

vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. APRIL / MAY 2018

Lou Richards' legacy helping kids with T1D

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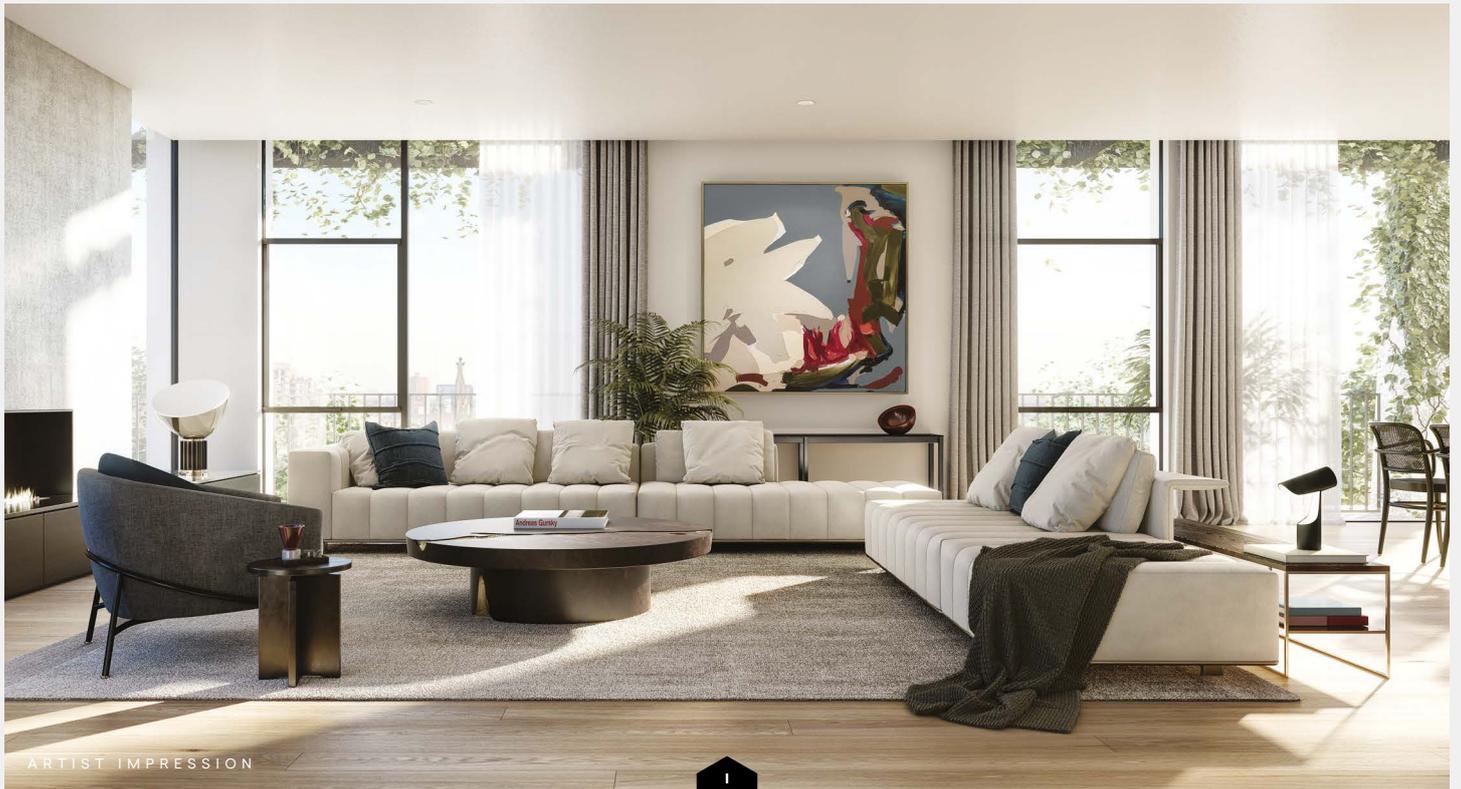
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FRONT COVER: The family of AFL legend Lou Richards is a big supporter of the Type 1 Foundation. Great grandson Jack Nicholls (sitting) with his brother Albert, dad Craig and mum Lucy. (Photo courtesy David Caird/Herald Sun)



Magazine of the Australian Medical Association Victoria

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Vicdoc is published by AMA Victoria Services Pty Ltd ISSN 1440-8945 ACN 004 158 614

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Vicdoc is printed using FSC mixed source certified fibre by Printgraphics Pty Ltd under ISO14001 Environmental Certification

Closing date for June 2018 issue submissions:

Editorial: 23 April 2018
Advertising: 1 May 2018

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Welcome from the editor



Thousands of preterm babies' lives could be saved by waiting for at least 60 seconds before clamping the umbilical cord, according to Monash researchers. See page 22.

There's a common belief in the media industry that if you feature the Collingwood Football Club on the front or back page of a newspaper you will sell more copies. Whether or not it has prompted more (or less) doctors than normal to flick through this edition of Vicdoc may well be determined by how much feedback we receive. After the Magpies' favourite son and football's first media megastar Lou Richards passed away last year, his family asked for donations to the Type 1 Foundation, in lieu of flowers. Lou's family is a strong advocate for better care for kids with type 1 diabetes and here we learn about how their support has helped make life easier at school for many of these children.

Deciding which path to pursue in medicine is not always straightforward for some. Our careers' experts outline some of the issues to consider. And for those unsure if they have headed in the right direction, our 'Careers Conversation' series introduces you to doctors who haven't followed a straight line in their medical journeys.

This Vicdoc also highlights some of the health areas we believe are in critical need of funding boosts, ahead of May's State Budget and we reflect on 10 years of the Peer Support Service (available by calling 1300 853 338 between 8am and 10pm, every day of the year).

We also have important contributions from the DHHS on epidemic thunderstorm asthma and an immunisation campaign for hepatitis A and meningococcal disease, along with news on exciting developments from the Hudson and Murdoch Children's Research Institutes.

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 June.



Barry Levinson

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NEW SPEAKER ANNOUNCEMENT

AMA Victoria is excited to announce that Western Health Supervisor of Intern Training, Dr Sean Fabri will be speaking at the Expo.



TICKETS

Tickets are still on sale at early bird prices. Time is running out, so buy now to avoid missing out: ticketebo.com.au/ama-victoria-events



MAJOR SPONSOR:



President's message



Firstly, a warm welcome to Ms Dianne Angus as interim CEO of AMA Victoria while the Board undertakes an executive search for an ongoing Chief Executive Officer.

After nearly two years as President I am writing my last Vicdoc article in this role. My first column described the feeling of the weight upon my shoulders when the chain of office was passed to me from Tony Bartone. It was a metaphor for the weight of responsibility I faced and I did not expect to carry it lightly. I hoped I would carry it well.

The weight has been considerable, largely due to the passage of three pieces of legislation that powerfully affect the medical profession – *The Medical Treatment Planning and Decisions Act*, *Voluntary Assisted Dying and SafeScript* (Real-Time Prescription Monitoring). This has not been easy for the association to manage. Member expectations of AMA Victoria's responses to these issues have sometimes been at odds with overarching AMA policy, which brought challenges in terms of those members' satisfaction with the outcomes.

AMA Victoria policy is not driven along party political lines, which gives us the freedom to represent the interests of the medical profession and the impact of legislation on good patient care and public health. However this can be a disadvantage when there are expectations from members that we can directly change a particular party's policy and the votes of members of parliament, or the outcome of an advisory group, where we are but one representative of many at the table. It has been very gratifying to see significant changes to draft legislation ensue from our advocacy where, without our presence, significant disadvantage to patient care, and the working conditions of doctors (and sometimes other health professions), would have ensued.

My presidency has been characterised by engagement with advisory bodies in the Department of Health and Human Services and the Department of Premier and Cabinet – an unprecedented number for any President. Throughout my term I have directly participated in a total of nine advisory groups or taskforces, ably supported by our policy staff and Board members. There have been numerous other high-level meetings on specific issues, including the trial of a supervised injecting facility which we were so pleased to see introduced by this Victorian Government.

Throughout there have been periods of great tension and heavy workload – but overarching it has been the sense that for many members, our advocacy has been greatly appreciated. The achievement of a very successful EBA – not just in salary increase but improved conditions – is a tribute not only to our excellent team in workplace relations but the input of member feedback. The dedicated efforts of those of you working in general practice and health services, literally working tirelessly during the severe and prolonged flu epidemic, was drawn to the attention of the Minister for Health and senior bureaucrats at every opportunity in meetings. This, along with member input regarding the very real gains in productivity through major health services, undoubtedly added weight to the argument for a salary increase and improved conditions for both senior salaried doctors and those in training.

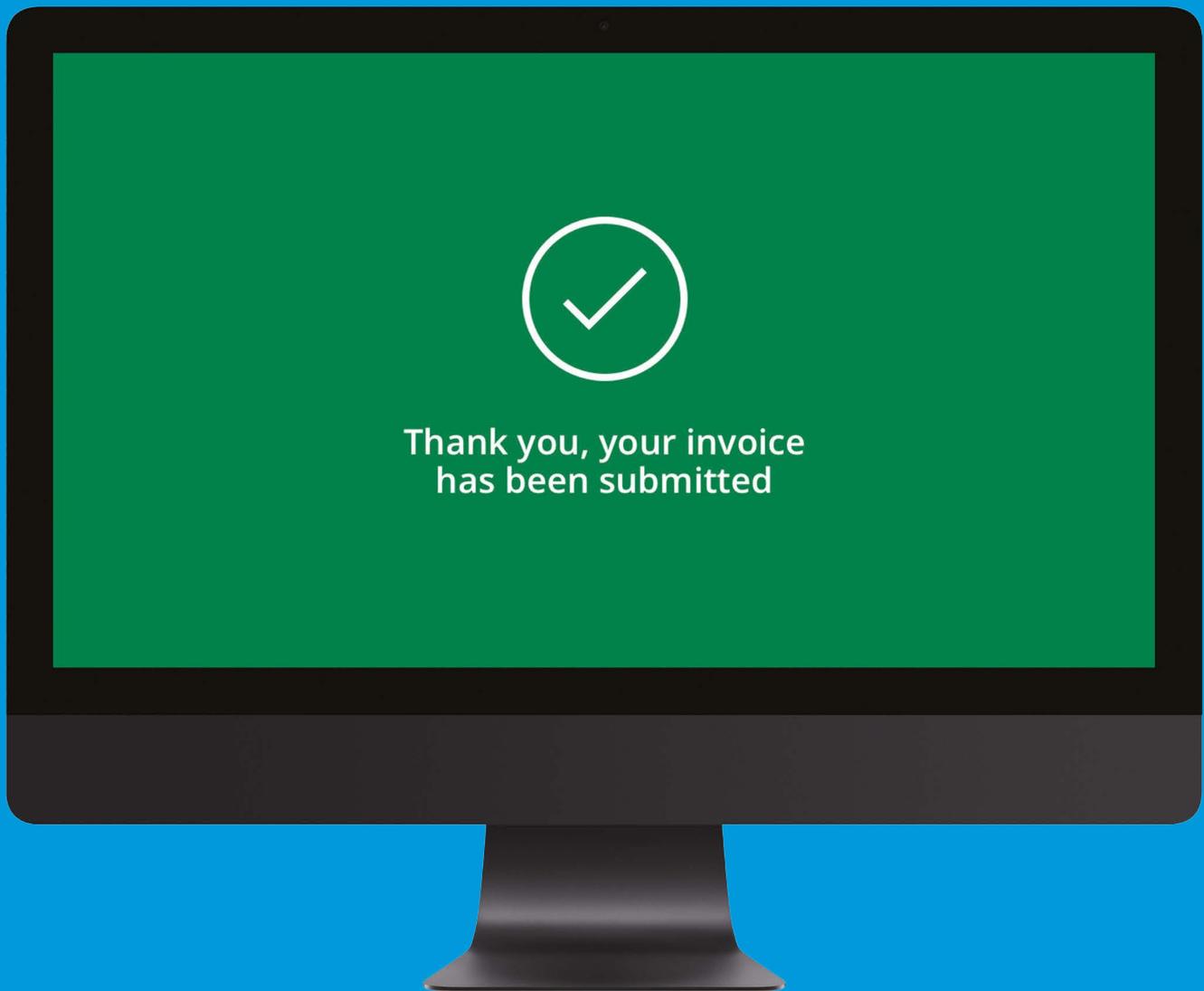
My eight-year Board term is also coming to an end, and I would like to pay tribute to all those Board members with whom I have worked during this period. Your generosity of time committed to assuring the ongoing viability of AMA Victoria has been (and for some, continues to be) extraordinary. New Board members bring new insights and energy. New issues are emerging around parental leave and pregnancy; part-time roles; a need to embrace and use social media to both hear from and respond to member issues; as well as the ongoing work contributing to mental health policy and workforce training and distribution. These are exciting times to be a member of AMA Victoria!

May I thank all of you who have offered me words of support throughout my presidency – those of you who have shared personal experiences with me having never met me, and most of all, those who elected me, for giving me this amazing opportunity to contribute to the organisation I joined in 1979 on graduation. The AMA Victoria Pledge was launched during my presidency. I hope I have led by example, have treated all with respect and fairness, and most of all, hope my behaviour has contributed (positively) to the culture of the medical profession.

Dr Lorraine Baker
President

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AMA Victoria appoints interim CEO

Ms Dianne Angus has been appointed the interim CEO of AMA Victoria. Ms Angus has worked as a senior executive within the biotechnology, biopharmaceutical and agritech industries for over 25 years.

She has held a diverse array of executive positions including most recently as COO of Prana Biotechnology and before that management of the joint venture alliance between Florigene (Australia) and Suntory (Japan) to yield and commercialise floricultural products.

With over 15 years' experience in an ASX and NASDAQ listed company, Dianne has expertise in capital raising, investor relations, business development, regulatory, intellectual property and finance, together with excellent corporate governance and compliance capabilities. She has successfully forged strong partnerships with key medical opinion leaders to create innovative clinical research programs. She has lead shareholder and investor relationship presentations and interactions. Dianne has also driven the development path for novel pre-

clinical agents to late-stage clinical assets before the FDA and European regulators. Underpinning her success in the biopharmaceutical sector is the desire to advance patient care and community health.

Her expertise includes responsibility for human resources including domestic and international (US and Europe) based employees and consultants.

Ms Angus currently serves as a non-executive director of the Grains Research & Development Corporation (GRDC).

President of AMA Victoria, Dr Lorraine Baker said, "On behalf of the Board of AMA Victoria I am pleased to welcome Ms Dianne Angus as CEO. She brings a depth of experience to this role, one she has undertaken for the interim while an executive search for a permanent CEO is undertaken."



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Enterprise Bargaining – Where to now?

A great number of changes have occurred to conditions for both junior and senior medical staff employed in Victorian hospitals. Planning by AMA Victoria and ASMOF over the past two years and negotiations with the employers and Department of Health and Human Services over the past year have been challenging but worth the effort.

A meeting of delegates in September and members in November gave clear direction that we needed to focus on ensuring remuneration moved Victoria closer to other states. It was also clear that using all possible means to settle the campaign in 2017 (if possible) was supported.

In the lead up to December, there had been little movement on salary increases with the Government sticking to its policy position. However we took the opportunity to discuss 'options' that were outside of policy but may, if proposed by the Government, settle the dispute.

December was an extremely busy time hammering out a package. Between 19 December and 19 January, we raced to prepare two agreements which are now before you.

The package has three parts – salary increases and changes to the conditions under which you work, along with an agenda for change in the coming months and years.

Salary changes

- A 9% increase from the first pay period to commence on or after 1 January 2018 will occur. Then 3% each year thereafter for three years.
- Other allowances will increase by 3% each year.
- Increase in DiT CME by \$1000, then indexing with 3% for three years.
- Sign-on bonus to those either full or part-time employed in a hospital on 1 January 2018 of \$2000 (DiT) or \$3,500 (specialists). Pro rata for part-time. This is a one-off payment and recognises the time between the last agreement concluding (1 April 2017) and the operation of this agreement.

Changes to conditions

Generally

A large number of changes apply to both juniors and seniors. These include:

- Consultation when the hospital wishes to make changes to your workplace.
- Redundancy processes that are detailed for the first time.
- A simplified dispute settling procedure.
- A disciplinary process that protects your rights.
- A right to flexible working arrangements in certain circumstances.
- Transition to retirement provisions that means older doctors can negotiate for step down later in their career.
- Workload management conditions can be activated so that excessive workloads can be managed.
- Replacement of doctors when on leave if the workload becomes unreasonable, i.e. can't be handled in normal day.
- Public holidays are clarified with full-time doctors getting paid for public holidays even if they fall on their day off.
- Fitness for work provision that ensures if the hospital has a concern about your fitness for work, it must follow a process and provide support.
- Breast feeding facilities to be provided.
- New family violence leave of up to 20 days.

For DiTs

- One year contracts will be reviewed during the life of the agreement with the aim to move, where possible, to two year contracts.
- Return to your hospital after maternity leave. Where a person who has an extended absence, i.e. more than three months, the hospital is to provide a new contract so that you can return to your current hospital. If you take maternity leave from the hospital for more than three months, the hospital will provide you with a returning contract.
- Hours of work have been amended significantly to:
 - maximise rostered hours for registrars to 16
 - 48 hours break between night and day shifts
 - restrict the maximum number of consecutive nights to seven
 - clarifying that overtime is to be paid on the hours worked in a week rather than averaged
 - clarification that a doctor must have at least 10 hours break between shifts without interruptions, i.e. phone calls.
- Training time requirements are now front and centre with clarity of payments required to be made if you are unable to access your training time.
- 'On call' is made clear that normal 'on call' means a doctor who is expected to take a call rather than actually having taken a call.
- Examination leave is to provide

three days of paid leave just prior to an exam.

- Location allowance now applies to all who are required to move residence as part of their rotation.
- Paid parental leave is now available to either parent who takes on the role of primary carer.
- Facilities when on rotation to include Wi-Fi and ensure a safe environment.

For specialists

- Fractional specialists must be provided with the days and times of when they are to work.
- Any new fixed term contracts are abolished unless there is a specific reason like replacement for maternity leave.
- Rights of Private Practice where a hospital acts as agent for the doctor require particular undertakings to be made and data provided to ensure no breach occurs to Medicare.
- Clinical support time is 20% (or College guideline) with clinical heads at 50%.
- Rosters must be designed to support safe hours of work.
- A new regime of shift penalty payments applies for afternoon shifts 25%, night shifts 75% Saturday and Sunday 75%. Night shifts Saturday are 75% and Sunday are 100%.
- Continuing Medical Education allowances are changed by:
 - including sabbatical leave expenses
 - registration with Colleges and Associations
 - childcare reimbursement can be claimed for \$250 per day for a primary care giver
 - claims can be lodged up to

three months after the year in which they are incurred, but will be refused if after this time

- if a hospital rejects part or all of a claim it must do so in 30 days and pay the non-disputed part(s)
- the reimbursement of airfares when there is an FBT component is clarified, in that the entire airfare is reimbursable (assuming it meets the criteria) and FBT must come from the reimbursable allowance
- in certain circumstances where a doctor was prevented from using CME because of parental leave or personal illness, it can be carried over to the next year.

- Clinical academics are recognised in particular clauses in the agreement such as public holidays and CME.

Agenda for change

A number of changes will occur within the life of this Agreement. The parties have agreed to set up committees to focus on the following:

- to reduce duplication of training and promote recognition of training across health services
- to identify opportunities for common applications for positions and the implementation of electronic orientation and credentialing
- to monitor the proper implementation of training time for registrars
- to better accommodate long service leave arrangements for doctors employed by two or more concurrent health services
- to develop guidelines to assist employers in facilitating genuine job-share arrangements for DiTs

- to establish a Fatigue Management Review
- to identify how and when two year contracts can be accommodated for DiTs
- continued support for private practice arrangements
- to review the rates of pay (paper versus actual) and other conditions with a view to identifying conditions that more accurately reflect current practice and a method to move the current paper rates to actual/market rates for full-time specialists
- to review existing manager allowances (however described) and adopt the descriptors and principles set out in Schedule E of the specialist's agreement.

Implementation

To say that these changes are significant is an understatement. Therefore the task of ensuring things change is joint. We must all become familiar with the changes and work with health services to implement them. This will require your support and work. It will also require you to talk to your colleagues about joining the AMA so that we are resourced should an argument occur during this time.

So please ask your colleagues if they are members, and if not encourage them to join. Your fees have paid for this change. The more we are resourced, the more we can focus on proper implementation and ongoing work.

If you would like to discuss the EBA or any other employment matter, contact the Workplace Relations team on eba@amavic.com.au or (03) 9280 8722.



Geoff O'Kearney
Director
Workplace Relations

When will the pay increases come into effect?

Hospitals are obliged to pay once the agreements are approved by the Fair Work Commission. The benchmark for approval by the Fair Work Commission is 50% within three weeks of lodgment, 100% within 12. AMA Victoria has requested that the department authorise payment sooner to minimise administrative delays.

How will the agreements come into effect?

Four actions will occur:

1. Your salary will change in your fortnightly pay to reflect an increase of 9%.
2. The sign-on bonus will be paid.
3. Hospitals will calculate back pay from the first pay period in 2018 and make a lump sum payment.
4. Conditions matters, such as shortened length of shifts, will be implemented.

Farewell Geoff

After 20 years of outstanding service, Geoff O'Kearney has left AMA Victoria. We thank him for his tireless work supporting doctors over the journey. With the new EBA Agreements, he has certainly left on a high note! Geoff was recently farewelled at a function at AMA House, attended by appreciative doctors, and many past and present colleagues and Presidents of AMA Victoria.

Choosing your specialisation

Ask any doctor how or why they ended up in their particular specialisation and you will hear diverse answers on a broad continuum: 'It's what I always wanted to be', 'I was inspired by a consultant in the field', 'I was told I was good at it' or 'by accident', 'because I didn't get a spot in my preferred training program', 'it was the only option available'.

Some doctors start studying medicine with a clear career pathway in mind, others commence with no idea of what pathway to specialise in. Either position can be right or wrong and both provide positive or negative implications depending on the individual. For some doctors opportunities may be missed in their rush to specialise in a pre-defined pathway. Fit for role and lifestyle alignment might be overlooked and subsequently role dissatisfaction may emerge at a later point.

For medical students and doctors who currently have no clear idea of the right specialisation to pursue, we want to highlight that it is okay to not know! It is our experience that with practise and exposure a path will emerge in time. For some however, it is a process of elimination down to a couple of options, two to five years after graduation.

The decision to pursue a certain specialty is one of the most important career decisions you can make. The choice may feel overwhelming. There is a perceived 'rush to know' and to act early. However senior educators and supervisors advise that it is okay to not know and prefer junior doctors take more time and consideration before pursuing a path.

The enormous investment of time, money and effort required by a doctor to specialise should only be commenced after thorough research of the available options. There are many factors - external and internal - you should take into account when formulating your decision and we strongly advise you tune into the information they provide you, to ensure an informed decision is made.

External cues

- Seek feedback and advice from authorities such as supervisors, peers and educators on your own fit for a role and understand what the role involves and how to pursue it.
- Engage with the colleges of the specialisations you are interested in and understand everything you can, such as training demands, timeframes, costs, sub-specialities etc.
- The AMA, hospital departments, medical educators and universities are also valuable sources of information and have a wealth of information on hand and good networks they can tap you into.
- Government health policy and funding - where are the roles of the future and how is public funding being applied?

Use all these resources to discover as much as possible about specialties that interest you.

Internal cues

It is also extremely valuable to be tuned into internal cues. Therefore during each rotation reflect on:

- **Skill alignment** - Is there natural alignment between your skills, competencies and the role? Does the role use your strengths and talents, does it feel natural and 'of you' and does the work engage you? Are you good at it or feel you have the potential to be good at it?
- **Role fit** - Does your personality, work and communication style align with the task profile of the role? Do you fit with others working in that environment, do you like the people and can you see yourself working in this role?
- **Environmental/lifestyle** - Where is the role located, does the environment fit, what hours are required, what is the structure of the role and does it fit with the way you like to work?
- **Value alignment** - Does the role feel right and align with the way

you like to work and engage with patients and other stakeholders? You should not feel that your values are compromised and believe in the work the role does.

- **Motivational fit** - What satisfies you in a role, what dissatisfies you? Does the work energise /de-energise you? Do the people you work with inspire you?
- **Interests** - Do you find the work interesting or do you 'lose yourself' in the work? Are you keen to learn as much as you can about the role and specialisation?

Finally, in a changing world of work, you need to also consider how medicine is evolving. Some parts of medicine traditionally managed by one specialty have adapted with changes in research and technology to being the domain of another specialty. How might this change further?

Remember there are many directions you can take your career - traditional paths, sub-specialties and even alternate non-clinical careers using medicine. It is important to set aside time for management of your own career and to constantly revisit where you are heading.

As consultants for the AMA careers advisory service, we see many doctors at all stages of this decision-making process, including those who are unsure which path to follow, others who enjoy their specialisation and want to investigate how to develop it further, and doctors who have concluded that their specialty is not right for them and are seeking alternate paths.

For careers advice, please book a free 15-minute career call or a coaching session on our website amavic.com.au/careers-advice



Carolyn Speed
Careers and
Pathway Consultant



Mardi O'Keefe
Careers and
Pathway Coordinator

Epidemic thunderstorm asthma: Challenges to public health and clinical medicine



The epidemic thunderstorm asthma (ETSA) event of November 2016 presented major challenges to the health system. For better preparedness, I briefly outline the actions taken by the Victorian Government since then.

The program of work aims to ensure that similar environmental conditions (the uncommon type of thunderstorm, high levels of grass pollen and other factors) do not result in severe health impacts again.

There is need for greater population resilience, which includes:

- reducing the number of people at risk who are exposed
- reducing the number of people with undiagnosed asthma or with

suboptimal asthma control

- increasing the number of people with asthma action plans who can effectively self-manage their asthma
- promoting greater understanding among people with hay fever of their greater risk, so that they know what to do to protect themselves
- improved community understanding.

The healthcare system needs the capacity to:

- identify higher risk days for ETSA by the development of a forecasting system
- manage surges to the system in an ETSA event
- develop a real-time emergency department presentation monitoring system, together with ambulance information and social media monitoring for

a whole-of-system perspective and more rapid dissemination of public information and warnings.

Since November 2016, work towards these objectives has proceeded as fast as possible. The development of a forecasting system was a priority.

Minister for Health, Jill Hennessy, launched the State Government's new ETSA forecasting system at the start of the 2017 pollen season, which runs from October to December. The Government invested \$15 million to partner with the Bureau of Meteorology, the University of Melbourne, Deakin University and other research organisations to create this warning system. The trigger is high grass pollen levels and certain types of thunderstorm. Wind changes, temperature, rainfall and grass coverage all influence the forecast. Simplified measures of thunderstorm and pollen count then lead to low, moderate and high risk assessments for ETSA.

Pollen data are now collected from an expanded set of locations, including Hamilton, Creswick, Bendigo, Dookie and Churchill, as well as the existing traps in Parkville, Burwood and Geelong.

It is important to recognise the contribution of other partners in the development of educational materials. Asthma Australia has developed a communication, engagement and education program for the general public, education providers, sports and recreation groups and workplaces on thunderstorm asthma. The National Asthma Council is developing a health professional education program, including the development of new resources and face-to-face workshops across Victoria, and the development of four online training modules.

As well as forecasting and educational measures, monitoring and response in a timely fashion are vital. There are three primary signals now in use, helping to target the response by the health system:

REDITS (Emergency attendance data - Real-time Emergency Department Information and Trending System): The REDITS report the number of presentations to public hospital emergency departments throughout the state in real-time (20 emergency departments). This provides an early indication of surges in total presentations on hospital emergency departments.

Social media activity: Real-time data is available via social media monitoring in the digital marketing and communications team at the Department of Health and Human Services. Sifting out activity that relates to an unexpected surge in asthma remains a challenge.

Ambulance Victoria activity data: Data that are almost real-time are now available. For ETSA monitoring, respiratory-related calls, proportion of respiratory cases transported to hospital, and total cardiac arrest calls are relevant.

Finally, to you, the readers of Vicdoc. All clinicians need to be aware of ETSA. General practitioners and many others will play a role in optimising prevention and management of asthma attacks, including ETSA. Promoting the measures for greater resilience above, aided by the new tools outlined, is a task that many of us share in the healthcare system.



Prof Charles Guest

Chief Health Officer

Department of Health & Human Services

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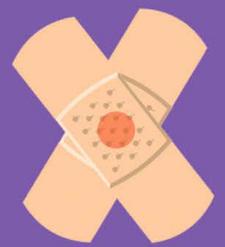
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TIME TO IMMUNISE

In recent months, men who have sex with men (MSM) have been affected across Victoria by an outbreak of hepatitis A infection, and also an outbreak of invasive meningococcal disease due to serogroup C (MenC).

Fortunately, safe and effective vaccines are available for these conditions, and in response, the Victorian Government Department of Health and Human Services has launched an immunisation campaign for MSM throughout 2018 to combat these re-emerging public health threats.

All immunisation providers across Victoria are encouraged to offer a free two-dose course of hepatitis A vaccine to MSM and also to people who inject drugs, and a free single dose of meningococcal ACWY

vaccine to all MSM. In order to bring together important existing and new vaccination advice for MSM, materials for this campaign also highlight a new offer to MSM aged up to 26 years of a free, three-dose course of four-valent human papillomavirus vaccine (Gardasil®) through 2018 to prevent HPV-related cancers. Finally, the campaign will remind immunisation providers of the ongoing recommendation for free hepatitis B (Engerix-B®) vaccine for MSM.

In total four different vaccinations are being offered free to MSM in Victoria during 2018. A targeted multi-vaccination campaign of this scope has not been undertaken in this state for this cohort before and should provide significant long-term health benefits for this population. The department encourages you to offer all four free vaccines to any MSM presenting to your clinic or service. In most instances, hepatitis B is the only one of these vaccines that requires a blood test before commencing the course.

These emerging infections remind us of the value of vaccines in protecting the public against an expanding list of vaccine-preventable diseases. In 2016, the Australian Academy of Science updated its popular booklet *The science of immunisation* (www.science.org.au/learning/general-audience/science-booklets/science-immunisation). The Academy described in highly readable language how vaccines remain the most effective form of prevention available to the medical community and society as a whole.

Changes to immunisation programs are now a regular occurrence. The Federal Government recently announced the introduction of meningococcal ACWY vaccine to the National Immunisation Program for all children at 12 months of age. We now have an Australian Immunisation Register to record a person's immunisation history across their whole life for all vaccines. And with influenza surveillance indicating 2017 showing some of the highest levels of flu activity since the pandemic in 2009, the Victorian Government announced a \$3.5 million program to fund free influenza vaccine for Victorian children aged six months to less than five years, for the 2018 season.

After only three cases of MenC were notified throughout Australia in 2016, Victoria experienced an outbreak of eight cases of MenC in MSM from May 2017. MenC infection causes sepsis, meningitis or both, with death in 10% of cases, and permanent disability in up to 20% of survivors. Transmitted through close contact, MenC spread across Melbourne, prompting a state-

wide offer of meningococcal ACWY vaccine to MSM. The free vaccine (Menactra®) is a single dose course, inducing good immunity within 10-14 days that lasts at least a decade. Search for 'meningococcal ACWY' on www.health.vic.gov.au for more information.

In late 2017, Victoria joined many other parts of the world when it experienced a large upswing in cases of hepatitis A infection. Affecting mostly MSM, but also people who inject drugs, there were already 39 confirmed cases as of February 2018 and rising, with nearly 70% hospitalised due to their illness. It is likely that infection was introduced into Victoria by returning overseas travellers, with local spread now occurring through close contact and sexual activity, in some cases associated with attendance at sex on premises venues.

Hepatitis A is a particular threat because risk is normally limited to overseas travel, but once acquired it can spread readily through direct contact or through contaminated food or drink, and many Australians are susceptible. The incubation period is between 15 and 50 days, with symptoms including fatigue, abdominal pain, nausea and jaundice. Hepatitis A is fatal in almost 2% of adult infections.

Crucially, people are infectious for around two weeks before they become ill until around a week after jaundice appears, giving plenty of time to generate the next cycle of infections. If notified to the department quickly, further spread to contacts and those eating food prepared by cases can often be prevented, including through administration of post-exposure prophylaxis. The latest Chief Health Officer (CHO) Alert contains information about when to suspect hepatitis A, what immediate infection control advice to give, what tests to undertake, and the importance of notifying the department by calling 1300 651 160 immediately on suspicion, 24 hours a day.

Inactivated hepatitis A vaccine is incredibly effective in preventing infection, providing almost 100% protection by four weeks after the first dose. A second dose of the free vaccine (Havrix1440®) given 6-12 months later probably provides immunity for life.

To halt this epidemic it may be necessary to achieve vaccination coverage rates for hep A up to 70% across all age groups for MSM and in people who inject drugs. This means vaccinating up to 25,000 MSM as soon as possible across Victoria,

through general practice and in other settings like sexual health clinics. Making the vaccine free has removed a barrier, but increasing awareness among health professionals and target populations is critical. Free vaccines are now available for order by all immunisation providers using order forms at www2.health.vic.gov.au/public-health/immunisation/vaccine-order-and-stock/vaccine-order-forms

There are simple steps all immunisation providers can take to help halt these outbreaks:

- familiarise yourself with materials for immunisation providers, by clicking on links at the bottom of the most recent CHO Alert - www2.health.vic.gov.au/about/key-staff/chief-health-officer
- put up posters and other *Time to Immunise* materials at your clinic or practice to promote awareness - www.betterhealth.vic.gov.au/timetoimmunise
- order all four vaccines by using the department's order form
- identify patients who are MSM and offer all four vaccines if indicated, and identify people who inject drugs and offer hep A and hep B vaccine to these patients
- consider bulk billing your patient to assist this public health initiative
- record the administration of all vaccines given on the patient's Australian Immunisation Register record, maintaining the integrity of this vital whole-of-life register.

Finally, one trick to getting ahead of outbreaks is for doctors and clinical leaders to have authoritative and up-to-date information on actions health professionals can take in response. Click on *Subscribe* on the CHO webpage to receive timely information on the latest public health threats (www2.health.vic.gov.au/newsletters). Alerts contain further links to information for doctors, and links to the department information resource for patients, known as the Better Health Channel.

Our thanks to all doctors for their help with getting the word out there about this initiative!



Dr Finn Romanes
Public Health
Physician
Department of Health
& Human Services

10 years of supporting doctors and medical students - AMA Victoria Peer Support Service

On Friday 1 February 2008, the Peer Support Service line rang for the first time. Since then the service has received about 750 calls. The Peer Support Service (PSS) was established to provide all medical students and doctors in Victoria and Tasmania with the opportunity to seek support anonymously from a colleague over extended hours, 8am to 10pm, every day of the year. It continues to serve that purpose 10 years on.

Volunteers

The service is based on the generosity of volunteers who are all experienced doctors. These volunteers remain anonymous and are not publicly recognised for their role. Three of the current 20 volunteers have been with the program since it first commenced. All volunteers participate in a training program before starting the role and also meet regularly for debriefing, support and ongoing training.

The volunteers enjoy their role and several recently outlined aspects of their motivation for participation in the service:

"I'm grateful to have the opportunity to receive AMA Victoria training to become a Peer Support counsellor. I believe it is a worthwhile service for doctors in all kinds of distress and we can provide a first port of call to help with many issues." - Dr K

"It has made me a better listener and it is an easy way to give back. We have all taught and mentored and this is another step along the progression." - Dr C

"We all have events in our careers that cause great distress and this has encouraged me to want to give support to others." Dr L

"Peer Support is awesome and has made me a better doctor." - Dr B

The volunteers are from a variety of specialties and include GPs, paediatricians, obstetricians, surgeons, physicians, anaesthetists, psychiatrists, academics and government employees. There is no typical volunteer but many are in the latter stages of their career, still practising but not full-time. All volunteers are familiar with the health system, the rigours of the college training programs, the challenges of balancing work, study and personal life events, as well as the demands

of medicine. All the volunteers are empathic and want to give back to their profession through this role.

Why call?

The reasons doctors and medical students call the service vary enormously, but generally they are seeking a listening ear from a colleague who understands medicine. The reasons behind the 102 calls the service received in 2017 are shown in the table below.

Reasons for calling in 2017 (May be more than one per call)	Percentage of calls (Total of 102 calls)
Stress	24%
Doctor in Training issues	10%
International Medical Graduate issues	8%
Personal affairs (total)	13%
Relationship breakup	3%
Family problems	7%
Difficulty getting on with others	1%
History of abuse, seeking help	1%
Neighbour issues	1%
Work issues	
Workload	13%
AHPRA/Medical Board issues	13%
Facing internal complaints	2%
Practice issues/protocol	3%
Career questions/dilemmas	0%
Finding work	5%
Terminated	1%

Anxious about starting work	3%
Anxiety re serious error	1%
Failing assessments	1%
Relationship issues with colleagues	2%
Safety concerns (two directly related to Box Hill incident)	4%
Legal	3%
Ethical	1%
Information request	2%
Financial	4%
Mental health	14%
Supporting fellow student post suicide attempt	1%
Bullying	7%
Caller being accused of bullying / harassment	2%
Aggression from patients	2%
Loss and grief	0%
Alcohol and other drugs	3%
Trauma/victim of crime	2%
Suicidal thoughts	9% (2% had a plan)

Here are a couple of examples of cases that have been assisted by the PSS.

Case 1

An intern calls and says she has only been practising for 11 weeks and is on her first emergency medicine rotation in a rural hospital, after a previous surgical rotation in a major metropolitan hospital. She discloses that she has been feeling anxious about the decisions she is making and worried that she might miss something critical. Although there is always a registrar to supervise her she says that the registrar is always busy and she doesn't like to interrupt them. She also is struggling with the different systems in this hospital. As her story unfolds she explains that today a local GP blasted her over the phone for sending home a patient who was later diagnosed with pneumonia and is now intubated in the ICU in a nearby major regional city because of the delay in diagnosis. The intern feels terrible that she missed this and also is worried that this will cause her to fail this rotation and thus her intern year.

The PSS volunteer listens to the intern and allows her to vent her anxiety, her frustration and her distress. They talk about what she might have done differently in the diagnosis and management of the patient with pneumonia. They discuss the importance of asking for help and seeking advice at this early stage of her medical career. They talk about the need for doctors to be flexible and adjust to different systems in different workplaces. The discussion identifies that the intern is reluctant to seek help - whether from the registrar or other hospital staff. They also talk about how she can approach discussing the missed diagnosis with her registrar and consultant and what she has learnt from this case. The PSS volunteer is also able to normalise the situation for the intern and reassure her. At the end of the call the intern says, "I feel calmer now and I am ready to talk with my registrar about

the GP's call. I can see that I need to ask for assistance rather than make mistakes. Thank you for talking with me it has been really helpful."

Case 2

A GP calls the service after receiving an AHPRA notification letter. Initially he is calm and says he saw the PSS telephone number on the letter and thought he would call to find out what support is available. However, as he explains that the notification relates to a complaint of sexual misconduct his voice quivers and he says, "I can't believe this is happening to me, this is simply not true but it will be my word against the patient's".

The PSS volunteer acknowledges his distress with the words, "It must be really upsetting to receive this complaint and feel that you may not be believed." The PSS volunteer reminds the GP that he needs to notify his medical defence organisation (MDO) and get expert advice before responding to the notification letter. They discuss the usual process involved in an AHPRA notification and what the GP can expect. They also talk about how a notification like this feels like a kick in the guts when as a doctor you have always done your best for your patients. The PSS volunteer listens and allows the GP to talk about his anxiety and his feelings of anger. The GP admits he is worried how his wife may respond when he tells her about the allegation and that it may impact on his marriage. They discuss how he might approach the conversation with his wife. As his emotion dissipates the GP says he is ready to make the phone call to his MDO. The PSS volunteer invites him to ring back at any time if he needs further support.



Kay Dunkley
Doctor Wellbeing
Advisor

Recruiting new volunteers

The AMA Victoria Peer Support Service (PSS) will be running training for new volunteers in Parkville on the weekend of 14-15 April. There will be 16 contact hours of training over the weekend which will run each day from 8.30am until 5.30pm. Training will be led by psychologist Claire Hutton and will focus on listening skills and provision of crisis support over a telephone. A module on suicide awareness is included and a significant proportion of the training involves role plays.

The PSS is now calling for expressions of interest from experienced members of AMA Victoria who would like to participate in this training. The expectations of those participating are:

1. A willingness to become a volunteer with the PSS. The role involves being on duty with a Peer Support phone from 8am to 10pm each day for a week, about four times a year according to availability. Rosters are self-selected.
2. An ability to commit to the full weekend of training on 14-15 April.
3. Experience as a doctor and broader life experience are essential. Both working and recently-retired doctors are welcome.
4. Personal qualities include being able to remain calm and provide non-judgmental support, whatever the situation.
5. An ongoing commitment as a volunteer to meet five times a year for debriefing and support. Those living outside metropolitan Melbourne can use teleconferencing to join these meetings.

The number of participants is capped, so if you can meet this criteria please respond before Friday 6 April by email to Kay Dunkley on KayD@amavic.com.au with your contact details and member number.

Career conversation

There has been an emerging pattern in recent years of doctors looking to explore alternate and non-traditional careers both within and outside of clinical medicine. Following on from our article on alternate career paths for doctors in the December 2017/January 2018 issue of *Vicdoc*, we are profiling a range of doctors who have transitioned to non-traditional paths - either instead of, or in parallel to a traditional clinical path. These stories are not only very interesting but can help other doctors understand that medicine can present diverse, often untapped career options.

Venita Munir - ED doctor and writer

Venita Munir initially had thoughts about studying design, but instead decided to pursue a career for many years in emergency medicine. After re-evaluating her professional life, Venita now works as a medical writer, in between some more creative story telling.

How would you summarise your career path?

I trained at Monash University, graduating in 1992. I worked at Box Hill Hospital for the first five years, which offered training programs in general practice and emergency medicine (EM). I joined RACGP for one year, but preferred the camaraderie and support of EM. I started EM training at Box Hill, then went to St Vincent's Hospital to complete it and stayed on as a staff specialist until 2011.

Both my husband and I are emergency physicians and the shift work wasn't conducive to how we wanted to bring up our daughter. In 2011 I left work to parent full-time and in 2014 I started studying Professional Writing and Editing (PWE) at RMIT. I have since combined writing, editing and medicine.

Why did you choose to study medicine?

When I finished secondary school, I wasn't sure what to do. I wanted to study design, like my sister who did Industrial Design at RMIT. I watched how creative she was and doubted whether I could generate ideas every day. I loved biology and was fascinated by anatomy, so I changed my first preference to Monash medicine and unexpectedly got in.

Who or what have been the influences on your career

pathway choices - people, stories, experiences?

The emergency doctors at Box Hill, under doyen, Edward Brentnall, were my main inspiration. Special mention goes to Sandra Neate, my close friend and mentor. She made me realise I could specialise, work part-time, have a family and a life outside medicine. My former boss, the late Andrew Dent, put all of us at St V's to shame with his unwavering dedication and humour. My study group, Anthony Cross, de Villiers Smit and the late Elizabeth Christian, were my motivators and support over many years.

Emergency medicine is not for everyone. It's for the true generalist who can't decide on a niche specialty. You treat such a varied cohort you are constantly on your toes. Even though the training was difficult, with years of shift work and often thankless conditions, I enjoyed the teamwork and the variation. You can always go home after a bad day and come back tomorrow to something different.

Every person working in emergency services has stories of the extraordinary: success, tragedy, fear, relief, trauma and gratefulness. It's a privilege but also hard to leave the stories behind.

What inspired/prompted the career pathway choices or changes you have made?

From 2008-2011, I had a run of back luck with my health and family. I felt like I couldn't give as much of myself (professionally) as I had previously, and I was finding emergency medicine less about patient care than directing traffic in a stressed system. I decided to stop working until my daughter started school.

I started writing to express emotions, did a short fiction course at RMIT and joined a writing group. I was tempted to do PWE but was unsure. I met author, Chris Womersley, who'd done the course and after reading his unforgettable novel, *Bereft*, I wanted to hone my writing craft. Through PWE, I'm now working on two manuscripts, have published short stories and microfiction, and write music reviews and interviews. I worked at the 2016 Ubud Writers Festival in Bali, and was a finalist in the ACT Writers' Centre 2016 HARDCOPY program for fiction. I have an inspiring writing circle, enjoy regular writing retreats to Musk (near Daylesford), and went to Varuna



(the National Writers' House) last year. What a nice life!

Combining medicine with writing and editing allows me a niche that has some demand. I'm working for the Melbourne Institute's MABEL (Medicine in Australia: Balancing Employment and Life) survey of 10,000 doctors annually. I'm glad to have access to this trove of data and promote the work as it helps guide health policy and doctors' health issues. I urge people to participate!

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

Nothing really, though I'd love to have more time to dedicate to my fiction projects.

Do you foresee any further changes in career paths in your future?

Having two professions leaves it wide open for me, which is a great place to be.

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

I spent years thinking I wasn't qualified to do anything else, whereas medicine offers so many transferrable professional skills. It's not the 20th century anymore where people got stuck in jobs/careers for life. If you dread going to work, as I did, change your life, try something creative.

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

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Clamping the umbilical cord later saves preterm babies' lives

Thousands of preterm babies' lives could be saved by waiting for at least 60 seconds before clamping the umbilical cord after birth instead of clamping it immediately - according to two international studies, including research from Hudson Institute, Monash University and Monash Health.



Published in the *American Journal of Obstetrics and Gynecology*, the review assessed morbidity and mortality outcomes from 18 trials comparing delayed versus immediate cord clamping in nearly 3,000 babies born before 37 weeks' gestation.

It found clear evidence that delayed clamping reduced mortality in hospitals by a third and is safe for mothers and preterm infants. It is estimated that for every thousand very preterm babies born more than ten weeks early, delayed clamping will save up to 100 additional lives compared with immediate clamping.

A lifesaving treatment at no cost

The review, led by researchers from the University of Sydney, confirmed

the tentative findings of another study. The Australian Placental Transfusion Study (APTS), published in the *New England Journal of Medicine*, cautiously reported that delayed clamping might reduce mortality before 36 weeks.

Co-author for the APTS and Head of Department of Obstetrics and Gynaecology at Monash University, Professor Euan Wallace said a simple change to the immediate care of these tiny, vulnerable babies can significantly improve their chances of survival.

"Best of all, there is no cost to the change. There are no fancy new drugs or new bits of equipment required. All that is needed is to delay clamping the baby's cord for a minute or so," Prof Wallace said.

Both studies were supported by hundreds of parents and professionals worldwide.

Significant advance

APTS study co-author and Monash Newborn neonatologist, Professor Arvind Sehgal said the finding is a significant advance in perinatal medicine that stands to benefit infants of all gestations.

"This is the largest study of its kind involving centres from across the globe and suggests a major change to care at time of birth for preterm infants," Prof Sehgal said. "The baby's own blood is stored in the placenta and its transfusion to the newborn through delaying cord clamping by 60 seconds has been shown to significantly improve outcomes.



Top: Professor Euan Wallace.
Middle: Associate Professor Graeme Polglase.
Bottom: Professor Stuart Hooper.

"This is a great example of collaborative physiology driven clinical research at the international level which ultimately benefits the most vulnerable infants in our care."

Understanding the science

Researchers from The Ritchie Centre (Hudson Institute and Monash University) discovered the importance of delaying cord clamping until after the baby starts to breathe. Associate Professor Graeme Polglase, who led part of the research, said birth is a critical and challenging time when a newborn must initiate its own breathing to supply vital oxygen to its organs.

He said one in five babies in Australia need help to take their first breath independently of their mother's

placenta when entering the world. "This study shows that simply giving the baby a bit more time to breathe before removing it from the life support of its mother has amazing immediate and long-term benefits for the newborn," A/Prof Polglase said.

A new teaching resource for midwives and doctors

A team of researchers from Hudson Institute and Monash University is now helping to improve care in Victorian hospitals by developing new teaching resources for midwives and doctors to explain how delayed cord clamping helps babies at birth.

Professor Stuart Hooper, head of fetal and neonatal health hub The Ritchie Centre, leads the team that has been researching delayed cord clamping

for 10 years and says it's vital that research evidence is translated to the delivery room.

"These teaching resources will ensure doctors, nurses and midwives working on the frontline are kept informed about current research and the simple evidence-based changes that can give preterm babies the best chance of life," Prof Hooper said.

To learn more, visit www.hudson.org.au/research-centre/the-ritchie-centre/

HUDSON
INSTITUTE OF MEDICAL RESEARCH

Generation Victoria: Better lifelong health and learning for all



Can a state create one of the world's largest birth cohorts? Can that cohort help transform the health of the state's children? These are two of the questions underpinning Generation Victoria (GenV), a program being led by the Murdoch Children's Research Institute in Melbourne.

GenV arose from an overwhelming frustration with the pace of progress towards better prevention, prediction, treatments, and health services delivery for kids. Current research structures are simply too slow, cumbersome and expensive to scale up to the speed and size needed to solve the burden of children's modern epidemics. Conditions like school failure, depression, obesity, autism, asthma, and antisocial behaviour aren't new, but they're all at epidemic proportions - and none has proved easy to shift through decades of 'traditional' research.

In creating a large-scale interventional birth cohort (GenV 2020), GenV has an ambitious goal - essentially, for the state of Victoria to become a dynamic platform with a solution-focused mindset. In November 2017, the Victorian Minister for Health launched the GenV program, hailing it as a world first in child health and development. Philanthropic and government support are confirmed for the GenV Foundation phase over the next three years, and work is now beginning in earnest.

'Big research' isn't 'small research' multiplied. Rather, GenV aims to embed innovative, cost-effective research into

the state's very fabric. What this means is that a research project no longer starts when a child arrives in your clinic or hospital, nor ends with your funding or your new rotation. The child with pneumonia has birth samples; the child with a head injury has outcomes 10 years hence; you can visualise how the babies born in your unit fare over time. GenV may also have a powerful 'trials within cohorts' capacity for children born in its window - potentially solving two of the biggest headaches for trialists, i.e. loss to follow-up and short-time horizons.

GenV has three major inter-related components:

- **GenV 2020:** This large birth cohort will be open to all 160,000 babies born in Victoria over two full years from late 2020. Its foundations rest on consent soon after birth, use of existing data, and storage of existing state-wide biosamples to research-level quality. As well as accessing health services data, GenV will seek out opportunities to embed novel information into health and other encounters as the children grow. GenV-specific contacts (for example, direct health

measurements) will be crucial but kept to a minimum. With such large numbers and a driving desire for inclusivity, every process must be streamlined, low-burden and essentially be 'business as usual' for participants - with the added benefit of a possible legacy of lasting changes to data systems. The design is simple but unique, bringing biology to the population level to drive both discovery and solutions.

- **GenV Solution Hubs:** These will bring researchers, policy-makers, practitioners and communities together to put this new resource "to work" even before it starts. Eight Hubs are initially proposed - Health Services, Population Health & Learning, Place-based Research, Discovery, Clinical Databanks, Clinical/Registry Trials, Population Trials, and Disaster Recovery. All address national and state health and wellbeing research priorities. Solution Hubs will help design the features that can maximise GenV's impact, and to shape and drive research priorities relevant to each age and stage as the GenV 2020 children mature. The first Solution Hubs will commence in 2018, with Terms of Reference now being established.

- **GenV Big Data:** Work on the GenV Data Repository began in January 2018, to hold complex datasets designed to integrate with Victoria's developing clinical informatics and data linkage capacities. It will also be responsible for making the GenV data safely available to all users within appropriate governance frameworks. The size and scope of the data will open new research and evaluation horizons - another exciting challenge is to make sure that Victoria is analytically and computationally ready for it.

What might a project like GenV mean for, let's say, childhood obesity? GenV could help map the epidemic and its consequences - geographic inequalities, successes and failures, and its true health and education costs. It could help develop and test more precise predictive tools - what is this child's risk of developing obesity, and what is this obese child's risk of developing disease? It might be a vehicle for trials of different 'nudge' messages regarding early life feeding and solids, formula content, functional foods, and physical activity. It could support genomic and metabolic discovery, and map and test cross-sectoral health services approaches for this complex issue.

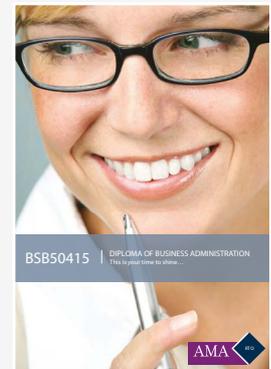
Through 2018, the GenV team at the Murdoch Children's Research Institute will be further developing its partnerships with hospitals, clinicians, peak bodies, state and federal departments, and researchers. It's early days yet, but over the coming year we are committed to shaping this 'Big Idea' into a reality with partners throughout Victoria.

By 2035, our vision is that the GenV program will be a cornerstone in driving collaborative research, policy and service design to solve complex health, development and wellbeing problems for children. In collectively learning how to build a strong early foundation for a healthy life, GenV may one day help turn around the unprecedented rates of adult diseases (like heart disease, diabetes, kidney failure, osteoporosis) that are otherwise set to take the GDP health spend beyond 13% by 2030.

For more information, email GenV@mcri.edu.au



Professor Melissa Wake
Paediatrician & Scientific Director Gen V
Murdoch Children's Research Institute



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Effective implementation of My Health Record in specialist practice

The difficulty of obtaining details about a patient's medical history and treatment creates safety risks as well as an administrative burden for doctors, practice staff and patients. My Health Record (formerly the Patient Controlled Electronic Health Record, or PCEHR) aims to provide practitioners with secure access to a patient's radiology and pathology reports, and the option to upload and access Health Summaries, Event Summaries and treating practitioner letters. Patients can also opt to upload additional information such as their allergies and Advanced Care Directives.

For the last decade My Health Record (MyHR) has been dogged by the challenges of establishing a secure, nationwide system that interacts with the multiple different clinical software systems. Multiple barriers exist to its use, including inadequate internet access. In 2016 these barriers prevented many Australian general practices from complying with government MyHR upload requirements for practice incentive payments (PIPs), leading the Health Minister to extend the compliance deadline to 2017. The lack of specialist use of MyHR compromises

the usefulness of the system and is a barrier to GP uptake - as is the poor uptake of MyHR use by hospitals, allied health practitioners and radiology and pathology providers.

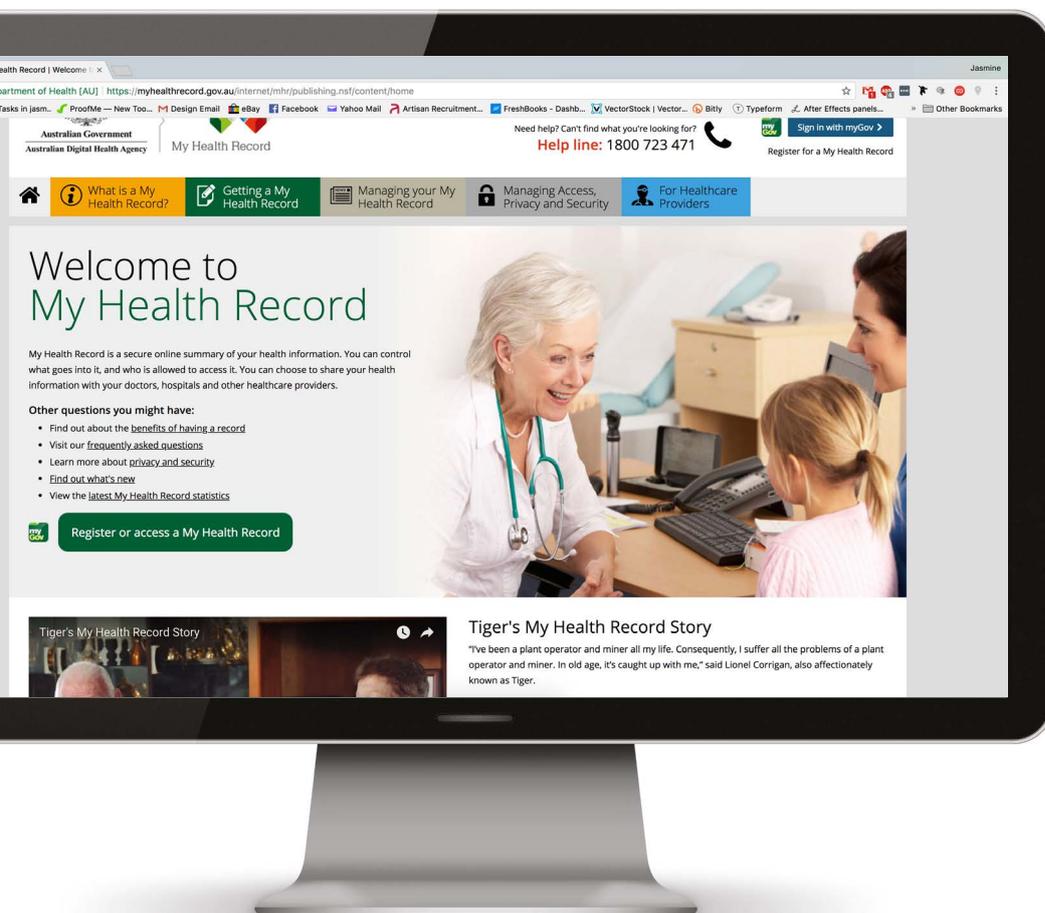
Currently over 5.5 million Australians have a MyHR - approximately 23% of the population. In 2018 MyHR will move from an opt-in to an opt-out system, following successful opt-out trials in northern Queensland and the Nepean Blue Mountains. The date for the opt-out change has not been set but this change is expected to dramatically increase the proportion of the Australian population who have a MyHR. An increasing number of radiology and pathology providers across Australia are also beginning to upload results to MyHR, which will further increase MyHR's usefulness.

In 2017 Dr Jill Tomlinson of Melbourne Hand Surgery conducted a Quality Improvement project examining the introduction of MyHR within her specialist practice. The following is a summary of some of the project, including issues encountered along the way.

MyHR and specialist practice

Our clinician-led project aimed to introduce MyHR to a specialist practice in a manner that identified and proactively addressed legislative, privacy and medico-legal issues. It was our hypothesis that a tested and successful implementation framework would reduce provider scepticism and facilitate the complex changes associated with MyHR uptake in other specialist practices.

MyHR use requires specific IT changes and training within a practice and brings new medico-legal and security risks and challenges. However, specialist practices have not been provided with government incentive payments or specific resources to aid them in MyHR implementation.



Project achievements and outcomes

Our project was a success, although specialists who embark upon this journey need to be aware that MyHR is still a work in progress, particularly in relation to integration with practice software systems. We were able to register for MyHR use and set up MyHR access through our clinical information system (Genie Solutions) without external IT assistance. We created a risk matrix, developed the necessary policies and implementation documentation, conducted training of clinical and non-clinical personnel, implemented workflow changes to support MyHR use, and examined the nature of the information that should be included in an Event Summary upload. We uploaded Event Summaries for 100% of eligible patients - that is, patients who had a MyHR at the time of their first post-operative appointment and who provided consent for the upload.

However, it wasn't all smooth sailing. Problems and unexpected error messages were encountered with 32% of Event Summary uploads, a level that does not give a clinician confidence that he or she can routinely upload a short Event Summary during a consultation. Issues that were able to be identified and corrected included:

- Administrative staff had difficulty in obtaining the Individual Healthcare Identifier (IHI) of some patients, without which MyHR cannot be accessed.
- Incorrect or missing demographic information allowed the patient IHI to be obtained but prevented upload of an Event Summary.
- Intermittently some patients were found to have duplicate IHIs in the Clinical Information System. This creates an inability to access MyHR for that patient until the IHIs are manually cleared for the two patients who have the erroneously duplicated IHIs and the correct, non-duplicated IHI is newly obtained. This appears to be an error with the clinical information system rather than with MyHR per se.

Problems encountered that were unable to be corrected or the cause determined included:

- Clinical Information System (CIS) crashing immediately after upload of the Event Summary in some instances.

- Two instances where an Event Summary could not be successfully uploaded unless microbiological results were omitted.

Looking forward, it is evident that the clinical usefulness of MyHR is currently limited by the scant amount of data within MyHR, but when MyHR reaches a point where there are many pieces of data in a patient's file it is evident that the inability to label uploads and search for specific terms within uploaded documents will hamper clinician efforts to locate specific data - for example, if a radiologist is searching for prosthesis details to determine if a prosthesis is MRI compatible. This is an issue that we anticipate will be examined and addressed by the Australian Digital Health Agency in due course.

A key element regarding use of MyHR that is not widely known is that only healthcare practitioners can access MyHR. Many specialists incorrectly assume that their receptionist or administrative staff will be able to access MyHR or troubleshoot technical issues. Due to the need to have an AHPRA issued HPI-I (Healthcare Provider Identifier - Individual) number, nursing staff can access MyHR, as can allied health staff can but administrative staff cannot.

Conclusions

This project has demonstrated that a busy specialist practice can successfully develop workflow practices and an implementation framework that permits the introduction of MyHR uploads as a routine part of clinical practice.

Clinicians can expect to encounter technological difficulties with the integration between their CIS and MyHR until software developers have ironed out issues.

The clinical usefulness of the MyHR will be influenced by:

- Widespread adoption by patients and doctors, which requires implementation barriers to be addressed.
- Usefulness of uploaded information.
- Ease of access to uploaded information.

To assist other specialist practices in introducing My Health Record use in their practice we have made our resources and protocols available for download from the Melbourne Hand Surgery website:

www.melbournehandsurgery.com/35-mhs/268-my-health-record-introduction-to-specialist-practice-resources-for-specialist-practices



Dr Jill Tomlinson
Hand Surgeon
AMA Victoria Board member

This project received funding through the 2017 Avant Quality Improvement Grant Program.

References available from the Editor on request.

Healthcare Identifiers

The delivery of safe, effective and efficient healthcare relies on good communication and systems that share information, where the subject of care can be reliably and consistently identified. The Healthcare Identifiers (HI) Service is a national system for uniquely identifying healthcare providers, healthcare organisations and individuals receiving healthcare.

The service is operated by the Department of Human Services and is a foundation component of all national digital health products and initiatives, such as the MyHR system. HI help ensure individuals and healthcare providers can have confidence that the right information is associated with the right individual at the point of care.

HI Service allocates and manages the following types of healthcare identifiers:

- Healthcare Provider Identifier - Individual (HPI-I) - for individual healthcare providers involved in providing patient care
- Healthcare Provider Identifier - Organisation (HPI-O) - for organisations that deliver healthcare (such as medical and allied health practices, or hospitals)
- Individual Healthcare Identifier (IHI) - for individuals receiving healthcare services.

New mandatory data breach notification requirements

Amendments to the *Privacy Act 1988 (Cth)* (the Act) which came into effect on 23 February 2018 introduce mandatory data breach notification provisions which all health service providers must comply with. 'Health service' is broadly defined, and includes all medical practices.

Part IIIC of the Act requires providers to notify the Office of the Australian Information Commissioner (the OAIC) and affected individuals when an eligible data breach occurs, i.e., when they suspect that a data breach has occurred and there is a real risk of serious harm to individuals as a result of the breach.

How will this impact medical practices?

Practices are increasingly storing personal and sensitive patient information electronically. Practices should:

- (a) review their information handling processes and policies and their storage and security systems to ensure they are able to comply with the mandatory data breach notification requirements of the Act
- (b) prepare a data breach response plan
- (c) ensure that staff training covers the risks associated with handling patient data and the damage that can be caused by mishandling.

Eligible data breach

An eligible data breach occurs when:

- there is unauthorised access to, or unauthorised disclosure of, information in circumstances where a reasonable person would conclude that the access or disclosure would be likely to result in serious harm to any of the individuals to whom the information relates; or
- information is lost and unauthorised access to, or unauthorised disclosure of, information is likely to occur, and assuming unauthorised access or disclosure of the information will occur, the access or disclosure is likely to result in serious harm to any of the individuals to whom the information relates.

Breaches may occur through data theft, hacking or by accidental loss or disclosure of information through internal errors or failure to follow policies.

Serious harm

If a reasonable person would conclude that the data breach is likely to result in serious harm, it is an eligible breach. 'Serious harm' is not defined, but the explanatory memorandum indicates that it could include serious physical, psychological, emotional, economic and financial harm, or serious harm to reputation.

Serious harm will be 'likely' if such harm is more probable than not, having regard to a number of factors set out in the Act, including the kinds of information accessed/ disclosed/ lost, the sensitivity of the information, whether the information is protected by security measures, the person(s) or kinds of persons who obtained or could obtain the information and the nature of the harm that may result.

Suspected eligible data breach

If a provider has reasonable grounds to suspect an eligible data breach may have occurred but cannot confirm this is so at the time, the provider has 30 days to carry out a reasonable and expeditious assessment as to whether there are reasonable grounds to believe that the circumstances amount to an eligible data breach.

Notification

If a provider has reasonable grounds to believe there has been an eligible data breach, the provider must prepare a statement setting out:

- (a) the identity and contact details of the provider

- (b) a description of the data breach that the provider has reasonable grounds to believe has occurred
- (c) the kinds of information concerned
- (d) recommendations about the steps which individuals should take in response to the data breach.

The statement must be provided to the OAIC and, if practicable, the provider must also notify the individuals to whom the information relates, or each of the individuals who are at risk as a consequence of the data breach, of the contents of the statement.

If it is not practicable to contact the individuals, the provider must take reasonable steps to publicise the contents of the statement and must publish a copy on its website (if it has one).

Exceptions

A mandatory notification is not required to be made if the breach is required to be, and is, reported pursuant to the *My Health Records Act 2012*.

A mandatory notification is not required to be made if effective remedial action is taken before any serious harm is caused by the breach.



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2018-19 Victorian Budget submission



AMA Victoria's 2018-19 Victorian Budget submission includes 24 detailed recommendations on priorities for investment in our health system. The full submission is available to download on our website, and includes the three critical priorities below.

Mental health services

Our submission offers a vision of a major increase in support of vulnerable patients with mental illness, providing access to much needed health services. In meetings with the Victorian Government over the past year, we made it clear that truly significant funding in mental health is paramount.

We recognise that investment in funding must be across public hospital inpatient and outpatient services, primary care and community mental health services.

AMA Victoria offered four overarching recommendations to guide investment in mental health, and urged the State Government to:

- provide significant funding to address the widespread inadequacies across the mental health sector
- provide significant funding for public inpatient psychiatric care, including funding for inpatient child and adolescent psychiatry services
- invest in outpatient consultation liaison psychiatry (CLP) clinics to ensure that patients with comorbid physical and psychiatric problems do not fall through the gaps of our mental health system
- provide funding to address dual diagnosis conditions (for example, we know that 'ice' is a significant

comorbidity for mental health patients) to ensure that people with mental illness receive timely treatment and to reduce the risk of homelessness.

Workforce planning and training

AMA Victoria has identified medical workforce shortages as a major health issue. We told the Government that more needs to be done in the short and medium term to address the current imbalance. We need more doctors. In the right areas. With the right skills mix.

We proposed four solutions to the challenges of workforce maldistribution and called on the Government to commit to:

- funding medical workforce planning initiatives to ensure Victoria has the necessary medical numbers, training/speciality and distribution across the state
- funding to support Victorian doctors to complete their necessary training requirements
- increase the number of medical intern, resident and registrar training positions (including at rural/regional hospitals)
- provide funding to ensure all public hospitals are appropriately resourced to enable doctors to undertake

teaching, training, quality assurance and research pursuits.

Violence in healthcare settings

Each year, the State Budget gives the Victorian Government an opportunity to address critical problems in our health system. One of the most urgent problems facing health services is occupational violence.

Doctors tell us that they are regularly confronted with violence and aggression. In our submission, we sent a strong message to the Government that ongoing funding is critical to track, prevent and manage incidents of violence. Violence is not just 'part of the job'. Our dedicated doctors deserve to feel safe at work.

We are especially concerned for the health and safety of doctors and nurses policing the ban on smoking, following the tragic attack on cardiothoracic surgeon Mr Patrick Pritzwald-Stegmann. We have called on the Government to prioritise funding to local councils to see smoking laws enforced safely and effectively, to extend the smoking ban to all outdoor drinking areas and to introduce licensing fees for tobacco vendors.



Nada Martinovic
Senior Policy Adviser

Summary of recommendations to Treasury

1. Provide funding to undertake specific medical workforce planning to ensure Victoria has the necessary medical numbers, training/speciality and distribution across the state.
2. Provide funding to ensure that Victorian doctors can complete their necessary training requirements. In particular, increase the number of medical intern, resident and registrar training positions (including at rural/regional hospitals).
3. Provide funding to ensure all public hospitals are appropriately resourced to enable doctors to undertake teaching, training, quality assurance and research pursuits.
4. Provide funding to implement electronic secure messaging in Victoria and invest in IT infrastructure to improve communication at the interface between one health service and another, and between health services like hospitals and primary care. This must be integrated with access to My Health Record. Victoria's health IT must be improved to ensure patient safety.
5. Provide ongoing funding to track, prevent and manage incidents of occupational violence against health practitioners in Victoria.
6. Provide significant funding to address the widespread shortages and inadequacies across the state's mental health sector.
7. Provide significant funding to increase public inpatient psychiatric services across the state.
8. Provide funding for outpatient psychiatric services, especially consultation liaison psychiatry (CLP) clinics across the state.
9. Provide funding for new models of mental health care that address dual diagnosis conditions.
10. Provide funding to meet public demand for public hospital services - this includes inpatient, emergency department, elective surgery and outpatient services.
11. Provide significantly increased funding for community palliative and end of life care services across the state, in particular for rural and regional areas.
12. Provide funding for perinatal and child health services, including resources to assist parents avoid developing obesity and other preventable chronic conditions.
13. Provide funding for Victorian-based Youth Education Sessions, targeting adolescents about relevant healthcare issues, including sexual health, alcohol and drug harms, and mental health.
14. Provide funding for a Youth Friendly Doctor program, to further enhance doctors' expertise in adolescent healthcare.
15. Provide funding to support further reforms to tobacco laws (specifically the ban on smoking should be extended to outdoor drinking areas).
16. Provide funding to councils to see smoking laws enforced effectively, especially outside hospitals, healthcare settings, schools and kindergartens.
17. Provide funding for advertising, public health information and quit campaigns regarding the harms of cigarettes, loose-leaf tobacco and shisha/water pipes.
18. Provide funding to introduce tobacco vendor licensing fees.
19. Provide funding for additional capacity in the state's drug treatment services to respond to patients with problem drinking and to deliver early intervention responses.
20. Provide funding for public health messaging of alcohol harms.
21. Provide funding to improve opiate addiction services, including the establishment of public multidisciplinary clinics in regional areas.
22. Provide funding for timely access to multidisciplinary pain management services in public settings.
23. Provide funding for drug treatment services targeting ice addiction and introduce a regulatory framework for private residential drug rehabilitation programs.
24. Provide funding to monitor new and emerging drug trends, and alert health practitioners and healthcare settings of these trends to help ensure effective treatment.

The State Government will deliver its Budget in May. Members can read our full 2018-19 Victorian Budget Submission in the policy section of amavic.com.au

Support services for doctors

VDHP

The Victorian Doctors' Health Program (VDHP) is a confidential service for doctors and medical students who have health concerns such as stress, mental health problems, substance use, or any other health issues. Sensitive to the needs of doctors and medical students, it's a non-judgmental service dedicated to improving the health and wellbeing of those within the profession. Call (03) 9280 8712.

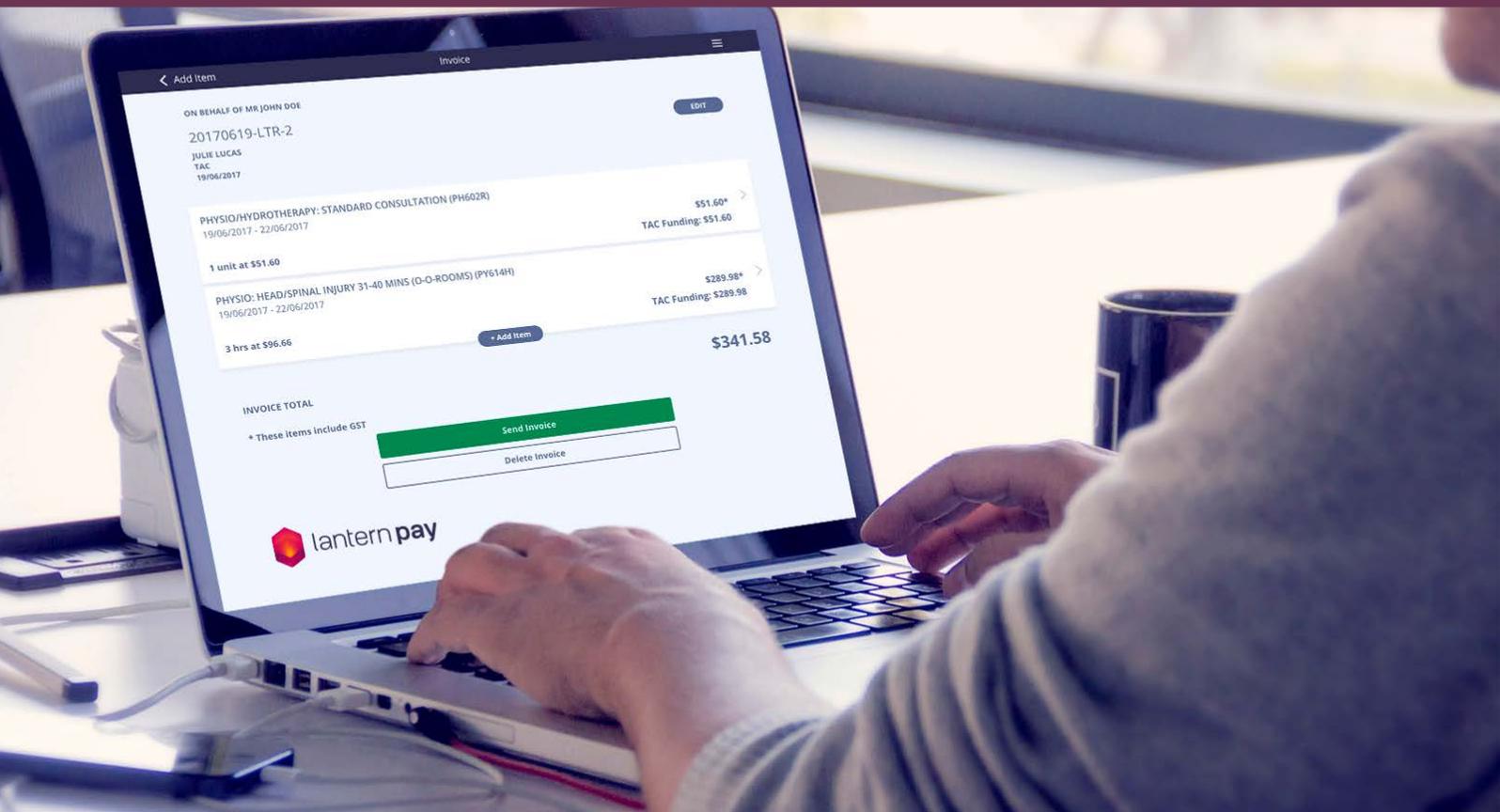
Peer Support

AMA Victoria provides peer support for doctors by doctors. For anonymous and confidential support call the AMA Victoria Peer Support Service on 1300 853 338 (for the cost of a local call). It's available 365 days of the year from 8am to 10pm.

First Response

First Response is a free, confidential telephone support service for all Victorian doctors who may be facing workplace bullying, discrimination or harassment. For support, counsel or advice on your rights and options, call First Response on 1300 AMA DOC (1300 262 362).

TAC announces no medical excess, less paperwork



Removal of medical excess

Victoria's Transport Accident Commission (TAC) has removed its medical excess, one of several changes introduced to improve the health outcomes of TAC clients.

For accidents on or after 14 February 2018, TAC clients no longer have to pay a portion of their medical expenses before the TAC covers the costs. Clients can immediately seek treatment without worrying about out of pocket expenses.

The excess for medical services had long been confusing for people injured in transport accidents and their health and service providers.

Minister for Finance, Robin Scott, believes these changes will improve the experience of both providers and clients in dealing with the TAC. "The Victorian Government is removing red tape so that people injured on our roads can get the support they need and get on with their recovery as soon as possible," Minister Scott says. "We want injured Victorians to spend less

time managing bureaucracy and more time managing their recovery."

Less paperwork

From mid-March, the TAC will also offer a wide range of pre-approved treatments and services, which you can deliver, and refer patients to, without sending a request or calling the TAC first. You can be assured of payment in line with the TAC fee schedule for any treatment or service on the pre-approved list, with no need to contact the TAC beforehand.

You will also no longer need to send reports or clinical notes unless you receive a request from the TAC. Real-time monitoring will flag unusual service consumption, prompting the TAC to contact you, or the client, only when needed.

"Our providers are critical to helping our clients get their lives back on track," TAC chief executive officer Joe Calafiore says. "We want you to be able to deliver the right service at the right time without going through

unnecessary hoops. These changes will remove ambiguity about what is required of you and streamline the process of treating TAC clients."

LanternPay

These changes follow September 2017's launch of LanternPay, a digital point-of-sale solution accessible via desktop, tablet, smartphone or integrated practice software. LanternPay has transformed how more than 3,000 providers transact with the TAC by improving their cash flow and eliminating the need to submit paper invoices or follow up payments.

These initiatives are in support of the TAC 2020 Strategy to eliminate road trauma and help clients get their lives back on track. For more information about ongoing improvements for providers, visit tac.vic.gov.au/changes





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When is it ok to breach patient confidentiality?

Doctors approach the doctor-patient relationship with diligence, and are usually reluctant to breach patient confidentiality. Situations can arise where doctors feel ethically and morally bound to release patient information to protect the welfare of others, as detailed in the case below.



A patient booked a follow-up appointment with Dr Johns, a part-time GP working in a small rural practice. The patient, Peter Jackson, was returning for the results of a CT scan. When Mr Jackson arrived for the last appointment of the day, he was told that Dr Johns was running behind time. Mr Jackson wasn't happy about the delay, but said he would rather wait than reschedule as he needed to see the doctor that day.

After 10 minutes, Mr Jackson advised the junior receptionist that he had been out of town for a while and wanted to check that his details were up to date. The receptionist, feeling slightly intimidated by the patient, agreed to check his details and opened the patient database. She was surprised when she heard a noise behind her and realised Mr Jackson was now standing directly behind her. The receptionist was alone in the practice except for the doctor. Although she was uncomfortable with Mr Jackson's request, she was reluctant to ask him to return to the waiting room.

Keen to get the patient away from her desk, the receptionist typed in 'Jackson' into the computer. A list of patient names appeared on the screen and the patient pointed to an entry for Peter Jackson, saying, "That's me". The receptionist

brought up the record - but before she realised it couldn't be correct because the date of birth only made him 12 years of age, the patient grabbed a post-it note and wrote down the address on the screen.

Mr Jackson smiled at the receptionist and said, "I don't need that appointment after all - but my ex might need a doctor now that I have her address".

The receptionist called for Dr Johns who came out of his consulting room immediately. The receptionist was distraught, realising she had inadvertently disclosed the current address of Mr Jackson's ex-wife and son. Dr Johns had not initially recognised Mr Jackson, but was familiar with the family and aware of a long history of domestic violence which had resulted in the patient being jailed for three years.

Even though Dr Johns had only seen Mr Jackson once, there was still a doctor-patient relationship to consider, so he turned his mind to the issue of privacy and patient confidentiality. He was aware that confidentiality can be breached under certain circumstances, and he formed the view that Mrs Jackson and her son were at serious risk of harm. Dr Johns called both the local police and Mrs Jackson to warn them of the breach and the potential danger to the family,

and he provided the police with Mr Jackson's current address.

Mrs Jackson was picking her son up from after-school sports when she received the call from Dr Johns, and she drove straight to the local police station. Mr Jackson was arrested outside the family home and was returned to jail for breaching his bail conditions.

Mrs Jackson was grateful to Dr Johns for raising the alarm, but was equally concerned about her son's personal details being released by the practice. The practice responded with an unreserved apology, and Mrs Jackson moved to another town for her own safety.



Nerissa Ferrie
Medico-legal Adviser
MDA National

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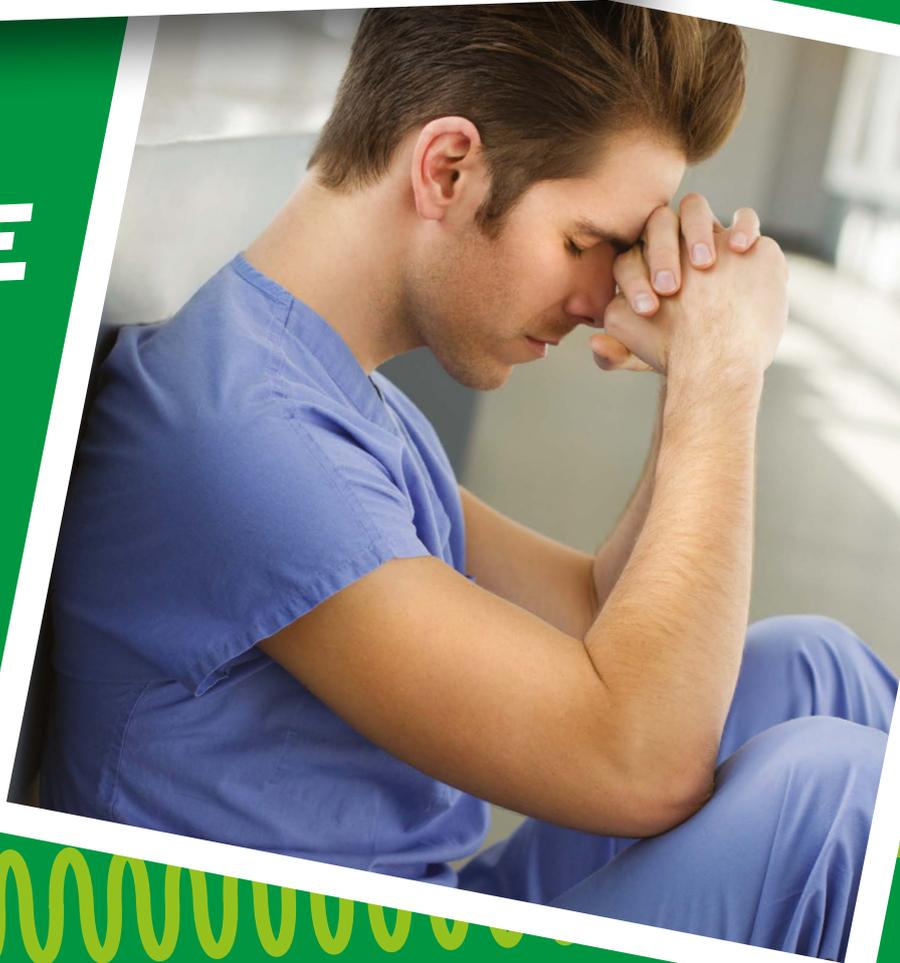
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Lou's legacy helping children with T1D return to school

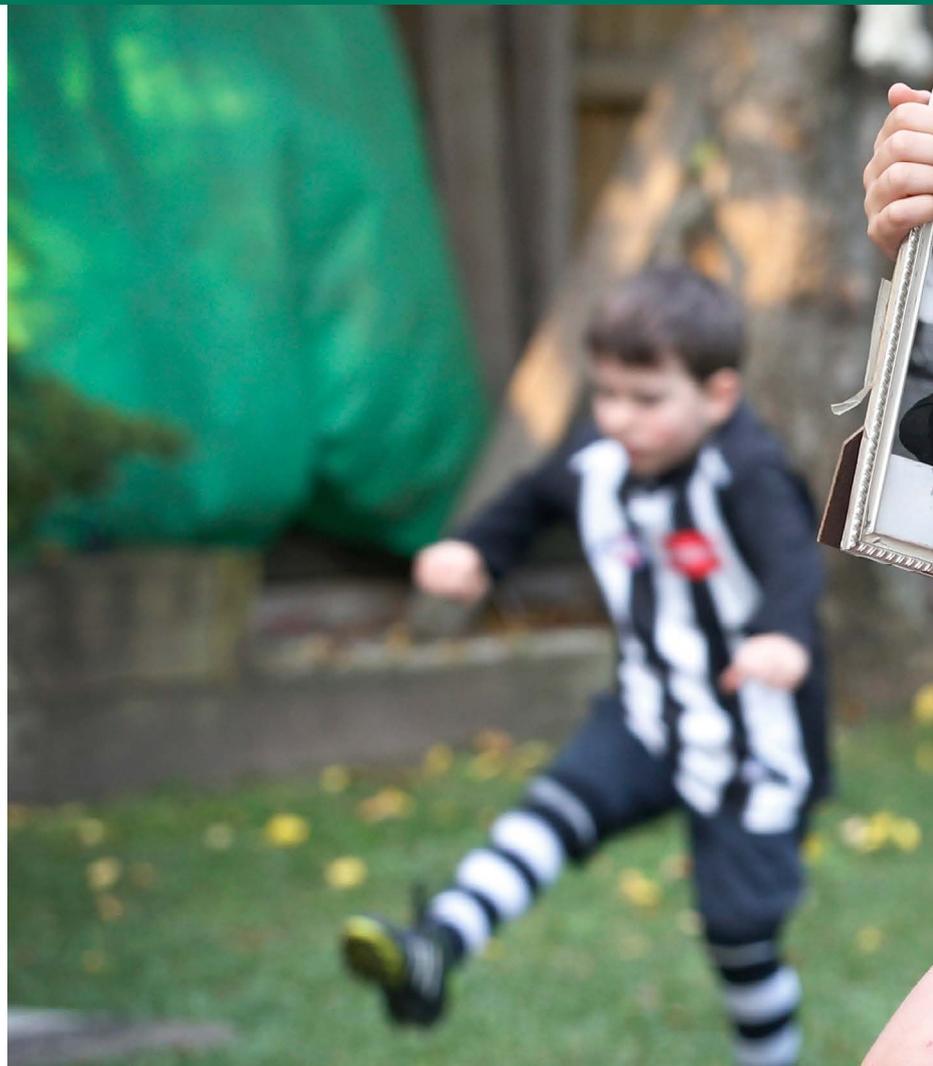
When AFL legend and media personality Lou Richards discovered that his great grandson was diagnosed with type 1 diabetes (T1D) at age five, he was devastated.

It is a common and understandable response when given the news of a lifelong condition in a young child. Family members experience feelings of powerlessness, grief and panic about whether they will be able to cope with the necessary management required each day.

Most families have no prior understanding or experience with T1D and are suddenly challenged with injecting their child multiple times a day, checking their blood glucose levels by finger-prick, counting carbohydrates in food and making major decisions around insulin doses and adjustments at each meal. A diagnosis of T1D required a lot of adjustment to the entire family as well as school and work lives.

However Lou's family elected to take a positive approach and quickly came to view T1D as a challenge that would not beat them. Now four years later, Lou's great grandson Jack is a normal, happy nine year-old, a star footballer in his under-age team and possesses plenty of fun and cheek, typical of his ancestry.

Insulin was discovered a year before Lou's birth (1923), removing a certain death sentence from T1D. Almost a century later, and by the time Lou's life was completed (2017), modern therapy, cutting edge technology and multidisciplinary teamwork are enabling normal life expectancy and



Lou Richards' great grandson Jack with mum, Lucy Morrison, as brother Albert works on his footy skills. (Photo courtesy David Caird/Herald Sun)

endless possibilities for all children living with T1D.

It was significant and poignant that Lou's family generously diverted donations in lieu of flowers at Lou's State Funeral to the Type 1 Foundation, a grassroots Geelong-based family support organisation. The Channel Nine *Footy Show* chipped in, adding a massive \$10,000 via Sam Newman's performance in a resurrected 'Lou's Handball'. In addition, the Collingwood Football Club has supported the movement by allowing the Type 1 Foundation to collect funds at the Collingwood versus Hawthorn AFL match.

There are over 11,000 school-aged Australian children with T1D. It is concerning that only 27% of these children currently reach international recommendations of diabetes health targets. The use of intensive insulin therapy (IIT) (multiple daily injections or insulin pump therapy used together with carbohydrate counting and insulin dose adjustment) is well recognised (and recommended internationally) as being the optimal strategy for all children with T1D to reduce morbidity and mortality of this disease.

However the successful management of IIT during school hours has been



a major challenge. The school day comprises over half of the child's waking hours, up to three meals and varying levels of activity, stress and excitement - all which impact upon blood glucose levels. For children with T1D, the right support and management MUST include school hours.

Without adequate training and support around the complex needs of a child with T1D, school life for a child and family with T1D can be daunting for both the parents and school staff. Some Australian states automatically fund young children with T1D to assist safe and accurate insulin delivery and

other complex care issues in the early years of school - Victoria does not.

A recent Australian parent survey on school experiences revealed that only half of respondents considered that schools adequately support their children with T1D. Almost 60% of respondents consider school staff with direct care responsibilities for their child to have inadequate knowledge about T1D management. The survey provided the basis of the quiz questions that are required to be answered correctly before the participant can continue the module course. Many parents reported distressing

experiences of their child in the current Australian public and private school system:

- *"My just five year-old is to attend kindergarten next year. We, as parents, are terrified for him. We have had no meetings one-on-one to discuss our son's needs. We were told that he needed to be able to inject himself and prick his own finger, as they can only assist. Told that an aide can only assist also. His fingers don't even reach the end of his insulin pen."*

CONTINUED ON PAGE 40

- *“Due to issues surrounding no safe place being available and no support available his insulin injections have stopped at school and he is no longer comfortable there.”*
- *“Our child has had many instances where his health had been compromised (no testing done, hypos not treated or incorrectly treated, left alone in a hypo state, given food without being ‘bolused’, told that hypo treatments are bad for him (jellybeans), been exposed to conversations that he would get fat from all of the jellybeans, had his school support staff say they are sick of diabetes etc.”*
- *“I left our enrolment in tears, wondering how we can send him to school safely. We have inadequate DE help, no knowledge of our rights with schools, no knowledge where to go for help or what help there is.”*

Optimal control of T1D throughout childhood significantly reduces risks of costly and life-shortening long-term health complications. The idea of ignoring T1D in school or running high blood glucose levels to ‘safely’ avoid hypoglycaemia is unfortunately something that still occurs, despite international best practice recommendations. Unfortunately, the effects of suboptimal control during childhood and adolescence cannot be reversed even if control improves in adulthood. Schools now may have legal exposure if they do not enact therapy designed to facilitate normoglycaemia as prescribed by the child’s medical team. However, Australia is underperforming in supporting children with T1D.

There is strong evidence that high and low blood glucose levels may have a negative impact on learning, affecting working memory, concentration, and verbal comprehension. Hence, it is imperative that we aim for normoglycaemia so that children with T1D can enjoy equal opportunity to participate in learning at school which will satisfy disability discrimination law.

To facilitate IIT and deliver the best chance of normoglycaemia, insulin administration is essential during school hours for children with T1D. This requires competency with dose calculation and correct administration techniques. Insulin is an essential but dangerous drug that, if given incorrectly, may have serious consequences. Because of

this, laws exist to regulate access and administration has become an issue in schools, where authorised personnel such as school nurses, are rare. Therefore, administration or careful supervision of insulin requires legally authorised school staff with informed parental consent.

Generally, school staff are very enthusiastic to support children with T1D but are under-resourced. The necessary training to support the complex care and medication needs of a child with T1D, including the Federal Government sponsored Continuous Glucose Monitors (CGM), has not been freely available. School staff must have adequate knowledge and training on T1D and then they must be resourced by governments to ensure the prescribed management, including insulin dose administration and adjustments required during school hours, is done safely and effectively.

Lou’s Legacy funds were used to support children with T1D in schools. The Type 1 Foundation supported the Australian Paediatric Society to create a cost-free, on-line learning resource for school staff to understand the clinical complexities of managing children with T1D in Australian schools. The initiative used the International Society of Pediatric and Adolescent Diabetes (ISPAD) clinical guidelines and has been co-branded by ISPAD, giving it international credibility. Leading healthcare professionals, teachers, parents and advocates donated their time and intellectual property to develop the e-learning modules. The much-needed resource was finalised in time for the 2018 Australian school year and early reports demonstrate reduced anxiety and stress for both families and school staff and greatly improved understanding of T1D.

Currently there are no options for flexible and cost-free diabetes training available to Australian school staff. The Australian Paediatric Society and other stakeholders, led by ADEA and APEG, proposed to the Federal Government in January 2017 that e-learning modules should be created in addition to direct training of school staff by the child’s medical team. When the proposal did not attract funding, parents and medical teams refused to wait any longer! The unacceptable support for children with T1D in Australian schools had gone on for too long. As a result, with the money from community donations in memory of Lou Richards, and the funds raised by the Footy

Show, the required on-line e-learning resource has been created.

The T1D modules are based on ISPAD guidelines and were created by a team of equally passionate healthcare professionals, parents and teachers. The result is an easy to use, innovative and world-class resource that should make a real difference. The e-learning courses can be done by school staff at any time. Those who successfully complete the courses receive a certificate.

The e-learning is free to school staff and anyone who may need a greater understanding of T1D. The courses have been successfully completed by extended family and friends to enable play dates and sleep overs. The website is www.t1d.org.au

The resource has been greeted with acclaim by families, teachers, adolescents with T1D, international diabetes experts, and healthcare teams in metropolitan and regional Australia. The resource has already engendered confidence in school staff to manage T1D. Improved school knowledge and understanding of T1D will have a positive impact and has the ability to improve the current poor outcomes for Australian children.

The provision of the e-learning modules has filled a large void and parents and medical teams have the right to request that schools complete the online courses. At the time of writing, over 1200 courses had been completed in the first few weeks of the school year. As a long-time AMA member, I want to express my appreciation of the association supporting the modules.

We have invited governments of all levels to have a bipartisan approach and promote the modules within the school system. Now all Australian children with T1D can safely and confidently attend school knowing their teachers have access to quality, free, T1D e-learning.

The backing of the AMA in promoting awareness and having governments understand the importance of this initiative has been invaluable for the doctors prescribing insulin in schools and for the children receiving the required medication safely and legally.



Dr Peter Goss
Paediatrician
Australian Paediatric
Society Diabetes
Working Party

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The problem with unrostered overtime



Unrostered overtime is supposed to be “only for unpredictable and therefore occasional work” but talk to any junior doctor in the state and a different picture soon emerges. The reality is that in many services unrostered overtime is a regular, sometimes even daily, occurrence.

Some rotations generate unrostered overtime in excess of several hours daily as residents and registrars struggle to find time for paperwork, ward rounds, audit meeting preparation, over-stuffed clinics and other mandatory activities. The reasons for this are many. In some cases the rotation is simply understaffed, with too few doctors to meet the demands of a busy service. In many surgical rotations there is an expectation that the day will be spent primarily in theatre, leaving little time for ward management and paperwork. These necessary and important activities are then hurriedly crammed into any time available.

Morning ward rounds stretch well into the afternoon as a single team tries to review and evaluate an enormous number of patients, with too few residents to keep up with both the documentation and the tasks generated for each patient. Once mealtimes and toilet breaks are colonised or eliminated, the work begins to encroach on evenings and the early morning. In many services an afternoon ward round is an expectation, an occurrence which requires the entire team to attend and never takes place before 5pm.

The scale of the problem is difficult to assess, because of course much of this goes unreported outside of anonymous surveys. Few institutions actively investigate the hours worked by junior doctors, instead relying on voluntary reporting in the form of claims for compensation. Unfortunately there are significant barriers, both cultural and institutional, to the claiming of compensation for overtime work.

There is a strong, and not incorrect, perception among junior doctors and medical students that claiming for overtime work reflects poorly on us as individuals and as doctors. 'If we were better at our jobs we wouldn't need to work overtime' is the insidious, prevailing view - often tacitly or even overtly encouraged by senior staff. Of course the reality is that no feat of efficiency could ever change the timing of a ward round or the acuity of the patient load.

There is a real and prevalent fear of repercussions for even attempting

to claim overtime pay. A final year medical student once confided in me his intention never to lodge an overtime claim for fear of being 'blacklisted' and not being offered a second-year job. Those applying for training programs fear that the censure of their supervisors will keep them from being successful in their applications and, judging by the attitudes of some senior staff, this is a fairly reasonable and accurate assessment of the situation.

Unrostered overtime also puts patients at risk. Study after study has shown the risk of serious error grows with increasing doctor fatigue. Long working hours and heavy workloads are also identified as causative factors in the ongoing crisis in mental health and wellbeing among junior doctors. Limits on rostered hours are put in place precisely for these reasons, not as a way to coddle junior doctors or swindle the public health system.

Hospitals need to take unrostered overtime seriously as a patient safety and staff wellbeing issue, as well as upholding the AMA Enterprise Bargaining Agreement. Knowing the barriers to self-reporting, hospitals should proactively seek evidence of unrostered overtime. Regular audits to accurately assess the workload generated by each department would give managers the information they need in order to allocate junior staff more appropriately. There is already a surplus of graduating medical students ready to fill the extra positions that will doubtless appear once rosters reflect the reality of the workload.

And on the (hopefully one day) rare occasion that unrostered overtime is worked, hospitals need to avoid raising further barriers to claiming compensation. This includes working to dispel the stigma that already exists. If hospitals are serious about creating a mentally healthy workplace and promoting patient safety, leaving work on time needs to become a regular occurrence.



Dr Daphne Cohen
Doctor in Training

A word from the AMA Victoria Workplace Relations team

Unpaid overtime is one of the most regularly raised issues with the AMA Victoria Workplace Relations team.

We recognise that there are some cultural barriers that exist that prevent doctors from feeling like they can claim unrostered overtime and these can be difficult to overcome. However by working unpaid, doctors are creating a self-fulfilling prophecy - the reason you are having to work overtime is often due to a lack of staff. The health service doesn't recognise this because all the work is getting done with the staff they assign. The CEO of your health service doesn't know how many free hours you are giving them to deliver their results. The best way to signal this is to through the budget - it is cheaper to employ another doctor than to pay you double time.

We often hear hospitals state that the reason a doctor is working past their rostered hours is because of the doctor's poor time management or they are 'not coping'. This is not a reason to refuse to pay overtime.

If a doctor does have poor time management skills then this is a matter of performance that needs to be addressed separately. But it does not change the fact that they actually worked the hours and should be paid accordingly.

It is your right to be paid for all work that you are required to do and AMA Victoria will do all it can to help you claim those hours. However it is important that you work within the protocols your health service has developed in order to make claiming as easy as possible. It is a requirement under the Doctors in Training Agreement that every health service has a protocol. If you do not know what it is, contact your medical workforce unit and ask for a copy.

One final thing to note is that there can be no dispute over whether or not you should be paid unless you have claimed for the time. So just claim it, and if the health service refuses the claim, give us a call and we will help you escalate the issue.

Tips for making claiming overtime easier

1. Know the protocols of your health service.
2. Know who has the authority to say 'yes' to overtime in your department.
3. At the end of a rostered shift check with your supervisor whether you need to stay. If they say 'yes' then overtime is 'authorised'.
4. Act collectively. It takes more than one person to change a culture, so the more doctors who claim overtime, the more likely it will become common practise.

To discuss unpaid overtime or any other employment matter, contact the AMA Victoria Workplace Relations team on (03) 9280 8722.



Grant Forsyth
Workplace Relations
Adviser

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Beware the over active owners corporation



Avoid over or under maintaining an apartment block.

If you like to stay in control, investing in an apartment is going to present a challenge. The venture's success isn't just dependent on selecting and prudently managing the correct asset. It is also contingent on the effectiveness and drive of the overall block's owners corporation (OC) committee.

It's hard to overestimate the value of a vibrant and responsive committee in comparison to a dysfunctional group that barely functions. A committee that ensures common areas - such as roofs, external walls and hallways - are well maintained will, via the market sorting mechanism that underpins capital growth rates, undoubtedly see unit owners tens of thousands of dollars better off compared with a corresponding OC that refuses to spend money and lets their building decay.

So you might be thinking that prospective apartment investors should only look in blocks with the most actively managed and cashed up OCs. Not necessarily. Just as it is too common for owners to overcapitalise on their on-title asset whereby improvement costs don't deliver the desired uplift in value, so it can be with apartment common areas.

Stuart Mellington, a veteran owners corporation manager and director at Select OwnersCorp Management, says that some owners corporations' ambitions have to be reined in. "There is a temptation for an OC that has the big ticket maintenance jobs under control to go looking for new projects. For instance, OCs sometimes seek to paint or render the original bare brick external walls. It's well meaning, but they are creating an expensive and ongoing maintenance issue down the track. They may have tired looking brickwork, but a power clean by professionals will achieve the desired outcome at a fraction of the price."

A domineering character can be the root of an over-active OC. "The OC is effectively controlled by one person through the force of their personality and work ethic. Others shrug and leave decisions to them," says Mellington.

An OC's priorities can be skewed by that individual's interests or skill set. "There's the professional engineer who insists every application by a unit holder to renovate walls shared with common property is supported with expensive engineering reports, no matter how minor the work," says Mellington. "Or the lawyer who

runs up large legal bills litigating every disagreement with third party suppliers or neighbouring properties."

Maintenance plans are a welcome feature of the modern OC, encouraged or mandated by legislation. Based on the current state of infrastructure and benchmarks on the lifespan of features, owners identify, cost, schedule and make financial provisions for projects. So internal common walls may be painted every five years, a boiler upgraded every 15 years and a roof replaced every 25 years and so on.

All wise and prudent. But, occasionally, members of the OCs can be hit with large one-off levies or recurring contributions to fund future maintenance that just isn't required or for the feel good factor of having a large maintenance fund just in case of a rainy day.

Potential buyers - particularly investors - can be put off by OCs with abnormally high annual contributions. It doesn't deter everyone, but even the absence of one or two prospective buyers on auction day can turn an expected dead-set hot auction into a fizzer.

Owners corporations are effectively a democracy of unit holders. Like most good democracies, they work well when the participation rate is high and a moderate path is taken between extreme views.



Richard Wakelin
Director
Wakelin Property
Advisory

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Managing your taxes as a self-employed medical practitioner

Leaving a public hospital and starting in private practice provides various new obstacles, one of which is managing your own tax. Do you know what your obligations are and will you be ready when they are due?



Where to start

Chances are you've never had to worry about this before. Your employer has withheld your tax for you each fortnight and once a year you receive a nice little refund from the tax office. Things may be different now, but they don't need to keep you awake at night.

Most practitioners will bill enough patients that they are required to be registered for GST. This does create an administrative obligation in your quarterly Business Activity Statement (BAS), however, this provides you with a good opportunity to track how your business is going and begin planning for your impending bill come year end. In calculating your income and expenses for your GST obligations, you will be able to get a gauge on a likely profit your business will be heading towards at year end and as a result, the associated income tax bill.

The PAYG Instalment System

The Tax Office has a system to assist in this regard called Pay As You Go Instalments (PAYGI). These are predominantly paid quarterly based

on your previous year's income. The common issue practitioners find is that you only enter the system once you lodge your first tax return as a self-employed practitioner. For those lodging through a tax agent, this can be as late as 23 months after you first enter private practice. At this point, you will then have to fund two years' worth of tax on your earnings over the period. Without planning, this could potentially lead to a liquidation of assets at a time that may not be ideal.

Strategies

Setting up a new interest bearing bank account will allow you to separate the monies put aside for tax from your everyday or business transaction accounts. Transferring an amount periodically from your business account to your tax savings account will allow you to continually chip away at your tax obligation. Use the tax bracket that you expect to fall into as a guide in deciding what the amount should be. You can then use your quarterly BAS to review whether you have paid too little or too much for that quarter and adjust as you see fit. Once you are placed in the PAYGI system, keep in mind that

your business is forever changing and so will your bottom line. You should continue to review your instalments as you have the option to vary them up or down if your income has significantly declined or increased.

The key is to not stick your head in the sand. If you create a system in which you periodically chip away at your tax obligations you will find that it creates a far more pleasant and bearable experience come the end of the financial year. Your advisor will appreciate your anticipation too. Should you wish to discuss any aspects of the above please contact Belinda Hudson of William Buck on (03) 9824 8555 or by email belinda.hudson@williambuck.com



Belinda Hudson

Director, Health Services

William Buck

 **William Buck**

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Director, Health Services

Contact Belinda Hudson on 03 8823 6819 to book your health hour.



BMW's first-ever X2 arrives at Melbourne BMW



BMW's first-ever X2 arrived in Australia in March 2018. With sDrive20i launch variant powered by latest-specification 2.0-litre turbocharged four-cylinder engine, generating 141kW and 280Nm for strong performance, it includes a new seven-speed dual-clutch automatic transmission that increases efficiency and response.

Melbourne BMW is proud to advise the first-ever BMW X2 Sports Activity Coupe has arrived in Australia. The striking all new BMW X2 is based on the highly-successful BMW X1's platform and will be introduced to the Australian market in front-wheel drive sDrive20i form.

"We are excited to be adding the BMW X2 to the small premium SUV segment," said BMW Group Australia CEO, Marc Werner. "The X2's dynamic stance and

highly efficient turbocharged petrol engine combine with outstanding connectivity and infotainment systems to create a sporty vehicle of outstanding versatility," he said.

Immediately distinctive, the first-ever BMW X2 presents a uniquely low and wide body style that accentuates its sporty intentions. From the front end the latest interpretation of the classic BMW double kidney grille sits proud above a deep hexagonal air dam

section. Aping BMW's sporting coupes, the double kidney grilles are mounted lower than the hexagonal LED headlight sections. Also for the first time, the bottom section of the kidney grille is wider than the top, adding further distinction to the X2's front end.

Perhaps the most distinctive element of the X2's side profile is the return of the c-pillar BMW roundel, made most famous by the legendary E9 Coupe that debuted in 1968.

An athletic side shoulder line rises from front-to-rear, splitting the coupe-like roof style with the adventurous lower section that is pivotal to BMW's X Line range.

Moving to the rear, L-shaped LED rear tail lights, two exhaust pipes and a smoothly integrated M rear spoiler are obvious highlights; subtler is the integration of the tail gate operation into the rear BMW roundel.

*Manufacturer's Recommended List Price is shown and includes GST and Luxury Car Tax (LCT) - if applicable, but excludes dealer charges, stamp duty, statutory charges and on-road charges, which are additional and vary between dealers and states/territories.

Customers are advised to contact their nearest BMW dealer for all pricing enquiries.

For further information or to experience the all New BMW X2 contact:

Andy Cho
Melbourne BMW
Corporate Sales Manager
118 City Road, Southbank
Andy.cho@melbournebmw.com.au
(03) 9268 2222

Key standard specification highlights

The BMW X2 sDrive20i's standard equipment list includes:

- 19-inch M light alloy wheels
- M Sport X Exterior Package
- M Sport suspension
- M rear spoiler
- LED headlights with cornering lights
- LED Fog Lights
- High-beam Assist
- Automatic tailgate operation
- Cloth Alcantara Anthracite with yellow contrast stitching
- M Leather steering wheel
- BMW Individual headliner in Anthracite
- Sports seats for driver and front passenger
- Interior Lights package
- Automatic air conditioning
- Rear-view mirror with anti-dazzle function
- Park distance control, front and rear
- Cruise control with braking function
- Rear view camera
- Parking Assistant
- Driving Assistant, including speed limit info, lane departure warning, Pedestrian Warning with City Brake Activation and forward collision warning
- Real-time Traffic Information
- Foldable second-row seats with 40:20:40 split
- Instrument panel with 5.7-inch TFT display
- Satellite navigation
- 6.5-inch colour touchscreen infotainment.

BMW X2 pricing*

X2 sDrive20i \$55,900

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**The Ultimate
Driving Machine**

Wonderland – Celebrating Alice's adventures on screen



The Australian Centre for the Moving Image (ACMI) invites you to venture down the rabbit hole into an enchanted world, where expectations are upended and curiosity is rewarded. A world premiere as part of the Victorian Government's Melbourne Winter Masterpieces series, ACMI's newest creation, Wonderland, will celebrate the screen history of Lewis Carroll's timeless stories - *Alice's Adventures in Wonderland* and *Through the Looking Glass*, and *What Alice Found There* - in an entirely original experiential exhibition.

The enduring fascination with Carroll's stories and characters uniquely traces the evolution of filmmaking, providing the perfect subject matter for Australia's national film museum, ACMI, to illustrate our ongoing fascination with new visual technologies over more than a century. From the earliest optical toys to silent film, animation, puppetry, live-action cinema, videogames, CGI, 3D and beyond, Wonderland explores how the moving image has kept Alice and her stories in the public consciousness, reinvented in contemporary contexts and mediums.

"This latest ACMI-created Melbourne Winter Masterpieces exhibition showcases the moving image adaptations of Carroll's seminal works through celebrating the evolution of filmmaking, from the earliest optical toys through to new technologies," said ACMI CEO and Director, Katrina Sedgwick. "With Wonderland ACMI has created an interactive exhibition where audiences explore the magic of film craft and its integral role embedding this much-loved story in our imaginations for generations."

Commencing in Lewis Carroll's drawing room, visitors are handed their own Lost Map of Wonderland, a physical and digital device unlocking surprising experiences during their exhibition journey and beyond. With their interactive map in hand, visitors wander the world of Wonderland, losing themselves in the Hallway of Doors, playing at the Queen's Croquet Ground and taking part in a magical Mad Hatter's Tea Party that comes to life before their very eyes. Along the way they will find more than 300 unique objects sourced from all around the world including first edition publications and illustrations, magic lantern projectors, concept drawings, animation cells, spectacular costumes, puppets, props and more.

Rich with inspiration for visual interpretation, Carroll's tales have been the subject of more than 40 films and over 30 television programs. Today Alice remains an icon - omnipresent and continually relevant through her presence across music videos, video games, high fashion and advertising. Wonderland takes audiences on Alice's journey through popular culture, demonstrating how artists, filmmakers and fans have returned to her story with the help of screen technologies for more than a century.

From the first screen adaptation by Cecil M Hepworth in 1903 to Disney's *Alice Through the Looking Glass* (2016), Wonderland reveals the development of special effects from pre-cinematic entertainment to silent film, animation to puppetry, live-action cinema, video games, CGI, 3D and beyond. The films featured include Norman Z McLeod's 1933 version featuring a young Cary Grant; Lou Bunin's *Alice Au Pays des Merveilles* (1949) which almost did not make it to the screen; Jan Svankmajer's acclaimed *Alice* (1988); the Quay Brothers' experimental *Alice in Not So Wonderland* (2007); and television versions by the BBC and NBC, and much more.

Made in Melbourne by the team at ACMI, this wholly original exhibition brings the museum's extensive creative and curatorial expertise together with a leading team of Australian collaborators, creating an immersive experience complete with playful environments and bespoke digital activities that draw upon the wonder and curiosity of Carroll's stories.

The world premiere season of ACMI's Wonderland exhibition will run from Thursday 5 April to Sunday 7 October 2018. Tickets and information at www.acmi.net.au/Wonderland



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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**

Kilmore Medical Centre

General practitioner positions available at Kilmore Medical Centre, Victoria. Full vacancy details can be found on website: www.rwav.com.au

For further information contact:

**Kilmore Medical Centre
36-38 Melbourne Street,
Kilmore Vic 3764
Email: admin@kilmoremedicalcentre.com.au
Phone: (03) 57 830 555
Fax: (03) 57 822 591
Contact person: Practice Manager**

Ivanhoe Medical Clinic

Opportunity for PT VR GP to join one of Melbourne's most famous practices. Modern, 13 GPs supportive colleagues & full time nurses, flexible, friendly, no A/Hs, good remuneration, accredited, mixed billing.

**Contact: Dr Stephen Smith
(03) 9499 1245**

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

Sunbury Specialist Centre

Large consulting rooms in Sunbury for sessional lease.

Our recently renovated building is dedicated to specialists and allied health professionals. Offering reception support, pathology and ample parking - the rooms are a must see.

**Enquiries: Melinda
(03) 9740 7447 or 0412 716 031
sunburyspecialistcentrepm@gmail.com
www.sunburyspecialistcentre.com.au**

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* Terms and Conditions

1. To be eligible for the offer, applications to join Doctors' Health Fund must be received by 11.59pm (AEST) 25th February 2018. 2. Offer is only available to those who are eligible to join Doctors' Health Fund restricted access group and who do not currently hold private health insurance with Doctors' Health Fund. 3. The new member must take out combined hospital and extras cover or hospital only cover to be eligible for the gift. 4. Policy cover start date must commence within the campaign period of 2 January and 25th February 2018. 5. Only one gift will be provided per policy. 6. Member needs to be active and financial for 6 continuous weeks and remain on a combined hospital and extras or hospital only cover to receive the gift. The gift will be issued within 8 weeks of joining the fund. 7. The offer does not apply to policy upgrades, or when a spouse, or dependant is added to an existing Doctors' Health Fund policy. 8. This offer is not available to those who have held an active health insurance membership with Doctors' Health Fund in the last one year (either in their own right or under a Couple/Family/Single Parent health insurance membership). 9. Doctors' Health Fund is entitled to disregard the gift if within six weeks of joining the new member has requested a refund or has separated/downgraded their cover to extras only or has terminated their policy for whatever reason. 10. Policy holder must be over 18 years old to be eligible for the offer. 11. This offer is not available with other offers or discounts. 12. This offer is not available to Avant Mutual or Doctors' Health Fund staff members. 13. Doctors' Health Fund is not responsible for any lost, stolen or damaged gifts. Gift is subject to availability. 14. Each recipient should look to the product issuer for all warranties, terms and conditions, which are subject to change without notice. 15. The promoter shall not be liable for any loss or damage whatsoever which is suffered (including but not limited to direct or consequential loss) or for any personal injury suffered or sustained in connection with any prize/s, except for any liability which cannot be excluded by law. Private health insurance products are issued by The Doctors' Health Fund Pty Limited, ABN 68 001 417 527 (Doctors' Health Fund), a member of the Avant Mutual Group. Cover is subject to the terms and conditions (including waiting periods, limitations and exclusions) of the individual policy.

** The Doctors' Health Fund Member Satisfaction Research Report 2017.

*** Dental check-ups limited to an examination, fluoride and a scale and clean where the fees are within the range of usual, customary and reasonable charges.

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