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THE NSW doctor

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AUSTRALIAN MEDICAL ASSOCIATION NEW SOUTH WALES

Bad reviews

How to deal with online criticism

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Rural and regional **opportunities**

Investment in rural and regional training is starting to pay dividends, but more needs to be done.

I RECENTLY had the pleasure of visiting the Central West of NSW, and spent some time talking to both junior and senior colleagues at Orange and Dubbo Hospitals about the issues affecting them. As I have always found, doctors in rural sites are deeply committed to providing great care to the people in their regions, but also connected to the community in a way that we city-based practitioners rarely are.

After sustained investment by the State and Federal Government, it would appear that the option of living and working in rural settings is becoming a more popular option for doctors. Increasing numbers of graduates have spent a substantial period of their undergraduate medical time at rural clinical schools in places like Orange, Dubbo, Wagga Wagga, Bathurst, Lismore, Port Macquarie and Coffs Harbour. For many years junior medical officers have rotated out to rural and regional hospitals. Advanced trainees are now increasingly able to spend large chunks of time in rural settings during their specialty training. It would appear that these doctors are establishing roots in rural cities and towns and building their lives there.

The junior doctors I met talked about the broad range of hands-on experience they achieve right from internship, and higher levels of responsibility than their city-based colleagues. They feel well supported by each other and the consultants. The physicians I spoke to talked about the breadth of their practice, and the satisfaction of being able to provide both high quality care to patients, and high quality education and training to students, and trainees alike. They were at pains to point out that, while supportive of the rural generalist training program, rural settings badly need good coverage of specialists.

AMA (NSW) has lobbied the NSW Government for a number of years now to establish and maintain funding for rural registrar positions, and the Government has delivered. This funding was again delivered in this year's State Budget.

Unfortunately, there remains some bias against the quality of specialist training in rural settings. This is reflected in a very cautious approach by some of training colleges who, in my opinion, could do more to promote specialist training outside of the big cities. I am pleased to report though that the RACP now holds its clinical exam in Orange, Wagga Wagga, Port Macquarie, Tamworth, and Dubbo. Albury will be coming on board next year, and hopefully Lismore and Coffs Harbour in the future.

I was also privileged to visit the Aboriginal Medical Services in Orange and Wellington, and we were able to discuss a broad range of issues relating to the community and the work of the AMS.

In many ways, Aboriginal community-controlled medical services provide a model of care that is a template for quality comprehensive medical care more generally. Dedicated Aboriginal health workers, with deep connections in the community, work alongside nursing, allied health, administrative staff, and very special medical practitioners. I witnessed some very innovative programs and a very holistic approach to care, delivered by people with great passion. An increasing role for visiting specialists is integral to the development of these services. Finding doctors with the right skills remains a challenge, especially in areas such as paediatrics and mental health. Remunerating these dedicated doctors adequately remains a challenge.

I also had a very interesting discussion with the staff at Wellington AMS about "Closing the Gap". I have felt for a while that the term "Closing the Gap" has lost some of its impact, but had to pause for thought when the staff expressed how anxious and embarrassed they feel every year when the CTG report is released, seemingly always showing very negative statistics. For Aboriginal and Torres Strait Islander people, this is an annual reminder of their struggle, and for non-Indigenous people, an annual reminder of our failure to do better. The data is important. But the way it is presented may not be doing anyone much benefit. It also makes me wonder why our only aspiration for our First People is to "Close the Gap"? Surely as a society our aim should be for our own Indigenous people to be leading the rest of us?

I also wish to reiterate my support for AMA's position statement on marriage equality. I am disappointed that the Federal Government has decided to hold a postal plebiscite on this issue, and my fears that this will be an opportunity for people to express homophobic and damaging opinions are already being realised. I believe that, as doctors, we have a duty to not only provide the best individual care to our patients, but also to advocate for the health of the community generally. That advocacy includes fighting against discrimination, and ensuring the human rights of all. I stand with my LGBTIQ patients and colleagues, and I will vote 'yes', albeit with reservations about the process. dr.

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Mandatory reporting – **the real story**

The recent COAG announcement to adopt a nationally-consistent approach to mandatory reporting is a step in the right direction, but it pays to understand how we got here in the first place.

WHILE 2017 has been a year of big issues, without a doubt one of the biggest issues has been mandatory reporting. The AMA, along with many other groups have correctly identified mandatory reporting as one of the key barriers to doctors getting help for their health conditions. The problem is both the legislation itself and more significantly, the perceptions of the legislation and the potential for reporting to the Medical Council.

Mandatory reporting has always been controversial and this controversy has sadly taken away from some very important facts about the issue. In light of the current dramas, I thought it was worth revisiting some of those facts.

Mandatory reporting arose during the short-lived ministerial term of Reba Meagher. It was in direct response to the daily media hysteria around Graeme Reeves, the obstetrician and gynaecologist subsequently convicted in relation to his patient care. Mr Reeves – also known very unfairly as the Butcher of Bega, was headline news. Like all headline news, the truth of the issue (including that Mr Reeves spent very little time practicing in Bega) was lost in the drama.

At the same time, we were battling with the proposed changes to the registration of health practitioners as part of the move to the national registration of doctors. For reasons which turned out to be very wise, AMA (NSW) had significant concerns about the impact of national registration for doctors. We feared that the scheme would be expensive, bureaucratic and would undermine the role of doctors in regulating the profession. At the time, we were working with the NSW Government on whether NSW could hold out from the strong momentum of this scheme – a scheme which was being portrayed by politicians across the land as the basis upon which patients would be protected from the Graeme Reeves of the world.

By working with the Government, we drafted mandatory reporting legislation which made no mention of impairment – for treating doctors or for any other doctors. This was because we could see that no doctor should need to report impairment where they were managing that impairment effectively. The legislation was also drafted in the present tense – that is it focused on current and immediate risk, not past risk.

Unfortunately, this approach was not adopted in Queensland and then was not included in the national law. The national law creates a direct obligation to report impairment and also potentially requires the reporting of past behaviour (subject to assessment of risk). These are things we need to change because they are impacting on the trust doctors have in getting care. We know change won't be easy – for every struggling doctor, there is a bad news story which also hits the headlines. However, we are pleased to see the commitment to start towards a change – returning to the situation in which impairment was not a relevant factor would be a good start. dr.

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Fiona Davies CEO, AMA (NSW)

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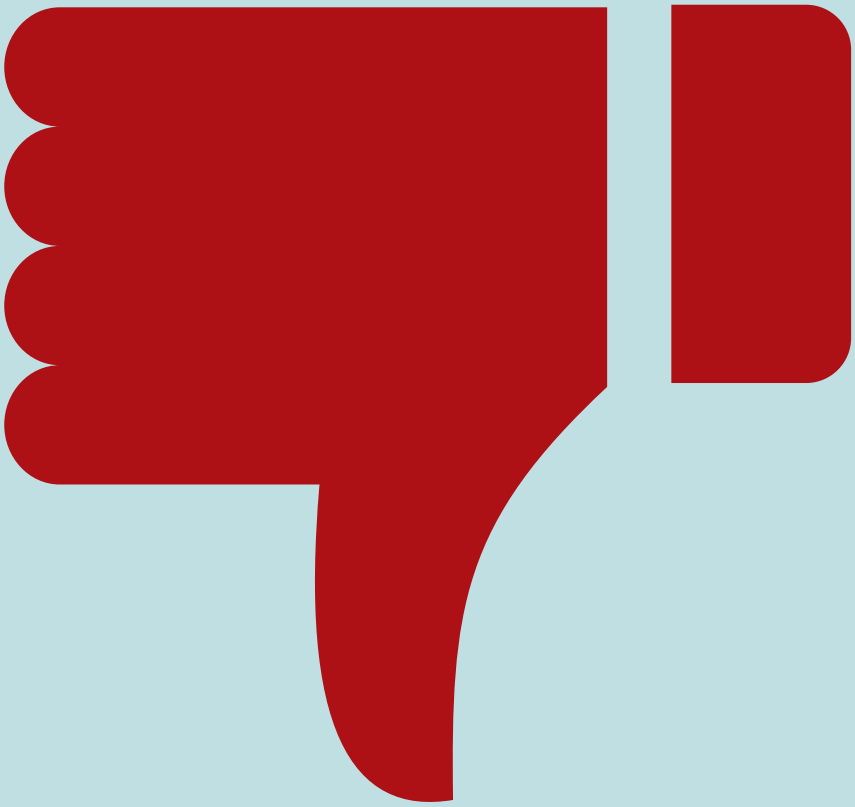

Bad Reviews

Negative feedback online is a difficult pill to swallow, particularly when it attacks your skill as a medical professional. So what's the best response?

HOTELS, RESTAURANTS, auto services, hair salons, schools – even playgrounds – are all subject to online reviews. Many Australians have turned to the collective wisdom of the internet to make decisions on where to eat, travel, shop and work, and increasingly, which doctor to trust with their healthcare needs.

As a search tool, the internet is a fantastic way for medical professionals to reach potential patients and let them know about their practice and what they offer. But, of course, as an interactive environment, the internet also provides patients with a means of communicating their healthcare experience with other potential patients. And it's not always positive feedback.

Just how important are online reviews? Statistics from the US company Invesp reveal that 90% of consumers read online reviews before visiting a business, and 88% of consumers trust online reviews as much as personal recommendations.

While it's difficult to find statistics specific to healthcare in Australia, a 2012 survey conducted in the US found that 42% of respondents had used social media to access health-related consumer reviews. And a more recent survey in 2015 found 16% of patients at the Mayo Clinic had visited a doctor rating website.

According to MDA National, the most common website their members seek advice on is RateMDs, which is hosted overseas. In Australia, Whitecoat – which was developed and launched by private health insurer NIB in 2013 – also includes an online provider directory, as well as more than 250,000 customer reviews of medical practitioners. "Think TripAdvisor but for health care" boasts its website. And there's HealthEngine, a national medical directory that includes an online booking system and ratings.

According to Dr Sara Bird, MDA National's Manager, Medico-legal and Advisory Services, "if you look at the data – the limited research that's been done – the vast majority of ratings on these sites are incredibly positive."

A 2010 review of 33 doctor rating websites found 88% of comments were positive, 6% were negative and another 6% neutral.

The number of negative reviews, however, appears to be climbing. Avant's Senior Medical Officer, Dr Penny Browne, indicated negative online reviews are a growing area of concern for their members and the MDO is increasingly fielding calls from distraught doctors.

"You can postulate as to why, but across the board there is a 15% increase in complaints against doctors and this is really just another mechanism – a modern mechanism – for bringing up complaints against doctors. And it's kind of an easy one. It's immediate and you can do it anonymously – so you can see it's an easy option for someone who is aggrieved to bring their concerns about a doctor."

For the doctors featured in these negative online reviews, the effect can be devastating.

> *"The fact that it's out there on the internet for everyone or anyone to see seems to bring a level of humiliation and upset and anger."*

"I find these matters cause the most enormous distress to doctors," Dr Bird said. "It's probably one of the things where it's hardest to try and reassure doctors. It seems to really hit a nerve with them. The fact that it's out there on the internet for everyone or anyone to see seems to bring a level of humiliation and upset and anger."

Dr Bird added that she's heard from doctors getting up at 3am every night and logging onto the sites to re-read the review and look for new reviews.

Part of the frustration is that, according to MDA National, most practitioners find doctor rating websites fundamentally flawed.

Medical groups question how a handful of ratings can properly represent an adequate assessment of a doctor who may see thousands of patients over the course of his or her career? As well, the anonymous nature of these websites means there is no way to verify the patient's identity, or even check whether they are a patient, someone with a grudge, or even a colleague who is in competition with them.

MDA National also questions a patient's ability to assess a doctor's clinical expertise. Waiting times, a curt disposition, or higher fees may spark patient ire, but they are not indicative of a practitioner's skill as a doctor. A 2015 study in the *Journal of the American Medical Association* found no evidence that doctor rating websites were associated with clinical quality measures.

Dr Browne says doctors take criticism particularly badly, in part, because of all the reasons that they are a doctor in the first place. "They are high-achieving, perfectionistic personalities. And really doctors don't want to do people harm, they want to do the best by their patient. I think, feeling that the patient couldn't bring their concerns back to them, and would rather write on some social media site is really, really offensive to a doctor."

WHAT CAN YOU DO?

"Option number one is to do nothing and wait," Dr Browne said. "And ultimately, hope that other patients put something positive on the website. But that can be quite difficult, particularly if it's quite painful and very hurtful. But that would be the top of the list if you can bear it."

She stressed that, as medical professionals, doctors really have their

hands tied when it comes to responding to negative reviews online. Maintaining patient confidentiality is a paramount concern and a primary constraint. As well, they can't counteract bad reviews by putting positive patient testimonials on their own website or social media sites.

The second option is to respond to the patient – either online or directly – to address their concerns.

According to Dr Bird, "There are limited circumstances where it may be appropriate to write something in response. A lot of the bad reviews are from people who are angry about wait times, parking, crap chairs in the waiting room. So if you've introduced a new appointment system to reduce waits, or you've bought new chairs for the waiting room, there's no problem in responding to those sorts of things, which is along the lines of what hotels do in TripAdvisor."

She cautioned doctors who respond online to be careful not to breach patient confidentiality; to not respond while angry; and to ensure their reply is caring and demonstrates a willingness to improve.

"In my anecdotal experience, if you can identify the patient – and sometimes you can't – there often is value in contacting the patient and saying, look I've seen your concerns and I'm really sorry to read about them, can we discuss."

In both instances, doctors are encouraged to contact their MDO before they respond to the patient's review.

If the comment violates the website's terms of use or conditions, the doctor has the option of utilising the website's policy to have it removed.

According to Dr Browne, "We have had some success in trying to get the owner of the website or the review site to actually take down the comment if it's particularly egregious. But that has to be balanced with, is that a reasonable comment to make?

MDOs caution that doctors who write to websites asking for comments to be removed can sometimes draw more attention to the adverse rating. There have been cases where letters sent to the website proprietor were published to further embarrass the doctor.

The last course of action – and this would be reserved for extreme cases – would be to threaten or commence defamation proceedings.

But defamation suits are notoriously difficult to win. 'Defamation of character' is the term used to describe when a false statement is written or spoken about an individual with the intent of harming or slandering their reputation. To win a defamation case you must prove that what was said or written about you is not true; and that the other person said or wrote the false statement with the intent of causing you harm.

Finally, it is only considered defamation of character if the statement has actually caused you harm, not if it has the potential to cause you harm. In order to win the claim, you are going to need to prove that the false statement has ruined your reputation.

Defamation is tricky to prove, as patients can always claim that the comments were 'honest opinion', rather than a statement of fact.

[For an extreme example of defamation, read our profile of A/Prof Munjed Al Muderis on p.12]

GOING FORWARD

If we have established that online reviews are the modern word-of-mouth, then maybe – as a profession – we need to rethink how we respond to this brave new world.

"I think the profession should control it," Dr Bird said. "I think we should be managing this rather than allowing the rating groups to control it."

She cited the UK's website iWantGreatCare.org as an example. Launched in 2008 by founder Dr Neil Bacon, the service collects information from patients about the quality of care they received from their doctor and other healthcare professionals. While the website initially evoked a backlash from doctors, the medical community has since come to embrace it as an effective way to improve patient experiences and measure the quality of service.

In many ways, HealthEngine is quite similar.

Started in Australia by doctors, HealthEngine is primarily a directory and booking site, but its number patient reviews is growing. Some practices have upwards of 150 reviews.

A key point of difference is that each review is made by patient who has actually used the service, as verified by the site's booking system.

As part of HealthEngine's revenue depends on practices subscribing to be a part of its service, it's not in the website's interest to have too many bad reviews. As a result, it does not list reviews of clients that fall below 80%.

The alternative to supporting an online review site run by medical professionals – is to let the private health insurance industry increase their dominance in providing this information. In 2016, Bupa and HBF announced a joint venture with NIB to expand Whitecoat to cover doctors and specialists, with reviews and a guide to gap fees. NIB managing director Mark Fitzgibbon flagged that he hoped the expanded scheme would eventually allow patients to see clinical information from hospitals such as readmission rates, infection rates, mortality rates and self-reported patient outcomes.

The concern, as outlined by the AMA and other health experts, is that these services might lead some hospitals and doctors to steer clear from more difficult cases to protect their target ratings, which, in turn, would lead to care being denied to some of the country's most vulnerable patients. dr.

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Protecting your turf

Establishing a strong online presence will help protect your professional reputation from internet trolls.

ONE WAY to minimise the impact of online harassers is to claim enough online real estate that you crowd them out of the first page of search results when someone looks for you online.

Research shows that most people using Google don't look beyond the first page of search results.

The best way to occupy as much of that first page as you can is to get yourself there before you find yourself in a situation where someone is trying to create content using your name.

This isn't just because prevention is better than a cure, it can often be the case that a longstanding website can be viewed as more reliable by a search engine than a newer one.

Broadly speaking, this is called Search Engine Optimisation or SEO and it's a term often used by website developers describing ways they can generate traffic for a site they are building.

It is also an important tool in protecting your online reputation.

It is not unusual for doctors, especially if they have a private practice, to have their own websites.

This is a good start in claiming your online turf, but to really prevent any potential online harassers from getting into search results for your name or practice, it is worth considering doing some SEO.

Companies like Google are constantly changing their methods for determining the relevance of websites when it comes to keyword searches to prevent people from gaming the system.

That said, you should ensure content on your website is:

- Well-written and uses keywords important to your practice, such as your name, your practice name, your specialty, your location, and so on
- These keywords should also appear in text that is not usually seen by website visitors like alt text for images (this is the text that displays in a web browser if there a problem loading the image for whatever reason)
- Keep the information on your website up-to-date and provide regular updates
- Ensure your website is easy to navigate and responsive for use on mobile devices and tablets

If you are really dissatisfied with your own website's performance in Google search results, you may want to consider paying for professional SEO services.

Since SEO is all about getting the top spot on a Google search results page, simply searching for the term SEO is often a good way to find skilled practitioners.

A website isn't the only type of online space you can claim, though; you may want to consider social media accounts.

SOCIAL MEDIA

A Facebook page (as opposed to a personal account) for your practice is another way you can claim your space on the web.

A Facebook page differs from a personal account in several ways but the most noteworthy is that when someone likes a page, they do not share the same level of information with it as when they have friended someone's personal account.

In this respect, a Facebook page is a tool for information broadcast rather than a reciprocal friendship arrangement.

A Facebook page is something that any Facebook user with an existing account can create and, once created, you can provide other people with posting rights so they can manage it for you (eg your practice manager).

Many practices already use Facebook pages to provide patients with important updates and general health news.

One thing you should keep in mind with a Facebook page is that they usually come with reviews and ratings systems turned on by default.

So you don't run afoul of regulations on advertising standards for medical professionals, it is best to disable these.

Facebook goes through regular updates, and the specific settings to turn reviews and ratings on and off have varied over time but, as of writing, they can be found under settings > edit page > tabs – you should see an option there to disable the reviews tab, if it is active.

In the general section on page settings you should also consider what sort of content you will allow visitors to post, review moderation settings, and how strong you want to set the profanity filter to prevent your page from being vandalised.

You should also keep an eye on comments that people do post on your page and hide or delete inappropriate visitor posts or, in some cases, even ban users who cause trouble.

You may also want to consider creating a LinkedIn page or Twitter account for your practice, or even branch out into making videos for your practice on YouTube or similar service (just be careful to turn comments off for videos you post about your practice).

The more online spaces you claim in your name or your practice's name, the better you are able to crowd out harassers from search results in the event you attract them.

Be careful, though, some social media pages come with mandatory review and ratings systems, which you cannot turn off. dr.

The power of your online presence

Coffs Medical Centre makes a strong case study for building an engaging website and Facebook page to improve your patients' perceptions of your practice.

THE FIRST question many doctors ask themselves when it comes to expanding their online and social media presence is 'why bother?'

It can seem like another chore on a long list of daily activities you've got to get through to keep your business running, but there are some very compelling reasons to put in the effort.

A great case study on how to build a successful online presence is Coffs Medical Centre, which has made engaging with patients online and through social media a priority.

Their online calling card is, of course, their website – www.coffsmedicalcentre.com.au, which really emphasises the people that work there.

This is complemented by their Facebook page, which strives to not only provide patients with information, but to give patients a sense of the doctors' and staff members' personalities.

"It is an amazing tool to connect to our patients and the local community. Our patients love it and they get to see a 'real' side to our doctors within the practice, as we share photos with them," said Mandy Harrison, practice manager. "We are also able to promote awareness of many diseases and attach support details, et cetera."

To date, Coffs Medical Centre has 1,312 followers.

Their Facebook page includes photos of the doctors and practice staff members, as well as public health announcements, such as reminders to use sunscreen. There are industry news reports, inspirational photos, and calls to support various campaigns.

But perhaps the biggest reason Coffs Medical Centre's Facebook page is so effective, isn't necessarily the content they're providing, it's the frequency at which they're posting updates.

The practice has a dedicated staff member who is in charge of updating the Facebook page regularly.

It's important that whoever is in charge of your Facebook page or Twitter account, is aware of social media rules for medical professionals. Check out these guidelines for more information: https://ama.com.au/tas/social-media-guide-medical-professionals. dr.

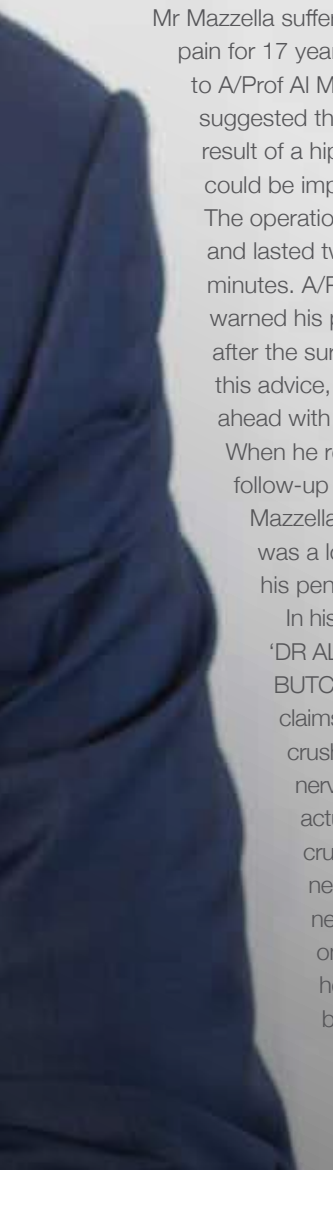
THE COST OF A GOOD REPUTATION

After enduring years of harassment from a former patient that included verbal threats and cyber bullying, A/Prof Munjed Al Muderis was awarded $480,000 in a landmark defamation case. But is it really over?

"I BELIEVE STRONGLY that the vast majority of people are good. There's goodness in everybody and there are a very small minority of bad people. Unfortunately, I was unlucky to deal with one person that is genuinely a bad person."

Associate Professor Munjed Al Muderis performed hip arthroscopy on Gerardo Mazzella in March 2010.

What happened next was a campaign of harassment that was so vitriolic in nature that A/Prof Al Muderis considered leaving the country, not only for the sake of his reputation, but for the safety of his family.



Mr Mazzella suffered from chronic pain for 17 years when he came to A/Prof Al Muderis, who suggested the pain was the result of a hip condition that could be improved with surgery. The operation went as planned and lasted two hours and 40 minutes. A/Prof Al Muderis warned his patient not to fly after the surgery, but ignoring this advice, Mr Mazzella went ahead with his trip to Thailand.

When he returned for his follow-up appointments, Mr Mazzella complained there was a loss of sensation in his penis and scrotal area.

In his online video titled 'DR AL MUDERIS THE BUTCHER', Mr Mazzella claims A/Prof Al Muderis crushed his pudendal nerve. "What he had actually done was crushed my pudendal nerve. It's a bi-lateral nerve that comes out on two sides and he crushed both branches, which means my penis is numb."

As a result of these complaints, A/Prof Al Muderis sent Mr Mazzella for tests with a urologist and a neurologist, each of whom tested the nerve signals in the pudendal nerve. Neither found any evidence of damage.

With each follow up appointment, Mr Mazzella became increasingly hostile and aggressive. His brother Rodney Duncan attended the last appointment with him in September 2010, and said to A/Prof Al Muderis: "My brother lost his dick; I'm going to chop your dick off."

A/Prof Al Muderis recalled, "Initially, he was constantly harassing me on the phone – trying to extort money from me. Then he started making threats, and eventually the threats became violent and started becoming very aggressive."

After dismissal of the medical negligence suit and the complaint to the HCCC, the calls and texts from Mr Mazzella became more frequent and intimidating.

He intimated that he knew where A/Prof Al Muderis' wife worked and where his children went to school, adding that "we can get to them".

Mr Mazzella sent photos of himself holding a semi-automatic rifle. He tattooed the number A/Prof Al Muderis was given – 982 – at the Curtis Immigration Detention Centre on his neck. Mr Mazzella was obsessed.

"At some stage I was considering leaving the country and operating abroad," A/Prof Al Muderis said, adding that the situation has even affected his decision about buying a house. "I am living in a flat that is secure because I fear for the safety of my family.

"Sadly, these kinds of actions and these kind of people become so psychologically disturbed they don't let go. And quite often it can escalate to serious consequences."

A/Prof Al Muderis reported Mr Mazzella to the police and an AVO order was taken out against him. He received a suspended sentence in prison for four months, but that didn't deter him. He stopped contacting A/Prof Al Muderis in person, and took his harassment online.

Mr Mazzella and his brother Mr Duncan created a website with the surgeon's name in the web address and posted videos in which they referred to A/Prof Al Muderis as a "butcher" and, according to the Supreme Court NSW documents, suggested he was unethical, arrogant, and had a reckless disregard for human life.

The brothers purchased Google ads to ensure the website displayed prominently in any searches for A/Prof Al Muderis. They used several different social media sites to post defamatory comments, such as Facebook, You Tube, Vimeo, Video Bash, Internet Archive, Ru Tube, Daily Motion and Pinterest.

Eventually word of these virtual attacks reached A/Prof Al Muderis.

"I heard about them from colleagues, staff and patients – I don't search myself online, but eventually I started doing that. I had to be aware of what's going on, because he used to come out with different stories every day. And the whole incident was his canvas – and he was very colourful and creative coming up with multiple stories and videos. Because he had all the time on earth and unfortunately he knows that, as doctors, the biggest thing that we have is our reputation and that can be damaged very easily."

The NSW Supreme Court ordered the first website to be taken down in 2016, but like weeds, the brothers simply created more: www.almuderis.org.au; www.almuderis.me; www.dralmuderis.com. Two of these were removed, but one website remained.

In his defamation suit, reputation

witnesses recalled the effect these online attacks had on A/Prof Al Muderis.

Orthopaedic surgeon Dr Solon Rosenblatt stated that when patients mentioned the websites to A/Prof Al Muderis during appointments, he saw his “shoulders drop, his head and face drop and a look of despair and/or desperation come over him.”

His co-workers were well aware of the virtual smear campaign and more than once A/Prof Al Muderis overheard comments in the lunchroom at Macquarie University Hospital about the websites. A/Prof Al Muderis said support from colleagues and the hospitals he worked for varied.

“To be honest, my close friends were very supportive. In the medical community there is also the good and the bad. They are humans as well, some were supportive, and some were not.”

When Mr Mazzella plastered Norwest Private Hospital with leaflets and banners denouncing A/Prof Al Muderis, the hospital administration directed staff to collect and bin the defamatory materials. They also used their security staff to protect A/Prof Al Muderis.

Unfortunately, the doctor says he didn’t receive the same level of support from another hospital he worked for, and Mr Mazzella was allowed to freely distribute his materials.

A/Prof Al Muderis filed his civil suit against Mr Mazzella in September 2016. It became clear in the defamation proceedings that A/Prof Al Muderis is a well-respected surgeon, who has already undertaken an exceptional journey to become a doctor in Australia. In 1999, he was forced to flee Iraq after refusing to surgically remove the ears of soldiers who had escaped the army. A/Prof Al Muderis narrowly escaped the hospital by being smuggled in a bus to Jordon, then flew to Malaysia and then Jakarta, Indonesia. From there, he made the perilous 36-hour journey by boat to Christmas Island with 165 other refugees.

He was then detained at Curtin Immigration Detention Centre for 10 months – a place he refers to as “hell on earth”. He was granted refugee status in 2000, and after a period of further medical training obtained a Fellowship of the Royal Australian College of Surgeons in 2008. He is also a Fellow of the Australian Orthopaedic Association, and has two post-specialisation fellowships: Lower Limb Arthroplasty, Hip and Knee Arthroplasty and Trauma.

Justice Stephen Rothman noted that A/Prof Al Muderis was “the perfect plaintiff”. He is an ambassador for Red Cross Australia, Amnesty International, the UN Refugee Agency and International Settlement Services, and is a patron of the NSW Amputee Association. He has twice been nominated for the Australian of the Year in 2015 and 2016 and was also nominated in the Humanitarian category of the Beirut International Awards.

The judgement states, “he is involved in charity, works for the Australian Defence Forces, gives of his time and money for persons who are less fortunate and has put Australia at the leading edge of medical technology.”

The Judge ordered Mr Duncan and Mr Mazzella to jointly pay $320,000 in damages, while Mr Mazzella must pay an additional $160,000.

Despite the successful defamation suit, A/Prof Al Muderis doesn’t believe the situation has completely been resolved with his former patient.

“No, definitely not. I’m pretty certain that he will resurface again at some stage and maybe this time he will come with a gun or a knife, but when the time comes, we’ll deal with it. I’m a very realistic person and I don’t believe in fantasies, but this kind of person is totally fixated and his life is circumnavigating around me at the moment and I don’t think he will change.”

Despite the emotional toll, as well as the personal expense in terms of time and money that this suit has taken, the surgeon says other doctors shouldn’t ignore cyber attacks on their character.

“The message is very clear. Don’t put your head in the sand. Don’t close your eyes and think that it never happened. You need to face it, you need to fight it. Unfortunately, it takes time, it takes money, but there is no price you can put on your reputation and your peace of mind. There are channels to fight back and avenues where justice can be had.

“We live in a country which has a constitution and we have the order of the law and if you follow the right steps eventually you’ll get the right outcome.” dr.

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CHANGING THE FACE OF CANCER CARE

Using their experiences as oncology doctors, Dr Nikhil Pooviah and Dr Raghav Murali-Ganesh have created an app that is helping cancer patients and their families navigate through their cancer journey. *The NSW Doctor* finds out how they became an international success.

DOCTORS ARE USED to being under pressure. They juggle long hours with little sleep, while making life and death decisions for patients on a daily basis.

Yet, despite these experiences, Dr Nikhil Pooviah and Dr Raghav Murali-Ganesh said nothing could have prepared them for the stress of going on the reality TV show for entrepreneurs *Shark Tank*.

"It was probably the hardest thing Raghav and I have ever done ever in our lives," said Dr Pooviah, who presented his app CancerAid – a tool to help patients navigate through their cancer experience – to the business experts at the start of Season Three of the popular series.

"Going on the show can leave your company a bit exposed and vulnerable for critique on national TV, but we handled ourselves quite well, and not only got offers from all five, but we got to take our pick of which sharks we were interested in."

CancerAid was founded in 2015 by Dr Pooviah and Dr Murali-Ganesh, who were

Dr Raghav Murali-Ganesh (left) and Dr Nikhil Pooviah

working together at the Chris O'Brien Lifehouse cancer hospital.

Dr Pooviah said he was inspired to create the app by his interactions with cancer patients, many of whom struggled not only to keep up with all the information presented to them at the time of diagnosis, but also with the isolation they sometimes feel while going through treatment.

The app provides patients with four solutions. The first solution is personalised cancer information, which allows patients and their families to learn about their type of cancer, diagnosis and the developing stage of their cancer.

"A lot of the time when Raghav and I see patients in clinic we discuss the cancer thoroughly, but we don't necessary provide any written information. So CancerAid allows the patients to take the information home and read it at their own pace and talk about it with their family," Dr Pooviah said.

The second solution is an organiser that includes a personal journal where patients can microblog their experiences, as well as a symptom journal and a medications area.

The third solution, which was launched in June at one of Apple's secret press events, is called Champions.

"We've been working on it for about six months and we're very excited about it. It allows the patient, who we call the hero, to nominate a support network of champions. Champions can be personal champions, or they can be medical champions. Heroes can share aspects of their profile with their champion. So for a medical champion such as a doctor, nurse, or allied health team member, they can now monitor progress of their patient and provide care without being face to face. We're actually doing two world first research studies with this component," Dr Pooviah said.

And the final solution they're providing is a community, which allows patients to connect with others going through similar experiences. The e-space, which is similar to Facebook or Twitter, includes patient stories, caregiver stories, cancer news, research and tips. For patients who report feeling very isolated by their experience with cancer, this is one of the most important features of the app.

"There are hundreds of apps out there that deal with cancer patients. There's a reason why we rank ahead of all of them. We don't mean to sound arrogant when we say that. We had a lot of feedback from patients, clinicians, and other stakeholders in the cancer patient journey before we started putting pen to paper and actually started designing this product. We also drew on our experiences as cancer doctors. So all of this combined has really allowed us to create a product that has been appealing to cancer patients. We have 30,000 people engaged in our community and that's not an easy feat, especially since the app has only be released for six months," Dr Murali-Ganesh said.

The doctors stress that the app is not just for patients, but they also designed it with caregivers and providers in mind.

"It's not just a 70-year-old patient with prostate cancer who will be using the app, it's designed for his daughter, " Dr Murali-Ganesh said.

For health providers, the app is designed to enhance your patient's experience by being a reliable resource of information. It also allows providers to monitor progress and provide care without needing to be face-to-face with patients. Finally, the app facilitates clinical research to be conducted more efficiently by giving providers a platform to recruit patients for clinical studies and capture real-time patient data.

How does one make the transition from doctor to healthcare tech entrepreneur? According to the doctors, their background in oncology and their experiences as end users of technology gave them a basis, but the design and development process was something they have learnt on the go.

"It was a bit of a steep learning curve for Raghav and I – being in a start up and not having as much business experience. But we've done quite well and achieved quite a lot which we're proud of," Dr Pooviah said.

The reality is most apps fail – for a variety of reasons – but the doctors have been lucky (or smart) enough to secure financial support. Late last year, they secured $1.25 million in funding from a group of high net worth business leaders.

"A lot of digital health products that come out are borne out of hospital innovation," Dr Murali-Ganesh said. "But even innovative ideas need to have sustainability. And without the sustainability they fizzle out and die. So it was very important for us to keep that socially responsible message of being free to patients, but outside of that also having a model that allows it to be sustainable."

He added, "Late last year we were lucky enough to have an investment round with some investors who see our vision of trying to improve the way cancer care is delivered, and more recently on *Shark Tank* as well."

The doctors went on *Shark Tank* to get exposure for their business. Not only was it a boon from a marketing standpoint, but they walked away with a partnership with SmartCompany investor Andrew Banks. Since the program was filmed, they have been taking advantage of Mr Banks' US contacts to broaden the app's reach internationally.

Dr Murali-Ganesh and Dr Pooviah are now both working full-time on CancerAid.

For more information about the app visit canceraid.com.au. dr.

Improving **health literacy**

The Water Well Project, which has been promoting better health outcomes in refugee and asylum seeker populations in Victoria since 2011, has recently expanded to NSW.

BORN IN AUSTRALIA to refugee parents, Dr Linny Kimly Phuong recalls acting as an interpreter for her family during doctor visits.

"It was quite funny because they were obviously learning English and how the Western world worked, and I was this four year old who came to appointments and was translating for them. So I could understand at a very young age that language was a big issue and that was only one aspect of the bigger picture."

Dr Phuong's parents came to Australia in the 1970s. They had fled Vietnam by boat and ended up in a Malaysian refugee camp. Eventually they were accepted in Australia under the United Nations Humanitarian Entry Program.

"When I was growing up I don't think I realised what they had done or where they had come from and their story. My sisters and I are the first generation to go through university, while my Dad did the equivalent of Year 12 and my mum didn't finish high school."

Dr Phuong is currently an Infectious Diseases fellow at The Royal Children's Hospital, and studying a Masters in Public Health at Melbourne University.

And while her early experiences helping her parents navigate the Australian health system might have sparked her interest in medicine, they also planted a seed about the importance of health literacy. A seed that – almost 30 years later – would germinate and slowly grow into The Water Well Project, a not-for-profit health promotion charity, which aims to promote equitable access to healthcare for migrants, refugees and asylum seekers enabling them to live healthier lives.

In 2011, Dr Phuong and a colleague facilitated a pilot health information session with an Ethiopian community group in Melbourne. Almost 200 people crammed into the Church to participate in the diabetes session – eagerly listening and asking questions through an interpreter. This was the auspicious start to The Water Well Project.

"Suddenly, before we knew it, we had a committee, we were a not-for-profit, we had charity status, we were applying for grants and we'd become a Victorian registered organisation. It really just snowballed," Dr Phuong said.

Today, more than 300 volunteer healthcare professionals donate their time and expertise to deliver interactive health sessions specifically aimed at refugee and asylum seeker communities.

Dr Phuong was recently presented with the AMA's Doctor-in-Training Award at the National Conference held in May for her inspirational efforts in building The Water Well Project.

How does it work?

The charity partners with organisations and community services already working with people of migrant, refugee and asylum seeker backgrounds, such as the Brotherhood of St Laurence, Spectrum Migrant Resource Centre and the Australian Red Cross.

Topics for the sessions are requested by the community. Typical sessions cover issues such as cardiovascular health, healthy eating, and how to navigate the Australian health system.

"In developing countries, people may not present to a hospital unless they're extremely unwell. The concept of preventative health is very much a Western concept, as is shared decision making, which makes things extremely confusing for new arrivals presenting for medical assistance."

Dr Phuong added, "In a lot of countries people don't go to hospital unless they're dying and they might not know that you can go to the emergency department if you've broken something. Also it's just a very different mentality, and that shared decision-making that we do in Western medicine is so foreign to outsiders."

The sessions are run for 1 to 1.5 hours and are facilitated by a minimum of two volunteer health professionals, and where necessary an external professional interpreter is brought in. (The Water Well Project has been fortunate to secure a Translating Interpreting Service (TIS) exemption for face to face interpreters in both NSW and Victoria.) Volunteers are also briefed on any cultural sensitivities within the group prior to the sessions.

Dr Leisel Trompf, who joined The Water Well Project as a volunteer five years ago, said interacting with people from culturally and linguistically different backgrounds has made her a better doctor.

"Absolutely – both in terms of my cultural awareness, but also in terms of my communication skills and how I talk to families about issues. It really forces you to think about how you are explaining something and really engaging people in that communication."

Dr Trompf was inspired to join The Water Well Project after hearing Dr Phuong speak at an AMA Women in Medicine event.

"I think it was the idea of actually using my skills and knowledge to help people in the community that drew me to the project. As a medical student, there wasn't a lot of opportunity for that. And I found even as an intern you do a lot of paperwork and not that much seems to help people directly, whereas this was an opportunity to really get out in the community, meet people and do something beneficial."

Dr Trompf, who recently transferred to The Children's Hospital at Westmead, has been instrumental in expanding the reach of The Water Well Project into NSW. The organisation held a training session for new volunteers a few months ago. And while they now have 20 trained facilitators, Dr Trompf said the next challenge will be to connect with local organisations.

"Finding organisations is difficult because we're very much an unknown entity in NSW. In Victoria, word is really spreading, so when you approach an organisation there's a good chance they've already heard of Water Well."

According to Dr Trompf, the sessions are quite individual and really depend on the group's level of health literacy.

"There is huge variation of health literacy among the groups. I remember speaking to a group in Geelong and one of the women said 'can you please explain to the other women here, that the gender of their baby is not their fault?' Because in that community that was a big deal. If the women had girls instead of boys the husband often blamed the wife."

She also recalled facilitating another workshop where the group basically ran the session themselves.

"There was one particular group where their level of knowledge was higher than I was expecting. It was a women's group and they were so engaged. And because their level of knowledge was so excellent, really they almost ran the session, and I was a true facilitator. It was great to see these women interact with each other, as some knew each other, but a lot of them didn't. And it was more like a group of friends chatting."

These types of experiences is part of the reason The Water Well Project inspires so many volunteer healthcare professionals.

According to Dr Phuong, "I think the feedback we've had has kept us going. Some of our volunteers said after their session one particular group got up and sang their national song to say thank you. There have been lots of groups which have asked the volunteers to stay behind and have lunch with them. We had a mother's group that was sending their kids to school with really unhealthy lunches, pastries and packaged food and their request from us was could you please deliver us a session around nutrition, mainly around how to package a child's lunch. So we delivered a session on healthy eating which centred around teaching them how to make healthy sandwiches and consider healthier snacks. The feedback the week after was that it had a dramatic impact and the schools were commenting how these kids were now eating better food. It was one more piece of the puzzle."

If you're interested in learning more about The Water Well Project, visit www.thewaterwellproject.org. dr.

The story behind the name

The organisation chose 'The Water Well Project' because in many traditional communities, a river, water pump or water well is often the gathering place where people would talk informally about their lives. It is also a metaphor for community, shared stories, knowledge and wellbeing. The aim of this project is to find public spaces in communities where people gather and facilitate conversations with healthcare professionals and community groups to build health literacy.

The right answers to the wrong questions

AMA (NSW) DIT Committee Chair, Dr Tessa Kennedy examines gender and pregnancy discrimination in recruitment and workforce policies.

"So when are you planning to have children?"

a.) While I may wish to have children at some time in the future, I would never interrupt my training as work is my first priority and it would be inconvenient for all involved.

b.) I'll be getting pregnant ASAP after locking down this contract. It's just a gateway to paid maternity leave.

c.) I've actually chosen not to have children. Will that reflect positively or negatively on me?

d.) I'm sorry, it sounded like you were asking me a question that has no relevance to my knowledge, skill or merit for employment in this role. Next question.

There is unprecedented competition for access to specialty training programs, with an excess of medical graduates battling their way through an ever-tighter bottleneck. Yet any edge achieved on merit may be blunted for just over 50% of doctors-in-training (DITs) who dare to enter an interview room with a uterus, especially if there is a wedding band accompanying it.

I have noticed that career advice chats have two distinct trajectories. For me, regardless of what training I've said I am interested in, I am given well meaning advice that I should consider how easy it will be to work part time when, not if, I have children. It implies not only an assumption about my future gravidity, but my future priorities – to cut back on work to focus on childcare. Yet my male colleagues don't tend to receive such advice. Instead, their conversations focus on networking opportunities, skills acquisition and prospects for more dollars in the bank..

In 1966, married women were no longer barred from working, and in 1984, the Sex Discrimination Act made it unlawful to discriminate against a person because of their sex, relationship status, family responsibilities, pregnancy or potential pregnancy, or breastfeeding. Yet as much as we might like to deny it, these biases are ingrained in our society, and in the culture of medicine.

Recently, a colleague told me that during an interview for a specialty college she was asked whether she was planning to have children. After picking my jaw up off the floor, I emailed DIT members asking if they had similar experiences, and I received the first 10 responses within the first hour.

Here are some of the responses:

"I wanted to get onto a specialist training program and was told that 'as a mother' I stood no chance of ever making it. "

"I was 12 weeks pregnant at my interview. The first question was, "So I believe you are with child at the moment? How are you planning on working in this role?" I cannot remember much else from this interview as I was completely thrown by his question and felt embarrassed, victimised and unsure what to say or do."

"I was told when enquiring about a position that the department doesn't tend to employ women so I probably wouldn't have much of a chance at getting the job."

"I was told jokingly 'You better not get pregnant' – and when I did, I became completely ignored. All talk of research and PhD went away."

"At two interviews I was asked about my family life 'to help the practice with planning'."

"A friend was told she would not have her contract renewed because the LHD did not want to set a precedent of people taking maternity leave."

"During a job interview for a full time position I was asked about my family. When I said that I have two young children, I was asked, 'Do you miss them?' I replied, 'Yes' and was then asked, 'Why don't you work part time?' I found this line of questioning very out-dated and upsetting. I doubt this same sequence of questioning would have occurred if I had been male."

I doubt she would have either. I asked a group of around 30 DITs and while a majority of females said potential employers had enquired about their family plans at some point in a recruitment process, formally or informally, no male had been.

All these experiences are indicative of the prevailing mentality in medicine that parental leave and flexible training are the singular dominion of women. Training posts for the Colleges of Physicians and Obstetrics and Gynaecology seem to have the dubious honour of being at the root of most of the anecdotes I received, and also appeared the most blatant in their practices. Pre-interviews for basic physician training jobs also seem to be particularly compromised.

Perhaps even more upsetting than inappropriate interview questions, is the response from above. Many trainees have been told by directors of training, mentors or peers that while these kinds of questions shouldn't be asked, to accept they probably will be, especially to women who wear a wedding ring – so best take that off, and if they do ask then just lie. Give the "right" answer to the wrong question – for those unsure, it's (a) in the little quiz at the start of this article.

Why aren't we calling this practice out instead? It's fraught for trainees – I asked the same DITs how many of them would feel comfortable reporting discriminatory questions – only two of 30 said they didn't think there would be negative consequences, such as not getting on your program. Fear and disempowerment is driving silence and submission.

Now one could argue with some validity that asking about plans for pregnancy contravenes no laws, but rather the laws prohibit the answers to these questions from factoring into a decision about hiring. What if you need to ask to plan your workforce, but wouldn't let the answer bias your decision?

Frankly, if the answer to the question is not going to factor into your hiring decision, why is it being asked at an interview? As with clinical practice, you don't do the investigation if it isn't going to change your management.

This is not to say that parental leave doesn't impose an upfront cost and inconvenience. Of course it does. But if that's a challenge for your department, don't put pressure on female trainees not to have babies, join us instead in advocating for system change – a centralised funding source, and equitable provision of parental leave regardless of gender or sexuality so every candidate is equally 'risky' to hire. If you don't have enough senior trainees to staff your department if someone goes on leave, create bigger networks so there is more flex in the system when it needs to accommodate life. Work hard to encourage those who do take leave to return to work when they are ready, by supporting part time or other flexible work practices. Not just because it's the right and lawful thing to do, but because it's financially beneficial in the long run, and will ensure the best candidates for your Colleges, departments and patients, for decades to come.

The Federal Workplace Gender Equality Act 2012 has replaced the Equal Opportunity for Women in the Workplace Act 1999, in recognition that equal opportunity is not just a women's issue. Yes, many of us will have babies. But amazingly most of those babies will have two parents, and it's possible for the one who didn't give birth and breastfeed them to do pretty much everything else they need to be happy and healthy little humans.

In our recent NSW Hospital Health Check Survey, respondents were asked about their views on part time or other flexible working arrangements. Only 6% of females and 2% of males had applied for flexible work arrangements in the last year. However a further 50% of women and 29% of men said they would consider it in the future or had applied in the past.

We need to recognise that Dads can be equal contributors to parenting. And we need them to if women are going to be able to participate to the extent they want, and that our community needs, if we want the best possible healthcare delivered by the best possible doctors.

How to do this? Now you're asking the right questions. dr.

Check your **privilege**

Despite the challenges doctors-in-training face, it's important to step back and look at the many rewards this career offers.

CONTEMPORARY medical training has many challenges. I won't list them here because these hardships have, quite rightly, dominated media and community discourse for the last six months.

But in the midst of these challenges, it can be hard to recall the ambition that pushed us towards medicine in the first place. Even under the weight of our modern condition there are rewarding aspects to being a doctor. I've sought to remind myself of the things that make medicine a privilege, if only to get through yet another after-hours shift without having a tantrum and throwing the on-call phone in the toilet.

At the top of my list of what makes being a doctor worthwhile, is the academic pursuit of medicine and the opportunity to assist people in need. Admittedly, "helping people" sounds like a saccharine line from a medical school interview, but stereotypes sometimes find origins in truth. The world can be a heavy place. It is a privilege to be able to say to a patient 'don't worry I am here with you' in a crisis, knowing that you eased their burden, even if only slightly. The concept of a profession that develops compassion as a special skill comforts me. Actually giving successful treatment is even better. Everyday we see afflictions that at any other time in history (and in many countries still) would inevitably cause death. It's the patient's good fortune that they encountered a doctor with the training and resources to restore them to health, and that's a good feeling.

Of course, without the thirst for knowledge we wouldn't have the means to treat complex medical conditions. Thousands of individuals have observed, considered, and experimented to add their findings to the pool of our scientific knowledge. The opportunity to do your own research and discover something

that, although perhaps not a game changer, was never previously known is very satisfying. When the job gets overwhelming, instead of crying in the cupboard, I highly recommend heading to radiology and staring at the MRI for awhile, contemplating what it actually took to create such an object. Radiology also has relaxing low-lighting, which helps too.

Friendships feature as another major reward. This is not only from a shared trenches experience; medicine grants access to a secret language. Laypeople don't speak health jargon, which can only be learnt through a long commitment to study and practice. Outside of purely practical applications, shibboleths, in-jokes and codes can be used to speak to your friends. I need only murmur "high-expressed emotion" with a raised eyebrow to let my mates know exactly what they're in for with a new patient. It may be slightly pretentious, but when you consider the complexity doctors can convey in a couple of sentences it is an amazing linguistic feat. Whether friends or not, we meet some of the most intelligent people in the world in our fellow clinicians. And finding out who doctors are outside of work is always fascinating; musicians, pilots, painters, writers, athletes and a few refractory party animals.

Medicine is a hard road. Many young doctors are struggling with a mounting lack of job security and the lack of guarantee our hard work will be rewarded in the long term. Still, there are good things to be found in our day to day and reminding myself of this from time to time keeps me on the path. dr.

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Dr Eliza Milliken Junior Doctor

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Through the **looking glass**

Returning to the same hospital where his mother passed away, medical student Gerald Riordan reflects on the care she received and his own emotional journey.

A WEEK after my mum died I went back to the same hospital she passed away in. But this time, I went back as a student trying to complete my final year of med school. I struggled a lot in those first few weeks back (and most of the weeks after that). Part of the reason I struggled was related to the care I was involved in – I sat in on two family conferences and watched on as families were told their loved ones would die. Each time I tried my best not to cry, to avoid embarrassing myself.

But I think the biggest reason I found it difficult was because I was so angry.

I was angry at the hospital itself. I'd heard from my sister-in-law how ED hadn't told Mum or my family what tests they were running on her. How they hadn't explained that her potassium was seriously elevated and that's why they needed to keep taking more blood, which frustrated and upset her. How ED hadn't called her treating physician when she arrived (even though he knew she was coming in and had asked to be notified), which potentially delayed her admission overnight.

I was angry at the people around me – fellow med students who avoided me and changed the subject when I tried to bring it up. I was angry that for all the talk about mental health, most people were clearly too concerned with their own sense of awkwardness to ask if I was okay.

I was angry at patients, something I am now a little ashamed to admit. Angry at people who came into ED with relatively trivial issues that could easily have been sorted by their GP, or at patients who complained about nurses not paying them enough attention. Obviously now I can see I was being incredibly unfair, but at the time I couldn't help but blame these people for the shortage of hospital beds and staff, which had potentially hindered my Mum's care.

I probably saved most of the anger for myself though; it hurt so much to think that I had let Mum down, that when she had needed me most I hadn't been there. And that because I was so wrapped up in my own sadness, I wasn't there for the other people that needed me – my younger brother who cried too much, and my older brother who didn't cry enough.

After a while, some of that anger started to settle down. Part of me didn't want to let go of the anger though, as if it meant letting go of Mum. But slowly it became a little easier to see the great aspects of her care – how some of the staff had bent hospital protocol so that while she was having a liver biopsy she could hold a necklace my brothers and I had given her. How someone in ED had tracked down some jelly and custard for her, because that was the only food that didn't make her nauseated.

I also realised how incredibly lucky I was to know some great staff – the registrar who cared for my Mum and stopped me in the hallway to offer a shoulder to cry on. And the rheumatology advanced trainee who spent hours talking with me about our favourite burgers, pizzas and milkshakes when I was feeling particularly crap.

In about my fourth week back I went to the oncology ward for a tutorial. We went into the same room Mum was in. The patient in Mum's bed was being treated by one of the nurses that had also treated Mum. Seeing this nurse again made me smile, because it reminded me of how Mum had given every nurse on the ward L'Occitane hand cream to thank them for caring for her. And how even though Mum was incredibly sick, her biggest concern was that she'd accidentally got one of the nurse's names wrong.

I don't think the nurse recognised me, which was probably lucky, because Mum had a pet name for me which all the nurses knew. And while it's a cute pet name, I'm glad the nurse didn't call me Geraldy Bear in front of my supervisor and peers. After all, I'd probably prefer not to be called Dr Geraldy Bear for the rest of my career. dr.

Gerald Riordan (right) is a 6th year medical student at UNSW. His mother, Dr Margaret Gardiner was a well-known GP and inspirational breast cancer advocate.

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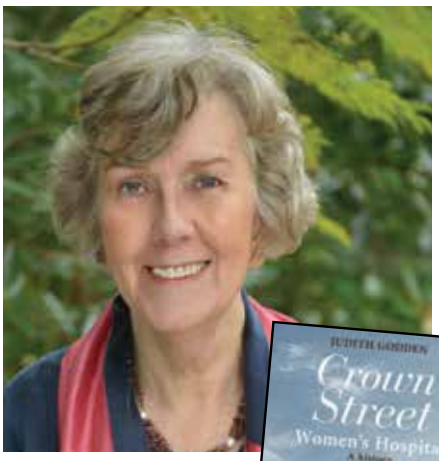
NEWS

If you've got a news story, book review or letter to the editor please email andrea.cornish@amansw.com.au or phone (02) 9902 8118.

The Women's Hospital, Crown Street



HISTORIAN Dr Judith Godden has documented the historical importance of an iconic Sydney institution, Crown Street Women's Hospital.

The hospital facility was closed in 1983 under Premier Neville Wran and former Health Minister Laurie Brereton's direction to fund new hospitals in Sydney's west. The closure was met with much resistance from staff and the general public – particularly those who had had babies there.

Founded in 1893, 'Crown Street' grew to become the largest maternity facility in NSW, delivering an astounding 273,569 babies and training 6,705 midwives in its 90 years of operation.

Crown Street had trained most of the state's obstetricians and become world famous for its successful treatment and prevention of eclampsia.

It was also the institution for women with nowhere else to go, and had a long history of caring for Aboriginal women and babies, as well as immigrants.

The book is available from the State Library of NSW, the author, and Allen & Unwin at www.allenandunwin.com. To contact the author to receive a signed copy, mail 12 Boronia Avenue, Epping NSW 2121 or via email judith.godden@uni.sydney.edu.au. Cost is $40. Send a cheque or EFT to BSB: 082204, Acct: 136999087. dr.

COAG flags amendment to mandatory reporting

DOCTORS should be able to seek treatment for health issues with confidentiality whilst also preserving the requirement for patient safety, stated COAG Health Ministers who met in Brisbane in August.

The decision, which was applauded by the AMA, will see the development of a nationally consistent approach to mandatory reporting provisions.

"The real work begins now. We need action from all our governments," said AMA President, Dr Michael Gannon.

Council will push AHMAC to recommend a nationally consistent approach to mandatory reporting, following discussion paper and consultation with consumer and practitioner groups, with a proposal to be considered by COAG Health Council at their November 2017 meeting, to allow the amendment to be progressed as part of Tranche 1A package of amendments and related guidelines. dr.

HOSPITAL WINS **DESIGN AWARD**

THE $700 million Blacktown and Mount Druitt Hospitals Expansion Project was recently voted "Best in World".

The award, which was presented at the International Academy for Design & Health Academy Awards in Vienna, brings the project's trophy total to 13. NSW Health Infrastructure, project architects Jacobs, and arts consultants HARC had previously won Best international hospital project (under 40,000 sq.m); Best use of art in public and private spaces; and Best interior design.

Patients and hospital staff are starting to see the end result of previous NSW Budget hospital infrastructure promises, with Stage 1 of the expansion project being completed last year.

Health infrastructure continues to play a major part in NSW's Budget promises. The $23.2 billion Health Budget for 2017-18 included a $720m upgrade of Sydney's Prince of Wales Hospital. dr.

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LETTERS TO THE **EDITOR**

To the Editor,
It was heartening to read the opinion piece from Dr Tessa Kennedy in the May/June edition of *The NSW Doctor* regarding suicides of junior doctors. We write to support many of the sentiments expressed in the article, but also to draw attention to the need for junior doctors to feel safe seeking help.

I agree that doctor training, whatever the specialty, deprives us of many factors protective against poor mental health. Dr Kennedy mentioned a number of these, calling them 'psychological immune system boosters'. They are all things required to keep us human, to be more than just robots so that we can provide care and compassion, not just time in the game. They are the things that give us hope, and allow us to tap into our best selves to provide hope to our patients.

However, I was concerned to read Dr Kennedy's comment that junior doctors may not feel safe seeking help for mental health concerns, let alone taking a sick day. This perception has been raised before, and seems to be widespread. On that basis I would like to clarify the following:

Firstly, there is no requirement for the mandatory reporting of mental illness in NSW. The requirement for mandatory reporting under Federal law is that of 'impairment'. That is, that professional conduct is impaired and thereby places the public at risk. Mental illness does not automatically impair conduct.

Secondly, outside of any requirement to report impairment, junior doctors are entitled to the same standard of confidentiality as anyone else.

There are many sources of help, including online resources provided by the AMA.

Dr Anthony Llewellyn, a psychiatrist in Newcastle, has written about his experience treating mental illness in doctors in the blog *On the Wards* (https://onthewards.org/despite-recent-reports/). Mandatory reporting is uncommon in his experience.

AMA (NSW) President, Prof Brad Frankum was quoted in *The Daily Telegraph* on 18 March this year as saying that the health industry needed to 'face facts' on doctor suicide. It needs to face facts on much more than that. Doctors operate on the basis that patients come first, willingly fulfilling the Declaration of Geneva. Unfortunately, this leaves the junior members of the profession vulnerable. We have seen recently in England that it is all too easy for governments to take advantage of this vulnerability. I suggest that it is time for Australian Governments and Departments of Health to recognise that vulnerability is not something to be exploited, but it must be strengthened. Doctors need the opportunity to live normal lives too. Recent suicides are just one indication that many doctors are at breaking point. Urgent action is needed to prevent further deaths.

There is a perception in NSW – and likely beyond – that a doctor reaching out for help will be seen as weak and potentially incompetent. Although this may not be the reality and doctors can seek help with a reasonable expectation of accessing it without adverse impact, clearly there is a need to work on changing this perception. The risks of doctors hiding their struggles include suicide, but also adverse patient outcomes. It is imperative that all of us acknowledge our own limitations and seek to support our peers, and more importantly those doctors for whom we are responsible. The merest hint of judgement in talking to a vulnerable colleague may be all it takes to perpetuate fear and delay appropriate help. Our patients deserve this, and so do we. Tradition is no longer an acceptable excuse for failing to improve the working conditions of junior doctors. Lives depend on it.

Some useful resources can be found at:

http://www.jmohealth.org.au/where-to-get-help.html

https://onthewards.org/

https://www.yourhealthinmind.org/get-help/first-steps-to-get-help

Yours Faithfully,

Dr Andrew Belford
Vice-President – Welfare
NSW Association of Psychiatry Trainees

To the Editor,
I have just been flicking through my first edition of *The NSW Doctor* after recently becoming a member of the AMA/ASMOF Alliance and noted Prof Brad Frankum's response regarding the AMA's stance on marriage equality.

I am a junior doctor (PGY2) and I myself identify as gay, and it was after seeing the AMA come out in full support of marriage equality that I finally was prompted to join. I commend Prof Frankum not only for his stance on this issue, but his response in the July/August issue clearly speaking to those members who have perhaps not been happy with the AMA supporting marriage equality.

I agree that the ongoing discrimination of the Australian Government and many of the Australian people has a huge detriment on the mental health of the LGBTIQ community. I have a loving partner of four years, and am very much open about our relationship, but still feel a sharp pang of anxiety when telling people for the first time that my partner is female. I have also been approached on Oxford Street in Sydney while holding hands with my girlfriend and told that if I am going to walk around openly displaying my homosexuality I am 'asking for trouble'. I don't believe anyone who isn't LGBTIQ could possibly understand what it is like to feel that your loving relationship is somehow inadequate, so I continue to be baffled by the fact that a proportion of the population continue to display strong opposition to the union between people of the same sex when it has nothing to do with them. I consider myself pretty level headed, with very strong supports, so I can't imagine how difficult it must be for younger, more vulnerable individuals who are coming to terms with their sexuality.

Thank you so much for making a stance on this. It is something that needs to change, as does discrimination against all minorities.

I look forward to a long career of being a proud member of the AMA.

Kind Regards,
Dr Kathleen Fixter

16TH ANNUAL CONTINUING PROFESSIONAL EDUCATION (CPE) SEMINAR

The annual CPE seminar is a unique opportunity for experienced clinicians to share insights, discuss current trends, and learn about advancements in healthcare.

Clockwise top left, Prof Connie Katelaris, Dr Kean-Seng Lim and Dr Robyn Napier, attendees, Dr Sara Bird, Dr Nisha Sachdev and Prof Greg Nelson.

THIS YEAR'S 16th annual CPE Seminar, held 22 July at Macquarie University, featured several presentations on current developments in medical practice, with updates in the treatment of diseases and preventative health issues.

The seminar attracted more than 150 highly experienced clinicians – all of whom share a life-long commitment to learning and clinical excellence.

This annual seminar aids clinicians in providing patients with a high standard of healthcare and is a reflection of AMA (NSW)'s engagement with its members.

Technology and research have significantly accelerated the rate of change in medicine, and as a result it is even more important than ever for clinicians to take part in these educational seminars. dr.

AMA (NSW) would like to give special thanks to the presenters who shared their time and expertise with delegates.

DR ROBYN NAPIER
Welcome and Introductory Remarks

DR KEAN-SENG LIM
Official Opening, Diabetes Management in General Practice, Application of Medical Home Principals

PROF CONNIE KATELARIS
Use and Abuse of ANA Tests

DR SARA BIRD
Medico Legal Update 2017 including Medicinal Cannabis and New Mandatory Data Breach Obligations

PROF GREG NELSON
Updates in Cardiology

DR NISHA SACHDEV
Updates in Ophthalmology

MR ALEKSANDAR GAVRILOVIC
Current Trends with Anabolic-Androgenic Steroids

PROF SIMON WILLCOCK
Diagnostic Error and the Effect on Patients and Doctors

A/PROF MARK BOWMAN
Management of Fertility Therapeutic and Social Trends

"The best meeting by AMA that I have attended"

"One of the best revision days I have attended"

"All the updates were outstanding and relevant to my clinical practice"

Is the electric car finally viable?

Electric car sales have taken off overseas, but not as much in Australia. There have been some good reasons for that, but it's all about to change.

Electric cars are beginning to rule the roads in Europe and the US, but not so much in Australia. Some perceived shortcomings of electric include lack of options, a belief that they don't have the range of petrol cars, and a lack of charging stations. According to a Herald-Sun report from January this year, only 219 electric cars were sold across Australia in 2016. By contrast, in Norway, the electric vehicle (EV) capital of the world, almost one in every three new cars registered is an EV. In fact, the Norwegian government has announced plans to phase out all fossil-fuelled cars by 2025.

What has held electric cars back?

Dr Chris Jones, National Secretary of the Australian Electric Vehicle Association, says a piece of legislation passed in 1989 to protect the now non-existent Australian automobile manufacturing industry prohibits the direct importation of various makes and models of cars. This limited the choice for any low-volume type of vehicle, including EVs.

Many national governments offer incentives for EV manufacturers to sell their vehicles, but the Australian government does not, Dr Jones says.

"I see this improving," Dr Jones says. "Next year the legislation is under review, the Tesla 3 will be available, as will the Hyundai Ioniq. Nissan has also confirmed they will be bringing in the new Leaf in 2018."

Can electric cars last longer?

Perth-based professional Ant Day currently owns a Nissan Leaf, a 100 per cent electric vehicle. Prior to that he owned a Mitsubishi i-MiEV, also fully electric, but the Leaf offers greater internal space, has a longer range and boasts a more luxurious driving experience, Day says.

An average petrol car would typically run for 400 to 600 kilometres between fills, while more recent EVs have a range of 300 kilometres.

The top-of-the-range EV

Many of the recent global advances in EV technology and popularity are down to the Tesla brand, which has simultaneously made electric cars sexy, desirable and deliciously technological.

The Model S (and soon the more affordable model 3) achieves a range of 372 to 572 kilometres, depending on the version. The only issue now is the expense —the current model costs from $108,700 to $209,800.

However, Brett Robinson of BOQ Specialist does not see this as a barrier, "We've definitely seen an increase in the number of Teslas being financed over the past four years, with many of our medical, dental and veterinary clients realising not only the time saving benefits of being able to charge your Tesla car at home, but also the fact that they are continuously improving their vehicles via software updates."

Benefits of electric car ownership

One of the positives of EV ownership is maintenance.

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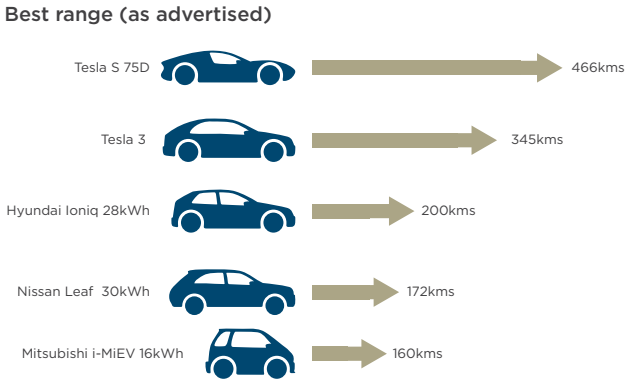

Day's service centre originally quoted $260 for the annual service. "I asked what that was for," Day says. "They said they would change the oil filter and I said there is no oil filter. They said they would replace the air filter and I told them there is no air filter. The list went on. They finally did their research, then told me they would charge $106 for the service.

"With an electric car there is almost nothing to service. The brakes hardly wear because you're using regenerative breaking. The tyres wear like any other car but there is almost nothing else. There are something like 2700 moving parts in your average petrol car and only about nine in an electric car, so maintenance costs virtually disappear."

Plus, fuel is free if you have solar panels on your home and charge during the day, or at one of an increasing number of free fast-charge points around Australia (EV drivers use the app 'PlugShare' to find their closest charging point). Even if you charge in your garage at night, the cost is about 25 per cent of petrol for the equivalent vehicle, Day says.

Living full-time with an EV

The driving experience is extraordinary, with unmatched acceleration and a peaceful cabin, Day says. A 20-minute charge at a fast-charge point typically brings the battery back up to around 80 per cent. Thanks to increasing numbers of charging points, it is becoming more possible to live full-time with an electric vehicle. Day has even taken his camping.

"Charging added about 90 minutes to our trip," Day says, "And at the caravan park I could charge the car for nothing, so we did all of our sightseeing for free."

AMA (NSW) Golf Society
PRESIDENT'S CUP

Despite perfect conditions, Stonecutters Ridge Golf Course challenged golfers contesting the President's Cup. Congratulations to individual winner Jeremy O'Dea, and runner up Scott Chapman.

FIFTY-NINE hardy golfers headed west very early on a cold winter's morning to contest the President's Cup at the Stonecutters Ridge Golf Course. A heavy frost on the first fairway and a cold westerly wind greeted them. However, the day improved dramatically and the conditions were spectacular for a great day on the course.

Regrettably, the overall scores didn't reflect the perfect conditions. For the record, the average individual stableford score was 27 points. As has been mentioned in previous articles, the course is designed by Greg Norman, which means the benign appearance soon swallows up any player who does not remain perfectly focused for the entire 18 holes.

The individual winner was Jeremy O'Dea with 35 points. Runner up was Scott Chapman on a count back. It is worth noting that Scott has been a great supporter of the AMA (NSW) Golf Society since its inception. It was also pleasing to welcome back several of our other original supporters, including Alec Harris and John Grey. For the many readers who always inquire about Alec Harris' results, we can honestly say that on this occasion he was desperately unlucky, missing out on a win by one point.

Other results were 2BBB Winners – Brian McCaughan and Nigel Champion with 44 points, and runners up were Jeremy O'Dea and Mick Pich with 43 points. Nearest the Pins went to Nigel Champion and Mick Pich.

Congratulations goes to all players as the customary raffle raised $810 for the AMA (NSW) Charitable Foundation.

A special recommendation for all golfers who haven't played Stonecutters to take the time to visit the course for a game – well worth the time.

The Golf Society wishes to thank all the staff at Stonecutters for their tremendous assistance in running the day, and it can't go without acknowledging the excellent egg and bacon rolls for breakfast and the superb hamburgers for lunch. Make sure you try them when you visit the course.

Our next event will be the Spring Cup at Elanora Country Club on Tuesday 31 October, 2017 with a PM tee off. Any inquiries about events should be directed to Claudia Gillis at AMA (NSW) amagolf@amansw.com.au

The Golf Society also extends best wishes and good luck to our team who will be representing NSW at this year's AMA International Shield to be held in South Africa in September.

A special invitation is extended to all golfers to join us at future events.

Good golfing to all our members. dr.

1. Group photo. 2. Winner Jeremy O'Dea with George Thomson 3. Ross Emerson, Keryn Emerson, John Barlow & Stephen Patterson 4. David Cocks, Chris Fairbarn, Brian McCaughan, Hutch Ranck & Nigel Champion 5. Runner up Scott Chapman with George Thomson. 6. Laurie Pincott, Robyn Napier, Nerida Campbell & Glenn Cooper.

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A warm welcome to all of our new members this month

DA/Prof Oran Rigby
A/Prof Susan Connor
Dr Abhishikta Dey
Dr Alfred Mahumani
Dr Alissa Norsworthy
Dr Allan Campbell
Dr Amani Harris
Dr Ambreen Mansoor
Dr Andrew Arrowsmith
Dr Andrew Chesher
Dr Andrew Lovett
Dr Anil Kurien
Dr Ann Sunderland
Dr Anna Waldie
Dr Annabel Smith
Dr Anthony Hodsdon
Dr Arridh Shashank
Dr Arthur Jones
Dr Asela Ponweera Arachchige Don
Dr Ashishkumar Shah
Dr Ashok Kumar Murugesan
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Dr Avalon Moonen
Dr Ben Taylor
Dr Brian O'Connell
Dr Bruce Graham
Dr Carla Flynn
Dr Chathupa Wickremaarachchi
Dr Chloe Tetlow
Dr Christian Said
Dr Clare Griffin
Dr Clare Shiner
Dr Clement Chu
Dr Colin Williams
Dr Craig McDonald
Dr Daniel Abosh
Dr Danielle Diem Pham
Dr Daria Fielder
Dr David Wong
Dr Dayashan Perera
Dr Deepak Puri
Dr Deirdre Little
Dr Dinah Bennett
Dr Donald Hannah
Dr Edward Fairley
Dr Edwina Wing-Lun
Dr Elise Carpenter
Dr Elissa Tong
Dr Elizabeth Luxford
Dr Emma Gregory
Dr Eric Sticklen
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Dr George Marinos
Dr Georgiana Tang
Dr Hae Won Kim
Dr Harjinder Johar
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Dr Julia Whitby
Dr Justin Fong
Dr Kam Yin Siu
Dr Karthic Jayanthi Chinnaiya
Dr Kate Tree
Dr Katherine Lee
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Dr Kathleen Tan
Dr Kerrie Clarke
Dr Kevin Hall
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Dr Sharmin Ahmed
Dr Sharon Tsetong
Dr Simon Hanning
Dr Stephane Hemmerter
Dr Stephen Prineas
Dr Stephen Thackway
Dr Sunshine Hill
Dr Swan Chong
Dr Swetha Kumar
Dr Talila Milroy
Dr Thananchayan Elalingam
Dr Ting-Ting Liu
Dr Tun Myat
Dr Tung Pham
Dr Vanaja Sivapathasingam
Dr Vicky Sifneos
Dr Victoria Sabbouh
Dr Wayne Carstens
Dr Wynne Sum
Dr Xiran He
Dr Yuriko Watanabe
Dr Zoe Walker
Ms Eva Rosenbaum
Prof Simon Lewis

The AMA (NSW) offers condolences to family and friends of those AMA members who have recently passed away.

Dr David Pope
Dr Edmund Barbour
Dr George McDonald
Dr Howard Frankland
Dr Ian Edwards
Dr Kyrle Mattocks
Dr Margaret Mills
Dr Michael Harris
Dr Patrick Cregan
Dr Peter Kendall
Dr Robert Tebbutt
Dr Victor Bear
Dr Virginia Noel

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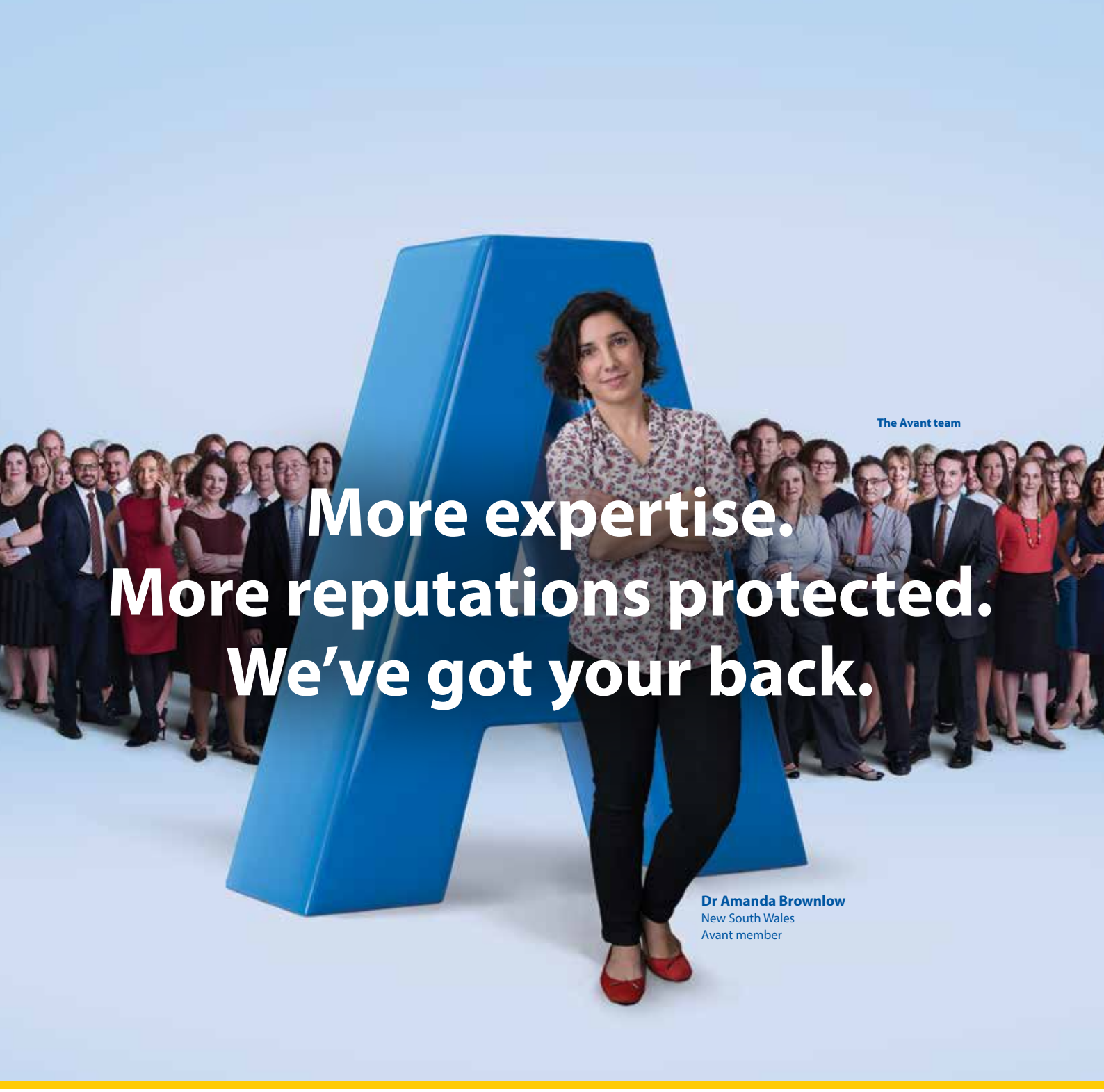

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