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Safely reclaiming some sense of normality

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President's message

Victoria needs to reclaim some sense of normality, but safely

Victoria has arrived at a fork in the State Government's COVID-19 roadmap.

We are all relieved that the stage 4 lockdown successfully brought the case numbers down from close to 800 per day - an incredibly important achievement in protecting our community from COVID-19 and ensuring our health system was not overwhelmed.

Yet, lockdowns are not a permanent solution. The health implications of a never-ending lockdown are serious. Obviously, all doctors are battle weary and conscious of the mental health effects and secondary health impacts of the stage 4 lockdown on patients and their families. Melbournians are exhausted with the unrelenting nature of Victoria's lockdown strategy. Socially and economically there have been very substantial costs. Many people have been significantly impacted by isolation, unemployment, and mental distress.

No matter how low our cases go, it is clear we will need to live with COVID-19 going forward and we must be prepared.

Victoria is looking for a way forward. As we carefully begin to open up, living with the virus will require all our ingenuity and rigour to reclaim some sense of normality until we get a vaccine. A cautious balanced middle path - with some modest relaxation of restrictions - would seem to be the best way.

It is very important that as restrictions are released, we do so in a measured and considered way. It might be difficult for our public health teams to keep the daily case numbers at a reasonably low level over the next few months, especially if social interactions increase dramatically ahead of Christmas. Furthermore, logic would suggest that our case numbers could increase again if we open up too far. In fact, some would argue that it is almost inevitable that by opening up more, at some point in the future (probably after Christmas) we will have to tighten restrictions again.

Living with the virus will require much better contact tracing. We are cautiously optimistic Victoria's new system will be stronger eventually, but is it there yet? Modelling our new system on the more successful New South Wales devolved model - with local public health units established across the state – is a good idea but importantly, our new system is not well established and has yet to be truly stress-tested with higher case numbers, so time will tell.

Best practice testing and infection control measures in all healthcare settings and aged care facilities will be required. Infection in healthcare workers occurring where all prevention interventions have not been applied is not only morally and legally indefensible - it has a massive impact on health service capacity, aged care infection prevention and our outbreak response.

All hospital workers should be wearing properly fitted N95 masks with an airtight seal. The fit-testing rollout across all of our hospitals must occur more quickly and we are advocating for this on a daily basis. An audit of ventilation systems, air conditioning and air circulation is also necessary to make sure there are no dead spaces where the virus might 'hang about' inside hospitals and AMA Victoria has argued for such testing to become a priority. We have still been seeing a number of sporadic cases that could only be prevented by having a higher level of respiratory protection.

Additionally, we must monitor health service and staff capacity as we open our health system up, as many public health staff are exhausted and are very concerned about how they will manage with normal (or excess) demand and ongoing need for coronavirus precautions. AMA Victoria recently wrote to the new Victorian Minister for Health, Martin Foley, outlining these concerns and requesting workforce planning to address this.

As always, we welcome feedback from you. As your member organisation, our highest priority is your health and wellbeing and we endeavour to ensure our advocacy efforts reflect the views of our members. Please provide us with feedback so that we can continue to advocate effectively for you during these challenging times. Contact AMA Victoria's Director of Communication and Advocacy, Ms Taryn Sheehy at TarynS@amavic.com.au

A/Prof Julian Rait OAM
President
AMA Victoria

Your membership - it counts

Thank you to all of our members for the part you've played in the management of the COVID-19 pandemic and for supporting AMA Victoria to successfully advocate on behalf of the medical profession. This has been a challenging year for all of us.

Through your support, we have advocated for and constructively influenced government policy on a range of issues affecting the medical profession including:

- consistency of PPE guidelines
- PPE supply and distribution
- the prevention of healthcare worker infection
- access to N95 masks and mandatory fit-testing
- transparency around healthcare worker infections
- healthcare worker accommodation
- the need for general practitioners to be central in the planning and delivery of COVID positive care in the community and in residential aged care facilities
- streamlined notification by general practitioners for patients who are COVID-19 positive
- copies of all results to go from screening clinics to a patient's usual GP
- clear and consistent guidelines in relation to patient care.

Early in the year, AMA Victoria urged the State Government to swiftly set up dedicated testing sites for the collection of COVID-19 swabs across Victoria. We advocated for streamlined pathology testing and argued for widened testing criteria and improvements in contract tracing.

Mid-year, AMA Victoria called for enhanced public health measures to suppress our state's second wave and prevent our health system from being overwhelmed. We advocated for Victorians to wear face masks, even further improvements to contact tracing and stage 4 restrictions. We also advocated for stronger measures to protect regional Victoria such as checkpoints, improved access to rapid testing and stricter measures around students commuting from Melbourne for placements.

In the future, we will advocate with our members for:

- the declaration of COVID-19 as a 'proclaimed disease' under the *Workplace Injury Rehabilitation and Compensation Act 2013* so that healthcare workers can more easily access workers' compensation
- permanent and appropriate levels of resourcing and training for new local public health 'hubs' across Victoria
- a stronger relationship between the State Government and general practitioners with meaningful dialogue so that State Government understands general practice, and works with general practitioners more collaboratively
- a more coordinated health system which better integrates the different but inter-connected arms of public health, primary care, public hospitals, aged care and general practice
- improved communication between general practice, government departments, public hospital management, primary care and aged care to assist with improved planning
- general practice at 'the table' for state healthcare system planning and responses
- support to Federal AMA for the 10 Year Framework for Primary Care Reform
- specific improvements to Victoria's capacity and readiness to prepare, respond to and manage COVID-19 outbreaks in the aged care sector.

Can we count on your support for the medical profession in 2021?

The COVID-19 pandemic has significantly impacted the medical workforce and Victoria's health system. With your help, we will continue to advocate for the medical profession during this pandemic and beyond, to build a sustainable and resilient workforce and health system for the future.

A/Prof Julian Rait OAM
President
AMA Victoria

GPs must be central to managing COVID-19

COVID-19 has not only caused an unprecedented disruption to our lives, it has also highlighted some inadequacies with our health system. The Victorian Government's health department struggles with GPs and general practice – they don't fund them, and they don't understand them. So, they don't always remember to include them – even when planning for a pandemic. It's time for that to change – for the sake of our community.

I am a GP. I also have several other health roles – in the Australian Medical Association, at a Primary Health Network and at the City of Melbourne. As such, I understand healthcare delivery from both a coalface and helicopter viewpoint.

When the nine public housing towers in North Melbourne and Flemington went into lockdown with no advance notice on Saturday 4 July, several colleagues contacted me concerned that the planned healthcare for the 3000 residents stuck inside was focusing on an emergency hospital response, and did not understand or even recognise the resident's complex health needs and existing long-term relationships with local GPs and other health and social services.

I called in some GP colleagues who were providing hotel quarantine medical services and GPs at the local community health centre (Cohealth) that provide services for many of the residents. I asked if our Primary Health Network (North Western Melbourne PHN) could support Cohealth to become the lead agency and pull in other services. They all said that with the right support, they could and would.

At the lockdown sites, in a dystopian like world, together with Ambulance Victoria's Field Emergency Medical Officers, we crafted a healthcare model that responded to the needs of residents. We found that the overwhelming majority didn't need to go to hospital, but desperately required all their needs, including primary healthcare, to be met.

Cohealth became the primary care lead. We found a room. We called local pharmacies asking them to trawl their databases to find out who needed time-sensitive medication delivered. The hotel quarantine GPs brought in personal protective equipment and the knowledge of how to safely provide physical assessment and care. We brought 'no touch' thermometers and oxygen saturation meters.

We organised with ambulance services to divert 000 calls from the towers to us if they didn't need to go to emergency. We contacted local community and multicultural leaders to find out what they needed and the best ways to provide information. The GPs were consulting by Sunday afternoon, with services expanding over the following days.

We called in other GPs and practice nurses who had volunteered to help. We asked all our local GPs, pharmacists and maternal child health and mental health services to proactively mine their databases to determine if any of their patients were locked down in the towers and to call them; to provide support, information, and healthcare.

The onsite GPs and nurses dealt with babies with fevers, bronchiolitis, anxiety, heroin withdrawal, diarrhoea, asthma, medication issues and more. They dealt with most issues over the phone, but provided face-to-face consultations in a person's home if needed. Only a few adults and children needed to be transferred to hospital.

Since these dramatic days in early July, Victoria then moved to over 700 new cases per day, with more than 7000 active cases in the community and a subsequent move to stage 4 lockdown. This harsh lockdown has provided the time to improve contact tracing systems, decrease spread and gain some semblance of control.

So, what happens next? We are all waiting to see what happens with our lives, our community and spread as restrictions begin to ease after this 'second wave'. Whatever happens, for the vast majority of people who contract COVID, few will require hospitalisation and healthcare will mainly be needed in the community. This needs to be a supported general practice-based response, not a hospital and bureaucratic response.

Yet, as a GP, I still struggle to know who my patients with COVID are. Most Victorians are being tested at both Federal and State Government-run screening centres. Thankfully, the Victorian run ones were recently directed to ask who a person's GP is. However, this is still occurring sporadically. I worry especially about my most vulnerable patients, who may languish at home getting sicker. We need a model where a patient's regular GP is informed about their patients who are COVID positive, and for those without a GP, that they are tapped into one.

As we have seen in the towers, the GP would check-in and provide telephone/video support followed by face-to-face assessment if needed. In this way, I could provide advice suited to that person on how to decrease transmission to their family and other household contacts, maximise the other health conditions so that their COVID infection is less likely to cause harm, and get them to hospital in a timely and seamless way if needed. The six Victorian PHNs are working with hospitals on such a model. Some hospitals are more open and collaborative than others, however, most want their own model, rather than one that is clear and consistent across the state for all healthcare providers and the community.

The Victorian Department of Health and Human Services is putting a significant effort into managing this pandemic. So are hospitals. It really is not clear to me why they don't support a state-wide consistent model for the 80 percent of people who are COVID positive that can primarily be cared for by their GP. Such care would be more appropriate and individualised, hospital capacity would be maintained, and it would be a lot less expensive.

Dr Ines Rio
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Victorian Health Department needs significant change post-COVID

Buried in the evidence presented to the Hotel Quarantine Inquiry in September was an important document that described in one diagram why Victoria's Health Department needs a total restructure.

Not only did it definitively show that Prof Brett Sutton, Victoria's Chief Health Officer, did not have "absolute control" over COVID-19 responses (as claimed by some bureaucrats at the Inquiry), it also showed how completely ridiculous and unmanageable the Department of Health and Human Services (DHHS) has become.

Given this, now is a good time to start planning a revitalised post-COVID structure that could better serve Victoria. To do this, we don't need an expensive review by KPMG or PWC – we simply need to look at what aspects of the current Victorian structure are worth saving, then assess the health structures of other states that have managed COVID better than Victoria, to identify those elements that could be emulated.

First, the good bits that should be retained. Clearly, the integration of public health with the world-class Doherty Institute reference lab that can undertake genomics in a manner that massively guides COVID investigations and contact-tracing, has proven to be totally critical in understanding how best to control COVID spread.

Second, the recent and begrudging call for help by the DHHS in which a number of senior infectious diseases clinicians have volunteered to be seconded from their hospitals into Lonsdale Street has shown the value of medical knowledge and expertise in a structure totally dominated by non-medical career bureaucrats.

Pre-COVID, Victoria had only seven doctors working at the DHHS – for a population of 6.7 million – roughly one doctor per million. Compare this to our neighbor South Australia, which has 11 health department doctors for 1.7 million (roughly one per 150,000 population). Thus, increasing senior medical expertise seems to have value in a health department, with recent improved outcomes proving this point.

The key change, however, needs to be in structure. The current DHHS is simply too big and unwieldy – it is dealing with everything from at-risk children and family violence, right through to the accuracy of COVID testing kits and the supply of adequate-grade face masks. At a minimum, it needs to be divided into two – health and, separately, human services.

The health structure should look to NSW for a robust, well-funded, hub-and-spoke model where regional public health units can rapidly respond to local outbreaks, recognising they have enhanced local "on-the-ground" knowledge (especially important in areas with large immigrant populations where English may not be their first language), but where they are guided by standardised state-wide (and preferably, national) policies and procedures.

For medical leadership structure, Victoria should copy Queensland, where their Chief Medical Officer is a senior medico of key authority and competence, and is also a Deputy Director-General of Health. In this structure the CMO has much greater authority (and responsibility), as well as enhanced direct access to the Director-General (or Secretary) of Health and the Health Minister and cabinet at times of crisis.

In this model the CMO commands over an integrated health team that includes the Chief Health Officer (responsible for public health), plus separate experts in key areas such as hospital-based healthcare, quality and safety activities, HIV, vaccination policy and insect vector control. By incorporating these two structural changes, Victoria would have a system far better able to respond to outbreaks in a coordinated, effective manner than has been evident with COVID.

Finally, there needs to be a total change in health mindset. For decades, Victoria has had an obsession with outsourcing everything it possibly can, rather than developing in-house expertise. As an example, only a few years ago, the DHHS tried to outsource all management and follow-up of active tuberculosis patients – something that totally horrified infectious diseases specialists like me. Similarly, the perpetual hymn of how cheaply Victoria's health system is run and how it leads Australia in cost-effectiveness has now been shown to be the mistruth it has always been for those of us who have worked in the system.

In the coming weeks, there should be a parliamentary commitment to sensibly restructure the Victorian Health Department. I don't think any Victorian could tolerate a re-run of the current COVID response when the next disease outbreak occurs – which it will.

Prof Lindsay Grayson
Professor of Infectious Diseases
University of Melbourne

This article was also published in The Age on 22 September.

Paying tribute to a pioneer in women's sexual health

Dr Gytha Betheras was a pioneering and leading female gynaecologist who set up the first Family Planning Clinic at the Royal Women's Hospital in Melbourne in 1971 and the Sexual Counselling Clinic in 1977. Her work was highly valued by the many women who were assisted to manage their reproductive and sexual health and wellbeing.

Vale Gytha Betheras (nee Wade) AM
19/2/1929 to 30/7/2020

Dr Betheras graduated from the University of Queensland in 1952 at a time when women made up only about 10 per cent of the group, as many ex-servicemen were encouraged to enrol. At that time the Women's Hospital in Brisbane didn't even have a bathroom for female doctors.

After graduation, Dr Betheras moved south to Melbourne to initially work at the Queen Victoria Hospital, which was known as a trailblazer for female doctors of the time. In 1957, she moved to the Royal Women's Hospital where she practised until she retired in 1995.

Gytha married Rex Betheras, a leading neonatal specialist with a punishing work schedule. She decided to shape her own career around family planning and counselling, while raising her two children.

Reflecting the conservative attitude of the time, many people thought the young shouldn't have access to contraception; they saw it as a licence to misbehave. However, Dr Betheras thought otherwise. Her own study of 200 pregnant teenagers under 18 in the late 1960s proved to herself and colleagues that the girls had no idea how to seek sexual health advice. She was very sympathetic to this age group.

In 1971, the Royal Women's Hospital board invited Dr Betheras to head a Family Planning Clinic. Her staff of female doctors became known as 'Gytha's girls'. Their work had a significant impact on the birth rate at the hospital. Then in 1977, despite reservations by the more conservative members of society, the Royal Women's Hospital opened a sexual counselling clinic. Dr Betheras was still practising as a sexual health counsellor for a few long-term private patients as she approached 80 years of age.

Looking back on her work Dr Betheras is quoted as saying, "What I always wanted was for women to have an equal chance in this field, and to give women choices. Women have biological needs that change your life".

In addition to her many other achievements Dr Betheras was the President of the Royal Women's Hospital's Board of Management from 1993 to 1995.

In 2001, Dr Betheras was included in the Queen's Birthday Honours as a Member of the Order of Australia for service to medicine in the field of obstetrics and gynaecology, and to women's health issues, particularly in the areas of family planning and sexual health.

Gytha also established the Rex Betheras Prize in Neonatal Services at the Royal Women's in 2003, in honour of her late husband. Dr Rex Betheras had a particular interest in ultrasound imaging.

Dr Betheras was a long-time member and supporter of the Walter and Eliza Hall Institute. The Institute's Page-Betheras Award was created in 2013 to honour Gytha and her dear friend, the late Marion Page. This award provides technical assistance to female scientists while they are on maternity leave, helping them to maintain the momentum of their research.

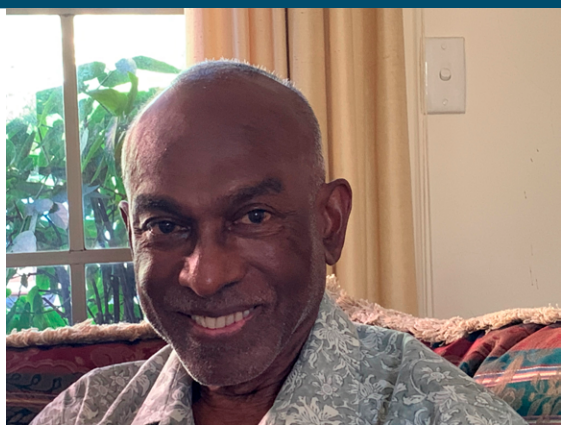
In her later years, Dr Betheras participated in the AMA Victoria Peer Visitor Program, receiving visits from Dr Alice Stewart, a neonatologist from Monash Health. Despite the many years difference in age, they had plenty to discuss including mutual professional colleagues.

The AMA Victoria Peer Visitor Program is open to any retired doctor who would enjoy some companionship and is especially suited to doctors who feel isolated from professional colleagues after retirement. If you know an older doctor who would enjoy a regular visitor, please contact Kay Dunkley at KayD@amavic.com.au

Tribute compiled by Kay Dunkley, Coordinator of Doctor Wellbeing

The AMA Victoria Peer Visitor Program is proudly sponsored by VMIAL, the name behind PSA Insurance.

Open letter to the AMA: A plea for equity for all doctors



I would like to thank the AMA Federal and Victorian Branch for the messages of congratulations following my Member of the Order of Australia award on the Queen's Birthday in June 2020. I feel proud to be the recipient of this prestigious award, in recognition of my contribution to medicine, to psychiatric health care, and to professional groups.

As an Indian who chose Australia as my home 49 years ago, I am very pleased to have been able to make a contribution in two areas about which I am passionate – psychiatry and anti-discrimination.

Psychiatry is my first passion, and I am grateful for the opportunities I had to contribute to the betterment of mental health care in both the public and private psychiatric services in Victoria. I remain most appreciative of my colleagues in the healthcare system who worked with me to achieve our collective vision - this honor must be shared with them.

My second passion is about eliminating discrimination of any kind, and striving to achieve equal opportunities for all, regardless of race, colour, gender, sexuality, religion or health status.

In the mid-1980s, I confronted discrimination when I applied for senior management positions in the Victorian Health Department in pursuit of my chosen career. I remain indebted to the many individuals, professional and community groups and other activists who supported me in my fight to achieve justice. I think that it is fair to say that the activism and advocacy of these fair-minded concerned citizens and the human face that my struggles provided eventually enabled Ms Jan Wade to enact the 1994 Equal Opportunity legislation in Victoria.

The generous invitation from AMA Victoria to highlight my work and achievements in Vicdoc magazine has given me cause to reflect upon my experience as a doctor in Australia. There is one unresolved issue that stands out – the disparity that continues to exist between those in the dominant 'in group' and people like me who come from a vastly different background.

What matters most to me is that the discrimination and exclusion that exists within the culturally dominant 'in group' of doctors be eradicated. As someone who experienced this problem firsthand, I feel compelled to emphasise how important it is that the misuse of the power and privilege afforded to the dominant group is addressed. Regardless of whether this misuse occurs as the result of conscious or unconscious bias and discrimination, it is an indictment on our profession.

Although I enjoyed a fulfilling career in which I benefited from working with many accomplished and open-minded colleagues, it would have been most helpful for me if the professional bodies representing medicine had policies and procedures in place to ensure merit based and non-discriminatory support and opportunities for all doctors. Furthermore, availability of a professional life coach or mentor to guide, advise and advocate for me as I strove to establish myself as a psychiatrist in Victoria would have been most helpful. Not only would this have assisted me in my personal journey, it would have also ensured that the medical profession derived the best possible benefit from my contribution.

In the short-term, one 'quick-fix' initiative to assist overseas trained doctors today could be a partnership between the AMA and the Overseas Medical Graduates Association (OMGA) to introduce a mentoring program to better support them. I am sure that such an approach would be enormously helpful for many skilled migrants, including doctors, in our workforce today.

Given that Australia continues to rely so heavily on doctors from overseas to keep our healthcare system going, it is perplexing that these very same doctors so often face systemic discrimination, obstacles and organisational cultures that prevent them from achieving their potential and/or being fully accepted by the dominant group.

The disparity that exists between those in the dominant 'in group' and the others, who come from a wide range of gender, cultural, religious, racial, political, and linguistically diverse backgrounds, is a longstanding issue for the medical profession, and hence for the Australian society as a whole.

Rather than ostracise and marginalise doctors who do not fit the stereotypical profile, we must respect, embrace, and support them to achieve their full potential as valued members of our profession.

Some very important steps have been taken over recent years towards achieving equity for all doctors, and I applaud the AMA's efforts at both the National and Victorian levels. The AMA has formally adopted the World Medical Association's Declaration of Geneva (updated October 2017), which is often considered a modern version of the Hippocratic Oath. The Declaration emphasises the doctor's primary obligations to patients and articulates the obligations of doctors

to not only respect their teachers, but to also respect their colleagues and students. It also acknowledges the importance that physician wellbeing, in the broadest sense, has on a doctor's ability to provide a high standard of patient care.

The AMA's Anti-Racism Statement is a powerful assertion that racism and discrimination in all its guises have no place in the healthcare industry and in the broader Australian society. I am particularly impressed by the definitions of racism contained in the statement.

The AMA Secretary General, Dr Martin Laverty, has informed me that a Diversity and Inclusion Plan 2020-2022 has been developed. It sets out what the AMA will do to address the cultural and systemic barriers that inhibit equity, inclusion, and diversity in the medical profession. I understand that there is an Equity, Inclusion and Diversity Committee responsible for overseeing the implementation of this two-year plan, and I am pleased to see that there are some monitoring and accountability mechanisms in place to ensure that progress is made. The specific focus of the plan is on gender equity, and whilst I support this priority, I respectfully urge the Equity, Inclusion and Diversity Committee to concurrently focus on other diversity groups for whom inequity is a common experience. As many of the actions proposed in the plan are also relevant to other groups, a broader focus could be taken without adding work to what I am sure is already a very busy committee.

These initiatives are a solid foundation upon which the AMA can pursue equity for all doctors. However, the task of translating the spirit and intent into practice is a daunting challenge. Behavioural and attitudinal change takes time and requires strenuous and brave and highly visible leadership over a prolonged period. Collaboration with State and Commonwealth governments, health service senior executives and managers and other relevant bodies will be imperative. This work could be advanced by allocating dedicated human and financial resources to a 10-year project that could systematically assess the extent of the inequities within our profession, develop affirmative action strategies to address the issues, and monitor and report on progress made. In this way, the AMA could be an early mover and leader in bridging the gap between the dominant 'in group' and the many 'out group' members who comprise our diverse and multicultural society.

People of my generation in Australia have seen this country make vast strides; from the 'White Australia policy' to a widespread acceptance of the richness and joy that multiculturalism brings to our communities and lives. Whilst the progress is pleasing, there is still a long way to go. I am hopeful that the AMA will intensify its efforts to address this complex and endemic blight within our profession, and I encourage all members to commit to enacting their obligation to respect their colleagues from a wide range of gender, cultural, religious, racial, political, and linguistically diverse backgrounds. In this way, all Australians will receive the best possible healthcare and be richer in every way.

Dr Arumugam Alagappa Arumugam, AM
Retired psychiatrist

AMA Victoria's Mentoring and Career Services for International Medical Graduates

The AMA Victoria Doctor-in-Training Mentoring Program is open to all DiTs and international medical graduates (IMGs) who are members of AMA Victoria. Doctors who have trained overseas and are seeking registration in Australia can join AMA Victoria as associate members, with a reduced fee.

The mentoring program at AMA Victoria is a 12 month match and we encourage IMGs to become involved in the mentoring program after they have successfully completed their AMC multiple-choice question (MCQ) exam, have passed English language proficiency testing and are preparing for their AMC Clinical Examination and subsequent employment in Australia.

The aims of the mentoring program for IMGs are to assist with understanding the Australian health system and Australian career pathways, familiarity with Australia communication styles, to build networks within the Australian medical profession as well as to assist with personal and professional goal setting. The mentoring program does not assist with exam coaching, work experience or job placement.

The AMA Victoria Careers Advisory Service can assist with resume review, cover letter preparation, career coaching and interview training. Membership of AMA Victoria provides significant discounts for accessing these services.

AMA, Ahpra, MBA support program to improve notification experiences

The AMA, Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (Ahpra) catch-up every year to talk about changes to notification processes that support better experiences. Matthew Hardy, National Director Notifications at Ahpra, explains what changes are being made and why.

Assuring the public that medical practitioners are practising safely and professionally is everybody's business. One important way of ensuring this is the National Law's notification process.

We've been working hard to make sure that the process to respond to notifications better reflects a contemporary approach to regulation.

We are reforming our intake and assessment process. This includes replacing existing correspondence with phone calls to practitioners and notifiers. We are able, more rapidly and with less formality, to acquire information that helps us assess the need for any regulatory intervention in relation to a practitioner's practice.

These reforms will allow us to improve the experience for individuals involved in a notification process and effectively manage increases in the number of notifications across 2019/20. The number of notifications about medical practitioners has increased 38 per cent in the last two financial years.

The rise in notifications can be attributed to a range of factors including greater public awareness around reporting healthcare concerns and community confidence in reporting.

Despite the rise in numbers of notifications received, our timeframe for progressing and closing notifications during the assessment phase is improving. Early input from medical practitioners employed as clinical advisers by Ahpra and a new, national assessment committee has resulted in more notifications being closed during the assessment process than ever before.

Key changes

- Ahpra now employs 18 doctors from a range of specialties and geographic locations whose key role is to medically contextualise information in notifications for Ahpra staff. This means **a medically qualified clinical advisor has input into all notifications** very soon after they are lodged.
- We're also applying **a more sophisticated risk assessment** that looks more holistically at the practitioner, the notification, their practice and their practice setting as well as any risk controls in place that will mitigate future risk.
- We're investing in the **Notifications Committee: Assessment, made up of practitioner and community members**, who meet five times a week to assess all notifications.

We know that a notification is stressful for both the notifier and the practitioner, which is why it is so important for us to be timely and more empathic in our assessment approach.

Update on mandatory notifications

Earlier this year, Ahpra implemented changes to mandatory notifications in line with changes to the National Law. The amendments apply in all states and territories except Western Australia and affect the mandatory reporting obligations for treating practitioners.

Ahpra set up a hotline to help practitioners decide whether or not a mandatory notification is necessary. Senior staff members are rostered to the hotline and aim to keep the identity of the practitioner anonymous.

Since the hotline was established in March, Ahpra has received around 200 calls, covering all professions. Very few calls have been received from treating practitioners. Most calls are from employers, in relation to concerns about performance.

Feedback to date reflects that, after speaking with hotline staff, callers are less likely to make a report because they are clearer on reporting requirements.

We have seen a shift in the type of mandatory reports made about impairment, with fewer about mental health illness and more about substance and alcohol abuse. In terms

of regulatory action, more notifications about mental illness are tending to result in no further action, while regulatory action is more likely to be taken in relation to substance and alcohol abuse.

Increased confidentiality safeguards for notifiers

We are also improving the way we manage confidentiality safeguards for notifiers. This includes improvements to the administrative management of confidential and anonymous notifications, improvements to communication about privacy and confidentiality for notifiers, and managing the risk of vexatious notifications.

Vexatious notifications

There is a perception that a high proportion of notifications that close with no action are likely to have been brought to us by a vexatious complainant. The reality is this is not matched by data. While a notification might not need the MBA to take action, most are made with a motivation to improve the way health services are delivered.

Ahpra staff have received training to recognise genuinely vexatious notifications early. This will be supplemented during 2020/21 by a guideline to support identification of vexatious complaints, which the AMA and medical defence organisations will be consulted on. Despite the number of truly vexatious notifications being low, we understand that the impact on practitioners who are the subject of a vexatious notification is serious.

Our commitment

While there is a lot of work underway to improve the notifications process and experience, patient safety remains the focus. We remain committed to supporting safe, professional practice by encouraging:

- complaints and feedback processes in practice
- reflective practice when things go wrong
- actions by practitioners and within health services to prevent repeats of issues.

Ahpra and the MBA will continue to review and improve the notifications process, as we recognise that it is stressful for both the notifier and the practitioner concerned. We are committed to being transparent, fair and timely in our approach and to continuously strive to improve.

More information

For more information about the notifications process visit: https://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process.aspx

Read our regulatory guide to explain how Ahpra and the Boards asses notifications

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Matthew Hardy
National Director Notifications
Australian Health Practitioner Regulation Agency

How can coaching help doctors with their careers?

Coaching is a way of developing your skills and abilities, while simultaneously boosting your performance and self-confidence in roles.

It can assist you to:

- Identify strategies to address challenges
- Better navigate organisational systems
- Actively manage and plan your career
- Assess options and make career decisions.

A central feature of coaching is that the individual is in charge of their own decisions and development to realise their full potential. The coach is there to facilitate this process through structured questioning, reflection, and observation - often challenging the status quo, helping the 'coachee' to find their own solution. Coaching is NOT mentoring, teaching, supervision or counselling.

Many doctors seeking coaching are looking for support to find answers to one or many questions. Some of the more common questions are:

- Am I doing work that stimulates and engages me?
- Is the mix of work that I am doing the right mix?
- Is my work environment supportive?
- Is my role structured in a way the meets my needs?
- Am I working too much or too little?
- Do I have positive and supportive professional relationships at work and outside of work?
- Where do I see myself in 10 years and what do I need to do to get there?
- Do I want to be a doctor anymore?
- What else can I do with my medical training?
- How can I develop my leadership capabilities?
- I am looking to retire – how do I transition from medicine?

AMA Victoria's career coaching service has experienced increased demand over the past 12 months from doctors, at all stages of their careers, seeking coaching to work on their career plans. We offer several different coaching options for doctors from one-off coaching sessions to tailored programs for career planning, specialty choice, alternate pathway exploration and progression to and within a leadership role.

Coaching involves a doctor working with one of our internationally certified coaches in a formal coaching relationship, with the purpose of creating space to 'reflect and review' on their career, to identify opportunities for development and transition and to formalise a plan to achieve their personal and professional goals. This is done in a safe, supported and non-judgmental environment - which is something that for many is absent in their workplace.

Coaching is different from a formal employer performance appraisal. The key difference being that it sits outside of a specific role, workplace and craft group and is holistic, taking a helicopter view of your professional life, while encompassing both personal and professional aspirations and goals.

This service is available to AMA Victoria members (at a reduced fee) and to non-members. Further details can be found on our website at www.amavic.com.au/careers-advice.

If you would like to find out more about how AMA Victoria's Career Service can help you, contact our consultants between 9am – 5pm, Monday – Friday on (03) 9280 8722 or careersadvisor@amavic.com.au

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Carolyn Speed
Senior Careers Consultant

Mardi O'Keefe
Director, Career Management

Reflections of part-time internship

It's been four years since I completed my part-time internship. I did so back in 2015-16, starting when my children were one and two years old. I am still grateful for the opportunity to train part-time, as it was rare. In 2015, I was one of just five part-time interns, out of approximately 800 interns in Victoria. Austin Health was the flexible and daring hospital that employed me in a supernumerary manner.

At this time, hospitals could receive government funding for such flexible intern programs. I completed my internship at 0.5FTE over two years, and fulfilled the usual requirements. I was an additional 'half' of an intern placed in some of the busiest units in the hospital, in order to facilitate my experience, and to make sure my co-interns and I didn't miss out on any training opportunities. I completed the same mandatory requirements as other interns - in emergency medicine, general medicine and surgery.

The positives of part-time internship

Well, there's the obvious: it was excellent for work-life balance and my family life. It was also great for my mental *and* physical health.

I was largely spared the unpredictable nature of unrostered overtime, as I was usually encouraged to handover and leave on time. This was a great opportunity to develop handover and other communication skills.

I was able to ease into work, as opposed to being thrown in the deep end. A far better option when I also had two young children to consider, and was still awake around the clock looking after them.

I had a constant roster for two years, more or less. I spent 20 weeks in each rotation, instead of 10, which was excellent for learning the job and developing relationships within each unit.

I had a longer time between job applications - two-yearly instead of yearly.

I finished my two years as a competent intern, ready for residency. I received very good assessments along the way. I learnt the same information and had a very similar experience to my colleagues; it just took longer. I have gone on to work full-time and part-time residencies without issue.

I encountered supportive bosses and colleagues along the way, mostly.

The negatives of part-time internship

A slow, more gradual learning curve - in my first year, I learned slowly compared to my co-interns. I was present less, so I experienced and learnt less in the short-term. Due to the nature of full-time internship – over 40 hours/week rostered plus unrostered hours, my colleagues were immersed in experience, and I was far less so. It was hard to watch my peers surpass me. But, the good news is, I caught up! At the beginning of my second year, I was the fast and experienced intern, which was good for my confidence and good for the teams I worked with. My co-interns quickly caught up as you would expect.

Commencing a career is hard anyway, but trying to establish one as the only part-timer is even harder. It is different to returning to a job you know well in a part-time capacity.

It took two years to complete. My preference was to work 0.66FTE over 18 months, but logistically this was harder to arrange for the hospital, so I worked 0.5FTE for two years.

Part-time training is not *yet* (!!) streamlined. It took me a lot of time and effort to arrange my part-time internship, and the stress of forging my own pathway was hard.

I did encounter some unsupportive colleagues, mostly from other doctors-in-training. Some seemed envious. Some took the opportunity to belittle, for example being told, "You'll know what medicine is really like when you work full-time", or cynically being asked, "What do you *do* on your days off?".

Overall, I would do my internship part-time again. I am still grateful for the opportunity. For me, it

meant that I didn't have to choose medicine over family. However, some of the pros and cons I have listed are somewhat contradictory. For example, while easing in was beneficial, complete immersion would have been advantageous in other ways. This highlights the fact that it is difficult to 'have it all', but at least you can 'have a bit of it all', when you have multiple large priorities.

If part-time medical training became a regular option with all health services, many of the challenges I encountered could be minimised. I really hope to see more part-time and flexible training options in medicine in the future.

Dr Elysia Robb
GP registrar

Editor's note: According to the Postgraduate Medical Council of Victoria, there's no set number of part-time intern positions in Victoria. The number of part-time interns has varied from year-to-year based on the number of candidates seeking part-time positions. In 2021, there will be just the two candidates commencing part-time internships, through job sharing. AMA Victoria would like to see every hospital have at least one intern position available as a job share. It may not always be filled, but they should have the capacity to offer one.

Parenting in Medicine: Your questions answered

AMA Victoria's Women in Medicine Committee hosted an online seminar earlier this year to discuss the issues and your rights surrounding Parenting in Medicine. The seminar, which was run over two nights, featured plenty of interactive discussion and questions to our presenters and panellists.

Doctors were also encouraged to submit questions to our Senior Workplace Relations Advisor, John Ryan. A selection of these are included below, but members can login to the AMA Victoria website here for full access to the extensive questions and answers, as well as case studies.

AMA Victoria has advocated strongly for improved employment conditions around parental leave and the issues involved with caring for a family. These improvements have been reflected in the 2018-2021 Enterprise Agreements (EA) for doctors-in-training and specialists. The consultation process for the next EA agreements has now begun, with our Workplace Relations team hosting online meetings with members to canvass which conditions – including parental leave – need updating.

Look out for Resident Medical Officer society and Senior Medical Staff group notices regarding AMA bargaining meetings if you wish to participate in these discussions throughout the next few months. If you are not a member of an RMO Society, or your health service does not have one, please get in touch with us via eba@amavic.com.au

Pregnancy

What measures are in place to ensure the safety of pregnant women and their child from infectious diseases in the hospital?

This is an issue where the obligations on health services are quite onerous. Every health service has an overriding obligation to maintain a safe and healthy workplace for all of its employees and all health services take these obligations seriously.

Where any employee of a health service has a pre-existing illness or injury or condition that makes them more vulnerable if exposed to any infectious disease then the health service must take the person's state of health into account when determining how to meet its obligations to provide that employee with a healthy and safe workplace.

During the COVID-19 pandemic all health services have introduced specific measures to deal with a range of matters to manage the provision

of a healthy and safe workplace to employees. Some of these health service specific plans address the needs of some pregnant employees and the needs of some employees with pre-existing conditions.

None of the health specific plans address every possible contingency but every health service has the capacity to make decisions based upon the specific issues facing a particular employee.

Doctors with some level of immune suppression and doctors with particular histories relating to pregnancy are the types of employee who may not fit neatly into a health service's COVID-19 pandemic response plans and may require special consideration and special decisions being made to ensure that they experience a healthy and safe workplace.

Whenever a doctor has a concern that their safety as a pregnant employee is not being adequately addressed, then the doctor needs to raise the issue immediately with more senior levels of management.

If you have any doubts about your health and safety at work while you are pregnant, then the best and soundest advice is to advise your employer that you are withdrawing from work immediately and then seek advice from your treating medical practitioners and from the AMA. Even if your concerns are unfounded about any physical dangers you and your unborn child may face from staying at work, you are likely to inflict upon yourself significant emotional or mental stress if you stay at work when you feel unsafe.

Leaving the workplace, getting professional advice from your treating medical practitioner and then engaging in a genuine discussion with your health service will generally lead to a quick resolution of the matter.

AMA Victoria will assist any member in dealing with these matters.

Doctors-in-Training

Will maternity/paternity leave lengthen training time?

Yes. Parental leave is an absence from work and training, so the amount of time that it will take a doctor to complete the training requirements to become a specialist will be extended by an amount equal to the amount of time taken as parental leave.

How do I negotiate maternity leave and rotations?

The basic entitlement to parental leave is not negotiated. It must be provided to you and will be provided to you as set out in the DiT EA. If you are pregnant or planning on becoming pregnant you should apply for a rotation, even if the rotation is to commence after you have given birth.

Once you have been offered and accept a rotation, if having a baby and taking parental leave prevents you from starting or completing the rotation, the health service will be obliged to offer you an extension of the contract, equal to the period of parental leave. The EA makes this very clear.

When is the best time to have children in relation to training?

The structure of the DiT EA is designed to allow junior doctors to have children when they want to! The key benefit in the DiT agreement is that when a doctor takes more than three months parental leave, the health service must offer the doctor an extension to their contract equal to the amount of leave taken.

Specialists

Are you entitled to parental leave if on an annual VMO contract?

The answer will depend upon the nature of the VMO contract. Some health services are engaging VMOs on 'independent contractor' agreements. If you are genuinely an independent contractor then the health service does not provide any paid leave to you. Your leave arrangements are funded by yourself. The issue for VMOs on 'independent contractor' agreements is whether you are genuinely an independent contractor running your own business, or whether you are really an employee working for the health service. That's a debate for another day!

If you are a VMO employed by a health service, being on an annual contract is not the issue. The entitlement to parental leave under the AMA Specialists Agreement is based upon your continuous service.

If you are on rolling annual contracts, then you will most likely have continuous service. If this is your first annual contract with your current health service, but you have worked for other health services, then you may still have continuous service if there are no breaks between being employed by different services.

Are there any maternity leave options for those almost finished with their specialist training, who anticipate having children at the conclusion of this training, but are yet to secure a consultant contract?

If you plan to have a child after your last training time contract has ended and before you start working as a specialist, you will invariably have no parental leave entitlements.

To have any entitlement to parental leave, you must be employed either as a DiT or as a specialist. If you are in between these two stages of your career, you are not employed and there is no employer to provide you with parental leave.

John Ryan
Senior Workplace Relations Advisor

AMA Victoria members can click here *for the complete series of questions and answers, covering a wide range of topics including your rights relating to breast feeding and pumping, and adoption.*

Click here *to watch the online seminar with Senior Workplace Relations Advisor John Ryan discussing your parental leave entitlements.*

Click here *to watch the online parenting in medicine panel discussion.*

Career spotlight: The diverse opportunities in general practice

General practitioners play a crucial role in the Australian healthcare system. Their important role on the frontline is evident as the world continues to manage the impact of COVID-19. In this series, we are introducing you to a range of general practitioners, highlighting the diverse and rewarding career possibilities.

Dr John Malios

Why did you choose to become a GP?

During my hospital residency, I enjoyed the different medical specialties offered, but my interest was to focus on "real world" and community medical care. Specialisation in medical practice was increasing and the era of the traditional GP who managed most illnesses and only occasionally referred a patient to a consultant, was changing.

I was an early advocate for recognition of general practice as an important speciality delivering medical care. There were differences in opinion that general practice could not be a specialty, hence other terms such as family physician or primary care physician were proposed. I became an active member of RACGP, later a board member, and member of the medical education committee, participating in training activities with the College.

I had the pleasure of an interview with the late Dr Monty Kent-Hughes at his rooms when the RACGP was introducing a rotating residency for prospective GPs. I completed one of the first rotating internships for the College's training program.

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

Individuals and situations have influenced and guided my career which included my elder brother and my family GP in Williamstown, who I recall treated all conditions including my tonsillectomy at the local hospital. I have been fortunate to have had opportunities and been influenced by some specific individuals and patients' experiences, that have resulted in an interesting and diverse career whilst still maintaining my primary role as a GP.

Thalassaemia

During my residency at QVMH, the deputy superintendent suggested that I should take an interest in the thalassaemia patients attending the hospital. I became aware of the lack of knowledge by both the medical profession and the relevant populations, regarding the genetic implications of this hereditary disease. This led to my interest in the management of thalassaemia patients.

After completing my residency, I commenced working in general practice and continued a sessional basis at the paediatric clinic managing thalassaemia major patients.

In the mid-70s, I was involved with the establishment of a thalassaemia screening service at the QVMH under the direction of the consultant paediatrician, the late Dr Rae Matthews. I later held similar clinical and counselling services at the Royal Children's and Royal Women's Hospitals.

During this time, I was involved in various publication and media activities that increased awareness of thalassaemia, particularly within the Greek community. Together with other practitioners, we helped establish an information and counselling centre for thalassaemia. The Thalassaemia and Sickle Cell Association of Australia is now a well-established organisation providing ancillary care to patients.

I recently returned full circle to my interest and involvement with thalassaemia. Having been a life member of the association and since my retirement from general practice, I have become more active, and am now the medical advisor to the management committee. Next year we will be celebrating TASCA's 45th anniversary.

Medical education

Believing in the fundamental importance of general practice in the health system, I pursued an ongoing interest in GP training. Supported and inspired by leaders in the field, I lectured part-time at Monash University in the department headed by Prof Neil Carson. I provided training in communication between health professionals and non-English-speaking clients. The medical profession was more widely using interpreters, however initially interpreters were not specifically trained and were generally sourced from multilingual migrants.

I developed a series of lectures for medical students and presented papers at various forums, including a Victorian teacher training college.

I continue to be involved with training medico-legal practitioners with AMA Victoria's Impairment Assessment Training Program, as a member of the Training Course Management Committee, and facilitator for the core module component of the course. This ministerially approved training course is a requirement for medico-legal examiners to undertake impairment assessments.

General Practice diversity and community

Having done a few GP locum placements I commenced working with the late Dr Peter MacCallum (the son of Sir Peter MacCallum) in a practice in Blyth Street Brunswick, where I learnt many of the skills of general practice that are not taught in medical school.

I subsequently established my own general practice in Oakleigh from 1972-2018. Initially, as part of my general practice, I also practised obstetrics at several local hospitals including a small hospital in Oakleigh. This was a very satisfying era of my career and I established relationships with patients that lasted for my entire time in general practice, including the pleasure of managing different generations of families.

Managing my own general practice, with GP assistants, offered me the opportunity to explore other professional interests.

I always believed that the social circumstances of patients needed to be understood and considered in providing healthcare, and was supportive of efforts to establish a welfare society to meet the needs of Greek migrants.

With this approach, I applied and accepted an offer from the local government supported community health centre, to provide a sessional nurse and welfare worker. This was a time when there was extremely limited social care available for non-English-speaking people.

What started as a small group of elderly patients meeting for a cup of coffee in the sunroom at the back of the practice, then expanded with health education sessions with the nurse and the welfare worker. This soon became very popular and with the assistance of the newly-established Australian Greek Welfare Society, had to be relocated to larger premises. This was the beginning of the first dedicated Greek Elderly Citizens Club, now widespread throughout the Melbourne community.

I never imagined that this idea of assistance in providing comprehensive medical care would extend as it did.

Occupational health and medico-legal interest

My early interest in occupational health led to my appointment as a sessional conciliator with the WorkCover Conciliation Service. My subsequent appointment as a practitioner eligible for appointment to a Medical Panel followed, and my career progressed to an appointment as Deputy Convenor and then Convenor of Medical Panels, until my retirement in 2017.

The collegiate experience working with highly qualified medical specialists in assessing complex medico-legal cases was a significant learning experience, and also highlighted the importance of general practice. It is the generalist who has the skills and knowledge to coordinate the different views of the other specialists.

What do you love most about being a GP?

I have met and have had the opportunity of working alongside accomplished medical practitioners including general practitioners and specialists. I have also had the opportunity to understand and see the functioning of government bureaucracy and private industry.

However, the overriding enjoyment has been the privilege of looking after patients for long periods of their life, including some from their birth to adulthood, and then being trusted to care for their children - third-generation patients.

I recently had the pleasure of wishing a set of twins a happy 50th birthday! I had been the RMO at their birth and with their family they became and continue to be long-term patients of the practice.

I have learnt about life from my patients and their families. They may have suffered losses and had difficult periods, and providing medical care during such times is important and is also a learning experience for the doctor.

It is unfortunate that the home visit is disappearing from general practice. I cannot emphasise how many times my understanding of a patient's issue only became clearer after a house visit seeing the patient in their family environment.

Such enjoyment in guiding and helping the health and general wellbeing of patients and establishing long-term family medical care cannot be given a monetary value.

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

Overall, I would not change much. It took me a few years to structure regular holidays and breaks given the nature of my practice. I would certainly encourage anybody to ensure that this is an important part of their lifestyle.

What advice would you offer to other doctors in navigating their career as a GP?

General practice is now a different scene. Business and practice management has become much more complex, particularly with the involvement of government bureaucracy.

However, the principle of providing high-quality care on an ongoing basis to individuals and being available within reasonable limits for patients to access care by you, is the most important tenet of general practice.

It is also important that GPs never lose real contact with the community that they provide services to, including house and nursing home visits, and a knowledge of the community and the environment of where they practice.

And of course, ensure that you have your own GP.

Age and fertility: What your patients should know

Most Australians want to have a baby at some stage, but research suggests many don't realise how early their fertility starts to wane.

A survey of more than 700 Australians last year found only one in three knew a woman's fertility starts to decline from about the age of 30. The survey, conducted for *Your Fertility*, also revealed misconceptions about male fertility and IVF, with many placing too much faith in fertility treatment as a back-up measure.

So, if you want to help your patients maximise their chance of a healthy baby, here are five facts to share about the impact of age on fertility.

Age is the biggest factor affecting a woman's chance of conception

It's a biological fact that as women age, their potential to have children decreases, although the exact time when this starts to happen can vary among individuals. Research has shown that women younger than 30 have about a 20 per cent chance of getting pregnant naturally each month. By age 40, the chance of pregnancy is about five per cent each month.

In general:

- women are most fertile before the age of 30
- after 30, women's fertility starts to decrease
- after 35, fertility declines more significantly
- by 40, a woman's fertility is about half the level it was before she was 30.

A man's age can affect the chance of conception too

We've all heard about men in their 80s and 90s fathering children, but it's rare. It takes longer for partners of men older than 40 to conceive.

Assuming a woman is younger than 25; if her partner is also younger than 25, it takes an average of five months to get pregnant. If her partner is older than 40, it takes around two years, and even longer if he is older than 45.

For couples having IVF, the chance of having a baby is higher if the man is younger than 41.

Older age increases the chance of pregnancy loss and complications

The risks of miscarriage and complications in pregnancy and childbirth increase as women age. Older women have increased risk of gestational diabetes, placenta previa, placental abruption, stillbirth and caesarean birth than younger women.

Also, the risk of miscarriage is higher for women whose male partner is older than 45, compared to men younger than 25 years of age.

Older age increases the chance of abnormalities for the baby

Because of the changes that happen in eggs and sperm as we age, including damage to genetic material, children of older parents have a slightly higher risk of birth defects and genetic abnormalities. The risk of mental health problems and autism spectrum disorders is marginally higher in children of fathers older than 40 than in those with younger fathers.

It is estimated that the risk of having a baby with a chromosomal abnormality is approximately one in 400 for a woman aged 30 and one in 100 for a woman aged 40.

IVF does not guarantee a baby

Most respondents to the *Your Fertility* survey over-estimated the chance of IVF working for a woman in her 40s, suggesting misconceptions about fertility treatment.

IVF can help people with infertility have a family but cannot make up for the natural decline in fertility that happens as women and men get older. That's why very few women in their 40s achieve pregnancy with IVF using their own eggs.

The chance of having a baby after one IVF attempt is about 30 per cent for women aged under 35, but it's only about 10 per cent for women aged 40-44. For women over 45 there's almost zero chance.

Health professionals and your patients can visit www.yourfertility.org.au for more evidence-based information about fertility.

Your Fertility is brought to you by the Fertility Coalition which includes: Victorian Assisted Reproductive Treatment Authority (VARTA), Healthy Male, Jean Hailes for Women's Health, Global and Women's Health at Monash University and The Robinson Research Institute at The University of Adelaide.

Your fertility

Pride of the family: A 68-year medical career

The loving family of Dr Lee Westbrook Gregory wish to pay proud tribute to him, for 68 years of selfless service to the Australian community.

Lee Gregory was born in Queensland on 26 January 1926. He attended Brisbane Boys College and in 1949 graduated in medicine from Queensland University. From 1949–50, Lee was the resident medical officer at Brisbane General Hospital and then Brisbane Women's Hospital.

From 1950-54, Lee was the registrar at Launceston Hospital. As RMO, Lee was responsible for 140 patients. This included roles at a number of coronial inquests. For one year, he was assistant pathologist and carried out 168 autopsies.

Thereafter, Lee moved to Melbourne where he first worked was an outpatient registrar at Prince Henry's Hospital as assistant physician and he was attending doctor at the Melbourne Olympics.

In 1957, while working at Heidelberg Repatriation Hospital, Lee contracted hepatitis B and fell severely ill with jaundice and was admitted to hospital at Fairfield where he recovered, acquiring full immunity.

From 1957 – 1969, Lee was a GP and partner at Moonee Ponds Clinic, while also holding an honorary appointment at the Melbourne General Hospital. For the following 11 years, he moved to Robinson Street Medical Practice in Dandenong, while also holding an honorary position at Dandenong Hospital Outpatients Department.

Lee continued to work as a GP at several clinics in the eastern suburbs of Melbourne, before finally seeing his last patient on 10 August 2017. He officially retired from medicine at the end of that year, aged 91, after 68 years of uninterrupted practise. He had intended to continue working, until he was diagnosed with multiple myeloma.

For well over 20 years during his time at Moonee Ponds and Dandenong, Lee worked locums via a call-service, usually at night and on weekends. He sometimes had a driver but usually drove himself. At other times, one of his sons would drive. Lee estimates he did well over 30,000 home visits travelling all around Melbourne, some of which involved encountering physically threatening situations. Lee also did multiple country locum shifts during his holidays.

As Lee's family, we are extremely proud of his contribution to Australia's medical profession and the community. He was an old style doctor who saw his patients thoroughly and he was regularly commended by specialists for his painstaking work, often picking up on ailments that others had missed. He no doubt saved many lives. Lee worked tirelessly during personal and public holidays. He loved his work and he still misses it to this day. Over his long career, he treated patients for a vast array of medical conditions. This experience meant Lee was ready to handle almost any medical predicament.

Lee was made a life member of the AMA in 1999 and he was a long-standing member of the RACGP. Lee lives with his wife Erica and they have three sons, two of whom became lawyers and one of whom became a civil engineer.

As a loving family, we celebrate Lee's dedication and commitment to his career in medicine.

The Gregory family

Dr Lee Gregory with wife Erica.

JobKeeper 2.0: Payment extension explained

We understand many AMA Victoria members working in private practice will be preparing for a phased return to "business as usual" albeit restricted over coming months, however some members may continue to be eligible to receive revised JobKeeper payments.

To help you test your eligibility to continue to receive JobKeeper, we explain the revised eligibility tests and relevant dates to assist you to navigate the new rules.

Please contact Bongiorno Group if you would like to discuss your specific circumstances and how the new rules will impact your continuing eligibility to receive JobKeeper payments, either for yourself or members of your team.

The JobKeeper coronavirus wage subsidy has changed, effective 28 September 2020.

As the pandemic has continued to wreak havoc on the economy, the Federal Government has extended JobKeeper through to March 2021, but with different rights and eligibility requirements.

Here's what's changing:

Tier 1

This new JobKeeper will be $1,200 each fortnight if you worked the equivalent of 20 hours a week or more during the reference periods of either February or in June 2020.

Tier 2

If you worked less than 20 hours a week in both reference periods, then you will move to the new part-time rate of $750 each fortnight.

GST turnover

Businesses will need to show a 30 per cent drop in actual GST turnover in the three months to the end of September 2020 compared to the same period last year, the September quarter 2019. This needs to be done before 31 October 2020.

The rate of JobKeeper will remain at current levels for the period 28 September 2020 until 3 January 2021 whereby it will fall again. On 4 January 2021, the full time JobKeeper rate will fall to $1000 per fortnight, while the part-time rate will drop to $650 per fortnight.

Again, businesses will need to demonstrate a drop in revenue in the three months to December 2020 compared to the three months to December 2019 using the same rules as above. Please refer to the accompanying case study for further clarification.

Alternative decline turnover tests

Two important updates:

- The alternative decline in turnover tests have been released by the ATO Commissioner
- The ATO has provided guidance for individual Business Participants in making declarations about their hours worked.

Written declaration by business participant

The ATO has confirmed that the alternative decline in turnover tests are only available where there is no appropriate relevant comparison period for the purposes of satisfying the decline in turnover tests for JobKeeper fortnights starting on or after 28 September. For example, if the business commenced later than 1 July 2019. More examples can be found on the ATO website.

An individual Business Participant (BP) of a company, trust or partnership needs to make a written declaration of the hours that they were actively engaged in the business in the relevant reference period (generally February 2020 unless you need to use an alternative reference period).

Generally, the ATO has stated that the declaration must contain the following:

- full name
- contact phone number and/or email address
- a statement that the time you spent actively engaged in the business during your reference period was 80 hours or more.

The BP should keep records to show how they came to this conclusion.

There is no prescribed way the declaration must be provided to the entity. The notice can be submitted:

- through internal business process – for example, a business HR portal, or
- by their own form of communication channel – for example, email.

The declaration does not need to be sent to the ATO, but the eligible business entity should keep a copy for their records in order to substantiate their claim.

If the BP was actively engaged in the business for less than 80 hours during the reference period, they do not need to complete the written declaration and the Tier 2 rate will apply.

What about sole traders?

Sole traders need to make that declaration in their monthly declaration form to the ATO.

Key dates to remember

Now: notify your employees about the JobKeeper payment they can expect to receive.

28 September 2020: start paying your eligible employees Tier 1 and Tier 2 JobKeeper rates based on their hours worked.

From 28 September: if using Single Touch Payroll to notify the ATO of eligible employees, provide each eligible employee's Tier as part of your normal payday reporting. Enrol for the JobKeeper payment if you're doing so for the first time.

Between 1 – 14 October 2020: complete your October JobKeeper monthly business declarations to receive your reimbursement for the September fortnights.

Between 1 – 31 October 2020: prepare and submit your businesses actual decline in turnover to the ATO.

Before 31 October 2020: ensure you meet the wage condition for all eligible employees included in the JobKeeper scheme for the JobKeeper fortnights starting 28 September 2020 and 12 October 2020.

From 1 November 2020: complete your monthly business declaration and confirm what payment tier you are claiming for each employee.

Jim Tsirtsakis
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bongiornogroup
make every day a good day

Retesting turnover under the JobKeeper 2.0 extension

Chantelle owns and runs a small medical specialist practice in Melbourne with two employees. Chantelle started claiming the JobKeeper payment for her eligible staff and herself as a business participant when the payment commenced on 30 March 2020. At the time, Chantelle estimated that the projected GST turnover for her practice in April 2020 would be 70 per cent below its actual GST turnover in April 2019. To be eligible for JobKeeper from 30 March 2020 to 27 September 2020, Chantelle needed to show the turnover for the practice was estimated to decline by at least 30 per cent.

As a monthly BAS lodger, Chantelle submitted her BAS for the practice in April, May and June. For each of these, her actual turnover was as follows:

	2020	2019
April	20,000	200,000
May	50,000	200,000
June	100,000	200,000
Total for June quarter	170,000	600,000
Decline for June quarter: 72 per cent		

From July to September, actual turnover improved as follows:

	2020	2019
July	110,000	200,000
August	140,000	200,000
September	150,000	200,000
Total for September quarter	400,000	600,000
Decline for September quarter: 33 per cent		

The actual turnover decline for the September 2020 quarter was still greater than 30 per cent, so Chantelle's practice was eligible for the JobKeeper payment for the period of 28 September 2020 to 3 January 2021.

Business continued to improve for the practice, and actual turnover for the December 2020 quarter was 20 per cent less than the December quarter 2019, so Chantelle's practice was no longer eligible to claim JobKeeper for the second extension period starting from 4 January 2021.

Working out the JobKeeper payment rate to be claimed

In the scenario above, Chantelle also needs to calculate how much to claim for each of her staff, and for herself as a business participant.

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NIA helps medical professionals build big wealth... in fast and simple steps.

Where are you now?

As a dedicated medical professional committed to the health of the people you help, reaching your true potential in terms of building wealth is tricky... because you simply don't have time to give your money management the focus it needs to grow at the fastest rate.

Managing and growing your property portfolio. Fixing financial inefficiencies. Reducing debt. Minimising tax. Getting all these things right takes time that you don't have.

So at NIA, it's our mission to have your back when it comes to building wealth. Guiding and empowering you to set clear financial goals, ensuring you achieve them with tested, effective strategies that are tailored to work perfectly within your professional medical circumstances.

Put simply, you are not alone on your journey to financial freedom. And we're here to make sure you get there.

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At NIA, we've spent years building a brilliant team of highly skilled financial strategists and partners who specialise in building wealth for medical professionals.

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intelligent fund management

Sharpen your financials
manage money, legals & estate

See your growth in real-time
'My Wealth Management' portal

Together, we'll turn your income into passive wealth, capital and cash flow. Quickly.

When you engage NIA to help build your wealth, you'll be working with a team of top-shelf financial professionals who specialise in working with medical people and are committed to turning your income into lucrative passive wealth, increased capital and much heathier cash flow – quickly.

Getting to know you, how you work and how you want to live is the first step to ensuring your financial success, because we know building wealth needs the foundation of a lasting relationship. Knowing you enables us to support you, educating you throughout your entire property and financial journey.

Put simply, together we're better... with the know-how to ensure you achieve financial goals and open the door to the life you really want.

Click here to view NIA's Specialist Wealth Building Strategies for Medical Professionals.

To contact NIA, call 1300 565 888 or email contact@mynia.com.au

NATIONAL **INVESTMENT** ADVISORY

Top 4 ways to save on your health insurance premium – without compromising your coverage

At a time when many are facing financial pressures due to COVID-19, you may be surprised to know there are ways you can save on your private health insurance premium, while remaining on the same level of cover.

Increase your excess

An excess is the amount you agree to pay up front for a hospital admission, before your health insurance starts to pay for your hospital costs. Excess amounts and how often they need to be paid each year vary per policy and per health fund. Options generally range from no excess, up to $750 for singles, and $1,500 for couples and families.

Increasing your excess is a way to see immediate savings, as it will reduce the premium you pay. Having a higher excess means you accept paying more 'out of pocket' in the event you are admitted to hospital. If you are fit and healthy, with no plans for near-future elective surgery, this can be a practical way to save. However, your excess will still apply for unexpected hospital admissions, so you should take this into consideration before choosing a higher excess*. Speak to your health fund about what options are available to you.

*If you change your mind, waiting periods can apply when reducing the excess on your policy. Please refer to the advice from your health fund.

Adjust your rebate percentage

If your income has reduced over the last six months, you may be able to change the rebate tier of your health insurance policy.

The Australian Government provides an income tested rebate on private health insurance to help cover the cost of premiums. The rebate can be claimed either as a premium reduction (that is, you pay less upfront to your health fund), or, as a tax offset when lodging your annual tax return. More information about the rebate and the application income tiers can be found at www.privatehealth.gov.au

Not sure if you are currently claiming the rebate? Contact your health fund to find out your rebate tier and how it is applied to your premium.

Check if a youth discount is available

Are you aged between 18 and 29? Some health funds now offer young members a discount of up to 10 per cent on selected hospital policies. This initiative, led by the Australian Government, has been designed to make private health insurance more affordable for young Australians and increase their ability to access private hospital services.

The discount is between 2 per cent and 10 per cent, depending on when a health insurance policy is purchased between the age of 18 and 30. The discount is then retained until age 41, after which it reduces at 2 per cent per annum until age 45.

It is voluntary for health funds to adopt this initiative, so it's worth checking if your health fund is providing this discount. At Doctors' Health Fund, we have supported this initiative and have made it available on all our hospital covers for eligible members.

Understand your medical gap cover to minimise out-of-pocket expenses

Many health funds have medical gap cover agreements with doctors and healthcare providers to help cover some of the medical gap fees that can be incurred as part of a hospital admission. Gap fees occur when a doctor charges above the Medicare Schedule Fee for their services, and medical gap cover is in place to help cover some or all these additional fees.

Understanding if your health fund offers medical gap cover, and how it works, can be an effective way to save on your health insurance costs.

Doctors are free to decide on a case-by-case basis whether to use a health fund's medical gap cover arrangement, and are not obligated to participate. Have an open discussion with your doctor about your treatment prior to admission to ensure you understand their charges, and whether using your medical gap cover is an option. It's also a good idea to speak to your health fund before any admission, to ensure you will be covered for the procedure and understand any associated costs.

At Doctors' Health Fund, all our hospital policies include great value medical gap cover. This includes our high-end hospital cover, Top Cover Gold, which uniquely covers up to the AMA List of Medical Services and Fees and offers the greatest protection from out-of-pocket costs. Treating practitioners are not required to 'opt-in' to this arrangement, and medical fees will be automatically covered if charged according to the AMA List of Medical Services and Fees or less.

Established by the AMA in 1977, Doctors' Health Fund provides health cover to members of the medical community and their families. To view cover options or get in touch with our expert team, visit our website www.doctorshealthfund.com.au

doctors health fund

Avant mutual

Energis, supporting healthcare businesses to reduce energy costs and improve environmental sustainability

In this changed world there is increased awareness in regards to keeping businesses streamlined and efficient.

Energy bills have continued to increase with a 30 per cent rise over the last four years alone. These increases are set to continue well into the future. What can you do for your business to halt these increases and reduce your carbon footprint? Look no further than solar!

There are many reasons to choose a solar system for your practice or medical centre and so many reasons to do it today. Many businesses who have previously taken the initiative to install solar power continue to see ongoing benefits both financial and, more importantly, environmental.

An example of a business which made a wise choice in 2015 is The Health Care Centre in Morwell. Since having Energis install a 50kW solar system and replacing their old fluoro lights with efficient LED lighting, the business' electricity bills have been slashed by $1850 per month. Five years on, that's over a $100,000 in achieved savings! This is also accompanied with an estimated carbon offset of over 390 tonnes. This is a win for the centre's finances and a win for the environment.

The Health Care Centre's owner, Mr Teddy Apostle says, "We're very happy with the product and service supplied. I have recommended and will recommend Energis in the future".

Currently, there are several major points which show why taking action now will result in an immediate decrease in electricity bills, coupled with positive environmental impacts which will bring your business ongoing and long-term benefits.

- Federal Government STC Solar Incentive is available to all businesses and generally this will cover approximately 30 per cent of the total cost of a solar system.
- The Instant Asset Tax write off has been extended until 31 December 2020 for assets up to $150,000. Don't delay, do it today!
- Flexible finance options which enable businesses to install now with no adverse effect on finances. Many businesses will show a positive return from day one.

Energis is a leading corporate energy solutions specialist with exceptional experience working with businesses on customised solar power and intelligent energy management solutions. We have completed many successful projects for hospitals, medical centres and GP clinics across Victoria.

Via our partnership with AMA Victoria you can take advantage of a free sustainable energy audit for your business plus 7 per cent discount on all projects.

Speak with us about your project today!

Contact:
Andrew Blackburn 0424 818 884 or
Sheridyn Lynch 0412 708 344

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Kirsty Houston has a unique expertise as both a practice and finance manager for successful practices at Cabrini and Epworth Hospitals in Melbourne and for doctors at The Avenue, Holmesglen, Monash, Werribee Mercy, Western Private and Masada Hospitals.

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Better Billing Services offers the expertise from working with a wide range of medical practices each with specialist needs and requirements. We offer experience in bookkeeping, medical practice management, Medicare, DVA and health fund billing. We have the skills and experience to remove and manage the sometimes complex requirements of medical billing from you.

Better Billing Services can either login to your existing medical software or take care of your billing using their own secure, cloud-based software, Zedmed. Our software can verify the health fund and Medicare details of each patient before lodging claims. Better Billing Services has experience in clean-up/audits of medical billing to find those lost dollars.

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1800 979 679

To discuss the needs of your practice in confidence - please call Kirsty Houston at Better Billing Services on 1800 979 679,

Email betterdrbilling@gmail.com or visit betterbillingservices.com.au

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The EV question

With Audi entering a new era of mobility with the launch of their first all-electric e-tron models, we answer the most commonly asked questions from those looking at owning their first all-electric Audi.

Last month, Audi Australia introduced the brand's eagerly anticipated, first all-electric vehicles to the Australian market. The Audi e-tron SUV and e-tron Sportback marked the start of an e-offensive that will see a comprehensive range of new electric plug-in vehicles introduced over the coming years, with a global goal of developing and producing as many as 30 electrified models by 2025.

While this is exciting news, for many it constitutes unchartered territory surrounding the all-new technology and what that means to them in real world situations. Certainly, all-electric vehicles have been around for some time, but not everyone has had the experience of driving this style of vehicle. Even those who have will understand that the brand's approach to e-mobility with the e-tron models is new in Australia and brings a wealth of new technology, faster charging and greater range than ever before. So here are some of the most commonly asked questions surrounding electric drive and what it will mean to drive an Audi e-tron.

How long will it take to fully recharge an Audi e-tron 'on the go' in Australia?

Both the Audi e-tron 50 and e-tron 55 will take approximately 30 minutes to charge to 80 per cent of their capacity or 45 minutes to charge to 100 per cent using the ultra-rapid charging stations available around the country.

What range can I get from a fully charged battery?

As with a tank of fuel, range will depend on the style of driving, terrain and what other demands are made on the battery, but with its 95kWh battery, a fully charged Audi e-tron 55 quattro can deliver over 400km range. The Audi e-tron 50 quattro with its 71kWh battery can deliver in excess of 300km. Both models also recover energy during the course of driving which can extend range further.

How do I charge my e-tron when I'm away from home?

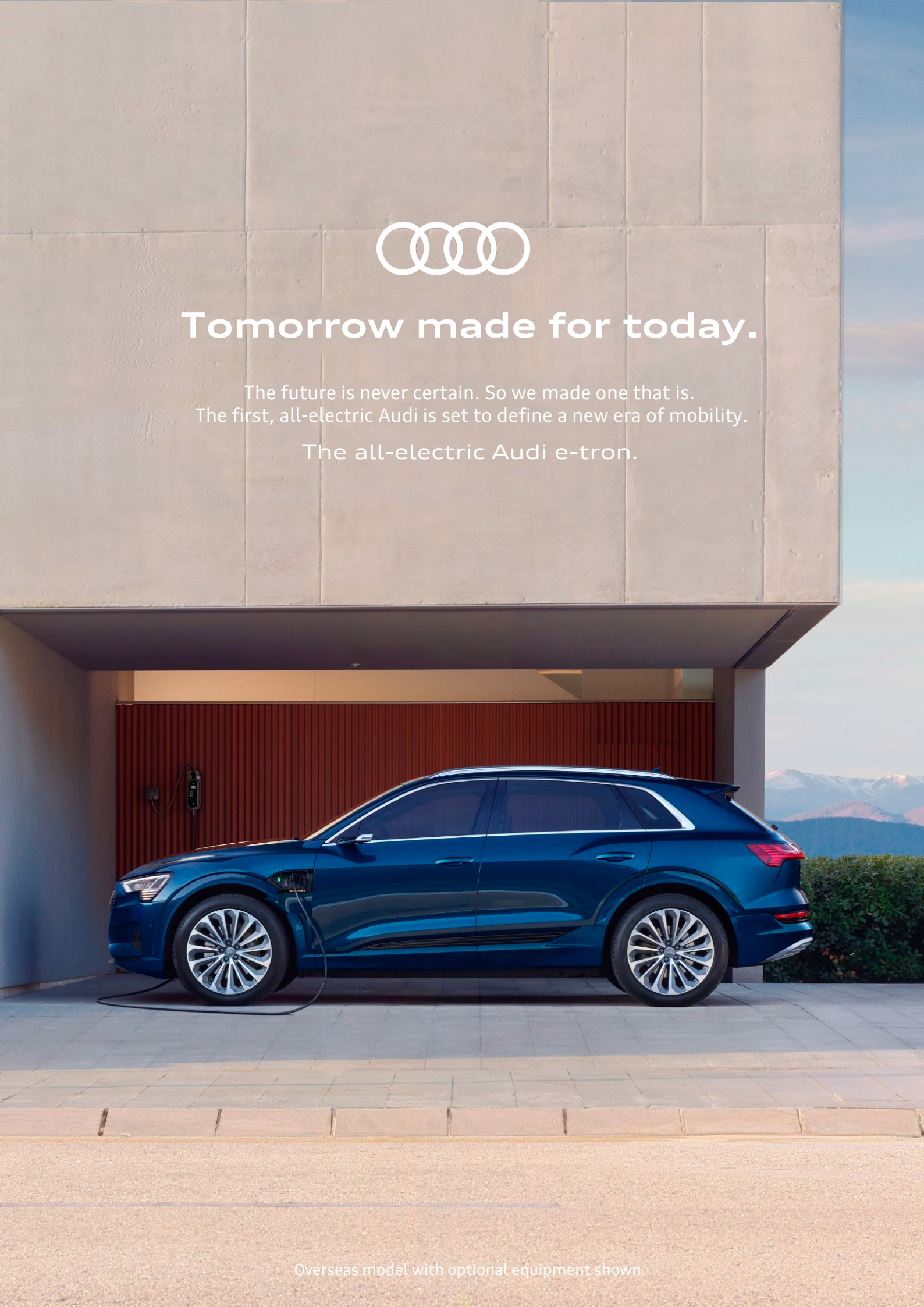
The Audi e-tron comes with a six-year subscription to the Chargefox charging network which boasts an extensive, nationwide network of chargers where e-tron owners have access to ultra-rapid and selected fast and standard chargers.

What would I do if I found myself away from home with no charge?

The Audi e-tron comes with six years roadside assist. Given the proliferation of charging units around the country it's unlikely you'd ever find yourself with no charge or charging options. But if the unthinkable should happen, Audi roadside assist can tow the vehicle to the closest 'high performance' charging station or closest Audi dealership.

What is involved in having a charging station installed in my home and does this provide much faster charging than standard mains power?

Audi Australia has partnered with JetCharge for home or office installation requirements. JetCharge will complete a home check and provide advice on the appropriate vehicle charging infrastructure/installation relevant to your home. In most cases this will provide a faster charge rate than a standard 10 Amp power point. For example, the 11kW AC home-charging solution can charge the e-tron 55 variants from empty to full in 8.5 hours and the e-tron 50 variants in 6 hours – ideal for charging overnight.


Tomorrow made for today.
The future is never certain. So we made one that is.
The first, all-electric Audi is set to define a new era of mobility.
The all-electric Audi e-tron.
Overseas model with optional equipment shown.

A smaller than usual spring market may surprise

It's spring, which usually heralds the busiest few months of the residential property calendar. By now, the season's early sale boards should be fastened upon picket fences, presaging a steady fattening of listings in the weekend papers and online portals.

In Sydney – and to a lesser extent, Perth – there are some early signs a fresh supply surge will happen in spring. New listings hitting the market in late August were up seven and five per cent respectively on the same period 12 months earlier in these cities, according to CoreLogic. Elsewhere it is varying shades of winter bleakness. Single digit drops of fresh supply in Canberra, Adelaide and Brisbane (down four, six and eight per cent respectively) are chilling enough, while Hobart, Darwin and Melbourne (down 19, 38 and an extraordinary 59 per cent respectively) are still frozen in deep mid-winter.

The lack of new stock would not matter too much if there was a surplus of unsold existing stock. But there is not. Remove Sydney – an outlier, with total stock levels effectively steady – and average capital city listings are down 19 per cent since 12 months ago. Melbourne leads the pack with just a 13 per cent drop in overall supply – likely caused by pandemic second wave restrictions all but stopping transactions in August and September.

Other capitals are down between a fifth to a third of the equivalent 2019 stock levels. These are remarkable falls and puts total stock at levels one usually associates with the depths of the summer holidays! Not even Perth is saved by the new stock surge mentioned earlier – total stock is down 25 per cent in the western capital.

Clearly, property owners outside of Sydney are unusually wary about selling, despite comparative little competition. This disengagement from the market has been interpreted as a concern about losing money. That is true but is an incomplete answer. If people were truly fearful, there would be evidence of panic selling. There is not. Rather, there is a tactical worry that the pandemic might take a temporary turn for the worst in their city mid-sale campaign. But overall, there is a wait-and-see attitude. Owners expect the economy and market to recover but want both to be on firmer grounds before making their own commitment.

Turning to demand, borrowing in July was 12 per cent higher than 12 months before, according to the ABS, despite the first wave having only recently ended. First home buyers led. Since then, employment has steadily improved over winter everywhere except Melbourne, according to recent Department of Treasury numbers.

In short, demand has been resilient throughout the pandemic. And with mortgage three-year fixed interest rates of just 2.3 per cent (around 100 basis points lower than 12 months ago) according to the Reserve Bank, it's reasonable to expect a steady stream of new buyers to emerge from the fortunate and sizeable pool of Australians not affected by JobKeeper or JobSeeker, although banks' slow and tortuous mortgage approval processes remains a drag on the scale of the buyer recovery.

It is true there are some persistent challenges for the property market – namely the impact on demand of reduced immigration, which is likely to persist until there is a vaccine (though somewhat mitigated by falling new supply). Yet as long as we can avoid a third wave in Melbourne – and a major second wave elsewhere – or a shock reversal in governments' willingness to support furloughed workers, the most likely path for the spring property market in most cities will be low volumes and steady prices.

Richard Wakelin
Founder
Wakelin Property Advisory

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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 Vicdoc Editor, Barry Levinson. We are also very keen to hear any other feedback on Vicdoc – particularly your thoughts on the new digital version or ideas on how we might improve the publication.

Email: BarryL@amavic.com.au
Phone: (03) 9280 8741
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COVID-19 concerns and feedback

We thank AMA Victoria members for providing ongoing feedback on the response to COVID-19. Your continued feedback is vitally important so that AMA Victoria can know the issues you are facing and can then advocate on your behalf.

All feedback is viewed and acted upon. Views are being collated and passed through to the President of AMA Victoria and AMA Federal (for federal issues) who are in regular contact with the relevant departments and ministers' offices.

Please email covid19@amavic.com.au

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