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President's message



Tireless healthcare workers require appropriate protection

Since the early 1930s, infectious disease researchers and public health officials have discounted the importance of aerosol transmission. The dominant view instead was that respiratory viruses are transmitted by larger droplets, or through contact with droplets that fall on surfaces and are then transferred to the respiratory tract via people's hands.

When SARS-CoV-2 (the coronavirus responsible for the COVID-19 pandemic) emerged at the end of 2019, the widespread assumption was therefore that it spread in the same way as other respiratory viruses and that airborne transmission was not important.

Converging lines of evidence now indicate that SARS-CoV-2, can pass from person to person in tiny droplets called aerosols that waft through the air and accumulate over time. These small particles are less than 5 microns in size and can hang in the air for minutes or even hours after an infected patient has been in the vicinity.

There are currently numerous sophisticated models and many case studies involving large-scale clusters that have indicated the pivotal role of airborne transmission. Consequently, on 6 July, Professor Lidia Morawska (who is an atmospheric scientist from QUT in Brisbane) and Professor Donald Milton (who is an aerosol scientist at the University of Maryland, USA), [published a thoughtful commentary](#) in the journal *Clinical Infectious Diseases* urging the medical community and public health authorities to acknowledge the real potential for airborne transmission. They were supported by an international group of 237 other clinicians, infectious

disease physicians, epidemiologists, engineers and aerosol scientists, who also called for preventive measures to reduce this type of risk amongst healthcare workers.

These researchers were frustrated that key agencies, including the World Health Organization (WHO), ignored their advice in their public messages. For months the WHO had steadfastly pushed back against the idea that there was any significant threat of the coronavirus being transmitted by aerosols and that these could accumulate in poorly ventilated venues and be carried on air currents.

This type of guidance hampered efforts by many doctors who felt that they could better prevent airborne transmission, including to our dedicated healthcare workers who should have, in retrospect, been given a much higher level of personal protective equipment than had been hitherto recommended.

However, following a 7 July press conference, Professor Benedetta Allegranzi, the technical leader of the WHO taskforce on infection control thankfully said, "We have to be open to this evidence and understand its implications regarding the modes of transmission and also regarding the precautions that need to be taken".

Furthermore, on 9 July, the WHO issued a scientific brief on viral transmission. It maintained that more research was needed but acknowledged that short-range small particle aerosol transmission was definitely possible in crowded and poorly ventilated spaces.

Overnight on 30 July, almost silently, the standards were updated by Safer Care Victoria. Face shields and N95 masks were now widely recommended for

President's message



healthcare workers dealing with any suspected or confirmed case of COVID-19. This change followed many weeks of gas lighting of medical staff at a number of our hospitals about how current standards were 'perfectly adequate' along with lectures about how N95 masks are 'hard to fit'.

But more is now required, including the widespread use of fit-testing for healthcare workers - a test which checks that the face mask is air tight so that no airborne pathogens can get through the sides.

In all workplaces, workplace fit-testing of respirator masks is required by Australian New Zealand Standard AS/NZS1715 before a user wears a respirator on the job, and this should be assessed at least annually. In addition, fit tests should be performed:

- whenever a different size, style, model or make of respirator is used
- when any facial changes occur that could affect fit, such as significant weight fluctuation or dental work.

With this new acceptance of the risk of aerosol transmission, it is incumbent on all employers of healthcare workers working with any suspected or confirmed cases of COVID-19 to adhere to the national industry standards in relation to N95 masks. Employers must also ensure all frontline staff wear appropriately sized and fitted masks; and it is of course absolutely the responsibility of government to ensure these supplies are readily available across all affected healthcare settings whether they be in hospitals, general practice settings, aged care or testing clinics.

Healthcare safety, for both patients and caregivers, is under great scrutiny at the moment. Safety for patients, staff and their families should be our number one priority and that foundation of trust should begin with adequate protection for our tireless healthcare workforce.

A/Prof Julian Rait OAM
President

How are Australia's doctors faring during COVID-19?

New research finds that general practitioners and other specialists are feeling the stress - not just from COVID-19, but also the broader economic fallout.

Australia's health workforce has been at the frontline in dealing with the COVID-19 pandemic. They have placed themselves and their families at risk in helping others.

But at the same time, health practitioners are having to adapt to significant changes in how they provide care amid ongoing uncertainty - not just about the pandemic itself, given Melbourne has been forced into another lockdown - but also how the pandemic will shape the longer term future of healthcare.

For example, many surgeons lost work when non-urgent elective surgery was suspended during April and May 2020. The pandemic also weighed on the demand for wider healthcare services as social distancing restrictions discouraged people from leaving home, and public fears of contracting or spreading the virus kept people away from health facilities.

Job losses and uncertainty throughout the community has also put increased financial pressure on household budgets, which can be expected to reduce the affordability of out-of-pocket payments for healthcare services.

So, how are our general practitioners and medical specialists faring? During May, we conducted a special national survey to examine the impact of the COVID-19 pandemic on GPs and specialists, with a focus on those working in private practice.

The longitudinal [Medicine in Australia: Balancing Employment and Life \(MABEL\)](#) COVID-19 Short Online Survey (SOS) was completed by over 2000 GPs and other specialists. The results suggest that the sector has been quick to adapt to providing telehealth services during the pandemic, which has the potential to become a permanent shift.

But at the same time, the pandemic has radically altered the way medical care is being delivered, led to significant financial challenges for doctors in private practice and increased stress for many.

Our results suggest that there was a more immediate and consistent fall in the use of healthcare for non-GP specialists because of the ban on non-urgent elective surgery.



Though non-GP specialists were more consistently affected compared to GPs - where there were more mixed effects on workload - there is evidence that the private non-GP specialist sector may bounce back more quickly compared to GPs, given the backlog when the ban is lifted.

A new era for telehealth

For both GPs and other specialists, the introduction of new Medicare funding for telehealth consultations helped protect doctors and patients from infection and also helped to stem the fall in the use of healthcare by patients.

Our data shows that more than one third of all consultations were provided by telehealth in April and May 2020, with almost all GPs using it and around three-quarters of non-GP specialists using it.

The use of telehealth was lower among GPs operating in solo practice, as well as among GPs in the most disadvantaged areas and in rural areas. There were no differences by GP age or practice size in the take up of telehealth.

Over 95 per cent of GP telehealth consultations were by telephone rather than video. This is a concern given doubts over the appropriateness of relying on telephone consultations for some areas of care. The results suggest that more effort needs to be put into encouraging a greater use of video consultations.

Around 84 per cent of doctors think that telehealth should be permanently funded by Medicare.

Telehealth is likely to create a structural shift in how healthcare is delivered, though this depends on how this temporary funding will continue into the future. It's very convenient for patients and could lead to an increased demand for GP services as people no longer need to take as much time off work to 'visit' a doctor.

Financial stress

The rapid changes to patient numbers and telehealth in April and May 2020 have significantly reduced incomes for some practitioners, with 65 per cent of

GPs and 83 per cent of non-GP specialists reporting a fall in monthly income.

Almost one-third of surgeons and anaesthetists reported a fall in income of 50 per cent or more, which mainly reflects the suspension of elective surgery.

Around 30 per cent of all doctors reported feeling very or moderately financially stressed about their private practice. Reported financial stress was particularly prevalent among larger non-GP specialist practices.

GPs in urban areas or in the most affluent areas were more likely to report a fall in income and experience financial stress and mental stress. These practices were worst hit probably because they were more likely to charge higher fees and bulk bill less before the pandemic. So, the substitution of face-to-face consultations for less profitable bulk-billed telehealth consultations may have hit them hardest.

Falls in patient numbers were also higher in urban and more affluent areas compared to rural and more disadvantaged areas.

Some 18 per cent of GPs and 51 per cent of non-GP specialists reported that their practice had applied for the Federal Government's JobKeeper payment subsidy and this was more likely in urban rather than rural areas.

A small proportion of GPs (5.6 per cent) and non-GP specialists (8.4 per cent) thought their practice might be sold or closed in the next six months. These respondents were more likely to be from smaller GP and non-GP specialist practices, or be older non-GP specialists. It may be that for practitioners nearing retirement, the pandemic may have brought these decisions forward.

The longer-term financial health of the sector depends on the mix of services between bulk-billed telehealth and full-fee, face-to-face consultations going forward, and how practices adapt in the context of recent and future changes in Medicare funding around telehealth.

In addition, extended economic hardship in the wider community may

cause a longer-term decline in demand for private medical care and private health insurance. This was already a key issue before the pandemic and is particularly an issue for non-GP specialists in the private sector.

Doctor wellbeing

Unsurprisingly, the survey reveals high levels of stress among doctors. The significant changes in the mix of care being provided, the increased risk to doctors' own health and the high levels of uncertainty about revenue flows caused by the COVID-19 pandemic are having an impact on doctors' stress levels.

Around 60 per cent reported feeling more stressed than usual, with those who experienced a fall in income more likely to report feelings of stress.

Significant proportions of non-GP specialists (almost a half) and GPs (around one-third) were dissatisfied with access to personal protective equipment during the pandemic, which was associated with increased feelings of stress.

The future

The pandemic and its consequences have accelerated a number of pre-existing trends in the healthcare sector and among the medical workforce, including the increased use of telehealth and the lower growth in the use of private medical care.

These changes present challenges, but also new opportunities for improving the delivery of medical care in Australia for the benefit of patients.

How these changes influence the quality, costs and access to healthcare in the future is a key issue going forward as everyone adjusts to the ongoing challenges caused by the pandemic.

Prof Anthony Scott

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This article was first published on [Pursuit](#). Read the [original article](#).

Starting in the unknown: An intern's perspective

**It's okay, I'm okay,
breathe.**

**It's okay, I'm okay,
breathe.**

When I approached the hospital for my first day of being an intern at the beginning of 2020, a new and shiny ID badge hanging off my belt, my biggest concerns were 1) not killing any patients with my inexperience, 2) keeping up with the expectations of my consultant and registrar, 3) not dying in the process. Although there was a global pandemic brewing overseas, already affecting thousands of lives, I was blissful in my own little world, freaking out over whether increasing a patient's 'Coloxyl' from one to two tablets would cause rapid, irretrievable death.

News about COVID first came as a trickle, then all at once. There was some concern early in January, though until Australia was directly involved, [quarantining evacuees from Wuhan on Christmas Island](#), it did not register as a serious news story. Even then it felt distant, small, and almost irrelevant compared to the momentous mountain that was internship. It wasn't until cases started to rise exponentially here, and the deaths started to occur, that it became very, very real.

Everything was thrown up in the air, and no-one was really sure how, or when, things would land. Would my parents be okay? Would my friends be okay? Would I be okay? The unknown became overwhelming. A media piece which I feel explains this early feeling of uncertainty and dread well is the [YouTube video by Hank Green 'The sudden obliteration of expectation'](#). The loss of, whether conscious or not, the expected future ahead and the sudden displacement into a new, alien future, was daunting.

The unknown elements of COVID-19 became present within the hospital system; uncertainty with how the virus would impact Australia at large meant our future working conditions were also thrown into doubt. As interns we particularly noticed the freezing of

rotations for an indeterminate amount of time and the murkiness of job applications. Concerns about the future of our training, this year and beyond, met with the anxiety over the health of ourselves and others, lead to a palpable mood of confusion, disappointment, and concern, even before the first 'COVID-positive' patients arrived.

Those on hectic rotations had heightened fears of burnout, while those on quieter rotations had fears of deskilling. There was additionally concern about whether the work conditions this year would be viewed in a negative light when considering job prospects in future. Further disarray was experienced when senior staff were required to isolate, due to sickness or sick contacts. It's hard to describe the feeling of terror that results when arriving to work and realising you have abruptly become a major point of continuity for the patient list, despite still trying to properly grasp how the list actually works.

There was one moment which I feel best encapsulated my experience of working in the early days of the virus; when I walked onto the designated 'COVID-ward' for the first time, to review a patient. We left almost all personal items behind, donned significant amounts of protective equipment, and walked onto a ward that was... quiet. Weeks before it had been noisy, busy, chaotic even. Now there was almost no-one there, and the few that were present were unrecognisable under the significant amounts of PPE. It did not feel like I had walked into another section of a hospital, but rather the set of a disaster movie and there would soon be a camera shift to an eccentric scientist having a frenzied pseudo-scientific monologue. Eeriness, uncertainty and new situations were daily occurrences during the early period. It was certainly not something we expected; not something anyone expected.

A few months after these tumultuous times started, the hope which underlined most discussions about COVID started to become realised: things were returning to 'normal'. Things were slowly resembling what

they were months prior to the start of the pandemic. The anxiety of the unknown coalesced into a sense of optimism that we and those we cared for, both literally within and figuratively outside the hospital, would be okay.

Then the second spike occurred. Initial shock quickly morphed into frustration. Weren't we so close to ending this? How long will this go on? Who is to blame? But we are better prepared, hospitals are better prepared, society is better prepared and we know what to expect. Knowing what to expect means we are faced with familiar challenges; concern for the health of family and friends, lockdowns, rotation suspensions, changes in the hospital. These are things we expect to return, but with a different feel. There is still anxiety about what will happen, but the sense of direction remains and hope that we can get through this.

As I walked into work this morning, the ID badge in my bag now carrying a few scuffs and marks, I could not help looking back at the year we've already had. COVID has had, and continues to have, significant impacts on society, both here and around the world. And there may still be a long journey ahead of us before we are through it. But I also remember the sense of community and togetherness we experienced getting through the initial challenge. I hope that we can continue to hold onto this solidarity. When we are finally through this for good (whenever that may be), I am confident we can make 'normal' even better than it was prior to the pandemic.

**It's okay, I'm okay,
breathe.**

**It's okay, I'm okay,
breathe.**

Dr Timothy Nasteka
Intern
Goulburn Valley Health
AMA Victoria Doctors-in-Training
Subdivision

Time to fix inequity in rural healthcare

When it comes to access to high quality healthcare, not all Australians are equal.

If you live in a major population centre, chances are you have ready access to the hospitals, health services and health professionals you need. If you live in a regional area, not so much. For a country that rightly prides itself on its system of universal healthcare, there remains a distinct and distressing gap between outcomes for those who live in the big cities and the one-in-three Australians who don't.

This gap is well documented. In 2019, the Australian Institute of Health and Welfare reported that on average, Australians in rural and remote areas had shorter lives, higher levels of disease and injury, and poorer access to and use of health services. Rates of potentially preventable hospitalisations were 2.5 times higher than in major cities and the total disease burden 1.4 times higher. In cancer care, regional patients generally have a 7 per cent higher mortality rate than their urban counterpart and for some cancers the discrepancy is up to 84 per cent.

Even accounting for risk factors such as the generally higher alcohol and tobacco use in regional areas and the dangers of workplaces such as farms and mines, these are damning statistics. And for marginalised and vulnerable groups such as Aboriginals and Torres Strait Islanders, they are much worse.

How has this happened? It does not make health, social or economic sense to have healthcare services concentrated in major population centres to the point that patients must go to cities to access most of their healthcare. The costs to a community are also more than the discrepancy of health outcomes. Patients are forced to travel, take more time off work and caring responsibilities. The loss of comprehensive healthcare infrastructure and services costs a community in its ability to attract and retain citizens - and doctors - and there is a loss in the economic and community

benefits of hosting healthcare facilities. Alongside this, we have all political parties wanting to regionalise our population and decongest the city and move doctors to the country. Without adequate healthcare, it just makes no sense and it is unjust.

Ironically, in some cases restricted services have been exacerbated by a black and white view of quality and safety. If a service in a regional centre struggles in areas of safety or quality, the quick and risk averse reaction is to close or limit the service. It's a much harder proposition to increase, upskill, connect and support workforce, upgrade local infrastructure, and develop systems and service to meet the standards and the population needs. Yet this is what is needed.

To see where the current mindset leads, consider the recent high-profile case of maternity services in Yass, a regional NSW town with a population of more than 6000. Since 2004, women in Yass have had to drive either 70km to Canberra or 90km to Goulburn to access maternity services - leading to several women giving birth on the roadside on the way to hospital. Many women in Victorian towns have even worse access than this.

Consider too the uncertainties posed by the current pandemic. As I write, Melbourne is in stage four lockdown, with coronavirus cases surging among healthcare workers. What does that mean for an immunosuppressed patient from country Victoria who needs to travel for treatment? And what would an outbreak look like in a region without ready access to comprehensive care?

Contrary to popular belief, the population of regional and remote Australia is growing. According to the ABS, it increased by 10 per cent between 2007 and 2017 and has been forecast to grow further still. The approach of forcing the people to go to the service rather than bringing the service to the people needs to change. Three recent developments mean that this could well be the ideal time to do it.

The first of these, radically accelerated by the pandemic, has been the acceptance and adoption of telehealth.

This means that rural hospitals and practices can have realistic, real-time and visual access to the best specialist expertise. An existing example of this is the Victorian Stroke Telemedicine Program, which has been running since 2011 and gives regional hospitals 24-hour access to a roster of stroke neurologists. According to the Florey Institute, interim results show that, "Eligible patients are being treated more quickly and more safely". There is no reason this could not work in other fields such as obstetrics, dramatically improving access to local delivery options for regional women.

The second development is the Rural Generalist Program, a federally-funded scheme to help recruit and train more doctors with a broad scope of practice to work rurally - from delivering a baby to emergency surgery. It is designed to attract many young doctors to rural areas, provide a more sustainable workforce and increase the provision, capacity and viability of services.

The third, and potentially most transformative, is the recent update to the National Health Agreement. What I hope this will do is drive a complete change in mindset, where larger hospitals think beyond their own four walls and consider what people, health professionals and smaller services in their region really need. If it works as I believe it should, it will see Local Hospital Networks working with GPs and Primary Health Networks to minimise duplication and fragmentation and put services back into the places that need them most.

Right now, Australia suffers from a damaging and persistent maldistribution of healthcare services. This inequality has been growing for years, but now we are presented with an opportunity to fix it. An opportunity we must take, for the sake of equity and common sense. For too long we've had a system that serves the needs of those who administer it in cities. The time has come for it to serve the people that use it across our entire land.

Dr Ines Rio

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Urgent Care Centres need more support to deal with their flawed reality



Victoria'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. AMA Victoria has called for this particularly to be addressed in regional and rural health so that every person across the state has equitable needs-based access to high quality and timely healthcare.

Our members based in rural and regional Victoria often raise their concerns with us about Urgent Care Centres (UCCs) and before commencing discussions with the State Government and other stakeholders on this issue, we asked for your feedback to help inform our advocacy efforts.

A/Prof Tim Baker is an emergency physician and the Director of Deakin University's Centre for Rural Emergency Medicine (CREM), based in Warrnambool. He works at the UCC in Portland and has visited most of Victoria's UCCs in his previous role of retrieval physician. A/Prof Baker has represented UCCs on many Department of Health and Human Services and Safer Care Victoria committees. He shares his thoughts and experiences with Vicdoc and explains why the present system is flawed.

Victorians like to do things differently. In most of the world, UCCs are urban, freestanding minor injury and illness clinics. In Victoria, the term means the opposite. Victorian UCCs are rural hospital-based facilities in small towns that accept any type of emergency presentation. They were labelled UCCs because they are supposed to see only minor ailments. They don't. This myth causes most of the issues in rural emergency care.

There are 70 UCCs in Victoria, scattered across towns of three to ten thousand people. Together they manage 150,000 emergency presentations annually - about the same as two urban emergency departments. Every facility is different. Some are tiny - just a room with equipment for basic monitoring and minor procedures. Most medium size UCCs lack onsite pathology and radiology. In contrast, the largest UCCs see nearly 10,000 patients a year and usually have access to a CT scanner in the hospital, although on an on-call basis after hours.

The term UCC was chosen to differentiate small rural facilities from emergency departments. Outcomes for seriously ill patients were thought to be worse in small hospitals, so the name was changed. They would now only see minor illness and injury. Ambulances with trauma patients would bypass UCCs. Patients should drive elsewhere if seriously unwell. With the name changed, the problem was solved. Well, that was the intention.

This was always a hope rather than a reality. Ambulances still bring patients to UCCs. Although they bypass small centres with major illness when they can, it is not always possible. Most small towns have one ambulance. If that ambulance has to travel to a distant regional centre, the area

is left without an immediate local ambulance response. Critical patients are stabilised and transferred, but over 90 per cent of UCC patients are discharged home or admitted to the local hospital.

The rural community is older, sicker and poorer. Like people everywhere, rural patients find it challenging to work out if their symptoms need immediate emergency care. Renaming a facility an UCC does not make this decision easier. One UCC a few years ago put this 'helpful' message on their website: 'Visit if your condition is urgent or semi-urgent but not if it is very urgent or not urgent at all'. Unsurprisingly, Deakin University's Rural and Acute Hospital Database and Register (RAHDaR) has found UCCs still manage seriously unwell patients.

What works well in Victoria's urgent care system? Clinicians are increasingly training for the context where they work. Nurses can become Rural Isolated Practice Endorsed Nurses (RIPERN), in recognition that they often treat UCC patients without an onsite doctor. Emergency nurse practitioners are employed by several services. Doctors can undertake an advanced emergency skill year as part of generalist training. Some are completing the Certificate or Diploma in Emergency Medicine. Unfortunately, doctors with extra training receive no additional remuneration.

The DHHS is also taking an interest in the issues with UCCs, commissioning several research and development programs for 2020. Although these have been delayed by COVID-19, the inclusion of rural clinicians in pandemic planning has provided a better platform for discussion than ever before.

What is lacking is a structure that supports what UCCs actually do,

rather than what the myth says they should do. Small hospitals supply equipment and nurses using their general funding. Visiting doctors bill Medicare and, sometimes, the patient too. Medicare funding works fine for booked patients in business hours. It is seldom financially viable for long periods on-call for patients who present at unsociable hours and may require several hours of care before transport. The next day's GP clinic also suffers. Larger UCCs receive some activity-based funding to employ onsite junior doctors. There is seldom enough money for senior supervision. Working as an unsupervised doctor in an isolated UCC may well be the scariest medical job in the country.

Uncertain funding impacts workforce models. Many GPs are reluctantly leaving UCC work. Emergency nurse practitioners can provide safe care but cost as much as an emergency registrar. RIPERN nurses need adequate supervision. Telemedicine is hopelessly fragmented, as Victoria lacks the state-wide advice line available in other states.

The urban readers who have made it this far may wonder why this issue is important to them. The answer is that it is not - unless you ski, surf, mountain bike, or spend weekends in boutique rural hotels. If you need care and are in an UCC, it would be better that they were supported to deal with reality, rather than the myth that you only have a minor complaint.

A/Prof Tim Baker
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The importance of psychological safety in your teams - and how to create it

The COVID pandemic has focused much attention on crisis leadership and rightly so. We needed effective responses as the pandemic emerged and then took hold. This has put incredible pressure on leaders at all levels of society and at all levels of organisations. This hasn't been easy. In fact, it has been - and continues to be - incredibly difficult. Operating in crisis mode for an extended period is exhausting. So, what can we do? What can help us during this time of sustained elevation and vigilance?

Effectively functioning teams not only make leadership more effective, they also spread the load, helping reduce exhaustion and the fatigue that unfortunately will only increase as the pandemic continues. This means that successful leadership comes not only from those in formal leadership roles, but from everyone. Indeed, every Australian is being asked to show leadership now by engaging in new behaviours, new ways of living and working and enacting the new rules of distancing and mask wearing. In this way, effective leadership is distributed and collaborative; characterised by and dependent on our interdependence. We rely on each other and we rely on each of us bringing our best self to the work.

Effective teams are not created out of thin air. They do not occur simply or organically. There are things we can and need to do to cultivate teamwork and create effective teams. **Psychological safety** is a concept that has much to offer this situation. It is a key aspect of team culture that supports people speaking up, sharing knowledge and acknowledging their mistakes. All of this makes teams more likely to improve and - especially important during these times - learn from mistakes and not repeat them once they have been made.

Psychological safety is the belief that I can speak up and I won't be criticised or humiliated by doing so. It is an identifiable and measurable characteristic of a team. Psychological safety describes a core characteristic of a climate where people feel they can speak up with candour.

Teams that share their mistakes are able to learn from them. Teams that speak up about mistakes are teams where there is high psychological safety; not having a climate of psychological safety is problematic and risky. If people don't speak up, if people remain silent with their ideas, their experience and their mistakes, then decision-making is impaired as it is not based on complete information and the learnings that can come from that. In complex work, this is a problem - and the problems can become very large indeed.

New problems demand and create new solutions, but they are rarely perfect in their first incarnation. But improvement can't occur when new processes and new treatments are not openly interrogated and discussed, when shortcomings and failures are not brought into the light. Without this they can't be fixed, and the individuals involved cannot be unburdened by the failures that are unlikely to be theirs alone.

Importantly, psychological safety is something that we can cultivate in our teams. There are things we can all do to create this climate in our teams each day.

And while leaders have a clear role to play in cultivating psychological safety, all of us can demonstrate good leadership by acting in ways to create, promote and sustain psychological safety in the groups and teams we work in. This means acting in ways that allow people to speak up with candour, without fear of humiliation or punishment.

Amy Edmondson and her colleagues have spent almost two decades researching psychological safety - how to measure it, how to cultivate it and how it contributes to effective teamwork. In her most recent book *The Fearless Organisation*, Edmondson suggests leaders can do three things to create psychological safety in the workplace:

1. Frame the work as a learning problem not an execution problem (uncertainty and possibility of failure and part of the work)
2. Acknowledge your own fallibility
3. Model curiosity by genuinely asking for input and responding appropriately.

Framing the work - or setting the stage - is about approaching the situation the team is facing as a learning opportunity rather than a bounded task to accomplish. For example, if a leader of a crisis response wanted to reduce people's fear of failure and making a mistake, she or he might say something like, "We are going to make mistakes - it's unlikely we're going to get this completely right the first time we try - so let's tell each other as soon as we suspect something's not working". This helps to frame the work as complex and uncertain and opens up the nature of the work required to include asking questions, voicing concerns and ideas, rather than following instructions.

When the leader **acknowledges their own fallibility**, this role models humility - an awareness that you don't have all the answers, have shortcomings and make mistakes. This is a very powerful way to engender psychological safety in the team. For example, a leader might say, "At the moment, I think that this makes sense, but I don't know, what do you think?", or "At first I thought that this was the best course of action, now I don't think it was and I am sorry for that".

Modeling curiosity is about leading through inquiry. Being genuinely curious about the work, means engaging more members of the team so that they feel comfortable participating in the process. This can include asking questions and finding out more, being interested in

what other people think and taking the time to listen to what they say - not interrupting, not talking over, not dismissing their suggestions too quickly.

So that's the theory. What might this look and feel like in your day-to-day work? Visit the [Leadership Coaching section of the Medical Career Service](#) on the AMA Victoria website for the extended version of this article, including tips on how to practically apply this advice through everyday leadership practises and behaviours.

Dr Anna Clark, PhD

Leadership consultant and coach

References available from the editor on request.

AMA Victoria's Leadership Coaching Program for doctors

AMA Victoria's Career Service has received more and more requests from senior doctors looking to develop their leadership capability, as their roles expand, new challenges emerge and the need for more effective models of leadership in health become more apparent. In response, we hope our new 'Leadership Coaching Program' will be a useful tool members can engage with to support them in effectively taking up their role of leader during this time.

We are delighted to partner with Dr Anna Clark in providing this coaching program to you. Anna has a PhD in social psychology and works as a leadership development consultant and coach designing and delivering programs and coaching in Europe, Singapore and Australia. Anna specialises in supporting individuals to create and enact nuanced personal action plans to support their work on the behavioural change they desire in a realistic and sustainable way.

Professional coaching provides a safe and objective developmental space for doctors to work on the current issues and challenges that they face in their day-to-day work, as well as in their professional work system. The Leadership Coaching Program extends this further and aims to provide expert support and guidance for doctors to focus on developing their leadership skills and practises through which they can grow their professional contribution to their work, their teams and the sector as a whole.

For more information about the Leadership Coaching Program please email careersadvisor@amavic.com.au

Television series takes viewers inside RMH emergency department



Emergency is a reality TV series which provides a fly on the wall account of working in one of Australia's busiest emergency departments at the Royal Melbourne Hospital (RMH).

The series, which is currently airing on the Nine Network on Wednesday evenings, was filmed in 2019, before RMH staff and the rest of the world's health professionals were hit front-on by the challenges of COVID-19.

RMH emergency physician and AMA Victoria Board member, Dr Sarah

Whitelaw, features in the show and says it's a stark reminder of a different time.

"What strikes us all when we watch it now is, 'Where are the masks and look at how close we are all standing together', so it is quite a strange experience to watch it when

it was filmed in quite a different environment to now and it feels like so much has happened since then," Dr Whitelaw explained.

The show also provides the staff with a rare opportunity to see more of the care provided to patients by their colleagues.

"It's lovely to watch the show and see how good our emergency nurses are from a different perspective; the compassion that they show in dealing with patients that we don't always get to see," Dr Whitelaw said. "Goodness me they do such a good job! We work in parallel with our colleagues and we don't often have the opportunity to sit back and watch them work, so that's been great to be able to see what they do."

Promotional material from the show's producers, WTFN said, "*Emergency* reveals the tribulations and triumphs of the RMH's dedicated doctors and nurses as they deal with victims of vicious assaults, horror car crashes and other tragedies, caring for the constant stream of patients coming through the door every day".

Dr Whitelaw also hopes the program gives viewers a better understanding of some of the challenges confronting ED staff, while they or a loved one are waiting for attention.

"I hope that they understand how much we love our jobs and how important it is for us to deliver an excellent level of care to them. I hope people take that away from the show."

"I think when you're sick and in pain, particularly when the emergency department is really busy, it can be a very stressful place to be and maybe

this gives people who are sitting in the waiting room an opportunity to have a look at what is sometimes going on inside that they can't see."

"Hopefully it also lets them know how much we care about looking after them, even when sometimes I can imagine it doesn't feel like that."

"I have enormous respect for the people that I work with, their level of expertise and their continued striving to be better. The way that we work as a team in emergency is just a joy and a privilege to be part of and it's lovely that other people get to see that."

The producers used their knowledge from working on the program *Paramedics*, which provided an insight into the experiences of Ambulance Victoria staff, when pitching the show to the RMH. It meant they already had a solid understanding of how to be respectful of patients and staff and preserving confidentially.

Fixed cameras and microphones were placed in walls and ceilings of the ED, with the clear intention of not impacting patient care in any way. Patients and staff had to give their consent to be featured in the program, while additional crews and cameras followed them around to capture all of the action.

"It was very important to the hospital that anyone who did not want to be

shown on-air had the right to refuse," Dr Whitelaw recalled. "We had a crew in the emergency department for a good couple of months. They were often there well into the early hours of the morning, so they were there at our busiest times."

"They would film some stuff and go back to the patients and their families and ask, 'Are you happy enough for this to be included in the show?' Well before we started we negotiated that our Director of the department, our Deputy Director and our Director of Nursing all had oversight over what went to air and what didn't and they were very protective of patients and very protective of staff in that way. That was very important to us to make clear before we started filming."

"It was quite easy to very quickly forget about the fact that you had a microphone on and a camera crew following you. But overall, it was a lovely experience. I'm really glad we did it."

The program is scheduled to air on Wednesday nights on the Nine Network until early September, with past episodes also available to watch on the [9Now streaming service](#).

Barry Levinson
Vicdoc Editor

Wood heaters: The cosy killers

Last summer's ferocious bushfires caused millions of Australians to breathe highly polluted air for most of January. This bushfire related air pollution is estimated to have caused 445 excess deaths, according to Menzies Institute researchers.

Bushfire emissions are very similar in composition to the emissions from domestic wood heaters and this winter, EPA Victoria has identified wood heaters as responsible for 27 per cent of Melbourne's PM2.5 emissions.

The impacts in rural communities with high numbers of wood heaters are likely to be even greater. EPA Victoria has conducted only limited air quality monitoring in many rural towns, but has found that domestic wood heaters were responsible for most 'exceedances' in air quality standards. Topography is a major factor in towns located in valleys, such as Gisborne, at the base of the Macedon Ranges, and Orbost.

Fine particle air pollution, or PM2.5, is the most harmful component of wood smoke. These are the tiny particles that penetrate deep into the lungs, can cross into the blood stream and have the greatest health effects.

Acute exposure triggers respiratory disease such as asthma and exacerbations of COPD and is associated with increased risk of cardiac arrest and cardiac failure. Chronic exposure contributes to a wide range of health problems including heart and lung disease, poor infant growth, some cancers, and cognitive impairment, including dementia. Small children, the elderly and people with multiple health conditions are particularly vulnerable.

Despite all this, the health impacts of domestic wood heaters, and wood burning in general, appear to be poorly understood.

The health costs of domestic wood heaters in Australia are estimated to be \$3.4 billion annually: around \$4000 per wood heater per year, according to multiple studies. About

10 per cent of Australian households use wood heaters as their primary source of heating. In addition, 40,000 - 50,000 new wood heaters are sold every year.

Critically, modern wood heater standards do not adequately reduce air pollution. A heater that meets the AS/NZS 4013:2014 standard, installed in 2018, when burning 5kg of firewood per hour still pollutes as much per hour as 73 modern Euro 5 rated diesel cars. When wood heaters in actual use have been studied, the particle pollution is often many times higher than that measured under laboratory test conditions.

Every winter, people in Victorian communities raise concerns about domestic wood heaters. They tell stories of kids with asthma subjected to neighbouring smoke, of older, vulnerable people unable to challenge neighbours who can't see the problem with 'a little smoke' and of living in towns and suburbs heavily polluted by wood smoke.

The stories they tell have a common theme: we are suffering harm as a result of our neighbours' wood heaters and neither local government or EPA Victoria offer us any protection.

In my community in East Gippsland, using domestic wood heaters is a way of life and a part of local culture. Firewood is readily available in nearby forests and 'getting a load of wood' is almost a ritual weekend activity for many people. There is no EPA air quality monitoring and the local shire provides minimal information about air pollution. Raising awareness will take a lot of work.

Firewood collection has other environmental impacts, too; it removes important habitat for threatened species such as hollow





logs and dead trees. This year, the Conservation Regulator and Parks Victoria noted the illegal removal of many thousand tonnes of firewood.

What can doctors do?

Doctors can make a big contribution in discussions about air pollution with our patients, local communities and government.

The discussion about wood heaters should resemble the discussion about tobacco smoking, which we have been having with patients for many years. Smoking in public places is recognised as harmful to public health. The same recognition should be extended to domestic wood heaters.

If we choose to operate domestic wood heaters, we are choosing to harm the health of our community. We are exposing our families and neighbours to another form of passive smoking. The cost of heating is a big issue in low socioeconomic communities, yet these communities are more exposed to, and vulnerable to, the health effects of air pollution.

Doctors can challenge EPA Victoria on the ineffective measures which it recommends to reduce the air pollution from wood heaters and especially any recommendation to install a new wood heater.

We can call on local and state governments to provide better protection to patients and

communities affected by wood smoke. This could combine targeted education on harms, financial incentives to switch to healthier heating options, and an evidence-based phase out program - as implemented for incinerators and open-flued gas heaters because of public health concerns.

In some cities, successful schemes such as that in Launceston have provided incentives to remove wood heaters and improve insulation to reduce heating bills. The Launceston intervention reduced winter PM10 levels from 44 to 27 ug/m3. Winter mortality from cardiovascular disease was reduced by 20 per cent and respiratory mortality by 28 per cent; reductions that nearly reached statistical significance.

We can press the Victorian State Government about progress on the Victorian Clean Air Strategy, which was due in 2019. The Strategy is intended 'to empower Victorians to reduce air pollution and their exposure to it.'

We can also ask for clean air advocacy from public health organisations such as VicHealth, the Lung Foundation and the Cancer Council.

Alternatives to wood heaters

Almost any form of heating is less polluting than wood heaters. Modern split system air conditioners are highly energy efficient, especially if they're powered by renewable energy. Wind

energy is more likely to be available at night, when heating is most needed.

Replacing wood heaters with electric heat pumps powered by renewable energy is the most environmentally sound way forward. Heat pumps have high upfront costs, but are highly efficient and have low running costs.

Gas is not a good option; it is a dirty fossil fuel that causes huge environmental damage during mining and transport due to fugitive methane emissions. In fact, medical advocacy group Doctors for the Environment Australia has a petition [#TurnOffTheGas](#) because of the unacceptable risks for human health.

One excellent cost analysis for efficient heating in various locations in Australia is [available here](#).

An Australian Facebook group, [My Efficient Electric Home](#), also has lots of useful pointers.

As we face the great challenge of COVID, let's not forget the public health goal of clean air.

Dr Rob Phair

Doctors for the Environment Australia

Dr Rob Phair is a rural generalist doctor in Bairnsdale and a member of Doctors for the Environment Australia. He is Vice President of the Rural Doctors Association of Victoria.

References available from the Editor on request.

Warning on gas heaters and carbon monoxide poisoning



We know heaters in winter can be a source of carbon monoxide (CO) poisoning, so it is important to be aware of the warning symptoms in patients and also ensure that your own home heating is checked from time-to-time.

Furthermore, we have been made aware of elevated CO levels arising in hospital rental accommodation, so if you are a resident medical officer on rotation, it is worthwhile checking when any heaters were last inspected before accepting such accommodation.

The issue was brought to AMA Victoria's attention after a registrar working in regional Victoria, living in hospital rental accommodation, was eventually found to be suffering from CO poisoning caused by a leaking gas heater. The doctor was suffering from persistent headaches and was fortunate to have the gas leak from the faulty heater discovered, before he and his family were seriously harmed.

The hospital where the registrar works has committed to implementing new policies regarding the checking of gas and electrical compliance in rental accommodation. Gas appliances in rental accommodation are recommended by Energy Safe Victoria to undergo two-yearly compliance checks. This is the responsibility of the landlord. Carbon monoxide monitors and alarms are also readily available from hardware stores for minimal cost.

How to tell if carbon monoxide is making you or a patient sick

Carbon monoxide building up inside your home can make you sick for a short time, have long-term health effects or even kill you and your family quickly.

Some of the symptoms are similar to cold symptoms, common in winter. This can make it difficult for doctors to diagnose carbon monoxide poisoning. The following symptoms can be caused by carbon monoxide leaking from a heater:

- dizziness
- feeling sick or nauseous
- headaches
- people and/or pets getting sick at the same time
- feeling unwell only when you're at home.

For more information about gas heater safety, visit the [Energy Safe Victoria website](#).

New AMA Federal President

The AMA on Saturday 1 August elected a new Federal President, Dr Omar Khorshid, and Vice President, Dr Chris Moy.

The election, at the AMA's National Conference, follows the conclusion of the two-year term of President, Dr Tony Bartone and Vice President, Dr Chris Zappala.

Dr Khorshid, an orthopaedic surgeon in Perth and a former AMA WA President, said governments should increase medical, health and aged care expenditure to both combat COVID-19 and help the economy avoid prolonged recession.

"State and Federal Governments have rightly funded the response effort to COVID-19," Dr Khorshid said. "Yet the Victorian aged care crisis, that could so easily occur in any state, arises from years of underinvestment in nursing, general practice and specialist geriatric care in aged care services."

"The crisis in mental health, that will get worse the longer COVID-19 is with us, arises from decades of underinvestment. Nations that adopt austerity and neglect health spending during recessions have taken longer to return to economic growth and

their populations have been sicker. Yet where nations have increased health expenditure or directed stimulus funding to healthcare needs, their economies recover faster and populations have been healthier."

"Given my term as AMA President will see Australia living with COVID-19 and its induced economic downturn, I'm putting governments on notice it is time to spend, and not cut health."

Dr Khorshid said his priorities for his term as AMA President are to:

- Reaffirm the AMA as a strong, independent voice for health, with a critical role to hold governments to account, particularly on their handling of COVID-19.
- Restart efforts to address financial sustainability of the nation's public and private health system and to fully utilise and develop the quality and capacity of public and private care.
- Halt the slide towards funder-directed managed care.



- Promote the value and cost effectiveness of high quality general practice at the core of the health system and as a gateway to more expensive care.
- Foster better gender equity within the leadership of the medical profession.
- Seek action from governments and the community on important public health issues, including climate change and climate health impacts.

Helping patients to maintain a healthy weight in an obesogenic world

With more than two-thirds of adults and a quarter of children in Australia now overweight or obese, there is a high likelihood you are seeing this reflected in your patient population. The health impacts of obesity are considerable - and your advice makes a difference.

A survey of 2000 Australians aged 25-49, conducted by the LiveLighter® campaign, found 31 per cent of respondents could recall having been advised by their doctor to address their weight. Of this group, around 39 per cent lost weight and maintained the changes, while 48 per cent lost the weight and regained it.

The LiveLighter campaign is an initiative of the Western Australian Government, delivered by the Cancer Council in Western Australia and Victoria, with a [national website](#). It is a reliable source of information for health professionals and patients, with a website offering dietitian-designed, free healthy meal plans and recipes. There is a dedicated webpage for health professionals containing various patient education resources that can be ordered for practices. LiveLighter also provides professional development opportunities for health professionals. A new one-hour online training module on *Talking to*

Patients about Health and Weight is being [launched in August 2020](#). It covers strategies to raise the topic of weight management and techniques for effective behaviour change conversations with patients and will be accredited for CPD points.

A new online resource, the Obesity Evidence Hub, also provides reliable and up-to-date information on obesity in Australia, including some of the societal shifts that have created our modern-day 'obesogenic' environment. A major contributor is the transnational ultra-processed food and beverage industry, which encourages poor dietary habits through the production and distribution of unhealthy products that are often cheap, aggressively marketed, readily available and sold in increasingly large portions.

As detailed on the Hub, settings-based interventions and social marketing campaigns can help

to rebalance the environment and promote healthy weight at a population level. The most effective way of limiting the health impact of overweight and obesity in the community is to prevent weight gain and limit the number of people developing these conditions. However, since a large proportion of the Australian population is already above a healthy weight, significant efforts need to be directed at providing effective weight management services and interventions to people living with overweight and obesity.

A section on the Hub covering treatment has been written and reviewed by specialists in the field to provide summaries of best-practice treatment for adults and children. Behavioural intervention remains the cornerstone of treatment for overweight and obesity, with options for pharmacotherapy and bariatric surgery where required. The Hub's



treatment section also covers management of weight-related infertility and complications during pregnancy and provides advice and resources for health professionals to support patients to overcome the wide-ranging effects of weight bias and stigma.

The Hub page on managing overweight and obesity in children links to resources developed by NSW Health to help health professionals manage children above a healthy weight, including videos showing how to raise the issue with families in a non-judgemental and supportive way. While diagnosis and monitoring of overweight and obesity during childhood and adolescence can be

challenging due to rapid growth and development during this time, effective management can help address current and future health impacts.

Aside from playing a vital role in supporting patients to maintain and achieve a healthy weight, doctors can advocate for governments to introduce evidence-based policy actions to reduce the impact of excess weight and poor diet across the population.

The Victorian Government has signalled that it will develop a strategy to address childhood obesity. In a consensus statement on obesity prevention, *A Healthier Start for Victorians*, key health organisations

have proposed eight practical measures for the state to turn the tide on obesity. These include protecting children from unhealthy food and drink marketing (particularly in publicly-owned places); implementing a state-wide public education campaign to encourage healthy eating; and developing a whole-of-government policy requiring healthy food procurement.



LiveLighter's health professionals page is available at <https://livelighter.com.au/Health-Professionals>

The training module *Talking to Patients about Health and Weight* will be available from August at Cancer Council Victoria's health professionals page <https://www.cancervic.org.au/for-health-professionals/training-education>

The objective of the Obesity Evidence Hub is to support evidence-based policy making and practice in Australia by making it easy for health professionals, policy makers and advocates to source high quality data, quickly and easily. It has resulted from a partnership between the Bupa Health Foundation, the Obesity Collective, Cancer Council Victoria and the Obesity Policy Coalition. You can visit the Hub at www.obesityevidencehub.org.au

Lockdown lessons: The unexpected upsides of Zoom



So many things about the way we live our lives, at home and at work, have changed recently. It's easy to focus on what's been hard - sweating under PPE (when we can get our hands on it), the lack of freedom and the painful distance between us and our friends and family. But recently, I've started noticing some wonderful things that have unexpectedly arisen out of the COVID-19 era, and one of these is Zoom meetings.

As a junior doctor, Zoom has completely opened up educational opportunities. In the early days of COVID, when none of us were sure how bad things would become, different departments at Western Health offered weekly teaching on topics from airway management, to end of life discussions - all centred

around COVID. This has sparked new, widespread interest in the flexibility around teaching sessions to maximise access while we're at work. For example, our Emergency and Obstetrics and Gynaecology Departments have opened up their regular teaching sessions to anyone in the hospital interested in learning,

and we're looking at improving access to education in other departments in future.

Removing geographical limitations has also allowed much larger audiences to attend events at reduced cost. We recently held the [AMA Victoria Women in Medicine Wellness Seminar](#), where we had the

opportunity to discuss emotional support, growth mindset and the importance of sleep with a panel of experts. Dr Helen Schultz spoke to us about recognising the difference between stress at work and patterns of depression or anxiety, and removing logistical barriers to seeking help. Professor Jill Klein highlighted how important a growth mindset can be for harnessing resources that are within our control, even when we feel powerless in the face of a global pandemic. Dr Linda Schachter emphasised practical strategies to reduce ruminations that keep us awake at night and ways to refocus on quality of sleep. Our audience members were able to submit questions through a chat box, allowing us to filter through and make sure they were answered seamlessly after the talks.

In moderating this event it struck me that, with a bit of planning, Zoom seminars have the potential to create a sense of connection that can be difficult to attain at a large in-person event. By keeping individual presentations shorter and leaving more time for questions and discussion, Zoom makes it easier to create the sense that you're part of an intimate conversation between experts, rather than listening to a series of speeches. You have the advantage of reaching a wide audience with the comfort of being at home, and it feels easier to ask questions without feeling self-conscious or put on the spot. Whilst online seminars will never replace the post-event connections that arise over drinks and canapes, they do provide an accessible alternative that I hope we continue to consider long after the COVID era is over.

Here are five lessons I took away from moderating an online seminar:

1. Set the stage

Because audience members are sitting at their computers without many distractions, it's important to have everything ready to go as soon as your event goes live. Our speakers did a practice Zoom session to make sure everyone was familiar with the technical aspects of the online format and Q&A system, and we all signed on 15 minutes before the session was ready to go live to test audio, voice quality, backgrounds and camera angles. As a moderator, I found a split screen useful to have my event 'run sheet' open next to my Zoom screen, so it was easy to keep on top of the event structure and timekeeping.

2. Make the speakers the main event

Some of our speakers' slides weren't able to project due to technical difficulties, but this didn't matter! Taking the focus away from slides and onto the speakers worked well to help our audience follow along with the message and the content, rather than having them reading the slides. If you are going to use slides, you could ask participants to make the screen projection 50/50 so the speaker's face is the same size as the slide.

3. Keep the talks brief and the discussion long

One of the hardest aspects of a Zoom presentation is to maintain attention behind a screen. We found it worked well to prepare a talk about half the length you would usually give in-person. Our speakers each gave an overview of their content in about

10 minutes, leaving 30 minutes for questions and conversation.

4. Look into the abyss

It feels unnatural at first, but looking into the camera away from your own face or your notes can help your audience to maintain an authentic connection that can be lost through a screen. I used a run sheet to keep me oriented to the structure of the event, but tried my best to keep my eyes on the camera when speaking to a panel member or the audience.

5. Continue to build your community

The technical aspect of Zoom seminars limits the opportunity to mingle with audience members like you usually would after a talk or panel session, which is why it's so helpful to follow-up with participants afterwards. If you create your Zoom settings to enable you to collect audience members' emails, you can send out links to the recording, answers to questions or resources that came up during the event, and naturally progress from an online conversation to a community network.

Connecting with others is one of the best ways to keep our morale going during this crisis. In a time where video chat is having a global moment, finding more ways to translate an online conversation into a robust community network is our best chance of making it through this storm together.

Dr Sonia Srinivasan
Doctor-in-Training
AMA Victoria Women in Medicine
Committee

Member profile: Dr Ghadir Omran, Peer Visitor Volunteer

Dr Ghadir Omran volunteered with the Peer Visitor Program for the opportunity to socialise with a senior doctor outside his work colleagues. He really enjoys the conversation and companionship when he visits his assigned senior colleague every two to three weeks.



His senior colleague, who chose not to be identified for this article, lives alone and values having someone drop by regularly for a chat and coffee and cake.

Ghadir reports that his role as a volunteer visitor has also opened his eyes to the perspective of someone who has lived through a lot of change in medicine and also in the wider world, especially in relation to technology. During the COVID-19 pandemic they have kept in touch over the telephone but also managed a couple of regular visits in the short time restrictions were eased in Melbourne.

Ghadir is currently a research fellow in the Department of Surgery at Monash University, working in conjunction with the Austin Health Department of Urology, looking at the effectiveness of cricket boxes (groin protectors) available in Australia. Currently there is no Australian standard for cricket boxes and anecdotal reports show a high failure rate resulting in scrotal injury.

Ghadir's research is looking at the products on the market in Australia to see if they meet the only standard available, the British standard. He is also seeking to establish if this is good enough to meet the demands of modern-day cricket. Recently, nine popular brands of cricket boxes available in Australia were tested in the United Kingdom and they all failed the British standard. Some of the necessary features of the cricket box are that it must be comfortable to wear and not restrict ability to run, as well as providing effective protection in order to be acceptable to the players. As part of his research, Ghadir is also undertaking a systematic review to assess the benefit of protective equipment in all sports.

Ghadir is also a volunteer tutor for disadvantaged year five and six students in mathematics through Ardoch, a children's education charity. He says it is really satisfying to be able to explain something in a way that a student understands and to see them grasp a concept. For Ghadir this

volunteer role followed on naturally from the tutoring he undertook to generate income when he was an undergraduate student.

At present, Ghadir is managing his volunteer roles around his research work, locum shifts as a doctor and his young family. Ghadir says that he has a strong belief in giving back and that if you have the ability and time to give back to the broader community then it is your responsibility to do so.

Kay Dunkley
Coordinator of Doctor Wellbeing

The Peer Visitor Program is proudly sponsored by VMIAL, the name behind PSA Insurance.



What every Victorian medical practitioner needs to know about voluntary assisted dying

Recent calls to the Peer Support Service indicate that some doctors are unclear about the rules regarding talking to a patient about voluntary assisted dying (VAD).

While many doctors will not be involved in VAD, it is important to know your obligations if you are asked about it by a patient or colleague. This article covers the key points for all Victorian doctors.

VAD became legally available in Victoria on 19 June 2019. VAD means administering a medication for the purpose of causing death in accordance with the steps and process set out in law. VAD must be voluntary and initiated by the patient themselves, and it is usually self-administered. Only those who are already dying from an incurable, advanced and progressive disease, illness or medical condition are able to access VAD.

Only the person wanting to access VAD may initiate discussions with health practitioners about the matter. A family member or carer can't request VAD on somebody else's behalf. A health practitioner is strictly not allowed to raise VAD with their patients - doing so constitutes unprofessional conduct within the meaning of the Health Practitioner Regulation National Law. A patient must raise VAD themselves.

Health practitioners should consider their level of involvement in VAD. Doctors involved in the provision of end of life care may receive requests for information from patients about VAD and should be prepared to respond to these requests.



A health practitioner may choose whether or not they participate in VAD.

- This decision may be made based on whether they have appropriate skills and training, whether they are available to perform the duties of the role, or if they have a conscientious objection to participating.
- A health practitioner may also choose what level of involvement they have with VAD. For example, they may be comfortable providing a patient with general information, but may choose to take no further part.
- If a health practitioner conscientiously objects to VAD they are under no obligation to participate.
- The health practitioner is under no obligation to refer the patient to someone who will assist them, but should not inhibit a person's access to treatment. The health practitioner should inform the patient as soon as practicable that they will not assist them.
- Health services may also determine whether or not they want to participate in VAD.
- To participate in VAD, a doctor must hold a fellowship with a specialist medical college or be a vocationally registered general practitioner. Note that doctors-in-training cannot participate in VAD whether in a hospital setting or in

general practice.

- The doctor must complete the specific VAD training, prior to conducting an assessment to determine whether or not a patient is eligible.

The State-wide Voluntary Assisted Dying Care Navigator Service (care navigator service) has been established to provide information and support regarding VAD for the community, health practitioners and health services across Victoria. The care navigator service can be contacted during business hours:

Phone: (03) 8559 5823
Mobile: 0436 848 344
Email: vadcarenavigator@petermac.org

Visit <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying> for more information.

Any doctors or medical students who experience distress in relation to any aspect of discussions about VAD are invited to seek anonymous and confidential support from the AMA Victoria Peer Support Service on 1300 853 338. This 'doctors supporting doctors' service is available every day of the year from 8am to 10pm.

Kay Dunkley
Coordinator of Doctor Wellbeing

The bidirectional relationship between diabetes and oral health

Diabetes mellitus has many complications. One complication often overlooked is the association between diabetes and oral conditions, particularly the bidirectional relationship between diabetes and gum disease. The association between diabetes and oral health is important as it directly impacts many chronic systemic conditions.

As medical practitioners and other diabetes care providers are often the central point of contact for people with diabetes, it's important to remember that identifying oral signs and symptoms, increasing oral health awareness and having efficient pathways for referral to dental practitioners can improve diabetes management.

Periodontitis

It is recommended that people with diabetes are routinely asked about their oral health by their medical practitioner and screened for any possible signs of periodontitis. The common symptoms include bleeding gingiva, bad breath and taste, tooth mobility, tooth movement and tooth loss. On diagnosis of diabetes or identification of any of these symptoms, it is advised to direct the person to a dental practitioner for a comprehensive oral examination.

Periodontitis, an advanced form of gum disease, is a major concern for people with diabetes who have sub-optimal blood glucose levels. It is a condition where the supporting structures of the tooth, including the bone and soft tissue, become inflamed and irreversibly destroyed if left untreated, leading to loosening or loss of teeth. Approximately 20 per cent of the Australian population are affected, with severe periodontitis affecting 7 per cent of the population. Tooth loss has both functional and aesthetic impacts and replacement options are limited without adequate supporting bone and gingiva.

The primary cause of periodontitis is dental plaque, however chronic high blood glucose levels (>7 per cent HbA1c levels) increase the risk of developing periodontitis. Substantial evidence shows that untreated periodontitis worsens glycaemic control and increases the risk of diabetes complications. This is mainly due to the chronic inflammatory stimuli from various periodontal bacterial products that increase insulin resistance. Periodontal treatment consisting of scaling, cleaning and proper plaque control can reduce HbA1c levels.

Periodontal disease is also a strong predictor of other complications for people with diabetes including cardiovascular, cerebrovascular and renal diseases. People with diabetes with severe periodontitis have 2.3 times higher mortality associated with ischaemic heart disease compared to those with no or mild periodontitis.

Other oral signs and symptoms of diabetes

Medical practitioners may also identify other common oral signs and symptoms arising from diabetes, including xerostomia (dry mouth) and hyposalivation (low saliva flow). These conditions can arise from medications that people with diabetes may be taking, or from the diabetes itself. The symptoms may include a dry tongue, cracked lips, difficulty swallowing, talking or eating and oral infections. Some relief can be achieved by avoiding food and drinks with sugar and caffeine, keeping hydrated, brushing and flossing well and chewing

sugar free gum. Regular examinations by a dental practitioner (every six to 12 months) are very important for people with low saliva flow to prevent tooth decay, oral candidosis and gum disease.

Access to dental care

Despite the link between diabetes and oral health, there is a lack of Medicare funding for people living with diabetes to access private dental services. Dental practitioners are also not included in the Team Care Arrangement scheme for people diagnosed with diabetes. There is also limited State and Federal Government funding for public dental services and eligible people may face long waiting times. With limited awareness and funding, the oral complications in those living with diabetes may be left undiagnosed and untreated, which can negatively impact their overall health and worsen their diabetes control.

As the first point of contact for most people diagnosed with diabetes, we encourage medical practitioners to be aware of their patients' oral concerns. Early recognition of oral symptoms for dry mouth, gum disease and other oral infections is vital not only in oral health management but their overall systemic health.

Dr Louise Lou

Periodontist

Oral Health Committee

Australian Dental Association Victorian Branch

For dental referral, visit www.dhsv.org.au (public) or www.ada.org.au/Find-a-Dentist (private)

Limitations have been placed on dental treatment at certain stages of the COVID-19 pandemic. As at August 2020, only urgent dental treatment can be performed in metropolitan Melbourne. Some treatment restrictions are in place in regional Victoria.

Obituary: Dr John Anthony Edward Goy

Born in the UK, John's family moved to Australia in 1957, where he finished his education at Launceston Grammar in Tasmania. The family eventually moved to Melbourne where John studied medicine at Monash University, graduating in 1968. The following years were spent at Prince Henry's Hospital and Royal Hobart Hospital, before heading back to the UK for a position at Western General Hospital in Edinburgh, where John developed an interest in gastroenterology.

On returning to Australia in 1976, John's family settled in Dandenong where he started an 'open access' endoscopy centre in 1977, the first in Australia. He also worked as a consultant at Dandenong Hospital for many years, where he lectured a host of young graduates, furthering their medical careers.

John was a pioneer in gastroenterological day surgery,

a very compassionate medical practitioner and a wonderful family man. He was a member of AMA Victoria for more than 50 years. As well as practising medicine, he was a keen competitor at cutting, a western riding discipline, on his favourite quarter horses. He also flew planes, sailed a trailer sailer and planted three large spotted gum eucalypt plantations, with the idea of producing the perfect timber for the building industry. He retired from medicine in 2011, living an active life, golfing and indulging more in his family and grandchildren.

John's diagnosis of Parkinson's disease was totally devastating. He touched the hearts of many friends, colleagues, patients and staff, but most of all his family. He is survived by his wife Libby and three children, Nicci, Chris and Andy, and five grandchildren, Heidi, Max, Alex, Elodie and Maelyse.



Dr John Anthony Edward Goy
MBBS (Hons.)
MRACP, FRCP (UK)
23/4/1945 - 13/6/2020

The contrarian buy signal for property

Residential property investors are in long-term retreat. Using ABS monthly loan commitments statistics as a proxy for buying activity, the cohort is only striking one in four property deals. That is a shadow of the 46 per cent market share seen back in April 2015, when investors borrowed \$10 billion of the \$22 billion new housing finance total.

That month was the high-water mark of a post-GFC 2012 to 2017 investor boom. But it turned out to be an exceptional period. Most of the 21st century has seen investor borrowings trend within a much lower \$5 billion to \$6 billion-a-month window, which of course has seen investor influence progressively wane given total lending and property prices have risen substantially over that time.

This weakness belies the often-held assumption that investors dominate the property market to the detriment of all others. In reality, investors have been increasingly crowded out by owner-occupiers, with resurgent first home buyers especially active in the last 12 months.

Now that outcome has undoubtedly been a social policy objective that has been delivered through various levers - for example, tightening of borrowing criteria for investors and increasingly generous first home buyer supports from Federal and State Governments - and will be a welcome result for many observers.

From an investor perspective, does this mean investing is doomed to wither or are there opportunities to make a sufficient financial return in the future?

There is a statistical trend that keeps me optimistic, even in these curious pandemic times.

Gross rental yields - income from rent divided by the property value

expressed as a percentage - have been drifting downwards. They currently sit at a skinny 3.3 per cent for houses across our capital cities, according to CoreLogic. Twelve months ago, the corresponding number was 3.6 per cent, a drop of 30 basis points. The mathematical reason is of course due to property price growth outpacing rent increases. On its own, without further context, this would seem a disincentive to invest in property.

However, look at borrowing costs over the same 12 months. New borrowers - according to the Reserve Bank - are paying just over 3 per cent mortgage interest on average today. A year ago, it was just over 4 per cent - so a drop of 100 basis points. There has been a similar drop for investor interest rates.

With interest payments the most significant cost of property investment, more of the holding costs are covered today compared to last year despite weak rental growth.

Looking forward over the next few months, it is likely that there will be little growth in rents and possibly even rent decreases due to several coronavirus impacts: a lack of population growth, young adults returning to their parents' homes and higher unemployment. But on the flip side, the worst of the virus and therefore rent challenge may well be behind us in most parts of Australia, other than Victoria and NSW. Yet we know mortgage rates are likely to remain low for months and even years

(based on RBA public statements).

If these expectations are right, then this very narrow gap between gross rental yields and mortgage interest rates is a buy signal for investors. That's because investors require less cashflow from their disposable income to finance an investment which means greater borrowing capacity and, in time, higher prices. Few people are attuned to the signal, but those investors with better antennas could profit now.

That doesn't mean investment success is assured. Prospective investors must overcome the comparatively tougher borrowing criteria set for them as well as the broader issue of banks struggling with mortgage application backlogs.

More fundamentally, as the exercise above illustrates, low rental yields are a reality of property investment. So investors should focus on finding those quality property assets that will deliver them an acceptable long-term return through capital growth, rather than through rental dollars.

Richard Wakelin
Founder
Wakelin Property Advisory

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COVID-19 concerns and feedback

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

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

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