



vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION (VICTORIA) LIMITED MARCH 2016

OUTDOOR SMOKING LAWS

OVERDOSE PREVENTION

THE RISE OF FOOD ALLERGIES

PRIMARY HEALTH NETWORKS



Melbourne Park Function Centre
Saturday 30 April 2016
9.00am–2.45pm

Melbourne Park Function Centre
Saturday 30 April 2016

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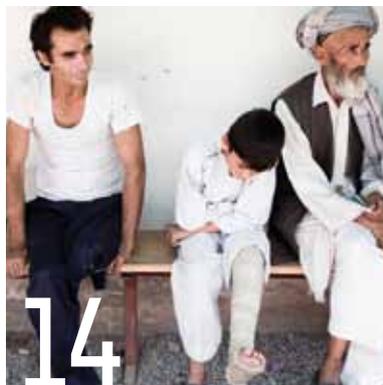
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Time to ban smoking in restaurants' outdoor dining and drinking areas

In my role as President, I undertake an enormous amount of media interviews. We have come out strong on the importance of immunisation, the need for better community mental health services, the need for more hospital beds, and of course Medicare funding. These (and many more) are serious issues that affect the community that the AMA indeed needs to be speaking out about.

However, not all media interview topics are of equal importance, in my view. We are often at the mercy of what is considered “newsworthy”. If you had asked me two years ago if I would field interviews on topics such as laser hair removal and peptides... well, safe to say I wouldn't have seen them arising.

One topic last year created enormous debate and not all in line with our position. When speaking out against cage fighting, citing the realities of brain injuries, the AMA was labelled as pushing for a “nanny state”. The nanny state rebuke has been used so much that there is now a Senate Inquiry into whether Australia has entered into such a mode. Leading this Inquiry into ‘Personal Choice and Community Impacts’ was DLP Senator David Leyonhjelm, who was reported by the ABC as saying:

“What I want to do is go back to the way Australians used to be... I want to change this culture that the Government is there to protect us from poor choices... Here we're a bunch of anal-retentives... The argument (against pool fences) is parents are responsible for their children and the Government is taking that responsibility away from them.”

In medicine, few would wish to see society go back to the way Australia used to be (perhaps with the exception of obesity!). Tobacco regulations, taxes on alcohol, bicycle helmets, seatbelts, farm safety, work safety, sunscreen, fluoride, immunisation, speeding, child-proof medication bottles, water safety – we know a lot more and we push to make society safer, less damaged by disease and accident.

In the coming month tobacco laws are back on the agenda and I am sure I will again be called a nanny state supporter. AMA Victoria has long called for smoking in outdoor dining areas to be banned. This refers to restaurants, bars and cafes' street seating, beer gardens, rooftops, balconies and courtyards where patrons are served food and drinks, and smokers smoke. The issue clearly is why must any Victorian be forced to inhale cancer causing, toxic, second-hand smoke?

The Victorian Government committed to introducing a smoking ban in outdoor dining areas by August 2017 – but our fear is that it will be full of exemptions, in particular, an exemption if there is no food being served in that area. The Victorian Government is considering two models on smoking bans. The Queensland model and the New South Wales model.

The Queensland model

Comprehensive outdoor smoke-free laws have been the norm in Queensland for a decade. Outdoor areas of cafes and

restaurants are smoke-free at all times. Smoking is allowed in designated outdoor areas of pubs and clubs, while ensuring there is still somewhere to eat and drink outdoors that is smoke-free. No food or drinks are served in the designated outdoor smoking area, to protect the health of hospitality workers, and the designated outdoor area is separated from the rest of the outdoor space.

The NSW model

Smoke-free laws covering only outdoor dining areas were introduced in July 2015, and are causing widespread confusion. This approach means the Government needs to define ‘dining’. For example, does a packet of chips count as dining? A smoothie? A biscuit with your coffee? The laws have created an enforcement nightmare for hospitality staff. In some cases, venues are deciding to stop serving food outside altogether and devote their outdoor area to drinking and smoking.

AMA Victoria is working with the Cancer Council and Quit in a joint effort to lobby the Government to introduce the Queensland model, and I encourage you to support this petition: www.cancervic.org.au/smokefree

With tobacco reform, it is likely that I will be called a nanny state doctor again – but as someone who thoroughly enjoys al fresco dining, I look forward to a meal without the bloody cigarette smoke.



Dr Tony Bartone
President
AMA Victoria

Complaints processes under review

On 2 February 2016, the Senate initiated a review of Australia's medical complaints process. Essentially, the Senate Inquiry is looking at AHPRA, the Medical Board, and their complaints handling processes, and bullying and harassment within the medical profession.

AMA Victoria will be making a submission to this Inquiry, and we know that many members have been disappointed (to say the least) with their own personal experiences with AHPRA.

We are seeking feedback from members to help inform our response, and I encourage all members who have been involved with complaints processes to let us know what areas need to be improved.

The Senate Inquiry's terms of reference are:

- a) the prevalence of bullying and harassment in Australia's medical profession;
- b) any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;
- c) the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;
- d) the operation of the *Health Practitioners Regulation National Law Act 2009* (the National Law), particularly as it relates to the complaints handling process;
- e) whether the National Registration and Accreditation Scheme, established under the National Law, results in better health outcomes for patients, and supports a world-class standard of medical care in Australia;
- f) the benefits of 'benchmarking' complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;
- g) the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith; and
- h) any related matters.

AMA Victoria has taken the lead on addressing bullying and harassment within the medical profession, and we will detail the findings from the AMA Summit, and a strategy forward, in the next edition of *vicdoc*. You will also be emailed these outcomes. Last year, we made two submissions on bullying, discrimination and harassment within the profession – to the RACS' Inquiry and to the Victorian Auditor-General's review.

AMA Victoria will continue to be vocal on this issue and work to improve the processes that are failing many doctors. To provide input to this inquiry, please contact our Policy Unit KatherineW@amavic.com.au / (03) 9280 8722. Alternatively, you may wish to speak to our Workplace Relations team.

This edition of *vicdoc* has a range of articles that we hope are of interest to members, including:

- the role of naloxone in general practice;
- news from the Walter and Eliza Hall and Murdoch Childrens Research Institutes on allergy and autoimmune disorders;
- advice to members who received lapsed treatment letters from WorkSafe; and
- the planned new laws to introduce a Health Complaints Commissioner (an expansion of the current Health Services Commissioner's powers).

Members may recall that last year AMA Victoria responded to the review of the Health Services Commissioner's powers, with a number of members concerned that unregistered practitioners were beyond the scope of the Health Services Commissioner. In part, this review was necessary as over the last decade, there has been a significant increase in the number of unregistered 'health' practitioners using medical equipment (e.g. lasers) or recommending health remedies (e.g. disease cures, weight loss, pain relief). These unregistered practitioners are outside the scope of the Office of the Health Services Commissioner and therefore AMA Victoria supports an amendment to the 'health service' definition.

In our submission to this review, AMA Victoria recommended expanding the definition of 'health service', when related to the powers of the Health Services Commissioner, to include "services provided by an individual, business or organisation that intends or claims (expressly or otherwise) to change the human body (physical appearance, physiological functioning, psychological and mental outlook)." We will work with authorities to address this current loophole. See page 17 for a related announcement from the Victorian Government.



Frances Mirabelli
CEO
AMA Victoria



Opioid overdose prevention: the role of naloxone in general practice

In 2015 the Coroners Court of Victoria released data about deaths relating to overdose in 2014.¹ As part of our campaign around International Overdose Awareness Day, Penington Institute highlighted that once again the number of deaths from overdose in Victoria was greater than the state's road toll.

The number of Victorians who died from overdose in 2014 was 384² compared with 249³ on Victorian roads. Of the 384 overdoses, 315 involved pharmaceutical drugs. Of the 154 fatal overdoses involving illegal drugs in 2014, 135 involved heroin. Pharmaceutical opioids were involved in 186 overdose deaths. There is significant evidence of the involvement of combinations of alcohol and other drugs in overdose (see diagram below).

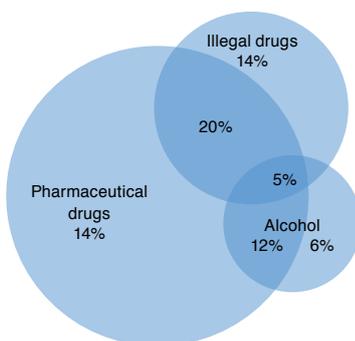


Diagram 1: The pharmaceutical-illegal-alcohol nexus in overdose deaths in Victoria 2009-2014.⁴

Opioid overdoses are rarely instantaneous. Most commonly, people will slowly stop breathing, minutes to hours after taking the drug/s. This means that in most cases there is time to intervene between the start of an overdose and the point at which a person would die. Even if a person were to stop breathing immediately, an appropriate response with naloxone could reverse the overdose and keep the person breathing and alive.

The availability and use of naloxone mini-jets has been shown to reduce the incidence of fatal opioid overdose. These mini-jets can be administered by an observer who has been trained in their use. Penington Institute encourages the prescribing of naloxone mini-jets by general practitioners who have patients under their care who are considered to be at high risk of opioid overdose. Naloxone is available on the Pharmaceutical Benefits Scheme (PBS) (schedule 4) for prescription as a take home medication for patients identified to be at high risk of opioid overdose.

As of 1 February 2016 naloxone is also available on the PBS at pharmacies as pharmacist only medication (schedule 3). One of the reasons for this additional scheduling was stated to be that, "International experience and the outcomes of a trial conducted in the Australian Capital Territory support the

view that easier availability of naloxone is likely to decrease the proportion of opioid overdoses which result in death."⁵

It is very important to note that there is no evidence that the availability of naloxone results in increased drug use. "A growing body of evidence suggests that provision of naloxone does not encourage opiate users to increase their drug consumption."⁶

Several studies⁷ report that in 60% of fatal opioid overdoses, someone else was present, indicating the importance of access to naloxone and training about the medication for lay people. We advise calling an ambulance immediately, and before the administration of naloxone by a lay friend or family member as part of their response plan.

Naloxone is indicated in overdose situations involving illicit opioid drugs such as heroin, and pharmaceutical opioids including methadone, codeine, oxycodone (e.g. OxyContin[®]), fentanyl and pharmaceutical morphine (e.g. MS Contin[®]).

For a detailed response plan for opioid overdose see the COPE Australia⁸ fact sheet at: copeaustralia.com.au/wp-content/uploads/FactSheet_OpioidOverdoseResponsePlan.pdf

GPs are in a prime position to identify individuals who are at high risk. GPs have

“GPs HAVE A VITAL ROLE TO PLAY IN EMBEDDING NALOXONE AS A STANDARD OVERDOSE PREVENTION TOOL BY PRESCRIBING NALOXONE TO INDIVIDUALS AT HIGH RISK.”

a vital role to play in embedding naloxone as a standard overdose prevention tool by prescribing naloxone to individuals at high risk. Penington Institute, with the support of the Stepping Up Consortium, has developed two videos which you can use to help educate your patients about naloxone: penington.org.au/overdose-prevention-resources/

Penington Institute is actively encouraging GPs to routinely screen patients to identify those who are at high risk of opioid overdose. We recommend that routine screening for overdose risk be incorporated into care planning for individuals being prescribed opioids for conditions such as chronic pain and those on opioid pharmacotherapies. We also recommend that patients at risk be educated about recognising and responding to opioid overdose.

Patients who may be considered as at high risk for opioid overdose include those who:

- have had recent medical care for opioid poisoning/intoxication/overdose;
- have a suspected or confirmed history of heroin or non-medical opioid use;
- are at high risk for overdose because of a legitimate medical need for analgesia,

coupled with a suspected or confirmed history of substance abuse, dependence or non-medical use of prescription or illicit opioids;

- are being prescribed high doses of opioids for example for long-term management of chronic malignant or non-malignant pain (≥ 100 mg/day morphine equivalence);
- have recently been released from prison and have a history of opioid use;
- have recently been discharged from drug withdrawal or rehabilitation program;
- are being inducted onto a methadone or buprenorphine maintenance program (for addiction or pain); and
- are on any opioid prescription and have known or suspected:
 - smoking history, chronic obstructive pulmonary disease (COPD), emphysema, asthma, sleep apnoea or other respiratory system disease;
 - renal or hepatic disease;
 - alcohol use;

- concurrent benzodiazepine use; and/or
- concurrent antidepressant prescription.⁹

With appropriate education, patients on long-term opioid therapy and others at high risk of opioid overdose may benefit from having naloxone in the event of an overdose. All individuals identified at high risk should be made aware of naloxone availability and use, and offered the option of receiving a naloxone prescription.



John Ryan
CEO
Penington Institute

Penington Institute is a Melbourne-based drug research and education organisation. Penington Institute's mission is "to actively support the adoption of approaches to drug use that promote safety and human dignity". It does so through: thought leadership, community education, health worker training, research, and policy formation. John Ryan (BA, LLB) is an internationally-recognised expert in public health and safety approaches to drug use.

Note: Penington Institute received an educational grant from UCB, the manufacturers of naloxone mini-jets. The funds were used to make the copeaustralia.com.au website more accessible from smartphones.



1 'Pharmaceutical drugs in fatal overdose: A coroner's perspective' presented at the International Medicine in Addiction Conference, 21 March 2015 by Magistrate Audrey Jamieson, Coroner, Coroners Court of Victoria. coronerscourt.vic.gov.au/resources/b26dd3d9-4aed-4a48-9fc7-cc3503a9a238/coroners+prevention+unit++pharmaceutical+drugs+in+fatal+overdose++17march2015.pdf

2 ibid

3 Transport Accident Commission website tac.vic.gov.au/road-safety/statistics/road-toll-annual

4 Adapted from Jamieson op cit. p.3.

5 Therapeutic Goods Administration (TGA) website tga.gov.au/part-final-decisions-matters-referred-expert-advisory-committee-11-14

6 Bazazi AR, Zaller ND, Fu JJ, Rich JD. Preventing Opiate Overdose Deaths: Examining Objections to Take-Home Naloxone. *Journal of health care for the poor and underserved*. 2010;21(4):1108-1113. doi:10.1353/hpu.2010.0935.

7 Darke & Zador, 1996; Loxley & Davidson, 1998; McGregor et al., 1998 as quoted in Lenton, S. 'Making Naloxone available to potential overdose witnesses: evidence and policy opportunities' atoda.org.au/wp-content/uploads/Making-Naloxone-available-to-potential-overdose-witnesses.pdf

8 COPE Australia is a program of Penington Institute.

9 'Opioid overdose information for health professionals', COPE Australia (a program of Penington Institute) copeaustralia.com.au/wp-content/uploads/Info-for-health-professionals.pdf

What is driving the increase in allergic and autoimmune disorders?

Food allergies have increased to the point where one in 10 babies in Victoria – and around Australia – develop food allergy during their first year of life.

This has been paralleled by a rise in the incidence of immune and inflammatory allergic and autoimmune disorders more generally, including eczema, asthma, type 1 diabetes, multiple sclerosis and inflammatory bowel disease. This phenomenon can only be due to environmental factors acting on our genes, as the genes themselves haven't changed during this relatively short time frame.

How the environment impacts on genes (epigenetic modifications) to alter immune development during early life is likely to be the key. It is critical to look at pregnancy and early life to understand why immune and inflammatory disorders such as allergies have increased in childhood and later.

Understanding food allergies

In Australia, hospital presentations due to food allergy have increased three-fold over recent decades. Most of this increase has been among children under five years of age.

Food allergy is common, has an early onset and can be clearly defined, making it an ideal candidate to begin research that uncovers the link between the environment and genes during pregnancy and early life.

Recently, in *Science Translational Medicine*, we reported that babies born with activated immune cells called monocytes were more likely to develop an allergy to milk, eggs, peanuts, wheat or other

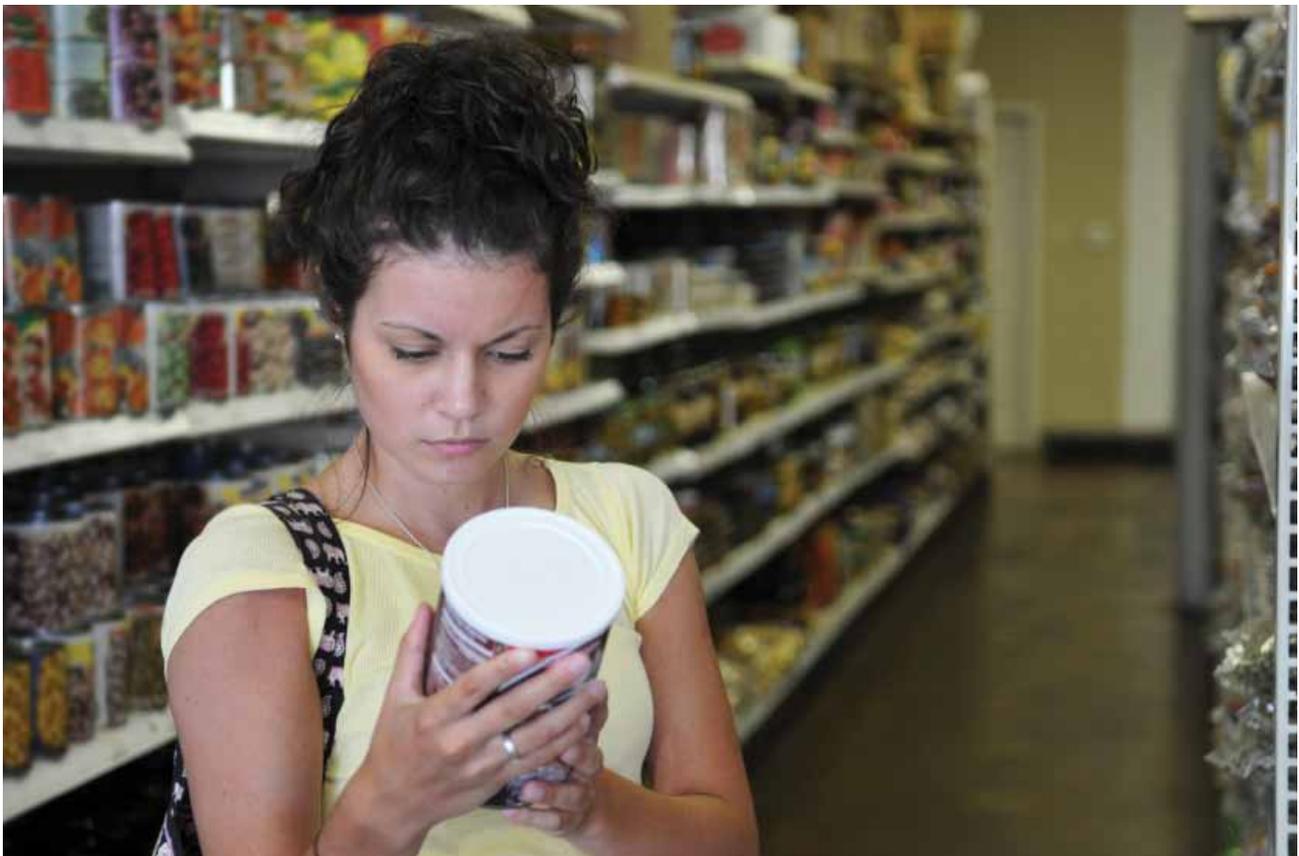
common foods in the first year of life. In essence, these babies have immune systems that are 'primed' for allergy by the time they are born. This finding could lead to new approaches to decrease the risk of food allergies in babies and infants.

Using blood collected at birth from the umbilical cord, we captured a 'snapshot' of the baby's immune system at the time of birth. Monocytes that had been stimulated either before or during birth were a 'signature' of high risk for food allergy in the baby.

Immune origins of disease

As part of our food allergy study, we went on to show that hyperactive monocytes changed the 'landscape' of the immune response more generally. Monocytes are the front-line troops of the immune system, the 'foot soldiers' that react first to dangers such as an infection or other types of immune stress. They produce messenger proteins called cytokines that shape how other more specialised immune cells called lymphocytes (T cells and B cells) will develop.

In our study, we showed that cytokines made by the hyperactive monocytes drove T cells to adopt the characteristics that we know are responsible for causing allergic reactions. Our challenge now is to determine why these babies have hyperactive monocytes in the first place. Are the immune cells inherently activated because of the baby's genes or do they become activated at the time of birth or earlier in pregnancy in response to the environment? Genes may contribute but are unlikely to be the major factor because the rising





incidence of allergies can only be explained by changes in the environment.

The contemporary environment differs in many ways from that of our grandparents: the quantity and quality of food we eat (more calories, more saturated fat and refined carbohydrate, less fibre, less micronutrients); the presence of additives (preservatives, emulsifiers, antibiotics); the amount of physical exercise and exposure to sunlight and rural life; use of medications including antibiotics; delivery via caesarean section; and many others.

We know already that food allergies are less common in kids brought up on farms and in families with pets. In particular, maternal exposure to livestock during pregnancy, has been associated with a reduced risk of allergic disease.

The microbes within

The missing link between environment, genes and changes in the immune system of the baby – particularly during, or even before, pregnancy – is intriguing. We are particularly interested in how the environment changes the microbiome, the collection of bacteria and other microorganisms that we all carry in our gut

and elsewhere. Changes in the composition of the microbiome, reduced diversity and altered production of metabolites such as short chain fatty acids, have been associated with an increased risk of allergies and other inflammatory and immune disorders.

The mother's microbiome may have an effect on the baby before birth, and certainly at birth. When a baby is born, he or she becomes 'colonised' initially by the mother's microbiome. The baby must be 'colonised' properly at this time, in order for their immune system to develop normally.

While there are many unanswered questions about allergies and immune disorders, it's becoming increasingly apparent that lifestyle changes may hold the key to prevention, at least in some cases.

Pregnancy, birth and beyond

Understanding the immune origins of allergy was one of the drivers behind the Barwon Infant Study (BIS). The study, which began more than seven years ago, includes more than 1000 babies and their mothers from the Barwon region of Victoria, and is a joint collaboration

between Barwon Health, Deakin University, the Murdoch Childrens Research Institute and, recently, the Walter and Eliza Hall Institute of Medical Research.

We have followed mothers during their pregnancy and their infants from birth to look at the environmental and genetic factors that influence immunity and allergy, and heart, lung and brain development.

However BIS is not the only study we are undertaking to examine the link between early life exposures and immune disorders. In 2015, we launched in Australia the world's first study to follow babies before and after they are born to understand how environmental factors interact with genes to increase the baby's risk of developing type 1 diabetes.

The Environmental Determinants of Islet Autoimmunity (ENDIA) study (endia.org.au), a unique collaboration between hospitals, universities and medical research institutes across Australia, is recruiting 1400 women from early pregnancy and their babies to three years of age to understand how the environment promotes the development of type 1 diabetes. The babies have a close relative with type 1 diabetes.

This ambitious program, initially supported by the National Health and Medical Research Council, has been boosted by an \$8 million investment from The Leona M. and Harry B. Helmsley Charitable Trust (US), and JDRF Australia (Juvenile Diabetes Research Foundation).

Our goal is to understand why the incidence of inflammatory and immune disorders is rising, so we can design intervention strategies, including changes to environment and lifestyle, which will prevent babies from being born with an increased risk of developing allergy and autoimmune disease.



Professor Len Harrison
Clinician-scientist
Walter and Eliza Hall
Institute and The Royal
Melbourne Hospital



Associate Professor Peter Vuillermin
Paediatrician
Deakin University, Barwon
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Workplace Relations update

AMA Victoria's Workplace Relations Unit has continued to provide member service over the summer months, with the volume of interactions being unaffected by the holiday period. The following is a recent 'snap shot' of the AMA providing representation and advice to our members:

Intern orientations

At the invitation of health services, we have had the opportunity to present to essentially all 2016 Interns. Our presentation included:

- The AMA's role as a national institution and lobbyist (using examples: co-payment reversal, medical education tax-deductibility cap reversal, MBS review advocacy, Commonwealth health funding reduction implications, and pressure on the training model quality and career path because of medical school intake increase);
- The nature of employment and our role in enterprise bargaining. Discussion included: history of entitlement advancement, interaction between contract and AMA agreements, the responsibilities of leaders and bullying and harassment; and
- The nature of non-clinical risk using three case studies to show the important role of the AMA's workplace services to protect members.

Bullying

- We have influenced the terms of reference for a health service's review into bullying and harassment, following some media attention about its alleged workplace behaviours. We will continue to be engaged as a primary stakeholder.
- We have successfully conducted mediation between a senior consultant and head nurse to resolve interpersonal tension through giving expression to each person's perceptions and by coaching alternative behaviours.
- On three separate occasions we have represented senior consultants confronting multiple allegations of bullying towards nursing or junior staff. On occasion, after our advice, the member's presentation of events changes from their original understanding, which can reduce risk when answering allegations. Their articulation of mitigation, insight, remediation and remorse, where appropriate, can influence a lower level disciplinary outcome.

Disputes

- We have begun negotiations to settle a \$250,000 underpayment of wages claim on behalf of two consultants. We allege their contract rate does not meet the minimum required under our statewide agreement.
- We are representing a medium size GP practice in response to an adverse action claim lodged in the federal tribunal by a former employee. It has been alleged termination occurred for a prohibited reason (absence due to short term illness). Our defence is that the ongoing conduct of the employee had caused substantial business loss and that there is no legal jurisdiction available to the applicant.
- On behalf of public health specialist members employed by the Department of Health and Human Services (DHHS), we have acted as bargaining agent (under the *Fair Work Act*

(*Cth*) 2009) to negotiate within the current Community and Public Sector Union enterprise bargaining round. We worked with members to develop an evidence-based claim agenda and held multiple face to face negotiations with the DHHS and Industrial Relations Victoria.

- We are developing strategy for a unit to resist substantial workplace change. The changes are not yet declared, although members know informally there has been a decision to implement the outcomes of a review. As consultation has not occurred under the AMA Senior Medical Staff agreement, this is a clear actionable breach of the agreement, which provides leverage to have our members' voice heard to improve outcomes.

For any issues relating to your employment, professional relationships, registrations or Learned College, contact AMA Victoria as your first point adviser on (03) 9280 8722.



Andrew Lewis
Senior Industrial Relations Adviser

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Dealing with lapsed treatment letters from WorkSafe?

Have you ever received a lapsed treatment letter from a WorkSafe agent? If so, how do you respond?

Often this is a reasonable request from an insurer involving a degree of complexity in a particular case. However we also receive feedback about pro forma responses from insurers who do not take the time to understand the injury or treatment regime. In this instance it can be helpful to supply the information without costing the patient, scheme or the practice great expense.

To assist with this goal, a member has constructed a pro forma letter, which may be of use to others. While we will always advocate for less red tape, it can be helpful in the interim for practices to have a response prepared so as to not hold up a claim.

The draft is self-explanatory but provides useful information to the insurer. It can be used when the request is obviously a simple matter, where the information should already be available from the file.

This pro forma is provided for your use.

If you need assistance with a WorkSafe issue, please contact the AMA Workplace Relations Unit on (03) 9280 8722.



Geoff O'Kearney
Director, Workplace Relations

Dear

The lapse in treatment you have identified in relation to the above patient has been caused by one or more of the following events occurring:

1. The patient has attended for treatment but the accounts have not been sent to you or your firm.
2. The patient has not attended for treatment due to being unable to attend.
3. The patient has elected to manage their medical problem without medical intervention.
4. The patient has been using alternative practitioners and methods to manage their ongoing medical problem.

In answer to your questions:

- A The treatment is directly related to the patients accepted work place injury claim or you would not have received the account.
- B The treatment initiated will cease when there has been a satisfactory outcome or the patient no longer needs to continue with the instigated treatment.

Please rest assured that this consultation was attended in relation to their ongoing and chronic qualifying medical problem or you would not have received the account. A gap in treatment does not imply recovery. If a consultation was required to formulate the above answers then an account will be raised.

Yours sincerely

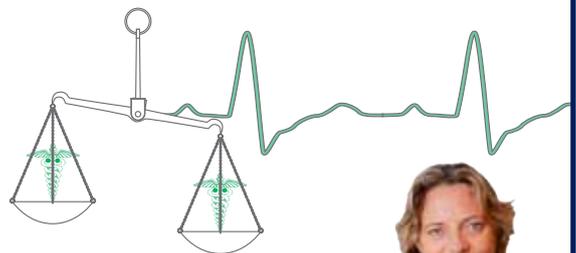
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Behind the front line

Dr Theresa (Terri) Bidwell is Fellowship trained in Paediatric Orthopaedics, children's hand surgery and trauma. She has been practising at Auckland's Starship Hospital since 2006. In August last year she went on her first field assignment with the international medical aid organisation Médecins Sans Frontières (MSF) to Afghanistan.

Why did you decide to work with an international medical aid organisation?

Before being able to work for MSF, I was a donor as part of their 'Field Partner' scheme. The monthly newsletters made me even more aware of the great work this medical aid organisation was doing all over the world.

There were a number of things that set MSF apart for me as a doctor and surgeon. MSF is mandated to provide aid in the form of emergency medical care. It doesn't do other types of aid or development work so it can focus its considerable resources on doing what it does well. MSF is independent, impartial and neutral, which means it will treat people in need even without sanction from governments and truly operates in a 'borderless' way.

Where did you go and what was your role?

I went to Kunduz in northern Afghanistan and worked at the MSF hospital there called the Kunduz Trauma Centre (KTC) in the role of Orthopaedic Surgeon. 99% of the caseload was trauma. This was made up of violent trauma (bomb blasts and gunshot wounds, most of which were conflict related), and road traffic collisions, which caused many severe injuries and falls. The hospital treated patients from all sides of the conflict and provided trauma care to the local population. My role included advising and assisting

the national surgeons, operating on acute trauma and performing internal fixations. I also did inpatient ward rounds and outpatient consultations, just as you do in any hospital.

What does it take to go into the field and do this work?

In this line of work, preparation is the key! This means understanding the context you will be working in and what you will be expected to do. You need to anticipate likely challenges well in advance and have a flexible strategy to deal with them. I prepared myself for the clinical work by doing the STAE (Surgical Training for Austere Environments) course at the Royal College of Surgeons in London and by making sure I was familiar with all the amputation procedures. I had a plan for communicating with OT staff who might have had a limited grasp of English and a general plan for how I was going to manage working collaboratively with the national surgeons. You are also expected to 'leave knowledge behind' so some plans for teaching need to be organised. Being aware of the cultural rules and protocols ahead of time is also important.

What impacted you most?

We were treating people from all sides of the conflict as well as civilians injured in the crossfire. Sometimes soldiers from both sides



MSF trauma centre in Kunduz, Afghanistan. Copyright: MSF



Najibullah (left), a father of 11 children, had his left leg amputated after an injury. On July 4, 2013, he was working at a construction site when a fire broke out nearby in the Chardara district of Kunduz Province. Trying to escape, Najibullah was shot in the leg. The road was closed by police and his relatives had to keep him at home while he was losing blood until the fighting stopped the next morning. He arrived at the Kunduz Trauma Centre (KTC) in a critical condition. The security situation is often a fatal barrier for people seeking medical care in Afghanistan. In this photograph, Najibullah's waiting for a check-up outside the OPD of the KTC. Copyright: Mikhail Galustov



Eight-year-old Abid was hurt in a traffic accident. Copyright: MSF

as well as women and children were all being treated in our hospital at the same time. What really made an impression on me was the humanity present in each person irrespective of who they were or what their role had been in the conflict. It really emphasised for me the importance of neutrality, impartiality and independence. It also underscored for me the importance of proximity which made emergency medical care accessible to these patients despite some of the difficulties and risks in providing it.

How does being a surgeon in a humanitarian context differ from working in Australia and New Zealand?

In this context our work was focused primarily on saving life and limb, preventing infection from war wounds and returning mobility to what was otherwise a young, relatively healthy population. The oldest patient I operated on was 68 years and another patient was 72. There were a lot of injured children. Due to a restricted number of tools and implants there were some conditions that we were unable to treat as well as we would at home but you just have to accept this when you can't change it and do the absolute best you can with what you have. The principles of doing good surgery actually remain much the same.

Did the experience make you a better surgeon?

Definitely. For example, one thing that we don't often experience in Australia and New Zealand is dealing with multiple seriously injured casualties at once, often on a daily basis. I learnt a lot from the Afghan national surgeons on how to deal with this situation quickly and effectively. You also need to think flexibly if you are short of certain equipment and really use the local knowledge of your national surgeon colleagues.

Have you been able to apply the skills you gained in the field to your work in Australia and New Zealand?

Working back at home, I have a better understanding of how things are managed in multiple casualty or disaster situations and what type of approach is required. The experience has inspired me to undertake >



Ahmad Jan is 80 years old and he was caught in crossfire in his village while trying to go to the bazaar. He was taken from his district of Imam Sahib to Kunduz City by local villagers. The road was very unsafe and the trip took more than an hour. He is now learning, with the aid of an MSF orthopaedic, to exercise his legs so he doesn't lose his ability to work. Copyright: MSF

more training in disaster management, an area that surgeons in my area do not have a lot of experience in.

How has the experience changed or affected your life?

I now have a much greater appreciation of the difficulties faced by populations affected by conflict. This includes working alongside national surgeons who did a great job despite the risks and difficulties faced by them and their families. My international colleagues - both medical and non-medical - were very motivated, professional and dedicated, with many having impressive skills sets in a number of areas.

Do you have any advice for other surgeons considering work with an international medical aid organisation?

Life as a humanitarian worker is not luxurious and not necessarily always safe. However I found providing emergency medical care to populations in need due to trauma and conflict to be professionally

very satisfying. MSF enabled me to work in a project that was very well run, had appropriate resources for the context and was well accepted by the local population. No matter where you work, good medical ethics and good surgical technique remain the same. Be prepared for the clinical problems, the context and communication (3C's). Be prepared to teach. Be prepared to learn.



Note: After Dr Bidwell completed her assignment, the MSF Trauma Centre in Kunduz was hit by a US military airstrike, on 3 October last year, that killed at least 42 people, including 14 MSF staff members, and destroyed MSF's hospital. The attack deprived hundreds of thousands of people of access to medical care at what was the only specialised trauma hospital in north eastern Afghanistan. MSF is calling for an independent investigation by the International Humanitarian Fact-Finding Commission (IHFFC).



Dr Terri Bidwell (right) with colleagues at the KTC. Copyright: MSF



Doctors examine a head trauma patient in the ICU of the KTC. Copyright: Mikhail Galustov

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New laws to crack down on dodgy health providers

Victoria's health complaints watchdog will be given greater powers to name and shame dodgy health service providers and practitioners, and protect the public by banning them from practising.

On 9 February, the Andrews Labor Government introduced the Health Complaints Bill 2016 into parliament, to establish a tough new complaints system to crack down on dangerous, unregistered health practitioners.

Under the proposed new laws, the existing Health Services Commissioner will be replaced by a new watchdog, the Health Complaints Commissioner, creating a more comprehensive health complaints system that better protects the public and providers of health services.

The new Commissioner will receive beefed up powers to take action against dangerous and unethical health providers who are not registered under national health practitioner regulation law. In a major change, the Bill will allow anyone to make a complaint, rather than just the person who received the health service.

The Commissioner will also have the power to instigate an investigation even when no complaint is lodged, for

example, if the media has uncovered an unscrupulous unregistered provider making fake or harmful claims.

"We're taking action to crack down on dangerous health practitioners who take advantage of vulnerable Victorians," Minister for Health, Jill Hennessy said. "Our tough new laws will give the Health Complaints Commissioner the power to name and shame and put these dodgy health providers out of business for good."

Under the proposed laws, the new Commissioner would have the powers to investigate and crack down on high profile cases such as the blogger who faked cancer to profit from her wellness app, the fake gynaecologist performing 'fertility treatments' on women for a decade, or the unregistered 'dodgy' dentists, and ban them from providing these unethical and dangerous treatments.

Other examples include a formerly registered dentist who claimed 'ozone therapy' could cure cancer, or people purporting to be able to 'convert' gay people through medical or therapeutic means.

Individuals who breach the Commissioner's ruling would face up to two years in prison.

If the community is at risk, the Commissioner will be able to issue public warnings and name and shame providers in the media in order to protect the public.

The laws will also prevent dodgy healthcare practitioners who are not regulated under national health practitioner regulation law, and are banned in other states, from moving to Victoria and offering their healthcare services here.

For example, under the new legislation, a midwife who is prohibited from practising in South Australia would automatically be banned from practising in Victoria, whereas previously a complaint would need to be lodged about the midwife's care before the Health Services Commissioner could take action.

"We're closing loopholes in the existing legislation to make sure Victorians receive the healthcare protection they need," the Health Minister added.



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Primary Health Networks report they're off to a positive start

It's just over eight months since the often-maligned Medicare Locals were abolished and replaced by the Federal Government's Primary Health Networks. So how are the new PHNs faring? A city and a regional operator both provide *vicdoc* with an update.

North Western Melbourne

A strong connection to the local health community has helped Melbourne Primary Care Network make a smooth and successful transition into the Primary Health Network environment, writes MPCN CEO Adj/Associate Professor Christopher Carter.

Melbourne Primary Care Network (MPCN) managed to hit the ground running as the operator of North Western Melbourne Primary Health Network, effectively transitioning all clinical services from the four previous Medicare Locals and continuing to deliver on all our commitments and external expectations.

Making the establishment of the PHN as smooth as possible was paramount, because we knew there were a lot of people in the community, both practitioners and the public, relying on services and support to continue seamlessly.

This process was helped immensely by being able to recruit some excellent staff with sound knowledge of our expanded region, complementing our existing highly skilled team members.

Health professionals, particularly GPs, remain central to the work of PHNs, so the first step was to ensure ongoing support was made available to GPs and practice staff throughout the transition and beyond.

MPCN has already conducted well over 650 practice visits right across north and west Melbourne, and our managers and executives have had more than 270 meetings with key health stakeholders. This face-to-face contact is crucial to identify support needs and forge common understanding on key activities, and has only become more important in the expanded PHN environment.

Our Clinical and Community Advisory Councils were also established and began operating in the second half of 2015, making us the first PHN in Victoria to do so. With strong GP and community representation these Councils are already providing another channel for our core communities to influence and guide our operations.

As well as ongoing communication we've also continued to provide practical support to GPs through channels like HealthPathways, which is a best practice assessment, treatment and referral support tool localised to our region for a range of common conditions.

Fifty-five new pathways have gone live since 1 July, including ones on stroke and heart failure, which brings the total number of localised pathways to 202. We are in the process of scaling up the program to be available beyond the inner city, adding locally relevant referral information for the entire region to new and existing pathways.

Delivery and facilitation of patient services has also continued, including a significant expansion of Access to Allied Psychological

Services mental health programs. GPs have referred 1,527 new people to our CAREinMIND™ program, with 6,617 sessions being delivered by over 150 providers.

Mental health will become an even more important part of what we do over the coming years, as detailed in recent Federal Government announcements. We will play a key role in mental health reform, with flexible funds from government available for consumer based, family orientated and outcomes focused services.

While national PHN priorities have already been set – including Aboriginal and Torres Strait Islander health, aged care, mental health, health workforce planning and eHealth – identifying and beginning action on locally relevant health priorities will be a big part of 2016 for us.

This is where the sixth national PHN priority, population health planning, will play a vital role. MPCN published an initial population health snapshot in September last year, and a partner has since been chosen to assist us in the development of a more comprehensive population health plan for the region – which will be developed in close collaboration with a range of partners.

Another major piece of population health work is the Aboriginal and Torres Strait Islander: *Closing the Gap* information paper, which was released late January this year. This report is just one element of our organisation's commitment to Aboriginal health, which also features an Aboriginal health team to coordinate the range of Aboriginal and Torres Strait Islander focused programs and services we support.

There is much more work already in train in a number of areas, including collaborative work around Advance Care Planning and also refugee health, to name just two.

Overall it's been a busy and productive seven months or so since we officially came into being, and as we move into 2016 we expect it to get even busier. But given the great support we've already received from GPs, Local Hospital Networks, health practitioners, organisations and community members right across the north and west, we're confident that there is the appetite and capacity to make real, positive change to the primary healthcare system in our region.

We're looking forward to being right in the middle of it.



Adj/Associate Professor Christopher Carter
Chief Executive Officer
Melbourne Primary Care Network



Gippsland

Primary healthcare is often the first point of contact for a wide range of health issues from preventative healthcare to complex health management. It is provided by a range of health services delivered in the community such as general practice, allied health, and dental, as well as public health services. It also interacts with the supply of medications and diagnostic services such as pathology and radiology.

The current primary health reforms are guided by the 2013 National Primary Health Care Strategic Framework which identified four priority actions (Department of Health 2013):

- build a consumer-focused integrated primary healthcare system;
- improve access and reduce inequity;
- increase the focus on health promotion and prevention, screening and early intervention; and
- improve quality, safety, performance and accountability.

Health reform is also about financing the system and working across a complex mix of public and private funders and providers to achieve more out of the available resources as demand grows. Nationally, primary healthcare accounts for almost as much health spending as hospital services and represents a higher proportion of individual expenditure than any other area of health expenditure.¹

It's no surprise then that primary healthcare has been the focus of much reform, placing pressure on general practice as it balances demands, changes to pricing of services, and delivering high quality services. In December 2015, the Primary Health Care Advisory Group put forward a range of recommendations to the Federal Government to address the question of the mix of bundling payments to reflect both fee for service and outcomes payments.

It is on this backdrop that Primary Health Networks were established in 2015 as federally funded meso level primary healthcare organisations, with a focus on supporting general practice, health planning, creating efficiencies in our health system through system integration and commissioning services in line with national and local health priorities.

Gippsland PHN commenced operations in July 2015, and by the end of September had recruited to its staffing structure methodically, working from Chief Executive through to all program officers. During that period, three office locations were implemented, opening up access from Moe, Wonthaggi and Bairnsdale.

A new function for Gippsland PHN has been the re-emergence of a practice support team. This support service has been developed with specialty portfolios delivering expertise in practice management, practice nursing, eHealth, after hours and education/workforce development, ensuring practice support is available for general practices across the entire catchment.

Other new functions include building data capability in general practice to assist GPs and their teams to use their own data to target health improvements for their patients and communities. This data capability will also feed the Gippsland PHN population health planning role, re-balance hospital service demand and emergency department presentation data and inform future investment in community based service delivery.

The Gippsland PHN Care Pathways program has commenced, with hospitals signing up to the system and GP editors being recruited to lead engagement and the credibility of this work for general practice. The system will also enable direct referral to hospital and community services and connectivity from the GP desktop system. These are just a few of the immediate improvements and capacity building projects that have been implemented over the first six months of the program.

A key enabler to the success of the organisation is re-engagement with general practice and other health professionals and hospitals. Gippsland PHN has visited all general practices to understand their challenges and to provide information on future programs. This visiting program will continue as a fundamental way of working, to build relationships and trust and ensure ongoing grassroots input to the organisation.

Other critical enabling functions have been the establishment of the Clinical Councils and Community Advisory Committee. Chaired by local GPs, three sub-regional Clinical Councils have been established representing Latrobe and Baw Baw; Bass Coast and South Gippsland; and Wellington and East Gippsland, and are supported by multi-disciplinary groups of health providers in those sub regions. These structures ensure local services and general practice are major contributors to the operations of the Gippsland PHN organisation and overcome the patchy engagement of the past. It is integral to Gippsland PHN that general practice and other health professionals, as well as the consumer voice and experience of care, is centrally involved in planning and advising decision-making about health solutions.

So what does this mean for general practice? By sharing data, Gippsland PHN can assist general practices to target and report on patient health outcomes. This in turn will build capacity to claim funds for future outcomes based funding. Care pathways, maintaining the National Health Service Directory, and linking secure messaging/e-referral mechanisms will improve systems and access to community and specialist care.

Gippsland PHN will be measuring GP engagement, changes in community equity of access to care, and improvements to health systems and service integration and coordination. This will also inform Gippsland PHN's purchasing of services to support GPs to share the care for complex patients, so we can together re-design access to programs to help the most vulnerable in our community, such as the imminent changes in mental health services.



Marianne Shearer
Chief Executive Officer
Gippsland PHN

1. Australian Institute of Health and Welfare 2014. *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

From riches to riches: the effect of affluent medical students on patients

Thousands of bright-eyed and bushy-tailed students recently found out whether they had been accepted into Australian medical schools.

Selection is a highly competitive process, requiring an impressive combination of high secondary school results (ATAR/GPA), high results on various medical admissions tests (UMAT/GAMSAT), cogent personal statements and/or performance in multiple mini interviews. Only the most successful students are selected.

As selection interviewers for an Australian medical school, one of our scripted questions was “How have you helped disadvantaged people?” A memorable candidate began, “Well, our family has a maid...”.

Other applicants told stories of well-intentioned overseas trips to help ‘poor people’ in other countries. Strikingly, of the nearly 20 aspirants we interviewed, none told stories of socioeconomic disadvantage involving themselves, family or friends.

Although we cannot say whether these students were selected, it is likely some of them were. These well-to-do students will become the future of our medical system.

About two-thirds of Australian medical students come from affluent backgrounds. Fewer than one in ten come from low socioeconomic status backgrounds. This is unsurprising as selection criteria such as ATAR and personal statements are known to be biased against low-socioeconomic-status candidates.

Universities have created special access schemes, and tests such as the Undergraduate Medical Admissions Test (UMAT), Graduate Australian Medical School Admissions Test (GAMSAT), personality tests and interviews which are supposed to reduce bias against low-socioeconomic-status candidates.

However, low-socioeconomic-status applicants are still less successful than their high-socioeconomic-status counterparts at getting into medical schools, perhaps due to the lack of access to role models, support, and opportunities necessary. Females from low socioeconomic backgrounds are the most disadvantaged.

Consequences for patients

Socioeconomic status is associated with important differences in values and beliefs.

Two families recently delivered very premature newborn babies who needed life support. If the babies survived, they were faced with a high chance of disability requiring lifetime care.

The families came from different socioeconomic backgrounds, and expressed different concerns. The parents who were struggling with money said they would not be able to afford the high costs of looking after a disabled child.

The well-off parents expressed they were worried the child’s disability was going to be so severe their child’s quality of life would not be worth putting the child through the intensive and traumatic treatments.

Although both sets of parents wished to withdraw care, they were perceived and treated differently by their health team. One set of parents was eventually referred to child protective services, and the other family had their wishes carried out.

This example highlights the difficulties in shared decision-making when values and priorities are different, and the extent of their impact. People with lower socioeconomic status consistently have poorer health and are more likely to die earlier than their more affluent counterparts, and are less involved in medical decision-making.

Conversely, patients with higher socioeconomic status tend to be more assertive, take an active role in their medical management and receive more explanations.

Selecting a medical community with such differences in socioeconomic status to the Australian population (in which only 25% of people are classified as affluent) holds the risk that the patients they serve have contrasting priorities, values and life situations to their own.

It is human nature to feel more comfortable with, and be more persuaded by patients who hold similar values and articulate them in a familiar way. Patients who have divergent preferences or goals of treatment may have their intentions

misconstrued or experience conflict with their doctors.

What can be done?

Medical schools should continue refining medical selection processes to give students with lower socioeconomic status a fair opportunity to become doctors. The medical fraternity and patients would be better off with a broader representation of doctors from different backgrounds.

Doctors do not need to have the same backgrounds as their patients to deliver good care, but they should strive to understand and respect their patients’ needs, expectations and values when delivering healthcare. Doctors should be aware of the effects socioeconomic status has on the doctor/patient relationship and that patients’ intents and styles of communication may vary from their own.

Much emphasis has been placed on ‘cultural competency’, but this is often framed in racial, linguistic, ethnic and religious differences. The medical profession is more aware of the possibility of value conflicts when patients speak a different language or have a different ethnic, racial or religious background to their own.

However, when a patient shares the same language or culture, there is an unspoken assumption that there will be common understandings. Expanding these lessons to socioeconomic status is essential to creating a system that serves those who need it most.



Dr Paul Leong
Registrar
Monash Health



Dr Evelyn Chan
Management consultant
Boston Consulting Group

THE CONVERSATION

(First published on *The Conversation* 27 January 2016) theconversation.com/au



Vale Professor Graham Burrows AO, KCSJ

BSc,MB,ChB,DPM,MD, DipMHLthSc(Clinical Hypnosis)
DSc,FRANZCP,FRCPsych,MRACMA,FACHAM

AMA Victoria's Section of Psychiatry pays its respects to Professor Graham D. Burrows (1938-2016), who passed away on 10 January. A leading psychiatrist and academic, Prof. Burrows made a significant contribution to AMA Victoria.

A valued AMA Victoria member for 35 years, Prof. Burrows was the Chair of the Section of Psychiatry, a Councillor, a former Chair of Council and Board member.

Prof. Burrows was involved in numerous mental health advisory boards at state, federal and international levels. He was the Foundation Professor of Psychiatry at the Austin Hospital. He had a long history of involvement in the RANZCP and was Victorian Branch Committee Chair on various occasions. In 2010, Prof. Burrows received the RANZCP College Medal of Honour.

In addition to his significant contribution to AMA Victoria, Prof. Burrows played an active role in the World Federation for Mental Health, the Society for Mental Health Research, the Royal Society of Victoria and voluntary mental health organisations including The Mental Health Foundation of Victoria and The Mental Health Foundation of Australia. Prof. Burrows was appointed an Officer of the Order of Australia in 1989 in recognition of his contribution to medicine.

We are grateful for Prof. Burrows' long-standing commitment to the AMA, the medical profession and mental health. Our thoughts are with Dr Barbara Burrows, and their family.

AMA Victoria's Section of Psychiatry

AMA Victoria

ANZAC

MEMORIAL SERVICE

Friday 22 April 2016
10.30am
President's Garden
293 Royal Parade
Parkville

The memorial service will be followed by morning tea.
All members are welcome to attend and should RSVP by Wednesday 20 April to:

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p (03) 9280 8722



Funding black hole for over-stressed public hospitals

The AMA's latest snapshot of the performance of Australia's public hospitals points to an imminent crisis as the effects of federal funding cuts make it harder for hospitals to meet growing patient demand and to reach significant performance benchmarks.

The *AMA Public Hospital Report Card 2016* shows that, against key measures, the performance of our public hospitals is virtually stagnant, and even declining in key areas.

Federal AMA President, Professor Brian Owler, said the disappointing results are a direct consequence of reduced growth in the Commonwealth's funding of public hospitals, and things will get much worse in coming years unless the Commonwealth reverses its drastic cuts from recent budgets.

"The states and territories are facing a public hospital funding 'black hole' from 2017 when growth in federal funding slows to a trickle," Professor Owler said.

"From July 2017, the Commonwealth will strictly limit its contribution to public hospital costs. Growth in Commonwealth funding will be restricted to indexation using the Consumer Price Index (CPI) and population growth only.

"Treasury advised the Senate Economics Committee that this change will reduce Commonwealth public hospital funding by \$57 billion over the period, 2017-18 to 2024-25. As a result, hospitals will have insufficient funding to meet the increasing demand for services.

"In the 2015-16 budget, Commonwealth funding for public hospitals was reduced by \$423 million for the three years to 2017-18. A further \$31 million was cut in the December 2015 MYEFO budget update.

"Public hospital funding is about to become the single biggest challenge facing state and territory finances – and the dire consequences are already starting to show.

"Bed number ratios have deteriorated. Waiting times are largely static, with only very minor improvement. Emergency Department (ED) waiting times have worsened. The percentage of ED patients treated in four hours has not changed, and is well below target. Elective surgery waiting times and treatment targets are largely unchanged.

"Public hospital performance has not improved overall against the performance benchmarks set by all governments. On top of all that, the Commonwealth is creating additional and unnecessary demand for hospital services by reducing Medicare payments for diagnostic services in the community by \$650 million. These services are essential to diagnosing and treating people early to keep them out of hospital."

Professor Owler said the Commonwealth Government continues to retreat from its responsibility in regards to public hospital funding arrangements with the states and territories. "There is no greater role for governments than protecting the health of the population," he said.

"Public hospitals provide essential healthcare services across the community. The dedicated and hardworking doctors, nurses, and other healthcare practitioners who work in public hospitals

continue to provide Australians with world class healthcare. Their professionalism means they are doing more with less.

"Public hospitals are the foundation of our healthcare system. They are the training ground for the future medical workforce. They are the safety net for the people who can't afford private health insurance. They are the places where extraordinary gains in medical science are developed to constantly improve patient outcomes. Public hospital funding and improving hospital performance must be a priority for all Australian governments," Professor Owler added.

Key findings from the *AMA Public Hospital Report Card 2016* include:

- hospital bed to population numbers have remained constant over recent years, while there has been increasing demand for hospital services;
- nationally, only 68% of ED patients classified as urgent were seen within the recommended 30 minutes; and
- in 2014-15, no state or territory met the interim (2014) or final (2015) National Emergency Access Target of patients being treated within four hours. Performance in Victoria and Western Australia was below their 2013 targets, and performance in South Australia, Tasmania, the Northern Territory and the ACT was below their 2012 targets, with the Northern Territory performance in 2014-15 failing to meet their baseline for this target.

The *AMA Public Hospital Report Card 2016* is available at ama.com.au/ama-public-hospital-report-card-2016



AMA Report Cards use the latest available information published by the Commonwealth Government. The *AMA Public Hospital Report Card 2016* was compiled using information from:

- Australian Institute of Health and Welfare, *Australian Hospital Statistics: Hospital resources 2013-14*; *Australian Hospital Statistics 2014-15: emergency department care*; *Australian Hospital Statistics 2014-15: elective surgery waiting times*; *Health Expenditure Australia 2011-12, 2012-13 and 2013-14*.
- Commonwealth Budget documents, *Budget Paper No. 3 2013-14, 2014-15 and 2015-16*; and *Mid-Year Economic and Fiscal Outlook (MYEFO) 2012-13, 2013-14, 2014-15, and 2015-16*.
- Council of Australian Governments (COAG) Reform Council, *National Partnership Agreement on Improving Public Hospital Services: Performance Report for 2013 (NEAT and NEST targets)*.

Medical certificates

Doctors may be called upon from time to time to complete various forms of medical certificates for patients. These may include:

- Sick or Sickness Certificates – to certify that a patient is unable to attend work, school or even to appear in court;
- Carer's Certificates – to certify that an individual was providing care for your patient, and was unable to attend to their regular duties;
- Certificates of Capacity – to certify that a patient who is being compensated by either WorkSafe Victoria or the Transport Accident Commission (TAC) is either eligible for payments, or able to return to work; and
- Medical certificates for early release of Superannuation.

There are unfortunately no statutory principles governing the issue of certificates per se. In each of the above circumstances, the general principle is that a certificate should only be issued where there is a clinical basis for doing so. Doctor/patient confidentiality is the second principle to bear in mind when dealing with issues relating to certificates.

Ethical principles issued by the Medical Board of Australia call for doctors to be honest in dealing with such requests, and to take reasonable steps to verify the authenticity of information presented to them by patients.¹

The following points should be taken into account when completing medical certificates:

- Keep a copy of all certificates (and information related to the issue of any certificates) that you issue.
- A certificate must always be dated on the day on which it was written and should never be backdated.²
- A certificate should state the date/s on which illness is certified.
 - In some circumstances the practitioner may certify the patient incapacitated for work during a period prior to the date of consultation, but this should only be stated where unequivocal to the practitioner that the patient was incapacitated during that time.³
- If there is sufficient clinical basis to exempt a patient from attendance on a date prior to the day you saw the patient,⁴ you may indicate this on the certificate.
- The certificate should bear your name, practitioner registration number, and the name and address of the practice or hospital (as applicable).
- Diagnosis of the patient's condition should ordinarily not be included on the certificate, a statement that the patient has a 'medical condition' is sufficient.⁵



In certain circumstances the employer might contact a medical practitioner to discuss the certificate or verify its veracity. In this circumstance the practitioner can confirm to the authenticity of the certificate, but should not disclose the patient's medical condition without the patient's express consent.

Carer's Certificates

Employees may be entitled to personal leave if care or support needs to be provided to a member of the employee's immediate family or household because of illness, injury or emergency.⁶ In these situations, an employer is able to request evidence from the employee in the form of a Carer's Certificate.⁷

A medical practitioner should only issue a carer's certificate if he or she has personal knowledge of the requirement of the patient to care for a member of their family or household and with consent of the person requiring the care.⁸

For information on Certificates of Capacity for WorkSafe and TAC claims, and certificates for the early release of superannuation, please visit the Legal Services Facts Sheets section of our website and look for Medical Certificates.

(Last reviewed February 2016)



This article is intended to provide general advice only. The contents do not constitute legal advice and should not be relied upon as such. Readers should seek specific expert and legal advice in relation to the information provided in this article.

1 The Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*, 2009.
 2 Australian Medical Association, *AMA Guidelines for Medical Practitioners Certifying Illness*, 2011, s 8.1.
 3 Australian Medical Association, *AMA Guidelines for Medical Practitioners Certifying Illness*, 2011, s 8.1.
 4 Australian Medical Association, *AMA Guidelines for Medical Practitioners Certifying Illness*, 2011, s 8.1.
 5 Australian Medical Association, *AMA Guidelines for Medical Practitioners Certifying Illness*, 2011, s.2.
 6 *Fair Work Act 2009* (Cth) s 97.
 7 *Fair Work Act 2009* (Cth) s 107(3)(a).
 8 Australian Medical Association, *AMA Guidelines for Medical Practitioners Certifying Illness*, 2011, s 10.1.



Celebrating a surgical milestone

Robotic-assisted surgery is on the increase in Australia and is predicted to be more readily available and utilised as medical technology becomes more advanced. Between 2014 and 2015, Australia has seen a 25% increase in the utilisation of the da Vinci robotic systems.

In late 2014 Knox Private Hospital made the commitment to acquire a da Vinci Robot. It's one of a number significant evolutions that have transformed surgery at the hospital over the past decade. The hospital's goal is to provide its patients with the least invasive and most precise options available, allowing the patient to get back to their everyday activities as quickly as possible.

The arrival of a da Vinci Robot saw Knox Private hit the ground running

with surgically assisted robotic cases and many new specialists joined the program throughout 2015. Knox Private Hospital is now able to offer a number of multidisciplinary robotic-assisted surgery options for its patients. These include urological, gynaecological and general surgeries. The hospital also offers a permanent onsite virtual simulator, enabling exercises to safely train surgeons in a realistic but controlled environment.

Urologist, Professor Damien Bolton, led the hospital's first robotic-assisted surgical case in December 2014. "Robotic urology surgery is becoming established as the preferred option for most patients," Professor Bolton said. "It's giving primary local access to the highest quality of surgical techniques and surgical equipment, resulting in inherent

benefits including reduced pain, faster recovery and better surgical outcomes overall.

"The Knox robot is beautiful to use. It is able to give precision of movement that every surgeon would want. The optics provide magnification of your vision in ways beyond what you can achieve in open surgery. And the training of the Knox robotic staff has been thoughtful and intelligent, allowing them to demonstrate their capabilities from the first case."

During a da Vinci procedure, the surgeon is 100% in control of the robotic-assisted system, which translates the surgeons hand movements into smaller, more precise movements of the instruments inside the patient's body. The endo wrist instruments are designed to



provide surgeons with natural dexterity and a range of motions greater than the human hand.

The intuitive motion maintains a corresponding eye-hand-instrument tip alignment, allowing for instinctive instrument control. The surgeon's hand movements are scaled, filtered and seamlessly translated to the robotic arms and instruments at the patient's side. The da Vinci system also features a magnified 3D high-definition vision system that enables the surgeon to operate with enhanced vision and precision.

The device puts Knox Private Hospital at the forefront of minimally invasive surgery, being able to offer Firefly Fluorescence Imaging. This allows the surgeon to have the following imaging while performing surgery:

- real-time endoscopic visual and near-infrared fluorescence imaging;
- soft tissue perfusion; and

- vessel identification and solid organ perfusion (liver, kidney).

"We are committed to our mission of putting our patients first and strive to continue providing them with minimally invasive surgical options," Knox Private Hospital's General Manager, Justin Greenwell said. "We are truly thrilled to be a leader in this field. As the only hospital offering the option of single site da Vinci robotically-assisted surgery for patients in Victoria, we are demonstrating our ongoing commitment to providing patients with up-to-date surgical options. We were able to reach the 100th case, completed by Professor Bolton in November 2015, just before our one year anniversary."

The single site capabilities of the surgical assisted robot at Knox Private Hospital allows the operating surgeon:

- trans umbilical entry, enabling a virtually scar-less surgery; and

- instruments and camera cross within the single-site port and use of remote centre technology to avoid cannula collisions, arm interferences and port-site movement.

What's most exciting for robotic surgery is what the future might hold. Some specialists are predicting the introduction, growth and acceptance of telemedicine that incorporates long-distance operations. As our internet becomes faster and bandwidths become even cheaper, the access to this medicine becomes inevitable, with the possibility of specialists being able to operate on a patient in another city, state, or even on the other side of the world.



Market outlook 2016

The world's two largest economies are continuing their economic transition during 2016. The process of re-orientating the Chinese economy away from manufacturing and investment to services and consumption will not occur in a straight line. As a result, it is expected that Chinese economic data will remain lumpy during 2016 as this transition continues.

In the US, the economy is in the process of adjusting to the first rise in interest rates in nine years. While US economic data remains robust, the US Federal will remain cautious about further increases in interest rates. Employment growth remains strong and the economy continues to grow at an acceptable rate.

The Australian share market is likely to churn sideways for much of 2016 in what is likely to be a volatile year. Opportunities are likely to present themselves when good businesses with stable cash flows are oversold during market volatility. An income return of 5% and modest capital gains would be a good outcome in what looks to be a transitional year.

International equities will continue to play an important role in portfolios during 2016. The sector provides important diversification away from sectors which are prominent in the Australian market. International investing provides the opportunity to reduce exposures to the financial and resources sectors and increase exposure to the IT and healthcare sectors. Investing internationally also provides the opportunity to benefit from the continued fall in the Australian dollar.

The uncertainty surrounding the global economy has meant that it has been a bad start to the year for equity markets. However, there are number of steps an investor can take to limit the negative impact of share market volatility.

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Firstly, every serious investor should have a long term financial plan in place and stick to it. Volatile investment markets increase the probability that you will make the wrong investment decision at the wrong time. It's generally not a good idea to make investment decisions when equity markets are volatile.

The prospect of losing money can also cause an investor to lose objectivity. The focus turns to the very short term and away from the long term, where the best investment decisions are made. As investors, we are now focused on the short term more than ever with a stream of information available through smart phones and apps. A sound financial plan helps to keep you focused on your long term goals.

Secondly, an investor can also limit the impact of volatility on their portfolio by ensuring it is appropriately diversified across shares, property, fixed income and cash. The weighting to each of these investments will be dependent on your goals, objectives and attitude to risk.

2016 is already shaping up to be an eventful year, making it even more important to ensure that you have the right financial plan in place for your needs. Please feel free to contact William Buck Wealth Advisory to discuss how we can assist you to meet your specific financial goals and objectives, including a review of your current portfolio and financial strategy.



Brad Hunt

Private Wealth Advisor
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Dr Sam Wylie is an Associate Professor of the University of Melbourne and 7 times the winner of Melbourne Business School's Teaching Excellence Award.

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AMA VICTORIA

BYPC&E 2016

BUILD YOUR PRACTICE - CONFERENCE & EXHIBITION

Saturday 15 October 2016

Melbourne Convention & Exhibition Centre

Building, renovating and running a medical practice can be challenging, even for the most experienced practitioner.

BYPC&E2016 will explore the ways that doctors and staff in private practice can own, operate and develop a successful medical practice while also providing sustainable, high-quality care to patients.

Expression of interest e: practicesolutions@amavic.com.au

SAVE THE DATE



AMA National Conference

AMA Victoria members who are interested in attending the national conference are invited to nominate for a delegate position.

The number of positions, once ex officio positions have been allocated, is likely to be seven (7) and those nominating must be a financial member.

The conference will to be held at the Canberra Convention Centre from 27-28 May 2016. The conference theme will provide key topics for discussion.

Your nomination and a supporting statement of no more than 50 words should be sent to JudithC@amavic.com.au by 5pm on Friday 1 April 2016. All nominations will be acknowledged.

If required, a formal ballot of Council Members will be held to determine a ranking of all nominees to fill vacant positions.

Advice of the result of the ballot will be sent by 8 April 2016.

For more information, visit ama.com.au/nationalconference

Fair Work Ombudsman audits medical practices

What is happening?

The Fair Work Ombudsman (FWO) is in the process of auditing approximately 50 medical practices (specialist and general) in Victoria for record-keeping, pay slip obligations and rates of pay. The audit is focused on receptionists, administration officers, cleaners and other support employees. So far, AMA Victoria has been contacted by three practices subjected to audits.

Practices contacted for audit will be sent an email or letter from the FWO asking for information such as:

1. confirming the structure of the entity that employs staff (an Entity Information Form);
2. a copy of the employees' timesheets or rosters (if irregular hours worked); and
3. corresponding pay slips for the last pay cycle.

The practice will also be provided with a privacy letter to give to affected employees regarding the audit.

What should you do?

We hear that some practices are receiving cold calls. This is not how the FWO operates. If your staff receive an enquiry over the phone from someone purporting to be from the office of the FWO, ask the caller to put any request for records in writing by email or fax to the practice manager or principal. If this happens, we advise you call the AMA Victoria Workplace Relations unit immediately on (03) 9280 8722.

Information about the campaign, plus the FWO's online tools can be found on the website fairwork.gov.au

Please contact our Workplace Relations Unit if you have any questions.

AMA VICTORIA PRACTICE SOLUTIONS YOUR VISION...OUR BRIEF



YOUR VISION:

Build and develop your new dream practice

OUR BRIEF:

- Turn your dream into a concept
- Initiate a feasibility study and business plan
- Coordinate the building project & practice set-up
- Develop your policies and operational protocols
- Mentor your management and support team

YOUR VISION:

Expand an existing practice

OUR BRIEF:

- Develop a project plan
- Review the operational & business structure
- Coordinate your building project
- Minimise disruptions to your business
- Guide your team through change management



2016 EVENTS CALENDAR

AMA Victoria is pleased to announce the following events that are planned for 2016. More events will be announced soon. We hope to see you throughout the year.

DATE	SPEAKER	EVENT	VENUE
Tuesday 1 March	Dr Grant Davies, Health Services Commissioner	Southern Subdivision Forum An update from the HSC	Sandringham Yacht Club, Jetty Road, Sandringham
Wednesday 2 March	Dr Krishna Mandaleson	East Gippsland Subdivision Forum The Stroke Program	The Criterion Hotel, Macalister Room, 90 Macalister Street, Sale
Thursday 3 March	Prof. Judi Walker	CWS Gippsland Subdivision Forum Hazelwood Health Study	Little Prince, 58 Hotham Street, Traralgon
Tuesday 8 March	Dr Grant Davies, Health Services Commissioner	Eastern Subdivision Forum An update from the HSC	QPO Cafe Bar Restaurant, Cnr High St & Cotham Rd, Kew
Wednesday 9 March	Paul Geddes	Peninsula Subdivision Forum Progress on the new Ramsay developments at Beleura	The Counting House, 787 Esplanade, Mornington Peninsula
Thursday 10 March	Dr George Heriot	Northern Subdivision Forum Infectious Disease	CH James, 88 Station Street, Fairfield
Monday 21 March	Katherine Walsh	Wimmera Subdivision Forum Current medico-political update	Ducks Nuts Restaurant, Wimmera Room 118 Baillie St, Horsham
Tuesday 22 March	Dr Grant Davies, Health Services Commissioner	Western Subdivision Forum An update from the HSC	The Strand, 1 The Strand, Williamstown
Thursday 14 April		Mental Health Forum	
Saturday 30 April		Medical Careers Expo	Melbourne Olympic Park, Function Centre, Olympic Boulevard
Thursday 2 June		Women in Medicine	
Wednesday 15 June	The Hon. Jill Hennessy MP	State Health Minister Dinner	
Thursday 23 June		Senior Salaried Staff Subdivision Forum EBA 2017	
Wednesday 29 June		Retired Doctors Singin' in the Rain and lunch	Her Majesty's Theatre The Locanda Restaurant
Thursday 25 August		Retired Doctors Luncheon and tour	
Wednesday 12 October		Section of GP AGM Dinner	
Saturday 15 October		Build Your Practice Conference & Exhibition	Melbourne Convention Centre, 1 Convention Centre Place, South Wharf
Thursday 20 October		Ministerial Dinner	
Tuesday 22 November		Retired Doctors Christmas luncheon	

For updates on the event calendar, please visit amavic.com.au



Monthly wrap

The Retired Doctors special interest group held its first event for the year on 4 February in Bendigo. The day commenced with morning tea at the Bendigo Art Gallery, followed by a guided tour. A lovely two-course lunch was served at Lynnvale Estate winery, before our group was offered some private wine tasting by the owners of the winery.

POSITIONS VACANT

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or T: (03) 9489 6472.

FOR SALE OR LEASE

MITCHAM Brand new fully furnished Specialists Consulting Room is available for full time or sessional lease at Mitcham Specialists Group. There is a shared reception and waiting area. Located within walking distance from Mitcham Private Hospital and parking onsite.

📞 **Enquiries: Panah 0401 756 333**

MELBOURNE Solo GP Practice - Established 1988 - 15 Collins Street, Melbourne. 5 days, no after hours or weekends. May suit 2 doctors to share.

📞 **Contact Dr HG Simmons E: denlark@bigpond.net.au or M: 0407 886 820.**

FOOTSCRAY Two adjoining suites in the heart of a Medical Precinct, opposite two great Footscray hospitals. Suite 4a, floor area 123 sqm. approx. includes fitting out items plus 9 onsite car parks. Suite 4b, floor area 57sqm. approx. Plus 5 car parks. Favourable terms are offered. PPTY ID 9090812 commercialview.com.au follow link Medical/Consulting.

📞 **Enquiries: Frank, M: 0418 922 669**
E: afaimpala@westnet.com.au

RETIREMENT

DR ESTELA PAPIER Psychiatrist - has now retired from clinical practice at 913 Dandenong Road, Malvern East. Patient records will be archived as per legislation. She will undertake medico-legal work only.

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Travel hot spots for 2016

From the Olympic Games in Rio, to surfing in the Solomon Islands, we have selected ten of the best destinations for you to add to your 'must do' list for 2016. Here are the first five of them. Stay tuned for more next time.

Brazil

Known as the 'Cidade Maravilhosa' (Marvellous City), the glimmering Brazilian metropolis of Rio de Janeiro certainly lives up to its title. As the host of the 2016 Olympic Games, Rio is undeniably South America's hottest destination. Lined with white-sand beaches, lush rainforests and surrounded by mountains, Rio delivers drama from almost every angle. From the Corcovado Mountain, the striking Christ the Redeemer statue overlooks the city's pristine beaches, that have attracted Cariocas (Brazilians born in Rio de Janeiro) and visitors alike for more than 500 years. And there's no livelier event than Rio's Carnival, held every year in February (there's always next year!).



Solomon Islands

For those seeking an authentic South Pacific experience or an off-the-beaten-track adventure, the Solomon Islands are hard to beat. Discover WWII relics scattered in the jungle, leaf-hut villages where traditional culture is well and truly alive and scenery reminiscent of a David Attenborough documentary. Volcanic islands jut up dramatically from the cobalt blue ocean, side-by-side with croc-infested mangroves and emerald forests. Climb an extinct volcano, surf uncrowded waves, snorkel pristine reefs and you'll feel like you have the whole place to yourself. With traditional guesthouses and hideaways, it's tailor-made for ecotourism. And all just a three-hour flight from Brisbane.

Ethiopia

Mysterious and incredibly diverse, Ethiopia has a rich history, jaw-dropping landscapes, unique wildlife and an extraordinary tribal heritage. It is home to unusual species such as the Ethiopian wolf and Gelada baboon; while its festivals are some of the most colourful in Africa. There are opportunities to experience village life and learn about local customs, explore bustling markets and old churches, and cruise to remote monasteries as well as the source of the Blue Nile. Lodgings and food are basic, though improving all

the time, but there is so much to see here which more than makes up for that.

Madagascar

Lemurs, baobab trees, rainforest, beaches, desert, trekking and diving: Madagascar is a dream destination for nature lovers. The world's fourth largest island is unique: 5% of all known animal and plant species can be found here, and only here. The extraordinary wildlife is matched by epic landscapes of incredible diversity ranging from rainforest to desert. Those who relish adventure, will discover it in Madagascar; the off-road driving is one of a kind, there are national parks that only see 100 visitors a year and resorts so remote you'll need a private plane or boat to get there.

North Korea

There is quite simply nowhere on Earth like North Korea. It's a chance to visit the world's most secretive nation, where the internet and much of the 21st century remain unknown, and millions live under the auspices of an all-encompassing personality cult that governs all of daily life. Few people realise that it's even possible to visit North Korea. You'll be

accompanied by state-employed guides at all times and hear a one-sided account of history. Those who can't accept this should stay away – but those who can will be rewarded with a journey into a world unlike any other.

To book your adventure to any of these incredible destinations, simply contact one of our travel specialists. They will not only put together a fabulous itinerary for you, but also save you valuable time and expense.

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