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AMA VICTORIA

WINTER 2023



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Growing our future leaders*

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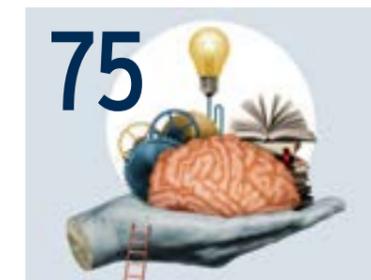
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YOUR  
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# NEWS, VIEWS+ REVIEWS

VICDOC

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**AMA VICTORIA PRESIDENT, DR JILL TOMLINSON RESPONDS IN THE AGE TO THE ANNOUNCEMENT THAT THE ROLE OF COMMUNITY PHARMACISTS WILL BE EXPANDED FROM OCTOBER AS PART OF A NEW 12-MONTH PILOT.**

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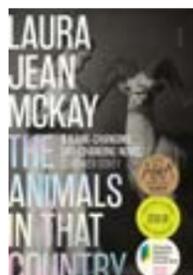
**ON HER FIRST DAY AS AMA VICTORIA PRESIDENT, DR JILL TOMLINSON SPOKE TO 3AW'S NEIL MITCHELL ABOUT HOW THE HEALTH SECTOR FARED IN THE VICTORIA STATE BUDGET.**

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**FORMER AMA VICTORIA PRESIDENT DR RODERICK MCRAE RESPONDS TO THE THREAT OF HEALTH DEPARTMENT CUTS IN THE VICTORIAN STATE BUDGET.**

[Click here to read](#)

## IN REVIEW: READ | WATCH | LISTEN



### THE ANIMALS IN THAT COUNTRY

*Speculative fiction by  
Laura Jean McKay*

The timing of Melbourne-based writer Laura Jean McKay's debut novel, *The Animals in That Country*, was uncanny. Released just as COVID kicked in in early 2020, it imagined a pandemic scenario – but not COVID, 'zooflu'. In McKay's taut, stunning and somewhat disturbing story, zooflu enables humans and animals to communicate. Sure, it's a little far-fetched but animal expert McKay manages to convincingly and at times disturbingly take readers inside the heads of animals, along with her main character, Jean, an alcoholic grandmother trying to keep life and her family together who works at a wildlife park. The book won McKay a host of awards, including the Victorian Prize for Literature, the Fiction Award at the Victorian Premier's Literary Awards and the Arthur C. Clarke Award. You'll never look at crows in the same way again.



### SWEET TOOTH

*Fantasy drama series on  
Netflix by Jim Mickle*

Sweet Tooth is another exploration of what the world might be like under pandemic conditions where the line between humans and animals has shifted. Based on Jeff Lemire's comic book series and created by Jim Mickle, it premiered on Netflix in June 2021. It's set in a dangerous post-apocalyptic world where a pandemic has wiped out most of humanity and hybrid children, part human and part animal, have started to emerge. The central characters are Gus, a young hybrid deer boy and a wandering loner named Jepperd who embark on a perilous journey to find answers about Gus' origins and the world around him. Along the way, they encounter characters and obstacles that test their courage and determination with themes of hope, resilience, and the power of human connection shining through. The much anticipated second season started in late April.



### RADIOLAB

*WYNC Podcast hosted by  
Lulu Miller + Latif Nasser*

[Radiolab](#) is quality investigative journalism in podcast form. Its unusual subject matter, blend of science, legal history, travel and global intrigue, underpinned by committed, sometimes multi-year research makes for a compelling format. For one recent episode, *The Library of Alexandra*, reporter Eli Cohen researched Sci Hub, a shadow library website that provides free access to millions of research papers, free, in disregard of publisher paywalls and international copyright laws. Cohen tracked down Sci Hub's founder online and spent months chatting to her online before travelling to Kazakhstan to meet and interview her in person. It's a fascinating listen. Others worth diving into are *Where Am I*, starring author and neurologist Oliver Sacks and exploring missing limb syndrome, and *Laughter*, which explores why we laugh (spoiler alert: humour has very little to do with it).

## RESEARCH

# PATIENTS MORE LIKELY TO MODIFY LIFESTYLE WHEN THEY VISUALISE HEART DISEASE

Visualising early heart disease using cardiac imaging helps with patient understanding of risk and adherence to medication and lifestyle change, according to a new study by researchers from the Baker Heart and Diabetes Institute and the Menzies Institute for Medical Research.

Researchers found patients who viewed calcium or plaque build-up in their arteries using cardiac imaging had improved levels of risk factors like cholesterol and high blood pressure and overall heart risk reduction, the paper in [JACC: Cardiovascular Imaging](#) shows.

The study, led by PhD candidate Kristyn Whitmore, involved six randomised controlled studies involving over 7000 patients and is believed to be the first to determine whether patient visualisation of heart images improves the 10-year Framingham risk score and individual risk factors.

Senior author and cardiologist at the Baker Institute, Professor Tom Marwick says, "It can be difficult to get a person who feels completely well to take tablets every day to reduce their cardiac risk but once you show people that the blood vessels are damaged, they realise it's not about controlling a risk factor that may never cause a problem – it's about treating a disease that has actually started."

"We need to look closely at how to better support GPs to promote risk modification and prevention strategies, and patient visualisation of early heart damage using cardiac imaging is one tool that warrants further investigation," Professor Marwick says.



*Click here to  
read about  
Prof Marwick*



*Click here for  
imaging  
research*



## What's On —

1–31 JUNE

[Bowel Cancer  
Awareness Month](#)

12–18 JUNE

[International Men's  
Health Week](#)

21 JUNE

[MND Global Day](#)

1–31 JULY

[Dry July](#)

1–31 JULY

[Donate Life Week](#)

5 AUGUST

[Jeans for Genes Day](#)

7–13 AUGUST

[National Stroke Week](#)

25 AUGUST

[Daffodil Day](#)

AMA VICTORIA'S NEW PRESIDENT

DR JILL TOMLINSON

# WELCOMING DR JILL TOMLINSON AS INCOMING AMA VICTORIA PRESIDENT

Jill brings over 20 years of clinical, research and leadership experience to the Presidential role. She has been actively involved with the AMA Victoria Board since 2017, and has served as Vice-President (2022-23), Chair of the Audit, Risk and Compliance Committee (2019-22), and Area Representative on Federal Council (2016-21). Jill is a plastic, reconstructive and hand surgeon who runs an innovative, technology-led private practice, established in 2013. We sat down with Jill for a broad-ranging and insightful Q&A.

INTERVIEW VANESSA MURRAY



#### WHAT'S YOUR ELEVATOR PITCH ON THE IMPORTANCE OF AMA VICTORIA?

AMA Victoria plays a vital role in advocacy for Victorian doctors and their patients and the Victorian healthcare system. Through my involvement in state and federal AMAs I've come to realise just how broad and complex our healthcare system is, and that there are many silos and disparities preventing quality healthcare and communication. AMA Victoria has a prominent voice and important seats at important tables, and it's the only organisation in Victoria that's advocating for all doctors and medical students, not solely a single craft group or special interest group.

#### WHAT DOES GOOD LEADERSHIP LOOK LIKE TO YOU?

A good leader is somebody who listens, and acts. They might not act immediately, and they don't act reactively. They're somebody you can take a problem to, who will listen and seek to resolve the problem in a way that achieves the best outcome for all involved. I think I'm a leader who encourages people from different fields and people who might otherwise stay silent to become engaged and speak up about issues that matter to them. I consider servant leadership, where the goal of the leader is to serve, is very important in an organisation like AMA Victoria. We need and respond to leaders who are actively engaged with the profession and have members' and patients' interests at heart.



*A good leader is someone who listens and acts.*

#### YOU'VE BEEN A LONG-TIME ADVOCATE FOR DIVERSITY, EQUITY AND INCLUSION. WHAT HAS THAT LOOKED LIKE?

During my plastic surgical training I received an \$89,000 Commonwealth Grant from the Office For Women to run a leadership program for the Australian Federation of Medical Women. Then, one of my first motions at Federal Council in 2016 related to introducing gender targets, which were later implemented and finally achieved last year. Going forward there will be 40% men, 40% women, and 20% flexible representation on the various committees, councils and boards. AMA Victoria is a gender equity leader in the national AMA family, in that we are the only state AMA with a gender quota for our Board. That said, there is more work to be done in terms of broader inclusion and diversity within our board and membership. We know that the face of the AMA membership is changing, and this reflects the changing nature of the medical profession. But beyond gender we need to look at diversity more broadly to include ethnicity, culture, sexuality and disability.

WE'RE THRILLED TO ANNOUNCE THAT DR JILLIAN (JILL) TOMLINSON IS THE NEW PRESIDENT OF AMA VICTORIA.





### *Jill's presidential priorities*

- 1 Healthcare workforce matters, including burnout, funding and planning
- 2 Primary care and general practice, including payroll tax
- 3 Mental health, including ensuring that the views of medical specialists are sought and included within Victoria's mental health reform
- 4 Sustainability of workforce, fiscal, environmental, public hospital, aged care, general practice
- 5 Digital health initiatives to drive improvements in safety, quality and efficiency
- 6 Dealing with delayed and deferred healthcare resulting from the Covid-19 pandemic
- 7 Equity and inclusion, especially social determinants of health such as housing shortages, food insecurity, income/poverty, social inclusion, access to affordable and quality healthcare, early childhood development, education
- 8 Rural and regional health

#### HOW CAN WE ENSURE THAT EVERYBODY IN VICTORIA CAN ACCESS THE HEALTHCARE AND TREATMENT THEY NEED?

We are very fortunate that we have a world class public hospital system. While it's under significant strain we don't have the same disparities that exist elsewhere in the world, such as in the United States, where if you don't have the ability to pay for insurance and healthcare you sometimes simply cannot access essential treatment. There is differing access between public and private but overall, we have relatively good access when we compare ourselves to other countries. However, access could be improved for rural and regional areas and that remains a significant focus for AMA Victoria because the Government can be metrocentric, and we need to ensure that everybody across the state has access to quality healthcare, regardless of their postcode.

#### WHAT IS YOUR PERSPECTIVE ON DIGITAL HEALTHCARE AND DATA?

Digital health offers tremendous potential for connecting healthcare system silos, but uptake of digital healthcare, including My Health Record, has lagged. I've been involved with the Department of Health's Clinical Informatics Advisory Group, and I implemented My Health Record in my practice in 2017. Those experiences allow me to better understand some of the great challenges in interoperability between different parts of the healthcare system, and software design. We need software and digital health systems that work for doctors rather than create work for doctors; that facilitate workflow and allow doctors to focus on patient care rather than on

entering and classifying data. It's important that we have accurate and detailed data, because without that data it's very difficult to determine what is high value healthcare and where we should be investing to get the greatest benefit for patients.

#### WHICH OF YOUR OTHER PRIORITIES WOULD YOU ESPECIALLY LIKE TO HIGHLIGHT?

General practice is under significant strain. It's the most efficient part of the healthcare system, and it's where we should be allocating more resources and creating more respect for the work of general practice, which is unfortunately at times undervalued and poorly understood. In mental health care, as Victoria undergoes a significant period of reform, AMA Victoria has been lobbying to ensure that the medical perspective is not sidelined. I am determined to continue this advocacy over the next two years.

#### WHO HAVE SOME OF YOUR MENTORS BEEN?

Professor John Mearra was a surgeon from Boston at the Royal Children's Hospital Melbourne when I worked there in 2003. He was an excellent leader who prompted me to reflect on the important roles played by heads of units and healthcare systems leaders. Dr Desiree Yap and Dr Kate Duncan, who I met through the Victoria Medical Women's Society, have been exceptionally supportive and influential. I believe Kate was the first AMA Victoria Councillor to have a baby while in office, and the fact that I'll do that as AMA Victoria President later this year perhaps reflects the changing times and face of AMA Victoria and its leadership.



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## LEADERSHIP FEATURE



# ON LEADERSHIP

*Six healthcare industry leaders on how they lead, what constitutes good leadership and where leaders need to focus.*

SERIES VANESSA MURRAY





## ADJ PROF KAREN PRICE

IMMEDIATE  
PAST PRESIDENT  
OF THE RACGP

**Karen is the immediate past President of the RACGP (2020-2022), a Clinical Adjunct Professor at Monash University and a co-creator and director of GPsDownUnder, an online learning forum for 10,000+ Australian and New Zealand GPs. She is a former Chair of the Women In General Practice Committee Victorian Faculty, and current Chair of the Host Organising Committee for the WONCA World Conference 2023, which is being hosted by the RACGP in Sydney from 26-29 October. Karen has 30 years' experience in general practice and is completing a PhD on The Role of Peer Connection in General Practice with Monash University.**

### **I'VE ALWAYS BEEN A COMMITTED HUMANIST.**

In my first practice, we got together and changed some of the ways that we operated within the practice, for the good of the patients and the doctors. Even back then I was able to sit outside the day-to-day and see things in a more systemised way – but also to zoom in, in a very human way. It's often a matter of getting the balance right. Having a good sense of humour and being able to relax and go with the flow has been helpful.

### **IT'S IMPORTANT TO REALISE THAT YOU MIGHT NOT BE IN A FORMAL LEADERSHIP ROLE, BUT YOU'RE STILL ABLE TO LEAD.**

There are all types of leadership. There's leadership in your community and your family. Maintaining your relationships in your community, with your family and friends, requires a fair bit of effort. It's important to make sure that you are not neglecting one for the other, and that you don't let your career eclipse your personal and family life.

### **AS A DOCTOR, EVEN IF YOU NEVER VENTURE INSIDE A COLLEGE, OR CANBERRA, YOU'LL BE CALLED UPON TO LEAD IN ALL SORTS OF SITUATIONS.**

You'll be called upon to make all sorts of decisions, in every single consultation. And your license basically depends on making the right decision. There is an element of leadership and we first experience it in medical school, when we're asked to make decisions – it's the training we've had to have that clinical leadership. Being able to take responsibility and change direction are both necessary. When we talk about clinical autonomy, we're talking about who has responsibility for that decision. Clinical decision making is an enormous responsibility for patient care. It comes with a whole set of privileges and responsibilities.

“

*Compassion is a human quality, and it's part of good leadership. If we can bring a sense of compassion to our leadership of other people, we're lifting everybody up. It's an enormously strong quality and it requires a lot of strength to maintain empathy in the face of this world.*

**ADJ PROF KAREN PRICE**



**IF YOU'RE GOING TO LEAD, YOU'RE GOING TO BE A BIT OF A CHANGEMAKER.**

You're going to come up against resistance, and you have to stand firm with your vision and your values in a reasonable way. Sometimes you're going to have to stand against a lot of resistance. This is especially true in the discipline of expert generalism and complexity.

**WE HAD PUSHBACK FROM ALL SORTS OF PEOPLE REGARDING THE ESTABLISHMENT OF THE GPSDOWNUNDER COMMUNITY.**

There's very deliberately no hierarchy in GPsDownUnder, which is essentially a learning and advocacy platform. There was definitely some resistance and distrust at its establishment, despite the fact it helps to connect and engage over 10,000 GPs in Australia and New Zealand. The Women In General Practice Committee, we stuck at that. We were committed to delivering business skills and leadership discussions for women. We were committed to professional development for women including public speaking. We felt that it was part of the professional skillset GPs need. And at that time, it wasn't recognised as a skill that could be recorded as continuing professional development. But now it is. I think sticking at it, despite the pushback, was really important. Professional development and leadership have many skill requirements which benefit patients.

**CONTEMPORARY MEDICAL LEADERSHIP REQUIRES A WHOLE RANGE OF SKILLS, AND MANY OF THEM ARE UNDERESTIMATED.**

Under the current model, nearly all doctors are essentially practice owners. Some host other practices within their practice and they own or lease the building and take responsibility for that. Others are contractors and have their own business within that business. So, understanding the environment of business and politics is important. Governance is important. Public speaking, communication and negotiation are important. To have a sustainable practice we need to understand the legislative and fiscal environment that health fits in, so understanding systems is important. We don't have to know everything, but we have to be aware of where we sit.

**COMPASSION IS A HUMAN QUALITY, AND IT'S PART OF GOOD LEADERSHIP.**

If we can bring a sense of compassion to our leadership of other people, we're lifting everybody up. It's an enormously strong quality and it requires a lot of strength to maintain empathy in the face of this world. I hope I have done that, and when empathy fails me, that I am self-aware enough and skilled enough to know how to restore it.

A portrait of Dr. Simon Judkins, a middle-aged man with glasses, wearing a light brown blazer over a white shirt. He is standing outdoors in front of a brick wall. The portrait is partially overlaid by a dark blue circular graphic on the right side of the page.

## DR SIMON JUDKINS

DIRECTOR OF  
EMERGENCY MEDICINE  
ECHUCA REGIONAL  
HEALTH

**Simon is the Director of Emergency Medicine at Echuca Regional Health. Prior to that he spent more than 20 years as an emergency physician with Austin Health, including a stint as ED Director at the start of the Covid pandemic. Simon has been an AMA Victoria Board member since March 2021, and is Past President of the Australasian College of Emergency Medicine (ACEM), where he continues to focus on workforce planning, health system reform and mental health advocacy. He was a conference convenor for the International Conference on Emergency Medicine 2022 in Melbourne, and is especially interested in health equity, social justice, regional and rural health, and mental health.**

### **I'VE BECOME ACUTELY AWARE OF THE INEQUITIES BETWEEN URBAN AND RURAL HEALTH.**

When I first started in Echuca, the staffing was heavily reliant on locums, with not many people committed long-term. We're now accredited for training with three different colleges, and we have a very stable medical workforce which is delivering really good care. Even so, if we see a hundred patients in a day it can be fairly overwhelming because we're a relatively small department with less resources than in a major urban setting with all the bells and whistles. There need to be a lot more resources directed to rural health.

### **BEING A LEADER IS IN LARGE PART ABOUT BECOMING AN ADVOCATE FOR CHANGE.**

I've learned it's about working with, or sometimes working against, the system to try and improve patient care. We need to do better; we need to be able to achieve better patient outcomes and better work conditions. As doctors our goal is essentially to make things better for our patients.

### **YOUR PATIENTS NEED TO SEE YOU AS SOMEBODY WHO THEY CAN TRUST, WHO IS HONEST AND HAS INTEGRITY.**

Medicine is about humans interacting. You can be the best technician or the smartest person in the room, but if you can't engage your patients and create trust then the clinical outcomes you desire may not get delivered. The same applies for the teams you work with. Trust and honesty are critical for truly effective leadership.

**I TRY TO LEAD IN A WAY THAT INSPIRES THE PEOPLE AROUND ME TO WANT TO TURN UP.**

That might be by delivering better care or pursuing learning opportunities or progressing their career or passing their exams. My role as a leader is to try to inspire people and provide opportunities so they can be the best people they can be. If you lead successfully, then you can really make a difference in peoples' lives.

**I THINK DIVERSE, DISTRIBUTED LEADERSHIP IS INCREDIBLY IMPORTANT.**

I rely on every one of my clinicians to step up and be a leader. I try to instill in them is that every time they step on the floor, they're taking on a leadership role. Because the wider team will be looking for them when things get busy, or there's an unwell patient. They'll be looking for them to step up and take control and lead.

**I'VE HAD PLENTY OF FAILURES. I'VE EITHER LET PEOPLE DOWN OR LET THE TEAM DOWN OR HAVEN'T MET THEIR EXPECTATIONS.**

And I've certainly been held accountable. Every one of those incidents or events was an opportunity to reflect and learn and do things better the next time. Good leadership or really, just being a good person is about learning from your mistakes. Get clarity on your values, be honest and encourage people; if people trust you, you'll ultimately achieve those leadership goals.

**WHEN I BECAME PRESIDENT AT ACEM WE WERE VERY MALE DOMINATED. I MADE A DELIBERATE EFFORT TO CHANGE THAT.**

That was in 2017. We were an all-male board, and most of our leadership positions were taken up by men. I'm a real believer in the saying "You can't be what you can't see." Now, a number of years later, we have the second female president of the college. Our board is very equitable. There's much more female representation in our leadership position, and I'm the first male member of the Advancing Women in Emergency Medicine Network. The next stage is to work that through into leadership positions in emergency departments across Australia and New Zealand.

**WE'RE MOVING TO A STYLE OF LEADERSHIP THAT IS COLLABORATIVE, SUPPORTIVE, ENGAGING AND GROWTH-ORIENTED.**

When I was a junior doctor, professors in white coats were the leaders in the hospital. They led with an authoritarian style. "This is the way you are going do things around here" and you aren't going to question them. That style of leadership is still in existence in some places, but it's dying out.

**GOOD LEADERSHIP IS ABOUT MAKING SURE THAT YOU ARE AT SOME POINT REPLACEABLE.**

The best leaders are going to get to a point where they say, "Well, I've done my bit now and I've helped all these people grow, I've supported all these people around me, and it's time for me to step away and let somebody else take the reins."

“

*I rely on every one of my clinicians to step up and be a leader. I try to instill in them is that every time they step on the floor, they're taking on a leadership role. Because the wider team will be looking for them when things get busy, or there's an unwell patient.*

**DR SIMON JUDKINS**





**A/PROF  
SHALINI  
ARUNOGIRI**

CLINICAL DIRECTOR  
STATEWIDE CENTRE FOR  
ADDICTION + MENTAL HEALTH  
AT TURNING POINT

Shalini is the Clinical Director of the Statewide Centre for Addiction and Mental Health at Turning Point and a NHMRC Emerging Leader Research Fellow at Monash University's Monash Addiction Research Centre. She chairs the RANZCP Faculty of Addiction Psychiatry and is an elected board member and training officer for the International Society of Addiction Medicine. Shalini is a passionate advocate for clinician-researchers in mental health and addiction and enjoys mentoring health professionals. A clinical addiction psychiatrist, Shalini's research focus is on novel treatments for substance use disorders, and for concurrent trauma or PTSD.

**AS MEDICAL PRACTITIONERS, AS SOON AS WE'RE HATCHED AS JUNIOR CONSULTANTS, WE TAKE ON LEADERSHIP ROLES WITHIN MULTIDISCIPLINARY TEAMS.**

At first, we find ourselves leading in lots of little ways. And now 12 years into working as a psychiatrist most of my work involves leadership and management rather than direct clinical-facing work. In terms what that means for me, I lead teams within our organisation, and do broader public-facing leadership work that can also happen through advocacy, role modeling, influencing policy or community change.

**I TRY TO BE AN AUTHENTIC LEADER.**

I have a collaborative leadership style. As a psychiatrist, I naturally quite enjoy listening to others and understanding where people are coming from. I'm an introvert and I think an introverted leadership model can look a bit different from an extroverted one. I lead from the middle, rather than the front. In terms of approaching difficult conversations, I try to listen and engage and bring people back to the basics of what we're trying to achieve, and why. If we can get on the same page that provides a lot of momentum for us to be able to resolve those differences.

“

*In my own space coming through, I can say that in my specialty there were few rooms that I was in where there was another female leader. But now there is a growing shift, where we're seeing more women, more diversity.*

**A/PROF SHALINI ARUNOGIRI**



**CONNECTING WITH THE WHY OF WHAT WE DO HAS BEEN TREMENDOUSLY HELPFUL FOR OUR LEADERSHIP TEAM AT TURNING POINT.**

A couple of years ago we had the opportunity to be involved in a documentary series on SBS about addiction, Addicted Australia. We'd never done anything like this before, and it was a bit of a journey. It prompted a lot of internal thinking about why we were doing the documentary and why we thought addiction was an important cause to address – essentially, why we do our jobs. Now a few years down the track, the why that we developed for ourselves has become a core part of our identity. It's helped us be able to inspire our own teams and the organisation, to work in alignment. And then externally, we've been able to provide leadership within the addiction medicine space and the addiction sector more broadly. The why we've discovered along the way is that we want to treat addiction as a health disorder, like any other health disorder. When we're able to remove the stigma and the judgment from what we bring to the discussion, we can treat it like a health disorder and focus on treatment. Recovery is possible for anyone.

**I FEEL LIKE WE'RE VERY MUCH EVOLVING AS MEDICAL LEADERS.**

One obvious aspect of this is around gender. In my own space coming through, I can say that in my specialty there were few rooms that I was in where there was another female leader. But now there is a growing shift, where we're seeing more women, more diversity. When I was coming through, I was looking for role models that represent diversity and how culture plays a role and how people express themselves and the different ways people may lead. Penny Wong is a great example.

**WITH INTERSECTIONAL BARRIERS TO LEADERSHIP, THE ONE I'VE FOUND MOST CHALLENGING TO NAVIGATE IS MY AGE.**

I tick the gender diversity box and the ethnic diversity box. I'm a woman, and I'm a first-generation migrant. I came from Malaysia, and I did university and my training here in Australia and stayed on. I'm quite young, relative to my colleagues, and I think I've experienced discrimination in terms of how I'm perceived and how my skill sets or my capacity to express myself might be perceived, because of my age. That intersectionality between age, gender, and ethnic diversity means that part of my process is to approach communication with intentionality, and to think consciously about how to communicate and present my arguments more effectively.

**HAVING MENTORS IS ESSENTIAL TO MY DAY-TO-DAY SANITY.**

I've sought out mentors and I also engage in coaching. The coaching is invaluable. It's helped me to develop some specific leadership skills and given me a space to reflect on and understand dynamics or things that I want to change. I've got several mentors within my workplace and more broadly, from other fields, even from outside of the medical sphere and outside of academia. It helps to see something more broadly, to know that most of the problems I face have been encountered before, and to realise that some things are bigger than medicine, or academia.



**DR  
AMEER  
SHEHAB**

**CO-CHAIR OF THE AMA COUNCIL  
OF DOCTORS-IN-TRAINING**

**Ameer co-chairs the AMA Council of Doctors-in-Training (AMACDT), which is a Federal council, and chair of the General Practice Training Advisory Committee (GPTAC). Both provide forums for GP stakeholders to discuss issues related to the training of doctors seeking to become specialist GPs, and advice to Government to maintain and improve outcomes of GP training. He is currently completing his general practice training at a mixed billing practice in south-east Melbourne. He has experience in general medicine, women's health and paediatrics, has a keen interest in mental health, and is a mentor in AMA Victoria's mentoring program.**

**THERE WERE PLENTY OF OPPORTUNITIES TO LEAD OR TAKE ON A MORE ACTIVE LEADERSHIP ROLE WITHIN THE MEDICAL SCHOOL, BUT I NEVER REALLY THOUGHT MUCH OF IT.**

To be blunt, at that stage, I thought it was just CV padding. But now I've formed a much more mature view. Looking back, I hadn't found what I was most passionate about yet, and what I wanted to work on safeguarding, which is probably the reason why I hadn't decided to get more actively involved at that time. But now, what I'm doing with the AMA helps to refill my cup. It keeps me invigorated and energised to get into clinic and go to the meetings and have the difficult conversations.

**I'M 29, SO I'M A VERY EARLY OR FLEDGLING LEADER. I'M STILL LEARNING HOW TO LEAD, BUT AT THE MOMENT I SEE MYSELF AS AN AGENT OF CHANGE.**

I'm clarifying the needs of the group and acting as a voice. I'm constantly seeking out my peers' opinions so I can form that view and then feed it up the chain or present it as part of the agenda or say, this is what we are needing as a group; this is what I'm hearing from everyone. I'm always asking, what direction are we looking to head in? How are we going to work on this? How can we turn that into actionable goals?

**THE LEADERS THAT I GRAVITATE TOWARDS ARE PEOPLE WHO MAKE A SAFE SPACE FOR YOU TO PARTICIPATE IN, AND WHO LEAD BY EXAMPLE.**

That space is one that you can fail and learn from that failure and grow and develop in. Expectations are high – because they need to be – but people can be wrong. The important thing is to learn from your mistakes. I've experienced a couple of leaders who didn't expect anything of others that they didn't expect of themselves, and who led by example constantly. I noticed that, and I really appreciated that.

**GOING THROUGH MEDICAL SCHOOL, THERE'S NOTHING SPECIFIC ABOUT HOW TO LEAD, BUT I THINK IT'S PART OF THE HIDDEN CURRICULUM.**

The sessions about the art of medicine, communicating with patients, and conflict management – those things inform how to be a good leader. I'd argue that it's not necessary to have it formalised within the training. I think that it's probably much easier to pick up on those more technical skills once you've found your niche, the place you belong within the scope of the medical field, and you've found something that you're passionate about, that you want to support and defend.

**THE ACADEMIC AND TECHNICAL ABILITY OF OUR MEDICAL LEADERS SAW US THROUGH THE COVID-19 PANDEMIC.**

It was a completely foreign territory that the entire world had to traverse. And we turned to academics and people with technical expertise in infectious disease and epidemiology and healthcare resources. It fell to those leaders to help us make informed decisions and choices. There's the academic aspect of it, where we want to know the reasons for the decisions we're making. We need to be able to say, we have looked at things objectively and critically analysed them and found that this is the best course of action. And that necessarily involves some level of technical expertise. That manifests in being able to convey that to our patients, or those difficult decisions to our peers.

**I TOOK PART IN THE AMA'S MENTORING PROGRAM AND IT WAS BRILLIANT, ESPECIALLY IN MY EARLY DAYS WHEN I DECIDED TO START GP TRAINING.**

I had a lot of questions that needed answering and I just wanted to speak to someone else who'd been there and done that. It was amazing to just be able to sit across from a colleague and ask all the questions I wanted. Their answers weren't coming from a textbook, but from the same experience I was about to live. It helped to connect me with the community more broadly. In the last couple of years, I've started mentoring some of my junior colleagues, and it's very rewarding to be able to pay it forward and help people find their way as they traverse their studies. I just want to support people to feel better and do better.

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*The leaders that I gravitate towards are people who make a safe space for you to participate in, and who lead by example. That space is one that you can fail and learn from that failure and grow and develop in. Expectations are high – because they need to be – but people can be wrong. The important thing is to learn from your mistakes.*

**DR AMEER SHEHAB**





## DR LUCY CROOK

CHAIR OF THE  
DOCTORS IN TRAINING  
SUB-DIVISION AT  
AMA VICTORIA

Lucy is Chair of the Doctors in Training Sub-Division at AMA Victoria. She has been in the role since November 2021, where she acts as a point for junior doctors and advocates for improvements in workplace relations and cultural change. Lucy is also a Branch Councillor at the Australian Salaried Medical Officers' Federation Victoria (ASMOF). A junior emergency department registrar currently completing a Certificate of Emergency Medicine, Lucy brings a background in employment law to her leadership and advocacy roles.

### I'VE ALWAYS BEEN PASSIONATE ABOUT ADVOCACY AND JUSTICE AND FAIRNESS.

Before I was a doctor, I worked as a lawyer in the area of workplace relations and employment. Changing careers and becoming an employee in the public hospital system, I've been appalled by the working conditions, especially the demands placed on junior doctors. Constantly exposed to a working environment which is at odds with my personal values, I've felt compelled to use my existing skills to push for change.

The health system is under such immense pressure that we're really just focused on keeping our heads above water. I may feel like this because I predominantly work in an emergency department, but there's a sense at the end of the shift that, as long as you haven't made a catastrophic error, it doesn't matter how you got there. I know many doctors (including myself!) who are interested in mentoring and teaching and have the ability and passion to be excellent leaders – but unfortunately, day-to-day, don't have the time or energy to contribute in this way.

### MEDICINE STILL SUFFERS FROM BEING QUITE OLD SCHOOL AND HIERARCHICAL.

Traditionally, medicine has had a culture where leadership is a very hierarchical, one-way kind of relationship. Of course, that's been typical in other parts of society too, but I think progress and change in medicine has been particularly slow. There continues to be a significant gender imbalance in senior positions in public hospitals – and even though this imbalance is often acknowledged, I feel like traditional leadership styles are still acceptable. For real change to be achieved, I strongly believe that we need to change the very idea of what it means to be successful in these roles.

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*When you're an intern, you're very well supported by a formal leadership and educational model. There's lots of formal teaching, structured training and assessments. But then after that, when you become a resident or a pre-vocational doctor, you all of a sudden lose those supports and are expected to cope on your own.*

**DR LUCY CROOK**



**AS AN INTERN YOU'RE WELL SUPPORTED, BUT AS A RESIDENT I'VE FELT A SIGNIFICANT LACK OF LEADERSHIP WITHIN THE WORKPLACE.**

When you're an intern, you're very well supported by a formal leadership and educational model. There's lots of formal teaching, structured training and assessments. But then after that, when you become a resident or a pre-vocational doctor, you all of a sudden lose those supports and are expected to cope on your own. There's limited training and teaching, and you're often working strange, isolated hours. In my experience, feedback is only provided when you've done something wrong and often this is done in a manner and setting that is dismissive and unhelpful. Add to this, that because of a training bottleneck, many junior doctors find themselves in these roles for many years. I've personally felt directionless and unsupported and even considered quitting medicine at times – the lack of leadership and mentoring in these roles definitely played a part in that.

**EVEN AS AN INTERN YOU MIGHT HAVE STUDENTS OR JUNIOR DOCTORS ASSIGNED TO YOU ON A SHIFT. BUT THERE'S NO FORMAL TRAINING IN HOW TO MENTOR THEM, OR HOW TO BE IN THAT ROLE.**

How to be a good and effective healthcare industry leader wasn't talked about at all when I was at medical school, which is mostly focused on technical knowledge and technical skills. There is some acknowledgment of the importance of effective communication and interpersonal skills, predominantly in relation to patient interaction. But in terms of leadership teaching, mentoring and so on, you're just expected to know what you're doing.

**THERE'S A LOT OF BARRIERS FOR WOMEN IN REACHING LEADERSHIP POSITIONS IN MEDICINE.**

I'm a junior doctor, so I don't have experience of what it's like right at the top, but my impression is that there's still a long way to go in that department. A lot of things need to change. We need more support for flexible working and training arrangements. For example, most hospitals don't offer part-time roles for junior doctors; you have to actually go and find someone to job share with and then argue your case. This would be unacceptable in any other industry! We need to acknowledge that there is value in being a parent and carer, and that those with broad skills and experience make better doctors and better leaders.

**SUCCESSFUL LEADERSHIP IS BASED ON A SENSE OF COMPASSION, KINDNESS AND SHARED EXPERIENCE.**

When I think of how I'd like leadership to be, I think of Jacinda Ardern. In her final speech to the New Zealand Parliament, she spoke about realising that she could be emotional and kind and compassionate and still be a successful leader. That's the sort of leadership I subscribe to and feel that is really needed in medicine, which after all is supposed to be an industry grounded in compassion and care. That's what we should be striving towards and encouraging.



**DR  
JAY  
RAO**

—  
**RETIRED DOCTOR**

Jay spent more than 50 years working in the field of obstetrics and gynaecology before retiring, aged 76, in 2020. Jay worked at various hospitals in New South Wales and Victoria, including his own private practice. Prior to retiring he was Head of Waterdale Unit at Mercy Hospital for Women for many years. Most of his career he was attached to major teaching hospitals – the Royal Women’s, Monash Medical Centre and the Mercy Hospital for Women – where he taught and mentored medical, nursing and midwifery students along with training junior doctors and aspiring specialists in obstetrics and gynaecology.

**I AM CONSTANTLY MOTIVATED BY THE PEOPLE AROUND ME.**

Those people might be junior, or senior colleagues, patients or my wife, children and grandchildren. That motivates you to get into the action of doing things. We all have to learn from each other, but I especially enjoy teaching what I've learned. Whatever you do, enjoy what you're doing.

**A GOOD LEADER MOVES THROUGH FIVE STAGES.**

First, it's finding that motivation around you, then listening and listening patiently and then learning, and learning with passion. Then comes practising and practising to perfection. When you've done all of that, it's time to preach and teach. But when you preach and teach, you have to make sure that you do it with respect and dignity, and without discrimination. You have to find enjoyment of each stage, because each stage takes you to the next one.

**I THINK IT'S IMPORTANT FOR DOCTORS TO BE WILLING TO BE ROLE MODELS.**

When you're a doctor you're meeting people all the time, and they're constantly seeking your advice and leadership. It could be patients, or colleagues. When people come to see you for advice, they're looking to you to lead them with or through something, and we need to be ready for that.

“

*The future of medicine is going to be an extremely interesting but also challenging time for our future leaders. With progress comes new and sometimes unexpected challenges and problems. How will future leaders manage the evolution of artificial intelligence and robotics?*

—  
**DR JAY RAO**

**I WOULD SAY MANY JUNIOR DOCTORS ARE NOT AS WELL PREPARED FOR LEADERSHIP AS THEY COULD BE, BECAUSE THERE'S NO FORMAL TRAINING.**

I don't think any of the universities have got formal leadership training as part of their medical degrees, although over the last 10 to 12 years, there has been some degree of mentorship. At the Mercy Hospital for Women, each consultant had medical students to mentor, which meant that the students had someone to report to and discuss cases with. This is a good start, but there could be much more being done in terms of preparing junior doctors to be role models and leaders. I'd like to see a formal leadership program incorporated into the curriculum, right from the beginning. This should begin as soon as students enter medical school, because I think leadership starts with good motivation in the early stages.

**THE FUTURE OF MEDICINE IS GOING TO BE AN EXTREMELY INTERESTING BUT ALSO CHALLENGING TIME FOR OUR FUTURE LEADERS.**

With progress comes new and sometimes unexpected challenges and problems. How will future leaders manage the evolution of artificial intelligence and robotics? In my early days these things did not exist. Minimally invasive and remote-controlled surgery have been introduced into the medical field in my lifetime, and as a leader it was my job to be across the pros and cons of new technology as quickly as possible.

**MEDICAL LEADERS WITH THE APPROPRIATE AUTHORITY MUST GET BETTER AT PLANNING AHEAD FIVE TO SIX YEARS, OR EVEN FURTHER.**

The current GP shortage, for example, could have been alleviated with better planning. My feeling is that medical students could be mandated to do two or three years of service in regional and remote centres once they graduate. Some may decide to stay and continue to practice there, which would be wonderful.

**I BELIEVE IT'S A LEADER'S JOB TO IDENTIFY AND WEED OUT BAD THINGS HAPPENING IN THEIR INDUSTRY, BEFORE THEY TAKE HOLD.**

One aspect of modern healthcare that bothers me, as in every walk of life, is an extremely small percentage of exploitative colleagues charging exorbitant fees for vulnerable patients. I have had private patients with private hospital cover still opt to go public because they're afraid that they'll get multiple amounting bills, which is very possible in the current climate with large out of pocket fees. It's impacting patients and patient health, and I think it's the job of medical leaders to work with legislators to implement changes that will protect patients.

**EVERY NOW AND THEN, I GET SOMEONE I'VE TAUGHT OR MENTORED APPROACHING ME IN A SHOPPING CENTRE TO SAY HELLO.**

I have helped to guide more than 10,000 babies into the world – it's been a real honour. I was exposed to quite a lot of complicated births, including triplets and twins, and there's an element of leadership that comes through in each of those more complex situations. It gives me immense pleasure and satisfaction to be approached and remembered in that way. It might be someone who I guided through their first caesarean section. Once I had a mother who recognised my voice, without seeing me, while shopping, and remembering me telling her to push, push and push while guiding her through the birth of her child.

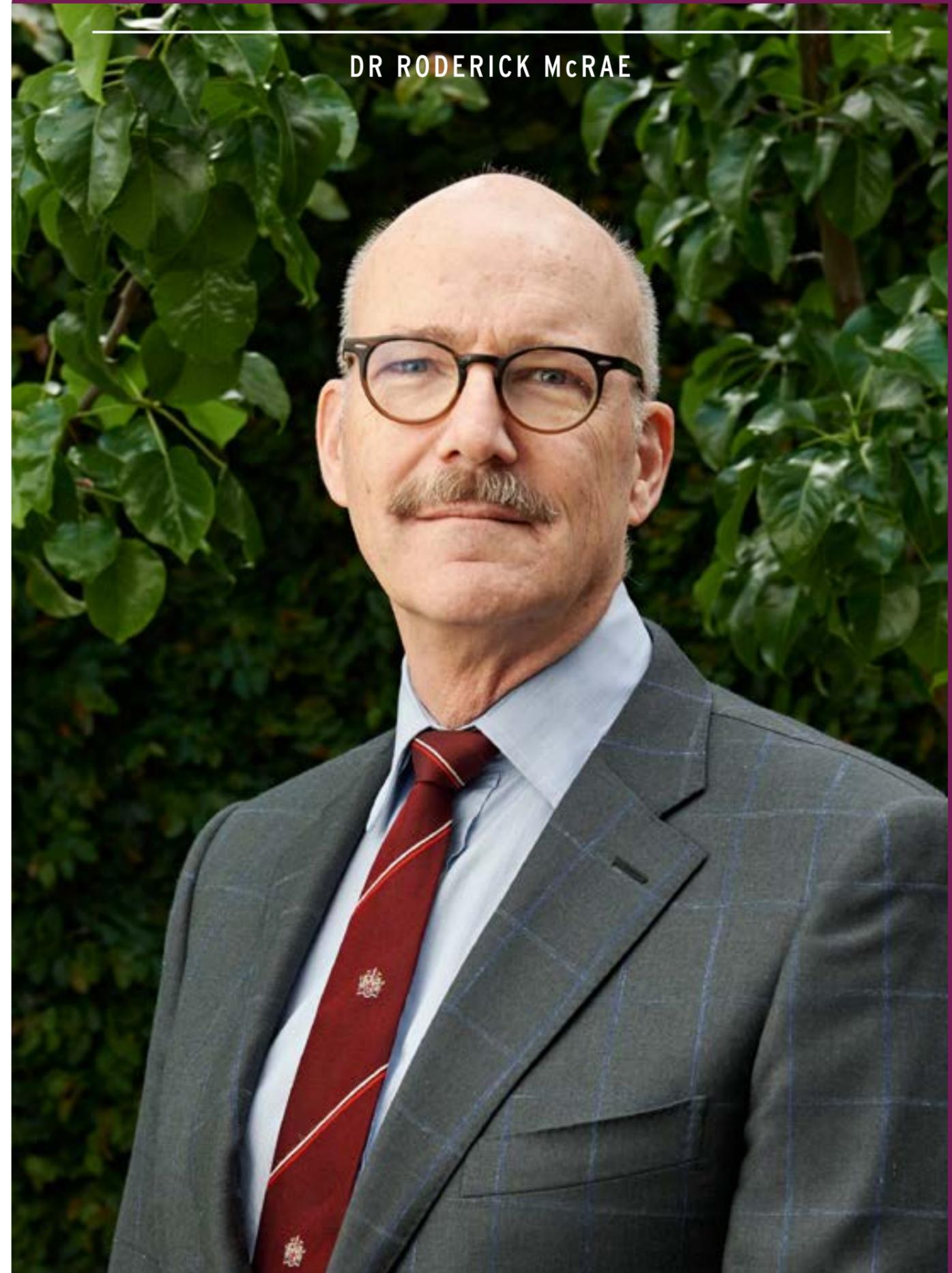


# ACKNOWLEDGING DR RODERICK McRAE AS IMMEDIATE PAST PRESIDENT

We say thank you to Dr Roderick McRae, whose two-year term as AMA Victoria President (2021-23) has come to a close. Roderick stepped into the role as COVID-19 was in full swing, and advocated with vision, strength and determination on multiple issues. A qualified anaesthetist, intensive care physician and an admitted lawyer, Roderick brought diverse experience and insights from other roles to his term, including Vice President of AMA Victoria (2018-21), Federal Secretary of ASMOF (2022-present) and Chairman of the Victorian Doctors Health Program (2020-present).

BASED ON A SPEECH GIVEN BY STEVEN BURRELL,  
CEO OF AMA VICTORIA, 23 MAY 2023

DR RODERICK McRAE



“

*His impressive, unwavering determination to achieve successful advocacy outcomes, particularly behind the scenes, has resulted in remarkable policy achievements for AMA Victoria, for members and the medical profession.*

Members will remember that in May 2021, when Roderick commenced his Presidency Australia had yet to complete its COVID-19 vaccination rollout, leaving many people vulnerable to the Delta variant, and Victoria was on the verge of lockdown number 5.

With our health workforce and system under immense strain, it might have been “a baptism by fire” for Roderick. But with decades of experience leading advocacy work for AMA during challenging times, Roderick was unfazed as he stepped into his new role.

Roderick first became active in the AMA back in 1985 when, as a graduate, he got involved in (what is now known as) the doctors-in-training subdivision. He eventually became Chair of that group and when the AMA created a national doctors-in-training role, Roderick was elected to it – helping, over six years, to lay the foundations for today’s current Federal Council of Doctors-in-Training.

Roderick went on to be Chair of Federal Council from 1999-2001 and again from 2009-13, and Vice President of AMA Victoria for three years, prior to becoming President.

#### AN ENDURING PASSION FOR WORKPLACE ISSUES AND INDUSTRIAL RELATIONS

In the 1990s, keen to prevent the formation of one super healthcare union, Roderick fought hard for the creation of a standalone medical union for doctors, operated by doctors. He and his colleagues won and as a result, decades later here in Victoria, the medical profession is well represented – both at the bargaining table with the State Government and, more broadly, by AMA Victoria and jointly with ASMOF Victoria, representing all doctors working in the public health system across our state.

Roderick’s early advocacy experiences sparked an enduring passion for workplace issues and industrial relations. His impressive, unwavering determination to achieve successful advocacy outcomes, particularly behind the scenes, has resulted in remarkable policy achievements for AMA Victoria, for members and the medical profession.

In his very first meeting with the Victorian Minister for Health in July 2021, Roderick outlined his strategic advocacy priorities as President: improve public hospital access and resolve wider health system failures; support general practice and address critical workforce shortages.

But there were also other issues that required immediate attention. The State Government’s hasty proposed introduction of a new Mental Health and Wellbeing Bill which proposed, among other things, the elimination of restrictive interventions within 10 years, was described by Roderick as a “principles-based approach divorced from a practical understanding of the challenges involved in utilising such legislation.”

Roderick publicly explained that the banning of restrictive intervention would be dangerously flawed and divorced from our members’ known realities. Completely eliminating these practices, he argued, would inevitably result in mental health services being unable to meet the health needs of a proportion of people experiencing serious mental illness.

Roderick urged the State Government and Health Department to genuinely involve medical experts in developing the Mental Health Act over a much longer period to avoid the suboptimal and unintended, harmful consequences which often result from a rushed and incomplete consultation period. The outcomes he sought took time. But he achieved them and shaped a different bill, with the State Government eventually changing the seclusion and restraint ban to an aspiration; and making the commitment to seek medical expertise earlier in any mental health consultation processes when feedback can be meaningfully incorporated.

#### DRIVING A HEALTHCARE-LED RECOVERY FOR VICTORIA

In Roderick’s first six months, as pauses in elective surgery continued to frustrate members and patients, Roderick wasted no time in conveying to the Victorian Health Minister that these surgery restrictions were disproportionate. He pushed for a decisive plan to manage and fund the resumption of Victorian elective surgery and create a higher surgical capacity through surgical hubs.

In April 2022, a month before the State Budget was handed down, the Victorian Government announced a \$1.5 billion investment to boost safe, elective surgical activity and the establishment of Rapid Access Hubs to exclusively perform specific surgical procedures across metropolitan public hospitals.

It was a significant win but only part of Roderick’s achievement at that time. During his first six months as President, Roderick had formulated an advocacy vision for 2022: a healthcare-led recovery for Victoria. Not only a medical recovery for Victorians, it was also an economic recovery through investment in essential health infrastructure and services.

For months, he campaigned behind the scenes, in the halls of State Parliament, in regular meetings with ministers and senior bureaucrats, progressively gaining traction on the idea.

In its 2022 Putting Patients First budget, the Victorian Government unequivocally placed health at the centre of its agenda. Twelve billion dollars of new spending to boost health infrastructure and workforce in the coming years, including the training and hiring of 7,000 healthcare workers, was the outcome – much of which the Minister’s Office told us was shaped and influenced by AMA Victoria.

In that year, a Division of General Practice within the Victorian Department of Health was not achieved but consistent advocacy was starting to result in State Government engagement with and investment in general practice. Roderick was determined to support the efforts to embed an understanding of general practice within the very machinery of government and improve GP/hospital communication and interaction. And he got there.

#### ACHIEVING ADVOCACY WINS ACROSS THE BOARD

Roderick's advocacy achievements in general practice have been substantial:

- > A commitment from the State Government to instal a Chief GP advisor within the Victorian Health Department
- > Block grants for vaccination in targeted local government areas and for vaccinations in schools
- > The removal of untenable COVID-19 exposure site rules for general practices
- > GP registrar incentive payments to incentivise junior doctors to pursue general practice.

A stand-out advocacy achievement in 2022 was also Roderick's successful lobbying effort for a new Albury-Wodonga public hospital, a well overdue hospital infrastructure project. The Victorian Government, in partnership with the NSW Government, announced a \$558 million redevelopment of the Albury Base Hospital, in the lead up to the November election. Prior to the announcement, the Minister's Office informed AMA Victoria that our advocacy had been influential in the decision to join with NSW and allocate funding for the new hospital.

As Roderick often states, "AMA Victoria does so much behind the scenes that goes largely unknown by many" and indeed the successful passing into law of the Health Legislation Amendment (Information Sharing) Bill, is a good example of this. The Bill provided for the establishment of a secure electronic system to enable public hospitals and specified health services to share specified patient health information for the purpose of providing medical treatment to patients. There was concern, at the time, from the Liberal Party and certain crossbenchers about privacy issues and the state government feared they would not have the numbers to pass the Bill into law. Roderick invested a considerable amount of time lobbying the Coalition and crossbench to ensure they better understood the importance of health information sharing. Numerous meetings were held behind the scenes; countless discussions took place, and, in the end, the Bill was passed. It was a great tribute to Roderick's efforts and appreciated by the State Government too.

#### CHAMPIONING MEDICAL PROFESSIONALS AND PATIENTS ALIKE

Roderick always remembers how stressful his doctors-in-training years were, and how too often, learning to be a doctor can feel like "a fight to prove oneself superhuman, on so many fronts."

Roderick must be applauded for his strong belief in and support for the doctors-in-training class action as one of the most important steps we can collectively take to reform the workplace. Committed to driving the structural reform we so desperately need, together with our current cohort of doctors-in-training, he is looking forward to strongly supporting this cause in his continuing role as President of ASMOF Victoria.

“

*Roderick always remembers how stressful his doctors-in-training years were, and how too often, learning to be a doctor can feel like, in his words, “a fight to prove oneself superhuman, on so many fronts.”*

As Chair of the AMA Victoria Board, Roderick has been determined and resolute in his preparedness to tackle the challenges facing our organisation. Leading the introduction of the AMA Victoria Associate Membership of course attracted controversy at the time but it contributed significantly to growth in membership; both assisting in retaining members and attracting new ones.

As part of a three-year Federation Agreement between the National AMA and state and territory AMAs, AMA Victoria ceased offering Victoria-only Associate Membership from 1 January this year. However, in negotiating this agreement we secured substantial revenue benefits for AMA Victoria. We also protected member benefits with lower fees and the creation of new lower fee categories of conjoint membership for part-time doctors in training and members on parental leave.

Under Roderick's leadership, member subscription revenue in 2022 rose by 6% on the previous year.

In 2022, after achieving operational surpluses from 2019 to 2021, we again kept AMA Victoria in operational terms.

Roderick has been a great warrior for the interests of AMA Victoria and members, and we are sure Roderick will continue to be so in his new role as Victorian representative on the AMA Ltd Board, the governing body of AMA Federal. His commitment to doctor wellbeing will also continue in his role as Chair of VDHP, a position he has held since 2019.

We extend our thanks to Roderick for his passion, vision, and unwavering dedication to our members and organisation. Roderick's legacy will continue to inspire us as we carry forward his mission of advocating for the rights and wellbeing of medical professionals and patients.



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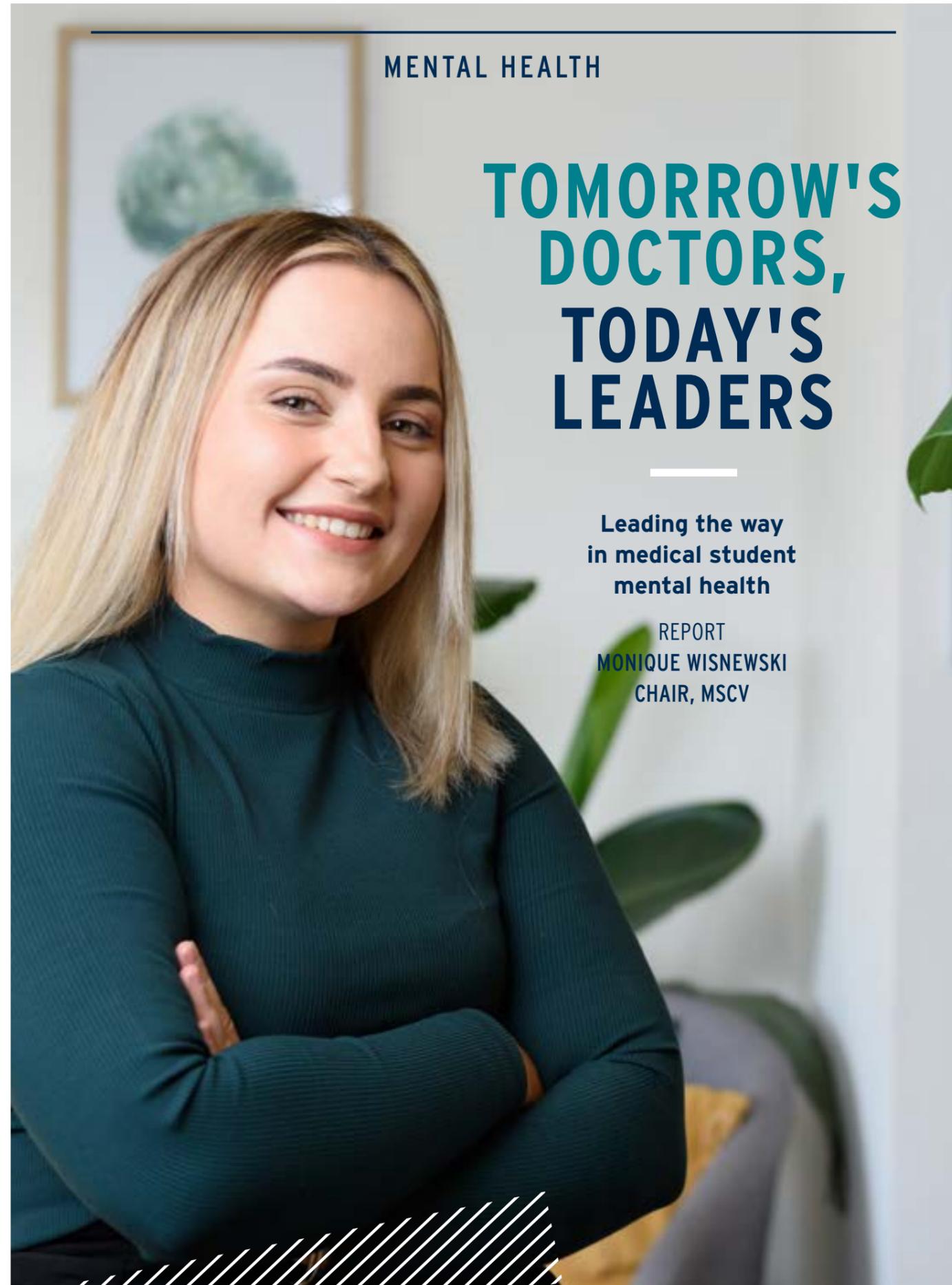
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MENTAL HEALTH

# TOMORROW'S DOCTORS, TODAY'S LEADERS

Leading the way in medical student mental health

REPORT  
MONIQUE WISNEWSKI  
CHAIR, MSCV



## MEDICAL STUDENT WELLBEING

It's well known that doctors are a vulnerable group in terms of mental health, with nearly one in five diagnosed with depression and one in four reporting suicidal thoughts, according to a 2019 survey by BeyondBlue. Perhaps less recognised is that these issues often take root in medical school, where students are first exposed to both the high-stress conditions of medical training and a perceived stigma towards doctors with poor mental health.

Thankfully, the importance of stamping out stigma and safeguarding psychological wellbeing early on is becoming increasingly well recognised within our medical schools, with students taking an increasing interest. I spoke with some of the students stepping up to improve student wellbeing through advocacy, research and policy change to hear their thoughts on leadership and mental health.



**MONIQUE  
WISNEWSKI**

CHAIR, MEDICAL STUDENT  
COUNCIL OF VICTORIA

### *Monique Wisniewski*

#### **SAFEGUARDING THE WELLBEING OF MEDICAL STUDENTS**

Escalation of wellbeing concerns has long been problematic within medical schools, with convoluted reporting pathways, perceived stigma, and confidentiality concerns. This was a key concern for Shreya Mago and Virginia Su, the 2022 co-chairs of Monash's then-small Community and Wellbeing subcommittee, who formed the working group advocating for the introduction of year-level wellbeing representatives and a Vice President on Monash University Medical Society (MUMUS)'s executive committee. Now with Caroline Younan at the helm, the committee has rebranded, focused on fostering community spirit, advocating for more accessible reporting pathways and actively destigmatising mental health in the medical profession.

#### **WHAT INSPIRED YOUR INITIATIVE?**

*"Our primary goal was to improve medical student wellbeing across the cohort. Historically the role of the committee worked on smaller initiatives to brighten students' days, but we needed a way of formally ascertaining and raising wellbeing concerns within our cohorts."*

#### **WHAT DO YOU HOPE TO ACHIEVE THROUGH YOUR WORK IN THIS AREA?**

*"Our mission focuses on the role of representation, advocacy and accessible support pathways in enabling students to seek support. With proper upskilling, Community & Wellbeing representatives develop an in-depth understanding of those complex pathways, enabling them to be approachable points of call for concerned peers. Proactively, they can identify key wellbeing risks within their cohorts and work alongside MUMUS to represent the greater student voice to faculty. Meanwhile, we continue to generate discussion through events such as Caroline's popular Elephant in the Room series and distribute resources including incident reporting flowchart posters and our Get-a-GP guide."*

#### **WHAT DOES LEADERSHIP MEAN TO YOU?**

*"Leadership means advocating for the hard realities faced by students. It's breaking norms and having those difficult discussions, because no change comes from complacency."*

## SUPPORT + PREVENTION + CONNECTIONS

**ELIZABETH HU**

PRESIDENT, UNIVERSITY OF MELBOURNE MEDICAL STUDENTS' SOCIETY

### Elizabeth Hu

#### LEADING A PIONEERING STUDY INTO THE MENTAL HEALTH OF VICTORIA'S MEDICAL STUDENTS

With the support of Melbourne Medical School and fellow medical student societies, University of Melbourne Medical Students' Society (UMMSS) President Elizabeth Hu is leading a first of its kind, inter-university study into the mental health of Victorian medical students. In doing this, she hopes to place more emphasis on support and prevention for students in the face of an emerging mental health crisis.

#### WHAT INSPIRED YOUR INITIATIVE?

*"It was a late night thought in light of recent student deaths. It's devastating – one day you wake up and the person you expect to see at placement is no longer there. Mental health is a matter very close to our hearts, and it's a serious one at that, having claimed so many lives within our community."*

#### WHAT DO YOU HOPE TO ACHIEVE THROUGH YOUR WORK IN THIS AREA?

*"We expect to identify the factors both contributing to and protecting against poor mental health among Victorian students, as well as identify periods during the year when they are at the highest risk. Victorian medical students face unique challenges and stressors, so gaining insight into local issues will enable our medical schools and student organisations to develop solutions that better support our students."*

#### WHAT DOES LEADERSHIP MEAN TO YOU?

*"It's the ability to unlock the skills of those around you and collaborate to achieve a common purpose. Working with a good team is one of the best feelings in the world – with each other, you feel like you can really change the world."*

### Alicia Chan

#### ADVOCATING FOR A RICHER MENTAL HEALTH CURRICULUM

For Deakin Medical Students' Association (MeDUSA) President Alicia Chan, ensuring students are equipped to deal with the mental challenges of a medical career is vital. Together with Deakin School of Medicine and AMA Victoria, she's currently working to create a formal longitudinal mental health and wellbeing curriculum throughout the entire degree which will come into action later this year.

#### WHAT INSPIRED YOUR INITIATIVE?

*"We had a student suicide at the end of 2022 and seeing the devastating impact it had made me reflect on what medical school doesn't prepare us for. The curriculum focuses on patient care, but being a good doctor starts with being able to take care of yourself. So why not include teaching on that? Students and junior doctors are told to reach out for help if they're struggling, but we aren't taught how to recognise that distress or know where to go. And there's still a perceived stigma surrounding doctors' mental health, so it's important we start to talk about these issues earlier in our careers to eradicate the taboo."*

#### WHAT DO YOU HOPE TO ACHIEVE THROUGH YOUR WORK IN THIS AREA?

*"I hope it creates longstanding change in students' perception of self-care and in doing so contributes to ongoing efforts in suicide prevention and wellbeing improvement in the medical profession."*

#### WHAT DOES LEADERSHIP MEAN TO YOU?

*"Leadership is about fostering genuine connections and providing people around you with the platform to succeed. It is impossible for one person to do it all and I truly believe that "teamwork makes the dream work"."*

**ALICIA CHAN**

PRESIDENT, DEAKIN MEDICAL STUDENTS' ASSOCIATION

**MENTAL HEALTH IS A CAUSE FOR WHICH LEADERSHIP IS VITAL. AND FOR TOMORROW'S LEADERS, LEADERSHIP MEANS MANY THINGS; IT MEANS ADDRESSING THE ELEPHANT IN THE ROOM AND REJECTING COMPLACENCY, UPLIFTING THOSE AROUND US, AND CREATING A SHARED VISION. AND PERHAPS MOST OF ALL, IT MEANS BEING THE CHANGE ONE WISHES TO SEE, WHICH IS PRECISELY WHAT OUR UPCOMING DOCTORS ARE DOING.**

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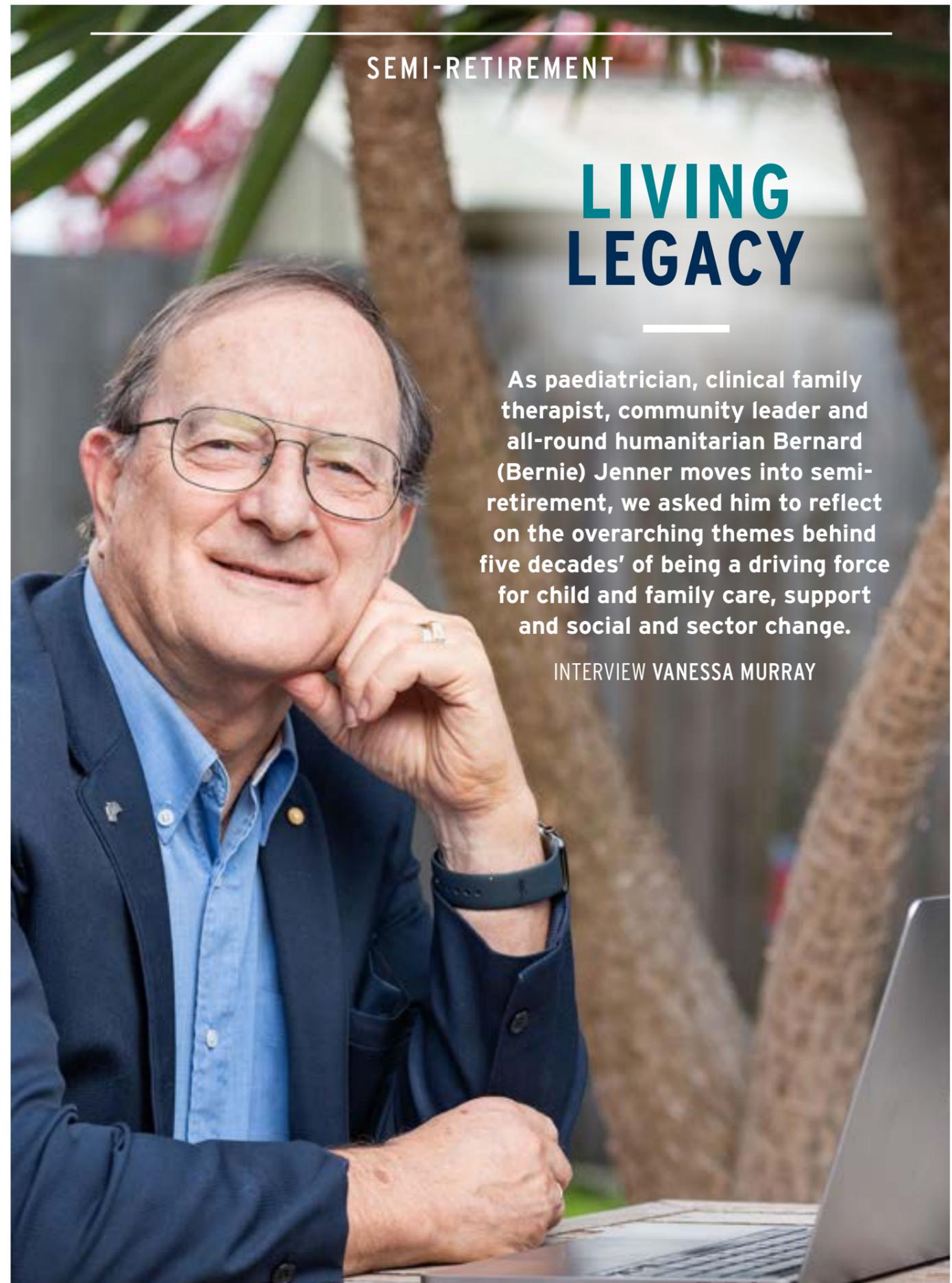
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## SEMI-RETIREMENT

# LIVING LEGACY

As paediatrician, clinical family therapist, community leader and all-round humanitarian Bernard (Bernie) Jenner moves into semi-retirement, we asked him to reflect on the overarching themes behind five decades' of being a driving force for child and family care, support and social and sector change.

INTERVIEW VANESSA MURRAY



## BERNARD JENNER

Lived experience of lifelong trauma gave Bernie great compassion for suffering, and a desire to contribute to a caring and inclusive society.

His German Jewish father, Frank, was a Holocaust Survivor.

“Like their parents, children of Holocaust Survivors commonly suffer Post Traumatic Stress Disorder. I have PTSD and felt alone until adult life due to my upbringing's conspiracy of silence about my father's experiences of loss of family, culture, language and country,” Bernie says.

Frank was expelled from university for being Jewish, and most of his family were murdered. After surviving six months in Buchenwald concentration camp, Frank was able to relocate to Australia as an orphan refugee on a farm management rotation.

“My father was never angry, but he had a lot of internalised grief. My medical career and training in family therapy enabled me to understand his experiences and to help others, particularly those who feel alone and without answers.”

Over the years Bernie developed special interests in child learning, ASD, intellectual disability, ADHD, developmental and behavioural problems, bereavement, asthma, incontinence and constipation.

He leaned in and sat with patients and families in their pain and fear. Faced with systemic gaps in those interest areas, he worked to correct them – drawing on his profile and networks to mobilise his peers, source funding, create support systems and encourage a culture to improve support of those suffering fears, pain and loss. He taught, and he led.

Two examples of filling the gaps are the award-winning not-for-profit community organisations he founded, Gateways Support Services and Hope Bereavement Care.

Gateways is a “one stop shop” facilitating advice, early intervention, case management, respite, accommodation, sport and recreation for families with children with a disability in Western Melbourne, Barwon and Western Victoria.

In 1985, Hope began offering free counselling and support groups to those affected by the sudden and unexpected death of a loved one, initially an infant or child, but now any age death. It provides education and support in schools, workplaces and traumatised communities, and facilitates remembrance events.

Both were born from Bernie's observation and experience of the suffering and confusion of patients and families, within the first decade of his graduation from Monash University and his work as a consultant paediatrician.

“I was shocked and heartbroken when I started paediatric practice to see patients lost, bewildered and unsupported due to gross underfunding of disability and no funding for bereavement,” he recalls.

“Over and over again I met amazing mothers caring alone a child or adolescent with a disability. They were often in poverty, limited public support, no contact or time to meet with other, similar families.”

“I remember despairing when women and families who experienced a miscarriage or stillbirth were shunned, placed in isolation, in the postnatal ward, or simply sent home and not able to grieve,” he says.

“I felt equally helpless seeing families experiencing a sudden unexpected death such as from SIDS, trauma, illness, or suicide, sent home with no follow up, nor a professional structure to assist with grief within the community, short or long-term.”

## HUMANITARIAN

“There was no support for those bereaved, grief-stricken sufferers feeling alone, not able to talk, ashamed to talk, feeling a failure by continually emotionally suffering, and not wanting to offend or burden others.

Gateways employs approximately 800 people and supports more than 3,000 children with disability and their families. In 2022, Hope Bereavement Care supported more than 600 individuals experiencing grief, including 200 suicide-related and 200 perinatal deaths.

A 1999 paper Bernie co-authored with other Geelong paediatricians in the Journal of Paediatrics and Child Health demonstrated that 80% of clinical paediatric practice was in neurodevelopmental and behavioural paediatrics. It led to a greater focus on neurodevelopment and behaviour in paediatric training programs, both nationally and internationally.

Bernie plans to remain closely involved in both charities as he moves into semi-retirement and contribute his expertise to select projects, including his medical practice Barwon Paediatrics, the Western Victoria Primary Health Network to improve access to health care for those with intellectual disability or ASD, and ROMAC providing life-changing surgical treatment for children from developing countries.

There will be more time for family and other interests too. Bernie is a passionate supporter of the Geelong Cats, having been past Host Parent to 20 draftees including superstars Tom Hawkins and Joel Selwood, and plans to spend more time gardening, exercising and listening to podcasts. He is husband to Hilary, a father of four and grandfather of three.

**DR BERNARD M JENNER OAM  
MBBS, FRACP, DIP CHILD  
PSYCHIATRY, GRAD DIP SOCIAL  
SCIENCES FAMILY THERAPY, AMA(M)**

Dr Bernard Jenner OAM is a consultant paediatrician and family therapist. He is former Head of Paediatrics at the University Geelong Hospital Barwon Health and St John of God Hospitals (1995-2007). He has been involved in undergraduate, postgraduate and community education, a consultant to numerous Barwon regional support services, been on many hospital and community committees and is a co-creator of the Sensory Zone, Kardinia Park Stadium (2019). He was founder and president of two award-winning organisations in the Barwon Region, Hope Bereavement Care (founded 1985) and Gateways Support Services (founded 1982). Over the years he has received more than a dozen awards, most prominently 2019's Order of Australia for Services to the Geelong Barwon Region.



*Click here for  
more info about  
Gateways*

# EQUITY, MEDICINE + POLITICS

In March, I had the privilege of attending and helping to host the AMA Women in Medicine dinner with Dr Monique Ryan as our esteemed guest, where the topic of equity in relation to medicine and politics was discussed.

REPORT DR SARAH ARACHCHI  
A MEMBER OF AMA VICTORIA'S  
WOMEN IN MEDICINE COMMITTEE



“  
*So, how do we change the narrative?  
How do we make society more equitable?  
How do we reduce the pay gap, the digital gender gap, stop gender-based violence and ensure women have a seat at the table?*

As I stood alongside Dr Ryan, I looked over at the audience of predominantly female doctors who applauded, asked questions, and discussed issues facing us as females and as doctors. It was clear from the faces I saw in the crowd, the smiles, the nods, the cheers and the overwhelming support that we all shared and understood the challenges women face, despite our achievements. Often, our assertiveness is judged as bossy, and climbing the ranks seen as power hungry. We are often portrayed in a certain light based on ideals that society has created, and often women are not seen or heard, as they should be.

So, how do we change the narrative? How do we make society more equitable? How do we reduce the pay gap, the digital gender gap, stop gender-based violence and ensure women have a seat at the table?

As a woman of colour, I recognise the importance of intersectionality which impacts upon how we are perceived by society. It is not one person, not one organisation, but all of us that play a part in whom society represents. There are things I cannot change about myself, nor want to. The colour of my skin represents a part of me which is significant and embodies deep cultural roots, which connects me to my Sri Lankan heritage and similarly, I love all aspects of being a woman. Society however, has judged me on both fronts, at different moments in my life and this is the story that I heard last night, sitting next to many wonderful female doctors from all specialties ranging from physicians, general practitioners to surgeons.

As a group of collective women leaders, we had strength in numbers and the feeling in the room that night, the unsaid feeling, that I sensed, was of understanding, respect and resilience, the traits that have carried us through those difficult corridor conversations, being talked down to by a male colleague or patient because we were female and not standing up for ourselves, as often as we should.

When I was a paediatric fellow, working my last year of training, in a rural hospital, a few months before I received my consultant letters, I walked in, to see an eight-year-old child who had presented with abdominal pain, together with my male resident, who was tall, Caucasian background, and had one year of paediatrics under his belt. I stood, at the curtains, smiling at the patient and parent, and before I began to speak, the mother looked up and acknowledged him, as the doctor. He hesitated and looked at me.

I nodded and let him lead the conversation, concluding at the end, the plan with the parent.

Part of being a leader is to let others have a go and later, I commended him on his strengths in that conversation. It was not my first experience in such a situation and there have been many more but I wonder, how many male doctors have been questioned about who they are, when they step into a cubicle to see a patient?

Perhaps, people will call us bossy, continue to deliver cupcakes on International Women's Day, tell us to stop breastfeeding in court rooms but we can, collectively take a stand together.

Women for women. This was the message I received that night. We need to support each other and embrace equity for each other. Help a female colleague out with interviews, give advice to your junior staff and make time for each other. Listen to each other's stories and elevate the women around you by supporting them. The change is happening.

We need to all be part of that change today.



“  
*We need to all be part of that change today.*  
—

“

*As women, we need to let go of what society thinks of us, and change the narrative by leading, believing in ourselves and not taking no for an answer.*  
—



## IN MY OPINION

“

*I'm a GP and I can't afford to bulk bill*

DR SARAH LEWIS  
AMAV BOARD MEMBER



**O**n Monday, as usual, GPs will turn up to work, and look forward to seeing their patients.

They will check the baby's ear, discuss a mother's concerns about their child's development, have a suicidal patient divulge their childhood abuse, give a cancer diagnosis, help a domestic violence victim, manage diabetes, help a woman plan for a pregnancy, remove a melanoma and discuss end-of-life care. They will provide patients with a familiar face, a safe place to reveal concerns, and keep many out of hospital.

I qualified as a specialist general practitioner in 2010, and in 2013, I opened my own practice in inner Melbourne. In the same year, a budget saving measure – the Medicare Freeze – was introduced. For five years, there was no increase in rebates. When the freeze ended, the thaw was slow. The average rebate rise over the past 10 years is 0.5%, versus health inflation at an average of 5% a year from 2010-2019. This hit hard and undermined the financial model of owning and operating a clinic.

Estimates suggest there has been a 35-50% reduction in real practice income over 10 years.

My clinic's annual fixed costs are well over \$1 million. I'd be insolvent if I bulk billed. Except for a few state-funded clinics, GP clinics are largely private businesses. When you see a GP, the money you pay has to support the entire business – the fees cover the rent, reception staff, nurses, electricity, phones, equipment and more.

The government covers \$39.75 per 15-minute consultation. If you have a Health Care Card, a Pensioner Concession Card, or are under 16 years, and you are bulk-billed, your GP accepts that amount as payment, and receives an extra \$6.60 if they are in the inner city. So the GP receives a total of \$46.35.

In Tuesday's budget, the Government announced that from November, the \$6.60 extra payment will be tripled to \$20.65 for those inner-city bulk billed patients, so the GP will receive a total of \$60.40 for that consultation. It's a help, but it means we are still going backwards.

## DR SARAH LEWIS – SPECIALIST GP

“

*This is why GP bulk billing rates have been plummeting over recent years – we have been left with two options: charge a fee to cover the difference, or close the doors. No business can sustain a persistent loss.*

To have a sustainable business, inner-city clinics need to generate enough revenue to cover their overheads, which vary greatly. If the fee a GP requires to keep the lights on is around \$95 for a standard 15-minute consultation, they will still be effectively losing \$34.60 per standard appointment. This means their private business is providing free healthcare at its own personal cost, and at the risk of the business going under.

This is why GP bulk billing rates have been plummeting over recent years – we have been left with two options: charge a fee to cover the difference, or close the doors. No business can sustain a persistent loss.

This cash injection is a great start, and will help so many vulnerable people. The bulk billing incentive is higher in rural and regional areas, and the tripling of this will make a huge difference in the bush, where it is desperately needed.

But the closer you get to the CBD, the higher the rent and other costs. Even with this incentive rise, most inner-city GPs will still not be able to afford to bulk bill

because every such consultation will run at a loss. We want to help people. We care about our patients. We just can't lose money doing it. The extra incentive payment helps, but when the base rebate is woefully inadequate, it still isn't enough to bulk bill concession-card holders.

All the GPs I know like to spend time with their patients. I can't recall the last time I finished a consult in under 20 minutes. We want to understand each patient's concerns and address them. I can't do that in five minutes, and for me to bulk bill, even with this incentive rise, I'd have to see almost five patients in the time I usually see three. I can't sacrifice the quality of my care in this way. I love my job and want to help mypatients have the best outcomes.

GP clinics are small businesses, and we want to help our patients, but altruism is not a sustainable business model.



*Click here if you have a different view or another Opinion piece.*



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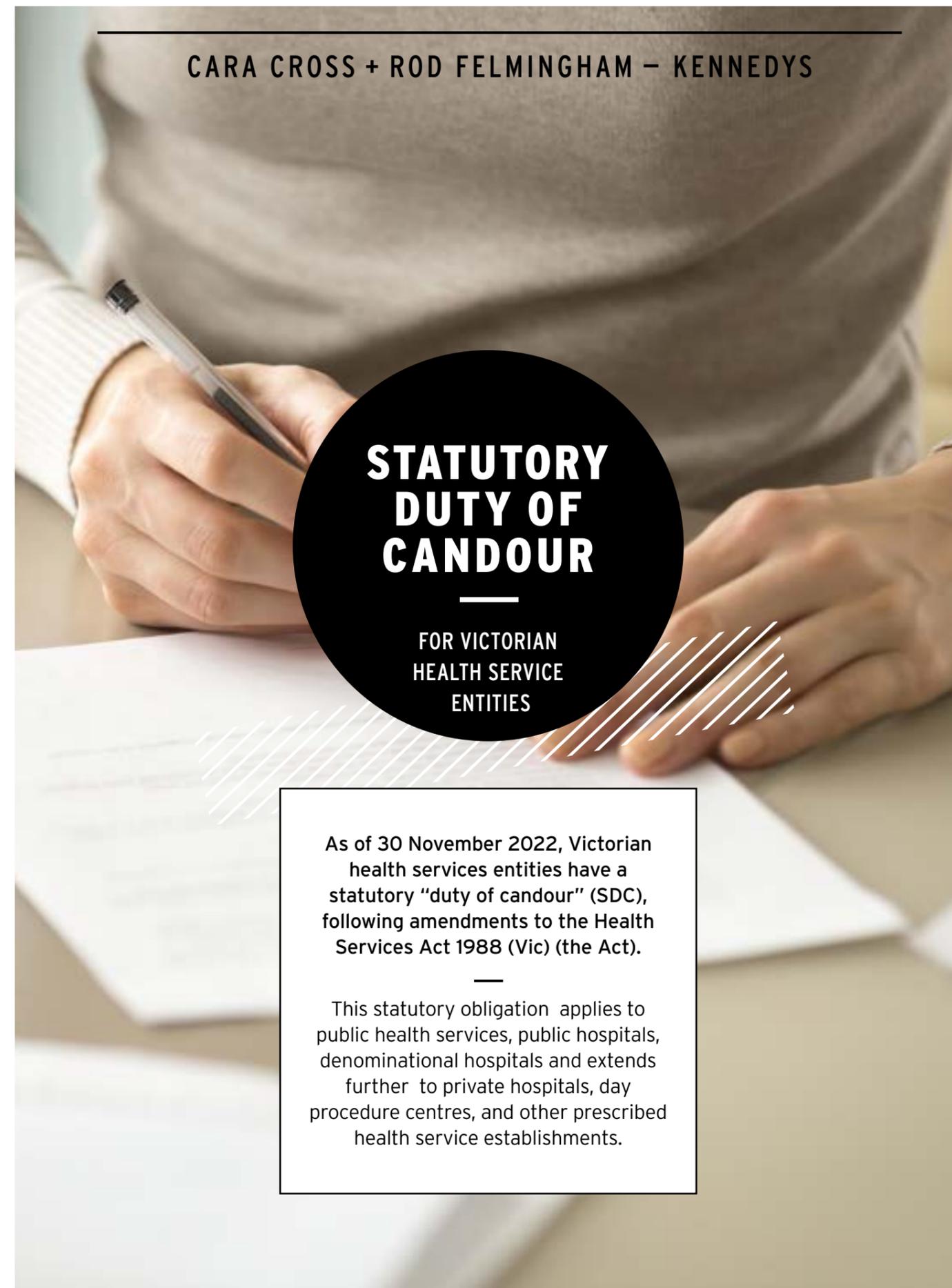
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# STATUTORY DUTY OF CANDOUR

FOR VICTORIAN HEALTH SERVICE ENTITIES

As of 30 November 2022, Victorian health services entities have a statutory “duty of candour” (SDC), following amendments to the Health Services Act 1988 (Vic) (the Act).

This statutory obligation applies to public health services, public hospitals, denominational hospitals and extends further to private hospitals, day procedure centres, and other prescribed health service establishments.

The SDC applies where a patient suffers a serious adverse patient safety event (SAPSE), meaning an event that:

- (a) resulted in harm to one or more individuals;
- (b) occurred while the patient was receiving health services from a health service entity (including an event identified following the patient's discharge); and
- (c) in the reasonable opinion of a registered health practitioner, resulted in, or is likely to result in, unintended or unexpected harm being suffered by the patient.

Unless the patient has opted out, where a patient suffers a SAPSE, health service entities must provide the patient, or their next-of-kin or carer, with:

- (a) a written account of the facts regarding the SAPSE;
- (b) a genuine apology for the harm suffered by the patient;
- (c) a description of the health service entity's response to the event; and
- (d) the steps that the health service entity has taken to prevent re-occurrence of the event.

The Victorian *Duty of Candour Guidelines* promulgated by the Minister for Health set out detailed steps and strict timelines regarding this duty, including obligations to:

- (a) provide a genuine apology within 24 hours;
- (b) organise a meeting with the patient within three business days of the SAPSE being identified; and
- (c) hold the meeting within 10 business days.



The meeting must include:

- (a) a factual explanation of what occurred;
- (b) an apology for the harm suffered by the patient;
- (c) an opportunity for the patient to relate their experience and to ask questions;
- (d) an explanation of the steps that will be taken to review the SAPSE and any immediate improvements that have been made; and
- (e) any implications and follow-up for the patient.

A copy of the meeting report must be provided to the patient within 10 days of the meeting taking place.

The amendments also provide that when a SAPSE occurs a health service entity may appoint a SAPSE Review Panel, and must do so if directed to by the Secretary of the Department of Health. The panel cannot include a person directly involved in the SAPSE. Where a health service entity receives a report from a SAPSE panel, the entity must offer copies of the report to the patient, the patient's nominated person and next of kin or carer where those persons have sufficient personal or professional interest in the report. The Act also contains protections limiting the use of a SAPSE Review Panel report.

Health services have been, and still are, subject to the existing Australian Open Disclosure Framework. The 2016 Hospital Safety and Quality Assurance review in Victoria – the *Targeting Zero* report – found there was a widespread lack of compliance within Victorian Health services with the principles of open disclosure. That report recommended introducing a statutory duty of candour to ensure that any person harmed while receiving care in a hospital was informed of the fact and apologised to by an appropriately trained professional in a manner consistent with the national Open Disclosure Framework.

## ISSUES TO NOTE

The apology will not constitute an implied admission of liability in civil or disciplinary proceedings.

Factual statements, including the written reports of SDC meetings, are not privileged or protected.

Resourcing issues will no doubt arise within health service entities in attempting to ensure compliance with the SDC, including whether there are adequate, appropriately trained, staff and adequate reporting systems.

The SDC process is not mandatory – a patient can opt out. Provided that the health service entity asks the patient to sign a statement to this effect and provides a point of contact should the patient wish to participate in the SDC process in the future, the health service entity does not have to comply further with the SDC process.

If it is identified during the SDC process that an individual health practitioner has acted in a way that constitutes notifiable conduct under the *Health Practitioner Regulation National Law Act 2009*, a staff member of the health entity must submit a concern to the Australian Health Practitioner Regulation Agency (Ahpra).

Unless directed to do so by the Secretary of the Department of Health, it is a matter for the health service entity to decide whether to establish a SAPSE Review Panel in a particular case, or to investigate by some other means. Factors relevant to that decision will include resourcing, and the relative utility of a Review Panel report compared with a report generated through existing quality assurance mechanisms.

The SDC process may have the potential to reduce notifications to Ahpra that arise from complaints made by patients or their families where they feel that they have not been able to obtain an explanation or an apology following an adverse outcome.

Despite the fact that an apology cannot be taken to be an admission of fault, the SDC process could lead to an increase in civil claims, as hospitals are obliged to provide patients and their families with factual descriptions and explanations of serious and moderately serious adverse events. Patients' medical records are discoverable.

Established quality assurance activities in many health services include peer discussion of patient outcomes in regular Morbidity and Mortality meetings which facilitate shared learning and practice improvement. Records of such quality assurance meetings are protected by qualified privilege under the *Health Services Act 1988* to enable open discussion between practitioners. Health service entities should consider how the existing quality assurance processes and the SDC processes should relate to one another.

The process will likely be a bureaucratic one, carried out by hospital administrators and consumer relations officers, not by the treating doctors. It will be important to ensure that treating doctors (who may be liable to be notified to Ahpra or be sued in the civil courts as a consequence) have sufficient input in the process and in the terms of descriptions, explanations and apologies to ensure that they accurately reflect the clinical circumstances.

**Kennedys**

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# GROWING OUR FUTURE LEADERS

**We need radically different ways of leading and working to meet our current challenges and emerging needs. And crucially, we need leaders and leadership to grow and nurture a sustainable workforce to lead successfully into the future.**

REPORT DR ANNA CLARK



## LEADERSHIP IN HEALTHCARE IS DIVERSE AND EVOLVING

If the pandemic has taught us anything, it's that there isn't a single, correct way to lead. People, including leaders, are diverse, each with different skills, weaknesses, and deeply entrenched preferences and habits.

We need skills and practices for working in this context – one with a diversity of people, ways of thinking and working, and for dealing with work that is always changing.

In healthcare we need expert and talented individuals capable of performing the most difficult of tasks. We need individuals who can work effectively in highly complex and collaborative situations that demand interpersonal and team skills and who can field uncertain and changing parameters. Add to that, we need them to remain healthy and engaged members of a workforce that is exhausted and overstretched.

## OVERCOMING THE LEADER PROTOTYPE BARRIER

Because we hold the leader prototype in our heads, it can be a real barrier as we consciously (or unconsciously!) measure ourselves against it. We all have our own insecurities and self-doubts, our unique backgrounds and experiences. So, when we do take on or look toward a leadership role we are likely to stop and check ourselves. Am I good enough? Do I know enough? Am I certain enough?

In these moments, remind yourself that anyone can be a leader. Effective collaboration requires everyone to take leadership and work together on the task at hand – regardless of whether or not they hold a formal leadership role.

Effective leadership involves understanding yourself and others, to coordinate and motivate how together, you can best face the challenge ahead.

The healthcare industry leaders I talk to are engaged leaders. Curious, reflective, and adaptive, they're riding a wave of continual change and unprecedented need that the Covid-19 pandemic has brought to the surface.

When working in and under such pressure it can be tempting to think "there must be a right way to do this", or "there must be a set of leadership skills I can learn or style I can adapt to that will help".

Of course, it's not only medical leaders thinking like this. I work with leaders from many different sectors and countries who are looking for a set of tools and to learn a necessary set of skills.

## THE STEREOTYPICAL LEADER IS NOT THE ONLY GOOD LEADER

In recent decades, research has shown that we hold a very strong prototype of what makes a good leader in our minds.

The leader prototype is someone who is confident, assertive, and takes charge easily. They're action-oriented and directive, always available and they put work first. This is a powerful model. It impacts on how we assess ourselves – and others – in terms of leadership potential. Can I be an effective leader if I am quiet? Shy? Like to collaborate and involve others in decision-making? Can I be a leader and raise a family at the same time?

We know that this prototype doesn't equal good or effective leadership per se. Effective leaders come in all shapes and sizes – different qualities, styles, and characteristics, and so on. And what constitutes effective leadership isn't all about the person, but depends on what a situation requires, and how a team is mobilised to bring its expertise and skills to meet the need of the moment and achieve the best patient outcome.

### EFFECTIVE LEADERSHIP INVOLVES MANY INTERSECTING ELEMENTS

Each of us brings something unique to leadership. We must consider:

- > The person and the attributes, experience, values, and style they bring to the role
- > Their knowledge, expertise and set of skills
- > How they apply their awareness, knowledge, and skills to a complex collaborative task to ensure each team member can contribute to a good outcome
- > How they create and maintain a healthy and sustainable workforce – creating purposeful and engaging roles and work and growing future leaders.

### IN HEALTHCARE, GOOD LEADERSHIP MEANS BEING READY FOR WHAT COMES NEXT

This means being prepared for the unknown and being able to work collaboratively in and with constant change. We must be good at:

- > Reflecting on ourselves and others and understanding our strengths and limitations
- > Observing and managing the personal, interpersonal and group dynamics that emerge as we come to work together
- > Establishing and maintain strong professional relationships – to support immediate collaborative work and to build strong networks over a career and across our healthcare systems and professional organisations
- > Establishing and maintaining safe, effective, and innovative work environments – through establishing psychological and cultural safety and the possibility for adaptive changes.

### GROWING THE NEXT GENERATION OF LEADERS

A crucial part of leadership work is growing the next set of leaders around you – stepping up and stepping in as needed. We need a future workforce full of leaders who are:

- > Agile and adaptive – able to bring themselves and others to a dynamics and uncertain task
  - > Comfortable with not knowing – and thus committed to complex collaboration, to staying curious
- and to working with others who bring different perspectives, expertise, and experience
- > Knowledgeable and aware – of themselves and of others around them, with high emotional intelligence for teams and teamwork
  - > Skilled in building strong collaborative teams and enabling teamwork – for flash teams, stable teams and for organisational cultures more broadly – so that large organisations can stay agile and adaptive for the next challenge too.

*I look forward to a cohort of healthcare leadership who ask good questions, ask for help, reach out and work with colleagues and in new partnerships, and who can carefully and thoughtfully challenge the status quo when needed to achieve safe and sustainable change.*

*In 2023 our leaders in medicine are more comfortable and engaged, and it bodes well for a healthy and sustainable future.*



## CALL FOR VOLUNTEERS

# PEER VISITOR PROGRAM



*Click here for more info about the AMA Victoria Peer Visitor Program*

The AMA Victoria Peer Visitor Program links elderly doctors who are experiencing isolation or in a residential care with a volunteer visitor who is also a doctor. The volunteer visits the elderly doctor on a regular basis and provide companionship, connection and conversation. The program has been developed in partnership with the Community Visitors Scheme. All volunteers will receive ongoing support and training and is especially suited for doctors who have a good rapport with older people.

Dr Ross Ulman has been a volunteer in our Peer Visitor Program since 2014. He visits a retired doctor for 30 minutes each week.

### WHAT INSPIRED YOU TO VOLUNTEER?

I do quite a bit of non-medical volunteering in my community, and it seemed natural for me to do some in the medical realm too. It's said that the best volunteering is with young people or old people – the Peer Visitor Program fits the latter well.

### WHAT ARE THE BENEFITS OF VOLUNTEERING?

It's extremely rewarding to spend time with older members of my profession, to hear about their experiences, to enjoy their company and to know that they derive benefit from my visits and look forward to them.

### WHAT'S YOUR ADVICE FOR DOCTORS CONSIDERING JOINING THE PROGRAM?

If you have the time – and 30 minutes per week or fortnight is fine – it's definitely worth trying. If it works out it's enjoyable and rewarding, and if it doesn't then at least you tried.

Volunteer visitors must be current members of AMA Victoria and will participate in a screening and induction process before being matched. If you know an older doctor who would enjoy having a visitor, please put them in contact with AMA Victoria. They do not need to be current members of AMA Victoria.

THE PEER VISITOR PROGRAM IS PROUDLY SPONSORED BY VMIAL, THE NAME BEHIND PSA INSURANCE.



## CALL FOR VOLUNTEERS

# PEER SUPPORT SERVICE



*Click here for more info about the AMA Victoria Peer Support Service*

The AMA Victoria Peer Support Service is on the end of the phone for any doctors and medical students all year round. This valuable anonymous service is provided by a great team of volunteers; doctors who have undertaken training to be able to give appropriate, non-judgmental support over the phone. Our volunteers come from a range of specialities and generously give their time to talk to colleagues in need of a listening ear, advice or support.

### WHAT IS IT LIKE BEING A PEER SUPPORT SERVICE VOLUNTEER?

As a volunteer, you'd go about your daily routine but remain able to take a phone call. There is voicemail for the occasions where you're unavailable and need to return the call. Most calls take between 20 to 30 minutes, but the benefits last a lot longer – and not only for the caller. Our volunteers get a lot out of the experience too!

As an incoming volunteer, you will be trained on all aspects of non-judgmental crisis support, in a small group, over a weekend. Once you're onboard, you'll be part of a team of volunteers working together to make sure there is always someone available to take a call, with lots of flexibility.



**FOR ME, PEER SUPPORT IS A WAY TO PAYBACK THE HELP I RECEIVED WHEN I NEEDED IT.**

### WHAT ARE SOME OF THE TOPICS YOU MIGHT NEED TO SUPPORT CALLERS WITH:

- > A stressful incident
- > Violence and trauma in the workplace
- > Bullying or harassment
- > Workload concerns
- > Stress or inability to cope
- > Burnout
- > Career plans
- > Personal issues

### WHO CAN VOLUNTEER?

Volunteering is best suited to experienced doctors who can be available to answer the phone when a Peer Support Service call comes through. It's an especially great fit for recently retired doctors who have a lifetime's experience to draw on. The role is not suited to doctors-in-training, or doctors who are working full-time.

# AMAV ADVOCACY



*Click here if you have a policy issue you would like to discuss, or have some feedback about our priorities.*

## THE 2023-24 VICTORIAN STATE BUDGET: AMA VICTORIA'S PERSPECTIVE

The Victorian Government has been emphasising for some time that its 2023-24 State Budget would be the “most difficult” of its nine years of government, with most of the public sector to be impacted. While health was by no means immune, the Government has mostly stuck to its election commitments, several of which AMA Victoria was influential in shaping. AMA Victoria’s advocacy in the leadup to Tuesday’s announcement centred on investment into public hospitals, general practice, and mental health. In addressing these interlinking components, the core focus of our advocacy was in ensuring that a healthy medical workforce into the future was at the forefront of the Victorian Government’s agenda. To this end, we argued that particular attention must be paid to workforce burnout, workforce funding, and

workforce planning. Our advocacy priorities document noted that we can no longer act in a “state of emergency”. Instead, we must turn our focus to building a sustainable workforce for the post-pandemic world.

### WORKFORCE

On workforce, lamentably, Tuesday’s budget can only be seen as a disappointment.

We welcome and acknowledge the \$270m ‘free study’ initiative for nursing and midwifery nurses who join the public health system, amongst others announced. However, the Department of Health’s spending on training and development has been cut from \$497m to \$440m, at a time when we have a healthcare workforce shortage. Moreover, funding for the training of emergency workers has remained static.

With Victoria’s Health Workforce Strategy due to be released in the next few months, AMA Victoria is hoping the Victorian Government will rectify this unfortunate oversight – and members can be assured that we will be advocating for this.

### INFRASTRUCTURE

As it committed during the most recent state election, the State Government has provided an initial investment of \$320m for a Hospital Infrastructure Delivery Fund to initiate planning, development and land acquisition for new and upgraded hospitals across the state. Moreover, \$969m will be spent to ensure new and upgraded facilities are patient ready, including at the Royal Children’s Hospital, Albury Hospital and Wonthaggi Hospital, amongst other facilities.

### GENERAL PRACTICE

We have continued to achieve some advocacy gains for general practice in this state budget but much more work needs to be done. Thirty-two million dollars was provided for the GP Registrar incentive payment – a financial incentive for those who enrol in the GP training program. AMA Victoria has long campaigned for this package, which will deliver \$30,000 top-up payments for first-year trainee GPs, ensuring they don’t take a significant pay cut when entering GP training, and will also cover the costs of trainee GP exams in their first year, investing \$10,000 per trainee.

The State Government has also funded a Chief GP Adviser position within the Department of Health – one of our core asks in the context of embedding high level general practice knowledge and authority within the Department. The first Chief GP Adviser will be named and announced publicly very soon.

However, disappointingly the State Government will spend \$20m to deliver a 12-month pilot to expand the scope of pharmacy - including by

enabling pharmacists to treat minor illnesses and ‘straightforward’ urinary tract infections, reissue prescriptions for contraceptives, and administer travel vaccinations – a measure we have advocated against and labelled [a retrograde step for Victoria and the health of Victorians](#).

Additionally, nothing of substance for medical practitioners has been announced on payroll tax, for which we have been [consistently advocating](#). The Government did announce that it will increase the current payroll tax-free threshold of \$700,000 to \$900,000 from July 1, 2024, and again to \$1m from July 1, 2025, but that, of course, will be of little benefit to most metro Melbourne-based general practices.

### MENTAL HEALTH

Finally, mental health. In what was most pleasing to AMA Victoria, \$157m will be spent to fund 96 mental health beds across the state, of which 24 will be Hospital in the Home, and 12 at The Alfred dedicated to treating eating disorders in what will comprise the state’s first publicly funded

residential eating disorders treatment centre- something for which AMA Victoria has campaigned forcefully.

Further, in the context of widespread cuts to community government programs, it should be acknowledged that all lapsing programs within the mental health portfolio have had their funding renewed.

### CONCLUSION

We wish to assure members that AMA Victoria will continue advocating to the State Government for increased investment in health, including relevant staff training, education, development, and recruitment, into public hospitals, general practice, and mental health. It is our conviction that expenditure on health must not be seen as a drain on Victoria’s finite resources, but instead as sound economic policy and investment.

If you have specific questions on the contents of the budget, or questions regarding our advocacy priorities more broadly, please contact senior policy adviser, Lewis Horton, at [LewisH@amavic.com.au](mailto:LewisH@amavic.com.au).

## FED FACTS

# PUBLIC HOSPITAL FUNDING



*Click here if you have a workplace relations issue you would like to discuss*

### PUBLIC HOSPITAL FUNDING AGREEMENT NEEDS COMPLETE MAKEOVER

The Australian Medical Association has found the key objectives of Australia's public hospital funding arrangement are not being met and says the agreement needs a comprehensive makeover.

In a submission to the Government's mid-term review of the National Health Reform Agreement Addendum 2020-25, the AMA said the agreement is not fit for purpose and has resulted in ambulance ramping, burgeoning elective surgery waiting lists, bed block and over-stretched emergency departments.

AMA President Professor Steve Robson said the agreement, which still has more than two years to run, is failing our public hospitals, which are in logjam.

"The AMA has carefully reviewed the objectives of the funding agreement and found the majority pertaining to patient

outcomes, like equitable access to care or reduced emergency department demand or improved mental health outcomes, are not being met. If the agreement is failing our hospitals and our patients, it needs a radical overhaul, yet we are stuck with this flawed formula until 2025.

"With waiting lists continuing to grow and public hospital performance failing to meet key performance targets, there is a compelling case for additional funding to be made available to give our crumbling public hospitals the support they need to deliver the care patients need while we wait until a new, improved agreement comes into force.

"The next agreement needs a complete makeover. We want to see improved performance rewarded, funding to expand hospital capacity to meet community demand and measures introduced to tackle avoidable admissions and unnecessary re-admissions.

"You only have to look at our last 16 [Public Hospital](#)

[Report Cards](#) to know the system is failing. All the graphs go steadily downwards with hospital performance now at its lowest in many years.

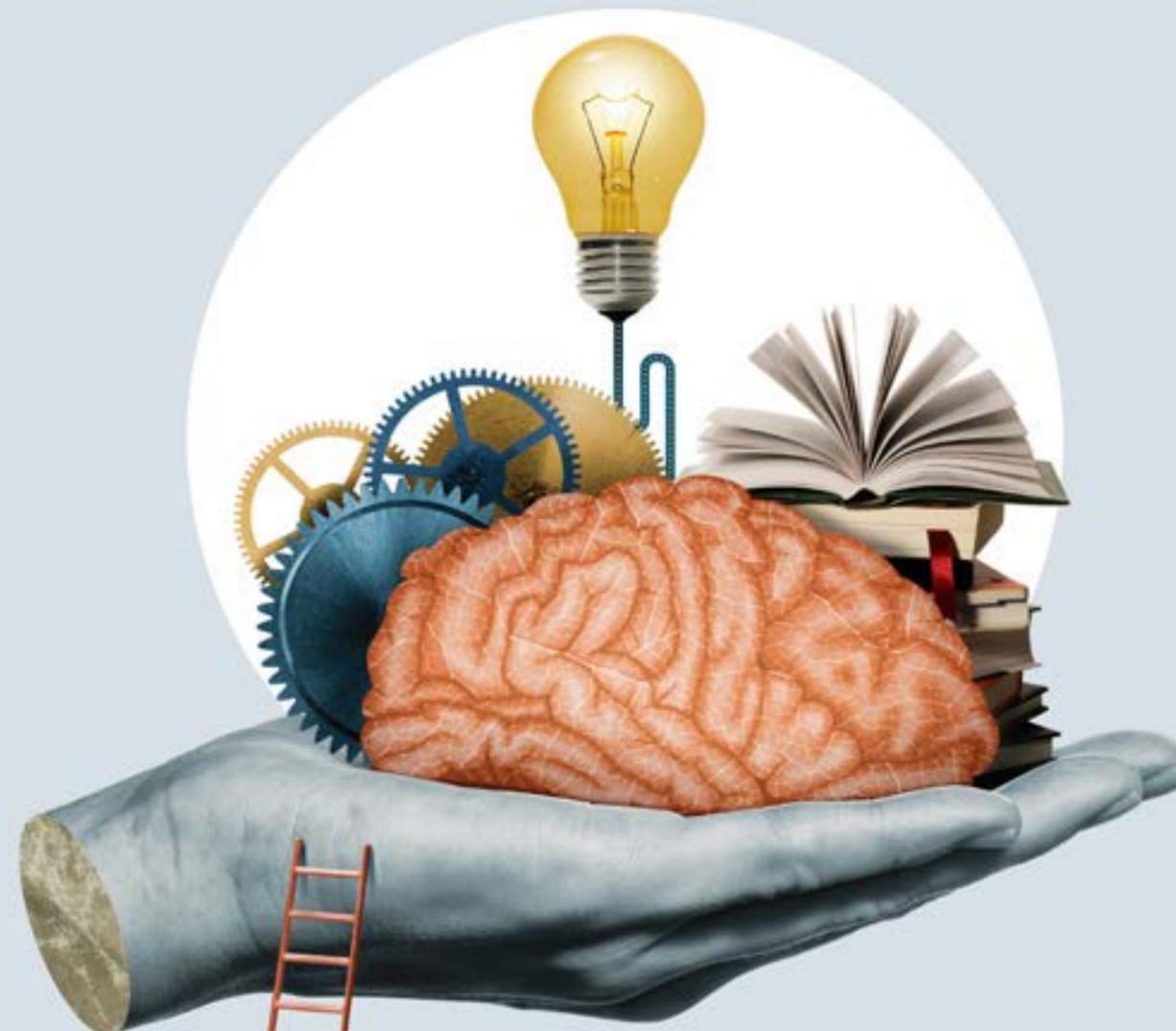
"That's why we've been campaigning since before the last election on this issue. Our [Clear the hospital logjam campaign](#) calls for 50-50 shared Commonwealth-State funding for our hospitals and scrapping the imposed artificial cap that prevents growth in the system.

"We want to see funding for increased capacity of our public hospitals and the reintroduction of funding for performance actually rewarding those hospitals which reach their performance targets.

"We implore all health ministers and all levels of government to work together to get this right for the future and to help our hospitals out in the meantime with an immediate injection of new funds."

[Read the AMA's full submission to the mid-term review.](#)

## DR YINGTONG LI – MEDICAL INTERN



# THE INTERN DIARY

**Yingtong is a newly commenced medical intern. This year, he is bringing us along on his internship journey, and sharing his experiences in The Intern Diary.**

“

*Bed 1. Urgent clinical review.  
BP 180/100, asymptomatic.*

*Bed 6. Urgent clinical review.  
HR 55, asymptomatic.*

*Bed 5. Urgent clinical review.  
BSL 16.4, asymptomatic.*

**M**y pager sounds, bringing me news from across the hospital of the latest pre-dinner blood sugar measurements and routine observations. It is 5pm, and my first afternoon cover shift.

I review the gentleman in bed 1. He is sitting in a chair eating dinner. He has no headache, abdominal pain or visual disturbance. He has no neurologic deficit. His bloods are unremarkable. I review his file – his blood pressure is usually similarly elevated and a known long-term issue. His medication chart features a smattering of stat antihypertensives scrawled in at various times this last week, though the Therapeutic Guidelines do not require it.

As an intern, I cannot change the acceptable parameters for vital signs; even if I could, it would seem unwise for me as an inexperienced intern to circumvent a safety measure designed to detect deteriorating patients early. I often hear from senior clinicians their stories as junior doctors, dropped into managing cardiac arrests and critically unwell patients with limited support – experiences which have now led to the development of medical emergency teams (METs) and mandatory urgent review criteria. I am thankful to be practising in our present environment, with stricter systems and better support.

And so policy appropriately prevents me from exercising any discretion about when to respond to out-of-range observations. It is an interesting juxtaposition, though, that I have no policy impediment in choosing how to respond from a wide range of options. If I decided that bed 1 needed IV hydralazine, bed 6 isoprenaline and bed 5 an insulin infusion, it would be the discretion and experience of my nursing and pharmacy colleagues – rather than absolute policy – that would prevent me executing those ill-advised plans.

Waxing philosophical and exploring hyperbolic hypotheticals do not help with my dilemma, though – what to do about my patient’s blood pressure. If I do nothing and suggest the day team review the regular antihypertensives, I or my overnight colleague will assuredly be paged again when the blood pressure remains elevated in the evening (and again in the morning, and again...). If I prescribe a stat oral antihypertensive, I can pat myself on the back for a job well done, while ignoring the piercing disappointment my medical school tutors would surely feel for prescribing an unnecessary medication to “chase a number”.

In the last issue of VICDOC, I discussed developing confidence as an intern in prescribing common medications. Now I must develop experience in deciding when to intervene, and when not to.

For my stable patients on ward cover, it perhaps usually matters little. But one month later I am in the emergency department, my patients are sicker and more undifferentiated, and my supervision is more indirect. The patient I fluid bolus may turn out to have heart failure and develop pulmonary oedema. The patient I am too quick to request a D-dimer for may end up with a whopping dose of radiation they didn’t actually need. I discuss my cases with my seniors, but I am acutely aware there is much I do not know that I do not know.

Much of my learning in the emergency department has been about developing comfort with uncertainty. My medical school exams did not admit uncertainty. Every multiple-choice question had a single best answer. Every patient with an abdominal complaint had either an unambiguous benign diagnosis, or a clear need for emergency theatre. Rarely was safety-netting of an unlikely but possible differential required. Rarely was a CT abdomen required to clarify diagnosis.

Though I navigate increasing independence, my registrars and consultants are supportive, and I do not make these decisions alone. I discuss with my seniors about when serious differentials are made sufficiently unlikely to enable safe discharge, and conversely, when sufficient uncertainty exists to warrant additional investigation. The purpose of my training is to develop my knowledge, skills and experience, so that when I do come to make these management decisions on my own, they will be safe and appropriate.



## JOIN THE CONVERSATION

# AMAV SOCIALS



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

### THE AUSTRALIAN FEDERATION OF MEDICAL WOMEN (AFMW)

Congratulations Jillian Tomlinson! New President of Australian Medical Association Victoria – former webmaster and Treasurer of Victorian Medical Women's Society (VMWS) and valued member of The Australian Federation of Medical Women (AFMW).

### PROF MARIE BISMARK

[On Jill Tomlinson's appointment as AMA Victoria President]: Fabulous news @jilltomlinson! The medical profession and the communities we serve are so lucky to have you in this role as President of @amavictoria.

### DR ALAM YOOSUFF

[On Jill Tomlinson's appointment as AMA Victoria President]: Congratulations on your new role as AMA vic president!

### AMA VICTORIA

Healthcare is responsible for 7% of Australia's total carbon emissions; the majority arising from hospitals. Yet we are only at the beginning of the journey away from high carbon, high cost healthcare.

There is an innovative road ahead to ameliorate this by: measuring and reducing our environmental footprints, reducing low value care, and supporting primary care/preventive health, including general practice.

At UniMelb we are engaging across the medicine, dentistry, and health sciences faculty to lead the way towards more sustainable healthcare.

Our work reaches also into our myriad affiliated UniMelb GP practices, hospitals, and other health sciences facilities. Further, it's exciting to be collaborating with other faculties including Engineering, Science, and Architecture to transition towards a more sustainable, low carbon healthcare future," says A/Prof Forbes McGain, recently appointed Associate Dean of Healthcare Sustainability at The University of Melbourne.

Forbes joins a strong medical team in this role at the UniMelb faculty. His colleagues include Professor Eugenie Kayak, A/Prof. Ken Winkel, Dr Laura Beaton,

A/Prof Grant Blashki, and Dr Hayden Burch.

Eugenie is a leader and champion for sustainable healthcare, who has worked with the AMA, Doctors for the Environment Australia, her own specialty and the wider medical profession to raise awareness of, and address, healthcare's carbon footprint and environmental impact. Ken Winkel (DEA member) is deeply involved in teaching medical and other health sciences students about the links between healthcare, biodiversity, and climate change.

Congratulations Forbes on your new role as first Associate Dean of Healthcare Sustainability!



### DR DAVID PROUD

It's #CrazySocks4Docs day, time to reflect on how hard medicine can be on mental health. Look out for yourself and your colleagues.



### MATT HOPCRAFT

#CrazySocks4Docs I couldn't decide which pair. ¿Porque no los dos! We know there are high rates of depression, anxiety, burnout, psychological distress & suicidal ideation amongst dental practitioners. Time to tackle that stigma head-on.



### DR DAVID KU

Too often we forget to look after ourselves, when looking after others. Here's to good physical and mental health for all! #CrazySocks4Docs



### PROFESSOR STEVE ROBSON MPH MD PHD

AMA Federal President About to start a big day of operating and it's #CrazySocks4Docs day. I'm always very reflective on this day after my own experiences and having lost close friends and not seeing that they were suffering.



### DR JOE GARRA

Let's start by being nice to each other #CrazySocks4Docs

### AMA VICTORIA

Great appearance from former AMA President and current AMA Victoria Chair of Council, Dr Mukesh Haikerwal, on ABC's #QandA. Constructive discussion on the menace of vaping, and the fundamental importance of general practice, amongst other issues. Missed the episode? [Catch up here](#)

### AMA FINANCIAL PLANNING

The [AMA Financial Planning](#) and [AMA Finance Brokers](#) teams were delighted to partner with [Vanguard Australia](#) to host a seminar for [Australian Medical Association \(Victoria\)](#) members on whether you should pay off debts or invest. It was a fantastic evening with a lot of engagement with the members and attendees.





# MAKING A DIFFERENCE THROUGH PHILANTHROPY



MANY AUSTRALIANS ARE NOW STRIVING NOT ONLY FOR PERSONAL SUCCESS IN THEIR CAREERS AND HOME LIVES, BUT ALSO TO MAKE A POSITIVE IMPACT ON SOCIETY.

## THE INSPIRATION

The inspiration to give in the first place may vary, but often stems from several common sources, although they can overlap:

<b>LIQUIDITY EVENTS</b>	The release of substantial funds by virtue of selling a business or assets; or, from receiving an inheritance or an unexpected windfall.
<b>LIFE EVENTS</b>	The birth of a child, coming of age, marriage or divorce, retirement.
<b>DETERMINATION TO ADDRESS A SOCIAL ISSUE</b>	Often spurred by an illness impacting a family member or someone within your social circle; or, heightened awareness of a social issue.
<b>CREATING OR UPDATING A WILL</b>	Prompts many to consider how they might continue their support after they are gone.
<b>A DESIRE TO CREATE A LEGACY</b>	Many Australians who've been closely associated with a cause often want to continuing supporting it long into the future.

## STRUCTURED GIVING

To achieve this, donors are incorporating philanthropic activities into their tax, wealth and family succession planning. Whilst there are many pathways, more and more Australians are looking to structure their giving through (Public or Private) Ancillary Funds. This allows donors to create a long-term, structured giving program that can endure way beyond any one person's lifetime to potentially provide an in perpetuity positive impact on the community. Some of the common benefits of structuring your giving in this manner include:

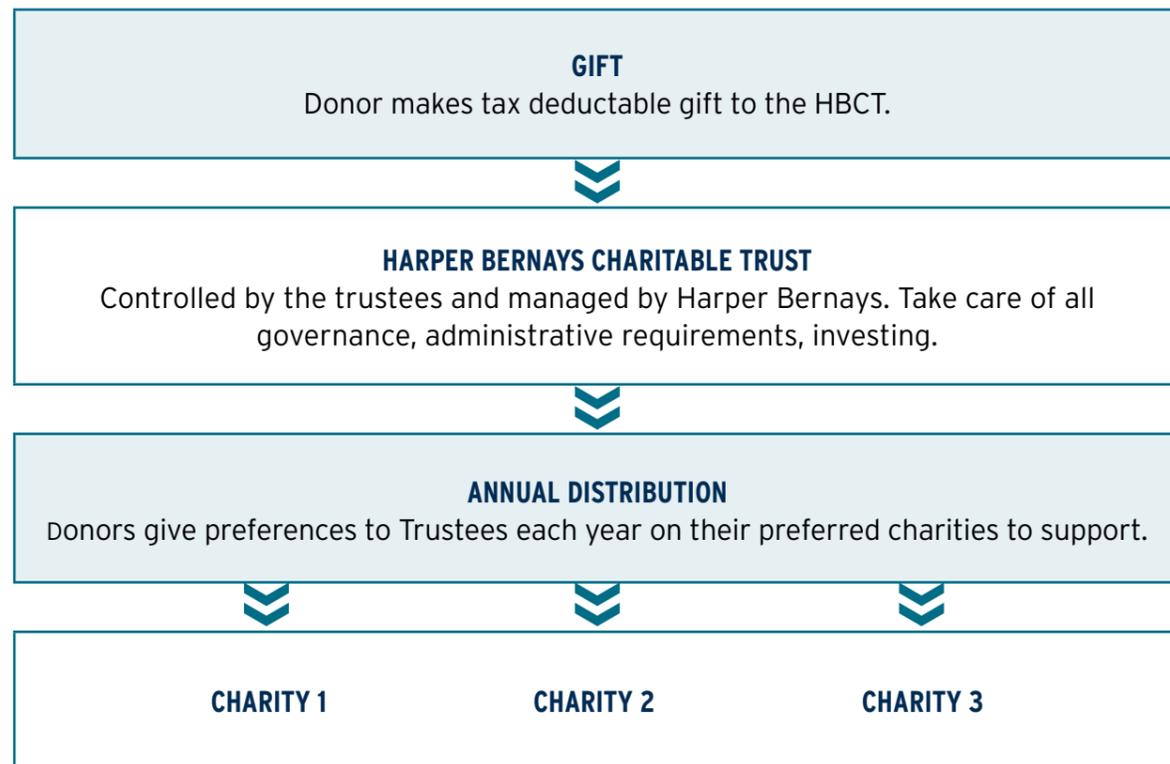
<b>TAX EFFECTIVENESS</b>	Initial and ongoing gifts are tax-deductible. Deductions may also be spread over five years. This allows donors to separate the timing of their deductions from their grants to charity. The assets held operate in a tax-free environment and benefit from franking-credit refunds, allowing for greater appreciation of the corpus and more income generation over time.
<b>FAMILY</b>	Philanthropy is increasingly being used as a pathway for future generations to engage in a family's wealth.
<b>ENHANCED IMPACT</b>	It allows you to plan your giving and maximise your impact more effectively.



### HOW THE HARPER BERNAYS CHARITABLE TRUST WORKS

With even a modest amount of capital it is possible to establish a sub account that will invest your tax-deductible contribution in a tax-exempt vehicle. Establishing a named sub-fund in the Harper Bernays Charitable Trust, allows donors to structure their giving, without the administrative burden

and cost of managing your own private foundation, allowing donors to focus their time and energies on what matters most to them - their preferred recipient charities. Below is an illustration of how structured giving through a vehicle like the Harper Bernays Charitable Trust (HBCT) works:



<b>MINIMUM CONTRIBUTION</b>	\$50,000 to \$100,000 depending on the type of sub account. Additional donations can be made to each sub-account in future years, from any source including the general public and those unrelated to the original donor.
<b>ESTABLISHMENT TIME AND COST</b>	Same day. Zero establishment costs. Ongoing administration and investment costs are between 1.4% and 2.2% of the sub fund's value, per annum, depending on the size / type.
<b>CONTROL</b>	Controlled by the fund's co-Trustees. Manage administration, investment, governance and compliance.
<b>INVESTMENT STRATEGY</b>	Assets are pooled and managed centrally by Harper Bernays. Assets are managed in a tax-exempt environment.
<b>ANNUAL DISTRIBUTION TO CHARITY</b>	Donors make distribution nominations to the trustee. Usually at least 4% of the previous financial year end's net assets. Distributions are restricted to ATO endorsed charities with Deductible Gift Recipient Item 1 status (DGR 1).
<b>LEGACY</b>	A sub fund can continue beyond your lifetime, with responsibilities handed over to family, friends or the Trustees of the fund. Gifts to the sub-fund can be made through your Will.

### AMA VICTORIA CHARITABLE FOUNDATION

In future such donations can be made to the AMA Victoria Charitable Foundation, AMA Victoria's own philanthropic vehicle which is focused on supporting charities in the areas of public health and medical research. Members can also continue to support the Foundation directly with donations.

# Would free carer support benefit your clients?



Click here for  
*The Caring Way*  
magazine



Email  
*Carer Gateway*  
*Merri Health*

**Carergateway.gov.au**  
1800 422 737 Monday-Friday 8am-5pm



**C**arer Gateway is an Australian Government program that provides free services and support for the 2.65 million unpaid carers in Australia – 750,000 of whom live in Victoria.

These are the unpaid family members and friends who loyally and lovingly support people with disability, illness, age or mental health issues.

Merri Health is the lead service provider for Carer Gateway in Victoria, supported by six other service providers across the state. These include Alfred Health, Barwon Health, Bendigo Health, FamilyCare, Grampians Health Ballarat and Uniting VicTas.

## CARERS NEED CARE TOO

It may seem surprising, but a lot of carers don't think of themselves as a carer. They consider themselves a daughter, mother, partner, sister, father or friend simply doing what's expected of them, regardless of the emotional, physical or financial stress it puts them under. That's why they often don't seek help, and can end up physically and emotionally drained.

## WHY YOU'LL OFTEN COME ACROSS CARERS

One of the key responsibilities of being a carer is accompanying the person in their care to healthcare and medical appointments. Carers may meet with and seek the advice of clinicians, doctors, allied health professionals and other healthcare professionals as part of their caring role.

## HOW CARER GATEWAY CAN HELP

If any of your patients/clients are carers and are feeling overwhelmed and in need of some support, Carer Gateway was created purely to help them. We offer free emergency respite, group support, counselling, tailored support packages, coaching and online skills courses.

We can also help them apply for carer payments or equipment from the Government, show them how to move people safely without injuring themselves, and educate them about what legal responsibilities they may need to consider.

Plus, we have a carer engagement team readily available to provide further information and advice, or organise a session at your premises to help connect your clients with Carer Gateway. Simply contact them at [cgce.team@merrhealth.org.au](mailto:cgce.team@merrhealth.org.au)

## REFERRING IS EASY

If you are a service provider and would like to refer a carer who lives in Victoria, simply visit [ereferral.carergatewayvictoria.org.au](http://ereferral.carergatewayvictoria.org.au) and we'll take care of the rest.

If a carer is in need of emergency respite, please call 1800 422 737 to speak to a Carer Response Officer. Sometimes, just having a day off to themselves, catch up with their own life-admin or visit a friend is all they need to reset.

## HELPING MORE CARERS

If you have a lot of carers visiting your practice, it may be beneficial to have some Carer Gateway posters, brochures and information sheets on hand to help them. These are provided free-of-charge to assist organisations and individuals like you. You can order them online at [publications.carergateway.gov.au](http://publications.carergateway.gov.au) publications or call 1800 050 009 (during work hours).

## FREE CARERS MAGAZINE

The Caring Way is a free magazine for carers to learn about other carer's experiences, how they manage, supports that are helpful, and how best to navigate carer services. Feel free to also share this with your networks so more carers can get the help they need: <https://bit.ly/426KgPH> Or for free hard copies, please email [cgmarketing@merrhealth.org.au](mailto:cgmarketing@merrhealth.org.au)

JARROD MCCABE – WAKELIN

# A PROPERTY MANAGER CHECKLIST

MAXIMISING RETURNS  
WITHIN THE ACCELERATING  
RENTAL MARKET



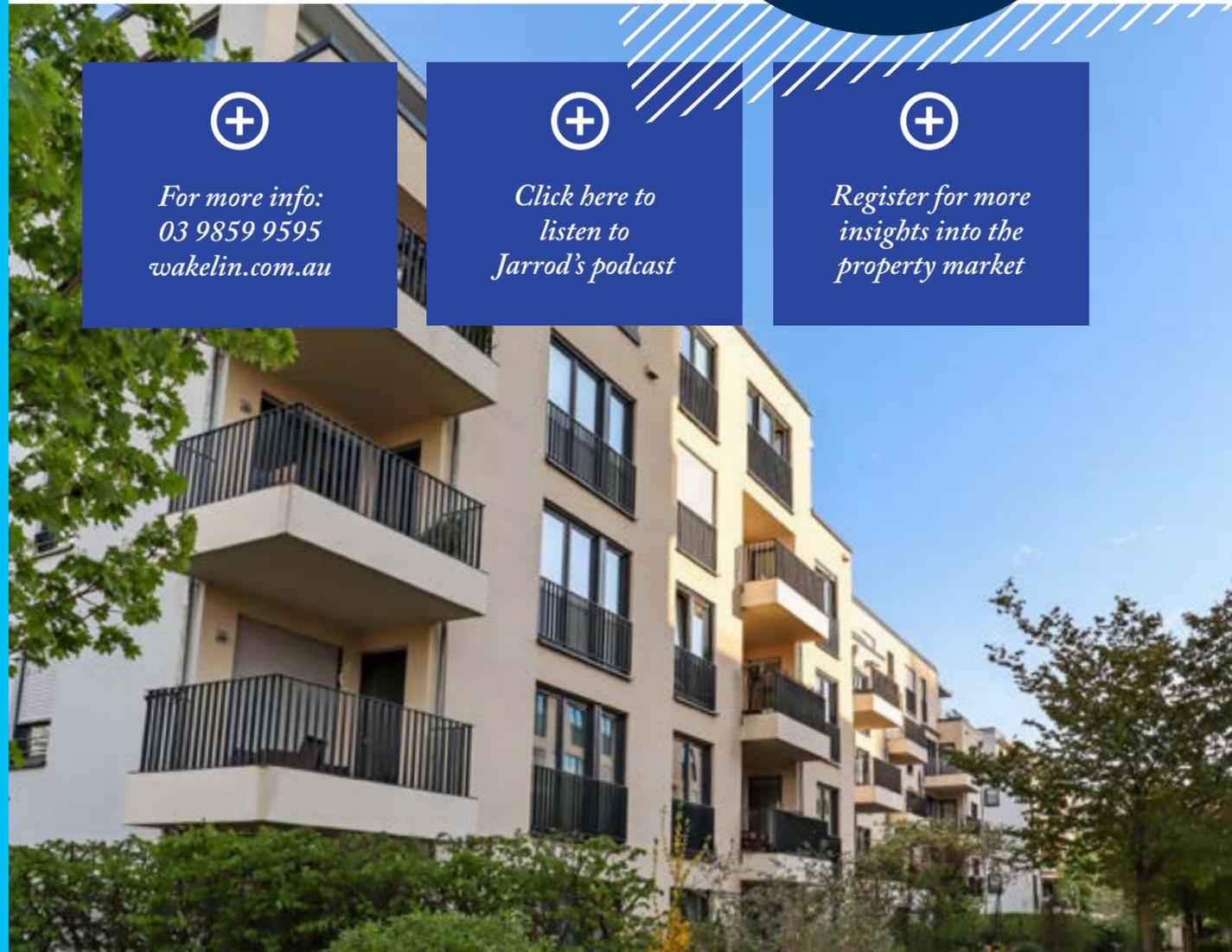
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Jarrod's podcast



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insights into the  
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**S**urging demand for rental homes means investors seeking yield are reaping the benefits. Melbourne house and unit rents rose for the sixth consecutive quarter to match the longest rental price growth period achieved in 2007-2008, according to Domain's March 2023 Rental Report.

Having said that, it is pivotal for investors to ensure their property is managed astutely if they are to optimise the rewards.

Unlike residential property, most mainstream investment asset classes are passive. You invest your money and entrust others to make it grow. Direct property investment is unusual in that it brings with it a management function which, depending on how well it is executed, can heavily influence the success of the venture.

Naturally, most investors recognise that they don't have the time or requisite knowledge and look to outsource the tenant recruitment and management role to property managers.

The challenge is finding the right property manager; one who will provide a high standard of service at a fair price. So how do you identify prospective candidates?

Taking control means not just opting for the status quo and giving the role to the agent who you bought the property from. They need to prove that they are the right property manager for you.

It is also important not to be too fee focused. Don't necessarily go for the cheapest quote. You are looking for value for money. Remember, a thorough – but possibly more expensive – manager will likely result in better quality, happier tenants; lower tenant turnover and higher occupancy rates; lower maintenance costs and higher income.

The ideal way to source prospective property managers is through a referral, but regardless of how you source candidates, it is critical you ask the right questions to ensure that the manager is the right match for you.

## HERE IS A LIST OF QUESTIONS YOU MAY WISH TO ASK A PROSPECTIVE MANAGER:

- 1 What comparable properties have they leased recently and how long were each of those properties on the market before they rented?
  - 2 How do they plan to market your property for rental?
  - 3 Does the agency take professional photographs and write a thorough and realistic description of the property to attract tenants?
  - 4 How do they use online marketing?
  - 5 Does the agency do thorough and complete condition reports including photos to protect me from any damage to the property?
  - 6 Does the agency conduct regular rent reviews so I can make sure I am getting the best rental return from my investment?
  - 7 When finding a tenant for a property, what is the process of approving a tenant? Do they interview the tenant and do thorough and comprehensive checks including tenancy database checks?
  - 8 Who will be managing the property? How many other properties do they personally look after? How long have they been in the property management industry for? Does my property manager undertake regular training and is up to date with legislation?
  - 9 Does the agency conduct regular periodic inspections, which include photographs and a report sent to me?
  - 10 Does the agency have a team of qualified, reliable, and trustworthy tradespeople?
  - 11 What are the property management firm's leasing and management rates?
  - 12 Ask to speak to 3 referees.
- Residential property investment is not a passive holding. Even if you outsource property management, you still need to manage the manager. But it need not be a chore if, from the outset, you demonstrate that you expect a high service and will hold the property manager to account.

# MIDDLE LEADER PROGRAM



*Click here  
to enrol*



**Excellence in healthcare requires expert collaboration within and between diverse teams of highly specialised healthcare professionals. Middle leaders play a significant role in developing a culture of collaboration and performance through their influence on both senior and junior roles.**

**Join this program to increase your knowledge of effective leadership and learn practical skills you can apply immediately in your current role.**

AMA Victoria's Middle Leader Program is a professional development course for doctors, consultant level and above keen to develop their leadership capability in complex collaborative environments.

Middle leaders will be currently leading or managing teams in a variety of clinical/health settings which require them to both lead up and down to be effective in their role, hence the term middle leader.

Delivered in-person across two days, this program supports each participant to find their own leadership voice and style and provides the opportunity to learn and practise a skill set for their role.



*Thought provoking  
and personalised.  
Providing excellent  
coverage of the  
fundamental tenets  
of leadership in  
clinical practice.*



LEADERSHIP – DR ANNA CLARK

## WHAT IS LEADERSHIP DEVELOPMENT



**Our leadership coaching and professional development programs support doctors to lead with increased clarity, confidence, and skill.**

### DR ANNA CLARK (PHD) DELIVERS THE LEADERSHIP COACHING AND PROFESSIONAL DEVELOPMENT PROGRAMS AT AMA VICTORIA

Dr Anna Clark (PhD) delivers the leadership coaching and professional development programs at AMA Victoria. Anna has worked in leadership development for over 15 years, including consulting and coaching in INSEAD Business School's flagship leadership programs in Europe and Singapore. Anna facilitates leadership programs and one-on-one coaching for doctors at all stages of their careers. She creates a safe space for doctors to work on the issues and challenges they face in their work and build strong leadership identities, skills and practices.

Anna has a PhD in social psychology from the University of Melbourne and has held academic positions in psychology and organisational behaviour in the Netherlands, France, and Australia. Anna is now based in Melbourne, designing and delivering leadership development programs in education and healthcare sectors. Anna also writes regularly for AMA Victoria, publishing on topics relevant to the complex care and collaborative leadership required in healthcare settings.

# EMERGING LEADER PROGRAM



*Click here  
to enrol*



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*Dr Clark has been very helpful in supporting my professional and personal development. She displayed a very caring, respectful, and expert attitude which allowed meaningful and relevant learning that I was able to apply in my professional context. I highly recommend any clinician to use this opportunity to develop a better professional identity as leader.*

**H**ealthcare is a complex and collaborative setting that requires strong personal, interpersonal and team skills. It requires skilled leaders to mobilise people and teams to approach tasks collaboratively, to be motivated and engaged and part of a workforce that is healthy and sustainable and able to face and overcome huge challenges.

## OUR COACHING PROGRAMS

Our coaching programs provide a private and confidential series of one-on-one sessions, where doctors are supported to work on a highly personalised set of development goals, designed to support the work they want to do.

## OUR PROFESSIONAL DEVELOPMENT PROGRAMS

Our professional development programs have both group and one-on-one formats to suit different learning styles and very busy schedules that can sometimes limit attendance across set program times.

## WE'RE CONTINUALLY ADAPTING AND MODIFYING OUR PROGRAMS

This year we are running both the Middle Leader Professional Development program and the Emerging Leader Program in group and individual formats to meet demand. This year we are also able to offer parts of the programs face-to-face for the first time.

As doctors progress in their careers they often step into leadership positions and are required to coordinate and engage diverse teams with little or no training. We're here to meet that need in a very personalised way.

While upskilling in this important area can happen at any point in a career, we know there are particular transition points for this to occur. For example, junior doctors stepping into roles in hospitals and other

settings for the first time, middle leaders taking up area or unit lead positions, and doctors stepping into head of department type roles.

Our programs are designed to support these transition points. The group programs have the added bonus of bringing people at a similar stage together to share and reflect on commonalities.

## OUR APPROACH INVOLVES MIXING THE SLOWER, DEEPER WORK OF PERSONAL DEVELOPMENT AND SELF-AWARENESS WITH A GROUNDED AND PRACTICAL FOCUS

For example, someone might know their strengths and weakness in a general and abstract way, and have sense of their abilities and style, and then be faced with a difficult conversation or an overwhelming workload, and struggle to identify or try more adaptive and effective behaviours.

Our approach navigates the two. I take the person and what they do well and not so well into account, and based on the situation at hand and what skills and behaviours are required for effective action, work out small, realistic action plans for more effective skills and behaviours.

In a healthcare setting we have worked to create programs that are effective within busy schedules and can be worked on and implemented on the run.

I believe it's powerful. Leadership development work doesn't have to be an intensive residential retreat or a multi-day conference, sometimes it's finding an hour here and there to maintain momentum.

I continue to be impressed by the level of self-awareness and the commitment to improvement that our members show.

We support their deepening personal knowledge and the insight that builds as they do this work and witness themselves gaining confidence and new ways of working.

MAYA PARBHOO (PARTNER) +  
ISABELLA VAN SCHAİK (ASSOCIATE) – KENNEDYS

# VICTORIA'S ELECTRONIC PATIENT HEALTH INFORMATION SHARING SYSTEM

AN OVERVIEW OF THE  
HEALTH LEGISLATION  
AMENDMENT  
(INFORMATION SHARING)  
ACT 2023



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contact Kennedys*

## HEALTH LEGISLATION AMENDMENT

### BACKGROUND TO THE ACT

On 9 March 2023, the *Health Legislation Amendment (Information Sharing) Act 2023* (the Act) was passed by the Victorian Government and received Royal Assent on 28 March 2023. The Act was developed following recommendations from the Targeting Zero report to support the Victorian hospital system to eliminate avoidable harm and strengthen quality of care.

The Second Reading Speech noted that most Victorian patients will visit more than one health service for health care and treatment, which has led to:

- > Sharing clinical health information in Victoria being outdated;
- > Treatment often becoming fragmented and inconsistent with modern health record sharing including that performed by other states;
- > Clinicians not having a complete and integrated picture of a patient's history; and
- > A failure to correctly identify patients across health services, leading to poor health outcomes for patients.

The Act establishes a centralised Electronic Patient Health Information Sharing System (the System) for participating health services to share certain health information for the purpose of improving patient safety, decreasing avoidable harm and deliver person-centred care.<sup>1</sup> It will enable hospitals and health services to quickly access accurate patient information in one centralised location.

The System will include health information, including but not limited to medical images, laboratory results, medication lists and patient allergies.

Pursuant to s6C of the Act, the System will be accessible by 'participating health services' including:

- > Ambulance services;
- > Denominational hospitals;
- > Metropolitan hospitals;
- > Multipurpose services;
- > Public hospitals;
- > Registered community health centres;
- > Residential care services; and
- > Mental health services.

The System can only be accessed by a participating health service and clinical staff for the purpose of providing medical treatment. Insurance companies will not have access to the System, and there are penalties for unauthorised access to the System (\$44,300 or two years imprisonment).



## ISSUES RELATING TO THE ACT

Pursuant to s 134 ZL of the Act, a patient's consent is not required for the collection, use or disclosure of their health information which is permitted or authorised by the Act. Therefore, the Act creates a centralised database for medical records of patients to be stored without patient consent and patients cannot 'opt out'.

The idea that a patient can 'opt out' is based on the Federal My Health Record Scheme, as in that case, patients can withdraw consent to have their health information being uploaded to the system at any time. In addition, the System is said to have created a privacy risk of having confidential health information available to participating health services without adequate safeguards in place.

The Victorian Government has recognised *"both the sensitive nature of health information and the importance of having critically strict safety, security and privacy measures put in place to ensure it is protected"*<sup>2</sup>. As such, they have planned to implement safeguards, frameworks and audit processes to securely manage patient data and protect patient privacy.

In this regard, the Act establishes a Privacy Management Framework by delegating such power to the Minister. The Privacy Management Framework is intended to safeguard sensitive health information and develop a process for regular audits and compliance checks. However, the specifics of the safeguard or compliance check process are not outlined in the Act.

## BENEFITS OF THE ACT

The benefits of the Act are:

- > It will facilitate public hospitals and other relevant health services to share health information between each other efficiently and securely, for the purpose of providing safe, effective and informed medical treatment and care to patients;
- > It will allow quick access to vital patient information in an emergency, where that patient has received care elsewhere;
- > It will assist patients with language barriers; and
- > It will provide better support for health services with regards to telehealth consultations.

Whilst supporting the Act, the Victorian Government has noted that *"secure health information sharing will deliver Victorians the same benefits that patients around the country are already getting, ensuring they receive the best possible care"*.



<sup>1</sup> Second Reading Speech, Ms Thomas, delivered on 8 February 2023

<sup>2</sup> Second Reading Speech, Ms Thomas, delivered on 8 February 2023

## KEY TAKEAWAYS

The Act will assist with the fragmentation of patient health information and improve the ability of clinicians to start treatment with greater efficiency and reliability. Further, the Act brings Victoria into line with other Australian states who have successfully implemented health information sharing, such as NSW, Queensland, ACT and South Australia.

It is ultimately the responsibility of the participating health service to ensure information stored on the System is accessed and used appropriately. We recommend health services and practitioners review the Privacy Management Framework to ensure they have developed a process for regular audits and compliance checks.

In addition, we remind practitioners that accessing information held on the System will only be permitted for the purposes of providing medical treatment. Practitioners should therefore use their discretion in accessing patient records on the System for those patients with highly sensitive health information such as sexual health issues, mental health issues, family violence and child protection.

## AMAV POSTSCRIPT

*In supporting the legislation (and opposing any attempts to amend the legislation by allowing patients to "opt-out" of the system, we were in no way diminishing privacy concerns, particularly for mental health and reproductive health records. But the status quo bear acknowledgement as comparator; it is a reality that patients' health information is already stored in hackable databases or manila folders by individual health services, and data in the government's model would be ring-fenced with the strictest of protections.*

*It is AMA Victoria's belief that the Act will greatly improve the ability to connect health information across Victoria's public healthcare system, which will reduce the burden on patients having to remember their past medical history. This will allow clinicians to start treatment sooner. It will reduce the number of unnecessary tests and investigations and reduce the risk of medication errors. Indeed, in an emergency department in the early hours of the morning- by ensuring that medical teams quickly learn what conditions and medications their patient has – it could be lifesaving.*

Kennedys

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AMA VICTORIA EXCLUSIVE PODCAST

# THE DOCTORS' ROOM

A PODCAST FOR MEMBERS WITH DOCTORS FOR DOCTORS

HAVE YOU EVER FELT LIKE AN IMPOSTER OR DOUBTED YOURSELF DESPITE YOUR STACK OF QUALIFICATIONS + ACHIEVEMENTS?

DO YOU OFTEN FEEL LIKE YOU'RE NOT QUITE GOOD ENOUGH?

OR DO YOU FIND YOURSELF PUTTING EVERYONE ELSE'S NEEDS ABOVE YOUR OWN?



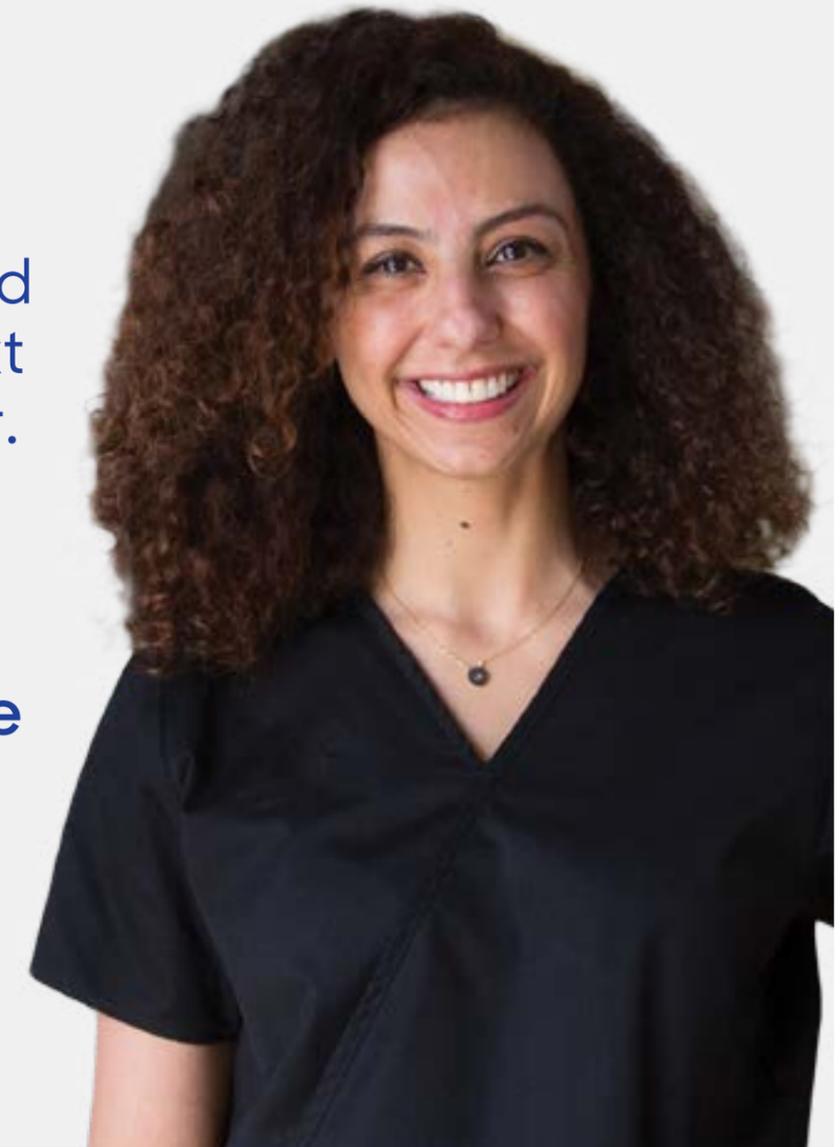
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MORE THAN MED

# MEDICINE + WRITING

*Dr Denis Robertson*

REPORT JEANIE WATSON



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an interest or hobby  
that is away  
from medicine*

## **I HAVEN'T ALWAYS BEEN A WRITER, BUT I HAVE WRITTEN THROUGHOUT MY MEDICAL CAREER.**

Many years ago, I wrote a medical book about clinical exercise testing based on work I was involved with in London and Canada. I've written a few medical papers, of course, and occasionally I write to *The Age*. But when people read something I've written – like a draft chapter of my book – they say that I am a writer.

## **MY FATHER, GRAEME ROBERTSON, WAS A PROMINENT AUSTRALIAN NEUROLOGIST. IN HIS SPARE TIME, HE'D PHOTOGRAPH AND STUDY THE USE OF DECORATIVE CAST IRON IN ARCHITECTURE.**

I'm sure his creativity rubbed off on me. He bought me cameras when I was young and I've continued to take photographs throughout my life. Sometime before my father died in 1975, I asked him about his father. His reply, "You would not want to know", planted a seed. I didn't get the feeling that there were any really nasty family secrets – but he was clearly reticent to talk about his family.

## **AFTER I RETIRED FROM MY ROLE AS A RESPIRATORY PHYSICIAN IN 2015 AND HAD MORE TIME, I STARTED RESEARCHING OUR FAMILY.**

Eventually I had enough information to write a book about my father, and *E. Graeme Robertson: Physician, Photographer, Preserver* is the result. It's about my father, his life and his family. I wasn't driven to write this book quickly. It was probably 10 years ago when I first put pen to paper. Not being a professional writer, I didn't allocate a time each day to start writing. As I researched each part of the book, I would put that section together before I moved on to the next.



**THE BOOK EVOLVED AS I CONTINUED TO FOLLOW THE CLUES, IF YOU LIKE, THAT EMERGED THROUGH THE PROCESS OF RESEARCH AND WRITING.**

I started with basic genealogy – names, places, dates of birth, marriage, and the deaths of my parents and ancestors. I also had a lot of information at home about my father, including his old files which I worked through, and I read his books. For my mother, I researched her family and parish that she came from in England. There was a book published about that parish, which detailed some of the parish records. I visited Scotland to find out where my great-grandparents came from and collected books about the area. My father died nearly 50 years ago, so there weren't many people with memories of him but I spoke with some family members who provided their recollections. I also looked at newspapers on the National Library's site, Trove, which keeps digitised versions of old newspapers.

**THE MOST SATISFYING THING ABOUT WRITING IS ACTUALLY GETTING SOMETHING DOWN ON PAPER.**

My process was to handwrite my draft first and then dictate it into a Word document using a voice recognition system. It has been even more satisfying to see it all printed in a book.

**THE PROCESS OF GETTING PUBLISHED WAS MORE DIFFICULT THAN THE WRITING ITSELF.**

My family read through most of the book and people I knew who had done some editing or writing looked at some sections and made useful comments. Thankfully, it didn't require a lot of editing. Once I was happy with the manuscript, I submitted it to publishers in Melbourne that I knew or were recommended to me. The feedback I got from all of them was that it was not a commercial proposition, so it was up to me to self-publish, or custom publish it. A publisher in Canada accepted it. It's now available in local bookshops and in other countries through distributors such as Amazon. Copies have been sold in the United Kingdom and the United States.

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*The most satisfying thing about writing is actually getting something down on paper.*

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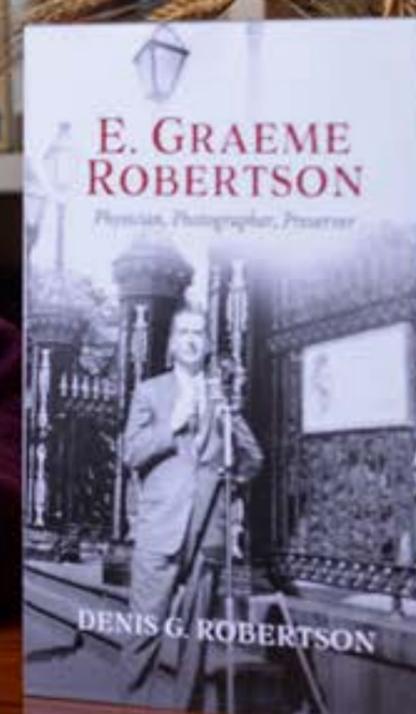
*I started writing and it emerged from there. Until you start, you haven't got a hope of getting anywhere.*

**HAVING A WEBSITE FOR THE BOOK IS RECOMMENDED, AS IS SOCIAL MEDIA, BUT I AM NOT A SOCIAL MEDIA TYPE.**

I'm not sure that the people who might want to know about this book are social media types either. I've been promoting the book to physicians and the National Trust of Victoria because both audiences may be interested in my father's life and his life's work. I'll be speaking at the Australian and New Zealand Association of Neurologists and launching the book on the Polly Woodside. He led the restoration of this square-rigged sailing ship for the National Trust.

**MY ADVICE TO OTHERS IS IF YOU FEEL AN URGE TO DO SOMETHING CREATIVE, WHETHER IT'S WRITING OR SOME OTHER ACTIVITY, JUST GET STARTED.**

I started writing and it emerged from there. Until you start, you haven't got a hope of getting anywhere. And, once you start, it can be much easier and even more satisfying than you expected. Now that I've finished this book, my family have said I need to write about my own history, but I think that'll just be for the family, rather than publication. Time will tell.



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