VICDOC

AMA VICTORIA

SPRING 2021

HEALTHCARE + CLIMATE CHANGE

» PERSONAL COVID-19 RISK

» MENTAL HEALTH

» PROFESSIONAL NETWORKS

"A POINT TOO SOON"

Is your self-education expense designed to maintain or increase the knowledge required for your current position, or is it designed to open up a new income earning activity? The tax office has specific rulings that disallow some self-education expenses that are deemed "a point too soon" to claim against your current income earning activity. If you can demonstrate a sufficient nexus between the self-education expense and your current job – the expense is likely to be tax deductible. If, however, the education is designed to create a new income earning activity, with no clear connection with your current position, the expense is likely non-deductible. Be sure to discuss "a point too soon" expenses with your trusted tax adviser.

Medical resident: Your tax return

You can claim

All expenses claimed must have a direct link to the job title on your employment contract

- RACP Fees
- Medical courses and conferences
- Tertiary courses. E.g. Masters of Medicine
- Textbooks and journals related to Medical training
- AMAV membership

You cannot claim

Anything that cannot be linked back to the job title on your employment contract

- Tertiary courses such as a Masters of Public Health for the purpose that you may want to explore hospital administration down the track.
- Conferences, courses or exams related to a separate medical eld. e.g. Surgery or Psychiatry. You may be boosting your CV or upskilling in order to move across to a dierent medical eld.
- Application fees to medica colleges other than RACP

Surgical resident: Your tax return

You can claim

All expenses claimed must have a direct link to the job title on your employment contract

- GSSE Exam
- RACS JDOCS subscriptions
- Surgical related courses and conferences
- Loupes and related medical equipment
- Tertiary courses. E.g. Masters of Surgery
- Textbooks and journals related to surgery
- AMAV membership

You cannot claim

Anything that cannot be linked back to the job title on your employment contract

- Tertiary courses such as a Masters of Public Health for the purpose that you may want to explore hospital administration down the track
- Conferences related to a separate medical eld. You may be boosting your CV or upskilling in order to move into a dierent medical eld.
- Application fees to medical colleges other than the college of surgeons. e.g. RACGP OR RACP

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SPRING! *Check it out*

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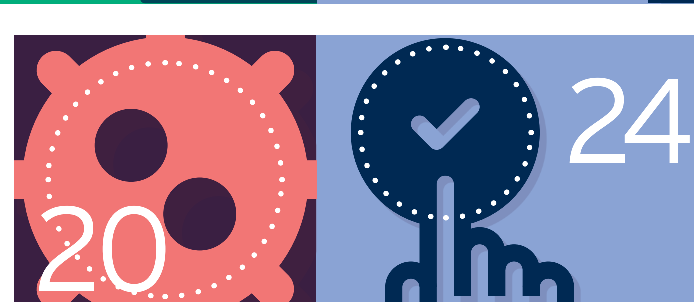

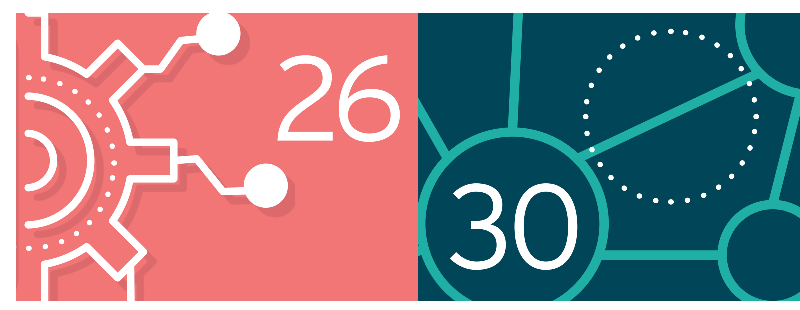

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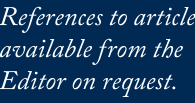

References to articles available from the Editor on request.

ADVOCACY WORK DURING THE NEW NORMAL

DR RODERICK McRAE

AMA Victoria President

As I write to you, parts of Australia including our own state remain under the scourge of the Delta variant of SARS-CoV-2 and we in Victoria are enduring 'Lockdown 6'.

Overseas experience is showing that we are building to a pandemic of the unvaccinated, with a battle between the Delta variant and each person's genetic make-up and inflammatory response. We are unaware if the Delta variant will be noted as the most efficient combination of transmissibility and morbidity, or if another mutation in the unvaccinated cohort will introduce more pain and suffering, including eluding our current vaccines.

Vaccination is a large part of the public health response, coupled with mask wearing and reduced movements. Lamentably, we have the ongoing saga of the adverse public perception of the AstraZeneca vaccine, with many over 60 years of age continuing to 'wait for Pfizer'. Moreover, the lack of hospital infrastructure capacity investment over the years is very much starting to show around our public hospitals, which have very limited workforce capacity to manage any surge in any type of presentations, particularly if staff are also furloughed due to real or potential exposure to COVID-19.

Whilst AMA Victoria's advocacy work around COVID-19 continues, we also push on in other policy areas as well.

Victoria's *Mental Health Act 2014* is to be repealed, to be replaced by a *Mental Health and Wellbeing Act*. I regret that all medical practitioners, not simply psychiatrists (who were consulted very late in the piece) need to be alarmed. Management of mental illness is being de-medicalised and bureaucratised. Overly idealistic inputs, which have influenced the recent Royal Commission into Victoria's Mental Health System, are amplifying a human rights perspective that handholds the not-so-severely mentally ill, and neglects the evidence of profound mental illness, which regrettably does occur, and requires medical treatment, within a medical model, no matter what anybody may wish.

It appears the drafters lack an understanding of the nature of work in managing seriously mentally unwell patients. While recommendations for a more human rights-based mental health system and Act are laudable, it is my view that a broader conception of rights is needed. The rights of fellow patients, carers, healthcare workers and indeed the community itself must also be considered. AMA Victoria Council's formation of a taskforce across many relevant medical crafts coordinated a submission on this topic.

Similarly, I have supported Council's formation of a working group to consider matters of regulators' bureaucratic overreach as it applies to medical practitioners and the negative effect on their practices, seeking to assist in ensuring fairness, timeliness, due process, natural justice principles and, importantly, increased transparency. In a not-distantly-unrelated circumstance, I am advised WorkSafe is pursuing a course of what I consider to be an *ultra vires* interpretation of the words 'other persons' in the *Occupational Health and Safety Act,* seeking to trawl through patient histories in public hospitals, since these are workplaces. They simply cannot be permitted to do so and I am working to ensure appropriate education is provided. Alternatively, urgent legislative amendment is required. Happily, many politicians are very interested.

> " Overseas experience is showing that we are building to a pandemic of the unvaccinated, with a battle between the Delta variant and each person's genetic make-up and inflammatory response."

Council also agreed to establish a multi-craft taskforce to consider deterioration in patient care related to their presentations at public hospital emergency departments. There are multiple barriers to admission to every level of inpatient hospital care, most of which are related to an inability to discharge previous patients in an efficient and timely manner. In parallel, I have met with key representatives of Victorian faculties in general practice and emergency medicine to alter the incorrect narrative about 'inappropriate' category 4 and 5 patients presenting to emergency departments. There is just no data to support that this is the case, so we need to impress that on decision-makers.

I recently appeared before a public hearing held by the Legislative Council Standing Committee on Environment and Planning on the topic of the health impacts of air pollution in Victoria. After noting the adverse health consequences of air pollution, I restated AMA Victoria's position that Government strategies should be adopted that focus on improving energy and combustion efficiency, transitioning to non-combustion energy sources and promoting active transport (walking, running and cycling). I have recently reminded our own Victorian Minister for Health of the Government's undertaking for a 100 per cent renewable electricity pledge for our public hospitals by 2025, including a potential to revisit a decision for the forthcoming Footscray Hospital to have 50 per cent energy supply as gas. (Read more about this on page 13.)

We are also busy representing your interests monitoring Enterprise Bargaining negotiations and class action developments. As always, we have an opportunity to represent your views around private medical matters to AMA Federal, where that work for 50 per cent of your membership fee is undertaken.

Best wishes as you continue to assist Victorians.

Dr Roderick McRae is an anaesthetist, intensive care physician, lawyer and bioethicist.

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293 Royal Parade Parkville Victoria 3052
T: 03 9280 8722 | F: 03 9280 8786
Country Freecall 1800 810 451
amavic.com.au

EDITORIAL:
Editor Barry Levinson
BarryL@amavic.com.au
Designer Shelley Heaney
ShelleyH@amavic.com.au
Advertising Frances Morell
FrancesM@amavic.com.au

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NEWS + REVIEWS

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We love to hear from our members. Email: vicdoc@amavic.com.au

AMA SOCIAL

Energis
Partnering [with] Australian Medical Association AMA Victoria during these challenging times makes us feel proud. Thank you AMA Victoria and members. Another successful [solar power installation] project delivered at Tarneit Family Medical And Dental Centre.

@DrEricLevi
We had a Clinician Wellbeing discussion last night with @amavictoria @M_Kay_Dunkley @KymJenkins36 @DrJaneMunro @Tahnee_Bridson. Common themes appear: People matter. Kindness matters. Find your tribe. Be connected. Be the change you want to see.

NEW UNDERPAYMENT CLASS ACTION AGAINST WESTERN HEALTH

Dozens of junior doctors have joined a new class action against Western Health, amid claims the industry is understaffed, underpaid and patients' lives are being put at risk, reports *news.com.au*.

If you are, or have been, a doctor-in-training in Victoria at any time since January 2015, please register to stay informed. It's strictly confidential, quick, free and non-binding. No record of overtime is required.

Please join us and help achieve real change.

EMERGING LEADER PROGRAM

Registrations are now open for AMA Victoria's Emerging Leader program, designed to support the professional development of emerging leaders in medicine.

As an early career doctor, you can start to develop the leadership skills necessary to participate effectively in collaborative work and to lead and support those with whom you work. Join this program to increase your knowledge of effective leadership and learn practical skills for use in your current role.

Our first session was very popular in August and there is a second intake, with limited places available, commencing on Saturday 23 October 2021.

RESPONSE TO THE MENTAL HEALTH AND WELLBEING ACT

AMA Victoria has provided a submission to the Victorian Department of Health in response to its discussion paper on the development of a new *Mental Health and Wellbeing Act*.

Upon review of the paper, we conveyed to the Department significant concerns on multiple levels. Our overarching perspective is that the proposed Act does not empower doctors to treat highly vulnerable, severely ill patients in the best way possible and that this sentiment is shared equally by doctors-in-training, psychiatrists and other specialists alike. We also noted that coupled with the burdensome compliance requirements mooted by the Engagement Paper, if the *Mental Health and Wellbeing Act* is implemented as proposed, the predictable result is that there will be further attrition in the mental health workforce.

BREAKTHROUGHS

NEW AI TECHNOLOGY FOR EARLY DETECTION OF PROSTATE CANCER

Researchers have developed a diagnostic tool that can spot prostate cancer before patients have any symptoms, using artificial intelligence to analyse CT scans in just seconds.

Prostate cancer is the most diagnosed cancer and a leading cause of death by cancer in Australian men. Early detection is key to successful treatment, but men often dodge the doctor, avoiding diagnosis tests until it's too late.

Now an artificial intelligence (AI) program developed at RMIT University could catch the disease earlier, allowing for incidental detection through routine computed tomography (CT) scans.

The tech, developed in collaboration with clinicians at St Vincent's Hospital Melbourne, works by analysing CT scans for tell-tale signs of prostate cancer, something even a well-trained human eye struggles to do.

CT imaging is not suitable for regular cancer screening because of the high radiation doses involved, but the AI solution could be used to run a cancer check whenever men have their abdomen or pelvis scanned for other issues. RMIT's Dr Ruwan Tennakoon said CT scans were great for detecting bone and joint problems but even radiologists struggled to spot prostate cancers on the images. "We've trained our software to see what the human eye can't, with the aim of spotting prostate cancer through incidental detection," he said. "It's like training a sniffer dog – we can teach the AI to see things that we can't with our own eyes, in the same way a dog can smell things human noses can't."

Prostate cancer is slow growing and is usually detected incidentally, so can go undiagnosed for years. In Australia, it was responsible for an estimated 12 percent of male cancer deaths in 2020.

For the study, published in *Nature's Scientific Reports*, researchers from RMIT and St Vincent's Hospital Melbourne studied CT scans of asymptomatic patients, with and without prostate cancer. The team trained the AI software to look for features of disease in a variety of scans and where exactly to look for them, avoiding the need to manually crop the images.

The AI performed better than radiologists who viewed the same images, detecting cancerous growths in just seconds. Plus, the AI improved with each scan, learning and adapting to read images from different machines to spot even the smallest irregularities.

RMIT's Head of Artificial Intelligence, Prof John Thangarajah, said the study demonstrated how AI can and should be used to create public good. "Our health sector needs smarter solutions and AI can help, but we're only scratching the surface," he said. "There's a lot of good that artificial intelligence can bring to the world, which is our focus at RMIT, and this study forms a big part of that."

Dr Mark Page, Head of CT in Diagnostic Imaging at St Vincent's Hospital Melbourne, said early intervention for prostate cancer was key to a better health outcome. "Australia doesn't have a screening program for prostate cancer but armed with this technology, we hope to catch cases early in patients who are scanned for other reasons," he said.

"For example, emergency patients who have CT scans could be simultaneously screened for prostate cancer. If we can detect it earlier and refer them to specialist care faster, this could make a significant difference to their prognosis."

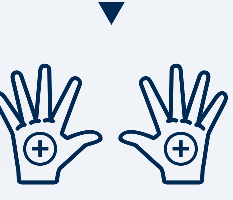
The technology can be applied at scale, potentially integrating with a variety of diagnostic imaging equipment like MRI and DEXA machines, pending further research. "It was excellent to tap into the AI expertise at RMIT and we look forward to future possibilities for analysing more radiology scans," Dr Page said.

The multi-disciplinary team, including researchers from RMIT's School of Engineering and School of Computing Technologies, is looking for interested commercial partners to develop software to further integrate the AI technology with hospital equipment for possible clinical trials.

IMAGE (L-R): A/PROF PETER BROTCHIE (ST VINCENT'S), DR RUWAN TENNAKOON (RMIT), PROF JOHN THANGARAJAH (RMIT), DR MARK PAGE (ST VINCENT'S).

ENQUIRY

AT THE TABLE



DR MAGDALENA SIMONIS

MBBS FRACGP DRANZCOG MHHS

AMA Victoria GP Subdivision member

01 What is your current role in medicine?

I am a full-time GP in the Melbourne CBD, and conduct research as a Honorary Senior Research Fellow with the Department of General Practice, University of Melbourne. I'm an examiner/teacher of medical students and an RACGP examiner/trainer and wear several other 'hats'. These include being on the RACGP Expert Committee for Quality Care; the President of the Australian Federation of Medical Women (AFMW); Co-Chair of the Medical Women's International Association (MWIA) Scientific and Research Subcommittee; and being on the board of Women's Health Victoria.

02 Why did you choose to study medicine?

The decision to become a doctor was made by me, at the age of seven. As a young child, I grew up in a milk bar which was opposite my primary school. I would offer to clean and dress grazed knees with Dettol and provided tissues to kids with runny noses. Even as early as grade 2, I was the 'go to' for injuries that occurred in the playground. There are no other doctors in my family so during my teen years, watching MASH was hugely inspirational. I still love watching the replays and even Alan Alda was impacted by his role and set up the World of Science Festival.

03 What is the best part about your work?

The human contact and building relationships that teach me about people, life and medicine.

04 What is the hardest part about your work?

Keeping to time. My patients now know to call in advance and double check how late I am running. I have given up on running to time – it's the only way I can be present and in the moment with my patients.

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

For me, medicine has really been like a 'calling' or a passion. For some, it's not, but it is still a wonderful career path for anyone with an inclination towards science-based leaning. For those considering a career in medicine I would emphasise to them that dealing with human frailty, emotion and disease requires a mix of patience and empathy, not just academic excellence. My advice is to consider what specialist path you take, based primarily upon your ability to listen and your willingness to consider the patient presentations holistically. This means taking an interest in the social determinants of health and weaving aspects of this into the decision-making process, with a spirit of co-design. People are people first, not diseases and conditions and to remember to start every conversation from this premise.

06 What do you enjoy doing away from medicine?

Many things, but mostly being with my family. I love hosting big dinners and lunches – in fact, the running joke on Saturday mornings has been, "Who and how many are we feeding tonight?" I love playing the piano, even though lack of practise means I now play poorly, so I try to forget that others are listening and continue doing so. Although I call it exercise, swimming laps in the 50 metre outdoor local pool is great fun too. Add to this, walking in nature, on the beach and dancing to both Greek and disco music. Acting and writing nearly swayed me away from medicine in the early student days, so these are creative outputs that fulfill me. This list just touches the tip of the many things I like doing, other than medicine.

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[1] Corporate programme is available to approved corporations who meet the eligibility criteria and is available on selected new passenger cars only. The programme requires a minimum commitment over 24 months. [2] Purchase of a Compact vehicle will attract a discount of $1500.00 off the Manufacturer's List Price. Purchase of a Non-Compact Vehicle will attract a discount of $2000.00 off the Manufacturer's List Price. Refer to the Terms and Conditions of the Mercedes-Benz Corporate Programme and Fleet Support for further details regarding which vehicles are considered to be 'Compact Vehicles' and 'Non-Compact Vehicles.' [3] Available to customers who purchase a vehicle under the Corporate Programme on or after 1 January 2020. Access (including ongoing access) to Corporate Rewards is contingent on the customer holding a valid membership with the Mercedes-Benz Corporate Programme. Member Benefits is not a representative or agent of Mercedes-Benz and Mercedes-Benz accepts no legal responsibility for the Member Benefits website, any information supplied, or any goods or services provided by Member Benefits. [4] Not applicable to all models.

TURN OFF THE GAS + EMBRACE ALL-ELECTRIC

It is time for Victorian healthcare to urgently address its reliance on both gas and electric fossil fuels to reduce the harm of climate change on health and the environment.

REPORT **DR HAYDEN BURCH**
AMA VICTORIA MEMBER
CO-CONVENOR OF DOCTORS FOR THE ENVIRONMENT AUSTRALIA (DEA) VICTORIAN SUSTAINABLE HEALTHCARE SPECIAL INTEREST GROUP

- Victorian public hospitals and health services are responsible for a quarter of the State Government's reported carbon emissions from electricity and gas use.
- New developments in Canberra and Adelaide are examples for the future with all-electric hospitals with no reliance on fossil gas.

In keeping with Victoria's Climate Change Strategy, the State Government has pledged it will source 100 per cent renewable electricity for all government operations, including all Victorian public hospitals from 2025. The announcement has been welcomed by many medical professionals – including Victorian members of the AMA and Doctors for the Environment Australia (DEA) – who recognise the science regarding worsening health impacts of climate change.

Australia's healthcare sector is responsible for approximately 7 per cent of the nation's greenhouse gas emissions. In keeping with the need for leadership by the health sector, the AMA and DEA have released a conjoint call for the Australian healthcare sector to reduce its carbon emissions – 80 per cent by 2030 and net zero emissions by 2040 – to play its part in meeting the 1.5°C Paris Agreement target.

Transitioning hospital energy supply, from harmful fossil-fuel based gas and electricity to renewable electricity are key recommendations of DEA's report *Net zero carbon emissions: responsibilities, pathways and opportunities for Australia's healthcare sector*, and are essential for Victoria to meet its legislated emissions reduction targets.

Victorian public hospitals and health services are responsible for a quarter of the government's reported carbon emissions from electricity and gas use, yet to date less than 1 per cent of Victorian public hospitals' stationary energy has been renewable in supply. The 100 per cent renewable electricity pledge for public hospitals by 2025 is an obvious boost on efforts for the health sector to do its part.

What remains critical, however, is for Victorian healthcare to address its large reliance on fossil gas. As almost half of Victorian hospital energy use is gas, the Victorian Government pledge can be more realistically seen as only a 50 per cent pledge that switches hospital electricity use from coal-fired electricity to renewable electricity. Our hospitals will therefore continue to emit large quantities of greenhouse gas emissions associated with gas, undermining the very objectives of the health sector of protecting and promoting health.

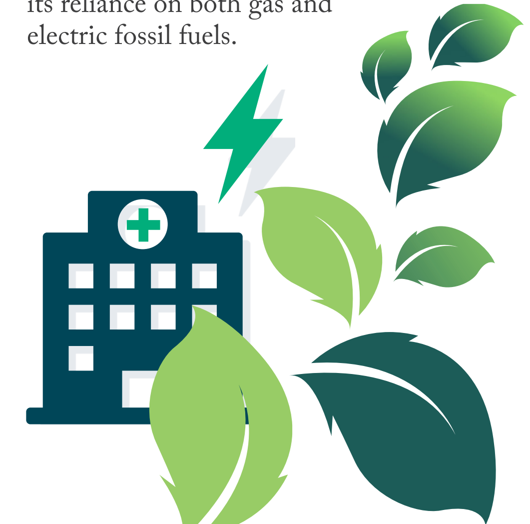
It is now possible to build all-electric hospitals with no reliance on fossil gas. In Adelaide, the entire Women's and Children's Hospital is planned to be all electric and powered by renewable energy and similarly, the Canberra Hospital extension will be powered with renewable electricity.

Despite this capacity, new hospitals in Victoria and elsewhere in Australia continue to be built with fossil gas for heating. This is particularly absurd given that these facilities will be functioning long past 2050, when fossil gas will likely be phased out. The new Footscray Hospital, for example, is planned to have gas infrastructure installed – and then likely to be retrospectively removed within the next three decades – at exorbitant financial, resource and environmental expense to the Victorian community. It is vital for Victorian healthcare to pledge for no new gas installations or upgrades in hospitals now and contribute meaningfully toward net zero ambitions. Some Victorian hospitals have already shown leadership in regards to reducing healthcare's carbon footprint, but much more can be achieved.

In summer 2019-2020, hospitals and healthcare staff saw first-hand the devastating health impacts of climate change from the unprecedented bushfires on the Australian east coast. A study in the *MJA* found the smoke from these horrific bushfires was responsible for 417 excess deaths, 1124 hospitalisations for cardiovascular problems and 2027 for respiratory problems, as well as 1305 presentations to emergency departments with asthma.

Healthcare sector staff are aware urgent action needs to be taken to address the impacts of climate change. A recent survey of Victorian healthcare CEOs published in the *Australian Health Review* showed a majority agreed that climate change is causing real harm to health and the environment, with impacts on patients, staff and services.

It is time for The Victorian healthcare sector to urgently work to ensure it does not remain part of the problem through addressing its reliance on both gas and electric fossil fuels.



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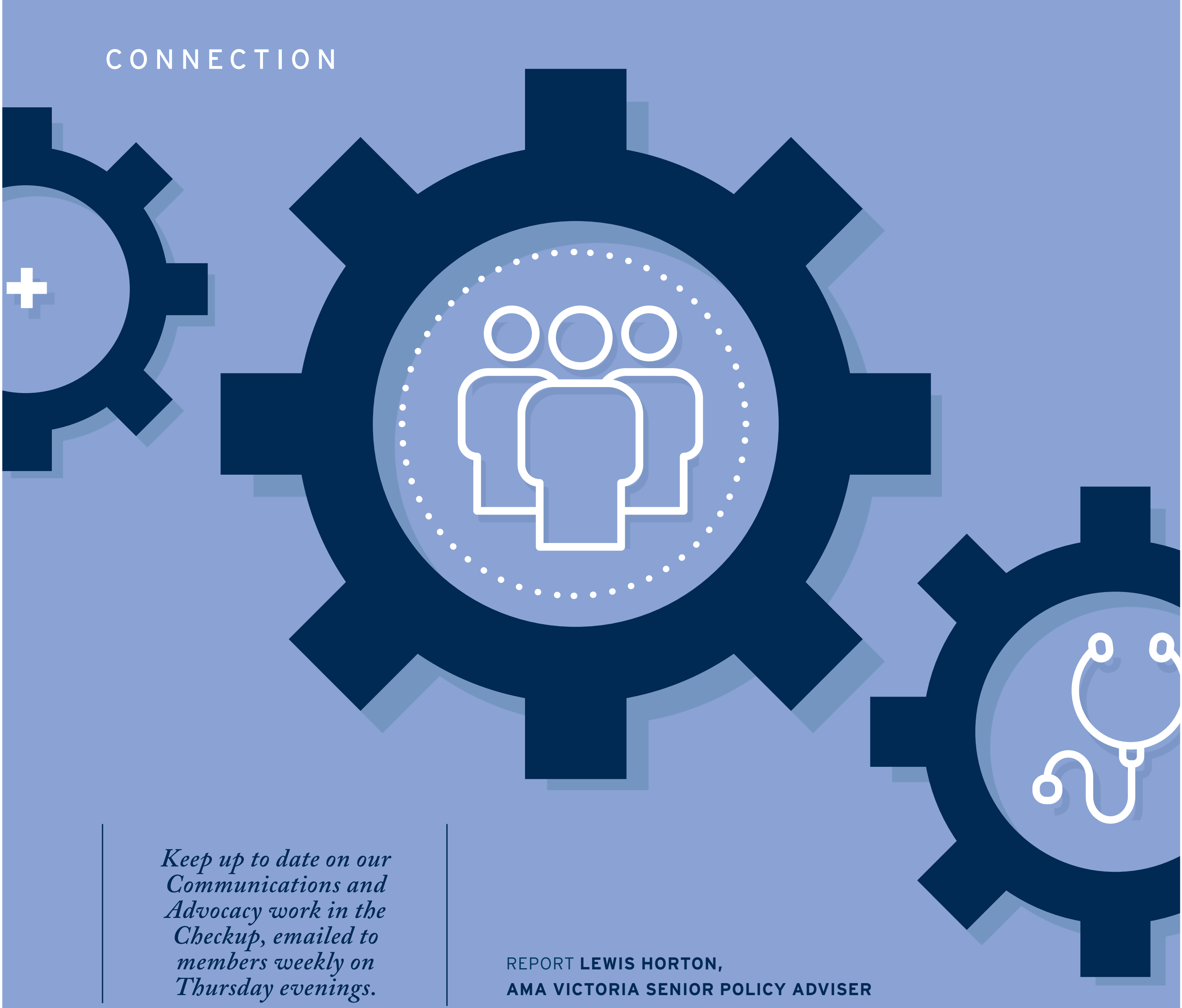


Keep up to date on our Communications and Advocacy work in the Checkup, emailed to members weekly on Thursday evenings.

REPORT **LEWIS HORTON, AMA VICTORIA SENIOR POLICY ADVISER**

COMMUNICATIONS + ADVOCACY

Here's an update on a few of the issues AMA Victoria has been working on for members.

RESPONSE TO THE *MENTAL HEALTH AND WELLBEING ACT*

—

AMA Victoria has provided a submission to the Victorian Department of Health in response to its discussion paper on the development of a new *Mental Health and Wellbeing Act*.

Upon review of the paper, we conveyed to the Department significant concerns on multiple levels. Our overarching perspective is that the proposed Act does not empower doctors to treat highly vulnerable, severely ill patients in the best way possible and that this sentiment is shared equally by doctors-in-training, psychiatrists and other specialists alike. Further, we noted that coupled with the burdensome compliance requirements mooted by the Engagement Paper, if the *Mental Health and Wellbeing Act* is implemented as proposed, the predictable result is that there will be further attrition in the mental health workforce.

We communicated to the Department that we believe that the proposals do not meet the Royal Commission's recommendations about the objectives and principles of the new Act because:

- the whole-time frame is too hastily constructed.
- the process to date has been totally lacking in expert psychiatrist and senior clinician involvement and urgently needs expertise from people with extensive practical experience in use of the Act.
- any revised Act needs to provide genuine approaches and solutions to the challenges people face when they are at their most vulnerable with serious mental illness, not just a principles-based approach divorced from a practical understanding of the depth of challenges involved in utilising such legislation.

We also noted that we would have been pleased if these proposals lived up to what the Royal Commission was meant to achieve. However, we informed the Department that this can only occur if the Department genuinely take the time and the depth of consideration to develop a Mental Health Act that involves proper involvement of the profession and consideration of all approaches.

Moreover, we relayed that funding, patient environments, resources, training, staffing and practices should all be developed before making drastic changes to existing legislation. Further, we noted that in the context of systemic underfunding, limited staffing and people leaving the system, overly idealistic principles-based proposals only add to the damage and create new difficulties and impact negatively on the care that patients receive.

If you would like a copy of our full submission, please contact Senior Policy Adviser, Lewis Horton, at LewisH@amavic.com.au

HEALTH AND HUMAN SERVICES CLIMATE CHANGE ADAPTATION ACTION PLAN

—

In late July, AMA Victoria, along with a range of other interested stakeholders in the healthcare sector, met with the Victorian Department of Health to discuss the draft Health and Human Services Climate Change Adaptation Action Plan.

The Draft Health and Human Services Climate Change AAP 2022-26 addresses the impacts of climate change and proposes 14 strategic actions that Victoria's Health and Human Services system can take during the next five years to address current climate change impacts, reduce barriers to adaptation planning and action, and lay the foundations for transformational adaptation.

We expressed our support for actions to secure climate-resilient health infrastructure and expressed our view that such measures provide opportunities to realise health co-benefits through adaptation measures that mitigate emissions and provide many additional social and economic benefits.

We also raised the possibility of Victoria adopting an equivalent to the UK Greener NHS Program which has a Net Zero strategy and uses a comprehensive carbon footprint mapping strategy looking at both direct and indirect emissions to target their interventions.

In addition, we have provided a written submission to the Department on the draft Health and Human Services Climate Change Adaptation Action Plan. Click here to read it.

MEETING WITH VICTORIAN HEALTH MINISTER

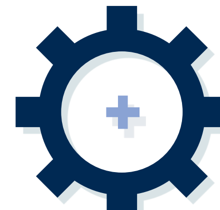
—

AMA Victoria recently met with the Victorian Health Minister, Martin Foley, and expressed our desire to work constructively with the Victorian Government in continuing to respond to the COVID-19 pandemic and in building an improved health system in a post-COVID Victoria.

To this end, we expressed to the Minister that key to us in improving our health system is:

- Addressing the very real difficulties that exist in public hospital access (acknowledging that ambulance ramping and crowded emergency departments are just perhaps the most visible manifestations of wider system failure).
- Ensuring medical expertise is heeded in reforming Victoria's mental health system (ultimately, the success or failure in fundamentally transforming Victoria's mental health system depends upon successful implementation of the Royal Commission's recommendations, and medical expertise is essential to successful implementation).
- Addressing critical workforce shortages (improving collaboration between health services and supporting/ pursuing a networking solution in regional Victoria which embraces referral pathways, staffing solutions and video linking, as opposed to outsourcing).
- Refining the interface between general practice and hospitals (particularly by improving discharge planning and IT linkages).
- Ensuring more doctors are involved in governance.

Though being critical where necessary (we raised, amongst other issues, concerns around the proposed *Mental Health and Wellbeing Act*, the conduct of WorkSafe and the lack of support for specialist practitioners during the most recent lockdown), we look forward to working with the Victorian Government over the period ahead to support the medical workforce and ensure quality healthcare for all Victorians.



INQUIRY INTO HEALTH IMPACTS OF AIR POLLUTION IN VICTORIA

—

On Monday 28 June, AMA Victoria President, Dr Roderick McRae, appeared before a public hearing held by the Legislative Council Standing Committee on Environment and Planning on the topic of the health impacts of air pollution in Victoria.

Dr McRae noted that as the peak professional organisation representing medical practitioners in Victoria, we have a longstanding interest in this issue, and stated that from a medical perspective, the adverse health consequences of air pollution range from acute and chronic effects, such as restrictions in physical activity, to emergency room visits for asthma and hospitalisations for respiratory and cardiovascular causes, to premature mortality.

Further, Dr McRae remarked that while over recent decades there have been general improvements in air quality in Australia, due to a mix of regulatory and non-regulatory approaches, considerable challenges remain and that various developments have called into question the effectiveness of current air quality management in Australia. These include an increasing reliance on road transport, the expansion of mining and industries producing hazardous air pollutants and the compounding effects of climate change and extreme weather on poor air quality.

Dr McRae then canvassed various mitigation strategies to address the issue of air pollution and restated AMA Victoria's position that strategies that focus on improving energy and combustion efficiency, transitioning to non-combustion energy sources and promoting active transport (walking, running, and cycling) should be adopted.

Members can view our submission on this topic here.

KEEPING FAMILIES SAFE FROM ALCOHOL RELATED VIOLENCE

—

In 2016, Victoria's Royal Commission into Family Violence recommended that the Victorian Government consider family violence in its review of the *Liquor Control Reform Act 1998* (Vic) (the Act) on the basis of the role of alcohol in fuelling family violence.

Five years on from the Royal Commission, proposals from the review are under consideration. The COVID-19 pandemic has made the need for reform of the Act even more pressing. We have seen sales of packaged alcohol soar, with alcohol retail turnover in Victoria increasing by 33 per cent between 2019 and 2020, from $2.6 billion to $3.4 billion. This increased flow of alcohol into Victorian homes is likely to fuel increases in family violence. AMA Victoria, in addition to a range of other organisations, has written to the Victorian Government urging it to implement the following reforms to the Act that would help prevent alcohol-related family violence:

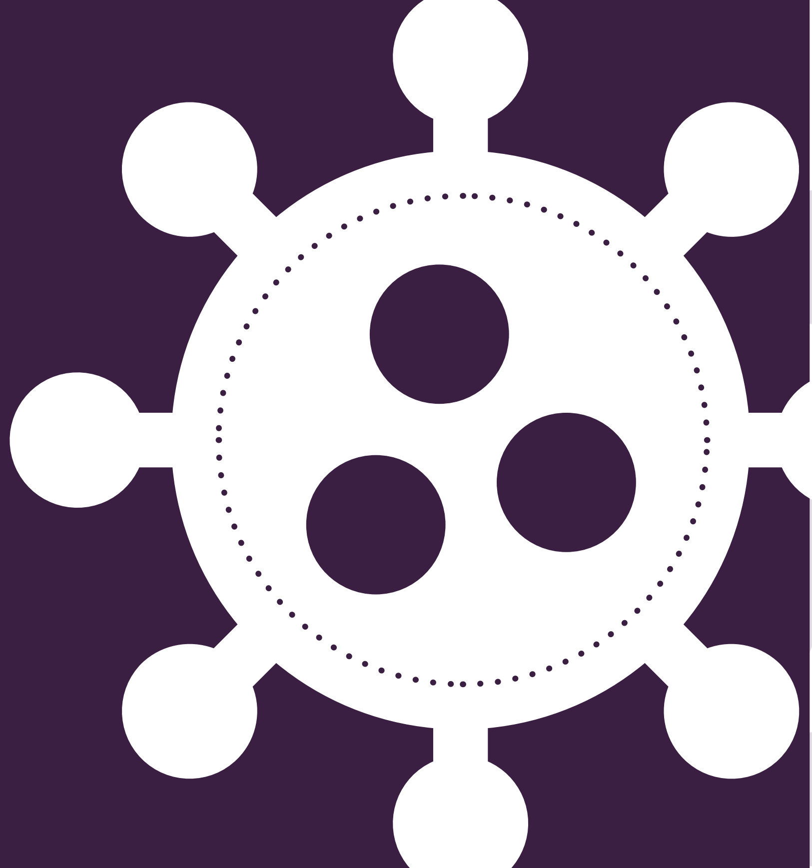
- Introduce a delay of two hours for delivery of online alcohol orders, to stop the rapid delivery of alcohol to people's homes.
- Shift delivery time to between 10am and 10pm, to reduce known risks of alcohol-related violence and suicide which peak late at night in the home.

AMA Victoria takes a keen interest in this issue. As doctors, our members are often at the frontline in dealing with the devastating effects of family violence, in addition to the impacts of excessive alcohol consumption more generally.

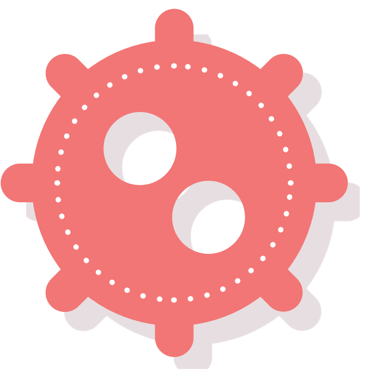
SHOULD DOCTORS RISK THEIR LIVES WHEN RESPONDING TO A DISASTER?

Medical professionals must weigh up their duty to treat individual patients infected with COVID-19 with their duty to ensure they do not develop COVID-19 themselves and become unable to work or risk infecting other patients, staff or those in the wider community.

REPORT **DR ANDREW J MILLER**
CHAIR, AMA FEDERAL ETHICS AND MEDICO-LEGAL COMMITTEE



The current pandemic has turned this potential eventuality into a stark reality for many doctors in Australia and worldwide.



On 5 March 2021, Amnesty International announced that at least 17,000 healthcare workers globally have died from COVID-19 over the last year, forcing doctors both in Australia and around the world to confront the very real question of whether they are willing (or should be expected) to put their own lives at risk to treat real or suspected COVID-19 patients.

The AMA's *Position Statement on Ethical Considerations for Medical Practitioners in Disaster Response 2014*, currently under review by the Ethics and Medico-Legal Committee (EMLC), briefly addresses doctors' risk of personal harm when responding to a disaster.

The position statement affirms that doctors must balance their duties to individual patients with their duties to protect themselves, other patients, staff, colleagues and the wider public from harm, highlighting that during 'ordinary' clinical practice, these duties do not generally come into conflict, but during a disaster, tensions between these duties may very well eventuate.

The current pandemic has turned this potential eventuality into a stark reality for many doctors in Australia and worldwide. Medical professionals must weigh up their duty to treat individual patients infected with COVID-19 with their duty to ensure they do not develop COVID-19 themselves and become unable to work or risk infecting other patients, staff or those in the wider community.

In addition to the professional duty to reduce risk of personal harm, doctors also have their own personal duties and interests in not becoming infected and risking sickness or even death, or spreading the virus to their own family members and friends.

So what level of risk of personal harm should doctors accept? While there is a general expectation within the community that doctors will accept a certain amount of personal risk when responding to a disaster, this risk is not unconditional or without reasonable limit. The current position statement says that doctors are entitled to protect themselves from harm and should not be expected to exceed the bounds of 'reasonable' personal risk.

But the global pandemic has made it clear that 'reasonable' risk is highly subjective and the level of risk that governments, employers, patients and their family members and others expect doctors to accept when responding to a disaster may not be 'reasonable' to the medical profession or to individual doctors or their loved ones.

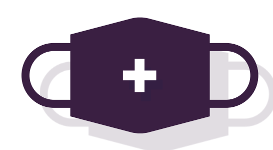
Globally, professional regulators and associations set varying standards regarding the expectations of doctors in relation to risk of personal harm when responding to disasters.

For example, the Medical Board's *Good Medical Practice* states that:

Treating patients in emergencies requires doctors to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other patients under your care; and continuing to provide that assistance until your services are no longer required.

The UK's General Medical Council is more explicit in its own *Good Medical Practice*, stating that:

You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making other suitable alternative arrangements for providing treatment.



- There is a general expectation within the community that doctors will accept a certain amount of personal risk when responding to a disaster, but this risk is not unconditional or without reasonable limit.
- The AMA will continue to advocate that governments and the wider community have an obligation to protect and support doctors who suffer harm when caring for patients.

Click here for news from AMA Federal

While the American Medical Association's *Code of Medical Ethics, Opinion 8.3 Physicians' Responsibilities in Disaster Response & Preparedness,* advises that:

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life. However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.

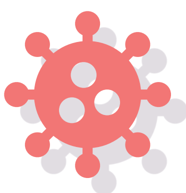
While the expected standard of doctors' risk of personal harm may be addressed differently in these examples, at least they are all consistent that it is unreasonable for doctors to be placed at risk of significant harm because of inadequate or inappropriate safety and protection, and advocacy to improve that protection is an important duty for medical professionals and those who control any aspect of workplace safety. Doctors with less agency or power, such as doctors-in-training or those in temporary employment, must be protected from any implied or overt obligation to practice in conditions that are not as safe as it is reasonably practicable for them to be. Employers, managers and workplace safety regulators have a duty to ensure that corners are not cut and peer group or management pressure is not acting to decrease safety for any doctor.

Doctors' willingness to risk significant personal harm when treating patients in disasters has also experienced a temporal shift. Doctors once entered the profession seemingly willing to sacrifice their own lives to care for patients, as exemplified in the *American Medical Association's Code of Medical Ethics* in 1847, which directed:

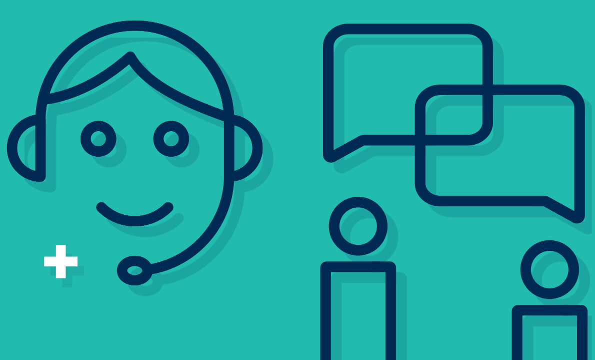
When pestilence prevails, it is their duty to face the danger and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives.

Many of today's doctors are not so willing to lay their lives on the line and will need to consider their own personal morals and values when deciding how much risk is reasonable to them.

As the EMLC examines this issue during our policy review, we will identify a range of factors that doctors should consider when determining what constitutes a reasonable risk of personal harm and what they can do to mitigate their personal risk. While it is not unreasonable for doctors to accept a certain amount of personal risk when responding to disasters, that risk is not unconditional and we will continue to advocate that governments and the wider community have an obligation to protect doctors and reciprocate and support doctors (and their family members) who suffer harm when caring for patients.



AMA Victoria Peer Support Service



For anonymous and confidential support*

1300 853 338

8.00am–10.00pm
365 days

Peer support for doctors by doctors

* Cost of a local call

IMPORTANT ROLE OF PATIENT ACTIVATION

When patients are active participants in their care, outcomes are better, but this takes extra time and should be reflected in remuneration for GPs.

REPORT **DR RICHARD KIDD**
CHAIR, AMA FEDERAL COUNCIL OF GENERAL PRACTICE

- The more activated patients are, the more the costs associated with the burden of disease are reduced for both the individual and society.
- The remuneration structure for GP attendances needs modification to allow for the additional time required for patient activation.

Delivering patient-centred care and supporting patients to be actively involved in their healthcare is something that we as GPs are well placed to do. Our trusted relationship with patients affords us insight to our patients and the opportunity to undertake meaningful discussions on preventing and/or managing health conditions. Our ongoing relationship with patients affords us the privilege of witnessing the real difference we can make to patients' lives when we encourage and support them in taking positive actions to improve their health outcomes.

With chronic disease the leading cause of premature morbidity and mortality in Australia, and with many of the risk factors for chronic disease able to be changed or controlled by the patient, supporting patient activation plays an important role in disease prevention and management. The more activated patients are, the more the costs associated with the burden of disease are reduced for both the individual and society.

Activating patients to be more engaged in their healthcare and to take more control of their health can reduce health inequalities, deliver improved outcomes, support better quality care and deliver lower costs.

I know the more activated a patient is, the more likely they will attend preventive health screenings, immunisations, regular check-ups and participate in good behaviours such as eating a healthy diet and regularly exercising. For those with chronic conditions, the more activated they are the more likely they are to adhere to their treatment and to monitor their condition.

Activated patients who have undergone surgery are also more likely to have better rates of recovery. Our more motivated patients are more likely to have clinical indicators in a normal range. Patient activation is also relevant for our patient's mental health, with those more activated likely to have a positive outlook, healthier coping strategies and greater medication compliance while being less likely to participate in substance abuse. Conversely those with low activation are more likely to have unmet medical needs and to delay medical care.

Patient activation, is underpinned by:

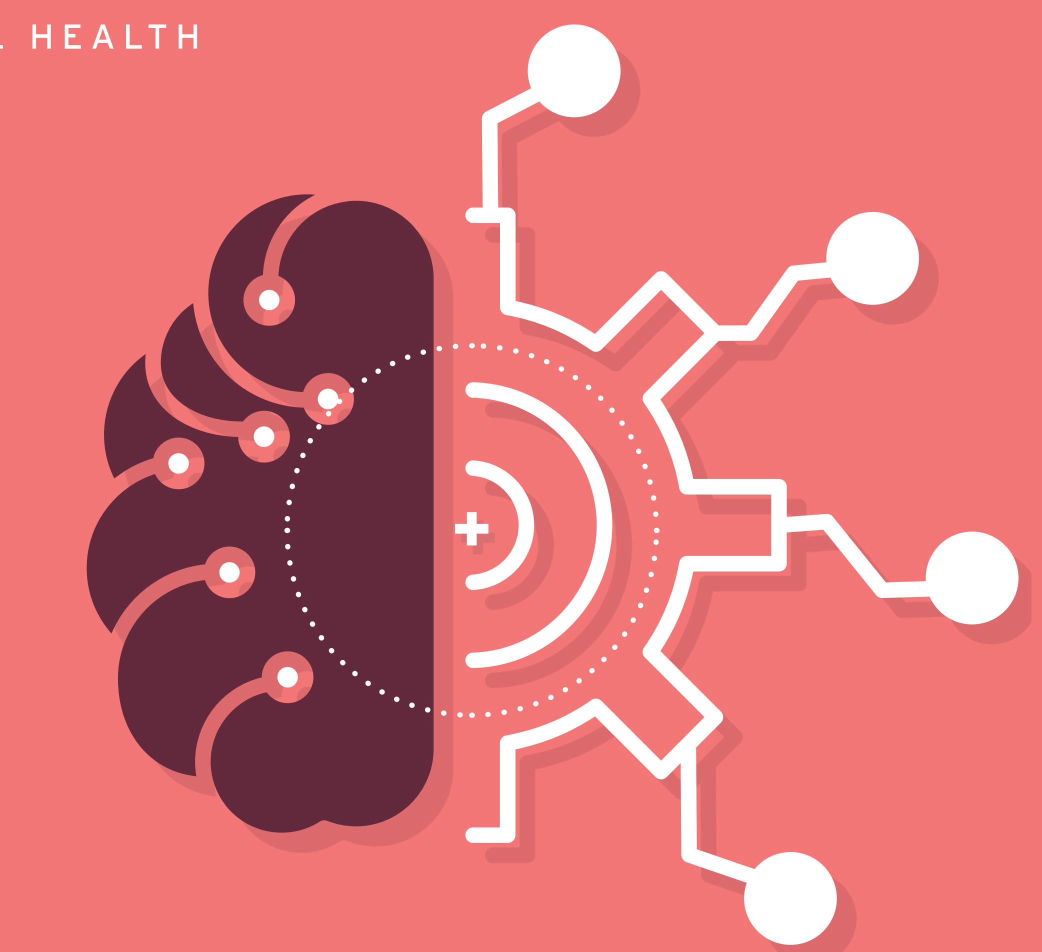
- *a positive and respectful relationship between the doctor and patient*
- *the assessment of a patient's illness, needs and goals*
- *the assessment of a patient's knowledge, motivation, capacity and support systems*
- *strong patient education and utilisation of motivational skills*
- *shared decision-making strategies.*

Determining a patient's ability and capacity to engage in their healthcare, understand their condition and its implications, make prescribed lifestyle changes and adhere to medication regimens and to treatment or management plans are already fundamental aspects of the general practitioner – patient relationship.

However, this work needs to be better resourced, so as GPs we can more fully support our patients to improve their health outcomes. The remuneration structure for attendances needs modification so the additional time required with patients on activities such as this are not devalued. We could also be better supported with ready access to tools, integrated into our clinical software, for assessment, behaviour guidance and improvement monitoring. This should all be backed by a model of blended funding that rewards both the facilitation and delivery of improved outcomes.

The AMA understands that enhancing patient activation is on the reform agenda and is in principle supportive of this, provided it reinforces the centrality of general practice, is appropriately funded and utilises codesigned and validated measures that are integrated within clinical software.

MENTAL HEALTH



LESS TALK, MORE ACTION REQUIRED ON MENTAL HEALTH

Much more needs to be done to ensure that government expenditure and reform of the mental health system is sustainable, effective, patient-centred and based on the best available clinical advice.

REPORT: **DR DANIELLE McMULLEN**
CHAIR, AMA FEDERAL MENTAL HEALTH COMMITTEE

- Clinical expertise should be at the centre of all mental health service delivery.
- It was disappointing to see nothing in the Federal Budget to inject much-needed investment into our public health system, particularly emergency departments and public psychiatry services.

The AMA Federal Mental Health Committee is pleased to see mental health at the forefront of the Federal Government's agenda. However, while the $2.3 billion in funding announced in the May Federal Budget sounds significant, we are worried that clinical perspectives are lacking, with very little (if any) of this funding going to existing services.

The Federal Budget offered an overall investment of $248.6 million into prevention, resilience and early intervention but the meaning of true prevention seems to have been lost. The AMA would have liked to see further investment into the broader determinants of mental health and wellbeing, such as welfare, poverty reduction and climate change.

The AMA is disappointed to see so much money being invested into new digital mental health platforms as compared to a lack of investment into existing mainstream mental health services, which continue to struggle under increased demand for services. The role of GPs and psychiatrists under these new models of care is yet to be established, with particular regard to referrals, treatment plans and medication.

The AMA believes that the best models for mental health care require long-term investment into the care and ongoing treatment of people experiencing mental ill-health, which will go some way to reduce suicide. One-on-one care with a trusted clinician is the most effective way to provide mental health care. The AMA emphasises the important role psychiatrists play in treating acutely unwell people. While we welcome the investment of $11 million to support 30 new psychiatry training places, a substantially higher number of psychiatrists are required to meet current need – even more in rural and remote areas.

It was also disappointing to see nothing in this Budget to inject some much-needed investment into our public health system, particularly emergency departments and public psychiatry services, which often see the most complex and unwell mental health patients.

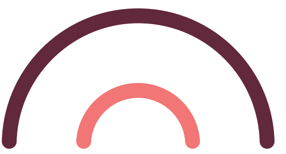
Psychiatrists and GPs on the AMA Mental Health Committee agree that clinical expertise should be at the centre of all mental health service delivery. We support increased investment into multidisciplinary mental health care teams, but we are disappointed this funding was not directed towards general practice and psychiatry clinics. We support the increased investment into after care for people who have attempted suicide. The AMA recommends, however, that after care is at its most effective when being provided by the clinical teams taking care of the patient. If this care is routinely outsourced, there is a risk of further fragmentation of care.

The mental health workforce is a welcome focus in this Budget, however, we are worried that there is not adequate funding allocated to support the existing workforce as well as create new resources for the expanded Head to Health and Headspace centres. We suggest adult mental health centres would be best vertically integrated with other public mental health service providers and well-connected to general practice, to ensure better coordination of care for mental health patients.

The AMA is disappointed that more funding was not allocated to patients with complex mental health needs, who currently suffer in an under-resourced, fragmented system.

We think there is more work to be done to ensure that government expenditure and reform of the mental health system is sustainable, effective, patient-centred and based on the best available clinical advice.

> *The AMA would have liked to see further investment into the broader determinants of mental health and wellbeing, such as welfare, poverty reduction and climate change.*



PROFESSIONAL DEVELOPMENT

EMERGING LEADER PROGRAM

TOMORROW WILL BE DIFFERENT. WILL YOU?

What is it?

The Emerging Leader Program is a professional development course for aspiring leaders in medicine. The program is designed to support early career doctors to develop skills and strategies for enacting leadership in their everyday work, as well as preparing them to step into leadership positions in the future.

Who is it for?

The program is designed for interns to registrars (PGY1-8) who are looking to develop their leadership capabilities for current or future leadership roles.

How does it work?

The program is delivered in a series of four webinars and a group action learning tutorial across six weeks. The webinars are highly interactive including expert presentations, group discussions, reflections and skills practice in small groups. Readings and resources will be provided for each webinar and participants will work on three personal action plans: a personal leadership development plan, a self-care plan and a professional network plan.

The program is run by Dr Anna Clark (PhD), AMA Victoria's Leadership Consultant and Coach with substantial experience in Europe, Singapore and Australia.

What content is covered?

- Who am I as a leader? Finding purpose, values and identity
- Effective leadership skills and practices in collaborative environments
- Leadership fundamentals: self-awareness, communication, motivating and influencing others
- How to create psychological safety at work
- Effective team communication: communicating vision, expectations and effective team norms
- Leading productive discussion and decision-making
- Giving effective feedback, navigating difficult conversations and conflict
- Role models, mentors and sponsors: how to create and sustain effective professional networks
- Leading sustainable change: how to lead change and innovation and overcome roadblocks
- Self-care and wellbeing: how to lead a sustainable career.

COST

AMA Victoria Member $903 + GST

AMA Interstate Member $1197 + GST

AMA Victoria Referral Partner $1638 + GST

Non-Member $2100 + GST

DELIVERY

Dr Anna Clark, a leadership development consultant and coach.

INTAKES

Click below to find out more about our 2021 / 2022 intakes.

HOW TO BOOK

You can enroll via the AMA Victoria website or click on the link below.

Intakes for 2021 / 2022

Enrol with the AMA Victoria Professional Development Team

IT'S NOT JUST WHAT YOU KNOW, IT'S WHO YOU KNOW

The importance of strong professional relationships and networks

REPORT: **DR ANNA CLARK PhD**
AMA VICTORIA LEADERSHIP CONSULTANT & COACH

Our professional relationships and networks provide knowledge and access to learning, career opportunities, mentors and sponsors and a buffer against disengagement and loneliness, which helps maintain our health and wellbeing.

We are often so focused on our individual contribution towards a goal – to share our expertise and experience – that we can forget about connecting with others and the powerful advantages and benefits this brings. Our professional relationships and networks provide knowledge and access to learning, career opportunities, mentors and sponsors and a buffer against disengagement and loneliness, which helps maintain our health and wellbeing.

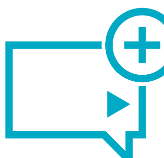
Being able to review and reflect on your own network is an important leadership skill. It allows you to identify where your network is strong and supportive and where you might need to make new relationships and strengthen existing ones to feel the benefits of this support structure across your career.

In a highly-specialised field such as medicine, the process of building a diverse network to support leadership development and career management can easily fall off the radar and be neglected. Networks can become narrow, restricted to a workplace(s), or to a chosen specialty field and typically, they are also often heavily weighted in medicine, with limited access to other industry sectors or professional fields.

Networks can serve different needs at different times and at different points in a career. In early career, they provide role models, mentors and sponsors, which are important for career advancement and satisfaction. In mid-career, thinking about our professional colleagues and networks is important for delegation, building strong teams, recruiting and developing high potential people, as well as continuing to benefit from strong role models, mentors and sponsors. For senior leaders, networks continue to support the career pathway – even after retiring from practice – and support the development of others progressing into senior roles, providing the pipelines and succession plans for future success.

However, this is bigger than professional development. Strong relationships protect us from disconnection and loneliness at work. So increasing our awareness of our relationships and investing in their care is important work.

▶ For more on what strong professional relationships and network look and feel like and how they support career and leadership development read this Stethoscope article.



Click here for information on AMA Victoria's leadership coaching programs

HOW TO IMPROVE YOUR PROFESSIONAL NETWORK

–

From my experience working with leaders across all career stages, creating a drawing of your professional network is an effective way to start. Draw your network map by locating everyone who is significant and important to you professionally. The purpose of this is:

1) For this to be self-affirming, to remind you of your 'tribe' out there and who you can reach out to.

2) To highlight where you might want to strengthen and extend your network to increase the strong connections and their diversity by including people in different roles, areas, workplaces, locations and experience.

You could note the following significant others: a role model, mentor, sponsor, supporter and trusted friend. The next step to reach out to these people – say "Hi", share what you're up to and ask them how they are. It's simple, but often so hard for us to prioritise.

References and resources for this article are included on our leadership resources page (see Professional relationships and network section). This article and podcast from the ABC explore the challenges to making and sustaining friendships in busy working lives.

SEIZE THE MOMENTUM TO REFORM AGED CARE

Reforming aged care in Australia to be based on the rights of the individual and moving away from a system that focuses on aged care providers, will be key to ensuring that older people live with dignity and respect.

REPORT **DR CHRIS MOY**
CHAIR, AMA FEDERAL MEDICAL PRACTICE COMMITTEE

It was in early March 2021 that the Royal Commission into Aged Care Quality and Safety (Royal Commission) handed down its long-awaited Final Report after two years of hearings, thousands of submissions by affected older people and their families and a bulk of independent research and reports.

In May, along with its Budget 2021-22 announcement, the Federal Government provided its response to the Royal Commission's recommendations. For health professionals working in aged care, the Budget and the Government's response produced some positive outcomes, but further work is needed to ensure they are implemented.

On 1 March, the Royal Commission's Final Report was handed to the Governor-General. With aged care in such a dire situation, it came as no surprise to many of us that the Commissioners gave 148 recommendations on how to fix the system. The AMA agreed with and supported the majority of the final recommendations. In fact, we have been calling for some of them for years.

Over the past two years, the AMA Federal Medical Practice Committee and Council of General Practice have been spearheading the development of submissions to the Royal Commission, in addition to a long history of aged care policy work. The AMA provided seven submissions to the Royal Commission and developed four aged care position statements as the basis of AMA aged care policy: Resourcing Aged Care; Innovation in Aged Care; Medical Care for Older People; and Palliative Care in the Aged Care Setting. All of them outline key AMA priorities: mandatory minimum staff to resident ratios in nursing homes; registered nurse availability 24/7; minimum qualifications for personal care attendants; increasing home care package availability; and increases in MBS rebates for GPs who visit aged care. Most of these were recommended by the Royal Commission.

Ahead of this year's Federal Budget, the AMA published a research paper titled *Putting healthcare back into aged care.* The paper summarises key AMA policy positions and provides cost-benefit analysis of their implementation. It found that $21.2 billion could be saved from avoidable public and private hospital admissions, presentations and stays from older people in the community and in nursing homes through better provision of primary care. This includes through access to the older person's usual doctor and availability of registered nurses (RN) on site 24/7.

In the 2021-22 Budget, the Government responded to some of the Royal Commission's recommendations. From October 2023, providers will be required to meet a mandatory care time standard of an average 200 minutes for each resident, including 40 minutes of RN time, with nursing homes required to have a nurse on site for a minimum of 16 hours per day. This is below what the AMA has called for, but is a step in the right direction. A major issue is that, as we all know, healthcare issues do not sit conveniently into a 16-hour window – it's a 24-hour job. This decision may result in ongoing failures in care in the hours where no RN is available and potential transfer of both the patients and costs to already overwhelmed hospitals.

The Budget also provided an immediate investment to into home care packages with an extra $6.5 billion to fund 80,000 packages. This too is a positive development and in line with AMA advocacy. Finally, the Budget has provided $365.7 million over four years on improving access to primary care and other health services, including $42.8 million to boost the Aged Care Access Incentive (ACAI) from 1 July 2021, to increase support for face-to-face servicing by GPs in nursing homes, effectively doubling the maximum yearly payment to GPs to $10,000. The AMA is doubtful that this measure alone will be enough to incentivise more GPs to work in aged care and will continue to advocate for more funding. Importantly, in its response to the Royal Commission's recommendations and in the 2021-22 Budget, the Government has committed to the adoption of a new human rights-based *Aged Care Act*, which will be central to any future reforms in aged care.

Older people, the same as everyone else, have human rights regardless of where they live. The right of patients in aged care to self determination and access to high quality care, including choice in obtaining high quality medical care, is a fundamental basic human right that must be reflected in the new Aged Care Act.

Reforming aged care in Australia to be based on the rights of the individual and moving away from a system that focuses on aged care providers, will be key to ensuring that older people live with dignity and respect.

This concerns us all, because respecting, protecting and promoting the rights of individuals improves the welfare of the whole community. How we treat our vulnerable older people reflects who we are as a society. The AMA will continue to fight for a system of which we can all be proud.

AMA's aged care advocacy is available here

Click here to the read the AMA research paper Putting healthcare back into aged care

PARTNER CONTENT

THE IMPACT OF PRIVATE HEALTH INSURANCE REFORM

The private health insurance industry has been undergoing a series of government reforms that aim to increase participation, by simplifying health insurance and making it more affordable for consumers.

It is imperative that we continue to support and encourage our dual healthcare system at a policy level, to maintain its high quality and global standing more broadly.

The reforms have been implemented in stages as waves, with the first wave now reaching two years since implementation. We've taken a look at the impact of some of these reforms and our results show there have been some successes, while some key objectives are yet to be met.

What did we find?

Consumers value more comprehensive cover. With all hospital policies now categorised as Gold, Silver, Bronze or Basic, we've found over 70 per cent of consumers with hospital cover now hold policies categorised as either Gold or Silver.

Many young Australians are receiving a discount on their premium. The optional offering of the age-based discount provisions, where 18 to 29 year-olds receive a discount on their hospital premium, has been adopted by just over half of health funds, often only on selected policies. Over 400,000 young Australians now receive a discount of between 2 per cent and 10 per cent on their hospital cover, with the significant majority benefiting from the highest 10 per cent discount.

8,500 people have accessed psychiatric care earlier. An exemption on the waiting period for psychiatric care is aimed to improve patient access to important mental health and drug and alcohol treatment services. So far, 8,500 people across Australia have benefited from this initiative to provide access to early treatment for acute mental health conditions.

An array of policy options still exists in the market. Over 150 hospital policy combinations are available for consumers to choose from, all ranging in cover and cost. Health insurers can add a 'plus' feature to their policies that cover more clinical categories than the minimum clinical categories required for a certain tier (excluding Gold). While adding flexibility for insurers, this variability does somewhat conflict with the government's objectives of simplicity and comparability, making it difficult for consumers to compare the value of different products.

What's to come?

Reform is either occurring or planned for several other areas of private health insurance. Some areas include the age limits for dependent children, home and community-based mental health and rehabilitation care, prosthesis pricing and the transparency of out-of-pocket costs. The government together with all stakeholders must continue to focus on affordability and access while not sacrificing quality health protection. This last year, especially, has highlighted the importance of access to our first-class healthcare system.

Doctors' Health Fund continues to advocate for reform that drives quality and access for all Australians.

All figures and insights are current as of May 2021. References available from the Editor upon request.

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RURAL GENERALISTS AND THE CPD CHALLENGE

The ability for doctors in rural and remote Australia to prove competency objectively is important and will become more relevant as rural generalist medicine matures as a specialty.

REPORT: **DR MARCO GIUSEPPIN**
CHAIR, AMA FEDERAL COUNCIL OF RURAL DOCTORS

As the National Rural Generalist Pathway begins to gather steam, it is imperative to look at how a rural generalist fits into a complex system of medical education, credentialing and continuing professional development (CPD).

If we look at the Collingrove definition of a rural generalist, that is, a practitioner who is predominantly a GP but with skills in emergency care and one or more advanced skill disciplines, we are then forced to ask the question – how do we prove that these clinicians are up to the job? How do we ensure that they meet the standards and ongoing professional development required to provide quality care to our rural and remote communities? And how does a clinical governance professional resolve this issue?

At first glance, one looks at this issue and thinks the solution is simple – "There's a diploma for that!" – the last five years have seen the proliferation of diplomas from various subspecialty colleges. These include diploma qualifications in obstetrics, emergency medicine and prehospital and retrieval medicine, with upcoming diploma qualifications in anaesthesia and psychiatry in the works. Each of these qualifications is renewable and comes with their own separate college membership and CPD requirements. Hospital credentialing bodies then proceed to make the diploma the 'minimum standard' for practise in a given field. So, problem solved!

However, while this solution sounds fantastic on paper, underlying the concept are issues that demand and warrant attention.

The first issue is that of grandfathering. How do you address those already in practise in a particular field? This is an issue that tends to disproportionately affect early career doctors (usually 1-10 years post-fellowship) who face the prospect of needing to re-train to do a job they are already doing safely. How do you manage those with experience and current CPD but without the piece of paper? If you throw up roadblocks in this process, a large proportion of newly minted rural generalists will leave or opt to retrain in non RG specialties.

The second issue is that of CPD and fees. How many college memberships should a rural generalist maintain in order to practise? How many fees should they have to pay? How many months a year must a rural generalist spend on CPD for multiple different organisations at a loss to the community they serve?

The recently-fellowed rural generalist cohort is large, as it is a relatively new specialty. In a world where time and case numbers are assumed to be markers of competence, expectations around CPD and maintenance of skills dictated from and by subspecialists in the city quickly become unrealistic.

The end result of this is that these talented rural generalists opt for two pathways. Many will return to the centrepiece of rural medicine, which is the provision of good general practice care. A second cohort who enjoy working in the hospital setting will opt to retrain as non-GP specialists in order to avoid the unrealistic, multiple CPD burdens associated with a rural generalist skillset. Both of these options are a loss to rural medicine, as these cohorts of talented and skilled doctors lose the ability to practice their full scope as a rural generalist. A combination of poor clinical governance practise and an obsession with silos and diploma qualifications leads to them picking up their bat and ball and moving to greener pastures elsewhere.

It is important to note, despite all I have said, that the presence of diploma qualifications is not necessarily a bad thing. The ability to prove competency objectively is important and will become more relevant as rural generalist medicine matures as a specialty.

The two rural generalist colleges approach this problem differently, but this is not necessarily to the detriment of trainees who will enjoy greater choice as to which pathway to pursue. What is needed urgently is a discussion amongst our profession about the how we ensure that those who practise safely are not left out. It is time that we consider alternatives such as a competency-based framework as opposed to time in an accredited subspecialty position as the sole criteria for determining who is safe to practise.

If we fail to do this, and instead opt for misunderstanding to drive the process, we stand to lose our pioneering generations of rural generalists forever. We simply cannot and must not allow this to happen any longer. Rural and remote Australia deserves better.

THE ART OF DIVINING COMPARABLE VALUE

REPORT **JARROD MCCABE**
DIRECTOR, WAKELIN PROPERTY ADVISORY

WAKELIN PROPERTY ADVISORY IS AN INDEPENDENT BUYER'S AGENT SPECIALISING IN ACQUIRING RESIDENTIAL PROPERTY FOR INVESTORS

The dance between buyer and vendor when striking a mutually acceptable price on a property can sometimes be tedious and trying. This is particularly true in rising markets, where prices are based less on longer-term fundamentals and more on surging demand.

For buyers, it is easy to be exhausted by opposing impulses. On one hand, there is the hope of securing that dream home or investment for a reasonable price; on the other, the buyer fears being the fool who overpays or whose over-crafty low-ball offer sees them miss out. The vendor faces a mirror image of these concerns and each party will often spend more time than is healthy trying to second guess the mind and stratagems of the other.

The most important action a participant can undertake to support their negotiation position is to have a clear sense of the market value of the property in question. Knowledge is truly power. Typically, this involves gathering the results of recently sold similar or comparable properties. Naturally, adjustments are made to account for differences in the properties – such as location, aspect and quality of improvements – and time elapsed since the date of the comparable transaction.

The process is as much art as science and is of course never definitive. As mentioned, it is harder still when a market is on the move – be it up and down. In periods of strong growth or contraction, it is as vital to understand the rate of change of prices as the prices themselves.

The ideal approach is to have closely watched the target market for several months, as the price trend usually emerges. To calibrate value and where it's flowing, nothing beats tracking the ebb and flow of supply and demand by recording new listings and sales, attending open for inspections and auctions and assessing property features, the size and mood of the crowds and the disposition of agents.

Although all this involves substantial time on the road, those trying to divine prices are now fortunate enough to have access to quality tools online to make the intelligence-gathering campaign easier. One can download the latest weekend's auction results. Punch in your area of choice in the 'sold' section of the site and you'll receive several months of recent sales including prices and the estate agent's original listing. This allows investors to assess trends in prices over time as well as determining how differences in features between properties can affect value.

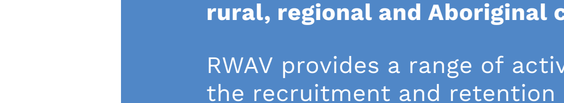
Another useful tactic is to view a home's historic sale and rental prices. It's a helpful way to benchmark whether a property has a history of performance in terms of capital growth and – if it was owned by investors – delivering an appropriate rental yield.

Of course, care must be used with all these online instruments. Data can be skewed by an unknown factor such as an above or below fair value transaction between family members or an expensive value-adding renovation flattering growth numbers.

Nevertheless, an intelligent use of data in combination with pavement pounding will set you up to negotiate well. Diligent and thorough reconnaissance now leads to smarter property investment decisions and long-term financial growth in the future.

For more property insights click here to listen to Jarrod's podcast, Rewarding Property Decisions.

FOR MORE INFORMATION:
(03) 9859 9595 WAKELIN.COM.AU



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FED FACTS: AMA VISION FOR AUSTRALIA'S HEALTH

REPORT DR OMAR KHORSHID
AMA FEDERAL PRESIDENT

> It's easy for governments to say they are undertaking "record spending" on hospitals... It's a smokescreen and I'm calling it out.

This is an excerpt of a speech delivered to the National Press Club by AMA Federal President, Dr Omar Khorshid on 9 June 2021.

This is my first address at the National Press Club, but not the first given by an AMA President. In fact, every year an AMA President stands here, at this lectern, and tries to convince you – our nation's media, our policy makers, ministers, governments and parliaments that health really is the best investment we can make in our society and for our economy.

We were always vying for attention among the other portfolios – defence, national security, industry. Times have changed. Health is now a key consideration of the Prime Minister, Treasurer and cabinet.

In any pre-COVID period, I'd also be following in the well-trodden steps of past Presidents calling for more medical practitioners to be involved in policy making. They are at the coalface; they should be given a voice in policy decisions that shape our country's health services.

Now, arguably, the nation's Chief Health Officers – doctors – are the key policy makers. One of them is now also the Secretary of the Federal Department of Health. A doctor running the health department. What will they think of next?

But there are things we must keep from this experience. The focus on health, the listening to experts, the overcoming of entrenched bureaucratic hurdles, must be retained.

This evolution in health policy is also our best defence against future pandemics – be they similar to COVID-19, or the pandemic that we've grown accustomed to and all too complacent with, chronic disease.

That's why today I'm not going to talk anymore about COVID. Instead, I want to lift our eyes beyond the immediate and focus on a healthier future for all Australians. I want to propose a goal of Australia becoming the healthiest country in the world. We're not number one and with our increasing burden of chronic disease – obesity in particular – we risk sliding down the rankings.

If this new paradigm of quicker decision-making is going to be utilised effectively in the AMA's goal of becoming the healthiest country in the world, we're going to need a plan. So today I'm releasing the *AMA's Vision for Australia's Health*. It is a detailed policy-based strategy and I believe we can start to implement it right now.

The beginning point of all reform should be safe, high quality, patient-centred care. Our plan is built around a set of core principles and covers five pillars of detailed policy reform.

GENERAL PRACTICE

Our first pillar of health reform is general practice. If we are to have any hope of stemming the tide of chronic disease in our nation, we need to bolster this first line of defence. Chronic disease dominates the Australian health landscape, contributing nearly two-thirds of the overall burden of disease and data suggests 67 per cent of Australian adults – that's 13.4 million – are obese or overweight. This translates into enormous direct healthcare costs in managing diabetes, heart disease and cancer, the biggest killers in our society.

For Aboriginal and Torres Strait Islander peoples these figures are even higher, at 74 per cent of adults and 38 percent of children who are overweight or obese.

According to AIHW data, 7 per cent of all hospitalisations are due to 22 preventable conditions – preventable conditions that could often be managed by general practice. In reality its likely to be much more than that. We can, and must, do something about this.

We also have a rapidly ageing population and whilst currently people over 65 represent only 16 per cent of the population, they account for 50 per cent of all public hospital admitted patient days.

Critical to dealing with the healthcare needs of older Australians – especially if we want to stop the flow of unnecessary hospital transfers – is to ensure greater access to GPs. That is why the AMA will continue to campaign for Medicare to better support GPs to look after patients in aged care facilities, so that more older Australians can maintain access to their usual GP once they enter an aged care home.

Primary healthcare professionals control or influence approximately 80 per cent of healthcare costs, with 83 per cent of patients seeing a GP each year. Yet spending on general practice accounts for only 8 per cent of total government health spending. There is a huge opportunity to save on expensive hospital care by investing in primary care. We know, when we back our health system it delivers. Now is the time to back our general practitioners.

PUBLIC HOSPITALS

Our public hospitals are in crisis. Every year the AMA's Public Hospital Report Card takes the Government's own data and reflects it back, for all to see. Just once it would be nice to have a reflection that looks better than the last, but it doesn't. It never does.

Elective surgical waiting lists continue to blow out – with patients waiting longer than ever before for important elective surgery. We're supposed to improve performance year on year – but unfortunately we continue to go backwards.

Our bed ratio per 1,000 people aged 65 years or older is at its worst – having declined for 26 consecutive years. Emergency department wait times are also the worst we've had since 2013-14.

And my members report dangerous conditions at the frontline. Doctors and nurses are unable to deliver the care that patients deserve.

It's easy for governments to say they are undertaking "record spending" on hospitals. You can spend a record amount and still go backwards. How? Because of inflation and because the population is growing and ageing, with increased health needs. It doesn't mean you are spending more per person, or on improving performance, or increasing capacity, or fostering integration with the rest of the health system, or stopping avoidable admissions. It's a smokescreen and I'm calling it out.

The funding agreement we have today doesn't even index against health inflation, which combined with the cap, has resulted in $32.4 billion being stripped out of the hospital system since 1 July 2016.

Hospitals aren't a federal issue, nor a state issue – they are a national issue. They need a national response. A new funding agreement, driven by and agreed to by National Cabinet. It is time for a funding agreement that improves not only efficiency, but performance. One that helps doctors treat patients on time. One that funds hospitals to improve not penalise them when they fail. One that funds them to be better, not just busier. And one that doesn't leave people in the back of ambulances – close to treatment, but far from safe. We can fix our hospitals, we know what we have to do.

It's time to fund performance improvement, increased bed capacity, targeted programs to avoid unnecessary admissions and a fair cost sharing agreement that allows the growth that is necessary to meet the immediate health needs of Australians.

During COVID-19 Australia has built a better way of making health policy. Let's build the same positive change for the rest of the health system. Let's make Australians the healthiest people in the world.

Dr Khorshid's speech also covers the private health system, future planning through medical research and technology, mental health support for doctors, improving healthcare access in rural and remote communities, and the need for a sugar tax.

Click here to access the full transcript

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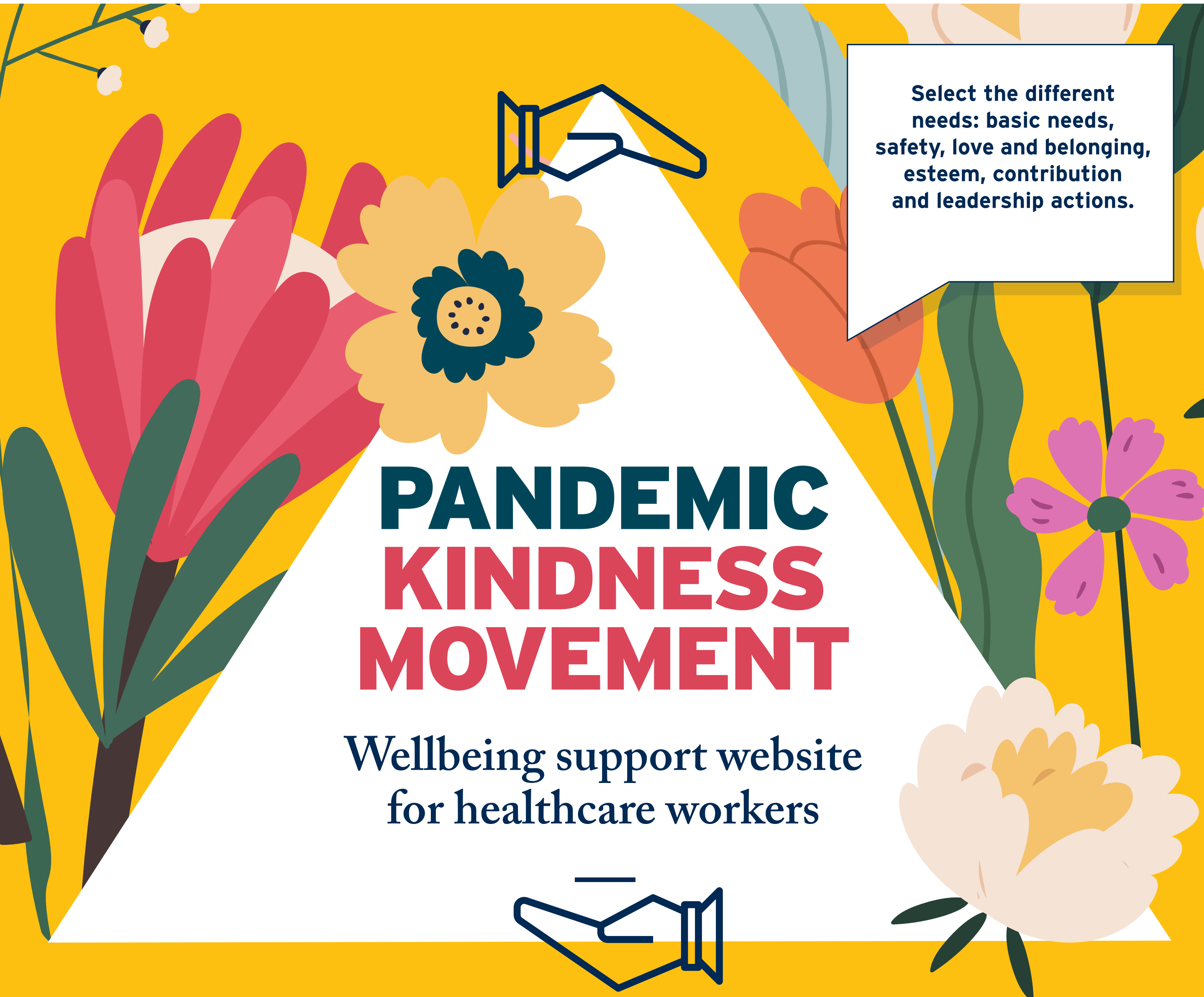

PANDEMIC KINDNESS MOVEMENT

Wellbeing support website for healthcare workers

Sparked by the extra challenges presented by COVID-19 last year, a group of clinicians across Australia established a wellbeing support website for healthcare workers. These clinicians have curated respected, evidence-informed resources and links to valuable services to support the wellbeing of the health workforce for the project dubbed the Pandemic Kindness Movement.

"We launched the website Pandemic Kindness Movement after five weeks of incredible work from clinicians and talented people across Australia coming together and investing in improving healthcare worker wellbeing for the long-term," A/Prof Jane Munro explained.

"It's been a labour of love amid the troubling times of COVID-19 and we've had a wonderful response to the website from healthcare workers from many different backgrounds."

A/Prof Munro, a paediatric rheumatologist at the Royal Children's Hospital, is one of the Victorian doctors behind the project, along with former Royal Australian and New Zealand College of Psychiatrists President, Dr Kym Jenkins.

The model for organising health worker support is based on Maslow's hierarchy of needs, with the pyramid representing these needs adapted to reflect the potential challenges of the COVID-19 pandemic on the health workforce.

Visitors to the website can explore the pyramid by selecting the different needs: basic needs, safety, love and belonging, esteem, contribution and leadership actions. Effective leadership is critical at all levels of the pyramid and is an additional layer represented in this model.

"We're excited that this resource will grow," A/Prof Munro said. "We would love for doctors to suggest resources to us via the email on the webpage.

Click here to visit the Pandemic Kindness Movement website

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CAN I HAVE THAT IN WRITING?

THE IMPORTANCE OF WRITTEN AGREEMENTS BETWEEN DOCTORS

REPORT NICHOLAS BLACKMORE AND ROD FELMINGHAM, KENNEDYS

Starting a new medical practice is an exciting time. You've taken the leap to set up your own practice with a small group of colleagues you know and trust. You all get along well and you share similar ideas about how a practice should be run. Why would you go to the trouble of hiring a lawyer and spending thousands of dollars to draw up an agreement to govern your relationship with your new business partners? Shouldn't a simple handshake agreement be enough?

Lawyers have a saying: *you don't need an agreement until, suddenly, you do.* The truth is that a handshake agreement probably is good enough, as long as your practice remains in this initial state of harmony. While everyone is getting on well and everything is going to plan, agreements sit untouched in drawers. Minor issues are easy to deal with while everyone is feeling generous and cooperative.

Unfortunately, as a medical practice grows and encounters obstacles, aspirations and circumstances can change and the harmony can wear thin. Sometimes it is an unexpected event that raises questions no-one thought about when the business began – this could be as minor as a disagreement over how to deal with a problematic employee, or as major as a doctor being found guilty of professional misconduct. Sometimes cracks appear because a practice is successful and business partners find that amounts of money that previously weren't worth arguing about gradually become contentious. All agreements come to an end eventually, one way or another. These are the situations in which a written agreement drafted by an experienced lawyer becomes invaluable.

Verbal handshake agreements can be just as legally binding as written ones. However, written agreements have two big advantages.

Firstly, a written agreement allows the parties to fix their agreement about how the practice should be run while they are still feeling positive and generous towards each other. It is relatively easy to reach agreement about how to handle potential problems in a business relationship in advance, when the problems are only theoretical in nature. Written agreements allow the parties to record their agreed position about how issues will be managed before they know which side of the problem they will find themselves on and self-interest takes effect.

Secondly, a written agreement prepared by an experienced lawyer will provide for a whole range of 'what if' issues that the parties might otherwise never consider, such as:

» What happens if a doctor decides to change their area of practice?
» What happens if a doctor fails to meet professional standards?
» What happens to a partner's interest if they become temporarily or permanently incapacitated or die?
» What happens if a partner becomes insolvent, is guilty of misconduct, or simply begins to neglect the business?
» What happens if a partner decides they want to leave and set up their own competing practice down the street?

These issues may not arise, but if they do, a written agreement ensures that everyone understands their rights and obligations and can avoid legal disputes which can easily cost 10 or 20 times more than the cost of preparing the agreement. Prevention is better – and substantially cheaper – than cure.

AMA Victoria has agreement templates that can be purchased to assist members with contract negotiations. For more information contact the Workplace Relations team on (03) 9280 8722.

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