vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. **DECEMBER 2017/JANUARY 2018**

Green light for supervised injecting

WORKPLACE MENTAL HEALTH

CHILDBIRTH TRAINING IN THE DEVELOPING WORLD

AVOIDING COMPLAINTS

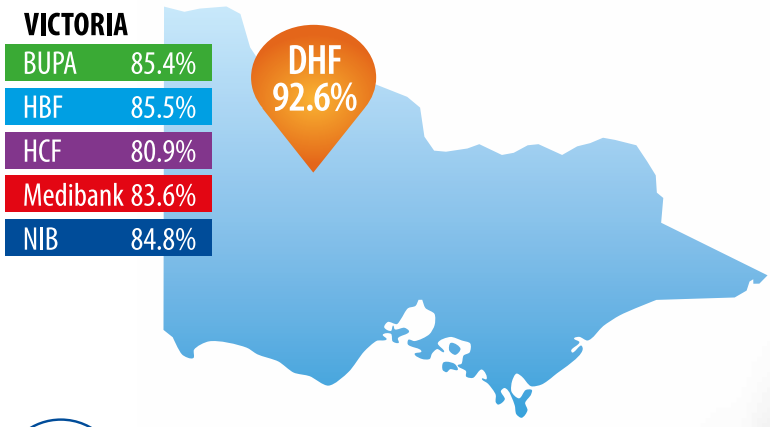
doctors health fund
Avant mutual

Dedicated to you, dedicated to the profession

How can you look after patients, when health funds don't look after you?

As a medical practitioner you know that health insurance funds can leave significant financial gaps after going to hospital.

In Victoria, Doctors' Health Fund outperforms the bigger, national, open health funds in terms of the percentage of medical services performed with no gap[1], giving you as a member, greater peace of mind.



10 MINS It's simple to switch your insurer

Switching from your current heath fund is easy. It takes just 10 minutes, and we do all the paperwork and deal with your current health fund for you.

Get a quick quote online at www.doctorshealthfund.com.au or call us for a detailed comparison to your current cover on

1800 226 126

AMA VICTORIA

Doctors' Health Fund is the preferred provider of AMA Victoria

1. 2017 AMA Private Health Insurance Report Card - % of medical services covered with no gap

Dr Dominic Barnes, General Practitioner
Doctors' Health Fund member since 1993

DHF 188_10/17

FRONT COVER: Supervised injecting will be trialled in North Richmond, at a facility similar to the one in Sydney's Kings Cross, which has been operating successfully since 2001. (Photo: Uniting MSIC)

Magazine of the Australian Medical Association Victoria

293 Royal Parade
Parkville Victoria 3052
T: (03) 9280 8722
F: (03) 9280 8786
Country Freecall 1800 810 451
amavic.com.au
Editor: Barry Levinson
E: BarryL@amavic.com.au

Advertising:
Daniel McLaughlin
T: 0400 916 742
E: DanielM@amavic.com.au
Vicdoc is published by AMA Victoria Services Pty Ltd ISSN 1440-8945
ACN 004 158 614

Chief Executive Officer
Frances Mirabelli

Closing date for February 2018 issue submissions:
Editorial: 18 December 2017
Advertising: 3 January 2018

Welcome from the editor

Federal Health Minister Greg Hunt at a dinner with AMA Victoria members. See page 20.

The end of the year is often a good time to pause and reflect, and enjoy some time with family and friends and perhaps even a spot of reading. So if you're keen to learn more about some of the news and developments in medicine, you may want to consider tucking this edition of Vicdoc under your arm as you head to the beach or have some time to fill during an Ashes tea break.

Supporting the health and wellbeing of doctors will always be an important focus of AMA Victoria and we are pleased to lend our support to *beyondblue*'s work. It's recently launched a guide to help health services develop their mental health strategy and here they explain some of the background behind it.

The exciting rise of 3D medical printing appears to be limitless. Member Mr Jason Chuen is very passionate about the potential of this emerging field and opens the door to his laboratory. We also meet another member passionate about giving newborns the best chance at life in the developing world and learn about some of the services available to patients from the Leukaemia Foundation.

This Vicdoc also includes updates on enterprise bargaining negotiations and real-time prescription monitoring and some sound advice on how to avoid patient complaints. There are also tips to help with managing a practice, and a very handy analysis of the pros and cons for anyone considering purchasing a holiday home.

We welcome the much needed trial of supervised injecting in Richmond next year and you can expect to read more about this in future editions of Vicdoc.

If you would like to tell us about an achievement in medicine or a personal interest others might enjoy reading about, please contact me on the details below. Vicdoc is sent to members every two months, so look out for the next edition in your mailbox in early February.

Barry Levinson

Editor
(03) 9280 8722
BarryL@amavic.com.au

YOUR EXCLUSIVE MEMBER BENEFITS

EXPERIENCE SUCCESS FROM A DIFFERENT PERSPECTIVE

LEXUS | BRIGHTON

LEXUS CORPORATE PROGRAMME

When we create our vehicles, our master craftsmen work with an attention to detail that can only be described as meticulous – down to the last stitch. The Lexus Corporate Programme builds upon this by providing a service uniquely tailored to AMA VIC members.

LEXUS CORPORATE PROGRAMME BENEFITS:

- Preferential Corporate Pricing
- 3 year/60,000kms complimentary servicing[1]
- Reduced delivery fee of $995 (ex GST)
- Priority ordering and allocation
- Encore Privileges Programme, including:
  - Service loan cars or complimentary pick-up/drop-off during servicing
  - Lexus DriveCare, providing 24-hour roadside assistance
  - Corporate Events

lexusofbrighton.com.au/corporate

Contact Dion Nugara or Joe Marchese on RSM@lexusofbrighton.com.au or 9524 2099.

LEXUS OF BRIGHTON 99 Nepean Highway, Elsternwick VIC 3185
PH: 9524 2099 lexusofbrighton.com.au

1. Complimentary scheduled servicing expires at 3 years or 60,000kms from the date of first registration, whichever occurs first.

Contents

10

24

42

President's message

The festive season is in full swing and I hope that all of you have some treasured time to spend with family and friends, and maybe even enjoy some actual leisure time.

The 'holiday' period brings into focus the value that must be placed on our wellbeing by finding a balance between paid work and 'leisure'. The hours doctors in public health services are working in excess of rostered hours – often with no pay and little acknowledgement of the impact on their wellbeing and the capacity for teaching and learning – have been central in my discussions with members during the prosecution of the new Enterprise Bargaining Agreement (EBA). Professor John Wilson – an AMA member who chairs our Committee of Chairs of Senior Salaried Staff, did an exhaustive analysis of increased 'productivity' in six health services over recent years. Put simply, the year on year increase in patients treated has not been met with a commensurate increase in the medical workforce costs. This is a powerful way to demonstrate what many of you already know – you are busier and busier treating patients, and your increased workload has not been valued.

How do you achieve this workload? You do it by missing protected time for teaching, learning and research. You do it by arriving early outside rostered hours to participate in grand rounds and unit meetings. You do it by arranging tutorials out of hours and you do it by taking the above-mentioned leisure time to study for specialist exams or further qualifications. You do it by losing opportunities to rest or otherwise enjoy life. I say this direct to you all – it is time to resist the pressure to do more. Why? Because you and your standard of practice will eventually suffer and so will the care of your patients – which we all value so highly and which motivates this self-sacrifice.

For most people in employment, time that is not paid work incorporates other unpaid work – cooking, cleaning, parenting, caring for others in our families and administering personal finances. However, doctors in almost every employment setting are often using unpaid time working in relation to their medical practice – be it study, teaching or unrostered unpaid overtime in hospital settings. It is time to not only acknowledge this but enforce it. Meetings with members during the EBA have highlighted how reluctant doctors are to take any action at the risk of compromising patient care.

It is distressing to hear the stories of the barriers to claiming overtime for both doctors in training (DiTs) and for some senior staff. It is not the employees' responsibility to keep services within budget – it is up to the service to provide a safe working environment and to look after its employees. Budgets are to be negotiated by heads of units with administrators. I have heard stories where heads of units have been constrained by budgets when they have no power to contribute to the decision-making at a higher level on expenditure in other areas (e.g. refurbishing waiting areas at a cost of hundreds of thousands of dollars versus no allocation for backfill of leave positions within a unit).

Until the new EBA is finalised, the existing one is still enforceable and AMA Victoria has a Workplace Relations team which is ready to act for you to ensure your rosters and working conditions comply with it. Senior doctors, please support your DiTs in recognising hours worked to deliver patient care, and support them in taking time allocated for learning. A secondary benefit will be that the real workload is documented and more doctors could be employed. Those of you with influence in learned Colleges, please advocate for more training positions in total, and for innovative training options within rural and regional Victoria which encourage retention and expansion of the workforce there. With the population in this state expanding at more than 100,000 a year the system needs all the graduates in the pipeline. They must be trained well, by senior colleagues who are well supported by rosters that value teaching. Equally, DiTs must be supported by rostering which allows for learning and the teaching they also do.

When doctors are working unconscionable hours dealing with an increasingly complex workload, they have little capacity to lobby for change. They are dispirited and risk becoming disengaged. This is not good for them. This is not good for patients. AMA Victoria is ready to support its individual members as well as promote the benefits of a valued medical workforce able to deliver best patient care throughout the system.

Dr Lorraine Baker
President

From the CEO

It's a historic time in Victoria, with the State Government finally heeding the call to introduce a supervised injecting facility at North Richmond Community Health. AMA Victoria has pushed for this for a long time and did not back down.

This was first stated in our 2012 policy position and while it took a long time to sway the minds of key politicians, the movement gained significant traction this year, as the heroin death toll continued to rise. We congratulate all those families, residents, community groups and health related services who have joined us in lobbying for this outcome.

AMA Victoria has been closely following the Voluntary Assisted Dying (VAD) Bill in the Victorian Parliament. At the time of printing, the Bill had passed the Lower House and is being debated in the Upper House. We will communicate any developments to our members via email, on our website, and in the next edition of Vicdoc.

There is little doubt that this is a very challenging and unprecedented issue for the medical profession, with divergent views prompting plenty of discussion and sometimes heated debate amongst members. AMA Victoria has received a lot of member feedback over the last 12 months, from both sides of the debate.

In the context of AMA policy, voluntary assisted dying is a form of euthanasia. AMA Victoria supports and upholds the AMA's policy position on euthanasia. This remains:

3.1 The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.

3.2 The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide.

3.3 The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.

3.4 If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:

• all doctors acting within the law

• vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society

• patients and doctors who do not want to participate

• the functioning of the health system as a whole.

3.5 Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.

3.6 Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.

In reference to point 3.4 of the AMA's position, AMA Victoria is satisfied that our concerns regarding conscientious objection have been addressed in the Bill. Much of AMA Victoria's submission to the Bill's discussion paper earlier in the year have been addressed in the Bill.

AMA Victoria's advocacy of the AMA's position in relation to the Bill has always been preceded by drawing attention to the need for significant funding to be directed towards end of life and palliative care services. In AMA Victoria's latest State Budget Submission (for the 2018-19 State Budget), AMA Victoria has called for significantly increased funding for community palliative and end of life care services across the state, in particular for rural and regional areas. We will continue to lobby the Government to improve these services.

As the year draws to a close, I thank each of you for your ongoing support of AMA Victoria, and I wish you and your family a safe and happy festive season, and look forward to working with you in 2018.

Frances Mirabelli
CEO

Helping health services develop a workplace mental health strategy

A large percentage of medical professionals choose their career because they care deeply about the wellbeing of others. Being accountable for the health of the general population drives and inspires them, yet statistics show doctors find it difficult to seek support when their own wellbeing is challenged.

A large percentage of medical professionals choose their career because they care deeply about the wellbeing of others. Being accountable for the health of the general population drives and inspires them, yet statistics show doctors find it difficult to seek support when their own wellbeing is challenged.

The working environment for health professionals can make them vulnerable to developing mental health conditions such as anxiety and depression. A combination of heavy workloads, working long hours, bullying and harassment and shift work are often absorbed in silence due to the stigma attached to seeking support.

Unfortunately, this leads to above average rates of mental health conditions in doctors, often with dire consequences. Statistics show 3.4% of doctors experience very high psychological distress compared to the wider community figure of 2.6%.

When the National Coronial Information System reported 153 suicide deaths of health professionals in Australia between January 2011 and December 2014 – the highest rate among white collar groups – it was clear a different approach to improving mental health across the industry was required.

In 2013, *beyondblue* pioneered the National Mental Health Survey of Doctors and Medical Students. More than 12,200 doctors and 1,800 medical students completed the survey, and the results confirmed doctors suffered substantially higher rates of psychological distress and attempted suicide compared to the Australian population and other professionals. Doctors, who spend countless hours caring for others, were actually saying they found it difficult to seek help when they needed it most.

At *beyondblue*, we recognise medical practitioners can find it challenging to admit they are struggling mentally. Yet the World and Australian Medical Associations' codes of ethics indoctrinates the importance of prioritising their own health:

- Take responsibility for your own health and wellbeing, including having your own general practitioner.
- Recognise colleagues who are unwell or under stress. Know how and when to respond if you are concerned about a colleague's health and take action to minimise the risk to patients and the doctor's health.
- Seek appropriate care and attention if he/she suffers from mental or physical illness.

It's there in black and white, so why is it so difficult for health professionals to seek medical support for their mental health? The National Mental Health Survey of Doctors and Medical Students found:

- About 40% of doctors felt medical professionals with a history of mental health disorders were perceived as less competent than their peers.
- 48% felt these doctors were less likely to be appointed compared to doctors without a history of mental health problems.
- About 58% agreed that seeking help for a mental health condition would cause them embarrassment.

These statistics paint a clear picture of the stigmatising attitudes that persist in the medical profession, however, it is only part of the story. Doctors face further barriers to seeking support due to the often unreasonably high expectations on them from the community and their personal networks, a culture of always putting the patient first and a fear of losing their license to practice. This complex set of challenges facing health professionals, confirms the need for a cultural overhaul of Australian health services.

In 2014, *beyondblue* and the AMA brought the medical profession together to discuss the survey results and begin tackling mental health from within. In 2015, prompted by the tragic and unnecessary deaths of four young doctors in one week in Victoria, *beyondblue* gathered leaders from the medical profession.

At this working dinner, key medical industry stakeholders agreed to improve the mental health of doctors and medical students. *beyondblue* then spent the next 12 months talking to Victorian health services to identify the barriers hindering changes in workplace culture before devising a course of action.

beyondblue found the sector often had one or two isolated support programs, such as employee assistance or peer support programs, with no overarching sustainable strategy. Health services also highlighted a gap in knowledge about creating mentally healthy workplaces.

The result was *Developing a workplace mental health strategy – A how-to guide for health services*, a practical guide that provides health service leaders the tools to develop and implement a sustainable mental health and wellbeing strategy for all staff. Although the guide alone is by no means the answer, *beyondblue* hopes it will help give health services the confidence to develop a strategy that supports staff and prevents suicide risk.

beyondblue's engagement with Victorian health services has highlighted that the stressors created by organisational culture and workplace conditions are not isolated to the medical profession. Nurses, allied health staff, administrative staff and others working in healthcare are also exposed to similar risk factors and require the same level of support for their mental health at work. Therefore, the health services guide establishes that, in order to support doctors, a workplace mental health strategy must aim to encapsulate the requirements of all staff, not just the medical practitioners.

The guide aims to assist health services protect the mental health of everyone in the workplace, promote wellbeing and the positive aspects of work, and ensure staff who experience mental health conditions are supported. And while occupational health and safety or human resources departments are usually tasked with implementing such a strategy, its success is incumbent on the authentic and ongoing support of health services leaders.

Senior staff, such as chief executives, must drive the cultural change required to create mentally healthy environments and destigmatise mental illness among doctors. The reasons to do so are many and varied.

Employers who create and sustain a great place to work will attract and keep the best staff. When employees are engaged, they are more willing to extend an extra hand or discretionary effort to help others. The result is improved performance, productivity and quality. From a financial perspective, every dollar spent on creating a mentally healthy workplace will, on average, have a positive return on investment of $2.30. The patient experience is better when staff feel they have a good working environment, low emotional exhaustion and support from co-workers and managers.

It is not difficult to understand why creating a mentally healthy workplace will benefit your staff and doctors, and all health professionals, do incredibly important work to keep our community healthy, and to support people at times of great vulnerability. It is incumbent on us as leaders, as workplaces and as a community, to ensure that those who do such important work in caring for others are supported themselves.

Waiting for a young doctor in your health service to tragically take their own life is quite simply too late to act. I urge all health services personnel to take action now – by looking after yourself, by supporting your colleagues or by promoting a new culture in your health service. *beyondblue* can help you every step of the way.

For more information about *beyondblue*'s Health Services program, visit the 'information for health services page' on the headsup.org.au website in the 'Healthy Workplaces' section.

Developing a workplace mental health strategy – A how-to guide for health services is available to download from das.bluestaronline.com.au/api/prism/document?token=BL/1728

Patrice O'Brien
General Manager
Workplace, Partnerships and Engagement
beyondblue

Five ways 3D printing is changing medicine

3D printing technology is set to revolutionise medicine from prosthetics and tissue engineering, to customised medicines that are manufactured on demand.

Before inserting and expanding a pen-sized stent into someone's aorta, the hose-like artery that carries our blood away from the heart, surgeon Jason Chuen likes to practice on the patient first. Not for real of course, but in plastic.

Which explains the 3D printer in his office and the brightly coloured plastic aortas that line his window sill at the Austin Hospital in Melbourne. They are all modelled from real patients and printed out from CT scans, ultrasounds and x-rays.

"By using the model I can more easily assess that the stent is the right size and bends in exactly the right way when I deploy it," says Mr Chuen, Director of Vascular Surgery at Austin Health and a Clinical Fellow at the University of Melbourne.

3D printing technology, he says, is going to transform medicine, whether it is patient-specific surgical models, custom-made prosthetics, personalised on-demand medicines, or even 3D printed human tissue. And his do-it-yourself approach has now grown into a 3D Medical Printing Laboratory at the hospital with help from the University of Melbourne's Department of Mechanical Engineering.

"At the moment 3D printing is at the cutting edge of medical research, but in the future the technology will be taken for granted by all of us in healthcare," says Mr Chuen, an AMA Victoria Councillor.

At its core 3D printing is the use of computer guidance technology to create 3D objects from digital plans by applying layers of material, such as heated plastic, or powders in the case of metals and ceramics. It is being used to print out anything from toys and food, to warships producing on-demand spare parts and even drones. Medicine is just another frontier.

In the *Medical Journal of Australia* Mr Chuen and his Austin colleague Dr Jasamine Coles-Black have recently published an article aimed at alerting medical professionals to the potential of 3D printing. Here are their top five areas that 3D printing is set to change medicine:

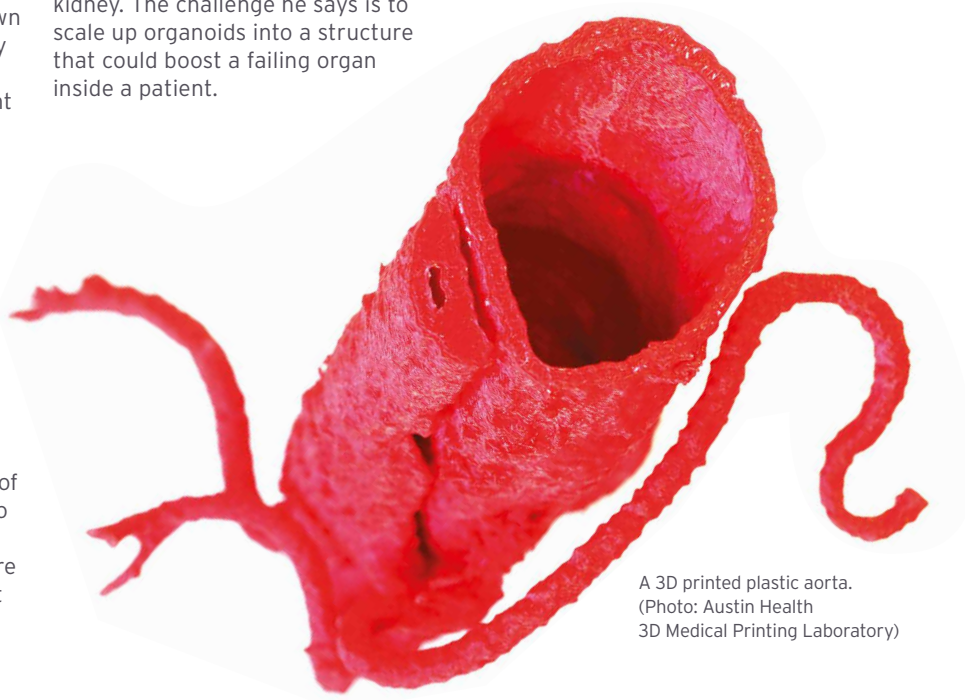
Bioprinting and tissue engineering

It sounds like something out of Frankenstein, but could we eventually 3D print human organs? Not exactly, says Mr Chuen. But he's convinced that in the future we will be able to 3D print human tissue structures that can perform the basic functions of an organ, replacing the need for some transplants.

Scientists are already using 3D printing to build "organoids" that mimic organs at a tiny scale and can be used for research. They are built using stem cells that can be stimulated to grow into the functional unit of a particular organ, such as a liver or kidney. The challenge he says is to scale up organoids into a structure that could boost a failing organ inside a patient.

Such "bioprinting" involves using a computer-guided pipette that takes up cell cultures suspended in nutrient rich solution and "prints" them out in layers suspended in a gel. Without the gel the cells would simply become a watery mess. The problem says Mr Chuen is that once inside the gel, cells can die in a matter of minutes. This isn't a problem for small structures like organoids that can be built quickly and then transferred back into a nutrient solution. But it is a problem when attempting to make something larger like an organ because the initial layers of cells will die before the organ is completed.

"Unless there is some breakthrough that enables us to keep the cells alive while we print them, then I think printing a full human organ will remain impossible. But where there is potential is in working out how to reliably build organoids or components that we could then bind together to make them function like an organ," says Mr Chuen.



A 3D printed plastic aorta. (Photo: Austin Health 3D Medical Printing Laboratory)

Pharmacology

People suffering from a range of ailments, such as the elderly, are often dependent on taking multiple pills throughout the day. But imagine if one pill could replace the ten pills your doctor has prescribed? According to Mr Chuen, 3D printing is on the way to making this possible, opening up a whole new world of customised medicines.

Rather than simply embedding a single drug in a pill that is designed to dissolve and release the drug at a set time, the precision of 3D printing means pills can be designed to house several drugs, all with different release times. A 3D printed "polypill" that contains three different drugs has already been developed for patients with diabetes and hypertension. It maybe that in the future instead of a prescription, a doctor will be giving a digital file of printing instructions.

Surgical rehearsal

Studies of surgeons using 3D printed models to rehearse procedures have shown that operations can be completed faster and with less trauma for patients. The potential cost savings alone are considerable. As Mr Chuen points out, running an operating theatre can cost $2,000 an hour. That is over $30 a minute.

Mr Chuen and Dr Coles-Black themselves have begun printing out copies of patient kidneys to help surgeons at the Austin in planning the removal of kidney tumours. Such hard plastic models can be made more realistic by printing them in more expensive flexible material such as thermoplastic polyurethane. The material cost of the hard plastic aortas in Mr Chuen's office is about $15, whereas if printed in soft plastic the cost can rise to $50.

The real cost in 3D printing biological models is not just materials or printers, but also the software used to translate the scans into files for the printer. The 3D segmentation software Mr Chuen uses costs about $20,000 a year.

Customised prosthetics

As soon as 3D printing began to take off people were quick to see the opportunity for creating amateur prosthetics for their pets – from puppies to geese, and even tortoises. Unlike for humans, there was no mass-supply chain of prosthetics for pets. But mass-supplied prosthetics are likely to be a thing of the past as 3D printing is increasingly used to manufacture prosthetics that are exactly tailored to a patient's needs.

3D printed kidney with tumour in blue and blood vessels in pink and purple. Such models are being used by surgeons to rehearse their surgery plan. (Photo: Austin Health 3D Medical Printing Laboratory)

"For example, with hip replacements, surgeons have to cut and ream a patient's bone to fit the prosthetic, but in the future it will be normal to 3D print a prosthetic to fit a patient," says Mr Chuen.

Distributed production

Just as 3D printing is allowing customised production of medicines and devices, the production itself is likely to become localised. The warehouses that are full of packaged medicines and prosthetics will in the future likely be replaced by digital files of designs that hospitals and pharmacies will be able to download and print on demand using stored raw materials, says Mr Chuen.

Such distributed manufacturing he says could make medicines and devices more equitably available across the world so long as a local hospital for instance has the printing technology in place and access to raw materials.

However, Mr Chuen warns distributed production will present new risks for ensuring the quality control of end products. It will need a fundamental shift in responsibility from the supplier to wherever the medicines or devices are manufactured. "That represents a huge shift and we have to work out how it could work. But if we get the regulation right then it will transform access to medical products."

But for Mr Chuen, the immediate overall challenge in medical 3D printing is ensuring that medical professionals themselves are up to speed with the technology because it is their clinical experience that will be needed to drive its successful application.

"It is a revolutionary technology that will make medical care better and faster, and more personalised. But what we need is for more medical professionals to start exploring and experimenting with what this new technology can do, because many things that we thought of as impossible are now becoming possible. I think we are moving towards a world where if you can imagine it, you will be able to print it – so we need to start imagining."

Andrew Trounson
Pursuit Senior Journalist
University of Melbourne

Visit 3dmedlab.org.au for more information on the work being done by Mr Chuen and his team.

This article was first published on *Pursuit* – pursuit.unimelb.edu.au

Public hospital doctors say ‘no’ to 20-hour shifts

Public hospital doctors attend an EBA meeting at AMA House.

AMA Victoria will not back-down on safe hours and fair conditions for public hospital doctors.

Since the start of the year, AMA Victoria has been negotiating the Enterprise Bargaining Agreement (EBA) for public hospital doctors with the Victorian Hospitals’ Industrial Association (VHIA). AMA Victoria will not back-down on important changes that will ensure safe and fair conditions.

“Currently, public hospital doctors are required to work an extraordinary amount of over-time (unpaid). Shifts creeping up to 20 hours must stop. These hours are unsafe for doctors, and unsafe for patients,” AMA Victoria President, Dr Lorraine Baker, said.

“AMA Victoria expects public hospitals to support patient safety and to support AMA Victoria’s fair EBA log of claims. It is essential that the state does everything in its power to keep good doctors in our world-class public hospitals. Unrecognised and dangerous 20-hour shifts must end. What patient would want to be treated by a doctor who has worked an 85-hour week?” Dr Baker added.

“Time for teaching, learning and research must be protected to ensure the highest standards of care.”

As the EBA negotiations enter yet another month, the AMA calls on Victoria’s public hospitals to recognise safe hours, the necessary training and teaching hours, fair rostering, fair leave, fair pay and all the other components of AMA Victoria’s EBA log of claims for public hospital doctors.

AMA VICTORIA

AMA Victoria media release, 28 September 2017

An AMA Victoria initiative

FIRST RESPONSE

A free, confidential
TELEPHONE SUPPORT SERVICE
for doctors facing workplace bullying, discrimination or harassment.

For support, counsel and advice on your rights and your options, call 1300 262 362

1300 AMA DOC

AMA membership provides unparalleled services and advocacy

AMA Victoria is leading the fight for your professional interests and better public health. This year, with your support, we've gone from strength to strength with major wins for doctors and the health system.

AMA membership gives you and your colleagues influence over health policy, as well as unmatched resources to support you at every step of your career including trusted advice from our in-house experts and workplace services, accredited training, professional development and networking. Our events provide unique opportunities for collegiate interaction across specialty interests and career stage. We are your voice and your champion.

For those in the public system, membership of AMA Victoria also grants you automatic representation by our union partner, the Australian Salaried Medical Officers' Federation (ASMOF). With the next enterprise agreement now being negotiated we are with you in the battle for improved pay and conditions.

When it comes to achieving the best possible pay and conditions, our strength is your strength, so it is a crucial time to renew your support and strengthen our bargaining power.

Our in-house Workplace Relations team has assisted salaried medical officers and doctors in training (DiTs) with over 8,000 queries this year, relating to bullying and harassment, appropriate rostering and payment of overtime and review of contracts. For members in the private system, we provide unrivalled workplace relations support and trusted advice on every aspect of private practice. Did you know we have a dedicated team who can provide advice on compliance with relevant legislation?

Together, we can do more. Your tax-deductible membership supports our advocacy for a world-class health system and world-class medical workplaces.

How to pay: Go to www.amavic.com.au and click on the 'Renew my Membership' button to pay by credit card, or call (03) 9280 8722.

If you wish to change your payment details or update your membership category or address, please contact the AMA Victoria Membership Team on (03) 9280 8722 or go to our website member portal www.amavictoria.com.au.

2016-17 Advocacy highlights

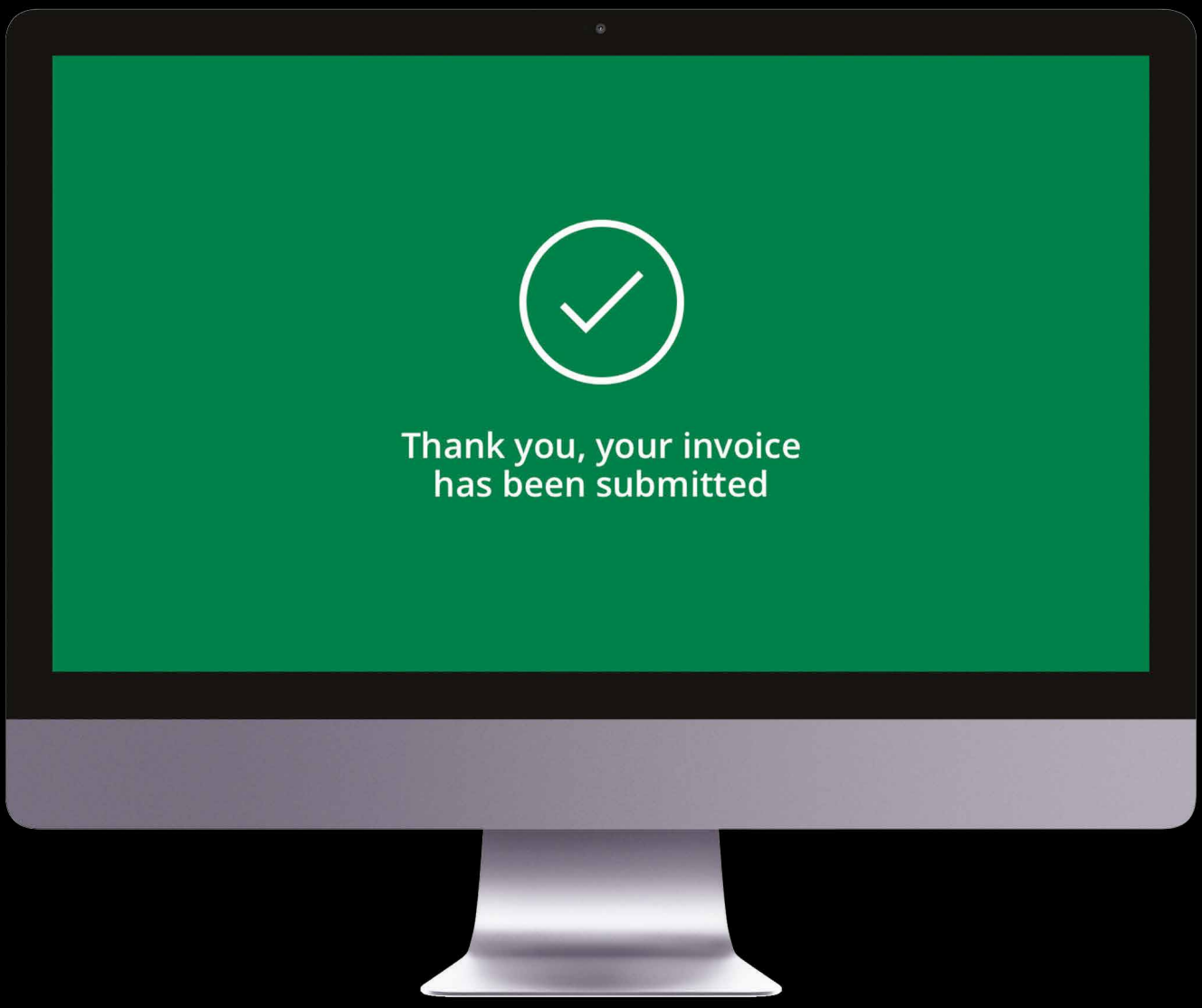
- Helped members with over 8,000 workplace relations queries from public and private practice.
- Compelled the Federal Government to phase out the Medicare rebate freeze.
- Secured Council of Australian Governments Health Council review of mandatory reporting laws to support improved mental health for doctors.
- Began the Enterprise Agreement campaign in partnership with ASMOF for improved pay and conditions.
- Released the AMA/ASMOF National Guide on Rights of Private Practice in Public Hospitals.
- Conducted a national Safe Hours Audit to highlight the need to improve rostering arrangements.
- Supported over 70 DiTs with trusted interview skills advice and resume review assistance through the AMA Careers Advisory service.
- Advocated to stop unfair changes to legislation in relation to lease arrangements between medical practices and pathology companies.
- Stopped pushes to permit pharmacists to alter prescriptions without the authority of the GP.
- Leader in addressing workplace bullying, discrimination and harassment, with the strategy Setting the Standard. This includes our First Response telephone service, which provides free and confidential advice to members and non-members by expert IR advisers (call 1300 262 362).
- Successfully lobbied for reforms to Victorian tobacco legislation to ban smoking in outdoor dining areas and also regulate e-cigarettes.
- Lobbied the State Government to secure $1.5m investment to tackle occupational violence against health workers and workplace bullying.
- Secured recurrent funding for the Victorian Doctors' Health Program (VDHP).
- Developed the 10 Minimum Standards... to foster better coordinated, technology-based communications between health services and doctors.
- Successfully won funding: $174.3m in Victorian Government funding for reducing elective surgery wait lists.
- Successfully won funding: $428.5m in hospital upgrades and medical equipment.
- Successfully negotiated settlements for numerous members, including:
  - Secured $65,000 in back-pay
  - Secured entitlement to clinical support time for VMO
  - Won $60,000 in payments for DiT who had not been provided with training time
  - Massive win of $200,000 for a senior doctor who had been paid under the agreement rate over an extended period of time
- Advocated on range of public health issues, including:
  - Task substitution (particularly lobbied against moves that would see pharmacists' scope of practice increase)
  - Supporting a trial of supervising injecting facilities in Victoria
  - Advocacy of strong immunisation policy.

AMA VICTORIA

Get TAC payments the next business day.

Paperless invoicing with the TAC's online payments platform, LanternPay.

Transport Accident Commission



Register at lanternpay.com/tac

lantern pay

The beginning of the end of Alzheimer's

Two new human clinical trials for Alzheimer's have just been announced by researchers from the Florey Institute of Neuroscience and Mental Health in Melbourne, and they're asking for your participation.

Dr Yen Ying Lim is a lead investigator of the Healthy Brain Project.

Alzheimer's disease was first described by Dr Alois Alzheimer in 1906, after treating a patient, Auguste D, who had overt symptoms of dementia. After Auguste died, Dr Alzheimer examined her brain, observing "dramatic shrinkage and abnormal deposits in and around the nerve cells".

Dementia is an umbrella term that describes a loss of memory and other cognitive abilities that is severe enough to interfere with our everyday activities. Alzheimer's disease causes between 60-80% of all dementia cases, but additional types of dementia include vascular dementia, frontotemporal dementia and Lewy Body dementia, among others.

Currently, dementias are the second leading cause of death behind cancer and there are over 350,000 Australians living with dementia. This will rise to around one million people by 2050. Alzheimer's disease incidence doubles every five years after the age of 65, such that 85 year-olds have a 30-50% probability of being diagnosed.

The biggest risk factor for developing Alzheimer's disease is age, and Australia's ageing 'boomers' mean that we expect to see a 365% increase in Alzheimer's diagnoses by 2050. Although one to two per cent of Alzheimer's can be traced back to a definite genetic mutation, the vast majority of cases are of unknown, or 'sporadic' origin.

We now know that the 'abnormal deposits' around the brain cells, observed by Dr Alzheimer, consist of a small protein fragment called the amyloid peptide. Amyloid is abnormally produced during the disease process and clumps around brain cells, inhibiting their normal communication – causing memory decline – and eventually leading to cell death.

Several studies, including a world-leading Australian study called the Australian Imaging, Biomarker and Lifestyle study, have now shown that the amyloid peptide doesn't just suddenly appear. Rather, in people who will go to develop Alzheimer's, it gradually but surely builds up over a 30-year timespan, beginning in middle age.

There are some current therapies undergoing trials that target this

Florey's Top Tips for a Healthy Brain

Although we don't know what causes 90% of Alzheimer's disease cases, we do know that keeping your brain healthy gives you the best chance of making sure it stays that way:

- Stay physically healthy, with 150 minutes of exercise a week, stop smoking as soon as possible.
- Stay mentally stimulated, and socially engaged.
- Eat a healthy diet, full of lean protein, fruit, vegetables, nuts, fish and olive oil.
- Try to get a good night's sleep regularly, around 7-8 hours.
- Reduce stress levels, practice mindfulness and meditate.

amyloid protein, either trying to clear away excess amyloid or prevent its production, but so far they don't seem to be showing much effect. The reason could be that they are being given to people too late in the disease process, after the bulk of the damage – brain cell death – has already occurred.

Ideally, these therapies would be given much earlier in the process, years before amyloid, and associated cellular damage, starts to build up. However, identifying these at-risk individuals is extremely difficult, as they are otherwise perfectly healthy middle-aged adults.

This is how the Healthy Brain Project was born. Dr Yen Ying Lim and Dr Rachel Buckley from the Florey are looking for 5000 Australians between the ages of 40-65 to help them nail down the lifestyle and genetic characteristics that make people more prone to the disease, and those which might be protective.

Volunteers will perform yearly online memory and learning tests, and contribute a saliva sample for genetic testing. They will also answer some simple survey questions about their physical activity levels, education and lifestyle, to build up a complete picture of what puts some people at higher risk than others.

Ideally, the information will allow Yen and Rachel to predict with a high degree of certainty who should go in for further amyloid testing, and potentially fast-tracking their enrolment into future clinical trials.

Participants will also have the chance to interact with one another in forums, swapping exercise tips, favourite mental games and the latest research.

To join the Healthy Brain Project, sign up at healthybrainproject.org.au, or email healthybrainproject@florey.edu.au for more information.

Two other Florey researchers are approaching the problem from the other direction, and have started a novel clinical trial on the basis of some curious observations. Dr Scott Ayton and Professor Ashley Bush observed that about 30% of people with high levels of the amyloid peptide, which would otherwise have grouped them in the mildly impaired or full Alzheimer's patients, were in fact entirely healthy and cognitively normal.

This finding was initially puzzling, until they also looked at the levels of iron within the brains of those patients. In conjunction with the CSIRO, the group developed a highly sophisticated method of measuring brain iron using a magnetic resonance imaging scanner. This removed the need for painful lumbar punctures of prospective patients.

Using MRI for iron in conjunction with positron emission scanning for amyloid, the pair discovered that those otherwise healthy patients with high amyloid invariably had low brain iron levels. Patients with high amyloid and high iron displayed cognitive impairments or overt Alzheimer's.

High brain iron is involved in other neurodegenerative conditions, like Parkinson's disease, so these observations were not particularly controversial to the team. But they did lead to the germ of an idea. What if they could lower brain iron levels in people with high amyloid peptide levels? Would they see an

Professor Ashley Bush is leading a trial that tests the impact of reducing the brain's iron levels.

improvement, or even just a 'levelling off', in symptoms?

This was the ultimate scientific test of their idea, and fortunately a safe and effective iron-lowering drug was already on the market, called deferiprone. In fact, deferiprone is currently being trialled in Parkinson's disease patients.

Scott and Ashley have now joined forces with Neuroscience Trials Australia, the Florey's clinical trials arm, to test deferiprone in a double blind, randomised, placebo controlled trial, with planned trial sites around Australia.

People who wish to enrol in the trial can visit www.florey.edu.au/3Dstudy or email 3Dstudy@florey.edu.au and they will be sent an enrolment questionnaire.

Dr Tom Keeble PhD
Neuroscience Communicator
The Florey Institute of Neuroscience and Mental Health

THE FLOREY
INSTITUTE OF NEUROSCIENCE & MENTAL HEALTH

Reducing the bowel burden: How GPs can help to prevent bowel cancer

Bowel cancer is our second biggest cancer killer, claiming the lives of more than 1,300 Victorians and 5,462 Australians each year. This is almost as many lives as breast and prostate cancer combined and it's too many; especially when you consider that a screening test is available.

The simple home test is offered for free through the Australian Government's National Bowel Cancer Screening Program. The program is being rolled out in stages and by 2020 all Australians aged 50 to 74 will receive a free test every two years.

But unfortunately we've seen that just sending the tests to the homes of eligible people is not enough. More than half of the kits are forgotten, untouched or even thrown away.

As GPs, we can help. It's widely known that doctors are extremely powerful when it comes to influencing patients' health behaviours. If a doctor recommends the home screening test to a patient, they are more likely to do it than if they simply receive the test through the mail without their health professional's endorsement.

The test used in the program is an immunochemical faecal occult blood test (FOBT). It is the most widely available and well-trialled screening test for bowel cancer and it's highly effective. It looks for traces of blood in a bowel motion which are invisible to the eye. This helps to identify bowel cancer in its early stages before any symptoms appear, when it has the greatest chance of being successfully treated.

In fact, if bowel cancer is found at stage one or two the patient has a 98 to 90% chance of survival. By the time a patient has symptoms their cancer could be at stage three or four, at which time chance of survival decreases significantly to 71% and 15% respectively.

There's no denying that the test is highly effective. It's also incredibly convenient, given the patient can complete it from the comfort of their home. Unfortunately this message just isn't getting through. Only 40% of eligible people are currently using the test, and this is where general practice can help.

Many of our patients have a trusted general practice they attend. We're uniquely placed to provide holistic and patient-centred care. GPs and primary care teams have a real opportunity to reflect on our current practice and systems and look at ways of improving our overall screening rate.

By making these changes we have the potential to make a significant difference to the lives of thousands of Victorians. It's something I'm very passionate about, which is why I've lent my voice to Cancer Council Victoria's recent campaign to increase bowel cancer screening.

It's their largest ever bowel cancer screening campaign and it's ambitious. If successful, an extra 20,000 Victorians could complete the screening test, this year alone. If screening continues to rise, within the next 10 to 15 years more than one million extra Victorians could be screening for bowel cancer, potentially helping tens of thousands.

We can support Cancer Council's campaign by including the screening for bowel cancer as part of an age appropriate health check-up. For many of us, preventative care is a major component of our daily work. We should not only look at minimising risk factors for IHD and stroke, but also appropriately consider cancer screening tests including FOBT in our daily contact with patients

Practices are encouraged to send a signed letter to 49 year-old patients to encourage them to use the test when they receive it in the mail. Participation in the program is currently the lowest for 50 year-olds, and there is strong evidence that this can be increased through a letter.

Another way we can encourage participation is by talking to patients about bowel screening, as part of regular health checks. A major reason that many people don't currently do the test is because they simply don't realise that bowel cancer is a widespread, deadly disease and that they could be at risk. You can request a sample kit through the national program to help you to demonstrate how it works and demystify the process.

Displaying brochures, flyers and posters in your clinic is a great way to support these conversations. A range of resources are available for order or download from Cancer Council Victoria, or through the National Bowel Cancer Screening Program.

I urge you to help us increase participation. They may be small changes, but they could mean a lifetime to a patient who is spared from aggressive bowel cancer, treatment or death.

For more information about bowel cancer screening, including dedicated resources for GPs, visit www.cancervic.org.au/bowel/gps

A/Prof Justin Tse
General Practitioner

References available from the Editor on request.

A/Prof Tse is a former Chair of RACGP - Cancer and Palliative Care Specific Interest and Director of Medical Education, St Vincent's Clinical School, University of Melbourne. This piece was developed in collaboration with Cancer Council Victoria.

Dinner with the Federal Health Minister

AMA Victoria was pleased to host the Federal Minister for Health and Sport, Greg Hunt, at a dinner at The Pavilion at the Arts Centre on 10 October. Members had the opportunity to hear from the Minister on a range of health issues, including a "pledge, commitment and guarantee" to change the mandatory reporting laws that are impacting on doctors' mental health. Thanks to our sponsors Little Real Estate, Pitcher Partners, and MDA National for supporting a great night.

Alternate career paths for doctors

Significant time and effort is required to establish a medical career, particularly to specialisation.

Traditionally once you had embarked on a medical career pathway, you stayed in it for life. However, now it is becoming more acceptable and mainstream for doctors to explore a change in career direction at any stage of their medical career. The challenge for most doctors contemplating a career transition is where, or how, to commence this process.

The number of doctors consulting AMA Victoria's Careers and Pathways team seeking advice on a change in career direction is steadily increasing. These doctors are often surprised when we tell them that we coach many others like them seeking a change.

Medicine as a career covers a broad spectrum of opportunities. The common pathway of hospital intern, registrar and resident, a specialty training program and progression to a long and rewarding career as a specialist is not the only way to utilise medical training and experience. Historically, leaving this traditional path was not contemplated by doctors, let alone considering working outside medicine entirely. This may have been for many and complex reasons – the time, effort and cost invested in becoming a clinical doctor, public perception and prestige, the professional status and identity being a doctor provides, a feeling of obligation and the requirement to maintain a certain level of income.

The reasons such a change is now more frequently sought vary widely. For some doctors a complete career change might be the best option, for others the development of a parallel career path or allocating time to other interests, medical or non-medical, may be a better solution.

Some of the reasons doctors seek advice on a potential change are:

- change in circumstance – existing path no longer fits
- personal goals and aspirations have changed
- bored and disengaged
- burnt out / health challenges
- do not like working in the hospital system
- unable to obtain a place on desired training program – what else suits?
- do not enjoy clinical work
- seeking 'life balance' – current pathway inhibits
- returning after a career break
- medicine was the wrong career choice
- work in, or pursuing a specialty, which does not fit anymore
- seeking redirection in order to become passionate about role as a doctor
- professional diversification – seeking to broaden the use of skills in non-clinical roles
- unable to pass exams to achieve fellowship
- seeking part-time or flexible work conditions obstructed by current role
- want to do something in the short-term using medical skills (not usual path)
- want more community involvement
- seeking an adventure.

You need to consider carefully why you are pursuing such a change. What are you seeking? A change requires a lot of time, thought and effort. Careful planning, research, networking, further study, willingness to contemplate a backward career step or a stepping stone approach may be necessary. It is a very individual process with many things to factor in.

There are so many career options available. Some will have equivalent or greater remuneration potential, many will not.

The skills doctors have gained from medical training and clinical practice are highly transferable to a diverse range of professions. Transferable skills, in addition to specific medical knowledge and experience, most doctors will have honed include:

- coping with pressure
- time management
- communication skills
- empathy and compassion
- problem solving
- professional integrity
- decision-making
- teamwork.

Other relevant skills some doctors will have gained are leadership, management or teaching. These skills lend themselves to hundreds of non-medical careers, but as most doctors are seeking roles utilising their medical knowledge and experience we focus on careers that utilise those skills. These include scientific, academic, technological, advisory/consulting, managerial and administration, media, retrieval, public health, health advocacy/education, other non-clinical medical roles and many more.

In future editions of Vicdoc we will publish a series of career conversations with doctors who have successfully embarked on a new career path and more detailed information about alternate medical careers available. We would also love to hear your stories if you have made such a change.

In the meantime, if you would like some assistance in investigating an alternate career path, please book a free 15-minute career call (available to AMA Victoria members only) or a career coaching session via our website amavic.com.au/careers-advice

Carolyn Speed
Careers and Pathway Consultant

AMA INSURANCE SERVICES VICTORIA

Planning a trip

Get quality **AMA Travel Isurance**

AMA Corporate Travel

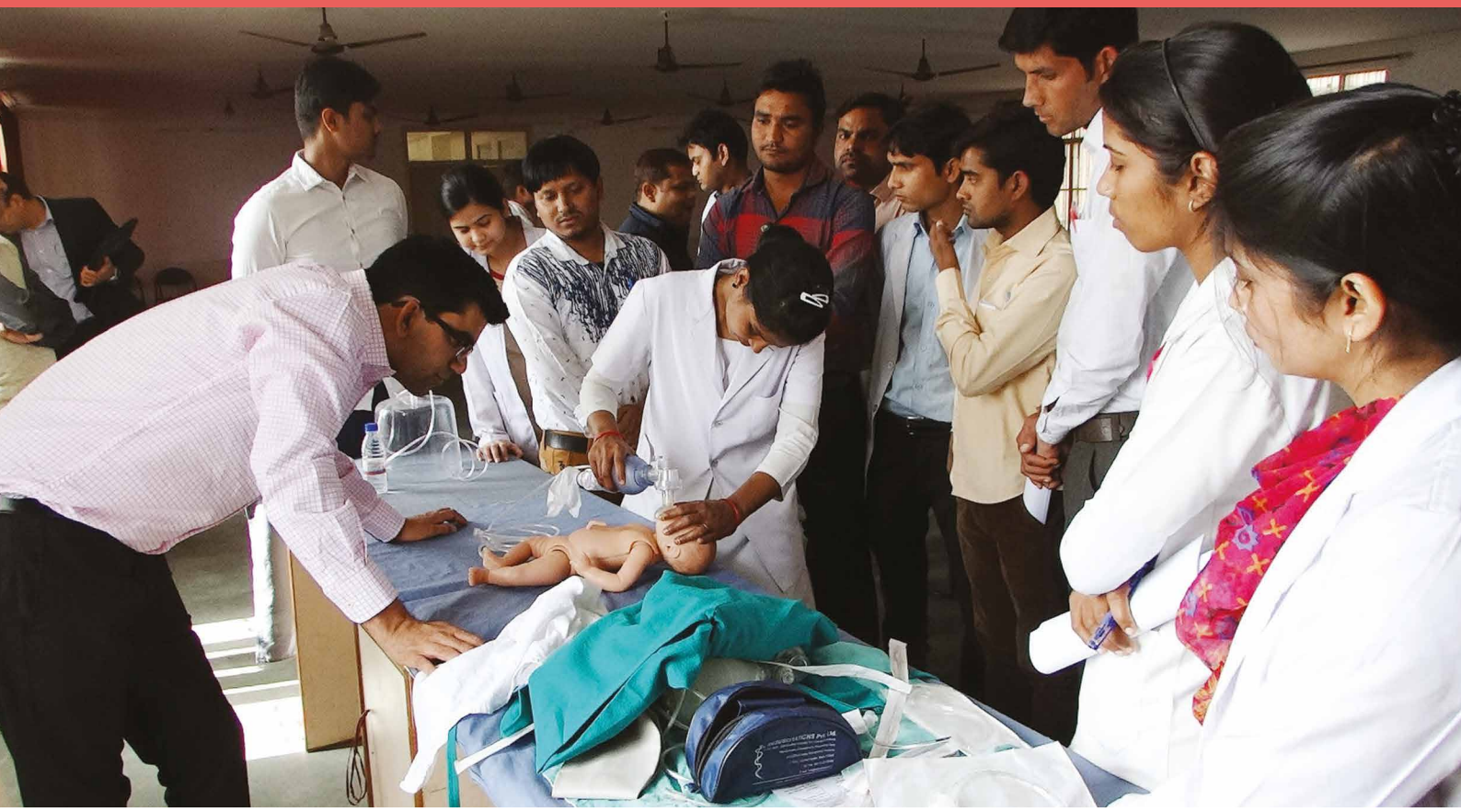
~~$750~~ **$440***

Single Trip Travel Insurance options also available contact us for more details.

Things happen. Exceptional value and protection, that's the AMA pledge.

Call **1800 AMA AUS (1800 262 287)** or visit **amainsurance.com.au to learn more...**

Member profile: Childbirth training in the developing world



Dr Atul Malhotra (left) runs a training session in India.

Dr Atul Malhotra works as a neonatologist at the Monash Children's Hospital, among a number of other interesting roles.

After beginning his medical training in his homeland of India, Dr Malhotra furthered his education in the United Kingdom before settling in Australia around 15 years ago. Deeply concerned about the training gaps in maternal and neonatal health in his country of birth, Dr Malhotra initiated a life-saving program in India, which he now runs with his obstetrician wife, Dr Arunaz Kumar, to help combat this. He spoke to Vicdoc about his work.

I love science and I love spreading it. We sometimes take things for granted and we don't always understand why things happen. If we don't understand the why, then how can we improve them? When I was training in India, I used to think there is so much work to do, but I never used to stop and think why are so many people getting sick and why is it so much worse compared to the developed world? Now when I stop and think, I still have many questions but luckily also a few solutions! There are things that can be done on a basic level that can really affect outcomes in a big way.

Tell us about the program you run in India.

For the past three years, every few months we've been going back to India to run workshops in communities which may be attached to medical universities or hospitals but are under-

resourced and under-staffed to run education programs.

The key focus is to have a safe childbirth for the mother and a safe start to life for the baby. There is nothing new or novel about it. We aim to do it in a manner that sticks in their memory so they are equipped to a handle a situation, instead of having to learn on the job. One of the biggest killers in these communities is post-partum haemorrhage. Much of the work on the obstetric side is to develop better understanding and insight into how to manage blood loss in an acute situation.

I'm a senior lecturer with the department of paediatrics at Monash University and I teach a lot of med students, nurses and post-graduates, so the educational role comes fairly natural to me. My three main roles are as a clinician, researcher and educationalist.

In India, after receiving some funding from the Bill Gates Foundation for ground-breaking intervention for neonatal brain injury, I realised I needed to move back one step and help improve their medical education first, before we could start translating our first world work into those communities. We wanted to make a good platform with basic education for healthcare first.

In most of the developing world, it's the basic things that are not being done right. I wanted to teach them how to look after women and newborns in a standard way first, before introducing new therapies.

What level of training do maternal health workers usually have in India, before seeing patients?

They get into medical or nursing school and get a standard degree, but following that they are put straight into the deep end, and start working without any hands-on training. They are made part of the workforce and expected to learn on the job. The biggest contribution in maternal and child mortality comes from India and parts of Africa.

When we first started our workshops, they were so grateful for us just being there and teaching them these things. They could be in their first month out of university and straight into a clinic, looking after women and babies and somehow expected to learn it on the job.

It's been a great experience for me. I have been doing it for the last three years and my wife has come on board in the last couple of years. We are able to contribute to a huge number of people. They look after thousands

Dr Arunaz Kumar (right) conducts a childbirth simulation session.

of people in just one jurisdiction. We've done training in Punjab, Uttar Pradesh and (soon in) Rajasthan and each of these states has a population larger than Australia. There's a huge amount of people that we can impact.

When you studied in India, were you aware that western medical training was much more advanced?

I initially trained for my own medical career 20 years ago in a big hospital in Delhi and as an intern and junior resident, there was hardly any skills training for us. Simulation was unheard of back then and even now it's hardly used.

In Australia, simulation training usually starts in year three or four of medical university and when the students come into our clinical rotations we get them to do some front loading clinical skills training before they get access to patients.

The advances in the way doctors and nurses are trained in the last 15 years in developed communities has gone much faster compared to the developing world. The biggest deficiency is a lack of trainers, so our focus has been to train the trainers. If we can train some master trainers, they can keep training others to do the job once we leave. If we can raise more awareness of our work, hopefully we can get more support and expand the program.

What are your main objectives for raising awareness about the program?

We are trying to raise awareness in the scientific and medical communities. The RACP has been really kind to me (funding support), as has Monash University. While extra funding is always helpful, we want to raise awareness about our work because there are a lot of doctors out there who want to do something to help, but don't necessarily know how.

We have doctors and nurses going to Laos, Cambodia, Vanuatu and Papua New Guinea with existing volunteer programs who are starting to use our simulation models and our training packages. With the funding and support we have received, we have a couple of models dedicated to our program called OneSIM – obstetric and neonatal emergency simulation. That's been fantastic!

What other work do you focus on?

I work at Monash Children's Hospital as a neonatal intensivist. I have been working part-time as a consultant for the past few years while I pursue my research interests. I'm a basic scientist, which means I do animal research and laboratory work at the Hudson Institute. Most of our work is translational in nature - we take the problems from a baby and replicate them in an animal. We use similar equipment and similar techniques as you would in the hospital. I mostly work with sheep because the sheep brain is very similar in structure to the human brain.

What do you enjoy most about your work?

Without a doubt, saving lives! I am directly involved in saving lives in the NICU but after that the most exciting work that I do is to actually take the problems back to the lab and try to devise new ways to help sick babies. I also educate doctors and nurses about how we can equip ourselves better to save lives. It's a circle for me and I'm lucky at Monash to have the opportunity to do all this work together.

For further information or if you want to contribute in any way, email atul.malhotra@monash.edu or arunaz.kumar@monash.edu

Real-time prescription monitoring in Victoria

Harm from non-medical use of prescription medicine is a rapidly evolving public health problem in Australia. For the last five years more Victorians have died from overdose involving prescription medicines than from traffic accidents or overdose involving illicit drugs.

Currently a person can obtain high-risk medicines from many different doctors and pharmacies without each knowing about the supply by others, and potentially receive unsupervised, uncoordinated, and risky high doses of these medicines beyond therapeutic need.

To reduce deaths and harm from prescription medicine misuse, the Victorian Government is implementing a real-time prescription monitoring system, an essential tool to provide information during a consultation to doctors and pharmacists about their patient's up-to-the-minute dispensing history of high risk prescription medicines, to support safe prescribing and dispensing of these high-risk medicines and ensure better patient safety.

The system will monitor prescription medicines that are causing the greatest harm to the community. Based on local and international research and recommendations by an expert advisory group, the system will monitor all Schedule 8 medicines, all benzodiazepines, Z-drugs (zolpidem and zopiclone), as well as quetiapine. A literature review report is published on the RTPM website (address below).

Due to the limitations of the existing Commonwealth software, specific fit-for-purpose software will be built for Victorian clinicians allowing minimal disruption to their workflow so you can maximise your time with patients. At the same time, Victoria will continue to work with Commonwealth and other jurisdictions towards a solution to share data nationally to prevent cross-border prescription drug-seeking.

A significant part of the initiative is the development of comprehensive training and education for doctors and pharmacists. Western Victoria Primary Health Network has been engaged as lead for a consortium comprising all Victorian Primary Health Networks together with NPS MedicineWise, to develop and deliver this training. Prescribers and pharmacists will be able to access online modules on demand. A number of face-to-face workshops will also be offered based on priority and demand.

Prior to the implementation of the software, a comprehensive campaign will be launched to raise public awareness about the problem and prepare consumers for the change.

The system will be rolled out in phases commencing in 2018 and made available to GPs, community pharmacists, prescribers and pharmacists in hospital emergency departments and outpatient clinics across Victoria.

For more information refer to the real-time prescription monitoring system website:

www2.health.vic.gov.au/public-health/drugs-and-poisons/real-time-prescription-monitoring

Accessing unapproved medicines and devices for your patients – what's changed?

It's now easier for doctors to access unapproved therapeutic goods for patients who need them. The government schemes which allow doctors to access unapproved therapeutic goods, such as medicines, biologicals and medical devices that haven't been approved in Australia, have been simplified and streamlined.

Most therapeutic goods need to be evaluated for quality, safety and efficacy by the Therapeutic Goods Administration (TGA) before they can be supplied in Australia. However, sometimes patients can benefit from therapeutic goods that have not been approved by the TGA. For example, there may be medicines that have been approved for use in other countries but not yet in Australia, or a manufacturer may not offer a particular device in Australia.

Since 3 July, two of the programs managed by the TGA – the Special Access Scheme and the Authorised Prescriber program – have become easier for doctors to navigate.

The biggest change is to the Special Access Scheme. Health practitioners can now simply notify the TGA if they are planning to treat a patient with a therapeutic good which has an established history of use in a country similar to Australia. The TGA provides a list of which goods meet this criteria, along with their indications and the type of health practitioner authorised to supply them.

Separate lists for these medicines, medical devices and biologicals are available via www.tga.gov.au/form/special-access-scheme and are updated regularly.

Health practitioners still need to apply to the TGA to access unapproved therapeutic goods that are not on the TGA's list. And health practitioners can still use the existing notification process when treating patients who are seriously ill with a terminal illness.

Detailed information about the Special Access Scheme including user guides and a frequently asked questions section are also available on the TGA's website. You can also contact the TGA on 1800 020 653 and SAS@health.gov.au.

Changes have also been made to the Authorised Prescriber program to streamline the application process and increase the potential period of approval. Under this program, the TGA can grant a doctor an authority to become an 'Authorised Prescriber' of a specific unapproved therapeutic good (or class of unapproved therapeutic goods) to specific patients (or classes of patients) with a particular medical condition.

Doctors now no longer need to submit to the TGA, as part of their application, the clinical justification for evaluation because the TGA will accept the approval already granted by a human research ethics committee or endorsement by a relevant specialist college.

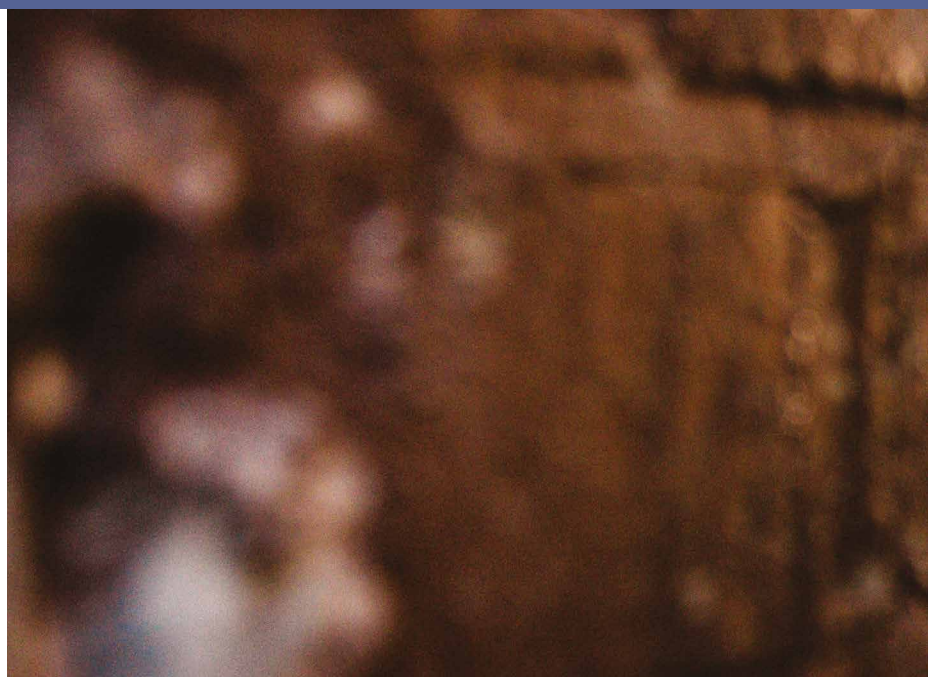
In addition, applications to become an Authorised Prescriber of therapeutic goods which the TGA considers have an established history of use, will be eligible for a longer authorisation period. The maximum authorisation period will increase from one year to two years for medical devices and from two years to five years for medicines and biologicals.

Detailed information about the Authorised Prescriber program including application forms and guides are available via www.tga.gov.au/form/authorised-prescribers. You can also contact the TGA on 02 6232 8101 and eps@health.gov.au.

If you want more information about accessing medicinal cannabis, detailed information is available from www.tga.gov.au/access-medicinal-cannabis-products.

Georgia Morris
Senior Policy Advisor
Medical Practice Section
AMA Federal

Looming mental health crisis after funding change



A crisis is looming for people with mental health conditions in Victoria due to the withdrawal of community based rehabilitation support as the National Disability Insurance Scheme (NDIS) rolls out.

cohealth fully supports the NDIS principles of increasing consumer choice and control and we welcome the opportunities for support that it will provide to some. However, the associated funding changes that come with including mental illness in NDIS mean there will be service gaps.

Victoria is the only state that has transferred funding for community managed mental health services to the NDIS. This means the state loses funding for Mental Health Community Support Services (MHCSS) – a key part of the mental health system that delivers community based psychosocial rehabilitation services. Many people with mental illness rely on the supports provided by MHCSS for stability and to live successfully in the community.

Once funding ceases for these essential community based mental health services (as the NDIS rolls out) there will be no service to replace them. The potential repercussions of this funding shift are significant. cohealth, along with many other organisations, anticipates that, in addition to the loss of support for many individuals, a greater burden of care will fall back on carers, primary health providers and acute services.

The Federal Government has made it clear that it is not the intention of the NDIS to support everyone with a psychosocial disability. And indeed, the practical disability support services that the NDIS provides are quite different in nature from the support provided by psychosocial rehabilitation services. Similarly, while clinical mental health services remain, and have recently received some welcome additional funding, they have a very different role (treatment, medication and stabilising a person's condition) – although complementary – from Mental Health Community Support Services. Specialist providers rely upon these services to assist in maintaining individuals in the community.

The impending loss of MHCSS is a source of increasing anxiety and distress for people who rely on these services, their carers and health workers. NDIS supports are not a replacement for the vital psychosocial community based services that cohealth and others deliver in local communities. These services are highly accessible and flexible and are best-placed to support people who are recovering from mental illness, enabling them to live at home and participate in community life.

We know that people living with a mental illness have poorer health, receive less healthcare and lower quality healthcare, and die earlier than the rest of the population. A clear advantage of providing mental health support in a community health setting, as cohealth does, is that we are ideally placed to address physical and social needs in addition to the mental health needs.

The people who use cohealth's mental health services can be linked in with general practitioners, nurses, allied health (physiotherapy, occupational therapy, dieticians, podiatry, and diabetes education), oral health services, alcohol and drug services, health promotion and community engagement activities. It is this holistic, wrap-around support that helps many people who live with severe mental illness to be physically well, positively

engaged in the community, and to lead a contributing life.

Critically, cohealth provides priority access to health services for mental health clients and encourages collaboration between cohealth mental health and allied and primary health services through the use of case presentations, case conferences and service coordination.

Our support for people experiencing mental health issues is provided in a range of different ways: outreach, meeting people in their homes or community settings; residential programs; group programs and activities; programs that link people into their community and enhance life skills; peer supports and advisors; and specialised outreach support for people who are also experiencing homelessness.

Regardless of how this support is provided, the common thread is our person-centred, recovery oriented approach.

Sadly, we will no longer be able to provide most of these services as the NDIS rolls out. NDIS is a disability service, not a mental health service, and was not intended to provide services to all people with mental health issues, yet all community based funding for mental health in Victoria (as well as Commonwealth funded support) has been rolled into NDIS.

Victorian mental health peak body, VICSERV, estimates that as many as 10,000 Victorians living with mental illness will be unable to access an appropriate service when the NDIS is fully implemented.

Other states have retained funding for community managed mental health services to provide psychosocial rehabilitation services, maintaining an integrated system. Victoria is on the cusp of losing a critical component of the system that should support all people with a severe mental illness.

As a carer said on hearing that we could no longer provide their child's trusted support worker as the NDIS rolled out in their area: "It really could be the difference between life and death. You simply don't play with systems that have the ability to intervene, promote hope and prevent suicide".

Significant investment in specialised psychosocial rehabilitation supports is needed to make up for the changes in service provision that will flow from the NDIS roll out.

We continue to advocate for the Victorian Government to adequately resource community managed psychosocial rehabilitation services in order to enable Victoria to realise the vision of its 10 Year Mental Health Plan – that "all Victorians experience their best possible health, including mental health".

Lyn Morgain

Chief Executive

cohealth

cohealth is a leading provider of public health and social support services in Victoria.

cohealth.org.au

Avoiding complaints

"To err is human, to forgive, divine." – Alexander Pope

Each day, thousands of medical practitioners head to work with the sole purpose of helping their fellow human beings. The job is rewarding, diverse and at times frenetic, with a vast array of problems presenting in any one shift. So how do we avoid the downside of this wonderful occupation, the inherent risk of medico-legal complaints?

Transparency, compassion, apology, and accountability – these are the keys to avoiding the prolonged and stressful process of litigation. The truth is that most of our patients will forgive us our mistakes if we are honest and humble when we inadvertently make them. They accept we are doing our best and that negative outcomes are sometimes unavoidable despite our best efforts.

Complaints

So why do some patients sue and not others? Generally, complaints occur when our patients feel their concerns are unheard or dismissed. This brings about feelings of mistrust and the need to blame medical professionals for an adverse outcome.

Contrary to the belief that greedy patients and their greedier lawyers are after compensation, the most common reason for litigation is for patients and their families to receive acknowledgement that an error occurred and an explanation of the incident with a view to preventing a similar incident in the future.

Consultations and communication

How can we achieve this in a 10-minute consultation? The University of Toronto's Dr Wendy Levinson revealed in a landmark study in 1997 that the chief difference between general practitioners who had never been sued and their peers who had been sued more than twice was entirely in how they talked to their patients.

The doctors who had never been sued spent more than three minutes longer with each patient, and they were more likely to make orienting comments such as, "First I'll examine you, and then we will talk the problem over" or "I will leave time for your questions." They were more likely to engage in active listening, saying things such as, "Go on, tell me more about that." And interestingly, they were far more likely to laugh and be funny during a visit.

Claims

So, despite doing our best to communicate with our patients, what do you do if you are facing a claim? Contact your medical indemnity insurer (MII) as soon as you are concerned about a possible adverse outcome that may arise in a claim. Your MII should be there to support you, and will help collate information to assist with defending a claim at a time when the details of the event are still fresh in your mind.

The importance of records

Do not alter your records. This is as good as admitting liability! I cannot emphasise enough the importance of good record-taking, despite how busy our day gets. It is only with good records that any potential case can be adequately defended. Particular emphasis on recommendations given to the patient if the condition is not improving is an essential part of the medical record.

This fact is highlighted by a recent case of a 12-month-old girl who developed meningococcal septicaemia more than 12 hours after presenting to her GP. Experts agreed it was not predictable that the child would go on to suffer catastrophic injuries including bilateral amputations. Despite this, the case was settled for a large sum without proceeding to a court hearing.

The doctor said he provided clear and concise information to the parents on the appropriate action to take if the condition was not improving. The girl's parents disputed this and, unfortunately, it could not be substantiated in the GP's notes.

So do not go forth and conquer. Go forth and communicate, and be compassionate and caring.

Dr Natalie Sumich
MDA National
State Advisory Committee Member

Contacting your MII is not an admission of error. It is an opportunity to discuss your case with a non-judgemental peer, who will help you come to terms with an adverse outcome to your patient with the aim of preventing the case proceeding to litigation. This can often be avoided by simply acknowledging that the patient and/or family has suffered an unfavourable outcome, which we all wish could have been avoided.

MDA National
Support Protect Promote

References available from the Editor on request.

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

AMAzing opportunity to save on your home loan

We understand how busy you are. That's why we developed a customised service for members of the AMA Victoria who are committed to growing their wealth. Premier Banking offers access to a wide range of financial services and specialists from across the group including a Personal Relationship Manager who understands your financial goals and helps you with your day to day banking.

For more information about how we can save you money and tailor a home loan solution that meets your needs please contact:

The Membership Team
AMA Victoria
T: 03 9280 8722 E: cba@amavic.com.au for a confidential discussion

AMA VICTORIA

Can

Sick leave needs to become a viable choice

"I would have to be almost needing admission into hospital myself before I would call in sick."

The above sentiment is all too commonly heard among junior doctors working in our public healthcare system. I have not only heard others express similar views, but have uttered similar words myself. I am not proud of these words.

Because pushing ourselves to work when we are physically or mentally not coping with the workload is not smart. Yes, perhaps our commitment to our jobs in the face of personal illness reflects a form of resilience. But it is very likely that, over the long-term, such an attitude will compromise our ability to look after ourselves, and unfortunately, our patients.

As doctors, we know the importance of rest and recovery. We write medical certificates on a daily basis, allowing our patients the opportunity to prioritise their own health over the demands of their workplace. Yet so often we deny ourselves the same right.

We are not a superhuman species for whom the regular rules do not apply. We are no more exempt from the effects of illness, fatigue and burnout than the rest of society. And if the data on medical student and doctor mental health is anything to go by, a great proportion of us are struggling with the demands of our job.

Our reluctance to take sick leave outside of some of the direst circumstances is a sign of a system that is failing the junior medical workforce.

Our hospitals are well-oiled machines with an absurdly small repository of spare parts. If one part needs maintenance, the entire system struggles to cope. So when the parts experience a little wear and tear, they are left in the machine. And they stay there, even if their work is suboptimal. Sometimes they stay there even if they are broken.

A system that lacks contingency is fragile. This fragility lies at the core of doctors' inability to take sick leave.

When we go to work feeling unwell, tired, or burnt out, often it is not because of some false bravado. It is not simply a 'cultural problem'. It is because we know there will be no cover. Calling in sick feels like a betrayal. We work in small teams during the day, and usually every team member is working hard to meet the bare requirements of their job. Calling in sick leaves the remainder of your team with an impossible workload. Patient care could be delayed, or worse, entirely compromised.

So when the alarm goes off in the morning, we do not rationally choose to go to work rather than opt for rest. It does not feel like a choice. We could not possibly call in sick. We cannot leave our colleagues unsupported. More importantly, we cannot leave our patients.

What is the solution? As is so often the case, funding lies at the core. The system needs redundancy, but redundancy is expensive. Hospitals may be reluctant to hire expensive locums to cover unexpected leave. While most networks have relievers on the roster, they are often spread thinly in coverage of expected leave.

We know there is a surplus of doctors graduating medical school – so many that our training programs are flooded. We also know there is an increasing desire for part-time and casual employment, to enable flexibility while training. We need to channel this opportunity into a repository of relievers and locums who can be called upon on short notice to cover an unwell member of the junior medical staff.

If you were unwell, and you knew that calling in sick (with reasonable notice) would result in your unit being staffed by a competent, willing and well remunerated covering doctor, would you feel more comfortable taking the day off? I certainly would be.

Our reluctance to take sick leave does not have a cultural aetiology. It is a cultural complication from an under-resourced system. But this solution is remote to our day-to-day choices. Our choice feels simple. The system is what it is, and self-sacrifice comes all too naturally to many of us.

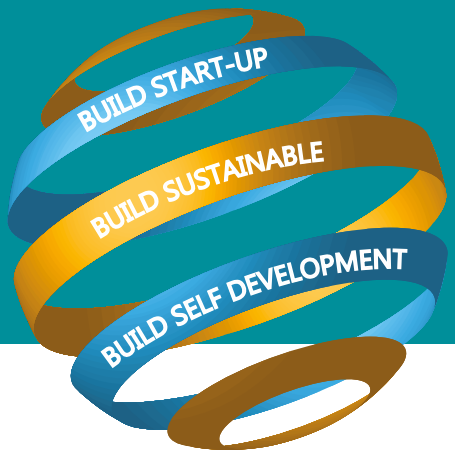
Finally, to my junior doctor colleagues – let us not judge each other when we are unwell. There is often a sense of annoyance when we are called in to work on our days off, sometimes even when we are not officially 'on call', because a colleague has called in sick. It is natural to feel frustration. But this frustration should not be directed towards our colleagues, who are unwell and smart enough to know that they need time off.

Let us focus our energies on searching for solutions. Chat to your workforce unit. Perhaps your health service needs a locum bank. Perhaps it needs more staff on a relieving roster at any given time. Or perhaps the State Government needs to be pushed to provide dedicated funding in order to introduce more spare parts into our hospital machines.

For the sake of our own wellbeing, sick leave needs to become a viable choice.

Dr Kunal Luthra
Former President
DiTs subdivision

If you are experiencing any concerns with sick leave or any other workplace issues, please contact the AMA Victoria Workplace Relations Unit on (03) 9280 8722.



BYPC&E 2017

BUILD YOUR PRACTICE CONFERENCE AND EXHIBITION

The Build Your Practice Conference & Exhibition (BYPC&E) 2017 took place on Saturday 23 September at the Melbourne Convention and Exhibition Centre. Over the past few years BYPC&E has grown significantly, and this year's event was another huge success, with more registrations and exhibitors than ever before.

This year the conference was separated into three streams of learning:

- Start-up – to establish a robust private medical practice
- Sustainability – for a practice that is financially viable long-term
- Self-Development – which deals with the human side of general practice. The Self-Development stream was a new addition to the conference, because we recognised that personal issues are as critical as financial issues.

The conference offered an exceptional team of presenters, from practice owners and business people to seasoned industry experts. They delivered valuable content and relevant case studies as they covered areas such as business planning, finance, marketing, legislation, risk management, resilience, dealing with patients and women in general practices.

Media personality Dr Sally Cockburn successfully reprised her role as Master of Ceremonies. The keynote speaker, Dr Kean-Seng Lim, delivered an insightful speech entitled, "Vision for Your Practice – The Ultimate Why". There was also an interactive panel, which focused on future trends in medical practices, to close the conference. The expert panel included Dr Mukesh Haikerwal AO, Dr Joseph Sgroi from Clinic to Cloud, Matthew Cherian from Global Health, Anna-Maria Gibb from Practicehub and Dr Magdalena Simonis, a GP researcher with the University of Melbourne. We received a great deal of positive feedback about the conference and its presenters.

At the exhibition, delegates had the chance to meet with a wide range of organisations and learn about various products and services on offer to assist with the building of a private medical practice.

AMA Victoria would like to thank all sponsors, including our major sponsor, MDA National, and professional partner, AAPM. We would also like to thank the delegates, exhibitors and speakers who attended the event. We hope those who attended took something valuable away from the day, and look forward to seeing you again next year.

James Masters
Digital Marketing & Engagement Officer

MAJOR SPONSOR

MDA National
Support Protect Promote

PROFESSIONAL PARTNER

aapm
Australian Association of Practice Management
excellence in healthcare management

SPONSORS & EXHIBITORS

JOSE HEALTH IT
COMPLETE IT CARE FOR HEALTH PROFESSIONALS

William Buck
CHARTERED ACCOUNTANTS & ADVISORS

TAC Transport Accident Commission

MEDICAL MEDIA

AOGP Serving health professionals

AUSTRALIAN Clinicalabs

Levitch Design Australia

COOPER GROUP australia

Xcllusive Business Sales

SOUNDMASK

CBRE

P+S Business Brokers

THE THREE SEAS GROUP

VConsult VIRTUAL CONSULTING ROOMS

Innovative Pharmacy Solutions
The business of Pharmacy

tonic HEALTH MEDIA

GLOBAL HEALTH Connecting Clinicians and Consumers

WorkSafe VICTORIA

miga ALWAYS

practicehub by MAvant

Clinic to Cloud

doctors health fund

CommonwealthBank

PRUSHKA FAST DEBT RECOVERY NO RECOVERY - NO CHARGE

Hoxton MPM

Exclusive Member Benefits

Commonwealth Bank

(03) 9280 8722 amavic.com.au/cba

Member benefits:

- Banking specialists who listen to your needs and deliver solutions — not products.
- Exclusive rates and offers on your banking
- A full suite of services — from lending and investments to risk management.
- Support: 24 hours a day, 7 days a week.
- Fast access to your cash when you link your CommBank merchant facility to a CommBank Business Account.

Terms and conditions apply.†

MDA National

1800 011 255

Member benefits: Discounted and complimentary medical indemnity insurance for eligible doctors in training. Greater access to education and promotion of doctors' health and wellbeing and collaborative events and activities of interest.

BMW Melbourne

(03) 9268 2222

Member benefits: Complimentary BMW service inclusive up to 5 yrs 80,000kms/ Complimentary use of BMW during scheduled servicing/ Door to door pick up during scheduled servicing/ Corporate pricing/ Reduced dealer deliver charges/ Exclusive finance rates offered by BMW Financial services/ BMW Advantage benefits extended to your spouse/ Reduced rate on BMW Driving Experience course.

Virgin Australia Lounge

1300 133 655

AMA members are entitled to great discounts and special rates. Partners of AMA members can also enjoy the Virgin Lounge at special rates.

Member benefits: Discounted Virgin Australia Lounge membership for AMA members – Joining fee $100 (save 230, annual fee $300 (save $120 per year).

Avis / Budget

(03) 9280 8722

AMAV members have access to a set rate usually only offered to corporate renters.

Member benefits: Valid all year round with reduced excess levels; earn Qantas or Flybuys points; free Avis preferred membership; exclusive 10% discount for Australian car rentals.

MyHealth1st

1300 266 517
MyHealth1st.com.au/ama

Member benefits: Online appointment booking solution, no costs for members (standard fees are $50-$75/practitioner/ month); free listing and online bookings through MyHealth1st.com.au and mobile app; free training & installation; integration with existing practice management software system; plus more!

TressCox Lawyers

(03) 9280 8722

Legal advice from one of the largest and most experienced health law practices in Australia. First contact must be made through AMA Victoria.

Member benefits: Receive an initial free over the phone consultation for routine medico-legal matters.

Wakelin Property Advisory

(03) 9859 9595

Wakelin Property Advisory finds and negotiates the purchase of the highest quality residential property in Melbourne for our clients to invest in with the objective of maximising return. We also offer home buying and vendor advisory services.

Member benefits: Discounted AMA Victoria-negotiated VIP rate across our services. Please call for details.

Qantas Club

1300 133 655

Member benefits: Save $140 off the joining fee; save $119.30 off 1 year membership or $227.50 off two years of membership

Devereux Recruitment

1300 99 5627

Member benefits: Access to professional recruitment services with discounted permanent placement fees and extended guarantee periods.

Member Permanent Placement Fee: 10% of Total Employment Cost

Member Guarantee Period: Doubled to 6 months

devereuxrecruitment.com.au

William Buck

(03) 9824 8555

Strategic accounting, taxation, superannuation & wealth advisory professional services for doctors.

Member benefits: Receive initial complementary consultation and discounted rates on certain serv ices.

Little Real Estate

(03) 9514 8992
property.littlerealestate.com.au/amavic

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

PRUSHKA

(03) 8872 5982

Prushka Fast Debt Recovery is the leader in collecting medical debts. Prushka operates on a No Recovery - No Charge basis, so all you pay is commission on monies recovered - from 11%.

Member benefits: Receive an ongoing discount of 10%.

Reho Travel

(03) 9823 5222

The only B Corp certified travel management company in the world, we use the power of business as a force for good.

Member benefits: 5% discount on a wide range of tours from a selection of operators; 10% discount on travel insurance; free Tesla airport transfer (up to 35km) for business class travel; Spot Specials – exclusive AMA Victoria member deals.

UptoDate

1300 133 655

UpToDate is the evidence-based, physician-authored resource doctors in training and physicians trust for reliable clinical answers.

Member benefits: One year subscription discount: Trainees save US$45. Professionals save US$75. Further discount for two year subscriptions available.

AMA Insurance

1300 763 766

Intelligent insurance advice and services at competitive prices tailored specifically to the needs of the medical profession.

Member benefits: Free advice / Best available rates / 30 years experience in serving the medical profession.

AMA Training

9280 8722

Comprehensive education and training for the medical industry. RACGP CPD courses and customised training for medical practices.

Member benefits: Generous discounts across all offerings.

AMA Auto Solutions

9280 8722 amavic.com.au/autosolutions

A one stop auto-tendering service tailored specifically to the needs of members.

Member benefits: Substantial discounts on new vehicles, as well as on financing, accessories and insurance. All provided with excellent customer service.

AMA RTO

9280 8722 www.amarto.com.au

As a wholly owned subsidiary of the Australian Medical Association (Victoria), AMA RTO works to uphold the core values of Quality, Integrity and Community. Offering VTG subsidised courses including Certificates III & IV in Health Administration, Diploma of Practice Management, Diploma of Business & Diploma of Business (Marketing).

Member benefits: Substantial discounts on courses — specifically designed to upskill your practice staff.

TERMS AND CONDITIONS

Commission Statement AMA Victoria and its related entities at times receive income from commissions paid by service providers that provide commercial benefits to members. This income allows us to provide improved services to members and keep subscriptions to a minimum. Also see our privacy policy at amavic.com.au.

COMMONWEALTH BANK TERMS AND CONDITIONS

† Offers available to referrals made via AMA Victoria. AMA Victoria may receive a fee from the Commonwealth Bank of Australia for each successful referral. Referral fees are not payable on referrals from existing relationship managed Commonwealth Bank customers. This information has been prepared without considering your objectives, financial situation or needs, so you should consider its appropriateness to your circumstances before you act on it. Terms and conditions are available from commbank.com.au Commonwealth Bank of Australia ABN 48 123 123 124. Australian credit licence 234945.

An evening with the President

This year's 'Evening with the President' was hosted at the Hotel Windsor's Grand Ballroom. The cocktail event offered key stakeholders the opportunity to network with AMA Victoria and receive an update from President Dr Lorraine Baker about some of the work undertaken in 2017.

McLaren
MELBOURNE

Once a dream. Now a reality.

From $357,900 drive away.*

The McLaren Sports Series features a 3.8 litre mid-mounted turbocharged V8 engine, with a lightweight carbon fibre MonoCell II chassis. All combining for a class-defining, game-changing, thrill-enhancing, power-to-weight ratio and a sense of control that makes driving pure fun.

No serious competitor. Unless you need to follow the pack?

Visit melbourne.mclaren.com

McLaren Melbourne
388 Swan Street
Richmond VIC 3121
T/ (03) 8420 8888

Exclusive AMA Victoria offer

Receive 3 Years/45,000kms free scheduled servicing# on all new and demonstrator vehicles.
All McLaren vehicles are backed by 3 years unlimited kilometre factory warranty and roadside assist.

* Drive away price based on White McLaren 540C Coupe in VIC. Model shown: McLaren 540C Coupe in McLaren Orange from $361,000 in VIC. #Whichever occurs first. Excludes wear and tear. Exclusive to McLaren Melbourne. LMCT 11527.

ZAGAME

Veterans' Medicines Advice and Therapeutics Education Services

The Veterans' Medicines Advice and Therapeutics Education Services (Veterans' MATES), funded by the Department of Veterans' Affairs (DVA), has been improving the health of the Australian veteran community since 2004. Our veteran community currently consists of approximately 200,000 veterans, widows and widowers, with an average age of 83 years and five or more chronic conditions per person.

Using DVA health claims data, Veterans' MATES provides you with patient-based feedback about the health services or medicines dispensed to your veteran patients. This information, which targets an evidence practice gap, aims to assist you to care for your veteran patients, and includes information that may not be in your medical records as data are from claims made by all health professionals who care for veterans. To further support you, we provide up-to-date educational materials relevant to the topic. This information is sent to other health professionals, including pharmacists and aged-care facilities, to encourage consistent care and advice. One month after materials are mailed to you, the veterans are mailed educational material specifically designed for them, which encourages them to visit their doctor to discuss the topic.

Our program has delivered 47 topics, and involved more than 290,000 veterans, 32,000 doctors and 8,500 pharmacies and accredited pharmacists across Australia. Topics have included oral anticoagulants, statins, heart failure, diabetes, renal function, insomnia and chronic obstructive pulmonary disease.

Our latest topic focuses on wound management. DVA fund many wound dressings for veterans, and to assist you and your practice nurses in appropriate dressing selection, DVA have created a wound care website www.dva.gov.au/woundcare. The Veterans' MATES topic on wounds was released in June this year. It highlights the importance of using compression therapy for the treatment and prevention of venous leg ulcers, and the application of a moisturiser twice a day to reduce the risk of skin tears in older people.

Putting the pressure on venous leg ulcers

In Australia, it is estimated that 3% of the population over 60 years of age are affected by venous leg ulcers, of which 70% will have a recurrence of their ulcer within 15 years. Venous leg ulcers can be painful, slow to heal and socially isolating for the patient, causing them significant distress and greatly reducing their quality of life. When patients receive best practice care, over 70% of venous leg ulcers are healed within 12 weeks.

Compression therapy is the cornerstone of venous leg ulcer management; it improves healing rates and prevents recurrences. A randomised controlled trial found venous leg ulcers heal significantly faster with compression therapy, compared with no compression therapy (see Figure 1). However, a large proportion of patients with a venous leg ulcer do not receive compression therapy, do not persist with it or do not wear medical-grade compression hosiery after the ulcer has healed. Venous leg ulcers almost always recur unless ongoing prevention is maintained.

Some patients find compression therapy restrictive, uncomfortable, stigmatising and costly. We encourage you to talk with your patients about the need, application and benefits of using compression therapy and the risks associated with not using it. We have provided some strategies for you to encourage patients to commence and persist with compression therapy.

Eligible veterans are able to receive compression bandages and hosiery as well as aids to help apply their hosiery for free through the DVA Rehabilitation Appliances Program (RAP) schedule. For further information, go to www.dva.gov.au/sites/default/files/files/providers/rap_schedule.pdf

Compression therapy should be applied by a health professional trained in the application of compression bandages. Bandages incorrectly applied can result in delayed healing or cause increased pain, tissue damage, skin necrosis and even amputation. You can find a health professional trained in applying compression bandages through:

- the Community Health Nursing services, at the DVA website: www.dva.gov.au/providers/community-nursing
- hospital wound management clinics or leg ulcer clinics
- hospital wound management specialist nurses

- hospital outpatient clinics
- wound nurse consultants or wound management nurse practitioners
- Wounds Australia website www.woundsaustralia.com.au/pages/wac.php

Things the patient can do themselves to promote wound healing include eating a healthy diet, elevating the affected leg to heart level when inactive, and heel-to-toe walking and ankle stretches to improve calf muscle function, which assists venous return and reduces oedema. So talk with your patients about what they can do to help their ulcer to heal.

Applying a moisturiser reduces the risk of skin tears

As many as 43% of residents in aged care facilities experience a skin tear. The most common cause of skin tears is trauma, sustained when having adhesive tapes removed, falls and knocking arms and legs against furniture or structures.

Application of a pH neutral, perfume-free moisturiser twice a day to a patient's arms and legs reduced the incidence of skin tears by almost 50% in the aged-care setting. So talk with your patients living at home or in aged care facilities about applying an appropriate moisturiser to help reduce the risk of getting a skin tear. An appropriate moisturiser to suggest that is available to veterans on the Repatriation Pharmaceutical Benefits Scheme is Alpha Keri® lotion.

In caring for veterans with a skin tear, use the TIME assessment, and the STAR Skin Tear Classification System (see image chart) to determine the level of injury sustained and to help guide treatment.

Assess, prepare and dress the wounds

We provide a guide to assessing, preparing and dressing venous leg ulcers and skin tears as a practical tool to help you and your practice nurses. The guide highlights the importance of choosing a dressing based on its function, the wound bed status and the amount of exudate from the wound, when dressing a venous leg ulcer. Applying a dressing that minimises the number of dressing changes for a skin tear and avoiding the application of any adhesive tapes to the wound is critical in preventing re-injury when removing the dressing. Drawing an arrow on the outside of the dressing to indicate which direction to pull when removing the dressing and ensuring the clinician knows the correct way to remove the dressing before doing so is also critical in preventing re-injury.

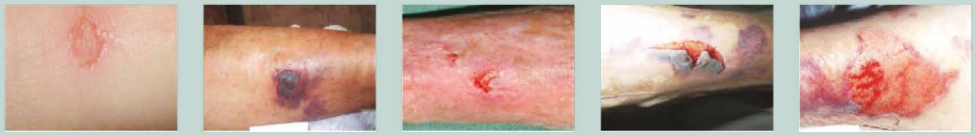
To access further information about this and other Veterans' MATES topics, visit www.veteransmates.net.au

Dr Kerrie Westaway
Medical writer

Prof Elizabeth Roughead
Director of the Veterans' MATES program

Skin tears

The STAR Skin Tear Classification System* facilitates assessment of skin tear injury.



Category 1a: A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.

Category 1b: A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened.

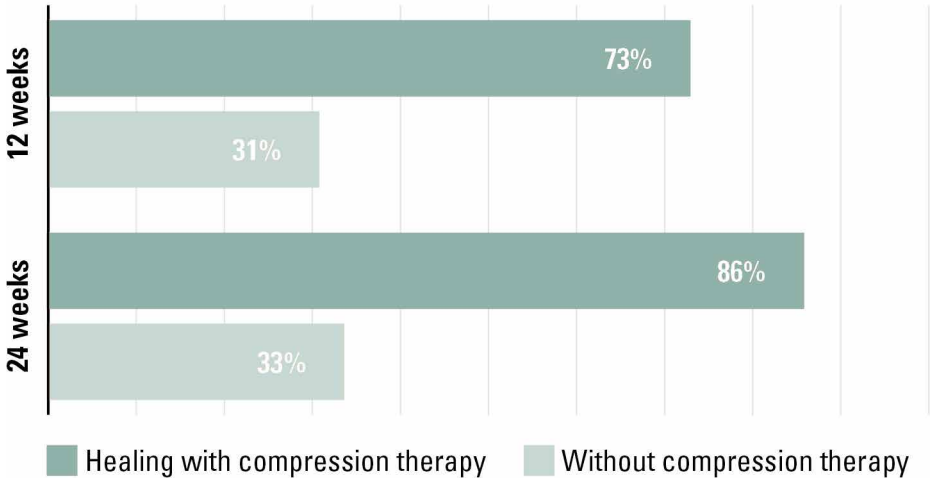
Category 2a: A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky or darkened.

Category 2b: A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened.

Category 3: A skin tear where the skin flap is completely absent.

* Adapted from Skin Tear Audit Research (STAR), Silver Chain Nursing Group Limited, Curtin University, Revised 4 February 2010. Reprinted August 2012. Reproduced with permission.

Figure 1: Approximate percentage of venous leg ulcer healing with and without compression therapy



Acknowledgements

This article is adapted and reproduced from the Veterans' MATES Therapeutic Topic, Wound management: Putting the pressure on venous leg ulcers and reducing the risk of skin tears. The Australian Government Department of Veterans' Affairs Veterans' MATES Program is provided by the Quality Use of Medicines and Pharmacy Research Centre, Sansom Institute, University of South Australia, in association with: Discipline of General Practice, University of Adelaide; Discipline of Public Health, University of Adelaide; Repatriation General Hospital, Daw Park; NPS MedicineWise; Australian Medicines Handbook; and Drug and Therapeutics Information Service. Veterans' MATES Program materials are available at www.veteransmates.net.au. We would like to acknowledge the contribution of the Veterans' MATES writing group in developing the Veterans' MATES materials for this topic.

Free support services from the Leukaemia Foundation

The Leukaemia Foundation is the only national not-for-profit organisation dedicated to the care and cure of patients and families living with leukaemia, lymphoma, myeloma and related blood disorders.

Each year we invest millions of dollars to providing better practical and supportive care for our patients. We endeavour to provide free services to support patients and their families. Our services extend to anyone who has been diagnosed with a blood cancer or a blood related disorder.

What troubles patients and families alike is the hardship that being ill takes on a family. The priority is always the wellbeing and treatment of patients and their families, but no one wants to have to think about the nitty gritty details that come along with it. This is where the Leukaemia Foundation will often step in.

Our Support Services staff, based all around Victoria and Australia in both regional and metro areas are the frontline of our organisation. They make sure that patients are receiving support and advice wherever possible.

Each Support Services team runs free support and education seminars. These programs are designed to empower people who have been affected by a blood cancer or disorder with information regarding diagnosis, treatment and recovery. They also provide an opportunity to hear from specialist doctors and allied health professionals. Lastly, these sessions allow patients to come together with people of similar experiences. So many of our patients agree that the best part of these sessions was the friendships formed afterwards and the ability to talk to someone who understands the situation completely.

Each state Support Services team comprises qualified health professionals. They regularly make visits to each of the major haematology treating centres across the country to support people and their loved ones.

Besides emotional support, the Leukaemia Foundation aims to provide practical support to patients and their families. Our Courtesy Transport Service is available at no cost to patients and is made possible by the sponsorship of Holden, Bridgestone, RACV and Gandel. Holden Commodores are based in five different locations in Melbourne. There is also one vehicle in Shepparton and one vehicle in Launceston. The service runs from Monday to Friday during business hours and is available to take patients and carers to all medical appointments.

The Leukaemia Foundation has a number of accommodation complexes located near major treatment centres around the country. They are designed to be a 'home away from home' for patients, carers and their families who have to temporarily relocate from regional and rural areas for specialist treatment.

The 15 apartments in our 'Building of Hope', located across the road from the new Victorian Comprehensive Cancer Centre and close to Melbourne's major treating hospitals, has been vital in providing the best treatment for our patients. For regional families, not having to travel thousands of kilometres to a medical appointment lifts a huge burden.

To succeed in providing this care and support across the country, the Leukaemia Foundation relies solely on fundraising and donations. Our national campaigns such as Light the Night are excellent ways of raising vital funds to continue to deliver our services.

Light the Night is a unique event bringing Australia's blood cancer community together to remember and reflect during a moving ceremony and short lantern walk. Last year, more than 35,000 people from every Australian state and territory attended 143 Light the Night events. Those attending raise money beforehand to help give local families facing blood cancer the emotional and practical support that will light the way forward.

Light the Night Melbourne was held on 6 October this year, with more than 100 other community events taking place across the country between September and November. Over $280,000 has been raised in Victoria.

To learn more about any of our support services available to patients and their families, please call 1800 620 420 to speak with one of our Support Services team.

Katherine Monotti

Leukaemia Foundation

IVF expert's holistic approach to fertility

For the past four decades, Australia's fertility rates have been declining. Currently one-in-six Australian couples of reproductive age encounter issues with conception, while the number of couples seeking professional help is steadily increasing. Males and females are in fact, equally affected by fertility issues – 40% of infertility is attributed to a female cause, 40% to a male cause, and the remaining 20% to unknown causes.

Leading Sydney-based fertility specialist and gynaecologist, Dr Raewyn Teirney, spent a number of years developing and commercialising a fertility kit that effectively and reliably tracks fertility and ovulation. The conceiveplease™ Fertility Kit represents a one-stop fertility shop, offering a clinically-rigorous, holistic, four-step plan with supporting products and medical devices to assist couples wishing to start or grow a family. Here, Dr Teirney explains her rationale for developing the kit.

There's a raft of reasons for why couples are turning increasingly to clinicians for fertility-related advice. For many couples, it's an age factor. Thousands are placing their parenting plans on hold to cater for their burgeoning careers, while others are motivated by social and lifestyle-related reasons. Even though 80% of infertility can be attributed to medical or pathological causes, for an astounding 20% of cases, the reasons for infertility is unknown.

Many couples present to me feeling completely overwhelmed, or misinformed about their fertility options. Although information is readily available and accessible on the internet, it's often difficult to distinguish reliable information from reputable sources, from misleading and highly inaccurate content.

More and more couples are seeking professional support and turning to reproductive technologies as a solution. The number of IVF cycles has increased almost four-fold from 17,874 in 1992, to 70,082 in 2012 across Australia and New Zealand.

Remarkably, a significant proportion (almost half) of the couples who present in search of IVF, don't require the treatment at all. In fact, in many cases, after examining their medical history and performing fertility tests in addition to those recommended by their GP, it becomes clearly apparent that access to better information, guidance around pre-conception care, education around timed sexual intercourse and lifestyle changes, is their best course of action.

Research suggests women who are more informed and aware of their fertile days, and those who track their cycle, are more likely to conceive, compared to those who don't. Couples can use various strategies to track their fertility, including monitoring of their basal body temperature and testing for a surge in luteinising hormone, both of which can be accurately recorded using a thermometer and urine luteinising hormone testing.

Having worked as a fertility specialist and gynaecologist for the past 16 years, I've had the privilege of assisting many couples to conceive, through both natural conception, and intervention. This privilege has offered me rare insights into the world of conception, and the various challenges many couples face. From many conversations, it soon became very apparent that a practical resource was required for women and men wishing to conceive, particularly given men constitute half of a baby's genetic footprint.

Removing the guesswork from the use of supplements and monitoring devices was critical, given infertility, or trouble conceiving naturally, can prove extremely distressing for couples, in some cases, even triggering clinical depression. Importantly, I wanted to design a fertility kit tailored to the individual as a whole, accounting for their exercise habits, diet, lifestyle and behaviours. Body mass index (BMI) and smoking for example, are two factors that can be modified. Research has shown smoking affects the quality of the egg and sperm through oxidative stress. Furthermore, research reveals it is much harder to conceive with a BMI greater than 25 for both men and women.

The conceiveplease™ Fertility Kit is founded upon evidence-based research, anecdotal evidence, and fertility guidelines from World Health Organization (WHO) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Initially, most couples wishing to start or grow a family will visit their GP for professional advice. Others may visit a pharmacy in search of pre-conception vitamins and fertility-related monitoring devices. The conceiveplease™ Fertility Kit, available in pharmacies, is a reliable, reputable and holistic tool that GPs can now confidently recommend to their patients who are wishing to conceive naturally.

To learn more, head to www.conceiveplease.com

Dr Raewyn Teirney

Fertility specialist & gynaecologist

Obituary

Dr Margaret Mary Henderson OBE
13/11/1915 to 16/8/2017

Dr Margaret Henderson was a trail blazer as a woman in medicine. She was well respected by her medical peers, the many students and junior doctors she taught, the broader community and her patients.

After enrolling in first year science at the University of Western Australia in 1933, Margaret moved to the University of Melbourne in 1934 and completed her MBBS in 1938, sharing the exhibition in surgery and was a resident at the Royal Melbourne Hospital (RMH), then in Swanston Street. She then began her studies for a Doctor of Medicine (MD) while undertaking research at the Walter and Eliza Hall Institute and working as a general practitioner in Ivanhoe and in the medical outpatients at RMH. Margaret graduated with her MD in September 1941. Of the 102 medical graduates only 15 were women and Margaret was the only female awarded an MD.

Margaret served with the Australian military forces with the rank of Captain from 1941 to 1942 and subsequently in 1945 was recruited by the Red Cross for post-war civilian work in Malaya (now Malaysia). While working for the Red Cross in London and Switzerland, she developed a special interest in respiratory and thoracic medicine.

Known for her brilliance, tenacity and perseverance in a male dominated field of medicine...

In 1947, Margaret passed the exams for membership of the Royal College of Physicians in London. Returning to the RMH, Margaret broke new ground becoming the first woman appointed to the senior medical staff. She was also an honorary physician at the Queen Victoria Hospital, medical officer to Janet Clarke Hall and served on the management committee of the Royal District Nursing Service for 18 years. Her work at the RMH continued from 1947 to 1982.

In the 1960s, specialisation within the field of medicine was beginning and while Margaret considered herself a general physician, she began specialising in respiratory medicine as no-one else was doing it. This stemmed from her significant experience with tuberculosis in Malaya and London.

Known for her brilliance, tenacity and perseverance in a male dominated field of medicine, the long-time AMA Victoria member was awarded the Order of the British Empire in 1976 for services to medicine, a rare distinction in that era. In 2002, Trinity Grammar School in Kew invited her to become the patron of the newly formed Henderson House to mark the school's centenary, and in honour of her father and uncles who had been foundation scholars at Trinity. In 2012, the University of Melbourne awarded her the degree of Doctor of Medical Science Honoris Causa. In retirement she spent time supporting many causes and writing about her career and family history.

Former protégé Dr Rosalind Terry said, "General medicine in Margaret Henderson's unit taught me how to mix medical knowledge with common sense and a feeling for people as probably few people learn it."

Kay Dunkley
Coordinator of Doctor Wellbeing

AMA Victoria holiday office closure

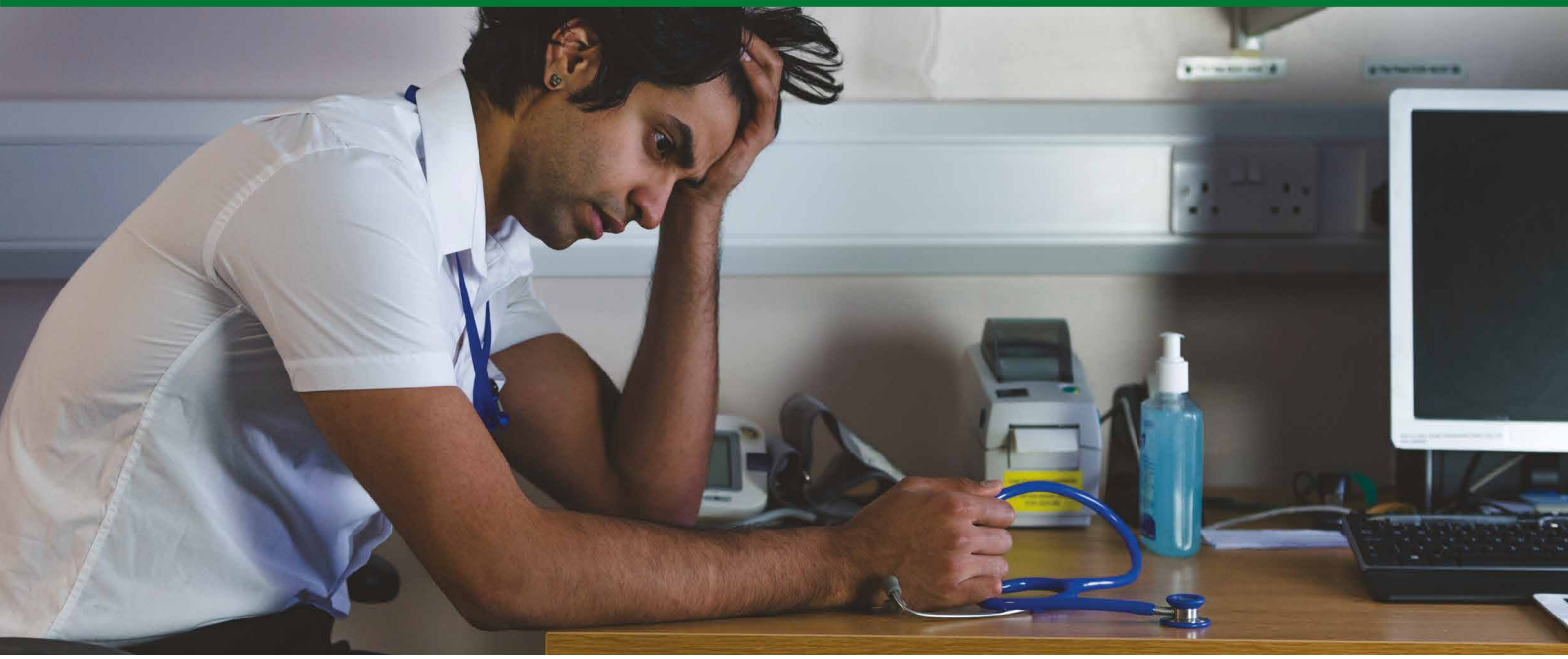
The AMA Victoria office will be closed from 12pm Thursday 21 December and reopen at 8:30am on Tuesday 2 January.

Our Peer Support Service is available every day of the year from 8am to 10pm. Call 1300 853 338.

We wish you and your families a safe and happy festive season and look forward to working with you in 2018.

Are you suffering from GP burnout?

ADVERTORIAL



Doctors shoulder a huge responsibility as a stoic pillar of society, working long hours to care for their patients. Behind the scenes though, doctors are more often overwhelmed, drowning in paperwork and struggling to meet increased regulatory requirements.

The AMA has recently reported the results of a survey conducted by the Canadian Medical Association that reveals over 50% of doctors have symptoms of stress and burnout. What's more alarming is that many physicians themselves don't like to talk about it given the infallible perception doctors have in the community.

As a general practitioner, how can you diagnose yourself when the signs of burnout begin to appear? And, how can you get help addressing the underlying causes?

Diagnosing GP burnout

GPs will often diagnose burnout in their patients but may turn a blind eye to their own symptoms of stress and burnout. Burnout is simply a state of exhaustion caused by a period of prolonged stress. Symptoms may appear subtle at first but will increase in severity over time.

Burnout manifests itself in three main ways:

1. Physical – feeling tired and drained most of the time.

2. Behavioural – an increasing need to isolate yourself from others and your responsibilities.

3. Emotional – feeling of being helpless, trapped and defeated.

How GPs can reduce stress and avoid burnout?

With administrative tasks and regulatory requirements cited as the main cause of prolonged stress, many GPs are choosing to outsource key functions or get consultative help to reduce the burden. Typically, this looks at systems and processes to increase operational efficiency, identifying and managing risks to reduce nasty surprises and putting plans in place to achieve the required regulatory compliance.

By getting help with the administrative aspects, the GP can focus on the needs of patients in the clinic with the peace of mind there is no paperwork building up back at the office.

Doctors are human. To reduce the inevitable stress involved in managing a health practice, a GP may wish to consider what areas are causing prolonged stress and re-engineer or outsource this aspect of the practice before a more sinister sense of burnout begins.

Want to know more?

Talk to an experienced consultant on strategies for setting up your healthcare business for stress-free success as part of our Clinical Business Consultation Services.

For more information, contact Health Project Services on privatepractice@amavic.com.au or (02) 8207 9998.

HEALTH PROJECT SERVICES

Holiday home pros and cons

We all love to 'get away' from home over the summer break. But that time away by the beach or in the bush can take an unexpected turn, with plenty of holiday makers resolving to buy a holiday home. So with a view to ensuring considered decision-making, here are the pros and cons of buying a holiday home.

Pros

Home-from-home. Buy a holiday property and you have another place you can call home; one that you'll furnish to your liking and, over time, accumulate memories of wonderful times.

Unlimited access. Own a holiday home and you can get away all year round – a fortnight here, a week there, plus several long weekends. Spontaneity is easy. No need to book ahead or worry about peak rate rentals.

Earn an income. Many holiday home owners decide to mitigate the holding cost of a holiday home by leasing it out for short term rentals. With peak weekly rents for even modest holiday homes often reaching four figures at certain times of the year, it's possible to make quite a dent in the mortgage. Moreover, for any period a property is available for lease, owners are able to offset any losses due to a gap between net rental income and holding costs in their tax return.

A place to retire. A holiday home can, in time, morph into the primary residence once the kids leave home and the owners shift from full time to part time work and, eventually retirement.

Capital growth. Finally, there is the potential for the property to appreciate in value over the life of the holding if it's well located.

Cons

They aren't cheap. They days of finding a cheap holiday home are long gone. Even a modest holiday home within one or two hours' drive of a capital city will usually cost from $400,000 upwards.

Empty most of the year. Even the most active users of holiday homes is rarely there for more than a fraction of the year. Unless you are renting out the property at other times, the effective cost of those visits can far exceed the short-term leases for renting a holiday property for the equivalent days or a trip to Bali, Fiji or Thailand.

Lack of variety. Some holiday home owners do get bored with visiting the same place and can feel 'shackled' to the property.

Leasing downsides. By leasing out a property, an owner can mitigate some of the above downsides. But beware of the sacrifices of leasing. You immediately lose some of the initial attractions of the property. You can't be so happy-go-lucky about how you furnish the place or the state you leave it in after every visit. It needs to be back in tenantable order after every visit you make. If you want to earn a reasonable rental income then say goodbye to using the property in the peak seasons of summer and school holiday periods. Further, beware that the costs of short-term leases are much higher than long-term leases: a high turnover of short-term renters subjects a property to much more wear and tear than a traditional lease; and managing agent fees can reach up to 20% of rent compared to 8% or so for annual leases.

Sub-investment grade capital growth. Capital growth for holiday homes tends to lag that of metropolitan properties in our capital cities. Ultimately demand is far more consistent in our cities and supply more restricted compared to holiday locations. Holiday homes are usually a discretionary purchase. In weaker economic times they are among the first assets to be sold.

For these reasons, if you are buying a property primarily as an investment to make money do not buy a holiday home – there are far better options out there.

Richard Wakelin
Director
Wakelin Property Advisory

WAKELIN
REWARDING PROPERTY DECISIONS

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

WAKELIN

REWARDING PROPERTY DECISIONS

22 YEARS INDEPENDENT

PROUD NEW AMA VICTORIA MEMBER BENEFITS PARTNER

Will you identify the distinctive **5%** of Melbourne properties that consistently achieve **strong capital growth?**

Learn the unique

Wakelin Strategy

for selecting investment properties

Special VIP Rates For AMA Members On:

- ☑ Investing property asset selection and negotiation service
- ☑ Home buying
- ☑ Vendor advisory
- ☑ Portfolio review

Richard Wakelin, Paul Nugent, directors

FOR MORE INFORMATION

(03) 9859 9595

wakelin.com.au

WAKELIN

REWARDING PROPERTY DECISIONS

ADVERTORIAL

Is buying your practice premises in your SMSF still an option?

With the recent changes to superannuation legislation, more investors are looking for alternative strategies to accumulate wealth in their superannuation fund. Purchasing your practice premises via your Self-Managed Superannuation Fund (SMSF) can still be a viable and attractive option. Rebecca Rossi of William Buck explains.

The introduction of Limited Recourse Borrowing Arrangements (LRBAs) in 2007 made it possible for SMSFs to borrow funds to purchase an investment asset in some circumstances, provided certain criteria are met.

What assets can be acquired under an LRBA?

A SMSF may only enter into an LRBA to purchase certain assets as outlined in section 67A of the *Superannuation Industry (Supervision) Act* (the SIS Act). Borrowings made by a SMSF are authorised provided that:

• The borrowing is applied for the acquisition of a single acquirable asset

• The acquirable asset is held on bare trust

• The SMSF has a beneficial interest in the acquirable asset and a right to legal ownership (i.e. the SMSF is entitled to all income, expenses and capital growth related to the asset)

• The recourse of the lender is limited to the asset which is the subject of the arrangement. This ensures that the other assets of the SMSF are not exposed in the event of default.

Examples of assets that may be purchased under an LRBA include: listed securities, commercial property (eg. medical consulting rooms), and residential property.

LRBAs in practice

A medical practitioner may use an LRBA to purchase a commercial property such as consulting rooms, which can then be rented back to the medical practice at commercial rates under a properly documented lease agreement.

Where the medical practitioner already owns his or her consulting rooms, the SMSF may be used to acquire the asset from the owner – freeing up the owner's accumulated equity. The small business CGT concessions may be used to minimise any capital gains tax on the transaction.

An LRBA can also be used to acquire other types of investments – such as residential rental properties. However, while business premises can be rented to SMSF members or their associates, residential properties cannot.

Advantages

Purchasing assets through a SMSF is often used as part of a tax effective wealth accumulation strategy for the following reasons:

• SMSFs are generally subject to an income tax rate of just 15%

• Tax on SMSF capital gains may be levied at just 10%

• Where the SMSF pays pensions to its members, its tax rate may be reduced to nil.

An LRBA enables a SMSF to purchase assets which it would otherwise be unable to acquire; particularly where a SMSF has insufficient available funds.

For example, a SMSF with $500,000 of available cash may be able to purchase an asset worth $1,000,000 by borrowing the additional 50% from a financial institution or related party to the SMSF (some lenders may even be prepared to loan up to 80% of the asset value). This may dramatically increase the SMSF's ability to leverage off its existing asset base to acquire substantial investments.

Disadvantages

While the benefits of an LRBA are clear, it is important to consider some of the intricacies around these arrangements:

• The cost of setting up an LRBA can be significant – typically between $3,000 and $10,000, but potentially even more in complex situations

• The SMSF will be required to comply with rules governing LRBAs both at the commencement of the LRBA and for the duration of the borrowing

• The SMSF will need to ensure that it is able to fund the borrowing – through member contributions and SMSF earnings

• The tax benefit on the interest expense is only 15% versus up to 46.5% if a negatively geared asset was acquired outside of superannuation by an individual and so an LRBA only "stacks up" if certain parameters (including in respect of capital growth rates) are met

• Consider the impact of LRBA repayments on your Transfer Balance Cap.

Professional advice must be sought before entering into an LRBA arrangement. If you are interested in investigating how an LRBA or other superannuation strategies could help you accumulate more wealth please contact Rebecca Rossi of William Buck. Rebecca is an SMSF Specialised Advisor who is licensed to provide financial advice and is happy to discuss any of the matters raised in this article. Please contact Rebecca on (03) 9824 8555 or rebecca.rossi@williambuck.com

Rebecca Rossi

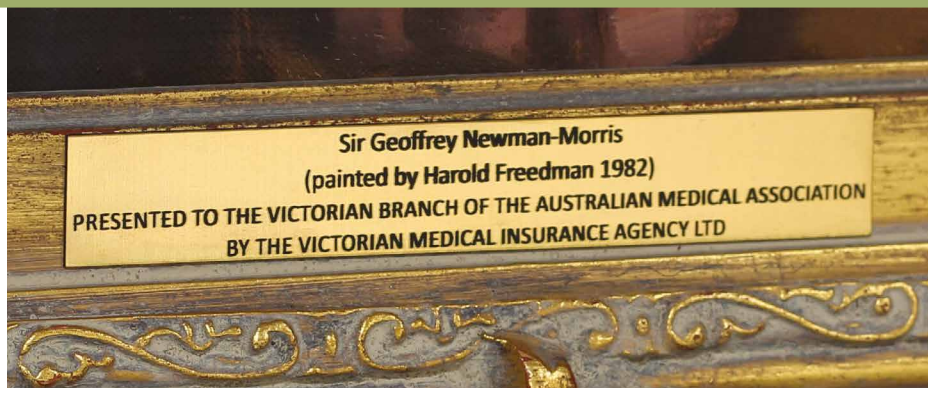
Director, Superannuation

William Buck

William Buck

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

The portrait that hangs there



It is appropriate to have portraits of distinguished personalities that have shaped and influenced an organisation displayed in prominent positions and the AMA Victoria boardroom is adorned with these. Until recently one such figure looked wisely upon the boardroom table and you could be forgiven for passing it by without a reflective glance as a plaque bearing the name of this distinguished gentleman was yet to find its spot below the canvas. This oversight has now been rectified and its provenance takes us back to an organisation established in 1925.

On his return from WW1, Major General Dr Fetherston, Victorian representative on the Australian Federal Committee of the British Medical Association (BMA), visits New Zealand in 1924. He returns impressed with the success of the NZ Medical Insurance Scheme, initiated by the NZ branch of the BMA, with the purpose of providing general and sickness insurance to its 400 members. Soon after, on 18 August 1925, a Victorian insurance scheme, similar in purpose to the NZ scheme, is established under the newly formed British Medical Insurance Co. Ltd. (BMI). Inaugural directors of BMI include: Dr Mollison, the company's first chairman, Dr Fetherston, Dr Hughes and Dr John Newman-Morris.

BMI is freshly installed at 43 Queen Street, headquarters of the Automobile, Fire and General Insurance Company of Australia. An advance from the BMA (eventually subsumed in today's AMA) of £250 is lodged with the E.S. & A Bank, the company's first bankers. The company's seal proudly displays a representation of the BMA building with the motto:

Semper Paratus

Under the aegis of the British Medical Association (Victorian Branch) and the Medical Society of Victoria.

By 25 June 1926 BMI is up and running with the collaboration of the Automobile, Fire and General Insurance Company of Australia. Later that year, the State Dental Society of Victoria gives official recognition to BMI.

BMI's product portfolio is expanded in 1928 to include life assurance via the Australian Mutual Provident, National Mutual and the Australian Provincial Assurance Company. An all risks policy on personal possession is also on offer by agreement with the North British & Mercantile Insurance.

During WW2, the business of BMI progresses steadily although the company faces considerable financial challenges due to the loss of revenue from subscriptions of members in active service. Financial deterioration is averted through an injection of funds from the Government. From these early stages BMI's close ties with the medical profession and corresponding representative Associations is on record with a £10,000 contribution in 1945 towards the purchase of a property at the corner of Albert and Lansdowne Streets, East Melbourne for use by the Medical Society of Victoria (MSV). A further £350 is also provided to assist the MSV in leasing offices for subletting to ex-service medical officers.

Further monies are provided to the MSV for its ongoing capital projects. Grants are paid for the establishment of the library of the College of Nursing of Australia, to the King George VI Memorial Appeal for the advancement of medical education in Victoria and to the medical faculty and colleges at The University of Melbourne. Similar monies are provided to the dental profession via grants to the Australian Dental Association (ADA) and the Australian Dental Congress.

By 1946, the company's financial woes are behind it and in 1950 the ADA is appointed an official agent of BMI. This marks the beginning of a long and collaborative relationship with the medical and dental professions as evidenced by BMI's commitment to focus its support initiatives exclusively in favour of doctors and dentists.

In 1957 Sir John Newman-Morris, the last of the company's original directors, dies and this vacancy is filled by his son Mr Geoffrey Newman-Morris. Born on 14 May 1909 in Violet Town, Victoria, Geoffrey Newman-Morris had followed his father's footsteps in the medical profession as a surgeon.

Joining the board of BMI firstly as director and subsequently as its chairman, Geoffrey Newman-Morris oversees an extensive period of the company's growth and expansion. In 1962 an agreement is entered with Edward Lumley & Sons of Victoria (an insurance company) to replace the Automobile, Fire and General Insurance Company of Australia on account of more favourable terms. The office of BMI is then relocated to 380 Collins St, the headquarters of Edward Lumley & Sons in the E.S. & A. Bank Chambers.

A series of grants are paid by BMI for a number of medical and dental causes and these are generally channelled through the AMA and ADA. In 1962, the company makes available £50,000 to assist the AMA in their purchase of a permanent site in Jolimont Terrace for their new building. Later on between 1966 and 1969, £20,000 and $20,000 is paid towards the cost of their new headquarters in Parkville.

The portrait of Sir Geoffrey Newman-Morris MBBS 1901-1981, commissioned by VMIAL in 1982.

Over the years that follow and as a result of changes in the legislation governing insurance companies, BMI restructures its insurance activities closer to one of an insurance intermediary in order to continue in its provision of tailored insurance solutions to doctors and dentists. In 1977, at an Extraordinary General Meeting, the company resolves to change its name to Victorian Medical Insurance Company Ltd (VMIC) and with that more relationships with a number of underwriters are formed in order to expand the company's insurance offerings. Throughout the years that follow VMIC, under the stewardship of its chairman, remains loyal to its purpose in seeing to the provision of insurance services tailored to the needs of doctors and dentists with an ever growing list of support payments to causes benefiting these professions. Later on the company changes its name to Victorian Medical Insurance Agency Ltd (VMIAL) to comply with new rules, a name that stands to this day.

Geoffrey Newman-Morris's accomplishments and achievements aren't exclusive to the business of VMIAL. His involvement and distinguished service as Chairman with the National Red Cross and Vice-Chairman of its international body saw him receive in 1979 the highest honour of the Red Cross – the Henri Durant Medal. Knighted in 1969, Sir Geoffrey Newman-Morris was the Honorary Secretary for BMA Victoria 1955 to 1957 and President in 1961. From 1965 to 1973 he was the Chairman of the AMA Victoria State Council. In 1967-72 he served as chairman of the AMA Federal Assembly; in 1974 he was awarded the AMA Gold Medal.

On 20 October 1981 Sir Geoffrey Newman-Morris passed away and his memory was immortalised in a portrait by Mr Harold Freedman in 1982. This was commissioned by VMIAL and presented to the Victorian branch of the AMA.

To this day and as the company passes its 90th birthday, Victorian Medical Insurance Agency Ltd remains true to its origins and purpose in the continued and uninterrupted provision of insurance services to the medical and dental professions via its "PSA Insurance" brand as well as a long suite of projects benefiting these professions. Over the last 11 years or so, in excess of $2.8M has been contributed towards tailor made support projects developed from the ground up by VMIAL in conjunction with a number of partners including the medical and dental schools at Melbourne, Monash, La Trobe and Deakin Universities, The Royal Children's Hospital and Victorian branches of the Australian Dental and Medical Associations.

These projects cover just about all stages of medical and dental careers from students to retired practitioners in care facilities. The latter refers especially to AMA Victoria's Peer Visitor Program which provides companionship to retired doctors in care facilities and at home by volunteer doctors and medical students. This program was developed in conjunction with Victorian Medical Insurance Agency Ltd which has been its principal financial sponsor since 2012.

VMIAL's legacy born out of its distinguished and visionary founders remains at the forefront of all we do. Despite this digital age and the relentless pressure and pursuit to keep up, change and modernise, there will always be a need for an organisation such as ours with unchanged core values and which is genuinely committed to contributing to the wellbeing and welfare of doctors and dentists. Our only concession to modernism is to add to our logo the words "We are unique" a change that, we respectfully submit, is quite appropriate.

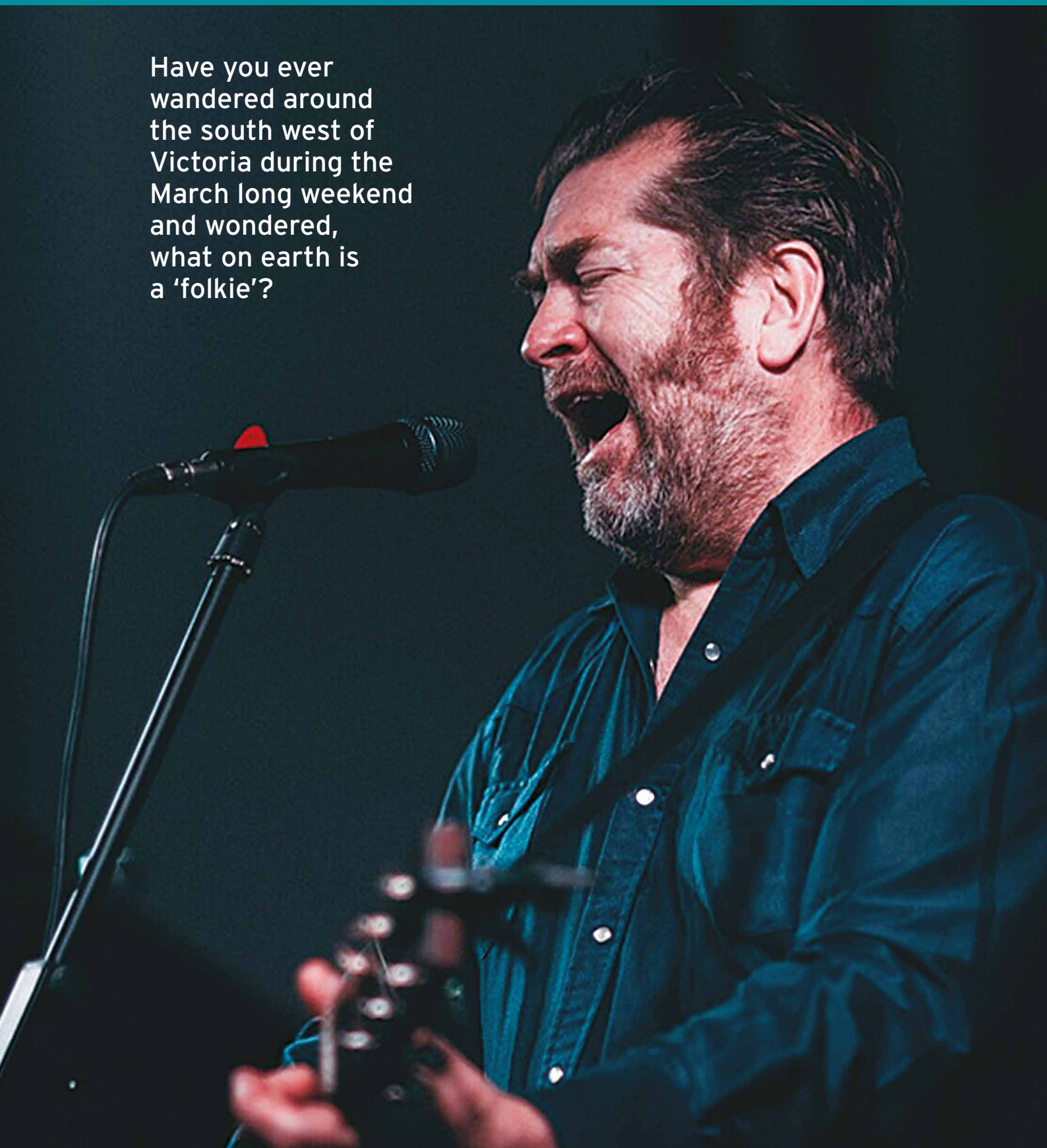
Sylvain Mani CA
Chief Executive Officer
Victorian Medical Insurance Agency Ltd

PSA Insurance
We are unique

This article was compiled from a story of BMI prepared by Sir Kingsley Norris and other connections of VMIAL. It was put together from company records, board minutes and other publicly available biographical material.

The Port Fairy Folk Festival – 41 years and counting!

Have you ever wandered around the south west of Victoria during the March long weekend and wondered, what on earth is a ‘folkie’?



For over 40 years now, music lovers have descended on the small coastal town of Port Fairy for the Port Fairy Folk Festival (PFFF) – a long weekend of music, food, performance and Guinness.

Opposite page: Mick Thomas. Above: Vika and Linda Bull.

The town receives an influx of over 40,000 visitors for the long weekend, swelling their population by over 1000% (around 3500 people live there through the year). Volunteers power the festival, many of them local, and what started in the main street in 1977 has grown into one of the world's premier folk music festivals, attracting artists from across the globe.

The local footy club still runs the bar tent, and neighbouring towns benefit from employment and some proceeds of the festival. If there's an overwhelming feeling of the PFFF, it's that it really is a community. The person scanning your ticket at the gate on Friday night might welcome you in again on Sunday, and the local primary school might sell you a delicious burger for lunch on Saturday.

If you're not entirely sure what folk music is, don't worry. There's a balanced mix of indigenous, Celtic, acoustic, blues and funk, folk rock, world music and singers. If you've been before you might have seen acts like Ani DeFranco, Weddings Parties Anything, Archie Roach, Colin Hay, The Waifs, Paul Kelly, Mick Thomas, The John Butler Trio, The Proclaimers, Mary Black, Kate Miller-Heidke, Vika and Linda Bull, Ruthie Foster, Deborah Conway and Willy Zygier, Arlo Guthrie, Tim Finn, Glen Hansard, Sinead O'Connor and Steve Poltz – just to name a few of the 10,000 acts that have performed over the last 40 years. The 2018 line-up has only recently been announced, but regular patrons buy their tickets automatically each year, assured of a wonderful set of artists – some known, and some yet to be discovered.

No matter what kind of music is your favourite, you'll find something to enjoy at Port Fairy. While the festival has a ticketed arena, the entire town is transformed with markets, free shows and events, so a weekend without a ticket is in no way wasted. But for me, the big event is in the arena. Here, you can roam between eight stages, armed with your folkie chair (a foldable low chair) to watch music from all over the globe, undercover and in comfort. Some stages have tiered seating and, later at night, some turn into 'dance-only' stages. The seating at PFFF has become a revered thing – it allows you to see many acts either on one stage, or moving around over the weekend. It allows patrons with children to spread out on a rug, and the breaks between acts are perfect for coffee and food excursions. There's a lovely community around the stages – a new neighbour might watch your space for you, or bring you back a hot chocolate. As the day goes on and the stages become busier, you'll be asked to do the Port Fairy 'shuffle forward', to make way for more patrons at the back.

The Folkie really is for everybody. It is a safe, family-friendly festival. While you're sitting at Stage 3, your children may be being entertained at the kids' tent. Children can wander back and forth from their parents around the arena, or parents can sit down and watch Red the Clown (who has been hosting for most of the 41 years) at the kids' tent. There are workshops – warning, you may come home with a ukulele – and events, like the festival of lights parade on the Sunday night that children can engage in. Roaming and scheduled street performers inside the arena will keep the kids (and you, if you're chosen for participation) entertained.

For the adults, the licensed area in the Shebeen tent is where you'll find the party, helped along by the local favourite tipple Guinness, and other beverages. The arena closes at 1am each day, but if you find yourself in the Shebeen at midnight, you'll likely be up at the stage, Irish jigging along with 50 new friends.

There are hundreds of traditions, themed concerts and celebrations that occur over the weekend. You may speak to someone who has been attending for 30 years (like me, since I was born), or someone who has come for the first time. We attend the Sunday singalong in the Shebeen every year, and make sure to get to the Women in Voice collective show of female artists in celebration of International Women's Day. We stay at the adjacent Southcombe Caravan Park each year, while some others might hire a house in Port Fairy, or come over each day from Warrnambool. Once you've been to PFFF, you'll start forming your own traditions!

If I've piqued your interest, head along to the festival website and sign up to the e-news, to make sure you're in the loop for ticket releases and other important information – like signing up for the ukulele collective!

www.portfairyfolkfestival.com

Classifieds

POSITIONS VACANT

GV SPECIALIST CENTRE

Dr Howard Webster has practiced in Shepparton and the Goulburn Valley for over 20 years. At our Shepparton Specialist Centre, Howard and his associates provide comprehensive nurse, GP and specialist plastic surgical multidisciplinary skin cancer care, and a Molemap / melanoma surveillance service.

Due to patient demand we are further expanding our GP skin cancer clinic services in Shepparton, and are about to establish a formal skin cancer clinic in our Melbourne office.

We are recruiting a further skin cancer GP or GPs to our Shepparton Specialist Centre.

Ideally a 2 – 3 day per week commitment is sought, but we are open to either a one day per week commitment or even a full-time role if the right applicant desires to work full-time in the area of skin and skin cancer.

- Modern clean bright rooms
- Central position close to both public and private hospitals
- Full nursing support and comprehensive clinical follow-up for patients
- Parking on site
- Family friendly hours that are flexible with school holidays off if required
- Supervision and mentoring by accredited plastic surgeons
- Attractive remuneration package
- Pathology onsite
- Allied health

An interest in skin and skin cancer treatment is required, as well as competence in office procedural work for skin cancer. Training is provided to ensure the procedural scope of practice for all our doctors is appropriate. If you are interested in this position, enquiries and an onsite tour is very welcome. Please contact Practice manager Jan Griffin for any further information.

20 Wyndham Street
Shepparton VIC 3630
Tel (03) 5820 0500
Fax (03) 5820 0501
Email: jan@gvsc.com.au
Website: www.gvsc.com.au

FOR LEASE

BOX HILL
Specialist Psychiatric consulting rooms available for lease on sessional basis. Fantastic location opposite Box Hill Shopping Centre. Car park, medical software package and excellent secretarial and practice management services provided. Suit psychiatrist, psychologist, or allied health professionals.

Enquiries: Robyn or Toni (03) 9843 5855 or email robyn.allen@easternhealth.org.au

CLINIC CLOSURE

Dr Bella Ajayoglu
40 Eleanor St
Footscray 3011

Will cease private practice from December 2017.

Always the first choice for medical indemnity insurance and protection for doctors

miga ALWAYS

Earn Qantas Points on your insurance payment to MIGA[1]

Annual or monthly direct debit with no fee

Comprehensive medical indemnity cover[2]

Risk education - free with a premium discount on completion

24/7 emergency medico-legal advice and support

Personalised advice and claims support

Dr Martin Altmann
Chairman

75,000 bonus Qantas Points

when you first insure with MIGA between 22 December 2017 and 31 January 2018[3]

Get a competitive quote on your insurance **1800 777 156** or **www.miga.com.au/bonus75**

BUSINESS REWARDS | FREQUENT FLYER

[1] A business must be a Qantas Business Rewards Member and an individual must be a Qantas Frequent Flyer Member to earn Qantas Points with MIGA. Qantas Points are offered under the MIGA Terms and Conditions www.miga.com.au/qantas-tc. Qantas Business Rewards Members and Qantas Frequent Flyer Members will earn 1 Qantas Point for every eligible $1 spent (GST exclusive) on payments to MIGA for Eligible Products. Eligible Products are Insurance for Doctors: Medical Indemnity Insurance Policy, Eligible Midwives in Private Practice: Professional Indemnity Insurance Policy, Healthcare Companies: Professional Indemnity Insurance Policy. Eligible spend with MIGA is calculated on the total of the base premium and membership fee (where applicable) and after any government rebate, subsidies and risk management discount, excluding charges such as GST, Stamp Duty and ROCS. Qantas Points will be credited to the relevant Qantas account after receipt of payment for an Eligible Product and in any event within 30 days of payment by You. Any claims in relation to Qantas Points under this offer must be made directly to MIGA by calling National Free Call 1800 777 156 or emailing clientservices@miga.com.au.

[2] Insurance policies available through MIGA are underwritten by Medical Insurance Australia Pty Ltd. MIGA has not taken into account your personal objectives or situation. Before you make any decisions about our policies, please read our Product Disclosure Statement and consider your own needs. Call MIGA for a copy or visit our website.

[3] 75,000 bonus Qantas Points offer only available to registered Australian medical practitioners who first insure with MIGA in a fully insured category, as a doctor in private practice, for cover commencing in the period between 22 December 2017 and 31 January 2018, and who pay in full by 31 January 2018 or enter into a direct debit arrangement with MIGA by 31 January 2018. MIGA Terms and Conditions for bonus Qantas Points for Fully Insured are available at www.miga.com.au/qantas-bonus-tc-pp.

The online healthcare platform you and your patients will love

MyHealth1st makes caring for your patients more efficient by reducing your vacant appointment slots and so much more. It's the all-in-one digital platform to connect, engage and manage the entire patient journey.

onlineappointments

Our Online Appointments Service is included with your AMA Victoria membership
Sign up now at myhealth1st.com.au/ama

AMA VICTORIA

myhealth1st.com.au