

# vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. AUGUST/SEPTEMBER 2019



## The Flying Doctor

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FRONT COVER: The flying doctor, Dr Graeme Dennerstein.



Magazine of the Australian Medical Association Victoria

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Vicdoc is published by AMA Victoria Services Pty Ltd ISSN 1440-8945 ACN 004 158 614

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Vicdoc is printed using FSC mixed source certified fibre by Printgraphics Pty Ltd under ISO14001 Environmental Certification

**Closing date for October 2019 issue submissions:**

Editorial: 26 August 2019  
Advertising: 2 September 2019

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## Welcome from the editor



AMA Federal President Dr Tony Bartone (left) presents AMA Victoria President A/Prof Julian Rait with a winner's trophy at the National Conference. See page 32.

This edition of Vicdoc has a big focus on doctors' mental health. We thank the doctors who have opened up about their own battles with depression for the purpose of helping others. While there is plenty of progress still to be made, times are changing and doctors don't face the same level of fear about being judged by their colleagues as they once did.

Mental health advocate, Dr Geoff Toogood, has devoted so much to the cause in recent years and we congratulate him on his AMA President's Award and another successful Crazy Socks 4 Docs campaign. I encourage you to read the brave declaration from psychiatry registrar, Dr Kieran Allen on page 10.

Your August Vicdoc also includes thought-provoking articles on the future cost of medicine and a strong explanation of why doctors support pill testing trials at music festivals.

It's an exciting time for Western Health, with the construction of the

new \$1.5 billion Footscray Hospital set to commence soon, but first they share with us the story of the opening of the Joan Kirner Women's and Children's Hospital.

We also meet Dr Graeme Dennerstein, an O&G who has combined his love of flying with medicine for over 50 years. If you would like to tell us about an achievement in medicine or a personal interest you believe other members might enjoy reading, please contact me. We are also very keen to hear any other feedback on Vicdoc - particularly your ideas on how we might improve the publication. Vicdoc is sent to members every two months, so look out for the next edition in your mailbox in October.



**Barry Levinson**

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# President's message



In August 2015, the former chairman of consumer watchdog the ACCC, Professor Allan Fels, slammed the 7-Eleven franchise model saying that, "The only way a franchisee can make a go of it in most cases is by underpaying workers, by illegal behaviour. I don't like that kind of model."

His blistering assessment followed allegations of widespread underpayment of wages and the doctoring of payroll records within Australia's biggest convenience store chain. Subsequently, a number of 7-Eleven operators were fined for short-changing workers and falsifying records to conceal their underpayments. Furthermore, the 7-Eleven Chairman Russ Withers resigned from the board, along with the chief executive officer Warren Wilmot and another senior executive, in the wake of this worker exploitation scandal.

Of course, wage theft of this sort has become commonplace in recent years and some argue that it has emerged as a successful business model for many organisations. Wage theft arises when employers deliberately underpay workers by refusing to pay mandatory entitlements such as overtime, long service leave or shift allowances. And while it is unfortunately affecting thousands of low-paid employees every year, AMA Victoria is suspicious that a similar approach is being taken by Victoria's public hospitals.

As members will recall, AMA Victoria and ASMOF negotiated new enterprise agreements for specialist doctors and doctors-in-training (DITs) with the Victorian Government, which were certified by the Fair Work Commission on 31 July, 2018 and became effective from 9 August, 2018.

These agreements delivered significant pay increases and were widely welcomed by the profession. They were also supported by additional funding from the Department of Health and Human Services. This was confirmed in a letter provided to AMA Victoria on 20 August last year, where Secretary Kym Peake assured us that, "The Department of Health and Human Services has released recurrent funding to the affected public hospitals and health services to support the implementation of these new enterprise agreements".

However, over the ensuing months a number of industrial disputes have arisen which make us doubt whether sufficient support for our health

services has been forthcoming. As a consequence, health services appear to be selectively interpreting the two enterprise agreements to the disadvantage of many public hospital doctors. Executives of one of our largest health services have even suggested that they cannot fully implement these entitlements due to insufficient funding and a very large deficit for 2018-19.

In particular, the disputes relate to the following subject matters:

1. Long service leave entitlements of fractional specialists who are concurrently employed by two or more health services.
2. The continuity of service for long service leave purposes of doctors who are on zero hours casual contracts, but have not worked any hours whilst on that contract.
3. The date upon which a specialist is considered to have become a specialist, for the purpose of determining the remuneration level of the specialist.
4. The service, including periods of leave, of specialists which health services will take into account for the purpose of determining the remuneration level of the specialist.
5. The interpretation, application, and implementation by health services of Clinical Support Time (CST).
6. The interpretation, application and implementation by health services of Continuing Medical Education (CME) support.
7. The action of health services to use the interpretation, application and implementation of clause 32\* to arbitrarily reduce the superannuation contributions made by health services for the benefit of specialist doctors.
8. The entitlement of doctors to be paid for a public holiday which falls on a day on which the doctor is not rostered to work.

The exact details of each dispute have been provided to the State Government and the Fair Work Commission, including the steps taken to resolve each part under the established dispute resolution procedure.

However, it would seem that some health services are determined to circumvent their obligations to public hospital doctors and are being "mean and tricky" in their interpretation of these two agreements. Furthermore, it appears likely that health services are coordinating their arbitrary restrictions in order to avoid the widespread adoption of some of these contractual entitlements.

Consequently, AMA Victoria and ASMOF have applied to initiate a formal hearing of these disputes via the Fair Work Commission. This is an application for the Commission to deal with our

disputes in the first instance via conciliation, but to proceed to an arbitrated decision if no progress is made. We will naturally keep members fully informed as this dispute evolves.

**A/Prof Julian Rait OAM  
President**

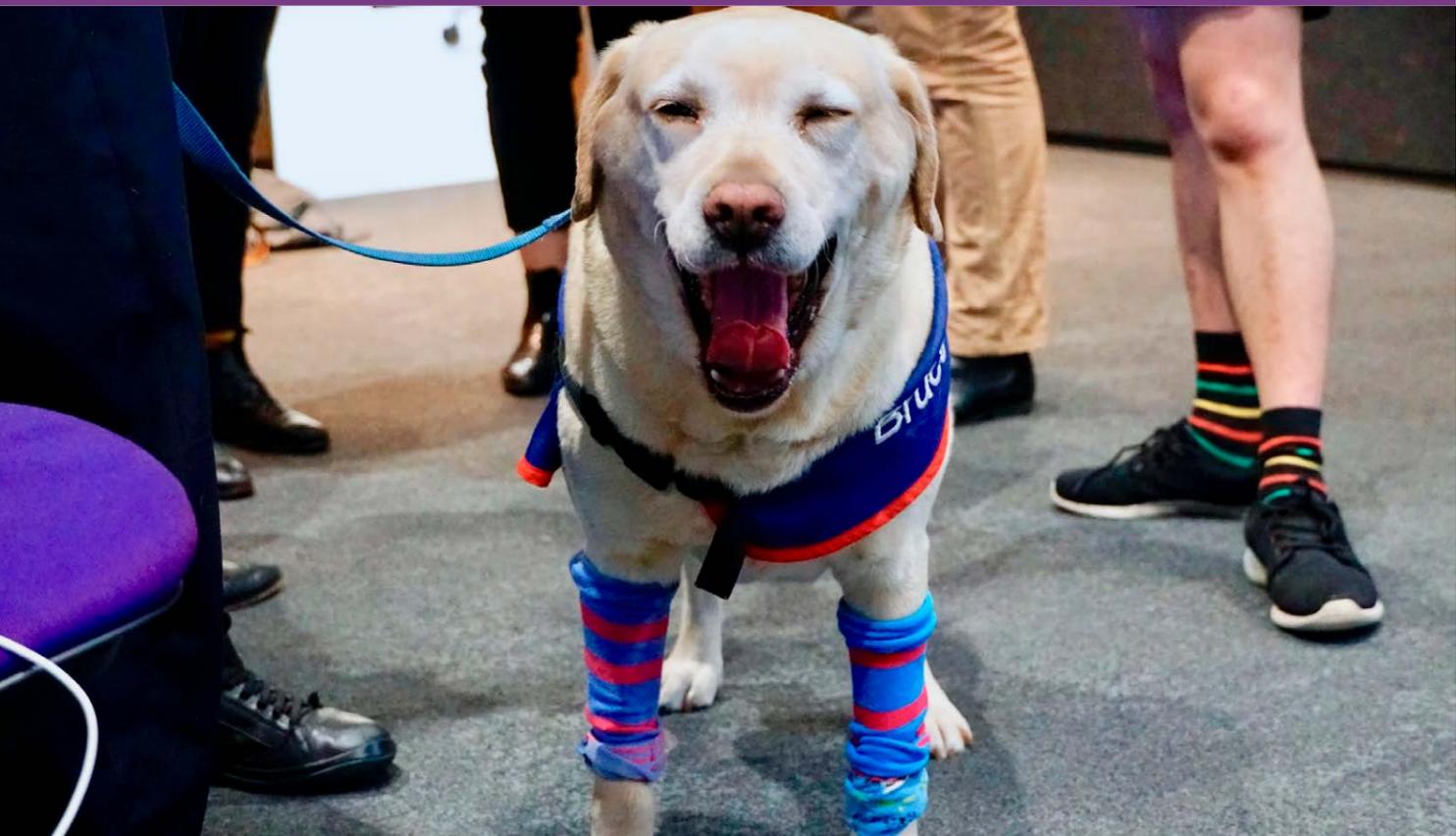
\* The full enterprise agreements, including an explanation of the clauses, can be found at [amavic.com.au/enterprise-agreement](http://amavic.com.au/enterprise-agreement)

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# Opening up about doctors' mental health



It takes courage to share your mental health problems with the world, particularly for doctors fearing judgement from colleagues. However, for Crazy Socks 4 Docs Founder, Dr Geoff Toogood, it's been an important part of his recovery process.

Speaking at the launch of this year's Crazy Socks 4 Docs day, which dominated social media on Friday 7 June, Dr Toogood said he is regularly thanked by members of the medical profession who have experienced their own troubles with depression.

"You don't get many questions during the talks, but after the talks you get many people coming up and thanking me," Dr Toogood said. "After I received the (AMA President's) award numerous people came up and told me their story and said they wouldn't have had the courage and feared speaking about their own story."

Michael Myers is a Professor of Clinical Psychiatry based in Brooklyn, New York.

An expert on doctors' mental health, he treated his first physician patient on Christmas Day in 1970.

"There's a long history in medicine of keeping things like this to ourselves," Prof Myers explained. "Thankfully with people like Geoff and Miko and many others who are speaking openly (about their own issues), it makes such a difference to bring it out in the open that we're human too. The problem is that in some circles there's still a fair amount of judgement."

'Miko' is Dr Yumiko Kadota, a one-time aspiring plastic and reconstructive surgeon left broken by the system after her experience as an unaccredited registrar at a Sydney hospital last year.

The harrowing tale documented on her personal blog ([www.mindbodymiko.com](http://www.mindbodymiko.com)) has led to significant media attention and a new role as a mental health campaigner, but it's not something she envisaged as she struggled to come to terms with her condition.

"The day I resigned was actually Crazy Socks for Docs day (last year) and I didn't even know about it at the time, I was so deliriously exhausted that I didn't even know what day or month it was," Dr Kadota recalled. "I was working my 24th day in a row and it happened to be 1 June last year that I resigned. The week after that I was diagnosed with depression and that is something that I have really struggled with, especially because of the culture that we're in.

"I think I'm also guilty of holding that (negative) perception of mental illness. I had to fight my own prejudices against mental illness because I have not had a history of mental illness before, so for me to accept it was really difficult, especially coming from the surgical fraternity."

Dr Kadota believes her determination to earn an accredited training position stopped her from recognising the signs and seeking help earlier. "That's why I held off for such a long time. It took a lot for me to walk away from something that I really wanted to do. A lot of people have asked, 'Why were you hospitalised in October, when you resigned in June?' I think of a lot of it was because I was still in denial that I had a mental illness. I just thought I was really tired and burnt out."

The inability for some to understand mental illness, compared to a physical ailment, can often add to the difficulty experienced by the sufferer, making them feel even less comfortable about disclosing their condition.

"The guilt I felt about having a mental health issue and severe depression and, 'How come you're not better in three weeks?'... it takes a considerable amount of time to recover," Dr Toogood said.

Prof Myers believes this issue is compounded for doctors. "Guilt is one of the symptoms of depression but it's also one of the symptoms of our medical culture," he explained. "Very few physicians who develop a psychiatric illness don't feel guilty; that somehow they've let down the medical profession, they've let down their colleagues and their branch of medicine."

Dr Toogood credits exercise and finding a better life balance away from work for playing an important role in his recovery. "I've changed my work-life balance," Dr Toogood said. "After the second bout (of depression) I learnt not to work 60 hours a week and be the head of a department. I went back to normal working hours for other people. I swim a lot for exercise, I cook for mindfulness and I spend a lot of time with my children."

It's a similar story for Dr Kadota. "I make sure I have good nutrition, sleep well, exercise and last year I became a yoga teacher," she said.

For many, recovery from depression is an ongoing process and certainly not something which can be overcome quickly. "A severe illness takes anywhere between three and 12 months (recovery)," Dr Toogood said. "When I went back to work (after) the

first time, I went back to full-time work and that was a mistake. I had a lots of protective factors, but I got crushed and it wasn't enough."

Prof Myers called on other doctors to be as supportive as possible. "Many say after they return to work, 'I wish I was using a cane or crutches, because then my colleagues would know that I'm still limping, I'm still on the mend and I need more time. They will need more time (to recover), maybe another three to six months."

"In the club of medicine, we have to watch out for each other. Sometimes it's inter-generational when we're mentors to younger physicians, but (we need) a better sense of watching out for each other."

Dr Kadota wants the medical profession to be mindful that depression isn't always easy to recognise in colleagues, particularly those who are good at masking their problems. "I'm an example of someone who may have an atypical presentation of mental illness. I was always chirpy and outgoing and even this year I've had messages from colleagues saying they had no idea I was going through a tough time. I often say ask your strong friend how they are doing because a lot of people put on a veneer for the outside world and you have no idea what's going on inside."

"I encourage everyone to keep doing their activities that protect their mental health, but if there is a colleague who does raise concerns about his or her mental health, don't ignore their pleas for help. I ask hospitals to take it seriously when junior doctors are expressing concerns about their health."

'Crazy Socks 4 Docs Day' is an annual event on the first Friday in June.

The day is all about raising awareness of the mental health of all doctors and health practitioners around the world. For any doctors struggling with mental health or other life pressures, you are not alone. Support is available through:

- AMA Victoria's Peer Support Service - 1300 853 338
- Victorian Doctors Health Program - (03) 9280 8712
- Lifeline - 13 11 14
- Make sure you have a regular GP.



Barry Levinson  
Editor



Photos from top to bottom.  
The Crazy Socks for Docs panel, hosted by Dr Sally Cockburn (left).  
Prof Michael Myers  
Dr Yumiko Kadota  
Dr Geoff Toogood

# I have a mental illness... and one day I might be your doctor

Did you feel that? That little jolt in your stomach as you read the headline? Perhaps, your muscles tensed for just a moment? Maybe your heart skipped a beat, or a mild sense of fear came over you. What was that? An insignificant flutter? A meaningless moment to shrug off in your busy day? Perhaps that fleeting feeling is explained by looking to the stigma that pervades our culture, known all too well to sufferers of chronic mental illnesses.

Few forces exert such power in our society, influencing our subconscious mind and invoking our innate, self-protective responses. This is the power that stigma holds over us all; those who suffer mental illness and those who don't.

Stigma is fuelled by fear and a lack of understanding of what mental illness truly is. Stigma creates a chasm between those who struggle with mental illness and those with the good fortune not to have been dealt a bad hand in life. Of course, we bemoan stigma and may even claim to be above it. I, as a sufferer of mental illness, could even claim to be immune from its effects.

To assert any of these beliefs, however, would be a vain attempt to delude ourselves. Every fleeting thought, each subtle comment, every little doubt is stigma rearing its ugly head. Yet perhaps the most damaging form of stigma is that directed inwardly by those suffering from mental illness. This is the stigma we rarely see: the irrational shame, the self-doubt, the relentless fear of relapse.

As doctors, we are not above such stigma, despite soaring levels

of psychological distress in our profession. Doctors continue to take their own lives at alarming rates despite years of awareness campaigns. We employ words like 'burnout' and blame systemic failures of an ageing population with complex health needs, the ever increasing paperwork, inadequate sick leave cover or punishing on-call rosters. These challenges are genuine avenues for significant change to improve doctors' mental wellbeing. But for a moment, let us consider our own biases.

Many of us still guardedly believe that fellow doctors who are brave enough to seek help for their mental illness are somehow failing, particularly if they do not immediately recover. Beliefs that those with a history of mental illness are somehow less competent, less reliable and less trustworthy still perpetuate. I recall being asked some years ago whether I agreed that, "A doctor who gets sick all the time can't really ever be a good doctor to their patients". This was not the dated perspective of an ageing doctor in their twilight years, but rather those of a bright-eyed medical student, with their whole career ahead of them. Attitudes like these must end if doctors are to feel safe in seeking help for their mental ill-health.

As a psychiatry registrar, what I have found most striking, and the most difficult to communicate to my non-psychiatric colleagues, is the profound grief and loss suffered by those diagnosed with a chronic mental illness. 'Schizophrenia', 'bipolar disorder', 'personality disorder'. These are terms that invoke fear, indeed terror, at times, in those who hear them in much the same way that hearing the word 'cancer' might.

The range of responses to these diagnoses are as varied as the illnesses themselves: denial, bemusement, even aggression. I am often witness to patients who completely shut down on hearing a psychiatric diagnosis. It pains me to see patients' attempts to negotiate, to bargain, to rationalise the incomprehensible nature of their illness. Of course, where a diagnosis like cancer differs to psychiatric illness is in the true, bitter isolation. The cold feeling of having to secretly suffer after being hit with a psychiatric diagnosis.

Each time I educate a patient about their newly diagnosed illness I feel, in some small way, a shared

understanding of their grief and pain. Only through this have I been able to give meaning and learned to accept my own illness. In some small way, my own illness allows me to empathise in a way I may never have been otherwise able.

Fear has dictated that I, and others, hide our emotions and thoughts, lest our secret 'unwell' identities be known to those whom we work with or treat. We are one person to our friends, another to our patients and yet another to our colleagues. For many years, my world was controlled by this fear - a fear that my professional life would fall apart if people knew my secret. I feared looking pathetic and weak and that I would be seen as unable to cope with the pressure of medical study and practise. I felt an unspoken obligation to my peers and superiors to present a bravado and confidence hiding what is a daily battle to remain well.

On the first Friday in June, doctors celebrate #crazysocks4docs day. For one day each year, we celebrate the change we are driving within our profession with the simple, yet brilliant, act of wearing odd socks. Twitter lights up with an assortment

of quirky foot-art as we smile and laugh at the various colours and patterns, enjoying a brief moment worthy of celebration.

For too long, the wounded healer has battled on, overworked in an under-resourced system (with boring matching socks!). On this day, we celebrate doctors' mental health and wellbeing and call out the challenges leading to burnout, stress and depression. We shine a light on the need for systemic change to ensure doctors have the best chance to remain well and celebrate our tentative early steps toward genuinely supporting one another.

However, through the thousands of bizarrely unmatched soles, sporting spots, stripes and shades dotted around hospitals and clinics across the globe, we must not forget that which matters most. Doctors' mental health is so much more than a hashtag. For many, it is a daily battle. Today, I win this battle, but sometimes I do not. Today, I say that the time has come for doctors who struggle with mental illness to step out of the darkness. Today, my cloak is dropped, the secrecy thrown out in the hope that others feel a little safer to do the same.

I also ask you to celebrate your imperfection. Take a moment to pause. Maybe, even laugh at yourself. To paraphrase Winnicott's seminal work on the "good enough mother", I ask you to be the "good enough doctor". Share your struggles, even if only with a friend. It is time for us all to hear of the struggles of doctors at all levels. But, critically, do not forget to interrogate your own beliefs about mental illness. Only then can we hope to foster a greater understanding, tolerance and acceptance that mental illness need no longer be something to be kept hidden and ashamed of. And only then can we hope to reduce the scourge of doctors' suicides.

Before I forget, I have one last thing to say to that doubting medical student of years past... Today I say, yes, I have a mental illness. And I might just be a better doctor for it.



**Dr Kieran Allen**  
Psychiatry Registrar  
AMA Victoria Council  
Member  
DiT subdivision  
@kidsankyran



# Mental health awareness - not just one day a year

On Friday 7 June, healthcare professionals and their supporters across the world posted photos of their colourful and mismatched socks on social media to raise awareness of the mental health of doctors and health practitioners.

The aim of Crazy Socks 4 Docs Day is to normalise conversation about mental health and increase psychological safety for health professionals discussing their own mental health.

There is a great deal of stigma in relation to mental health in our society and this is exacerbated for those in professions such as medicine, which is held in high regard. There is an unspoken rule that doctors do not get sick and in particular must not experience mental illness. Fortunately, we are starting to see a change in attitudes and there are some doctors who are willing to make themselves vulnerable by talking publicly about their mental health.

In addition to stigma, other barriers for doctors include fears in relation to mandatory reporting. Although the bar for mandatory reporting is quite high, this is not well understood and some doctors will not seek help, as they fear losing their registration. Conversely, some treating doctors report a colleague unnecessarily, even when the public is not at risk of harm.

The highly competitive nature of medicine also makes it hard for doctors to speak openly about something they consider a weakness, as they fear that

they will not be successful in their profession if others know their flaws.

To counter these negative attitudes towards discussion about mental health, the spirit of Crazy Socks 4 Docs must continue throughout the year. Some tips to assist in open conversations about mental health include:

1. Create opportunities to have genuine conversations with your colleagues.
2. Support your colleagues in practical ways such as buying your team a coffee once a week.
3. If you observe a colleague with a heavy workload working late, offer your help.
4. Make sure your team members are all able to take their meal breaks.
5. If a colleague is going through a difficult time, be there for them, ask how they are feeling and listen. They will value your presence.



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# The future of Australia's doctors



## A new report investigates the future of Australia's medical workforce and finds a number of pressures are changing the way doctors deliver care to patients.

As Australia's health expenditure continues to grow, currently at \$181 billion and 10.3 per cent of our gross domestic product (GDP), governments and health insurers are increasingly concerned about both the growth in spending and its value - whether this growth is delivering improved health outcomes and access for the population.

This also reflects the concerns of the average Australian, including high out-of-pocket costs, the value of private healthcare and persistently longer public hospital waiting times. This mix of issues reflects the complex structure of our healthcare system, the changing patterns of disease (especially the

increasing prevalence of chronic disease), high public expectations and technological change.

Within this context, our new ANZ-Melbourne Institute Health Sector report focuses on the future of the country's medical workforce.

### The pressure of competition

Doctors are a major part of the health system and play a key role in delivering high-value healthcare. The diagnoses they make and the treatments they recommend directly influence costs, quality and health outcomes, as well

as driving other areas of spending like pharmaceuticals and hospitals.

But doctors are also facing a number of trends and challenges that are influencing the way they work, where they work and the care they provide.

The first challenge is the increase in the number of doctors - the number of medical graduates has more than doubled from around 1,400 in 2000 to 3,500 now. As a result, the number of junior doctors has increased by an average of 8.9 per cent per year since 2005 and the overall growth in the total number of doctors is sitting at 5.3 per cent per year. This is creating a much more competitive career ladder for doctors.

Medicine has always been competitive, but this increase in competition for coveted specialty training places will flow through to competition for jobs once they're qualified. Junior doctors are increasingly reporting stress and burnout, mental health problems, bullying and gender discrimination, while female doctors have a higher rate of suicide compared to the general population.

There's already some evidence that changing the culture of medicine could improve patient's health outcomes, which in turn puts pressure on governments, medical colleges and employers to work toward this goal.

### Healthcare costs

The second challenge is that although there are more doctors, their earnings continue to rise. In line with national wage growth, all types of doctors across most age groups, for both males and females and across most specialties, are sharing the average 1.8 per cent annual growth in median earnings per hour.

The increased number of doctors has obvious implications for healthcare costs and it's important that population health outcomes also increase in line with this increase in supply. Doctors need to be working in specialties and locations where there's an under-supply and a high need for healthcare, like in rural areas, or focusing on chronic disease. How to best use these extra doctors is a key issue for current policy and the future health of the population.

### The wage gap

The third challenge is the persistent gap in earnings between men and women. This gap, with men's earnings per hour between 43 per cent and 55 per cent higher than women's, hasn't changed over the past 10 years, although there is some weak evidence that this might be narrowing.

Men's working hours have fallen much faster than for women. In fact, for some women in some age groups their working hours worked have started to increase.

Hourly earnings for women GPs are growing faster than those of men. This could reflect increasing opportunities

for women and their preferences to work more hours; or it could reflect a slowly improving culture as the proportion of women in the medical workforce increases over time.

### Extra doctors, extra costs

This increase in supply will impact doctors once they complete their training and enter into independent clinical practice. Given tighter budgets in public hospitals, it could be that these extra doctors are more likely to spend time working in private practice. But demand here could also be limited, especially given the current issues concerning out-of-pocket costs and the value of private health insurance that is leading to a fall in private sector hospital admissions.

More competition in the private sector could lead to more consolidation of private medical practices - practices being merged with or sold to larger corporates in order to reduce costs - which could lead to higher fees and reduced access to care for patients.

### Digital disruption

Technology isn't only influencing diagnosis and treatment but is also producing much more information and data that needs to be channelled into improved health outcomes and the lowering of costs.

With doctors taking up digital technologies, barriers such as privacy, medico-legal concerns and the effects on workflow need to be addressed. There's also the challenge of how doctors will use this technology and information compared with other health professionals, as diagnoses become more automated through artificial intelligence and the time it takes to provide care falls - all of which have implications for fees, skill mix and increases in productivity.

Shared medical records like My Health Record have considerable potential to reduce waste and repetition and could help increase much-needed co-ordination of care for patients with complex conditions.

Technology will also bring doctors and patients together online more often; benefiting those living in

rural areas where access to medical care is limited. But again, uptake, regulation and funding are key issues in ensuring that these technologies benefit patients at lower cost.

### Challenges and trends

The current increase in the number of doctors will have far reaching impacts on medical care and the health system. It seems clear that increased supply will alter the trajectory of medical careers, though strong policy is needed to ensure doctors work in specialties and localities with the highest need to maximise improvements in population health.

Improving the culture of medical training is necessary and will have positive impacts on the quality of care and the mental health of doctors and potentially reduce the gender earnings gap.

As doctor's earnings continue to increase, more competition in private medical practice could place pressure on costs and so it will be necessary to monitor these trends and their impact on patient's access to care.

The use of digital technologies and shared records hold much promise, but need to be used for those most in need of healthcare and carefully evaluated for their impact on population health and access to care.

Together, these challenges and trends will change the nature of doctor's work and the markets in which they operate. Given the central role of doctors in the healthcare system, ensuring these changes will benefit patients whilst keeping costs under control is a key issue.

The full report can be accessed via [www.pursuit.unimelb.edu.au/articles/the-future-of-australia-s-doctors](http://www.pursuit.unimelb.edu.au/articles/the-future-of-australia-s-doctors)



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*This article was first published on Pursuit - [pursuit.unimelb.edu.au](http://pursuit.unimelb.edu.au)*

# The flying doctor



*"Oh! I have slipped the surly bonds of Earth and danced the skies on laughter-silvered wings." – John Gillespie Magee Jr, World War 2 pilot.*

I was introduced to flying by chance. It was 1963, my second year after graduation. I had moved out of my Melbourne home for the first time to take a job with the University Department of Surgery at Royal Perth Hospital. One night on duty, the nurse in charge, Sister Hicks, asked me how I was enjoying living in Perth. I replied, "I love it, but I'm at a bit of a loose end when I'm off duty." She responded, "Well, you'll have to learn to fly". Somewhat shocked, I asked why and received the simple reply, "Because my husband's a flying instructor" and she organised my introductory flight that week!

Phil Hicks, being a good salesman, arranged the next lesson and it wasn't long before I was hooked on flying; something that went on to transform my life. The flying school was at Perth International Airport, which was the only airport in the Perth vicinity in those days. No pilot forgets their first solo flight. Sitting alone at the controls of the school's single engine, two-seater, fabric-covered Piper Colt, I was joined in the circuit by an Air India Boeing 707. As they say in aviation, only my laundryman and I will know how I felt! I managed to land uneventfully and received

my unrestricted private licence the following year. By then I was a registrar at Royal Perth Hospital.

Somewhat reluctantly, I left Perth to commence my obstetrics and gynaecology training back home at the Royal Women's Hospital (RWH) in 1965. I kept my flying current, taking several of my RWH colleagues flying and managed to purchase my first aircraft, a second-hand Piper Colt, similar to the one in which I trained.

One of my fellow registrars in Perth was in the Air Force Reserve medical branch based at RAAF Pearce. When he landed an overseas job and asked me if I would like to take his place, I jumped at it, excited by the thought of flying military aircraft. I managed to do this on several thrilling occasions, including flying supersonic in a Mirage while working at the No. 4 RAAF Hospital in Butterworth, Malaysia in 1983.

Apart from the flying and the extra income, I enjoyed the professional aspects of 30 years in the Air Force Reserve, until compulsory retirement due to age in 1994. I retired as the consultant O&G to the Air Force with the rank of Group Captain.

The Air Force trained me in aviation medicine, which I consider my second specialty. I have been able to maintain currency in it with the help of the Australasian Society of Aerospace Medicine, the Civil Aviation Safety Authority and the Royal Flying Doctor Service (RFDS), on whose council I served. I remain associated with the RFDS in the position of Emeritus Councillor. I would like to see RANZCOG create a similar position for its Fellows who, like me, have served on Council.

We can learn a lot from aviation medicine with its emphasis on procedural safety. I continue to derive much from this aspect of my professional life (apart from the personal need to keep fit and pass my annual aircrew medical) because it keeps me in touch with general medicine. For example, I can boast that I am one of the few O&Gs who knows much about ophthalmology.

My first opportunity to mix business with pleasure (apart from the air force) arose in 1968 while completing my training at RWH. The hospital informed me that Devonport Hospital on the north coast of Tasmania was desperate for an O&G locum. It was prepared

to use me even though I was not yet officially qualified. I duly departed Moorabbin Airport in my little Colt for my first Bass Strait crossing, with the bonus of being paid for it!

My first experience as the only specialist O&G in a major rural hospital was certainly memorable. In my first week I delivered a baby with severe erythroblastosis foetalis from an Rh immunised mother. The nearest paediatric service was in Hobart, so with a nurse holding the phone to my ear connected to the paediatrician on call at RWH Melbourne, I successfully performed the only exchange transfusion of my career. I completed the two weeks without any significant untoward event and managed the return Bass Strait crossing very happy indeed.

I subsequently upgraded my pilot's licence with an instrument rating permitting flight in all weather day and night. This provided the option to seriously (and safely) use it for work. After starting my own practice, I called a few rural practices with hospitals and airfields and Kerang (north of Bendigo, close to the NSW border) took me on. Initially, I would operate under the direction of the local GPs (a couple of

whom were excellent anaesthetists), but I soon realised that I needed to see the patients myself in order to choose the optimal procedure. This meant organising consulting as well as operating visits. I subsequently extended my flying visits to Echuca, Cohuna, Kyabram and most recently (in locum capacity) Port Augusta Hospital in South Australia. I have enjoyed them all and appreciate the patient gratitude as well as the challenge of neglected pathology that I rarely see in Melbourne.

Flying enables access to interesting places that might not otherwise be practical. This ability to fly anywhere also prompted me to become a cattle grazer on the side. I acquired the grazing lease of Passage Island from the Tasmanian Government. This 600-acre paradise is the south-eastern member of the Bass Strait Furneaux Group, of which Flinders Island is the largest. It provided me with 38 years of pleasure (and extra income) until I had to finally admit that 600 remote acres and 60 head of cattle was too much to manage for a septuagenarian without regular assistance.

I can thank the RFDS for the acquisition of my current aircraft, a Cessna

Bird Dog - a Vietnam War veteran operated by the United States Army for forward air control. At the annual general meeting of the RFDS in 1994, in Kalgoorlie WA, the councillors were shown the RFDS fleet in their hangar and I was fascinated to see the Bird Dog at the rear. It had been imported from Thailand and restored by a local engineer, who had recently died. The RFDS chief engineer was a close friend and undertook to sell it for the widow. I bought it originally for enjoyment, but it proved to be such fun and so reliable that I had it upgraded to instrument flight. It has since been the aircraft I have most frequently used to do my rural work.

Every now and then, I sit back and reflect on a long career in medicine, which has been more enjoyable than I could possibly have imagined, thanks to the night nurse in charge at Royal Perth Hospital.



**Dr Graeme Dennerstein**  
RFD, MBBS, FRCOG, FRANZCOG

**If you would like to tell us about an achievement in medicine or a personal interest you believe other members might enjoy reading, please contact [BarryL@amavic.com.au](mailto:BarryL@amavic.com.au)**

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# The trouble with testimonials

A chiropractor was found to have used false and misleading advertising about being able to cure cancer and to have used testimonials in website advertising. He was given a criminal conviction, fined \$29,500 and deregistered for two years. Although the claims about curing cancer were more serious than the use of testimonials, the findings in one of the hearings included the following:

*The two testimonial offences demonstrate that the practitioner took no steps to stay up to date with current professional laws and standards on advertising and failed to understand why such material may be dangerously misleading to patients.*

## The law

Section 133(1)(c) of the Health Practitioner Regulation National Law states that a person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that uses testimonials or purported testimonials about the service or business.

## What are testimonials and why are they banned?

A testimonial is a statement, review, view or feedback about a service. AHPRA advises that in the context of the National Law, a testimonial involves recommendations or positive statements about clinical aspects of a regulated health service.

Testimonials may be found under a tab or heading 'Testimonials' on a practice website or information brochure; in the Reviews tab on a practice's or doctor's Facebook page; or in comments on a practice's or doctor's Instagram feed.

Testimonials are banned as they can be misleading and one person's outcome may not be relevant to others. They are not objective or scientific and patients cannot assess their validity.

## Which testimonials am I responsible for?

You are responsible for reviews or testimonials which appear in advertising that you control - e.g. if you are the practice owner, you control your practice's Facebook page.

You are not responsible for removing (or trying to have removed) testimonials published on a website or social media over which you do not have control, for example, ratemds.com. However, a breach of the National Law may occur if you use such a review to advertise, respond to the review or republish it on your website.

You are not required to try and remove Google reviews. However, if you respond to a Google review, this could be considered a testimonial if, for example, the response includes clinical aspects of care.

## What reviews are allowed and can I edit reviews?

AHPRA's testimonial tool helps advertisers understand which reviews can and can't be published. You can't refer to clinical aspects, such as symptoms, diagnosis, treatment, outcome, or the skills or experience of the practitioner.

Recent publicity about HealthEngine altering negative patient reviews and publishing them as "positive customer feedback" led AHPRA to issue guidance that selectively editing reviews or testimonials may break the law.

## What if my advertising contains testimonials?

If AHPRA becomes aware that advertising contains testimonials, they will write to the responsible practitioner asking them to check their advertising and correct the content to comply with the National Law. Usually a practitioner is given 60 days for this, after which AHPRA may conduct an audit to see if the changes have been made.

If the audit finds the advertising still non-compliant, AHPRA can impose conditions on a doctor's registration that restrict how and what they can advertise. Fines may also be imposed by a court and the Medical Board can take disciplinary action.

## Why can't I use testimonials if my colleagues and competitors are using them?

This is like saying, "Why can't I speed when other cars are speeding?"



**Karen Stephens**  
Risk Adviser  
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**MDA National**  
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References available from the Editor on request.

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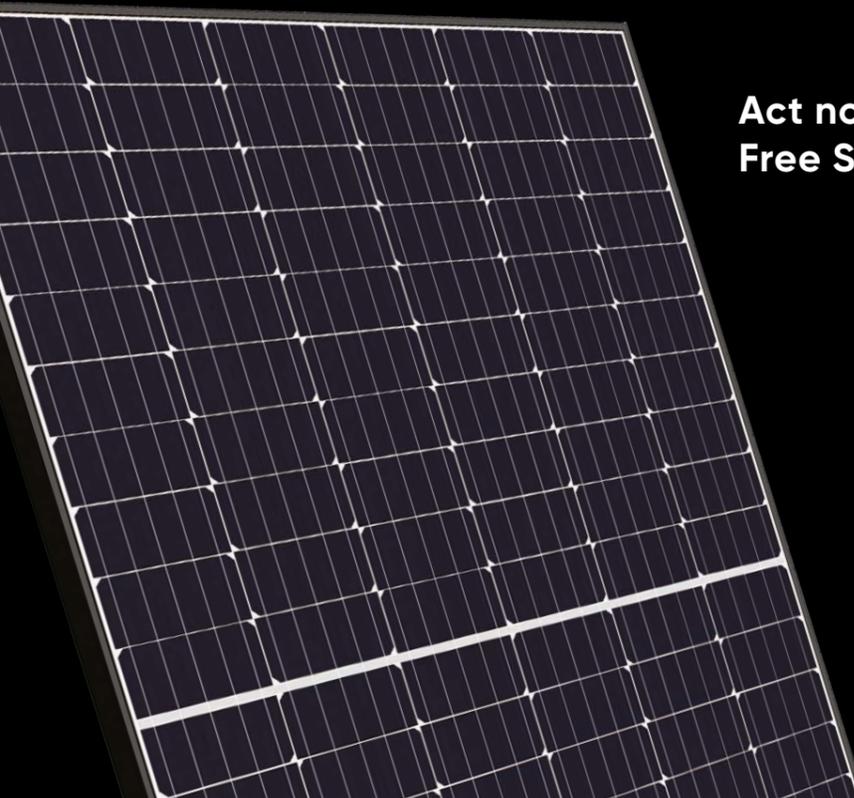
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# Bullying, discrimination and low morale continue to afflict junior doctors

In May 2019, AMA Victoria published the findings of the 2018 Hospital Health Check (HHC) survey. Designed to quantify issues surrounding junior doctor welfare and assess adherence to accreditation standards, the 2018 HHC successfully surveyed 674 hospital trainees across Victoria. Findings of the survey reveal that endemic issues of bullying, discrimination and low morale remain pervasive within the profession. Furthermore, it is evident that excessive workloads, poor working conditions, and unpaid overtime continue to affect a significant number of doctors-in-training (DiTs) despite advocacy efforts and negotiation of the 2018 Enterprise Agreement.

Quantitative data regarding junior doctor welfare has been critical in advocating for change. A key source of Australian data has been the 'Hospital Health Check' (HHC). Originally developed in 2015 by the AMA WA DiT subcommittee, the HHC is a confidential, self-reported survey of DiTs that seeks to quantify issues affecting junior doctor welfare, assess hospitals' adherence to industrial, accreditation and education standards, and guide advocacy efforts. Hospital Health Checks have since been conducted in other Australian states, including New South Wales, Queensland and Victoria.

Data from the 2018 HHC continue to highlight issues of morale, unacceptable work behaviours and over work as significant areas of concern. Twenty-nine per cent of respondents rated morale among medical staff as poor. High rates of unacceptable work behaviours likely contribute to this result: 42 per cent of trainees reported being the target of bullying, discrimination or harassment. Furthermore, over half of trainees (58 per cent) reported that a fear of negative career consequences acted as a barrier to reporting such behaviours. Thirty-eight per cent of trainees

perceived hospital support for mental health and wellbeing as poor.

Results of the 2018 HHC highlight poor working conditions for trainees. On average, trainees reported working nine hours of unrostered overtime each week. Seventy-six per cent reported being paid for less than a quarter of these hours. Furthermore, 71 per cent of trainees reported often working through meal breaks due to excessive workload and 48 per cent of trainees reported ongoing breaches to the 2018 Enterprise Agreement. Poor working conditions have a detrimental effect on trainees: over half of trainees reported that their workload often prevents them from investing time in their physical and mental health. Furthermore, 37 per cent of trainees considered resigning from their current hospital and 31 per cent of trainees considered leaving the medical profession due to issues of workload and poor working conditions.

Data from the 2018 Hospital Health Check survey continues to demonstrate poor working conditions for DiTs in Victoria. Significant rates of low morale, unacceptable work behaviours and overwork remain pervasive. Contextually, these results are sadly unsurprising. HHC surveys in other Australian states have historically painted a similar picture of junior doctor welfare, while increasing rates of physician burnout have been observed worldwide. Where to, then, from here? No magic bullet exists to address the long-standing cultural and systemic factors that perpetuate these issues: resolving these issues will require active, persistent and determined efforts to bring about meaningful change.

First steps involve raising awareness about the existence and magnitude of these issues among medical staff, administrators, executives, and the public. AMA Victoria has already begun to facilitate discussions with Victorian hospitals regarding survey results and

solutions for change and efforts are underway to explore broader release of HHC data to the public. Other initial steps include ensuring that the gains achieved in the 2018 Enterprise Agreement are implemented by health services.

The current state of junior doctor welfare - locally, nationally, and globally - remains far from ideal. Rather than accept this as the norm, we believe that these findings should act as a rallying call-to-action for medical staff, the wider public, hospitals, and government institutions. Victoria has a proud and accomplished history of excellence in medical care, education and training. The vision statements of various Victorian health services document their commitment to excellence and it is clear that these organisations possess the drive, talent and determination to achieve great things. Through active engagement, determination and genuine commitment, we believe that Victoria and its health services have the opportunity to set a world-leading example in caring for its junior doctors.

Most importantly, we again call upon all doctors, both junior and senior, to use this information to raise awareness about the endemic issues that affect our profession. It is our responsibility to actively engage with these issues, stand in solidarity with our peers and advocate for real, meaningful change. We hope the publication of the 2018 Victorian Hospital Health Check will empower you to challenge the norm, raise awareness about these issues and encourage you to engage with local advocacy efforts to address them.



**Dr Chris Lim**  
DiT subdivision  
Hospital Medical  
Officer  
Royal Melbourne  
Hospital

The full findings of the 2018 AMA Victoria Hospital Health Check are available at [amavic.com.au](http://amavic.com.au) in the 'Assistance for Doctors' section. DiT subcommittee meetings are held monthly. All AMA Victoria members are welcome to attend. Please email Grant Forsyth at [GrantF@amavic.com.au](mailto:GrantF@amavic.com.au) for more information.

# A call to arms in the fight for gender equality

I was recently talking to my dad and brother about the legendary women of the world who have fought endlessly for our rights. All of the women who have loudly demanded equal pay, or boldly faced a harasser, or endured protests and shaming and egging to ensure we all have reproductive rights.

Each big win in feminism we owe to bold women who refused to accept inequality and prioritised the needs of our entire gender over the needs of one person. That is enough for me to be unashamedly fierce in my own feminism and wholeheartedly embrace the woman that I am.

I am incredibly fortunate to be surrounded by extraordinary feminists. At the top of the list, of course, are my parents and my brother. My family is the definition of supportive. They are vocally proud of their radical feminist daughter, identify themselves as feminists and will disapprove (loudly) of any injustice or inequality they see. Our family text chain receives a daily ode to Alexandria Ocasio-Cortez and Kamala Harris (dad). International women's day is celebrated more than my birthday (mum). A feminist Facebook page was created to interview men and women about ideas to improve gender equality (brother). I recently got told off by my dad for introducing myself to a media outlet as a 'woman scientist'. "You are a scientist," he said. "What does gender matter?" What I thought was a pro-diversity statement was actually undermining my message and he was right. I certainly don't call myself a 'woman doctor'.

I am also blessed with a group of extraordinary friends within and outside medicine. My best friend (a man) is a paediatric registrar who is passionate about minority rights and calls out racism, sexism and homophobia whenever they cross his path. He does the right thing and refuses to accept anything less than complete acceptance and tolerance from everyone in his life - colleagues, friends and family. It is inspiring and joyous to know someone with such

a fierce moral compass. My other best friend (a woman) is a surgical registrar who is a practising Muslim in a hijab. Consider how difficult that might be. She mentors all of her interns and residents daily and dotes on them like a mother duck. Any inkling that her junior doctors of any gender have experienced unfair treatment, harassment, discrimination or unequal pay and my friend will take charge like a lioness.

At the university where I work, I share an office with a friend (a man) who is as passionate a reader as I am. We have a Whatsapp message group with another academic GP friend and every day we exchange articles and book recommendations that are increasingly inclusive, diverse and thoughtful. I estimate that about 75 per cent of the articles our male friend enthusiastically sends us has a feminist overtone. One of the things I appreciate most about this friend is that he carefully considers his opinion on an issue before he engages in a discussion. He once entirely declined to comment in a conversation about women feeling unsafe at night because he felt it was more important for him to hear the perspectives of the women in the room. This kind of respect is rare.

The inevitable point I am trying to make is that the world is a kinder and more supportive place for women when we are surrounded by feminist men. And I mean men who are proud to call themselves feminists because they understand the true meaning of the term. It isn't enough for men to not be the harasser; we need you to help us call it out when it happens. Don't doubt the woman or offer a justification of the perpetrator's behavior. If a woman tells you she was uncomfortable or felt unsafe, be

brave and ask her how you can help. If you hear inappropriate comments or locker room talk, be brave and shut that conversation down. If you know your resident or registrar is being unfairly treated because of her sex, then be brave and make it your business too. If you know you are receiving more pay than your equally qualified woman colleague, be brave and tell her and tell your employers.

Having a reputation as 'the feminist' is not a source of shame. Be our ally. As women, we can spend years and decades trying to campaign for our rights because 'it's a women's issue' but that's unfair and it's exhausting. The generations of women doctors before us had to fight this on their own and we applaud them; but it's 2019 so roll up your sleeves and help. Come to our Women in Medicine events. Listen to the challenges faced by the women around you. Make friends with your women colleagues; and understand there is no obligation for that relationship to be anything more. Be openly passionate about improving gender equality. Make a bit of noise. Make a lot of noise.

I'm done with feminism being a women's issue because, as the saying goes, "Equal rights for others doesn't mean less rights for you. It's not pie". So thank you to the feminist men and women in my life who help to drive change for equality. It is because of you that I am safe and happy.



**Dr Pallavi Prathivadi**  
Secretary, AMA  
Victoria Women in  
Medicine Committee  
Academic General  
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# Career conversation



Dr Brandon Carp: Healthcare solutions entrepreneur

An emerging pattern in recent years has seen some doctors looking to explore alternate and non-traditional careers both within and outside of clinical medicine. In this Career Conversation series, we are profiling a range of doctors who have transitioned to non-traditional paths - either instead of, or in parallel with a traditional clinical path. These stories can help other doctors understand that medicine can present diverse, often untapped career options.

## How would you summarise your career path in medicine?

Interesting and varied. I trained at the Alfred Hospital and spent over 10 years in the hospital system searching for the 'right' specialty for me. Anaesthetics, internal medicine and rehabilitation were all specialities that I explored. I eventually settled on dermatology where I enjoyed the mix of surgical procedures and diagnostic challenges. After successfully completing the first dermatology program exams and awaiting a training position I spent several years working in my father's general practice. It is there I started to see health-related problems, outside of those of my patients, that I wanted to solve and decided to abandon my aspirations to be a dermatologist.

My first business venture tackled the torn old *Women's Weekly* magazines filled with health-related misinformation sitting in the waiting room. I saw an opportunity to provide up-to-date medically sound health information to a captive audience of patients while they were waiting to see their GP. Together,

with another GP and a journalist, we created *Dr Know*, a patient information magazine funded by advertisers and distributed through waiting rooms.

A few years later I started a business with my wife, Unified Healthcare Group (UHG), and was forced to quickly learn how to run a business. UHG solves problems for organisations including insurers, corporates and government agencies who require health information and services. Initially I was the doctor, salesman and operations manager, but it soon grew enough for me to hire people to help and I have been active as CEO or executive chair ever since.

## Why did you choose to study medicine?

I never felt I chose medicine as I never considered anything else. My father is a doctor and as a child I was in awe of him and his unrelenting desire to help his patients. The love and respect that his patients had for him left an indelible impression on me. He was the true incarnation of an old-fashioned GP, seeing patients in his solo practice in Prahran, doing

anaesthetics and regularly rushing out at night and on weekends to do house calls and deliver babies. At 84 years old he is still seeing patients and he is still an inspiration.

## What have been the main influences on your career pathway choices?

It was December 1996 while I was doing some shifts at my father's practice, a young guy asked me to clear him to ensure he was fit to work as a dealer at the new Crown complex that was opening in April 1997. I was not sure exactly what to do and made a call to the human resources manager who clarified it for me but also shared the administrative burden these pre-employment assessments caused for her, as she attempted to recruit about 2000 new people who each had different doctors. I understood her problem and recognised an opportunity to help. I proposed a solution (which I had no idea how I would deliver) which would see all the pre-employment medicals managed at my father's medical clinic with a simple consistent process. Crown bought this solution and UHG was born.

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

I wouldn't change a thing. I loved practicing clinical medicine for 20 years and helping my patients. I have also enjoyed building UHG and creating innovative tech-led health solutions for organisations.

## Do you foresee any further changes in career paths in your future?

I don't feel that my career path has really had 'changes' but what I

would better describe as 'different trails'. I believe my medical training has helped me identify problems and have the skills and confidence to try to solve them. I would like to utilise the experience I have gained both in business and healthcare to advise and guide organisations and government to improve inefficient systems and deliver better health outcomes for Australians. I was recently a member of a taskforce looking forward to 2040 at the challenges for Australia's health system which I really enjoyed. I have also recently taken on board roles at the Murdoch Children's Research

Institute and Victorian Clinical Genetics Services.

## What advice would you offer to other doctors in navigating their career in medicine?

No medical career is the same. There is a clear, well-established career path for those who wish to follow it, but there is equally an opportunity to forge your own trail. Don't be afraid to veer off the traditional path if your heart or gut is leading you there - you can always go back!

We would love to hear from you if you have a career story you would like to share. Alternatively, if we can assist you in exploring your career options, please book a free 15-minute career call or a career coaching session via our website [amavic.com.au/careers-advice](http://amavic.com.au/careers-advice)

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# World-class maternity and paediatric services for Melbourne's west



## Western Health has a brand new site for women's and children's services at Sunshine Hospital following the opening of the Joan Kirner building in May.

The new site houses 20 maternity delivery rooms, including a number with birthing baths, 39 special care nursery cots, four theatres and much-needed additional space for its busy women's and children's specialist clinics. The special care nursery level also has capacity for four neonatal intensive care unit beds, the first such facility to be built anywhere in the western suburbs.

Public areas across the eight-storey-over-basement facility are designed to a high standard and include amenities such as outdoor balconies and play spaces on various levels, as well as an interactive play wall and various striking art installations on the ground floor.

Following the commencement of construction in November 2016, the building phase featured some impressive statistics including 5,500 tonnes of panelling used along with 38,000 square metres of plasterboard and 9,700 cubic metres of concrete - enough to fill almost four Olympic-size swimming pools.

The resulting \$200 million building was officially opened by the Victorian Minister for Health, The Hon. Jenny Mikakos on Sunday 5 May, with a crowd of over 3,000 later attending a public open day featuring tours of the new facilities.

Patients were moved to the Joan Kirner Women's and Children's on Wednesday 15 May, in what was a huge logistical operation involving some 200 staff and 40 volunteers, transferring 137 patients from the old accommodation to their new beds. It was the single largest move operation in Western Health's history.

The entire undertaking occurred smoothly and without incident and the vast majority of patients were moved across in the space of just four hours through link corridors. Specialist clinics commenced operation on Monday 20 May, meaning the new site is now fully functional for both inpatients and outpatients.

Overall, around 150 nurses and midwives will be added to the workforce as the service moves from the current level of around 5,500 births per year to an expected 7,000 by 2026.

Over 100 babies were delivered within the first week of the new birthing rooms and theatres opening, meaning the new space is already well on its way to catering for more births. They followed on from the first baby to be born at the Joan Kirner building - Tallia Baez-Mikhael, who promptly arrived at 9.22am on the morning of the move.

The building also contains a number of tributes and references to the eponymous Joan Kirner, Victoria's first female premier. The towering five-metre statue of 'Joy', designed by Renata Slusarski from the BigFish agency that previously created an

instillation for the Joan Kirner House in Williamstown, commemorates the politician's spirit in the ground floor atrium. The figure is imprinted with images of rare and vulnerable Victorian plants and animals which Joan Kirner helped to protect under the *Flora and Fauna Guarantee Act* of 1988.

Further images of a similar nature can be found in a public corridor on the ground floor and a plaque featuring a picture of Joan Kirner was also unveiled by the late premier's husband, Ron Kirner at the official opening ceremony.

Members of the Kirner family were present at the opening and attended a tour of the facility alongside the Health Minister, Western Health CEO Russell Harrison and Victorian Health and Human Services Building Authority CEO, Robert Fiske.

With this monumental project now complete, further exciting developments are getting underway for Western Health with the start of works on an emergency department expansion at Sunshine Hospital set to be swiftly followed by the commencement of construction for the new \$1.5 billion Footscray Hospital.



Western Health



Pictured opposite - The new hospital's first baby, Tallia Baez-Mikhael, with mother Lauren Mikhael and father Edwin Baez. Above - 'Joy' Below - Theatre staff on move day.



# Social media - the dos and don'ts

Use of social media today is widespread both for personal and work related use. Whilst initially some social networks were intended only for personal use and others for work related purposes, the line is becoming blurred and recent high profile cases where disciplinary action was taken against Israel Folau by Rugby Australia and Dr Christopher Kwan Chen Lee by the Tasmanian Health Practitioners' Tribunal should act as a warning that care needs to be taken by any professional when using social media.

The Australian Health Practitioner Regulation Agency (AHPRA) has developed a Social Media Policy to help medical practitioners understand their obligations. It makes clear that medical practitioners should not only be cautious about posting information that is in breach of their legal obligations, but also their ethical and professional obligations.

## Professional conduct

Even if social media is not being used for a work related purpose, social media use can and will be scrutinised by medical regulators when determining what is appropriate professional conduct.

In the case of Dr Lee, the Tasmanian Health Practitioners' Tribunal suspended him for a period of six weeks and imposed conditions requiring him to undertake education on ethical behaviour and communications, particularly in the use of social media. The Tribunal found that comments he made on a personal online forum in 2016 were:

*'... socially unacceptable and extreme sentiments which are disrespectful of women and comment upon violence towards or sexual abuse of women. Some of the online posts might reasonably be interpreted as being racially discriminatory and contrary to acceptable social norms in Australia... a reasonable person reading the online posts, could reasonably infer from the tenor of them*

*the respondent... would not ethically and professionally treat particular patients or fully abide by the Hippocratic Oath expected of medical practitioners in Australia....'*

Other case examples include:

- A senior hospital doctor in the United Kingdom being disciplined for ranting offensively about accident and emergency patients at the hospital where the doctor worked.
- An American doctor found to have engaged in unprofessional conduct for revealing patient information on her Facebook account. The doctor did not share personal details of patients but in describing her experiences in a hospital emergency department, she included enough detail to allow a third party to identify patients.

## Advertising

The Social Media Policy should be read in conjunction with the AHPRA Guidelines for Advertising Regulated Health Services. Any form of advertising on social media is subject to section 133 of the Australian Health Practitioner National Law which prohibits advertising that is:

- a) false, misleading or deceptive
- b) offers a gift, discount or other inducement

- c) uses testimonials or purported testimonials
- d) creates an unreasonable expectation of beneficial treatment or encourages the indiscriminate or unnecessary use of health services.

## Summary

Therefore, when using social media:

### DO

- think before you post
- only post something that you would be comfortable to say in person, face-to-face
- be aware of your professional obligations as a medical practitioner
- consider who, and how many people, will read your post
- be aware of the social media policy at your workplace.

### DON'T

- post anything that could be considered offensive or discriminatory
- post anything at all about patients
- post personal content on professional accounts
- advertise medical services
- identify yourself as a medical practitioner if using a personal account, or hold yourself out as a professional.



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- Selling your practice including helping to get ready for sale, workout and earn-out arrangements;
- Resolution of disputes about restraints, contracts (including building contracts and shareholder agreements) and debt collection;
- Regulatory issues including investigations by the AHPRA, Medicare, Privacy Commissioner and HCC;
- Your personal matters including buying, selling and leasing property; and
- Estate planning including creating and documenting strategies to transfer wealth from one generation to the next.



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# AMA Awards



## Doctors' health campaigner honoured for international mental health movement

**A Melbourne cardiologist who singlehandedly started an international movement to encourage doctors to openly discuss their mental health is the recipient of the 2019 AMA President's Award.**

Dr Toogood overcame significant mental health issues, with the support of his family, family GP and other health providers. But on his return to work, he faced discrimination and unfounded speculation about the state of his mental health. As part of his recovery, he wore bright socks and adopted a puppy. As anyone who has ever lived with a puppy knows, socks and pups are not a good mix.

One day in 2016, his dog Sammy chewed one of his socks as he was on his way out the door to work. When Dr Toogood grabbed another, non-matching sock and wore it to work, he became aware that his colleagues were laughing at him behind his back and whispering that he was 'going crazy again'.

"A simple question or chat would have cleared up the matter," Dr Bartone said. "Geoff decided it was time to break down the stigma and get people talking about mental illness in the medical profession. So he made the first Friday in June Crazy Socks 4 Docs day and encouraged members of the

health profession to share photos of their odd, crazy socks on social media."

Crazy Socks 4 Docs is now a global phenomenon, with doctors around the world donning odd socks. "Geoff's message is that it is okay for doctors not to be okay and that by talking openly about mental illness, depression and anxiety, we can empower our colleagues to seek help or offer assistance."

A *beyondblue* survey of 14,000 Australian doctors and medical students in 2013 found that they are burnt-out, more likely to experience psychological distress and suicidal thoughts than the general community and are drinking too much alcohol.

"We have lost too many of our colleagues in recent years to ignore our own health," Dr Bartone said. "Dr Geoff Toogood has led the way in raising awareness around the world of the need to support each other and talk openly about mental health. I commend him for his work."

Dr Geoff Toogood was presented with the award at the recent AMA National Conference in Brisbane. The President's Award is given to a person who, in the opinion of the President, has made an outstanding contribution towards furthering the objectives of the AMA.

"Dr Toogood is a most worthy recipient on the basis of his demonstrated commitment to, and advocacy for, doctors' health," AMA Federal President, Dr Tony Bartone said. "Geoff speaks from lived experience and is a passionate and authentic advocate for the medical profession."

## Cave rescue hero receives AMA Gold Medal

**Dr Richard Harris, the Adelaide anaesthetist who played a crucial role in rescuing 12 Thai boys and their soccer coach from a flooded cave last year, has been awarded the prestigious AMA Gold Medal.**

AMA Federal President, Dr Tony Bartone, made the announcement at the AMA National Conference. "Dr Harris's credentials to receive the AMA Gold Medal are self-evident," Dr Bartone said.

"In all aspects of his career, he has displayed all the attributes of the best of the medical profession - compassion, dedication, and excellence. His contributions to the medical profession, to emergency services and to humanitarian work would be enough on their own to warrant recognition."

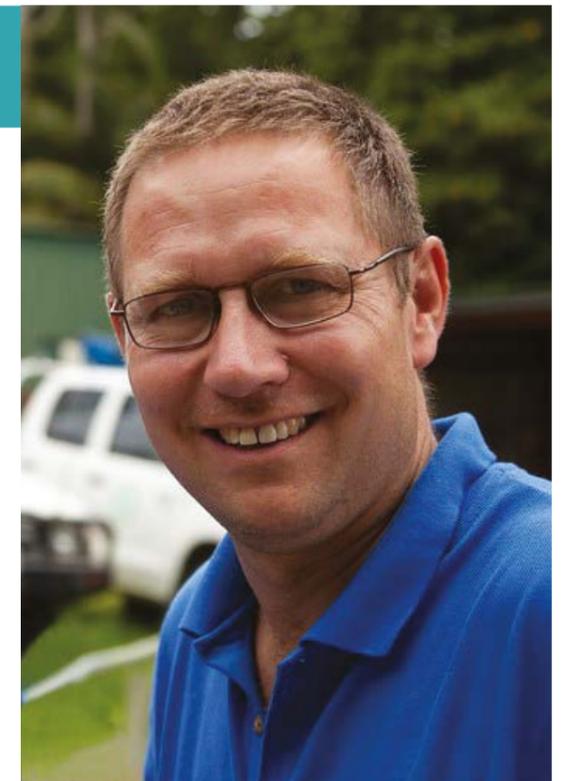
Dr Harris worked with AusAID in the Pacific for two years, providing anaesthesia and intensive care services in Vanuatu's developing medical system. His love of diving led him into the field of hyperbaric medicine and into search and rescue operations. Dr Harris established Australasia's first sump rescue training course and has built strong relationships with emergency services.

The Adelaide anaesthetist became the centre of world attention in 2018 when he and his dive partner, veterinarian Craig Challen, took part in the heroic and dangerous rescue of the Wild Boars soccer team, after

17 days trapped in Thailand's Tham Luang cave system. A Thai Navy SEAL had already died during the dangerous mission and Dr Harris and the other rescuers risked their lives to swim, walk, and crawl to reach the boys.

Dr Harris assessed the boys medically and determined the order in which they should be helped out. Crucially, he used his anaesthetics expertise to sedate the boys with ketamine before divers guided them unconscious through the treacherous cave system, as there was a real danger that the boys might panic during the three hours of diving and swimming through narrow passages and put themselves and their rescuers in danger.

"The priority of doctors is 'first, do no harm'. I can only imagine the range of emotions Dr Harris must have felt as he submerged that first unconscious boy to test the full face mask that would be used in the



operation," Dr Bartone said.

It took three days to bring all 12 boys and their coach out of the cave. With the world watching, Dr Harris was the last person out.

Dr Harris is the 2019 Australian of the Year, along with Dr Challen. He has been awarded Australia's second-highest civilian bravery award, the Star of Courage (SC), the medal of the Order of Australia (OAM) and has been granted royal honours by the King of Thailand.

"Dr Richard Harris is truly a worthy winner of the AMA Gold Medal," Dr Bartone said.

## AMA Victoria claims honours at National Conference

**AMA Victoria was recognised for exceptional work in advocacy and communications, winning two awards at the National Conference.**

### Best Public Health Campaign 2019: The Medically Supervised Injecting Centre at North Richmond

AMA Victoria has been advocating for a medically supervised injecting centre (MSIC) since 2012 as a proven harm minimisation measure, based on thorough research and sound science.

There was substantial opposition to

the North Richmond trial when it was proposed in 2017, with the Victorian Liberal party announcing it would stop the pilot trial if it won the 2018 state election.

AMA Victoria established itself as an expert source on the subject of harm minimisation, presented unbiased information and counteracted misunderstandings and used the

experiences of members who, as doctors, have had to resuscitate overdose patients in car parks and other public areas.

From the centre's opening in July 2018 through to April 2019, it had 40,000 visits and 650 overdoses were prevented.

Judge Amanda Bresnan, executive officer at National Family Violence Prevention Legal Services, said the campaign demonstrated a consistent and long-term process and strategy to achieve an outcome.

"It also tackled a very difficult issue, but did so in a way which built a case on evidence-based policy and being consistent with AMA Victoria's policy and position," Ms Bresnan said. "They set out to achieve - and did so - clear messaging, had a credible and respected spokesperson, used parliamentary process and the media and developed a range of materials to build their campaign."

"They confronted negativity and misinformation directly and stayed consistent with their case, which led to the intended outcome of the

supervised injecting facility being established, supported and continuing."

### Best State Publication for 2019: Vicdoc

Judge Sue Dunlevy, the national health reporter at News Corp, said that Vicdoc's highly engaging and wide-ranging content made it the standout AMA publication for 2019.

"The fascinating interview with Dr Graeme Killer, the doctor to five sitting Australian Prime Ministers, gave a terrific insight into a rare and unusual medical job," Ms Dunlevy said. "The

article about the bush GP being asked to operate on an injured dog was a gem.

"There was plenty of great practical information for doctors on subjects from choosing a specialty to managing a family while practising medicine. Up-to-date medical information on thunderstorm-related asthma, cervical cancer screening and other issues made the publication useful and directly relevant for doctors."

Thanks to all of our members who have contributed to Vicdoc and our advocacy work over the past year.

# Why doctors are backing pill testing at music festivals across Australia

For many years, experts in the field of drug policy in Australia have known existing policies are failing. Calls for total abstinence (“just say no to drugs”) and tough enforcement strategies have not eliminated the use of drugs or the extent of their harmful effects on the community.

Whether we like it or not, drug use is common in our society, especially among young people. In 2016, 43 per cent of people aged 14 and older reported they had used an illicit drug at some point in their lifetime. And 28 per cent of people in their twenties said they had used illicit drugs in the past year.

The use of MDMA (the active ingredient in ecstasy) is common and increasing among young people. In the last three months of 2018, five people died as a result of using illicit drugs at music festivals and many more were taken to hospital.

The rigid and inflexible attitudes of current policy-makers contrast dramatically with the innovative approaches to public health policy for which Australia was once renowned. Since the 1970s, many highly successful campaigns have improved road safety, increased immunisation rates in children and helped prevent the spread of blood-borne virus infections.

The wearing of seatbelts was made compulsory throughout Australia in the early 1970s. Randomised breath testing and the wearing of helmets by bike riders were introduced in the 1980s. These measures alone have saved many thousands of lives.

The introduction of needle exchange and methadone treatment programs in the late 1980s and, more recently, widespread access to effective treatments for hepatitis C have dramatically reduced the health burden from devastating infections such as HIV and the incidence of serious liver disease.

Each of these programs had to overcome vigorous and sustained hostility from opponents who argued they would do more harm than good. But in all cases the pessimists were proved wrong. Safety measures on the roads did not cause car drivers and bike riders to behave more recklessly. The availability of clean needles did not increase intravenous drug use. Easier access to condoms did not lead to greater risk taking and more cases of AIDS.

We believe - along with many other experts in the field - that as was the case for these earlier programs, the evidence presently available

is sufficient to justify the careful introduction of trials of pill testing around Australia.

Specifically, we support the availability of facilities to allow young people at venues or events where drug taking is acknowledged to be likely to seek advice about the substances they're considering ingesting.

These facilities should include tests for the presence of known toxins or contaminants to help avert the dangerous effects they may produce. Such a program should be undertaken in addition to, and not instead of, other strategies to discourage or deter young people from taking illicit drugs.

Although pill testing has been widely and successfully applied in many European countries over a 20-year period, it has to be admitted the evidence about the degree of its effectiveness remains incomplete. That's why any program in Australia should be linked to a rigorously designed data collection process to assess its impact and consequences.

However, we do know that the argument that pill testing programs will increase drug use and its associated harms is very unlikely to be true. Most people seeking advice about the constituents of their drugs will not take them if they are advised that they contain dangerous contaminants.

And it's easy to avoid false reassurances about safety by careful explanations and detailed information. The opportunity to provide face-to-face advice to young people about the risks of drug taking is one of the great strengths of pill testing programs.

Over the last half century we have learnt public health programs have to utilise multiple strategies and provide messages carefully and tailored for different audiences. What works to combat the harms associated with drug-taking in prisons is different from what works for specific cultural groups or for young people attending music festivals.

The available evidence suggests pill testing is an effective and useful approach to harm minimisation in this last group. We believe it has the capacity to decrease ambulance calls to

festival-goers, help change behaviour and save lives.

It has taken until now for pill testing techniques to be developed to a level where they are able to identify the constituents in analysed samples with sufficient precision, reliability and speed. These techniques, and the range of substances for which they can test, will continue to improve over time. On the basis of experience gained in the UK, Europe and Australia it's clear pill testing is now feasible and practicable.

The members of the Australasian Chapter of Addiction Medicine within the Royal Australasian College of Physicians are the main clinical experts in the field of addiction medicine in this country. Together with the AMA and many prominent members of the community with experience in this area, we feel this is the time for pill testing to be introduced, albeit in careful and controlled circumstances. We believe this position is also supported by peer users, concerned families and past and present members of police forces across Australia.

The fact the 'war on drugs' has failed does not mean we should give up. There are many new weapons available to us, as we have learnt from the successful public health campaigns of the past. Pill testing will not abolish all the harms associated with drug taking, but if handled carefully, carries the likelihood of reducing them significantly.



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Honorary Senior Lecturer  
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President, Chapter of  
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**Prof Paul Komesaroff**  
Professor of Medicine  
Monash University

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# Retiring well: Dr George Santoro AO

Retirement is emerging as one of the big issues for which our senior members are seeking support. In response, our Medical Career Service has expanded its coaching offering to deliver a targeted retirement solution designed to support senior doctors to retire well. This program assists doctors to navigate the retirement process and can be tailored to each doctor's individual needs. In this regular series, doctors share their retirement stories.



Dr George Santoro, pictured in front of his portrait in the Council room at AMA House.

Dr George Santoro AO

## Can you tell us about your career and what you are doing now?

I graduated from Melbourne University in 1962 and after doing a year's residency at the Queen Victoria Hospital I commenced my own solo general practice in Richmond. I saw patients there for 35 years. During this time I was very active within the AMA and was President of AMA Victoria in 1983. I also acted as Treasurer for a number of years and represented the AMA on many committees.

I also enjoyed being on a committee for 10 years selected by the Governor-General to help choose Australians for post-nominal honours, such as the Order of Australia. I was lucky enough and truly honoured to be recognised as an Officer of the Order of Australia myself in 2010.

I retired from my practice in 2000, but I am still on the Committee of the Victorian Medical Benevolent Association, helping doctors and their families during difficult times. Helping to look after sick doctors has been a hobby for me for many years and I still like to visit them now and maintain relationships.

I was also the President of AMA Victoria's Archives and Heritage Committee until retiring recently. The AMA has been a big part of my life.

## What was your approach to retirement? What steps did you take to prepare?

I slowed down gradually. Another doctor took over the practice from me and he took over some of my patients while I reduced my numbers and kept seeing patients at home.

I had plenty of time to think about it and it all went fairly smoothly. Twelve months before I wanted to sell, I made sure all of my patient records were in good order for someone else to take over.

## What worked well for you during this transition?

I had my mail redirected to home and kept up with patient home visits. Maintaining patient relationships has meant I never felt like I ever left the profession.

This also allowed me to keep up my CME and accreditation points as I headed towards retirement, but I still keep up my accreditation to this day, as I still enjoy going to seminars and keeping up to date with medicine. I have always had an interest in medicine after following my father into the profession and I still like

to read all the journals and stay informed with developments.

I also had a really good relationship with my secretary and she kept working with me all through to the end. She still comes to see me.

## What resources or support did you utilise in implementing your retirement?

Not much really. I just advertised that I wanted to sell my practice and went from there.

## Were there any challenges or surprises for you during or after the transition process?

It was all quite smooth for me because I had reached an age of 65 where I wanted to stop. I had saved enough money to be able to retire and it was time to pull back.

## Do you have any advice for others considering retirement?

I kept myself busy with hobbies. My wife Susan and I have enjoyed spending time at our property in Gippsland and I belong to the Athenaeum Club in the CBD.

I recommend getting good financial advice before retirement. Also, if you feel concerned about being bored, it's worth considering making an arrangement to still see patients and keep some relationships going, even if it's just for half a day, once a week.

**If you are interested in sharing your story as part of this Retiring Well series or if you would like assistance with planning your path to retirement, please contact the AMA Victoria Medical Career Service on [careersadvisor@amavic.com.au](mailto:careersadvisor@amavic.com.au) or (03) 9280 8722.**

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# Obituary

## Dr Thomas H. Hurley



Dr Thomas Henry Hurley died on 10 May, 2019 at the age of 93 years.

The fifth child of Victor and Elsie Hurley, he obtained his secondary schooling at Melbourne Grammar, his tertiary education at Melbourne University and his professional training at The Royal Melbourne Hospital (RMH).

Dr Thomas H. Hurley AO, OBE, MD, FRACP, FAMA 1925 - 2019

His career trajectory emulated that of the extended Hurley family. His father, Victor, was a surgeon who had been President of the Victorian BMA (the forerunner to AMA Victoria) and had served at the RMH for 50 years (including as hospital President). Other members of the extended family were physicians, pathologists, anaesthetists and GPs. Several medical and non-medical members of the family went on to have professorial appointments.

Dr Hurley had a long association with the RMH, where he trained as a medical student before undertaking his residency years. His subsequent 40-plus year association with the RMH was interrupted only by periods of:

- service in the Australian Navy Reserve (1943)
- service in the British Commonwealth Occupying Forces (BCOF) in Japan (1949)
- time at Hammersmith Hospital, London (1953) and Cleveland Hospital (Western Reserve University) Ohio (1953-1954).

At the RMH he served as outpatient physician, inpatient physician, head of unit, Chairman Division of Medicine, Vice Chair of Senior Medical Staff and eventually President of the RMH Board of Management. Much of the first two decades at the RMH were as honorary appointments.

Dr Hurley had two great achievements at the RMH. Firstly, together with

Dr John Sullivan and Dr Richard Bell, he established a specialist haematology - oncology unit to enable the delivery of chemotherapy regimens that had become available in the late 1960s.

Secondly, he met his wife of 70-plus years, Yvonne, in the hospital residents' quarters. Yvonne was one month off the boat from England after WW2. Within a matter of weeks after they met, he proposed to her (reputedly on the hospital fire escape). Yvonne asked him if he was sure (he was); she accepted, they married, and he then left for 12 months service with the BCOF in Japan. The Japan service was a pre-arranged commitment.

Dr Hurley served extensively as either a member, or more often the chair, of numerous committees, boards or councils outside the RMH including:

- the research committee for the NHMRC (Chair, 1975-1981)
- the executive committee, Anti-Cancer Council of Victoria (Chair, 1980-1986)
- the Commonwealth Serum Laboratories (CSL) (Chair, 1986-1988)
- the Walter & Eliza Hall Institute (Board member, 1966-1985).

He served for many years as an advisor with various philanthropic organisations including:

- The Ian Potter Foundation
- The Van Cleef Foundation

- The Menzies Foundation to assist with funding recommendations for community projects.

There were numerous other committee appointments. He also had a long, established private practice in Parliament Place.

In addition, he was widely read.

- His medical research interests were in the diagnosis of sarcoidosis, a TB like pulmonary condition. Together with his pathologist brother, Professor John V Hurley, he published several articles on diagnostic aspects of this elusive condition. For 20 years he was a member of The International Committee on Sarcoidosis.
- He had non-medical reading interests. He published a description of non-medical writing by three doctors from Victoria (Dr Graeme Robertson, Sir Clive Fitts and Professor Richard Lovell). [Hurley TH. Doctors writing outside the square. *Medical Journal of Australia*. 2011 Jan;194(2):87-9.]

He was awarded a FAMA (1979) for services to the medical profession and the AMA and an OBE (1980) and AO (1989) for services to medicine.

**Tribute compiled by Dr Hurley's son, A/Prof James Hurley FRACP.**

# Australian-first clinic gives clearer picture of eye conditions

A new clinic to help treat patients with genetic eye conditions has opened at The Royal Victorian Eye and Ear Hospital, as a partnership between the Eye and Ear and The Royal Melbourne Hospital.

It's the first Ocular Genetics Clinic in Australia providing care for patients who have an inherited eye condition, are at risk of inheriting or passing on an eye condition or have a genetic disease that affects their eyes.

The clinic offers diagnostics, genetic testing, advice and treatment and is staffed by ophthalmologists, clinical geneticists, orthoptists and genetic counsellors working as a team - providing a 'one stop shop' for Victorian families.

Ophthalmologist, Dr Jonathan Ruddle from The Royal Victorian Eye and Ear Hospital, is excited about the progress already being made at the clinic to provide care for patients with hereditary eye conditions.

"This multidisciplinary clinic will empower the patients and their family members to learn, achieve better diagnosis, gauge progression rates, and in the not too distant future offer world beating treatments," Dr Ruddle said. "The clinic model that has been developed involves both pre and post clinic discussions to ensure that the most comprehensive, accurate and appropriate information is obtained."

The Royal Melbourne Hospital's Director of Genomic Medicine, Professor Ingrid



Ocular Genetics patient Linda Nancarrow (right) opens the new clinic with Health Minister Jenny Mikakos, supported by the Eye and Ear's Director Ambulatory Services Tracy Siggins and ophthalmologist Dr Jonathan Ruddle.

Winship, said the partnership between the two health services is a critical factor in the success of the clinic.

"This service is a close collaboration with the Eye and Ear and The Royal Melbourne Hospital and a great example of a collaborative partnership approach by health services," Prof Winship said. "The key for the two organisations is to address specific medical needs of patients who have genetic eye disease and to protect their vision and help plan for their future."

More than 50 patients have already accessed the clinic, including Linda Nancarrow, who has the genetic eye disease Autosomal Dominant Cone Dystrophy and was one of the first patients to be seen at the new service.

"My condition makes day-to-day activities, such as getting around, difficult. I feel frustrated, and isolated sometimes, and the decision to have children, knowing they could inherit the condition, was incredibly difficult," Ms Nancarrow said.

"In my mind, the stand-out feature of the clinic is having a genetic counsellor working alongside a specialist ophthalmologist. This ensures that families not only obtain a detailed and accurate understanding of the implications of genetic test results, but also receive the essential emotional support and guidance necessary at such a difficult time."

"It is my wish that one day I will be able to read an article explaining that researchers have the ability to eliminate the trait that causes genetic eye disease," Ms Nancarrow added.

The clinic will run fortnightly at The Royal Victorian Eye and Ear Hospital. Visit [www.eyearandear.org.au](http://www.eyearandear.org.au) for more information and referral guidelines.



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**Member benefits:** Little Real Estate has partnered with AMA Victoria to offer you 6 months of free professional property management services. Based on weekly rental payments of \$450, this will equate to approximately \$900 in savings for the first year. To arrange, speak with our dedicated account manager, Lida Roshan on (03) 9514 8992.



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**Member benefits:** AMA Victoria has partnered with Clear to Work to offer our members a 'best in the market' price on National Police History Checks. It's a very simple process - all you need is your passport and driver's licence, or other recognised ID and you're good to go. To start your police check go to [amavic.com.au/corporate-partners/clear-to-work](http://amavic.com.au/corporate-partners/clear-to-work)



**Westpac** 1300 361 159

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**Wine Direct** 1800 649 463

**Member benefits:** AMA Victoria members can benefit from free freight for orders totalling 12 bottles or more anywhere in Australia right to your door, exclusive savings up to 70%, no membership or obligation to purchase and members may unsubscribe at any time.



**Care Super** [www.caresuper.com.au](http://www.caresuper.com.au)

**Member benefits:** AMA Victoria's preferred provider in superannuation, Care Super is an award winning industry super fund that's been helping members with their super for over 30 years. They're driven by a clear and genuine commitment: to help members achieve their personal goals.



**Core SME** (03) 9133 8905

**Member benefits:** Core SME provides multiple services under one banner to reduce operating costs and increase profits for your practice. If you are reviewing current costs, expanding existing operations or opening your first office, Core SME will work to understand your requirements and provide a cost effective solution.



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**AMA Insurance** 1300 763 766

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**Member benefits:** Free advice / Best available rates / 30 years experience in serving the medical profession.

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Commission Statement AMA Victoria and its related entities at times receive income from commissions paid by service providers that provide commercial benefits to members. This income allows us to provide improved services to members and keep subscriptions to a minimum. Also see our privacy policy at [amavic.com.au](http://amavic.com.au).



**AMA Training AMA4** (03) 9280 8722

**Impairment Assessment Training:** AMA Victoria is delivering courses to enable medical practitioners to assess impairment for TAC, WorkSafe and for the purposes of Part VBA of the Wrongs Act 1958 (personal injury). [amavic.com.au/training/impairment-assessment-training-ama4](http://amavic.com.au/training/impairment-assessment-training-ama4)

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**AMA Auto Solutions** (03) 9280 8722

[nationalsalarypackaging.com.au/ama-auto/](http://nationalsalarypackaging.com.au/ama-auto/) A one stop auto-tendering service tailored specifically to the needs of members.

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# Lower interest rate tide won't lift all boats

It's been hard yakka in the residential property industry these last 18 months. Few sellers. Even fewer buyers. Understandably, there have been outpourings of relief – and even signs of giddiness – from real estate commentators about the prospects of better days now that interest rates are falling and the spigots of credit are opening.

Buyers will need to brace themselves. Every property firm will be redoubling their marketing and sales efforts to entice them their way. But while lower interest rates and easier finance may be necessary conditions for capital growth, they aren't, on their own, sufficient. One needs to drill down to demand and supply fundamentals to see which assets will continue to struggle and therefore should be avoided, regardless of the purveyor's sales pitch.

The high-rise apartment sector remains dangerously oversupplied. As of December 2018, the ABS reported that there was a near-record \$38 billion pipeline of attached residential work. Now, there has been an admirable rear-guard effort by developers to shelve, downscale or delay plans, as illustrated by a 27 per cent shrinkage of attached commencements in the three months until December 2018, but given a Reserve Bank estimate that apartments take about 18 months on average to build, there will be major overhang of supply expected in the next 12 months.

It is also a sector that can't get a break. Federal Labor's plan to exclude new property from its negative gearing changes looked like a marketing opportunity for developers to differentiate themselves from established property, but that's now a non-starter. Meanwhile, state governments are comfortable squeezing demand from overseas buyers, most recently illustrated by May's Victorian Government state budget which matched settings in New South Wales by raising stamp duty for overseas buyers to 8 per cent.

On the flip side, looking at demand, we're now seeing a cyclical cooling in interest for regional properties in most parts of Australia. Having outperformed capital cities over the last two years off the back of comparative affordability, it is likely

that these areas will have to work through their own correction over the next year or so, notwithstanding the impact of interest rate cuts.

Indeed, a cyclical weakness in regional markets may be exacerbated by the property equivalent of a share market 'sector rotation'. Experience shows that property market recoveries tend to start in traditional blue-chip areas – often in Sydney and then Melbourne – and then ripple out through the middle and outer suburbs. So don't be surprised if erstwhile regional investors abandon original plans and head to the cities, especially if they see some price growth green shoots appear in late winter or early spring.

With a little more confidence in the capital city suburban market, watch for the change in conversation. The focus will turn to the positive fundamentals of this sector – superior long-term economic outlook, strong population growth and restricted supply – casting aside the dominant theme of further price falls and unaffordability.

However, I believe this will be a measured recovery. Talk of fear of missing out (FOMO) in some quarters is giddily misplaced. Buyers remain in the ascendency for a little while yet and well-prepared investors have every chance of buying quality assets at good values over spring – as long as they apply a sceptical and critical eye to the marketing claims they hear in coming weeks.



**Richard Wakelin**  
Founder  
Wakelin Property Advisory

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*Wakelin Property Advisory is an AMA Victoria Member Benefits Partner and an independent buyer's agent specialising in acquiring residential property for investors. wakelin.com.au*



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Richard Wakelin, founder  
Jarrod McCabe, director

# The importance of a healthy, strong super

Most people are unaware that once you retire and are of the age of 60 or greater, your superannuation fund can be converted to a tax free environment. Whether your fund earns income from investments, takes a capital gain or pays you a pension of \$10,000 or \$100,000, as long as your fund is under \$1,600,000 it will all be tax free, the perfect legal "tax haven". You have worked hard and paid your taxes throughout your working career - with the right strategies and investments, its then time to enjoy the rewards of your hard work!

For many, the realm of superannuation can be a minefield of confusion.

Trying to understand the different strategies at your disposal and what they could mean for your retirement can seem like an impenetrable task. At Lanteri Partners, we have 27 years of experience in the wealth management industry and work to illuminate the path to superannuation success for our clients. Here are some of the key strategies that could help you grow your super fund and ensure a financially healthy retirement.

## Employer contribution

Also known as superannuation guarantee, this is the percentage of your wage that your employer pays into your fund as mandated by law. The current rate is 9.5 per cent, but it will increase to 10 per cent on 1 July, 2021.

## Salary sacrifice

Employees can also choose to make voluntary contributions to their super fund from the remainder of their pre-tax salary. Choosing to sacrifice your salary in favour of higher annual superannuation contributions can create a significant tax benefit. People who earn less than \$250,000 only pay 15 per cent tax on these contributions, while people who earn more than \$250,000 pay 30 per cent tax. This \$250,000 income threshold also includes your reportable super contributions and fringe benefits. The current limit on how much you can choose to sacrifice of your pre-tax salary is set at \$25,000 per annum, which is inclusive of an individual's employer contribution.

## Salary sacrifice top-up for under \$500k balance

Since 1 July, 2018 people with a total superannuation balance below \$500,000 have been able to contribute more than the \$25,000 per annum threshold. If you contribute less than \$25,000 of your pre-tax salary to your super fund in a given financial year, you can carry the unused amount forward and add it on to the following financial year's contribution. For example, if your pre-tax contributions total \$22,000 one year, then the next year you are eligible to contribute a total of \$28,000 in pre-tax super contributions. Unused amounts can be carried forward for up to five years on a rolling basis.

## Non-concessional

Non-concessional superannuation contributions come from any monies you have already paid tax on, for example after tax salary, savings, inheritance, etc. They can only be made if your total superannuation balance is less than \$1.6 million at the end of the previous financial year. The limit for this kind of contribution is \$100,000 per annum. People over the age of 65 can only make these contributions if they are gainfully employed for at least 40 hours in a consecutive 30-day period in that financial year.

## The bring forward rule

If you are under 65, you may be able to contribute more than the annual non-concessional contribution limit of \$100,000 in a single year. Currently, the maximum amount you can bring forward is up to \$200,000 of the following two years' worth of non-concessional contributions, where your total super balance is below \$1.4 million at 30 June

of the previous financial year.

This bring forward total amount is reduced to \$200,000 for those with a total super balance of between \$1.4 to \$1.5 million at 30 June of the previous financial year. For instance, it is possible to bring forward two years' worth of non-concessional contributions and pay \$300,000 into your super fund in one year, which utilises the following two years' of non-concessional contributions.

The above assumes you have not triggered the bring forward rule within the previous two financial years. The total super balance includes all of your super if you have more than one super fund.

Lanteri Partners has the knowledge and experience to ensure you can utilise every tool available to maximise your superannuation fund.

Instead of fumbling around in the dark with super strategies, contact us and receive the best treatment from industry professionals.

**Give us a call and book in for a complimentary financial check-up on 03 96503722.**  
[www.lanteri.com.au](http://www.lanteri.com.au)



*This information is general advice only, you should consider your own circumstances before making any amendments to your strategy. Contact your financial adviser for further information.*

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PRIVATE WEALTH MANAGEMENT

# The right financial advice at the right time is everything

Throughout your medical career you will face various challenges. These might include financial, legal and personal challenges. How you prepare for these challenges, your timing and your advisory team can make all the difference to the outcomes you will achieve.

## Financial - Life is expensive

Whilst you all enjoy different lifestyles and will prioritise financial decisions differently, there are consistent challenges all doctors will likely face:

- family home - funding and ownership
- medical practice opportunities - entering and exiting
- retirement - timing and funding.

Access to finance in the current market can be challenging with financial institutions increasing their level of scrutiny over your financial viability. Medical professionals, compared to the general population, should fair pretty well in a financial assessment. However, your lifestyle decisions and how you spend your money will impact on the assessment. Planning well ahead will give you the best chance of a smooth application process should the need arise.

Your financial health and wellbeing will be relevant for both the acquisition of your home and any potential opportunities to enter into private practice. There may also be opportunities to effectively tax structure the overall debt position to achieve the best outcome.

Retirement may be closer for some than others and it is never too early or late to plan for your retirement. When will you retire? How much will you need to retire? Will you

have enough when the time comes? Taking a proactive interest in your superannuation will ensure you are making the most of the opportunities and strategies that exist to maximise your retirement nest egg.

## Legal - Life is complicated

Opportunities will present themselves from time to time and setting yourself up to make the most of them is vitally important. Getting it wrong can be costly and there are some critical considerations to reduce your risk:

- structuring - asset protection and wealth creation
- insurance - when, what type and how much?

There are potential risks unique to medical professionals that should not be ignored. In the event of a legal claim, the protection of your assets becomes of great importance. Effective asset protection can be achieved when appropriate structuring measures are taken at the right time.

Aside from asset protection, effectively structuring your assets can provide tax efficiency in managing the wealth that you accumulate over the years.

Insurance has a place at all stages of your life. How much, what type and when you need it are important considerations which should be addressed in conjunction with your financial advisor. As with structuring,

there are tax efficiencies to explore when undertaking an insurance review.

## Personal - Life is uncertain

Despite the best laid plans, life has a funny way of catching us by surprise. The worst we can do is ignore the uncertainty hoping that things will all be ok. There are some key areas on which to focus your attention:

- estate planning
- life planning.

Death and divorce are two of the more unexpected life events. As your financial affairs become more complicated and your wealth accumulates, it becomes increasingly important to consider how your assets will be handled in the event of death or a family law dispute.

How will your wealth be divided, who are the beneficiaries and do their personal circumstances make inheriting your wealth problematic. The best outcomes are achieved when these questions are considered carefully and ahead of time.

All these challenges come with their own set of complications and there is no single solution that can be applied to everyone. The right advice at the right time is everything. When considering them, it is important you have a strong team behind you and that they actively engage with one another in assisting you to manage the risks. The best results are achieved when your accountant, financial planner and lawyer are on the same page and can work together in assisting you manage life's challenges.

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# Women to the Front: The extraordinary Australian women doctors in the Great War

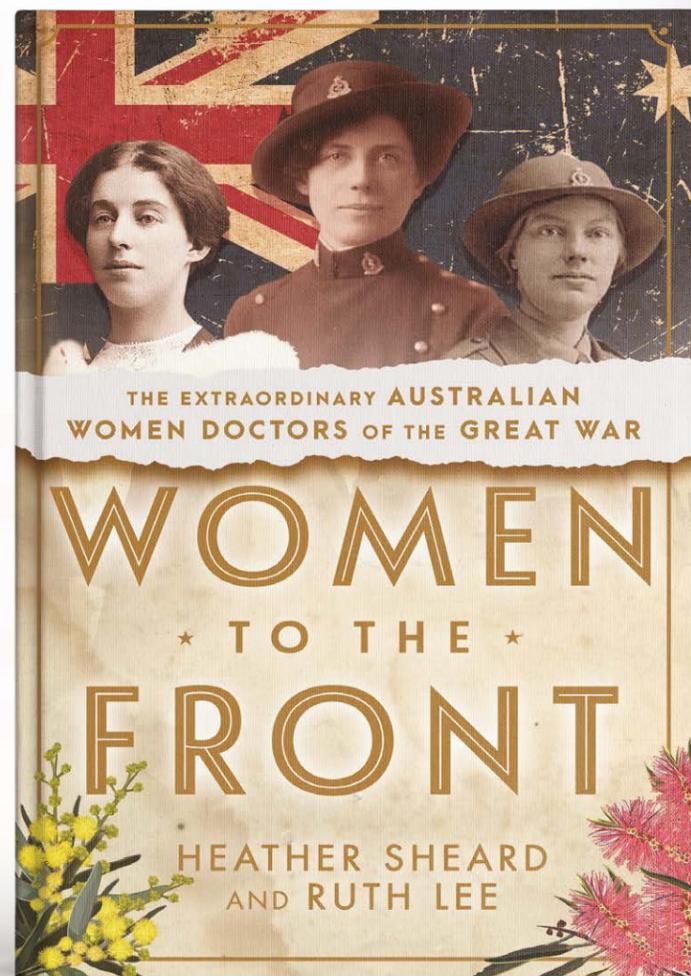
At the outbreak of World War I, 129 women were registered as medical practitioners in Australia, and many of them were eager to contribute their skills and expertise to the war effort. For the military establishment, however, the notion of women doctors serving on the battlefield was unthinkable. Undaunted, at least 26 Australian women doctors ignored official military policy and headed to the frontlines.

This book explores the stories of the Australian women who served as surgeons, pathologists, anaesthetists and medical officers between 1914 and 1919. Despite saving hundreds of lives, their experiences are almost totally absent from official military records, both in Australia and Great Britain, and many of their achievements have remained invisible for over a century. Until now.

Heather Sheard and Ruth Lee have compiled a fascinating and meticulously researched account of the Great War, seen through the eyes of these women and their essential work. From the Eastern to the Western Fronts, to Malta and to London, we bear witness to the terrible conditions, the horrific injuries, the constant danger and, above all, the skill and courage displayed by this group of remarkable Australians. *Women to the Front* is a war story unlike any other.

*Women to the Front* is available in paperback and ebook. Visit [www.penguin.com.au](http://www.penguin.com.au) for more information.

The following extract is republished with the permission of Penguin Random House Australia.



World War I, known at the time as the Great War, was a humanitarian crisis of massive proportion. Lethal new technology that killed and wounded people en masse joined with pandemic infections producing unprecedented loss of life and terrible affliction. Hundreds of thousands fled, carrying disease with them while also encountering new ones. Life in the war years was outside everyone's previous experience and this unexpectedly allowed women to circumvent some of the barriers faced pre-war; but not without a struggle.

When the German army marched into Belgium in August 1914, Melbourne doctor Helen Sexton went straight to the British War Office (WO) in London to offer her services to the Royal Army Medical Corps (RAMC). At the time, 129 women were registered as medical practitioners in Australia with around 1000 medical women in Britain, and many wanted to serve. For military officialdom, however, the notion of women doctors serving on the battlefield was outrageous. The answer throughout the British Empire was an unequivocal, "No!". Women doctors were not required for the war effort and advertisements were taken out to that effect in the newspapers.

But these were women accustomed to discouragement and to the denial of their professional capabilities. With routine determination and practised agility, at least 26 Australian women doctors ignored official military policy and served as surgeons, pathologists, anaesthetists and medical officers between 1914 and 1919. They served in Great Britain; on the Western Front in Belgium and France; on the Eastern Front including Serbia, Macedonia, Montenegro, Greece, Galicia and Russia; on the hospital island of Malta; and in Egypt and Palestine. *Women to the Front* is their story.

Women had pried open the doors of Australian medical schools 25 years before, with the first medical women graduating in 1891. Highly motivated and self-confident, they nevertheless needed a thick skin to succeed in qualifying and practising as doctors. Initially they had few role models and their experience at university and in postgraduate attempts to gain professional standing had deepened their feminist ideas and commitment to each other.

However, in 1914 the acceptance of women into the medical profession remained tenuous. Their access to hospital residencies and the development of specialist medical skills, such as surgery, was extremely limited. In Melbourne this led to the creation of the Queen Victoria Hospital in 1896 for the provision of women doctors for women patients, but also to provide valuable clinical experience for women doctors. Most practised within the sphere of women's and children's health and were referred to as 'lady doctors'. And 'lady doctors' did not go to war.

Yet the Great War's unrelenting need for medical services would clear the way for women doctors. Medicine was essential to war; it took centre stage in emergency treatment, in healing the wounded and sick, in health and hygiene for the armed services and in dealing with the dead. English doctor Flora Murray said that in August 1914, "Women doctors knew instinctively that the time had come when great and novel demands would be made upon them, and... an occasion for service was at their feet".<sup>1</sup> Like their British counterparts, many Australian medical women saw the war as an extraordinary opportunity to validate their professional status by demonstrating their competence alongside their male peers in war.

Given the official discouragement, why did Australian women doctors want to go to war? Much of their motivation was the same as that of their male colleagues. They had been educated from childhood in a curriculum steeped in the centrality of the British Empire, its history and culture, and the need to contribute to the Empire's war effort was self-evident. They believed that it was their duty to use their medical training and experience to alleviate suffering, including on the battlefield.

It is hardly surprising that many women wanted to share the patriotic burden of World War I with their brothers, fathers, uncles and fiancés serving overseas. The war provided a context, although a tragic one, of intensive clinical practise for medical personnel and over its course ensured their exposure to the latest developments in medical research: infection control, blood typing and transfusion, the use of X-ray technology and new methods for saving damaged limbs. The chance to use and improve their medical skills was a professional opportunity that women doctors did not want to miss.

1. Murray, Flora, *Women as Army Surgeons*, Hodder & Stoughton, London, c. 1920, p. 4.

# Parkville: Find your new home in the home of medicine

**Paediatrician Sarah Nguyen wanted a home that captured the essence of her lifestyle as a busy doctor with an active social life. She wanted a home that was modern and functional, but still exuded the warmth and feel of a traditional Victorian streetscape. Above all, she wanted to be at the heart of Victoria's medical industry in Parkville.**

After 18 months her search led her to Parkville by Oliver Hume - a stunning new project that has been exquisitely designed and curated to perfectly blend old world style with modern convenience.

Sarah formed an immediate connection with the project due to its proximity to parks, the medical precinct and the rich lifestyle of Melbourne's inner-north. She ultimately purchased one of Parkville by Oliver Hume's three-bedroom homes in Bridleway Walk and is looking forward to enjoying the perks of living at the city-side address when it is completed in August.

"It wasn't a tough choice," Sarah says. "Parks on either side, easy access to the Upfield line, trams into the city, the buzz of Sydney Road and friends just a block away!"

Each privately addressed residence at Parkville by Oliver Hume is the result of a creative collaboration between DKO Architecture and Carr Design, enhanced by landscaping from Jack Merlo.

The 20 residences represent the epitome of inner-city living with a uniquely Melbourne twist. The project is divided into three groups - Royal Parade, made up of four four-bedroom homes, Bridleway Walk, where there are nine three-bedroom homes and The Avenue, consisting of three-bedroom homes. Bridleway Walk is a three-level project, while Royal Parade and The Avenue are both four levels.

The smart use of space to create a range of numerous 'zones' through each residence was a key priority of the design team. For Sarah, this focus on space was an important factor in her decision.

"In addition to looking forward to moving into a new place with more space, the layout of the open-planned, but zoned, ground floor layout for entertaining will really suit my lifestyle. I also think the location is perfect," she says.

All residences are equipped with a prominent and sunlit staircase, an individual rooftop retreat, rear garden and integrated lock-up garage, capable of holding two to four cars depending on the residence. Specific residences include a private elevator for convenient access to each floor.

But for Sarah, along with many of the buyers at Parkville by Oliver Hume, it is the location that sealed the deal.

For healthcare and medical professionals of all ages there is no better place to live than Parkville. Since 1848 and the opening of what's now known as The Royal Melbourne Hospital (RMH), the suburb has built a reputation as the beating heart of Victoria's healthcare and medical research fraternity.

As well as the RMH, today the suburb is home to the Royal Children's Hospital, CSL Limited, Walter and Eliza Hall Institute of Medical Research, Murdoch Children's Research Institute, the Monash Institute of Pharmaceutical Science (MIPS), the Melbourne Biomedical Precinct and the Victorian Comprehensive Cancer Centre. Together with several private practices, the Parkville precinct now employs thousands of doctors, researchers, nurses, scientists and administrators that together represent one of Australia's largest and fastest growing employment hubs.

While healthcare employment has underpinned Parkville's economic growth, lifestyle factors have also played an important role in the suburb's reputation as a great place to live.

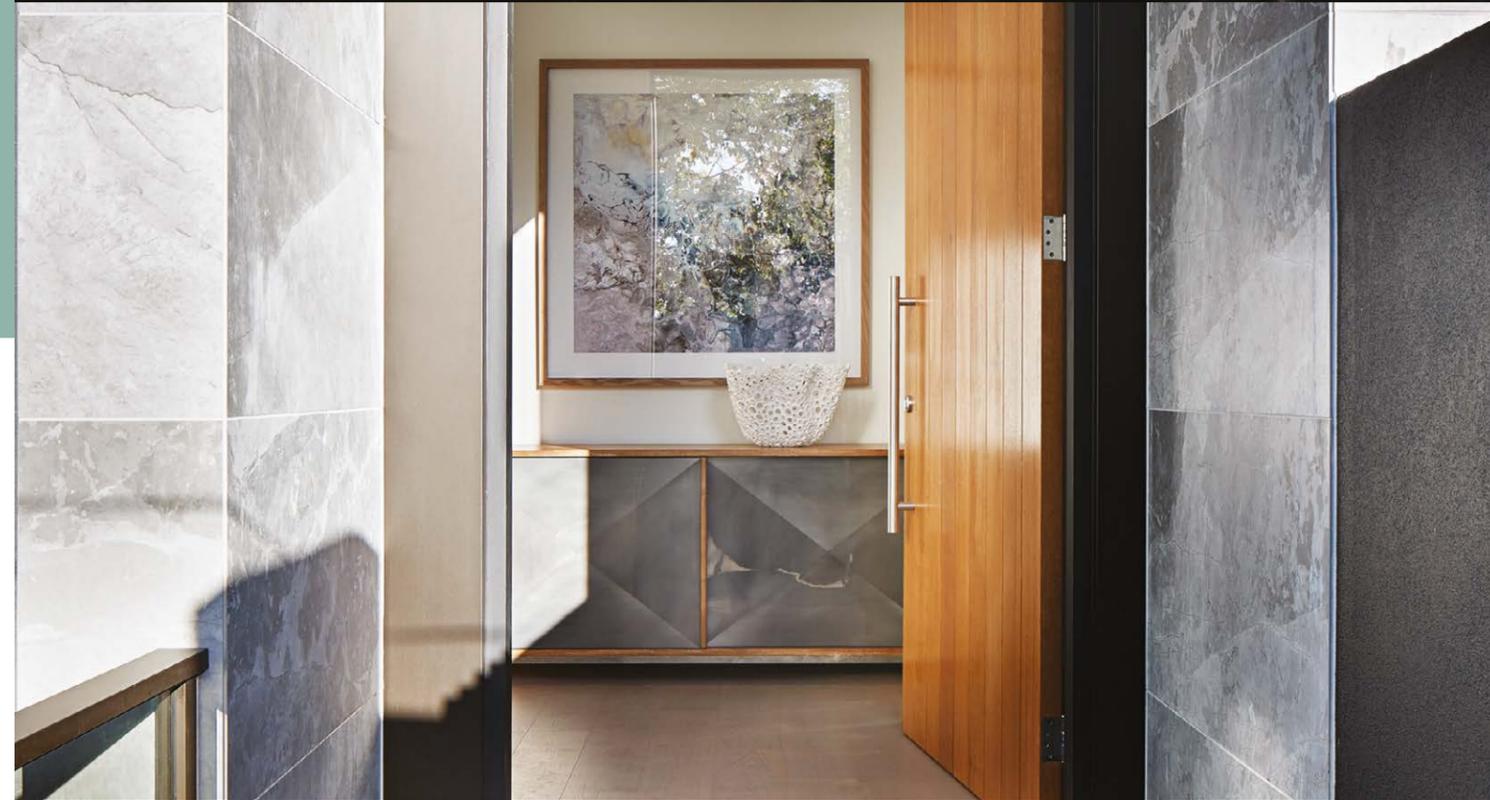
Located just three kilometres north of the city, Parkville has been synonymous for much of its life with the neighbouring Royal Park and the Royal Melbourne Zoological Gardens, a 180-hectare oasis of green that is the largest of Melbourne's inner-city parks.

The area's quiet, tree-lined residential streets and quintessentially Victorian terrace homes hark back to a history when horse and buggy ruled the roads. Much of the suburb is subject to heritage protection laws that ensure it will always retain its unique character.

For lifestyle, it includes many of the elements you would expect from an inner-city suburb; top quality public transport, cafes, restaurants and family-friendly parks.

Families eyeing off local schools are spoilt for choice. Princes Hill Secondary College is among Melbourne's most sought-after schools in proximity. Princes Hill Primary School, Brunswick South Primary, Carlton Primary School and Carlton North Primary are also nearby, while the University of Melbourne is just two kilometres away.

PARKVILLE  
BY OLIVER HUME



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# Best practice medical billings and collections

Traditionally, the billings and collections functions of medical practices tend to fall between the cracks. The focus of every practice is going to be on providing high quality medical care to its patients. The practitioners invariably will have minimal interest and experience in backroom office functions.

As a result, the billings and collections functions are invariably delegated to the bookkeeper, accountant or receptionist (depending on the size of the practice). The first step for every practice to take is to recognize that this is a specialised area and in most practices, it is handled poorly.

For the practice to change direction, a critical first step is to appoint someone who is responsible for this function. For convenience, I will refer to the appointed person as the 'credit officer' (a clunky term which I would not recommend you adopt). In most practices, the credit officer will also be handling other functions. I would not recommend that the role be carried out by one of the practitioners.

For the credit officer to be effective, he or she must be provided with a clearly defined role, be given the resources to carry it out and be given the authority to make decisions. The credit officer need not be the person who actually handles the function, but in small practices it is likely that the credit officer would also be the hands-on operator.

The credit officer must define the credit terms for each category of service provided. For example, many categories may involve bulk billing or payment at the time of service, whereas ongoing treatment and specialist services may involve provision of seven, 14 or 30 day payment terms.

The credit officer will examine every step in the process, from the time a patient registers with the clinic, the process for generating invoices and the different payment methods. Most invoices are poorly designed and do not allow for a simple and clear cut process for the patient to effect payment.

Ensuring that full patient information is obtained is critical to the success of the system. In particular, email and mobile numbers are now more important than postal addresses, because this is the most effective way to contact most patients.

Reporting by the credit officer to the practice manager (or practitioners, in the case of smaller practices) is critical and is the means by which the credit officer is ultimately judged. The practice manager should be provided with a weekly report which details the status of all outstanding invoices.

A successful credit officer will increase the payments on delivery of service, reduce the amount outstanding beyond allowed credit terms and will be taking action against all accounts which are outstanding beyond allowed credit terms.

In summary, none of the above is difficult to achieve. The cost to the practice in implementing best practice is almost zero, the changes can be made quickly and the results will be tangible, in that there will be significantly improved cash flow and a reduction in losses from bad debts.



**Roger Mendelson**  
CEO  
Prushka Fast Debt Recovery

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