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MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. **FEBRUARY/MARCH 2019**

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ROYAL COMMISSION INTO MENTAL HEALTH

IMPROVING MEDICAL WORKPLACE CULTURE

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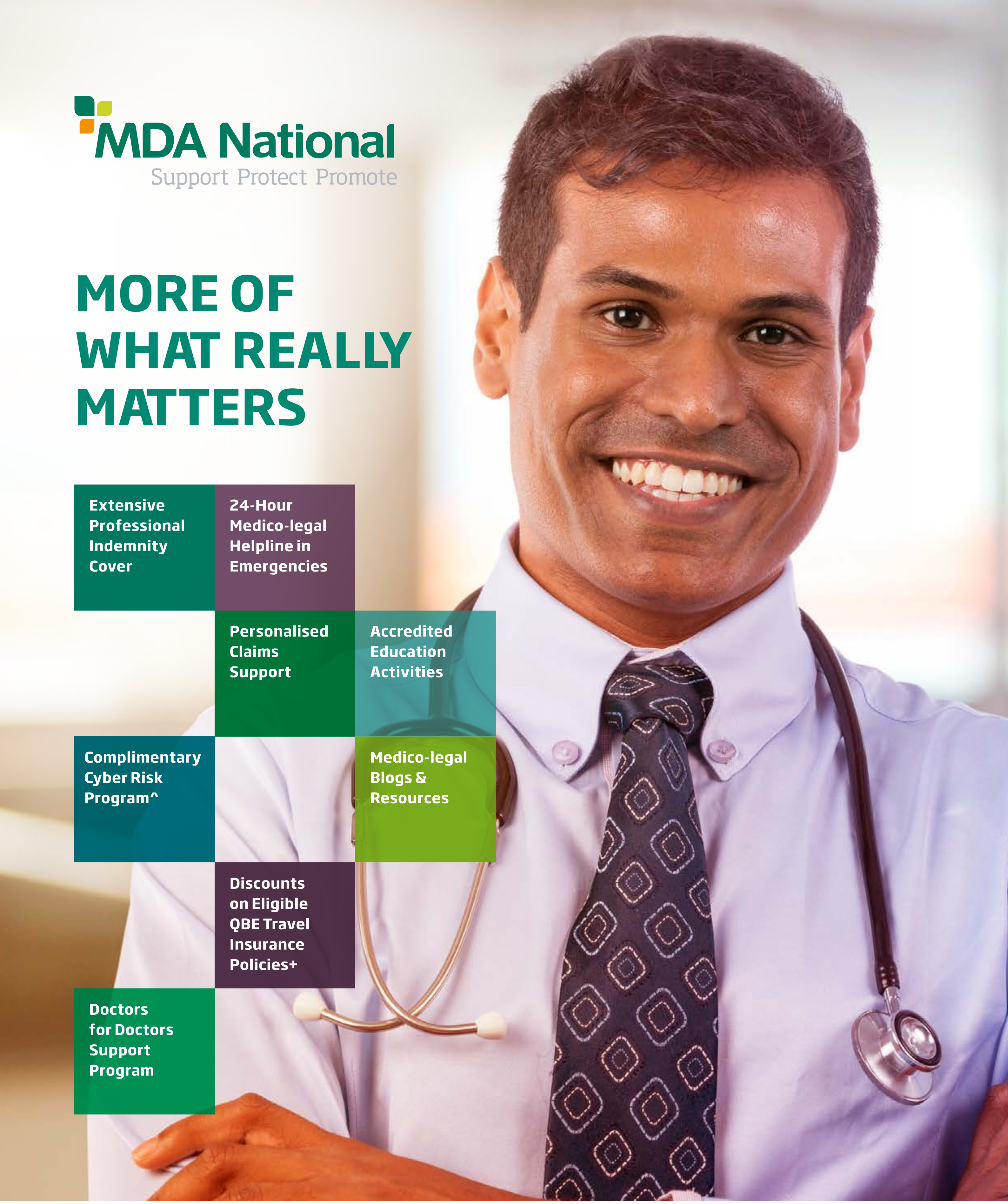

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FRONT COVER: A new program is helping to improve care in the birth suite.

Magazine of the Australian Medical Association Victoria

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Welcome from the editor

How a strikingly real sculpture is being used to spark people into action on advance care planning. See page 8.

Welcome to a new year of Vicdoc and a warm welcome to our new intern members who are beginning the exciting first stages of their medical careers. Our workplace relations, careers and policy staff have enjoyed meeting many interns during January's orientation programs and we look forward to supporting you across all stages of your career.

All doctors in Victoria have been sent this edition of AMA Victoria's membership magazine and if you are not a member, please take the time to have a read and discover some of the ways we can enhance your medical journey.

The Royal Commission into Mental Health will be a big focus for us in 2019 and in this edition, our Section of Psychiatry outlines some of the issues and how our members can play a role in improving Victoria's critically under-funded mental health services. We will be regularly keeping members informed on our website, as the Royal Commission progresses.

AMA Victoria President, Associate Professor Julian Rait writes passionately about improving the workplace culture in our hospitals and our Doctors in Training Subdivision President, Dr Nathan Abraham calls for strong senior leadership to help drive change to allow junior staff to thrive.

You can also read about how a non-dispensing pharmacist can make life better for GPs and their patients; an extra incentive for hospitals to improve care in birthing suites; the experiences in the health system of a cystic fibrosis patient; and we gain an insight into the difficult introduction to Australia for asylum seekers and refugees and the critical healthcare doctors and other staff are providing as volunteers.

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 April.

Barry Levinson

Editor
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25% off your membership fee per referral!

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President's message

Changing patients' lives for the better and feeling respected for our work are arguably the two most important aspects of job satisfaction for doctors.

Many studies have demonstrated these elements of job satisfaction in medicine are linked to the emotional connections we form in our workplaces and the types of relationships we have with our colleagues.

A respectful and supportive workplace can bring enormous benefits to hospitals and the performance of staff. Doctors who feel respected and supported by hospital managers are more satisfied with their jobs and more loyal to their organisations. They are frequently more cooperative and more likely to take direction from hospital administration.

Conversely, a lack of respect in the medical workplace can inflict real harm to employees and patients alike. Research shows 80 per cent of employees who are treated poorly spend significant time ruminating on colleagues' bad behaviour and 48 per cent deliberately reduce their efforts, as a result. Disrespectful treatment in the medical workforce can also spread amongst co-workers and have a flow-on effect to patients and the provision of quality of care.

Last year's AMA Victoria hospital health check survey revealed 65 per cent of responding doctors in training rated their hospitals' support for their mental wellbeing as "very poor to average" and more than half rated the morale of the medical staff at their workplaces in this low category.

Too many doctors in public hospitals experience low levels of morale, fatigue, high levels of stress, low levels of support and high levels of burnout. Young doctors are particularly vulnerable. Continuing examples of bullying and harassment of students, trainees and other medical staff, and especially of women, has emphasised the need for us all to do more to support cultural improvement in our workplaces.

We as a profession can no longer ignore the full range of such negative behaviours or continue to passively follow the institutional permissiveness that allows such conduct to occur. The deep humanity of medicine must not be lost because of poor hospital culture or by our desire to trial the next new drug or pursue better surgical techniques or because "I had it tougher in my day".

There is an important shared responsibility to improve the workplace culture in Victoria's public hospitals. This responsibility obliges the cooperation of multiple stakeholders, including governments at federal and state levels, public hospital administrators and of course, the staff.

While many leaders in our public hospitals are to be congratulated on their excellent leadership in this space, some still fall short of nurturing workplaces of high engagement, support and respect.

Most clinicians realise that connecting with patients and their suffering is just as important as the treatment and science; that it is indeed a doctor's duty to connect with patients, understand their perspectives, and teach them and their families about their condition.

But what about our connections with colleagues?

Looking back, the doctors who had the greatest impact on my career were the ones who demonstrated a deep humanity towards their doctor colleagues, as well as their patients. They took very seriously their responsibilities to teach younger practitioners about the science of medicine, but also to nurture, guide and support them on their journeys as the next generation of doctors.

On reflection, I can now see how critical this emotional support was in creating and sustaining a culture of peak performance - of which patients, of course, are the greatest beneficiaries.

I'm sure we can all remember colleagues who have supported us throughout our careers, and who have displayed the skill and patience to explain complex problems in clear language, the generosity to mentor and gently guide us, the compassion to look out for our wellbeing and the courage to stand up for us.

It's these senior doctors who have had the most impact on the wellbeing and careers of younger doctors; who have helped us make better medical decisions and be better medical practitioners. These are the types of practitioners who have had a truly great impact on the delivery of patient care and on the medical profession; and who are no less relevant now as we stand shoulder-to-shoulder with younger doctors determined to change public hospital culture for the future.

A/Prof Julian Rait OAM
President

References available from the Editor on request.

A ‘Voiceless’ sculpture sends a strong message

Few doctors will have stood by the bed of a sick, frail patient, with advanced chronic illness who is beyond making any decision for themselves and not have agonised as to whether to do everything to try to save the patient or to palliate. This dilemma should only be resolved on the basis of what the patient would want, something that is so often unclear.

A/Prof Charlie Corke with the 'Voiceless' sculpture and its model, Claire Adams.

Advance Care Planning is designed to ensure that the patient's perspective and wishes are communicated, facilitating appropriate decisions. Planning ensures that patients have a voice when these decisions have to be made. Despite the obvious advantages of making sure that wishes are known, most people don't have a plan. With the developments of modern medicine this is a significant problem.

It's a difficult thing to get people to consider and it is not surprising that we do our best to avoid thinking about being in a dreadful situation! This makes Advance Care Planning a really difficult marketing challenge – but one that we have to address.

A desire to promote good planning led to a unique event late last year in Southbank. Those walking by the Yarra encountered a frail, elderly woman lying in bed on life support. This was a hyper-realistic, silicone sculpture of Claire Adams by the sculptor Dale Bradford. Claire, the model, is a remarkably healthy, beautiful, lively and bright 91 year-old lady – but the sculpture shows an alternative future. The work is strikingly real.

An artwork is intended to be closely observed, something that could never be appropriate in the case of a real patient, so the sculpture gives the public an opportunity to see and, begin to understand, what doctors see every day. The work starkly illustrates the implications of 'whatever it takes' at the extreme of life. Some are reassured by this vision, while many readily share their desire to avoid anything like this sort of outcome.

Good art provokes emotion and reflection and the sculpture certainly achieves this. Though the sculpture is titled 'Voiceless' it speaks eloquently to those who see it and sets them thinking. We plan for the 'Voiceless' sculpture to tour Victoria, in order to create interest right across the state.

Action must follow though and the underlying purpose of the sculpture is to promote a free, online program MyValues (funded by the Victorian Department of Health and Human Services) that assists people to understand where they stand with regard to 'how far you'd want to go'. The program evaluates attitudes and creates a report that summarises the answers. The program also enables users to automatically include their report in a Victorian Advance Care Directive.

The program can be used by anyone, anywhere, but only those with a Victorian postcode have the opportunity to include their report in the Victorian Advance Care Directive. The program can be accessed at www.myvalues.org.au.

Everyone who has been involved with Advance Care Planning recognises that the process is rarely quick, and people often find it quite difficult. Helping patients plan can be very time consuming and is often incompatible with a busy medical practice. In some jurisdictions there is opportunity to refer patients to skilled Advance Care Planning facilitators (which permits detailed conversations), but this may be unavailable or impractical.

MyValues offers an easily accessible solution that enables patients to convey their opinion in a way that can usefully inform doctors (and family) at the time of a medical crisis and permits them to further elaborate their wishes, if they wish to do so.

Busy doctors who wish to encourage patients to plan may find MyValues a useful option to offer patients. Flyers may be obtained by contacting me at charliec@barwonhealth.org.au

A/Prof Charlie Corke
Senior Intensive Care Specialist
Barwon Health

Helping some of our community's most vulnerable

Cabrini's Asylum Seeker and Refugee Health Hub in Brunswick is helping some of the most vulnerable in our community. Since opening in 2016, the Hub has received more than 500 referrals of patients and currently has 320 active clients.

The operation is twofold, with a nurse-led primary care service and a specialist mental health service, largely staffed by pro bono health professionals. Medical Director for the Hub, Dr Gillian Singleton, said the service filled an unmet need in the community. "There aren't many health services in the north-eastern corridor with the capacity to meet the needs of the individuals and families we see, so we are filling a huge gap," Dr Singleton said.

"More than half of the people we see have no access to Medicare and more than 80 per cent have no source of income or financial support and so have barriers to accessing other medical services. Referrals to our service are increasing every month and the demographics of our clients are shifting, with increasing numbers of women and children presenting to the Hub.

"At the primary care service, we see a lot of complexity, more than 60 per cent of our patients have at least one chronic disease, 18 per cent have multiple chronic diseases and 22 per cent have concurrent mental health issues such as post-traumatic stress disorder (PTSD). Other common conditions managed at the Hub include chronic pain, hepatitis B, nutritional deficiencies, diabetes and latent tuberculosis."

Of those patients presenting to the mental health service, more than 50 per cent have experienced torture and trauma and 18 per cent have been transferred from offshore detention.

"It is very hard to maintain your resilience when you have received so many setbacks," Dr Singleton said. "The evidence is clear that the longer people are living in uncertainty, the more likely they are to experience significant physical and mental health issues.

“Generally speaking, people seeking asylum who arrive in Australia are incredibly resilient people and there is good evidence that if they are well supported, they have enormous potential but detention and prolonged processing times can impact their ability to maintain that resilience. It’s important to recognise that people who arrived by boat and are awaiting resolution of their claims, even if successful, will not be eligible to settle in Australia permanently, at best they may be able to access a three or five-year temporary visa.

“The most common thing we see in individuals presenting to our service, is a sense of hopelessness and injustice, they feel unsupported and can’t see any potential for respite in the future, which impacts their mental state and their sense of self. This can lead them to give up on life because they feel they are out of options.”

Dr Singleton said recent changes to Federal Government legislation meant many people who were previously eligible for income support and other services, such as torture and trauma counselling and casework support, are now ineligible.

“Most of the asylum seekers we see are on temporary bridging visas and are learning English. They are expected to find a job but this can be very difficult if you are on a temporary visa with minimal English,” she said. “Unlike permanent residents, they have no access to Centrelink so most of them have no income at all to support themselves.”

Most of the asylum seekers are reliant on charitable organisations to provide housing, food and other vital resources. The Hub also offers pharmaceutical waivers, which enable asylum seekers to access essential medications they require.

Hub clients have come from 37 different countries, but the majority are from the Middle Eastern region, particularly Iran, Pakistan and Iraq.

Dr Singleton said many of the individuals who consult her at the Hub had been in detention centres and faced waits of more than five years for processing in Australia. “Most are fleeing persecution, which in itself can cause significant mental health problems,” she said.

“Some are very severely affected by what they have experienced. Living in uncertainty for years makes it very difficult to plan for the future because individuals don’t know what it holds for them, if they will see their families again or where they will eventually be settled.”

Dr Singleton said for many of the asylum seekers, Australia was not the fresh start they had been expecting. “They have come here in the hope of a better life and have instead faced further hardship including detention, destitution and many years waiting for their visa applications to be processed. Many lose contact with their relatives back home as they are ashamed that their new life has not turned out as expected.”

However, for many who come through the doors of the Hub it is just the help they needed. “We have had some patients who have been granted permanent residency, though that is rare,” Dr Singleton said. “For others, we have been able to provide access to services they would never have otherwise been connected with. We have provided a safe, compassionate and respectful therapeutic space for them, so it feels like we are making a difference.

“We often see individuals at their most vulnerable, when they first present, and then, months later, when you can see the small positive changes in their lives and an improved sense of self and hope, which can be incredibly rewarding. Everyone we see is extremely grateful for the assistance they receive.”

Aside from a small number of paid staff, the majority of the clinicians provide their services pro bono, including GPs, psychiatrists and a physiotherapist. “It is really inspiring that there are so many health professionals who are dedicated and passionate about these issues and are willing to regularly give up their own time to provide this care to people in need,” Dr Singleton said.

“Personally, I have been passionate about refugee and asylum seeker health for a long time and I’m privileged to be able to provide care to those who otherwise couldn’t access it.”

Cabrini’s Asylum Seeker and Refugee Health Hub is located in Sydney Road in Brunswick and is open Monday to Friday as well as some Saturdays.

Tom Roth

General Manager

Cabrini Outreach

Cabrini OUTREACH

The Hub has been receiving large numbers of referrals, particularly to the specialist mental health service, and is currently in need of psychiatrists who are willing to provide pro bono care. To express your interest in being involved, phone Tracey Cabrie at the Hub on (03) 8388 7874.

Incentivising safer births in Victorian hospitals

A new program is helping to improve care for women and babies in the birth suite, while giving back to Victorian public hospitals for their investment.

In Australia we enjoy some of the best maternity care in the world. Still, there are instances when care doesn't go to plan. Every year, about one in 10 babies born in Victoria require assistance to begin breathing and around one in 100 need extensive resuscitation and specialist support.

Victorian healthcare professionals are exceptional people trained to high standards. But emergencies are unpredictable and there are always more gains to be made to prepare staff.

Developed by the Victorian Managed Insurance Authority (VMIA), the Incentivising Better Patient Safety Program encourages health services to ensure at least 80 per cent of their staff undertake evidence-based maternity training. In return, health services receive a partial refund on their obstetrics premiums.

The human cost of claims

As the Victorian Government's insurer and risk adviser, VMIA insures the public hospital and health network. Project Lead for VMIA's Medical Indemnity Programs and former midwife, Shevaun O'Loghlen, explains part of that role involves helping health services better understand what leads to insurance claims.

"While very few in numbers, errors in the birth suite can carry devastating impacts. Sadly, we know that in many cases, these may have been avoided," Ms O'Loghlen said. "For example, our claims data shows the common factors that can lead to neonatal hypoxic ischaemic encephalopathy (oxygen deprivation to a baby's brain). These include delaying or failing to recognise a complication in labour or incorrectly interpreting the fetal heart rate pattern."

VMIA worked together with Safer Care Victoria and the health sector to identify gaps in care leading to obstetrics claims. As a result, the program prioritises training in three areas of risk in the birth suite:

- multidisciplinary maternity emergency management
- fetal surveillance
- neonatal resuscitation.

"The program is still in its early days, but we are confident it will lead to better outcomes for women and babies," Ms O'Loghlen said. "Similar training, alongside other risk management initiatives, has already led to a 64 per cent drop in obstetric medical indemnity claims for maternity services since 2003.

"At the end of the day, clinicians and insurers want the same thing. We are both on the same journey towards better patient safety."

A culture of safety

Victorian obstetrician and gynaecologist, Dr Owen Stock, describes the Incentivising Better Patient Safety Program as a "carrot" to sustaining a culture of safety.

"This initiative helps to ensure that staff who work at the clinical coalface can participate in quality training that has a clear association with improved patient care," Dr Stock said. "It's rewarding hospitals that are already delivering good training and incentivising those that might feel they need more support to increase the amount and quality of training they implement."

Dr Stock formerly trained healthcare professionals in the multidisciplinary maternity emergency training. This experience proved to be invaluable during an emergency with a patient.

"One of the things we teach during the training is how to manage shoulder dystocia, which is when a baby's shoulders get stuck during birth," Dr Stock said. "Last year one of my patients had a severe shoulder dystocia and if I didn't have the advanced skills to manage this emergency, the outcome may not have been as good as it was. On reflection, it went as well as these things can go, but it might have also gone even better if everyone in the room had done the same training.

"As medical professionals none of us works alone. During an emergency there are many different people in the room with different skills. This type of training helps you to work better in a team, to get to know people's strengths and to ensure we're all speaking a common language."

Lasting change

The Incentivising Better Patient Safety Program is expected to channel up to $16 million back into the health sector. Safer Care Victoria CEO, Professor Euan Wallace, hopes hospitals will continue to reinvest those savings into gold standard training.

"This is an opportunity for hospitals to say to their staff: we are using this money to invest in you. There is always pressure on medical professionals to lift the standard of care even higher, but we need to support them to get there," Professor Wallace said.

"Hospitals will soon realise the full value of that investment. When staff are engaged and willing participants, they become advocates for better patient safety. In turn, we will see a reduction in adverse events and when there are less claims, hospitals will have even more capacity to improve the quality and safety of care."

Large health services can receive a five per cent refund on their obstetric insurance premiums, while smaller health services are eligible for a minimum refund of $15,000.

To receive the refund, participating health services need to demonstrate that 80 per cent of clinical staff working in birthing suites have completed training in the three areas of practise over the course of the 2018/19 financial year.

For more information visit vmia.vic.gov.au/ibps

vmia
Risk Management and Insurance

Strong senior leadership required on hospital culture

The revised Enterprise Agreements for Medical Specialists and Doctors in Training that came into effect in August last year have brought several welcome improvements to our working conditions as doctors.

Furthermore, the AMA has received assurance from government that the Department of Health will fund their implementation.

As a representative of Victorian trainees, I feel compelled to stress that without strong advocacy for trainees from senior doctors, major achievements of the agreement will not be fulfilled.

Even within the term of the previous agreement, many of the clauses and entitlements owed to doctors in training were not honoured, and in some cases, actively ignored and disregarded.

On a daily basis, trainees hesitate to speak up about these issues due to fear: fear of 'not being taken seriously'; fear of negative repercussions or loss of opportunities to advance our careers; fear of overburdening our colleagues if we utilise sick leave – as adequate replacement staffing is seldom offered.

Exacerbating our fear is the ever-increasing competition for accredited specialty training positions, where speaking up may jeopardise opportunities for re-employment or selection for such roles. As a result, many trainees stay silent and many trainees continue to experience high levels of burnout.

I acknowledge that many senior doctors proactively advocate for junior medical staff. To these individuals – thank you. We admire and appreciate your active engagement and genuine intention to understand the challenges and issues faced by our modern workforce and your desire to change the workplace for better. But in stark contrast, some leaders unfortunately fail to act in this way. These medical leaders claim it was worse in their day and they imply that conditions denying basic entitlements are acceptable.

These basic entitlements include predictable working hours, the ability to realistically take sick leave when required and adequate time to spend with loved ones, on leisure, and for recuperation. Even simple concepts such as adequate staffing, or acknowledgement and payment of unrostered overtime, make a world of difference to trainees.

Outdated views regarding the nature of our work, training and employment status continue to stubbornly persist in the higher echelons of our medical hierarchy – ignorant to changes in the type, scope and amount of work that junior medical staff undertake in a modern healthcare system.

This is further perpetuated by varying perception of the responsibility and duty-of-care that unit heads have for their junior medical workforce: particularly for rotational staff (often our most junior colleagues).

We are aware of the real and extreme pressures clinical leaders face from hospital executive to maintain efficiency and fiscal responsibility. Far too often, however, the welfare and rights of trainees are among the first to be compromised to achieve this as the path of least resistance.

We urge senior doctors to engage with us on these issues and utilise the opportunities afforded by the transition to the new enterprise agreement to address the many issues we face. This involves fostering a culture of mutual respect and professionalism, actively addressing issues regarding rostering, overtime and adequate redundancy to allow for leave. Although the implementation of these changes will almost certainly be challenging, it is the right way for our workforce, for our hospitals and for our patients.

We seek your help and your action, in the way that your superiors should have fought for you. Strong, proactive, top-down leadership will be the only way to consolidate the achievements of the recent enterprise agreement and to transform our culture into one that respects and values its junior staff.

Dr Nathan Abraham

President

AMA Victoria Doctors in Training Subdivision

Overseas model shown.

Update from AMA Victoria's Section of Psychiatry

Due to an unfortunate lack of access to mental health services in Victoria and throughout Australia, there is currently a great deal of interest in the mental health system, mental illness and its treatment.

Even though there have been numerous ineffectual enquiries into mental health before this time, AMA Victoria is pleased that the Victorian Government has funded a Royal Commission into Mental Health commencing in March; and (at the time of writing) is currently undertaking consultation into the inquiry's terms of reference.

AMA Victoria has formed a taskforce of doctors from a wide variety of backgrounds to prepare the necessary material to supply for the Royal Commission, so that this enquiry actually produces significant improvements for patients. We are planning extensive consultations with all AMA Victoria members who have an interest in mental health.

The AMA is uniquely placed to be able to coordinate the different initiatives required for improved mental health delivery, because we represent the key different medical groups which can be linked, for example, GPs, psychiatrists, emergency medicine physicians and paediatricians. To be effective in arguing the case, AMA Victoria needs robust feedback from our members.

The AMA Victoria Section of Psychiatry, chaired by Dr Ajit Selvendra has been working collaboratively with the Section of General Practice, and the AMA Victoria President, Associate Professor Julian Rait to advance new policies in mental health.

Before the Royal Commission commences, we are keen to embark on a process of consultation with psychiatrists about the types of changes they support to improve the delivery of mental health services. How can we ensure public psychiatrists can have closer contact for feedback to GPs when it comes to mutual patients? How can Medicare be improved, to allow private psychiatrists to treat a wider demographic of patients? Would you agree to a change in government policy to abolish purely episodic care and replace it with the principle of ongoing treatment and care for patients with ongoing or recurrent illnesses?

In February, there will be a specific consultation evening with psychiatrist members to obtain feedback into how we can build workable mental health services for a modern society. This meeting will be followed by a series of policy development meetings. We are happy to receive feedback from non-member psychiatrists too, but please consider offering deeper support to your colleagues, by joining the AMA. Feedback can also be made by email to me at bpring@ozemail.com.au or to AMA Victoria's Public Affairs team at NadaM@amavic.com.au.

Psychiatrists are very encouraged by the fact that our AMA colleagues are recognising that, if things are going to change, psychiatrists themselves will need to be consulted and given the opportunity to provide leadership in policies that are likely to really help, based on psychiatrists' extensive knowledge of psychiatric illness, patient behaviour and system faults.

Royal Commissions can be mixed in their results, depending on the arguments of interest groups. This time, we need solutions to come out of this Commission, and there is an opportunity for AMA Victoria to lead with solutions.

Dr Bill Pring

AMA Victoria Section of Psychiatry

Nominations are called for Independent Member positions on the AMA Victoria Council 2019-2020

Independent Member Positions

All ordinary members are eligible to nominate as an Independent Member of Council.

Nominations must be:

1. made in writing;
2. submitted to the Returning Officer before the close of nominations;
3. signed by the candidate; and
4. accompanied by a signed expression of support by another AMA Victoria member.

Each candidate may submit a written statement in support of their nomination, not exceeding 250 words.

There is no fixed form to submit a nomination, however, the secretariat staff can provide you with a template form should you wish to use one.

Please submit your complete nomination to the Returning Officer:

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

Any queries, including requests for forms, should be directed to Sarah McKaig on (03) 9280 8722 or by email to returningofficer@amavic.com.au

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Dr Ken Sleeman
Former President of AMA Victoria
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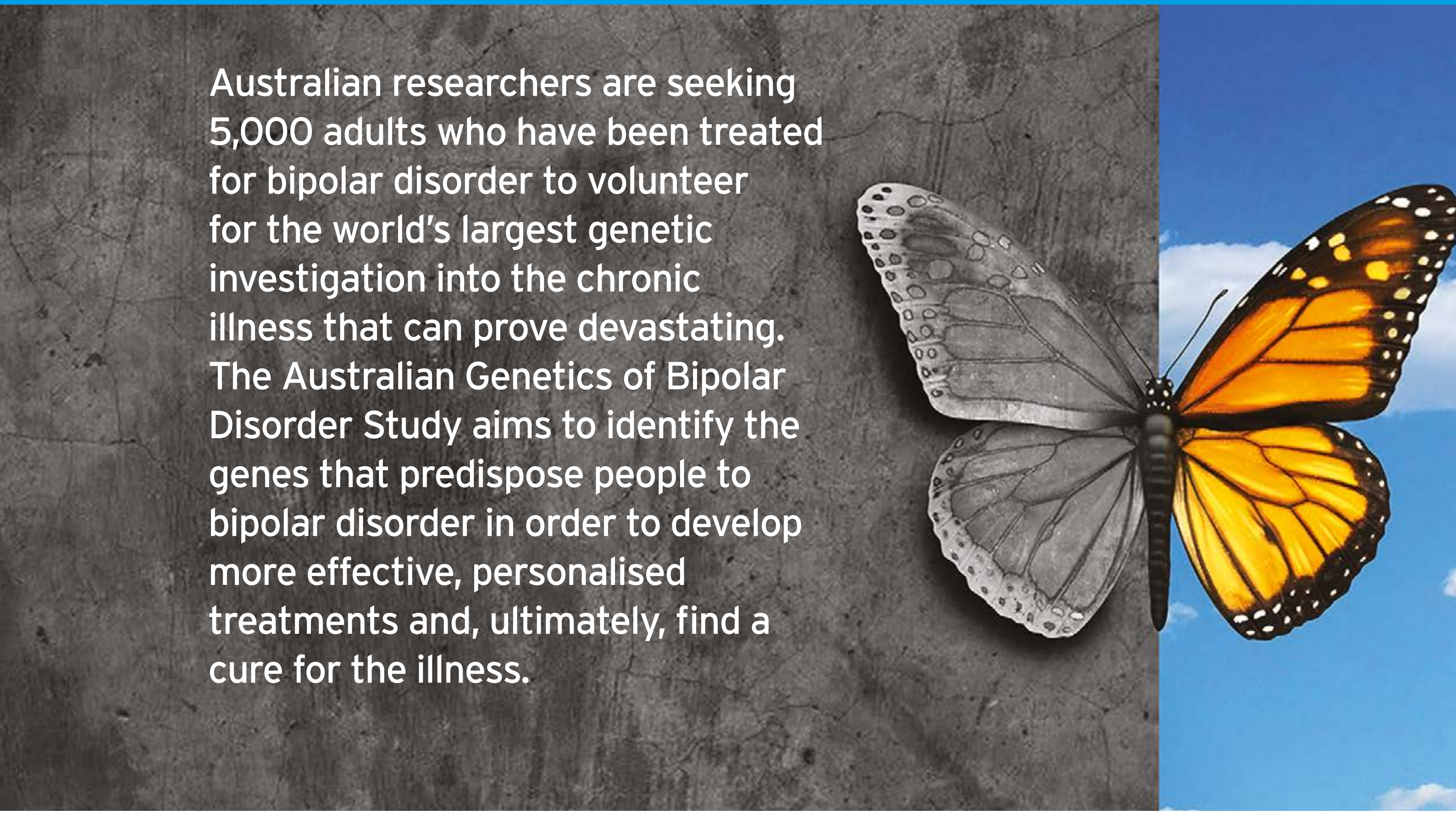
Cracking the genetic code of bipolar disorder



Australian researchers are seeking 5,000 adults who have been treated for bipolar disorder to volunteer for the world's largest genetic investigation into the chronic illness that can prove devastating. The Australian Genetics of Bipolar Disorder Study aims to identify the genes that predispose people to bipolar disorder in order to develop more effective, personalised treatments and, ultimately, find a cure for the illness.

QIMR Berghofer Medical Research Institute (QIMR Berghofer) is the base for the Australian arm of the international study, with collaborating centres throughout North America and Europe. The study aims to recruit 100,000 participants, with Australian researchers hoping to contribute 5 per cent of the overall study population.

Approximately one in 50 Australians (1.8 per cent) will experience bipolar disorder during their lifetime. The complex disorder, which occurs commonly in families, typically results from a combination of genetic and environmental influences. Those living with bipolar disorder may be at higher risk of developing other health issues, including alcohol and drug abuse, anxiety, cardiovascular disease, diabetes and obesity. They also carry a 15 times greater risk of suicide than the general population, accounting for up to 25 per cent of all suicides.

Professor Nick Martin, Australian study co-investigator and Head of the Genetic Epidemiology Research Group at QIMR Berghofer, said researchers are seeking 5,000 male and female Australian volunteers aged 18 and older who are currently, or have been treated in the past for bipolar disorder. Their involvement will allow researchers to shed light on the genes that predispose people to the illness to ultimately develop more personalised treatments.

"There is a strong link between genetics and bipolar disorder," Prof Martin said. "The human genome contains around 20,000 genes. Although we do not yet know all the genes that influence bipolar, what we do know is how to identify them. We just need a large enough study, performed in the right way, to identify these genes."

Globally, about one in 50 of the population experiences bipolar disorder during their lifetime. In Australia, it is estimated that 1.8 per cent of males and 1.7 per cent of females have experienced bipolar disorder in the previous 12 months.

"Australian research has shown that from the average age of symptom onset (17.5 years), there is a delay of approximately 12.5 years before a diagnosis of bipolar disorder is made," said Prof Sarah Medland, Lead Investigator and Head of the Psychiatric Genetics Group at QIMR Berghofer. "The aim of this study is to increase the number of known genetic risk factors for bipolar disorder, with the aim of being able to develop a risk score that could be used to assess if someone is at risk of going on to develop the illness when they first experience depression or mania. Being able to assess this and potentially intervene at the first presentation would have a dramatic effect on the lives of individuals affected by bipolar disorder and their families."

Study participation

Participation in the study is strictly

confidential, free and simple – volunteers complete a 20-minute online survey and those who qualify will be asked to donate a saliva sample. QIMR Berghofer researchers will send a saliva collection kit together with a pre-paid return envelope to selected participants.

Anyone interested in volunteering for the Australian Genetics of Bipolar Disorder Study can head to www.geneticsofbipolar.org.au, email gbp@qimrberghofer.edu.au or call 1800 257 179.

About bipolar disorder

Bipolar disorder is the ninth leading contributor to the burden of disease and injury in Australia among females aged 15-24 years and the 10th leading contributor for males of the same age. While the exact causes of bipolar disorder are unknown, factors believed to play a role in the development of the illness and its onset include genetics (which account for approximately 70 per cent of the risk); abnormal neurotransmitter chemistry in the brain; environmental factors, including stressful life events and seasonal factors; certain medication and illicit substances.

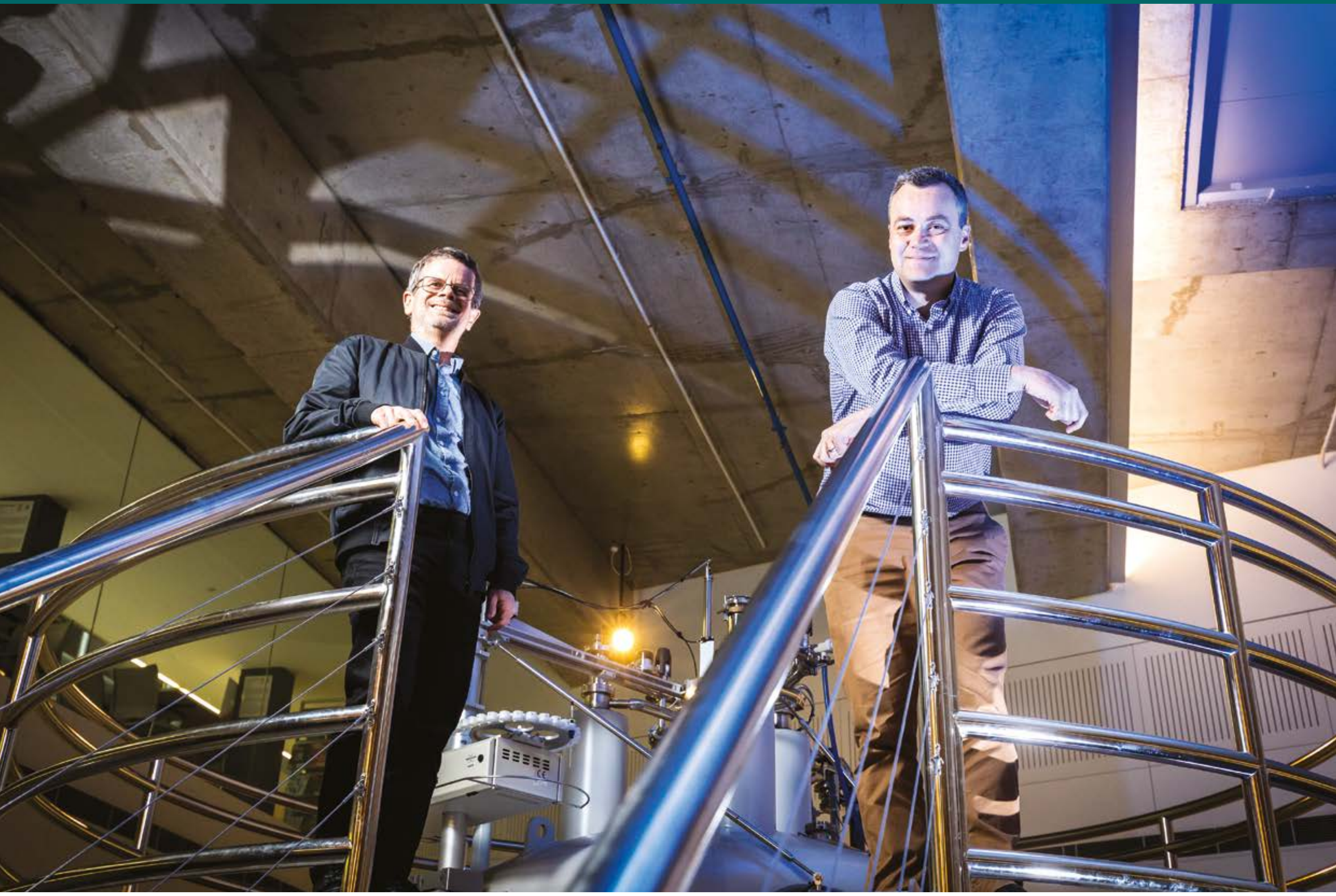
About QIMR Berghofer

QIMR Berghofer is a world-leading translational research institute, based in Brisbane, specialising in mental health, cancer, infectious diseases and a range of chronic disorders. Working in close collaboration with clinicians and other research institutes, QIMR Berghofer aims to improve health by developing new diagnostics, better treatments and prevention strategies. To learn more, head to www.qimrberghofer.edu.au. QIMR Berghofer recognises the National Health and Medical Research Council (NHMRC) for its involvement in coordinating this study.

Australian Genetics of
Bipolar Disorder Study

References available from the Editor on request.

Breaking the tension – new directions in schizophrenia research



Dr Daniel Scott (right) works with A/Prof Paul Gooley at Bio21 to unpick the molecular secrets of peptides like nuerotensin. (Photo: Chris Hopkins)

Dr Daniel Scott is digging through old pharmaceutical tailings, determined to unearth overlooked nuggets in the search for new schizophrenia treatments.

While he's unlikely to find gold, he'd be very happy to discover a neuropeptide – small proteins used by neurons to communicate with each other. "Neuropeptides were a hot topic in big pharmaceutical companies for decades," says Dr Scott, head of the Florey Institute of Neuroscience and Mental Health's receptor structure and drug discovery laboratory.

"Unfortunately, when the big pharmas tested neuropeptides in the lab, a range of side-effects led to many clinical trial failures in areas like depression. As a result, large scale commercial drug discovery for psychiatric diseases has stalled."

When the pharmaceutical industry decides to walk away, it leaves a space which is often filled by nimble academics working in not-for-profit institutes like the Florey.

"There is the possibility of finding an absolute treasure trove of new drug targets for devastating conditions like schizophrenia. About one per cent of Australians are affected, but schizophrenia has a hugely disproportionate societal and financial impact, in the order of billions of dollars every year."

Dr Scott believes he may be about to hit a rich seam with a molecule called neurotensin and its receptor NTS1. Untreated patients with schizophrenia have lower neurotensin levels in their spinal fluid and the lower the level, the worse their symptoms. After standard antipsychotic treatment, neurotensin levels increase in patients' brains.

"This gives us a pretty strong clue that drugs that activate the receptor directly, or enhance signalling, could be used to treat schizophrenia," says Dr Scott.

However, the pickings in this field aren't easy. Drug companies haven't been able to find an artificial drug and have only managed to create short proteins to activate the receptor. The problem with these is that the molecules are large and therefore unable to penetrate into the brain where they need to work.

Dr Scott thinks he's cracked the problem though, by examining the neurotensin receptor in unprecedented detail, almost down to the atomic scale. "A few years ago, we used X-rays to probe neurotensin receptor crystals to solve its molecular structure. This gave us a beautiful picture, but it's just a snapshot. It doesn't reflect the intricate, complicated dance that happens in a working brain.

"I have a fantastic collaboration with Associate Professor Paul Gooley at Bio21, using a technique called nuclear magnetic resonance spectroscopy to directly probe the molecular movements that occur when neurotensin binds its receptor. Using this technique, we saw that neurotensin continues to wiggle around when bound to its receptor and this movement may be vital for turning the pathway from off to on. So now we know what a small molecule drug needs to do at the atomic scale, we can crack on with designing one that mimics the stimulating action of neurotensin.

"This sort of basic research will allow us to design small molecules that will let us validate neurotensin as a schizophrenia target, as suggested by animal and clinical studies and may lead to new clinical trials."

This story demonstrates the extraordinary complexity of research involving the minutiae of brain function. Searching for a speck of gold in a pan seems simple by comparison.

Dr Tom Keeble PhD
Neuroscience Communicator
The Florey Institute of Neuroscience and Mental Health

THE FLOREY
INSTITUTE OF NEUROSCIENCE & MENTAL HEALTH

The patient experience: Living with cystic fibrosis

Monash Cystic Fibrosis Foundation Chairman Garry Cregan with wife, Rose and son, Ellis.

Garry Cregan is a 47-year-old husband and father living with cystic fibrosis. As the Chairman of the Monash Cystic Fibrosis Foundation, he is committed to helping doctors and researchers enhance the lives of CF sufferers. He shares his experience as a CF patient.

Mum and Dad said that from the time I was born I was always screaming, always hungry, but not putting on weight and had a very distended stomach. It took five years of persistence, visiting various doctors and hospitals before anyone determined it was more than the normal growing pains for a baby who was just a bit underweight. Some thought my Mum was being too overprotective or over-concerned as a parent, but in desperation a GP sent us to the Great Ormond Street Hospital for Children in London. Even there the doctor who saw me couldn't reach a conclusion until my Dad mentioned as we were leaving that I never crawled as a baby and just shuffled across the room on my bottom. It prompted the doctor to do a sweat test, which then led to a stay in hospital and more unpleasant tests for a five-year-old, like an endoscopy, before it was finally figured out and CF was diagnosed.

At the time Mum was eight months pregnant and a doctor from her antenatal clinic advised, "You don't want the challenge of having two CF babies; we can terminate your pregnancy". Mum had no interest in taking them up on the offer! She barely knew anything about CF having only been aware of it for two weeks and decided to press on. Thankfully my sister was born just a few weeks later, without CF.

The impact of CF on the patient (and those closest to them) can be severe and very impactful, or can have a range of impacts down to sufferers such as myself who are more mildly affected. Even though people tend to hear more about lungs and respiratory issues, for the first half of my life – up until university – my illness was all about digestion. My pancreas doesn't secrete the enzymes which break down the fat in foods, so I wasn't putting on weight or building up my strength. In my younger years, I was also strongly encouraged to observe a very low-fat diet (counter-intuitive to putting on weight!). I really didn't start to struggle with respiratory issues until after university. I had an active childhood playing soccer at school and swimming, but with a struggling digestive system and bouts of severe stomach pain.

I remember when I was 14, being in with a doctor without my parents and he told me about an episode of *Panorama* that was about to air on the BBC on CF. He said, "You're going to hear about life expectancy being around the low 20s, but you don't need to be alarmed because you're not unwell. And, of course, you'll hear about not being able to have children." I'd never thought too much about having children as a 14-year-old – I'd only recently discovered girls – but that one conversation then informed my belief that I wasn't able to have children. When I first met my future wife, over a decade later, in one of my early conversations with her I said I wasn't sure if I'd ever be able to have kids, without really knowing anything about it.

I met my wife, Rose, in 1994 when I was traveling as a backpacker in Australia. She moved to London in 1996 and we came back to Australia every year to visit her family. In 2001, during a holiday we visited CF Victoria to find out about the healthcare available if we moved back to live; essentially what the medical knowledge and the drug availability was like for CF patients. As part of the conversation the CF volunteer commented about us wanting to have children and we laughed and said, "What via adoption?" and she said, "No, IVF!" We've been living in Melbourne since 2008 and thanks to IVF we are blessed to have an eight-year-old son, Ellis.

I've been going to Monash outpatients since I arrived in Australia. Their care has been phenomenal and a major reason for me settling in Australia so well and loving every minute of it. From the first engagement with the Monash CF clinic, they really made me feel like they knew me and really cared about me personally. At the Royal Brompton Hospital in London (a specialist centre for the treatment of heart and lung disease) I felt more like just another person on the list – I'd see different doctors all the time and have to regularly recount my history. The doctors at Monash are always keen to try new drugs and always looking for new angles. I've had three different consultants over 10 years and all have been outstanding.

Monash introduced me to the lung transplant team at the Alfred; not because I'll need one tomorrow, but so I can get to know the team and have a history with them, so that when I do end up on the list, they'll know all about me and know my chances of recovery. For the last five years, I've been visiting the Alfred once a year to talk about my health. They're very candid in telling me that I will very likely need a transplant in the future and when that day comes, I'm comfortable that I will be in the hands of doctors who know me, rather than just being a name on a list.

When I think about how I've lived with CF until now, I was in a beautiful state of denial for the first stage of my life, since I was mostly well. I was probably scared for the first time at the end of university, having to do my final exams in a medical centre. That was when the capacity of my lungs really started to plummet, but I pushed on with the support of others through my 20s and 30s. Now I'm 47 and I still stay well but CF does have a slightly more marked impact – I'm restricted from activities like having a kick of a soccer ball with my son in the backyard and I avoid hills or too many flights of stairs if I'm with people I don't know well.

Nevertheless, I've gone from keeping my condition quiet and not telling anyone, to now being happy to talk about it. I was never ashamed of it, but I didn't want to be defined by it. Getting together with other CF sufferers to share stories was never an option given the cross-infection risks in CF. For the most part, I'm well and it's not at the forefront of my mind. I've had the benefit of living through a changing landscape in terms of treatment and understanding. I feel it's also important for me to tell parents of kids with CF that there's not only the doom and gloom prognosis that they'll get from Google. There are more positive outcomes too.

I currently have lung function of about 33 per cent. The trigger for thinking about a transplant is below 30 per cent. The majority of sufferers with a similar capacity are on the ward or resting at home, but I'm lucky enough to be working full-time and trying hard to keep up with Ellis.

Many CF sufferers less fortunate than me endure a lot of hospital stays. Since the age of five I've really only had one and that was because one of the Monash consultants insisted I experience some of the newer care options available, particularly IV antibiotics. I went in for a two-week treatment and lifted my lung function by 10 per cent. When I was there I was encouraged to become the adult voice of the charity.

Everyone on the Monash Cystic Fibrosis Foundation board has a link to CF care at Monash. The doctors do an amazing job, but they are working within the limits of public hospital resourcing. The foundation raises money to assist with:

- the purchase of medical equipment
- supplementing personnel resources
- developing programs that support patient care
- CF research.

Drugs such as Kalydeco and Orkambi are significantly reducing the impact of CF. Younger people are lifting their lung function and weight and reducing their frequency of infections. This is big news in CF, but while this is awesome for those who it works for, there are others who it won't help. I have the most common CF gene and also another that it is very rare in Australia. It means the likelihood of one of these drugs helping me is very low. I'm very keen to help the big push to find out what else can be done.

Visit www.monashcffoundation.com.au to find out more about the Monash Cystic Fibrosis Foundation.

Garry Cregan

Chairman

Monash Cystic Fibrosis Foundation

Take care with Medicare

With a recent increase in the number of investigations and audits, it seems an ideal time to provide some guidance on what you should do if you receive correspondence from the Department of Health about your billing.

Doctors are often confused and concerned about why they have come to Medicare's attention. Some doctors feel they have been unfairly targeted by the Department of Health (DOH). In our experience, Medicare investigations tend to be one of the most black and white jurisdictions doctors are subject to.

Put simply, most doctors receive a tap on the shoulder from Medicare because they are statistical outliers. Medicare runs a series of computer algorithms which measures each doctor against every other doctor in Australia. If you are above the 90th percentile for a specific item number, your profile may be reviewed under the Practitioner Review Program. Other statistical triggers could be daily billing which exceeds the number of hours in a day, or ratios which are vastly different from your peers, e.g. Level B: Level D.

If the anomalies are not readily explained by your practice profile, you may be asked to participate in an interview with a DOH medical adviser. You are more likely to come to Medicare's attention if you are a specialist with an unusual sub-specialty, or a GP with a special interest which alters your patient demographics.

Certain item numbers may be on Medicare's radar and we see some item numbers more regularly than others, including Chronic Disease Management and GP Mental Health Treatment Plans. Each investigation is unique to the individual doctor on the basis of their practice profile.

If you receive a letter from the DOH asking you to participate in an interview, you should contact your medical indemnity insurer (MII) immediately.

Medico-legal advisers at your MII should be able to review your documentation and take you through your practice profile, discuss the concerns raised, go through each of the relevant item descriptors and generally assist you to prepare for your interview. After the interview, the DOH medical adviser may recommend no further action, a six-month review period, or a referral to Professional Services Review (PSR).

Some of the more common criticisms we see from the DOH include poor documentation and billing for services which are not clinically relevant. One of the most significant failures is not understanding the item descriptor, or believing that "near enough is good enough." We hear a lot of reasons, which simply don't cut it with Medicare – *I work 90 hours a week; the practice does all my billing; no other item number fits the service; I didn't know those items couldn't be billed together; I have never read the MBS*. And one to really avoid – *but all my colleagues do it*.

Nerissa Ferrie
Medico-legal
Adviser
MDA National

MDA National
Support Protect Promote

References available from the Editor on request.

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

If the DOH makes contact with you, it doesn't mean you are doing something wrong. It means you are a statistical outlier and you need to satisfy the DOH that your billing is appropriate.

MDA National provides a range of support to doctors, from assisting with a simple self-audit through to full PSR Hearings. We are assisted in this process by external lawyers who are experts in this area.

General practice and pharmacists working together

General practices are increasingly rising to the challenge of providing a comprehensive suite of services focused first and foremost on the patient.

The GP is the keystone in this provision - only a GP is trained and capable of assessing and, along with the patient, planning and monitoring for their holistic care needs. However, for our patients with complex and chronic health problems, many other health professionals with more specific skill sets are frequently valuable in working alongside GPs in addressing a patient's mental, physical and social needs.

It's the ideal encapsulated in the evidence-based and increasingly influential Patient Centred Medical Home (PCMH) model, and I've recently been given an opportunity to see how a key component of that model could work. Over the past few months, my patients and I have enjoyed the services of a non-dispensing pharmacist at our practice.

Non-dispensing practice pharmacists provide a wealth of potential benefits to both patient and doctor. Their deep expertise in pharmacotherapy positions them to help drive reductions in polypharmacy and drug-related problems (a cause of a significant number of hospital admissions), improve patient compliance through simpler dosing, enhance patient understanding of self-medication techniques, and save time for the GP.

This is a totally different concept and practice to dispensing pharmacists and those who provide independent services, with this model increasing fragmentation and working at odds with the PCMH.

Central to the role of the pharmacist in practice is active medication reconciliation. This involves making a thorough audit of all current medications a patient may be taking and comparing the list to prescribers' orders. The value of this becomes apparent when you consider that up to two-thirds of medication histories contain at least one error and a third of those are potentially harmful. The majority of these errors occur during transition to and from hospital. Additionally, patients who are missing medications on discharge are more than twice as likely to be readmitted.

It's a problem likely to get worse without conscious planning. Our rapidly ageing population and the corresponding rise in chronic conditions means the number of people taking multiple medications is growing swiftly. Accurate, comprehensive and easily accessible records of those medications are crucial. Pharmacists in practice are ideally placed to work with GPs and patients to ensure these are accurate by liaising with hospital and community pharmacists on the patient's behalf.

Through the reconciliation process, the pharmacist at my clinic found several cases where prescribers and patients weren't on the same page. They also found patients taking old medications alongside the new and cases where opiate analgesic patches were being confused with hormone replacement patches.

The pharmacist was also able to help our GPs provide better care. After it was found that different doctors were providing different dosing instructions on the same medicine, we were able to standardise and in some cases simplify our approach. The pharmacist was available to advise on cases of potential medication-related falls. They were also able to suggest a simplification, decrease or cessation of some medicines, and on one occasion prompted me that a patient was eligible for a zoster vaccination.

Internationally, there is a general recognition of the value of practice pharmacists. In the UK, for instance, more than 40 per cent of practices will soon have pharmacists. Happily, this recognition is starting to spread in Australia. Following advocacy from the AMA, the Pharmaceutical Society of Australia (PSA) and other organisations, the 2018-19 Federal Budget provided financial incentives for around 5000 general practices to employ allied health professionals, including non-dispensing pharmacists.

In the case of my practice, funding was directed through the North Western Melbourne Primary Health Network and the project was managed by the PSA. A number of other clinics in Melbourne's north-west are involved in the program, with similar projects under way across the country.

Evidence from overseas shows that having a non-dispensing pharmacist in general practice leads to greater interdisciplinary practice, improved management of chronic disease, better use of medication and reduced costs to both individuals and government. A recent survey by the PSA found high levels of productive communication between practice and community pharmacists, while a study in the ACT reported that both GPs and pharmacists viewed the arrangement positively.

In short, non-dispensing pharmacists in general practice is an evidence-based model with significant potential benefits for individual patients, GPs, pharmacists and the healthcare system as a whole. It is supported by the AMA and the PSA and underpins truly coordinated and comprehensive multi-disciplinary care. It would be much better value for our patients if pharmacy stops developing other models that fragment and compromise care and instead focus on a sustainable funding mechanism to make non-dispensing pharmacists available for every general practice.

Dr Ines Rio

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Supporting and connecting women in medicine

The AMA Victoria Women in Medicine Committee is very excited to be bringing you a regular column to Vicdoc. For our first article, I thought it would be best to tell you all about the committee and why we exist!

(Left to right): Dr Nayomi Perera, Dr Sarah Benyon, Dr Laura McKinley and Dr Hannah Bills at one of our WIM events.

Females make up approximately 50 per cent of medical students and are increasingly represented in all medical specialties, including traditionally male-dominated areas such as surgery. Despite an increase in female doctors in the workplace there is an underrepresentation in leadership positions and women still face challenges when weighing up career and family. The difficulties of balancing multiple roles including those of doctor, researcher, partner, mother and friend can often determine what sort of career a female may choose. Of course, these challenges are not only limited to medicine, but all professional women.

The Women in Medicine (WIM) Committee was formed in 2009. Our group is passionate about working towards a future free of imbalance between individuals within the medical profession. However, until this is achieved, it is the committee's aim to connect and support women to allow them to thrive in all aspects of life, both professionally and personally. We endeavor to inspire one another and support each other in balancing competing demands and promoting that one does not have to choose between excelling professionally and having a family and social life. These can and should coexist.

Each year we run several events to serve this purpose. Over the years our speakers have included Dr Wirgina Maixner, Dr Sally Cockburn (AKA Dr Feelgood), Dr Eugenie Kayak and Dr Bronwyn King. Most recently we had our Inspiring Women Series late last year at the Botanical in South Yarra. We heard from two incredibly brilliant women who have excelled in their lives. Associate Professor Kate Drummond, Head of Neurosurgery at the Royal Melbourne Hospital, co-editor of the *Journal of Clinical Neuroscience*, Deputy Chair (formerly Chair) of the Royal Australasian College of Surgeons' Section of Women in Surgery and Chair of Specialists Without Borders (soon to be known as Pangea) enthused about what she's learnt about life and shared stories of her struggles before her successes. Dr Ruth Mitchell, neurosurgical trainee and Chair of the Australian Branch of the International Campaign to Abolish Nuclear Weapons, which won the 2017 Nobel Peace Prize, inspired the audience with her stories of her humanitarian work and what is able to be achieved outside of medicine.

In the last year we have also held wellness workshops to encourage mental wellbeing in female and junior doctors. We held an Inspiring Women's Series in Geelong where we had a laughter-filled evening listening to tales by Dr Kathryn McLeod, a consultant urologist, and Dr Jacinta O'Neill, a general practitioner. Both women connected and motivated the audience with their journeys through medicine to where they are now. We hope to extend events to Gippsland in 2019. If you would like to see a WIM event in a rural area near you, please contact me on the email address below, as the committee would be delighted to assist in extending our network if there is interest.

The AMA Victoria WIM Committee is made up of female doctors and students. We will work with the newly-established AMA focus group comprising of non-medical representatives to continue our community of networking and support. Our committee exists to help support women in medicine. If there is anything that you would like to see this committee do, or you're interested in being involved, please feel free to email me.

Dr Nayomi Perera
Chair
AMA Victoria
Women in Medicine
Committee
amavicwim@gmail.com

2019 Events

AMA Victoria will be hosting forums, workshops and regular meetings throughout the year on issues of interest to medical professionals and students. These events are ideal for doctors seeking to enhance their knowledge on important topics, while also providing an excellent opportunity to network with colleagues.

Here's a snapshot of our events list for the first half of 2019. Check out amavic.com.au/events for the dates and details.

FEBRUARY

Southern Subdivision

Northern Subdivision

Eastern Subdivision

Western Subdivision

Geelong Subdivision

Mallee Subdivision

Senior Salaried Subdivision

Bendigo Subdivision

Wimmera Subdivision

WIM Wellness Workshop

MARCH

East Gippsland Subdivision

CWS Gippsland Subdivision

WIM Information Session on Enterprise Agreement Entitlements

Peninsula Subdivision

Ballarat Subdivision

Retired Doctors Event

APRIL

Financial Information Breakfast

First Home Buyer's Seminar

MAY

WIM Wellness Workshop

Medical Careers Expo

IMG Careers Information Session

Retired Doctors Event

WIM Brunch with Specialities

JUNE

WIM Information Session on Parental Leave Entitlements

Wakelin Bus Tour

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Choosing Wisely: Driving a culture shift away from unnecessary healthcare

Choosing Wisely Australia is part of an international collaboration of healthcare professionals, consumers and other key healthcare influencers working to drive a culture shift away from unnecessary tests, treatments and procedures.

Launched by NPS MedicineWise in April 2015, today Choosing Wisely continues to advance across primary care, in our hospitals and among consumer health organisations and complements an increasing focus on the delivery of high-value healthcare across Australia.

The premise of Choosing Wisely is simple – clinicians and consumers having good conversations about healthcare, including necessity, risks and other options. Choosing Wisely's success to date, having spread to more than 20 countries, has been attributed to the following core principles:

1. health profession-led
2. emphasis on improving quality of care
3. patient-focused
4. evidence-based
5. multidisciplinary
6. transparency

In Australia, we are in a unique position within the global Choosing Wisely network being able to leverage NPS MedicineWise's expertise in quality use of medicines and health technologies. The organisation provides the framework and resources for members to effectively implement the initiative, including educational tools for health professionals and consumers, survey instruments and evaluation support.

Our growing membership comprises more than 40 specialist health professional colleges, societies and associations (80 per cent of medical colleges), more than 20 health services who are championing Choosing Wisely in hospitals and three consumer information partners – all committed to identifying and preventing healthcare practises with little or no benefit.

Choosing Wisely Australia is led by the health profession, with specialist bodies developing lists of the latest evidence-based recommendations of tests, treatments and procedures that should be questioned. Almost 200 recommendations (www.choosingwisely.org.au/recommendations) have been published to date – including recommendations developed under the Evolve initiative of the Royal Australasian College of Physicians which drives high-value, high-quality care in Australia and New Zealand – and are disseminated through a range of channels including clinician networks and industry media.

The recommendations – covering areas such as pathology, antibiotics, genetic testing and imaging – are intended as guidance for healthcare providers and consumers to formulate appropriate healthcare plans together.

This leadership role by Australian health professional colleges, societies and associations gives credibility to the message and shows a commitment from these organisations to resource stewardship and improving quality of care for their patients.

On the patient side, we are encouraging people to ask questions about the interventions being recommended to them, so they can make more informed, shared decisions with their healthcare providers. Our Five Questions resource (available on our website) can help guide this conversation.

Why is unnecessary testing occurring?

The reasons behind the ordering of unnecessary tests, treatments and procedures are varied and complex. Surveys of health professionals and consumers conducted by NPS MedicineWise show an interesting disconnect about why people believe unnecessary healthcare practices are occurring. Our data shows 63 per cent of GPs and 42 per cent of specialists cite patient expectations as a driver, while only 14 per cent of patients say they asked for a test. This is one challenge we are working to address through Choosing Wisely.

Health professionals also reported the potential for medical litigation, uncertainty regarding a diagnosis and difficulties accessing information, including results, from doctors in other settings as explanations for ordering unnecessary interventions.

Implementation of Choosing Wisely recommendations

In NPS MedicineWise programs

Each year NPS MedicineWise launches new national educational visiting programs for general practitioners, providing the latest evidence-based guidelines on managing specific conditions.

Programs cover therapeutic areas where a gap is identified between best practice and actual medicine and medical test use and embed Choosing Wisely recommendations. Most recently these programs have covered neuropathic pain, managing gastro-oesophageal reflux disease with proton pump inhibitors, low back pain and the management of acute ankle and knee injuries.

Each program is evaluated and the outcomes published to demonstrate impact on practice. For example, 59 percent of the GPs who participated in the ankle and knee program reported they were more likely to decrease imaging referrals for ankle injuries. You can read our survey results on www.nps.org.au/news.

In Australia's hospitals

From the outset, health services from across Australia have been proactively looking at how Choosing Wisely can be implemented in hospitals. To harness this energy, NPS MedicineWise established a formal network of Choosing Wisely Australia Champion Health Services, now at 24 members, providing communications and evaluation support and hosting regular forums for health services to share information and best practice.

Austin Health and Eastern Health were the first Victorian health services to join Choosing Wisely. Following the success of a "No Unnecessary Tests" project at Eastern Health and, particularly, a whole-of-organisation approach at Austin Health, Safer Care Victoria (SCV) opened Expressions of Interest for health services to apply for funding to participate during 2017–18.

Austin Health involved every strand of its organisation, including staff at every level, into tackling issues of low-value care and developed policies, decision-making tools and education to support clinicians to choose the most appropriate interventions for patients. This model was adopted for a state-wide scale-up of Choosing Wisely in Victoria.

Join the Choosing Wisely conversation

To find out more about how you can become part of the Choosing Wisely Australia network visit www.choosingwisely.org.au.

I also encourage you to attend the 2019 Choosing Wisely Australia National Meeting which will be held in Melbourne on Thursday 30 May. This annual event brings together Choosing Wisely members and supporters, health professionals, policy makers, consumer advocates and other healthcare influencers for an interactive day of discussion, including highlights, challenges and opportunities as the initiative continues to grow. Visit www.choosingwisely.org.au/members/2019-national-meeting for more information.

Steve Morris
Chief Executive Officer
NPS MedicineWise

Choosing Wisely
Australia
An initiative of NPS MedicineWise

References available from the Editor on request.

Sharing the care when medical treatment is not enough

While healthcare professionals recognise that modern medicine and new technologies have enormous benefits for patients with visual problems, many patients need support above and beyond what can be achieved with science alone.

Unless you have had personal experience with sight loss, it is hard to imagine the impact on life that visual impairment creates. Whether this is a progressive disease or an immediate loss, often there will be an enormous impact to everyday life. In most cases the adaption needed is detrimental to the quality of that person's life.

Blindness or low vision affects a person's ability to perform many activities, such as general mobility and navigation, digital communication, employment status, social outings and recreational activities, shopping and domestic tasks, and medication management, just to list a few.

Add to this that many studies have indicated the risk of falls or other injuries, social exclusion and depression are significantly increased as vision decreases. Safety concerns and lack of independence often threaten a person's ability to remain in their own home. Maintaining a patient's independent living is arguably the most important support clinicians should preserve.

What can be done once medical care is no longer enough?

The great news is that life doesn't stop after vision loss. By assessing a patient's sight Vision Australia can maximise remaining vision and tailor services to achieve their personal goals and aspirations.

How is this achieved?

Regardless of remaining vision, financial situation, or the stage of life your patient finds themselves in, Vision Australia can provide the relevant support services. Here is a short summary:

- In-home assessment and modification by occupational therapists to promote safe and improved living spaces.
- Mobility training to develop the confidence and skill to safely navigate the environments. This may include using a white cane with or without a seeing eye dog.
- Consultants can recommend a range of adaptive technology options based on individual requirements. The solution will meet each patient's needs at home, school or at work.
- Support to prepare for, gain and stay in meaningful employment.
- Facilitate understanding and access to the NDIS or My Aged Care funding streams.

When to refer

There is no single answer, but these basic guidelines apply:

- Upon diagnosis of a permanent, non-correctable or progressive eye condition.
- If you have any concerns that vision impairment is putting your patient at risk.
- When your patient needs support adjusting to vision loss.
- When vision loss starts to impact the quality of daily life.
- Refer sooner rather than later when vision may be severely impacted (✥ 6/12).

Vision Australia has been providing services and programs to the blind and low vision community for over 150 years. The message is this: a simple, easy and timely referral to Vision Australia can be life-changing and even life-saving for a newly diagnosed or long-suffering vision impaired patient. Please take the time to refer your appropriate patients and we will take it from there.

Visit www.visionaustralia.org/medical-and-health-professionals for more information.

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Complete your Advanced Life Support update online

For most doctors requiring Advanced Life Support (ALS) credentialing, the last time they actually utilised it was when they did their last credentialing. Outside of an emergency department (ED) setting it is an infrequent event, but we recognise the need to maintain the skills, as many of us are required to keep it current every three years to maintain our professional CPD requirements.

This was certainly my experience after having worked as a VMO in an ED in metropolitan Adelaide for 13 years and now as a visiting general practitioner to rural and remote South Australia.

One might use the phrase "in my own time" to denote the use of online learning by doctors when and where they want it. Most of us are time poor in our work environment and giving up a weekend to do the usual two-day ALS update is not something we look forward to. Thankfully, all that is now in the past, as the AMA has joined with CRANAPlus to deliver an innovative online ALS module combined with practical assessment that can even be done via Skype.

The online component of the course takes approximately three hours to complete and can be done in multiple segments if desired. I really liked the fact that most modules allowed you to go straight to the assessment at the end of the section if you passed a pre-test demonstrating you had 100% competency in the topic. This directly fits with adult learning principles of recognising what we already know and allowing self-direction.

Module structure flows well in easy to understand steps. The layout and graphics are of excellent quality and provide in-depth knowledge of the subject. The module includes plenty of linked resources for you to read further on any topic easily accessed via the imbedded links, which have practical examples and case studies to assist in learning.

Online learning saves time in planning, transportation and cost. I was able to complete this ALS module in three hours, in my own time without having to leave my clinical duties or my family commitments. Online learning is the new format that doctors will have to get accustomed to for their overall CPD requirements.

The CRANAplus Advance Life Support course can be accessed via doctorportal Learning. Once all components are completed you are directed to the CRANAplus website to arrange your practical assessment. The course is accredited with the RACGP and ACRRM and CPD points are tracked to your CPD Tracker.

It couldn't be simpler. Perfect for busy doctors and significantly cheaper than a two-day course and does the job. I recommend giving it a try.

Visit learning.doctorportal.com.au/catalogue/module-details/151 for more information.

Dr Nicholas Williams
MBBS, DRACOG, FACRRM, MScPHC, FAFPHM, FCRANAplus

dp Learning

Dr Williams is currently working with the Aboriginal Health Council of South Australia as a GP Supervisor, Aboriginal Health. This involves supporting the GP workforce in rural and remote Community Controlled Aboriginal Health Services in SA and supervising GP registrars. He spends more than 60 per cent of his time working in rural general practice and loves it.

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property.littlerealestate.com.au/amavic

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

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General practice at the centre of identifying elder abuse

In a busy practice, the health needs of a patient are the primary focus of general practitioners. Yet, with a growing number of seniors experiencing some form of abuse, health professionals are in a unique position to identify those at risk.

Recognising the signs of elder abuse can be difficult due to the subtle ways it can present. A lack of understanding of what constitutes as elder abuse means that it often flies under the radar.

The World Health Organisation highlights the need for primary healthcare and social service sectors to be equipped to recognise and deal with the problem. Latest figures compiled by Seniors Rights Victoria show that financial, psychological, sexual and physical abuse are the most common forms reported by senior Victorians. Financial abuse represents over 60 per cent of reported cases. Victims are mostly female (72.5 per cent) and 60 per cent of the perpetrators are male. The perpetrator is usually someone known and trusted by the older person.

The National Ageing Research Institute (NARI) has developed a tool to help health professionals identify if someone is at risk. This technology acts as a screening instrument to access the need to refer the patient on to suitable support services and is currently being trialled by St Vincent's Hospital. The draft tool can be viewed at www.nari.net.au/resources/health-professionals/elder-abuse.

The most common signs for health professionals to look out for include: unexplained bruising; changes in behaviour such as worry or anxiety; weight loss; social isolation; and not being able to pay bills or afford food and clothing.

Luke Wright, Relationship Manager for State Trustees Victoria is very familiar with the most common form of elder abuse – financial abuse. At any given time, State Trustees are investigating up to 200 cases of alleged financial abuse.

"We see cases involving transfer of property, theft of thousands of dollars from our clients' bank accounts; cases where the older person is deprived of access to their pension and is at risk of eviction because their rent has not been paid. Often the financial abuse is perpetrated by the person's son or daughter."

Mr Wright acknowledged that while detecting financial abuse can be very difficult, there are some signs that can help uncover it.

"The senior person may hint at controlling behaviours or pressure for financial support from the perpetrator," he said. "They may display outward signs of looking uncharacteristically dishevelled or complaining of having no money."

It is not commonly understood that elder abuse is a form of family violence. State Trustees has partnered with Victoria Police to produce a video to help identify the signs of abuse, which is available via www.youtube.com/watch?v=WBYX5iaAg3k.

There are several organisations and specialists that medical professionals can contact for advice if elder abuse is suspected. Listed right are some resources that can be used if you suspect any type of elder abuse.

state trustees

Resources and organisations for GPs

By phone

- Victoria Police, call 000, ask to speak to a family violence liaison officer
- State Trustees Victoria 1300 138 672
- Seniors Rights Victoria 1300 368 821
- Domestic Family Violence 24/7 Counselling Service 1800 737 732
- Office of the Public Advocate 1300 309 337
- Aged Care Assessment Service 1800 200 422
- Safe Steps Family Violence Response Centre 1800 015 188

Online resources

- GPs can refer to the Aged Care Assessment Service through MyAgedCare.gov.au
- Dementia Australia can provide advice to health professionals 24 hours a day – www.dementia.org.au
- NARI has a number of resources for health professionals – www.nari.net.au/resources/health-professionals

Off-market offers too good to be true?

There has been a noticeable increase in estate agents presenting 'off-market' or 'silent market' properties to buyers in recent months. This scenario, where assets are only offered to a restricted number of buyers rather than marketed broadly, typically becomes more common in weakening conditions – the reasons for which I'll explain here. But should buyers be tempted by these offers?

The short answer is: sometimes, but not always. A longer answer requires an understanding of the motivations of the key protagonists: the vendor, the vendor's agent and the buyer's agent.

When property prices fall, there is always a cohort of vendors who decide this is the time to sell. Some are reasonably sanguine about the price drop and typically use it as a prompt to act on a long-term plan to dispose of an asset towards, say, preparing for retirement. But there are others who want to 'get out now', rightly or wrongly fearing further price drops or who indeed are in some financial stress. This latter type tends to be disproportionately represented in off-market sales.

There are other vendor motivations. Some vendors value their privacy more than most and do not want the intrusion that comes with the archetypal sales campaign; be it images of their property online or in the newspapers, or strangers trampling through their bedrooms.

Other vendors are cost-conscious. They aren't willing to spend the tens of thousands of dollars often associated with marketing and renovation works to make a property ready for sale. Meanwhile, there is the vendor that is strapped for time. They have other obligations which demand the property is sold quickly. Finally, there are properties that are exclusive or exceptional such that there are only a few – and known – prospective buyers. There really isn't any benefit in approaching anyone else.

But it isn't always the vendor pushing for an off-market transaction. Agents may encourage vendors to take this approach. Their agenda isn't always pure. Some less scrupulous agents are anxious to earn commission and are attracted by the faster turnover of off-market sales. The agent might also be using the off-market approach to convert an apathetic prospect. They 'shop' the property around – often to buyer's agents – to see if any interest can be mustered despite not having a sales authority and use evidence of curiosity to try and sign-up the prospect for a genuine campaign. Or only slightly less cynically, they have a client who is 'testing the market' and who may not sell, even if a fair market price is offered, so risk wasting buyers' time and money.

Lastly there is the buyer's agent's motivation. As volume buyers of properties, they are the natural first phone call for a vendor's agent holding an off-market property. Naturally, reputable buyer's agents will assess an off-market property on its merits and do the necessary due diligence. But some buyer's agents can be flattered by supposed exclusive offers and like to crow about this access as a marketing tool, which potentially weakens their resolve to maximise their client's interests.

Buyers should treat off-market property cautiously.

- Check that the vendor's agent has both a signed sales authority and a vendor's statement prepared.
- Ask how exclusive this offer is.
- Enquire whether the property is 'fresh' or whether it has been on the market in recent months.
- Probe the agent to justify – using recent comparable sales – the price they have asked for.

Then go away and do your own independent research.

Richard Wakelin

Founder

Wakelin Property Advisory

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Wakelin Property Advisory is an AMA Victoria Member Benefits Partner and an independent buyer's agent specialising in acquiring residential property for investors. wakelin.com.au

Book reviews

The iconic, independent Sun Bookshop has been a hub for readers in in Melbourne's inner-west and beyond for 21 years. Here's a taste of what their booksellers have been reading lately.

Cordelia has been reading *Normal People* by Sally Rooney.

Normal People is the story of Marianne and Connell, told in chunks of time spanning over four years. We skip forwards in increments of weeks or months, sometimes minutes, dipping in and out of their lives. It begins in the close parochial days of high school and spins out to the more expansive world of Trinity College, cataloguing their shifting power dynamic and how they are constantly pulled back to each other.

It's about the way, when we're young, we inadvertently hurt the people we desperately love. The way we trip ourselves up imagining what someone else is thinking or wanting, most of the time getting it wrong. It's about the relief you feel when you're with someone who intrinsically understands you – how you save up sentences for them; how you can be your most essential self when you are with them.

A customer recently asked me if he should buy *Normal People*. He said, "Someone like me, an old man, am I going to like it?" I wasn't sure what to say. I suppose because there's still a part of me, quite a large part, which assumes men have no interest in the interiority of women. I told him I loved the book and he should let me know what he thought of it. What I should have said was, "Yes, someone like you will like this book".

It's easy to fall into the trap of thinking this is a book about young people, written by a young person (Rooney is 27) for her contemporaries. But really it's just the story of two people who are drawn to each other and all the messy, radiant moments that sets in motion. It's a story of two people falling in and out of love, trying again, hoping next time they'll do a little better.

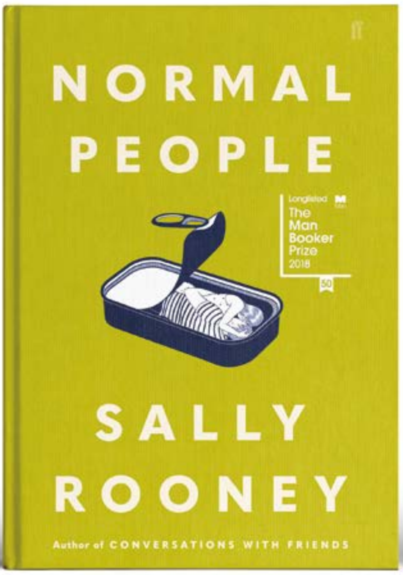
Josh has been reading *The Lost Man* by Jane Harper.

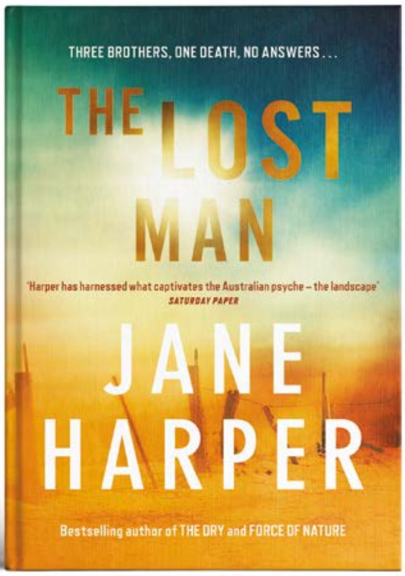
Jane Harper's third novel goes against expectations in the best and most rewarding ways. While we expected our complicated hero Falk to be at the forefront, he doesn't feature at all in *The Lost Man*; nor is his absence felt. In fact, the police are mostly absent here, with the action unfurling domestically, contained within one family's secrets.

The prologue hooks you instantly, describing a lonely gravestone, with a body against it, surrounded by a ring of kicked-up dust. A search helicopter spots the corpse by its blue jeans against the red earth.

The story is narrated by Nathan Bright, a divorced father and disgraced local who lives a solitary life on acres of almost-useless land. His son Xander is visiting for Christmas from Brisbane and is regrettably in the car as Nathan drives to the lonely gravestone to meet his youngest brother Lee, nicknamed Bub. It's their brother, middle-born Cameron, whose corpse now lies under a tarp against the gravestone.

The mysteries around Cameron's death are all explored and investigated within the family and their close associates. How does a man whose farm is doing incredibly well, who is seasoned with outback survival, walk to the middle of nowhere, miles from his working and well-stocked car, and die of thirst? It would take away too much to explain what follows, but Harper mixes dark family histories, small-town politics, the hardships of outback stock farming and the complexities of mental health to create a totally gripping story where none of these things feel forced or too pronounced.





Cameron's death casts suspicion on everybody and brings long-buried secrets out of the woodwork, which are made all the more effective thanks to the isolation in the novel. It's also a testament to Harper that death in her novels has never felt gratuitous – she ensures that it always carries weight and that its effects are complicated and devastating.

Harper proves once again that she's a formidable writer, using the landscape as a character that creates a mood that's distinctly Australian. *The Lost Man* is not only a masterful crime novel but also proof that Harper is a writer unafraid to take risks and these risks always pay off (and then some).

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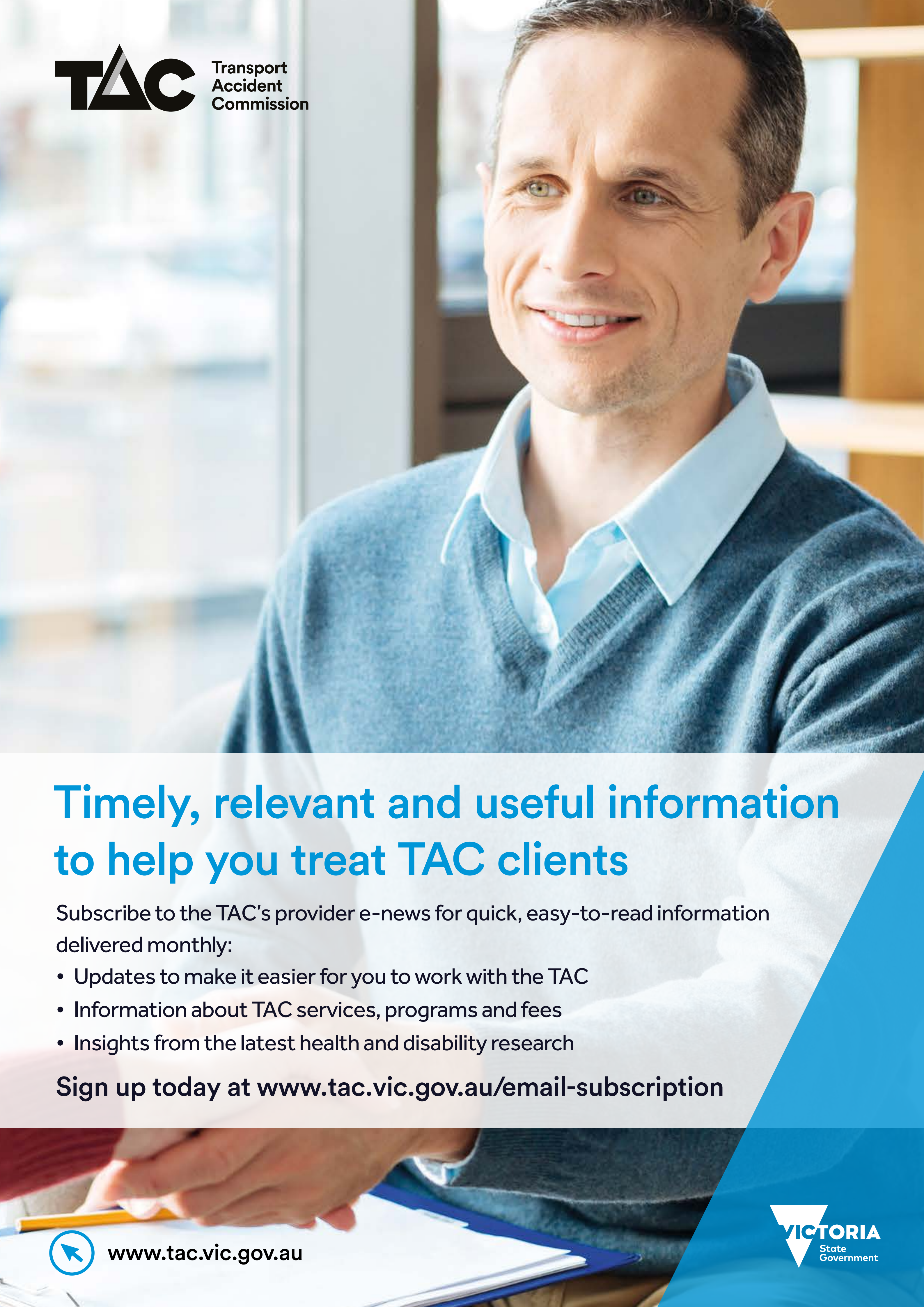

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