

vicdoc



MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. AUGUST / SEPTEMBER 2018

The impact of CrazySocks4Docs

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AND MEDICINE**

**THE NEXT STEP FOR
MY HEALTH RECORD**

**THE RISE OF
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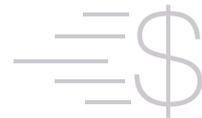
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Welcome from the editor



Congratulations to life member, Emeritus Professor John Murtagh, who has been recognised for his outstanding contribution to medicine as both a doctor and educator with the AMA Gold Medal. See page 33.

It goes without saying that AMA Victoria is right behind the initiative to raise awareness about doctors' mental health by long-time member, Dr Geoff Toogood. In just its second year, CrazySocks4Docs made a massive impact on social media throughout the world. In this edition of Vicdoc, Dr Toogood shares his thoughts on this year's campaign and where it might lead.

The sharing of health records electronically has been a major challenge for the industry for many years and the next step in the process for the implementation of My Health Record is automatic accounts for patients, unless they choose to opt out. We explain the recent changes to make the process smoother for you and your patients.

We also feature some great chats with members who have been happy to share stories about their interesting and diverse medical journeys - rural GP Dr Michael Connor, who has just commenced retirement after 50 years; while medical administrator Dr Sue Abhary and anatomical pathologist Dr Alison Skene take us through

the decision-making processes behind their career paths.

This Vicdoc also outlines some of the challenges doctors face combining a medical career with raising a family. While many other industries have improved their flexibility to support the need to balance work and life, medicine has been sadly lagging behind. The new enterprise agreements are a step in the right direction but there is still a long way to go. AMA Victoria will continue to fight for better employment conditions when it comes to parenting.

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 October.



Barry Levinson

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President's message



Almost 40 years ago on 28 November 1979, Air New Zealand Flight 901 crashed into Mount Erebus, Antarctica killing all 237 passengers and 20 crewmembers aboard. This crash and its aftermath was a great tragedy. However, despite the sadness and grief that no doubt still lingers for the families involved, this accident was instructive in understanding how errors occur and illustrates how far some industries have progressed, relative to healthcare, in the management of risk over the past 40 years.

The initial accident report compiled by New Zealand's chief inspector of air accidents, was released seven months later. It cited pilot error as the principal cause of the accident and attributed blame to the decision of the pilot, Jim Collins, to descend below the customary minimum altitude level, and continue at that height when the crew was unsure of the plane's position. However, in response to a public outcry, the New Zealand Government announced a further one-man Royal Commission of Inquiry into the accident, to be performed by a highly respected judge.

Justice Peter Mahon's report, released in April 1981, cleared the crew of blame for the disaster. On the contrary, Justice Mahon said, "The single, dominant and effective cause of the disaster was the mistake by those airline officials who programmed the aircraft to fly directly at Mt Erebus and omitted to tell the flight crew".

The need for air accident investigators to appreciate the wider organisational and systemic issues that can lead to incidents has since been appreciated for nearly four decades. Other industries have also looked very seriously at the cultural factors that appear to be important in preventing and minimising mistakes. They have become less inclined to attribute blame at the "pointy end" to pilots, train drivers and control room operators and more inclined to find fault with the environment in which people work.

So how do we explain the deregistration and manslaughter conviction of Dr Hadiza Bawa-Garba following the death of a six-year-old boy at the Leicester Royal Infirmary in the UK?

Dr Bawa-Garba, was a specialist paediatric registrar in year six of her postgraduate training (ST6), who had recently returned from maternity leave, and was solely in charge of the emergency department and acute Children's Assessment Unit at the hospital. Her patient, who had Down syndrome, was suffering from a known heart condition, diarrhoea, vomiting and difficulty breathing. Furthermore, on that day there was no senior consultant available and there was an IT system failure which led to delays in obtaining test results.

You can read more about the case in the June/July 2018 Vicdoc but for members of our profession who are familiar with what occurred, the circumstances surrounding this child's death are deeply disturbing, with Dr Bawa-Garba struggling against all odds to care for her young patient. She was undertaking the roles of three or four doctors in the absence of her supervising clinical consultant and it seems clear that even the most competent junior doctor would have struggled to keep their patients safe under such conditions.

Despite the lessons learned over the past 40 years and the need to approach human error differently, the regulation of healthcare in many jurisdictions remains mired in the past. Indeed, it seems fixated with the culture of blame that was implicit in the initial report of the Mt Erebus disaster. Furthermore, several other recent cases that have been pursued against junior doctors appear to arise from this same blind imperative to punish clinicians when things go wrong.

However, approaching such events in this fashion leaves a devastating personal and professional toll on the doctors concerned. Some years ago, Dr Colin West and his colleagues from the Mayo Clinic published an article in the *Journal of the American Medical Association* on the effect of errors on physicians-in-training and on the outcomes of their future patients. The researchers found that self-perceived errors not only increased the risk of burnout and depression but also adversely affected subsequent patient care. Over time, young doctors who believed they were responsible for errors felt less and less empathy toward their patients, which then led to an even greater risk of subsequent mistakes.

New CEO appointed

Unfortunately, adverse patient events can follow or precipitate personal problems in doctors such as anxiety, depression, or concerns about the ability to perform well. Few doctors receive institutional support to assist them with such stress and many within our healthcare system suffer alone. Indeed, our recent survey of Victorian Doctors in Training revealed that 65% of the trainees who responded rated their hospital's support for their mental health and wellbeing as being "very poor to average" and more than half rated the morale of medical staff at their workplace in the lowest category.

AMA Victoria believes it's imperative for healthcare administrators to redesign the workplace culture and change their adversarial approach to errors. There is a great need to develop an improved understanding of effective and immediate surveillance and support strategies for healthcare staff after serious adverse events as well as for patients and their families.

AMA Victoria is optimistic that following our recent consultations with a number of hospital CEOs and AHPRA that the traditional approach might be amenable to change. We will continue to advocate for more enlightened attitudes in order to reduce the numbers of professional 'second victims', produce less adverse events and result in fewer cases of vocational impairment being reported.

I would therefore like to thank all our members for their ongoing support of our association and its mission to assist our colleagues when professional difficulties such as these arise. We will continue to be a strong advocate for the health and wellbeing of all doctors and for improving the environments in which they work.

**Associate Professor Julian Rait
President**

AMA Victoria is delighted to announce the appointment of Mr Steven Burrell as Chief Executive Officer. Mr Burrell has significant experience in the executive management of a membership association, currently working as CEO of the Governance Institute of Australia.

Over the past three years, Steven has been responsible for leading the development and execution of the Governance Institute's mission, strategic direction and long-term strategy, while also representing the organisation externally to government.

"We are very excited to appoint someone of the calibre of Mr Burrell," AMA Victoria President A/Prof Julian Rait said. "He will bring strong leadership to the association, with a particular focus on membership services and governance."

Mr Burrell was previously General Manager, Communications and Public Affairs, at the Australian Institute of Company Directors from 2009 to 2015. In this role he managed media and government relations, policy and advocacy for another membership organisation.

With a Bachelor of Economics, he has also had a long and distinguished career as a finance journalist, holding senior management and editorial roles at the Sydney Morning Herald and Australian Financial Review.

Mr Burrell will formally commence his new role in September, but had the opportunity to meet members who attended the recent Council meeting on 17 July at AMA House.

A/Prof Rait would like to thank Ms Dianne Angus who acted as our interim CEO for five months. "Dianne was able to hit the ground running and have a very positive impact on the association in a short space of time. The staff will continue to build on the strong foundation that she has established. We wish Dianne well in her further endeavours in the corporate sphere."



CrazySocks4Docs: Championing doctors' mental health around the world

Cardiologist Dr Geoff Toogood is the founder of CrazySocks4Docs day, an awareness campaign about doctors' mental health which dominated social media recently. Following his own battle with mental illness, Dr Toogood now champions mental health support for doctors. The idea for the campaign started when he wore odd socks to work one day and a colleague who knew of his past mental health history, became concerned and asked if he was well. Dr Toogood, an AMA Victoria member, shares his thoughts on the day and where it may lead.

I started the second CrazySocks4Docs day bright and early - already the tweets were coming through predawn from New Zealand. The formal launch was at 7.30am at Peninsula Health and 36 hours later we had reached over 45 million people in many countries - even the South Pole!

What had initially begun as a social media challenge to a few of my friends 12 months ago was now taking on a global reach. The day engaged all sorts of people from health ministers to the newest members of healthcare. It struck a chord not only in Australia but elsewhere - in corners of the globe I hadn't expected. It was great for the day to be supported in the USA, Canada and UK, but I was also touched to hear about campaigns in countries such as Pakistan, Turkey and Nigeria. Clearly doctors' mental health is a worldwide, cross-cultural issue.

My basic premise for the day was to establish awareness about the mental health issues doctors can face, normalise the conversation, create a safe place for that conversation to occur, encourage honest authentic leadership in the space, and importantly, allow us to admit our vulnerability as a strength not weakness.

Although I feel generally that the wider community has embraced mental health awareness, we as doctors have for a number of reasons been very slow to recognise or act upon our own problems. We must find this awareness internally, but this would also be helped by a system that encourages doctors to speak up and ask for help, without fearing it could jeopardise their careers, or what colleagues might think. There is still much room for improvement in all of these areas.

Around the world doctors - and all health workers - are under increasing stress with rising incidences of burn out, depression, anxiety and sadly suicide. The medical profession experiences a higher suicide rate than most other professions. The day provided a reason or opportunity for doctors to tell each other they are perhaps suffering, or remember friends or colleagues who are no longer with us. For me the day was both emotionally challenging and tiring. I had been very ill in the past but it was extremely rewarding to see what has now flowed as a result of my personal experience. I know it was also an emotional time for many others. The social media sharing was at times heartbreaking, honest and confronting. It also had many smiling faces and coloured socks in a show of unity.

The campaign even managed to attract criticism from some senior individuals in health - both here and overseas. At times this has felt very hurtful, but on reflection, maybe it's a sign that we are making some headway. Once the critics roll in, I think it means you are rocking some boats, however these detractors need to know the campaign has already saved lives, with some doctors having already sought help directly due to the day.

It was not only doctors who benefitted from the day, however, as I have received messages from many different health craft groups about how important it has been to them. They benefitted from the senior leaders who gave their time to present on the day, and have stressed its value.

Establishing dialogue among doctors on the issue will flow not only to others in health but those we treat, because healthy doctors who show leadership in this space can ultimately only be good for all. The statistics show just here in Australia that suicide took 2866 people in 2016. It stretches way beyond doctors, but if we are showing vulnerability and normalising the conversation, it will hopefully break down barriers for the rest of the community who might be suffering.



An early morning start at Peninsula Health for the 2018 launch of CrazySocks4Docs. Left to right: State Member for Frankston Paul Edbrooke MP, Peninsula Health Chief Executive Felicity Topp, RAAF Group Captain and orthopaedic and trauma surgeon Miss Annette Holian, Dr Geoff Toogood, Ambulance Victoria CEO A/Prof Tony Walker and AMA Victoria President A/Prof Julian Rait.

So where does the future lie for the campaign? It starts with a big, juicy bone for my co-founder Sammy the sock-eating golden retriever who forced me to wear odd socks to work one day, a few weeks for me to gather some mental rest and self care, then it's about making sure we continue to run the day and gain the most for all out of it.

I started with the premise if CrazySocks4Docs saves one life a year I would be pleased. I now hope it saves many more. Hopefully we can advocate for more funds towards better care in mental health and suicide prevention programs for the entire community.

What needs to remain, however, is the authentic and heartfelt background to the campaign. The day's success was built on this and the global need for doctors' mental health to be acknowledged.

My thanks go out to the many people who are helping in this space both here in Australia and internationally, and those who attended and supported the launch.



Dr Geoff Toogood
Cardiologist
CrazySocks4Docs founder



VDHP: Supporting doctors for 18 years and still going strong

The Victorian Doctors Health Program (VDHP) was established jointly by the Medical Practitioners Board of Victoria (MPBV) and AMA Victoria in 2000.

Due to an increasing awareness of the shortcomings in the provision of health services to the medical profession - particularly those health problems that are likely to cause impairment - the VDHP was based on already established physician health programs throughout the USA and Canada.

Since its inception there has been an extremely high demand for the VDHP's services across a wide range of clinical problems, including stress and burnout, mental health issues and substance use problems.

While doctors suffer from the same range of disorders as the general population, there is a tendency for doctors to present late. This may be due to procrastination or denial that there actually is a health issue that may require professional intervention. Doctors may minimise or rationalise symptoms, or be hesitant to reveal what they may regard as an 'inadequacy', when it is actually more likely to be reflective of either an illness or a natural reaction to role strain and prolonged stress.

The primary objective of VDHP is to offer the best possible service for sick and impaired doctors and medical students and to assist them in achieving optimal health.

Each year we receive anywhere up to 650 contacts by either phone, email or through our website - www.vdhp.org.au - and the degree of VDHP involvement will vary. Some callers solely seek information such as the recommendation of a good GP in their area, or they call to discuss the health issue of a colleague, employee, family member or friend (this can be done anonymously).

Doctors and medical students needing to be seen are offered a prompt

appointment with one of the VDHP doctors. Strictest confidentiality is maintained - the only exception being if a practitioner continues to work while impaired and subsequently puts patients at risk. Health concerns are assessed and treatment options discussed and arranged.

The VDHP is also able to offer intensive, regular, ongoing support if needed through the Case Management Program. The VDHP is supported by a dedicated team of treating professionals who are keen to assist doctors in their ongoing health management including GPs, psychologists, psychiatrists and addiction medicine doctors - all of whom are used to seeing doctors as patients.

The VDHP is a confidential and free service for doctors and medical students in Victoria.

It is independent of AMA Victoria and the Australian Health Practitioner Regulation Agency.

In addition to clinical services, the VDHP also:

- raises awareness about the importance of doctors and medical students maintaining good health and wellbeing through educational presentations at hospitals, universities, colleges, conferences, and related expos
- assists doctors who are re-entering medical practise after a health-related absence

- provides compassionate and non-judgmental support in all situations
- provides advice to anyone who is concerned about a doctor or medical student.

The VDHP has a very dedicated team of staff which includes Medical Director Dr Tim Dewhurst, Senior Clinicians Dr Fiona McGlade and Dr Brendan Steele, Psychologist and Case Manager Cheryl Wile, and office manager Sally Gallucci.

In 2017 a decision was made to move the VDHP from its original home in the Aikenhead Building at St Vincent's Hospital to AMA House in Parkville. While there were some initial concerns expressed that relocating to AMA House could deter medical practitioners from accessing the program, this has not been the case.

Since the move, the VDHP has assessed and supported more than 4200 medical students and doctors. I have been privileged to have worked at the VDHP for 15 years and have seen it help hundreds of medical practitioners whose work as doctors has ultimately been enhanced - not diminished - by their personal struggles.



Cheryl Wile
Psychologist & Case
Manager
VDHP

The VDHP is an independent legal entity (AMA membership is not needed to access the service) which is funded by Doctors' Health Services Pty Ltd. Call (03) 9280 8712.

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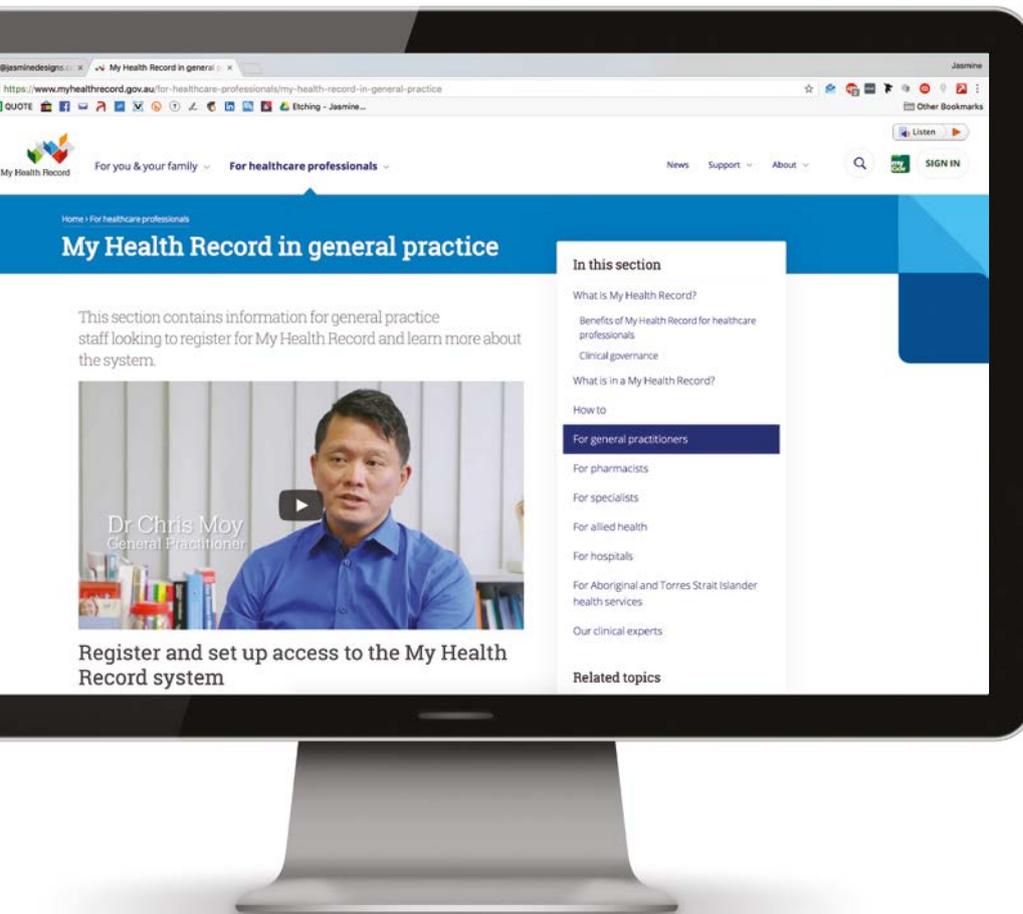


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My Health Record: A safe and secure clinical health service



Clinical leadership is essential in the transformation of healthcare. Australia has a momentous opportunity with My Health Record to create the digital health infrastructure that will produce benefits long into the future.

My Health Record (MHR) offers health professionals secure digital access to a patient's record at the point of care, wherever that may be. For patients the message is this - MHR puts your health in your hands.

In his recent National Press Club speech, Australian Digital Health Agency CEO Tim Kelsey said, "We are at the start of a journey: the history of technology in healthcare has been mixed.

"We must manage our expectations. Technology has transformed other industries - airlines, finance - and it will change the experience of healthcare. But this will take time and patience. This is an evolution much more than a revolution."

He also acknowledged that some people will be apprehensive about MHR. However, he also reflected on the status quo.

"I saw a GP right at the start of my work with the Agency who showed me a single paper record of a new patient that he was treating that was literally three foot high - and he was taking it home that night to try and identify the key clinical data. Paper based healthcare is not just inconvenient and threatening for people who have to remember their history in the emergency room when they are at their most vulnerable - how many times have I heard that - it is also dangerous.

"My Health Record is a part of the solution - it is not everything. It will not solve all the information challenges of modern Australian healthcare but it is an important step forward on our collective journey, one of the digital health basics," Mr Kelsey added.

Already, more than 5.8 million Australians have an MHR and 6,413 GP practices are connected to the system. As well, 51 pathology and diagnostic imaging services and 2,797 community pharmacies are connected.

Benefits

MHR is an online summary of an individual's key health information. For your patients, it means their medical conditions, medicines, allergies and test results are kept together in one place. Individuals can choose who sees their MHR and what's in it. They can choose to share their information with the healthcare providers involved in their care.

It allows people to take more control of their own health and wellbeing, manage their children's health, and upload key documents, like advanced care directives.

Every Australian with a Medicare or Department of Veterans' Affairs card, will be offered an MHR, unless they choose not to have one, during the three month opt out period that runs from 16 July to 15 October 2018. During this period individuals who do not want a record will be able to opt out by visiting the MHR website - www.myhealthrecord.gov.au - or by calling 1800 723 471 for phone-based assistance.

When the opt out period dates were announced earlier this year, then AMA Federal President Dr Michael Gannon welcomed the move.

"The current system of medical records means that we may have incomplete information on a patient - especially if the patient has recently seen another specialist or has been discharged from a hospital," Dr Gannon said. The My Health Record will result in doctors having access to better information, in a more timely fashion, via secure means. Less time chasing up paperwork means more time can be spent treating our patients."

In the past year there have been significant additions to MHR including a medicines information view and growing capacity to include pathology and diagnostic imaging reports.

As more people use MHR and information in the system grows, it will help support clinical decision-making. However, it is important

that GP practices ensure their clinical information software is using the latest version available to ensure the practice can access the enhancements to the MHR System.

Further information on CIS and MHR is available at: www.myhealthrecord.gov.au/for-healthcare-professionals/my-health-record-in-general-practice

Security

Strict privacy control is a central feature of MHR. The security of the system and the privacy of Australian's health data is taken very seriously. The MHR is built to industry standards for storing and processing sensitive information and there has never been a security breach of the system. It balances safety and security with the benefits available to consumers and healthcare providers at the point of care.

MHR has various safeguards in place to protect an individual's health information including encryption, firewalls and secure login. MHR data is stored in Australia and is managed by the Australian Digital Health Agency in line with the Australian Government Protective Security Policy Framework.

MHR has security controls that protect health records from unauthorised access and guard against cyber-attacks. These controls include secure gateways and firewalls, encryption, authentication mechanisms, and malicious content filtering.

The Australian Digital Health Agency's Cyber Security Centre monitors for suspicious activities. The centre will trigger an investigation when required. The Agency works closely with other Australian Government organisations including the Australian Cyber Security Centre, the Department of Home Affairs, the Department of Human Services, the Australian Signals Directorate, and the Office of the Australian Information Commissioner to ensure that any suspicious activity is appropriately dealt with and reported.



Australian Digital Health Agency CEO Tim Kelsey.

In addition to these measures, the MHR system is protected by legislation which governs the way the system is accessed, managed and used. Criminal penalties for unauthorised access to information can include up to two years in jail and up to \$126,000 in fines. Civil penalties can incur up to \$630,000 in fines.

All patients can benefit from having a digital record of their medical history that is accessible by their treating healthcare providers. Particularly those who have complex health conditions or who see several healthcare providers.

Many healthcare services are already uploading information to and/or viewing information in the MHR. GPs may see important health information they might not otherwise have had access to - such as hospital discharge, prescription and dispense information. The level and range of information included in MHR, and therefore its value, will increase over time.



My Health Record

What you need to know about My Health Record

All Australians will get a My Health Record (MHR) by the end of 2018 unless they choose to opt out between 16 July and 15 October 2018.

All doctors and frontline staff need to know:

- the basic concepts of MHR
- the personal choice elements, including that an individual may choose to not have an MHR created
- how MHR is used within the context of their organisation.

This article addresses some frequently asked questions to help you understand MHR.

Must I open a patient's MHR if I notice they have one?

No, you are not compelled to do so as a matter of routine, and you can decide whether you clinically need to access it.

Do I need to get consent to access an MHR?

No, as long as you are accessing the record to provide healthcare to the individual. Patients consent to this when they register for MHR. However, if you access it in their presence, it would be courteous to inform the patient. Patients can place controls on who can access their whole record or documents within their record. They can also view which organisations have accessed their record, and can get SMS or email notifications when an organisation first accesses their MHR.

Can my staff access an MHR for me if I am at the hospital?

Yes, if they have been authorised. Once a healthcare organisation is registered to participate in the MHR system, individual healthcare providers and other relevant employees can be authorised to access the system.

Do I need consent when I upload documents?

When a patient registers for MHR, the patient provides a standing consent for documents to be uploaded to their MHR. So it is

not necessary to obtain consent each time you upload a document, except for Shared Health Summaries (see below). However, the AMA recommends informing patients when you upload all documents, particularly if the information is sensitive. If a patient requests that a document or a certain piece of health information not be uploaded, you are obliged to comply. Patients are able to remove documents you have uploaded, but not edit them.

What is a Shared Health Summary?

A Shared Health Summary (SHS) provides a patient's status at a point in time. These are especially beneficial for patients with chronic conditions or multiple comorbidities.

To create an SHS a healthcare provider must obtain the patient's agreement that they are to be a nominated healthcare provider (NHP) for the patient. If you are not the NHP (but you are authorised) you can still access the patient's MHR, and you can upload clinically relevant information using an Event Summary which details significant healthcare events relevant to ongoing care, e.g. a new diagnosis or a clinical intervention. Any healthcare provider at an organisation participating in the MHR system can upload an Event Summary.

Can I bill Medicare for uploading to an MHR?

There are no MBS item numbers for uploading to an MHR. However, the time taken to prepare documents for uploading counts toward consultation time for billing the MBS, as long as the document preparation was part of providing a clinical service, and the patient was present.

What happens to the MHR on the death of a patient?

The record is retained in the system for 30 years (or if date of death is not known, for 130 years after their birth date). It will not be accessible to healthcare providers, but only where allowed by law for purposes such as audit or maintenance.

Does the MHR form part of the record for the purposes of a subpoena?

No, as a doctor does not have possession and control of the MHR. However, if a doctor downloads documents from the MHR (e.g. a discharge summary or test results) into their own record, those documents will be part of the doctor's record for the patient and will need to be produced in response to a subpoena.



Where can I find more information?

Australian Digital Health Agency:

- Shared Health Summary (example clinical document): www.digitalhealth.gov.au/files/assets/cdaExamples/CDASharedHealthSummary.html
- Using the My Health Record System: www.digitalhealth.gov.au/using-the-my-health-record-system

Royal Australian College of General Practitioners:

- Digital Business Kit 1.5 My Health Record: www.racgp.org.au/digital-business-kit/national-ehealth-records-system

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The challenge of pursuing medicine and raising a family



AMA Victoria has undertaken a significant amount of work during the last few years to modernise employment practises for doctors. In the past, medicine has been a male-dominated profession and employment conditions have not kept pace with the changing environment, where many doctors now have to balance family responsibilities with their medical careers.

One-year contracts and the insecurity that these create raise a number of issues from an industrial relations perspective and add to an already stressful work life for Doctors in Training (DiTs). The insecurity of this type of employment can lead to doctors feeling reluctant to raise issues and fix problems in the workplace, as they believe the individuals they need to raise issues with may have some influence on their careers and ongoing employment.

Indeed some hospitals use the fact that doctors have one-year contracts as a form of performance management, knowing that if they have a doctor who is not fitting in or performing well enough that they can just opt not to renew his or her contract. This is poor management practise and does nothing to improve the doctor's performance or behaviour - it just moves the doctor on to the next health service.

Another issue is the increased workload created by the need to reapply for jobs every year - writing cover letters, seeking references and attending interviews. This process can be exhausting and very stressful in an environment where doctors are already under a great deal of pressure due to the nature of the job.

All of the above concerns and issues are heightened significantly when a doctor is considering starting a family. We know from the hundreds of calls we receive each year that doctors agonise over this decision, which is often taken out of their hands. Under the AMA Victoria 2013-2017 DiT Agreement, when a doctor (female or male) took unpaid parental leave, their employment contract would have most likely expired. Rather than being on parental leave, this technically left

them unemployed. When the doctor decided to return to work they were forced to compete for roles alongside others who may not have had the same carer's responsibilities. In addition, they usually did not feel they were able to request part-time or flexible working arrangements as it may have limited their chances of being offered the job. It's a unique problem, compared to every other industry in Australia, where all permanent workers who take parental leave are entitled to be given their job back for up to two years, along with an entitlement to request part-time hours.

These factors were the key consideration that led to the development of AMA Victoria's claim for two-year contracts as a first step to move the industry towards permanent employment of DiTs (as is the case in New Zealand) and to the development of a new parental leave clause in the new Enterprise Agreement for DiTs.

The new clause is non-gender specific and allows for a doctor to have the remaining portion of their contract honoured by the health service where they work at the time of taking parental leave. This means that a doctor with six months left on their contract at the time of taking parental leave of more than three months will be entitled to come back to complete the six months after their leave, if they choose to do so. At that time they will also be able to negotiate part-time arrangements with their health service. While we recognise that this is not a perfect solution yet, it is a significant step forward for the medical profession.

The improvements to the parental leave clause go further, with doctors now being able to access their personal

leave in order to attend pre-natal appointments or parenting classes that are only available or can only be attended during the doctor's ordinary rostered shift. There is also now a requirement under the agreement for the health service to provide a paid break to express milk or breastfeed a baby under one year-old. The health service must also provide a location, free of intrusion, for this to occur.

There have been other improvements to clauses that will impact doctors who have carer's responsibilities, such as one that has expanded the circumstances in which a doctor is entitled to request flexible working arrangements, for example, part-time work. This now includes carer's responsibilities for dependents with disabilities, a medical condition, mental illness, or those who are frail or elderly.

In addition there is now an entitlement to take family violence leave of up to 20 days for doctors who are experiencing such problems, as well as access to personal leave to support a member of their family who is experiencing family violence.

AMA Victoria will continue to advocate for improved employment conditions around parental leave and the issues involved with caring for a family. We would like to hear the thoughts and experiences of doctors at all levels. Please contact Vicdoc Editor Barry Levinson on BarryL@amavic.com.au if you are keen to contribute.



Grant Forsyth
Workplace Relations
Advisor

In profile: Choosing a speciality



Dr Alison Skene - Anatomical Pathologist at Austin Health

Why and how did you choose your speciality?

When I started learning pathology in third-year university (it was the traditional model with the first years spent studying anatomy and physiology), I thought 'Wow, finally, this is what medicine is all about'. It was only through the study of the body's response to disease that I could hope to understand clinical medicine. Through the rest of my undergraduate training I always enjoyed the diagnosis part of medicine, and the people who taught pathology always seemed the smartest.

One of my influential teachers was Dr Ted Cleary, a physician and researcher, who ran the most challenging clinicopathological correlation teaching sessions. After fourth year I took a brief sidestep into Ted's research lab, doing a BMedSc in basic science (monoclonal antibodies were the flavour of the moment). Although I was open to other specialties, pathology still seemed at the heart of medicine. Like many back in those days, I started registrar training with the attitude of 'giving it a go', but not having much of an idea

Choosing a specialty is one of the most important career decisions for a doctor. Some study medicine with a clear career pathway in mind; others commence with no idea of the direction they might head. Following our April/May article on choosing a specialty, we profile a range of specialists who reflect on their careers and selected fields, with the aim of helping others who are still to make a decision.

about what the life of a pathologist entailed. Luckily I found I was suited to it and haven't looked back!

What personal qualities and skills/strengths do you think are integral to reaching your potential in the role of anatomical pathologist?

Intellect, a strong work ethic, empathy and commitment to lifelong learning, are all essential traits of a good doctor. In the modern pathology world one also needs an enquiring mind, good written and verbal communication skills, 3D-spatial awareness, and some would say a certain degree of obsessiveness. I would also add a degree of pragmatism and ability to accept uncertainty.

What do you love and what do you find challenging about your role?

I love that my diagnoses provide the basis for patients' care, even if our medical colleagues and the patients themselves are unaware of this! From the tissue we are given, we can also provide a wealth of prognostic and predictive information to help guide treatment. We have had to embrace the incorporation of molecular

testing into our armamentarium, which is challenging to keep up with. Many of the tools we use today may seem archaic (the light microscope was invented in the 1600s, the haematoxylin and eosin stain in the late 19th century) but are still fundamental to our practise. And with the application of new techniques or adaption of old ones (such as immunohistochemistry for markers of molecular alterations) the information we can obtain from smaller and smaller specimens continues to astound me.

In our department we resist the trend to super-subspecialisation, but that increases the challenge of keeping up to date in multiple fields of medicine. Stress also comes from ever-increasing demands on our services, in a resource-constrained and siloed environment, where we have little control over our workload. The modern patient-focused and collaborative approach to medicine is not only good for patients but is also translating into better recognition of our role in patient care.

Describe your typical day as a pathologist.

A fair part of the day is spent on diagnosis, especially cancer, using light microscopy with special

techniques as required, often working closely with a registrar. Like most pathologists in my department I see a range of histological and cytological specimens, slanted to my specialty interests of medical renal and gynaecology. I do at least a couple of multidisciplinary meetings a week, which involve review of cases, presentation and discussion - these are an essential part of our quality assurance and also opportunities to forge links with other clinicians. A public hospital anatomical pathology department relies very much on teamwork, and there are many informal interactions with colleagues, registrars and laboratory staff around cases. Our work is also highly scrutinised, and continuing education and formal quality assessment activities take up a few hours a week. Throw in frozen sections and some administrative duties and that doesn't leave much room for research. I have some collaborative projects on the go, but certainly this is not a major focus of mine. I am most interested

in making more efficient use of our resources, such as through the 'Choosing Wisely' campaign.

How do you see the practise of pathology changing over the next 20 years?

In the short term I see digital imaging having a big impact, including the use of scanned images rather than glass microscope slides for primary diagnosis and reviews. This is likely to impact the structure and distribution of our workplaces; perhaps the work will be outsourced to another country. Artificial intelligence is a long way off replacing us for diagnosis but radical change will certainly come from 'liquid biopsies' and other less invasive methods than tissue biopsies. These may render our morphological skills redundant, but only after they can be proven to be better than the gold standard. It happened very quickly with pap smears, so I'm on my guard.

What advice do you have for those doctors considering your specialty?

If you have the passion for pathology, seek out opportunities to learn more about it, as many medical students and junior doctors are not exposed very much to the working environment. It is difficult to know if you are suited unless you spend time, say in an elective. You will need the attributes mentioned above, plus copious stamina to get through the inordinate number and complexity of exams. The life of a registrar is very different to that of a pathologist, but the rewards include more autonomy, and opportunities for part-time work. You might miss patient interaction, but you will still need interpersonal skills. As broad-based experts in understanding disease, and translating research into practise, pathologists are well-placed to remain at the heart of modern medicine.

We would love to hear from you if you want to share your story about choosing a speciality, or if you would like assistance in navigating your career path. Please contact our Careers Consultant Carolyn Speed on CarolynS@amavic.com.au



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Annual General Meeting Dinner

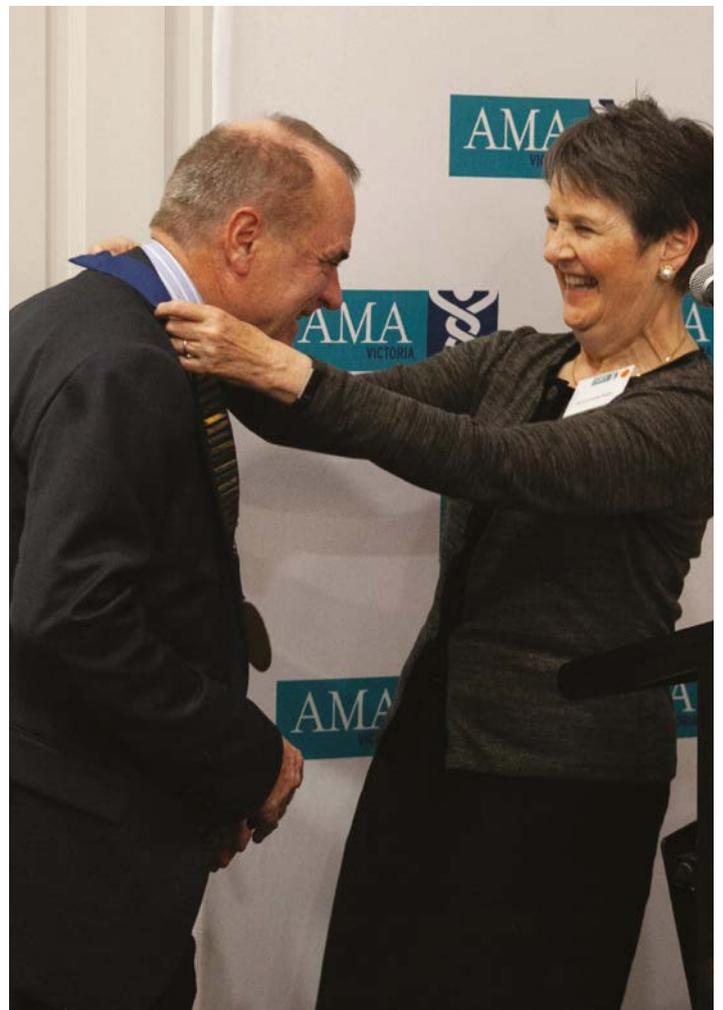
AMA Victoria officially welcomed a new President and Vice President at the Annual General Meeting held at the Treacy Conference Centre in Parkville on 22 May.

Prior to the meeting, A/Prof Julian Rait was elected President, while Dr Roderick McRae returned to the Board after a one-year break and was voted Vice President. Dr Catherine Mandel and Mr William Blake were re-elected for two-year terms and were joined by newly elected Board member Dr Enis Kocak. Dr Michael Levick (Treasurer) and Dr Sarah Whitelaw remain on the Board.

At the Council meeting on 17 July, Dr William Pring (Chair of Council), Dr Rosalind Terry, Dr David Monash and Dr James Lisik were elected to fill the remaining positions on the AMA Victoria Board.

We would like to thank retiring Board members Dr Lorraine Baker, Dr Xavier Yu, Dr Sue Abhary, Dr Jillian Tomlinson, Dr Bernadette Wilks and Dr Vladimir Vizec for their outstanding contribution to the association. A particular special mention to Dr Baker and Dr Yu for serving as President and Vice President for the past two years.

The 2017 Annual Report can be viewed on the AMA Victoria website.





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Rural GP retires after 50 years of helping patients



A much-loved and admired rural GP is hanging up his stethoscope after 50 years of serving the communities of Beeac and Colac in the Western District of Victoria. Dr Michael Connor has also been a valued AMA Victoria member since 1968 and was the Vice Chair of Council in the early 1990's.

Staff at the Otway Medical Clinic were very keen to pay tribute to Dr Connor and fill us in on his medical journey.

His father was a rural GP who did everything and covered a large area on the South Australian border and Dr Connor decided to follow in his footsteps, but his dad wasn't the only source of inspiration.

"I am just re-reading a novel that I read as a teenager. I wasn't aware of it at the time, but it probably influenced my decision," Dr Connor recalled when he spoke to Vicdoc. "It's Taylor Caldwell's *Dear and Glorious Physician* (1958) about Saint Luke, a very good for his time medical practitioner. I had no idea what I wanted to do, apart from knowing I wanted to do something in the country. I was thinking initially about agricultural science until one night it hit me, 'Why don't I become a doctor?'"

Dr Connor graduated from Melbourne University in 1967 at the young age of 22. "After I had done the two years in hospitals, my father said there was a practice vacancy up at Beeac (20 minutes north of Colac) and said if I came up to do his anaesthetics during surgery, then he would keep an eye on me and also do the same. It was a learning by apprenticeship scheme."

After beginning in a solo GP practice in Beeac in 1969, he moved to a group practice in Colac in 1971 - now known as the Otway Medical Clinic. Dr Connor never looked back after receiving the

approach to move to Colac, staying all the way through to retirement. "After an initial surge in patients during the 1970 flu epidemic, numbers in Beeac just gradually fell. Not for any bad reputation issues - people just became used to traveling into Colac for their services after the grocery and butcher shops and the bank in Beeac closed."

Dr Connor has guided many of Colac's community members into the world and gently farewelled others. He has cared for many families over generations, particularly delighting in delivering babies to new mothers who he had previously delivered himself.

Dr Connor enjoyed the diversity of skills required of a rural GP, but the responsibility had its advantages and disadvantages. "We all used to enjoy being challenged by the full range of medical care but now everything is split up and sub-specialised. The country is still a great place to raise your family as a doctor but night work can be very onerous. Lately we've just got Hospital Medical Officers now being paid for by the government who run our casualty department (at Colac Hospital), so the GP workload has dropped off hugely."

Progress has also been appreciated in other areas. "When I first came here we used to do all the road trauma cases in the days before seat belts and laminated windscreens. We'd spend our Friday and Saturday nights sewing up people from car accidents stinking of alcohol. That's all changed now. The

high helicopter retrieval service has also made a huge difference there."

Away from work, Dr Connor's passion is aviation and after spending six years building his own plane in the 1980s, he flew himself everywhere for the next 25 years. He has been an instructor in Advanced Life Support Obstetrics, teaching management of obstetric emergencies for many years and with the flexibility of flying his own plane, he has taught all over Australia and had locum positions on Norfolk Island.

In his younger days he raced motorbikes and production cars at Bathurst, Phillip Island, Calder Park and Winton, and was quite successful, winning or being placed in many events.

These days he enjoys watching the racing and only rides a bicycle now. He also enjoys travel, photography, a little whisky distilling for medicinal purposes only, singing and playing the bag pipes in a pipe band. Dr Connor and his wife Denise have been married for 51 years and have six children, 15 grandchildren and six great grandchildren.

What will he miss most about working? "The social contact with patients," he said. "I've got to know lots of them over

many generations. In a couple of cases I've looked after five generations from the same family!"

Otway Medical Clinic Practice Manager Di Loubey said the decision to retire was very difficult for Dr Connor. "He is an exceptionally humble and clever man who has made a positive impact on so many," Ms Loubey said.

"His colleagues will miss his support and guidance, our patients will miss his care and dedication and the team at the Otway Medical Clinic will miss his friendship and 'dad jokes' in the workplace. Colleagues and staff have accepted that no one will ever be able to fill his enormous shoes. We could always bank on Mike coming to lend a hand in times of need, even when he had a day off."

Ms Loubey said Dr Connor has always been a strong advocate for the local community and has championed the cause of residents at the Colanda Centre since it opened in 1976 as a home for people with intellectual disabilities.

"Mike provided on-site medical care to the residents for decades and ensured that our current premises (built in

1998) had suitable door jambs for their wider wheelchairs," she said.

Dr Connor has also trained and mentored registrars and students, gained FRACGP in 1981 (winning the Monty Kent-Hughes Memorial Medal for achieving the highest exam marks), DRANZCOG, aviation medicine qualifications and has been a member of the Australian Society of Anaesthetists and a Fellow of the Australian College of Rural and Remote Medicine.

"We wish him good health and happiness in his retirement," Ms Loubey said. "His good work, knowledge and skill will never be forgotten. Dr Michael Thomas Connor is our legend!"



Thanks to Di Loubey for her assistance with this article. We are interested in sharing more stories about the working lives of rural doctors. Please email BarryL@amavic.com.au if you have a story to tell.



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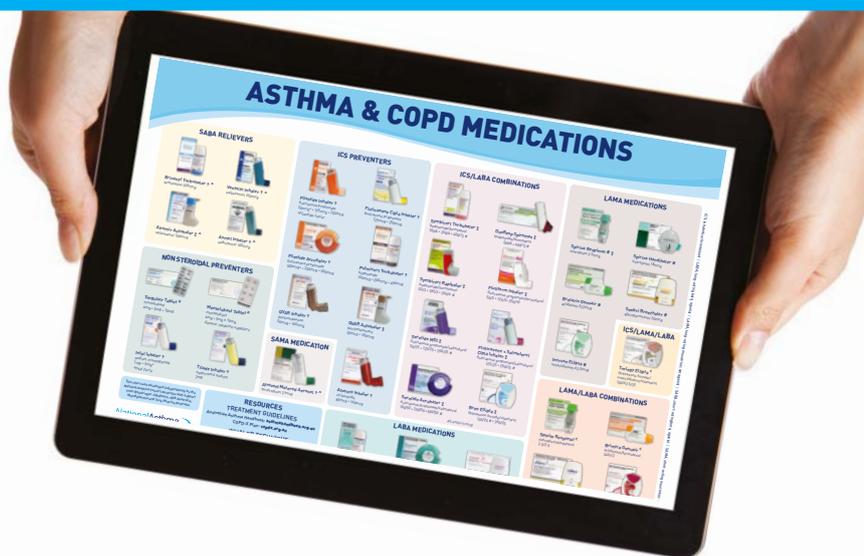
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**The Ultimate
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Help your patients better control their asthma

The National Asthma Council Australia has recently released a package of new and updated resources for primary care health professionals to help combat the problem of incorrect inhaler technique.



Research shows up to 90 per cent of patients incorrectly use their inhalers for asthma or chronic obstructive pulmonary disease (COPD). Moreover, a patient's own assessment of his or her ability is not a reliable guide. An Australian study found that 75 per cent of patients using an inhaler for two to three years reported they were using their inhaler correctly, but on objective checking, only 10 per cent had the correct technique.

The National Asthma Council Australia (NACA) has released an updated version of its popular *Inhaler technique for people with asthma or COPD* information paper to provide clearer practice recommendations and incorporate new medicines and devices that have come onto the market in the last two years.

"It's really hard for health professionals to keep track of all the inhalers, especially as new medicines and devices continue to become available," said NACA asthma and respiratory educator and nurse, Judi Wicking.

"And many health professionals don't realise how common poor technique is, nor how big an impact this can have on asthma and COPD management. The good news is that correcting patients' inhaler technique has been shown to improve lung function, quality of life and asthma control."

The updated information paper summarises the latest evidence

on the prevalence and impact of incorrect technique and includes checklists for using the expanding range of new respiratory devices available on the market. "The paper reflects the advice in the Australian Asthma Handbook, which recommends that inhaler technique should always be checked before considering dose escalation or add-on therapy," Ms Wicking said.

Alongside the information paper, the popular *Asthma and COPD Medications and Allergic Rhinitis Treatments* charts have also been updated to include the latest inhalers and the main intranasal treatment options available in Australia. These charts are intended as useful educational tools for health professionals to help with identification and explanation of different treatments.

Demonstration videos for new devices have also been added to the NACA how-to video library, including for the new *DuoResp Spiromax* device. Each how-to video shows an asthma and respiratory educator and a patient demonstrating correct technique for the device, accompanied by simple captions of the key steps.

"It's important that health professionals ask their patients to show them how they use their inhalers and then provide one-on-one training to ensure that proper technique is used," Ms Wicking added. "It's a good idea for all of us to check our own

techniques, especially for new devices, by reviewing the new resources."

For more information on asthma, downloadable versions of the resources, and to view the how-to videos please visit www.nationalasthma.org.au

The updated *Asthma and COPD Medications and Allergic Rhinitis Treatments* charts are also available for download and/or order via the NACA website.

Respective sponsor representatives will assist with the distribution of the printed resources, delivering them to GPs, practice nurses and pharmacists nationally over the coming months.



References available from the Editor on request.

The National Asthma Council Australia maintained strict editorial independence in developing these resources. The information paper revision was supported by an unrestricted educational grant from Teva Pharma Australia. Revision of the *Asthma and COPD Medications* chart was supported by AstraZeneca, Boehringer Ingelheim, Mundipharma and Teva Pharma Australia. Revision of the *Allergic Rhinitis Treatments* chart was supported by Mylan Australia. Development of the *DuoResp Spiromax* how-to video was supported by Teva Pharma Australia.

Were you paid properly over Easter?

Some members in the public health sector have raised concerns that they were not properly paid for work over the Easter period. There were four public holidays at Easter: Friday 30 March, Saturday 31 March, Sunday 1 April and Monday 2 April.

Sunday 1 April is not specifically mentioned in the AMA Doctor in Training or Specialists Agreements as a public holiday but it is picked up by the public holiday clause in each agreement - and it is a declared public holiday in Victoria.

If you did not work on any of these days you were entitled to be paid an ordinary day's pay for each public holiday. This includes public holidays which fall on your rostered off days. If you worked on any of the public holidays you were

entitled to be paid the public holiday rate of 2.5 times your ordinary rate of pay.

Each public holiday which falls on a day on which you are rostered to work counts as part of your ordinary hours for that week. For example:

Dr A normally works a 38 hour week Monday to Friday and does overtime as required.

Monday 1 April was a public holiday and Dr A did not work that day. Dr A worked 10 hour days on each of Tuesday Wednesday, Thursday and Friday.

Dr A should have been paid 38 ordinary hours pay, which includes the Monday public holiday and 7.6 hours for each of Tuesday, Wednesday, Thursday and Friday. Dr A should have been paid overtime

for 2.4 hours on each of Tuesday, Wednesday, Thursday and Friday.

There is a suggestion that some health services have not included public holidays falling on a rostered work day as counting as part of the ordinary hours of work. There is also a suggestion that some health services have not paid for all four public holidays.

Please contact AMA Victoria on (03) 9280 8722 if you consider that you have not been paid correctly for the weeks in which public holidays fall.



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GPs a leading source of weight and nutrition information

The general practitioner is one of the most popular sources of health and nutrition information, especially for people in regional areas, according to new survey results from LiveLighter.



About LiveLighter

LiveLighter is a public health education campaign which encourages Australians to lead healthier lives by changing what they eat and drink and being more active. In Victoria, the LiveLighter campaign is delivered by Cancer Council Victoria.

On average, more than a third of Victorians (36%) reported turning to their GP for health and nutrition advice. This places GPs ahead of the Australian Dietary Guidelines (31%) and dietitians and nutritionists (22%), making them the second most popular go-to for health and nutrition advice.

According to the LiveLighter survey of more than 1000 Australians aged 18-64, friends and family were the overall favourite, with 41% of people turning to those closest to them to learn more about nutrition. But in regional Victoria, GPs were the number one source (38%), equal with friends and family (37%).

LiveLighter Campaign Manager Alison McAleese said these findings show just how influential GPs are in helping patients prevent obesity-related conditions like heart disease, type 2 diabetes and 13 types of cancer.

"Weight management can be a difficult topic for a GP to navigate, even without the lack of resources and time available to support patients to achieve a healthier weight," Ms McAleese said. "Medicare doesn't incentivise lifestyle interventions in the same way it does diabetes treatment, for example.

"Time can also be an issue. Often, people see their GP for a specific, acute issue, not to talk about their lifestyle more broadly. So a typical 15-minute consultation doesn't often allow enough time to expand the conversation."

General practice registrar Dr Gihan Jayaweera said given the health implications of obesity, it's important doctors feel well equipped to speak on weight management and nutrition. "I absolutely love talking about lifestyle intervention because it empowers the patient to take control of their own health," Dr Jayaweera said.

Dr Jayaweera feels doctors need to work with the patient to brainstorm strategies to improve their lifestyle, rather than just prescribe a list of interventions for them. "Having a brainstorm style chat about their

What the LiveLighter survey found

Where do people get their health and nutrition information?	Victoria (overall)	Melbourne	Regional Victoria
Family/friends	41%	43%	37%
General practitioner	36%	35%	38%
Australian Dietary Guidelines	31%	31%	29%
Books/magazines	30%	30%	29%
Cooking shows on the television	25%	26%	22%
Dietitian/nutritionist	22%	22%	22%
News and current affair television programs	22%	22%	21%
Internet blogs	21%	23%	17%
Social media (e.g. Facebook, Twitter or Instagram)	20%	21%	18%

The LiveLighter survey involved 1,097 Victorian adults aged 18-64 years via an online panel.

lifestyle more broadly gives patients the opportunity to articulate areas of their health they would like to change, such as weight or diet," he said. "Asking questions like, 'In what way does what you eat or drink affect your health?' is a great way to start an open discussion about someone's eating habits."

LiveLighter has a range of resources doctors and clinics can use to help make weight management a routine part of care. Patients can also create their own LiveLighter online account and receive a meal plan tailored specifically for them.

Unsure how to speak to your patients about weight? Check out LiveLighter's top tips.

Use open-ended questions

- As tempting as it may be to jump straight in with advice, you're likely to have more success by starting with some open questions, like, "How do you feel about your current eating pattern?" or "How would you describe your lifestyle at the moment?"
- This creates ambivalence which provides an opening for the patient to articulate areas of their health they are dissatisfied with.

Introduce a weight management policy for your clinic

- Work with your practice manager and other doctors and nurses to

incorporate weight management advice into usual practice, for example, weighing all patients and continuing to weigh regular patients annually.

- When weight management is part of routine care, patients will expect these conversations as a normal part of seeing their GP.

Congratulate them for keeping the weight off

- Congratulating patients who are maintaining their weight and continuing to discuss their lifestyle habits can encourage them to continue their healthy behaviours.

Build your skills

- LiveLighter delivers workshops for health professionals to learn how to approach weight management guidelines with patients. Training explores weight management guidelines and recommendations, as well as practical tips for discussing healthy eating and physical activity. For more information visit www.livelighter.com.au and find the 'professional development' link in the section for health professionals.



Treating to target: A Parkinson's disease trial

Professor Malcom Horne of the Florey Institute has recently commenced a national study looking at a 'treat to target' approach to managing Parkinson's disease using the PKGD watch. The wrist worn device records symptoms and movements and also provides patients with medication reminders.

Parkinson's Victoria, the Michael J. Fox Foundation, Shake It Up and Global Kinetics are all supporting the project.

The aim is to establish whether objective measurement aids in improved clinical care and leads to improved control of Parkinson's disease and quality of life.

It will compare current standard clinical practise that patients receive from their doctors, with the 'treat to target' practise of managing Parkinson's disease. This practise asks some participants to modify their current medication so that they are using them more effectively, and therefore managing their Parkinson's more effectively too.

People with Parkinson's will participate at 10 sites across Melbourne, Hobart, Shepparton, Adelaide, Brisbane and Sydney. The study will still be recruiting participants over the next month, with a momentum to conclude the first stage by the end of the year.

For more information, visit www.florey.edu.au/parkinsons-movement-trial or email Holly Woodrow at PKG@Florey.edu.au



What to tell your patients

Early stages of recruitment have indicated that people with Parkinson's disease consider their GPs integral to their overall care, including their PD management.

If you have a patient who you think could benefit from participating in this trial, we ask that you refer them to register their interest online or via email. See the contact details on the left. We will continue to keep you informed of their status should they join the study.

The study involves:

- no cost to the patient
- 3-6 visits over 6 months
- travel to study sites
- potentially modifying oral therapies.

We are looking for people who:

- have been diagnosed with Parkinson's disease
- are aged between 59 and 75
- take a levodopa medication four or more times a day
- have not had any device assisted therapies
- are not troubled by hypotension or cognition problems.

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The rise of biomedical HIV prevention: Pre-exposure prophylaxis or PrEP

Pre-exposure prophylaxis, or PrEP, represents a game changing opportunity to decrease HIV transmission across Australia.

We know Victorians at risk of HIV are keen to protect themselves against HIV transmission and maintain their health as well as the health of the community. Between 2016-2018 unprecedented numbers of the community enrolled in the Victorian PrEPX public health study. In fact, at one point more Victorians had enrolled in the study and were accessing PrEP than was occurring in all of France.

If the recent listing of PrEP on the Pharmaceutical Benefits Scheme (PBS) has raised questions about what PrEP is, who is eligible for PrEP and how to prescribe it, then fear not. Here is the key information you need to know about this revolutionary biomedical HIV prevention tool - including resources and state-funded free training options available.

The Victorian Government supports all aspects of combination prevention to reduce the HIV epidemic. Together with condoms, frequent and regular sexual health screening, and effective treatments for people living with HIV, Victorians have more tools than ever before to help prevent transmission of HIV.

The Victorian Government has the bold goal of achieving the virtual elimination of new HIV infections by 2020. I urge you to take advantage of the training being provided to support GPs, pharmacists and nurses, because only

by working together will we achieve this vision of stopping HIV infections.

PrEP on the PBS

Since 1 April 2018, individuals at medium to high-risk of acquiring HIV have been able to access PrEP through the PBS to help them reduce their risk of HIV.

PrEP is listed as an s85 General Schedule medication, and can be prescribed by any GP and nurse practitioners.

But what is PrEP?

PrEP is the use of specific HIV medications to prevent the transmission of HIV. Evidence from the Victorian study and other randomised control studies such as IPERGAY and PROUD have shown that PrEP is one of the most effective HIV prevention tools available and when taken daily it can reduce the risk of HIV transmission by up to 99 per cent.

The currently available PrEP tablet contains two drugs, tenofovir and emtricitabine. Three companies have approval to provide their PrEP tablets to people living in Australia. These two drugs have been used for many years to treat HIV in people living with the condition.

PrEP offers a unique opportunity to reduce HIV infections and progress towards the goal of the virtual

elimination of new HIV transmissions by 2020 as set out in the *Victorian HIV Strategy 2017-2020* and the *Seventh National HIV Strategy 2014-2017*.

Who is eligible for PrEP?

Anyone who is considered at medium to high risk of acquiring HIV is eligible and can be prescribed a full course of PrEP. These include men who have sex with men, people who inject drugs, trans and gender diverse people. PrEP is also indicated for heterosexual men and women at greater risk of HIV, for example those whose partner is HIV positive and not on treatment, or has a detectable viral load.

In addition to condom use, regular screening for HIV and an undetectable viral load (when a person living with HIV is on treatment, and is virally suppressed, they cannot transmit the virus), PrEP gives people another option to help prevent the disease. This combination prevention approach has the potential to significantly reduce HIV transmissions in at-risk populations.

Prescribing PrEP

Before prescribing PrEP, it is important that GPs or nurse practitioners discuss and assess the behavioural eligibility criteria with their patients.



If a patient is considered eligible for PrEP, prescribers should conduct a baseline HIV test to confirm that the patient is negative. They should also test for sexually transmissible infections (STIs), including gonorrhoea, chlamydia, and syphilis as per best practice outlined in the Australian STI testing guidelines: www.stipu.nsw.gov.au/wp-content/uploads/STIGMA_Testing_Guidelines_Final_v5.pdf

Prescriptions may be issued for 90 days of medication. PrEP does not prevent other STIs so it is important that patients return for follow-up appointments every three months, where HIV and STI testing are repeated. Diagnosing early and treating fast will promote effective STI control at a population level. Periodic tests of bone density and renal function may also be required.

Gay and bisexual men are disproportionately affected by STIs. This is in part attributed to changes in sexual behaviour, including a decade-long trend increase in condomless anal intercourse with casual partners. In this context it is important to ensure that patients understand condoms should be used to prevent STIs and provide advice, if required, about making condoms more useable for them. Patients should also be directed to use condoms to prevent HIV infection if they miss doses of PrEP.

Further support for prescribing PrEP

Victorian guidance on pre-exposure prophylaxis

To support GPs prescribing PrEP, the State Government recently released *Victorian guidance on pre-exposure prophylaxis* which can be found on the Department of Health and Human Services website.

The guidance includes clinical guidelines for prescribing PrEP, behavioural eligibility criteria, monitoring and ongoing care, and evidence for PrEP and other biomedical prevention strategies. For more information visit: www2.health.vic.gov.au/public-health/preventive-health/sexual-health/prep

ASHM Guidelines

Full prescribing guidelines, including risk assessment criteria and patient information can also be found at www.ashm.org.au/hiv/prep in the 2017 *Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine HIV pre-exposure prophylaxis: clinical guidelines*.

VHHITAL PrEP and STI training

The Department of Health and Human

Services has partnered with the Victorian HIV and Hepatitis Integrated Training and Learning (VHHITAL) program to offer PrEP training.

The program delivers free comprehensive education and training for GPs, pharmacists and nurses on PrEP and also for the diagnosis, treatment and management of HIV, hepatitis B, hepatitis C and STIs. For information on the training visit the blood borne virus and sexually transmissible training calendar: www.bbvsti.vphna.org.au/

More information

For immediate questions about prescribing PrEP you can also contact the Victorian HIV Service at Alfred Hospital on (03) 9076 6081 or www.alfredhealth.org.au/services/hiv-service.

The Victorian AIDS Council provides information on PrEP designed for patients interested in taking PrEP and can provide more information on (03) 9865 6700 or www.vac.org.au/prep.



Dr Bruce Bolam

Chief Preventive Health Officer

Department of Health and Human Services

Career conversation



An emerging pattern in recent years has seen some doctors looking to explore alternate and non-traditional careers both within and outside of clinical medicine.

In this Career Conversation series, we are profiling a range of doctors who have transitioned to non-traditional paths - either instead of, or in parallel with a traditional clinical path. These stories can help other doctors understand that medicine can present diverse, often untapped career options.

Dr Sue Abhary - Medical Administrator, Clinical Director

How would you summarise your career path in medicine?

In a nutshell - unique! In addition to an academic background, I tried several clinical avenues (ED, psychiatry, ophthalmology, medical administration), before I finally decided to follow a career path which combined my research, clinical knowledge and medical administration skills.

Why did you choose to study medicine?

My initial choice was made when I was a teenager. My father had a life-threatening accident when I was young, and I wanted to be that doctor who would save lives and make the world a better place! This attitude shifted as I got older and realised that I was not made for clinical practice and that I should leave that to my fellow colleagues who I admire deeply, and are made for such work. This instead led me to leave clinical practice to influence the health systems that I work in to be optimal ones for doctors and patients. It took a lot of self and career exploration to finally find the right choice for me, but ultimately the courage to face and turn any fears of the unknown, including repeated so-called failures, into a growth mindset and experience in life.

Who or what have been the main influences on your career pathway choices?

Ultimately it was recognising and accepting that I could not achieve happiness in the initial choices I had made, no matter what avenue I tried, and that I had a diverse skillset that was versatile and adaptive to most industries.

What would have helped you in making career choices?

Ultimately I would have loved to have been able to utilise a career advisory service that can offer all-encompassing advice, including a non-clinical career

path. No-one was able to direct or help me among my colleagues, with some comments like "You'll come back, you'll see. They all do" as departing best wishes. We need to help our profession with this. I get regular phone calls from around the country from medical students to doctors wondering what they can do if they want to leave clinical practice. A special recruiting agency for doctors who are wanting to do this is still necessary and a big gap in the profession.

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

The only thing is wishing I had the courage to listen to my heart and leave clinical practice earlier. But I recognised quickly that nothing had been wasted in my career, and collective knowledge, experience and wisdom in life has all helped me in being a leader in health.

Do you foresee any other changes in career paths in the future?

No, I don't.

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

Think hard, consult with as many people you know and keep an open mind for your options. Don't make hard or set decisions that may be irrational. Be flexible in your decision-making when choosing specialties and subspecialties and keep yourself and personal life in the highest order when doing so. Also, do not let advice from others place fear or doubt in your decisions to listen to your heart in finding or doing what makes you happy. At the end of the day, reality check - it is only a job, and life is made up of so many other important factors!

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

Gold Medal for the man who wrote the book on general practice

The doctor who wrote *John Murtagh's General Practice* - the pre-eminent reference textbook for general practitioners, medical students and registrars - has been recognised with the AMA's highest honour, the AMA Gold Medal. Emeritus Professor John Murtagh AM was announced as the recipient at the AMA National Conference in late May.

"Professor Murtagh's contribution to medicine and general practice as both a doctor and an educator in Australia is incomparable," then AMA Federal President Dr Michael Gannon said. "He is the highly acclaimed author of several internationally adopted medical textbooks, including *John Murtagh's General Practice*, which is now in its sixth edition, and has been translated into 13 languages since it was first published in 1994."

Professor Murtagh originally started his working life as a secondary school teacher, teaching maths and science in country Victoria, having completed degrees in science and education at the University of Melbourne. In 1961, he retrained, fulfilling his childhood ambition to become a doctor, graduating with an MBBS from Monash University in 1966. He was among the first intakes at the newly established medical school.

While studying medicine, Prof Murtagh met his wife Jill, a fellow medical student, and after completing their medical studies, they took over the general practice at the Neerim South Hospital in country Victoria - John providing the surgical skills and Jill the anaesthetics. Combining his love of teaching and medicine, training visiting Monash medical students at Neerim South was a natural fit. He was invited to write educational programs for the Royal Australian College of General Practice (RACGP) and to provide a rural teaching base for the Department of Community Medicine at Monash University.

In 1979, he relocated to Melbourne to accept a full-time senior lecturer position at Monash University. During

the 1980s and 1990s, as medical editor for the RACGP's *Australian Family Physician* publication, Prof Murtagh introduced new features, including *Brain Teaser*, *Practice Tips*, *Patient Education*, and *Cautionary Tales*. Prof Murtagh later developed these journal articles into published books, following an approach from McGraw-Hill publishers.

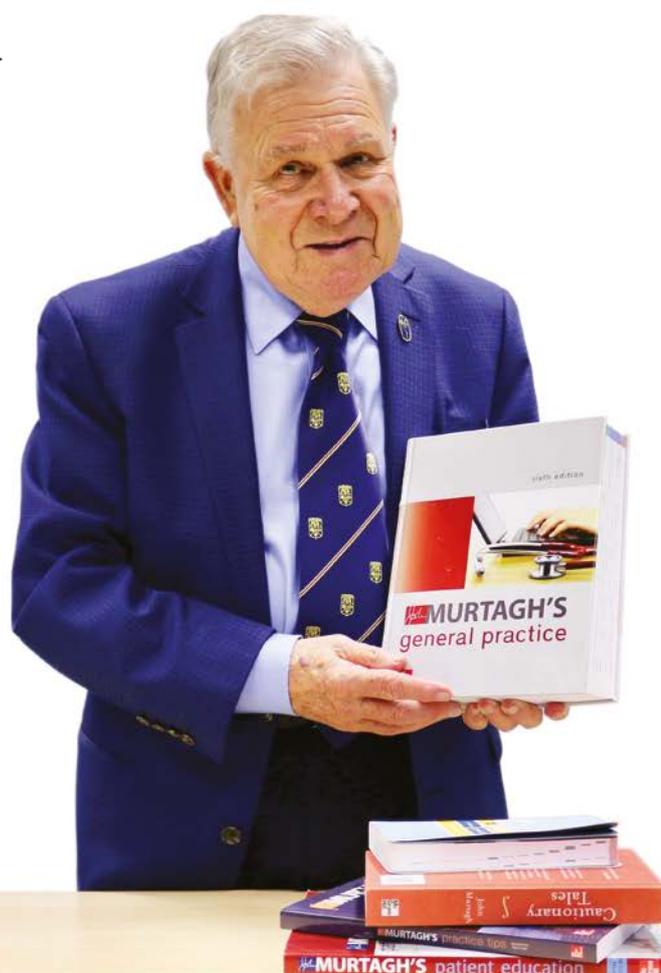
In 1991, McGraw-Hill requested that Prof Murtagh write a new type of medical textbook, one that defined the nature and content of general practice. Using chapters based on symptoms, rather than disease categories, and building on the diagnostic model he developed, the textbook - *General Practice* - was pitched in the way that undifferentiated disease presents in a GP's consulting rooms. Two years later he was appointed Professor of General Practice and Head of Department at Monash University, a position he held until his retirement in 2002.

Post-retirement, Prof Murtagh continues to teach both undergraduate and postgraduate students, provide lectures to doctors around the world, and write medical books and, most recently, flashcards, morphing from books to apps.

He was made a Member of the Order of Australia in 1995 for significant services to medicine, particularly in the areas of medical education, research, and publishing, and was awarded the inaugural David de Kretser Medal from Monash University in 1996. In 2007, he was awarded the AMA Victoria Gold Medal for services to medicine.

"Emeritus Professor John Murtagh has rendered outstanding services to the practise of medicine and, without question, is deserving of the award of the Gold Medal of the Federal AMA," Dr Gannon said.

Prof Murtagh has been a valued member of AMA Victoria for over 50 years. We salute you on this fantastic achievement!



Rent control for pathology collection centres

The Health Insurance Act 1973 (Act) has contained “prohibited benefits” laws since 2008, but Medicare has not enforced them.

Following up on a deal the Commonwealth Government made with Pathology Australia before the last federal election, the Department of Health (DoH) is promoting a new enforcement regime which commenced from 1 July 2018. The DoH "Red Book", recently mailed out to medical practices, sets out guidance on laws relating to pathology and diagnostic imaging prohibited practises.

The laws prohibit a number of practises which could constitute inducements to doctors (typically GPs) to request services from pathology or diagnostic imaging services. This article focuses on the rents paid to medical centres by pathology providers for co-located pathology collection centres.

Penalties for contravention

The penalties for contravening the provisions are substantial - \$126,000 for an individual and \$1,260,000 for a corporation. Liability for offences extends beyond requesters and providers of pathology services to persons connected to them, to directors and officers of corporations, and to persons who "aid, abet, counsel or procure" a contravention.

Impact on medical practices

The framework of the law (Part IIBA of the Act) is that a requester of pathology services must not ask for, or accept, a benefit from a pathology provider, and a provider must not offer or provide a benefit to a requester. The prohibition extends to persons connected to a requester (trustee companies, directors, relatives and others).

Some benefits are permitted under the Act, and one permitted benefit is a rental payment. A provider may lease premises from a requester, provided that the rent is "not substantially different" from the market value of the rent for the premises.

It is speculated that medical centres routinely benefit from rents paid by pathology providers which are significantly above the rental that could be charged on the open market to the average commercial tenant. Because

Medicare does not appear to have previously attempted to enforce the prohibited benefits provisions relating to pathology rental, the likely impact of an enforcement regime on medical practices is uncertain.

Market values

If the rent is more than 20 per cent above the market value it is substantially different. The market value of property, goods or services is defined as the amount that a willing purchaser would have had to pay at the time the arrangement was made to a seller who was willing, but not anxious, to sell. In a leasing context, this means the rent that a willing tenant would (at the relevant time) have had to pay a willing, but not anxious, landlord to secure the lease or sub-lease of the premises. Market value assumes an arms-length transaction with each party acting knowledgeably, prudently and without compulsion. The concept aligns with the approach taken generally in Australia by property valuers. The DoH guide acknowledges that in determining market value, some value could be attributed to the convenience of a location.

Other relevant elements not referred to in the guide but which would arguably add value would be entitlements ancillary to space in the premises, such as the signage rights, use of reception and waiting room facilities, and access to car parking.

What is 'the market'?

The meaning of 'market value' is reasonably clear, but identifying the actual market is not. Market value may be in the rental market for pathology collection centres, or in the commercial rental market generally. What rent could a medical centre realistically charge if the space was leased to a florist, or to a coffee shop, for example? Would a florist or coffee shop want to rent space in a medical centre? Even if they did, how likely is it they would be outbid on rental price by a willing pathology provider who wants the space for a collection centre?

DoH appears to acknowledge that 'the market' is, at present, an unknown. In outlining its enforcement strategy, DoH states that it intends

to develop a dataset to help it understand the state of the market for collection centre rents, and will use that to direct its enforcement activities. Its focus will be, in the first instance, on identified 'outliers'.

A key feature of the enforcement regime is that from 1 July 2018 all new collection centre lease agreements must be lodged with Medicare for review (and by implication, approval).

Existing leases

While the enforcement strategy is new, the laws have been there since 2008. Existing leases are not exempt from review and the enforcement strategy envisages a broader regulatory audit.

Medicare has strong investigatory powers under the *Human Services (Medicare) Act 1973*, which include inspecting premises, obtaining warrants to enter and search premises, copying any document, record or book on the premises, including electronic records, taking photographs, and requiring persons to provide information or produce documents. One result of the new enforcement regime could be that many existing service contracts, leases and other agreements or understandings will need to be reviewed.

Recommendations

The announcement of the enforcement regime does not require any doctor to do anything yet. It is strongly recommended that practitioners who receive letters or other enquiries from the DoH regarding pathology rental agreements do not make any response or provide any information to DoH without first obtaining legal advice.



Rod Felmingham

Lawyer

Kennedys (Australasia)
Pty Ltd

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Environmental sustainability in healthcare

AMA Victoria's Women in Medicine Society hosted its much anticipated 'Environmental Sustainability in Healthcare' event, in late May. The audience of over 70 was treated to a live jazz band and refreshments followed by insightful presentations, as they took in the splendour of Mayfair Apartments on St Kilda Road. Mayfair Apartments is the first residential project by world-renowned Zaha Hadid Architects. They combine functionality with natural beauty and provided an appropriate setting for speakers Dr David Pencheon and Dr Eugenie Kayak.

Dr Kayak is a Melbourne-based anaesthetist and the National Deputy Chair of Doctors for the Environment Australia (DEA). She is a fierce advocate for improved environmental healthcare sustainability. Dr Pencheon is the Founding Director of the UK's National Health Service (NHS) Sustainable Development Unit, which aims to make the NHS a leading sustainable and low carbon healthcare service.

Together they unpacked current environmental issues and detailed some successful case studies. The audience heard that climate change and the quality of our environment is a major health issue, and that urban air pollution causes more deaths in Australia than road accidents.

Currently, the carbon footprint of Australian healthcare contributes more than 7 per cent of our total greenhouse emissions, but some hospitals are successfully addressing the issue. The Mater Hospital in Brisbane has saved more than \$2.3m since 2008 by implementing various environmental sustainability initiatives, and by changing anaesthetic gas from desflurane to sevoflurane. Western Health is saving about \$30,000 and 140 tonnes of carbon dioxide emissions each year.

It was put to doctors that more hospitals must follow these examples, and it is up to them, as trusted voices in society, to lead the discussion on environmental change.





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An aerial photograph of a lush green golf course. In the center, there is a white clubhouse with a dark roof. The course is surrounded by trees and has several water features, including a large pond in the foreground. The sky is clear and blue.

Is it safe to sell in a spring buyer's market?

Auction clearance rates are now regularly sitting in the 50s in Melbourne. Is this a cue for prospective vendors to sit out this year's spring market?

It's fair to say we are now in buyer's market territory, however, even when auction clearance rates are low, most properties do still sell; it just isn't always under the hammer. Invariably, properties are sold in the hours, days or - very occasionally - weeks after the auction.

Another reason to be sanguine about the likelihood of success is that prices are only a little off their peaks - down just 1.4 per cent in Melbourne over the three months to the end of June, according to CoreLogic. That is, in part, because there are fewer new properties being listed compared with 12 months ago. According to CoreLogic, new listings are down six per cent in Melbourne in the 12 months to June.

However, it does show that while demand for property has softened, it hasn't evaporated. In practical terms this means many auctions that might have delivered the vendor three or four bidders in 2017 are now typically only pulling one or two bidders in 2018.

Therefore, don't use the lower auction clearance rates on their own as a reason to shelve plans to sell a property. Indeed, if your property is of a type in your area where the auction method is generally used, I would persist with that approach (rather than opt for a private sale) even if there is a good chance of a pass in on the day.

Why my continued faith in auctions? Experience shows that a well-run auction campaign is unsurpassed at flushing out prospective buyers in a well-defined period of time. Should a



property pass in, a good, experienced real estate agent knows how to obtain a quality outcome for their vendors in subsequent negotiations.

In a buyer's market, the key to vendor success is two-fold:

1. Select an estate agent for your campaign who is strong at marketing the property and at negotiation. The latter skill is the rarer of the two qualities, as it is usually only honed in tougher markets rather than the seller's market of the last six years.
2. Inform yourself about the fair value for your property in the current climate based on recent sales of comparable properties.

Finding that star estate agent is tricky but not impossible. There are usually one or two in any one area. Use the 'sold' section on property websites (such as www.domain.com.au) to research recent campaigns in your area of homes similar to yours. Shortlist the agents who win a disproportionate number of listings and whose body of work shows a high standard of

professionalism. Take soundings from your network. Then interview those two or three individuals and probe them about their estimates of your property's value and their experience and approach to pass-in negotiations.

The right agent will stand out: he or she will be the one who demonstrates a realistic and evidence-backed estimate of value and who can show a track record and method to pass-in negotiations.



Richard Wakelin
Director
Wakelin Property
Advisory

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Investing in the current global economy



As investors look outside the domestic market for opportunity, it's critical to keep abreast of world events and economic environments to understand how they may impact your investment decisions.

We note that currently collective global growth is generally in positive territory but with some interesting nuances. In our view, the recent economic data indicates that the epicentre of world growth is shifting towards the US, with indications of some lags, and even softness, out of China and Europe.

US interest rates continue to push higher, although markets view a lag

The market view of future US Federal Reserve (Fed) tightening has again started to lag significantly behind the timeframe indicated by the Fed itself. In fact, it's interesting to note that US personal consumption expenditures price inflation has hit the Fed's target of two per cent for the first time since early 2017, when the index first hit that target in January and February - after not reaching that level since 2011. US company earnings growth for the next 12 months also looks robust, driven in part by the 'great Trump-tax giveaway'.

The Reserve Bank of Australia (RBA) has indicated no desire to move interest rates

Here in Australia the RBA looks set to keep rates on hold in the medium term as our economy sputters, and in particular, the residential property market remains soft. Australian corporate earnings growth outlook is also not quite as robust as that of the US, however, earnings growth is positive, and valuations do not appear extreme. Nevertheless, we should note that Australian wage growth outlook continues to disappoint.

From these observations, there are three key trends to keep an eye on for Australian investors

1. The strength in the US economy, and inflation touching the Fed's target level should allow them to continue to raise rates and unwind quantitative easing, keeping upward pressure on US interest rates.
2. The combination of weak wage growth in Australia and a softening housing market will continue to steady the RBA's hand in relation to raising local rates.

3. Higher US interest rates and flat Australian interest rates should apply downward pressure on the Australian dollar.

Part of the weak outlook for Australian equities is driven by the large weighting of major banks in the index

This factor, in conjunction with the lower overall earnings growth outlook and high historic relative valuations (compared to international markets), have collectively subdued growth prospects. As has been the Dixon Advisory Investment Committee's stance over recent quarters, current conditions and the imbalances of the index suggest that an active approach in Australian equities remains the preference.

None of the broad asset markets are demonstrating what we consider obvious good value

Accordingly, there is little 'buffer' in those values to help us weather geopolitical uncertainty and market volatility. Despite low Australian cash rates, we continue to advise holding a sensible weighting to cash or term deposits, to provide the buffer that current valuations do not.



Patrick Broughton
Investment Committee
Chairman
Dixon Advisory



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9 simple but crucial steps for improving your cash flow

A medical practice has no hope of providing a satisfactory return to the proprietors unless it escapes the clutches of bulk billing. To do this requires setting up and operating a best practice billing and collection function.

Based on our experience in acting for many thousands of medical practices over our 42 year history, my simple but critical steps which are required in order to achieve this are set out below.

1. Appoint a Credit Officer ("CO"). This would normally be one person in your practice who takes responsibility for the whole billing and collections function. The CO need not necessarily do the work but must ensure that all required steps are in place and are followed. The CO must be empowered by the practice to carry out the role and must be provided with sufficient resources to do so.
2. The practice must have a Credit Policy. This will cover all classes of patients and categories of services provided by the practice. Few medical practices would have a written credit policy but in order to be systematic, it is critical.
3. All new patients to complete a New Patient Form. This will provide the practice with the full name, contact details of the patient and will list the names of all patients for which the person will be liable. For example a male patient may accept liability for his wife, two children and two stepchildren (who will all be named in the form). In order to avoid reinventing the wheel, I suggest that you go to www.prushka.com.au/forms/req_forms_CreditApplication.cfm and download a free form.
4. Incorporate essential practice trading terms. The best place to do this is as part of the New Patient Form and a critical clause to incorporate is a default clause, which will provide that in the event of the account being referred to a debt collection agency, all debt collection costs will be added to the account and will form part of the account. If this clause is in place and the form is signed by the patient, you will effectively be able to add the debt collection costs on to the debt and if it is paid in full, all debt collection costs will have been borne by the defaulting patient.
5. Ensure that wherever possible, payment is requested by the receptionist at the completion of the consultation.
6. Get away from monthly statements. They merely send the message to your patients that you are not serious in collecting the accounts. Your invoice should be headed as "Invoice and First and Final Statement".
7. A polite but firm phone call should be made to all patients who are overdue in their accounts and the question should be asked: "Is there any reason why this account is unpaid?" The aim would be to get credit card payment over the phone.
8. Use debt collection agency demand letters no later than 30 days after an account is overdue. These letters are non-threatening and basically isolate the slow-payers from the bad-payers. Use of the letters would normally produce a recovery rate of over 60% and no commission should be charged on monies recovered.
9. Outsource the overdue accounts to a **NO RECOVERY - NO CHARGE** debt collection agency absolutely no later than 90 days after payment is due.

As an AMA Victoria member, you are entitled to an ongoing 10% discount on commission charged by Prushka on debts collected as well as a 10% discount on Prushka products, including Prushka Online Self Send Demand Letters.



Roger Mendelson

CEO

Prushka Fast Debt Recovery

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MoMA at NGV: New York art comes to Melbourne



In an international exclusive, the National Gallery of Victoria (NGV) presents a major exhibition of modern and contemporary masterworks from New York's iconic Museum of Modern Art (MoMA) in the world-premiere exhibition *MoMA at NGV: 130 Years of Modern and Contemporary Art* at NGV International in Melbourne.

Co-organised by the NGV and MoMA, the exhibition features more than 200 works - many of which have never been seen in Australia - from a line-up of seminal 19th and 20th century artists, including Vincent van Gogh, Henri Matisse, Pablo Picasso, Marcel Duchamp, Salvador Dalí, Frida Kahlo, Georgia O'Keeffe, Edward Hopper, Louise Bourgeois, Jackson Pollock, Mark Rothko, Diane Arbus, Agnes Martin and Andy Warhol. Bringing the exhibition up to the present are works by many significant 21st century artists including Jeff Koons, Cindy Sherman, Olafur Eliasson, Andreas Gursky, El Anatsui, Rineke Dijkstra, Kara Walker, Mona Hatoum and Camille Henrot.

MoMA at NGV is the largest instalment of the Melbourne Winter Masterpieces exhibition series to date, for the first time encompassing the entire ground floor of NGV International. Showcasing MoMA's multi-disciplinary approach to collecting and the breadth of its collection, the exhibition features works drawn from the museum's six curatorial departments: Architecture and Design, Drawings and Prints, Film, Media and Performance Art, Painting and Sculpture and Photography.

MoMA at NGV will explore the emergence and development of major art movements and represent more than 130 years of radical artistic innovation. The exhibition will also reflect the wider technological, social and political developments that transformed society during this period, from late 19th century urban and industrial transformation, through to the digital and global present. In recognition of both MoMA and NGV's long-standing dedication to the study and presentation of architecture and design, the exhibition explores the deep-seated connections between 20th century art and design practise, with a

particular focus on developments that shaped Europe in the 1920s and '30s and the globalised world of the 1960s and '70s.

Unfolding across eight loosely chronological thematic sections, the exhibition opens with 'Arcadia and Metropolis', examining how artists at the dawn of the 20th century responded to the rise of cities. 'The Machinery of the Modern World' highlights the simultaneity of foundational avant-garde movements (Futurism, Cubism, Orphism, Dada) and references MoMA's 1934 *Machine Art* exhibition, while 'A New Unity' presents the cross-media manifestations of the Russian avant-garde, de Stijl, the Bauhaus and Joaquín Torres-García's School of the South. In 'Inner and Outer Worlds', iconic surrealist paintings are seen alongside contemporaneous works that negotiate the relationship between interior and exterior landscapes.

'Art as Action' highlights key examples of Abstract Expressionism and expands to include other forms of kineticism in the 1950s. The exhibition's largest section, 'Things as They Are', encompasses the varied production of the 1960s and '70s, from pop art to minimalism and post-minimalism, followed by 'Immense Encyclopedia', focusing on gestures of appropriation and reflections of identity from the 1980s and '90s. The last section of the exhibition, 'Flight Patterns', considers contemporary ideas of movement, migration, and globalisation. Installation and performance works (Olafur Eliasson's *Ventilator*, Simone Forti's *Huddle*, and Roman Ondak's *Measuring the Universe*) will also run throughout the course of the exhibition.

MoMA at NGV is on display at NGV International until 7 October 2018. Tickets and information are available via www.ngv.vic.gov.au





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* Averages published by the Department of Health <http://health.gov.au/internet/main/publishing.nsf/content/privatehealth-average-premium-round>. Individual premium increases may vary from the average due to impact of the PHI rebate and product claims experience.

[^] Doctors' Health Fund Member Survey 2018.

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