnity style income protection insurance which means that, if you were to make a claim, you would be eligible to receive up to 75 per cent of your income earned in the 12-month period immediately before the claim.

Typically, the amount payable is subject to a maximum which is a percentage of your income at the time of application.

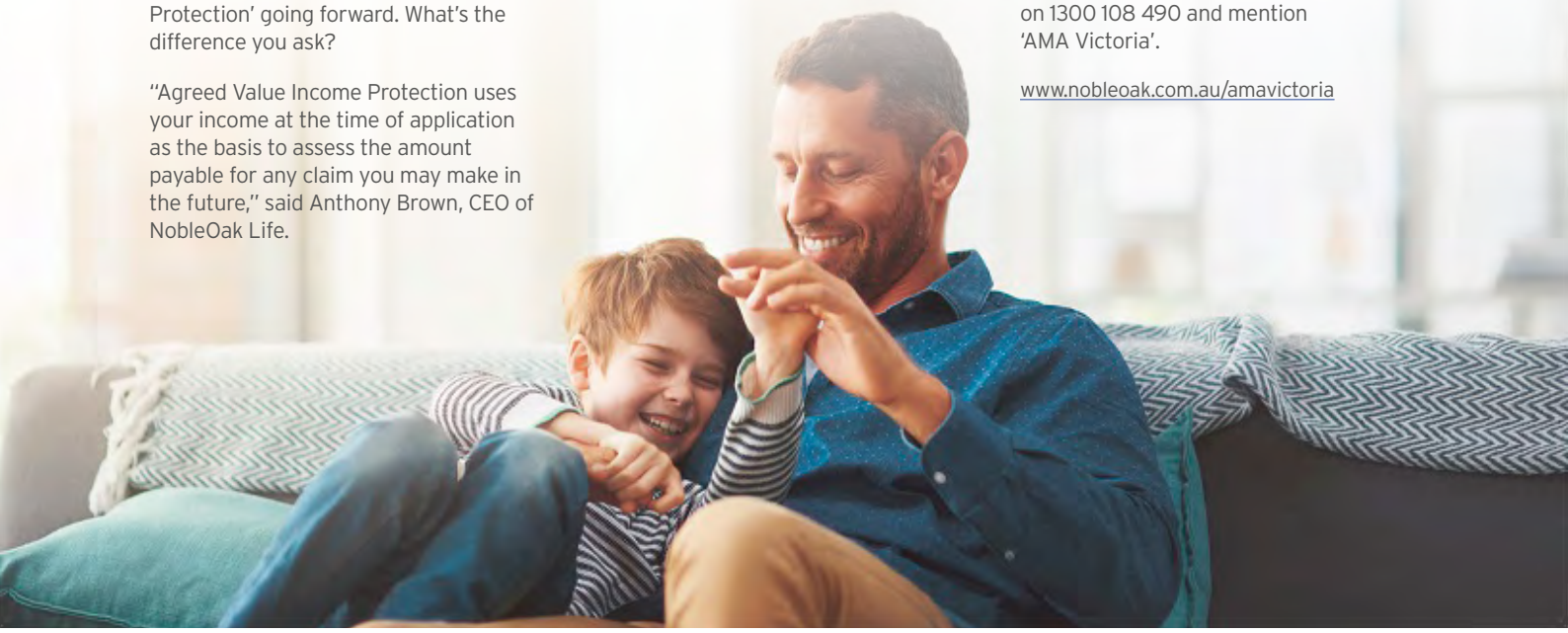
"As an insurer we are pleased that our income protection product did not need to be updated as we have always offered indemnity style income protection and not agreed value," said Mr Brown.

NobleOak's income protection cover is fully underwritten, which means your health and lifestyle is assessed through a series of questions at the point of application and, in some instances, a medical is also requested. This means that there is more clarity and no surprises in the event of a claim.

"Also, the important thing to know is that your cover with NobleOak is guaranteed renewable until the cover expiry age, as long as premiums are paid when due. If you already have cover with us, we cannot change the terms and conditions to make them worse for you."

To see NobleOak's AMA member offer, visit NobleOak's website for a quick quote or call now to speak to our team on 1300 108 490 and mention 'AMA Victoria'.

www.nobleoak.com.au/amavictoria



Legal statements. Premium Life Direct is issued by NobleOak Life Limited ABN 85 087 648 708 AFSL No. 247302. Address: 66 Clarence Street, Sydney NSW 2000. Phone: 1300 108 490. Email: sales@nobleoak.com.au.

Cover is available to Australian residents and is subject to acceptance of the application and the terms and conditions set out in the Premium Life Direct Product Disclosure Statement (PDS). This information is of a general nature only and does not take into consideration your individual objectives, financial situation or needs. Before you purchase an insurance product you should carefully consider the PDS to decide if it is right for you. The PDS is available by calling NobleOak on 1300 108 490 or from www.nobleoak.com.au. Clients should not cancel any existing Life Insurance policy until they have been informed in writing that their replacement cover is in place. NobleOak cannot provide you with personal advice but our staff may provide general information about NobleOak Life insurance. By supplying your contact details, you are consenting to be contacted by NobleOak, in accordance with NobleOak's Privacy Policy.

How to let a property in a pandemic

Leasing a residential property remains a significant challenge, with a landlord facing constraints on several fronts - not least are the practicalities of opening a property for inspection.

Even with recent relaxation of social distancing rules across states and territories, some prospective tenants remain reticent about entering a property and the issue is further complicated if there is a sitting tenant who is wary of strangers trooping through their home at this time.

Then there is the increased competition for long-term tenants. Owners of many Airbnb and other erstwhile short-term rentals have switched their properties into the long-term market, naturally concluding that the holiday market will remain weak for many months. Further, with most Australians hunkered down and few international arrivals, rental demand is down.

Consequently, it is absolutely a buyer's market for tenants.

The smart landlord will do their research to understand and adapt to these new conditions. And because the rental market is not homogeneous, the aim is to obtain the granular understanding of the subject property, including the pandemic-altered going rental rate, amount of competing supply and the comparative strengths and weaknesses of the property relative to its up-for-lease peers. Fortunately, it is possible to undertake this research using online rental portals such as domain.com.au.

Ideally, a landlord should work with a professional leasing manager – usually their current property manager – to obtain on-the-ground insights as well as tap their pool of prospective tenants. But this process is likely to be most fruitful if the landlord has done some research of their own, making them the property leasing manager's informed 'partner' in the discussions.

A landlord must be realistic and meet the market. Pushing the rent up to test the limits of demand might be a brave but perilous strategy. Instead, reduce the expensive risk of the asset lying vacant for a month or two by charging $20 or even $30 a week less than usual if the leasing manager recommends it. To enable an early rent increase should demand bounce back sooner than current expectations, consider marketing the rental property with an initial lease length shorter than the typical 12-month period (but avoid a lease end date that falls around the quiet Christmas break).

Extra efforts should be made to present the property at its best. There is a tendency for some rental properties to be listed with amateur images taken by the landlord or agent. That is never sensible and especially not now. Try to obtain permission to use the most recently taken professional shots – usually taken before the property was last sold – or failing that, commission new pictures.

If the incumbent (but soon-departing) tenants are in residence, sensitivity is paramount. Open a dialogue through the property manager to understand and allay any worries they might have about inspections and work with them on setting appointments.

Due diligence on applicants must still be thorough. One needs to minimise the likelihood that potential tenants will lose their employment, given the moratorium on evictions in most jurisdictions. References from past landlords and the current employer should be sought and followed up.

If a landlord is unhappy that the likely rent in this depressed market will be too low and they have sufficient financial buffers, then consider making a virtue out of a necessity. Now could well be an opportune time to undertake the major maintenance and capital improvements that smart investors execute when necessary. Doing the work now brings the expense forward rather than creating new costs. Indeed, parts and labour may be cheaper than usual. And by undertaking renovations and perhaps adding features such as heating or air conditioning in this weak rental market, the enhanced property should fetch a much higher rent as we head towards spring.

Richard Wakelin
Founder
Wakelin Property Advisory

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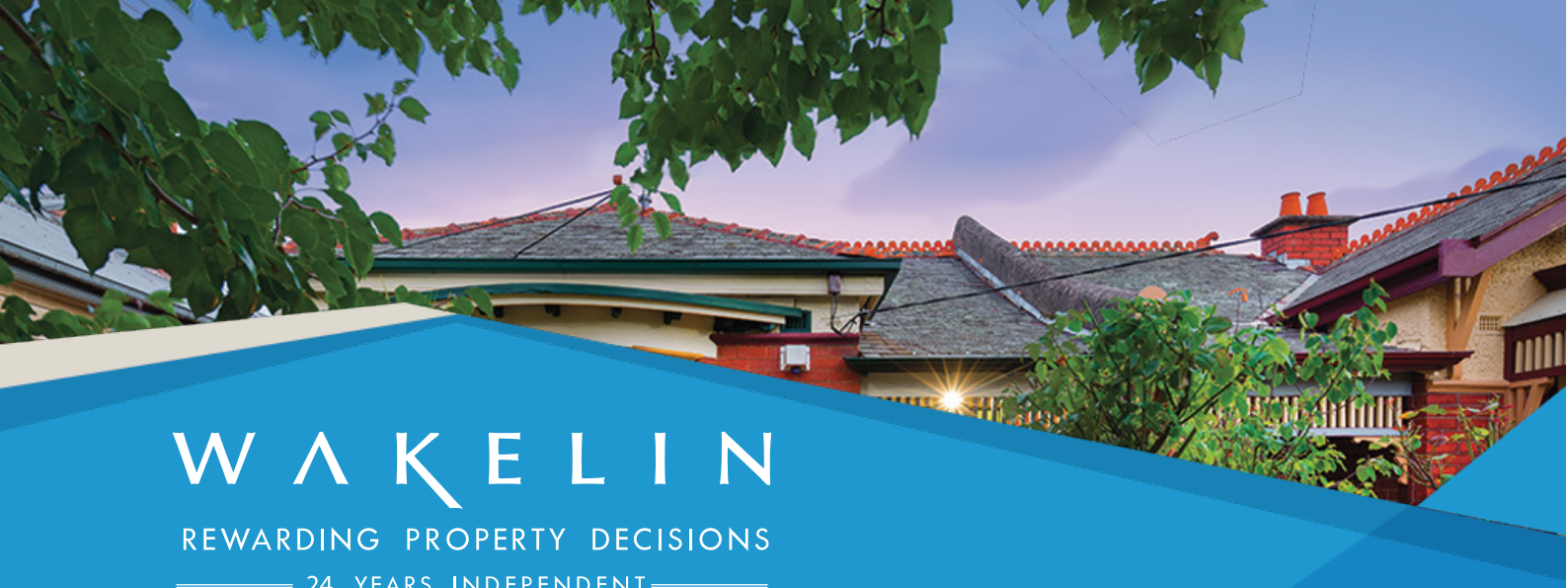
Wakelin Property Advisory is an AMA Victoria Member Benefits Partner and an independent buyer's agent specialising in acquiring residential property for investors. wakelin.com.au



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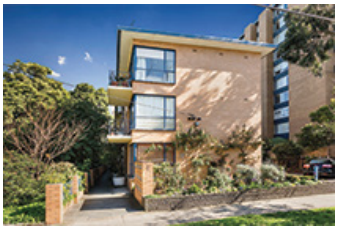

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FOR MORE INFORMATION

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wakelin.com.au

Richard Wakelin, founder
Jarrod McCabe, director

Quick guide to get you through the COVID-recession... and come out a better practice

This article is a summary of the *Prushka Business Survival Guide*, but adapted for medical practitioners.

The 4 stages

All recessions involve four stages, regardless of the cause:

- Chaos – The stage we are currently in.
- Worst case scenario – The event you have to plan for, even if it does not eventuate.
- Emerging pattern – The stage we are now close to reaching.
- Rebuilding – Where there is real opportunity to build your practice beyond where it was before.

The chaos stage

Don't deal with this problem on your own or just with your partners. You need to build a 'survival team', which will ultimately become a 'strategy team'. Survival means more than receiving JobKeeper. It means strategic thinking to analyse all of the risks and plan a pathway through them.

The survival team should include the key players in your practice, because all will have a different perspective to offer and a stake in the outcome.

The risk to a medical practice

The risk of insolvency is low, for the obvious reason that the major asset of the practice is the expertise and reputation of the practitioner(s). However, whilst we are still going through restrictions and there is a real risk that they may return, the practice could really flounder and lose its way.

Cash flow

This must now become a front room function rather than a back room one. There are many tips available from the Prushka website including a free 'new patient form'. I suggest that you download this form and adapt it for your practice. This will be the case particularly where the dollar fees per individual patient can be high and thus there is a risk of the debt becoming a bad debt.

Worst case scenario

For many practices, this point may have already been reached and passed. It is the situation where overheads of the practice continue but the revenue is insufficient to meet them. Plan for a 'second wave' and work out how you would handle this scenario.

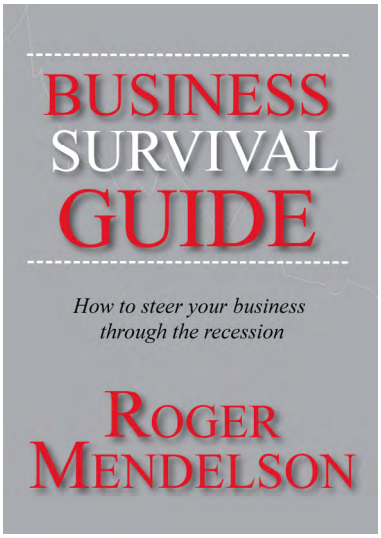
Emerging pattern

I believe that we are close to reaching this stage. This is when the pandemic becomes page five news and most businesses are getting back to some form of normality.

Rebuilding

Planning for this should be underway now with the strategy team. The practices which prosper in the future will be those which have proven to be nimble, flexible and who listen carefully to their patients, not just in a clinical sense but in a customer sense.

The chances are that the practice's wage structure and costs will be too high for the 'new world', so planning will need to take this into account. The question is: how can we reduce our overall wage costs by 20 per cent per annum?



A good idea is to hold round table discussions with all team members and be open to all ideas. Whilst there will always be a demand for medical services, the particular challenge is to reduce overheads and increase revenue by both greater efficiencies and charging a more premium rate per service.

The next step

Download the full 15-page free Prushka Business Survival Guide from www.prushka.com.au and start your serious planning.

Roger Mendelson
CEO
Prushka Fast Debt Recovery

PRUSHKA
FAST DEBT RECOVERY
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The writer is CEO of Prushka Fast Debt Recovery Pty Ltd and is principal of Mendelsons National Debt Collection Lawyers Pty Ltd. Prushka acts for in excess of 58,000 small to medium size businesses across Australia and operates on the basis of ***NO RECOVERY – NO CHARGE****. www.prushka.com.au Free call 1800 641 617. The writer is also the author of* The Ten Mistakes Businesses Make and How to Avoid Them *and* Business Survival*, both published by New Holland Publishers. Prushka is a partner of AMA Victoria and offers AMA members an ongoing discount of 10 per cent on its products and services.*

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COVID-19 concerns and feedback

We thank AMA Victoria members for providing ongoing feedback on the response to COVID-19. Your continued feedback is vitally important so that AMA Victoria can know the issues you are facing and can then advocate on your behalf.

All feedback is viewed and acted upon. We apologise for not always responding immediately, due to the volume of calls and emails. Views are being collated and passed through to the President of AMA Victoria and AMA Federal (for federal issues) who are in regular contact with the relevant departments and ministers' offices.

Please email covid19@amavic.com.au

Telehealth feedback

If you have specific feedback regarding your experiences with telehealth, please email Director of Communications and Advocacy, Taryn Sheehy at TarynS@amavic.com.au and let us know your views on retaining the telehealth benefit.