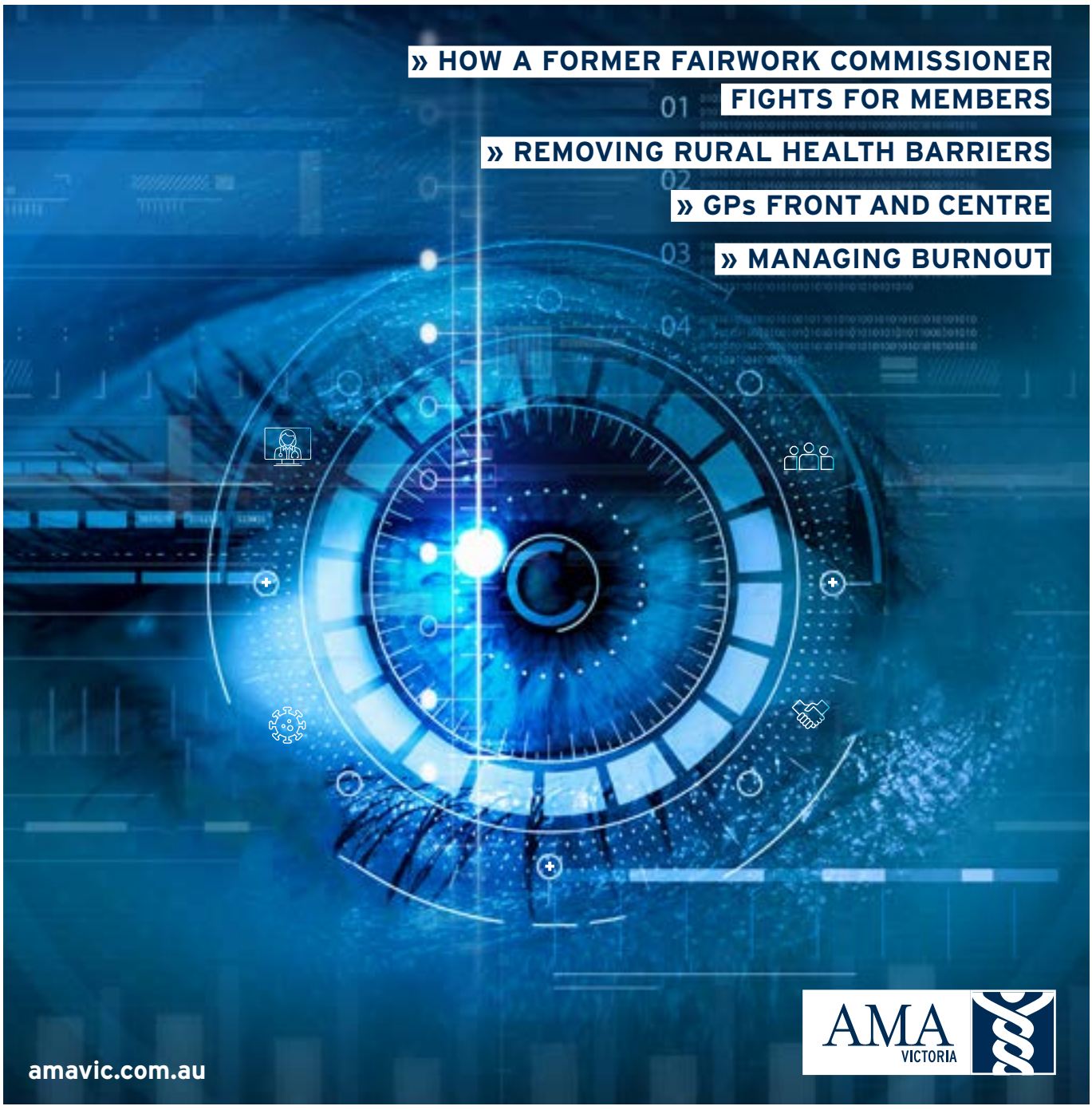
VICDOC

AMA VICTORIA

OCTOBER 2021

INSIGHTS INTO THE WORLD OF ADVOCACY



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Look for this symbol and click for more information; websites, podcasts, videos etc

References to articles available from the Editor on request.

AMAV ADVOCATES FOR BOOSTERS FOR HEALTHCARE WORKERS

DR RODERICK McRAE

AMA Victoria President

The current pandemic has undoubtedly pushed everyone to the brink.

I understand that the issue of a third booster dose of COVID-19 vaccine for healthcare workers is front of mind for many members. I share that view.

AMA Victoria has asked the Australian Technical Advisory Group on Immunisation (ATAGI) to substantially bring forward its timeline for considering and recommending a third/booster dose of COVID-19 vaccine for 1A high-risk workers, including healthcare workers, in Victoria. We have expressed to ATAGI, as well as the Federal and State Governments, that the current timetable will leave many healthcare workers in Victoria with potentially significantly waned immunity at a time when COVID-19 transmission in the community is likely to rapidly increase through increased movements. We argued that individual healthcare workers, the healthcare workforce as a whole, and patient care, would all be jeopardised if booster doses are not made available as a matter of urgency.

We proposed that booster doses be immediately offered to group 1A high-risk workers as well as other 1A listed recipients given there is sufficient supply of COVID-19 vaccine available for the current population. We have requested that vaccine doses not used in the current rollout, that are about to expire or be discarded, be offered to willing healthcare worker recipients in preference to being discarded.

The last 18 months have left Victorian healthcare workers absolutely exhausted. Many of our members have not had proper breaks for this period of time.

Despite the profound challenges currently facing the medical workforce across general practice, private practice and the public hospital system, I know that all of our members are doing everything they can to ensure the best possible care for all patients with the resources available to them, and for which I thank you on the community's behalf. AMA Victoria is here to assist you as required.

Breaking news

Just as VICDOC was being published, Federal Health Minister Greg Hunt announced the country's coronavirus booster program will begin no later than 8 November, pending final advice from ATAGI, with Australians in aged care and disability a priority.

Please email us at: amavic@amavic.com.au if you have feedback or want to raise concerns about how the health system is coping, or how you are coping as frontline workers. Let us know what you need. Your feedback always informs our advocacy to government.

Be assured of our support as we navigate the coming months together.

VICDOC

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NEWS, VIEWS ⊕ REVIEWS

Would you like to share your thoughts, suggestions and views with us?

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

AMA SOCIAL

AMA Queensland
Some great advice from our Victorian counterparts: Added pressure on healthcare systems during #COVID19 is tiring and exhausting our healthcare workforce. As this pandemic will be with us for quite a long time, it is essential that all healthcare workers, including doctors, pace themselves and make adequate rest a priority.

Dr Kieran Allen @kidsankyran
It's more complicated than "wellbeing". Thanks to @amavictoria for sharing my story about living with a relapsing mental illness. #MentalHealthMonth #MH4Docs

Rob Phair @robphair @RuralDocsVIC has met with @amavictoria, @GPRALtd, @GPRAPresident and @GPSupervisors this week to discuss GP VMO contracts in Victoria, as well as other shared interests. I can report that we found ourselves in strong general agreement. Onwards & upwards! @VicGovDH

COVID-19 EXPOSURE CHANGES FOR GP CLINICS

In recent weeks, AMA Victoria, and particularly our Section of General Practice, have been advocating extensively, both publicly and privately, on the issue of general practice closures due to COVID-19 exposure, and have urged the Government to adopt a more proportionate, risk-based approach to ensure access to vital primary care. On 7 October, we received a pleasing update from the Victorian Department of Health, representing due recognition of our tireless advocacy on this issue.

Click here to read more

PREPARE FOR SWAMPED HOSPITALS, SAYS AMAV

Victoria's health system needs to prepare for coronavirus patients swamping hospitals well into next year, AMA Victoria has warned. While there is a current focus on COVID-19 patients overwhelming the already under-pressure health system, AMAV Vice President Dr Sarah Whitelaw told the *ABC* preparations needed to be made for what would happen when the virus became endemic after the country reopens.

Dr Whitelaw, an emergency physician at Royal Melbourne Hospital, said there needed to be better coordination between State and Federal Governments, especially given GPs would need to play a greater role in looking after non-acute patients as hospitals were overrun.

Click here to read more

MENTAL HEALTH LAW REFORMS WILL UNDERMINE PATIENT CARE

Australian Doctor recently featured an article regarding our concerns around proposed changes to mental health legislation in Victoria:

"Patients with deteriorating mental health will slip through the cracks under legal changes proposed by the Victorian Government, AMAV says. *Victoria's Mental Health and Wellbeing Act* is being redrafted so patients can only be placed under involuntary treatment orders in the case of 'serious psychological distress'. It is a more limited requirement than the current criteria of 'serious deterioration' in a patient's mental or physical health.

*Click here to read more**
** subscriber only*

Information on our position on the proposed reforms

BREAKTHROUGHS

REPORT + READ + WATCH + LISTEN

NEW RESEARCH IMPROVES SCREENING EFFICIENCY FOR TYPE 1 DIABETES

Researchers from Melbourne have led a global collaboration to develop a simplified blood test that increases the overall screening efficiency for type 1 diabetes. Current screening methods to identify those who are at risk are costly and logistically difficult.

The study, led by researchers from the Royal Melbourne Hospital (RMH) and the Walter and Eliza Hall Institute of Medical Research (WEHI), showed that a single finger prick blood test could be used in place of the current method of multiple venous blood samples during a two-hour oral glucose tolerance test.

Researchers have analysed data from four different studies from participants aged two to 45 years and in their first and second stage of the disease.

The group of researchers, from Australia, Sweden, Canada, United States and Germany, compared a large number of oral glucose tolerance tests from 3,500 people throughout the course of many years.

The study, led by RMH endocrinologist and WEHI clinician-scientist A/Prof John Wentworth found the simple blood test was able to provide the same information and was far less invasive, particularly for young children.

"For several years, we have believed that multiple blood samples increased the accuracy of the oral glucose tolerance tests," A/Prof Wentworth said. "What we found, is that the blood sample taken two hours after the glucose drink predicted a clinical diagnosis with high accuracy."

Information collected from the study will lead to improved screening efficiency and early diagnosis and treatment for type 1 diabetes.

The work was made possible with support from JDRF, the Australian National Health and Medical Research Council and the Victorian Government.

> *"... a single finger prick blood test could be used in place of the current method of multiple venous blood samples during a two-hour oral glucose tolerance test."*

THE INVISIBLE LIFE OF US

Kate Jones & Mandy Hose

Kate and Mandy have experienced the highs and lows of parenting – and wouldn't change a thing. The pair met a decade ago and bonded over their premature twins with additional needs. As they grew closer, they confided that they often felt lonely because nobody was talking about what life was like for families like theirs. It was time to give their community a voice.

So began *Too Peas in a Podcast*, a conversation in which they discuss the surprises, challenges, and joys of parenting twins with additional needs. It was meant to support multiple-birth parents and those of children with disabilities, but they were shocked to discover health professionals, teachers and even people without kids were listening.

Now, sharing their story in this book, they delve deeper into the issues they care about and offer reassurance for those navigating a child's disability. They write candidly, and above all, they convey immense love for their children.

TEN WAYS TO HAVE A BETTER CONVERSATION

Celeste Headlee

In this short Ted Talk, Celeste Headlee shows us 10 immutable ways to conduct a better conversation. There is no doubt that every conversation has the potential to lead to an argument.

For any practitioner wishing to excel in conversational competence, this Ted Talk is a must view. In fact, it's so good, you could share this talk with your whole family.

After many views, it is this reviewer's opinion that all points are worth memorising, with the most powerful being points 1, 2, 6 + 9.

Find out how learning to ask open-ended questions can dramatically change your doctor-patient relationship.

I have no doubt you will enjoy this talk and get a lot out of it.

CAUTIONARY TALES

Tim Harford

We've always warned children by telling them unsettling fairy tales to teach them life lessons, but these *Cautionary Tales* are for the education of the grown-ups – and they are all true. Tim Harford (Financial Times, BBC, author) brings you stories of awful human error, tragic catastrophes, daring heists and hilarious fiascos.

Oil tankers crash in broad daylight, vital military ideas are carelessly given away to the Nazis, and a shouty man in a uniform pulls off an audacious heist. Alongside the drama, each story has a moral that emerges from psychology, economics, even design. They'll delight you, scare you, but each story will also make you wiser.

Click here for the TED Talk

ADDITIONAL RESOURCE

Kate Jones and Mandy Hose have also produced 'Letters to You – A booklet of hope for parents' which they have written with other parent advocates of children with additional needs. Some health professionals find it useful to give a copy to parents at diagnosis time.

Click here to order free copies

ENQUIRY

ON THE ROUND

Six questions about work & life

DR PAUL MACKEY

Rural Family Practice Anaesthetist

AMAV member based in British Columbia, Canada

01 Can you briefly summarise your role in medicine?

I received my MBBS from Melbourne University in 1989 and then obtained a Diploma in Obstetrics (DRANZCOG) and a Diploma in Anaesthesia (MRCA (UK)). I worked as a full-service Rural Family Physician in Fort St John, British Columbia (BC) for 20 years. During that time, I developed and was Site Director for the UBC Family Practice Residency Program for seven years. I've done brief stints of volunteering at Karanda Mission Hospital in Zimbabwe and Bwindi Community Hospital in Uganda. I currently provide dental anaesthesia several days a month for a maxillofacial surgeon and I locum for rural family practice/anaesthesia physicians, primarily in BC but occasionally in other provinces and in the Arctic.

02 How have you maintained resilience and balance over past two years?

We are extremely fortunate that Kamloops, BC, where we have lived the past four years, offers easy access to outstanding downhill and cross-country skiing, mountain biking, hiking and paddling. The explosion of medical, scientific and behavioural information during the pandemic has presented the opportunity for a lot of learning. Learning new pieces of music on the piano and guitar and participating in a virtual physicians' choir has provided a relief. I worked as an immuniser in the large community COVID-19 vaccine clinics held in Kamloops and surrounding communities and that made me feel I was directly helping to stem the pandemic. Like many other people, I have tackled 1000-piece puzzles and delved deep into series on streaming services with my wife and our youngest daughter.

> "The explosion of medical, scientific and behavioural information during the pandemic has presented the opportunity for a lot of learning. Learning new pieces of music on the piano and guitar and participating in a virtual physicians' choir has provided a relief. "

03 How have the added challenges impacted your life away from work?

My eldest daughter's wedding in September 2020 had to be changed to an immediate family-only event, and that was disappointing for her and her husband, as well as for us. My father in Melbourne has undergone two major surgeries during the pandemic and it has been difficult to know that I could not immediately travel to Australia if the situation warranted. My father-in-law died in 2020 and his funeral had to be very small and interring his ashes was delayed a full year until a larger event was feasible. I miss participating in the local drop-in ukulele and guitar groups as well as the community choir, which was supposed to travel to New York last year. I also miss attending concerts and other live events.

04 What are you most optimistic about for the next year ahead?

I'm somewhat optimistic that Collingwood will finish higher on the ladder next year.

05 What do you value most as an AMAV member?

In 2017, I worked as a family physician in an under-serviced community in Tasmania. I encountered an issue with my Medicare payments as my full credentials were not being recognised and I was not being reimbursed correctly. The AMA was very helpful in providing me with assistance to resolve the problem. I also appreciate the *MJA* and emails as a way to stay current with research as well as issues of interest in Australia.

06 What are you most proud of at this stage of your medical career?

I'm most proud of my role in educating medical students and family physicians. Several of my former family practice residents work in remote, rural parts of Canada and this is very gratifying. I also reflect proudly on the efforts I made to convert the family practice clinic in Fort St John to an electronic medical record system in 2007 and the collaboration I was part of to introduce the same system at the hospital in Zimbabwe and build capacity there.

Click here for Twitter

SECOND OPINION

ASK THE EXPERT

How did you prepare for retirement?

DR ANDREW ROBERTS

Vascular surgeon

Initially with great difficulty, but finally very happily. It was not until I was in my 60s that I really even thought about it. Fortunately, my wife (a nurse and my practice manager) and I were able work through many of the uncertainties that retiring raised. I doubt that I could have done it without her help and support.

I had several doubts. Can I afford to? Why was I retiring while still very busy as Unit Head in a University Teaching Public Hospital with many teaching and other commitments? I was actively involved in College of Surgeons and Specialist Societies' activities. Would I miss the contact of my surgical friends and colleagues, the camaraderie of the public and private hospitals in which I worked? Would I feel deflated or be troubled by the loss of perceived status or position?

Having talked through all of these concerns over many months and attending 'Preparing for Retirement' seminars, then conducted by the College of Surgeons and reading many articles published by the AMA and also my medical defence insurers, the decision was made.

I was able to retire, without apprehension or reservation but rather, with a very positive mindset, that I was about to enter the next phase of my life rather than feeling I had one foot in the grave!

Happily, in the last nine years since retiring completely from any surgical practice or medical administrative work, life has been amazing! Highlights include: seeing so much more of family, particularly grandchildren, and friends; reading for pleasure, gardening, golfing; participating in University of the Third Age (U3A) activities in person or online; and many other activities. How did I ever have time to work?

DR SUZANNE SILBERBERG

Endocrinologist

Being a perfectionist procrastinator, like many of us, this meant that I hadn't considered retirement until I formed the opinion that I would quite like to.

When speaking with a psychiatrist I was referring a patient to for treatment, we developed a rapport and I thought this doctor was so lovely that I too would benefit from speaking with them and so began my thought process. One of the outcomes of those sessions was that I realised after over 40 years of practise I was tired and ready to step away, being very much at peace with this decision, and being the natural step to take.

Whilst I will miss the daily camaraderie with colleagues and my patients, I'm looking forward to reconnecting with my interests and passions outside of my profession – of which there are many – spending more time with family and friends and fully embracing this meaningful and fulfilling next chapter of life.

DR KATE DUNCAN

Obstetrician

As a young medical student in the 70s, I was told by a member of the profession that medical training was wasted on women as, "All they do is go off and get married". Given my contrary nature, I immediately decided that I would work full-time until at least 65! So, after 35 years of 24/7 on-call as an obstetrician in private practice, I just retired at the end of the financial year.

Big changes need adjustment. I tackled the mental side first, working with my psychologist for the last two years to change my priorities and self-image. I have succeeded to the point where I only need one mobile phone (not two) and can now leave it on the bedside table occasionally.

Financially, retirement has been hugely expensive. I had set aside funds to pay long service leave to my staff ($50,000-plus). To work part-time as a surgical assistant (and earn about 3 percent of my former income) I have had to maintain registration, college fellowship and medical indemnity insurance. This has required me to pay my own 'run-off' cover and would have cost $32,000 for each of the first three years, had I not changed funds and applied for the premium support scheme.

The alternative was to cease medical practice abruptly and completely. Had I done this, it would a been a profound and echoing loss, not just a 'big change'.

If you would like to feature in Second Opinion email vicdoc@amavic.com.au

"Whilst I will miss the daily camaraderie with colleagues and my patients, I'm looking forward to reconnecting with my interests and passions outside of my profession – of which there are many – spending more time with family and friends and fully embracing this meaningful and fulfilling next chapter of life."

Dr Suzanne Silberberg

GENERAL PRACTITIONERS FRONT + CENTRE

The Victorian State Government is finally listening to general practitioners. It is a positive step, says Dr Mukesh Haikerwal but there is still more work to be done.

REPORT **TARYN SHEEHY, AMAV DIRECTOR OF COMMUNICATIONS + ADVOCACY**

- In 2020, many general practitioners felt sidelined by the State Government in the fight against COVID-19.
- AMA Victoria has played a significant role in bridging the gap between general practitioners and the State Government.

In January 2020, AMA Victoria State Council Chair and former AMA President, Dr Mukesh Haikerwal looked on in despair as bushfires raged in Victoria. He wondered, as he had for decades, why general practice was not considered part of the chain of emergency response.

Victorian state disaster planning had traditionally excluded general practitioners but Dr Haikerwal always knew there existed a real opportunity to harness the valuable skills of a comprehensive primary care practitioner into a coordinated state system approach.

In an *MJA* paper that same month, Dr Haikerwal and Dr Lena Sanci stated that general practitioners have a vital role in responding to healthcare during disasters. That same paper argued the case for video consultation.

It was prophetic for just one month later Australia would start preparing itself and its healthcare system for a once-in-a-lifetime pandemic and the need for telehealth would become more important than ever.

THE INTRODUCTION OF TELEHEALTH

Dr Haikerwal says the introduction of telehealth was fundamental in continuing to provide healthcare to the community once COVID struck. "You suddenly really needed to do telehealth because it was a way of getting access to services whilst keeping the practice safe and clean," said Dr Haikerwal. "The Commonwealth came to the party but the original offer was pretty bad. We transformed it into a useful offering and that's the AMA, obviously working with others, but really working behind the scenes to make that happen," said Dr Haikerwal.

ADVOCATING FOR INVOLVEMENT OF GENERAL PRACTITIONERS IN THE STATE'S HEALTHCARE RESPONSE

In July 2020, many general practitioners continued to feel sidelined by the State Government in the fight against COVID-19.

AMA Victoria made these points in its submission to the Public Accounts and Estimates Committee in July 2020, strongly emphasising that there had been a lack of support from the State Government for general practitioners over many years and that general practitioners needed a much stronger dialogue with the State Government for more effective planning, model development and enactment, collaboration and feedback. The submission stated that, "in a pandemic, we see that disconnect and stress play out very clearly, whereby GPs are ignored or excluded from our disaster preparedness."

During that same month in his Altona North practice, where COVID-19 cases had gone from zero to 18 positive cases in three days, Dr Haikerwal and his staff experienced this disconnect acutely.

Expressing his frustrations publicly on behalf of general practitioners, Dr Haikerwal told the media that general practitioners were being completely ignored in the state's COVID-19 response, despite being ideally placed to help.

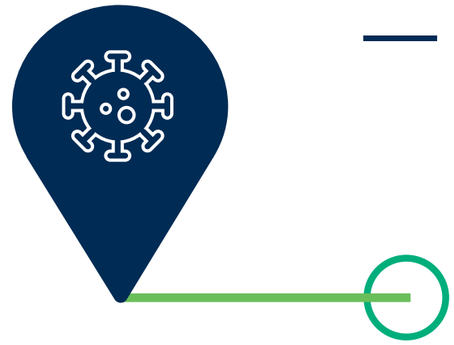
He urged the State Government to provide information to general practitioners about cases in their neighbourhoods and to ensure everybody working in the healthcare system was properly engaged and informed about when their patients had tests and their test results. He pleaded for clarity around quarantine rules and isolation requirements and guidance on contact tracing. "It had been hopeless to that point," said Dr Haikerwal. "We had the military trucks coming down and members of families all receiving different accounts of what was going on from the Victorian Department of Health."

Dr Haikerwal rang Victoria's Chief Health Officer, Prof Brett Sutton and said, "I've got a good database. I can map for you where these cases are and we can do something," and that was when the first intervention in Hobsons Bay occurred.

That was the turning point, according to Dr Haikerwal. "The State Government finally started working with general practitioners and with local government to put interventions in place to support local people. We began working together to understand why people weren't getting tested and what the barriers were for them when isolating. We advocated for standardised and comprehensive hymn sheets so everyone sang the same words. General practice and the AMA were a big part of that push to make sure that the right messaging was happening, the right information was being given and people were supported through this and it wasn't punitive," said Dr Haikerwal.

THE CURRENT RELATIONSHIP BETWEEN GENERAL PRACTITIONERS AND THE VICTORIAN STATE GOVERNMENT

Dr Haikerwal reflects that the relationship between general practitioners and the Victorian State Government is still very exploratory but much more positive and mutually respectful. "They're actually coming to us proactively now to work through issues such as how we manage care for patients with COVID-19 out of hospital and how we manage an influx of COVID-19 cases in the community. So they're actually thinking this way now. They're thinking about how to work with general practice. It had never in a month of Sundays been part of the thinking before."



IMPORTANT ADVOCACY ACHIEVEMENTS FOR AMA VICTORIA

Whilst AMA Victoria played a significant role in bridging the gap between general practitioners and the State Government, Dr Haikerwal believes another advocacy achievement was just as important. "AMA Victoria was advocating for COVID-19 to be treated as an airborne disease long before it was fully accepted. Some very significant changes were brought about as a result of this advocacy," said Dr Haikerwal. "Specifically, that all healthcare workers should be afforded proper personal protective equipment. "The state scheme in hospital changed in front of any other jurisdiction and it kept healthcare workers in Victoria safe and AMA Victoria ought to be proud of that."

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

AMA Victoria Advocacy update

A NOTE FROM THE POLICY DESK

REPORT **LEWIS HORTON, AMAV SENIOR POLICY ADVISER**
DELWYN LAWSON, AMAV POLICY + ADVOCACY OFFICER

FIT TESTING ACCESS FOR GENERAL PRACTICE

AMA Victoria has asked the Federal Health Minister to facilitate improved access to appropriate personal protective equipment (PPE) and fit testing for general practitioners. We advised that our GP members continue to face issues regarding supply of P2/N95 masks. We noted that the Primary Health Networks (PHNs) advise primary care providers to source their PPE through their normal commercial means in the first instance. AMA Victoria urged that, with case numbers escalating across the state, GPs need assurances that they have reliable and adequate access to PPE.

We also raised the lack of support for GPs when it comes to accessing fit testing. In addition to managing their practice load, playing an integral role in the vaccine rollout, and providing care to an increasing number of COVID-19 patients in the community, GPs are currently expected to organise their own fit testing. We proposed that a more coordinated, centralised approach is needed with PHNs being best placed to facilitate this. We argued that Victorian GPs must be assisted in every way possible to continue to safely offer patient care during the pandemic.

URGENT MEASURES REQUIRED TO SUPPORT VICTORIA'S HEALTHCARE WORKERS

We have written to the Victorian Department of Health requesting that it urgently implement several measures to support Victoria's healthcare workers in this time of crisis:

- **Implementation of disaster management principles/ expertise**
  We urged the Department to engage the services of Victorian disaster medicine experts to supplement clinician input around how to best manage these unprecedented circumstances.
- **Leadership in relation to discussions around essential care**
  We pointed out the need to take note of lessons learned overseas in relation to burnout and moral injury in healthcare workers. We asked the Department to give health service management and clinical unit leaders permission to discuss with their staff what is now "essential", and what will no longer be possible, rather than leaving individuals to take responsibility, make decisions, and bear the brunt of system overload.
- **Additional support for staff and grieving families**
  We asked the Department to provide additional support (in the form of social workers, grief counsellors, and other resources (both on and offsite)) for families impacted by hospitalisation and 'no visitor' policies. We suggested that this support would help grieving and vulnerable families as well as protecting staff and allowing them to safely provide care to their patients. Leaving staff unsupported to deal with family grief, anger and fear leads to substantial stress and trauma.
- **Recognition of the impact of repeated requests to work more shifts**
  AMA Victoria members have reported that the current workforce shortage is leading to constant, unrelenting requests for staff to work more and more shifts. We recommended that leadership is needed from health services and the Department in supporting staff to not work beyond their physical and mental capacity. We noted that it is not acceptable to leave the onus on individual staff to repeatedly turn down shifts, knowing the impact this will have on their colleagues.

  Importantly, we highlighted to the Department that, in implementing these measures, care must be taken to not divert healthcare workers away from the acute healthcare system and that the Department and health services should support staff with the use of non-clinical resources.

COVID POSITIVE PATHWAYS

We have recently written to the Victorian Government urging increased resourcing for COVID Positive Pathway Programs. In light of the epidemic growth rate, it is a matter of simple necessity that Victoria uses general practice more effectively to prevent hospital admissions via such pathways.

North Western Melbourne Primary Health Network (NWMPHN) has such a pathway that was developed in the second wave last year. Essentially, how this pathway operates is that CoHealth conducts the triage for NWMPHN (they perform a clinical assessment and risk stratification, a social and welfare needs assessment, and provide information to patients). CoHealth then hands over to either the hospital, Hospital in the Home (HITH), or the patient's usual GP as per protocol. GPs then provide care to the patient/ household contacts and also fill-in monitoring details for the hospital.

During last year's second wave, about 85 per cent of people with COVID-19 in the North Western Melbourne region received care under this model at home with a GP or CoHealth.

With increasing COVID numbers, we have put to the Government that what we now need urgently is state-wide adoption (at the very least in metro Melbourne) of such model, and appropriate resourcing to ensure its viability. AMA Victoria envisages that this model would:

- Be a well-known and understood single point of access.
- Be available 24 hours a day (so that the emergency department can refer to them when patients do not need to be admitted or go to HITH (ambulance and other GPs can similarly refer)).
- Work with the defined regions to develop escalation/de-escalation protocols.
- Link to social care and support alongside medical.
- Look after other household members (providing testing, advice and support).
- Provide for seamless patient care between the different levels of care that may be required.

Our understanding is that the proportion of low-risk patients that can be cared for in general practice is now about 80 per cent. Accordingly, if the Government gets this model supported and resourced across the state, only 20 per cent of patients will need HITH, emergency department, or inpatient care (we note that other regions have COVID-19 Positive Pathways, but they are hospital-based triage and support and don't usually involve GPs).

In addition to taking pressure off our already over-stretched hospitals, our view is that adoption of such a model would prevent otherwise avoidable deaths. And we have expressed to the Government that, unfortunately, it is a simple reality that without more resources to safely monitor patients and ensure they have the medical care and social support that they need, lives will be placed at risk.

LOCAL ADULT AND OLDER ADULT MENTAL HEALTH AND WELLBEING SERVICES

The Victorian Department of Health has concluded the initial phase of its consultation on the establishment of up to 60 Local Adult and Older Adult Mental Health and Wellbeing Services. The establishment of such services was one of the reforms recommended by the Royal Commission into Victoria's Mental Health System.

In the Department's telling, these services are intended to provide easier access to treatment and support for people aged 26 years and over experiencing mental illness or psychological distress, and those who may also have issues with alcohol and other drug use. The Department says these new services will act as a 'front door' to the reformed mental health system; allowing Victorians to access the care they need sooner and in their own community.

In response to the Department's invitation to provide feedback, we expressed our view that these services should not duplicate what is done already in the primary care and private sectors. Instead, they should target those who 'fall between the cracks' (for example, particularly disabled or unwell people, or those who have difficulties attending a GP) rather than people who could be effectively managed in other parts of the health system. Moreover, we informed the

Department that the services need to be able to recognise who is best managed in other services and have the linkages and support to provide that transition, and that the clinical culture, skills and experience to manage the most complex or disabled 'missing middle' patients will be necessary. Importantly, these should not be solely early intervention centres, taking on new people at the onset of illness.

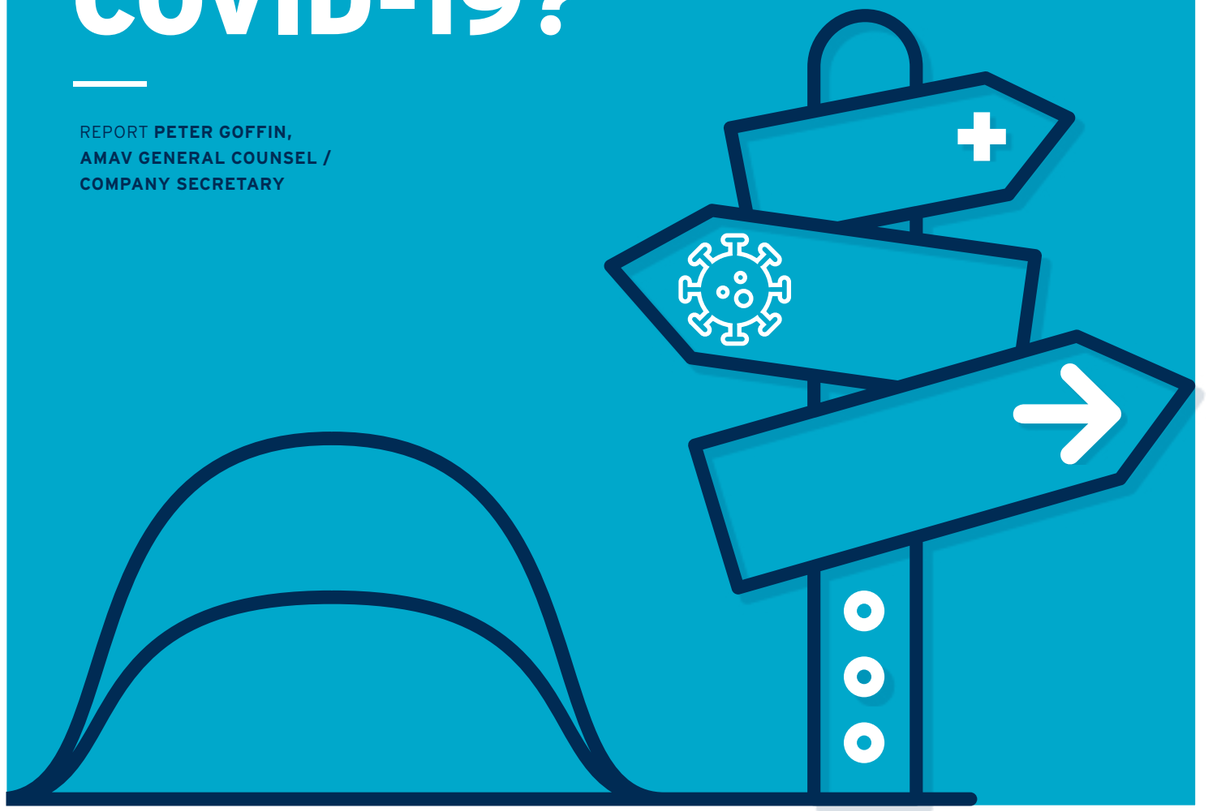
We also noted that many mental illnesses are relapsing and remitting, and the most vulnerable are forgotten and poorly supported. Accordingly, there should be capacity to support and manage patients treated in acute area mental health services intensively, who have been stabilised and are to be stepped down in care once improved.

Here's an update from AMAV Council

> *"Dr Price argued for a move from a competitive to a collaborative mindset and with leadership that focussed on patient care."*

WHAT WILL HEALTHCARE LOOK LIKE BEYOND COVID-19?

REPORT **PETER GOFFIN, AMAV GENERAL COUNSEL / COMPANY SECRETARY**



Members of the AMA Victoria Council enjoyed a special presentation at the September meeting on 'Healthcare Beyond COVID-19', compered by Council Chair Dr Mukesh Haikerwal AC. The guest list of senior public health bureaucrats and medical practitioners included:

- From the Victorian Department of Health, Deputy Secretary Ms Jodie Geissler, Deputy Secretary Public Health Dr Zoe Wainer and Chief Aboriginal Health Adviser, Ms Nicole McCartney.
- From the Commonwealth Department of Health, Deputy Chief Medical Officer and Principal Medical Advisor, Prof Michael Kidd AM.
- The President of the Royal Australian College of General Practitioners, Dr Karen Price.
- Rural Doctors Association of Victoria Council representative, Dr Carolyn Siddel.
- AMA Federal Council Chair and AMA Victoria Immediate Past President, A/Prof Julian Rait.

Ms Geisler gave examples of how COVID-19 has changed the healthcare landscape including impacts on patient care, resourcing and workforce wellbeing, unpredictable patterns of demand including for mental health services and public and private health services partnerships and collaborations.

The 'phenomenal' service response included using new innovative and multi-faceted means such as 'roadmaps' and 'pathways' to escalate health services within the community as overlays into the system.

Dr Wainer reflected upon a number of key concepts and opportunities relevant to healthcare.

She articulated the goal of integrating the system to create a seamless healthcare path for patients and in particular by bringing various public health elements 'into the system'. She stressed the importance of inclusion of prevention and population health in public guidelines and how to sustain the speed and agility of delivery without the level of risk that drove it, including continuing to think collectively rather than territorially.

Ms McCartney summarised how the pandemic has amplified challenges facing the Aboriginal community including social and mental wellbeing. In particular, she identified the ability to access culturally safe healthcare, utilising the strengths of that community including leveraging the strong leadership, supporting the non-Aboriginal community in partnership and collaboration and using technology to get back 'in country'.

Prof Kidd posed the question as to what 'opening up' would really look like, with the community living with significant levels of community transmission. He related his Toronto experience of the long shadow of SARS and its impact on the healthcare workforce which has influenced healthcare planning and preparedness for pandemics.

Dr Price stressed various challenges including the need to 'enable' the integration of the healthcare sectors and reconstruction of a complex healthcare system, the 'erosion' of medical specialities and salary and geographic disparities in the workforce. She argued for a move from a competitive to a collaborative mindset and with leadership that focussed on patient care.

A/Prof Rait shared with the meeting his slides on the role of the private sector in COVID-19.

Dr Siddel provided commentary on the impact of COVID-19 from a rural and regional perspective.

AMA Victoria President, Dr Roderick McRae and Vice President, Dr Sarah Whitelaw also contributed to the discussion.

The online presentation generated a lively and informative commentary from members and guests on the chat line.

Members can look forward to a follow-up session at the next Council meeting on 9 November, with two distinguished economists presenting on 'Investment in Healthcare is a Good Investment'.

DID YOU KNOW:

The Council provides an excellent forum for members to advocate, escalate and engage in discussion on issues relevant to the profession on behalf of the subdivisions and affiliated organisations which they represent. Members are encouraged to get the most out of their Council by bringing matters and ideas about which they feel passionate 'to the table' for debate and sharing with their peers.

PREVENTING BULLYING IN THE MEDICAL PROFESSION

REPORT CHRIS MOLNAR AND SARAH RICKARD, KENNEDYS

Without intervention, bullying can be a significant and pervasive issue in the medical industry. This article provides a snapshot of the laws relating to bullying, so medical practices and their staff are aware of their obligations and can act to reduce the risk of bullying.

WHAT IS BULLYING?

Under the *Fair Work Act 2009* (Cth) (FW Act), a worker is bullied at work if an individual or a group of individuals repeatedly behaves unreasonably towards the worker, or a group of workers of which the worker is a member, and that behaviour creates a risk to health and safety. This definition excludes reasonable management action carried out in a reasonable manner.

The legislation does not limit the definition of bullying by listing specific conduct, but it encompasses insults, yelling and swearing at people, making impossible demands, withholding information and many other forms of violent or manipulative behaviour.

WHAT ARE THE EMPLOYER'S LEGAL OBLIGATIONS?

Employers, which include medical practices, have a duty of care towards their employees, whether doctors, nurses or administrative staff, derived from several sources:

1. the law of contract, as an implied term of the employment contract
2. the law of tort, as an element of a negligence claim state and federal work health and safety (WHS) legislation.

As such, medical practices who do not fulfil their duty of care may be exposed, directly or vicariously, to a number of different claims. These claims can be expensive to defend, with courts often awarding successful applicants substantial sums for serious mental harm and pecuniary losses. Under WHS legislation the bullying may be reported to WorkSafe or ComCare, who may charge the medical practice and perpetrators for breach of the WHS laws, possibly leading to criminal penalties.

Bullying could involve different categories of staff, including doctors, nurses and administrative staff. It could involve a subordinate bullying a supervisor and vice versa.

To mitigate liability, employers must provide and maintain, as far as reasonably practicable, a working environment that is safe and without risks to health. Importantly, this duty encompasses an obligation, "… to guard against the risk of psychiatric injury," including bullying.

WHS law requires employers to adopt a risk management approach to deal with the potential hazards, including bullying hazards, in their workplace. Mitigation of risks will at least require medical practices to implement anti-bullying policies that set out what bullying is, and establish clear reporting mechanisms and grievance resolution processes, as well as engaging in staff training on anti-bullying, including refresher courses. A medical practice must show a proactive approach in dealing with cases of bullying.

WHAT ARE THE EMPLOYEE'S OPTIONS?

An employee who is bullied may take legal action against the employer for breach of contract, negligence or report the matter to WorkSafe, as indicated above, and they may:

a) Apply to the Fair Work Commission under the FW Act for an order to stop bullying.
b) Report the matter to the police. Under the *Crimes Act 1958* (Vic), the offence of 'stalking' encompasses bullying behaviour.
c) Raise a concern with Ahpra about a medical practitioner, including a colleague.

GETTING THE RIGHT ADVICE

This article provides a broad overview of the laws surrounding workplace bullying, but their application will differ according to the circumstances. Accordingly, if you want to learn more about your legal obligations and options, we recommend you seek independent legal advice.

Level 9 360 Elizabeth Street Melbourne VIC 3000 Australia T (03) 9498 6699

Kennedys

"I take my responsibilities at AMA Victoria so seriously that I am ready for the fight, right from the beginning to the end of the process."

Insight from AMAV Workplace Relations

FORMER FAIR WORK COMMISSIONER FIGHTING FOR AMAV MEMBERS

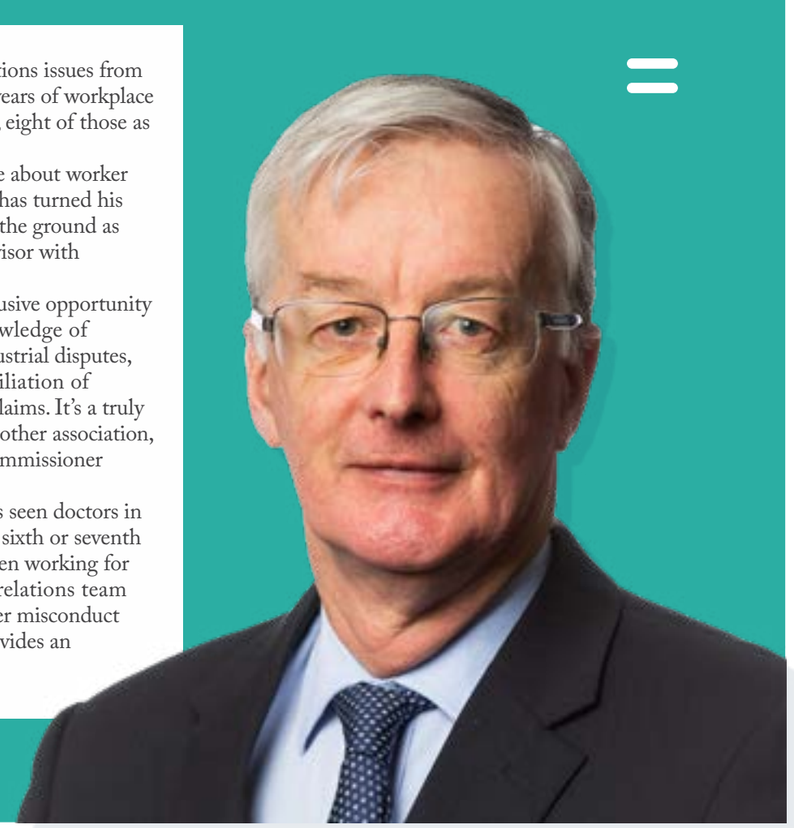
REPORT **LILY PAVLOVIC, AMAV COMMUNICATION + ADVOCACY TEAM**

John Ryan has seen industrial relations issues from all sides. This year, he notches 41 years of workplace relations experience under his belt, eight of those as a Fair Work Commissioner.

John has always been passionate about worker rights. For the past three years, he has turned his focus to advocate for members on the ground as a Senior Workplace Relations Advisor with AMA Victoria.

AMAV members have the exclusive opportunity to tap into John's specialised knowledge of conciliation and arbitration of industrial disputes, unfair dismissal claims, and conciliation of bargaining disputes and bullying claims. It's a truly unique membership benefit, as no other association, employer or hospital has an ex-Commissioner working for them.

In John's time at AMAV, he has seen doctors in their intern year, registrars in their sixth or seventh years and consultants who have been working for 20 years, come to the workplace relations team after receiving letters alleging either misconduct or underperformance. Here he provides an insight into a typical experience.



No-one goes into medicine expecting to be the subject of allegations or thinking that they will be accused of doing something wrong. When it happens, it can be earth-shattering.

In the Enterprise Agreement, if a hospital wants to pursue disciplinary action, it must put allegations in writing. For this reason, the first time a doctor understands there is an issue is sometimes when they receive a letter from their hospital, signed by their department head or higher, detailing a list of allegations. The letters are always confronting, because they suggest if the allegations can be proven, then it could lead to disciplinary action being imposed upon the person up to, and including, termination of employment. For many health professionals, this is the first time in their life something like this has taken place.

Letters such as these contain a time that the doctor must meet with their employer. In some cases, the period from the date of the letter being signed to the expected meeting date is only one week away. Often by the time a member contacts AMAV, a couple of days have gone by – doctors may be still rostered on to work while they navigate a response to the allegation letter and prepare for a meeting with their employer.

My first job after being contacted by a member is to speak one-on-one with the doctor to assure them that their situation is manageable. We let the member know that they won't go to any meetings without AMAV supporting them.

I contact hospitals directly to organise more time to respond to the documentation on the member's behalf. The doctor needs to have sufficient time and the opportunity to understand the nature of the documentation and allegations to properly respond to them. My practise is that I do not send any emails to the hospitals without running it past the doctor first. There is consistent communication between AMAV and our member. I can do the hard work on the member's behalf, but they must be the one to make the decisions and control the outcomes.

The next conversation I have with the doctor is to explain how the disciplinary process works and talk about how we respond. I work with our member to recall the contextual information surrounding the claims and clarify the overall situation.

Doctors have the right to a representative in disciplinary meetings. There's an enormous benefit to a doctor having a professional representative, and as part of AMAV's member service, I can stand between the hospital and the member to advocate as a spokesperson for the doctor.

From 41 years working in industrial relations, I know how to cooperate effectively with employers to get a better outcome. My presence in the room is comforting for the doctor and adds a level of professionalism, in the sense that hospitals can throw questions at me and expect that I know how to interpret their questions based on my experience.

I always prepare for the possibility that a matter could end up at the Fair Work Commission. From our very first conversation, I work with our member to obtain their best and honest recollection of events. In the event a doctor is put in the witness box at the FWC, their recollection needs to be clear and strong enough to submit as sworn evidence. If the process fails a member, we are ready to escalate internally under a hospital's dispute resolution process, take the matter to the FWC to have the situation reviewed, or consider conciliation and later arbitration if necessary.

I take my responsibilities at AMA Victoria so seriously that I am ready for the fight, right from the beginning to the end of the process.

AMA Victoria's membership is just like an insurance policy for doctors. AMAV plays a central role in advocating for your rights at work and overall workplace wellbeing. Membership also protects your emotional health, providing you peace of mind as you move through your career. You insure your car and your home – it makes sense to invest in yourself, too. Membership means AMAV can represent and support you through any individual workplace issues, at every stage of your employment. Members across the entire medical profession can rest assured that if unexpected events occur, like an unfair dismissal or bullying or harassment at work, we will fight for you.

Whenever you need it, you can get support from AMAV's team of experienced workplace relations advisors to help understand the T&Cs of your position, check you are receiving your correct entitlements and negotiate your employment contract.

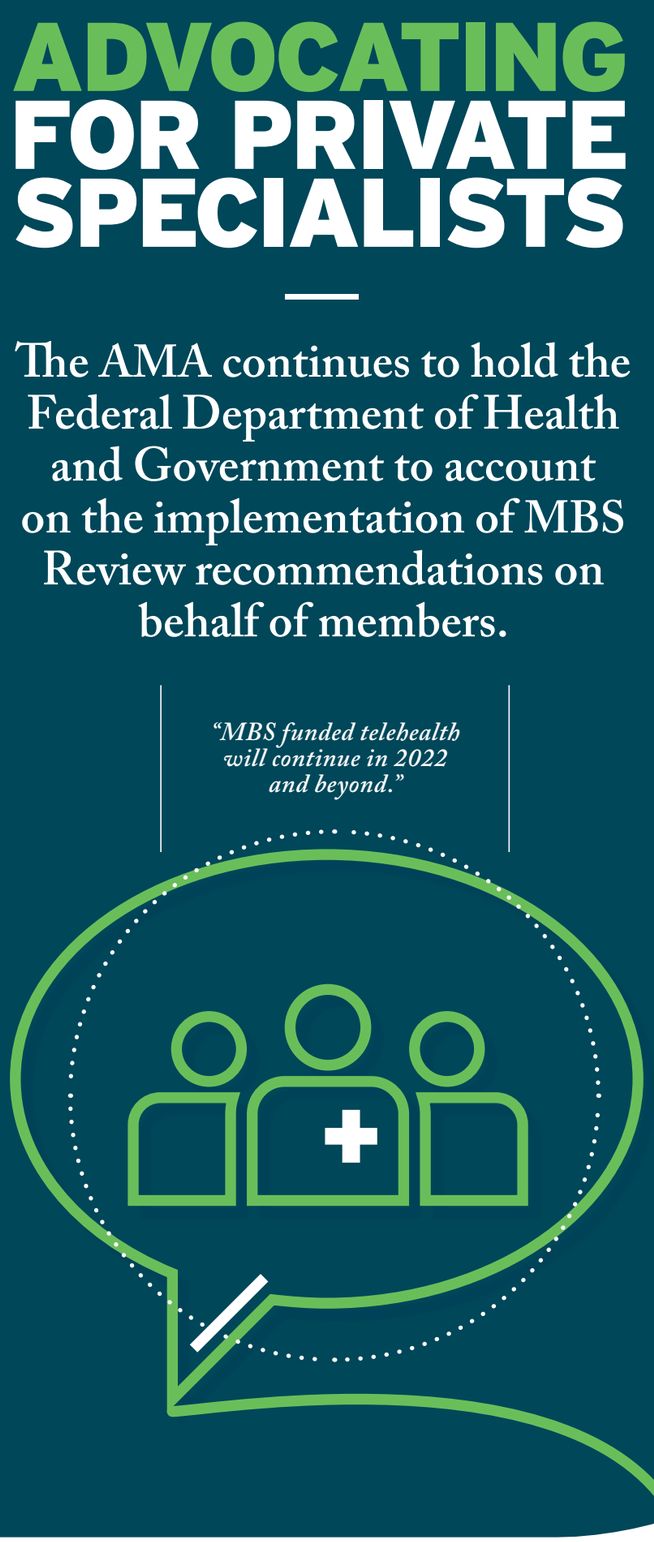
Your membership also contributes to collective power to drive negotiations in improving workplace terms and conditions for all doctors across Victoria, such as current enterprise bargaining negotiations for public hospital doctors. The more member power we have behind us, the more effective we can be in advocating for your rights. Our strength is in numbers and every member counts.

RECOMMENDATIONS

ADVOCATING FOR PRIVATE SPECIALISTS

The AMA continues to hold the Federal Department of Health and Government to account on the implementation of MBS Review recommendations on behalf of members.

"MBS funded telehealth will continue in 2022 and beyond."



- The AMA Federal office continues to strengthen its relationship with the Department of Health, particularly in the areas responsible for MBS policy, MBS reviews and MBS compliance.
- AMA advocacy secured an extension of temporary MBS telehealth items for non GP specialists until December.

Whilst the MBS Review implementation process has been far from perfect, the AMA's ongoing work is contributing to incremental improvements.

MBS REVIEW

The AMA continues to be engaged in the MBS Review since its commencement in 2015. The AMA has nominated representatives participating on MBS Review Implementation Liaison Groups (ILG) to ensure the MBS Review recommendations are implemented with reduced errors and unintended consequences for medical practitioners and patients. This includes AMA representatives on the pain management, general surgery, thoracic surgery, orthopaedic surgery, cardiac surgery and psychiatry ILGs just to name a few.

Whilst the MBS Review implementation process has been far from perfect, the AMA continues to make incremental improvements to the functioning of the MBS Review ILGs, through quiet advocacy with the Federal Department of Health and Government. For example, ILG representatives were previously unable to consult with their peers and home organisations regarding considerations of the draft MBS items and, only due to AMA advocacy, this process has improved where the Department has now made provisions for appropriate sharing of information by ILG members. The AMA continues to hold the Department of Health and Government to account on the implementation of MBS Review recommendations on behalf of members.

The 1 July 2021 changes to the MBS made national headlines and dominated the media, following an AMA media release outlining concerns that patients and practitioners did not have the information they needed to be ready for 1 July. In response to the media and public response, the Government (see Minister Hunt's media release here) agreed to three significant requests the AMA has advocated for in recent years:

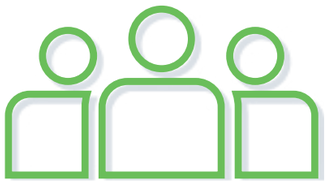
- a rapid process to review some of the oversights and errors or unintended consequences that are buried within the review recommendations.
- to work together to co-design the administrative processes that support implementation of future changes to the Medicare Benefits Schedule (MBS) to ensure all parts of the system are ready.
- change to have private health insurer rebates monitored by the Government, and for the first time, published on the Government's fees website.

MBS ADVOCACY WINS AND VALUE ADD FOR MEMBER SERVICES

The AMA Federal office continues to strengthen its relationship with the Department of Health, particularly in the areas responsible for MBS policy, MBS reviews and MBS compliance. This relationship is invaluable in obtaining the most up to date information on MBS changes to support member enquiries and provide opportunities for AMA advocacy on Government policies.

For example, AMA advocacy secured an extension of temporary MBS telehealth items for non GP specialists until December. More recently, the Minister for Health confirmed that MBS funded telehealth will continue in 2022 and beyond, with the AMA currently in negotiations to finalise the details of this.

Furthermore, the MBS policy team are specialists who have the expertise and knowledge to navigate the complex information sources and changes to the MBS and have assisted dozens of members on their MBS and MBS compliance enquiries over the past year.



MENTAL HEALTH

BURNOUT: WHERE WE ARE + WHAT CAN WE DO?

Real concern is mounting around the issue of burnout. Many doctors are working with and through burnout. While planning for how to improve the workload and working conditions in our healthcare system is essential, knowledge about burnout and how best to deal with it are important too.

REPORT **DR ANNA CLARK (PHD), AMAV LEADERSHIP DEVELOPMENT CONSULTANT + COACH**

"There is no silver bullet for burnout. Rather, there is a small steps approach where we find ways to take action."

Research shows doctors and nurses are at high risk of burnout – even pre-COVID-19. According to Parker et al., factors implicated in physician burnout include:

- high levels of responsibility
- uncertainly over outcome
- constantly disrupted schedules
- ever present threat of legal action
- emotionally draining impact of incurable or dying patients
- the need to be a superhero and not show any weakness.

IT'S IMPORTANT TO BE OPEN ABOUT CURRENT LEVELS OF BURNOUT

Now, amid the COVID-19 pandemic, we are hearing more and more comments from members like:

- "I don't look forward to coming to work anymore"
- "I'm so worried I might not be able to provide adequate care for my patients tonight"
- "I am scared someone will die and their family will not see them again"
- "I am stressed because the junior doctors are so exhausted, I'm scared they will get sick and not be able to come to work"
- "I'm know I'm going to be asked to work more double shifts and I am just so tired. I'm scared I'm going to make mistakes but how can I say no?"

This is what burnout can look like. It's an ugly problem but realistically many AMA Victoria members report there is little choice but to keep going and try to manage as best as possible.

WHAT CAN WE DO NOW?

There is no silver bullet for burnout. Rather, there is a 'small steps' approach where we find small ways to take actions for timeout, rest and recovery. The aim of this article is to provide some support and resources.

According to Parker et al., there are three key components to resolving burnout

- **Addressing work issues**
- **Adopting de-stressing strategies and**
- **Addressing any perfectionism traits.**

It is important to find a realistic set of small actions to preserve and protect your energy, to de-stress and to create some time and boundaries to rest and recover when possible. We will look at these first.

ADDRESSING WORK ISSUES

The literature suggests that working during high pressure periods requires **goals to make small changes to get through**, and then, where there is a time when pressure eases, then it's time to remember that full recovery from burnout may need more time out and time off. This is the longer-term goal.

- Reduce workload where possible: Arrange leave to create single days off, creating a break, or ensuring you do take a meal break during a shift. These are not easy, but they are a must to get through weeks and months of tough times.
- Reducing workload can also mean being more realistic about what you can do (have a 'to do' list of 1-3 things, not 5-11 things), and prioritise – what is the one thing I must do, and then feel good about getting it done. Change small daily habits that might be contributing – don't reply to emails that don't absolutely need one; don't write extensive notes if not required, and delegate to someone else when you can.

FINDING WAYS TO DE-STRESS

This is essentially about carving out small amounts of time that are protected from work and other intrusions – quiet time to rest and recharge the batteries.

- Create regular 'timeout' – ensure you have some time out and protect it. This may be a day off/weekend day, or it may be 15 minutes in the car.
- Care for your body – eating, sleeping, gentle exercise and practising mindfulness or meditation are restorative. See previous articles on self-care here and self-compassion here.
- Connect with others – talk to a couple of colleagues or friends regularly, allowing yourself to share your feelings.
- Seek support when needed – while social connection is a key protective factor, there are times when you may want professional support. Reach out to a GP, or other professionals, using telephone call services when you need (contact details at the end of the article).

ADDRESSING THE ROLE OF PERFECTIONISM IN BURNOUT

Research suggests that perfectionism is a predisposing personality factor in burnout. There are many aspects of perfectionism that are often helpful and desirable, such as attention to detail, trying one's best, having high expectations and high standards – all characteristics that can assist us to reach excellence in our profession. However, perfectionism can also have high costs – and this is where it can contribute to burnout.

Perfectionism can mean that when the high standards are not met, and when doing one's best is thwarted or impossible, people feel a sense of failure, guilt, and shame.

- Find three things that you can do to reduce stress, rest and recover.
- Focus on the here and now and that 'good enough' is good; perfect is for another day.
- Getting through this next phase is the goal. Changes and new innovations are for next year.

This creates a situation where their response to the work they are performing is overwhelmingly negative. For example, because something didn't work out perfectly, it is a failure. These feelings contribute to symptoms of burnout – feeling depleted, negative about work and feelings of reduced efficacy.

What can you do? Again, we can't change our personality, and long-term habits take many months and years to change – but, again, we can curate small, realistic steps toward a healthier and more sustainable way:

- Good doesn't have to be perfect. Cultivate the mindset that you are good enough. Doing the work that you are doing and making the best of very difficult conditions and events is good enough.
- Compassion, for self and others. Think of a colleague who has high expectations and who is struggling with working in the current environment, and think of what you would say to them, to reassure them that they are doing enough, that they are doing the best they can and that it is enough to get through today. Now this is the compassion you must also practise on yourself.
- Notice the things that are working. Notice the 'small wins' in the hour or the day. Take time to notice them and celebrate them – just with an internal 'well done' or a smile for a colleague.

Below are some resources to support understanding and managing burnout. Please also use our leader/manager check-in to talk through current challenges.

REFERENCE

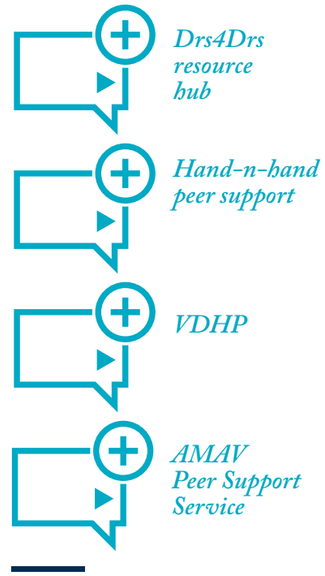
Parker, G., Tavella, G., and Eyers, K. (2021). *Burnout: A guide to identifying burnout and pathways to recovery.*

RESOURCES

Black Dog Institute – TEN

AMAV Leadership resources page

SUPPORT THROUGH CONNECTING WITH OTHER DOCTORS



RESOURCES

The World Health Organisation ICD-11 manual defines burnout as:

- Energy depletion and exhaustion
- Increased mental disturbance from one's job, or feelings of negativity and cynicism related to one's job
- Reduced professional efficacy.

This is predominantly based on the Maslach Burnout Inventory developing in the 1980s. Recent Australian research, 'Sydney studies' (described in detail in the book *Burnout: A guide to identifying burnout and pathways to recovery*) have refined this definition, noting:

- Exhaustion is a central component (exhaustion can be physical, mental, and emotional)
- There is a loss of empathy and more broadly a loss of 'joie de vivre'
- There is compromised work performance
- Impaired cognition such as difficulty concentrating, lowered attention span, poor memory, and distractibility
- Perfectionism heightens the risk of burnout.

AMA Victoria Peer Support Service

For anonymous and confidential support*

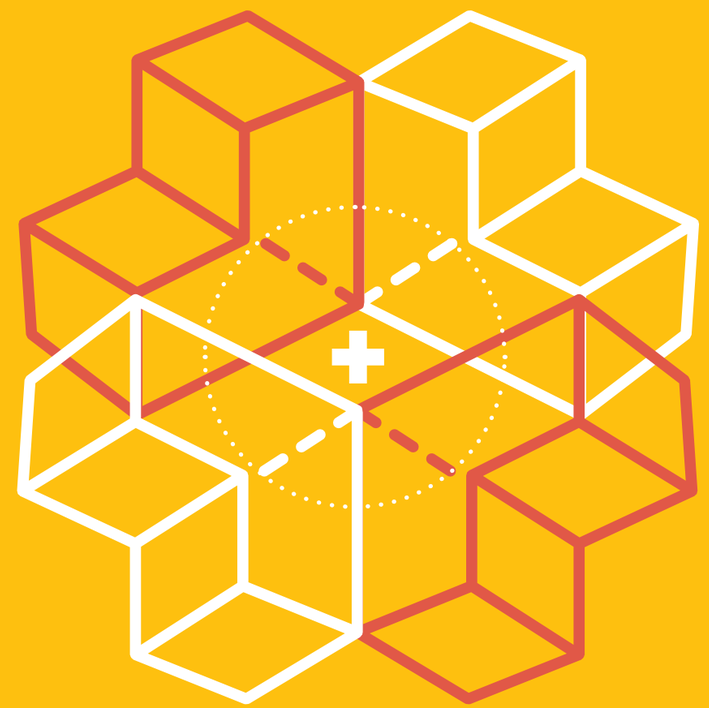
1300 853 338

8.00am–10.00pm
365 days

Peer support for doctors by doctors

* Cost of a local call

IMPAIRMENT ASSESSMENT



MEDICINE FROM A DIFFERENT PERSPECTIVE

AMA Victoria and the Personal Injury Education Foundation (PIEF) deliver impairment assessment courses using the American Medical Association Guides to the Evaluation of Permanent Impairment 4th Edition and other prescribed methods, as applied to relevant Victorian legislation.

TO LEARN MORE ABOUT THE COURSES, MEET ONE OF OUR PARTICIPANTS A/PROF DAVID WEBB OAM.

FIRSTLY, CAN YOU GIVE A BRIEF OVERVIEW OF YOUR MEDICAL CAREER?

—

Post residency, I opted out of mainstream hospital medicine for two years, entertaining the idea of general practice or obstetrics. After completing a Diploma of Obstetrics, working as a medical officer in the Pacific nation, the New Hebrides, and for a high-altitude Himalayan expedition, I settled down in London and decided on surgery.

I did my urology training at the Royal Melbourne Hospital (RMH). In collaboration with colleagues at the Royal Children's Hospital (RCH), 'keyhole' surgery was introduced to the paediatric population, and I gained the honour of becoming a 'Royal triplet' – one who has worked at the RCH, RWH and RMH!

I have spent the last 16 years performing da Vinci robotic surgery and am currently Consultant Urologist at Austin Health and the Olivia Newton John Cancer Wellness and Research Centre, where I do PCNL (percutaneous renal surgery) for the extremely complex calculi in spinal cord injury patients.

I am an Associate Professor of Surgery at the University of Melbourne and have been urologist to the RAAF Specialist Reserve (SQNLDR) for 35 years.

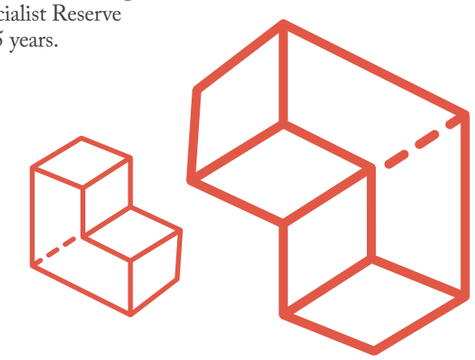
HOW WOULD YOU DEFINE THE ROLE AND RESPONSIBILITIES OF AN IMPAIRMENT ASSESSOR?

—

Impairment is defined as, "An alteration in an individual's health status resulting in the deviation of a body part or its function related to daily living". Initially the concept of Whole Person Impairments (WPI) – a functional rather than a diagnostic assessment – can be difficult to comprehend, even though it is a medical issue assessed by medical means. Correctly applied, WPIs provide a reproducible, responsible fair standard assessment of the severity of an injury or medical condition.

The role and responsibilities of an assessor are multifactorial. Firstly, to thoroughly assess and explain the physical clinical result of an injury and its effect on the client's social, employment, physical and particularly in my field, sexual and urinary bladder functions.

Secondly, to explain the clinical findings and functional results in plain non-medical language, so that anyone (eg, client, family, legal team, jury, employer) with an interest can easily understand the assessment, methodology, conclusions and rationale for that WPI by reading the report. As a result, WPI reports represent a marked contrast to routine doctor to doctor communications.



WHY SHOULD A CLINICIAN BECOME AN IMPAIRMENT ASSESSOR AND WHEN DO YOU THINK IS THE RIGHT STAGE IN A DOCTOR'S CAREER TO BEGIN THIS WORK?

—

The scope of medico-legal consulting is extremely varied. The range of assessments is stimulating, fascinating and changing – the recent firefighters and previous veterans legislation recognising prostate and bladder cancer as occupational injuries are examples. Doctors should not be reluctant to apply for training. The AMA4 Guides module is not arduous – it involves an interactive, broad, interesting and stimulating evening presentation and examination by follow-up case studies at the candidate's leisure.

During the module, candidates meet the medical facilitator and the authority advisers from the TAC and WorkSafe Victoria. The advisors input to the module significantly complements the medical component. I find their presence very encouraging. It allows the doctors on the course to become personally familiar with the advisors as well as their procedural input and commitment to participating in their client's compensation.

Lastly, it provides an understanding of the legal process, what lawyers require from a WPI report and comprehension of specific legal definitions such as causation, injury, impairment, performance, apportionment and stability, which are germane to all medico-legal reports.

Because WPI assessments are rarely urgent and usually booked by solicitors weeks or months ahead, they do not interfere with regular consulting. I believe the time when a practitioner becomes established and experienced, which tends to be early mid-career, presents the ideal opportunity to commence WPI assessments.

IN YOUR EXPERIENCE, WHAT IS THE MOST REWARDING ASPECT OF BEING AN IMPAIRMENT ASSESSOR?

—

WPI assessments expose one to diverse and complex medical questions and involve continued learning and updating of clinical skills. Injured patients are often treated by multiple specialists – in my case, mostly orthopaedic and neurosurgeons. It is often many years before a patient with urinary incontinence or erectile dysfunction is referred. Many have been 'too embarrassed to complain' or have required major surgery as a priority. As a result, the urological assessment is often the first time a patient discovers or understands the cause of their symptoms and that there are options for testing and treatment.

Although a WPI assessor cannot advise, treat or advocate, their WPI reports are scrutinised by their client's solicitors, TAC and WorkSafe facilitators. Should a WPI suggest a patient needs investigation, rehabilitation or other specialist referral they will facilitate these, so indirectly, WPI reports can make a considerable contribution to a client's medical management. Patients regularly express gratitude that someone has listened to their concerns in such detail.

WHAT IS THE MOST CHALLENGING ASPECT?

—

By far the most challenging aspect of WPI for me is the exposure to the tragedy resulting from severe trauma, in particular that involving young males, who, in a split second have become paraplegic, incontinent, impotent, alone, overweight and depressed – always tragic, distressing and heartbreaking. One can only hope that their WPI reports offer at least some hope, palliation, ongoing support and recompense.

A/PROF DAVID WEBB OAM

Urological Surgeon

HOW IMPORTANT HAS THE PRACTICE OF IMPAIRMENT ASSESSMENT BEEN IN YOUR PROFESSIONAL CAREER?

—

Medical practitioners are extremely fortunate. Our training and experience enable us to modify and change direction. The process of WPI is integral to medico-legal consulting. WPI discipline provides an excellent template for a thorough evaluation of a wide range of injuries.

My experience with WPI has developed a profile with solicitors and medical defence organisations throughout Australia. On a personal level, many colleagues are aware of my experience and seek counsel regarding their personal cases or when writing reports, which is very gratifying.

WPI opens a myriad of opportunities to apply one's years of clinical experience, an ongoing, fascinating, challenging and rewarding experience.

IMPAIRMENT ASSESSMENT TRAINING

—

Are you interested in diversifying your portfolio of clinical work by becoming a qualified Impairment Assessor for TAC, WorkSafe and the Wrongs Act in Victoria (AMA4) or Workers Compensation for SIRA applicable in NSW and other states (AMA5)?

Impairment assessment work can provide an attractive income stream for specialists (+5 years independent clinical practice) and has the flexibility to compliment private and public clinical practice.

It also provides an important social insurance function for government and the community.

AMA Victoria members will receive a special discount for courses only in Victoria.

Please enquire at: training@amavic.com.au

Impairment Assessment Training in Victoria

Impairment Assessment Training in New South Wales

PROTECTING AUSTRALIANS FROM THE EXCESSES OF MANAGED CARE

Many Australian doctors who have worked in the USA are deeply suspicious of managed care organisations. This arises not only through our experience as providers, but equally, as patients who have endured the painful consequences of managed care.

REPORT **A/PROF JULIAN RAIT OAM**
CHAIR, AMA FEDERAL COUNCIL

> *"In my experience of the US system, providers and patients are frequently short-changed by denial-of-claims manoeuvres."*

- When doctors are accused of 'self-interest' while highlighting the risks of managed care, it seems that such critics are oblivious to how managed care might affect many patients.
- The AMA is lobbying for a Private Health Authority to protect Australian patients and providers from the excesses of managed care and the growing participation of US health insurers in our private health system.

Members may have read of the Australian Competition and Consumer Commission's recent decision on the proposed collective bargaining joint venture between ASX-listed health insurer NIB and US-based Cigna corporation via Honeysuckle Health. The ACCC has granted a five-year authorisation for NIB and Honeysuckle Health to collectively negotiate contracts with doctors and hospitals, which is shorter than the 10 years requested and is on the condition that no other major health insurers join the group.

However, many Australian doctors who have worked in the USA are deeply suspicious of managed care organisations like Cigna. This arises not only through our experience of them as providers, but equally, as patients who have endured the painful consequences of managed care. And like other doctors who have worked in the United States, I can attest that a recent tragic story reported in the *New York Times* is not an unusual one.

Thirty-five year-old Brittany Lane gave birth to her daughter, Alexandra, in a New York City hospital a few days before Christmas in 2018. Unfortunately, she also arrived about 13 weeks early and weighed less than 1kg. Alexandra initially thrived in the neonatal intensive care unit at Mount Sinai West on west-side Manhattan, however her condition rapidly worsened after an infection, and she sadly died at 25 days old.

A flurry of small medical bills from neonatologists and paediatricians quickly followed. Ms Lane struggled to pay these and get her breast pump covered by insurance because, in the midst of a frightening preterm birth, she hadn't gone through her health plan's prior approval process and had changed employers (and thus her health insurer) in the weeks following Alexandra's birth.

Ms Lane started receiving debt collection notices in 2020. The letters, sent by her health insurer Cigna, said that she owed the insurer over $257,000 for the bills it accidentally covered for Alexandra's care given that Ms Lane had subsequently switched to another health insurer.

Thankfully, after the Lane's filed a complaint to a state regulator, Cigna sent them a letter stating they would withdraw their claim. "We empathise with the pain and confusion this experience has caused for Mr and Ms Lane," it said in a statement.

However, Ms Lane received her first collection notice about 18 months after her daughter's death. Her family had switched health plans in the middle of Alexandra's hospital stay because of a change in employment but it was only after this ridiculous attempt at cost shifting was raised with an industry regulator that there was any change of heart by Cigna.

Consequently, when doctors are accused of 'self-interest' while highlighting the risks of managed care, it seems that such critics are oblivious to how managed care might affect many patients such as Ms Lane. It is actually my experience of the US system that providers and patients are frequently short-changed by similar denial-of-claims manoeuvres, while insurers pursue even greater market power and eye-watering returns on equity for their shareholders.

However, the AMA is not against greater fee transparency. On the contrary, I have been pleased to represent the AMA via the Out of Pockets Transparency Reference Group which has been supporting the design of the Commonwealth's fee finder website for the Federal Department of Health. This has been pursued cooperatively with the AMA, consumers and insurers, in order to achieve greater transparency about the costs of services.

We expect that this will be readily available to both GPs and consumers in early 2022 and will help inform them of various treatment options, including the varying level of cover provided by different insurers. We anticipate that this initiative will continue to have the measured support of the AMA, while we also lobby for a Private Health Authority to protect Australian patients and providers from the egregious excesses of managed care and the growing participation of US health insurers in our private health system.

REMOVE BARRIERS: RURAL GPs WORKING IN LOCAL HOSPITALS

"Rural GPs are denied opportunities to work in their local hospital, while temporary locums are hired, charging costs far higher for their services."

The AMA has made a series of recommendations addressing doctor shortages in rural areas, with benefits to local hospitals and better healthcare for regional communities. These recommendations would also contribute to a more viable sustainable career for rural GPs.

The AMA is calling for easier pathways for rural doctors to work in their local hospitals and better support remote, regional and rural health in the community.

Examining rural workforce shortages, the AMA has found stringent bureaucratic processes by local hospitals or health services prevent some rural GPs and rural generalists from having any connection or involvement whatsoever in their local hospitals.

In a new AMA Position Statement on integrating GPs into rural hospitals, the AMA makes a series of recommendations addressing doctor shortages in rural areas, with benefits to local hospitals and better healthcare for regional communities. These recommendations would also contribute to a more viable sustainable career for rural GPs.

Among the recommendations are support for local GPs' clinical up-skilling or re-skilling in multiple domains by local hospitals or health services, consistent, fair and non-restrictive credentialling that assures competency and safe practice in rural settings and easier access to working in local hospitals.

The AMA Federal Council of Rural Doctors (CRD) has seen concerning situations around Australia where rural GPs are denied opportunities to work in their local hospital, while temporary locums are hired, charging costs far higher for their services than a simple contract with the GP.

AMA Federal President, Dr Omar Khorshid, said a properly functioning arrangement would have rural GPs remunerated by the MBS for services provided in their private practice and by the state for services provided in their local hospitals.

"At a time when our hospitals are under immense pressure, it's extraordinary that regional hospitals and health services are appointing locums – often at higher costs – when there are highly-skilled GPs prevented by administrative barriers from bringing their experience in the community to their own local hospitals. We need clear and fair arrangements in place so GPs and health services can work together to deliver better health outcomes for our regional and rural communities."

"The best model for our communities is where the talent and expertise in local rural general practices is harnessed by local hospitals and remunerated through the hospital system, while the MBS covers GPs' work in their practices. This increases job satisfaction for the GPs, contributes positively to retention of the rural workforce and means hospitals won't have to rely on a costly, impermanent workforce."

"GPs are the backbone of rural health, providing cradle-to-grave medicine for whole families through their practices, as well as emergency care for their communities through arrangements with their local hospitals," Dr Khorshid said.

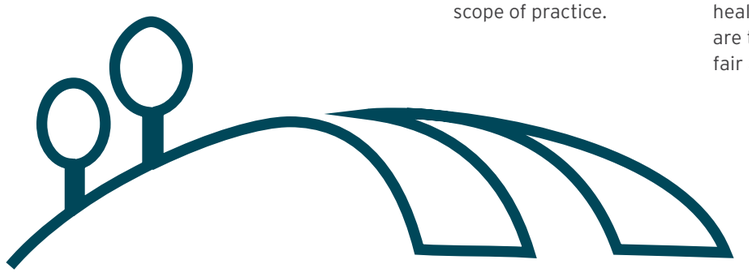
CRD Chair, Dr Marco Giuseppin, says the AMA is serious about addressing rural workforce shortages. "We're really attacking the problems GPs are finding and which can ultimately mean the difference between them staying in the community or deciding to leave. We want to build stronger, fulfilling, lasting careers for our rural doctors and that's what's behind the AMA's new position statement."

"Integrating our current and future rural GPs and rural generalists into a single healthcare environment is achievable and will deliver better outcomes for everyone; especially patients, but also hospitals themselves and we're hoping the position statement helps regional health services understand and move to realise the benefits of integrating local GPs into their services."

"Supporting rural GPs and rural generalists to work collaboratively between hospitals and private general practices gives these doctors more reasons to stay rural and serve their communities. Implementing the Commonwealth Government's National Rural Generalist Pathway can facilitate the industrial and cultural change necessary to achieve this," Dr Giuseppin added.

Click here to download position statement

- Rural hospitals and health services must have a local GP or rural generalist involved in decision-making processes.
- Nationally consistent credentialling must ensure rural GPs or rural generalists with advanced skills are not arbitrarily restricted in scope of practice.
- Enshrine models of employment with standard conditions for rural GPs and RGs providing clinical services at rural health services which are transparent, fair and consistent.
- Telehealth and virtual services must not be considered a direct replacement for face-to-face service in a rural town.



A POST-COVID LIFE

It may seem a long way away but there will definitely come a time when running a medical practice gets back to normal. It is certainly an issue of when and not if. There are steps you need to think about right now, so that you will be prepared for this time.

REPORT **ROGER MENDELSON, EXECUTIVE CHAIR, PRUSHKA FAST DEBT RECOVERY**

What has COVID-19 cost your practice?
You have lost professional time which you will never be able to recover. The situation is akin to a hotel. When a night passes and a room is vacant, the opportunity to let that room for that night has passed and it will never be replaced.

The impact will be quite profound, particularly for specialist practices. The reason is that the number of professional hours lost over the whole COVID-19 period will be immense and yet most expenses will have continued.

What should you think about now?

As professional (chargeable) time has been irreversibly lost, medical practitioners need to make-up for the lost revenue. In addition, the economy is clearly hitting a period of inflation, particularly in relation to wage costs. This will hit medical practices just as much as any other business. Accordingly, be prepared for the running costs of your practice to increase, because wage costs make up a significant percentage of overall expenses.

The reality is that your practice is a business and you are entitled to achieve a sufficient net profit, to justify the personal endeavours medical practitioners make and the fact that a substantial amount of time has been spent in training and gaining experience, to reach this point.

The logical conclusion is that with prices going up in so many areas, medical services will need to be in the game. Your competitors will be doing this, for exactly the same reasons. This is something to think about and plan for now, whilst COVID is with us and is something to implement sooner rather than later.

Seriously look at prices your practice charges for each item and build in increases which will be sufficient to meet increased operating costs and to allow a catch up for the lost COVID years. The obvious conflict between the financial needs of the practice and the medical needs of the patients can be easily overcome by adopting a discount policy for different categories of patients in need.

Best practice – credit and billing policy

Just as you adopt best practice in your professional work, why should you not adopt best practice in the operation of your practice? Adopting best practice effectively costs you nothing, can be implemented quickly and the benefits flow immediately.

Just several hours of the practice manager's time is required to set up best practice procedures. As a first step, set up a New Patient Form ('Form') for all new patients. Rather than reinventing the wheel, simply click here to download the Form and adapt it for your practice.

By doing this, you will have obtained invaluable information to allow you to make an assessment of the ability of the patient to meet your fees and information which will greatly assist in the event where the patient fails to pay and you need to recover monies.

The writer is the Executive Chair of Prushka Fast Debt Recovery Pty Ltd and is principal of Mendelsons National Debt Collection Lawyers Pty Ltd. Prushka acts for in excess of 58,000 small to medium size businesses and practices across Australia and operates on the basis of NO RECOVERY - NO CHARGE. www.prushka.com.au Free call 1800 641 617.

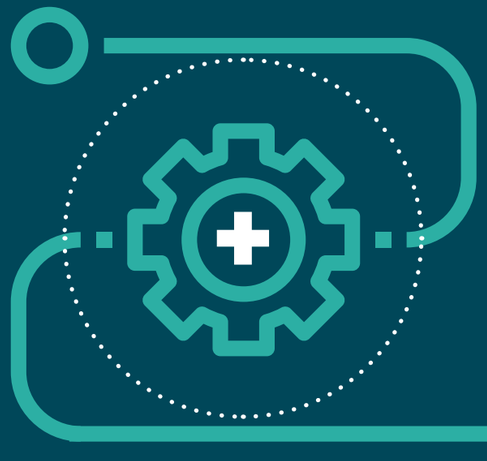
Prushka
NO RECOVERY - NO CHARGE

REGISTRATION + NOTIFICATIONS

AMA FRONTS SENATE INQUIRY INTO AHPRA PROCESSES

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

Registration and notifications affect every doctor around Australia. The ongoing Senate Inquiry into the Australian Health Practitioner Regulation Agency (Ahpra) presented a good opportunity for the AMA to raise our concerns with the system and to, once again, call on Ahpra and the Medical Board of Australia to ensure that the National Scheme is transparent, efficient and fair.



"Doctors are often deterred from seeking help due to mandatory reporting rules."

- Confidential mental health advice is available via www.drs4drs.com.au, a website developed by the medical profession for the medical profession.
- Through the network of doctors' health advisory and referral services, it offers an independent, safe, supportive and confidential service.
- The AMA Victoria Peer Support Service provides a listening colleague who understands the pressures of medicine. For anonymous and confidential support call 1300 853 338 (for the cost of a local call).

Implementation of the National Registration and Accreditation Scheme (the National Scheme) for medical practitioners is one of many topics that falls under the remit of the AMA Federal Medical Practice Committee (MPC). Over the years, MPC has had a continuous and strong focus on this area.

Earlier this year, the Senate set up an inquiry into the "Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law". The inquiry is investigating the standards of registration, role of Ahpra and the National Boards, arrangements pertaining to notifications, supports available to practitioners subject to Ahpra notifications, timelines of Ahpra's investigations of notifications, appeal mechanism for health practitioners, and any other related matters.

In April this year, the AMA provided a written submission to the inquiry. In our submission, we highlighted many areas where significant work still needs to be done to ensure the National Scheme is impartial and follows due processes. We raised the issue of impact of notifications on the mental health of medical practitioners and called on Ahpra and the Medical Board of Australia to ensure that the wellbeing and state of mind of the practitioners be at the forefront of any investigations. We reiterated that, while public protection is a critical role of the scheme, principles of natural justice must be upheld for all those involved.

Following our submission, the AMA was invited to appear before the Senate. On 8 July 2021, Dr Antonio Di Dio, immediate past President of the AMA (ACT), provided testimony, stressing the importance of implementing immediate improvements in the notifications scheme. Dr Di Dio highlighted that when doctors know they are under notifications, they start to question their practice, question their profession, and in some instances question themselves. In some tragic examples, this resulted in practitioners' suicides.

Dr Di Dio, himself a former member of the MPC who provided invaluable contribution to the Committee's work over the years, also raised the issue of mandatory reporting, warning that doctors are often deterred from seeking help due to mandatory reporting rules that compel their treating doctor to report on them. He urged the Senate to recommend the national implementation of the model employed by Western Australia, which has been proven to work.

Both the AMA submission and Dr Di Dio in his statement, reiterated the importance of addressing the key area of vexatious complaints. Pressing further action must be taken by Ahpra and the MBA to enable vexatious complaints to be identified and managed earlier in the notification process, thereby reducing harm to the practitioner.

The new framework released by Ahpra in late 2020 aims to identify and manage vexatious notifications by setting out the principles and indicators for their identification. The AMA provided strong advocacy for implementation of such a framework and worked closely with Ahpra in its development. It was at the urging of the AMA that the framework reinforced the position that vexatious complaints made by health practitioners against other health practitioners must be taken seriously and should result in punitive action.

The AMA, lead by the MPC, will continue to develop policy and engage in advocacy on the Health Practitioner Regulation National Law. MPC members, as medical professionals, have firsthand knowledge and the awareness of the importance of this topic for their professional and personal lives. This is one area where professional matters, often through no fault of our own, can have a terrible impact on not only our personal lives, but also the mental health and welfare of our families. It is crucial that the voice of the AMA continues to be strong in this area.

Click here for mental health support

FED FACTS

Advocacy from AMA Federal

Click here for AMA Federal media releases

Click here for Primary Health Reform Steering Group submission

Click here for communique from AMACDT meeting

Click here for domestic violence submission

COVID-19

Quarantine arrangements
The AMA made a submission to the National Quarantine Review as part of the further review into Australia's quarantine arrangements. The submission reiterates the AMA's position that Australia needs a permanent quarantine solution that is fit for purpose.

Vaccinations
The no-fault COVID-19 vaccine indemnity scheme was formally announced on 28 August. The scheme applies in all COVID-19 vaccination settings. Patients can register a claim through a Services Australia portal protecting doctors and patients from litigation processes. The AMA has been advocating for this throughout the pandemic.

The AMA called for mandatory vaccination of all healthcare workers on 31 August. The AMA called for states and territories to make public health orders to mandate vaccinations beginning in hospitals, then expanding to the entire healthcare system including support staff like cleaners, receptionists, and contractors.

The AMA called for modelling of the impact to the capacity of the health system of the 4 stage re-opening plan on 2 September. The AMA's main concern is that Australia's hospitals are already under considerable strain without the added pressure of increased cases in the community.

Prescribing
Following AMA advocacy, image-based prescription arrangements that were due to conclude at the end of September were extended until the end of the year.

GENERAL PRACTICE

The Federal Department of Health has restarted discussions with respect to the implementation of permanent telehealth, aiming for a MYEFO announcement.

The AMA made a submission in response to Primary Health Reform Steering Group Draft Recommendations, broadly welcoming the directions outlined and emphasising that implementation and funding will now be the key.

The AMA met with the Federal Minister for Health and the Department of Health on 19 August to discuss the AMA Federal Council's concerns with respect to the GP training transition. While the Minister is keen to proceed with the 1 February 2023 deadline for transition, the Department is further considering the timing of changes and whether some aspects of the RACGP's proposals properly fell within the remit of the college. The AMA met with the RACGP on 19 August to discuss the college's plans for the transition of GP training.

The AMA has finalised a submission in response to the review of General Practice Accreditation and this was lodged on 8 September. The submission was informed from consultations over the preceding months within representatives of Quality Practice Accreditation, Australian General Practice Accreditation Limited, RACGP and the AMA Federal Council of General Practice. GP members also assisted MP Consulting with background insight to inform the review consultation paper. The AMA submission supported maintaining the key strengths (i.e. voluntary and profession led) of accreditation, modifying the assessment process for practices mature in accreditation to provide ongoing assurance of conformity with the standards and to minimise the administrative burden, and streamlining accreditation requirements for practices and supervisors participating in training activities.

DOCTORS-IN-TRAINING

The AMACDT and Specialist Medical College Trainee Committee Chairs and Representatives met via video conference on 28 July to discuss costs of training.

The AMACDT has been talking to colleges about how to ensure examinations can progress wherever possible in a COVID safe manner for the remainder of the 2021 year and into 2022, and arrive at a situation where colleges inform trainees of examination plans and contingencies in advance. Most recently, the AMA pursued concerns with RACS over the cancellation of fellowship exams, noting that the exams were reinstated.

The AMACDT coordinated a meeting between expert doctors' wellbeing stakeholders, R U OK? and Black Dog Institute to discuss a campaign to target bullying and harassment in the medical workplace. This is an ongoing project which hopes to deliver a campaign in early 2022.

MEDICAL PRACTICE

The Annual Workshop of the AMA, Medical Board of Australia and the Australian Health Practitioner Regulation Agency (Ahpra) was held virtually on 4 August. Key issues discussed included an update on changes to the notification process and the impact they are seeing from these improvements; and the impact of the pandemic on their operations, but particularly on registrations and applications from overseas practitioners. The meeting was also given an update on the implementation of the new ministerial directions and the revised CPD Registration Standard and proposal for health checks for late career practitioners.

The AMA participated in TGA smoking cessation meetings on 25 August and 8 September. Dr Chris Moy reiterated the AMA's concerns and flagged our intention to further advocate for changes to nicotine vaping implementation. Dr Moy and staff have participated in several other meetings on this issue with various stakeholders such as Minister Hunt's office, TGA, RACGP, MIGA, Cancer Council, Quit, and the University of Wollongong.

On 26 August, AMA staff met with the Federal Department of Health to discuss the commitments announced by Minister Hunt in June regarding more time to be allowed between finalisation of changed MBS items and their commencement and a new rapid review process to correct any errors and unintended consequences. The Department advised that they would convene a high-level workshop of the key stakeholders including the AMA, private health insurers and private hospitals. The Department is also developing a framework to triage the errors and unintended consequences to prioritise MBS amendments to correct these.

PRIVATE SPECIALIST PRACTICE

The AMA continues to meet regularly with key stakeholders on Prostheses List reform issues.

PUBLIC HEALTH

The AMA appeared before the Select Committee on Mental Health and Suicide Prevention on 6 August. Represented by Dr Omar Khorshid and Dr Danielle McMullen, they spoke about fragmentation in the mental health system, mental health workforce, the need to support delivery of mental health care through GP clinics, shortages of psychiatrists and the underlying social determinants of mental health.

The AMA made a submission to the Department of Social Services' consultation on the Next National Plan to Reduce Violence Against Women and their Children on 31 July. The submission calls for increased support for first-line responders, focus on the underlying drivers of violence and a systematic approach to working with at-risk communities.

The AMA is undertaking significant advocacy work on health and climate change in the lead-up to COP26 in November.

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

HOLIDAY HOMES TO BUY OR NOT TO BUY

Wakelin Property Advisory is an independent buyer's agent specialising in acquiring residential property for investors. www.wakelin.com.au

Listen to Jarrod's podcast, Rewarding Property Decisions

With international travel off the cards for so long, many Australians may have the extra cash and inclination to consider purchasing a holiday home.

It's a trend we saw leading into summer last year, with popular Australian holiday spots, such as Byron Bay, Mornington Peninsula, Queensland's Whitsundays and Tasmania's Huon Valley all experiencing strong demand.

While there's no doubt holiday homes offer fantastic lifestyle opportunities, as an investment prospect they can be a little more complicated.

Let's dissect the pros and cons of buying a holiday home.

PROS

Home-from-home. Buy a holiday property and you have another place you can call home; one that you'll furnish with the fittings of your liking and, over time, memories of wonderful times. And whilst some pre-trip packing will always be necessary, those with a well-established holiday home needn't fill the car to overflowing every time they go away.

Unlimited access. Own a holiday home and you can get away all year round – a fortnight here, a week there, plus several long weekends. Spontaneity is easy. No need to book ahead or worry about peak rate fees. This is especially appealing amid international and inter-state travel restrictions, local lockdown predicaments permitting.

Earn an income. Many holiday homeowners decide to mitigate the holding cost of a holiday home by leasing it out for short term rentals. With peak weekly rents for even modest holiday homes reaching four figures, it's possible to make quite an impact. Moreover, for any period a property is available for lease, owners are able to offset in their tax return any losses due to a gap between net rental income and holding costs.

A place to retire. A holiday home can, in time, morph into the primary residence once the kids leave home and the owners shift from full-time to part-time work and, eventually retirement. In the ideal scenario, the city home is sold to help fund the retirement lifestyle.

Capital growth. Finally, there is the potential for the property to appreciate in value over the life of the holding. This factor has been particularly pronounced in the wake of COVID-19, which has seen significant price rises across many holiday home and regional markets, driven by the work from home trend and a preference for more space. Reading these pros, you would be forgiven for thinking that a holiday home is the gift that keeps giving. But there are downsides.

CONS

They aren't cheap. The days of finding a cheap holiday home one to two hours' drive from a capital city are long gone, particularly post COVID-19. So to realise the dream, you may have to take on a substantial mortgage.

Empty most of the year. Even the most active users of holiday homes are rarely there for more than a fraction of the year. Unless you are renting out the property at other times, the effective cost of those visits can far exceed the short-term leases for renting a holiday property for the equivalent days.

Lack of variety. Some holiday homeowners do get bored with visiting the same place and can feel 'shackled' to the property. They feel obliged to visit regularly to justify the holding costs or feel guilty if they don't reside there.

Leasing downsides. By leasing out a property, an owner can mitigate some of these downsides. But beware of the sacrifices of leasing. You immediately lose some of the initial attractions of the property. You can't be so happy-go-lucky about how you furnish the place or the state you leave it in after every visit. It needs to be back in tenantable order after every visit you make. You might be fine with that but it can dilute the holiday home ambience. If you want to earn a reasonable rental income then say goodbye to using the property in the peak seasons of summer and Easter. Further, when doing your calculations about potential income, beware that the costs of short-term leases are much higher than long-term leases. In the first instance, a high turnover of short-term renters subjects a property to much more wear and tear than a traditional lease.

Sub-investment grade capital growth. Capital growth for holiday homes tends to lag that of good properties in our capital cities. The work from home and regional living trends may impact this somewhat, but ultimately over the longer term demand has proven to be far more consistent in our cities, with supply more restricted compared to holiday locations. Sure there can be a run of years when impressive hikes in values are recorded, but these are usually offset by lean years. One of the biggest factors holding back holiday properties is that they are usually a discretionary purchase. In weaker economic times they are among the first things to be sold.

For these reasons, if you are buying a property primarily to make money do not buy a holiday home – there are far better options out there. However, if you are buying predominately for lifestyle and family enjoyment factors then it makes perfect sense. But perhaps consider leasing a property for a year in your desired location first, to gain a feel for the area before making a more permanent and long-term decision.

PAID PARENTAL LEAVE: WHAT YOU SHOULD KNOW

Are you contemplating how a baby might affect your life? There's one thing for sure. Besides the immense joy a baby brings, raising a child is a big responsibility. That's where the Australian Government's Paid Parental Leave (PPL) scheme can help.

REPORT VANESSA SMITH BBUS (ACC), ADV DIP FS (FP) CERT IV FMB SENIOR CONSULTANT, BONGIORNO GROUP

PPL reflects the Government's recognition that parents need time to bond with their newborn babies. Being with your baby full-time in those important first months also helps you adjust to parenthood.

The PPL program provides up to 18 weeks of paid leave at the national minimum wage.

To be eligible, you must:
- be the child's primary carer
- meet the program's income test
- meet the program's work test
- comply with the program's residency rules.

Income test

Australia's PPL is a means tested program. This means that to qualify, your individual adjusted taxable income in the financial year prior to the birth of your baby, or date of your claim, must be $150,000 or less. Adjusted taxable income includes:
- the final income amount on which your tax obligation is calculated after all tax deductions and tax credits have been subtracted
- reportable fringe benefits, as in grossed salary packaging
- reportable superannuation contributions, as in extra tax-deductible superannuation contributions
- net investment losses, as in negative gearing on a property
- income from foreign sources, including tax-exempt income.

Income test example

Claire is a registered medical officer at a public hospital. Claire's taxable income for the financial year before the baby is born is:
- Taxable income – $130,990 (gross income – $140,000, minus salary packaging at the cap threshold – [$9,010]).
- Plus 'grossed up' salary packaging – $17,000, plus negatively geared investment loss – $3,475.
- Final adjusted taxable income – $151,465.

Work test

To qualify for the PPL program, Claire must meet both of the following criteria:
- She must have worked over 10 of the 13 months prior to the birth of her baby.
- The number of hours she worked over this time period must total at least 330, which works out to around one day of work per week.

Residency test

Only Australian citizens, permanent visa or special category visa holders are eligible for the PPL scheme.

If you have questions about the Australian PPL scheme, please don't hesitate to contact Bongiorno Group for more information.

YOUR WELLBEING

Self-compassion for doctors

Click here to find out more

Having compassion for oneself is no different to having compassion for others. With self-compassion, we give ourselves the same kindness and care we'd give to a good friend. Self-compassion involves acting the same way towards ourselves when we are experiencing a difficult time, failure, or notice something we don't like about ourselves.

Instead of just ignoring our pain with a 'stiff upper lip' mentality, we stop to tell ourselves, "This is really difficult right now, how can I comfort and care for myself in this moment?"

Instead of mercilessly judging and criticising ourselves for various inadequacies or shortcomings, self-compassion means we are kind and understanding when confronted with personal failings. After all, who ever said we are supposed to be perfect?

REPORT **KAY DUNKLEY AMAV COORDINATOR OF DOCTOR WELLBEING**

THERE ARE THREE ELEMENTS TO SELF-COMPASSION:

01

SELF-KINDNESS VERSUS SELF-JUDGMENT

Self-compassionate people recognise that being imperfect, failing and experiencing life difficulties is inevitable, so they tend to be gentle with themselves when confronted with painful experiences rather than getting angry when life falls short of set ideals.

02

COMMON HUMANITY VERSUS ISOLATION

Self-compassion involves recognising that suffering and personal inadequacy is part of the shared human experience – something that we all go through rather than being something that happens to 'me' alone.

03

MINDFULNESS VERSUS OVER-IDENTIFICATION

Self-compassion involves putting our own situation into a larger perspective. It also stems from the willingness to observe our negative thoughts and emotions with openness and clarity, so that they are held in mindful awareness.

MORE THAN MED

DR DON McMAHON

Retired ENT Specialist

For my first eight years, I worked at the Royal Victorian Eye and Ear Hospital and lectured in the School of Audiology, as well as research into Evoked Response Hearing Testing of infants. This was in anticipation of the Cochlear implant being successful. I also represented the University of Melbourne a government committee for recommending the compulsory wearing of ear protection in noisy industry. The rest of my career was in both a standard ENT practice and a medico-legal practice specialising in noise-induced deafness. The last six years I was a member of the Medical Panels to the court system. After my clinical retirement, aged 66, I continued as a visiting lecturer, plus working with Australian Hearing. I was 72 years of age at my full retirement.

As retirement approached, I anticipated I would travel and study botany. I had collected specimens from 400 different species of Eucalypts. I had written a book called *Eucalypts for Enthusiasts* which sold well. I thought my retirement was all worked out, but things took a different course.

I was brought up in a church community that advocated following a healthy lifestyle. Once I was professionally established I started giving health talks. Initially on 'stop smoking' programs, but then to my church community on more general lifestyle habits.

For 40 years I have followed the literature and given weekly presentations to my community. The material just kept flowing in. I wrote a book on my church's involvement with healthful living. The book went worldwide. I lectured all over Australia and in 2005 I was invited on a three-month lecture tour of the USA. As well as many community lectures, I also assist my wife at a weekly program for lonely seniors. I bought an opportunity shop, raising money for charity including a woman's refuge. I smoothly shifted from medical to charity work without loss of work satisfaction.

Share an interest or a hobby away from medicine! Email: vicdoc@amavic.com.au

SPECIAL OFFER ON RANGE ROVER EVOQUE FOR AMA MEMBERS

With its sleek, contemporary design, the Range Rover Evoque is perfectly adapted to the city. Distinctive and individual, a true Range Rover in compact form. AMA Victoria Members can now enjoy the benefits of the Jaguar Land Rover Corporate Advantage Programme, including:

- 5 years free scheduled servicing*
- Reduced new vehicle delivery costs**

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**Reduced delivery fees of up to maximum of $1995+GST.