THE SHOUT OUT EDITION

VICDOC

AMA VICTORIA

SUMMER 2024

SHOUT OUT

In Depth
with Dr Linny Phuong

Shout Out Awards
celebrating our
member recipients

Beating Buruli
with Prof Paul Johnson

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IN THIS ISSUE

Photography: Ernesto Arriagada
References to articles available from the editor on request.

REGULARS

FEATURE

WHAT'S NEW

adora fertility

Making the chance of growing a **family more affordable for every Australian**

We are a private clinic committed to high quality, specialist led fertility treatment without the premium costs. At Adora Fertility, we bulk bill the majority of Medicare-eligible expenses, so your patients can access private clinic excellence, 75% cheaper than full fee clinics. Our streamlined service model allows us to keep costs down without compromising on quality or the chance of success. Recognising that every patient journey is unique, we offer a wide range of services and personalised treatment plans. With minimal wait times, options for face-to-face or telehealth appointments, an interpreter available if required and a donor program, we are making it easier for all Australians to access quality fertility treatment.

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- Intrauterine Insemination (IUI)
- In Vitro Fertilisation (IVF)
- Intracytoplasmic Sperm Injection (ICSI)
- Frozen Embryo Transfer (FET)
- Donor Program
- Egg Freezing

Our Fertility Specialists in VIC

Dr Julie Whitehead
MBBS, FRANZCOG, MMed

Clinical Director (VIC), Fertility Specialist, Obstetrician & Gynaecologist

Dr Amy Feng
MBBS, MSurg (Adv Gyn), MRMed, FRANZCOG

Fertility Specialist, Obstetrician & Gynaecologist

Dr Stephanie Sii
MBChB, MRepMed, DRANZCOG, FRANZCOG, CREI

Fertility Specialist, Obstetrician & Gynaecologist

Melbourne
9-13 Flintoff Street, Greensborough VIC 3088

03 9109 1800 enquiries@adorafertility.com.au adorafertility.com.au

NEWS + REVIEWS

AMA Victoria President, Dr Jill Tomlinson speaks to Channel 9 after Peninsula Health was ordered to pay more than $300,000 in penalties for failing to pay overtime to a junior doctor, sparking hope for Victorian class action settlements.


BREAKING POLICE INVESTIGATION UNDERWAY AFTER BODY FOUND IN BUSHLAND NEAR SYDNEY AIRPORT

Health service to pay 'groundbreaking' $316,000 penalty for doctor's overtime

By Emily Woods - AAP | 4:59pm Oct 31, 2024

Tweet Facebook Mail

A health service has been ordered to fork out more than $300,000 in penalties for failing to pay overtime to a junior doctor, which has sparked hope for class action settlements.

Equity must be embedded in Ahpra's registration fee systems if it is to achieve its intended aims and promote a safe and flexible health workforce, writes AMA Victoria President Dr Jill Tomlinson for the Medical Journal of Australia.

Dr Jill Tomlinson, President of AMA Victoria speaks to the 3AW Breakfast Program after the front page of The Age reports that Victorian hospitals would share staff beds and radiology services under a proposed overhaul of the state's health services.

It's a good start but AHPRA must go further, says AMA Victoria's Dr Jill Tomlinson after AHPRA cuts rego fees by 30% for doctors on long-term leave.

VICDOC

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IN REVIEW: SUMMER READS

THE CHECKLIST MANIFESTO

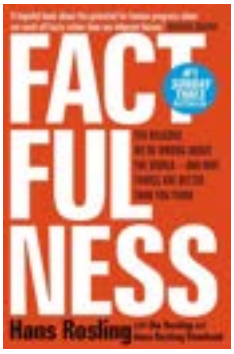
Atul Gawande (2009)

Atul Gawande is a well-known American surgeon, writer and public health researcher who makes a compelling argument for using checklists to improve safety and outcomes. Drawing on examples from surgery, medicine, and other high-risk fields, he shows how simple checklists can mitigate human error and ensure critical steps are taken. Emphasising that checklists are not a substitute for expertise but a tool that can support it by fostering consistency, reducing variability, and enhancing communication among teams, Gawande demonstrates how structured protocols can lead to better decision-making and fewer complications. In an environment where mistakes can be catastrophic, The Checklist Manifesto is a valuable resource for improving practice, reducing errors, and promoting a culture of safety.

QUIET

Susan Cain (2012)

Quiet: The Power of Introverts in a World That Can't Stop Talking explores the strengths of introverts and the challenges they face in an extroverted world. Author Susan Cain draws on psychology, neuroscience, and sociology to show how introverts excel in areas like deep thinking, creativity, and leadership, but often struggle in environments that prioritise outward social engagement and quick decision making. Cain provides practical advice for introverts on how to navigate extrovert-dominated spaces and encourages extroverts to appreciate the unique abilities of their introverted colleagues. Insightful and thought provoking, Quiet's work is helping to create more diverse and inclusive environments that appreciate, draw on and harness the full spectrum of human potential.

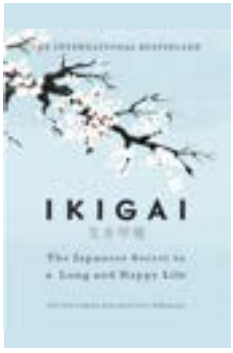


FACTFULNESS

Hans Rosling (2018)

Factfulness: Ten Reasons We're Wrong About the World – and Why Things Are Better Than You Think offers a refreshing perspective on global progress from Swedish physician, professor of international health and statistician Hans Rosling, with contributions by his son and daughter-in-law. Through data, storytelling, and critical analysis, Rosling challenges common misconceptions about poverty, health, education, and the environment. Factfulness identifies ten cognitive biases that distort our perception, and encourages us to adopt a fact-based worldview and think critically and objectively about global issues – a valuable resource for anyone seeking to understand the true state of the world and how we can shape a more optimistic and informed future.

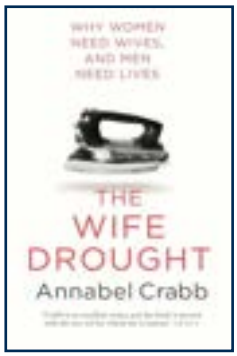
WE REVIEW THE SIX BOOKS SELECTED FOR OUR LATEST PODCAST SERIES ON LEADERSHIP AT THE DOCTORS' ROOM, BY HOST DR LINNY PHUONG.



IKIGAI

Héctor García + Frances Miralles (2016)

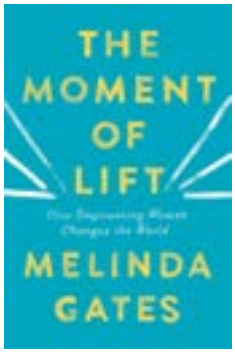
Ikigai: The Japanese Secret to a Long and Happy Life explores the concept of ikigai, a Japanese term meaning 'a reason for being'. Drawing on interviews with residents of Okinawa (famously home to some of the world's longest-living people), the authors examine how finding purpose in life can lead to greater happiness and longevity. Blending cultural insights with practical advice, Garcia and Miralles encourage readers to align their passions, talents, needs, and rewards and argue that living with purpose, engaging in meaningful activities, and fostering deep connections can lead to a more fulfilling life. Ikigai is a thoughtful guide to seeking balance, wellbeing, and lasting contentment, and offers valuable lessons for personal and professional growth.



THE WIFE DROUGHT

Annabel Crabb (2015)

Noteworthy as the only Australian-authored book on Linny's podcast reading list, The Wife Drought: Why Women Need Wives, and Men Need Lives is a sharp and witty exploration of gender inequality, focusing on how traditional gender roles impact women's careers – including the careers of women in healthcare. Written by Walkley-award-winning writer, journalist and political commentator Annabel Crabb, the book unpacks the imbalance of support that many women face, particularly in their professional lives, highlights the systemic nature of gendered expectations and calls for change. An engaging narrative offering valuable perspective for anyone keen to understand more about the complex dynamics of gender, work, and family in modern society.



THE MOMENT OF LIFT

Melinda Gates (2019)

The Moment of Lift: How Empowering Women Changes the World is about the transformative impact of empowering women and girls by philanthropist Melinda Gates, and her first book. Drawing on her extensive work with the Gates Foundation, Gates illustrates how investing in women's health, education, and economic opportunities can catalyse broader social progress. She highlights stories of women overcoming barriers, examines the systemic challenges women face and emphasises the importance of collective action and policy change to creating lasting impact. With a focus on tangible solutions, it is a call to action for global leaders, policymakers, and individuals to prioritise gender equity as a cornerstone of sustainable development.

READ MORE ABOUT LINNY PHUONG AND HER WORK ON PAGE 8

IN DEPTH WITH DR LINNY PHUONG

Dr Linny Phuong is a paediatric infectious diseases physician, PhD candidate, clinical tutor, charity founder and board director, and a parent. Herself the daughter of refugees, in 2010 Linny started The Water Well Project, a health promotion charity that has gone on to positively impact more than 25,000 individuals from migrant, refugee and asylum seeker backgrounds. Linny is the host of six new leadership-focused episodes for AMA Victoria's podcast, The Doctor's Room, and is a monthly guest on ABC News Breakfast TV. We caught up with Linny to talk health literacy, cultural safety, introversion, and podcasts.

INTERVIEW BY VANESSA MURRAY

IN DEPTH WITH DR LINNY PHUONG

Q1 /
WHAT IS THE WATER WELL PROJECT?

The Water Well Project is a not-for-profit organisation which delivers free, interactive and inclusive health education sessions to community groups from migrant, refugee and asylum seeker backgrounds. Working in partnership with community groups, the organisation facilitates tailored health education sessions, with its many volunteer healthcare professionals. To date, The Water Well Project has delivered over 1,700 health education sessions to over 27,000 direct participants in Victoria, new South Wales and Tasmania.

Q2 /
HOW DID IT COME ABOUT?

The Water Well Project started 14 years ago, with a kickstart for one of its projects from AMA Victoria. I was an intern at the time and with a friend had delivered an informal health education session to the Sudanese Homework Club. A chance party conversation with a friend who worked at a major refugee support organisation led to a formal meeting about formalising and scaling our health education session. Their organisation had been involved in a recent needs analysis of the refugee populations which identified addressing health literacy as a top priority.

The Water Well Project started 14 years ago, with a kickstart for one of its projects from AMA Victoria.

Q3 /

WHAT HAS YOUR CAREER JOURNEY BEEN LIKE?

Prior to studying postgraduate medicine, I was a pharmacist. In this work, I was able to see firsthand the value of primary healthcare and the value of being able to impart knowledge. One of the many pharmacies where I was based afforded me the opportunity to deliver local community health education sessions. So, I was exposed to this method of health education very early on in my career and could see the very translatable impact it could have. Fast forward to my intern year and I was at a metropolitan hospital serving a lower socioeconomic population. Many patients reminded me of my parents, with low English language and low health literacy levels. I was meeting patients who could have avoided a hospital visit if they had a greater understanding of preventative healthcare or knew how to access earlier intervention to avoid complications of their medical diagnoses.

Q4 /

IS THE AUSTRALIAN HEALTHCARE SYSTEM DOING ENOUGH TO SUPPORT MIGRANT POPULATIONS?

It is important to recognise that people from migrant, refugee and asylum seekers backgrounds all represent different groups with different healthcare rights. Many of these groups experience barriers to accessing healthcare services due to language and unfamiliarity with the Australian healthcare system. As healthcare professionals, we could do better in providing culturally appropriate services. Where possible, we should support programs which improve community health literacy and work on improving systems to ensure simple navigation regardless of a person's language or country of origin. A simple example demonstrating this is the outward appearance of a hospital. Many people would be forgiven for driving past some of our major metropolitan hospitals and not realising they're hospitals because of their uniform corporate look. Then, upon entering a hospital, signage is in English and sometimes wards are not intuitively named. Even when simple English is understood, this just adds to the complexity.

Learn more about not-for-profit organisation The Water Well Project

Q5 /

WHY IS THIS WORK IMPORTANT?

We are given the privilege of being invited into community spaces to talk about health topics. This establishes a safe space for communities to ask questions. As healthcare professionals, we hear first-hand about some of the beliefs, stigmas and assumptions. Within the hospital setting, we may assume that these diverse communities don't attend their antenatal appointments because they don't place enough importance on these appointments but, if you consider it from their perspective, when back in their home country, pregnant women would often exist outside of a hospital setting and not have checkups let alone blood tests or glucose tolerance tests, and then deliver their baby at home. I think we sometimes assume that everyone comes from the same knowledge and experience, and this puts everyone at a disadvantage.

Q6 /

IF YOU COULD CHANGE OR IMPROVE ONE THING ABOUT THE WAY WE DELIVER HEALTHCARE, WHAT WOULD IT BE?

I'd like to see a real focus on improving the cultural sensitivity and competence of our healthcare practitioners, and the system brought more broadly. We need to consider the perspectives of people who haven't experienced a western healthcare system before, those who have lower levels of English and those with lower levels of health literacy. On a day-to-day level, it might just be asking open questions to understand an individual's beliefs, and not making assumptions. In considering the greater picture, we need to remember that everyone we encounter holds diverse knowledge and experience. We as practitioners need to be open to keep learning too.

Q7 /

YOU'VE RECENTLY COMPLETED A SERIES OF PODCASTS FOR AMA VICTORIA. TELL US ABOUT THAT!

There are six podcasts in the series, each one is an in-conversation style interview with a fellow doctor. This year, I'm undertaking the Williamson Community Leadership Program through Leadership Victoria, which has allowed me to reflect on how I show up in the world.

My objective for these podcast episodes is to highlight leadership topics relevant to medicine. I chose six books off my bookshelf to pull themes from, and then used these themes as springboards for the interviews. Each podcast is about 30 minutes long. I've learned that making a good podcast involves a lot of behind the scenes work! This has been many months in the making, and I'm excited that AMA Victoria is launching the podcast episodes this month.

As a proclaimed introvert, one of the episodes features a favourite book of mine, Susan Cain's Quiet, which discusses qualities of introversion and conversely extraversion. Hopefully this episode will be an insightful conversation for all listeners.

LEADERSHIP WITHIN MEDICINE

Read our reviews of the six books Linny selected for the podcast series on page 6

THE DOCTORS' ROOM LEADERSHIP SERIES (NEW!)

RELEASED FEBRUARY 2025

IT'S A GREAT LISTEN!

Dr Linny Phuong is the host of six new leadership-focused episodes in AMA Victoria's podcast, The Doctor's Room. In each episode, you can listen to Linny in conversation with a doctor around broad themes of leadership within medicine.

EPISODE #1

The Checklist Manifesto by Atul Gawande, with Dr Stephen Warrillow

EPISODE #2

Quiet by Susan Cain, with A/Prof Kerryn Ireland-Jenkin

EPISODE #3

Factfulness by Hans Rosling, with Dr Georgia Behrens

EPISODE #4

Ikigai by Hector Garcia and Frances Miralles, with Prof Rob Moodie

EPISODE #5

The Wife Drought by Annabel Crabb, with Dr Robyn Silcock

EPISODE #6

The Moment of Lift by Melinda Gates, with Dr Rangi De Silva

AMAV SHOUT OUT

We celebrate our member recipients of the inaugural AMA Victoria Shout Out awards, which recognise doctors and teams going above and beyond in their delivery of quality healthcare and professionalism.

SERIES VANESSA MURRAY

MEMBER RECIPIENTS OF THE AMA VICTORIA SHOUT OUT AWARDS, AND THEIR NOMINATORS

DR LINCOLN J LIM
DR ZOE RUSCOE

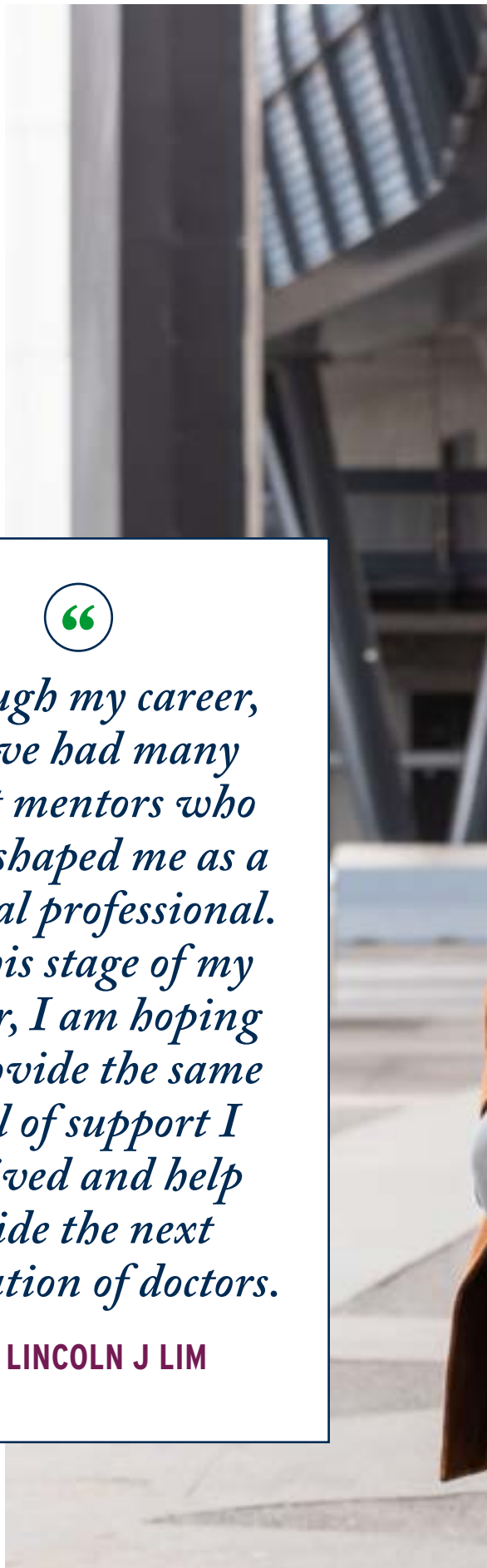
DR KEETH MAYAKADUWAGE
DR CAROLINE BOLT

DR STEPHEN FLEW
DR TERENCE AHERN
& DR BILL DONOGHUE

DR GABY BOLTON
DR JILL TOMLINSON

DR LISA MIFSUD for
ANDREW PLACE CLINIC
DR MELISSA CAIRNS

SHOUT OUT #1
DR LINCOLN LIM

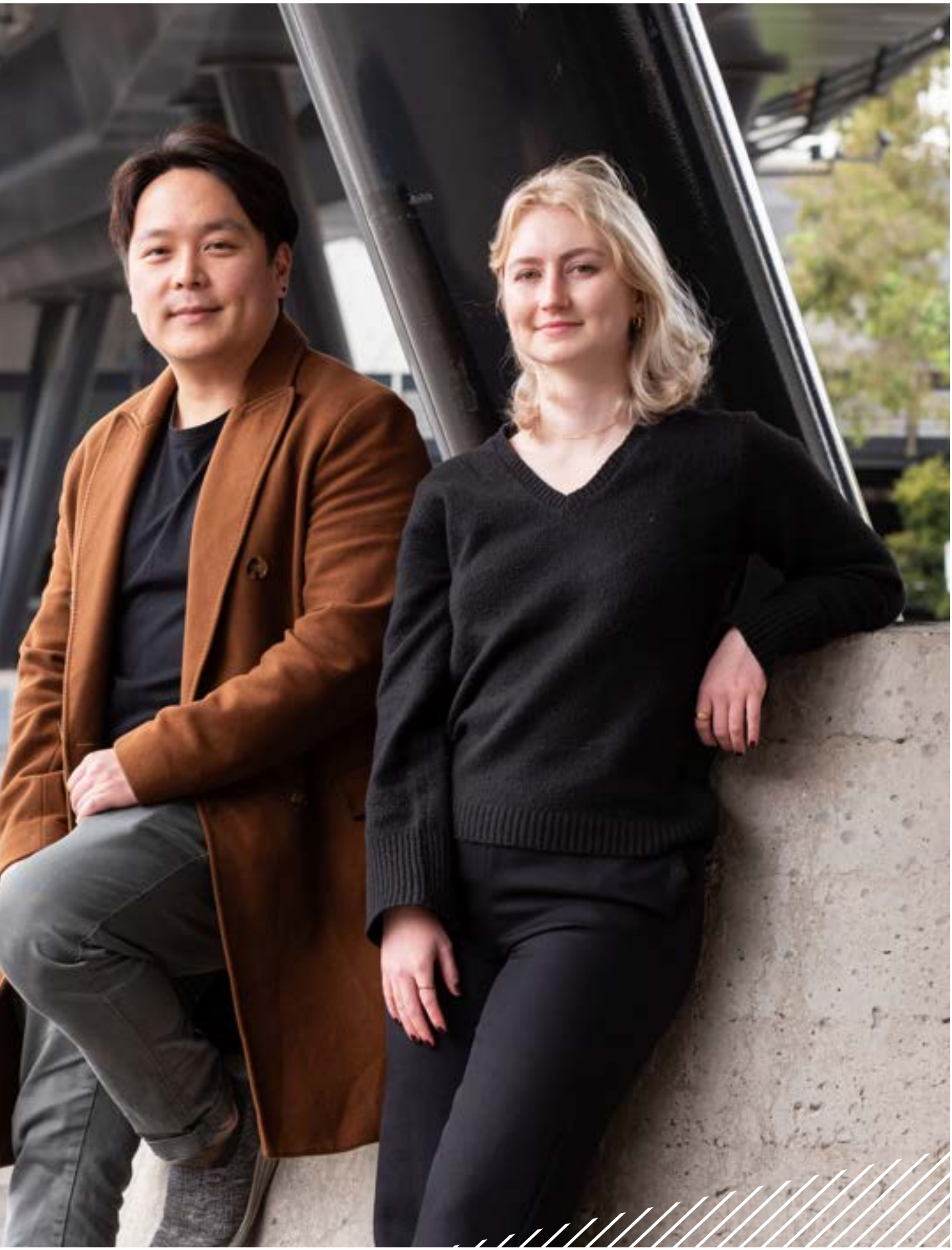


DR LINCOLN J LIM

DR ZOE RUSCOE

Dr Lincoln J Lim (MBBS (Hons), DipFMed, DipMSK, DFSEM (UK), AFCHSM, FRSPH, FRANZCR) is a consultant radiologist at Western Health, a clinical senior lecturer in the Department of Surgery at the University of Melbourne, and an AMAV State Councillor. Lincoln was nominated for a Shout Out by Dr Zoe Ruscoe (MD), a surgical resident at Western Health.

> *Through my career, I have had many great mentors who have shaped me as a medical professional. At this stage of my career, I am hoping to provide the same level of support I received and help guide the next generation of doctors.*
>
> **DR LINCOLN J LIM**



ZOE “

I HAVE A PROFOUND ADMIRATION FOR LINCOLN'S EXCEPTIONAL SKILLS AS A RADIOLOGIST AND HIS COMPASSIONATE NATURE.

Lincoln's willingness to mentor and support his juniors has significantly influenced my own professional development. He provides sound advice and guidance, helping me navigate challenges in my work and aspirations, especially in pursuing a career in radiology. His genuine care and understanding create an environment where I feel encouraged to grow and excel.

LINCOLN'S LEADERSHIP AND DEDICATION TO CONTINUOUS IMPROVEMENT INSPIRE US TO STRIVE FOR EXCELLENCE.

I am a surgical resident at Western Health, and Lincoln is one of my seniors. He fosters a collaborative and motivating atmosphere within the workplace. He has

founded a research committee aimed at guiding registrars through academia. This demonstrates his commitment to nurturing the next generation of medical professionals. His recent collaboration with Leaflet Health to enhance medical information accessibility for CALD patients showcases his innovative approach to improving patient care, especially for those in the Western suburbs, who come from up to 50 different countries.

LINCOLN'S IMPACT EXTENDS FAR BEYOND THE WORKPLACE; HE IS A TRUE CHAMPION FOR MARGINALISED COMMUNITIES.

His extensive volunteer work, including aiding in the aftermath of the 2004 tsunami in Thailand and providing medical assistance in rural India and Nepal, highlights his commitment to making a tangible difference in the lives of others. By rebuilding schools and offering essential medical supplies, he has brought hope to countless individuals in need. Lincoln's empathy and dedication to community service exemplify the values of compassion and global outreach, making him an inspiring figure for all who have the privilege to know him.

LINCOLN

I DID NOT PLAN A CAREER IN MEDICINE. I OBTAINED A UNIVERSITY POSITION IN AEROSPACE ENGINEERING FOR MY LOVE OF PHYSICS.

My life path changed after embarking on a medical mission trip to Nepal and North India before my mandatory military service in Singapore. I saw the great disparity in the access to health services between the rich and poor. It was at this point that I chose to embark on my path to pursue medicine as I wanted to help care and treat people with my own knowledge and skills. I am thankful that I can marry my love for physics and medicine in radiology.

MEDICINE IS A LIFE OF SERVING OTHERS AND HELPING PEOPLE IN NEED, ESPECIALLY WHEN THEY'RE MOST VULNERABLE.

Many doctors or healthcare practitioners have sacrificed a lot of their youth for the greater cause. A life in medicine can be challenging due to our constant pursuit of knowledge, exams and, at times, high stake decisions that can make a lasting impact for the remainder of an individual's life. Through these challenges, I have always felt that I am blessed and privileged to be able to help others.

HAVING GOOD MENTORS IS IMPORTANT.

Through my career, I have had many great mentors who have shaped me as a medical professional. At this stage of my career, I am hoping to provide the same level of support I received and help guide the next generation of doctors. As the founder and current executive committee member of my public health service's radiology research committee, I provide guidance and a centralised spot for junior doctors to begin their careers in academia. It was through this I had the pleasure of working with Zoe. Zoe is not afraid to take up a challenge and follows through with whatever she is trying to pursue. This includes working towards her private pilot's license! I have a lot of respect for her.

I THINK ONE FACET OF HEALTHCARE IN AUSTRALIA THAT COULD BE IMPROVED IS SUSTAINABILITY – WE NEED TO REDUCE OUR CARBON FOOTPRINT.

Our reliance on single-use medical equipment quickly compounds to significant wastage that impacts the sustainability of our industry. In addition, a technologically advanced specialty like radiology relies heavily on sophisticated machinery which inadvertently results in high energy consumption and carbon footprint. I believe that in our roles as healthcare professionals, we should be cognisant and mindful of our roles pertaining to sustainability in healthcare. Much more can be done in terms of research and initiatives to help reduce our carbon footprint in medicine.

ONE FACET OF MY RESEARCH INTERESTS LIES IN THE FIELD OF ARTIFICIAL INTELLIGENCE.

I am excited to be part of the National Lung Screening Working Group through the Royal Australian and New Zealand College of Radiologists and the Australian and New Zealand Society of Thoracic Radiology's AI and VNA [Vendor Neutral Archive] subdivision committee. We are collaborating with the Cancer Council and Australian Government to establish the world's first National Lung Screening Programme to help increase cancer detection, encourage early intervention and reduce morbidity through opportunistic screening.

SHOUT OUT #2
DR KEETH MAYAKADUWAGE

KEETH MAYAKADUWAGE

DR CAROLINE BOLT

Dr Keeth Mayakaduwage (BMedSc/MD, BMedSc (Hons)) is a resident medical officer at Monash Health and an adjunct lecturer in the Department of Obstetrics and Gynaecology at Monash University. Keeth was nominated for a Shout Out by Dr Caroline Bolt (MBChB FACEM), an emergency physician at Monash Health.

I strive to ensure that every patient feels they are in the hands of someone who is not only clinically skilled but also truly committed to their wellbeing.

DR KEETH MAYAKADUWAGE

CAROLINE

KEETH'S CONTRIBUTIONS HAVE ENRICHED THE FIELD OF OBSTETRICS AND PROVIDED INVALUABLE SUPPORT TO JUNIOR CLINICIANS AND FAMILIES AFFECTED BY STILLBIRTH.

His leadership in evaluating the Safer Baby Bundle has significantly advanced antenatal care practices in Australia. He also led the development of the Public Health Association of Australia's Pregnancy Loss Position Statement, advocating for better care for families affected by miscarriage or stillbirth and increased government funding for pregnancy loss research. As a member of the Stillbirth Advocacy Working Group within the International Stillbirth Alliance, he collaborates with fellow clinicians to ensure that stillbirth prevention remains a global health priority, and that sufficient education is provided to junior clinicians.

KEETH IS A DEVOTED MENTOR AND EDUCATOR.

He has dedicated over 100 hours to mentoring high school and medical students, and junior doctors through various programs at Monash University and Monash Health. Keeth's commitment to fostering the growth of future medical professionals is evident in the success of his mentees and his active participation in clinical teaching.

IN HIS CLINICAL WORK, KEETH CONSISTENTLY RECEIVES COMMENDATION FROM PATIENTS FOR HIS EMPATHETIC AND PATIENT-CENTRED CARE.

Keeth's ability to communicate treatment plans clearly and ensure patients feel heard and cared for has earned him numerous expressions of gratitude and the Monash Health Service Excellence Award. Additionally, Keeth's volunteer work with The Water Well Project highlights his dedication to addressing healthcare disparities and promoting health education among marginalised populations. Through his compassionate approach and relentless advocacy, Keeth makes a difference in the workplace and profoundly impacts the lives of those he serves, earning the admiration and respect of his colleagues and the broader community.

KEETH

MY INTEREST IN WOMEN'S HEALTH BEGAN ON THE THIRD DAY OF MY O&G PLACEMENT IN MEDICAL SCHOOL.

I was scrubbed in for a C-section, trying to stay out of the way as it was all so new to me. After the consultant made the incision, he guided my hands and supported me to deliver the baby. I felt the baby take his first breath in my hands – air filling his lungs – and the father, who was also in the room, looked overjoyed and began to cry. It was such a powerful moment. After that experience, I immersed myself in women's health research, advocacy, and education. It is an incredibly rewarding area of medicine.

I HAVE SEEN HOW DEVASTATING STILLBIRTH CAN BE FOR FAMILIES AND HEALTHCARE PROVIDERS.

This inspired my work on the Safer Baby Bundle, developed by the Stillbirth Centre of Research Excellence. First launched in Victoria in 2019, the bundle includes five evidence-based antenatal strategies to reduce stillbirth. Our analysis of its impact in Victoria has found that stillbirth declined with no evidence of harm. This data drove the bundle's national rollout, now implemented across Australia with the potential to greatly reduce stillbirth.

MY INTEREST IN MEDICINE WAS SPARKED AFTER MY OWN EXPERIENCE AS A PATIENT.

I was born in Sri Lanka and moved to Australia when I was 12 years old. When I returned for a holiday at 14, I contracted dengue fever. This was my second time contracting dengue fever, and often the second occurrence is when your body mounts a severe immune response. I was in the ICU for a month and came very close to losing my life. It was very traumatic for me and my family. However, I vividly remember the compassion of a particular doctor. She saved my life with her expert medical care, but it was her genuine compassion that made all the difference. Her care made me realise that being a doctor is not just about treating illness, but about humanity. This experience inspired me to pursue medicine, driven by a deep desire to provide my patients with the same care and compassion I received. I strive to ensure that every patient feels they are in the hands of someone who is not only clinically skilled but also truly committed to their wellbeing.

IMPROVING WOMEN'S HEALTHCARE REQUIRES A FOCUS ON EQUITY AND CULTURALLY SAFE CARE.

In women's health, there are significant disparities, particularly for Indigenous women, migrant women, and those in rural and remote areas. We must provide culturally safe care – care that respects and acknowledges each patient's cultural identity, values, and needs and ensures they feel understood, valued, and supported. This requires continuous education for clinicians, actively listening to community voices, and fostering an environment where patients receive care aligned with their cultural beliefs. For instance, in some cultures there is no word for 'placenta,' making it challenging for clinicians, even with an interpreter, to convey its importance in relation to stillbirth prevention. To overcome this, the cultural adaptation of the Safer Baby Bundle has developed analogies that ensure stillbirth prevention messages are communicated effectively and respectfully to diverse cultural groups.

SHOUT OUT #3
DR STEPHEN FLEW

DR STEPHEN FLEW

DR TERENCE AHERN & DR BILL DONOGHUE

Dr Stephen Flew (FACRRM, DCH, MPH, DRANZCOG) (Steve) is a GP and who spent his career working in remote communities in Australia, Papua New Guinea and Peru. Stephen was nominated for a Shout Out by Dr Terence Ahern OAM (MBBS), a principal GP in Brunswick and long-time colleague and friend, who drew on the recollections of Dr Bill Donoghue (MBBS) for the nomination. Steve's daughter, Ana, speaks on his behalf.

My parents were sought after because they were a duo; communities really liked having them, especially my mum for women's health issues.

ANA
(STEVE'S DAUGHTER)

TERRY

STEVE DEDICATED HIS LIFE TO THE HEALTH OF THE INDIGENOUS POPULATIONS OF PERU, PNG AND THE NORTHERN TERRITORY.

He performed surgical, obstetrical and medical care in the Amazon jungle and in Tari, Kavieng and Tabubil in PNG before working in Nhulunbuy and places like Groote Eylandt in the NT. He then returned to Victoria to work as a country GP in Edenhope and Mansfield for 18 years. About eight years ago, Steve developed cognitive problems and was diagnosed with Alzheimer's disease. Sadly, he had to retire prematurely at the age of 64.

BILL

IN THE AMAZON STEVE'S JOB WAS TO HELP TRAIN YOUNG MEN FROM ABOUT 100 VILLAGES IN WESTERN PREVENTATIVE AND BASIC CURATIVE MEDICINE.

These men became health promotors or barefoot doctors. Steve's work involved running regular courses on each of the five principal rivers of the region, then making long supervisory trips along each river to visit each health worker, give advice and help when necessary. The medical work was sometimes very difficult. Steve had to teach his western medical approach for mostly introduced diseases, without denigrating traditional beliefs. Steve married his Peruvian wife, Licenia, in 1983, and their daughter Ana was born in 1984. In 1989 they left Australia to work in PNG.

ANA

MY PARENTS WORKED IN PNG FOR NINE YEARS, FIRSTLY IN TARI, THEN KAVIENG AND FINALLY TABUBIL.

You just had to do the best that you could with the training and equipment that you had. My mum was a doctor as well; she was the first Indigenous woman to graduate in medicine in Peru. The community in and around Tari was quite tribal, and people frequently fought amongst the clans to settle disputes. From time to time the patients mum and dad attended had an embedded spear or an arrow because of tribal fighting. They also provided lots of obstetric and outreach care, and vaccination and education programs. My parents were sought after because they were a duo; communities really liked having them, especially my mum for women's health issues.

ISOLATION FROM FAMILY AND THE WIDER MEDICAL COMMUNITY WAS OFTEN A CHALLENGE.

He always worked on adding to his skills, but in PNG this demanded driving several hours up a highway that was prone to potholes, landslides and dangerous highway robbers to meet with other doctors at the hospital to learn about lifesaving surgical procedures. He was committed to working in areas of real need – often small rural and remote locations that find it hard to attract and retain doctors. Burnout was another challenge. My parents were lucky that they had each other and could take turns providing on call services to the hospital, but it was difficult to take time off as a family.

IN AUSTRALIA, PLACES THEY LIVED AND WORKED INCLUDED ARNHEM LAND, AND EDENHOPE, WHERE DAD SPENT PART OF HIS CHILDHOOD.

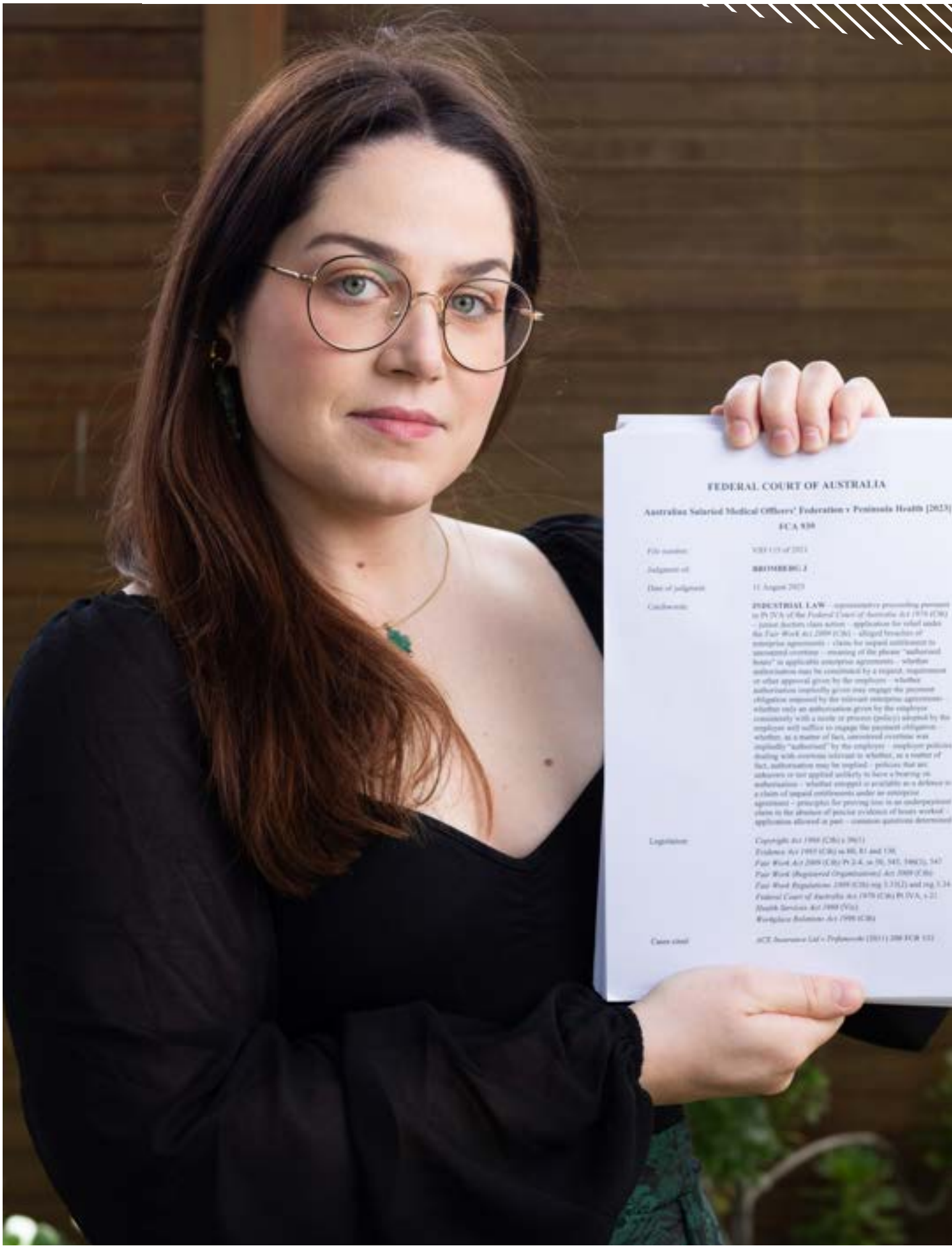
They spent a year living in Nhulunbuy providing care to the northern Aboriginal communities of Arnhem Land in the Northern Territory. Then they settled in Edenhope, in West Wimmera. The country doctor there, Dr Ron Bade, had been a mentor to dad when he was studying and wanted Dad to take over his GP practice so he could retire. My parents worked in Edenhope for 10 years before settling in the high country in Mansfield, Victoria. He was a very dedicated doctor; he'd throw himself in and give his all. He valued being able to have a positive impact and make a difference in people's lives. He just wanted to do everything he could for people.

HE WAS VERY ADVENTUROUS. IN ALL OF THOSE PLACES WHERE HE LIVED, HE'D IMMERSE HIMSELF IN THE LOCAL ENVIRONMENT, LANGUAGE AND PAST TIMES.

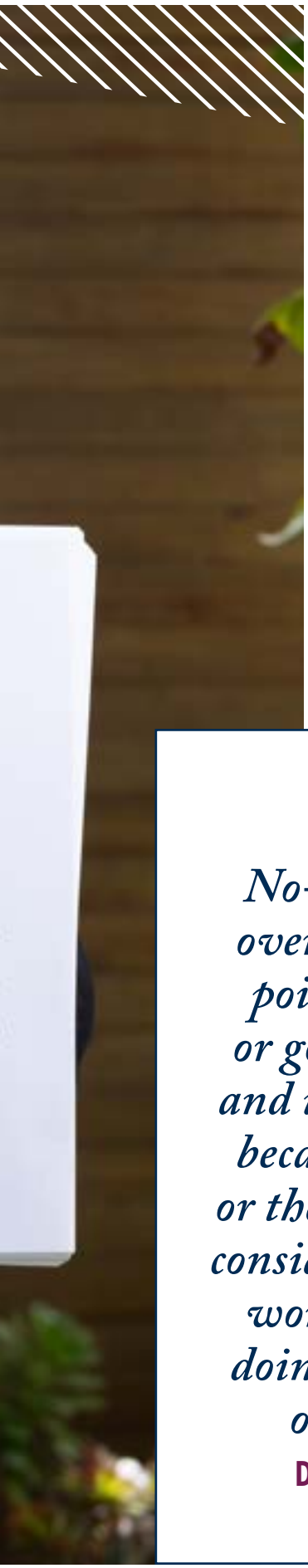
He has always had a spirit of adventure and perhaps saw medicine as a career that would enable him to explore the world and other cultures, and experience different languages and ways of living. In the UK he joined a sailing club and learned to sail a mirror. In Tari, Dad enjoyed bush walking, camping and caving. In Kavieng, he learned to scuba dive around the spectacular coral reefs and the plane wrecks from the war. In Edenhope he got into rock climbing. In Mansfield he immersed himself into bike riding. He approached everything with generosity, braveness and an adventurous and caring spirit.

HE AND MUM WANTED TO GIVE BACK, SO WE'RE SETTING UP A SCHOLARSHIP THROUGH THE UNIVERSITY OF MELBOURNE.

It will support medical students from PNG to come to Australia for a rotation, to develop their education and training and then be able go back to PNG to use those skills in their own careers. It's been a long process, but there are two medical students who will be coming to Melbourne in 2025.


FEDERAL COURT OF AUSTRALIA
Australian Salaried Medical Officers' Federation v Peninsula Health [2023]
FCA 930

SHOUT OUT #4
DR GABY BOLTON



No-one should be overworked to the point of burnout or go unrecognised and unremunerated because the system or their seniors don't consider the essential work that they're doing is important or necessary.

DR GABY BOLTON

DR GABY BOLTON

DR JILL TOMLINSON

Dr Gaby Bolton (MBBS (Hons)) is an anaesthetic registrar at Monash Health. Gaby was nominated for a Shout Out by Dr Jill Tomlinson (MBBS (Hons), PG Dip Surg Anat, FRACS (Plast)), a plastic, reconstructive and hand surgeon in private practice and the current President of AMA Victoria.

JILL

GABY WAS THE LEAD APPLICANT IN A CLASS ACTION COORDINATED BY THE AUSTRALIAN SALARIED MEDICAL OFFICERS' FEDERATION AND AMA VICTORIA.

In August 2023, Gaby won a landmark class action against her employer when a Federal Court judge found that Peninsula Health had breached the Fair Work Act in underpaying its junior doctors between 2015 and 2021. Gaby's bravery and determination has paved the way for the success of other class actions. Her win was a historic turning point in our campaign to end excessive and dangerous working hours for junior doctors, and to strengthen the healthcare system by creating safe working conditions.

MANY DON'T REALISE THE SACRIFICES GABY HAS MADE TO ACHIEVE CHANGE FOR VICTORIAN JUNIOR DOCTORS AND PATIENTS.

Being the lead applicant in a class action is onerous, but vital. Gaby's crucial evidence and strength were vital factors in the Federal Court judgement and penalty decision against Peninsula Health. Decisions to proceed with legal actions against Australian health services have not been made lightly. These class actions have been difficult for all involved doctors, particularly those required to provide evidence in court, and for the junior doctor lead applicants.

CHANGE MAKERS DESERVE OUR APPLAUSE AND SUPPORT.

It can be hard to speak up for what is right, and fair and just. It is easier to keep your head down, and to ignore the problem. This is particularly true in a strict and hierarchical medical culture, and for doctors in training for whom a negative reference can block entry to a desired training pathway. Gaby has stepped up, not for herself, but for patient care and for all junior doctors in Victoria.

GABY

THE GENERATIONAL UNDERPAYMENT OF DOCTORS, THE LACK OF RECOGNITION OF THEIR TIME AND THE IMPACT OF THIS IS STILL NOT WELL RECOGNISED.

As a junior doctor, you can feel like you don't belong anywhere, and you're not in a very safe or stable place in terms of job security. Acceptance into specialty training programs is incredibly competitive, and you don't want to do anything or say anything that will make things more difficult for your career progression. So, we bear the brunt of being at the bottom of a still very hierarchical system, where juniors are sometimes pushed around and expected to work extra hours, and to make medicine your entire life. Going through the junior years in this way is almost considered a rite of passage, and that's how the system has run for years and years.

MY CLASS ACTION AND THE OTHER CLASS ACTIONS IS SOMETHING MORE POWERFUL THAN US AS INDIVIDUALS.

I had a lot of support from ASMOF and AMAV, and from the lawyers involved and the department I was working in at the time, which is the main reason I was able to go ahead. It wasn't ever really about the money, but about principle – what's right. I realised early on that I was not as affected as some of my colleagues; unaccredited surgical registrars seem quite affected by this. No-one should be overworked to the point of burnout or go unrecognised and unremunerated because the system or their seniors don't consider the essential work that they're doing is important or necessary.

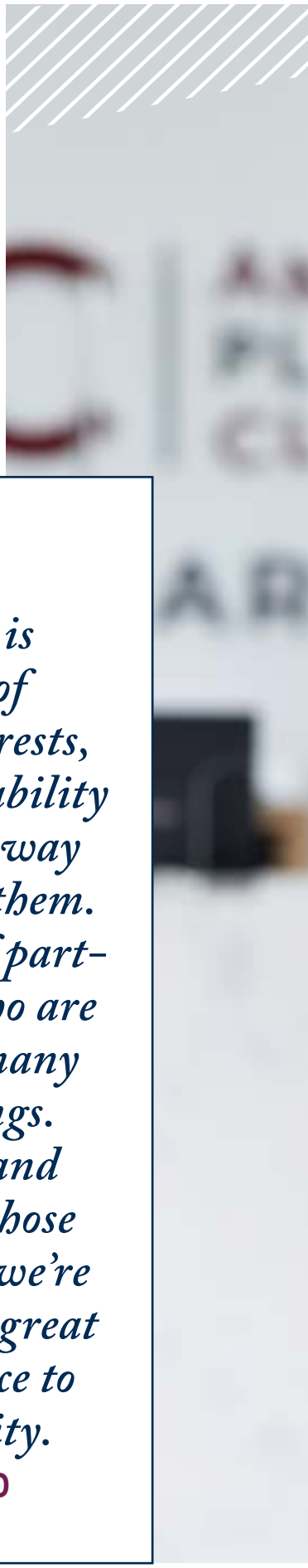
IT TOOK A LOT OUT OF ME. I SPENT LITERALLY HUNDREDS OF HOURS PULLING TOGETHER EVIDENCE AND PREPARING FOR TRIAL.

The timing was very unfortunate. I was due to sit my specialty exams about six weeks after the trial, and the trial preparation and then of course being on trial – being cross-examined in front of your peers – was incredibly draining. It's only this year, now that it's all behind me and I've been able to refocus, that I've been able to pass those exams. I had hoped it would only take me one year and one attempt, but it's taken me three years and four attempts, and a much more money than I would like to have spent on that. I've had to overcome a strong sense of failure and self-doubt.

MEDICINE NEEDS TO BETTER REPRESENT AND REFLECT US AS A SOCIETY.

People often assume I'm a nurse because of my gender. It's not offensive that they think I'm a nurse, it's offensive that they think I'm a nurse because I'm a woman. This is another systemic issue we need to overcome; women are just as able and entitled to be doctors as men. We also need to normalise seeing people of colour practicing and leading in medicine. You really can't assume anyone's role because of their gender or cultural identity; those days are gone.

SHOUT OUT #5
ANDREW PLACE CLINIC IN BUNDOORA AND MILL PARK



DR LISA MIFSUD
for ANDREW PLACE CLINIC

DR MELISSA CAIRNS

The entire team at Andrew Place Clinic was nominated for a Shout Out by Dr Melissa Cairns (MBBS, BSc (Hons), FRACGP, DRANZCOG), who is a GP and one of the practice's six owners. Dr Lisa Mifsud (MBBS (Hons), BMedSci, FRACGP, DRANZCOG, DCH, GradCertHIthProfEd) is another practice owner and speaks on behalf of the team.

> *Our culture is supportive of everyone's interests, and everyone's ability to work in the way that works for them. We have a lot of part-time doctors who are interested in many different things. By fostering and upskilling in those interest areas, we're able to provide great care and service to our community.*
>
> **DR LISA MIFSUD**

MELISSA

I'M PROUD OF THE WORK WE DO AND THINK ANDREW PLACE CLINIC IS A WONDERFUL PLACE TO WORK.

Andrew Place Clinic is a busy community practice that operates over two locations, in Bundoora and Mill Park. It opened in 1971, initially as a solo practice. It has grown into a very busy community practice with 20 doctors and seven nurses. Training new registrars is an important part of our work, and all six principals are actively involved in mentoring and training GP registrars. Most GP registrars have come from a hospital environment where they may not have enjoyed their work or felt like they were treated especially well. Then they land here and experience what being a GP is meant to be like – and they stay.

WE TAKE A LOT OF PRIDE IN OFFERING AN INCLUSIVE, CARING AND SUPPORTIVE WORKPLACE.

Andrew Place is owned by six GPs, four women (including me), and two men. We are continuously looking for ways to keep our skills and practice current and offer the healthcare our community needs. We are a strong and tight knit team who weathered Covid together and came out even stronger and ready to meet the next challenge. I think it's easy for a GP to feel downhearted and negative. At a team level, at a day-to-day level, we can make coming to work as fun and supported as possible and make work as good a place as possible to be for everyone.

LISA

THE CLINIC STARTED OFF AS A TRUE FAMILY PRACTICE, AND IT'S GROWN TO INCLUDE A LOT OF PRACTITIONERS.

But at the core, we're still really focused on a family practice model, offering family medicine and primary care. I think that that's a real success of ours. One of the original founders of the clinic, Dr Giuseppe (Joe) Giarrusso, passed recently and it was like losing a member of the family. An amazing number of patients and former and current staff attended his funeral, and that's a real testament to who he was and what the clinic is. So, despite us being a very large clinic we still retain those small family practice foundations and roots, which is important to us.

IN AUGUST 2022 WE EXPANDED OUR SERVICES INTO A SECOND CLINIC, SO WE NOW OFFER CARE IN BUNDOORA AND MILL PARK.

The second clinic serves a completely different demographic, which is interesting. All the partners work across both sites, and most of our registrars too. From a training perspective, that's a positive thing because it's going to expose doctors to a different clinical experience. Managing two clinics takes a lot of hard work. When it comes to decision making, no one has a majority say. We make sure each voice is heard. It also takes a great team around us.

(L>R) Melanie Hemsley, Eric Tay, Lisa Mifsud, Melissa Cairns, Tristan Barnes, Christina Illing

OUR CULTURE IS SUPPORTIVE OF EVERYONE'S INTERESTS, AND EVERYONE'S ABILITY TO WORK IN THE WAY THAT WORKS FOR THEM.

We have a lot of part-time doctors who are interested in many different things. By fostering and upskilling in those interest areas, we're able to provide great care and service to our community. Most of our doctors were registrars. We come here, we train, and we never leave. This is the backstory for all six of the partners. I came here for my first GP placement, and didn't realise how wonderful it was until I'd experienced others. I came back as quickly as I could!

WE TREAT MULTIPLE GENERATIONS OF A FAMILY: THE GRANDPARENTS, THEIR CHILDREN AND THEIR GRANDCHILDREN. THAT'S WHAT GENERAL PRACTICE IS ALL ABOUT.

It's not about five-minute medicine and medical certificates. It's about understanding the patient and their position in their family, their social aspects, their community, and then creating a wonderful, ongoing relationship where you can deliver excellent, preventative care. And we really encourage that longevity of care. Our entire team is an important part of that picture. Our nurses are highly skilled. Our receptionists know all our patients' names; they're an important part of creating our culture of community and connection and safety.

GENERAL PRACTICE IS WOEFULLY UNDERFUNDED. AS A COMMUNITY, WE NEED TO INVEST MORE IN PRIMARY CARE.

We need politicians and governments to recognise that by investing more into the Medicare rebate, they're going to be able to reduce the occurrence of Category 3 and 4 presentations to ED, and ultimately save the community a lot of money. That initial spend is going to be a significant overall benefit. We'd also like to see better acknowledgement of general practice and what it does. It's preventative healthcare, mental healthcare and family care to name a few. It's essential for our communities, and it feels it's been left to the side.

The scholarship means that this year I can really focus on furthering my interests in global health and infectious diseases.

CELEBRATING AN EMERGING LEADER

This year, AMA Victoria member and Chair of the AMA Victoria Doctors in Training Subdivision Dr Seamus Horan was awarded a Future Leaders Scholarship from the Westpac Scholars Trust. Congratulations Seamus!

BY VANESSA MURRAY

DR SEAMUS HORAN

(MD, DIPTROPMEDHYG, DIPARTS(INTREL))

The Future Leaders Scholarship is one of 17 awarded by the trust and is valued at $120,000. Seamus has been awarded the scholarship for his studies and research within the Trust's key priority area, Australia in Asia, identified by Westpac Foundation as central to the nation's future prosperity.

"I am particularly interested in neglected tropical diseases, a group of infections that disproportionately affect areas of the world with the least capacity to treat and control them," says Seamus, who is undertaking a Master of Public Health and Master of Global Health at the University of New South Wales.

Seamus completed his medical degree at Monash University in 2020. He is a resident doctor at the Royal Melbourne Hospital and has a keen interest in infectious diseases. He also volunteers as a respite carer.

"The scholarship means that this year I can really focus on furthering my interests in global health and infectious diseases. In April I attended the World Health Summit Asia-Pacific meeting, which was held in Melbourne, and in July I went to the World AIDS Conference in Munich."

"One thing that really struck me at both these events was the core focus on equity. At the World AIDS Conference, which is ostensibly looking at a single disease, there was so much focus on the social and political structures that contribute to ill-health. One of the most striking messages from activists who spoke at the conference, including people living with HIV, was that communities are experts – they need to be listened to and put at the centre of decision-making."

"In September I returned from Vanuatu, where I'm assisting a World Health Organization and Vanuatu Ministry of Health-run neglected tropical diseases program, supported by the Kirby Institute. I'm spending most of my time assessing a population-wide antibiotic administration program that's trying to eliminate yaws – a bacterial skin infection that the WHO are targeting for eradication by 2030."

INCREASING ENGAGEMENT WITH DOCTORS IN TRAINING AT AMA VICTORIA

In his role as Chair of the AMA Victoria Doctor in Training Subdivision, Seamus is keen to increase junior doctor engagement. He's driving a shift in junior doctor communications, organising in-person meets, and homing in on the Enterprise Bargaining Agreement (EBA).

"A big focus in our early EBA discussions is junior doctor wellbeing. Ultimately you need well doctors to be able to treat patients well. But we know that often the hospital system is not set up to support the wellbeing of junior doctors. That's what we're hoping to change," says Seamus. The subdivision is also getting involved in wider collective advocacy.

"We recently brought a motion to the AMA Council in support of safe injecting rooms in response to the Victorian Government reneging on its promise to create a second safe injecting room in the City of Melbourne. While the government hasn't yet budged, it was pleasing to see their announcement of a pill-testing trial in Victoria."

As a doctor in training (DiT) or career medical officer, you represent the future of the profession and are a leader of tomorrow. AMA Victoria is here to help you excel and realise your professional potential – whatever your chosen pathway. The DiT subdivision meets online on the second Wednesday of every month at 7pm. A Zoom link is sent to all DITs who are AMA members.

AMA VICTORIA

"We're trying to enrich the sense of community amongst the doctor in training subdivision. And part of that is creating some face-to-face meetings. In July we had our first face-to-face meeting since Covid at the London Tavern in Richmond, which was great fun."

An in-person meeting at AMA House in October focused on the EBA, and was open to all doctors in training, whether they're AMA members or not. With over 30 attendees, there were rich discussions ranging from increasing junior doctor pay, to incentivising working in rural and regional areas, to improving parental leave entitlements. There are further online EBA meetings planned over the coming months. "We're trying to involve as many doctors in training as possible, so we can hear directly from them what they want and need, and how we can make the workplace a supportive and enriching environment."

Stay up to date by joining the Doctors in Training: AMA Victoria Facebook group

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BEATING BURULI

Victoria has the highest incidence of Buruli ulcer in the world. AMA member Prof Paul Johnson has been at the forefront of research into this puzzling and persistent disease since the 1990s.

BY VANESSA MURRAY

PROF PAUL JOHNSON
(MBBS, PHD, FRACP)

> *Classified by the WHO as a 'neglected tropical disease', Buruli ulcer is in the same family as TB and Leprosy. However, in contrast to these more famous diseases, it is transmitted from the environment, rather than person to person.*

Buruli ulcer is a slowly progressive infection of skin and soft tissue caused by the bacterium Mycobacterium ulcerans. Infection usually begins as a painless nodule or plaque but progresses and eventually ulcerates. If left untreated or diagnosis is delayed permanent functional or cosmetic deformity may result.

"Classified by the WHO as a 'neglected tropical disease', Buruli ulcer is in the same family as TB and Leprosy. However, in contrast to these more famous diseases, it is transmitted from the environment, rather than person to person," says Prof Paul Johnson (MBBS, PhD, FRACP), an infectious diseases physician at Austin Health and the University of Melbourne.

In Australia, Buruli ulcer's geographical restrictedness means it is only acquired in specific locations – initially around Bairnsdale in East Gippsland (where the causative organism, M. ulcerans, was discovered in the 1930s and 40s) to Phillip Island and Westernport in the 1990s, the Mornington and Bellarine peninsulas in the 2000s and, most recently, inner Melbourne and Geelong. There are also endemic areas in far North Queensland and occasionally elsewhere in the wet tropics.

Overseas, Buruli ulcer occurs in 33 countries, but again only within very specific sub-regions. From a public health perspective, it is currently a significant problem in rural west and sub-Saharan Africa, in temperate southeastern Australia and at times in Far North Queensland.

For clinician-scientists like Paul, Buruli's prevalence in Victoria, which now has the highest incidence of the disease in the world, is an ongoing puzzle.

"In 1998, in response to a growing epidemic of Buruli ulcer in West African children, WHO launched the Global Buruli Ulcer Initiative. This highly successful group, now absorbed under Neglected Tropical Skin Diseases, mapped and identified cases, worked to de-stigmatise Buruli and led the paradigm shift from plastic surgery to curative antibiotic therapy."

A diagnostic PCR test, first developed in Melbourne in a research team Paul led, has become the gold standard for environmental screening and diagnosis worldwide.

PROF PAUL JOHNSON

THE DAWN OF THE MOLECULAR DIAGNOSTICS ERA, POSSUMS AND MOSQUITOES

Buruli ulcer first came to Paul's attention in the early 1990s when he was a newly minted physician at the Fairfield Infectious Diseases Hospital in Melbourne.

"It was the dawn of the molecular diagnostics era. Back then, diagnosis of Buruli ulcer was by histology, and only very slowly confirmable by culture. It took weeks and weeks to grow," says Paul.

"At the time, I was also working on a PhD at the Royal Children's Hospital. With support from my then boss, Professor Roy Robins-Browne, I diverted some of the research team to the problem of making a PCR for Buruli ulcer."

After a few weeks, the team's lead scientist, Dr Bruce Ross, developed the world's first diagnostic PCR for M. ulcerans.

"This meant that we could now also look in the environment. No one had ever done this before; direct culture had always been unsuccessful. And so began a 30-year program of PCRing everything we could to work out what was going on."

By the mid-2000s, after some false starts, Paul and his colleagues had figured it out. They were able to show that Buruli in Australia is linked to outbreaks in nearby possum populations.

"We discovered possums also get Buruli ulcer and excrete M. ulcerans in large quantities in their faeces, and we've shown that disease in possums comes first. We have also detected M. ulcerans in mosquitoes in Victoria, and recently in the Beating Buruli project shown that M. ulcerans strains in humans, possums and mosquitoes are the same. Mosquitoes link possums to humans – we now have two strong lines of evidence that mosquitoes are the predominant mode of transmission, at least in this part of the world."

WHAT DO AMA MEMBERS NEED TO KNOW?

Paul reckons Victorian GPs are well versed in Buruli ulcer, particularly in places where it is active. But it can take clinicians in other locations by surprise, and its long incubation period can also catch people out.

"A person only needs to spend a few hours in an endemic area to get infected, but the disease has a long incubation period with a median of five months," says Paul.

Once a surgical disease, Buruli is now predominantly treated with antibiotics and dressings, but may take months to heal. Specific anti-mycobacterial antibiotics are highly effective. Paul stresses the importance of accurate diagnosis, as Buruli will not get better with standard treatment and can have long-term consequences if misdiagnosed or left untreated.

"Diagnosis can be made with a swab that samples the undermined edge of the ulcer or if an ulcer is not yet present, with a biopsy. Clinicians also need to make sure they order the right test – the key one to order is the Mycobacterium ulcerans-specific PCR. It's very sensitive and specific, and the result is available in just a few days."

Victoria is on track for another record year of Buruli ulcer diagnoses, with over 350 cases expected. It must be notified within five days of diagnosis.

"Infections transmitted this summer will mostly be diagnosed next winter and early spring because of the long incubation period. This makes now the time for prevention, particularly if you or your patients are in an area where Buruli is prevalent. Wearing protective clothing, insect repellent and avoiding mosquito bites can help."

THE RESEARCH CONTINUES

Along with Professor Tim Stinear, Paul is a lead investigator for Beating Buruli, a research project launched in 2018 with funding from the NHMRC and the Victorian Department of Health. It is a multidisciplinary and collaborative partnership between the Department of Health, Doherty Institute, University of Melbourne, Barwon Health, Austin Health, CSIRO, Agriculture Victoria and the Mornington Peninsula Shire Council. The groups current focus includes mosquito lab work, possum faecal surveys, possum surveillance studies, and a field trial of a new mosquito trap.

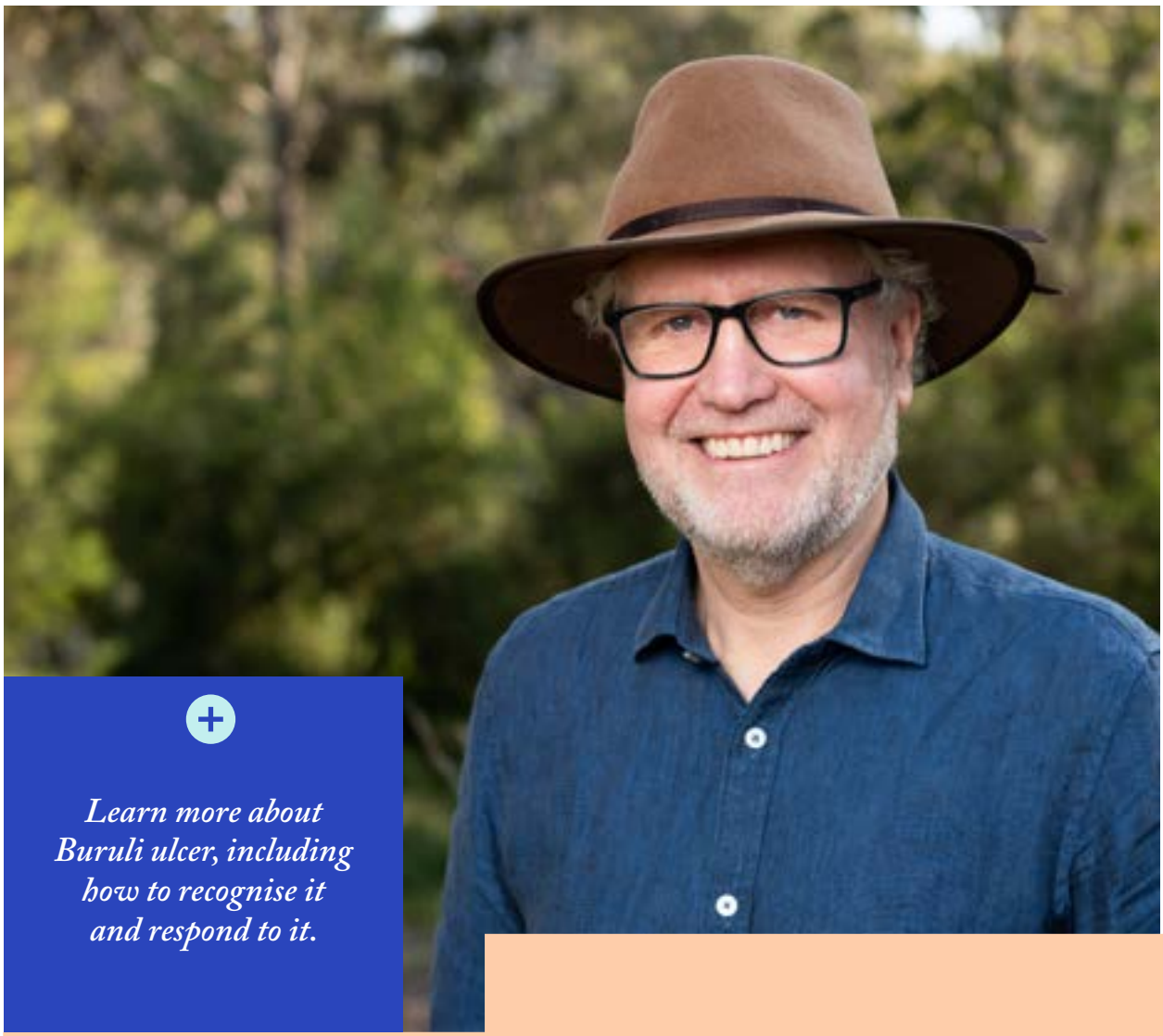
There are still many questions that remain unanswered, such as how do possums get Buruli ulcer? Where does M. ulcerans come from? How have continuous outbreaks in possums all along the Mornington Peninsula happened? How have isolated new outbreaks in possums in inner suburban Melbourne and Geelong happened? What exactly is going on in sub-Saharan Africa (where there are no possums) – what is the reservoir and mode of transmission there? Why does Buruli sometimes go away, as it seems to have done in Phillip Island, and some former endemic areas in East Africa?

Beating Buruli were finalists for a 2024 Australian Museum Eureka Prize, and the Victorian Public Healthcare Awards.

"Working on a local problem of international significance has been very fulfilling," says Paul. "It's been a privilege to work closely with skilled scientists who have helped me translate clinical observations and hypotheses into hard evidence. I hope that together we have made contributions to science and medicine that will outlast us."

There will be new Australian treatment guidelines for Buruli ulcer published soon.

> *Diagnosis can be made with a swab that samples the undermined edge of the ulcer or if an ulcer is not yet present, with a biopsy. Clinicians also need to make sure they order the right test – the key one to order is the Mycobacterium ulcerans-specific PCR.*



Learn more about Buruli ulcer, including how to recognise it and respond to it.

WAKELIN PROPERTY ADVISORY PARTNER

THE HIDDEN RED FLAGS TO LOOK OUT FOR WHEN INSPECTING A PROPERTY

Buyers often overlook key areas of due diligence, overlooking red flags that must be identified and evaluated before purchasing a property.

These issues may not necessarily rule out a property, but they are areas that require further investigation before purchasing.

Let's look at some common red flags that buyers should be aware of when they inspect a property.

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FRESH COAT OF PAINT

A fresh interior paint job can be conducted legitimately to brighten up the dwelling aesthetically, however it can also be used to cover up areas of concern.

These include cracks in the wall, which can be a sign of structural problems, rising damp, mold and leaks.

UNDER-FLOOR VENTILATION

While often out of sight and mind, the nature of the space below a house can throw up critical issues that must be identified and assessed. This is especially true of period homes.

Many period homes were built quite low to the ground, which can prevent ventilation, leading to damp issues under the dwelling, particularly impacting the stumps and the joist bearers.

As you can imagine this can lead to significant issues with the stumps, joists, and bearers; and go on to cause serious structural issues for the home.

MUSTY SMELL

Another red flag that is often missed is the smell of a property when you enter. If the home has a heavy musty odour, it can indicate ventilation or moisture issues.

Often the smell is caused by moisture and rising damp, which as discussed can cause significant structural issues.

This can often be masked by real estate agents by burning incense candles and odour removers.

A SPATE OF SALES

Whether it is an apartment, unit or townhouse complex, a spate of sales within the group can be a cause for concern, which should require further investigation.

It can be a sign there is a difficult resident in the complex making life unpleasant for neighbours or preventing property maintenance and upgrades.

It could also mean there is a large expense on the horizon as part of the owners' corporation, for which some owners are not prepared or do not have the capacity to contribute.

OWNERS' CORPORATION

The nature, history and recent activity within the owners' corporation is an issue for investigation. This can be assessed by reviewing the contract of sale, with the support of a conveyancer or solicitor.

If the block is looking particularly tired and shabby, it is useful to know if any upgrades or maintenance is being planned.

Conversely, if a block looks overdone with a high owners' corporation fee, it pays to know exactly how and why the money is being spent.

MODIFIED FLOORING

This is most common and easily recognised in a property with timber floors, particularly in period homes where there might be sections that have been changed or altered. It is important to find out why that is the case.

It might mean there have been damp issues underneath the floor that have required repairs. It could also indicate pest issues, such as wood borer or termite damage, or it could simply mean a mismatched timber or colour due to renovations.

SURROUNDING USES

Nearby or adjacent alternate uses such as commercial or retail properties may appear to be appropriate at the time, however a change of occupant could significantly impact a resident's lifestyle. Issues such as odours, noise or traffic congestion can have a significant impact on livability.

AT YOUR NEXT HOME INSPECTION

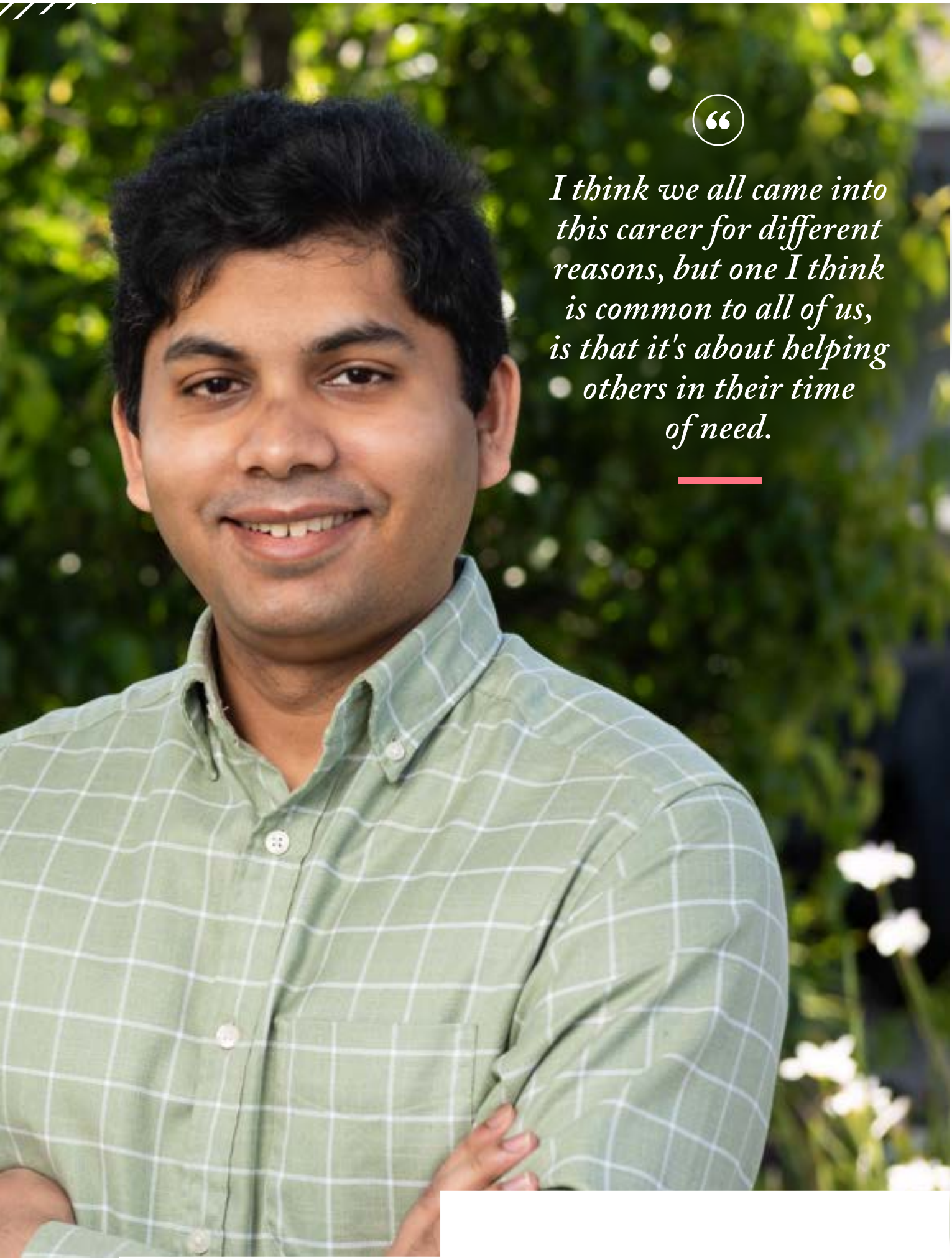
Be aware of any potential red flags before purchase and conduct adequate due diligence to avoid nasty surprises, diminished capital gains — and for homeowners — reduced livability.

Q&A WITH

DR AQUIB CHOWDHURY

The AMA Victoria Peer Visitor Program links elderly and retired doctors, who mostly live in residential care or are experiencing isolation, with a volunteer visitor who is also a doctor. The volunteer visits the elderly doctor on a regular basis and provides companionship, connection, and conversation.

BY **BETHANY ALLEY**
CO-AUTHOR **VANESSA MURRAY**


I think we all came into this career for different reasons, but one I think is common to all of us, is that it's about helping others in their time of need.

Dr Aquib Chowdhury is an ICU registrar who has been a volunteer with the Peer Visitor Program for over a year. He regularly visits a doctor living in aged care who unfortunately had to retire from practice due to illness.

Q1 /
WHAT DREW YOU TO MEDICINE?

I've always been interested in science, the machine that is the human being, but it's a lot more than that. It's about getting to know people and having relationships with people who are in their most vulnerable time, using your skills in a way to make a massive difference to their lives.

Q2 /
WHY DID YOU BECOME INTERESTED IN VOLUNTEERING?

Mainly the altruism component and the fact it allows me to be there for the most vulnerable in our society. You go through medical school, and then many years as a junior doctor… but there is so much more you can do outside that, which is more spiritually fulfilling.

Q3 /
WHAT BROUGHT YOU TO THE VOLUNTEER ROLE?

I took a look at quite a few volunteering roles, and part of the reason I found this one so worthwhile is that many roles don't really allow you to develop personal connections. I really wanted to try something that allowed me to develop a connection with someone from our field, and this was a perfect role for that.

Q4 /
HOW WAS THE FIRST VISIT AND MAKING A CONNECTION?

We were introduced by a volunteer liaison, and she attended the first visit briefly to make sure we were comfortable with one another. I was a stranger to him at that time, and he wasn't really comfortable talking to me about all of his personal experiences – fine with me. I just wanted to enjoy the time that we had and ensure that he got something out of it too.

I learned that he was an avid chess player. He has a chessboard that is left out in view, it's always on the table. I said to him, let's crack it open and play a game. That was probably the best icebreaker of all! I chose a pretty basic opening, he chose an advanced opening, and that's when I knew, okay, I think he's going to beat me. He's good. Sometimes we had to pause and figure out what move we were going to do next, and during that time, we just chatted: about life, about medicine, and he gradually opened up.

Q5 /
WHY MIGHT OTHERS FIND THE PROGRAM REWARDING?

As the visitor, it benefits you in a number of ways. You can build good friendships with retired doctors who understand your role and what you might be going through. I think it allows you to have those deep and meaningful conversations with people who are far further advanced in their careers than you.

I think we all came into this career for different reasons, but one I think is common to all of us, is that it's about helping others in their time of need. One of our responsibilities is to go and do these philanthropic sorts of roles; developing personal connections, becoming a more well-rounded doctor, and getting exposure to opinions that are from an entirely different point of view.

Q6 /
WHAT ARE YOUR VISITS LIKE NOW?

After that first visit, he was such a lovely guy to just hang out with. We always play a game of speed chess: you do a move every 10 seconds, no matter how bad. That way we actually finish some games! Once we we're done, we have a chat, about what he's been doing that week, what interests him about the outside world, his work as a GP in the past, or the current state of medical practice. He's pretty cooped up in there because of his physical disabilities. That's how we developed our connection, because we had something in common. Now I count him as a pretty good friend, who I enjoy visiting.

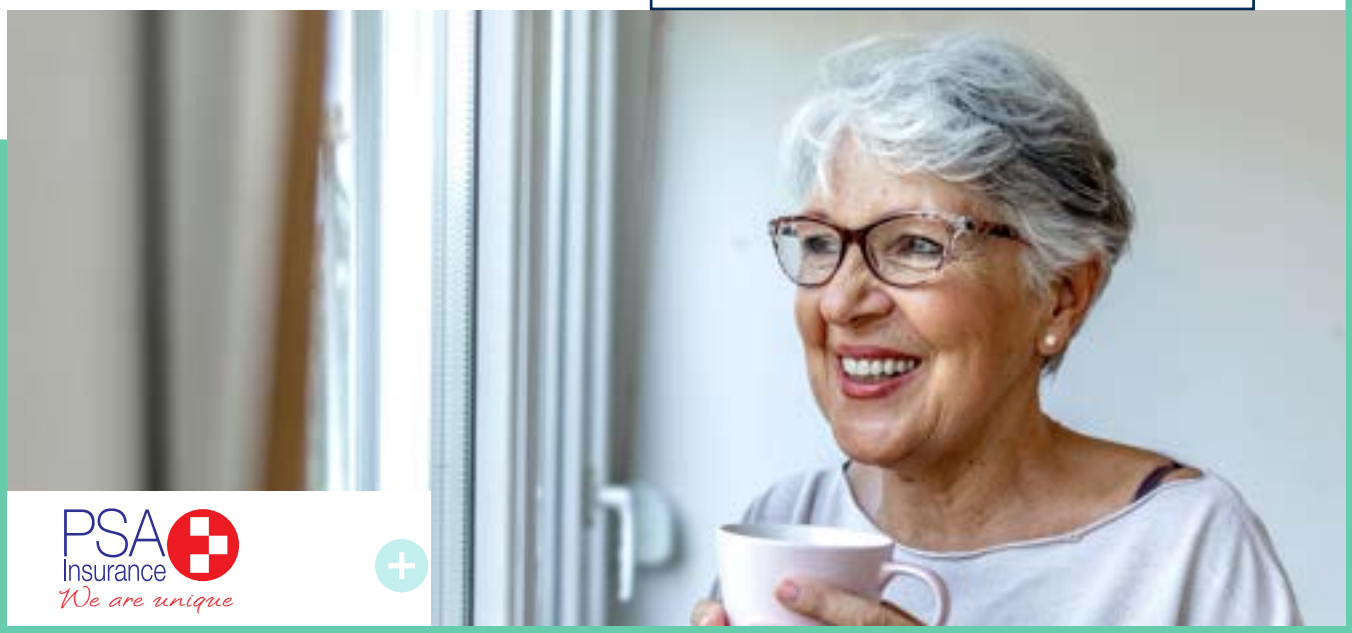
Click here to read more about AMA Peer Visitor Program

The AMA Peer Visitor Program currently has capacity to support more elderly and retired doctors who would enjoy some companionship from a volunteer medical colleague.

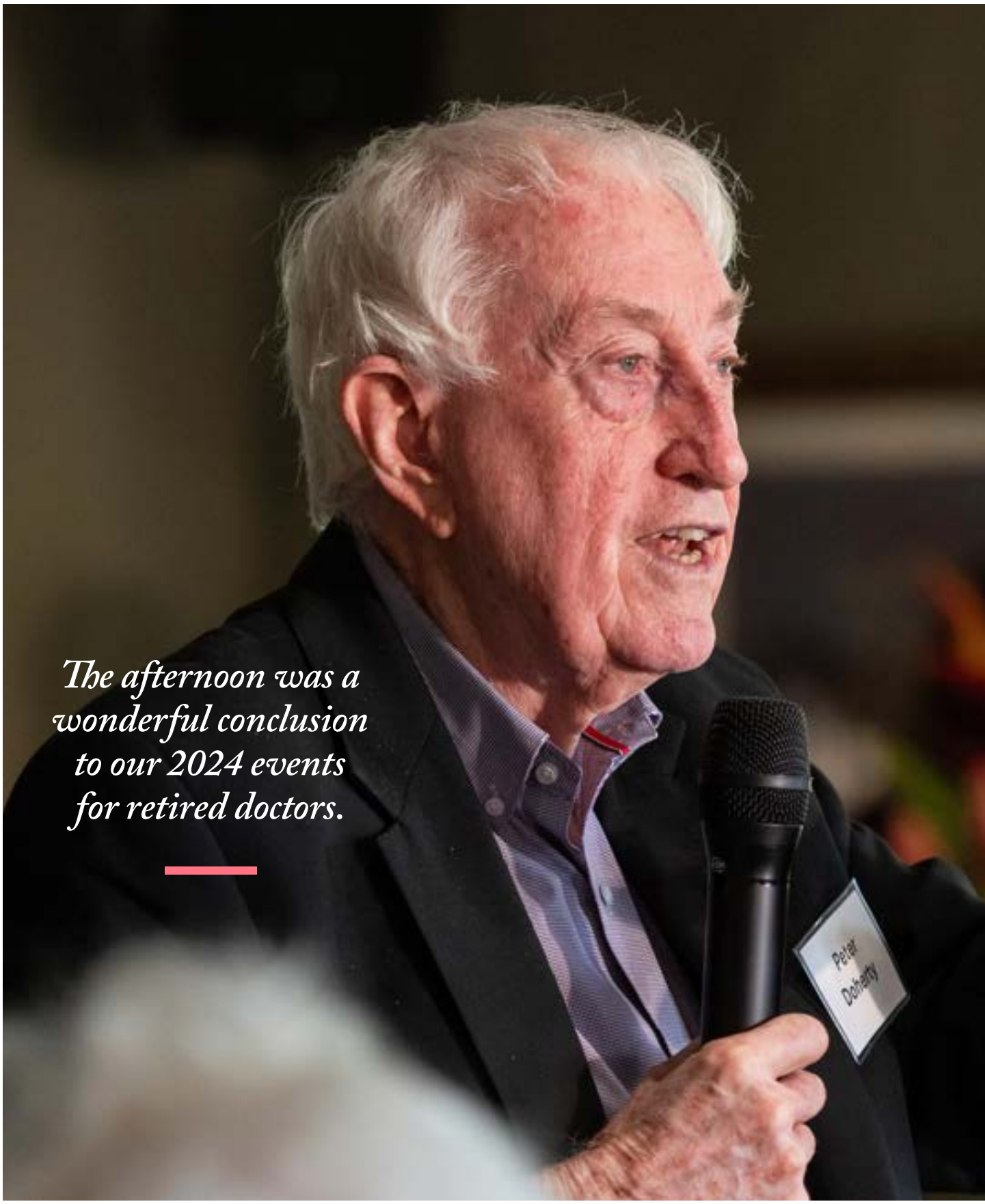
The AMA Peer Visitor Program currently has vacancies for older doctors who would enjoy some companionship from a volunteer medical colleague.

Volunteer visitors must be current members of AMA Victoria and undergo a screening and induction process before being matched. If you are interested in being visited or know an older doctor who may benefit, please contact Bethany at bethanya@amavic.com.au. Doctors being visited do not need to be current members of AMA Victoria.

The Peer Visitor Program is proudly sponsored by PSA Insurance.



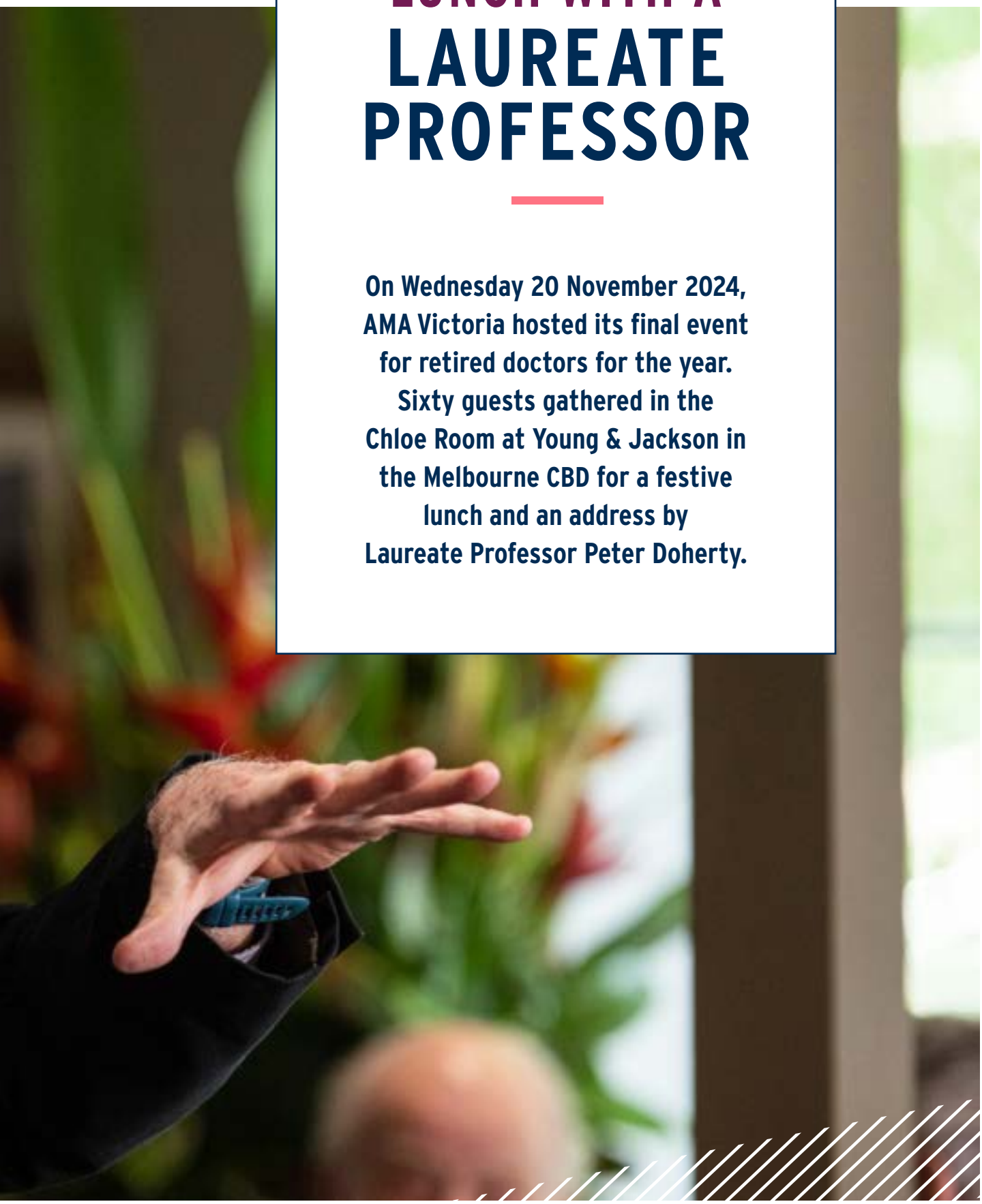
RETIRED DOCTORS LUNCH
LAUREATE PROFESSOR PETER DOHERTY



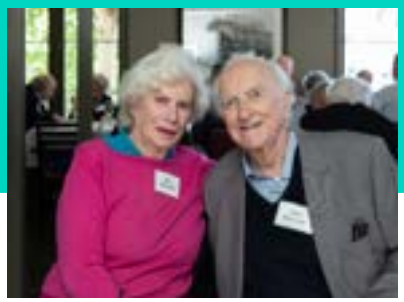
The afternoon was a wonderful conclusion to our 2024 events for retired doctors.

LUNCH WITH A LAUREATE PROFESSOR

On Wednesday 20 November 2024, AMA Victoria hosted its final event for retired doctors for the year. Sixty guests gathered in the Chloe Room at Young & Jackson in the Melbourne CBD for a festive lunch and an address by Laureate Professor Peter Doherty.



WEDNESDAY 20 NOVEMBER 2024
CHLOE ROOM YOUNG & JACKSONS MELBOURNE CBD



Peter Doherty shared the 1996 Nobel Prize in Medicine or Physiology for discovering the nature of the cellular immune defence – transplantation and 'killer' T cell-mediated immunity, an understanding that is currently translating into new cancer treatments.

The first veterinarian to win a Nobel, Peter remains active in research on immunity to influenza. He commutes between St Jude Children's Research Hospital, Memphis and the Peter Doherty Institute at the University of Melbourne, where he now spends most of his professional time.

He is a Fellow, or Foreign Associate, of the Australian, UK, US, and Russian Academies of Science, and the French, US, UK and Australian Academies of Medicine, a Fellow of numerous professional societies, he has been awarded more than 20 Honorary Doctorates and has published approximately 500 research papers and reviews.

In addition to his scientific output, Peter is also the author of six books for everyday readers, including the bestselling The Beginner's Guide to Winning the Nobel Prize, which was originally published in 2005.

He was Australian of the Year and received a Companion of the Order of Australia in 1997, is listed as a living National Treasure, had his face on a postage stamp, and has research fellowships, a street and two buildings (in Edinburgh and Melbourne) named after him – including, of course, the Peter Doherty Institute for Infection and Immunity, in Melbourne's Biomedical Precinct.

In 2006 the University of Melbourne and The Royal Melbourne Hospital partnered to create the Peter Doherty Institute, a centre of excellence where leading scientists and clinicians collaborate to improve human health globally. It has more than 700 staff who work on infection and immunity through a broad spectrum of activities. This includes discovery research; diagnosis, surveillance and investigation of infectious disease outbreaks; and the development of ways to prevent, treat and eliminate infectious diseases.

During his wide-ranging address to the attendees of our special end of year lunch at Young & Jackson, Peter shared his unique insights into the post-US-election landscape and delved into his adventures in public science communication, including

his extensive experience in making complex scientific topics accessible to the public. He was a wonderful speaker who drew plenty of laughs from the crowd.

Peter shared that he enrolled in vet school with the idea of researching domestic animals to aid food production. Peter joked that he is the only Nobel Prize winner who has had his right arm up the back of 2,000 cows, and also most likely the only winner to have been bitten by a pig!

He earned his PhD at the University of Edinburgh, where he researched animal diseases and went on to specialise in sheep diseases. It is here he became a veterinary neuropathologist.

In the years following, Peter moved between the US and Australia, diving into research and growing his career and his reputation. He and his research partner Rolf Zinkernagel (now a Professor at the University of Zurich) did theoretical work on T Cell discovery at the John Curtin School of Medical Research at the Australian National University in Canberra that led, some 22 years later, to the Nobel Prize.

He held a position at the Wistar Institute in Philadelphia, the oldest biomedical institute in the US, and went on to become Head of Immunology at St Jude's Paediatric Hospital in Memphis, Tennessee, a world leader in understanding, treating and defeating childhood cancer and other life-threatening diseases. Peter was working here, at St Jude's, when he got a call in the middle of the night, informing him he'd won the Nobel Prize. He initially thought it might be someone playing a prank.

What followed were a whirlwind few years, where he rubbed shoulders with royalty, diplomats, celebrities and fellow prize winners and of course, regular folk who were keen to know more about him and his work. During this time, he quickly learned to hone his science communication skills for a public audience.

The afternoon was a wonderful conclusion to our 2024 events for retired doctors. Others were a lunch and presentation on cyber security in February, a talk and tour of the Pharaoh exhibition at the NGV in June, and a lunch and presentation from AMAV President Dr Jill Tomlinson in September.

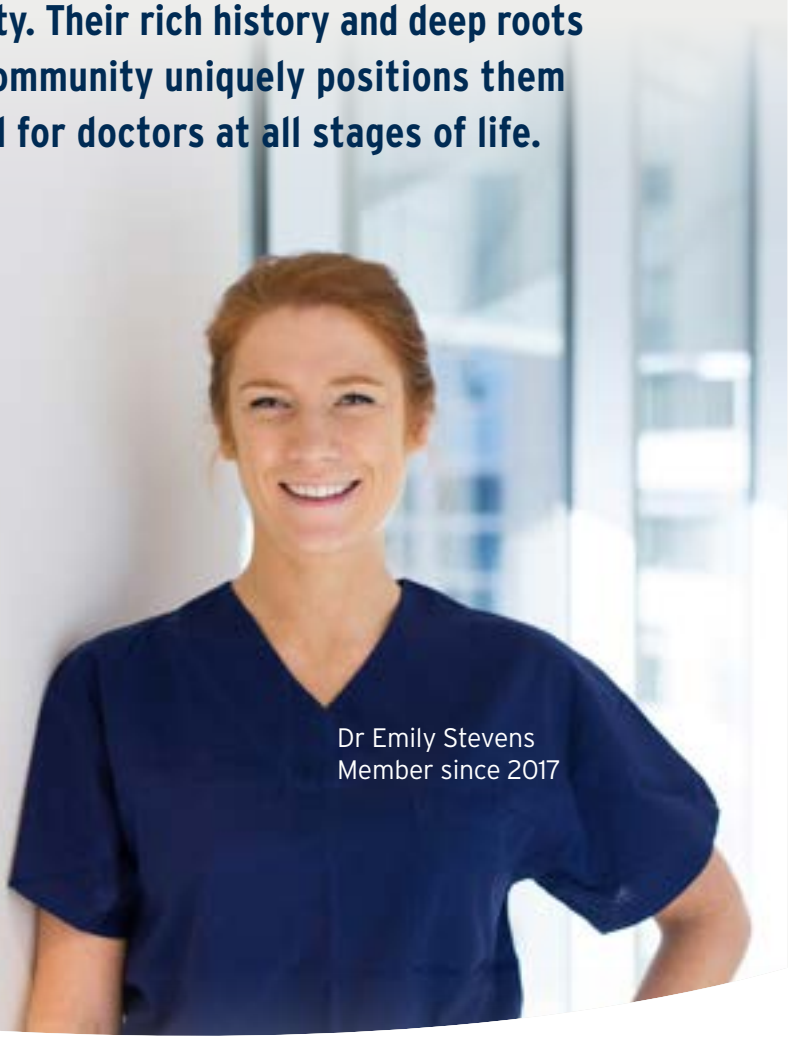
Thank you to all who attended, we look forward to seeing you at the next retired doctors' event on Wednesday 19 March 2025.

GET TO KNOW DOCTORS' HEALTH FUND IN UNDER 3 MINUTES

Part of a member-owned organisation and one of the fastest growing health funds, Doctors' Health Fund continues to play an important role in protecting the health needs of the Australian medical community.

Choice, clinical independence, personalised service and health cover that provides true value at a competitive price, continue to be Doctors' Health Fund's priority. Their rich history and deep roots in the Australian medical community uniquely positions them as the trusted health fund for doctors at all stages of life.

Click here to switch your health cover and skip the two-month waits on extras ^



Dr Emily Stevens
Member since 2017

Doctors Health by Avant

FOUNDED AND OWNED BY DOCTORS

Founded by the NSW Branch Council of the AMA in 1977 and first known as the AMA Health Fund, the health fund was created to ensure doctors and their doctor-patients were adequately compensated for medical fees.

To this day, Doctors' Health Fund continues to offer the best medical gap cover in Australia: benefits up to the AMA list of services and fees on Top Cover Gold hospital cover, protecting doctors as both patients and practitioners.

MEMBERS BEFORE PROFIT

As part of Avant, a member-owned organisation, Doctors' Health Fund is owned by doctors and any profits are reinvested to benefit their members and the community. Because of this, their goal isn't to maximise profits for public shareholders but to keep premiums affordable and improve services for their members. They're also part of Members Health, a peak industry body for an alliance of health funds that are not-for-profit or part of a member-owned group, regional, or community based. This only strengthens their focus on putting members first.

A FOCUS ON VALUE

Members of Doctors' Health Fund get value through industry leading gap cover, competitively priced Gold hospital cover and generous extras benefits and limits with:

» Doctors' Health Fund covering more medical services with no gap than any other health fund, with 93% of medical services covered compared to an industry average of 88.3%*
» Their Prime Choice Gold hospital cover providing comprehensive protection at a price that's comparable and, in some cases, cheaper than the big health funds**
» No-gap general dental checkups once a year for Starter Extras, twice a year for Essential Extras and unlimited for Total Extras.

Plus, unlike some other health funds, Doctors' Health Fund has no preferred provider networks for extras, so members choose the provider that's right for them.

LOCAL SERVICE TEAM WHO UNDERSTAND DOCTORS

The Doctors' Health Fund service team truly understands the unique demands on your time. They answer calls quickly, most in under 30 seconds, and with a 95% member satisfaction rating, the knowledgeable and helpful team is perfectly equipped with all the answers to really care and support both members and providers with any enquiry.

Doctors' Health Fund is the only health fund made for doctors, their families, and the medical community. Ready to switch to better value health cover? Join now on any combined hospital and extras policy or extras only cover, and they'll waive the two-month waits on extras.^ You'll be able to claim for health and wellness essentials like dental, optical and physiotherapy straight away.

Visit the website or call 1800 226 126 to see how your cover compares and what else Doctors' Health Fund can offer you.

* Private Health Insurance Ombudsman, State of the health funds report 2023, Ombudsman's website
** Comparing Doctors' Health Fund and the big health funds (BUPA, HCF, NIB, HBF & Medibank) only and is based on Gold hospital cover for one person – or a single policy – with a $750 excess, full or interim Medicare eligibility and doesn't include the Australian Government rebate on private health insurance. We have compared open, retail hospital policies and have excluded closed and corporate policies. Prices were sourced from privatehealth.gov.au on 1 April 2024 and are subject to change. Prices don't include extras cover. It's important to always consider your own circumstances when comparing health insurance policies as there's a lot of factors that make up the final premium amount.
^ New Doctors Health Fund members only. Must join by 24 January 2025. Offer & Policy terms and conditions apply, see doctorshealthfund.com.au/quickjoin for more details.

Harper Bernays Charitable Trust

A better, sustainable way to make a difference.

Many Australians strive to make a positive impact by giving to causes that matter. However, the right vehicle can take your charitable giving far further, providing more benefits to recipients, and helping you leave a lasting legacy.

Giving through the Harper Bernays Charitable Trust (HBCT) ensures your contributions count. Even with a modest amount, you can establish an HBCT account that will direct funds to your chosen cause. Contributions to the HBCT are fully tax deductible up front. They are held in trust and managed by Harper Bernays in a tax-free environment. That allows the pool to appreciate over time and more money to reach the charities of your choice.

GIVING THROUGH THE HBCT

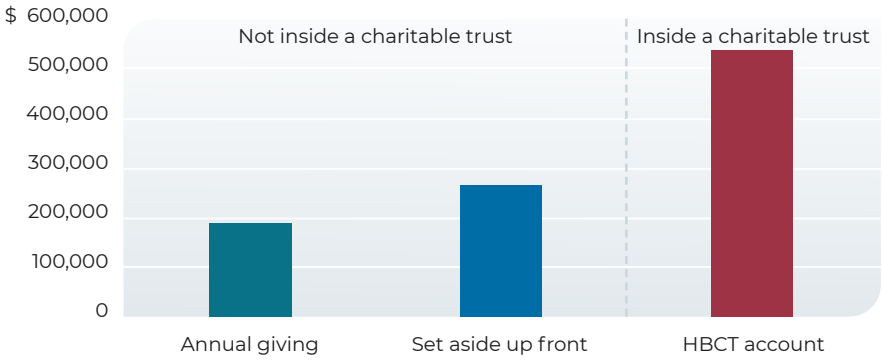
On behalf of it's account holders the HBCT has distributed over $4 million to more than 100 charitable causes. Account holders access the following benefits:

- **Flexibility to give to your preferred registered charity**
- **Better planning to maximise your impact**
- **Brings forward the tax deductions of future charitable donations**
- **Capital gains resulting from the investments are tax free**
- **Structured giving without the burden and cost of administration**
- **Involve family and younger generations via transferable perpetual account**

4% of the account balance is required to be distributed to charity each year. Investment earnings have historically exceeded 4% over the long term which has led to account balances and amounts donated growing over time.

REAL RESULTS: MAXIMISE THE BENEFIT OF EVERY DOLLAR DONATED

Charitable benefit over 20 years of $100k donated under different structures



NB: Assuming 7% post fee investment returns and top marginal tax bracket.

The HBCT is an effective way to make the most of your philanthropy and ensure you can make the most difference. Talk to us about how to maximise not only your impact, but that of your children and grandchildren too.

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MINISTERIAL UPDATE
PROGRESS STALLED ACTION NEEDED

As part of our enterprise bargaining in 2021–22, AMA Victoria/ASMOF Victoria, the Victorian Hospitals Industrial Association, and the Victorian Government agreed that some critical and complex issues affecting doctors' working conditions were too intricate to resolve through bargaining alone. To address this, the Victorian Government committed to establishing a Ministerial Review within six months of agreement approval.

Our submissions were provided to the panel in December 2023, and the interim report, originally expected by March 2024, was handed down in April. This report included 15 key recommendations for improving doctors' working conditions. In September, we were briefed on the recommendations and invited to provide feedback within a three-week timeframe. Despite the tight deadline, we delivered our input, which was overwhelmingly supportive, with minimal changes requested.

However, three months have passed since that feedback, and the State Government has yet to release the report publicly. Repeated inquiries to the Victorian Department of Health and the Victorian Health Minister's office have yielded no clear answers on when it will be made available. We are increasingly concerned that the report's release may be delayed until next year. Such a delay would significantly impact our ability – and that of the Victorian Hospitals Industrial Association – to incorporate its recommendations into the next enterprise agreements.

We need your help to keep this critical issue on the State Government's agenda.

WHAT CAN YOU DO?

We need your help to keep this critical issue on the State Government's agenda. We urge you to contact your local MP and request an update on the report's release. Ask them to emphasise the importance of these recommendations for improving doctors' working conditions in Victoria.

Your voice can make a difference. Together, we can ensure this vital process continues and the changes we advocate for become a reality.

SCOPE OF PRACTICE REVIEW

THE GOOD, THE BAD AND THE UGLY

DR DANIELLE McMULLEN
AMA PRESIDENT
(FRACGP)

DR DANIELLE McMULLEN — AMA PRESIDENT

After a year of discussion papers and countless workshops and meetings, the final report of the Scope of Practice Review was finally released in early November. The 194-page report contains 18 recommendations ranging from sensible, small reforms through to others I would politely refer to as questionable. Titled Unleashing the Potential of our Health Workforce, one of our major frustrations with this review from the start has been its title, and the assumption that all regulation is bad – that 'leashes' are just turf protection, rather than patient protection. Above all, there has been failure to answer the question of who should hold the leash. We firmly believe that decisions about scope of practice and workforce should be made by independent, expert bodies, with robust processes – not politicians with knee-jerk reactions.

The AMA recognised the potential threats to patient care posed by the review and was strongly engaged in the review through three public submissions and a confidential submission to the draft final report. We also provided a detailed literature review on the international evidence on non-medical prescribing. This showed autonomous prescribing is not as prevalent or successful as other stakeholders would have you believe.

We met with the lead reviewer, Professor Mark Cormack on many occasions, including inviting him to an AMA Federal Council meeting. We also discussed the review regularly with the GP colleges and other groups to ensure alignment in our positions.

In discussions with the Federal Government and the Department of Health and Aged Care, we have explained the risks with many of these recommendations, such as fragmented care. Sometimes I feel like a broken record in these meetings explaining that we need to invest in and support general practice, not eternally fund programs that only circumvent general practice, inevitably cost more, and are less efficient. We will continue to press this message.

I won't detail all 18 recommendations, but I want to highlight a few that we are particularly concerned about and will continue to advocate against.

Recommendation 3 is to amend the Health Practitioner National Law to grant health ministers the power to give Ahpra and National Boards even greater policy direction on registration and accreditation functions. We strongly oppose this on the principle that the regulation of health professionals exists to protect the community and ensure the highest standards of care for patients, and this is not something that politicians should be meddling in.

As we repeatedly highlighted in our submission, Australia has processes for reforms to scope of practice that are independent and consultative. The problem is these are regularly overridden by state and territory health ministers.

This leads to the absurd situation where scope of practice is now determined by political promises during election campaigns rather than independent bodies with expertise in relevant skills and standards.

Recommendation 6 is to introduce activity-based regulation of scope of practice. This recommendation demonstrates the review's continued failure to understand that scope of practice is dynamic and contextual – a qualification is not the sole determinant of scope. The determination of scope of practice should remain with the relevant National Boards. Proposals to expand scope should continue to proceed through the consultation process they currently undertake, with regulation impact statements conducted.

We continue to be very supportive of enhancing collaborative multidisciplinary care and ensuring all health professionals can work to their full breadth of scope in primary care, but this requires better funding models and improvements to the many reforms currently underway in general practice, such as MyMedicare. We need strong clinical governance to ensure that full scope is safe scope, and that we are truly working together.

Recommendation 12 is to introduce direct referrals from non-medical health professionals to non-GP specialists. We never understood where the suggestions in this list came from (for example, osteopaths referring to orthopaedic surgeons), but the AMA was not consulted. As I highlighted directly to the reviewer, there have been many instances where an allied health professional has referred a patient to me with the expectation that I would then refer on to a non-GP specialist, only for the issue to be one I can easily manage as a GP. The issue is that our allied health colleagues do not understand the scope of a GP. This recommendation risks both the MBS budget and creating backlogs to non-GP specialists through unnecessary referrals.

This recommendation is frustrating because our health system already has the Medical Services Advisory Committee (MSAC), which can consider the value of this recommendation. The same goes for recommendation 11 to introduce bundled payments for maternity care. MSAC is an independent, expert body that appraises proposals for public funding for new medical services and provides advice to government based on an assessment of its comparative safety, clinical effectiveness and cost-effectiveness. We need to support and use the mechanisms that exist – not reinvent the wheel.

It's not entirely bad news – there are a couple of recommendations that we do like in the review, such as recommendation 7, the harmonisation of existing legislation and regulation, and recommendation 9, the establishment of an Independent Mechanism to provide evidence-based advice and recommendations on workforce models and scope of practice, provided it includes economic assessment.

It is important to note this is just a review. The government is yet to announce any actions in response to the report, and we are working to ensure any actions do not further fragment care or undermine our GPs. All our public submissions are available on the AMA website including our response to the final report.

/ EXPRESSIONS OF INTEREST /

WORKSAFE TRANSPORT ACCIDENT COMMISSION (TAC) COMMITTEE

AMA Victoria is seeking expressions of interest from members to join its WorkSafe TAC Committee, an influential body for addressing issues affecting doctors and their patients in dealings with the Victorian workers' and transport accident compensation schemes (Schemes).

The Committee plays a key role in identifying emerging concerns within the Schemes, making recommendations to the AMA Victoria Board on policy and advocacy priorities at both the state and national levels. Members also help ensure robust medical participation in the Schemes and maintain relationships with Ministers, WorkSafe, and the TAC.

With recent significant changes to Victoria's WorkCover Scheme and ongoing uncertainty about its future operation, this is an opportune time to get involved, advocate for your profession, and influence the direction of these compensation systems.Your input will be essential in shaping the future landscape for medical practitioners and their patients under the Schemes.

We encourage representation from all relevant specialties, and currently, General Practice, Psychiatry, Surgery, Anaesthesia, and Occupational Medicine are represented. Meetings are held online via Microsoft Teams on the first Wednesday of every second month, starting at 7:00 am and lasting one hour. The first meeting of 2025 is scheduled for Wednesday 5 February.

If you're interested in joining this important committee, please send an expression of interest to Senior Policy Adviser, Lewis Horton, at LewisH@amavic.com.au.

GET INVOLVED

AMAV SOCIALS

Click here if you would like to contact our digital comms specialist

Dr Daniel Garcia
@DrDanGarcia
It's important for all doctors to be involved and to raise their voices to be heard as we enter EBA negotiations.

Well done on @jilltomlinson @amavictoria and ASMOF Victoria on leading the charge!

I know I'll be making my voice heard so that we can reach a fair EBA!

Dr Daniel Garcia
@DrDanGarcia
I'm so proud of @VictorianLabor, @amavictoria, @JacintaAllanMP, @IngridStitt, and @jilltomlinson for supporting and promoting pill testing. The evidence is clear: pill testing saves young people's lives.

Let's make safer choices this festive season. Read more here: https://premier.vic.gov.au/first-festival-chosen-pill-testing-trial

Simon Judkins
[on the announcement of commencing the pill testing trial of ten festival events]: "Very welcomed decision supported by evidence... more of this please."

Sue Velovski
[On standing up for international medical graduates]: "Thank you AMA Victoria in your advocacy for doctors who support our communities in so many ways."

AMA Victoria
A fantastic afternoon at our sold-out gathering for retired doctors at Young and Jackson, where attendees heard from our special guest presenter, Laureate Professor Peter Doherty.

Professor Doherty shared his unique insights into the post-election landscape and delved into his adventures in public science communication, including his extensive experience in making complex scientific topics accessible to the public.

Thank you to all who attended, we look forward to the next retired doctors' event in March next year!

Kay Bloom
[On the inquiry into women's pain]: "This inquiry is such an important step towards addressing women's pain and the broader impact it has on health equity."

Roisin Worsley
[On AMA Victoria's advocacy regarding parental leave payments to doctors on fixed term contracts]: "Great to see AMAV's focus on equity. Health services that aren't fair to their own employees aren't likely to be fair to patients either."

AMA Victoria
In an MJA Insight+ article, AMA Victoria President Dr Jillian Tomlinson explains why the way Ahpra (Australian Health Practitioner Regulation Agency) currently sets its fees is inconsistent with its stated values.

The National Health Practitioner Ombudsman is also investigating whether Ahpra's fee approach is fair and reasonable. With Ahpra's CEO Martin Fletcher stepping down next month, Ahpra continues its review of registration fees, focusing on "protected attributes" such as parental leave status and disability, which are recognised under anti-discrimination laws. While this is a positive step forwards, we know that applying the principles of equity is broader than merely avoiding unlawful discrimination, and we're making that clear.

Help us spread the word by sharing and signing our petition (megaphone.org.au/p/ahpra) and sharing the article below. Let MPs know that this issue is important to you. Help us create a fairer system for all, and push Ahpra to walk the walk when it comes to equity, inclusion and diversity within Australian healthcare.

Together we are making positive change.

Dr Anu Ganugapati
[On AMA Victoria's regional and rural clinician forum]: "Thanks for organising it @Jill Tomlinson. It was great to hear so many different ideas of rural Victoria."

Jill Tomlinson
Australian Medical Association (Victoria) President Dr Jill Tomlinson called on the Federal Government to invest more into Medicare.

"Preventative and primary health care, delivered by general practice, is why Australia has one of the world's best health care systems – and that's what we need to fight to maintain," she said.

Jill Tomlinson
Great meeting today for Australian Medical Association (Victoria) at ANMF headquarters discussing workforce, health service finances, data solutions and gender equality.

Dr Jill Tomlinson
Great to represent AMA Victoria at the General Practice Innovation Grants Co-design Workshop. The workshop, convened by the Victorian Department of Health, brought together key stakeholders to help shape the grants program, focusing on guiding its scope, project specifications, and measures of success for proof-of-concept projects. The grants aim to:
- Improve health and wellbeing outcomes for specific populations.
- Reduce emergency department presentations and prevent avoidable hospital admissions.
- Demonstrate the value of integration across the patient care pathway by addressing gaps between general practice and other health services.

It's encouraging to see the commitment to supporting innovative, patient-centered approaches in general practice, and AMA Victoria looks forward to seeing the impact of this important work on Victoria's healthcare system.

Preventative and primary health care, delivered by general practice, is why Australia has one of the world's best health care systems — and that's what we need to fight to maintain.

AMA Victoria
A win in the fight for fair pay for junior doctors!

As many are aware, ASMOF Victoria and junior doctors, with support from AMA Victoria, have advanced class actions against multiple Victorian health services over systemic failures to pay doctors in training for their overtime.

The Federal Court issued a major ruling, ordering Peninsula Health to pay a $316,260 penalty for neglecting to compensate a junior doctor for overtime. This significant penalty sends a strong message: doctors deserve fair pay for every hour worked, and this practice of forced, unpaid overtime must end.

With ASMOF Victoria, junior doctors and AMA Victoria leading the fight, we are working to uphold basic legal entitlements under enterprise agreements. In its ruling, the Court highlighted troubling practices:

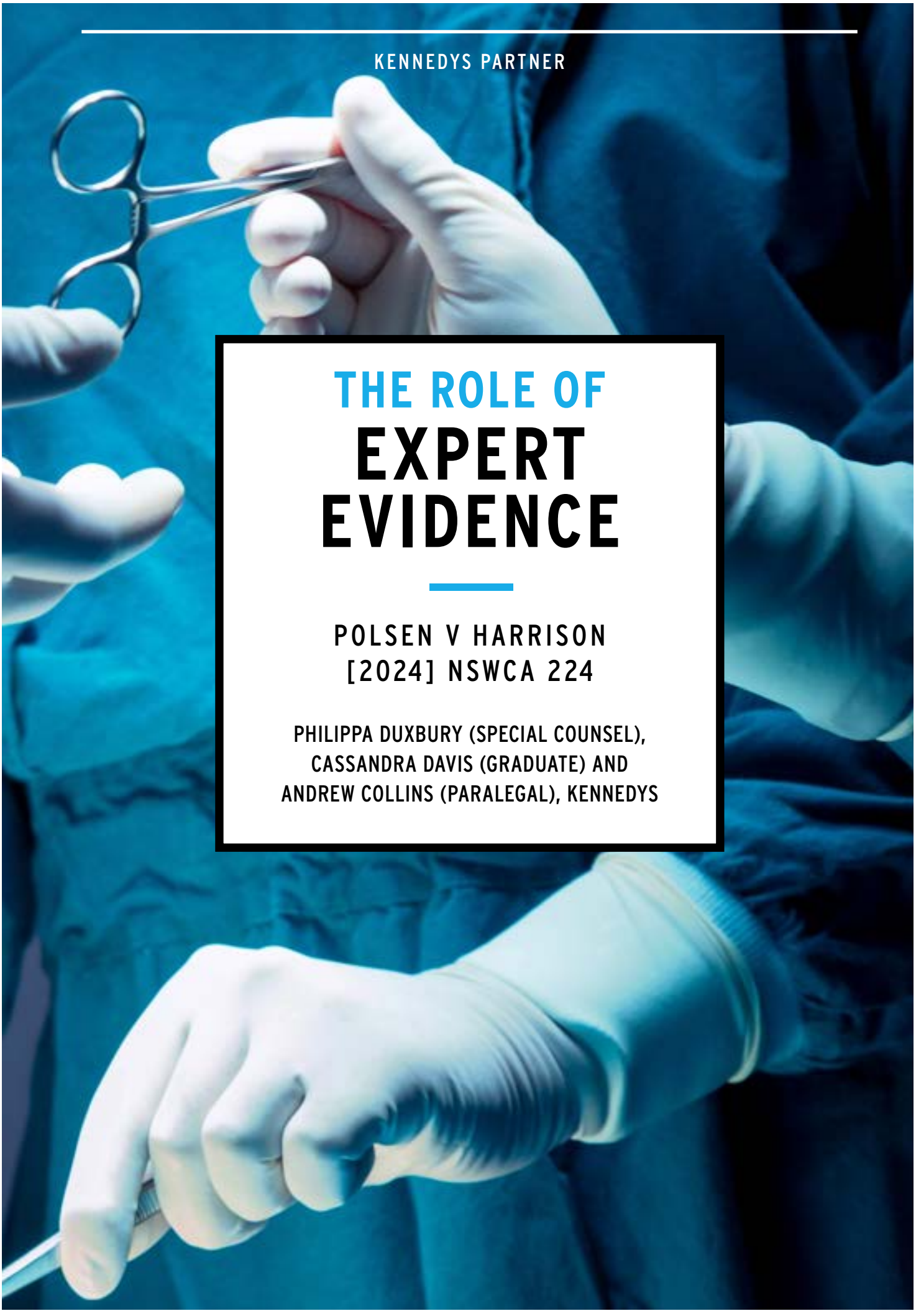
- "Peninsula Health was prepared to expressly and brazenly instruct junior doctors to perform unpaid work."
- Evidence pointed to a "highly irresponsible attitude by Peninsula Health to its obligations to pay for unrostered overtime that it authorised be worked."
- Underfunding of public health services is also part of the problem, the Court noted.

A mediation session with ASMOF Victoria, brave lead applicants, Victorian health services, and the State Government is set for 17 January 2025. We are hopeful for a global settlement, but if mediation fails, we are prepared to keep fighting in court to protect doctors' rights.

You can help by staying informed, spreading the word and supporting your colleagues by confidentially registering with Gordon Legal to stay updated on the Junior Doctors Class Action: https://gordonlegal.com.au/.../vic-junior-class-action/.

Let's stand together for the rights and futures of doctors in training in Victoria. It's time for the State Government to step up!

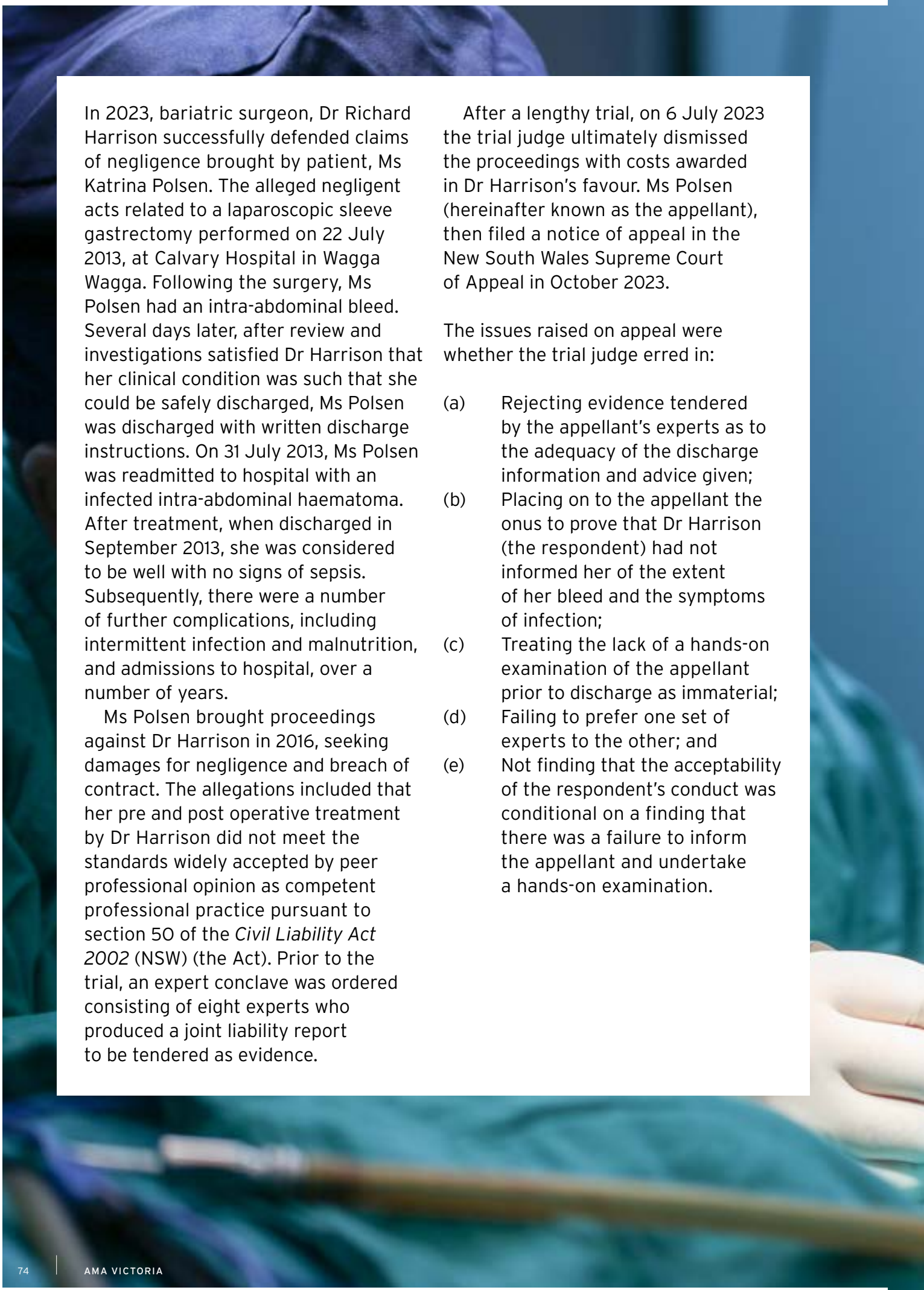
KENNEDYS PARTNER



THE ROLE OF EXPERT EVIDENCE

POLSEN V HARRISON [2024] NSWCA 224

PHILIPPA DUXBURY (SPECIAL COUNSEL), CASSANDRA DAVIS (GRADUATE) AND ANDREW COLLINS (PARALEGAL), KENNEDYS



In 2023, bariatric surgeon, Dr Richard Harrison successfully defended claims of negligence brought by patient, Ms Katrina Polsen. The alleged negligent acts related to a laparoscopic sleeve gastrectomy performed on 22 July 2013, at Calvary Hospital in Wagga Wagga. Following the surgery, Ms Polsen had an intra-abdominal bleed. Several days later, after review and investigations satisfied Dr Harrison that her clinical condition was such that she could be safely discharged, Ms Polsen was discharged with written discharge instructions. On 31 July 2013, Ms Polsen was readmitted to hospital with an infected intra-abdominal haematoma. After treatment, when discharged in September 2013, she was considered to be well with no signs of sepsis. Subsequently, there were a number of further complications, including intermittent infection and malnutrition, and admissions to hospital, over a number of years.

Ms Polsen brought proceedings against Dr Harrison in 2016, seeking damages for negligence and breach of contract. The allegations included that her pre and post operative treatment by Dr Harrison did not meet the standards widely accepted by peer professional opinion as competent professional practice pursuant to section 50 of the *Civil Liability Act 2002* (NSW) (the Act). Prior to the trial, an expert conclave was ordered consisting of eight experts who produced a joint liability report to be tendered as evidence.

After a lengthy trial, on 6 July 2023 the trial judge ultimately dismissed the proceedings with costs awarded in Dr Harrison's favour. Ms Polsen (hereinafter known as the appellant), then filed a notice of appeal in the New South Wales Supreme Court of Appeal in October 2023.

The issues raised on appeal were whether the trial judge erred in:

(a) Rejecting evidence tendered by the appellant's experts as to the adequacy of the discharge information and advice given;
(b) Placing on to the appellant the onus to prove that Dr Harrison (the respondent) had not informed her of the extent of her bleed and the symptoms of infection;
(c) Treating the lack of a hands-on examination of the appellant prior to discharge as immaterial;
(d) Failing to prefer one set of experts to the other; and
(e) Not finding that the acceptability of the respondent's conduct was conditional on a finding that there was a failure to inform the appellant and undertake a hands-on examination.

The expert opinion did not provide any basis for considering that the haematoma should have been identified as infected prior to discharge. The first ground of appeal was rejected in its entirety.

REJECTION OF EVIDENCE

The appeal judgment confirmed that the adequacy of the instructions given to the appellant on discharge was not part of her pleaded case and the court was not open to make such comments. As such, the trial judge did not err in rejecting evidence that the appellant attempted to tender from the experts.

The court considered the only material criticism put forward by an expert to be the respondent's treatment of the haematoma and not her discharge. However, it was emphasised that, as indicated by the experts, the respondent was required to only consider the risk of infection, which it was established he did. The expert opinion did not provide any basis for considering that the haematoma should have been identified as infected prior to discharge. The first ground of appeal was rejected in its entirety.

FAILURE TO INFORM

In the appeal submissions made by the appellant, it was stated that the respondent bore the onus of proof under section 50, to show that his practice was widely accepted. The appeal judgment provided that the nature of the statute was misunderstood. The section provides a standard against which a claim for breach of duty of care must be assessed. As such, it was the appellant who was responsible for identifying the conduct that she alleged breached the duty of care.

This ground of appeal raised issues of relevance with expert evidence at trial raising whether the appellant was informed that she had lost a large volume of blood when she was discharged. The trial judge rejected this evidence as it did not form part of the pleaded case, nor did it focus on the allegations of negligence at hand. On appeal, counsel for the appellant attempted to reframe the evidence by stating that it was "a failure to provide information about what [the appellant] should be on the lookout for, and to discuss how serious the situation was." The appeal judgment found that based on the expert evidence, the respondent adequately informed the appellant of risks prior to her discharge.

FAILURE TO UNDERTAKE HANDS-ON EXAMINATION

The court also considered the appellant's submissions that the respondent's experts did not address that a physical examination was not undertaken prior to discharge. It was found however, that the respondent's evidence did not contradict the scope of the questions asked of the experts. During the trial, evidence was tendered by the nursing staff in charge of the post-operative care of the patient and an ICU doctor, who advised the respondent of the appellant's condition. No expert raised concerns about this practice, nor that the evidence of the medical staff suggested incompetence and ultimately the submissions lacked substance on appeal.

ASSESSING THE MERIT OF EXPERT OPINIONS

The appeal submissions made by the appellant suggested that it was the function of the trial judge to conduct analysis of the competing approaches advocated by the experts and to decide on their merits. The appeal judgment confirmed that this was misconceived and the judge's function is to evaluate all of the opinions and decide overall, whether the expert evidence satisfies the relevant criteria.

The Court highlighted that, in the context of section 50(3) of the Act, a court is under no duty to compare the relative merits of competing expert opinions. There is express acknowledgment in section 50(3) that there can be "differing peer professional opinions widely accepted in Australia". Although one avenue of management might be preferred by some experts, a different approach constituting competent professional practice was not inconsistent with satisfaction of the section 50 standard. That some competent peers might have drained the haematoma before discharging the plaintiff was not inconsistent with satisfaction of the section 50 standard.

The court noted that it is common in negligence, where expert evidence is tendered, to ensure that the experts assess the correct "manner" of the respondent's medical services. In other words, the experts must provide opinion within the scope of the conduct, rather than comment on action taken by the medical practitioner that is not relevant to the proceedings.

The court clarified that although there may be conflicting views which refute a standard of care expressed by experts, this does not necessarily remove the standard from being widely accepted. In addition, the court determined that this ground of appeal was no more than an assumption. The assumption that the judge was required to prefer one set of opinions to another was inconsistent with the language and purpose of section 50 of the Act. This formed a central part in the court's rejection of the appellant's submissions.

CONDITIONALITY OF EXPERT OPINIONS

Finally, the appellant submitted that the respondent's experts expressed opinions that were conditional. It was suggested that the respondent's expert opinions were inadequate to support the respondent's conduct because their opinions were coupled with conditions, namely that it was a precondition to the appellant's discharge that she had been properly examined and informed. The appellant submitted that this condition was not satisfied. The appeal judge considered this submission without substantial basis, noting that the experts explained and justified their opinions.

Ultimately, the court dismissed the appeal by the appellant and ordered the appellant pay the respondent's costs.

KEY TAKEAWAYS

Polsen v Harrison provides clarity on the interpretation of the language under section 50 and emphasises that what is considered "widely accepted" in medical practice need not be universally accepted.

The "widely accepted" test is generally imprecise and requires final judgment by the Court. Various elements may impact a determination that a practice is widely accepted including the seniority of the expert, practice, knowledge and experience. The appeal judgment provided clarification that a judge must be satisfied that the questions asked of the experts in conclave, meet the parameters of the claim.

Essentially, the assumption that the judge was required to prefer one expert's opinion over another is inconsistent with the purpose of section 50. The purpose of the section is to allow a judge to decide if the expert evidence, even if conflicting, demonstrates a basis for accepting that the practice in question is widely accepted.

While this is a New South Wales decision, it is of interest in Victoria as the standard of care for professionals set out in section 50 in the New South Wales legislation is replicated in section 59 of the *Wrongs Act (1958)* Vic).

This case is an important reminder that expert opinion needs to be based on and supported by the evidence, as this is critical when assessing the respective merits of expert opinion and the issue of negligence. As always, this brings in to focus the need for detailed record keeping by clinicians which, in turn, enables experts to base opinions upon substantive evidence.

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