vicdoc

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COVID-19: What doctors need to consider during the pandemic

Magazine of the Australian Medical Association Victoria

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Contents

COVID-19 information for doctors

This is a rapidly changing situation and the AMA Victoria COVID-19 webpage will be regularly updated with new information.

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

Due to the high number of members making contact, we apologise for not always responding immediately. Please do not be discouraged. All feedback is viewed and acted upon. Views are being collated and passed through to the President of AMA Victoria and AMA Federal (for federal issues) who are in regular contact with the relevant departments and ministers' offices.

Please email covid19@amavic.com.au

Workplace questions and answers

In these extraordinary circumstances it is important to realise we are all in uncharted territory. AMA Victoria's Workplace Relations team has compiled answers to a series of questions that are regularly being asked by members in regards to workplace concerns resulting from the COVID-19 pandemic.

CLICK HERE INDUSTRIAL Q & A

CLICK HERE FOR GP & SPECIALIST PRIVATE PRACTICE FACT SHEET

Doctor wellbeing support services

AMA Victoria's **Peer Support Service** is available every day of the year from 8am to 10pm on **1300 853 338**.

The COVID-19 pandemic is an unprecedented situation which is creating stress and anxiety for the community and the health workforce. Doctors are on the frontline in this pandemic. AMA Victoria would like to remind all doctors and medical students to pay attention to your own wellbeing over the coming months.

Our Peer Support team is available to provide support over the phone for the times you need to debrief and talk about how you are feeling and what is going on. The principle of the Peer Support Service is doctors supporting doctors and the service is available to all doctors and medical students in Victoria and Tasmania. You can remain anonymous and your call is confidential – **1300 853 338**.

The Victorian Doctors Health Program (VDHP) will continue to be available 24/7 to all medical students and doctors in Victoria and Tasmania throughout the COVID-19 pandemic. Please call **(03) 9280 8738**. VDHP will be utilising teleconferencing and videoconferencing for all consultations during this time.

Protecting your mental health during the pandemic will keep you functioning at your peak.

CLICK HERE FOR SOME TIPS TO PROTECT YOUR MENTAL HEALTH

Financial assistance for Victorian doctors and their families

The Victorian Medical Benevolent Association (VMBA) continues to be available throughout the COVID-19 pandemic to assist with financial support and information for doctors. VMBA is a not-for-profit organisation which has existed since 1865 to assist Victorian medical practitioners and their families, including retired doctors and medical students.

COVID-19 will have financial implications for everyone. VMBA may be able to assist Victorian doctors who are experiencing a financial impact, such as loss of income or increased expenses. VMBA can be contacted by email on DianaC@vmba.org.au

CLICK HERE FOR MORE INFORMATION

Careers support available online and by phone

Our career coaching and transition services will be open as usual to support doctors navigate their careers and their roles during this period of significant upheaval resulting from the COVID-19 pandemic.

Please note all services will now be delivered either online, via webinar (zoom), or by telephone. We have delivered our service in a virtual format since its inception, successfully supporting doctors in regional and rural Victoria, as well as interstate.

As members of AMA Victoria you can access our '15-minute Career Call' service **via our website**. This is a member-only service.

Our career coaching, transition and professional coaching programs can also be booked via our website.

CLICK HERE TO MAKE A BOOKING

We will endeavour to make ourselves as available as possible to accommodate members over the coming months. Please email careersadvisor@amavic.com.au if you can't book your preferred day or time. Also email us if you have any queries and we can call you directly.

As your professional association we aim to support you as much as we can professionally during this challenging time.

President's message

The *New England Journal of Medicine*, a publication not usually associated with alarmism recently asked, "Are we seeing a replay of 1918?". In a February opinion piece written by Bill Gates – who has for years been warning us about the danger of pandemics – he bluntly cautioned that the COVID-19 virus could become a "once-in-a-century" pandemic.

Clearly, the world is now a very different place since the emergence on New Year's Eve of cases of atypical pneumonia whose cause was then unknown and which had been detected in Wuhan City, in the Hubei Province of China.

In the second week of January, the World Health Organization (WHO) was informed by the National Health Commission of China that the outbreak had very likely arisen within a wild food market in Wuhan City. At around the same time, Chinese authorities isolated a novel beta coronavirus. Almost immediately thereafter, China shared the genetic sequence of the virus with other countries such that they could commence developing diagnostic tests for this new pathogen.

Within days, Thailand and Japan reported imported cases of novel coronavirus infectious pneumonia (NCIP). South Korea then made a similar report in the third week of January.

Later in January, the Chinese government extended by three days the Lunar New Year holiday in order to keep people from returning to workplaces. Tour groups were also banned from leaving China in a further bid to limit travel and the spread of the coronavirus during the peak season for Chinese tourism. Seventeen cities across China were also placed in lockdown with enforced curfews and curtailment of public movement. Draconian measures, perhaps, but without them, the spread of the virus globally would likely have been far worse than it already has been.

On 1 February, our Federal Government quite presciently introduced a ban on anyone arriving from, or transiting through, mainland China from coming to Australia, unless they had been outside China for 14 days. The ban excluded Australian citizens, permanent residents and immediate family members. In retrospect, many more countries could have been included in the travel ban, but it was certainly ahead of the measures introduced by numerous other jurisdictions at the time.

By the beginning of March, the WHO had confirmed over 84,000 cases of the COVID-19 novel coronavirus, 96 per cent of which were in China. Tragically, more than 3,000 deaths from the disease were confirmed in the first two months, 98 per cent of which were in China. Simplistically, this suggests a mortality rate of more than 3 per cent. However, epidemiologists tell us that the mortality rate is more likely to be in the order of 2 per cent or less, given the high probability of parties contracting the disease being so mildly affected that they either do not present for treatment, or are not detected or diagnosed. This case fatality rate is thus far less than that for Severe Acute Respiratory Syndrome (SARS) or Middle East Respiratory Syndrome (MERS). Mortality also appears to be heavily concentrated in the aged and those with other medical conditions where comorbidity is at play.

Clearly the more recent death rates in Italy and Spain are extremely alarming, along with the sharp spike of cases within the USA, France and the UK. Australia has also been following a similar trend to these Western nations, so it's critical that we have cooperation between the state governments and Australia's federal health authorities during this crisis.

There is not yet a COVID-2019 vaccine at the time of writing. However, various groups have been racing to develop one since the COVID-2019 genetic sequence was shared by the Chinese government on 10 January, while the virus was grown by the Victorian Infectious Diseases Reference Laboratory at the Doherty Institute in Melbourne on 28 January.

For example, US-based Inovio Pharmaceuticals – which medical journal, *Lancet Infectious Diseases* cited for its development of a vaccine for Middle East Respiratory Syndrome – is already evaluating the safety and immunogenicity, through phase 1 human testing in the US of a vaccine it has developed targeting COVID-2019. Similarly, another pharmaceutical company, Moderna Inc, has released its first batch of vaccine targeting the coronavirus, for another phase I human trial that has just begun in the US at the time of writing. In addition, WHO Assistant Director-General, Dr Bruce Aylward , the WHO's Assistant Director-General (who led the WHO's response to Ebola), has stated publicly that he believes Gilead Science's Remdesivir to be the one drug that their scientists think could be effective at treating COVID-19.

President's message

There will be more, and I believe, reasonably rapid responses in this area; including perhaps some made here by Australian researchers, including those at the Doherty Institute who have received much expanded support from the Victorian Government.

In the past two decades, due to technological advances and a greater commitment by governments globally, and with the support of numerous non-governmental and commercial organisations, the time taken to develop vaccines and anti-viral drugs for emerging infectious diseases has dramatically shortened. Let's hope that one of these measures arrives soon.

However, one of my course teachers at the Johns Hopkins School of Public Health (Baltimore US) in the 1990s made some salient observations about the stages of an epidemic that we now seem to be witnessing:

1. The pathogen's identity is revealed and a new disease name becomes commonplace.
2. Various governments reassure the public that everything is safe (until it isn't).
3. Dissenters will critique governments for failing to prepare adequately (which they rarely do).
4. The media stigmatises the initially affected group (or country of origin), traces the pathogen's transmission and headlines the number of infected and dead.
5. Doctors will heroically risk their lives to fight the disease and ultimately medical science will contain the outbreak.

Of course, we all know that there are many practical things that we can do to reduce the risk of cross-infection now that community spread is occurring here. In particular, we need to practise not touching our face. Especially, we have to all practise not touching our eyes, nose or mouth and insist on adequate personal protective equipment.

We also need to remember that we need to wash our hands even more frequently and rigorously. Washing with soap and water for at least 20 seconds or fully rubbing our hands with alcohol-based hand gel is essential, before eating or touching food and of course, between examining patients. Routines for personal protective equipment need to be practised and strictly used for all scenarios where we might be dealing with COVID-19 infected patients. And if you manage a practice, you will by now have your disaster protocols in place, including the cross-training of key staff so that one person's absence won't derail your ability to provide other care.

Many of our members have expressed concerns about not having adequate facilities, resources and protective equipment to manage a pandemic and we have been passing these concerns on directly to state and federal health authorities. After receiving member feedback, we are particularly trying to improve the two-way communication channel between the Victorian State Government and our GP members.

Enhanced social distancing and personal hygiene measures will flatten our epidemic curve and make the disease more manageable, but unfortunately, it doesn't look like this epidemic will subside quickly. It seems now that COVID-19 will be with us throughout 2020 and possibly into 2021. It might even become a seasonal infection, returning each winter like influenza. But we need to do everything we can as a profession to slow the spread of this illness and encourage the community to change their behaviours. We equally need to ensure that we more adequately protect health workers so that we can continue caring effectively for those most at risk.

I wish you all the best of health, peace and wisdom in the challenging months ahead.

A/Prof Julian Rait OAM
President

Plans underway for virtual Medical Careers Expo

Due to the COVID-19 pandemic, AMA Victoria's 2020 Medical Careers Expo, in its original form, has been cancelled. We offer our sincere apologies and understand that many delegates and exhibitors will be disappointed.

We are investigating ways that we can reshape the day into a 'virtual event' by which health services, colleges and training providers can run a series of webinars or pre-recorded videos for delegates to access. We hope to run this virtual event on Saturday 2 May.

Thank you for your patience and understanding while we work through the details. More information will be provided soon.

Don't repeat the mistakes of a century ago

When the world was hit by the Spanish flu pandemic a century ago, a lack of clear advice and conflicting methods to manage the crisis unsettled and confused many. A/Prof Julian Rait researched the response to the Spanish flu during his studies at the John Hopkins University's School of Hygiene and Public Health in Baltimore, 30 years ago. We shouldn't make the same mistakes today.

The 1918–1920 influenza pandemic remains one of the greatest natural disasters of human history. Over the course of these two years, the disease affected hundreds of millions of people and killed between 50 and 100 million. After the disease finally reached Australia in January 1919, it caused more than 15,000 deaths. While the death rate was thankfully lower than in many other countries, the pandemic was a major demographic and social tragedy for Australia; it rivalled the era of the Great Plague in the 14th century in mortality along with its devastating social and economic effects.

Different hypotheses have been made about the origin of the Spanish influenza pandemic, with the three main ones being Northern China, a British army base in France and Kansas in the United States. However, the Spanish flu was initially observed in Europe during the final months of the Great War. Few families or communities escaped its consequences with possibly 25 to 30 per cent of the world's population being infected with influenza during the 1918–1920 period.

There was also a series of global pandemic waves, the first striking in the Northern Hemisphere during the spring of 1918. By October, the disease had reached New Zealand. And unfortunately, despite a vigorous policy of maritime quarantine, the disease reached Australia in early 1919. However, we are able to thoroughly investigate the circumstances of Australia's subsequent response, especially in New South Wales given that there was a Royal Commission conducted in 1920 to investigate the efficiency of the measures applied to contain the Spanish influenza Pandemic.

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It was recorded in the proceedings of the 1920 Royal Commission that the first case of pneumonic influenza actually appeared in Melbourne, on 9 or 10 January 1919. However, as these early cases were mild, there was initial confusion about whether the virus was the Spanish flu, or simply a continuation of the seasonal flu virus from the previous winter.

Unfortunately, this uncertainty delayed the confirmation of an outbreak by the Victorian health authorities, which allowed the infection to spread to New South Wales and to South Australia by the end of January 1919. Consequently, although the outbreak began in Victoria, New South Wales was the first state to officially proclaim an outbreak of pneumonic influenza on 27 January 1919, with Victoria deciding to follow suit the very next day.

The first wave that swept NSW peaked between mid-March and late May, affected half as many females as males and resulted in around 30 per cent of all deaths. The second wave peaked in June and July and was more virulent than the first—producing an even higher mortality rate, involving more females and affecting far more people over the age of 50 years.

Tensions within the new Federation emerged as the other states perceived Victoria's delay in confirming the outbreak as a breach of the November agreement that had been made with the Commonwealth. Consequently, each state soon made their own arrangements for handling and containing outbreaks, including organising their own border controls. The Commonwealth temporarily withdrew from the November agreement on 11 February 1919.

The experience of pneumonic influenza also varied by location. The city of Sydney implemented strict social distancing measures in an attempt to limit the spread of the disease. Such massive restrictions on public assembly included closing schools, Sydney University and places of entertainment (like music halls), while pubs were only allowed to be open for just minutes at a time.

The use of face masks in public was mandated, otherwise citizens were subject to heavy fines and public ostracism. And while such measures didn't prevent the spread of the disease, they did slow its spread in the community. Nonetheless, Sydney experienced three waves of outbreaks, with many deaths and many more infections. Ultimately, in NSW the case fatality rate was around 0.5 per cent, which was substantially less than the experience elsewhere in the world where a mortality of around 2 per cent was experienced.

In Perth, the combination of the city's relative isolation and effective state border quarantine control ensured that pneumonic influenza didn't appear there until June 1919. However, an early sense of complacency arose in Perth until the city experienced a dramatic spike in infections after crowds gathered to celebrate Peace Day on 19 July 1919. The city's relative isolation and effective state border quarantine had hitherto ensured few cases, but this phenomenon of mass gatherings 'super-charging' early case rates during the acceleration phase of an epidemic has been well-documented in other cities. Indeed, in Philadelphia, a huge outbreak of Spanish influenza followed the Liberty Day Parade of 28 September 1918.

By contrast, Dr Max C. Starkloff, who was the St Louis City Health Commissioner led the way during the Spanish influenza pandemic in the USA. Jefferson Barracks was hit first in St Louis with influenza on 1 October 1918. Within a week, 800 soldiers were hospitalised. Then, with the backing of Mayor Henry Kiel, Dr Starkloff closed city schools, theatres, moving picture houses, and places of amusement. He also banned public gatherings of more than 20 people. The following day, he closed churches for the first time in the city's history. That earned him the ire of Archbishop John Glennon, who protested that decision, but he eventually temporarily suspended the weekly mass obligation for Catholics.

Dr Starkloff also closed the municipal court, playgrounds, library reading rooms, pool halls, fraternal lodges and limited the use of public transportation. Busy downtown department stores operated under restricted hours. Dr Starkloff also distributed a four-page pamphlet that advised people on how to protect themselves including the catchy phrase, "Cover up each cough and sneeze, if you don't you'll spread disease." The pamphlets were printed in eight languages: English, Polish, Russian, Yiddish, Hungarian, Italian, Bohemian (Czech) and Spanish. All of the actions resulted in St Louis experiencing one of the lowest influenza rates of cities compared to its size. Of the 31,500 who got sick in St Louis only 1,703 died.

Although similar measures were ultimately adopted by many Australian cities, the pandemic

created major social upheaval, affecting the lives of millions of Australians. In the first six months of 1919, probably more than 15,000 died from influenza and possibly as many as two million Australians were infected.

Although the first community outbreak occurred in Melbourne, it appears likely that the first infected ship to enter Australian waters was the Mataram, from Singapore, which was recorded to have arrived in Darwin on 18 October 1918 but was quarantined. Over the next six months, the customs service intercepted 323 vessels, 174 of which carried the infection. Of the 81,510 people who were checked, 1102 were infected. Therefore, rigorous border controls were probably effective in preventing an earlier outbreak of Spanish influenza in Australia.

The federal government's second line of defence was to establish a consistent response in handling and containing any pneumonic influenza outbreaks that might occur in Australia. In Tasmania, where my father was born in 1909, the state was not overwhelmed by the disease but instead implemented strict quarantine measures for boats arriving on its shores that required all passengers and crew to be isolated for seven days. When the infection penetrated

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the island in August 1919, medical officers reported that it was a milder infection than that on the mainland. The death rate on Tasmania was one of the lowest recorded worldwide.

Globally, the mortality rate varied considerably. Australia experienced a mortality rate of close to three deaths per thousand, while in nearby New Zealand it was almost double this figure. In some isolated populations the pandemic took a much heavier toll. In Western Samoa there were 8,500 deaths in a total population of only 38,000—a death rate of 221.92 per thousand.

Australia, like most countries, was ill prepared to cope with a pandemic. The war had severely disrupted social and economic life, removed many medical personnel and disrupted public services. In an attempt to contain the outbreak, Australian authorities instigated a combination of strategies. Large public events were cancelled. Schools, theatres, dance halls, churches, pubs and other places of public congregation were shut, while streets were sprayed, special isolation depots were established, and people were compelled to wear masks in public. Movement by public transport was restricted and state borders were closed, with quarantine camps established at border crossings.

Scientifically questionable attempts were also made to produce a vaccine using a mixture of victims' sputum, streptococcus and staphylococcus concoctions. Hundreds of thousands of people were inoculated after the government established more than 1260 public inoculation depots throughout Sydney, including the use of many private practitioners. In a little over six months, more than 819,000 inoculations were performed, including more than 440,000 in Sydney, which was more than half of the city's population. People were urged to practice personal preventive measures such as cough etiquette, hand washing, ventilation and rigorous disinfection.

Of course, within a short time, doctors and nurses were pushed to breaking point as many of Australia's hospitals became overwhelmed. At the onset of the pandemic, NSW had only 2000 hospital beds. Between January and September, more than 25,000 people in NSW were admitted to hospital with influenza, requiring the establishment of hundreds of temporary influenza hospitals in schools, showgrounds, churches, gaols, bowling clubs, tearooms, drill halls, courthouses and private homes. The pandemic also took its toll on medical and healthcare workers. In Sydney, more than 800 were incapacitated with influenza and many temporary hospitals had to be staffed by lay volunteers.

A dearth of doctors soon arose, which was due partly to about 5 per cent of all registered practitioners still being on overseas service. Those who remained were generally older, possibly unfit or wounded, and invariably over-worked so that their ranks were diminished further as doctors themselves fell ill due to the pandemic

Finally, there was the spectacle of some of Australia's most eminent physicians squabbling with each other in the popular press over the nature, cause, prevention and treatment of the disease. With the experts in disarray, it was no wonder that people with limited resources to expend on medical purposes avoided consulting doctors in favour of 'snake-oil' remedies, especially when doctors could rarely provide anything more effective to treat pandemic influenza.

The public was also stunned by the ferocious nature of the pandemic while the daily newspapers fanned public reaction with exaggerated reports of cases and deaths and lurid descriptions of the great plagues of the middle ages. There were also regular reports of people waking up feeling fine in the morning but being dead from influenza by nightfall. With so many people off work due to illness, normal services and activities were severely disrupted.

Thousands sought popular cures and medicines. Many people rebelled by circumventing the quarantine blockade at state borders or refusing to wear masks. Waterside workers refused to unload ships for fear of infection and some public workers demanded extra pay given the perceived risks. People shunned outsiders and interstate visitors, fearing that they might be a potential source of infection.

The pandemic also caused disputes between all the states and between the states and the Commonwealth over multiple issues. There were differences over border controls and quarantine, interstate transport links and the quarantine of returning servicemen. Eventually, cooperation between the states and the Commonwealth authorities was completely abandoned, with each state imposing unilateral border closures and organising its own virus containment policies.

Clearly, there are many lessons to be learnt from Australia's experience of influenza in 1919. The pandemic tells us something about how people and communities react to severe disease crises, particularly in a context where governments and conventional medical science lack a single 'voice of truth'. In addition, Australia's experience with the Spanish flu pandemic demonstrates how ill-prepared the nation was for such a public health crisis and that our response might have better considered the impact on our hospitals and encouraged more coordination with the medical profession across Australia.

Moreover, it is clear that the popular press played a defining role in presenting a pandemic to the public in 1919 and at times seemed to settle or (more usually) aggravate public anxieties. Finally, the experiences of 1919 demonstrated that cooperation between various state governments and Australia's federal health authorities during such crises is critical to containing pandemics and minimising any associated loss of life.

A/Prof Julian Rait OAM
AMA Victoria President

Read A/Prof Rait's opinion piece written for The Guardian.

How to lead through a crisis

Our leaders are under an unprecedented amount of sustained scrutiny. With COVID-19 our political and health leaders are in the spotlight 24/7, giving daily briefings, television and radio interviews.

We ask so much of our leaders in a crisis. We ask them to be constantly available, informed and up to date, and able to communicate their technical expertise into effective mass communications, replete with soundbites for clips and social media. Complex concepts around transmission, infection rates, treatment and vaccine development are now part and parcel of news bulletins and social media posts – going back-and-forth between experts and novices.

Effective crisis leadership allows people to feel safe and empowered to do the critical work they need to do, and comfortable enough with the amount of uncertainty and change that goes with a crisis. Leading leadership theorist Ronald Heifetz writes that leadership, including in a time of crisis, "Is a razor's edge because one has to oversee a sustained period of social disequilibrium during which people confront the contradictions in their lives and communities and adjust their values and behaviours to accommodate new realities" (Ronald Heifetz (1994) *Leadership without easy answers*).

These are significant challenges for leaders. It requires much more than business as usual. Leaders must talk to people, reassure them and guide them in action while the amount of uncertainty and change is very high. They must work to contain rising anxiety so people can bring their best to this difficult situation. It is about filtering distractions to ensure resources, structures and processes are in place to enable effective action, while being flexible and adaptive enough to accommodate constant change. To quote Heifetz again, leadership, including in a time of crisis, is essentially about, "Keeping the level of distress within a tolerable range for doing the necessary work".

These challenges are the same for all leaders in medicine; whether you are responsible for a large team in a major public hospital, or a very small number of staff in a general or private practice. So how can we do this most effectively? What does it mean to contain anxiety in order to do the necessary work as efficiently and effectively as possible? The following pointers are drawn from psychology, organisational behaviours and leadership and include behaviours and actions that leaders can enact.

1. How do I feel?

We all experience emotions when bad news breaks and large-scale challenges unfold. Furthermore, stress and anxiety easily amplify emotions, especially fear and anger. Understanding our own feelings can help us get a handle on ourselves so we can be present and available to others. Leaders can't lead if they don't have a handle on their own emotions. So, a quick self-check-in (how am I feeling?) helps us identify our own response. It will also help us recognise similar and different feelings and responses in others. Understanding others' responses helps us connect to others – so we can reach many people effectively in our communications and actions.

2. Present as a strong and compassionate leader

How our leaders 'show up' matters. We watch them closely; body language, facial expressions and opening words are all observed and make an impression. This is so difficult for leaders and for many this public presence is well outside their comfort zone. It's difficult because it requires the in-the-moment management of self and others and the need to deal with the frustration of not being able to communicate a message of certainty.

3. Share information and expertise efficiently and consistently

Credible and reliable information and expertise is critical. Leaders must have constant access to accurate and up-to-date information and must share this with others, as well as the sources of information, providing public access where possible (for example, the WHO and DHHS websites have been widely shared in the public realm, plus frontline health workers will have more professionally aligned sources).

How much information should be shared and to whom? Information is containing and empowering, when people feel informed and have consistent information that enables them and their organisation to work effectively. When people feel information is being withheld, trust is damaged and information may be obtained from alternative sources that are not consistent or credible. This is disempowering, causing problems for effective collaboration. In general, sharing information as widely and publicly as possible builds engaged and informed teams, organisations and communities. Work is required to keep people listening, even to the same message, but this work is important to stop people switching off and turning to less credible sources.

What about the challenges around managing bad news and information overload? Crises involve being the bearer of bad news, repeatedly. While it can feel tempting to keep bad news hidden or to leave out some details, leaders need to work hard to combat this bias. Telling the truth and being open and transparent is critical to building trust, and trust between leaders and their followers is critical to keeping people engaged and staying connected to the expert leaders and their communications about the crisis. Skilled leaders don't hide bad news, they deliver it in a way that manages anxiety, as detailed above. Continuous information updates are

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also experienced differently to some extent – for some it is empowering, for others overwhelming. This is something leaders can acknowledge in their briefings and colleagues can support each other to find their comfort zone.

Crafting an effective message for these situations can include:

- sharing the information you have; be straight, don't hide the bad news; anxiety and fear heightened by the nature of the news can be contained by the following actions:
- sharing specific information about the action you are taking to understand and control the problem
- telling people that you will keep them informed and how you will do this
- giving clear direction on what you expect from people, within their roles. Containing others' anxiety here is paramount; it's important to say, "Please go and do x, y and z, and come back to tomorrow to hear what's next".

4. Think and plan strategically and openly

Share with your colleagues the concrete actions that are being taken to solve problems. This will improve communication and reduce anxiety amongst staff. Everyone knows there are potentially huge problems coming, so they will feel comforted knowing the actions being taken to solve them. They don't need all the details but just knowing helps. For example, you share what is being worked on right now and by whom. This step also includes being open about the level of uncertainty and ambiguity in this situation and saying that it is likely that plans and actions will change and evolve in response to new information and that is important.

When leaders share knowledge on strategic actions and decision-making, a greater shared understanding of what is happening exists in the workplace. People feel more confident knowing that something is happening – even if they don't agree with it 100 per cent – as uncertainty leads to anxiety.

These are the challenges of leading in VUCA environments – those that are Volatile, Uncertain, Complex and Ambiguous. Leaders need to lead in the moment, to take stock of the whole set of relevant factors, including those that have arisen suddenly and unpredictably, and make fast and effective decisions and include planning for changing and modifying actions on the run.

5. Support others by calling attention to the importance of personal and professional networks

In a crisis, everyone is being asked to do more with less. Part of the more is supporting yourself and others around you. This is a time to check-in with your colleagues, your team, your professional networks and being conscious about providing supportive resources. This is caring and compassionate leadership. Giving people the space to share their personal situations and be open about their needs helps people to stay at work across the long-term and small adjustments can help ensure that is possible.

These are five brief pointers that can be helpful. I don't profess that any of the above encompasses all of what's involved and important in crisis leadership, and neither do I suggest that they are easy. But I do hope they are helpful. Finally, writing this as someone who is not on the frontline, thank you to all of you who are.

Dr Anna Clark, PhD
Leadership consultant and coach

References available from the Editor on request.

AMA Victoria's Leadership Coaching Program for doctors

AMA Victoria's Career Service has offered professional coaching to members for the past several years. In recent years we have had more and more requests from senior doctors looking to develop their leadership capability, as their roles expand, new challenges emerge and the need for more effective models of leadership in health become more apparent. In response to this we have been working to develop a solution that meets the needs of doctors and addresses current and emerging health system challenges – but in all honesty, in developing this solution over the past several months we could not possibly have foreseen the crisis our doctors are currently facing. In response to this, we have brought forward the launch of our 'Leadership Coaching Program' and hope that it might be a useful tool members can engage with to support them in effectively taking up their role of leader during this time.

We are delighted to partner with Dr Anna Clark in providing this coaching program to you. Anna has a PhD in social psychology from the University of Melbourne and works as a leadership development consultant and coach designing and delivering programs and coaching in Europe, Singapore and Australia. Prior to working in leadership development, Anna held academic positions in psychology and organisational behaviour departments in the Netherlands, France and Australia. She has over than 10 years' experience coaching emerging, middle and senior leaders from a range of private and public sector organisations. Anna currently lives in Melbourne and works as a leadership development consultant and coach designing and delivering executive education programs and coaching at INSEAD Business School (ranked consistently in the top five business schools in the world) and for a range of other organisations and individuals around Australia. Anna specialises in supporting individuals to create and enact nuanced personal action plans to support their work on the behavioural change they desire in a realistic and sustainable way.

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

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

Exclusivity just became more exclusive

AMA Victoria is pleased to announce a new partnership with Audi Australia.

As a member of AMA Victoria, Audi Australia offers you access to premium benefits across the range of new Audi models including:

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* Terms & Conditions apply.
Click here for more details.

Career spotlight: The diverse opportunities in general practice

GPs play a crucial role in the Australian healthcare system. Their role on the frontline is never more evident as the world comes to terms with the impact of COVID-19. However, general practice is often a career path initially overlooked by medical students and junior doctors as they begin training in the hospital system, exposed to hospital specialties. In this new series, we are introducing you to a range of GPs, highlighting the diverse and rewarding career possibilities.

Dr Michael Baker
Procedural GP, Gippsland

Why did you choose to become a GP?

Country General Practice appealed to me. The variety in the work, living in a rural setting, the outdoors close by and no commuting.

How would you summarise your career path in medicine and the influences on your choices?

Take opportunities.

At first, I planned to go work in Africa. Six weeks in Kenya as a medical student was an incredible experience but I realised I was not going to change things there on my own. Country Victoria needed doctors so I set my sights on that. I did two years of hospital RMO work, then a year at the Royal Children's Hospital, including three months at a suburban general practice. I liked paediatrics, but you can see a lot of paediatrics in general practice. I came home from work one day and my wife, home on maternity leave after the birth on our first child, showed me an ad in the AMA magazine for a 12 month GP registrar position in Busselton WA, "For the lover of sun, surf and sail". We were both keen on the beach, surf and snorkelling, so off we went with our eight-month-old son.

It was amazing to work with Dr Kevin Cullen, a GP legend. He certainly taught me that you did not have to be in awe of your specialist colleagues. All of the local GPs gave me great support and I really appreciated this on two occasions in particular when I felt out of my depth when patients presented unconscious to the emergency department. As our house in Melbourne was still being rented out, we then went to the UK and I did a 12-month anaesthetics post. Baby number two was born while we were there. By the end of that, administering anaesthetics and dealing with unconscious patients were not as scary as I thought!

Back in Australia, I found an obstetrics diploma job waiting for me. Then a GP post in Maffra literally landed on my doorstep. We settled in Maffra and are still here 27 years later! The first 10 years was full procedural general practice with obstetrics and anaesthetics. Things changed and I became the 'ex-procedural GP' but that gave me time to be increasingly involved in medical education, especially GP registrars.

Continued on page 15

A few years ago the kids (the third was born in Maffra) had finished tertiary education and I had the opportunity to return to procedural practice by undertaking an advanced obstetrics diploma. Dr David Simon, an O&G at Warragul (now in Darwin) and a champion of GP obstetrics gave me great encouragement. The idea was to go on and do some remote work. That turned out to be more remote than I thought, a six-month volunteer post in the Solomon Islands helping teach junior doctors in Honiara. I had undertaken short-term volunteer work in the Pacific and after my experience in Africa I had decided that teaching doctors was the way to make a difference. The Solomon Islands post seemed to bring together so much of my medical experience.

I'm back in home in Maffra now, doing GP obstetrics work in Gippsland and have just commenced a part-time medical educator role. I might stay put for a while as our first grandchild is due shortly!

What do you love most about being a GP?

You really can make a difference to patients' lives. Placing a coronary artery stent is an amazing skill, but managing that patient through their depression, helping them off cigarettes, getting them to take their medication and perhaps even starting some exercise is, I think, the biggest challenge with the biggest rewards. And you can see that firsthand and be part of it over years and decades.

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

Well I always wonder what life would have been like if I had done marine science instead of medicine!

What advice would you offer to other doctors in navigating their career as a GP?

Have an idea of what you like and think about why you like it, but keep an open mind. I had never planned to practice anaesthetics but found I really enjoyed it. GP training seems to get more complicated with more rules but if you have an idea of where you are headed you can make it work for you. Learn from mistakes and criticism rather than being frightened off by them. Have confidence in your ability.

If you are interested in sharing your story as part of this series, or would like to book an appointment for careers advice, please contact the AMA Victoria Medical Career Service on careersadvisor@amavic.com.au or (03) 9280 8722.

Doctors for doctors – safe, supportive, confidential support and advice

We all know that every doctor needs their own GP. 'Physician heal thyself' is not a mantra that is conducive to good medical care and advice – this needs to be provided by someone you trust.

We know that finding support for your own healthcare can be challenging. The barriers that doctors experience are unique to the profession. The ability to take time away from a busy professional life, concern about confidentiality and mandatory reporting, as well finding a supportive and experienced doctor for doctors all impact on doctors seeking care. The barriers are even greater for rural and remote doctors, with geographical isolation preventing access to independent medical care and for doctors in small jurisdictions or communities.

Over the past 20 years, doctors' health services have existed across Australia, always offering a 24/7 urgent advice phone line. These services are supported by your medical colleagues who provide the initial confidential and supportive advice. In more recent times, doctors' health has been recognised as a far greater issue across the medical community and broader health system. The increase in the numbers of doctors 'burning out', leaving medicine and the tragic loss of doctors dying by suicide have brought greater attention and action to support the health of the medical profession. The stressors which lead to suicide ideation are not isolated to any one group within medicine.

In 2014, the Medical Board of Australia (MBA) recognised the need to invest in doctors-for-doctors' programs. To ensure that these services were at arm's length from the Board, the MBA agreed to provide this funding to the Australian Medical Association, which established a subsidiary company to support an independent national program called 'Doctors Health Service'", now known as DRS4DRS. Although funded by the Medical Board of Australia, DRS4DRS is independent of the MBA.

DRS4DRS, through its network of doctors' health advisory and referral services, offers an independent, safe, supportive and confidential service. This network of experienced and passionate doctors for doctors is here to help you find the support you need.

The new **DRS4DRS website** details many resources to help you maintain good mental health and wellbeing and links to the doctors' health services in every state and territory for when you need collegiate and confidential support or guidance. The site also has stories from doctors sharing their own lived experiences and encouraging their colleagues to seek assistance and support long before it becomes critical.

The DRS4DRS site also hosts the newly developed 'Caring for ourselves and our colleagues' education modules. This online learning will help broaden your understanding of your own health and the health of the medical profession. It explores the importance of prevention and timely intervention, understanding the help-seeking behaviour of doctors and the benefits of having your own GP. Completion of the course sets you up for being a better doctor for a doctor.

You can contact DRS4DRS at enquiries@drs4drs.com.au

The DRS4DRS website was launched in November 2019, at the Australasian Doctors' Health Conference in Fremantle, Western Australia by Mr David Brennan, Chair, Doctors' Health Services (DRS4DRS). The website is **www.drs4drs.com.au** and Twitter handle is **@drs4drs_Aus**.

AMA Federal President and DrHS Board member, Dr Tony Bartone, described the website as an important and practical step in ensuring the medical profession can easily find help for their own health when needed.

"The health of our colleagues and future doctors has been a significant focus for the profession in the last few years. Creating a platform so all doctors and medical students can easily access help is vital," Dr Bartone said.

The Victorian Doctors' Health Program (VDHP) is a free 24-hour, compassionate and confidential health service for ALL Victorian doctors and medical students. The VDHP offers a face-to-face service for all participants at our Parkville office during normal office hours and 24 hours by phone. For those that are unable to attend the offices we offer phone services and or telehealth services if participants wish.

For the VDHP please contact us on
P: (03) 9280 8712
E: **vdhp@vdhp.org.au**
W: **www.vdhp.org.au**

Contact can also be made via
Free Call: 1800 991 997

You can find all the links to the state services here.

DRS4DRS

SafeScript is compulsory for doctors from 1 April

As you would know, use of SafeScript became mandatory from 1 April 2020.

Recently, Associate Professor Julian Rait, President of AMA Victoria, wrote a joint letter to the Victorian Minister for Health, Jenny Mikakos, with Anthony Tassone, Victorian State President of the Pharmacy Guild of Australia.

The letter was to request that the introduction of the mandatory use of SafeScript in Victoria be delayed due to the COVID-19 pandemic.

Whilst our organisations fully support harm minimisation and the safety of our patients, we believe that during these unprecedented times, our members and colleagues should be supported to apply their focus and energy on the immediate challenges before them.

Unfortunately, Victoria's Health Minister has not agreed and responded as per below:

"Over the next 6 months, I recognise that health practitioners may need to adjust established procedures to prescribing or supplying medicines to patients, including checking SafeScript. However, it is important that health care practitioners take all reasonable steps to check SafeScript if they can, because it is an effective tool for providing up-to-date information about a patient's dispensing and prescribing history."

AMA Victoria will continue to advocate strongly for members so that the Victorian DHHS clearly understands the challenges being faced by our members and their teams to ensure that any compliance and other regulatory measures have consideration of the current circumstances the health profession is facing.

If you find yourself in a position where SafeScript penalties are being imposed upon you during the COVID-19 pandemic, please contact us so that we can advocate on your behalf.

These issues should be raised with Ms Taryn Sheehy, AMA Victoria's Director of Communication and Advocacy via email in the first instance: TarynS@amavic.com.au

AMA Victoria does wish however to bring to the attention of all members some changed medicine regulatory requirements for health practitioners during the COVID-19 pandemic.

To facilitate the supply of medicines during the COVID-19 pandemic and to reduce regulatory burden on prescribers, public health emergency orders have come into effect. For further information about the public health emergency orders, prescribers should read the advice documents and gazette notices found at:

www2.health.vic.gov.au/safescript

Please see advice for prescribers at: www2.health.vic.gov.au/about/publications/policiesandguidelines/advice-prescribers-medications-covid1

SAFE SCRIPT

Bushfire smoke clouding our skies can affect our health

This summer, Australians watched in horror as bushfires ravaged our country. Thirty-three people lost their lives, thousands lost homes and properties, many more were displaced and over one billion animals perished. Based on the experience of Black Saturday in 2009, the mental health impacts from the fires will likely be substantial for decades.

The bushfires have also resulted in significant smoke pollution which has shrouded cities and towns in NSW, Victoria and the ACT, in some cases for substantial periods of time..

On a day of particularly poor air quality in Victoria, Ambulance Victoria reported a spike in calls for breathing problems from an average of 187 per day to 282 (a 51 per cent increase). In a week of peak smoke in December, there were approximately 25 per cent more emergency department presentations at NSW hospitals than the weekly average and NSW Ambulance fielded 30 per cent more calls than usual.

While the effects of exposure to pollutants from a single bushfire episode may be short-term and relatively mild, the risks of repeated or prolonged exposure to air pollution can be cumulative. Therefore, while medium and longer-term health impacts of this summer's smoke pollution are not yet known, there is concern these could be substantial.

What is in this smoke and what are the risks to human health?

Bushfire smoke is composed of a complex mix of particles and gases, many of which can harm human health. Of these, fine particulate matter less than 2.5 microns in diameter (PM2.5) pose the greatest risk. Because of their size, these can penetrate deeply into the lungs and then enter the bloodstream.

Short-term exposure refers to a person being exposed to bushfire smoke for less than 24 hours. Short-term exposure to PM2.5 has been associated with exacerbations of lung diseases such as asthma and chronic obstructive pulmonary disease, as well as heart attacks, strokes, pre-term birth and deep vein thrombosis. Recently, a study from the US also found associations of short-term PM2.5 exposure with a number of other prevalent but rarely studied diseases including septicaemia, fluid and electrolyte disorders and acute kidney injury.

The range of health impacts attributable to PM2.5 is seen even at low concentrations, including those normally seen in Australian cities and lower than the World Health Organization guideline concentration for 24-hour average exposure of 25 µg/m3. Indeed, epidemiological studies have been unable to identify a threshold concentration below which PM2.5 has no effect on health.

However, the adverse health impacts from PM2.5 increase with dose. For instance, for the rarely studied disease group mentioned above, each 1 µg/m3 increase in short-term average PM2.5 levels was shown to be associated with an average annual increase of 2050 hospital admissions, 12,216 total days in the hospital and $US31 million in hospital and post-acute care costs. In a study from Japan, every 10 µg/m3 increase in short-term exposure to PM2.5 was associated with a 1-4 per cent increase in risk of out of hospital cardiac arrest.

Notably, PM2.5 concentrations this summer have peaked at over 400 in Brisbane and Melbourne, 700 µg/m3 in

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Sydney and 800 µg/m3 in Canberra. At these times, air quality in these cities was the worst in the world.

Smoke also contains pollutant gases such as sulphur dioxide (SO_2) and nitrogen dioxide (NO_2). Both cause an acute irritant respiratory response with cough and wheeze, especially in asthmatics. Short-term exposure to these gases has been associated with increased respiratory and cardiovascular morbidity and increased mortality. With longer-term exposures, SO_2 increases asthmatic episodes in children and reduces birth weights, while NO_2 reduces lung growth in children and increases respiratory symptoms in asthmatic children.

Carbon monoxide is also found at high concentrations in bushfire smoke. When inhaled, carbon monoxide passes from the lungs to the bloodstream where it binds to haemoglobin. Elevated carboxyhaemoglobin concentrations can cause headaches and confusion, thereby impacting the safety of those in close proximity to the fires. High level exposure can also exacerbate cardiac or respiratory illness and, within minutes, lead to suffocation and death.

Australian studies have also shown associations between lower background levels of carbon monoxide and increases in hospital admissions for cardiovascular disease and mortality. The strongest effects are in the elderly and those with pre-existing heart disease.

Importantly, carbon monoxide is not filtered out by respiratory masks, including those worn by firefighters.

Other toxic pollutants in bushfire smoke include polyaromatic hydrocarbons and volatile organic compounds - specifically formaldehyde, acetaldehyde, acrolein, benzene and toluene. Some of these substances can act as respiratory irritants and some are potentially cancer-causing.

Some groups are particularly susceptible to the health impacts of bushfire smoke. These include those with chronic lung or heart diseases, smokers, pregnant women, infants, children and the elderly. For those with underlying medical conditions, it is important to take prescribed medications as directed and to keep these close. Medical help should be sought if symptoms worsen.

How can people protect themselves?

The most important step that can be taken to avoid the impact of bushfire smoke is to minimise exposure.

- People should stay informed, using real-time, local air quality data to guide their activities and travel.
- They should stay indoors with windows and doors closed when air quality is rated poor or lower.
- Those with air conditioners should set these to recirculate internal air rather than drawing polluted air in from outside.
- Air purifiers with a high efficiency particle air (HEPA) filter can reduce the number of fine particles indoors, although to work well, the air purifier must be matched to the size of the room it is in and the room well sealed.
- Where possible, people should avoid outdoor physical activity, because increased breathing increases inhalation of pollution.
- When outdoors, P2 face masks can prevent inhalation of fine particles, but will only offer protection if well-fitted. In addition, wearing a P2 mask can make it harder to breathe and increase risk of heat-related illness. Cloth and paper masks are not effective against smoke pollution.

What can we do to minimise our exposure to bushfire smoke in the future?

Scientists have long warned that climate change would increase the risk of extreme bushfires in Australia. They have also told us that this risk will only accelerate over time. In Australia, there is an average projected increase of extreme bushfires of 30 per cent by 2070. Bushfire experts tell us that no amount of hazard reduction burning will prevent future devastation from bushfires in a heat-charged climate.

To curtail bushfire risk, we must cut our greenhouse gas emissions rapidly and deeply. The burning of fossil fuels, like coal, oil and gas, must be phased out.

With Australia's emissions continuing to rise year on year, doctors need to speak out about the need for a credible greenhouse gas pollution reduction policy for the sake of health.

An urgent plan is also required to prepare Australian communities, health and emergency services for escalating fire danger and pollution events. This must include widespread education about the risks of air pollution and how to stay safe.

In addition, because of the historically brief and episodic nature of past bushfire events, data on the health effects of prolonged smoke exposure is limited. With more severe and prolonged bushfire smoke episodes expected over time, research to enable us to better understand and manage the effects of smoke exposure on health will be essential.

A/Prof Katherine Barraclough
Victorian Chair, Doctors for the Environment Australia
Nephrologist

References available from the Editor on request.

Speaking out on climate change threat

Representing the AMA at the NCES: (left to right)) SA President Dr Chris Moy, AMSA President Daniel Zou, AMSA Global Health's Jackie Maher, Victorian President A/Prof Julian Rait and Federal Council of Doctors-in-Training Chair Dr Tessa Kennedy.

AMA Victoria President, A/Prof Julian Rait, represented the AMA at the National Climate Emergency Summit (NCES) held on 14-15 February at Melbourne Town Hall.

The NCES convened practitioners, advocates, governments, youth leaders and industry innovators from across Australia to explore what a climate emergency transition could look like at local, national and global levels.

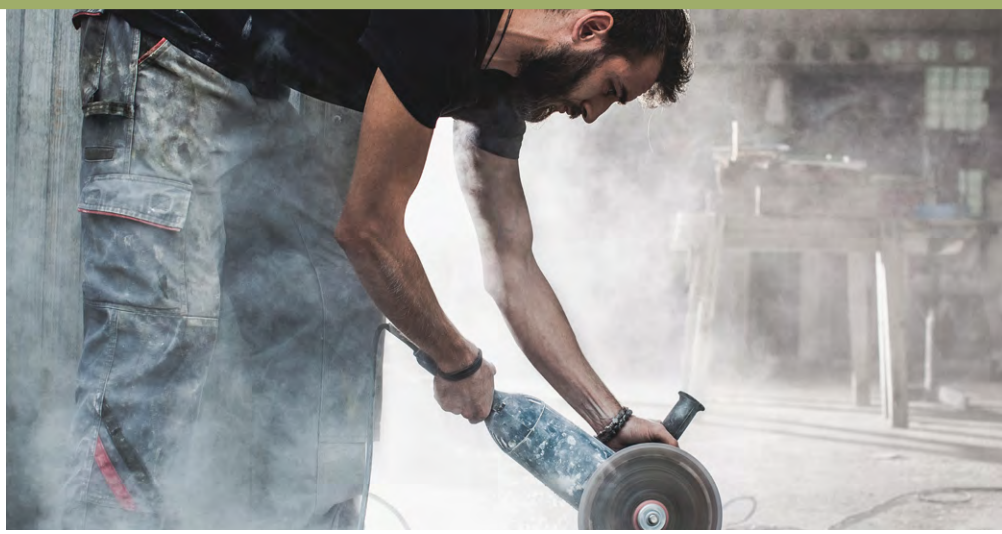
The Summit presented a series of workshops, panel discussions and debates that tackled issues spanning the political, economic, technical and social change dimensions of initiating and carrying out a full-scale response to the climate emergency.

A/Prof Rait was joined by AMA colleagues, SA President, Dr Chris Moy, AMA Federal Council of Doctors-in-Training Chair, Dr Tessa Kennedy, AMSA President, Daniel Zou and AMSA Global Health Vice Chair External, Jackie Maher.

The group presented on the threats to human health caused by climate change. "In short, the AMA believes continued global warming will be catastrophic for human health," A/Prof Rait told the Summit.

Fellow presenters at the Summit: (left to right) Dr John Hewson, A/Prof Julian Rait, Dr Tessa Kennedy and Tim Costello.

The new wave of silicosis



Despite silicosis being one of the oldest known lung diseases, one that was identified as early as the mid-16th century – and one we thought had all but disappeared in Australia - it has re-emerged in the 21st century.

Silica exposure was known to cause lung disease before tobacco smoke was identified as being a health issue and before asbestos was known to be a problem, so its re-emergence as a major health crisis is unfathomable.

During the initial 10 years of my work as a respiratory physician with an interest in occupational lung disease, I had seen maybe one or two patients with the condition but I am now treating more than 40 patients with silicosis. This is already an extraordinarily high number, but sadly I am only expecting this number to increase.

Silicosis is an entirely preventable lung disease, specifically caused by workplace exposure to silica dust. Patients recently diagnosed with this condition have primarily worked in the stone benchtop industry, fabricating domestic benchtops from artificial stone material. It is a young workforce. We have diagnosed workers in their mid-20s with the condition. The form of silicosis affecting artificial stone workers, known as accelerated silicosis, has a much shorter latency and higher risk of progression than the most commonly known form of chronic silicosis.

The first case of this recent wave of silicosis in Australia was reported in 2015. Since then, we have seen a rapid increase in presentations of the disease. We are seeing some of the first cases here in Australia because of active screening of workers in this industry, but I know from colleagues in America, Canada, China and Europe that they have also had an increase in presentations of patients with silicosis, due to the increased use of artificial stone in kitchen design around the world.

Screening programs have commenced in Queensland, South Australia and Victoria to identify affected workers. Further reporting and analysis of data from screening programs is required, however, the initial results from Queensland indicated as many as a third of workers in those workplaces could be affected by silicosis. The working population in the artificial stone cutting industry in Australia is about 10,000 people and we are certainly concerned that several hundred, if not a few thousand people, may be affected.

Screening is extremely important to identify silicosis as early as possible. In the early stages of silicosis, people don't have any symptoms. It is only once the disease progresses to the point that it has caused extensive pulmonary fibrosis that symptoms such as shortness of breath or cough will become apparent. We need to identify affected workers as early as possible so measures can be taken to reduce the risk of progression of the disease.

Unfortunately, many of the patients we are seeing with silicosis are presenting late, when the disease has progressed to an advanced stage. Although no medications are available to reverse or cure the condition, we are hopeful of developing clinical trials and new drug therapies.

At the later stages of silicosis, the only treatment option available is lung transplantation. Despite having one of the world's best lung transplantation centres in Melbourne, 10-year survival post bilateral lung transplantation is approximately 50 per cent. So while lung transplantation does offer some hope and relief for sufferers with late stage disease, it is certainly not a cure. The increase of silicosis presentations will put significant pressure on lung transplants in Australia and we are unlikely to be able to meet the additional demand at current rates of organ donation.

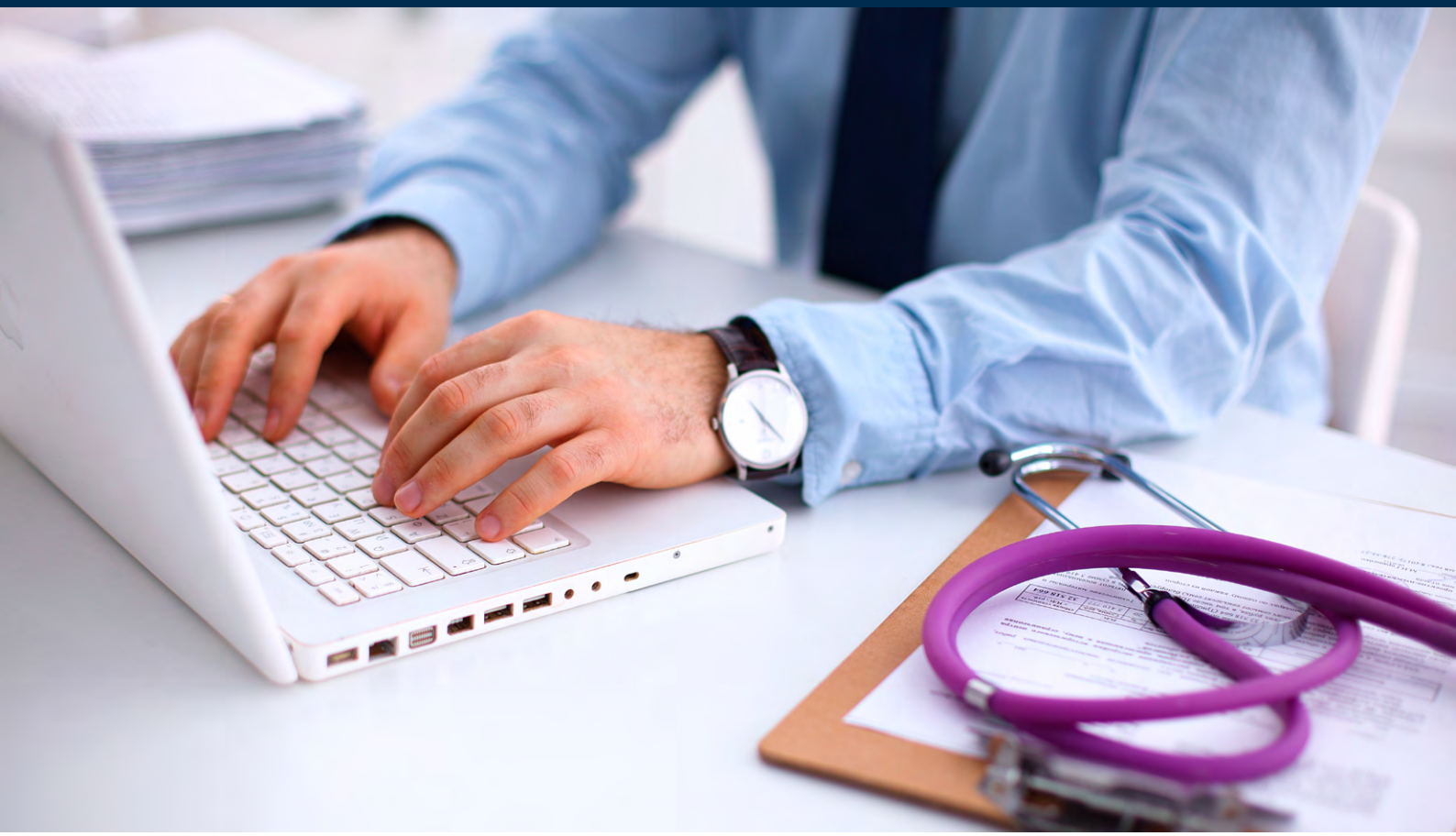
Despite clear regulations relating to occupational silica dust exposure, the re-emergence of silicosis demonstrates that there has been very little control of the dust levels in these workplaces and that there has been a failing in enforcement of these regulations. Considering high-silica content artificial stone materials were introduced to Australia in the early 2000s, almost 20 years of insufficient dust control measures in this industry has exposed a large number of workers to hazardous levels of silica dust. Even those workers without current symptoms of silicosis will require health surveillance for many years to come.

We now need to work with government and industry to provide assistance to those diagnosed with the condition, research to support future treatment methods and put in place practices to protect others workers from contracting this entirely preventable lung condition.

In Victoria, a free screening program can be accessed through WorkSafe. Click here for more information.

Dr Ryan Hoy
Respiratory and Sleep Physician
Cabrini Health

A positive experience with electronic medical records



Ask any doctor about their thoughts on electronic medical records (EMRs) and it's sure to elicit a passionate response. In last year's October/ November edition of Vicdoc, Associate Professor Julian Rait outlined his concerns with EMRs and how difficult systems can contribute to health system inefficiencies and physician burnout. AMA Victoria regularly receives feedback from members with similar misgivings.
So, are there any positive examples?

Paediatrician, Professor Mike South is the Chief Medical Information Officer at the Royal Children's Hospital (RCH). He explained to Vicdoc that the experience at the RCH could provide a template for other health services to follow, along with opportunities for future learning. He's presented on the topic at the Australian Health Informatics Conference and in the USA.

"It is inevitable that all sizeable Australian hospitals will have implemented EMRs in the next few years, so we should be guided by the mistakes of the past, learn from what does work well and actively obtain clinician engagement in improving these systems," Prof South said.

"Healthcare has been a long way behind most other industries when it comes to computerisation. Australia

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has also been slow to adopt these technologies compared with other countries and hospitals. It has also been slower to progress than primary care or specialists' offices, many of whom have been completely digital for a decade or more. The majority of complaints and dissatisfaction lies with hospital-based systems, and most GPs and specialists seem generally satisfied with their own clinical systems."

Prof South explained that not all EMRs or implementations are the same. There are many potential variables including:

- the choice of EMR vendor
- the implementation methodology - incremental introduction over many years, or a 'big bang' approach where every clinical area and process is converted from paper to electronic in one day
- the degree of customisation to support local specialty clinical processes
- the involvement of clinicians in the many decisions around vendor selection, workflow design and training plans
- the quality of training and support
- the ability to make post-implementation modifications based on clinician request and feedback
- the adequacy of the budget to do all of the above.

"There's no doubt some Australian EMR implementations have had little opportunity for clinician involvement in their design – and this can lead to many problems – but this has not been the universal approach and should not be tolerated in future developments," Prof South said.

"At the RCH we implemented the Epic EMR in a 'big bang' approach almost four years ago. Large numbers of our clinicians were extensively involved in the decision to switch to an EMR, in vendor selection and in system design. Most of the EMR team building the clinical functionality were recruited from doctors, nurses and allied health staff working in our hospital. They were therefore very familiar with local clinical practice and had good relationships with staff who they worked with during more than 250 design sessions to incorporate the requirements of every specialty. The system we eventually delivered was very different from a standard 'out of the box' US Epic configuration."

"The system more than pays for itself through savings and additional revenue. We have seen better bed-utilisation and increased throughput in outpatient clinics."

"We have repeatedly surveyed our users since go-live using an international benchmarking tool: The ARCH Collaborative Survey (KLAS Research - it has more than 100,000 international respondents; RCH has more than 1100 clinical respondents). The system is far from perfect, and of course, not everyone is happy with it and even those that do like it have some ongoing issues. Overall though, the feedback has been positive. Sixty-nine per cent of clinicians rated as overall 'satisfied or very satisfied' with the system, 14 per cent had 'significant frustrations' and 17 per cent were 'neutral'. Many clinicians selected 'agree or strongly agree' for the statements: 'EMR makes me more efficient in my day job' and, 'EMR improves the quality of patient care'. RCH was in the top 10 per cent for most metrics in the ARCH survey and the top non-US hospital overall."

Along with the findings about clinician convenience and satisfaction, Prof South said there's been several financial, operational and clinical benefits associated with the EMR. "The system more than pays for itself through savings and additional revenue. We have seen better bed-utilisation and increased throughput in outpatient clinics. There has been a reduction in duplicate laboratory testing and radiology imaging. We have seen a reduction in medication prescribing and administration errors and what appears to be a reduction in risk-adjusted mortality rate of around 20 per cent. It is not appropriate to claim a causal relationship for all of these benefits but the timing of the step-changes is striking.

Prof South believes much of the bad rap for "mind-numbing and voluminous data entry" stems from US system design and practise that has clinicians spending vast amounts of time in note keeping, driven by regulatory compliance, revenue generation and attempts to avoid litigation. "It does not have to be like this. We do not have to import these practises into Australia."

Prof South said good system design and good habits are equally important. "At the RCH we encourage very concise, clinically focused, note-keeping; aiming to avoid painful data entry and to make notes that are easy to read and assimilate. The average US outpatient clinic note is more than four times the length of an average RCH outpatient note (Epic data). Our clinicians also have a much lower burden of ordering, messaging and receiving system alerts than their US counterparts."

In regards to the risk of burnout linked to doctors spending time after regular work hours using the EMR system, the indicators are encouraging. "Monitoring reveals less than 10 per cent of our doctors doing any documentation or other work related to their clinic patients out of hours," Prof South said. "Most of the remote use of the system outside normal working hours is staff who are on-call and reviewing the progress and test results of their inpatients. Many staff tell us they actually finish their clinic days earlier than before the EMR was implemented because the semi-automated generation of correspondence removes the need for time spent dictating. We have also seen an 85 per cent reduction in the use of our transcription service."

Prof South says it is hard to know how to solve interoperability in Australia's highly-fragmented healthcare market. "There seems little chance of going 'back to the drawing board' now that so many hospitals have established systems from different vendors. Even different hospitals with the same EMR system can have difficulty sharing information. We therefore must advocate for the very significant improvements necessary for the My Health Record to become the universal system for the exchange of health information."

"Within the next decade, all large Australian hospitals, both public and private, will have implemented EMRs, as there are very strong practical, financial and quality drivers behind this move. Doctors need to be actively involved in improving the EMR systems so we can fully support the vision of improving the quality of care we can offer patients. If this is done well, it shouldn't be a burden on the clinical users or contribute to burnout."

New take on paediatric care produces positive results

MCRI Paediatrician, Professor Harriet Hiscock.

Over the past two decades, Australia's paediatric population has risen by 18 per cent or 855,215 people - enough to fill the MCG more than eight times over. In Victoria, the number of children attending emergency departments has also increased, with those aged 0-4 years old comprising the largest group. Waiting times for outpatient clinics are also rising.

"All my colleagues who participated in this project have learned quite a lot from the paediatrician and we are implementing what we learned in our daily practice."

However, a new concept in Australian healthcare of embedding specially trained paediatricians into GP clinics is resulting in better outcomes for kids. An Australian pilot study, led by the Murdoch Children's Research Institute (MCRI), found that having paediatricians in GP clinics reduced emergency department referrals and unnecessary prescriptions.

The new study showed this model of care saved almost 900 families about $153,216 collectively over 12 months, in less time off work and reduced travel costs for hospital appointments and ED visits.

The research was a collaborative effort between MCRI, The Royal Children's Hospital, North Western Melbourne Primary Health Network, Western Health (Sunshine Hospital), and Werribee Mercy Hospital.

Paediatrician and MCRI Professor, Harriet Hiscock, said the program, run in north-west Melbourne, also boosted GPs' confidence in treating common childhood conditions.

GPs had reported feeling undervalued in the care of children and lacking in support and training for paediatric conditions, according to Prof Hiscock. "During this pilot, GPs reported improved confidence in their ability to care for children in the short term, and follow-up over the longer term. Families developed increased trust in and preference for GP care," Prof Hiscock said. "It also provided an opportunity to discuss general approaches to caring for sick kids, parent reassurance and complex family dynamics such as child protection."

Prof Hiscock said the model of care also led to fewer unnecessary tests and prescriptions. "There were fewer referrals to private paediatricians and emergency departments, while outpatient clinic referrals remained steady. Some of the children needed ongoing management by a paediatrician, so needed to be referred on once the paediatrician left the clinic.

"Unnecessary prescribing of acid suppression medications to help treat reflux or unsettled behaviour in infants reduced by 20 per cent, with unnecessary steroid or antibiotic prescriptions for bronchitis decreasing by 9 per cent."

For the 12 month study, 896 families were initially seen weekly, and then fortnightly, for co-consults with their GP and a paediatrician across five clinics. Paediatricians also conducted monthly case discussions and provided clinical support by phone or email to GPs. Two of the pilot GP practices have subsequently hired their own paediatrician with plans for ongoing case-discussions and co-consultations.

Neal Street Medical Clinic partner Dr Umair Masood said the trial was one of the most productive projects he had been involved with. "As general practitioners, we do see quite a lot of children in our clinics. Some of these children have very complex needs," he said. "Having the paediatrician to do a co-consultation with us was very educational and very beneficial to the patient.

"All my colleagues who participated in this project have learned quite a lot from the paediatrician and we are implementing what we learned in our daily practice."

Dr Masood said the other major benefit was being able to keep quite a lot of children out of the hospital system and have them cared for in the community. "This obviously benefits both the patient as well as the hospital system," he said. "I hope in the near future there is enough funding to extend this project to other communities and GP practices."

The Victorian Government's Better Care Victoria Innovation Fund, North Western Melbourne Primary Health Network and The Royal Children's Hospital jointly funded the implementation of the project. Prof Hiscock said they were trialling an expanded program across 22 GP clinics in Victoria and NSW to test the model's sustainability and clinical and cost-effectiveness.

This healthcare concept was further supported by a recent study that found children with food allergies are seen 10 months sooner, and have fewer allergic reactions, when treated by a community-based paediatrician.

The MCRI led trial saw specially-trained paediatricians working in community clinics, where they could provide front-line allergy treatment and management advice. Children with three or fewer suspected food allergies took part in the trial. Kids with suspected anaphylaxis (a more severe type of food allergy) or more than three food allergies were excluded.

The trial resulted in faster assessment times, was more acceptable to families and delivered similar quality of allergy care to specialist hospital-based clinics.

Prof Hiscock said 63 per cent of those seen by a paediatrician in the community were treated without needing an allergist referral, freeing up valuable hospital resources. "As rates of food allergy rise, specialist allergy services are valiantly struggling to manage demand, but waiting times to access these services are long," she said.

"In many regions around Australia, allergy care is primarily delivered by allergists, due to limited allergy training opportunities for general paediatricians and primary care physicians."

Based on these results, the trial team is calling for investment in a larger program to train community paediatricians, especially in regions where there are no child allergy specialists. "A well-trained and well-supported primary care workforce underpins the provision of equitable and quality healthcare for children," Prof Hiscock said.

murdoch children's research institute

Member profiles: Celebrating International Women's Day

International Womens Day piece by Melbourne-based illustrator, Jasmine Holmes.

We celebrated the achievements of AMA Victoria's female members to mark International Women's Day on Sunday 8 March. This year's theme was #EachforEqual:

An equal world is an enabled world. Individually, we're all responsible for our own thoughts and actions - all day, every day. We can actively choose to challenge stereotypes, fight bias, broaden perceptions, improve situations and celebrate women's achievements. Collectively, each one of us can help create a gender equal world.

AMA Victoria strongly supports a gender equal world and medical profession. For those who missed our International Women's Day profile series on amavic.com.au, here's an introduction to some of our dedicated current and future medical leaders.

Continued on page 27

Dr Anita Munoz

What is your current role in medicine?

I am a general practitioner in private practice in Melbourne's CBD. I am also a medical educator, teaching general practice registrars training for their fellowships with regional training provider MCCC GP Training. I am Co-Deputy Chair of the Victoria Faculty at the RACGP and a member of the AMA. I complete my Master of Public Health mid-2020, with which I hope to continue my work in promoting the importance of general practice in the Victorian and Australian health systems.

Why did you choose to study medicine?

I always wanted to be a doctor. I love the science of medicine. It has never stopped fascinating me. I'm a little embarrassed to say this too, but I really did want to help people and it seemed the perfect way to do that.

What is the best part about your work?

Hackneyed though it may sound, being a GP is the best job in the world. It is intellectually challenging; it is predictable only in that it is predictably varied, surprising and complex; it is a commitment to a lifetime of learning. GPs are the champions of holistic care, provided within and alongside a patient's life and context. I love knowing everything about my patients and participating in their lives. I like being their advocate. I love the flat hierarchy of general practice - one in which no member of the team is more important than any other - where nurses, administrators and allied health work together in the best interests of the patient.

What is the hardest part about your work?

The negativity in the media and government about general practice causes me great concern, especially as a lot of what is reported is incorrect and ill informed. The constant struggle against under-funding, against the perception that non-GP health practitioners can do our job, which is incredibly complex and misunderstood, and reluctance to recognise the value of general practice is an ever-present preoccupation. The pervasive inclination to emulate NHS-type models of general practice regulation and funding is in my mind ill-conceived. It would be an ominous day indeed should general practice be lost or eroded from our health system.

If you were Health Minister for a day, what changes would you make to the health system?

I would recognise general practice as the essential element of a sustainable health system. There is an abundance of uncelebrated literature available that proves investment in a robust primary care system leads to a healthier population, less reliance on expensive secondary and tertiary care interventions and greater fiscal sustainability.

I'd also like to see every doctor who enters non-GP speciality training spend time in general practice before they fellow, as GPs do before entering general practice training. A greater experiential understanding of our specialty would have an impact on how our colleagues understand and interact with general practice.

Do you have any advice for others pursuing a career in medicine?

Medicine is the single most rewarding and wonderful career I can think of. It is stimulating, exciting, fulfilling and rapidly evolving. Medicine can be a hard taskmaster, however. Doctors need to take care of their physical and mental health, to have their own GP, to balance their lives so that medicine doesn't become all-consuming. And doctors need to care for each other - we have got to get better at treating our colleagues with kindness and support.

What do you enjoy doing away from medicine?

I am involved in music via an alumni ensemble group that rehearses on a weekly basis and performs regularly throughout the year. I am also an avid traveller, a clumsy but persistent jogger/walker/cyclist, a lover of food and wine, a reader of literature, an amateur gardener and an unstoppable socialiser.

Dr Marie Bismark

What is your current role in medicine?

My work weaves back and forth across multiple roles in medicine: junior and senior, public and private, clinical and research. I'm a psychiatry registrar with Melbourne Health, a director of New Zealand's fastest growing aged care provider, a law lecturer at Melbourne University, and the head of a public health research team. The work is varied and richly rewarding. Each of my roles gives me a deeper understanding of the health and wellbeing of patients, practitioners, and communities.

Why did you choose to study medicine?

When I finished high school I couldn't decide between law and medicine, so I enrolled for both degrees. I thought it would quickly become clear which one I wanted to do. But here I am 20 years later, working as a medical practitioner and legal academic, and I still haven't been able to choose between them!

What is the best part about your work?

The most rewarding part of my work in psychiatry is being able to sit with people during some of the hardest days of their lives; to hear their hopes and fears and dreams; and help them find a path back towards the life they want to live. I also love mentoring and collaborating with other doctors and researchers. It gives me so much joy to see others find their passion, and to see people making a difference in the world.

What is the hardest part about your work?

Not having enough hours in the day to say, "Yes" to everything I would like to be able to.

If you were Health Minister for a day, what changes would you make to the health system?

My first priority would be legislation banning the sale of cigarettes. It is beyond me that a product that kills half of its consumers when used as intended can be legally sold, rather than grounds for manslaughter charges. I would also advocate for reduced income inequalities, affordable housing, sustainable local food, parenting support, reproductive rights and climate reform. Many of the biggest improvements in health happen outside of the acute healthcare system.

Do you have any advice for others pursuing a career in medicine?

I think some of the most rewarding careers are found at the intersection of two passions. Do you adore general practice and wild places? You can be an Antarctica doctor like Dr Kate Kloza. Are you torn between medicine and music? You can create music for healing like Dr Cath Crock. Are you gifted in paediatric surgery and lactation consulting? You can specialise in supporting breastfeeding in babies with airway disorders like Dr Nikki Mills.

Be willing to take a path less travelled. Look for colleagues who bring out the best in you. Do more of what you love.

What do you enjoy doing away from medicine?

My 2019 New Year's resolution was to do a dawn yoga class every weekday. The practice of spending an hour on the mat each morning has been transformative. I also love hanging out with my three teenage children, planning sailing adventures with my husband and talking about books and life with my book club.

Visit amavic.com.au/stethoscope to view the full series of our International Women's Day 2020 member profiles.

Mercedes-Benz and the pursuit of accident free motoring

Mercedes-Benz vehicles have always been at the forefront of automotive design and safety.

From the beginning, inventing the first motorised car in 1886, it became clear safety would need to play a part in the future development of independent mobility.

Mercedes-Benz has designed, engineered and developed hundreds of safety systems, which are now common place in many vehicles built around the world. With firsts in innovation towards accident free driving.

Mercedes-Benz Australia / Pacific, in conjunction with Mercedes-Benz Mornington, is proud to be a vehicle partner with the Australia Medical Association Victoria, offering great incentives and packages to all members.

Reward yourself with the many benefits of our Corporate Programme.

The Mercedes-Benz Corporate Programme is designed to make ownership easier and more beneficial for you. As a qualified member, you are also eligible to receive exclusive benefits, including:

- 3 years complimentary scheduled servicing
- reduced retailer delivery fee
- pick-up and drop-off or access to a loan car when servicing your vehicle
- access to your own Corporate Sales Consultant.

Contact Ryan Shan at Mercedes-Benz Mornington for details: (03) 5923 0007

The Mercedes-Benz Timeline of Break-Through Safety Innovations

1886 The First Motor Vehicles

The self-propelled "Motorwagen" with a rear-mounted single-cylinder engine.

1931 4-Wheel Independent Suspension

The Mercedes 170 features the first-ever fully independent suspension, which allows each wheel to respond individually.

1967 Safety Steering

All Mercedes models are equipped with a new safety steering system as standard. The safety steering system reduces the risk of injury upon impact with the steering wheel.

1978 Anti-Lock Brake System (ABS)

ABS helps the driver retain steering control under heavy braking by preventing wheel lockup.

1999 Active Body Control

This is the Mercedes brand name used to describe hydraulic fully active suspension. It allows control of the vehicle body motions virtually eliminating body roll in many driving situations.

2002 Pre-Safe

A ground-breaking system to help passengers prepare for an accident before it happens. PRE-SAFE can detect that certain types of collision might be imminent. In the precious moments before impact, it can snug the front seat belts and adjust the front head restraints to help optimise the effectiveness of the restraint systems.

2010 Attention Assist

Attention Assist measures over 70 data points in the first few minutes of a drive. This helps to detect signs of driver drowsiness and audibly alert the driver to take a break.

[1] Corporate Programme is available to approved corporations who meet the eligibility criteria.

[2] Only available at an authorised participating Mercedes-Benz retailer on new and demonstrator passenger cars only. The program requires a minimum commitment over 24 months. Scheduled servicing is provided through a Service Solutions Pay Upfront Plan, up to 3 years or the relevant mileage-based servicing interval applicable to your model, whichever occurs first. Please refer to the Owner's Manual or an authorised Mercedes-Benz retailer to confirm the service interval for your vehicle.

[3] Not applicable to all models.

[4] Within 25 km of the participating servicing retailer and subject to availability. Only available during the period of complimentary servicing offer. Terms, conditions and exclusions apply.

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www.mercedes-benz.com.au/GLC
www.mercedes-benz.com.au/corporate

[1]Corporate Programme is subject to eligibility [2]Available at authorised participating Mercedes-Benz retailers on new and demonstrator passenger cars only. Scheduled servicing is provided through a Service Solutions Pay Upfront Plan, up to 3 years or the relevant mileage-based servicing interval applicable to your model, whichever occurs first. Please refer to the Owner's Manual or an authorised Mercedes-Benz retailer to confirm the service interval for your vehicle. [3]Not applicable to all models. [4]Within 25 km of the servicing retailer and subject to availability. Only available during the period of complimentary servicing offer. Visit the website or your authorised retailer for full terms and conditions. *Based on highest volume of sales - SUV Medium >60K Segment as set out in VFacts reports March 2019 to August 2019 inclusive, published by the Federal Chamber of Automotive Industries ACN 008 550 347 (FCAI).

A guide to social media and the medical profession

The use of social media by the medical profession is common and growing. It has changed the way we can communicate with each other and the wider community. We can now share information, create content, have meaningful social interactions and collaborate in real-time for professional and personal benefits.

However, social media has the potential to blur the boundaries between private and professional. There can be immense professional benefits by having an active presence through the proper use of social media, but inappropriate online behaviour has the potential to undermine professional integrity, doctor-patient and doctor-colleague relationships, future employment opportunities and public trust and confidence in the medical profession.

As doctors and medical students, our professional standards remain the same whether communicating through social or traditional media and social media can raise some ethical dilemmas that you might not have thought about as part of your everyday use.

The revised guide to social media and medical professionalism will help ensure you can enjoy using social media while maintaining the standards of ethical and professional conduct expected of doctors by the profession and wider community.

The guide is a joint initiative between the Australian Medical Association, the New Zealand Medical Association, the Australian Medical Students Association and the New Zealand Medical Students Association.

The guide includes tips and practical steps to help medical students and doctors navigate the social media landscape. The new guide encourages doctors and medical student to:

- Monitor their own internet presence to ensure that the personal and professional information on their own sites and content posted about them by others, is accurate and appropriate.
- Maintain appropriate boundaries of the patient-physician relationship when interacting with patients online and ensure patient privacy and confidentiality is maintained.
- Consider separating personal and professional content online.
- Recognise that actions online and content posted can negatively affect their reputations among patients and colleagues, and may even have consequences for their medical careers.

Click here to access the guide.

AMA

Doctors encouraged to upskill on care for eating disorders

On 1 November 2019, the Federal Government officially launched a system of reforms to the Medicare Benefits Schedule to transform available community care for Australians living with an eating disorder. Eating disorders are the first diagnostic category among mental illnesses to have their own illness specific item number for psychological and dietetic care under the MBS.

Eating disorders, contrary to even very recent mythology, are not rare. They have a conservative estimated prevalence of between 4 per cent and 8 per cent and are highly comorbid with other mental health conditions. Anorexia nervosa has one of the highest, if not the highest, mortality rates of all mental illnesses. All national and international clinical practice guidelines for eating disorders recommend treatment within a multidisciplinary team that includes, at minimum, a medical practitioner, a psychologist, and in most cases, a dietitian. All available evidence-based treatments for eating disorders are delivered in the community and require somewhere between a minimum of 20 sessions and 40 or 50 sessions to bring about satisfactory remission rates.

Within mental health, this redesign of the MBS system for eating disorder care is the first attempt to align the architecture of the system with the best available evidence for treating these illnesses within the community.

For people with anorexia nervosa, bulimia nervosa, binge eating disorder and other specified feeding and eating disorders who meet the criteria, the new scheme will deliver 40 rebated sessions of psychological therapy, along with 20 dietetic sessions (for all the details go to www.insideoutinstitute.org.au). Regular appointments with GPs are built into the architecture of the system and consultation with a psychiatrist and/or paediatrician is mandated. The scheme lists the approved evidence-based psychological therapies eligible for rebate and the minimum professional standards and training for delivering the items. InsideOut Institute provides access to online training programs that meet the basic training requirements for GPs, dietitians, and other providers, as well as more intensive training in the evidence-based therapies listed. In another first, the Federal Government is also considering credentialing providers of these items to ensure appropriate skill to deliver quality care.

Eating disorders have a reputation for being 'hard to treat', but this is perhaps a result of individual doctors and other community health professionals trying to treat these complex illnesses in relative isolation, without access to a team or an adequate dose of care. The best evidence actually suggests that if an adequate dose of evidence-based community care, delivered in a multidisciplinary team, is received early enough in treatment somewhere between 50-80 per cent of eating disorders can reach remission. This redesign of the MBS builds in that multidisciplinary team and the evidence-based dose, which will hopefully deliver a more supported treatment journey for both the person, their carers and the community clinician.

While structural health system reform is a huge step forward, it will not deliver on the promise of high quality care if GPs, psychiatrists, clinical psychologists, dietitians and the other approved mental health providers do not undertake the mandated minimum training in eating disorders.

Dr Sarah Maguire
Clinical Psychologist
Director
InsideOut Institute

INSIDEOUT
Institute for Eating Disorders

Dr Sarah Maguire is the Director at InsideOut Institute, the first national institute for research and clinical excellence in eating disorders. She is a clinical psychologist, researcher, educator and policy maker with 20 years' experience in the field of eating disorders. Dr Maguire was a member of the Advisory Group to the MBS Review Taskforce and the Implementation Liaison Group for the eating disorder Medicare changes.

Doctors who would like to register for an InsideOutInstitute training module, or to join the IOI Treatment Services Database, can head to www.insideoutinstitute.org.au

New clinical tool to prevent premature epilepsy deaths

Around 300 epilepsy related deaths are recorded in Australia each year, with up to half of these estimated to be a result of Sudden Unexpected Death in Epilepsy (SUDEP).

SUDEP is when a person with epilepsy dies suddenly and prematurely and no reason for death is found. Currently there is very little information or awareness of SUDEP, yet more people die from it in Australia than from Sudden Infant Death Syndrome (SIDS).

Furthermore, epilepsy deaths may have been under reported and based on international research it is possible that up to 250 deaths per year can be attributed to SUDEP alone in Australia. Tragically, research suggests that at least some of these deaths could be prevented.

When someone with epilepsy dies of SUDEP there may be obvious signs a seizure has occurred, but that is not always the case. In most cases, the person is found to have passed away in bed while they were sleeping.

Unfortunately, one cause of great anguish for many grieving families is an apparent lack of knowledge about SUDEP and the risks for it. While I can appreciate the sensitivities around this topic and the desire to not overwhelm or alarm patients, particularly those that are newly diagnosed, I believe it is the treating neurologist's duty to inform. The conversation between a doctor and their patient with epilepsy regarding SUDEP should be regarded as routine, in particular the importance of working to attain optimal seizure control in order to reduce this risk. It is part of the informed consent of the patient regarding the benefits versus risk of treatment for their epilepsy. Reducing risk factors associated with SUDEP and epilepsy mortality can save lives and give patients with epilepsy more peace of mind.

Epilepsy Action Australia has launched the SUDEP and Seizure Safety Checklist, the first clinical tool in Australia to assist neurologists, GPs and other health practitioners to discuss and monitor risk factors with their patients aged over 16 years. It is used in a 10-minute consultation that provides the latest evidence on risk factors for premature mortality in epilepsy.

This checklist was developed in the UK as a collaboration between SUDEP Action and Cornwall Partnership NHS Foundation Trust in 2015; the partnership between Epilepsy Action Australia and SUDEP Action has enabled this checklist to be made available in Australia. There is a Satellite Development Group in Australia, of which I am a member, comprising clinicians with expertise and interest in SUDEP and seizure-related risks who will collaborate with Epilepsy Action Australia and our UK colleagues on the ongoing review of the checklist.

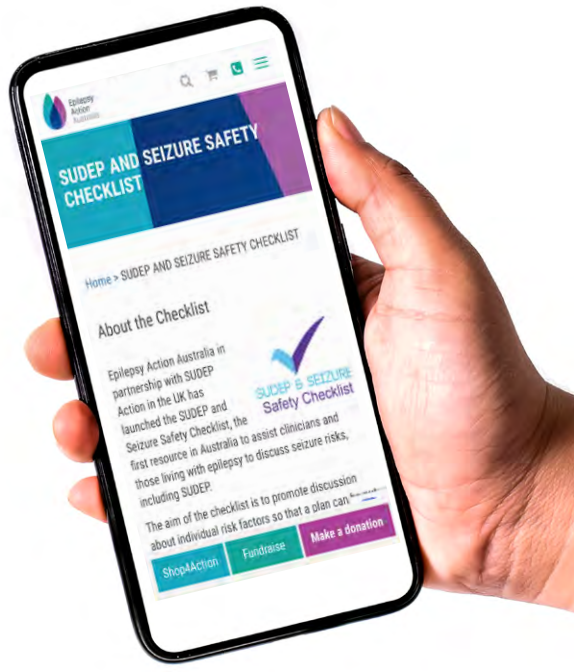
The checklist is a free, easy to use, evidence-based tool which can be downloaded through the Epilepsy Action Australia website by any health practitioner registered with the Australian Health Practitioner Regulation Agency (AHPRA). The website also provides a free short training video for clinicians intending to use the checklist. There are also safety factsheets that can be downloaded and handed to patients.

Safety for people living with epilepsy should be of paramount importance to medical and health professionals. There is a higher than necessary incidence of injury and death secondary to seizures and epilepsy. I encourage all treating practitioners to discuss risk with patients. The SUDEP and Seizure Safety Checklist is a tool that can help guide this potentially lifesaving discussion.

For more information visit:
www.epilepsy.org.au/sudep-checklist

Prof Terry O'Brien
President, Epilepsy Society of Australia
Head, Department of Neuroscience, Monash University

Epilepsy Action Australia
life changing impact



Mentoring and career support for refugee doctors

In 2018, AMA Victoria was approached by Adult Multicultural Education Services (AMES) Australia for assistance in preparing some Syrian and Iraqi refugee doctors for the Australian medical workforce.

Mentee Dr Safaa Waheed (left) with mentor Dr Rahul Khanna.

The six refugee doctors - three male and three female - who took up the offer ranged in experience from an early career doctor having completed the equivalent of an intern year, to a surgeon with many years of experience, but five out of the six had practised medicine for less than 10 years. All had experienced dislocation from their countries due to war and had entered Australia on humanitarian grounds as refugees. Several had practised medicine in war zones and refugee camps.

At the time of joining AMA Victoria, the refugee doctors were in the process of completing their International English Language Testing System (IELTS) course and preparing for the clinical exams set by the Australian Medical Council (AMC). No group members were planning to use the specialist pathway to registration. All were keen to restart their medical careers in Australia as soon as possible.

AMES had specific funding through the Career Pathways Pilot, a one-year federally funded initiative. This enabled doctors to join the AMA as associate members. Membership provided access to resources, such as the mentoring program and career guidance.

At the time of writing:

- four refugee doctors have had observerships
- two have passed AMC clinical exams, two have to re-sit and two are preparing to sit an exam for the first time
- four have secured employment as HMOs.

Participants were most interested in assistance with finding employment, so the initial focus was on access to careers advice, CV preparation, interview skills and employment seeking strategies.

However, there is a variation in hospitals' expectations regarding passing the AMC clinical exam. Some will not consider applications unless the doctor has passed the exam and others are more flexible.

Networking and having a medical colleague who can introduce you to the medical workforce unit opens opportunities to observerships which may lead to employment. However, employment prospects seem to depend on unfilled vacancies at hospitals.

A formal survey was not undertaken, but AMA Victoria received positive feedback from all mentees and mentors.

This was a small pilot program with only a single year of funding. While both mentors and mentees provided positive feedback (and relationships are ongoing), there are mixed results with respect to accessing employment.

Kay Dunkley
Coordinator of Doctor Wellbeing

The Hellenic Medical Society of Australia

The Hellenic Medical Society of Australia (HMSA) is a fellowship of doctors supporting the cause of medicine, community health, Hellenic culture and philanthropy.

As HMSA's representative on AMA Victoria Council, it's been so fulfilling to see the HMSA blossom into a vibrant professional body with international and local medical and community links, and cultural and philanthropic aims.

HMSA members are all passionate about medicine and research, Hellenic culture and heritage and serving the Victorian community, including those of Hellenic descent. There is particular need among the elderly, migrants, disabled or infirm, those not fluent in English, or socially isolated or financially disadvantaged.

Health promotion and educational presentations in Greek by our members for the Greek Australian community have included events on depression, heart disease, arthritis, diabetes, urological disorders, psychosis, paediatric first aid, and adolescent health. 2019 was another exciting and rewarding year of fellowship and giving back to the community. A highlight was an HMSA community education event on dementia during Dementia Action Week in partnership with non-profit aged care provider Fronditha Care, also attended by the Victorian Health Minister, Jenny Mikakos.

We have a holistic, patient-centred approach that values the importance of cultural and spiritual needs in the health of our patients and their community. For our health promotion messages and event announcements to reach the widest audience, we found we needed to make contact with the community in their native Greek language through Greek media, community groups, charities and aged care providers, bilingual schools and places of worship. We also host our events at these locations. This is especially relevant for the aged and those with special needs, so we have forged links of cooperation with the Greek Orthodox Community of Melbourne and Victoria (the oldest Greek organisation in Australia), Greek radio and print media and the Greek Orthodox Archdiocese of Australia.

HMSA Board members recently met with Minister Mikakos and MP Steve Dimopoulos to advocate for the health needs of Greek Australians and the wider Culturally and Linguistically Diverse (CALD) population, with the aim of better addressing their needs in the future.

HMSA supports medical student and doctors-in-training (DiT) mentorship and medical links, and the exchange of medical expertise between Australia and Hellas, including the sponsorship of visiting doctors from Hellas involved in medical research.

What I love about being an HMSA member is the opportunity to attend medical evenings to enjoy fellowship over dinner, or Hellenic social events highlighting the Ancient Greek development of medicine, surgery and ethics, philosophy and art. You can also choose to support community health education and advocacy, medical research and philanthropy.

Membership is open to all doctors with an interest in Hellenism, including DiTs and medical students, so if you'd like a taste of Hellenic culture and fellowship with doctors who support the cause of medicine and philanthropy, we would love you to join us. Visit hmsa.org.au/node/13 for more information.

We look forward to welcoming you at our social and medical events this year.

Dr Mary Stavropoulou
HMSA Board member
www.hmsa.org.au

Reducing the health risks from drinking alcohol: New guidelines released

The National Health and Medical Research Council (NHMRC) recently released newly-revised guidelines on reducing health risks from drinking alcohol.

"We're not telling Australians how much to drink," said Prof Anne Kelso, CEO of the NHMRC. "We're providing advice about the health risks from drinking alcohol so that we can all make informed decisions in our daily lives. This advice has been developed over the past three years using the best health evidence available.

"In 2017 there were more than 4,000 alcohol-related deaths in Australia, and across 2016/17 more than 70,000 hospital admissions. Alcohol is linked to more than 60 medical conditions, particularly numerous cancers. So, we all need to consider the risks when we decide how much to drink.

"We recommend that healthy men and women reduce the risk of harm by drinking no more than 10 standard drinks per week and no more than four standard drinks on any one day.

"However, we are not saying that this level completely eliminates risk. The less you choose to drink, the lower your risk of alcohol-related harm. For some people not drinking at all is the safest option.

"We recommend that adolescents under the age of 18 do not drink. There is no known 'safe' or 'no-risk' level of drinking alcohol for children and young people aged under 18 years. Alcohol can harm the way the brain develops, increase the risk of injury and other immediate harms, and increase the risk of developing alcohol-related conditions later in life.

To reduce the risk of harm to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol. "For women who are breastfeeding, not drinking alcohol is safest for their baby," Prof Kelso added. "We need to keep in mind that while the risk of harm to the fetus is likely to be slight when the mother drinks small amounts of alcohol (less than one standard drink per day) there is not enough evidence to know for sure whether the fetus will be safe from harm, even at this low amount of alcohol. That is why we recommend not drinking alcohol."

Australia's Chief Medical Officer, Prof Brendan Murphy, is a member of the NHMRC Council. "These guidelines will help all of us think about our personal risk and help us to drink responsibly," he said. "They are the result of a comprehensive and robust process over the past three years. They will help me and every Chief Medical Officer in the states and territories to provide clear messages about the risks of drinking alcohol, to ensure the health of all Australians. If all Australians follow these guidelines we won't stop every alcohol-related death, but we will save thousands of lives, especially younger lives."

The 2019 Guidelines build on the 2009 Guidelines. The revision process has taken three years and included:

- analysis of many studies and systematic reviews, including thousands of scientific papers studying millions of people over many decades
- a public call for evidence on the benefits, as well as the harms of alcohol
- mathematical modelling of the health effects of alcohol and different levels of consumption.

Drafting the guidelines was guided by the NHMRC Alcohol Working Committee and supported by NHMRC staff. The guidelines were reviewed and endorsed by the NHMRC Council, which includes the Chief Medical Officers of the Commonwealth and each state and territory, together with leaders in health, research and ethics.

The draft guideline recommendations are:

1. **Healthy men and women**

   To reduce the risk of harm from alcohol-related disease or injury for healthy men and women, drink no more than 10 standard drinks per week and no more than four standard drinks on any one day.

   The less you choose to drink, the lower your risk of alcohol-related harm. For some people not drinking at all is the safest option.

2. **Children and young people**

   To reduce the risk of injury and other harms to health, children and young people under 18 years of age should not drink alcohol.

3. **Pregnancy and breastfeeding**

   To reduce the risk of harm to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol.

   For women who are breastfeeding, not drinking alcohol is safest for their baby.

A standard drink contains 10 grams of alcohol, for example a shot of spirits, a small (100mL) glass of wine, or a pot of beer (285mL).

Following a public consultation process which concluded in late February, the draft guidelines will undergo expert review and a final revised version will be issued by the NHMRC in the third quarter of 2020.

Comprehensive supporting information is available online at www.nhmrc.gov.au/alcohol

Australian Government
National Health and Medical Research Council

NHMRC

What I did on my summer holidays

Cruising around the glaciers of the Antarctic Peninsula in our zodiac (photo by Will Rogen)

At my dinner table on a ship somewhere in the Southern Ocean: a post-doctoral scholar in astrophysics at Caltech, a Fulbright scholar from Tunisia researching dengue prevention in Saudi Arabia, a Czech infectious diseases physician working in Australian health policy, a Chinese data analyst working at World Bank in Washington DC, and the first woman elected to the Australian Academy of Sciences as a chemist.

My coffee buddy when the Antarctic snow and wind forced us indoors: an internationally renowned climate activist with a letter of recommendation from US Vice-President Al Gore.

My hiking companion in Patagonia when we arrived back on land: a Romanian business strategist at Amazon Luxembourg with an MBA from Harvard Business School.

A few months ago, I returned home from a voyage to west Antarctica with 98 other women leaders in STEMM from around the world, thanks to Homeward Bound, an initiative which aims to heighten the influence and impact of women in making decisions that shape our planet. We met in Ushuaia, Argentina, a city also known as the 'End of the World'. By ship, we crossed the infamous Drake Passage and were thankful to have waves about five metres in height; the Drake Lake. The women in the 2018 program of Homeward Bound were not so lucky; they suffered the 12-15 metre waves of the Drake Shake. There's video footage around on YouTube if you want to commiserate.

We sailed across the Antarctic Convergence at approximately 55-60 degrees latitude south, where the warmer oceans suddenly become the cold Antarctic waters. We started spotting icebergs. Note to medical students; describing an iceberg is exactly like describing a skin lesion and the oceanographers (like dermatologists) get very grumpy when you point and say, "Look at that bit of ice over there. No, not that one, the other one. The one that looks smaller. No, the other one."

We also started spotting Wandering Albatrosses and South Polar Skuas. I tried to help the ornithologists collect data about migration patterns of the sub-Antarctic birds. I say 'tried to help' because I counted seven Cape Petrels before the French seabird ecologist pointed out it was the same one Cape Petrel that had just done seven laps around the ship.

We followed pods of orcas by first spotting their 'blow' of water, then seeing the beautiful black and white body or tail. I've learnt that 'killer whales' is a) offensive to the orcas and b) scientifically incorrect. The orcas are actually a ruthless type of dolphin. More accurately, they are the 'killer of whales' and savagely tear apart their prey leaving litres of

Continued on page 38

From left to right

At the Argentinian Carlini base research station.

At the British Port Lockroy base station.

View from the top of a mountain at Cuverville Island with Gentoo penguin colony below.

Port Lockroy also houses the only post office on the continent, and the only place from which you can receive a letter stamped from Antarctica. Hence why some of the scientists on my trip were sending over 200 postcards!

oil and blubber floating on top of the waters. I watched them with a Puerto Rican shark researcher who said she would rather be in a cage with any shark of the world than an orca.

An average day on the ship consisted of breakfast, morning briefing with details about the day's expedition plan, three to four hours of leadership/science communication/visibility training, lunch, afternoon landing, dinner, and then lectures on various aspects of Antarctic science. The landings were entirely dependent on the weather conditions; frequently we rescheduled or renavigated if the snow, wind or waves were not safe.

We went hiking and climbing in the South Shetland Islands, explored Half Moon Bay and Cuverville Island. We melted at the unparalleled cuteness of weaning Weddell seal pups at Walker Bay. We crossed the Gerlache Strait at 64 degrees latitude south. We had a snowball fight at Portal Point. We watched male Gentoo and Chinstrap penguins carefully search and inspect stones to collect (and race back to their mate) for their nests. We saw pods of Humpback whales gliding through the ocean with their calves.

Of course, this was a science leadership program, so we also interacted with some humans. There are several science bases along the Antarctic Peninsula and we made it to three bases. Port Lockroy, the British base, is an island some 800m in circumference with four people staffing the base (three were women this season). There is no running water on the station, so visiting ships usually offer their shower and bathroom services when they dock. There is also no boat, or raft, or vessel of any kind for the Port Lockroy officers to use; they are stuck with each other and unable to leave their small island for the entire season. Port Lockroy also houses the only post office on the continent, and the only place from which you can receive a letter stamped from Antarctica. Hence why some of the scientists on my trip were sending over 200 postcards!

Carlini, the Argentinian base, was much bigger. Over the summer, the base houses approximately 40 scientists (only four were women during the 2019 summer season), and only 10 over the painful Antarctic winter. We met the military scientists undertaking deep sea diving research and were invited to explore their scuba tank and apparatus. You can imagine how moved we were by the spread of tea, coffee, biscuits and chocolate the base had put out for us. Supplies are only provided to the base by military vessels once or twice a season, so we were bowled over by their kindness in offering us scarce snacks.

Lastly, we were granted a very rare visit to the Chinese 'Great Wall' station. The Chinese scientists in our group had negotiated for months to arrange this visit and were utterly devastated when our plans were cancelled on three attempts because

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From left to right

Cautiously admiring the weaning seal pup (photo by Will Rogen).

First steps on Antarctic land at Yankee Harbour.

Orca watching from the ship deck (photo by Will Rogen).

of bad weather. It was particularly hard when we could see the station from the ship windows but couldn't travel in the small zodiac boats across the turbulent waves. Finally, one night, we were given the go-ahead from the Captain for an evening landing and made it to the sprawling Great Wall station; so large it has a museum, gym and basketball court.

Since I've returned, I've really struggled answering the question, "How was Antarctica?". I gave a one-hour talk and slideshow to my colleagues at the Department of General Practice at Monash University, because it honestly takes that long to describe the experience. I never thought that at the age of 30, I would have been to all seven continents, because Antarctica was never a place I planned to see. The land, governed by the Antarctic Treaty, is meant to be for peace and science (side note: standing on Antarctic land on the 60th anniversary of the treaty was unreal), and I'm not sure I really needed to be there. Most of the biodiversity of Antarctica is found within 3 per cent of land and, unfortunately, that's also the main part where humans go. With rapidly increasing tourism, we also risk increasing destruction to native wildlife. The tiny 10cm moss that could so easily be stepped on by a visiting human is 200 years old. I say 'visiting human' because that is what we are. Antarctica is not our land; it belongs to the seals and penguins and whales. It should also never be our land.

My adventure was once-in-a-lifetime and I am unbelievably grateful for the experience and the women I met. I now have friends waiting for me when I move to Stanford, and a network of game-changing STEMM leaders who will support and mentor me anytime I need it. However, if you ask me, "How was Antarctica?", I don't know how to tell you about my guilt from being there. It was spectacular, but massively suffering from the consequences of human action. We are destroying the last untouched part of this earth and I am worried that my visit and footprint was unnecessary.

After all, I am not an Antarctic oceanographer or environmentalist; I am a GP academic with a research interest in opioid prescribing. So, I'm sharing the story of all the wonderful things I did and people I met, because I was privileged enough to be part of this adventure and I want to use my voice for good. But please know that I will not be going back to Antarctica. It is better off without me.

Dr Pallavi Prathivadi
Chair, AMA Victoria Women in Medicine Committee
Academic GP, Monash University

COVID-19 impact on property market

The coronavirus crisis has certainly begun to impact the market, especially since mid-March. Overall, buyer numbers are down in my hometown Melbourne and there is less competition at auctions.
The impact is variable, however.

Some properties are still seeing strong interest. Open for inspections are busy and auctions are delivering the vendor a price near the top of the quote range or even above it.

At the other extreme, there are houses and apartments that are struggling to attract a single party. In many instances, vendors – if they are a discretionary seller – will withdraw the property until better times.

In the middle are the vast bulk of assets. Buyer interest is down, but not extinguished. Agents are monitoring the situation daily and nudging some clients to lower their price expectations, possibly by up to five per cent from where we were in February.

There is no one-size-fits-all advice for those active or contemplating transacting in coming weeks or months. In some circumstances, continuity is the best course. In other cases, take extreme caution. It hinges on whether demand for the target property is holding up or waning.

It also depends on whether they are a buyer or looking to sell. And whether the transaction is discretionary or non-discretionary. An example of a motivated vendor is one who has recently bought a replacement home and needs to sell the current one to reduce debt and avoid bridging finance. Incidentally, this may not be the right course of action if it results in a fire sale. Individuals in this scenario should speak to their bank or an experienced mortgage broker to chart a prudent course.

Richard Wakelin
Founder
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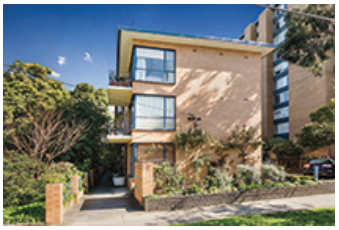

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