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MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. **FEBRUARY / MARCH 2018**

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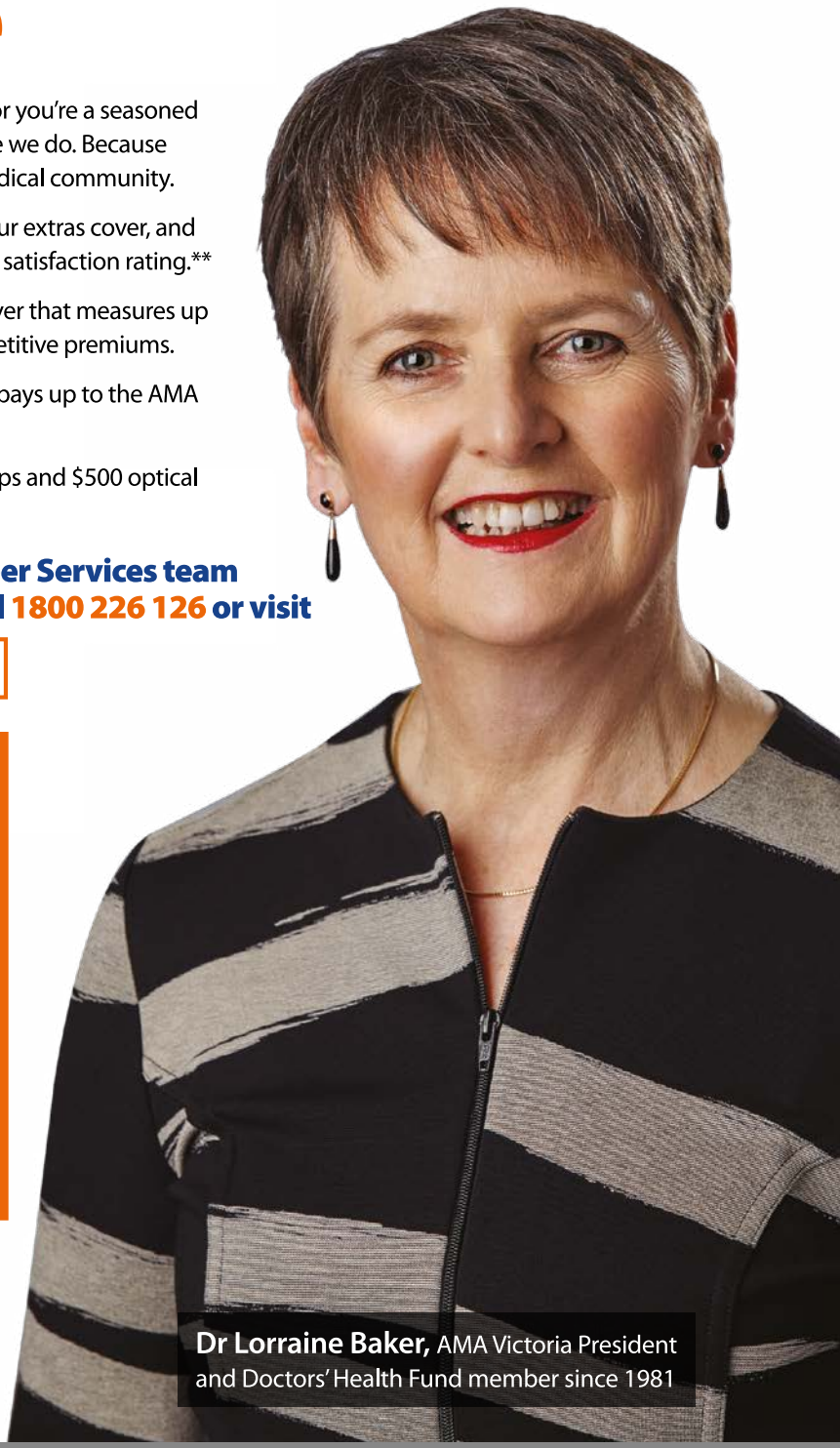

Dr Lorraine Baker, AMA Victoria President and Doctors' Health Fund member since 1981

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

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

DHF205_1/18

FRONT COVER: Christine and Bruce Wilson have pledged $5.5 million to help blood cancer patients.

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Welcome from the editor

AMA Victoria Masters. See page 16.

The weather might still be warm and the Ashes are safely back where they belong, but for many of us it's back into the swing of things as we settle into 2018.

It's been discussed and planned for a long time, but the beginning of February heralds the end of access to over the counter codeine medications and NPS Medicine Wise has outlined how this will impact you and your patients. And continuing the pain theme, we introduce you to a new website to assist with pain management.

This Vicdoc also includes updates on AMA Victoria's work securing new enterprise bargaining agreements for public hospital doctors, duty of candour policy and provides an insight into our Peer Support and Careers services.

All doctors in Victoria have been sent this edition of our membership magazine and if you are not a member, please take the time to flick through the pages and discover some of the ways we can enhance your medical career. Support is available from our Workplace Relations Unit and our events team hosts an array of great networking opportunities which also provide members with the chance to contribute to AMA policy and further their industry knowledge.

Vicdoc contains the latest news on issues affecting the medical profession and keeps you informed on lobbying and policy developments, industrial relations and employment concerns and medico-legal matters. We also like to include stories from Victoria's health leaders, such as Chief Preventive Health Officer Bruce Bolam and learn about the interesting work performed by organisations like the Snowdome Foundation.

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

Barry Levinson

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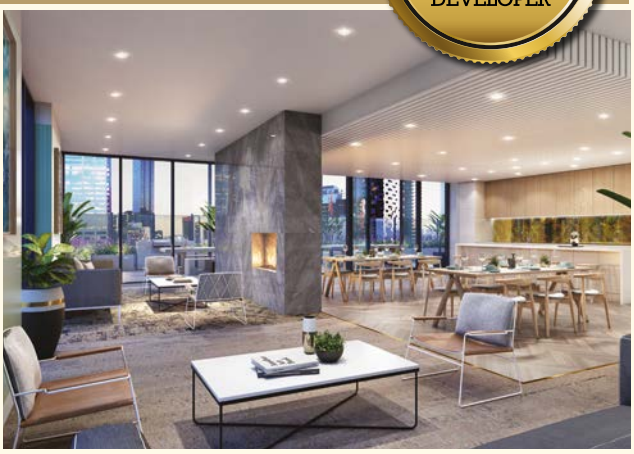

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President's message

Happy New Year! Much is ahead for the profession in 2018 and I know we will strive to keep abreast of it all on behalf of members. Welcome to new members – and in particular the cohort of interns. I hope you will enjoy the collegiate opportunities only membership of a cross-age, cross-stage association can bring – giving you the opportunity to contribute diverse opinions to policy and debate on issues affecting the profession and to gather from time to time at social events.

Late in 2017 the State Government announced the introduction of a Statutory Duty of Candour and we were able to respond with a tight turnaround time. Thank you to members who gave feedback so quickly and, in some cases, with such depth. This was valuable in shaping our response. We will watch closely as this unfolds.

In late November, the Medical Board of Australia released a report "Building a Professional Performance Framework" which is the outcome of a push over recent years regarding credentialing of doctors. Some of it is focused on doctors continuing to practise past the age of 70 (and there is an exemption from the *Anti-Discrimination Act* in place). Ongoing engagement by the AMA will be needed to ensure there are no perverse outcomes.

The Voluntary Assisted Dying legislation passed, and now the consultation on its implementation will begin. AMA Victoria will contribute in every way possible to make sure the regulations are consistent with our policy in relation to protection of the public and the profession. We will also continue our lobbying for improvement in access to palliative care services, as well as mental health services. We will keep members up to date throughout this process.

The President (or delegated AMA Victoria member) will continue to be involved on advisory groups to the Department of Health and Human Services including – Violence in Health Care Services, Safescript (Real-Time Prescription Monitoring), Ice Action Task Force, Chronic Disease Management in Pharmacy Pilot Project, Medical Workforce Planning and Advanced Care Planning. No doubt other groups will be created to deal with issues of concern to the Government.

One of the enjoyable aspects of my presidency has been to experience the enthusiasm of individual members for particular issues – often outside their direct personal or professional interest – but looking to the future health and wellbeing of the profession or the population. These include:

- doctors nearing retirement who commit to representing the need for improved working conditions for the next generation of doctors under the new Enterprise Bargaining Agreement
- doctors pushing the impact of climate change on the health of people as well as the planet, and the subtle ways this may increase the load on the healthcare system
- those who contribute to the shaping of our policy and recommendations to Government on various issues.

This enthusiasm sustains me through the sometimes challenging workload that can occur on a day to day basis. In particular, the media interest in certain issues can be surprising and gives an element of unpredictability to each day.

I look forward to meeting as many of you as possible before the end of my presidency term in May and encourage you all to enjoy your membership of this hard-working and influential organisation either through engagement with member meetings on medico-political issues or the social gatherings – or better still, both.

Dr Lorraine Baker
President

Will there be a flood? The transition to a post OTC codeine world

A flood of patients with pain will pour through the doors... Well, maybe not a big flood, but the up-scheduling of codeine to prescription only may initially increase patient numbers at practices. It also offers an opportunity to reassess and potentially improve pain management for these patients. How should we help these people looking for relief from pain or other conditions? How can we help people who are misusing codeine? Here are some ideas to get ready for a post OTC codeine world.

From February 2018 medications containing codeine (including low-dose codeine combination medicines) will only be available on prescription.

While in most cases pharmacists are well placed to help discuss the changes and suggest suitable alternative medications or treatments, there will be some people (perhaps a small flood) who need to see their GP. For this group, a GP consultation offers an opportunity to assess their condition and develop a plan for appropriate, effective care.

How should we deal with the people who come through the practice doors? Some may not be aware of the potential dangers of their low-dose codeine combination medicines such as Panadeine, Nurofen Plus and Mersyndol, so let them know. Documented harms in Australia associated with OTC codeine combination misuse include death, gastric haemorrhage, renal impairment and life-threatening biochemical imbalances. A 2017 study in Adelaide documented 99 hospitalisations related to OTC codeine misuse over a five-year period, resulting in poor patient outcomes and costs of over $1 million from just one hospital.

Some patients who have been using OTC codeine will present with acute pain conditions such as migraine, period pain and headaches. The evidence is mixed regarding the incremental benefit of codeine in OTC combination products, with the majority of studies showing no added benefit from codeine alongside other active ingredients. These patients should be helped with appropriate treatment for their pain, which may

include alternative OTC options such as paracetamol/ibuprofen combinations. Comparative studies have found that paracetamol/ibuprofen combinations offer pain relief similar to codeine-based analgesics and to combination analgesics with strong opioids used in the emergency department setting.

Patients with chronic pain may present for whom there is no obvious or single 'cause' and often no 'cure'. In these cases, take the time to explain that medications are only part of a shared broader pain management plan that may include non-pharmacological elements such as exercise, and psychological therapies like cognitive behavioural therapy (CBT). Such a pain management plan focuses beyond pain relief, to encompass realistic improvement in the functional capacity of the individual, while minimising harm. NPS MedicineWise provides advice on treating patients with chronic pain.[1] Specialised pain medicine physicians can also support patients if adequate progress is not being made.

The great danger and hence concern around codeine is its addictive nature, leading to tolerance and dose escalations. Studies in Australia and overseas have shown that those who misuse codeine often differ in a number of significant ways from users of illicit drugs. They tend to be better educated, more often employed and do not use illicit drugs. Some people will have treated multiple acute pain events with codeine, and there will be others dealing with chronic pain, finding themselves continually upping the dose. Some like how it reduces anxiety and creates mild euphoria, and eventually these people become physically and psychologically addicted to it. They can end up taking very high doses of codeine as well as the nonsteroidal anti-inflammatory drugs (NSAID) or paracetamol also present in the over-the-counter combination formulations. These people need better and safer treatment.

One of the most challenging parts of this transition away from OTC codeine is helping people who have become dependent on codeine. This dependency is often accidental, escalating from taking OTC codeine for an acute pain condition. People that have become dependent may show aberrant behaviours associated with substance use disorder. Such behaviours include aggressively complaining about the need of a higher dose or a specific drug, hoarding a drug during periods of reduced symptoms, or using drugs inappropriately (e.g. to treat mood or sleep problems).

The TGA has advice on how to handle difficult discussions with people who want codeine, do not accept your advice, and continue pressuring.[2] Speak frankly to the patient, expressing your concerns that the request for codeine may be a sign of dependence on the medicine. Explain how you can help them deal with the pain in a safer and more effective way. You can also refer to the Alcohol and Drug Information Service (ADIS) which has a 24/7 hotline for counselling and referral.[3]

The political debate is starting to cool, and we are entering the implementation phase. We should take this opportunity to help people manage their pain in a safer and better way. General practitioners and other prescribers need to use their strong connections with local pharmacists to help improve patient management across disciplines, and ensure consistent messaging from all healthcare professionals. This is especially an opportunity to help people that have become dependent on codeine. We are facing the flood together!

NPS MEDICINEWISE

References available from the Editor on request.

[1] www.nps.org.au/medical-info/clinical-topics/news/chronic-pain

[2] www.tga.gov.au/tips-talking-about-codeine-guidance-health-professionals-prescribing-authority

[3] www.campaigns.health.gov.au/drughelp

Time-saving tool for managing chronic pain

Soula Mantalvanos created Pain Train following her own frustrations with recalling her medical history and symptoms.

While one in five Australians experience chronic pain (and one in three over 65 years), the National Pain Strategy indicates that many health professionals have limited training in pain management. There is a shortage of pain clinics, public waiting lists are on average two years' long, and it's often left to GPs to manage complex conditions in short appointments.

One of the most challenging tasks is understanding the patient's pain story (medical history) including the complexities around their pain, which can take up to an hour – time most doctors just don't have. But technology is making it possible for systems being used in pain clinics to be made available even in the smallest of GP practices across the country.

Most public pain clinics in Australia are now using assessment tools developed by the ePPOC (electronic Persistent Pain Outcomes Collaboration). The tools help doctors better understand the patient's condition by collecting data and measuring patient outcomes as a result of treatment. ePPOC has been developed by the Faculty of Pain Medicine with the Australian Pain Society and the wider pain sector.

Dr Nick Christelis, Director at Victoria Pain Specialists, bases the survey he gives all his patients before their first appointment on the assessment tools developed by ePPOC. Dr Christelis explains that the survey "allows us to understand the patient's pain experience even before we see them. Chronic pain is subjective, unique and individual, each patient needs to be first understood then receive bespoke treatment."

One of Dr Christelis' patients, Soula Mantalvanos, completed this survey ahead of her first appointment and found it tedious and long. It wasn't the first survey she had completed for a healthcare practitioner. Since her accident when a fit-ball she was sitting on in her studio burst and she fell onto a concrete floor, she had spent a lot of time retelling her story to practitioners. Soula often had trouble remembering dates, names and her reactions to different treatments. It's important to note she was doing all of this while in excruciating pain.

While Soula struggled with the survey, the treatment and advice she was given by Dr Christelis made a huge difference to her level of pain and quality of life. "I felt like he really understood my condition and I think it was this understanding that led to better treatment."

Dr Christelis' approach is to put patients' health in their own hands. He says, "I will do all that I can to reduce the pain but it's up to the patients to get back on track, sometimes with the help of our allied health pain team."

This message resonated well with Soula. Having run a successful graphic design business before her accident, her pain had left her feeling like she had lost her independence.

After working with Dr Christelis, Soula felt motivated to develop the tools she needed to manage her health and life while still living with chronic pain. She also wanted to help other people with the condition. She realised that not everyone has the luxury of being able to access a suite of chronic pain experts.

So Soula used her skills as a graphic designer and understanding of the patient experience to create Pain Train, a website that enables chronic pain patients to summarise their condition and how it's affecting their life. The fields in the system are based on Victoria Pain Specialists' patient survey. Patients can subscribe to the service, fill in all their details in their own time and then share their profile with their various healthcare practitioners ahead of appointments. The graphical summary page on Pain Train has been designed to give practitioners the same amount of information in a couple of minutes as a 45-minute patient consultation.

Patients can update their information on Pain Train when appropriate including:

- the location, type and intensity of pain
- what's making it worse and better
- how it's affecting their life and mood
- treatments and medication they've had and how they're responding
- medical records
- what support they're receiving.

They can share their profile with anyone they choose from carers to family and friends and control this access.

"While a natural response to pain is to worry and sometimes even panic, people with chronic pain have to, among other things, retrain their brain to focus on things other than pain," Dr Christelis explains.

Soula found it very difficult to do this when she was being regularly asked how she felt and to describe her condition – a challenge often experienced by Pain Train clients. Now these patients just share their Pain Train profile.

Dr Christelis says, "A key step in multidisciplinary care is patient involvement. This resource empowers patients to take control of their pain journey and provides doctors with efficiencies needed to provide better treatment."

pain-train.com.au

PainTrain
My Health Summary

References available from the Editor on request.

AMA Victoria secures significant EBA deal

Public hospital doctors attend an EBA meeting at AMA House.

Public hospital doctors to receive 19.1% compounded pay increase

After extensive negotiations with the Victorian Government, AMA Victoria and ASMOF have reached an in-principle agreement with the VHIA for two new enterprise agreements for the state's public hospital doctors.

The cornerstone of these two EBAs (doctors in training, and specialists) is the significant increase in wages of 19.1% compounded.

The first salary increase will be 9%, effective from 1 January 2018. There will be a sign-on bonus of $2000 for full-time doctors in training (DiTs), and $3500 for full-time specialists, and an increase to DiTs Continuing Medical Education (CME) allowance to compensate for increased medical training and specialist college fees.

In addition to the 19.1% compounded pay increase, other important elements of the new EBAs include:

For doctors in training:

1. Rostered shifts down from 30 hours to a maximum of 16 hours per day.
2. A 10 hour break between work on one day and the next.
3. Night shifts to be limited to no more than 7 consecutive days.
4. Improvements to ensure the appropriate backfill for doctors on leave, reducing the occurrence of staff shortages.
5. Overtime rates to apply to part-timers who are asked to work in excess of contract hours.
6. Improved parental leave entitlements, including the extension of contracts where parental leave falls within the contract period.

For specialists (senior medical staff):

1. Improvements to ensure the appropriate backfill for doctors on leave, reducing the occurrence of staff shortages.
2. An increase to the minimum afternoon shift penalty and the introduction of night shift penalties:
   - 25% for afternoon shift Mon-Fri
   - 75% between midnight and 7am Mon-Sat
   - 100% penalty on night shifts worked on Sundays.
3. A new job sizing clause to assist with the understanding and review of doctors' workloads.
4. Improvements and clarifications to existing CME conditions, including:
   - the ability to claim the costs of registration with a

relevant Specialty College or Association (in the medical field in which the doctor is credentialed and practising)

- the ability to claim reimbursement for necessary childcare linked to attendance at a CME event (such as a medical conference or training seminar)
- the ability to claim sabbatical leave expenses.

"These are milestone EBAs for Victoria's public hospital doctors, and a true sign of their value in our public health system," Dr Lorraine Baker, President of AMA Victoria said. "AMA Victoria has held close to 220 meetings with our members (in metropolitan and rural health services) to ensure that the new EBAs respond to and reflect the needs of our members.

"A theme throughout AMA Victoria's two EBAs is centred on improved work-life balance and flexible work arrangements for doctors. This is in recognition of Victoria's highly skilled public hospital doctors whose personal health may, at times, run second to the needs of their patients," Dr Baker said.

Salary increases

- Sign-on bonuses and increased CME allowance.
- 9% from the first pay period commencing on or after 1 January 2018.
- 3% from the first pay period commencing on or after 1 January 2019.
- 3% from the first pay period commencing on or after 1 January 2020.
- 3% from the first pay period commencing on or after 1 January 2021.

Once drafting of the Proposed Agreements is complete, the Department of Health and Human Services will submit the Proposed Agreements for final Government approval prior to a ballot of employees being undertaken, as required by the *Fair Work Act*. All amendments to current arrangements will be implemented at the earliest possible date. Parties to this Heads of Agreement undertake to meet at the earliest possible opportunity with the view to having a final agreement by 12 January 2018.

AMA Victoria media release, 23 December 2017

Answers to questions you may have

Do sign-on bonuses apply to part-time doctors?

Yes. For DiTs the bonus is payable based on $2000/38 x number of part-time hours per week (43 hours for registrars). For fractional specialists, the payment is $3500/35 x fractional allocation.

Is the "sign on bonus" payable each year?

No. It is a one-off payment. The Government was steadfast in not agreeing to back pay. However, we were able to negotiate a 'sign-on bonus' which we view as payment in lieu of back pay. It is not repeated.

Does the sign-on bonus apply to people who first start with a hospital after 1 January?

No. While the detail is still to be finalised, it is expected that the bonus will only be payable to medical staff employed by public hospitals as at 1 January 2018.

If I have already signed a contract for 2018, do I still get the sign-on bonus and pay rise?

Yes to both.

If I rotate to anther hospital before payments are made, which hospital owes me the back pay?

If you rotate to another hospital, the Parent hospital or hospital that employed you directly on 1 January is obliged to pay. So keep in touch. Ensure you are an AMA Victoria member to follow-up.

Does parental leave apply from 1 January?

No, it will apply from the date the Agreement is registered.

When will we receive our salary increases and sign on bonus?

This will occur once the two agreements are finalised. There are still a number of steps to progress to finalise all the changes. However pay increases will be paid operative from the first pay period from 1 January 2018. So you will be back paid to this date.

What are the next steps to finalise all these changes?

We are aiming for the end of February for a vote and registration of both agreements. During this time we must finalise the two drafts with hospital representatives and the Department of Health and Human Services must submit the drafts for final Government approval. Once approved, a ballot of medical staff will be conducted as required by the *Fair Work Act*. If a majority of doctors (who vote) vote in favour, the agreements will be submitted to the Fair Work Commission for approval. The agreements operate once approved.

Does the Agreement apply to medical staff in all public hospitals in Victoria?

The agreement applies to all public hospital employed medical staff (paid hourly or weekly) in Victoria. It does not apply to those who are independent contractors (i.e. small rural hospital VMOs) or doctors who are paid 'fee for service'.

I am a specialist who already receives an afternoon shift allowance greater than 25%. Am I entitled to this new loading as well?

No, a number of changes to conditions for specialists (except for salary increases) will not be paid if the specialist is already in receipt of an equal or greater condition. This is in recognition that we are in the process of moving unregulated conditions into the specialist agreement to create state-wide conditions that are protected.

Is this "catching up" to other states?

One of our aims was interstate parity. Current agreements interstate have 2% – 2.5% p.a. wage increases and relatively few changes to employment conditions. This package better positions Victoria in terms of interstate salaries and conditions.

Email us at eba@amavic.com.au for more information. If you're not a member and want to join for access to our workplace relations services, visit amavic.com.au

We are working to finalise the draft enterprise Agreements. Once finalised (by early February) they will be distributed for voting by hospital doctors. If successful, these will be lodged with the Fair Work Commission for approval. Back pay and changes to conditions will occur from the date of approval.

Member profile: How a notebook on patients became a published work

Member Dr Mrin Nayagam has recently become an author and published her first book. She spoke to Vicdoc about her medical journey.

Why did you want to become a doctor?

This was the poem I read out at the start of the author presentation, at the launch of my book-"Silver Linings-True Stories of resilience from a General Practice":

Emily Dickinson 1830-1886
Part One: Life
VI
If I can stop one heart from breaking
I shall not live in vain
If I can ease one Life the Aching,
Or cool one Pain
Or help one fainting Robin
Unto his nest again,
I shall not live in Vain.

I always wanted to be a doctor. Perhaps it was just me, or perhaps it was the encouragement from my parents. Who can tell? This desire to be a doctor was always with me from a very young age. My father's words, "Tether your wagon to a star..." and my mother's, "Do noble things, not dream them all day long..." were my inspirations when growing up.

I recall year after year at school I documented my ambition of becoming a doctor. At times I wrote (in my ignorance) that I wanted to be a doctor or a surgeon one day. As I grew older, I fine-tuned this to be a children's doctor. In 1980 when I passed the MRCP (UK) Paediatrics, my wishes were realised.

Where did you do your medical training?

The road to medical school back in Sri Lanka is tough. 150,000 students vie for 150 places in the premier medical school located in Colombo. The life of a medical student was fun, but exams were hard because the standards were very high. Unlike the present day, we had real anatomy lessons, and we dissected human cadavers, with six students assigned to each body. Cunningham's Textbook of Anatomy was our prayer book and Gray's Anatomy was our Bible.

My initial post-graduate training was in Colombo. I interned in paediatrics in the professor's unit and had a great rotation in general surgery as well. After this, my extended residency was in a district hospital close to Colombo where I worked in the fields of medicine, surgery, obstetrics, emergency and paediatrics over a two-year period. That invaluable experience still gives me confidence in my work today.

Having passed the MRCP (Part I) in Colombo, my husband Prakash and I left for England in 1980 to sit Part II, which is only held in the UK. This comprised of six short cases and a long case, followed by a gruelling interview with three specialists from the chosen field.

Times were hard. While working at the Great Ormond Street Group,

I had to quit as child care was unaffordable. We moved to Brighton and Hove, and I stayed home to look after our two-year-old son, keeping my hand in with occasional weekend locums at the nearby Royal Alexandra Children's Hospital.

So, imagine my utter joy when six of us sat for the MRCP Paediatrics from the Brighton Area Health Authority (UK) and I was the only one who passed! It was unbelievable! The next day the senior dermatologist in the area offered me a post which was created for me under a scheme where women doctors with family commitments unable to work full-time (who also had post-grad qualifications) were entitled to jobs created for them to suit their individual needs. I chose my hours – it was the thin edge of the wedge and in time I was the clinical assistant (the equivalent of a staff specialist here) in dermatology. I practiced dermatology and paediatrics at the Royal Alexandra Hospital.

What brought you to Australia?

We spent 10 years in England and they were happy times, however consultancies were thin on the ground, especially physician/geriatrician posts (for my husband). Further, the climate did not suit my health – I had severe Raynaud's for nine months of the year. So, when an opportunity arose to migrate to Australia, we decided we were young enough and moved continents, once more, in 1990 – the same year Collingwood won the premiership! I have been a one-eyed Magpie ever since!

Moving to Australia presented its own obstacles when doors for paediatrician training in my local area did not open. Rather than fragmenting the family, I decided to do general practice with a special interest in paediatrics.

For a long-time you have collated a list of 'interesting patients' you have seen. What prompted you to do this and how did it lead to your new book?

Over the years I have surprised myself when, time and again, a gut feeling about a diagnosis came true and the patients were saved many months of investigations and the cost of many specialist visits.

As I had a part-time teaching appointment at the Department of General Practice at Monash University, a practical knowledge of real-life patients came in handy during teaching sessions. Whenever I used the deidentified patient's notes to enhance the students' knowledge of a subject I kept a note of the patient's details in a list. I like keeping lists – it's a relic from studying for exams. From these small beginnings, my list of patients with an interesting or even rare diagnosis grew. I transferred the names on the piece of paper to a book classifying the names under specific conditions or simply as interesting cases.

Patients are intrigued and at times amused when I pull my notebook out and include their names in one of the lists. As I made more exotic diagnoses by following clinical principles rather than referring to specialists, my list grew. I referred the patients to specialist for fine-tuning. Most specialists were happy to send them back for continued follow-up and management as they knew I would re-refer, if I needed further guidance. One of the first such cases was myasthenia gravis I diagnosed in a 30-year-old female at her first presentation. I referred her to Prof Edward Byrne for further management and it was this interaction early in my life in general practice that led me to appreciate the rewards of investigations.

One day a fourth-year medical student sitting with me at the practice leafed through my book of lists and suggested I could write a book. The seed was sown! I always wanted to be a published author, this being a consequence of extensive reading during my formative years, so I had given the subject much thought.

How did you select your stories for inclusion in the book and what level of cooperation did it require from your patients?

Writing a narrative about patients and their journeys when faced with a devastating diagnosis or a traumatic event (either physical or emotional) seemed an acceptable start. The main hurdle, however, was that I was unwilling to write about my patients for personal financial gain, so I decided diverting the profits to charity would be a good idea.

I first asked my solicitor to draw up a legal agreement incorporating all the caveats I could think of to get informed consent from the parents (if the patient was a child), or from the patients themselves, if adults.

Once this was done and all issues were covered I wrote to 50 patients for their consent to take part in the project. I explained that all the profits would go to charity. To my delight, all but one agreed. The patient who did not was moving away from our area.

Many stories were written during my vacations and on aeroplanes when the rest of the passengers were asleep, or at my home, in the still of the night. Once read, edited and re-edited several times over, the final version was presented to the patient to read and give signed consent for publication.

All of the proceeds from your book are going to your charity, the Silver Linings Charitable Trust. Can you tell us a little bit about this?

Since 2006, under the auspices of the Village Clinic and run with the support of all the doctors and staff, a collection of non-perishable food for distribution to the needy and financially disadvantaged of the Frankston area takes place at the end of each year. This is done in collaboration with Frankston Community Support. The food collected at the clinic – donated by patients, specialists, staff of the clinic, pharmaceutical reps/companies, pathology and radiology providers as well as friends and family of the Village Clinic – is packed by the staff and myself into 50-litre plastic tubs, hence the name – 15 Tubs Appeal – as the original target was to fill 15 such tubs.

In 2016 we filled 102 tubs, which was 5,200 litres of food that found its way to feed the needy at Christmas time. I felt it was important to sustain this through the year, as often the larder of Frankston Community Support is empty, so I established a charity – the Silver Linings Charitable Trust – aimed at supporting the financially disadvantaged throughout the year.

There is no administration fee, and the trust has been accorded a charity status by the ACNC and also has a DGR status from the ATO. All profits from the sales of my book will be directed to the trust. All donations made to the trust will be acknowledged with a tax receipt, and books may be bought in bulk for business purposes, for which a tax invoice can be issued.

To buy a book or make a donation, please visit www.silverliningscharitabletrust.com.au

AMA Victoria Masters

AMA Victoria members were treated to a lovely afternoon full of sunshine on 31 October, 2017, at Kingston Heath Golf Club. There was a great turnout of golfing members of varying degrees of ability and the round was followed by a delicious gourmet barbecue dinner. By all reports the event was greatly enjoyed by everyone in attendance. A special thank you to our sponsors Wine Direct and McLaren for making the day possible.


McLaren

Statutory duty of candour

In 2016, Dr Stephen Duckett led a review into hospital safety and found that the Department of Health and Human Services needed to strengthen its oversight of quality and safety systems. The department responded by establishing an Expert Working Group to provide advice on legislative reforms arising from the review.

A paper was released in October last year and AMA Victoria was invited to comment on the proposal to introduce a statutory duty of candour. This duty requires all hospitals to ensure that any person harmed while receiving care is informed of this fact and receives an apology.

Acknowledgement of harm and an apology, or expression of regret for the harm endured, are key components of the existing duty of open disclosure. The purpose of a proposed 'statutory duty of candour' and the existing practise of 'open disclosure' is to foster an open and honest culture in health services and improve the quality and safety of care.

The main argument from AMA Victoria is that the statutory duty must not apply to individual clinicians and practitioners, but rather to the organisations that manage and oversee the delivery of care.

In our submission, AMA Victoria insisted that:

- doctors must be supported to understand how the existing professional obligation of 'open disclosure' interacts with a 'statutory duty of candour'
- definitions of patient harm and trigger thresholds must be clearly defined
- protections under Victorian apology laws should be strengthened
- education, training and support is needed for hospitals and staff
- systems for reporting and monitoring compliance should be educative not punitive
- statutory protections should indemnify individual practitioners against any disciplinary action, or litigation which may arise out of statutory candour obligations.

To read the full submission, along with other policy submissions, visit the Policy & Advocacy section of amavic.com.au

Nada Martinovic

Senior Policy Advisor

NOTICE OF ANNUAL GENERAL MEETING 2018

Details

Australian Medical Association (Victoria) Limited and Medical Society of Victoria Inc.

Notice is hereby given that the Annual General Meetings of the Australian Medical Association (Victoria) Limited and the Medical Society of Victoria Inc. will be held at the Treacy Conference Centre (126 The Avenue, Parkville, Victoria, 3052) Melbourne on Wednesday 2 May 2018, commencing at 7.30 pm or thereafter following the Annual Election Meeting.

Business

1. Apologies
2. Adoption of Minutes of the Annual General Meeting of the Australian Medical Association (Victoria) Limited and the Medical Society of Victoria Incorporated held on 3 May 2017.
3. Reception and Adoption of the Annual Report
4. Appointment of Auditors

Proxies

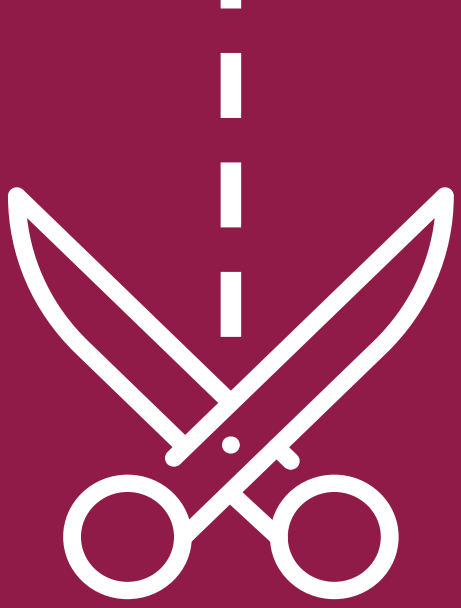
1. Each member is entitled to appoint a proxy.
2. A proxy form is available on request.
3. Proxy forms must be received at least 48 hours before the meeting.
4. A proxy may be received

(a) At the office of the Australian Medical Association (Victoria) Limited: 293 Royal Parade, Parkville, Victoria, 3052; or

(b) At the following fax number of the Australian Medical Association (Victoria) Limited: (03) 9280 8786; or

(c) At the following Australian Medical Association (Victoria) Limited email address: returningofficer@amavic.com.au

Members wishing to attend the AGM should email: CarolineS@amavic.com.au



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Prevention – Let's make it everybody's business

Evidence shows that brief interventions and motivational interviewing for smoking and alcohol use take a short

As the Chief Preventive Health Officer my role is to lead across the Department of Health and Human Services and Victorian Government more broadly by providing authoritative and strategic advice on prevention and population health issues to shape policy, programs and government directions.

This exciting new role will provide many opportunities for us to lift our game in prevention and earlier intervention and working with the Victorian medical workforce is critical in all my endeavours.

Of course prevention means different things to different people. Ultimately we need to drive better public health outcomes, which are often most efficiently done through primary prevention at a population level.

Tobacco control and road safety are classic examples of Victorian leadership on major public health concerns like this. But it's also the case that prevention is everybody's business, including, importantly, in the medical workforce.

There are many different ways in which clinical leaders and health services can help lead the charge for better population health outcomes above and alongside providing first class patient treatment.

Firstly, we know that we can save many lives by intervening earlier in many chronic conditions. Victoria has some of the best screening programs in the world but inequalities in access and outcomes remain, and when it comes to cardiovascular risk and identification management, there is room for improvement to match some other well-established cancer screening programs.

One current positive example is the work underway in the Latrobe Health Innovation Zone where we are working closely with primary health networks and community-based health organisations to test out new ways of better identification of cardiovascular risk for a population with very high levels of morbidity and mortality.

Secondly, the medical workforce plays a central role in providing evidence-based, person-centred preventive healthcare services. For example, evidence shows that brief interventions and motivational interviewing for smoking and alcohol use, and more recently screening for family violence and mental health issues, take a short time and make a real difference. But we know best practice for prevention needs is far from embedded across the health system.

An important place to start is in better data. This can be as simple as routine recording of health-related behaviours as a prompt to provide care for behaviourally modifiable risk factors.

The subsequent outcomes of a behavioural intervention may occur days, weeks or even years after the initial conversation. But the evidence is

Bruce Bolam, FPHAA, FFPH, PhD, MPH, MSc (Psych), PGCE (FAHE), BSc (Hons)

Dr Bruce Bolam is the Chief Preventive Health Officer in the Department of Health & Human Services, Victoria and a senior public health specialist with extensive leadership, policy and research experience in public sector, healthcare, university and non-government organisations.

Following academic work and training in public health in the UK National Health Service, Bruce has led policy and program development and delivery at a major national health non-government agency, the National Stroke Foundation, and the world's first health promotion foundation, VicHealth.

He has also acted as a Technical Advisor on non-communicable disease control to the World Health Organisation's Western Pacific Regional Office and became the inaugural Co-Director of the World Health Organisation (WHO) Collaborating Centre for Leadership in Health Promotion hosted by the Victorian Health Promotion Foundation (VicHealth).

Bruce maintains an active research profile and is the author of over 30 scientific publications, and is regularly invited to speak at national and international conferences.

time and make a real difference.

clear – talking with patients, motivating them to set goals and referring them onto specialist services works, and we need to do more of it.

At a broader level, health services and clinicians can play a key role as partners in prevention activities in an organisational or community level. Many of Victoria's greatest public health practitioners have been clinicians who have taken their passion outside the clinical environment to benefit the broader community, for example in tobacco control.

It's also important to emphasise that all medical professionals model health whether we like it or not. Often we fear the implicit judgement of talking about healthy weight or smoking and alcohol use and are aware of our own lifestyle limitations.

We also get frustrated when the advice we give so often seems ignored. Therefore, it's important to realise that what we look for in health promotion is not to label an individual but to empower people to take control of their own health – we are fighting smoking, not smokers.

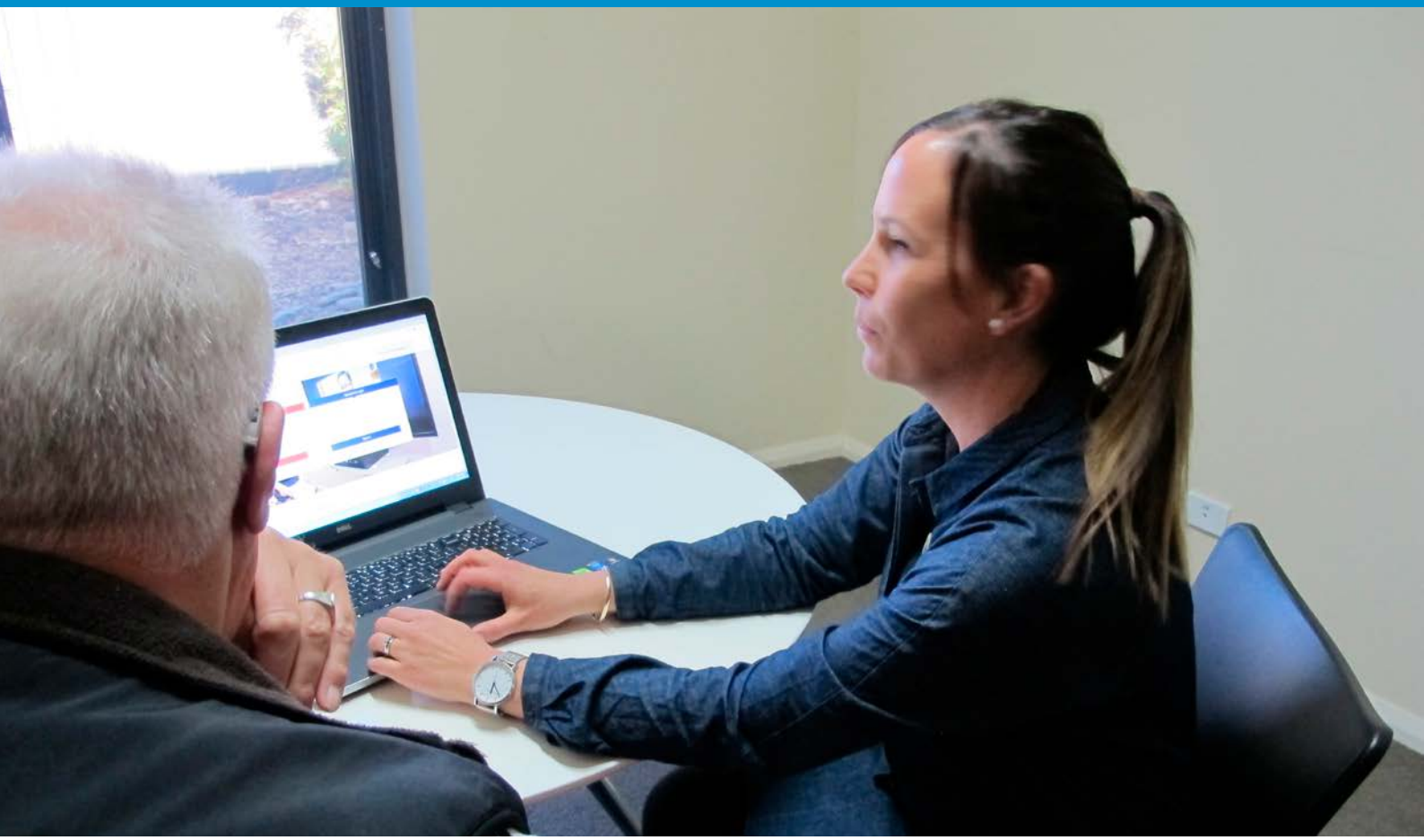
The logic of prevention applies to our health services too. By changing the default setting and making sugary drinks less accessible in healthcare services, hospitals like Alfred Health and a number of primary care organisations across the state have shown it is possible to create healthier food environments that don't lead to financial catastrophe and upset patients.

We need to look after ourselves through weight control, smoking cessation services, mental health first aid training and many other evidence-based programs that show how local health services, as local employers and local hubs of community, can model a healthier future. And we might want to think about the lollies on the reception desk and the chocolate frog fundraisers in that light too.

All medical practitioners play a vital role in promoting good health in individuals and populations. We're already doing a great job, but there is more we can do to unlock our shared passion for prevention. Please join me on that journey.

Bruce Bolam
Chief Preventive Health Officer
Department of Health & Human Services

Providing access to specialists for people in the bush



With support from Diabetes Educator Alex Carter, patient Ron Hick links with his Melbourne-based endocrinologist from the Northern District Health Service.

While a third of Australians live in rural areas, only 15% of medical specialists work in the bush. As a result, people living in rural areas often have worse health than those living in metropolitan parts of the country. It's perhaps no surprise that rural and remote Australians are deeply concerned about poor access to healthcare according to key findings from the latest Royal Flying Doctor Service (RFDS) research.

Health Care Access, Mental Health, and Preventative Health: Health Priority Survey Findings for People in the Bush, saw more than 450 country Australians surveyed. One-third nominated access to doctors and specialists as their single biggest healthcare concern.

To address this concern, RFDS offers specialist services via the Flying Doctor Telehealth platform. The service connects patients in rural areas with specialists via a secure online video appointment that is simple to refer to, has minimal wait time for appointments (two to four weeks at most) and is 100% bulk billed, making it convenient for GPs and patients.

Dr Luigi Luca from Robinvale District Medical Centre says, "the service provides immediate specialist care for

The Flying Doctor Telehealth platform offers:

A range of specialist appointments

Online, easy to use booking system

Ease of access through a web browser

Supportive telehealth concierge

Jeremy Eckermann connects with his endocrinologist at the Baker Institute, joined by diabetes nurse educator Leanne Huebner at Rural Northwest Health.

our diabetes clients, often within one month of referral, which is something that has never been available in this area before.

"We are having remarkable improvements in our clients HbA1c results and ongoing interaction with the endocrinologists which have assisted in improving my knowledge and treatment of my diabetes clients."

For patient Ron Hick, the 300 kilometres between himself and an endocrinologist meant an eight hour round trip to Melbourne every three months. Ron now receives specialist treatment without having to leave his home town.

Describing how this service has impacted him, Ron says "the greatest impact for me has been the fact that instead of having to travel four hours each way to see my specialist, I now travel four minutes. I have great respect and admiration for the service."

Flying Doctor Telehealth supports patients to book and attend appointments through their local health service. With a referral from a GP, patients can attend their local health service where staff then use the referral to book appointments. The platform also enables sharing of documents, test results, and GPs are also able to attend the appointment if they wish.

In Warracknabeal, patient Jeremy Eckermann says he has never felt more in control of his condition, as a result of using Flying Doctor Telehealth. The single parent of two has used the service to connect from his home town to an endocrinologist at the Baker Institute in Melbourne.

1 IN 7 PATIENTS WAIT 2 DAYS TO SEE A DOCTOR IN REMOTE & RURAL AREAS

15.6% of people in the bush are unable to see a doctor for urgent medical care for at least two days

58.6% of people are able to see a doctor within 4 hours for urgent medical care

Jeremy has lived with type 1 diabetes since he was 12, and had struggled to maintain regular blood sugar levels until he accessed a specialist via Flying Doctor Telehealth. After his GP provided a referral he connected to the service through Rural Northwest Health and gained the support of diabetes nurse educator Leanne Huebner.

"With telehealth, all I have to do is go up to the Warracknabeal campus," says Jeremy, who doesn't drive due to degrading eyesight. "Leanne and I sit in a consultation room with a computer and talk to the specialist online."

RFDS has offered Flying Doctor Telehealth for endocrinology appointments in Victoria since 2013, and has expanded to include specialists such as cardiologists, psychiatrists and respiratory physicians.

Since rolling out the platform, more than 1000 telehealth appointments have been delivered, saving patients more than 3,000 hours travel this financial year alone. This is anticipated to double over the next 12 months.

Learn more about Flying Doctor Telehealth at www.flyingdoctortelehealth.org.au

Royal Flying Doctor Service
VICTORIA

Peer Visitor Program – Alan and Maria

Alan and Maria meet every week as part of AMA Victoria's Peer Visitor Program

One of AMA Victoria's core philosophies is the concept of doctors supporting doctors. Many older doctors miss the companionship of their peers and colleagues when they retire.

The Peer Visitor Program was established to address this by matching volunteer visitors who are doctors or medical students with elderly medical professionals who may be isolated.

Dr Alan Davis and Dr Maria Shenfield live a few streets apart in a leafy suburb of Melbourne and meet together at Maria's home every week as part of the AMA Victoria Peer Visitor Program. After their first few meetings they realised they were actually at Melbourne University studying medicine at the same time. Despite different backgrounds, Alan and Maria find plenty to talk about when they catch-up.

Alan grew up in Melbourne. His father was a senior physician at the Alfred and was actively involved in the AMA including establishing the AMA Victoria Art Society. Despite experiencing an injury to his right arm which left Alan with a disability, he was never treated any differently as he grew up and this never hindered his desire to study medicine and become a doctor.

In contrast, Maria came to Australia in 1958 from Poland at the age of 29 with her husband and 18 month-old daughter. She had already completed her medical degree in 1952 and was working in paediatrics before she emigrated. On arrival she had the challenge of mastering English in six weeks with the assistance of her husband and daily tutoring from an English teacher in order to gain entry to medical school.

Maria is a holocaust survivor. She escaped to Russia with her mother at the start of World War 2 and was fortunate to be able to continue her education while in Russia. She started university after returning to Poland at the end of the war. At that time there were very few men and the student intake was at least 75% female. Maria met her husband in Poland after the war and became pregnant during her university studies. Like many Polish Jews, Maria's family was decimated during the war and on her mother's side of the family, only four out of 24 survived.

Alan entered medical school at Melbourne University in the same year as Maria, and the gender divide was in complete contrast to Maria's experience in Poland. Of the 250 or so medical students, only 10% of them were women. Both Alan and Maria graduated in 1961. Alan then headed to the Alfred Hospital for two years while Maria undertook her intern year at the Royal Melbourne Hospital, before moving to Queen Victoria Hospital for a year as a resident. As a parent of a young child, Maria was provided with the concession of only having to work two nights sequentially rather than the usual five night rosters.

Maria established her general practice working from a room in the family home. She experienced some prejudice as it was not common for women to work

as GPs at the time, with some patients even refusing to see her. However Maria also had a number of patients, both male and female, who were very pleased to have access to a female doctor. She worked as a solo GP throughout her career, finding that male GPs were not interested in joining her practice. Maria was widowed while she was still working and had young children. Her usual working week was 64 hours and she jokes that 48 hours of that was returned to the government as tax. She was very pleased when GP education became available and she really enjoyed the opportunities this provided for networking with other doctors, as a contrast to working alone.

After undertaking three registrar years in pathology and general medicine at the Alfred and Austin hospitals, Alan moved into medical administration as the deputy medical superintendent at the Austin, gaining a degree in medical administration. From 1973 to 1991, he was the medical director at Box Hill Hospital. Following this Alan became a consultant in medical administration, providing services to a number of small hospitals in central Victoria. He also rose to the rank of Deputy Commissioner for St John Ambulance Victoria and served this organisation for many years in a voluntary capacity, often involving up to 40 hours a week.

While at the Austin and Box Hill hospitals Alan was instrumental in developing and introducing medication charts and, along with Dr Edward Brentnall, the triage system in emergency departments. He was also involved in introducing vocational training for junior doctors at Box Hill Hospital who were interested in general practice. Alan says what he enjoyed most in his work was the ability to influence the practise of medicine in hospitals and the value of undertaking quality improvement activities which improved patient outcomes. Alan was also a surveyor for the Australian Council on Healthcare Standards (ACHS) for 19 years.

Maria really enjoyed her contact with patients in general practice and getting to know family dynamics through house calls. She believes that understanding a family history enables better care for patients. Maria also enjoyed preventative medicine and the difference this can make to the health of a community.

For Maria, having a Peer Visitor is a much appreciated break from the monotony of being alone during the day when her family has work commitments. She enjoys the opportunity to discuss a range of topics and life experiences with someone who also has a medical background.

Alan enjoys being a Peer Visitor as it provides him with the opportunity to meet and interact with people. He says he has found a connection with everyone he has visited. Both Maria and Alan have been involved in the Peer Visitor Program for more than three years and have been paired for visits for over 12 months.

Kay Dunkley
Coordinator of Doctor Wellbeing

The Peer Visitor Program is proudly supported by PSA Insurance.

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Unfair dismissal

In a recent decision by the Fair Work Commission, a nurse with multiple sclerosis was awarded compensation after being dismissed by a Melbourne medical centre over concerns she could not perform the inherent requirements of her role.

The nurse commenced employment with the centre in 2009, disclosing her medical condition prior to starting. During her time there, adjustments were made to accommodate her health including use of an electric wheelchair and time off as required.

In May 2016, the centre's management met with the nurse to express concerns that her medical condition was deteriorating. The directors of the centre – both GPs – submitted to the Commission that the deterioration manifested in the nurses mobility, hand tremors and ultimately her inability to perform modified duties. Concerns escalated during 2016 and 2017 and were regularly raised between the parties, involving the Australian Nursing and Midwifery Federation (ANMF) and the medical centre's legal representatives.

On 8 May 2017, the centre wrote to the nurse confirming termination of her employment due to concerns over her capacity to safely carry out duties and an inability to find other suitable duties.

In considering whether the dismissal was "harsh, unjust or unreasonable" under the *Fair Work Act*, the Commission noted the absence of medical evidence. In August 2016, the nurse provided a report from her neurologist which stated she was safe to be around patients. Enquiries made to AHPRA found there was no information to suggest the nurse's health condition was affecting her ability to practise. Furthermore, no independent medical examination was arranged.

While the directors had made observations on the nurse's medical capacity, the commission noted that they had not expressed a clinical diagnosis based on patient history or consideration of specialist reports. The directors also acknowledged that they would ordinarily refer a patient with MS to a specialist. The Commission was not satisfied that medical evidence supported a finding the nurse was unable to perform the inherent requirements of her role.

The Commission then considered a number of individual incidents where the nurse allegedly failed to perform her duties. The Commission found that on the basis of these, there was a valid reason for dismissal. However, as the centre failed to provide adequate warnings regarding performance, or an opportunity to appropriately respond to the reasons for dismissal, this rendered the dismissal unjust.

The centre was ordered to pay compensation of $4240 for lost earnings, plus superannuation. This case is a reminder of the importance of following fair procedures when considering dismissal of an employee on medical grounds.

It is also valuable to note the Commission's comments on medical capacity which require "a clear finding by an appropriate medical practitioner that the employee cannot perform the inherent requirements of the job". Practice owners must be cautious not to rely on their own observations in instances where independent medical information is required.

AMA Victoria's Workplace Relations Unit provides assistance and representation to members who have been dismissed, or to members who require advice in understanding fair procedures and valid reasons to terminate an employee. For advice on these or other employment matters, contact the team on (03) 9280 8722.

Katherine Stewart
Workplace Relations Adviser

Logan v Knoxfield Medical Centre Pty Ltd T/A Colchester Medical Centre [2017] FWC 5378 (18 October 2017)

NOMINATIONS FOR THE 2018 AMA VICTORIA COUNCIL ELECTIONS

Nominations are called for the following positions on the AMA Victoria Council:

Independent Member Positions

Eligibility: All ordinary members of AMA Victoria

Nominations: Nomination must be in writing, signed by the candidate, accompanied by a written expression of support from another AMA Victoria member and submitted to the Returning Officer by close of nominations at **5pm, Friday 23 February 2018.**

Five (5) Fellows Representatives Positions

Eligibility: All National AMA Fellows who reside in Victoria

Nominations: Nominations must be in writing, signed by the candidate, accompanied by a written expression of support by another National AMA Fellow who resides in Victoria and submitted to the Returning Officer by close of nominations at **5pm, Friday 23 February 2018**

Ballot: If required, a ballot will be conducted by post, concurrently with the Council Annual Ballot.

How to lodge nominations

Nominations for both Independent Member and Fellows Representative positions must be submitted to the Returning Officer:

By email: returningofficer@amavic.com.au
By fax: (03) 9280 8786 ("Attn: Returning Officer")
By post: Returning Officer, AMA Victoria, PO Box 21 Parkville, Victoria, 3052
In person: AMA Victoria, 293 Royal Parade, Parkville, Victoria, 3052

Any queries, including requests for nomination forms, should be directed to Rhys Davies on (03) 9280 8722 or returningofficer@amavic.com.au

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Members have access to career advice

AMA Victoria's Careers Advisory Service provides medically specific career management solutions. It assists members to achieve professional goals through active career coaching and supported transition. If you are thinking about utilising the service or want to know more about how it can help you, these are the recent stories of three members.

Case 1

A senior doctor who held a number of executive roles at a major hospital had reached the point where the work was just not enjoyable or rewarding anymore. After many years of being in a position of leadership, the prospect of transitioning back into a research or lead clinical role where their focus could be on clinical medicine and patients, instead of budgets and management issues became very appealing. They were also keen to take a sabbatical to explore some research opportunities and to travel.

While taking a sabbatical is an entitlement, this doctor was concerned about how an extended break would impact on the workload of their team. They had also been discouraged from taking a sabbatical by their workplace.

Our careers advisors initially sat down with the doctor to unpack all the issues, discuss how to transition from their current role to the next and to determine the steps they needed to take to achieve their goals.

Over several sessions we investigated what the blocks – real and perceived – were to taking a sabbatical and to transitioning workload. An important shift achieved in these sessions was the authorisation to ask and take the sabbatical they were entitled to – this was granted and taken. The doctor also felt confident about their decision-making process to transition their career and to articulate this to others, which led to a role in clinical leadership and research.

Case 2

Doctors tend to take their jobs very seriously and some struggle to manage the boundary between home and work as result. They may struggle to find an 'off' button, which can be draining. Always being 'on' creates pressure which can often become more pronounced as the demands of their personal lives increase.

One particular doctor was facing just this problem. While taking work very seriously, their inability to manage the boundary and switch off was impacting their personal life and was taking a toll on their general wellbeing. Subsequently, they started to question whether clinical medicine was right for them long-term.

AMA Victoria's career coaching service supported this doctor to clarify their thinking objectively and to assess what their options might be. We then explored what life beyond clinical medicine might look like and supported them in planning for this transition.

It was quite a lengthy process and we met many times over a 12-month period. Over that time we saw this doctor build confidence and clarity about their options and decision-making framework and reach a point where they became recharged, reenergised and ready to act. We then worked with them to redevelop the tools they needed to pursue alternate career pathways.

The doctor was successful in sourcing a non-clinical role as well as opportunities in research and is now on their way to realising their career aspirations in a new pathway.

Case 3

We had an overseas trained doctor come to us looking for assistance to increase their success in sourcing a supervised role in Australia. This international medical graduate (IMG) member had already approached the job market with full-force and had little success.

We sat down with them and quickly realised the problem was a common one shared by IMGs. Their presentation (both written and verbal) was simply not up to the standard expected by prospective employers. They also needed to revise their strategy and model of engagement with these prospective employers. There was lots of work to be done!

We worked with this doctor for more than 12 months on all of the areas we had identified which needed considerable work. After working very hard and taking on board all the advice we gave, the doctor came out of the process with two job offers. Both offers complied with the AHPRA supervision requirements.

This doctor is now commencing their Australian medical career in 2018 and is well positioned to be successful in their professional endeavours. They now recognise the importance of continuing to spend time developing their skills to support their successful transition into the Australian health system and beginning their role as an HMO.

To make a booking or to find out more about our Careers Advisory Service, please call (03) 9280 8722 between 9am – 5pm on Tuesday, Wednesday or Thursday, or email careersadvisor@amavic.com.au

Andrew Campbell
Membership Representative

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Mandy Anderson
CEO and Managing Director

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Philanthropy supporting personalised medicine for blood cancer patients

While the generosity of high net worth individuals in the United States of America has long been recognised as a source of significant capital for developing novel medical technologies and platforms, Australia has typically lagged behind in terms of the amount of philanthropic funds donated. However, in recent times, high net worth Australians are 'stepping up' and providing capital for research into diseases that have touched their lives in some way.

Christine and Bruce Wilson

Christine and Bruce Wilson are examples of those who have recently 'stepped up', making a very personal philanthropic pledge of $5.5 million, which will see an unprecedented number of Australian lymphoma patients having access to the latest genomic testing at the Peter MacCallum Cancer Centre, leading to more accurate diagnosis and better treatment choices.

Christine Wilson, who has been treated for lymphoma for 25 years, said her family felt moved to act after seeing many blood cancer patients not responding well to conventional treatment or relapsing much sooner than expected. "We were struck by how genetic testing can save lives, offer alternative treatments or improve quality of life, for a group of patients who are in dire need of other treatment options," Mrs Wilson said. "As a patient living with lymphoma, I have been fortunate enough to experience the benefits of leading, cutting-edge technology. My family and I hope that our support will make the Centre's ground-breaking work accessible to many affected Australians. We are also hoping this will inspire others to give generously towards making personalised medicine a standard of care for everyone with lymphoma and other blood cancers in the future."

The Christine and Bruce Wilson Centre for Lymphoma Genomics represents both Victoria's and Australia's ongoing global leadership in the emerging field of 'personalised medicine'. Its establishment will ensure the team at Peter MacCallum Cancer Centre can build on its leadership by expanding the repertoire of genetic testing to accommodate the needs of lymphoma patients more widely throughout Victoria and beyond.

Personalised medicine uses clinical genomics to test a patient's blood or tumour tissue to look for critical gene mutations known to play a role in cancer. If a mutation is found, the patient may be diverted to a targeted treatment – or enrolled in a clinical trial – to access drugs known to work more efficiently against cancers harbouring these specific mutations.

In order to obtain useful genetic information, many genes (typically 50-100) need to be tested simultaneously using a technique known as "Next Generation Sequencing". This new approach requires cutting-edge and highly specialised laboratory processes, instrumentation, computing power and analysis which is performed by experienced scientific and medical staff.

The Molecular Haematology Laboratory in the pathology department at Peter MacCallum Cancer Centre, led by Dr Piers Blombery, consists of a dedicated and innovative team of scientists, technicians and bioinformaticians providing world class diagnostic molecular testing for blood cancer patients. The generous support from the Wilsons will enable expansion of the existing genomic program as well as the development of new platforms to assess the gene expression profile of various lymphomas, create an inward and outward facing compendium of genomic information, and to explore the role of functional genomics in the diagnosis and treatment of blood cancers. In addition, the researchers will test tumour tissue from individuals against an array of potential targeted drug therapies to advance patient care.

When I co-founded the Snowdome Foundation in 2010, I knew there was an apparent gap in Australia that needed filling. To improve outcomes for Australians suffering from blood cancers, we needed to unlock new drugs and therapies by channelling philanthropic funding. Since its inception, the Snowdome Foundation has worked hard to raise awareness of blood cancers and raise vital funds to improve access to treatments. This hard work was recognised in 2016 when the Snowdome Foundation in collaboration with Maddie Riewoldt's Vision were awarded the inaugural National Telstra Business Award in the charity sector.

The launch of the Wilson Centre shows that acts of huge generosity can drive world-firsts. The leaps and bounds made possible by this new centre is what will make hope real for blood cancer patients. It will improve the way lymphoma is diagnosed, give patients better treatment choices and will immediately start saving lives.

In addition to this most generous donation, both the Peter MacCallum Cancer Centre and The University of Melbourne will commit additional resources to support broadening the scope of the Christine and Bruce Wilson Centre of Lymphoma Genomics by extending the concepts of complex genetic analysis to myeloid malignancies, such as acute myeloid leukaemia. The Snowdome Foundation's ultimate goal is to raise $10 million for the Christine and Bruce Wilson Centre for Lymphoma Genomics.

Prof Miles Prince
AM MBBS (HONS) MD, FRACP, FRCPA, AFRCMA, MACD, FAHMS
Snowdome Foundation Co-Founder

Protecting Victoria's forests is good for our health

Victoria's forests are simply extraordinary. They support our health in a variety of ways and there is currently a community call for a new Great Forest National Park in our Central Highlands. Despite this, State Government owned VicForests continues industrial clear fell logging. In addition to the push from environmentalists and scientists there is a strong argument for the protection of our remaining forests on health grounds.

Just over 90 minutes' drive from the centre of Melbourne are our magnificent Mountain Ash forests, home to the tallest flowering plants in the world and our faunal emblem, the tiny Leadbeater's possum. The tallest plant ever measured, the Ferguson tree, was found near Healesville in 1872 – this was a Mountain Ash and it was over 140m tall. Once over 150 years old, these trees form hollows in which some 40 species of animals, including the Leadbeater's possum, live. Mountain Ash trees can live up to 450 years.

In Victoria, we currently have 1886 hectares of old growth forest, which is less than 3% of the amount here prior to settlement. It is fragmented and spread across 147 different patches. The International Union for Conservation of Nature (IUCN) has assessed the state of our Victorian Central Highlands as 'critically endangered'. This is due to a long history of logging and bushfires which, because of climate change, are becoming more intense and frequent.

Our remaining wet, old growth forests are precious for their inherent value but also because they support human health. They protect our water catchments which is why Melbourne's water quality is consistently excellent. They also purify our air, removing pollutants including carbon dioxide for which they provide a giant carbon sink. These old growth forests store more carbon per hectare than any other forest studied in the world, including rainforests. According to the Lancet Climate Change Commission in 2009, "climate change is the biggest global health threat of the 21st century" and so, by drawing down CO2, these forests help to protect us from the health harms of climate change.

Importantly, over half of all medicines in use today have come from nature, and many exciting discoveries continue to come from ecosystems, including forests. For example, the milk of Tasmanian Devils has been found to contain compounds that may help fight antibiotic resistance.

Simply spending time in a forest has been found to have health benefits as blood pressure, cortisol levels and feelings of stress drop and activity levels of natural killer cells rise. For these reasons, in Japan, forests are protected and accredited for 'shinrin yoku' or 'forest bathing'. Physicians refer patients at high risk of stress related illness to certain forests for specified periods of time. Forest bathing involves walking very slowly through a forest, using all the senses and taking care to breathe deeply. It is thought that inhaling 'phytoncides', chemicals released by certain species of trees, is partly responsible for the physiological changes experienced by those spending time in the forest. It is likely that simply being away from the stresses of work, being in a quieter, less stimulating environment and breathing in the clean air of the forest are other factors.

Given that many of the health problems presenting to us in our consulting rooms relate to inactivity and stress, perhaps we could consider a similar approach here in Victoria. In Sante Fe, United States, cardiologists prescribe walking in nature as part of a treatment program for people with diabetes called 'Prescription Trails'. While in Washington DC, paediatrician Robert Zarr has developed a program called 'DC Park Prescription' to help his obese, inactive patients. This involved creating a software system which links into prescribing programs identifying the closest suitable park for families to spend regular time in. Given that over 25% of Australian children are either overweight or obese and most children are much less active than they should be, innovative ways of getting kids outside into nature are an important part of a preventative health strategy.

Pleasingly, in April, the Victorian Government released its 'Memorandum for Health and Nature' which states "the Victorian Government is committed to encouraging communities to interact more with nature, both in Victoria's parks and other open spaces, because being in nature is good for our health and is a highly cost effective health improvement strategy." It is encouraging to see the health and environment departments having this united focus on preventative health.

Despite this public statement of the value of green space and natural areas like forests, state sanctioned clear-fell logging continues apace in our remaining old growth forests and even in our water catchments. In East Gippsland's old growth Kuark Forest, logging has been suspended by legal action after citizen scientists found that VicForests was planning to log areas with trees some 500 years old. These trees should have been under special protection zones. It seems truly absurd that tax payers' money will be spent by the Government arguing not to protect this piece of Victoria's natural heritage and source of wellbeing.

As another busy year begins, it's important to be mindful of the need for opportunities for a break and restoration in between work. Consider a drive into our glorious forests for some forest bathing and see for yourself what all the fuss is about!

Dr Dimity Williams
Doctors for the Environment Australia

References available from the Editor on request.

Dimity Williams is a GP and the Biodiversity Convenor for Doctors for the Environment Australia. She is a co-founder of the Kids in Nature Network.

An introduction to the DiTs subdivision

DiTs subdivision President Dr James Lisik (left), with committee members Dr Jessica Dean, Dr Kunal Luthra and Dr Malcolm Forbes.

The AMA Victoria DiTs subdivision represents the interests of doctors in training in Victoria.

Who are DiTs?

A 'doctor in training' (DiT) is any doctor who has not yet completed a speciality training program. We range from interns in our first year of practice to highly experienced registrars. We come from a variety of backgrounds and vary in age. As a subdivision we enjoy a close relationship with our medical student colleagues and have a representative from the Medical Student Council of Victoria attend our monthly meetings.

What do we do?

We meet monthly to discuss issues relevant to DiTs including working conditions, public health and career development. A key focus for 2017 was the new enterprise bargaining agreement. Representatives from the DiT subdivision regularly attended negotiation meetings with AMA staff and hospital representatives to provide key insights of life as a DiT to these discussions.

We also work with AMA Victoria to run events for DiTs including social and educational events. Past ones include a DiT supper club and a welcome night for incoming interns.

Dr James Lisik currently chairs the DiTs subdivision and as part of this role represents the group on the national Committee of Doctors in Training (CDT). CDT is a Federal AMA body and is composed of all the DiTs subdivisions from across Australia. CDT represents DiTs on a national level and provides an opportunity for high-level advocacy on issues such as safe working hours and mental health.

How can you get involved?

First, by signing up as an AMA member! We love having new AMA members attend our meetings and getting involved in DiTs' projects. Meetings for the DiTs subdivision are held on the second Wednesday of every month at AMA House, 293 Royal Parade, Parkville. All junior doctors and medical students are welcome to attend. For more information, contact Grant Forsyth at GrantF@amavic.com.au

Dr Danielle Panaccio
Communications Officer
DiTs subdivision

Has property peaked or just lulled?

Economics is sometimes known as the dismal science. Not, as some might unkindly think, because of its practitioners' perceived deficiencies in understanding the economy, but rather the discipline's propensity to catastrophise.

While today's economists aren't as nihilist as the 19th century's Thomas Malthus – who believed population growth would inevitably lead to mass starvation – they can tend to be glass half-empty types.

For instance, we're now seeing a number of economists calling for interest rate rises, lest inflation rears its ugly head, despite scant evidence of price pressure in the economy and current interest rate settings that, if maintained, could see unemployment fall towards 5%. Despite years of modest growth and weak income growth, they are already calling time on our recovery from the GFC before it really gets going.

Now while economists may always feel it's their duty to be in the crow's nest, scanning the horizon for the next storm, investors can't live like that. To do so inevitably leads to excessive caution that delivers poor returns.

But resisting this pessimism is especially hard at the moment. We're in the midst of a parlour game called 'calling the top', where commentators vie to declare most emphatically that the property market has peaked despite it being far too soon to say.

Much of it, gratuitously, is coming from stock market analysts, with a distinct whiff of wishful glee that the property party might be over.

Others perhaps think their motivations are more pure but may be letting a high-minded desire for greater affordability, especially for first home buyers, distort their objectivity on whether the market is actually turning.

So let's have a reality check. In most capital cities, property prices went up in the quarter ending 30 November (Melbourne property prices rose 1.9%), while Sydney prices fell just 1.3%, according to CoreLogic. And this occurred in the second half of the year, a period when the market tends to slow. Moreover, it is likely that interest rates will remain steady in 2018, a highly supportive environment for property.

It's a sort of sport I suppose, but this dramatisation of current conditions from the dull reality of steady prices in most cities to a more exciting narrative of hastening decay is not without consequence.

There are plenty of retired people struggling today because they were warned off property – a pathway to security – by the self-righteous scribes of 20 and 30 years ago, despite most of those self-appointed sages owning property themselves.

Sure, the market will one day go through a downturn, which may last six months, a year or even two. But it hasn't yet. And regardless of the guessing game around the timing of this short-lived retreat, as future retirees we all should invest in property when we can afford to.

Prospective property investors have to face the world as it is rather than as they wish it to be. Reality is strong competition from a growing population for scarce housing resources and it isn't a temporary thing. So yes, the outcome is likely to be large mortgages and monthly repayments, but that's the least bad option. Following advice to stand aside from property will lead to disappointment – a truly dismal outcome.

Richard Wakelin
Director
Wakelin Property Advisory

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Richard Wakelin, Paul Nugent, directors

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ADVERTORIAL

Issues to consider when establishing a medical precinct

What is a medical precinct?

A medical precinct is the term given to the grouping of medical and allied health businesses in one physical location. Typically, these are anchored by a GP practice and include a pharmacy, pathology and dental practices. Other allied health businesses are quite often associated such as physiotherapy, radiology, psychologists, podiatrists, etc.

The grouping of such businesses together in one location has proven successful as it enables cross-referring and joint marketing as well as the economies of scale in overheads. Coinciding with the development of these precincts is the increase in the size of general practice medical centres. The success of the overall venture is quite often linked to the success of the GP practice and the volume of patients it can attract to the area.

Traditionally GP practices consisted of two to three consulting rooms and a treatment room requiring a floor area of 100m^2 to 120m^2. With the introduction of medical precincts taking shape it is common for GP practices to be established with a minimum of five to six consulting rooms, a treatment room and other facilities. The area required is closer to 250m^2.

Return on investment

Generally the owner of the commercial property will have a required return on investment – this income is generated by rental income from the various health providers in the precinct. The rent can vary for each of the tenants and generally relies on pathology and pharmacy tenants paying a higher rate than the GP practice. As the GP practice underpins the success of the precinct it has a lower rent expense to enhance this chance of success. The other tenants benefit from the patients being attracted to the precinct.

Oversupply in the market

As property developers build more shopping centres and community centres, the inclusion of a medical centre in the tenant mix has become almost an essential element leading to saturation in certain areas. With the increasing number of general practitioners in larger metropolitan areas there is increasing competition for patients. In order to ensure the medical precinct succeeds, careful financial management is required.

The combination of an increase in doctors and competition means that rather than buying into an older medical practice where the owners are looking to retire, some are joining newer practices or setting up new medical centres close to existing practices and recruiting doctors. The consequence for those looking to retire and sell their practices means the potential buyer pool is decreasing.

What next?

William Buck are medical industry experts, having worked with medical practices for years. We have experience in establishment of practices, financial modelling for practices and development of medical precincts. Should you wish to discuss any aspects of the above please contact Belinda Hudson of William Buck on (03) 9824 8555 or by email belinda.hudson@williambuck.com

Belinda Hudson

Director, Health Services

William Buck

William Buck

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Core (Stream 1)	Tue, 01 May
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Spine + SIGMD (Stream 1)	Mon, 25 Jun
Nervous System (Stream 1)	Tue, 26 Jun
Respiratory System (Stream 1)	Tue, 09 Jul
Cardiovascular (Stream 1)	Wed, 18 Jul
Urology (Stream 1)	Tue, 24 Jul
Visual System (Stream 1)	Tue, 31 Jul
ENT (Stream 1)	Tue, 28 Aug
Digestive (Stream 1)	Tue, 11 Sep
Dermatology (Stream 1)	Tue, 23 Oct
Haematology (Stream 1)	Tue, 20 Nov
Endocrinology (Stream 1)	Tue, 27 Nov

Registration opening soon. Visit iatvic.com.au or give us a call on (03) 9280 8722 for more information

*Stream 2 calendar will be published on the iatvic.com.au ASAP

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- **Urinary and Reproductive**
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- **Cardiovascular**

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To become an impairment assessor it is necessary to complete the requisite training in using the NSW Workers Compensation guidelines for the evaluation of permanent impairment which is run by AMA Victoria.

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A little taste of Japan

I've had Japan on my radar for a couple of years. So, when Qantas brought out a sale airfare to celebrate their direct flights from Melbourne to Narita I knew it was time to jump on board. With only one week, it was a bit daunting to think about what to see first. It's a small country size wise, but very diverse.

My first three nights were in Tokyo in the Shinjuku area, staying at the Citadines Shinjuku Tokyo. It was an easy 15 minute walk to the hub of Shinjuku with all the shopping, bars and restaurants. Wow what an eye opener! Great part of town, very lively, safe, clean, organised and busy! Melbourne is miniscule compared to Shinjuku. Highly recommended and when I come back to Tokyo I will be staying in Shinjuku again.

I booked a walking tour with Urban Adventures which started in Ginza. While it was written to sound exotic and a bit exciting to visit places that the average tourist doesn't go to, it left me rather disappointed. Our first stop was a Yakitori restaurant in the Yurakucho area of Ginza. While the alleyways were great to see, we were there a little too early in the morning, so it was like a ghost town with no atmosphere. Similarly, when we caught the Metro to our final stop at a Monjayaki restaurant in the Chuo-ku district, it was eerily quiet as well. The food here was very simple – pick your ingredients and then cook it yourself on the grill at the table.

From Shinkuju it's a bit of a walk or a couple of Metro stops to Shibuya. This is another fantastic place to visit. The latest fashion trends and artists have their wares here. The streets have music playing and advertisers spruiking the whole time. This is rumoured to be the busiest pedestrian crossing in the world! The tourists come to see the famous Shibuya crossing where there are lots of crosswalks which all swing into action as the traffic stops. It's exciting to watch and amazing to be a part of, especially as the crowds build. Starbucks has a great view of the street from the second floor.

My favourite meal of my time in Japan would have to be at Genki Sushi, Shibuya. It's the coolest sushi train I have ever been to! You sit at an allocated seat where you have a screen to order everything. When you have placed your order, the food comes directly to your station stop. There are 2 tracks, so the plates of food never smash into each other and as the restaurant gets busier, the number of items whizzing past you is fantastic to watch! It also gives you an idea of what you might like to order next if the menu is too much to handle. Once you have finished, you check out on your screen, hand back your electronic seat number that you got when you came in and pay at the cashier. Loved the whole experience, plus the food was truly outstanding!! Unfortunately, it was the only one I saw during my time in Tokyo.

Kyoto is also probably on most itineraries for Japan. It has a lot to offer in itself and is a great jumping point for Nara and Osaka if you're pushed for time. I stayed at the Dormy Inn Premium Kyoto Ekimae Natural Hot Spring. The location is close to the train station, but my intrigue was with the hot springs on their top floor. Unfortunately, you do need to bathe in the nude so I decided to give it a miss!

A day trip from Kyoto was spent visiting Nara and then Osaka. Nara has a deer park which is quite lovely. You can only feed the deer biscuits you buy there. Then it's good luck to you while the deer hunt you down until you have no more food! Some of those antlers can be quite scary to handle, especially when they're pulling at your bag and clothes to get to the biscuits. It's an easy 30 minute walk from the train station and a great way to spend the morning. In the afternoon, we moved onto Osaka. Wow – what a difference to Tokyo. For starters there are people eating, drinking and smoking while walking in the street. This is a big no-no in Tokyo. Secondly, they stand to their right on the escalators – opposite to Tokyo again. So, why come to Osaka? Well, it is the home of the Okonomyaki for starters! Also, well known for its octopus balls – yes read correctly. Both can be sampled at the canal area called Dotombori. This area comes alive as the sun goes down. Queues form where the best octopus balls can be found. They are delicious! The shopping street leading down to the canal is also spectacular – Shinsaibashi-suji. It goes for blocks and blocks and is all under cover – it was really lively and full of all sorts of shopping.

My final night back in Tokyo was in the Ginza district. I stayed at the Daiwa Roynet Hotel. Great location and a beautiful hotel. They have an amazing massage chair in each room which is worth checking out! Ginza for shopping is probably over budget for the average traveller. My guide on the walking tour said it's now more expensive than 5th Ave New York. The latest department store which opened in April 2017 is Ginza 6. It's massive – 14 storeys to be exact. My highlights would have to be the library with the bonsai trees, the beautiful art display in the foyer and the incredible dining options in the basement food court. Oh, it also has a roof top garden if you need some fresh air!

I travelled by Rail Pass for most of my trip. Very easy to use and extremely efficient. Great value for money too.

I really enjoyed Japan. I will definitely be back to sample some more before too long.

Lydia Ozich
Senior Consultant
Reho Travel

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But how it makes you feel is altogether something else. Prepare to push the limits of what you thought possible in a supercar.

Iconic design

The contours of the 720S are distinctly McLaren, yet the details are boldly different. Taking a breathtaking new design direction, the smooth flow of the exterior lines cleverly manipulates onrushing air to reduce drag and cool the engine. Slim pillars on the teardrop-shaped cabin allow for the extraordinary glass canopy that floods the interior with daylight and offers unrivalled visibility.

The majestic opening of the doors is one of the most alluring design features of the 720S. Like a geometric work of art, the twin-hinged dihedral doors sweep forwards and up, to make entering and exiting effortless and elegant.

Outstanding style

From the welcoming smell of superior leather to the tantalising touch of aluminium switchgear, McLaren's most luxurious cabin to date captivates the senses. One of the most sumptuous leathers in the world extends from the electronically operated and heated seats to the dashboard, headlining and rear luggage area.

Controls are carefully angled and positioned for easy reach with minimum distraction. It's an interior crafted around the driver, allowing you to commit to an exhilarating drive.

Excellence in innovation

An innovation of the technology first seen in the McLaren P1™ hypercar, the MonoCage II is a one-piece carbon fibre tub that now includes the roof. Unique to the 720S supercar, this high-strength, low-weight passenger cell provides unrivalled rigidity, resulting in thrilling driving dynamics and exceptional protection for you and your passenger.

Powerful performance

Blisteringly fast power is instantaneous and seemingly endless. Lighter, faster and even more dynamically capable than the McLaren 650S it replaces, the new 720S is powered by a 4.0-litre V8 twin-turbocharged engine that produces 720 horsepower. The result is astonishing, with acceleration from 0-200km/h in 7.8 seconds.

Always ready to give more, it devours road and track. Combined with the world's most advanced suspension system, the 720S gives you the ultimate balance of power with control.

The new 720S personifies the blend of extreme performance, crafted luxury and unparalleled driver involvement.

For more information please visit www.melbourne.mclaren.com.

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ZAGAME

Classifieds

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

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

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

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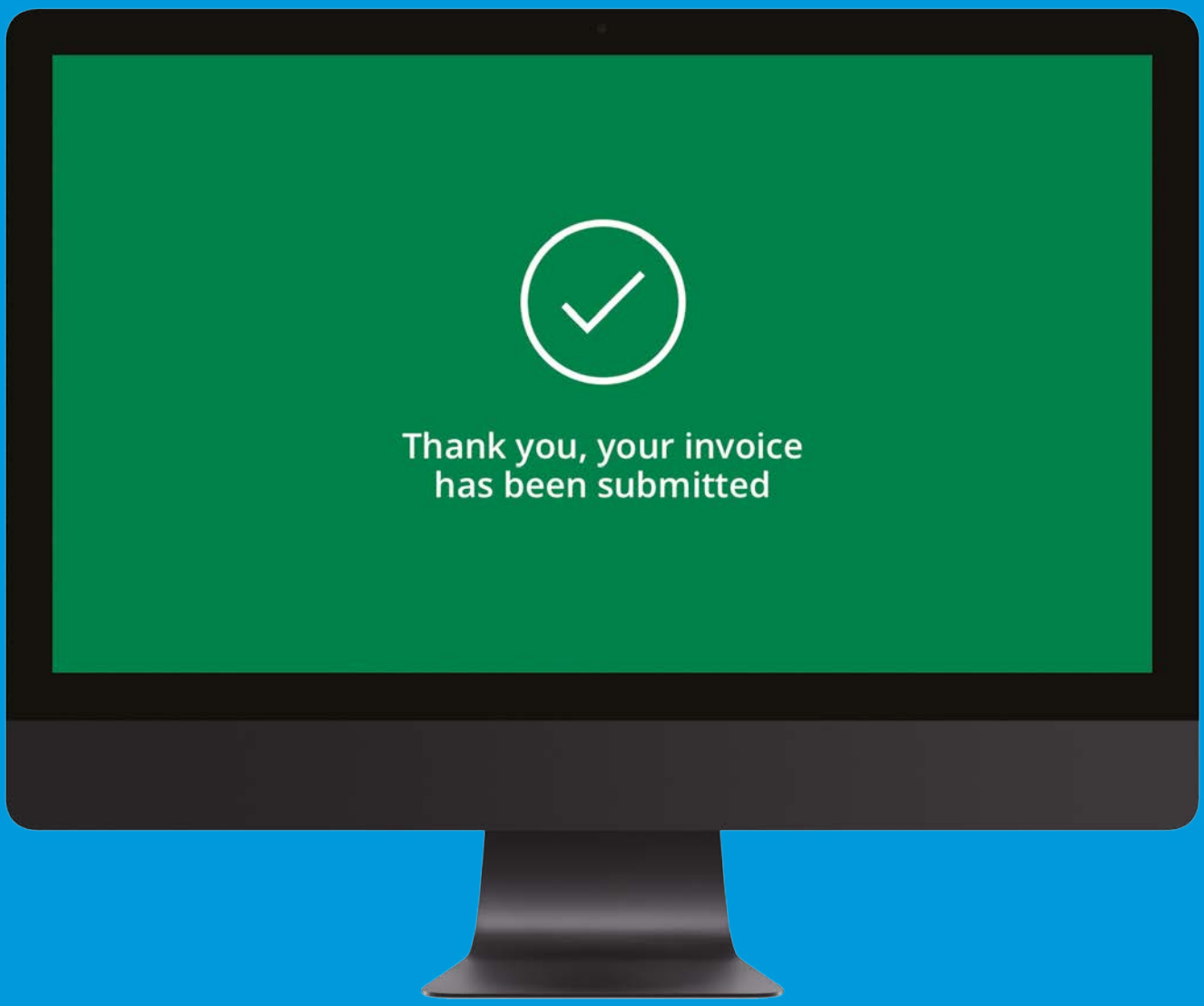

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