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MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. DECEMBER 2018 / JANUARY 2019



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IN VICTORIA**

**MINDFULNESS IN
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FRONT COVER: Dr Eugenie Kayak (right) talking environmental sustainability in healthcare with Nadine Sexton (left) and Pedram Rajabifard from the Medical Student Council of Victoria.



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Welcome from the editor



The Hon. Jill Hennessy with A/Prof Julian Rait at our annual 'Dinner with the Minister'. See page 14.

The end of the year is approaching and many readers will be looking forward to a break. Summer is a chance to spend some time with family and friends and read some of those books that have been piling up. It's also a great time to catch up on medical news.

In this edition of Vicdoc, Dr Eugenie Kayak, from Doctors for the Environment Australia, responds to the AMA's concerns about the impact of climate change on human health. Dr Kayak outlines what steps the health industry can take to reduce its significant environmental footprint.

AMA Victoria will continue to advocate throughout 2019 to establish Victoria as an international leader in high quality end of life care. At every opportunity, AMA Victoria will push for more investment to build a strong and integrated cross-health sector specialist palliative care workforce that can respond to community demand for palliative care services. In this edition, Palliative Care Victoria explains why palliative care is everybody's responsibility.

It's always enjoyable to hear about the careers and achievements of

our members. Professor Rinaldo Bellomo is a much-loved clinician-researcher at the Austin Hospital whose influence on healthcare extends around the world. His enthusiasm for learning and improving outcomes for his patients shines through in an inspiring story about his work.

One of AMA Victoria's great strengths is the sense of community amongst its members and it's very apparent during sad times. We received many heartfelt tributes to Dr David Andrew, an AMA Fellow and member of our Section of General Practice who died in October. We'd also like to express our condolences to the family and friends of former Board Member Dr Vladimir Vizek who passed away in November.

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



Barry Levinson

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President's message

The re-election of the Andrews Government on Saturday 24 November concluded a long election campaign where health and infrastructure were central issues.

Throughout, AMA Victoria advocated strongly with some excellent results. I'd like to extend my thanks to all members who participated. Powerful advocacy relies on high-level and meaningful engagement with our members. Some members contributed their insights and ideas to shape our policy platform; others shared their stories and experiences to help build our media campaigns; and a number of members gave media interviews. Thank you very much for your contributions to our 2018 advocacy campaign. I am very confident we will build on this work and continue to engage the Government successfully together throughout 2019.

One outcome of which we are very proud is the Andrews Government's pledge to provide \$1.5 billion in new funds for a redevelopment of Footscray Hospital. This issue was raised with the Government and a strong media campaign was led by AMA Victoria.

We were also most encouraged by other initiatives. The first was the additional support we received from the Health Minister for the Victorian Doctors Health Program, with an additional \$172,000 provided for doctors' health and wellbeing for the forthcoming year.

The Premier pledged to establish a Royal Commission into mental health services within 100 days of being re-elected. This is a positive outcome but AMA Victoria is concerned that chronic underfunding and gaps in the state's mental health system must be addressed now and cannot wait for the recommendations of a Royal Commission in two years' time. In two articles with *The Age*, AMA Victoria drew attention to ongoing problems with the state's struggling crisis assessment teams and highlighted the need to bridge these service gaps now.

AMA Victoria will continue to advocate for a further commitment from the Government to fund public psychiatry outpatient services in order to assist the "missing middle" for whom there are few options between seeing a GP and public hospital emergency departments.

A number of other undertakings were made by the Andrews Government:

1. \$562 million for Frankston Hospital with 120 new hospital beds, two new operating theatres and an additional 13 new emergency department beds, as part of an 11-storey redevelopment.

2. Additional funding for regional health infrastructure, including \$100 million to redevelop the Maryborough Hospital and \$100 million for a new women's and children's hospital in Geelong.
3. \$62.4 million to build five new flagship children's ED's at Geelong, Maroondah, Casey, Frankston and Northern hospitals.
4. \$2.3 million for planning work to explore a new public hospital at Melton.
5. An additional \$1.38 billion for staff expansion that includes funds for additional rural specialist consultations, including 75,000 for heart conditions, 50,000 for chronic pain, 40,000 for cancer sufferers and 30,000 for rheumatology.
6. A commitment to continue the trial of the medically supervised injecting facility in North Richmond.
7. A renewed focus on bullying and harassment of medical staff including a comprehensive education campaign in the public hospital sector.
8. \$232 million to provide more maternal and childhood nurses, help build seven new early parenting centres, refurbish two more and find more home support for families, and \$32 million for public IVF services for low-income couples struggling to conceive.

Following calls from AMA Victoria, the Liberal-Nationals promised to implement a new way of reporting elective surgery wait times, measuring from the point of referral from a general practitioner to treatment (referral to treatment or RTT). AMA Victoria will continue to advocate to the Government for this change to be accepted and implemented over the next parliamentary term.

Throughout the election campaign, AMA Victoria also highlighted the central role that rural and regional GPs play in our healthcare system; especially their role in reducing preventable disease in both children and adults who live in the country. However, despite the Rural Workforce Agency revealing that many GP positions remain unfilled across rural Victoria, and despite AMA Victoria highlighting a declining life expectancy in some regions, we are disappointed neither the Government nor the Opposition agreed to support any subsidies for GP training or provide any plans to assist GP services in rural and regional areas. This is a lost opportunity to support the health of rural Victorians.

AMA Victoria was critical of a Liberal-National proposal to close the supervised injecting facility in North Richmond. Despite the injecting room enjoying broad support from locals and successfully treating 320



overdoses, including 61 life-threatening ones, it was surprising that the Opposition would ignore the growing evidence of harm minimisation and undertake to abandon the trial. We are convinced that this initiative is saving lives and assisting people who would otherwise be at the margins of society.

As a further note, we wish to advise that we are seeking member consultation on proposed changes to our constitution. Members will recall that a consultation related to the revision of the AMA Victoria and Medical Society of Victoria Constitution was to begin within six months of our last AGM. Consequently, the governance committee of the Board would appreciate suggestions from members and would ask that all such suggestions be directed via email to our Chief Executive Officer at ceo@amavic.com.au. Additional opportunities for

consultation will be provided via Council and member meetings to be scheduled in 2019.

Finally, on behalf of AMA Victoria, I would like to wish you and your family an enjoyable and refreshing festive season and a successful 2019. I extend my gratitude to members for their ongoing support of our association and thank our Board, our Council, our new CEO and our management team and staff, who have again enthusiastically contributed to the success of AMA Victoria during 2018. We remain fortunate to have such a fine and dedicated team to support and promote the health of our community and the interests of the medical profession in Victoria.

A/Prof Julian Rait OAM
President

AMA VICTORIA'S

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Palliative care in Victoria: Why your participation matters



Access to palliative care matters

A substantial body of international evidence shows that palliative care improves the quality of life of people with a life-limiting illness and their families and in some cases prolongs life. Palliative care also results in more effective use of health resources than usual care alone. These benefits are enhanced when palliative care is available earlier in the illness trajectory, not only when someone is about to die. Around three-quarters of decedents would benefit from palliative care.

The holistic person-centred and interdisciplinary approach of palliative care provides a relevant model for all healthcare. It also plays a crucial role in facilitating high functioning health services in the context of an ageing population and the increasing role of chronic illness in mortality.

Unfortunately, substantial numbers of Victorians who die each year miss out on needed palliative care (see box).

Everybody's responsibility

International, national and Victorian policy frameworks indicate that palliative care is everybody's responsibility and must be integrated into all healthcare services. Sufficient specialist palliative care services are required to address complex needs and to provide consultancy, mentoring and education to other healthcare practitioners.

Actions to improve access to palliative care

Victoria's 2016 policy framework identified goals and priorities to improve access to palliative care and end of life care choices.

Achievement of these goals requires adequately resourced strategies to:

- Increase community awareness and understanding of palliative care; only 46% of Victorians have a good understanding of palliative care and even fewer among diverse communities.
- Develop generalist palliative care capacity among healthcare practitioners, especially in primary, aged care and inpatient services, where poor access is highest. Improve support for carers and facilitate more home-based care in line with community preferences.

- Strengthen workforce and service planning and development, including for specialist palliative care.
- Substantially increase investment in palliative care provision to address unmet and growing need.

End of life care choices

The introduction of Voluntary Assisted Dying (VAD) creates real urgency for universal access to palliative care by all Victorians who need it. Without this reality, the voluntariness of VAD is undermined, as is Victoria's goal of optimal end of life care for all Victorians and their families.

Who is palliative care for?

It can be challenging for doctors to introduce the subject of palliative care, especially if this is only understood as imminent death. Palliative care is often only considered for malignant conditions. However, it is relevant for other life-limiting illnesses, such as cardiac failure, respiratory failure, renal failure and progressive neurological deterioration. Palliative care can be relevant for patients of all ages, including children. Palliative care does not always mean referral to specialist palliative care services; many general practitioners and other specialists have the skills to provide a palliative approach to care.

Introducing palliative care earlier

Doctors and other health professionals have an important role in normalising the discussion about palliative care earlier in the illness. We need to help patients and families better understand how palliative care can assist with managing symptoms and optimising the patient's quality of life. This includes careful titration of opioids. Palliative care can be provided in tandem with disease modifying treatment and treatment of comorbidities. Introducing palliative care does not mean giving up on life-prolonging treatment or giving up on life; it is about getting the most out of the life that remains.

Ultimately though, as death approaches, all care is then focused on supporting the patient to die as well as possible. Diagnosing dying is really important as it allows the focus to be fully on maximising comfort and eliminating non-beneficial interventions such as routine observations, blood tests, imaging

Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.

- World Health Organisation

VAD is different from palliative care. Legal in Victoria from mid-2019, it will involve the administration of a specified substance for the purpose of causing a person's death, in accordance with eligibility criteria and requirements in the *Voluntary Assisted Dying Act 2017*.

Unmet need for palliative care in Victoria

- 40,000 Victorians died in 2016.
- At least 10,000 died without required palliative care.
- Palliative care provision has not kept pace with growth in need.
- Groups missing out most are aged care residents, people living in rural areas, people from diverse communities and people with special needs.

and non-essential medications. It prompts a discussion with family about dying and death and what would be important to the patient at this significant time. Communication needs to be clear and unambiguous; use the word 'dying'.

Palliative care also supports the family and friends in their grief - both before and after the death.

Communication

Before speaking, it is wise and helpful to listen. Explore the patient's experience of illness and the impact it has on their life. Connect with the emotions. The following questions can be helpful:

- Ask about their illness trajectory. For example: What were you able to do 12 months ago, six months ago, six weeks ago, one week ago?
- How are you coping with the illness?
- What are the things that matter most to you?
- What is the worst part about this illness?

Continued on page 10

- What do you worry about most (now and when you look ahead)?
- What do you hope for?
- Who do you talk with about your illness and how you are feeling?

Asking questions and listening makes it easier to know what to say and how you might help. Sometimes patients ask questions for which there is no answer. Acknowledgment that you don't know and showing genuine care will help support the patient.

As well as the support you provide to the patient and family, you might also consider whether referral to specialist palliative care is needed and offer advance care planning.

Referral to specialist palliative care

Consider referral to specialist palliative care for:

- difficult to manage symptoms
- assistance with decision-making about end of life care
- complex psycho-social situations
- dying.

Most larger hospitals will have a Palliative Care Consult service that can provide advice. For patients living at home, or in a residential aged care facility, the local community palliative

care service can be identified by entering the patient's postcode on the palliative care service search at www.pallcarevic.asn.au. Discuss the situation with the community service and how they might be able to help the patient and their family.

Advance care planning

Advance care planning is a way for a person with medical decision-making capacity to plan ahead for a time when they might lose capacity to make their own medical treatment decisions. In Victoria, this may involve one or more of the following:

1. Appointing a Medical Treatment Decision Maker
2. Completing an Advance Care Directive
 - a. A values directive describing preferences and values that the person would want their Medical Treatment Decision Maker to take into account when making treatment decisions for them
 - b. An instructional directive, in which the person gives consent and/or refusal to particular treatments in advance
3. Speaking with their Medical Treatment Decision Maker about their preferences and values and

how they would want decisions to be made for them.

Further information about Advance Care Directives and appointing a Medical Treatment Decision Maker is available on the Victorian Department of Health and Human Services website - health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

Discussions about advance care planning can help the patient to better understand the limitations of medical treatment and to consider what they would prioritise with respect to quality versus quantity of life.



Dr Barbara Hayes
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Palliative Care
Victoria Inc.



Odette Waanders
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References available from the Editor on request.

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The devoted researcher making a global impact

Professor Rinaldo Bellomo is regarded as one of the most influential and impactful clinician-researchers in the world.

In June 2018, the long-time AMA Victoria member was appointed an Officer in the General Division of the Order of Australia (AO) "for distinguished service to intensive care medicine as a biomedical scientist and researcher, through infrastructure and systems development to manage the critically ill, and as an author." Tessa Young wrote a fantastic feature on Austin Health's Director of Intensive Care Research last year. Here is an excerpt about his inspiring work.

When I go to visit Prof Bellomo, he is in his office in the Austin Health ICU, debating earnestly with colleagues about how to convince clinicians to drop the level of oxygen given to critically ill and anaesthetised patients, a reversal of 30 years of tradition.

"The biggest challenge of research is getting people to free their minds," he says. "People traditionally keep oxygen levels really high because they're scared to do otherwise, but there's evidence to suggest that it's better for the brain - and probably the lungs - to bring the level down to about 90 to 92 per cent. That's about the level you'd get at the top of Mt Hotham.

"People forget that a lot of the things we do now are not evidence-based. What we want is to be practising randomised medicine, not random medicine," Prof Bellomo says. It's one of his signature sayings.

Prof Bellomo - or Rinaldo, as he insists being called - wakes each day with a compulsion to do research that might be compared to the drive that sees musicians and artists wake with ideas that must be taken immediately to their instrument or canvas. In his final year of medicine, he would meet his nephrology professor at 3am to assist with medical experiments on rabbits.

As he gesticulates, photocopied journal articles flutter against the wall behind

him. Four of his most influential *New England Journal of Medicine (NEJM)* articles take pride of place in the centre - and every spare bit of desk is covered in neatly overlapping clusters of papers, with research trial or journal names written neatly in permanent marker across the top.

Rinaldo has produced more than 1200 papers, 170 book chapters and edited 15 books on intensive care medicine: numbers that really represent thousands of lives saved, and even more greatly improved. Typically, it's those articles in the *NEJM* - in which Rinaldo has been published 18 times - that go on to be the most influential.

Take his work on Medical Emergency Teams (METs), first introduced as a pilot project at Austin Health over 15 years ago. His most cited research on the outcomes, from the *NEJM* in 2011, has been cited hundreds of times and resulted in the introduction of METs as standard in both Australian hospitals and worldwide.

"Research offers the chance to be a part of the attempt to improve care for every patient in the hospital," he says. "The changes in practice as a result of these trials have worldwide repercussions. I think it's fair to say that we've saved people from thousands of cardiac arrests and saved lives worldwide."

Similarly, when Rinaldo and his team published research findings in the *NEJM* that showed that keeping ICU patients' blood sugar levels low actually increases their chance of dying - despite being recommended at the time by a number of professional bodies - he says, "We think we saved thousands of lives because of that." And, of course, it was a study on continuous renal replacement therapy that has been one of Rinaldo's most influential: 'Intensity of Continuous Renal-Replacement Therapy in Critically Ill Patients', published in the *NEJM* in October 2009. Because of that work,



Rinaldo says, "The use of continuous renal replacement therapy (CRRT) has grown from a few centres to the whole of Australia and then to many other countries to finally being the dominant form of acute renal replacement therapy in the world.

"It wouldn't be an understatement to say that there are hundreds of thousands - even millions - of people who wouldn't even know it, whose lives have been changed for the better because of Rinaldo," says Austin Health's intensive care director, Dr Stephen Warrillow. "From those who he's mentored, to those who've benefited from his research findings or his contributions to improvements in care - it would be a colossal number. His contribution is of that magnitude.

"He wakes every morning and thinks: 'what will I learn, discover and contribute today?' It matters a lot to him that the work is fun; to seek excellence and enjoy doing it."

Rinaldo is Austin Health's director of ICU Research. The small research corridor houses Rinaldo's office and that of three research nurses: the empire he has built since establishing the research office in 1994. At any one time, there are generally a number of research fellows too, who have travelled to Australia from all over the world to work with Rinaldo. They frequently pay their own way, purely for the experience of working with him.

Dr Warrillow says that, "Austin Health's ICU has a higher number of patients participating in clinical research than anywhere else in Australasia and possibly the world. Relatives are really stressed at the point when their loved one arrives here, but because of the way Rinaldo has normalised research, we find that everyone - nurses, registrars, or the allied health team - are very comfortable having a conversation with families about research, and usually, relatives say 'sure'. And if they say no, they know what they're saying no to."

The research culture Rinaldo has built in the ICU has had an impact on every aspect of the department - and most significantly, on the care patients receive. "He's normalised research as a standard part of clinical care, so that everyone is thinking: what opportunities are there for this patient to participate in clinical research?," says Dr Warrillow.

"What we see - and there's evidence to support this - is that patients who participate in clinical trials actually do better. When you have an array of people focusing on one person's clinical outcome and paying an excruciating amount of attention on improvements or deterioration, clinical care and research interact very favourably. It can't help but impact on clinical outcomes for the better," says Dr Warrillow.

As Rinaldo does his round of the ICU, he checks on the care of each patient - in one bed, a new mum separated from her newborn baby because she has pneumonia; in the next, a man who has been there for 60 days and whose chest has just collapsed. As he does, he gently teases the staff, pushing them to question if they are delivering care that is truly based on the latest evidence. Somehow, it seems like he has read every research paper ever published. "Haven't you read the latest paper on that yet?" he enquires of one surgeon. "It was in the *New England* last week!"

"Rinaldo gains great pleasure and internal reward from conducting and reading research. His idea of downtime is taking time to broaden his understanding of the world, with a particular focus on intensive care," says Dr Warrillow.

One of those research fellows who has crossed the world for the experience of working with Rinaldo is Dr Neil Glassford. "It would be easy to convey Rinaldo as a complex person, but he's really a simple person. He's a thoroughly decent man who just happens to be a genius, but at all times he's able to convey that genius in a very human way that makes no-one else feel small," Dr Glassford says. "It's very humbling to see someone with his international profile standing at the end of the bed saying 'I don't know what the best thing to do is, there are no trials in this area'.

"There are a lot of people walking around here who wouldn't know his profile, because he's not self-promoting," says research nurse Helen Young. He is known as an extremely compassionate doctor. "A small boy had to comfort him once, when Rinaldo was crying because he hadn't been able to save the boy's father," says Dr Glassford. "You see him sit down with relatives and take the time to show them the patient charts or an ECG reading and really make sure they understand," says Ms Young.

Dr Warrillow agrees. "He goes to extraordinary lengths to communicate with families. When a family is with Rinaldo, they'll feel like they have his full attention and that there is no limit on his time. In that moment, they're the only ones who matter. He assures them that no matter what the outcome is, he'll be with them throughout it and will do everything he can for them. For those of us who were his students, he has provided the example of how to do it and do it well.

"He's unusual for a professor of medicine: Rinaldo does the same proportion of clinical work as the rest of us - the same amount of on-call, night shift and weekend work as everyone else. There wouldn't be another academic intensivist in the world who does that. He is at the top of his game as a clinician. He is as revered for his clinical expertise as he is for his academic prowess. His primary motivation is what is right for the patient."

For Rinaldo, science promises solutions to humanity's greatest sufferings and a map to navigate our journey through the wonders of the human body, a territory that he describes as being, "As complex as the entire universe and about which we know almost nothing." Most specifically, it's large-scale, randomised clinical trials - those that recruit thousands of patients and randomly assign them either the traditional management of a disease or the one being trialled - that he

sees as the primary means by which he sees the practise of medicine becoming more precise, more effective and less a stab in the dark.

Walking into Austin Health's ICU, a white world full of high-tech machines punctuated by a soundtrack of beeps and pumping sounds, he says: "There is nothing in this place that is not the result of research!"

"When I started, we didn't have MRI. Before we had cardio-pulmonary bypass, if you'd suggested stopping someone's heart, people would have said you were insane. And it was probably the same when someone first suggested that you could put a balloon in people's arteries," he says. "Do you think machines grow on trees? Everything here is human-made, evolved through a process of continuous improvement, step by slow, agonising step. Everything that we have to use in medicine today is thanks to the people doing research and the people who agreed to participate."

As wondrous as it is to Rinaldo, the ICU is intimidating - terrifying even - to many of the people who are treated here and their families. Understandably, many are reluctant to become involved in clinical trials. "What we're doing here is the pointy end of research," he says. "We're already giving people the best care possible - standard care and then we see if we can improve care by adding one extra step. Before we begin a clinical trial in the ICU, there are animal studies, observations and evidence builds up that there is a better way. Then it's reviewed - by our colleagues, by funding agencies, by ethics committees - until we think 'yep, this is a reasonable hypothesis, and introducing this might actually make things better'.

"It's when they don't do research that they're experimenting on you!"

"The truth is really difficult to discern. We can't see it as individual doctors. It's something that's only possible to see by looking at the evidence from large, randomised clinical trials. If you can persuade the world to change, you can save thousands of lives and help millions of people for decades to come. There's never an end to this. It never stops."

Tessa Young
Austin Health

Read the full story at
austinhealth.atavist.com/truthseeker

Dinner with the Minister

Over 100 members gathered at the Royce Hotel on 25 September for Dinner with the Victorian Health Minister. Members had the opportunity to hear directly from the Hon. Jill Hennessy who outlined the Labor Government's priorities and achievements and spent a considerable amount of time taking questions from members.

AMA Victoria President, Associate Professor Julian Rait, also gave an address highlighting AMA Victoria's advocacy priorities. A/Prof Rait said that Australia's health system is ranked one of the best in the world and yet it is routinely marked down on indicators relating to health equity. A/Prof Rait called for this to be addressed - particularly in mental health and regional and rural health - so that every person across Victoria has equitable needs-based access to high quality and timely healthcare. He also announced other priority areas for AMA Victoria including public hospital culture and infrastructure, drug and alcohol rehabilitation and palliative care.

Thanks to our sponsors MDA National and Dixon Advisory for supporting the event.

On 29 November 2018, Jill Hennessy was appointed Victoria's Attorney-General. The Hon. Jenny Mikakos is the new Health Minister. We wish both well in their new roles.





During the state election campaign, members also had the chance to hear about the Coalition's health priorities from the Hon. Mary Wooldridge at a dinner on 1 November at the Arts Centre. Thanks to MDA National for supporting this event.

Thinking outside the script

For a GP, there are patients whose needs can be comfortably addressed within the confines of a consultation or the care provided by a multidisciplinary group of health professionals. However, how about the many others whose complex, and often chronic conditions, are rooted in long-term lifestyle and life issues well outside the scope of services provided by healthcare professionals?

On the front lines of medicine, we are increasingly seeing people whose physical and mental health is affected by factors such as poor nutrition, lack of exercise, obesity and social isolation. There's irrefutable evidence of the health burden effects of these - vascular disease, cancer, diabetes, dementia, bone and joint disease, addiction and mental health problems are just some; yet every GP (and patient) knows that treating the underlying causes is notoriously difficult.

When I diagnose hypertension or type 2 diabetes in a person with a BMI of 35, as well as assessing organ damage and cardiovascular risk, and controlling the biochemical or clinical parameters, I encourage them to increase their physical activity and to lose weight. I know that it's important; I know that my role in 'prescribing' behavioural change is evidence-based. But I also know that it's difficult and that most people need more than my advice and education to change. They need practical knowledge and help to undertake and maintain behaviour change.

That's where a growing number of health services around the world are turning to 'social prescription'. It's a holistic model by which GPs identify not just a patient's clinical needs but their underlying lifestyle issues. They then pass the patient and this information to a social prescriber, who is not usually a health professional but is knowledgeable about the local community and able to connect to the beneficial non-clinical services appropriate for that person.

This could mean putting patients in touch with local walking groups, men's sheds, craft or cookery groups, cultural or language specific groups, or local community and volunteer organisations. The social prescriber often accompanies them to their first meeting, helps them settle in and follows up over ensuing months.

Social prescribing has the double benefit of freeing GPs to deal with clinical issues and giving patients the skills and resources to help manage their own care. It has been used successfully in the UK and New Zealand, where it is known as 'green prescribing' and has been funded by the government since the late 1990s, particularly to address cardiovascular disease and diabetes. Studies show that it has been both cost-effective and beneficial to patients.

Reported outcomes from the UK include improved self-reported health and wellbeing, improved self-management skills, increased physical activity and reduced demand on medical professionals to deal with non-medical conditions.

A study of a scheme in Rotherham, England, showed that for more than 8 in 10 patients referred to the scheme who were followed up three to four months later, there were reductions in National Health Service use for accident and emergency attendance, outpatient appointments and inpatient admissions. A Bristol scheme showed reductions in general practice attendance rates for most people who had received a social prescription, while the Royal College of General Practitioners

recently concluded that social prescribing was among the most effective actions in reducing GP workload.

In Australia, a trial social prescribing program is underway in Brimbank, an area of north-western Melbourne known for high rates of chronic disease, obesity and psychological distress. A joint initiative of the local council, IPC Health, Victoria University and the North Western Melbourne Primary Health Network, it will see a 'community-link worker' embedded at IPC Health's Deer Park GP clinic until June. Depending on funding and outcomes, it could roll out across the wider north-west.

As a GP, I could easily see social prescribers becoming part of an integrated general practice team. I can imagine myself referring to them daily - it would save me time and make my advice more 'enactable' - hopefully leading to improved health outcomes and decreased pharmaceutical use.

Given the potential and evidence-based benefits, both economic and medical, it would be well worth an expanded trial; perhaps starting with a ratio of one social prescriber to 20 GPs across multiple nearby practices. The time for social prescription has come.



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Career conversation



Dr Amandeep Hansra
General Practitioner

**Founder - Creative
Careers in Medicine**

**RACGP Expert
Committee Member -
Practice & Management
(eHealth)**

**Director - Digital Health,
Evermed Consulting**

An emerging pattern in recent years has seen some doctors looking to explore alternate and non-traditional careers both within and outside of clinical medicine. In this Career Conversation series, we are profiling a range of doctors who have transitioned to non-traditional paths - either instead of, or in parallel with a traditional clinical path. These stories can help other doctors understand that medicine can present diverse, often untapped career options.

How would you summarise your career path in medicine?

Unique, interesting and a little crazy! I, like many others, tried lots of different things as my interests were so diverse. I enjoyed public health, infectious diseases, travel medicine, refugee health, Aboriginal health, psychiatry, emergency medicine, critical care, but ended up landing in general practice and digital health!

My journey has included setting up telemedicine businesses both in Australia and internationally and I have become deeply involved in the digital health sector. I now do a few sessions of general practice a week but spend the rest of my time consulting in digital health. I work with start-ups, entrepreneurs, health insurers, state governments and technology companies, assisting them with innovation and health technology strategies. I have also founded an organisation, 'Creative Careers in Medicine'. We run events, provide mentorship, advice and resources for clinicians wanting to explore all the possible opportunities available to them outside of traditional paths in medicine.

Why did you choose to study medicine?

It may sound clichéd but I wanted to take care of things. I had a nurturing instinct and thought I would be a paediatrician (when I realised my dream of being an actress wasn't going to quite work out!). I still love 'taking care'

of patients but now have an interest in systems and innovation in healthcare and my taking care of people has expanded from individual patients to also now include taking care of the whole system, including clinicians.

What have been the main influences on your career pathway choices?

I tried lots of things before I found out what I was passionate about. I didn't grow up having a deep interest in technology but this is the sector that excites me now. I 'fell' into it though; I wasn't purposefully seeking out a career in health technology. I started working for a company in occupational medicine and they happened to have a telehealth division and asked me if I was interested in moving across to help them set up a new service. I agreed, even though at the time I really had no idea what 'telemedicine' even was! Things have snowballed from there, resulting in me running Telstra's telemedicine business up until the end of 2017. This introduced me to the world of management, business, start-ups and digital health and I found my calling!

I then enrolled in another masters, which I have just finished, a global executive MBA. Experiencing business, innovation and the start-up scene in lots of different countries has reinforced my interest in this area. I think just saying 'yes' to opportunities and trying new things has helped shape my career path which has been anything but linear.

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

For a long time, I think I was searching for which specialty would keep me interested in the long-term. In medicine, my observation is once you obtain your fellowship (which for many will be in your 30s), you may end up doing essentially the same job for the rest of your career. This can be challenging for clinicians who are used to being driven and ambitious. Personally, I never wanted to stop learning and moving forward. My career choice has allowed me to mix my clinical work with work outside, which allows me to continue to be at the forefront of innovation and never get bored!

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

I wouldn't change anything, as all of my diverse experience has led me to the place that I am at now. My only advice to my medical student self would be to not listen to people when they say things like, "As a female, it would be hard for you to do that and have a family". I have managed

to balance having a family with an enriching and demanding career and I want all female graduates to know that it's possible to have the career you want and a family; it just takes a bit of juggling and compromise!

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

I never plan too far ahead because many opportunities that are presented in front of you are surprises. I like to keep an open mind so I can take advantage of things that come up. Who knows where I'll be in five or 10 years but I am right where I want to be now.

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

My advice would be to try lots of different things. Your working life now lasts 50 years and I think it's important to explore as much as you can. Making decisions in your early 20s that will impact you for the next 50 years is difficult. Don't be afraid to try something and if it doesn't work out, change your mind. Gone are the

days where one would join a company and stay in that same role for their whole career.

Also, think outside the square; don't be defined by those that have gone before you or what is 'written' or 'predefined'. As doctors we have so many transferable skills, we just don't always know it. We are great at problem solving, negotiating, organising, planning, being adaptable, leading, working in teams, communicating; the list is extensive. These skills can be useful outside of just treating patients. Find what it is that you love, even if it's different or unique. And finally, find meaning. Consider your 'why?'. Why is it that you do what you do? Watching Simon Sinek's *Start with Why* TED talk is a good place to start!

Visit www.creativecareersinmedicine.com for more information about Creative Careers in Medicine.

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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A support group for doctors with substance use issues



In an inner city location, a group of doctors sit down together once a week and talk about recovery from drug problems. They are part of 'Caduceus' - a Victorian Doctors Health Program (VDHP) support group for doctors with substance use issues.

Alcohol and other drug use is no less prevalent in doctors and medical students than in the general population - and being a drug addicted medical practitioner comes with its own unique problems. Frequently the shame, guilt and remorse that is felt by a doctor with a drug problem is a massive barrier to them accessing treatment. This is exacerbated by a fear of possible consequences of disclosure, followed by a tendency to self-treat. Sadly, doctors have died in their attempt to conceal their secret.

The VDHP views substance abuse and dependence as a disease/health issue. High quality treatment is readily available and the prognosis for an addicted doctor who participates in treatment programs is excellent. American and Canadian figures suggest over 90 per cent have successful outcomes and our experience over the years mirrors this.

When a doctor phones in reporting problems with substance use we urge them to come in and talk with us. Our approach is usually to implement a comprehensive treatment and recovery program which may entail referral to a GP and addiction medicine specialist, possible referral to a psychologist or psychiatrist, the commencement of chemical monitoring and regular attendance at Caduceus.

While the weekly numbers at Caduceus fluctuates, there can be anywhere up to 12 participants at each group. As well as providing general support and an opportunity to learn from others who have had similar problems, participants benefit from discussions around the specific challenges of having a drug addiction as a member of the medical profession. While Caduceus is not a 12 step program, some of the participants incorporate Alcoholics Anonymous and/or Narcotics Anonymous into their recovery activities.

VDHP regards Caduceus as an integral part of our case management and monitoring program. Some participants, valuing the ongoing support, continue to attend Caduceus long after their case management has finished. Most of the doctors who attend the group say it has been one of the most important aspects of their recovery program. In addition to helping alleviate feelings of isolation and seclusion, this unique group offers a supportive, non-judgmental, understanding environment where experiences can be shared and mutual support is offered.

I co-authored a qualitative research paper that asked Caduceus participants to complete an anonymous survey regarding their attitudes towards the group and its role in their recovery. Respondents overwhelmingly valued the group, seeing it as an integral and essential part of their recovery and ongoing health. Listed right is just some of the feedback from doctors.

During my years at the VDHP, I have seen many doctors with substance use problems. While the substance of choice varies (the more common ones include alcohol, pethidine, benzodiazepines, cocaine, heroin, methamphetamine and codeine), all the doctors expressed a fear of what was going to happen, particularly in relation to their career. Most are terrified about the repercussions of their situation and ask the same questions:

"Is this confidential?"

"If I come in to see you will you report me to AHPRA?"

"Will I ever be able to work again?"

When a doctor is committed to a recovery program and doing what is required, we would not contact AHPRA. Furthermore, we regard work as an important part of a doctor's recovery and motivation to stay well. If a participant's recovery is stabilised, then there is no reason why he or she can't work. In the event of a lapse or relapse, we ask that the doctor contacts us immediately to discuss what has happened.

While the recovery time of those who attend Caduceus varies, the common bond shared is a desire to live a life that is full, enriching, rewarding and not controlled by drugs. Furthermore, substance dependence is not a condition that goes away on its own - commitment to a recovery program and on-going support is essential.

If you are a doctor abusing substances, you are not alone. There are other doctors throughout Victoria who have experienced addiction problems and overcome them and now leading happy and productive lives - professionally and otherwise. I have been fortunate enough to have attended Caduceus on a number of occasions over the years and I never cease to be touched by the courage, care and camaraderie of this special group.



Cheryl Wile
Psychologist & Case
Manager
Victorian Doctors
Health Program

"Very apprehensive at first but then, realising we all had the same problems, I felt relieved and free to talk of my experiences."

"Although an addict is an addict, I do believe that doctors share common unique issues and a place to meet together is vital."

"Saved my life, family and work."

"It gives everyone an opportunity to share their experience in a safe environment and allows you to see how others are tackling their addiction, thus allowing you to develop your own recovery program and strategy."

"Recovery requires life-long management and Caduceus gives me a fantastic opportunity to maintain my recovery and help others do the same."

If you are a doctor experiencing issues with substance use, or if you think you know a medical practitioner who may have a drug problem, we urge you to contact the VDHP either by email vdhp@vdhp.org.au or by phoning (03) 9280 8712. Anonymous enquiries are welcome.

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An orthopod teaching mindfulness: Is it an oxymoron?

A busy orthopaedic surgeon is probably the last person that you would expect to become involved in something fluffy like mindfulness meditation. Several years ago I realised that things weren't quite right with my life despite having a successful career as an orthopaedic surgeon. I became aware that work was becoming overwhelming and I realised that I had several of the features of burnout, including emotional exhaustion and a loss of confidence in myself, particularly when things didn't go smoothly. I would often ruminate about complications and this was exhausting.

I was fortunate to find the Mindfulness Based Stress Reduction (MBSR) course over 10 years ago and this was a real game changer for me. This eight week semi-structured mindfulness program was brought into mainstream medicine at Massachusetts Medical School in 1979 by Dr Jon Kabat-Zinn. A molecular biologist by training, Dr Kabat-Zinn had spent several years training in Zen and Theravada Buddhist meditation in Asia. He incorporated the wisdom of these traditions into the secular MBSR program making it accessible to western medicine. This course is now available all over the world and has been subject to the scrutiny of many scientific studies demonstrating its efficacy in treating conditions such as chronic pain, anxiety and depression, as well as offering improved general wellbeing to all participants.

After completing this course, I continued meditating regularly. I went from being a person who was simply existing to one who is now flourishing and enthusiastic about life and work. Some of you might say that this is simply an anecdotal report. However, there is now very strong evidence that mindfulness meditation improves the quality of doctors' personal and professional lives.

I hoped that one day I might be able to teach the MBSR program. I was

fortunate to attend a workshop for health professionals with Jon Kabat-Zinn in Sydney. Following this, my wife Jo and I completed our MBSR teacher training. We were both involved in a randomised control trial looking into the efficacy of this program for patients undergoing joint replacement surgery. This study was done at St Vincent's Public Hospital in Melbourne and is about to be published. It has demonstrated a significant improvement in pain and function in those patients who did the MBSR course prior to surgery.

Jo and I have now been teaching mindfulness courses for staff at St Vincent's Hospital and the feedback has been overwhelmingly positive. In the last two years we have also commenced our Mindfulness in Medicine course specifically designed for doctors. Burnout in our medical workplace and in hospitals is receiving increasing publicity; which is a good thing. We are constantly dealing with patients who bring pain and suffering to the consultation. Empathy is an automatic response in dealing with another person's suffering. Constant exposure to the suffering of others can lead us to distance ourselves emotionally in order to cope. A great deal of emotional effort is necessary to block our natural empathic response and this often leads to emotional exhaustion.

Alternatively, we may over identify with the person suffering and this can result in feelings of overwhelm and empathic distress. Mindfulness helps reduce personal distress for doctors and leads to improved wellbeing. We are more able to shift our appraisals and recognise whose feelings belong to whom. Mindfulness assists us in developing sustained attention for managing emotional resonance to suffering, particularly when we are under pressure or in stressful situations. Mindfulness invites us to cultivate a sense of compassion for one's self as well as compassion for others. It has been demonstrated that compassion is one

of the best antidotes to burnout.

Some doctors have suggested that providing mindfulness or resilience training in our workplace is simply a cop out in the face of a widespread dysfunctional culture in our health system. There is a view that administrators have not done enough to address this problem and that this is what needs fixing, rather than doctors taking ownership of their own behaviours. I agree that there is a need for major structural and cultural change to reduce the emotional distress of being a doctor today. However, it doesn't have to be one or the other. If we can bring mindfulness into the medical workplace then I believe that this will enhance the possibility of cultural and structural changes. It is worth noting that medical workplaces that have prioritised a culture of civility and respect have noted a diminished burnout rate among their staff.

There is good evidence that mindful doctors experience fewer medical and surgical errors and respond with more wisdom and care for their patients when things do not go as planned. Patient compliance and satisfaction are further benefits of improved quality of care.

Over time I had come to dread consultations, seeing them as just another patient with hip or knee pain. I now see the person who comes into the consulting room as unique, with their own story. I am there to do the best I can for each of them. That is so much more rewarding and fulfilling.

For further information about our program for doctors see www.mcfm.com.au



Mr Tony Dunin
Orthopaedic surgeon
MBSR teacher

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How to end an employee relationship

For many years, including before I became a Commissioner with the Fair Work Commission (FWC), I have spoken to employers both singularly and in groups about dismissing employees fairly. My approach is based on an acceptance that we are dealing with a relationship involving real people and that what is sought is an ending of that relationship.

This is not just a legal issue or just a human resource issue. It is much more than that as it involves a real person. An employment relationship response should involve three elements:

- be firm
- be respectful
- be generous.

Forget about the three warnings before dismissal, forget about valid reason or opportunity to respond or the right to have a support person. All of that is the language of unfair dismissal provisions under the *Fair Work Act*.

If an employer comes to the view that the employment relationship should end; then end it. Why spend six months to a year trying to manage a person out when at the end you may still face an unfair dismissal or unlawful termination application?

The 'be firm' part of this approach is to hold to your decision that the relationship is at an end. It's the relationship that is at an end and nothing more than that. Don't be like the parents whose relationship has completely and irrevocably broken down but who stay together 'for the children'. They often inflict more damage on each other and on their children than if they had separated as amicably as possible and as early as necessary.

The 'be respectful' part of this approach requires the employer (or whoever is acting for the employer) to genuinely respect the human dignity of the employee to be dismissed. The employee has a name, a family, feelings, emotions, a sense of their place in society, a sense of their value as a worker, a group of friends including workplace friends and all of the other attributes that

make-up being a real person. They are not simply a set of numbers or values in a human resources spreadsheet.

The conversation with this person must be open, honest and direct. It is a conversation about the ending of a relationship. It is not a conversation about blaming the person, or accusing the person, or belittling the person. Remember always that the person being dismissed has to be able to explain their loss of employment to their family and friends and in some cultural groups they will have to explain themselves to their community leaders.

The 'be generous' part of this approach is all about creating an environment where the person who knows and understands that the employment relationship is to end and who knows that they are being treated respectfully can accept that a real level of generosity is being offered by their employer as part of an ending of the relationship.

What amounts to a generous offer from the employer will be different in each case. Most employers can accept the need to be firm and to be respectful but many fail to understand both the real value that comes from being generous and also what constitutes being generous. This is not the time to be stingy or parsimonious!

If an employee is entitled to eight weeks' pay on dismissal offering the person 10 weeks may not be generous. An offer of 16 - 20 weeks might be generous.

There is nothing in the *Fair Work Act* that requires an employer to provide a positive reference for an employee, yet an offer of a positive written reference with a guarantee

of a positive oral reference to any prospective employers can often have significant value to a person who is about to be on the hunt for a new job.

Allowing an employee to leave their employment in a dignified manner with the ability to say goodbye to workmates can be of enormous personal value to a person being dismissed. Inviting a person back to the end of year party might be required.

The point of being firm, being respectful and being generous is to ensure that the person being dismissed knows that it is going to happen and that it is proposed to be carried out in the best possible manner. It should also be made clear that what is on offer is more than could be obtained if the offer is rejected and the person has to run a case for compensation before the FWC or a court. Real generosity, when an employer has made the decision that the employment relationship must end, may be a very cost effective outcome.

In quite a few unfair dismissal matters where I have conciliated an agreed outcome, I have taken the opportunity to speak to the employer after the Terms of Settlement have been signed. I have explored with the employer how much time and effort they have put into the entire process of dismissing the employee and then responding to the unfair dismissal application and how much this has cost them. I then remind them that they have just agreed to a settlement. I then ask the employer to

consider how much they would have saved, in time, effort and money, if they had made a generous offer to the employee as part of the dismissal process. Generally, at this stage the penny has dropped and employers understand that there was a better way that they could have handled the ending of the employment relationship.

When you consider that nearly 90 per cent of unfair dismissal applications are resolved without arbitration it would appear that if employers adopted a better way to end the employment relationship a very large proportion of unfair dismissal applications would never be made.

If the relationship is to be ended on agreed terms then there needs to be a document that formalises the end of the relationship. Terms of Settlement should be prepared and the person to be dismissed needs to understand that what is on offer is conditional on the person signing the Terms of Settlement.

Standard Terms of Settlement contain three important provisions:

- A mutual surrender of most rights to take any further legal action against the other side for anything relating to the employment relationship.
- A mutual undertaking not to say or do anything which harms the reputation of the other side.
- A mutual undertaking not to disclose the Terms of Settlement or any of the circumstances leading to the ending of the employment relationship.

A practical point in offering generous terms to end the employment relationship by agreement is that part of the conversation can make clear that what is on offer is generous and is in excess of what the FWC could order in an unfair dismissal case.

If an offer is made to end the employment relationship, the offer should be kept open even if it is rejected

and even if the person commences an unfair dismissal or unlawful termination application. It can make for an interesting dialogue with any conciliator or mediator if a generous offer from the employer is still on the table and the employee has rejected it.

Finally, there is often an overlooked element in this whole process of ending an employment relationship with one employee. Whatever approach an employer adopts in ending the employment relationship with a particular employee, a very clear message is also being given to all remaining staff about how the employer deals with its people and how they view the nature of employment relationships.



John Ryan

Workplace Relations
Advisor

John has 38 years of experience in workplace relations. Prior to joining AMA Victoria in 2018, he was a Commissioner for the FWC for the previous eight years, where unfair dismissal claims were among his key functions. If members require assistance in preparing to dismiss an employee, please contact the Workplace Relations team on (03) 9280 8722.

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Improving the health literacy of refugees

New arrivals to Australia face a number of barriers to health and wellbeing, something Dr Linny Kimly Phuong knows only too well as the daughter of Vietnamese refugees.

"My parents came to Australia as refugees in 1979, so I am quite passionate about refugee health for that reason," she said. "They were Vietnamese boat people who sought refuge and were in a refugee camp in Malaysia. They were lucky to be accepted by the United Nations Humanitarian Program (for refugees) and came to Australia to start their new lives and their family."

In 2012, Dr Phuong, an infectious diseases registrar and AMA Victoria member, founded The Water Well Project, an Australian not-for-profit health promotion charity which aims to improve the health and wellbeing of migrant, refugee and asylum seeker communities by improving their health literacy. The charity is run by a dedicated group of volunteer healthcare professionals and recently celebrated its 500th community health education session.

The Water Well Project delivers culturally-sensitive health education sessions in Victoria, New South Wales and Tasmania based on the needs identified by refugee support organisations. There are many topics covered including navigating the Australian healthcare system, healthy eating, exercise, diabetes, mental health, contraception and immunisation.

"The Navigating the Australian healthcare system session is an



effective one for new arrivals and even those who have been in the country for a number of years," Dr Phuong explained. "During sessions we might roleplay how to make an appointment to see a doctor, talk about what you would bring along to the appointment, ensure community members are aware of interpreter services and, importantly, discuss when to present to an emergency department instead of a general practice clinic. These are fundamental things that you would only understand if you've grown up in this country."

Topics delivered depend on the brief provided by referral partner organisations. "For example, if we run a women's health session we rely on the community partners who we work with to provide a brief of what the community actually wants and needs," Dr Phuong said. "We aim to fill knowledge gaps and try and make our sessions really interactive and practical. A women's health session may involve us passing around speculums, Pap smear brushes and pelvic models, to get the conversation going and make the session engaging, interactive and fun."

Left: The Water Well Project founder Dr Linny Kimly Phuong.

Right: Water Well Project volunteers Steph Nesbit (left) and Dr Anna Power presented a session on bone and joint health.

Below: Water Well Project volunteers Dr Annie Kilpatrick (left) and Dr Elise Yong presented a session on child development.



Dr Phuong established The Water Well Project around the time she began her intern year and devotes much of her time outside of work to the organisation. It has also challenged her to work well outside her comfort zone.

“I never set out to create an organisation,” she reflected. “It just kind of happened and gathered a lot of momentum. Before I knew it we were in three states!” She recognised early on what her strengths and weaknesses were and has brought a range of people from diverse backgrounds onto the board to help assist with responsibilities like balancing ledgers,

running social media campaigns and navigating not-for-profit law. “There is so much stuff that you do not learn in medical school!

“The main aim for us (now) is to build awareness of our service across refugee support organisations,” Dr Phuong said. “We want to more effectively reach at-risk populations. This has been hard because until recently we haven’t had any marketing expertise in our organisation. We are also focused on building a sustainable organisation that provides quality sessions tailored for the community.”

The Water Well Project is always looking for medical professionals to become involved. Doctors interested in supporting The Water Well Project can:

- Register to become a volunteer healthcare professional facilitator at www.thewaterwellproject.org or
- Donate to the project - As a registered health promotion charity, The Water Well Project has deductible gift recipient (DGR) status. All donations above \$2 are tax deductible.

What can a doctor do to improve healthcare's environmental sustainability?

Healthcare's environmental footprint is significant due to high resource usage and waste production. Our workplaces and practices may be disproportionately contributing to greenhouse gas emissions and pollution and thereby adversely impacting human health.

In January 2018, published modelling in *The Lancet Planetary Health* estimated that Australia's healthcare sector is responsible for 7 per cent of Australia's total greenhouse gas emissions, more than the state of South Australia. Hospitals are responsible for almost half of the sector's emissions (44 per cent of the total), while pharmaceuticals contribute 19 per cent, capital expenditure for buildings 8 per cent, community and public health 6 per cent and general practice 4 per cent.

This level of environmental impact is unlikely to be either sustainable or acceptable in the longer-term, particularly as efforts to reduce carbon emissions and combat climate change intensify. Climate change is considered the 'biggest global health threat of the 21st century' with the potential to undo many of modern medicine's advances. Hence it is ironic that our hospitals, which aim to heal the sick, are in fact contributing adversely to the health of present and future generations.

Fortunately, many of the changes needed to improve environmental sustainability within healthcare can concurrently deliver financial sustainability and quality improvements. For example, processes that promote resource and waste efficiency, prevent avoidable activity, focus on value and cost-effectiveness and place greater emphasis on primary care, prevention and self-management will often lead to better environmental, financial and healthcare quality outcomes.

While there are several state-based, hospital and practitioner led initiatives aimed at improving the environmental profile of the sector, Australia does not have an overarching coordinated strategy in place. This potentially forgoes the associated financial and quality



benefits that such coordination could foster.

France, Austria and the United Kingdom have national healthcare sustainability units (HSU). In England, the National Health Service's Sustainability Development Unit (SDU) facilitated an 11 per cent reduction in greenhouse gas emissions between 2007 and 2015 despite an 18 per cent increase in activity. Associated cost savings for the NHS have been estimated at £90 million (\$166.5m) annually. An Australian HSU could model the English example to achieve similar environmental and financial gains.

So what can a doctor do?

Successfully advocating for a national HSU, with state-based HSUs as appropriate, is likely to be the most effective measure we could take to improve environmental sustainability in our health sector. Doctors for the Environment Australia (DEA) has an *Australian HSU proposal* that can be found on its website, www.dea.org.au. Within an individual hospital/ workplace, the first priority should be to ensure there is an Environmental Sustainability Officer to drive change and engage staff. For other actions individual doctors can take, see DEA's practical guide entitled *Improving a hospital's environment impact: what can a doctor do?*

Actions led by both doctors and hospital sustainability officers exist across Australia. Over the last decade, following the employment

of an environmental sustainability officer, the Mater Misericordiae in Brisbane has explored or implemented more than 190 initiatives involving thousands of staff, saving more than \$2.3 million. Environmental and financial life cycle analysis research conducted at Footscray Hospital has led to a change from single use to reusable anaesthetic breathing circuits, facemasks, plastic trays and other anaesthetic equipment, saving more than \$6,000 annually per operating room. In addition, the shutdown of selected steam sterilisers at times of low activity has saved around \$15,000 per annum.

General practices can also benefit from addressing their environmental footprint. Following recommendations derived from an energy audit in 2016, the Benalla Church St Surgery in North East Victoria reaped immediate financial savings of over \$4,000 per annum (the audit cost less than \$1,500). With the implementation of additional sustainability measures (addressing waste management and paper use), a further \$3,130 was saved annually.

Australia's professional medical colleges and associations are beginning to consider the need for environmentally sustainable practice. The RACP has led with their 2016 position statement *Environmentally Sustainable Healthcare* while the ANZCA released a draft *Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice* earlier this year. The

AMA has a position statement on *Climate Change and Human Health* and the Council of Presidents of Medical Colleges (CPMC) recently held a Climate Change and Health Roundtable coinciding with a visit to Australia from the UK's SDU's founding director Dr David Pencheon. The CPMC subsequently released a communiqué on *Managing and Responding to Climate Risk in Healthcare* which has been endorsed by 11 medical colleges.

Conclusion

The Australian health sector faces many challenges including a rapidly expanding burden of chronic disease, an ageing population, continual costly advances in medical technology and the need to build resilience in the face of predicted amplifications in climate-related health impacts. In this context, the future of expanding, high quality healthcare relies on it being delivered in ways that are both environmentally and financially sustainable.

As doctors, we have an over-riding duty of care to "do no harm" which mandates that we consider and address the environmental impact of our day-to-day practise. We also have a responsibility to advocate for appropriate action to protect health and humanity.



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How dangerous is sport-related concussion?

Just 25 minutes into the 2015 Rugby World Cup Final, pitting the Wallabies against the All Blacks, Aussie veteran Matt Giteau attempted a tackle on Kiwi lock Brodie Retallick that went wrong, crashing him to the ground where he lay in a daze. After stumbling about on all fours for a few seconds, Giteau slowly rose to his feet and staggered sideways as he tried to walk, a classic sign of concussion. Although he seemed to recover quickly, a medical officer pulled him from the pitch and he was out for the rest of the game.

"They wouldn't have done that a decade ago," says Dr David Hughes, Chief Medical Officer at the Australian Institute of Sport (AIS) and co-author of a new CPD learning module on concussion in sport. "That they pulled a key player off in such an important match shows just how seriously the football codes are taking the issue of concussion."

Dr Hughes says there's been an enormous cultural shift in how sport-related concussion is approached over the past few years. "There was a time, particularly in contact and collision sports, when getting up and playing on after a concussion or even after being completely knocked out was seen as being tough or a sign of your commitment to the game. That has shifted and a lot of the heavy lifting has been done by the sports codes themselves."

Nowadays, he says, you'll rarely see a professional player returning to the field until six days or so after concussion, let alone in the same game. And for many top athletes who are concussed, it may be weeks before they're competing again. "There is far more focus on the welfare of the athlete. We understand that there's no such thing as a good concussion."

Dr Hughes says the new awareness around the issue of consciousness is happening at the grassroots as well and not just at the professional level. "There's parental concern, and there's an understanding that concussion is not just about professional contact and collision sports, but it's actually a public health matter. In professional sports, you've got access to medical professionals and video, which makes identifying and dealing with concussion that much easier, but at school or amateur level it's a lot more difficult."

To address this need, the AIS and AMA put out a joint statement on concussion this year and the two bodies have also set up a website - www.concussioninsport.gov.au - with information for parents and teachers as well as coaches and medical practitioners.

Dr Hughes says there's still a lot of confusion over the issue in the general community. "You have the situation where a child suffers a concussion and the parent immediately thinks their child will have long-term brain issues and there's just no evidence that this is the case. But we do know there's a need to differentiate between children and adults. Children take longer for symptoms to resolve and the

recommendation is to wait 14 days following symptom resolution before the child resumes competitive sport."

Then there's the question that has been all over the media in the past couple of years of whether repeated concussion can lead to degenerative brain disease. Dr Hughes says he thinks the jury is still out. "There was a paper published in *JAMA* by a group in Boston which has maintained a brain bank of professional athletes. Out of 220 people who had donated their brains, 210 had signs of degenerative brain disease. So you get all these headlines saying 90% of football players have degenerative brain disease. The problem is you can't extrapolate from this study because it's such a skewed sample. Everyone who donated their brains already had symptoms and that's why they donated."

He says the fact is that the vast majority of people who suffer sport-related concussion will go on to lead perfectly normal lives. "The AIS and AMA are not saying there are no long-term effects. All we're saying is the studies have not been done. There is no research to date that clearly demonstrates cause and effect between sport-related concussion and later degenerative brain disease. There's a lot of passion and emotion around the subject. You can hold up a slice of someone's brain and then show a video of that same person being concussed many years ago and it's a very powerful image. But it's not good scientific research."

Are you interested in learning about concussion in sport? Access doctorportal's free learning module to gain CPD points:

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References available from the Editor on request.



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Obituary Dr David Andrew 1944 - 2018



Dr David John Doidge Andrew passed away unexpectedly on 3 October, 2018

A Fellow of the Australian Medical Association, his outstanding commitment to the organisation and the community in general stands as an inspiration to all.

Born on 27 January, 1944, Dr Andrew graduated from The University of Melbourne in 1968 and joined the AMA the following year. On graduation, Dr Andrew worked in Auckland, New Zealand, before working as a visiting medical officer at The Royal Children's Hospital and The Royal Women's Hospital. Dr Andrew also worked as an obstetrics and gynaecology registrar in Wellington and Auckland in 1972 and 1973.

In 1971 Dr Andrew joined the Royal Australian Navy Reserve. He retired with the esteemed rank of Surgeon Commander in 2009.

Dr Andrew practised as a general practitioner for the Whittlesea and Epping Medical Group from 1974 to 1975 before starting a solo practice in Epping in 1976. He retained this solo practice until 2009.

Since joining AMA Victoria in 1969 and becoming an active member in the late 1970s, Dr Andrew has served as:

- Secretary and Chair of Northern subdivision
- AMA Victoria Council representative for the Northern Division of General Practice
- AMA Victoria representative for the Department of Veterans' Affairs on the Local Medical Officer Advisory Committee
- Member of the AMA Victoria Section of General Practice
- Treasurer of the Section of General Practice
- Member of the AMA-RACGP Liaison Committee.

Throughout his career Dr Andrew worked as a locum doctor intermittently in rural Victoria. He was a strong advocate for doctors working in rural areas and for rural health. One of his major concerns for the medical profession was the loss of obstetric skills in the new generation of doctors.

Dr Andrew made a great contribution to the AMA. Beloved husband to Vaoese, proud father of Jason, Bronwyn, Peter, Stephanie and David, and proud grandfather of Maximus, Austin, Celeste, Matilda, Alice and Wolfgang. He is sorely missed.

I have known David Andrew for the best part of 12 years; initially meeting him in the Victorian Section of GP, where he was an active, passionate and thoughtful contributor and resourceful participant.

David was a very close friend and an ardent loyal supporter. He was always a friendly, gentle and good natured colleague who genuinely loved his craft and his patients.

He was a defender of good clinical practises and the appropriate resourcing of a strong, quality-focused health system. He especially championed the causes of both veterans and rural populations and their access to quality healthcare.

He will be dearly missed by all who knew him. I certainly will.

Goodbye my dear friend.

Tony Bartone

I got to know Dr David Andrew when I joined AMA Victoria several years ago. He was the outgoing Treasurer of the Section of General Practice when I took over the role. David was meticulous with his documentation; nothing was missing and the handover was done with military precision.

He briefed me and was extremely supportive while I settled in. He had guarded the funds held by the Section with great vigour and had grown the return on investment handsomely. David was wise in his counsel at Section meetings, humorous when the discussion got thorny and tenacious when he advocated for his community and his patients' rights.

I am very sad he left us in this cosmic vibration, as I will miss him at the meeting.

It is said that warriors dine with Gods in Valhalla when they exit this life. I am sure David is enjoying the celestial red wine.

My condolences are for his family, who will be very proud of his achievements.

Nelum Soysa

I have known David since 1993 with our work on the Northern Division of General Practice and then with our work with the AMA. I have found David to be a passionate, caring, genuine man who had incredible energy for his passions of veterans' health, rural medicine and general practice. I never heard him utter an angry word despite banging his head against the impenetrable wall of bureaucracy.

He was a mentor of mine and probably one of my best, if not the best, supports of mine over the years.

The world will be a much better place if we could learn the David Andrew method of achievement, which was to calmly, logically and persistently state and push your case without unnecessarily upsetting people along the way. I think the people of Cohuna would agree with me.

I did say thank you to David in the past but regret never saying the above to him directly. My memory of David will always be him dressed in his resplendent white navy suit at the AMA National Conference Dinner with that great smile on his face.

David, you will be missed.

Michael Levick

It is very hard to add more about this wonderful man.

He loved life. He loved working in general practice and more recently in aged care, listening to all his patients and offering helpful care.

He loved his family: his wife Vaoese, his five children and six grandchildren.

He loved the Bombers. But if they lost on Anzac Day, he would congratulate me on my team's success.

We'd meet often and have a drink at AMA meetings over 25 years. He would be the first to ring me if I had some achievement and would be the best ear to listen to my woes.

David was a vocal advocate for the health of the community and the aged, veterans' health - especially their mental health - and rural health, especially obstetrics.

His words were followed by his actions in working locums in rural Victoria, representing AMA Victoria in Department of Veterans' Affairs matters and working long hours caring for his patients to the very end.

Rest peacefully David.

Terry Ahern

Vale David.

I was deeply saddened by the sudden loss of my friend and colleague David.

I first met David about a decade ago and over the past few years worked with him on AMA Victoria's Section of General Practice. His commitment to his patients and community - especially veterans and rural communities - was unflinching and an inspiration to us all.

Recently David advocated and worked hard to ensure that both rural and regional health and mental health were central aspects of AMA Victoria's *Priority Goals for Victoria's Health System*.

His gentle words of wisdom, care and respect for others and warm curiosity were ever present. With him around, we had better discussions, made better decisions and had more fun.

At a personal level, he made me feel special and valued. I felt I always had his ear and he always had my back. I always delighted in seeing him and will miss him so very much.

With my deepest condolences to his beloved family and loved ones.

Requiescat in pace David.

Ines Rio

Farewell David.

I remember the first time you came to relieve me in Cohuna; it was in the summer of 2009.

It was such a relief to meet you; qualified in obstetrics, experienced, competent and interested. I had a great week away knowing Cohuna was safe and you told me lots of stories where you were pushed to use all your skills. I think for you this reinforced your beliefs in rural medicine being a worthwhile challenge.

Every year from then we had the enjoyment of your skills and your frequent emails and phone calls on matters political, clinical and personal. The great delight you had in all your children and in your daughters following your footsteps became apparent during those quiet chats we had.

So many patients were delighted to meet you and were safely guided to good outcomes. It was funny to hear them talk about the old bloke with the beard but it wasn't me they were talking about. You have always had the interests of the bush at heart and I can only thank your long-suffering wife for releasing you to us now and again.

I rang you last year when we were under threat of loss of services at our little hospital and you mobilised the AMA to support Cohuna with letters and questions to people in high places. How grateful we are that you could do that for us. It was significant that we succeeded in standing firm. We could feel the support of the AMA and you in particular.

I feel very privileged to have met you and to feel your blend of compassion and skill over the years. Your life has ended too soon but it was full and has left many like me all the better for your contact.

Enjoy your wine and rest well after the inaugural AMA committee meeting in St Peter's Hall, Heaven.

Peter Barker

Members selected for Homeward Bound expedition to Antarctica

Two AMA Victoria members have been selected for the prestigious global leadership initiative Homeward Bound, which aims to heighten the influence and impact of women in making decisions that shape our planet.

Dr Pallavi Prathivadi and Associate Professor Jill Sewell are two of just 95 women from around the world accepted into the program, which will involve the largest-ever female expedition to Antarctica, departing from Ushuaia, Argentina, in November 2019 after an intensive 11-month program.

Dr Prathivadi, who is a member of AMA Victoria's Women in Medicine committee, is a practicing clinician and researcher with interests in women's health and pain management. She completed her MBBS and BMedSc (Hons) from Monash University and MMed (Pain Management) from the University of Sydney, studying worldwide opioid access and utilisation. Dr Prathivadi is currently undertaking her PhD in the area of improving opioid prescribing in Australian general practice at Monash University, where she is also an assistant lecturer.

A/Prof Sewell, a consultant paediatrician, is the Clinical Director of the Children's Bioethics Centre at the Royal Children's Hospital. She is working to improve the health and developmental trajectory of individual children and promoting early childhood and the life chances of all



Dr Pallavi Prathivadi

children. Bioethics responsibilities to support clinicians with ethical decision-making when complex care leads to disagreements between parents and doctors.

A/Prof Sewell has had leading roles in medical training, workforce development and regulation, community development, childhood advocacy and quality and safety in healthcare. She chairs the Victorian Clinical Council, advising the State Government on health policy. A/Prof Sewell also leads the Australian Medical Council, setting standards and accrediting all Australian medical training organisations.

The Homeward Bound leadership program is for women in science, technology, engineering, mathematics and medicine (STEMM).

"I am so delighted and humbled by the opportunity to join the Homeward Bound program and I sincerely appreciate the phenomenal support and encouragement from my family, friends and colleagues," Dr Prathivadi told Monash University's *The Insider*.

"The program offers me the opportunity to collaborate with incredible global leaders in STEMM



Associate Professor Jill Sewell

who are equally passionate about gender equality, sustainability of our planet and improving worldwide health, economic and educational outcomes, especially for women," she said.

"I'm particularly interested in global health policy relating to opioid analgesia and I hope to use this experience to continue to build towards becoming a leader in the area of safe, equitable opioid prescribing, access and use."

Homeward Bound said Antarctica was chosen for the expedition because some regions are showing the fastest responses to some of the global sustainability problems we currently face. Antarctica offers an unparalleled opportunity to observe firsthand the influence of human activities on the environment and provide critical insights into the global-scale change required.

Dr Prathivadi is currently fundraising and seeking sponsorship to help cover the costs of the program. Visit www.chuffed.org and type her name into 'search' for more information.

Follow the Homeward Bound journey at www.homewardboundprojects.com.au

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SafeScript is now live

SafeScript, the new system that supports the safer prescribing of high risk medicines, is now live. While any doctor in Victoria can register now, the initial focus is in Western Victoria with the focus moving to the rest of the state in early 2019.

If you haven't already, join the over 2000 clinicians that have already registered and start using SafeScript today.

Register via www.safescript.vic.gov.au.

Videos and quick reference guides about how to set up SafeScript and receive pop-up notifications can be found at www.health.vic.gov.au/safescript. These notifications help you to quickly identify when there is a need to view information in SafeScript, enabling a better user experience.

Please remember that patient records in SafeScript may only be lawfully accessed when you are involved in that patient's medical care and in the context of the medicines which are monitored. You

should only access a patient's record in SafeScript if you can substantiate this in your capacity as their health practitioner.

It is important to know that SafeScript is more than an IT system. Other facets of this initiative include:

- SafeScript training will put you in the best position to use SafeScript productively. Online training is open to all prescribers and covers safe supply of high-risk medicines, using respectful communication to discuss medicine dependence and how to use SafeScript. Training attracts CPD points and is available now via www.vphna.org.au/safescript-hub.
- SafeScript GP Clinical Advisors are now available (1800 812 804) to provide peer-to-peer support to GPs in Western Victoria, responding to the needs of patients using high-risk prescription medicines. Drug and Alcohol Clinical Advisory Service (DACAS) consultants are available to

all clinicians on this same phone line, ahead of the GP Clinical Advisors state-wide roll out in early 2019.

- The SafeScript Pharmaceutical Helpline (1800 737 233) offers free and confidential advice to all patients that are concerned about their use of prescription medicines and risk of dependency. The helpline is available 24 hours a day, seven days a week. You are encouraged to refer patients who have concerns to this helpline.
- Reconnexion (1300 273 266) provides counselling, telephone information and online support services to people experiencing anxiety disorders and benzodiazepine dependency. More information can be found at www.reconnexion.org.au.

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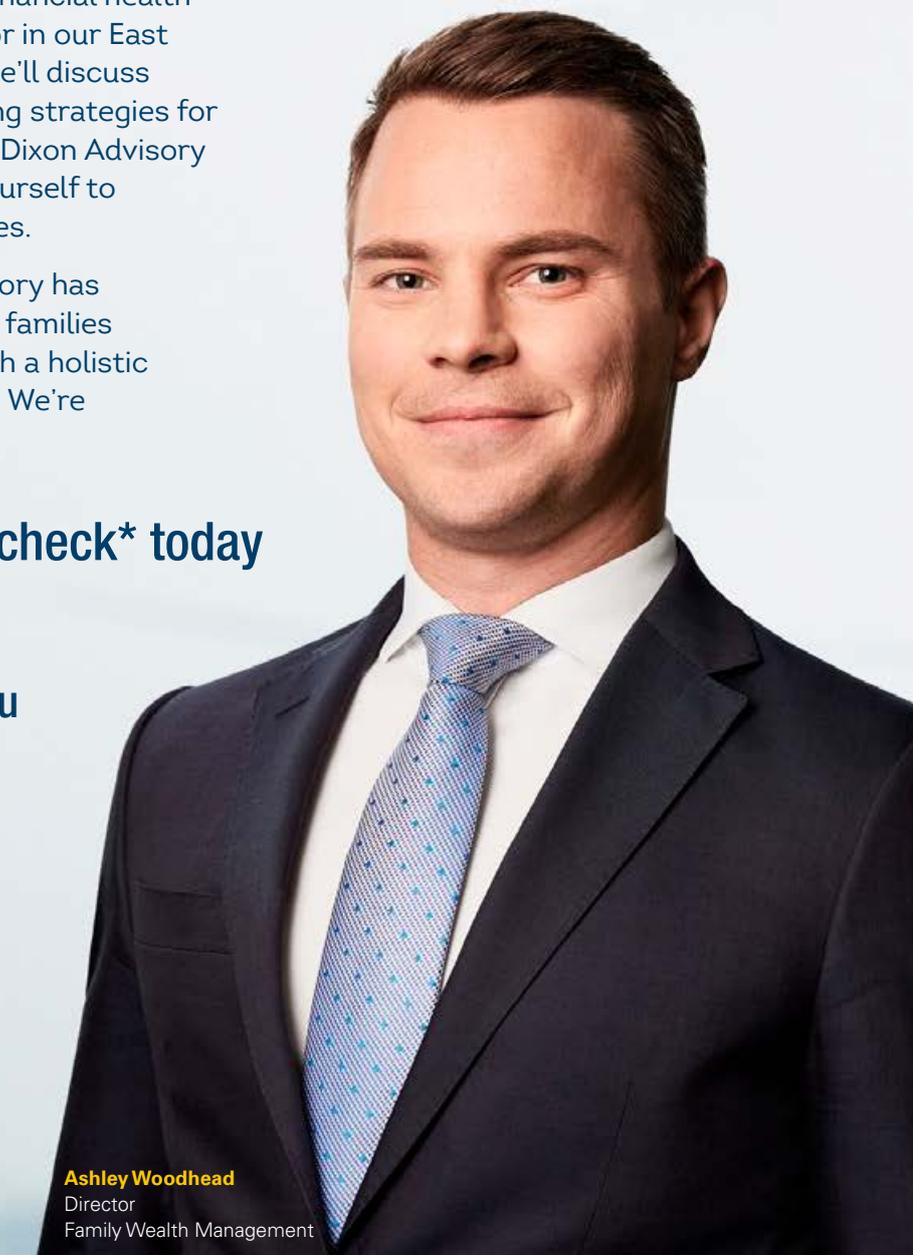
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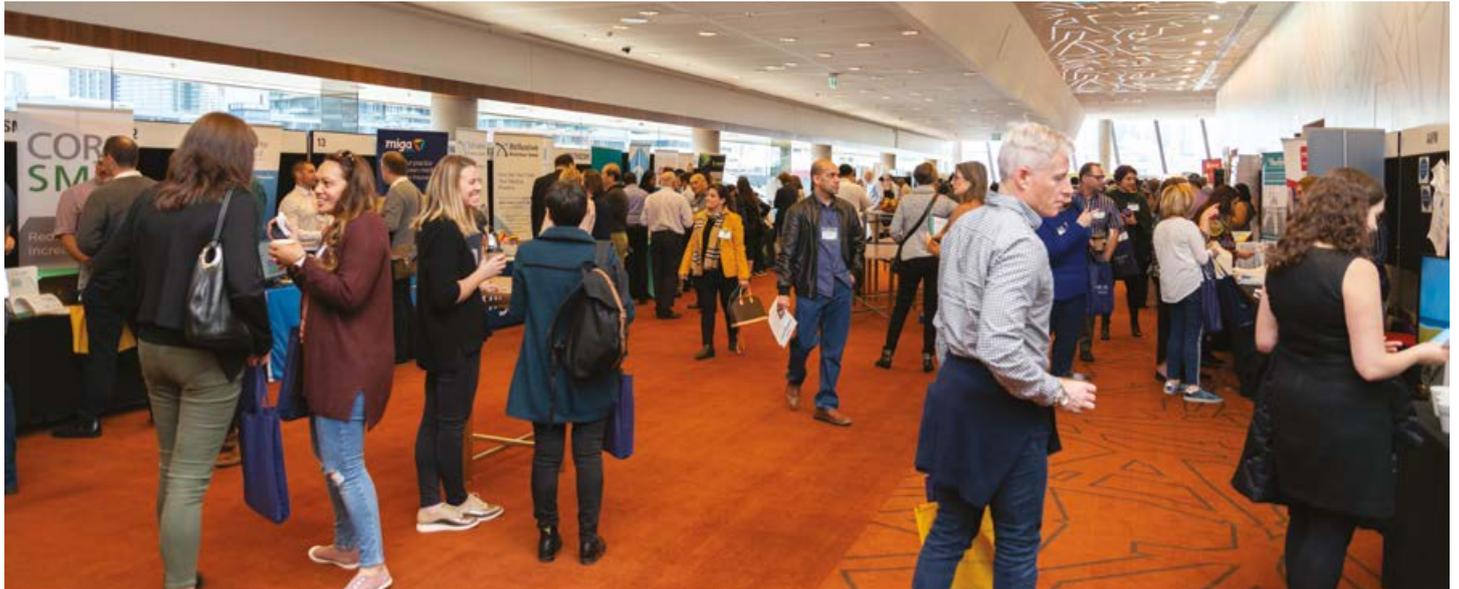
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Around 150 people attended this year's event at the Melbourne Convention and Exhibition Centre on 22 September. AMA Victoria would like to thank all our attendees, exhibitors and sponsors for supporting the event, including major sponsor, MDA National.



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Speaking the common language of medicine

Dr Jun Jung and Dr Brian Oliver have been meeting regularly through the AMA Victoria Peer Visitor Program for more than four years, starting soon after Brian moved into an aged care facility in the western suburbs of Melbourne.



During this time, Jun has completed his medical studies at Deakin University and is now a PGY2 at Western Health. The bond between them is so strong that for two years Jun travelled from the Deakin clinical school in Warrnambool to see Brian whenever he was visiting Melbourne, as well as keeping in touch more frequently over the phone. Brian says he values the common understanding the language of medicine brings in his friendship with Jun, as communication can be challenging due to his hearing loss. Jun enjoys hearing Brian's stories about his experiences as a doctor and learning a little history about the practise of medicine, as well as the companionship and emotional support that their relationship brings.

Brian began his medical studies in 1940 during World War 2, completing a shortened course which he says left him "under-baked" as a doctor. When asked what lead him to pursue medicine, he states that he was deemed a "bit of a brain" at school and as he was told his mother would like to have a doctor in the family, he headed to Melbourne University with a Leaving Certificate.

Brian graduated in 1947, after repeating third-year medicine and

was a junior resident (now known as an intern) in Launceston. This was followed by working as an "associate with a view" in several medical practices to gain further experience and to find his niche in medicine. He recalls working in Mansfield and once a fortnight travelling to Woods Point to provide medical services to the local community. In those days this required an overnight stay at Woods Point for a journey that today would take under two hours. Another recollection of working in country Victoria involved successfully reducing a working dog's dislocated hip without incision and only the assistance of ethyl chloride and ether for anaesthesia. The local farmer was very happy when the dog got up and started running around again!

Dr Oliver subsequently moved to practise in Moonee Ponds at the Margaret St Clinic, taking over from Dr John Farrer who returned to the UK to take up a Squiredom. Brian stayed at this clinic, working alongside a team of other GPs, specialists and surgeons for 23 years. Although the original premises at 34 Margaret St Moonee Ponds has now been redeveloped, the area is still associated with several medical

practices. Brian recounts that he enjoyed working with children and being part of the local community. His work included a weekly session with the outpatient clinic at the Children's Hospital. Brian's practice included minor surgery such as tonsillectomy, as well as removal of warts, clearing blocked nasolacrimal ducts and managing fractures. He did undertake a few appendectomies but was advised he should refrain from this due to inadequate experience!

The Margaret St Clinic included an operating theatre for use by the GPs and the other specialists working there. Brian recalls undertaking tonsillectomies on two generations of patients from the same family and also remembers diagnosing the congenital defect coarction of the aorta in a student from Essendon Grammar during a routine general physical examination of boys at the school. The problem was identified when the young student had a systolic blood pressure over 190.

Brian left the Margaret St Clinic on 1 July 1975, the day Medicare (then known as Medibank) was introduced. He moved to the Department of Public Health in the Victorian Health Department for the next 14 years.



Dr Brian Oliver (left) and Dr Jun Jung.

During this time he undertook a Diploma of Public Health and worked as a District Health Officer. One particular incident that Brian remembers during his time working in environmental health is an outbreak of gastroenteritis at Mt Buffalo Chalet, when even those sent to investigate the outbreak became infected and unwell. The epidemic was later written up in the *Medical Journal of Australia*.

Jun arrived in Australia from Korea in 2002 to study optometry because as a student in year 12 he did not like blood! While practising as an optometrist, Jun loved working in Darwin, Katherine, Mataranka and remote areas near Alice Springs and developed a particular interest in Aboriginal health during this time. He says it's a privilege to provide care to the Aboriginal and Torres Strait Islander population and really admires the beauty of this part of Australia. Jun says he's also gained much satisfaction from visiting developing countries as an optometrist.

Jun has an uncle who is a gastroenterologist in Korea but his interest in medicine came from being a patient in hospital and realising how

much healthcare staff can impact a patient's life. As an optometrist, he also encountered medical conditions that he wanted to learn more about and be able to treat. Jun describes reaching a turning point in his life when he decided to pursue medicine at Deakin University, subsequently spending two years in Geelong and two years in Warrnambool.

The young doctor is hoping to become involved in providing healthcare in regional, rural and remote areas by combining his medical and optometric skills. His career interests are anaesthetics or GP/anaesthetics and Jun is also keen on medical education and would like to be involved in a medical student teaching program.

The AMA Victoria Peer Visitor Program is open to any older doctor who would like a visitor. All volunteers are members of AMA Victoria and range from medical students, doctors at varying stages of their career and retired medical professionals. If you know an older doctor who would like a visitor, please contact Kay Dunkley on KayD@amavic.com.au as we have volunteers who are waiting for someone to visit.

The visits to Dr Brian Oliver are facilitated through the Community Visitors Scheme (CVS) which is coordinated by Melbourne City Mission. Most aged care facilities throughout Victoria are linked to the CVS under the auspices of a range of program providers across the state. The AMA Victoria Peer Visitor Program can also facilitate visits in private homes.

For more information about the Peer Visitor Program visit www.amavic.com.au/assistance-for-doctors/Support-Programs/peer-visitor-program or email Kay Dunkley on KayD@amavic.com.au



Kay Dunkley
Doctor Wellbeing and
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The AMA Victoria Peer Visitor Program is proudly supported by PSA Insurance.



Exclusive Member Benefits



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Member benefits: 5% off business saver and economy saver fares across all Emirates destinations; 8% off Business and Economy Flex / Flex Plus fares across all Emirates destinations; 10% off Business Flex Plus fares on select flights.



MDA National

1800 011 255

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



BMW Melbourne

(03) 9268 2222

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



Virgin Australia Lounge

1300 133 655

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

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



Avis / Budget

(03) 9280 8722

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

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



Doctors' Health Fund

1800 226 126

Member benefits: The Fund was created specifically with the needs of the medical community in mind. Their cover supports freedom of choice and clinical independence. Visit www.doctorshealthfund.com.au to find out more.



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(02) 9974 3046

The Scotch Malt Whisky Society is the foremost whisky club in the world and allows its members exclusive access to whisky.

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Wakelin Property Advisory

(03) 9859 9595

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

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Qantas Club

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9280 8722 www.amarto.com.au

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

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Little Real Estate

(03) 9514 8992

property.littlerealestate.com.au/amavic

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



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amavic.com.au/corporate-partners/clear-to-work

Member benefits: AMA Victoria has partnered with Clear to Work to offer our members a 'best in the market' price on National Police History Checks. It's a very simple process - all you need is your passport and driver's licence, or other recognised ID and you're good to go. To start your police check go to amavic.com.au/corporate-partners/clear-to-work

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

Retired doctors visit Cranbourne's Royal Botanic Gardens

After meeting one September morning at Flinders Street Station, our retired doctors group caught the train to Cranbourne Station, before our waiting bus drove us the short distance to Cranbourne's picturesque Royal Botanic Gardens.

Guests were treated to a delicious two-course lunch in the beautiful Tarnuk Room, overlooking the gardens. Following the meal, the group was split into two, with one half free to roam in the gardens while the other jumped onto the exclusive bus tourers for a guided trip around the grounds. After half an hour, the two groups swapped, with members expressing a desire to return to the gardens and explore the many areas in more detail.

Thanks to our partners Doctors' Health Fund for supporting the event.



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Artist impression

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The lovelorn patient

There is no rhyme or reason to the romantic feelings some patients develop for their doctor. It may be a physical attraction, the result of an exaggerated deference to authority, or a reflection of the patient's personal situation.

A sympathetic ear, or simply being heard, can often trigger an emotional response from a patient. Whatever the reason, the potential blurring of the doctor-patient relationship can lead to significant professional consequences if not managed promptly and appropriately.

Case study

A female patient in an abusive relationship always saw a female doctor in the practice. She was booked with a male doctor at short notice after her usual doctor left to deal with an emergency. The male doctor was sympathetic towards the patient who had been verbally abused by her partner the previous night.

The patient's usual doctor returned from leave, but the patient continued to book with the male doctor. The frequency of the visits increased and the patient asked the doctor for his mobile number in case of emergency. He provided it, concerned about the patient's previous history of domestic violence.

The patient didn't use the number until late one night when the doctor received a text:



The doctor was very concerned, and he was unsure what to do. His wife, also a doctor, urged him to contact his medical indemnity insurer for advice.

Discussion

In hindsight, the doctor was able to recall the warning signs. The patient didn't need to attend so often. She always booked his last appointment for the day and spent much of the consultation engaging him in conversation. The doctor was aware she was vulnerable and didn't know how to raise the issue without causing her distress. Once he received the text, he realised the doctor-patient relationship was unhealthy and that he would need to end the therapeutic relationship.

A medico-legal adviser assisted the doctor to write to the patient, stating it was in her best interests to find a new doctor or practice.

Due to the risk of repercussions if the letter was opened by the patient's partner, it was agreed that the doctor would explain the situation and provide the letter to her in person. The patient was embarrassed and she opted to move to another practice.

Things to remember

- Doctors may feel responsible for the patient developing feelings towards them, but this is not usually the case. Over time, boundaries can blur gradually and subtly.
- It may seem easy to continue to see the patient rather than address the issue - but if warning bells are sounding, seek advice about ending the therapeutic relationship.
- The lovelorn patient is often vulnerable and should be managed sensitively. 'Firm but kind' is usually the best approach, as the patient may feel hurt and

embarrassed when their advances are rejected.

- Embarrassment or naivety in these circumstances is understandable, but will carry little weight with AHPRA if it becomes clear professional boundaries have been breached and the doctor has not dealt with the matter in a professional and timely manner.
- Keep your professional and personal life separate, e.g. don't accept friend requests from patients on Facebook and avoid discussing your personal life during consultations.
- Doctors sometimes continue the therapeutic relationship, fearing that the patient will make a complaint if they end the relationship. In our experience, we find that the risk of a complaint increases the longer you continue to see the patient.
- Return any gifts, but keep a record of text messages (as screenshots), emails, letters or cards in a separate medico-legal file.

If the therapeutic relationship is causing you concern or no longer healthy, please contact your medical indemnity insurer for advice on how to manage the situation.



Nerissa Ferrie
Medico-legal Adviser
MDA National



References available from the Editor on request.

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

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Tips for selling property in a challenging market

The buoyant property market of the last five years is history. It was a time when many residential property participants could make some mistakes in their strategy and execution and believe they had done okay, carried to safety by a rising market. But the market is likely to expose these errors in coming months.

So for today's vendors, flawlessness is the name of the game. It starts with understanding the likely buyer and then targeting them with a story that resonates.

Thankfully for vendors, there are some useful online tools now available to help reveal that ideal buyer's profile. Take 'Home Price Guide', the analytics feature of Domain.com.au., for instance, which allows vendors to gather valuable insights. The natural place to start is keying in the property to be sold, which delivers statistics regarding sales and rental history plus an estimate of current value. While handy for prospective buyers, it probably reveals little new to owners, especially as the price estimates are rather broad.

The real utility of Home Price Guide comes at the street and suburb levels. Enter an address without its street number and click on the 'street' option. Domain will provide a breakdown of property types on that street, the proportion of owner-occupier to tenanted properties and average tenure length. It will also present several years of sales transaction data for the street and capital growth rates of recently transacted properties.

Realistically, unless a street is very long, there will only be a few genuine comparable sales - dwellings that are sufficiently alike to the subject property. So I recommend researchers identify similar streets (in terms of location, streetscape and level of traffic) and rerun the street search. Finally, run a suburb search and learn about the area's demographics - average age, the ratio of families to singles and occupation types - plus the school catchment areas and trends for property prices.

From this data picture it will become a fair bit clearer whether the target market is home buyers or investors (or possibly both) and if the former, whether the property is likely to appeal to first home buyers, upgraders or downsizers. By looking at the presentation of comparable properties, vendors will

obtain clues about the level of renovation a property requires and the appropriate style and form of advertising copy.

The next step for a vendor is just that. Step outside and burn some shoe leather for several weeks visiting open for inspections and auctions for similar properties that come on the market. Talk to agents and take note of which ones impress in terms of passion and knowledge.

Between the desktop work and pounding the pavements, a vendor is then well-placed to select their estate agent. Invite two or three candidates to your property and discuss the following:

- What is a conservative estimate of my property's value?
- How would you present the property?
- What is the best method to sell the property?
- What type of advertising and marketing strategy would work best?
- What is your typical fee level and structure?
- How do you obtain the best price in negotiations?

The standout agent will have thoughtful and persuasive answers.



Richard Wakelin
Director
Wakelin Property
Advisory

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Richard Wakelin, Paul Nugent, directors



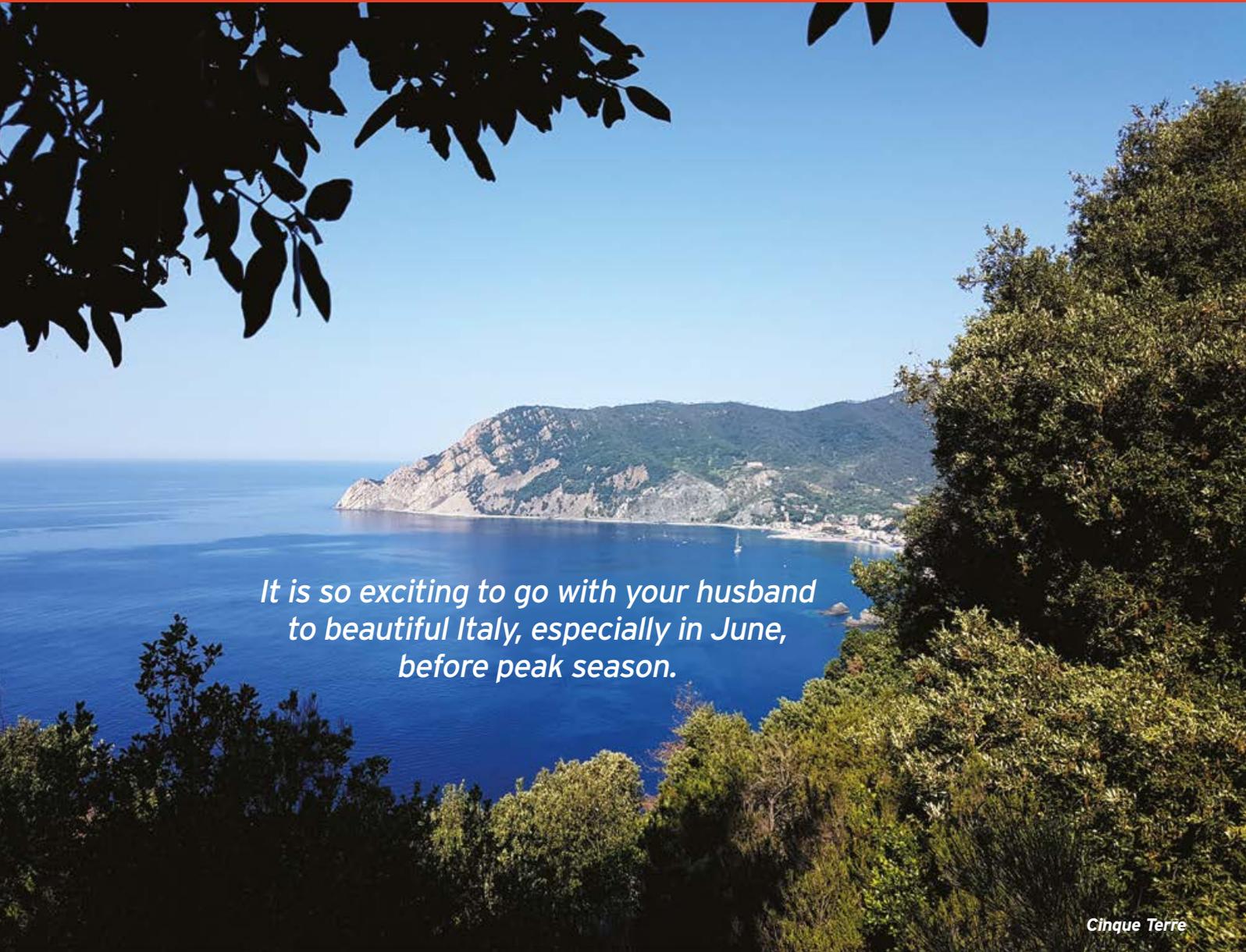
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Cinque Terre

Rome

Having been to Rome before, we chose to stay in the exciting area of Trastevere, on the west bank of the river Tiber. It is a fabulous area away from all the tourists who congregate in central Rome, but very lively at night where many locals go out.

It is fabulous to walk through the back streets of Rome to get to the centre which is also easily accessible by tram. We stayed at Relais le Clarisse a Trastevere, a gorgeous hotel where we had breakfast in the courtyard every morning.

Rome is an easy place to get around

as it is not a big city and you can visit all the main attractions in one day. Just be prepared to share the place with lots of other people. A good way to avoid all the tourists is getting to the attraction early in the morning. My favourite location in Rome is the Pantheon, which can be a beautiful and calming place if you manage to beat the crowds.

The Vatican is a separate a city on its own and a tour through the Sistine Chapel and the Vatican museum should not be missed. The best way to do this is a night tour, however, there is limited availability as it doesn't

operate daily. With no air conditioning in this old building, a night tour is a great way to avoid the heat.

On our last day in Rome we did a Tivoli day trip to Hadrian's Villa and Villa D'Este which is a UNESCO World Heritage site. It is an incredible piece of history as it was a resort area used by ancient Romans to escape the hustle and bustle of the city. The gardens at Villa D'Este are absolutely stunning. So relaxing; so serene. In addition, there are waterfalls galore and lots of areas to explore. To top it off, the site is not crowded as it is still relatively undiscovered.



San Gimignano



Puglia

Puglia

Next destination was Puglia to the south east, where we stayed six nights at a campsite. Puglia is right on the Adriatic Coast with limestone cliffs and a countryside that is laden with beautifully kept olive groves. It's a fantastic area to do the most beautiful hiking and/or bike riding. It is very different to the north, Tuscany or any other area in Italy, with strong influences from Greece and Turkey. The typical, traditional white houses with a conical roof called Trullo give Puglia its unique look. Some farmers still live in these properties, but many have turned into Airbnb's in recent years.

We had a very exciting afternoon checking out caves. These limestone caves are an amazing natural wonder and one of the most important attractions. There are English speaking tours twice a day, although to get the most out of your experience you should take the longer tour, which takes you all the way into the Grotto Bianca. Stunning colours; stunning formations.

When in Puglia, you cannot go past nearby Matera, which is in Basilicata. Matera is world heritage listed and is the third oldest city in the world after Jericho in Palestine and Aleppo in Syria. The old part, or the grotto, is called the Sassi. The very poor lived in the grottos until the 1960s before the Italian Prime Minister at the time visited and was blown away by the poverty of the cave people. He set up a program to move the people out to the outskirts of Matera. Of course, like many places like this in the world, it now is fashionable to live in the grottos so people have moved back and are now renovating under tight guidelines.

San Gimignano

Our trip to San Gimignano was a long one - a fast train to Rome, then another one to Florence, before a connecting bus to our destination. The city, with its 72 towers, is located on top of the hill which meant the last part of our journey on foot was a good workout, walking up the hill dragging our suitcases. It was worth it though, as we stayed right on the plaza in the historic centre of UNESCO World Heritage listed San Gimignano. We loved San Gimignano, despite the volume of tourists during the day. Luckily things quietened down at night, especially as cars aren't allowed in the historic centre.

San Gimignano is a fabulous base for day trips. We did one by bus to Sienna, which has an impressive Grand Duomo; an enormous structure made entirely of marble. We also did a 13km hiking trip through the surrounding vineyards which was absolutely amazing. There are a number of walks in the area, from short ones to long ones with the added bonus that wherever you looked the city popped up with all its towers.

To top it all off we went to the opera on the last night to witness a beautiful performance in an old church, Chiesa San Jacopo, with lots of frescos on the walls. The pianist was from Florence and the soprano from Israel. I still get goose bumps writing about this and just thinking about it still brings a tear to my eye. It was such a beautiful performance for only a small group of people, with no microphones needed. These kinds of intimate performances are happening right around Italy. Just check at the information centres and you can buy a ticket on the spot for only 15 Euro.

Cinque Terre

Off on a bus and train again, we arrived at La Spezia which is the gateway to the Cinque Terre. If you want to walk the Cinque Terre, you purchase a train ticket, which includes the entry fee to the park.

You can now only walk two sections along the cliffs - Monterosso to Vernazza; and Vernazza to Corniglia, due to a mudslide back in 2013. To beat the crowds and the weather, the secret is to start early. We walked Vernazza to Monterosso and had to remind ourselves to stop plenty of times to take in the view as it was absolutely stunning! So beautiful.

Bologna

Our last stop in Italy was Bologna, which was so different from all the other cities. On a rainy day, the old city of Bologna is a place where you can walk without getting wet as it has big undercover walkways. The San Petronio Basilica was very interesting; it's amazing how they built the church around the St Petronius Meridian line, which is the longest indoor Meridian line in the world. The sun comes through this tiny little opening in the roof and it tells you along the brass line what time of year it is. The old city is closed to traffic on a Saturday and Sunday, which works well.

Bologna is also home to delicious food; lots of outdoor cafes and restaurants. What a way to finish a beautiful holiday in Italy!



Ria Hilderink
Senior Consultant
Reho Travel

Beyond luxury: Melbourne's most exclusive residence

The Muse is a 14 level residential development that will comprise of no more than 42 penthouse-style dwellings in a space that would ordinarily house around 200 - a sentiment that goes some way in describing the opulence The Muse offers.

The recently unveiled project is a totally unique prospect for Melbourne and represents the pinnacle of residential property, on a level that has not previously been seen in the city.

Envisioned by its creators as offering the ultimate in apartment living for the most discerning of audiences, The Muse residences will range from 200m² to over 1000m² for the super-penthouse, that is set to break the apartment price record for Victoria by nearly double and is valued at around \$45 million.

Taking pride of place on the corner of St Kilda Road and Toorak Road West, The Muse boasts direct frontage onto Fawkner Park and with panoramic north-facing views over the The Shrine, Royal Botanic Gardens and the city skyline.

The building itself is designed as a work of art with a silver-blue glass façade gathering in crisp pleats that resemble a fine veil caught in a gentle breeze.

With every residence being painstakingly conceived as an individual home, The Muse provides buyers with the opportunity to fully customise their own residence with some of Australia's top interior design studios: Bruce Henderson Interiors, K.P.D.O. and Greg Natale, or alternatively, they can engage their own.

Taking the idea of customisation one step further, the total personalisation of living spaces draws inspiration with the world's best couture, where the form is entirely tailored for individuals, then handcrafted using materials that enhance and flatter.

With a clear understanding of the purchaser demographic, The Muse developer, Devitt Property Group, has identified security as a top priority within the building and the bespoke, high-level home automation interface will enable residents to truly customise processes, ensuring day-to-day living is made easy.



Customisable elements may include heating and cooling system operation, automated blind control and intelligent lighting controls, among any other requirements to suit the resident's lifestyle and needs. Residents may create an automated system that ensures the household is almost entirely self-managing.

Arriving at The Muse will be streamlined with numberplate recognition technology that goes beyond security. With bespoke system integration, numberplate technology will ensure that upon entry a lift is dispatched awaiting the resident's arrival, air-conditioning systems are turned on and any other requirements or wishes are taken care of. Other entry access to The Muse will be via biometric systems, facial recognition,

fingerprint scanner recognition and personalised 'fob swipe'. The Muse will have the latest in technology, but will also cater for those that prefer the non-technical applications.

Car charging technology will future-proof for increased numbers of electric cars in the coming years and provision for off-grid battery systems will be provided.

Designed for the corner of St Kilda Road and Toorak Road West, The Muse has been envisioned as the ultimate in luxury living, offering absolute privacy and security, with residences predicted to become virtually unattainable in the future.

Sales for The Muse are being managed by Knight Frank. Please contact Daniel Cashen on 0438 346 313.



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In Australia, the premium performance marketplace has never been more competitive. As a result, we need to be agile and responsive - and being a small company, ALPINA is able to quickly react to the market as a result.

"The close manufacturing relationship in place between ALPINA and BMW is no doubt why both brands can deliver exceptional vehicles, yet produce a totally different drive experience," says ALPINA Automobiles Australia Sales Manager, Phil Jeffery. "The new B5 arrived into a fiercely competitive Australian market, demanding the very best from the manufacturer. We are focused on delivering not only the greatest drive experience and the highest level of premium quality to our customers, but a vehicle that represents excellent value for money and allows more consumers to experience this truly bespoke brand."

The new BMW ALPINA B5 Bi-Turbo Sedan combines high-performance with outstanding levels of refinement. Power in the BMW ALPINA B5 Bi-Turbo is delivered to the rear wheels by a new generation of the excellent 8-Speed Sport Automatic Transmission with ALPINA SWITCH-TRONIC. This takes the luxury sedan from 0 to 100 km/h in just 3.5 seconds and boasts a top speed of 330 km/h, making it the fastest accelerating model ever produced by ALPINA.

A newly developed ALPINA sport suspension together with active rear-wheel steering (Integral Active Steering) and light-weight forged aluminium wheels means the new BMW ALPINA B5 Bi-Turbo has the agility and handling of a much smaller car. The bespoke nature of ALPINA is further enhanced by factory cost options such as sumptuous Lavalina leather, a leather dash and massage function for both driver and front seat passenger. Exclusively available at selected BMW dealerships across Australia, experience ALPINA at Melbourne BMW or Doncaster BMW today.

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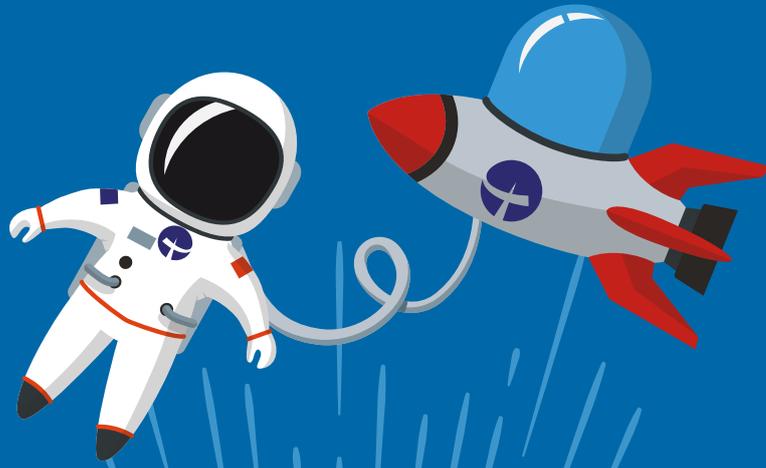
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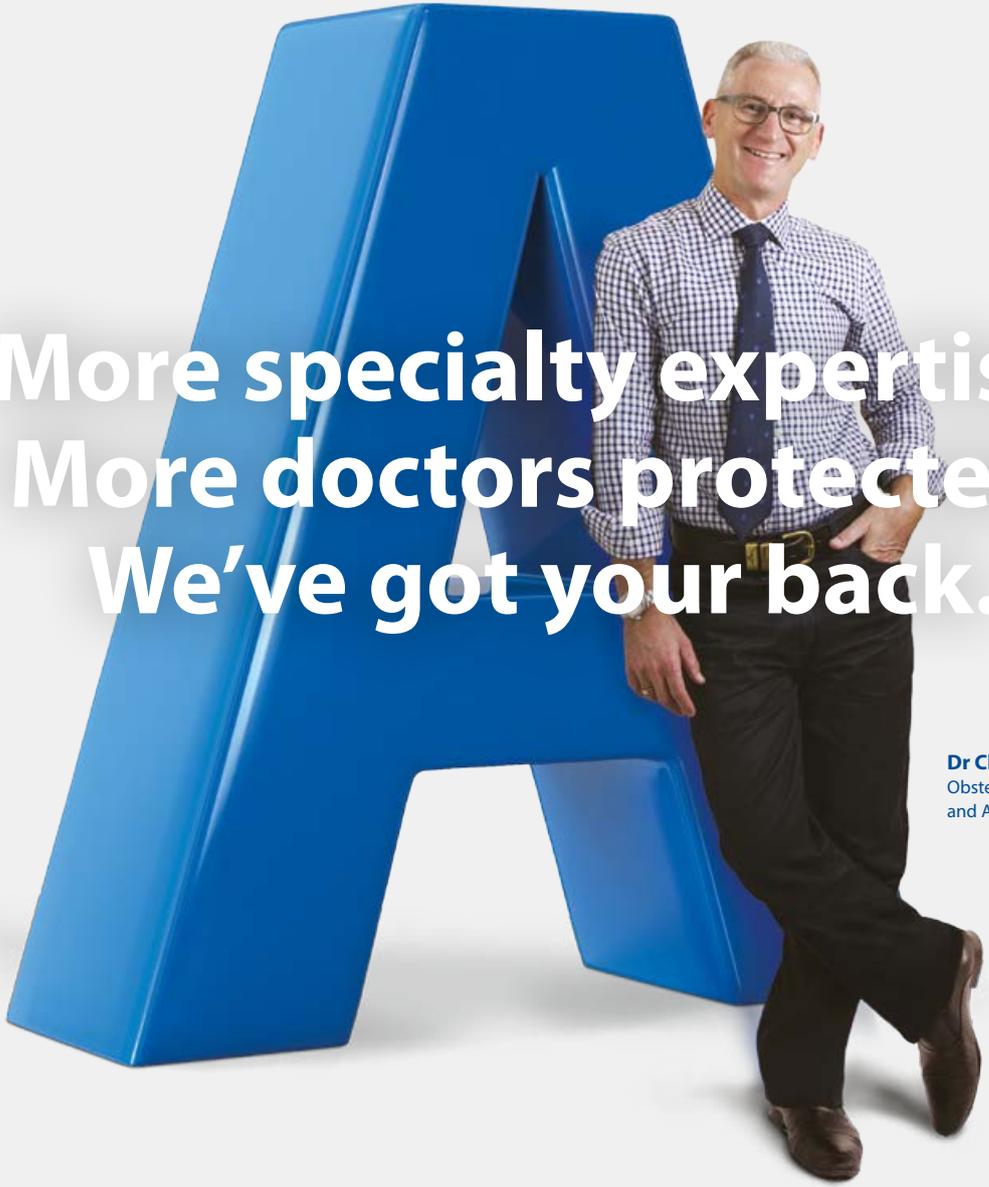
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