DIGITAL HEALTH

# VICDOC

AMA VICTORIA

SPRING 2023

## ON DIGITAL HEALTH

Reflections from thought leaders

How data shaped the National Medical Workforce Strategy

AI + doctor-patient communication

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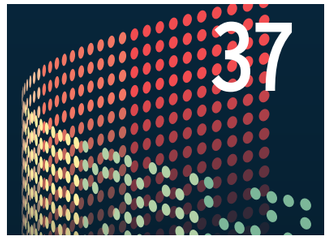



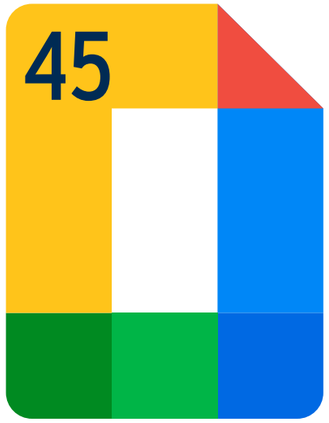




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# NEWS, VIEWS & REVIEWS

**IN RESPONSE TO A LEAKED DOCUMENT OUTLINING THAT VICTORIA HAS FAILED TO HIT ITS TARGET FOR MONTHLY ELECTIVE SURGERIES NEEDED TO CLEAR THE COVID-19 BACKLOG, AMA VICTORIA PRESIDENT DR JILL TOMLINSON SPEAKS WITH THE AGE.**

*Click here to read*

**AMA VICTORIA HAS BEEN RAISING ITS SERIOUS CONCERNS ABOUT THE UPCOMING PHARMACY PRESCRIBING PILOT WITH THE VICTORIAN GOVERNMENT, A TOPIC WHICH MEDIA HAS REPORTED ON WIDELY:**

*Click here to read*

*Click here to read*

**AMA VICTORIA HAS BEEN ADVOCATING TO THE STATE GOVERNMENT SINCE 2020 TO RELIEVE GENERAL PRACTICE FROM STATE PAYROLL TAX. STAKEHOLDERS RECENTLY COMBINED THEIR VOICES ON THIS ISSUE:**

*Click here to read*


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## IN REVIEW: READ | WATCH | LISTEN


**BRUNY**

*Fiction by Heather Rose (2019)*

A fine piece of Australian fiction with a plot that seems all too possible, Bruny is award-winning writer Heather Rose's eighth novel. Set in Tasmania, it's a story of family, politics and love in a changing world. Part fiction, part love story and part thriller, Bruny's major story arc explores the building of a huge bridge to connect Bruny Island with mainland Tasmania, and what happens when terrorists blow it up. Main character Astrid Coleman, a UN trouble shooter with war zone experience, returns home to help her politician brother navigate the bombing's social and political fallout before an upcoming election. The novel delves into themes such as political manipulation, environmental concerns, and family dynamics. As Astrid navigates the complexities of the situation, she must confront her own past and make difficult choices that will impact her family and her home.

**BARBIE**

*Movie directed by Greta Gerwig (2023)*

We know, we know. We didn't think we'd ever go and see the Barbie movie either. But this Barbie has been deconstructed and reinvented by a dream team of writers, actors and producers, including director Greta Gerwig (Lady Bird, 20th Century Women) and Australian-born producer-star Margot Robbie (Neighbours, The Wolf of Wall Street, Tonya) with wit, humour and a dose of subversive irony on the agenda. In the beginning, Barbie exists in a perfect pink Barbieland where iterations of herself are in charge – think President Barbie, Lawyer Barbie and Journalist Barbie. But when she and Ken leave for the real world, they each journey – Ken into the patriarchy and Barbie into an existential depression that prompts her to question her place in the world. It's ridiculous, clever and riotously entertaining, with pithy cultural references, self-deprecating humour and laugh out loud moments at every turn.


**WISER THAN ME**

*Podcast hosted by Julia Louis Dreyfus (2023)*

"Each week, I'm going to get schooled by women who are older and much wiser than me," says Julia Louis Dreyfus (Seinfeld, Veep), as introduction to her new podcast. And she does, chatting with the likes of Jane Fonda, Rhea Perlman, and Isabel Allende. It's a refreshing, sometimes personal listen as they reflect on their careers, family, relationships and the challenges of ageing. Wiser Than Me launched in March 2023, and to great success – shortly after its debut, it was the number one show on Apple Podcasts. The only negative is the presence of lengthy advertisements at the midpoint of the hour or so long podcast, where Dreyfus endorses various products – presumably at the behest of production company, Lemonada Media. It's a touch forced, so tune out of that bit if you can – because the rest is pure gold.



RESEARCH

# CO-TRAINING AI TOOL CAN MIMIC SECOND OPINION PROCESS

*Click here for study published in Nature Machine Intelligence*

A new co-training AI algorithm for medical imaging, developed by researchers from Monash University, is said to mimic the process of seeking a second opinion.

The research aims to address the limited availability of human annotated, or labelled, medical images by using an adversarial, or competitive, learning approach against unlabelled data.

PhD candidate Himashi Peiris of the Faculty of Engineering said the research design had set out to create a competition between the two components of a "dual-view" AI system.

"One part of the AI system tries to mimic how radiologists read medical images by labelling them, while the other part of the system judges the quality of the AI-generated labelled scans by benchmarking them against the limited labelled scans provided by radiologists," Peiris said.

"Traditionally, radiologists and other medical experts annotate, or label, medical scans by hand, highlighting specific areas of interest, such as tumours or other lesions. These labels provide guidance or supervision for training AI models.

"This method relies on the subjective interpretation of individuals, is time-consuming, and prone to errors and extended waiting periods for patients seeking treatments."

The availability of large-scale annotated medical image datasets is often limited, as it requires significant effort, time and expertise to annotate many images manually, the researchers said.

The algorithm is designed to allow multiple AI models to leverage the unique advantages of labelled and unlabelled data, and learn from each other's predictions to help improve overall accuracy.

"Across the three publicly accessible medical datasets, utilising a 10% labelled data setting, we achived an average improvement of 3% compared to the most recent state-of-the-art approach under identical conditions," said Peiris, claiming the algorithm demonstrates remarkable performance even with limited annotations, unlike algorithms that rely on large volumes of annotated data.

"This enables AI models to make more informed decisions, validate their initial assessments, and uncover more accurate diagnoses and treatment decisions."

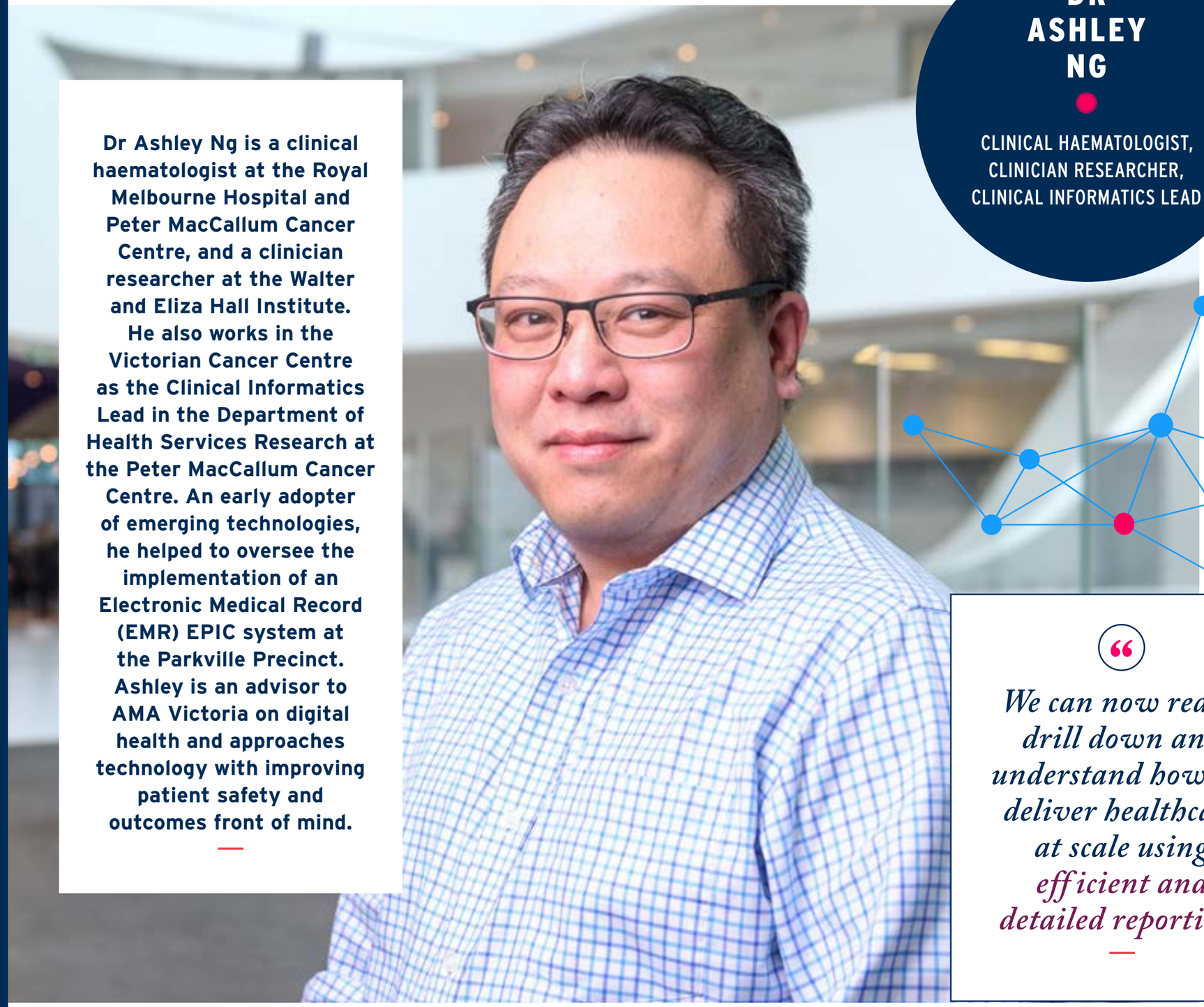
The next phase of the research will focus on expanding the application to work with different types of medical images and developing a dedicated end-to-end product that radiologists can use in their practices.

DIGITAL HEALTH FEATURE

# ON DIGITAL HEALTH

**Reflections from thought leaders on digital healthcare, data security and how digital technology is shaping future healthcare.**

SERIES **VANESSA MURRAY**



# DR ASHLEY NG

CLINICAL HAEMATOLOGIST, CLINICIAN RESEARCHER, CLINICAL INFORMATICS LEAD

**Dr Ashley Ng is a clinical haematologist at the Royal Melbourne Hospital and Peter MacCallum Cancer Centre, and a clinician researcher at the Walter and Eliza Hall Institute. He also works in the Victorian Cancer Centre as the Clinical Informatics Lead in the Department of Health Services Research at the Peter MacCallum Cancer Centre. An early adopter of emerging technologies, he helped to oversee the implementation of an Electronic Medical Record (EMR) EPIC system at the Parkville Precinct. Ashley is an advisor to AMA Victoria on digital health and approaches technology with improving patient safety and outcomes front of mind.**

*“We can now really drill down and understand how we deliver healthcare at scale using efficient and detailed reporting.*

## AT A FUNDAMENTAL LEVEL, CLINICAL INFORMATICS USES CLINICAL DATA TO UNDERSTAND AND IMPROVE PATIENT OUTCOMES.

Clinical informatics isn’t a new concept – it’s a decades-old interdisciplinary field that describes the practice of analysing health data to help understand and improve our healthcare services. We’re thinking about how we use information technology in medical care, how we analyse patient data and how we can use that information to inform our decision making, including how we may personalise care to improve health outcomes for our patients. In today’s world, where patient care can be dependent on several different technological platforms, it’s also about understanding how we integrate medical data and information technology to better manage patient treatment. This means we must now consider the spectrum of patient data management – from understanding how best to use technological tools to the laws and regulation around the use of health data while maintaining patient privacy and data security.

## OUR IMPLEMENTATION OF AN EMR SYSTEM HAS HIGHLIGHTED THE ABILITY OF DIGITAL TECHNOLOGY TO FACILITATE BETTER CLINICAL CARE.

At the Parkville Precinct we went live with the EMR system in August 2020. Previously, we had decades’ worth of patient information on paper. To access the data, we had to request large paper folders from our archives for every patient encounter that needed a lot of manual handling, filing and re-filing. The EMR has been revolutionary for us. Not only can important information be available to several healthcare providers at once, its efficiency and structure as a large health database allows us to analyse our metrics in a more ambitious way. We can now really drill down and understand how we deliver healthcare at scale using efficient and detailed reporting. It has also helped us to understand more about how our service operates and integrates with other hospitals at a whole new level.

> *Our ability to analyse health data is improving all the time. The next step is to think about how best we can use our data infrastructure within current regulations around patient data privacy and secondary use of health data, to be able to better understand how healthcare is delivered at a whole of system level.*

### I EXPECT THAT IN 10 YEARS' TIME, EMRS ARE GOING TO BE IN PLACE ACROSS AUSTRALIA, IF NOT INTERNATIONALLY.

Australia is in the fortunate position of being able to afford and implement EMRs for healthcare services. While these systems are expensive, I think as the benefits of EMRs become more apparent, it is just a matter of time until most hospitals will have them implemented. New South Wales Health, for instance, is moving to implement a single EMR system for their hospitals over the next decade. EMRs will become the gold standard for how we record and analyse health information, how we securely communicate with our patients and colleagues, as well as how we analyse and report our health data.

### WE'RE WORKING TOWARDS A BETTER UNDERSTANDING OF THE SOCIAL DETERMINANTS OF HEALTH AT A WHOLE OF SYSTEM SCALE.

Our ability to analyse health data is improving all the time. The next step is to think about how best we can use our data infrastructure within current regulations around patient data privacy and secondary use of health data, to be able to better understand how healthcare is delivered at a whole of system level. This will inform how healthcare is delivered from the ground up to our patients, but also from the top down as governments seek to understand where the deficits are, and to formulate policy to address those deficits. This includes the ability to think about important social determinants of health that can significantly impact healthcare delivery and health outcomes. This lies at the heart of health services research where, by using a learning health systems approach, we can understand and progressively improve our healthcare systems.



### WE NEED TO UNDERSTAND AND KEEP IN MIND THE LIMITATIONS OF ARTIFICIAL INTELLIGENCE BY DEVELOPING A SOPHISTICATED AND NUANCED UNDERSTANDING, AND APPROACHING ITS USE CONSTRUCTIVELY, NOT REACTIVELY.

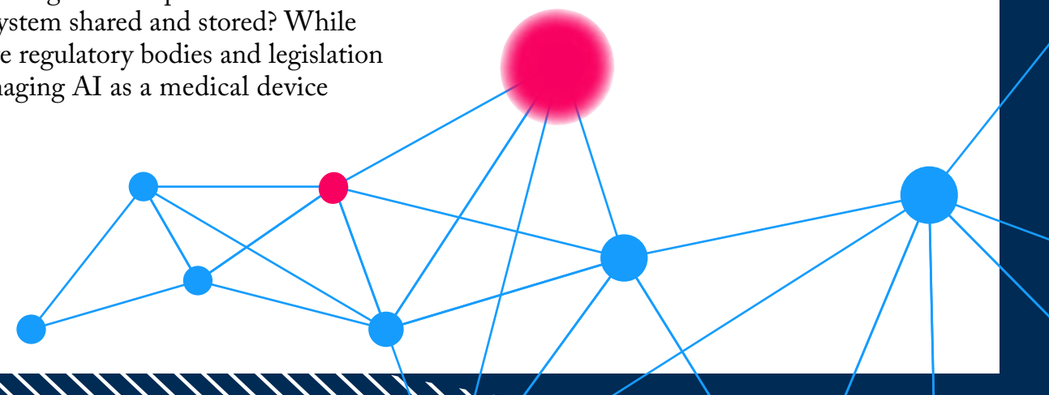
In the past, someone had to be a specialist to be able to implement and use sophisticated AI models. If we have learnt anything from the large language model revolution that's happened over the last year, it's that lowering the bar by using simple interfaces to complex AI tools will encourage people to use them! So now it's become possible to query a large language model trained on a large corpus of written knowledge and get a very human response back. Of course, this information includes the potential to answer medical questions. This has prompted a renaissance into how AI can be used in healthcare.

### LIKE ANYTHING ELSE WE USE FOR CLINICAL DECISION MAKING AND PATIENT TREATMENT, ALL OUR ACTIONS IN A DIGITAL HEALTH ENVIRONMENT MUST KEEP A PATIENT'S BEST INTERESTS AT THE FORE.

When it comes to AI, important questions remain. For instance, how have the models been trained? Are they up to date? Are there inherent biases in the training data that will influence how the model responds? How might the answers potentially be reasonably accurate for some patients, yet yield inaccurate or inappropriate answers for others? What kind of data is the AI model drawing on, or generating? How is private data entered into a system shared and stored? While there are regulatory bodies and legislation for managing AI as a medical device already in place in Australia, before we even contemplate implementing any type of clinical decision support tool, we need to properly consider the implementation and monitoring of these systems as part of our quality control measures. Issues really arise when things go wrong. We need to know when this occurs, and how to deal with them.

### DATA SECURITY IS PARAMOUNT TO DIGITAL HEALTH.

There is government legislation that governs patient privacy that we must all adhere to. This is enshrined in Section 95A of the Privacy Act. Within this act is also the NHMRC's Australian Code for the Responsible Conduct of Research which clearly defines who can access patient data and for what purpose. When it comes to digital health, data security is a major concern for the general public – and for us. Protecting the public and their health data is paramount, which is why we have very strict guidelines and laws in place. To comply with these requirements, we must have secure information technology platforms that allow for the appropriate use of health data while preventing inappropriate data use and access. With so much of clinical care now relying on these platforms, information technology departments must be acutely aware of data security, as hacking of health data systems is a very real and present danger that can significantly impact the delivery of healthcare for our patients.



# DR HONOR MAGON

CLINICAL PRODUCT SPECIALIST, FULBRIGHT SCHOLAR

**Dr Honor Magon is a practicing doctor training in occupational medicine who was awarded a Fulbright Scholarship in 2022. Honor took a hiatus from clinical care to undertake a Fulbright Future Scholarship, which has included completing a Master of Science in Clinical Informatics Management at Stanford University, working on research, papers and conference presentations, and experiencing working on the tech side of healthcare with digital company Komodo Health. Honor was an AMA Council of Doctors in Training and Digital Health Subcommittee member. Honor is passionate about clinical care and plans to maintain her clinical license and return to Australia in the next few years.**

*“In medical school and beyond, I always felt a bigger drive to do more with the expertise of being a medical doctor than just treating one patient at a time.*

**I'VE BEEN INTERESTED IN THE INTERFACE BETWEEN TECHNOLOGY AND HEALTHCARE FOR MOST OF MY LIFE.**

My dad worked for the public health service in Queensland. He was a systems administrator focused on writing and maintaining epidemiological databases during the HIV-AIDS epidemic. In medical school and beyond, I always felt a bigger drive to do more with the expertise of being a medical doctor than just treating one patient at a time. In 2019-2020, I became actively interested in digital health through a group called Creative Careers in Medicine that got a group together to do the Australasian Institute for Digital Health's Certified Health Informatician Australasia (CHIA) certification. I did that certification at the beginning of 2020, and it inspired me to call the director of the Digital Health Service at Metro South Health – Australia's first digital health service – to see if he'd be open to me working with them. Surprisingly, he said yes.

**ANOTHER EXPERIENCE THAT INFLUENCED ME WAS BEING OUT IN LONGREACH [QUEENSLAND] PRACTICING AS A JUNIOR DOCTOR AND SEEING SOMEONE RECEIVE TELECHEMOTHERAPY FOR THE FIRST TIME.**

This patient's specialist was at the Royal Brisbane Hospital, more than 20 hours' drive away. But they were able to receive immunotherapy at their small-town local hospital. The patient had a video consultation with their consultant medical oncologist directly before receiving the immunotherapy treatment. I was able to observe firsthand how technology was able to facilitate a high level of care, while enabling that rural patient to stay close to home. I thought, how amazing is that? I'm still in awe of how we can use technology to augment patient experience.

**WHILE I WAS AT STANFORD, I SPENT SOME TIME RESEARCHING HOW WE ARE MEASURING PHYSICIANS' WORKLOADS.**

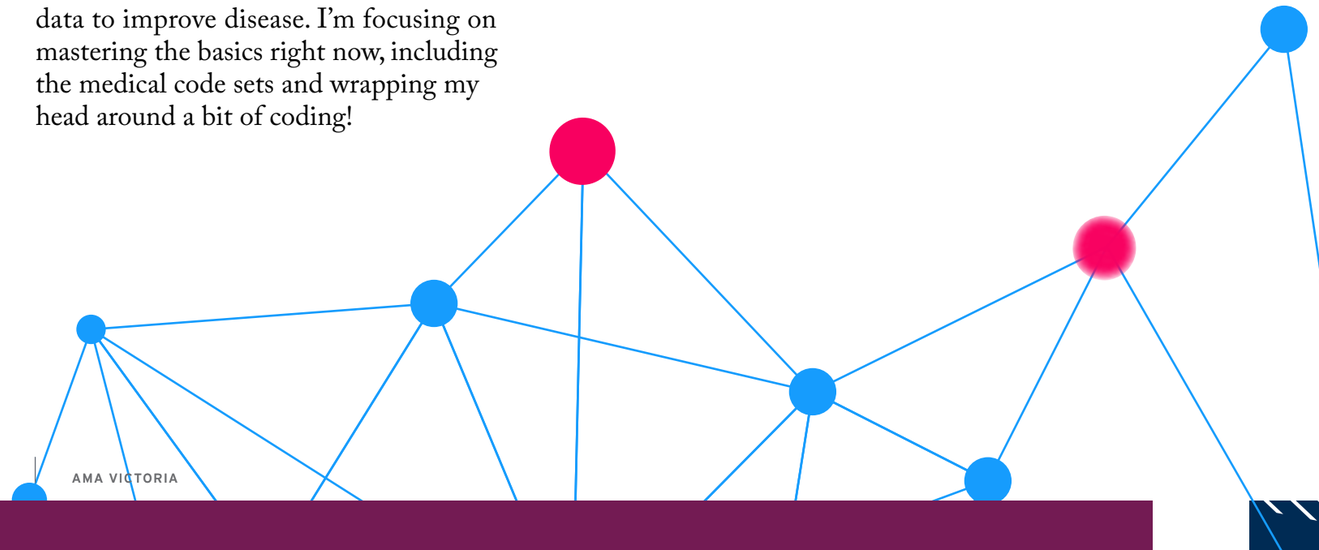
This research was in addition to completing my Masters at Stanford, while on my Fulbright Scholarship. I'll be presenting on this research at the American Medical Informatics Association National Conference and the American Conference for Physician Health at the end of the year. It looks at how we best measure the amount of time that physicians are spending on computers. Another paper that I'm working on is about the clinician perceptions of AI and video monitoring technology in an ICU department at a local hospital.

**WHAT'S CURRENTLY OCCUPYING ME IS A FULLTIME ROLE AS A CLINICAL PRODUCT SPECIALIST FOR A COMPANY CALLED KOMODO HEALTH.**

Komodo Health is a health technology company with the mission to ease the global burden of disease. It does this by combining data about patient encounters with innovative algorithms and clinical expertise to power its HealthCare Map. This is a view of the US healthcare system, and one of the largest aggregated sources of patient data in the US – like claims, electronic health records and other data sets. Data is powerful, and I'm working at Komodo as I want to learn how we can use data to improve disease. I'm focusing on mastering the basics right now, including the medical code sets and wrapping my head around a bit of coding!

**WE DON'T KNOW WHAT THE FUTURE OF TECHNOLOGY IN HEALTHCARE IS GOING TO LOOK LIKE IN 10- OR 20-YEARS' TIME.**

Technology and AI are moving so fast. I'm watching generative AI carefully, and I think a lot of other people are too. How is generative AI in large language models going to transform the way that we look for information in healthcare? How is it going to transform the way that we use information in healthcare? It's such an exciting area. I'm especially interested in the potential that generative AI has for reducing the burden of documentation for clinicians, for example by creating summaries and quickly finding relevant patient information in notes that a doctor would otherwise have to take time scanning for, like finding and summarising every cardiovascular intervention a patient has had – this is information that I used to spend hours trying to find as a junior doctor. It could enable us to do less paperwork and spend more time in front of patients.



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**I'VE BEEN REALLY IMPRESSED WITH HOW MUCH AUSTRALIA HAS ACHIEVED IN THE DIGITAL HEALTHCARE SPACE IN THE PAST FEW YEARS, PARTICULARLY AROUND ACCESS TO DATA.**

It seems that Australia is more open to sharing data and working towards an integrated health record for everyone by virtue of My Health Record. It has its issues, but overall, to have that level of access to data is fairly progressive. If you try and do something like that here in the US, it's very difficult. There are a lot of private entities that are unwilling to relinquish those data sources and share them with one another to benefit patient care. There's lots of duplication of tests, a lot of misdiagnoses, and missed diagnoses. That's one of the bigger barriers I see here.

**THE DEPLOYMENT OF INNOVATIVE MODELS OF CARE IS AN AREA WHERE THE US IS REALLY PUSHING THE ENVELOPE.**

There's a larger scale for deploying innovative models of care in the US, and there are different incentives as well. Australia seems more risk averse in this space, but then Australia has less than a tenth of the population the US does, so scalability is harder. I'm particularly interested in studying Telemental healthcare here in the US, and the model of being able to provide someone with a person-centered service around their mental health that doesn't just stop in the consult room. There's been a big investment in mental healthcare in the US, and I'm interested in things like chat-based therapy, video game-based therapy, voice and digital biomarkers to monitor progression or onset of mental health conditions, and personalised mental health care. It's really an exciting time.

# DR RICHARD HORTON

DIRECTOR – DEPARTMENT OF ANAESTHESIA, PAIN & PERIOPERATIVE MEDICINE, AND CMIO

**Dr Richard Horton is Director of the Department of Anaesthesia, Pain & Perioperative Medicine and Chief Medical Informatics Officer at Western Health. Prior to that he was Deputy Director of the Department and had various leadership roles within the Australian and New Zealand College of Anaesthetists including being an examiner, Regional Education Officer and chairing various committees related to curriculum development. In 2021 Richard spent six months on sabbatical with the Digital Health branch of the Victorian Department of Health, where he focused on health information sharing, privacy assurance, meaningful use of My Health Record and clinical governance.**

*"I had my own library of textbooks and made all my notes by hand which helped imprint the information into my brain.*

**WHAT DRIVES ME IS IMPROVING HEALTH CARE; FUNDAMENTAL TO MY ROLE AS THE CHIEF MEDICAL INFORMATICS OFFICER IS IMPROVING CLINICAL INFORMATION SYSTEMS.**

This role represents the clinical needs of medical officers regarding information science. I am also the co-chair of our organisation's national standard 6 committee, Communicating for Safety, which is what information science is all about in the health sector. In large organisations, roles that speak the language and understand the issues faced on both sides of the technological divide are required. I am a bridge for information science between our non-clinical directors who roll out our systems and our health services executives who have ultimate responsibility for the quality and safety of patient care.

**I STARTED MY CAREER BEFORE THE ADVENT OF PERSONAL COMPUTING AND THE INTERNET.**

Halfway through my intern year, we were able to view pathology results on a screen rather than ring or visit the pathology department for a printout. To view medical imaging, we had to go to their department and find a radiologist. Everything else was on paper and a lot of time was spent dictating and reviewing discharge summaries. I did not buy my first computer until I finished my specialist exams. I had my own library of textbooks and made all my notes by hand which helped imprint the information into my brain. I made a pledge to myself to embrace technology as it became available.

> *[AI's] ability to replicate autonomous human movement is a long way behind the ability to replicate autonomous human thinking, so those of us in medical specialties with a large procedural component are unlikely to see any significant impact for some time.*

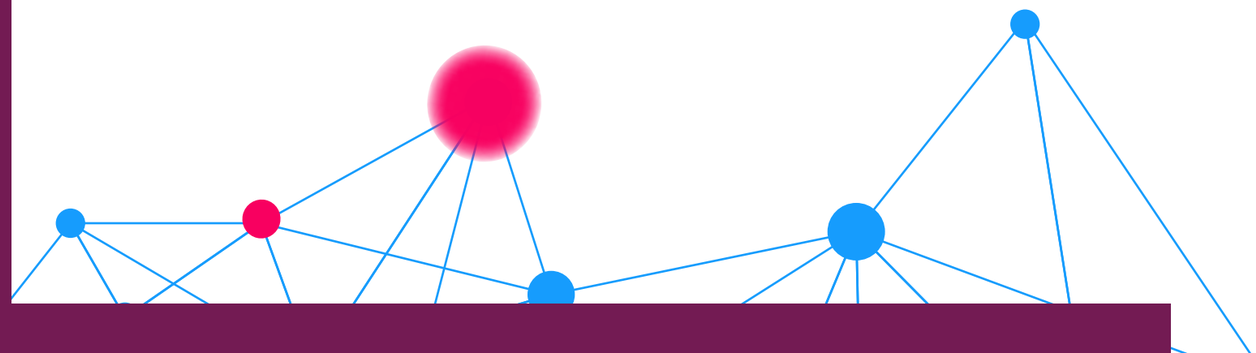
**MY VISION IN MY ROLE IS TO HAVE EFFECTIVE TEAMS THAT CAN DELIVER CLINICAL INFORMATION SYSTEMS THAT ENABLE CLINICIANS TO DELIVER THE BEST POSSIBLE CARE.**

Healthcare is only becoming more complex, and team dependent, as time goes on. Through digitisation, we can improve the legibility and accessibility of clinical information as well as monitor outcomes in real time rather than depending on retrospective and time-consuming audits.

In the initial stages any new systems must be thoroughly tested to allow for review and design improvement. Once we get the fundamentals of new systems right, we can then move on to introduce more cutting-edge technologies.

**DATA SECURITY IN HEALTHCARE IS FUNDAMENTAL TO THE INFORMATION SIDE OF OUR BUSINESS.**

The experts in this area are the non-clinicians within the health information management area for what is still on paper, and the digital technology area for what has been digitised. What we can do is ensure that these teams have the support and oversight to be doing their job to the best of their ability. At Western Health we have access to 24/7 data protection services, which means we have experts monitoring and responding to any threats in real time, at all times. Accreditation of healthcare facilities must ensure that external oversight is also provided.



**WE HAVE PROBABLY HAD MORE ISSUES WITH BREACHES OF PATIENT PRIVACY WITH HARD TO TRACE PAPER BEING LEFT AROUND AND PHOTOCOPIED THAN WE DO WITH OUR DIGITAL INFORMATION, WHERE WE CAN TRACE A DIGITAL FINGERPRINT.**

There is concern that the wider the access to digital health data we provide, the greater the risk that someone will access and use information inappropriately. I think we can be reassured that the existing checks and balances that are in place seem to be working well. One interesting suggestion I've heard that may be worth considering is to let health consumers have free access to their own records and see who has been accessing them to provide a degree of reassurance.

**DEVELOPING A TECHNOLOGY AND THEN LOOKING FOR A USE FOR IT MAY POTENTIALLY CREATE A PROBLEM THAT DOES NOT CURRENTLY EXIST. IT IS LIKE PUTTING THE CART BEFORE THE HORSE.**

I am also concerned about the potential that technology brings to lessen incidental human interaction. We are finding that our junior medical staff are not spending enough time on the wards as they can complete many of their tasks elsewhere. This may be affecting the building of professional relationships that are so important to healthcare.

**I USE TECHNOLOGY AS A TOOL IF IT WILL IMPROVE MY ABILITY TO BE EFFECTIVE, EFFICIENT AND BUILD GOOD WORKING RELATIONSHIPS.**

It's very important to understand the limitations of technology. If there is important information a GP needs to know when a patient leaves hospital, get them on the phone and have the discussion then provide the patient with something in writing that they can hold in their hand. If you need to have a difficult conversation with a colleague, do it face to face if you can.

**IF WE APPLY THE SAME RIGOROUS ETHICAL AND SCIENTIFIC PROCESSES TO AI AS WE HAVE TO OTHER ASPECTS OF MEDICINE, WE CAN BE OPTIMISTIC.**

We are starting to see the benefits of using mobile devices rather than having clinicians stuck behind a desk. Decision support tools, including those driven by AI rather than simple algorithms are showing potential but are probably still the subject of research rather than established and accepted parts of everyday practice. The ability to replicate autonomous human movement is a long way behind the ability to replicate autonomous human thinking, so those of us in medical specialties with a large procedural component are unlikely to see any significant impact for some time.

**THE JURY IS IN: SINGLE VENDOR HEALTH INFORMATION SYSTEMS THAT COVER AS MUCH AS POSSIBLE ARE THE WAY TO GO FOR ACHIEVING TRULY INTEGRATED HEALTHCARE.**

But there is still a lot of work to do to join all the dots and fully digitise health consumers' information. The introduction of digital health and e-records had some bad press, particularly overseas in countries that have been early adopters and where lessons have been learnt. Australia has come on board later and our experience has been relatively positive. The initial change is very disruptive and challenging. There is only so much that can be done to mitigate this. Even so, there are not many people who would advocate going back to paper. We now have the more exciting opportunity for iterative and continuous improvement. Roles like mine are fundamental for driving this process and realising the ultimate potential of what we have created.

# CLASS ACTION WIN FOR VICTORIAN JUNIOR DOCTORS

**In a groundbreaking class action victory set to expose the excessive unpaid hours of junior doctors in our hospitals, health services across Victora must now face the prospect of paying millions of dollars for wage theft.**

**REGISTER**

**The AMA calls upon junior doctors to register your interest and support for this important campaign**

The Federal Court of Australia has ruled that one of Victoria's largest health services, Peninsula Health, breached the Fair Work Act when it did not pay class action lead applicant, Dr Gaby Bolton, for her hours of work at Frankston Hospital in 2019 and 2020.

Lawyers Gordon Legal and Hayden Stephens and Associates (HSA) represented the Australian Salaried Medical Officers Federation of Victoria (ASMOF) and junior doctors in this landmark victory.

The AMA calls upon junior doctors to register their interest and add their support for this important campaign.

Hayden Stephens is a lawyer representing junior doctors in Victoria and across Australia.

Dr Kate Maxfield is a junior doctor who worked at Eastern Health and has witnessed firsthand the devastating effects of long hours for junior doctors.

Kate recently spoke to Hayden about the recent class action victory.

**KATE** • The past few years have been crazy. I think we spoke by phone about three years ago.

**HAYDEN** • Yes, it's been a long road.

**KATE** • You rang me to ask me questions about my experience working at Eastern health and my unpaid overtime. I remember we talked about how it was detrimental to doctors' health, and you explained to me that you thought it was time doctors did something about it.

**HAYDEN** • That's right, I had been looking at this issue in NSW and was reading a lot at the time about doctors who had suffered enormous distress from the pressure and the fatigue caused by working such long hours. You might recall a book published at that time by a doctor named Yumiko Kadota which was very damning of the culture of the hospital workplace; the bullying and the harassment in particular. That, together with other media reports around that time, sparked my interest to explore this issue more.

**KATE** • How did those first calls with doctors go?

**HAYDEN** • Doctors felt angry, not so much about their unpaid hours, but the fact that their work was not being properly recognized. They felt worried that their excessive hours were causing fatigue and with that, a sense that a catastrophe was just around the corner if making a clinical error or overlooking something for a patient.

**KATE** • This is one of the reasons I really wanted to get involved but there's a culture in medicine that you don't speak up. We are taught to deescalate; we are taught to not ruffle any feathers. There's a lot of pressure for doctors to perform, to get on training programs and to get good results and good marks. Anything that could potentially jeopardize that, like speaking up about your overtime, is something doctors tend to avoid.

**HAYDEN** • That's so true. In those early discussions, it struck me how hierarchical the workplace is for doctors. There was this perspective held by junior doctors, that consultants were these demigods, and that Heads of Departments ran these mini kingdoms that set the hours that should be worked, irrespective of what was fair or reasonable or compliant under the law.

**KATE** • Isn't your job like that?

**HAYDEN** • Law is also hierarchical too, but over the last 20 years, it now resembles more a modern workplace through corporatization and improved work practices. There are exceptions as in any sector, but I was fortunate in my early career to be part of a law firm that valued the contribution of its junior employees. I'm not saying medicine is never this, but what struck me when I spoke to junior doctors was that our public hospitals are still stuck in yesteryear. It felt like a workplace that hadn't really changed over the years; that some work practices doctors are complaining about today are the same work practices doctors tolerated 30, 40, 50 years ago.

**KATE** • And this is why the recent calls to action are so important?

**HAYDEN** • That's right. It's about forcing hospital management to face the reality that their work practices must change. And unless they change, junior doctors will leave the system.




**KATE** • Can you tell our readers a little bit more about the recent judgement and what it stands for?

**HAYDEN** • It stands for what's fair. Justice Bromberg of the Federal Court of Australia ruled that our lead applicant, Dr Gaby Bolton, had performed unrostered unpaid overtime and that her work was deserving of recognition and payment. The Judge determined that Dr Bolton had performed a range of duties that were authorized and that in the absence of payment for that work, Peninsula Health had breached the Enterprise Agreement and the Fair Work Act.

**KATE** • When I talk to my colleagues, everyone is intrigued how a junior doctor stood up to the system.

**HAYDEN** • It was a significant court victory and one that I'm very proud to have been involved in. I'm especially proud of Gaby Bolton for her courage shown in being the lead applicant. Full marks also to the leadership of ASMOF and the AMA, for supporting Gaby. As far as I'm aware, it's the first time in Australian legal history, a junior doctor has held an employer the size of Peninsula Health to account for wage underpayment of this scale.

**KATE** • What does the future look like for the campaign?

**HAYDEN** • We've commenced several other class actions in Victoria against 12 health services. Some time back there was a decision made by the government of the day that Victoria should be split into 38 or so different health services. Each of those health services have a board, a senior level of management, and their own infrastructure that runs the hospitals within that health service.

Each Health Service is also the direct employer of junior doctors who work at their hospitals. That means that when we're thinking about lodging claims on behalf of junior doctors for their unrostered unpaid overtime under the statewide Enterprise Agreement, you take that action against the individual health service that has the direct employment relationship with the doctors in their employ.

> *There's a culture among some health services of having little appreciation of what their workforce is doing or what work is actually being performed. Speaking from my own experience working in large organisations, cultural change does not come about unless there is a concerted effort by the leadership to change it.*
>
> **HAYDEN STEPHENS**

**KATE** • Who are the 12 health services?

**HAYDEN** • Peninsula Health, Monash Health, Latrobe Regional Hospital, Bairnsdale Regional Health Service, Western Health, Eastern Health, Royal Women's Hospital, Alfred Health, St Vincent's Health, Northern Health, Bendigo Health, and Melbourne Health.

**KATE** • How long is all this going to continue?

**HAYDEN** • As long as it takes. As I've said publicly, I don't think doctors should be in the courts fighting for their rights, they should be in hospitals caring for patients. It's time the Victorian Government stepped in and said to the Secretary of the Department of Health, Professor Euan Wallace "this is happening on your watch"; support the Government's commitment to stop wage theft and resolve these cases now".

**KATE** • A lot of doctors I speak to think that their entitlement to overtime payment is futile because they say, "no one went to the head of the department for sign off" or "It was just understood you don't claim". What were the key arguments in the case that addressed those points?

**HAYDEN** • Under the Enterprise Agreement, a doctor is entitled to payment for their unrostered overtime in circumstances where the work that they perform is authorised. A central issue in the case was the interpretation of "authorisation" and how does that operate in a workplace like a hospital?

Peninsula Health argued that this idea of authorisation was limited to express authorisation, that is, in the absence of a senior doctor giving an express direction, it cannot be said that the junior doctor was required to work overtime.

But we know when we talk to doctors it doesn't work that way, that often doctors are starting early to prepare for ward rounds, or staying back doing discharge summaries, or complete a handover, or they're waiting for their registrar to return from theatre so they can speak to the registrar about a patient. There's so much in their working day that's not expressly directed but the work is still expected to be done.

We argued that these duties were necessary and often performed in overtime with the expectation or knowledge of their supervisor. It was on that basis that Dr Bolton was able to persuade the court that her duties were not just sometimes expressly authorised but were also authorized in other ways, for example when her duties were deemed necessary and carried out with the expectation or with the knowledge of her supervisor.

**KATE** • You act for junior doctors in NSW and ACT. Are the same issues in question?

**HAYDEN** • There are different employment regimes in each state and Territory but the 'gateways' for a doctor's entitlement for payment for overtime are similar in these other cases. What is striking is the near identical way health authorities are defending these actions in each jurisdiction.

They've run the argument, "You know what, doctors aren't needed to stay back, they're just there of their own volition" or "they need not stay back, they could just hand over their discharge summaries to the incoming shift". Health authorities have also argued that because doctors failed to make a claim for overtime at the time, they should now be prevented from receiving payment.

**KATE** • It all sounds so unrealistic. It's so disrespectful. It's as if we volunteer to stay back late, because hey, who would want to go home after a 10 hour shift!

**KATE** • But on a small positive note I've been chatting to some doctors and since these class actions have started, it seems like the hospitals are listening, and there's some health services that have said, "Look, if you just claim it, we'll authorise it. You don't need to jump through 1,000 hoops to get there". There's no way those changes would've occurred unless these court proceedings had taken place.

**HAYDEN** • Some doctors I've spoken to also say that they're seeing green shoots of change emerge within individual departments, with some senior doctors leading the charge. They're seeing the action taken by junior doctors and are now encouraging more junior doctors to make claims for their unrostered overtime. We're also seeing improvement around rostering.

There's still a lot of work to do, a long way to go, but we feel that these changes are really encouraging and will continue, but only if doctors continue to voice their concerns.

**KATE** • Who is part of the class actions in Victoria?

**HAYDEN** • Doctors who worked at specific health services in which we have issued proceedings are automatically group members, if they've worked unpaid unrostered overtime.

**KATE** • If you are a doctor who has worked unpaid overtime, what can you do to help?

**HAYDEN** • Most importantly, you should register your interest. Registration is important because it allows us to seek information from doctors about the nature of duties they've performed, and the circumstances in which they've done that work.

Doctors should be aware that registration with our website is confidential. We don't share the information with your employer, we don't even tell your employer that you have registered, but it is an important way for us not only to seek information from you, but also to keep you updated in relation to the status of the class actions as we move forward.

**KATE** • I heard on the radio a few weeks ago, the Federal Health Minister was speaking about how he wants this to be sorted out as soon as possible.

**HAYDEN** • Minister Mark Butler appeared on RN and called upon state governments to resolve these actions. He made the point that junior doctors were an integral part of the delivery of health, not just in Victoria, but across Australia, and that his genuine concern was that unless things change, doctors will leave the system. Having a Federal Minister express these views is really encouraging; it should give doctors confidence that their complaints are validated.

**KATE** • When there is an outcome, what's the compensation going to look like?

**HAYDEN** • We've learnt from our client interviews that doctors can sometimes work anywhere between three or six - 10 or sometimes 20 to 30 hours on average per week of unrostered unpaid overtime. If successful, we think the payments may span anywhere between say $10,000 to $40,000 by way of compensation. There are some extreme examples of doctors, particularly in surgical departments, whose unpaid work equates to much higher figures.

**KATE** • I personally don't even know where some of my old pay slips are.

**HAYDEN** • I've heard from doctors worried that they no longer hold documentation. Of course documents help but if you don't have them, it shouldn't be a concern. As the trial of Dr Bolton demonstrated, a doctor's evidence can be their best recollection. The court largely accepted Gaby's best recollections of the overtime she performed and awarded her damages accordingly.

**KATE** • What's next in the Peninsula proceedings Hayden?

**HAYDEN** • The next important step in the Peninsula proceeding is what's called a Penalties hearing. This is where ASMOF, the union that represents junior doctors, will be afforded the opportunity to put evidence before the court to argue that Peninsula Health's breach and contraventions of the enterprise agreement, should now mean that they be penalised for their conduct.

**KATE** • I had friends that have worked to the point that their hair has fallen out to exhaustion from stress, that they have finished every shift and cried every single night on the commute home. I've had friends that have come in to work on weekends to do discharge summaries because they didn't finish them during the week. That's unpaid because they said, "I didn't get them done, so I've come in to catch up," on their weekend. I've seen many colleagues become depressed, clinically depressed, and particularly during their training programs where you disappear, and you're studying full-time, and you're working full-time. One of my senior registers collapsed from exhaustion. He hadn't seen his children in weeks because of how much he was working and studying, and he lived with them.

I've heard one story of a surgical registrar that stayed at work for two weeks, didn't leave the hospital for two weeks.



> *Minister Mark Butler…called upon state governments to resolve these actions. …His genuine concern was that unless things change, doctors will leave the system. Having a Federal Minister express these views… should… give doctors confidence that their complaints are validated.*
>
> **HAYDEN STEPHENS**

My first introduction to a hospital, my first clinical placements as a student, my intern took her own life. And her work was not necessarily the main cause, I'm not saying that that's what caused it, but what I am saying is that when you work to the point of exhaustion, your resilience is not there to cope with all of the other stresses that you experience through your life. And I know you know other people as well that you've heard of, that you've come across through this work that have taken their own lives. And I think you can take a lens and look at this and say "Look, this isn't just about unpaid overtime: this is actually about saving lives of patients and saving lives of doctors".

**HAYDEN** • If you want to see just one thing that happens from these class actions, what would that be?

**KATE** • I want to see a healthy workplace culture for doctors. That's what I want to see: doctors being able to be happy to go to work and enjoy it.

**HAYDEN** • Yeah. There's a culture among some health services of having little appreciation of what their workforce is doing or what work is actually being performed. Speaking from my own experience working in large organisations, cultural change does not come about unless there is a concerted effort by the leadership to change it.

**KATE** • You've created a registration site called doctorovertime.com.au. Why should doctors sign up to the campaign?

**HAYDEN** • There's something to be said of strength in numbers. A strong signup number will signal to your health service that this is a serious issue for junior doctors. It's important that that signal is loud and it's clear.

The second reason is that your registration offers real assistance to us in understanding how systemic the problem of underpayment is across each particular health service.

### *Three reasons to sign up confidentially to the doctor in training overtime campaign*

1. Strong numbers signal (loud and clear) to your health service that this is a serious issue for junior doctors.
2. Registration helps us understand how systemic the problem of underpayment is across each health service.
3. Keeps you in the loop about the status of actions and what you can do to help your colleagues in their role as lead applicants.

REGISTER TODAY @ DOCTOROVERTIME.COM.AU

And the third and most important reason is, so that we can keep in contact with you about the status of the actions and what you next need to do to help your colleagues in their role as lead applicants.

**KATE** • That makes sense. If any doctors have some really interesting stories where they have been significantly underpaid or overworked, should they keep in contact with you?

**HAYDEN** • Absolutely. And my call-out is not just the junior doctors, but it's the senior doctors or even heads of department who are now or have previously worked in these health services. I've been incredibly encouraged, particularly in the Peninsula health case, to see senior people step forward, senior consultants, even a member of the medical workforce unit who used to work at Peninsula Health, come forward and support Dr Bolton in her case. Dr Bolton was incredibly encouraged by that, as we were. The evidence they gave was incredibly persuasive and figured prominently in the Court's final decision.

**KATE** • Hayden, thank you. Hopefully in our next conversation we'll be reporting on another great class action win.

**HAYDEN** • Yes, let's hope so, or just maybe, we'll be talking less about court victories and more about the positive outcomes of these victories, where doctors' hours are properly recognised and they start to feel better supported in their work.

THE POLICY DESK

# AMAV ADVOCACY

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

## MEETING ROUNDUP – DEPARTMENT, HEALTH MINISTER, PAYROLL TAX SUMMIT, HCW UNIONS, VCAT, COLLEGES

AMA Victoria regularly meets with a variety of individuals and organisations to advocate for members. Over the last several weeks, we have met with the Secretary of the Victorian Department of Health, the Victorian Health Minister, the Victorian Opposition, the Australian Nursing and Midwifery Federation, the Victorian Allied Health Professionals Association, the Health and Community Services Union, the Victorian Civil and Administrative Tribunal, and specialty colleges, amongst others.

With the **Department and Minister**, we discussed issues including workforce, payroll tax, the GP Registrar incentive payment, the pharmacist prescribing pilot, the doctor in training class actions, Ahpra fees, elective surgery announcements and targets, improving communication between public hospitals and general practice, and issues in emergency departments (especially the consistent failure to meet 4-hour targets statewide – with this issue most pressing in regional/rural hospitals).

With the **Opposition**, we attended a payroll tax summit, where we again put forth our position – that despite our GP members strongly believing in universal access to healthcare, given the lack of movement from the Government on this issue, we anticipate that, of those practices that remain viable, most will move to private (not bulk) billing for the majority of patient services. We anticipate the average out-of-pocket cost for seeing a GP will increase by at least $10, and that the move to impose payroll tax on GP income will be the nail in the coffin for bulk billing, with patients footing the bill. At this summit, we urged the Victorian Government to exempt medical practices from payroll tax and commit to 'no retrospective application of payroll tax obligations' for independent GP contractors.

*More on payroll tax: Payroll tax update and request for member questions (amavic.com.au); Victorian GPs threaten to name, shame Daniel Andrews on medical bees in payroll tax dispute (theage.com.au)*

With **healthcare worker unions** (the ANMF, VAHPA, and HACSU) we discussed the combined union position regarding Special Leave removal on 1 September, and our shared interests in ensuring mental health reform provides safe care provision.

With **VCAT**, we met to express concerns regarding what we understand to be a common practice of VCAT requesting medical practitioners to complete a form titled Medical Report Template – Guardianship List, while rejecting out of hand the payment of fees.

*More on concerns regarding VCAT and the Medical Report Template – Guardianship List: Communications and advocacy update: 28 June (amavic.com.au);*

With **specialty colleges**, we have continued our campaign to change the policies of certain colleges excluding trainees who are on parental leave from applying to sit and sitting fellowship examinations. In our view, policy change that allows trainees who are on parental leave to apply to sit and to sit for fellowship examination would promote a culture of inclusivity, diversity, and equal opportunity.

*More on college policies regarding applying for and sitting fellowship examinations while on Interrupted Training: Communications and advocacy update: 13 July (amavic.com.au)*

## VICTORIAN PHARMACY PILOT: OPPOSITION AND ADVOCACY

On 30 May, the Victorian Government introduced legislation to parliament to establish a 12-month Victorian Community Pharmacist Statewide pilot to expand the scope of pharmacy – including by enabling pharmacists to treat 'minor' skin conditions (what constitutes a minor skin condition is still to be determined) and reissue oral contraceptives and medication for 'uncomplicated UTIs'.

When first announced in the context of the November 2022 State Election campaign, AMA Victoria labelled this a measure a "retrograde step for Victoria and the health of Victorians". More recently, in reaction to the legislation's introduction, AMA Victoria (President Dr Tomlinson in The Age) called the pilot a "poorly conceived thought bubble" that won't solve access and affordability problems.

AMA Victoria has since written to the Victorian Government regarding specific concerns we have about the Pilot.

We have informed the Government that we consider the current schedule for the Pilot's commencement (October 2023) wholly unrealistic, and if the Pilot proceeds according to this timeline, this will not facilitate safe, quality healthcare delivery to Victorians who receive treatment under the Pilot.

We have further advised the Government that all components of the Pilot should be conducted as a registered clinical trial, with ethics approval, and that failure to do so will pose significant risks to patient safety, undermine public health and waste public funds.

*More on the pharmacy pilot: Communications and Advocacy update: 3 August (amavic.com.au)*

## VICTORIAN GP TRAINEE INCENTIVE PAYMENT

In November 2022, the Victorian Government pledged support for GP training, offering a $30,000 incentive payment to first-year trainee GPs and $10,000 for exams.

This initiative garnered enthusiastic support from AMA Victoria and the medical community.

However, recent news, relayed informally and not through official channels by the Department, has indicated that only cohorts from 2024-2025 will be eligible for these payments, causing frustration and disappointment, especially among current GPT1 and GPT2 registrars. These registrars reasonably relied upon the Government's clear commitment to funding and support as they embarked on their training journeys.

In light of these concerns, AMA Victoria has contacted the Victorian Government requesting the following:

1. A commitment to uphold promises made – providing the payment to current GPT1and GPT2 registrars- reinstating trust in the Government's support for general practice.
2. Clarification and transparency regarding the timeline and implementation plan for the GP registrar incentive payment for affected registrars.
3. Open communication to address concerns of affected registrars and the broader medical community.

We have since met with the Victorian Government regarding this issue and look forward to engaging in further discussions that will contribute to a resolution benefiting the future of general practice and the welfare of our prospective GPs.

## INDEPENDENT REVIEW OF VICTORIA'S COMPULSORY TREATMENT CRITERIA AND DECISION-MAKING LAWS

AMA Victoria has provided a submission to the Independent Review of Victoria's Compulsory Treatment Criteria and Decision-making Laws.

Beginning by noting that "AMA Victoria has had a longstanding active involvement in the development of Victorian Mental Health Acts, and also close involvement during various stages of the Royal Commission into Victoria's Mental Health System and now its implementation", the submission stated that AMA Victoria has "an ongoing interest in participating with the *Mental Health and Wellbeing Act process*".

The submission, in providing context for some of the difficult issues encompassed by the Independent Review, also emphasised the need to address comorbid conditions and social determinants to poor mental health and stressed the need for early intervention. The submission also advocated for trauma-informed, recovery-based care, shared decision-making, multidisciplinary teams, staff training, and the importance of resourcing for effective implementation.

In terms of the substance of the submission, AMA Victoria:

- Re-iterated that compulsory assessment and treatment is – and will remain – very important for a very small percentage of the population at key points of their lives during episodes of significant and devastating mental illness, and in these cases is used to facilitate rapid access to effective treatment.
- Supported the continuation of the current criteria for compulsory assessment and treatment.
- Stated that the status quo should prevail regarding the process for signing off on assessment orders, temporary treatment orders, and treatment orders (mental health cli nicians/ medical practitioners, psychiatrists, and external tribunals, respectively).

## STRATEGY TOWARDS ELIMINATION OF SECLUSION AND RESTRAINT

AMA Victoria recently provided a response to the Victorian Department of Health's Strategy towards elimination of seclusion and restraint.

In our response, we conveyed to the Department that the frequent use of seclusion and restraint is a symptom of an inadequately resourced mental health system. We stressed the urgent need for major investments in mental health beds, the establishment of mental health and substance abuse hubs in Emergency Departments (EDs), and the upgrading of physical facilities within psychiatric inpatient units.

Moreover, we emphasised that while we support the reduction of restrictive practices, it is essential to balance patient autonomy with the need for health and safety, especially for those lacking insight into their illness.

We also underscored the importance of OH&S considerations and urged the Department to ensure the safety and wellbeing of healthcare workers when striving to minimise restrictive practices.

Our submission concluded by noting that the reduction of seclusion and restraint (while ensuring safe care provision) requires a comprehensive and holistic approach to mental health reform in Victoria. We believe that Victoria will be best placed to minimise the use of seclusion and restraint by addressing the root causes, enhancing workforce resourcing, and maintaining a laser focus on patient and healthcare worker safety.

## NEED FOR CONSISTENT NATIONWIDE REGULATION OF E-SCOOTERS

Following on from our previous state-based advocacy on this issue (Communications and advocacy update: 25 January (amavic.com.au); Communications and Advocacy update: 23 March (amavic.com.au)), AMA Victoria has written to the Australian Government to call for consistent nationwide regulation of e-scooters. AMA Victoria's position is that e-scooter use is largely underregulated and has the potential to cause unnecessary injury.

AMA Victoria supports all states and territories adopting a nationally consistent, optimised Australian Road Rules model regulatory framework for the legal use of e-scooters, and we called on the Australian Government to facilitate this. This framework should be evidence designed to optimise safety and accident or injury prevention and decrease the burden of health costs on the Australian community.

## NATIONAL HEALTH AND CLIMATE STRATEGY – AMA VICTORIA SUBMISSION

AMA Victoria recently provided a submission to the National Health and Climate Strategy.

In our submission, we highlighted various aspects that require attention and proposed potential actions to achieve a more sustainable and climate-resilient healthcare sector in Australia. These actions included phasing out certain anaesthetic gases, improving access to public transportation for healthcare facilities, and promoting the use of reusable medical equipment.

Our primary emphasis was on promoting a low carbon, high-value healthcare system in Australia, which requires both mitigating climate change and adapting the healthcare sector to its impacts. We underlined the significance of collaboration among stakeholders, comprehensive data collection, and setting science-based targets to achieve these objectives effectively.

In conclusion, the submission advocated for a proactive and well-coordinated approach to address climate change's impact on the healthcare sector in Australia. By adopting sustainable practices, acknowledging the root causes of climate change, and setting clear objectives, we asserted that we could create a climate-resilient and environmentally conscious healthcare system that benefits both current and future generations.

## MEDICAL REGISTRATION FEES

AMA Victoria has joined AMA Federal in writing to Rachel Stephen-Smith MLA, Chair of the Health Ministers' Meeting, and our own Health Minister, expressing our strong objection to increases to medical registration fees, with much of this increase being driven by initiatives that have been determined by Health Ministers.

Our letter noted that there is a strong public interest in the effective operation of the National Scheme, and the profession continues to work to support this. However, Health Ministers are helping to drive up the costs of the Scheme through increasing intervention in its direction and operation. Given this, AMA Victoria believes there is a strong case for additional funding for Ahpra so that it can perform its usual functions effectively while also being able to satisfy the increasing demands being placed on it by Health Ministers.

## CLARITY NEEDED ON GOVERNMENT'S COVID CATCH-UP PLAN – ELECTIVE SURGERY ANNOUNCEMENTS AND TARGETS

AMA Victoria has written to the Victorian Government to seek clarity regarding its COVID Catch-Up Plan and the Planned surgery recovery and reform program elective surgery targets and related announcements in this regard.

While we acknowledge the Government's commitment to addressing the elective surgery backlog and welcome the impressive progress made under the Planned surgery recovery and reform program to this date, confusion exists regarding the specific percentage target or intended uplift arises from statements about the elective surgery targets made by former Minister Foley, the Acting Premier, and the Premier in April 2022, including that the plan was for a 125% increase in the first year and a sustained 140% in the years following.

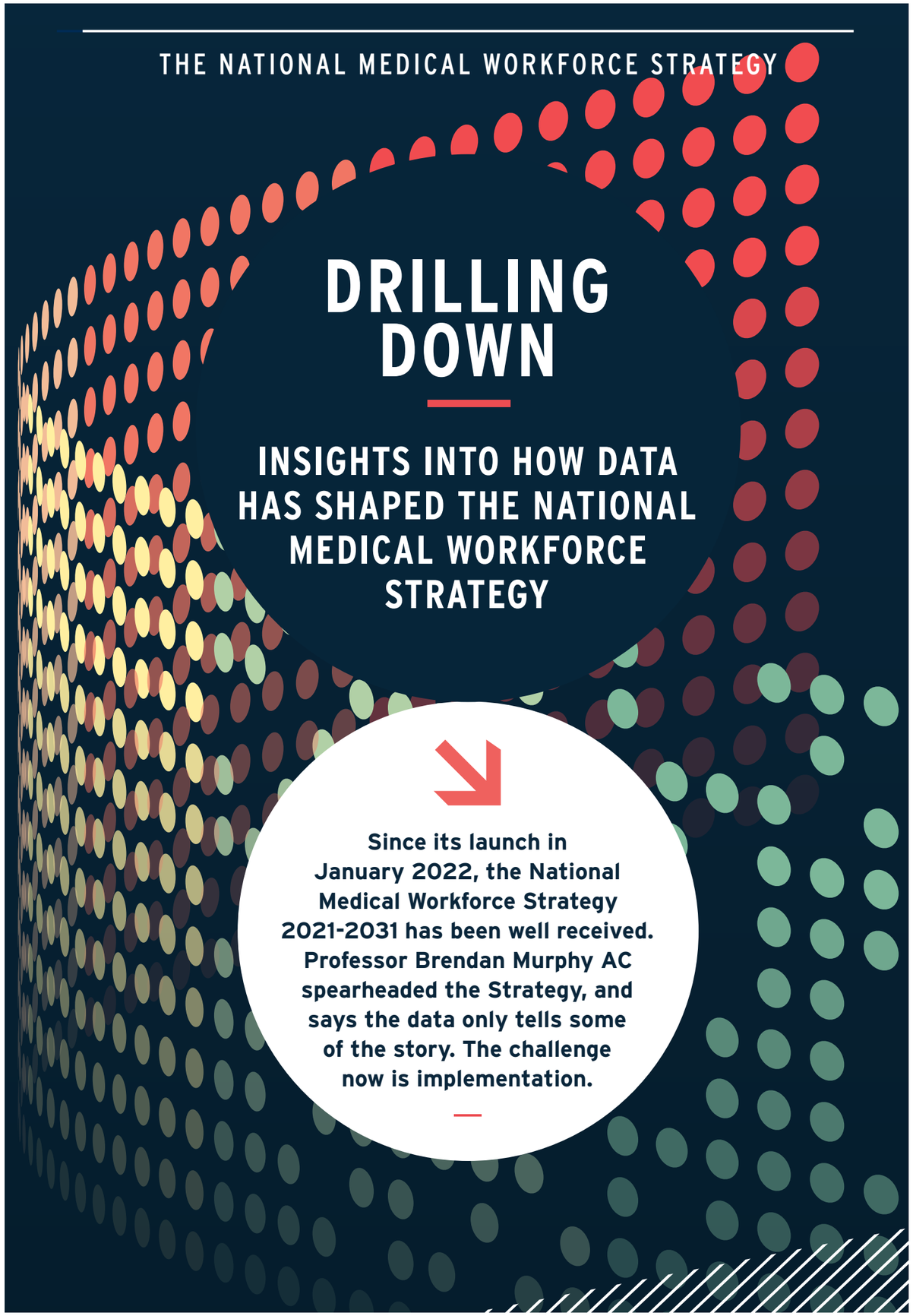
In writing to the Government, we have noted that clarification on the intended targets and numbers of the Planned surgery recovery and reform program and that confirmation of the baseline pre-pandemic elective surgery numbers on which the targets have been set, would be most useful.

Our letter concluded by noting that clarification would greatly assist in resolving the confusion surrounding these targets and their projected delivery times, and the success of the Planned surgery recovery and reform program.

More on elective surgery targets: Ambitious surgery goal 'unlikely' as Victoria considers reform (theage.com.au)

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





## THE NATIONAL MEDICAL WORKFORCE STRATEGY

Developed to guide the long-term planning and development of Australia's medical workforce over the next decade, the Strategy is the first of its kind for Australia. It was developed by the Medical Workforce Reform Advisory Committee, which includes representatives from states and territories, specialist medical colleges, and medical professional associations — including the AMA. Its strategic vision is for sector bodies to work together, using data and evidence, to ensure that the medical workforce sustainably meets the changing health needs of Australian communities. Five action — and outcome-focused priority areas and three cross-cutting themes underpin its plans for reforming and resetting the nation's medical workforce.

Cross cutting themes: Growing the Aboriginal and Torres Strait Islander medical workforce and improving cultural safety; Adapt to and better support new models of care; Improving doctor wellbeing.

Priority areas: Collaborate on planning and design; Rebalance supply and distribution; Reform the training pathways; Build the generalist capability of the medical workforce; Build a flexible and responsive medical workforce.

## PROFESSOR BRENDAN MURPHY AC

**THE STRATEGY IS AN ATTEMPT TO COLLABORATIVELY IDENTIFY WHAT THE PROBLEMS ARE IN THE MEDICAL WORKFORCE, AND THEN MAP OUT A PLAN TO GET US TO SELF-SUFFICIENCY.**

That means not raiding other countries' medical workforces to achieve the right numbers of doctors in the right specialties and in the right geographic locations. I think everybody agrees with the problems we've identified in the Strategy – and the approach and the priorities to fix it. The challenge now is implementing it; we've got to crack some of those hard nuts if we're going to implement the Strategy properly.

**WHEN IT COMES TO DOCTORS PER POPULATION, WE'RE ABOUT IN THE MIDDLE OF THE OECD PACK.**

Looking at Australia as a whole, it looks like we've got enough doctors to meet the needs of our population. We're graduating close to 4,000 doctors a year, which is far more than the numbers that are leaving the profession. In fact, we're growing our medical workforce at a compound annual growth rate of around 3.5%, although our GP growth rate is, disappointingly, only 2%. These figures are both higher than the population's compound annual growth rate, which is around 1.5%. And yet workforce shortages are quite significant in various parts of the country. This tells us that one of our main medical workforce challenges isn't supply, it's distribution, both geographically and between specialties.

# THE NATIONAL MEDICAL WORKFORCE STRATEGY

**ONE OF OUR MOST CRITICAL REALISATIONS IS THAT THE SERVICE NEEDS OF OUR HOSPITALS HAVE DETERMINED THE NUMBER OF SPECIALISTS THAT HAVE BEEN TRAINED.**

We have this conundrum where we have allowed trainee numbers (other than for general practice) to be determined by the service needs of major hospitals, rather than matching numbers to the national need for the specialist medical workforce coming out of those training programs. In response to challenges with hospitals not being able to find enough junior doctors, and country towns and some outer metropolitan areas not being able to find enough GPs or even some non-GP specialists, for a long time the response has been to call for a significant increase in the number of Australian medical school graduates. But massively increasing global supply won't necessarily solve the problem of distribution, as our experience in the last 10 years has shown.

**THE MEDICAL PROFESSION MUST COLLECTIVELY EMBRACE THIS STRATEGY OR THE PRESSURE TO CREATE THOUSANDS MORE DOCTORS WILL BE HARD FOR OUR GOVERNMENTS TO RESIST.**

While there is likely to be value in targeted increases in medical student places, for example in rural end-to-end training programs, any proposed changes to graduate numbers need to be carefully mapped to desired future workforce numbers and locations. The solutions to training and distribution identified in the Strategy must be implemented as the highest priority, as simply increasing numbers will otherwise potentially compound rather than solve the problems we face now.

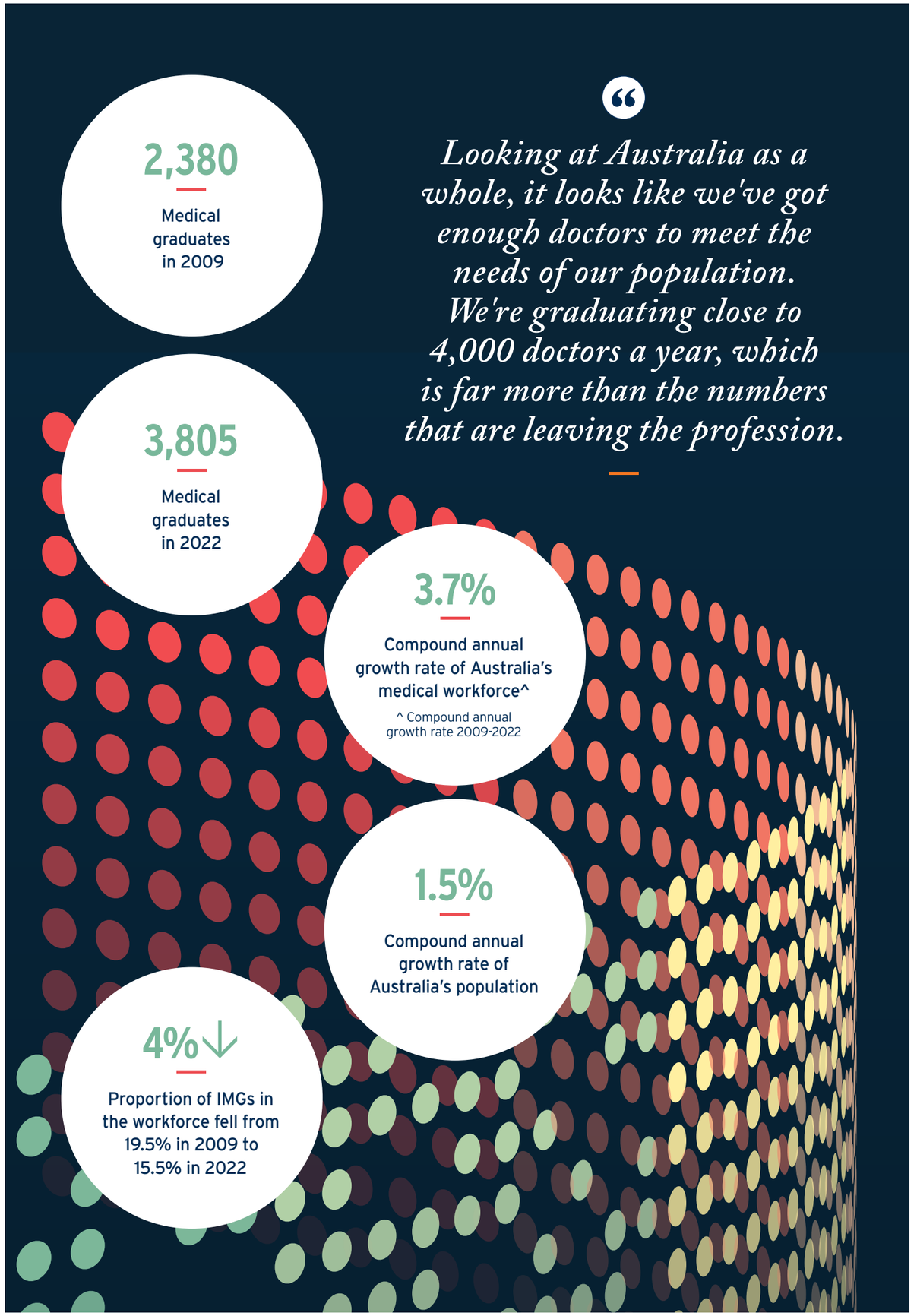
**WE KNOW THAT THE RAW DATA DOESN'T NECESSARILY REPRESENT REAL WORLD DEMAND. THE REPLACEMENT RATE FOR DOCTORS IS NO LONGER ONE TO ONE.**

Let's say we're replacing a country GP who was a sole practitioner, who worked seven days a week and was on call most of the time. No young doctor is prepared to do that. These 'heroes of the past' need to be replaced with two or even three doctors who may not be prepared to commit their whole working life to the one location. Planned expansions mean the service needs of hospitals will only grow, while the continued implementation of safe hours changes will create a huge demand for a hospital service workforce which can no longer be largely met by advanced trainees. A properly supported career medical officer workforce is essential along with other potential service roles, such as advanced practice nurses.

**ONE OF THE FINDINGS THAT SURPRISED US WAS HOW MUCH OF AN ISSUE LOCUMS HAVE BECOME IN RURAL IN REGIONAL AREAS.**

A hugely competitive market for locum doctors has emerged in under-served areas. Some locums are paid very significant multiples of what a normal doctor would get paid to work there. And they might work a few weeks, every few months. Because the hospitals are desperate to fill these roles, there's a bidding war, and they're paying increasingly exorbitant rates to get doctors. This is not a sustainable model. We need to deal with this issue and it may require some regulatory responses, similar to those used to control the 'bidding war' with agency nurses in the past.





*The solutions to training and distribution identified in the Strategy must be implemented as the highest priority, as simply increasing numbers will otherwise potentially compound rather than solve the problems we face now.*

**3.3%**

Compound annual growth rate of registered medical practitioners*

**4%**

Compound annual growth rate of registered specialists*

**2.9%**

Compound annual growth rate of registered specialists-in-training*

* Compound annual growth rate 2015-2021

**5.9%**

Compound annual growth rate of registered hospital non-specialists*

**6%↑**

The number of medical graduates who were female rose from 47% in 2009 to 53% in 2022

### WE'RE FOCUSING ON CREATING A NEW CAREER PATHWAY FOR CAREER MEDICAL OFFICERS.

A longstanding expectation is that all medical students will start as junior doctors, then train as registrars, and finally fellow as specialists. However, this progression no longer fits the workforce needs of specialties that provide 24/7 acute care, as more doctors are needed in middle-grade roles than as specialists. We also recognise that there are a group of doctors who don't particularly want to do specialist training. Many have fallen into unaccredited registrar positions, which aren't properly industrially defined and are open to exploitation. So, there's a clear need to create a proper career pathway for doctors like these so that they can provide valuable service needs and still have a rewarding career.

### I THINK WE ARE IN QUITE AN EXCITING TIME IN DIGITAL HEALTH; THE AUSTRALIAN DIGITAL HEALTH AGENCY, WHICH OWNS MY HEALTH RECORD, IS ONE TO WATCH OVER THE NEXT FEW YEARS.

My Health Record is not a very sophisticated tool; it's largely a document repository. It must be modernised and there was money in the May budget to start that process this year. It has to become integrated, and real time. The Digital Health Agency has recently launched an app [my health], and Government has flagged that it wants to make it a requirement for pathology and imaging providers to upload diagnostic tests into My Health Record. We've got to make it easier for doctors, GPs and others to use it, so that it links to and integrates with their clinical information systems.

### RESTORING GENERAL PRACTICE AS THE MAINSTAY OF THE MEDICAL SYSTEM IS AN IMPORTANT PART OF THE STRATEGY'S LONG GOAL.

General practice must reassert its role as the primary patient's medical home, where the coordination of care, prevention and chronic disease management takes place, with specialists used as appropriate to provide additional expertise and interventions.

We need to make it more attractive and expose young doctors and even medical students to high quality general practice in their undergraduate or early clinical career so that they can realise how rewarding it is. The Primary Health Care 10 Year Plan outlines a range of strategies to enhance General Practice. There were some important first steps taken in this year's May Budget but there is lots more to be done.

*Read more about the National Medical Workforce Strategy or access the full Strategy*

ONLINE LEARNING

# THE RISE OF THE GOOGLE DOC

**Monique Wisnewski ponders the pros and cons of online learning and what impact being part of the 'Google Doc generation' is going to have on today's medical students.**


OPINION
MONIQUE WISNEWSKI, CHAIR, MEDICAL STUDENT COUNCIL OF VICTORIA

## THE GOOGLE DOC GENERATION

Amidst the chaotic whirlwind that is my final year of medical school, yet another email lands in my inbox, which, over the recent months has become the only reminder that I am in fact enrolled at a university. The promise is alluring – reducing burnout through the magic of compassion training in the form of eight hours of mandatory online modules. The irony of assigning eight additional hours of work to an already stretched medical student as a cure or burnout isn't lost on me.

Yet in the grand mosaic of a medical student's life, obligation often speaks louder than reason and I dare not question the wellbeing experts.

In a desperate attempt to tame my ever-mounting workload, I multitask, playing the videos as I go about housework and half-listening to the narrators expound on the psychology of compassion, empathic burnout and the need for self-care. There are some paragraphs of text and links to what I can only assume is evidence-based literature, but like the far majority of my cohort, I wouldn't know because I don't read it. I speed through eight hours of content in a mere fraction of the time. Not because I was enthralled by the intricate nuances of empathic connection, but because it had become just another bland task to tick off the to-do list.

I close the tab, having gained more burnout than compassion, and move on. There's no time to fret; I've got another forum post due tomorrow, which I will write without reading the content and reply to without reading my peer's responses. Such is the way of the modern medical student.

*I do wonder what my training could have been like in a different context. In-person workshops, lively discussions with those with lived experience and face to face interactions with peers I've barely seen since 2019 seem like a distant dream.*

### FACE TO FACE LEARNING FEELS LIKE A DISTANT DREAM

I do wonder what my training could have been like in a different context. In-person workshops, lively discussions with those with lived experience and face to face interactions with peers I've barely seen since 2019 seem like a distant dream.

Since the Covid-19 pandemic, such dreams have been increasingly replaced with 'self-directed learning' in the form of reading lists and online modules, supplemented with pre-recorded lectures, Zoom sessions and the occasional clinical skills session.

It's a convenient and cost-effective solution for universities, but at what cost to the quality of medical education?

Are we shaping up to be the 'Google Doc generation' – a cohort of doctors who have completed medical school post-pandemic and almost entirely online? Like the similarly coined Dr Google, today's soon to be doctors have learned medicine mostly from doing their own research on the internet, albeit with the guidance of a structured curriculum, clinical placements and ever-looming threat of failing exams. Is it a bad thing? Well, no. At least, not entirely.

## THE BENEFITS OF ONLINE LEARNING

The adoption of online learning and flipped classroom models brings several benefits. Most obvious is flexibility, with the ability to deliver standardised teaching across both metro and rural sites and for students to complete their learning at a time and place that works best for them. Online and pre-recorded content is also reusable and resource-light, allowing universities to redirect funds elsewhere.

Most importantly, flipped classroom models have demonstrated a range of benefits by repurposing class time into an opportunity to apply and consolidate knowledge. Such benefits include increased student satisfaction, efficient curriculum delivery, promotion of higher-order processing and greater engagement during class time.

But for these benefits to outweigh the drawbacks, the delivery must be done well.

## THE DOWNSIDES OF ONLINE LEARNING

As education moves to virtual screens, reduced motivation and 'Zoom fatigue' set in, tempting one to turn off the webcam and walk away. Students also find themselves increasingly navigating self-directed learning, which, without proper guidance, carefully prescribed resources and a structured curriculum, can lead to confusion and misinformation, potentially placing patient safety at risk.

The flexibility to manage clinical placements and independent study paradoxically heaps an unanticipated load onto students' shoulders. Juggling the roles of worker, learner, and teacher is an exhausting feat and this trifecta of responsibility can be overwhelming, threatening to undermine the very intention of fostering comprehensive learning.

Finally, and perhaps most importantly in this epidemic of poor mental health, virtual campuses create an unintended by-product in the form of social isolation. As a course with a traditionally high proportion of rural, interstate and international students, face to face classes play a pivotal role in fostering connection and wellbeing amid a demanding medical curriculum.

Meanwhile, practical learning, the cornerstone of medical education, suffers in the digital realm. The tactile experience of holding instruments, dissecting cadavers, and working in teams is difficult to replicate through screens and keyboards, compromising the hands-on mastery and interpersonal skill-building integral to the making of a skilled practitioner. Incorporating this predominantly into the clinical years' curriculum during medical school's final years is simply too late.





*Practical learning, the cornerstone of medical education, suffers in the digital realm. The tactile experience of holding instruments, dissecting cadavers, and working in teams is difficult to replicate through screens and keyboards, compromising the hands-on mastery and interpersonal skill-building integral to the making of a skilled practitioner. Incorporating this predominantly into the clinical years' curriculum during the final years of medical school is simply too late.*

## AN UNCERTAIN FUTURE

We're yet to see the true capability of this new breed of doctor, and whether these pandemic-driven changes will truly stick is another question. Admittedly, it's still early days for the transition and with adequate planning and consideration of student feedback, there's an opportunity for flipped classrooms and blended learning to be highly effective.

Alas, in a world where checkboxes eclipse the path to true learning and where digital screens attempt to replicate human connection, the rise of the Google Doc serves as a reminder of the importance of balance.

As a final year completing full-time placement, I crave the opportunity to once again sit in a classroom among my peers, to sit back and relinquish the responsibility of teaching myself, to sample the traditional university experience; I want to feel like a student, just one last time. Perhaps this will be the case again sometime soon. But for now, I'll have to stop daydreaming; I've got another forum post to get done.

# EMERGING LEADER PROGRAM

*Click here to enrol*

AMA Victoria's flagship leadership development program for emerging leaders in medicine is back in 2023. Registrations are now open for our second intake, commencing Saturday 14 October 2023. We'd love for you to join us.

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

This year's emerging leader professional development program delivers an engaging educational experience to support the next generation of doctors (PGY1-PGY10) to develop their leadership identity and to build a strong skill base for enacting leadership in their everyday work. The program also provides a solid foundation for stepping up into leadership positions in the coming years.

The program structure is four modules and one tutorial delivered via Zoom over five weeks (one Saturday and three Tuesday evenings). The learning environment is a small group setting, highly interactive, inclusive, and safe.

For any queries, please call us on 03 9280 8797 or email us at careersadvisor@amavic.com.au

AMA VICTORIA



IN THE NEXT ISSUE

# TRAILBLAZING WOMEN

**VALE – DR ELIZABETH LEWIS AM, FRACS, FRCS (ENG) FRCS (GLAS) 30/01/1935 TO 24/08/2023**

Dr Elizabeth Lewis, who passed away on 24th August, had a long and outstanding career in Medicine. Among her many and varied achievements was the distinction of having been the first female neurosurgeon and the first Paediatric neurosurgeon to practise in Australia. Dr Lewis first trained in general surgery at the Queen Victoria Hospital and in the UK, then finished further neurosurgical training in Cambridge in 1972.

Dr Lewis held senior appointments as Head of Neurosurgery at the Queen Victoria Medical Centre (later Monash Medical Centre) and at the Royal Children's Hospital, building an active career which lasted 30 years. Alongside her surgical career, she took an active part in teaching and training. She served with MDAV and Avant as a Medical Advisor and Board Member assisting many grateful doctors in dealing with medico-legal issues, and as a member on Medical Panels.

Dr Lewis regularly visited Papua Niugini helping to establish medical and surgical services. Following the devastating tsunami in 1998 in which over 2000 people died, she led a group of doctors to accompany the Australian Army disaster-relief deployment.

Dr Elizabeth Lewis is remembered with deep respect and love as a caring and expert surgeon, a teacher, a mentor, a colleague, and a friend.

*Written by Dr Kate Duncan*

Read more about Dr Lewis in our summer edition of Vicdoc due out in December. If you were mentored or inspired by Dr Lewis, please contact our Director of Communication and Advocacy, Ms Taryn Sheehy at taryns@amavic.com.au to share your memories and stories.

And, as we prepare for International Women's Day 2024, we want to know about more 'Trailblazing Women in Medicine'. Who has inspired you with their achievements and service in medicine and why have they been important to you?

# SWITCHED ON

## FACILITATING WOMEN'S INVOLVEMENT IN DIGITAL HEALTH

**The 2023 Australasian Institute of Digital Health's Women in Digital Health (WiDH) Leadership program wrapped at the end of August. We asked one of the program's six mentors, A/Prof Magdalena Simonis, about digital health and why it's important to nurture women's involvement in the field.**

INTERVIEW **VANESSA MURRAY**

### Q: HOW DO YOU DEFINE DIGITAL HEALTH?

**A:** There are many different aspects to the digital health interface. Day to day, doctors use some form of digital health. We're accessing information on a computer, we're adding to patients' electronic health records, we're onboarding patients to digital systems. Patient booking systems are a form of digital health that are a gateway through which people in the community can access healthcare. Digital health can build links and systems between sectors in terms of information, services and healthcare providers. Then we've got digital health in the form of the wearables that can track our physical markers and health behaviours prompts, transdermal patches and sensors, and precision care according to your genetic markers. Those are just some! There are so many different aspects of digital health.

### Q: WHY IS THE PROGRAM ESPECIALLY FOCUSED ON WOMEN IN DIGITAL HEALTH?

**A:** The Australasian Institute of Digital Health undertook a joint research project in the digital health space and found that just as in the IT industry, there are fewer women in the digital health space and even fewer in leadership positions. That's despite the fact that women comprise around 70% of the healthcare workforce. The program is addressing that gap. It's a great potential leveller for the gender disparity that exists in the industry. Another consideration is that if we don't have women involved in making decisions or supporting processes or creating algorithms, then we're not going to have a system that really represents the community it's meant to serve. So, it's not just about addressing gender bias and gaps from a workforce perspective, it's also about addressing the issue of misrepresentation and inequitable healthcare delivery if the system is not designed with the input of women.

### Q: WHAT DO YOU THINK DIGITAL HEALTH IS GOING TO LOOK LIKE IN 10- OR 20- OR 30-YEARS' TIME?

**A:** Digital health will only progress from here. The term digital health is very broad; it involves technology and our interaction with this with respect to our health and health systems. Digital health should make participation in our healthcare system fairer, faster, better, safer, more accurate, less costly, and more accessible for everyone. The outcome should be healthier people, and healthier populations. One thing I'm excited to see evolve is real time sharing of information. We don't yet have that in our day to day practice, but I think it's going to be a big enabler of doing things faster and better for our patients.

### Q: DO YOU THINK THERE'S A ROLE FOR AI IN THE MEDICAL PROFESSION?

**A:** Artificial intelligence is the term which refers to the process of automation and rapidly synthesising information, to produce outcomes which humans traditionally perform. Machine learning has existed for some time, but AI is one step beyond this in that it produces outputs that require a form of reasoning. When we see patients, we do this in our heads all the time; we draw on all sorts of information simultaneously. We interpret verbal communication, nonverbal communication, historical knowledge, recollection of past visits, previous files, updated results. Humans cannot be replaced in medicine; AI is a tool that will permit us and our systems to reach diagnosis in a timelier manner, and to have greater focus on our patient relationships.

### Q: HOW ARE WOMEN AT THE PATIENT END OF THE SPECTRUM USING AND ACCESSING DIGITAL HEALTH?

**A:** Women's health issues are different from men's, so we're often using digital health differently. A lot of our concerns revolve around gynaecological issues, menstruation and pregnancy, body image, dieting, and mental health. But then women are often also mothers running households, and managing healthcare for their partners, seniors, and children. I think it depends on the age group of the women too. We've got tech savvy gen Z, gen Y, gen X digital health users, and they're all pretty adept at using technology. They have smartphones. They're doing their own research. They might be taking advice from social influencers on Facebook and TikTok. They might be using period tracking or ovulation apps.

### Q: WHAT ARE SOME OF THE BENEFITS YOU'RE OBSERVING THAT PROGRAM PARTICIPANTS COME AWAY WITH?

**A:** The aim is for women to advance in their abilities as leaders, and to activate their potential so that they feel confident taking on new directions in the digital health industry. We've found that digital health is in its infancy, which makes it a very exciting space. If you're a woman with a pioneering spirit, the program offers the opportunity to explore new systems and acquire new knowledge. You become part of a group that's journeying together. We're seeing exponential growth in skills, problem solving and insights. Many are choosing to stay in touch with each other, and to remain involved in the program as informal mentors. It's such a valuable opportunity.

### ABOUT THE WiDH LEADERSHIP PROGRAM

The WiDH Leadership program is an initiative of the Australasian Institute of Digital Health. A six-month blended learning program supporting women's development as leaders in digital health, it aims to ensure participants have the confidence, competency and connections to succeed in the digital health space.
The program is delivered across three in-person retreats, networking events and monthly webinars, with self-directed learning, a group project, and executive coaching in the mix.
The 2023 program ended on 30 August 2023. Expressions of interest for the 2024 program will open in November 2023 and close in January 2024.

*Register to express your interest in the WiDH program*

JARROD MCCABE — WAKELIN

# UNDERSTANDING 'EXPRESSIONS OF INTEREST' (EOI) PROPERTY SALES

*For more info: 03 9859 9595 wakelin.com.au*

*Click here to listen to Jarrod's podcast*

*Register for more insights into the property market*

WAKELIN
PROPERTY ADVISORY

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

WWW.WAKELIN.COM.AU

With the cooler months now behind us, the spring selling season is ramping up. Most are familiar with auction campaigns, but expressions of interests (EOIs) are less understood.

EOIs see vendors invite buyers to make an offer to purchase their property, by a specified time and date.

Prospective buyers submit their offer over the course of the campaign. The vendor can then accept the best offer, or if none meet expectations, the property can be placed back on the market.

Agents who handle EOIs on a regular basis often have an information sheet setting out what's required throughout the process.

However, some agents will provide less information about the process, so it's important to have clarity on some key points to ensure you're able to put your best foot forward.

## ASK FOR A COPY OF THE CONTRACT

If a contract is not yet available, it means a formal offer can't be secured. It may mean the vendor still has a number of matters to finalise before they are able to lock in a potential offer.

## CLARITY ON SALES CONDITIONS

What are the conditions within the contract and is there any room for flexibility? Are you able to buy the property subject to a building inspection or does it need to be carried out beforehand? Is there any information in the contract of sale that's missing?

## LEVEL OF COMPETITION

Having an idea of the number of people you are competing against can help shape your approach to the campaign. The agent is not obligated to disclose this, but any information you can garner is valuable.

## VENDOR EXPECTATIONS

An EOI quote is different from an auction quote. Is it likely to go beyond the quote range — which is quite regularly the case in an auction — or is it likely to sit within a quoted range? While you might not receive a definitive figure, probing can help draw out a more defined price range. The quote range can be found in the statement of information.

## SETTLEMENT TERMS

Understanding a vendor's settlement timeframe preferences can help you shape your offer accordingly, to ensure you don't miss out on a property due to discordant timeframes.

## CAMPAIGN TIMEFRAME

This is a consideration specific to expressions of interest. Does the campaign conclusion date need to be reached before the vendor accepts an offer?

## THE OFFER PROCESS

How many opportunities do you have as a buyer to make an offer? Is it a one-chance opportunity with a best and final offer? Or will the agent give you the chance to make a higher offer if you're sitting marginally below your competition?

Buyers who take the time to understand the particular dynamics at play before they enter into an EOI, give themselves an edge against their competitors.

JOIN THE CONVERSATION

# AMAV SOCIALS

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

**DR JILL TOMLINSON**
The class action judgement in favour of junior doctors is a historic win and a clear turning point in the campaign to end dangerous working hours for junior doctors. This action is about patient safety, doctor welfare and ensuring doctors receive fair pay for the hours they work.

**ADJ PROF KAREN PRICE**
[On the landmark win for junior doctors in wage theft case]: Great win. Any worker working for "free" for fear of repercussions is being exploited by the system.

**JENNY DAVIES**
[On the landmark win for junior doctors in wage theft case]: What great news. As a mum of a medical student who will begin internship next year, I'm so happy. Hopefully all hospitals will take note.

**DAVID POPE**
[On the article Melbourne doctor wins landmark wage theft case]: Most doctors I know have experienced wage theft while working in hospitals. There is so much pressure/intimidation /bullying to not accurately record hours worked. Wage theft is a crime in Victoria.

**JARROD MCMAUGH MPS**
[On AMA Victoria's call for more access to pharmacotherapy in Victoria]: Very important issue, and good to see @amavictoria recognising the need for greater access. The critical issue in Victoria is access to prescribers.

🙏 **DR JILL TOMLINSON**
to every @amavictoria member for their support of advocacy and policy that strengthens support for primary care – the most efficient part of the health system, and the foundations on which the health system relies. Together we can.

**DR MARY-ANN FOX**
[On reversing the RANZCO decision to exclude trainees on parental leave from applying for or sitting exams, following AMA Victoria advocacy]: Wonderful news Dr Tomlinson and well done to all who assisted in reversing this dreadful decision affecting candidates at a vulnerable time in their careers.

**KIRRA**
[On reversing the RANZCO decision to exclude trainees on parental leave from applying for or sitting exams, following AMA Victoria advocacy]: That is fantastic news! Thank you for championing this issue
🙏

**DR HELEN SCHULTZ**
Jill you are truly walking the walk and exactly what AMA and our profession need right now when it comes to leadership. Love seeing your updates and thank you for advocating or us so fiercely.

**JULIE WEBSTER**
[On the AMA Victoria President's Listening Tour]: Jillian Tomlinson your listening tour is such an awesome concept ..nothing like getting first hand insights



**DR JILL TOMLINSON**
Workers and trainees must not be discriminated against on the grounds of parental leave. @amavictoria is taking action against this discrimination.
We have:
- ✔ Successfully advocated for one College to reverse a newly announced training policy that was to exclude trainees who are on interrupted training from applying to sit, or from sitting examinations.
- ✔ Asked members to advise @amavictoria of training Colleges that have policies or procedures that prevent or hamper trainees on parental leave from applying to sit or sitting examinations.
- ✔ Asked Federal AMA to make it official AMA policy that trainees should not be prevented from applying to sit, or sitting examinations simply because they are on parental leave.
- ✔ Asked multiple Colleges about their policies with regards to trainees sitting examinations while on parental leave.
- ✔ Identified 3 Colleges/Societies whose policies (regarding trainees applying to sit or sitting examinations while on parental leave) or their application warrants reconsideration.
- ✔ Commenced writing to and interacting with relevant Colleges advocating for change that would see trainee parents treated equitably, and never prevented from applying to sit, or sitting, examinations simply because they are on interrupted training due to parental leave.

**If your College has problematic policies, or you would be willing to lend support to our advocacy to Colleges, please let us know. Together we can make changes to stop parental leave discrimination.**

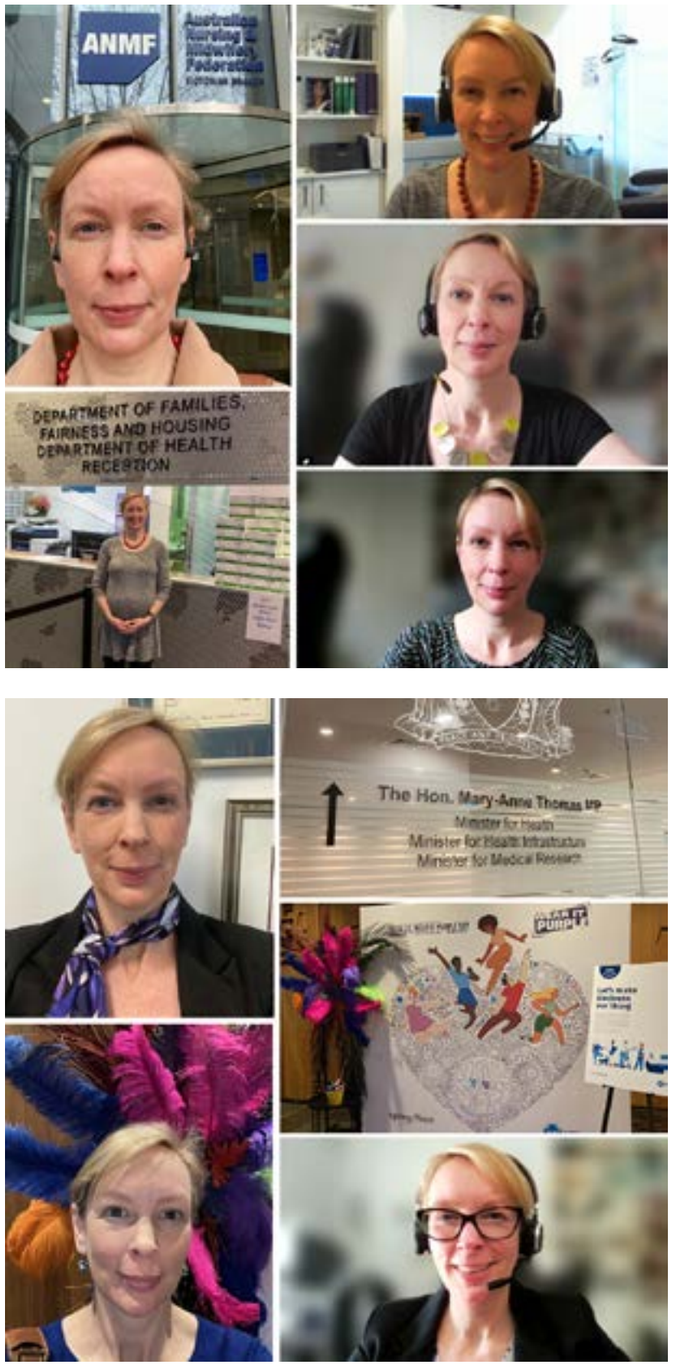
**PROF DANIELLE MAZZA AM**
[On AMA Victoria's advocacy to State Government outlining our concerns with the Pharmacist Pilot, emphasising the need for greater support for primary care, and advocating for improved GP-hospital interaction]: Thanks for your advocacy on these important issues
Jillian Tomlinson

**DR SHALINI ARUNOGIRI**
[On the 2023 Winter VICDOC]: Grateful for the opportunity to be part of this series alongside amazing colleagues in @amavictoria @ama_media #VICDOC sharing views on #leadership in #health and finding our purpose @TurningPointAU
Thanks for the sponsorship @DrJaneMunro always paying it forward #WomeninSTEMM

**DR SONIA MOORTHY**
[On the article 'Why female surgeons are less likely to live outside the big cities']: @Jillian Tomlinson a really interesting read and concurs with my experience as a female ophthalmologist in region and reflected within RANZCO current female workforce.

**AMA VICTORIA**
A lot happening in the #AMAVAdvocacy space! Great individual meetings with the Victorian Health Minister's Office, the Secretary of @VicGovDH and the @VictorianGreens to discuss wide ranging matters including our concerns with the Community Pharmacist Prescribing Statewide Pilot.

**AMA VICTORIA**
AMA Victoria's President Dr Jillian Tomlinson caps off another busy week of online and face to face advocacy and stakeholder meetings. Highlights include online meetings with Health and Community Services Union (HACSU) and Safer Care Victoria, plus in-person visits to the Health Minister at 50 Lonsdale St for productive discussions on workforce, payroll tax, GP registrar incentive payments and the doctor in training class action, followed by a contribution to a mural in the Spring Place lobby ahead of #WearItPurpleDay.



AMA VICTORIA EXCLUSIVE PODCAST

# THE DOCTORS' ROOM

## A PODCAST FOR MEMBERS WITH DOCTORS FOR DOCTORS

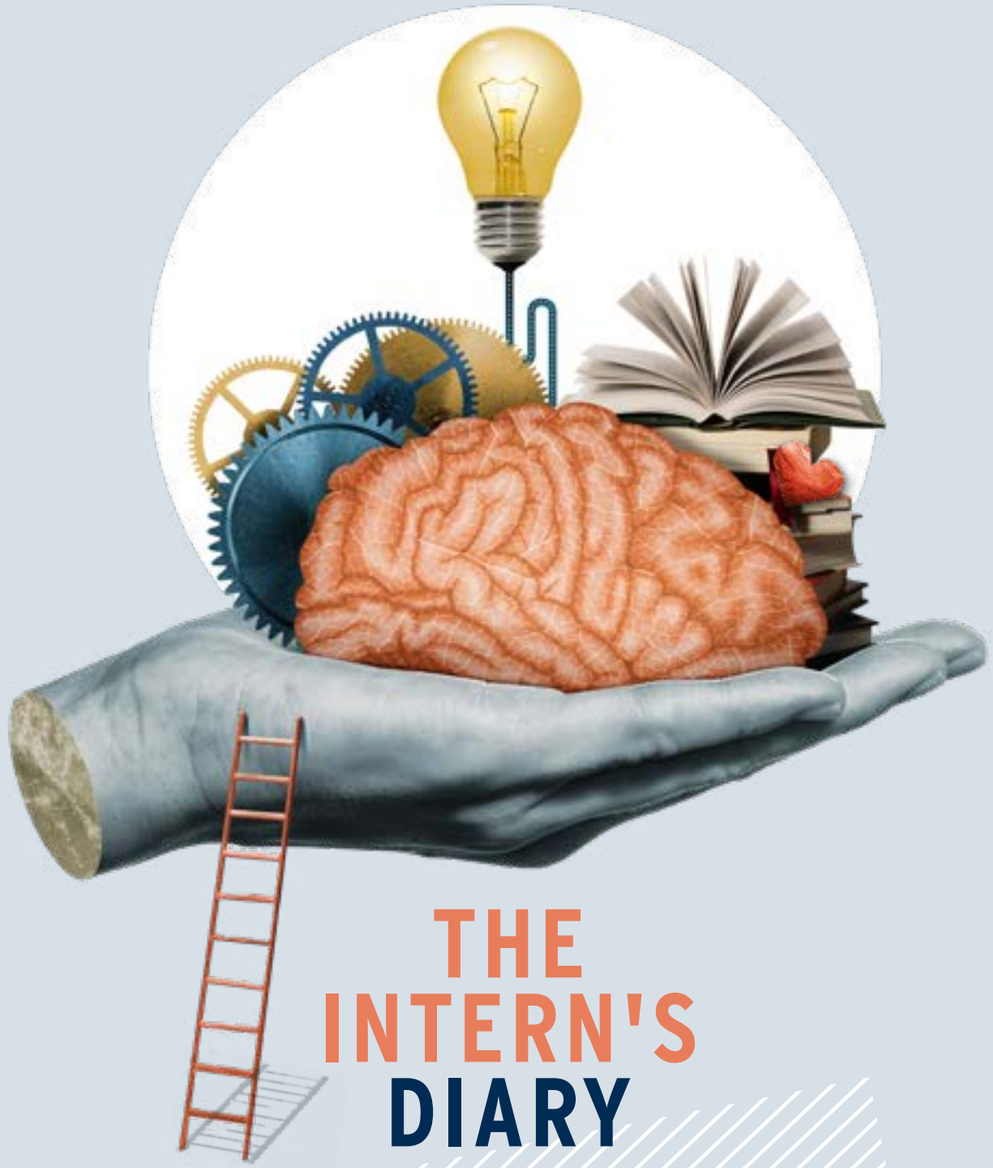
HAVE YOU EVER FELT LIKE AN IMPOSTER OR DOUBTED YOURSELF DESPITE YOUR STACK OF QUALIFICATIONS + ACHIEVEMENTS?

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

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

LISTEN NOW

DR YINGTONG LI



# THE INTERN'S DIARY

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

> *"So how is internship going?"*
> *"It's busy."*
> *They look concerned.*
> *My eye bags must be bad today.*
> *"But it's good, I'm learning a lot",*
> *I add hastily.*

Internship has been educational, enjoyable and fulfilling, but it has also been a big step up from medical school. As a medical student, you do the jobs that are assigned, and you leave when rostered to finish – or earlier, "for a tute". As a doctor, there is no picking and choosing – all the jobs are your jobs, and there is no leaving until all the jobs are done, the scripts are written, the bloods are checked, and tomorrow's notes are prepared. Most nights I sit in bed scrolling through dinner delivery apps, too exhausted to contemplate cooking. Some nights I'm too tired to drive home safely. In the last AMA Victoria Hospital Health Check survey, half of junior doctors reported making a clinical error due to fatigue. So it was not necessarily a surprise when my time came.

It was 7:30am, in the final hour of my final week of night shift. My last job – to ask if the cardiologist at the nearby private hospital would like to admit my patient. Exhausted but keen to finish my jobs before handover, I called the private hospital switchboard and asked to speak with the cardiologist. I didn't quite catch the name of the person who picked up, but it sounded approximately right.

"Good morning, I'm one of the ED interns, I was hoping to discuss…"
But they seemed less interested in the patient's cardiac complaints, and more interested in the patient's insurance details – which I didn't yet have open. After stumbling awkwardly through more of the conversation, the explanation for the confusion emerged: "Oh, no, I'm not the cardiologist. This is the bed manager."

We laughed it off and the bed manager gave me the cardiologist's phone number. But the cardiologist's phone went to voicemail and suggested leaving my number and details by text message. Keen to make progress, I did just that, and soon received a call back. I launched, full steam, into my opening spiel. "Good morning doctor, thanks for returning my call, I was hoping to—"

"Hold on, stop there. You have the wrong number again. This is the bed manager." More exasperated, this time, and audibly juggling a few other conversations in the background. In my bleary-eyed stupor, I had mixed up the phone numbers I'd scrawled onto the scrunched up scrap paper in my pocket.

In the end, the transfer did go smoothly, and so ultimately it's fortunate that my first big fatigue-related mistake amounted to no more than a few unnecessary phone calls and a healthy serving of embarrassment.

But I wonder what might have happened if my final job on that run of night shifts had been something else. Might I have misread an ECG and sent a patient home with a STEMI? Might I have made an arithmetic error and prescribed a medication overdose?

As doctors, we of course have responsibilities towards our patients, and what we do can have significant impact, positive or negative. Even as interns, though many of our plans will be made in consultation with more senior doctors, we do come to make decisions on our own, and increasingly more as the year progresses. It is clear that among our responsibilities is to recognise fatigue and to seek help when needed. This experience was a timely reminder of the impact of fatigue.

At the same time, responsibility for avoiding fatigue does not rest solely with individual doctors. Unsustainable workloads and unsafe staffing are clear drivers of fatigue, and the junior doctor class action lawsuits led by AMA Victoria and its interstate counterparts have made this an issue of public importance. The ruling in favour of junior doctors in the first Victorian class action has clearly demonstrated the responsibility that health services have to maintain safe workloads and staffing. And it has made it acceptable – indeed, a duty – for doctors to raise concerns about workload, staffing and overtime.

It has been empowering, this year, to see countless consultants, of all levels of seniority and experience, across multiple hospitals and departments, medical and surgical, discussing workload and overtime and standing up for junior doctors. I am optimistic that, as we all support each other and advocate for our colleagues and our patients, we can leave unsustainable workforce practices in the past and create a safer future for our communities.

> *This experience was a timely reminder of the impact of fatigue.*

DOCTORS VISITING DOCTORS

# PEER VISITOR PROGRAM

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

## CONNECTION TO REDUCE ISOLATION AND LONELINESS THROUGH THE PEER VISITOR PROGRAM

The AMA Victoria Peer Visitor Program is based on the principle of doctors supporting doctors. Many older doctors miss the companionship of their peers and colleagues when they retire, especially as they become frail or move into a residential aged care facility. Our Peer Visitor Program offers companionship by linking older doctors or doctors who have become incapacitated with a volunteer who is a doctor or medical student for regular visits.

One of the key aims of the program is to address loneliness. Loneliness is a function of our need for companionship and belonging. As social beings, we rely on safe, secure social surroundings to survive and thrive. When we begin to feel lonely, we feel vulnerable and often experience a loss of self-worth, which can take a toll on both our physical and mental health.

While the program addresses isolation and loneliness for the older doctors or doctors who have become incapacitated, the volunteer visitors also benefit from their involvement. For medical students, the opportunity to meet regularly with an older doctor leads to refined communication skills and increased confidence when talking with older people. Some medical students and early career doctors miss older relatives who live in distant locations. The program can provide them with someone to connect with outside their university-based peer group and work colleagues.

The doctor volunteers involved in the program also report enjoying the regular companionship of the older or incapacitated doctor they are visiting. In contrast to the practice of medicine with respect to patient relationships, in this role they can form personal bonds with the person they are visiting. Our volunteer visitors enjoy hearing about how medicine was practised in the past and sharing details of current medical practice. Medicine is a small world and often the matched pairs find commonalities in people they know or places of work.

While we have many doctors and medical students willing to volunteer, we find it hard to identify older or incapacitated doctors as many are no longer in contact with AMA Victoria. We welcome referrals from colleagues, family and friends.

If you are aware of any former doctors who may benefit from a visitor please contact Kay Dunkley.

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

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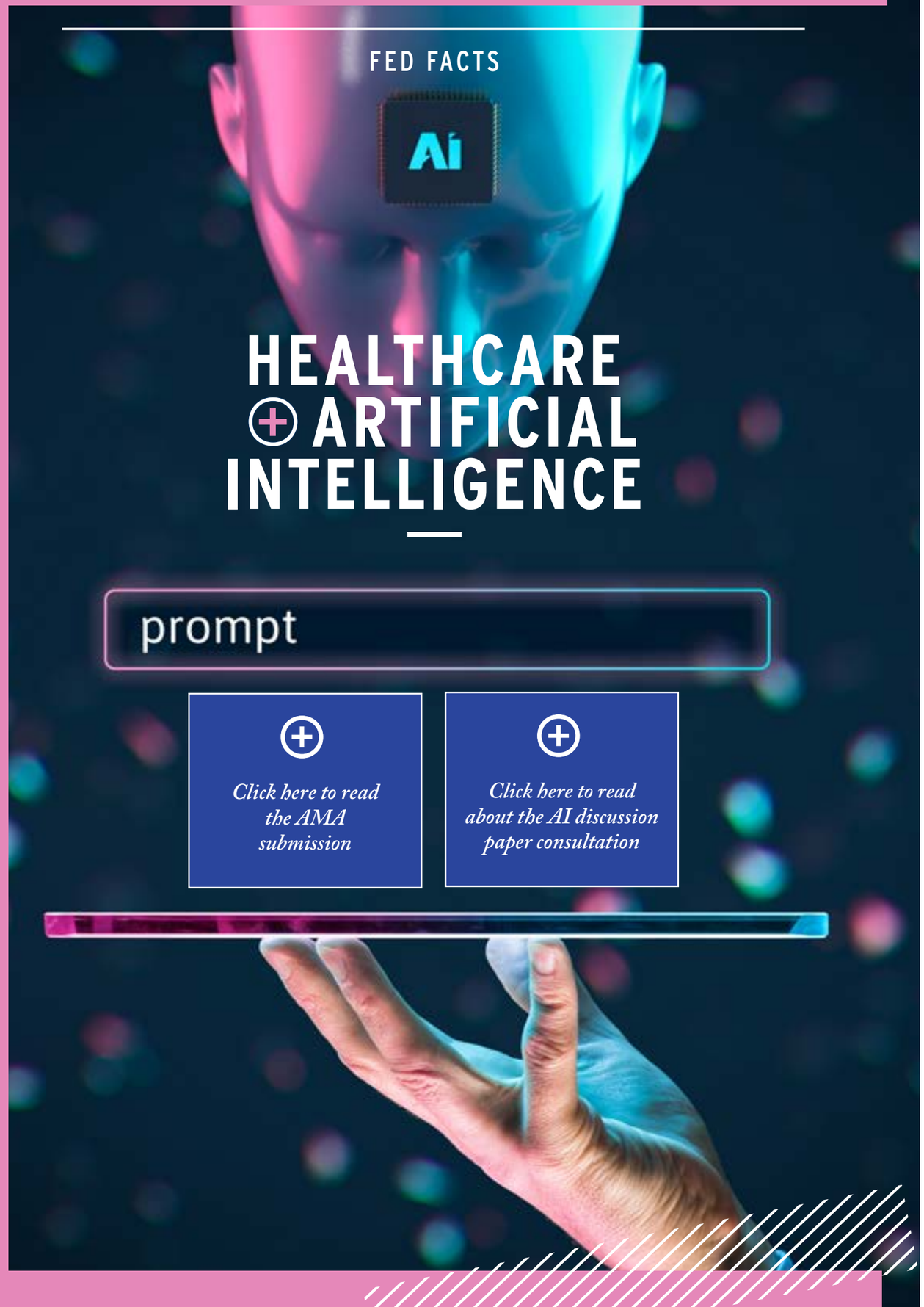



## HEALTHCARE SECTOR APPROACH TO AI REQUIRED

*This AMA Media Release was issued: Thursday 27 July 2023*

Australia needs stronger governance and regulation of Artificial Intelligence (AI) and the health sector requires its own separate strategy to protect patients, consumers, healthcare professionals and their data.

In a submission to a Department of Industry, Science and Resources discussion paper, Supporting responsible AI, the Australian Medical Association said the key challenge with AI in Australia is it remains largely unregulated with a lack of transparency on the ethical principles of AI developers and no real governance arrangements in place.

AMA President Professor Steve Robson said the AMA sees significant opportunities in the appropriate application of AI in healthcare, provided proper governance arrangements are put in place.

"AI is a rapidly evolving field with varying degrees of understanding among clinicians, other healthcare professionals, administrators, consumers and the wider community.

"We need to address the AI regulation gap in Australia, but especially in healthcare where there is the potential for patient injury from system errors, systemic bias embedded in algorithms and increased risk to patient privacy.

"We applaud the government for undertaking these important discussions and we think a separate discussion with all health sector stakeholders needs to happen.

"There are key health principles that need to be introduced into AI, for example ensuring patients and practitioners consent to the episode of care and/or their personal data being used for machine learning.

"There has been a lot of good work done by the EU, Canada and other countries around privacy, data ownership and governance that we can learn from and adapt to the Australian and healthcare contexts, and we need to examine this through the healthcare lens, so we get it right for the future wellbeing of our patients."

The AMA's position on successful regulation of AI in healthcare, is that a common set of agreed principles are embedded in legislation that establish a compliance baseline for all those involved under appropriate governance of AI.

Those principles should ensure:

- safety and quality of care provided to patients
- patient data privacy and protection
- appropriate application of medical ethics
- equity of access and equity of outcomes through elimination of bias
- transparency in how algorithms used by AI and ADM (application data management) tools are developed and applied
- that the final decision on treatment should always rest with the patient and the medical professional, while at the same time recognising the instances where responsibility will have to be shared between the AI (manufacturers), the medical professionals and service providers (hospitals or medical practices).

## AI CAN IMPROVE HEALTHCARE FOR AUSTRALIANS, BUT WITH ROBUST RULES IN PLACE

Medical care delivered by human beings should never be replaced with AI, but AI technology can potentially achieve improved healthcare, the AMA said today.

The AMA's first Position Statement on the use of AI in healthcare outlines a set of ethical and regulatory principles based on safety and equity which should be applied to the application of AI technologies in healthcare.

The position statement covers the development and implementation of AI in healthcare and supports regulation which protects patients, consumers, healthcare professionals and their data.

AMA President Professor Steve Robson said with appropriate policies and protocols in place, AI can assist in the delivery of improved healthcare, advancing our healthcare system, and the health of all Australians.

"The AMA sees great potential for AI to assist in diagnosis, for example, or recommending treatments and at transitions of care, but a medical practitioner must always be ultimately responsible for decisions and communication with their patients.

"There's no doubt we are on the cusp of big changes AI can bring to the sector and this will require robust governance and regulation which is appropriate to the healthcare setting and engenders trust in the system.

"We'd like to see a national governance structure established to advise on policy development around AI in healthcare.

"Such a structure must include all health-sector stakeholders like medical practitioners, patients, AI developers, health informaticians, healthcare administrators and medical defence organisations.

"This will underpin how we carefully introduce AI technology into healthcare. AI tools used in healthcare must be co-designed, developed and tested with patients and medical practitioners and this should be embedded as a standard approach to AI in healthcare.

"Decisions about healthcare are the bedrock of the doctor-patient relationship and these will never be replaced by AI. People worry when they hear that machine learning is perfecting decision-making, but this is not the role AI should play in healthcare. Diagnoses, treatments and plans will still be made by medical practitioners with the patient – AI will assist and supplement this work.

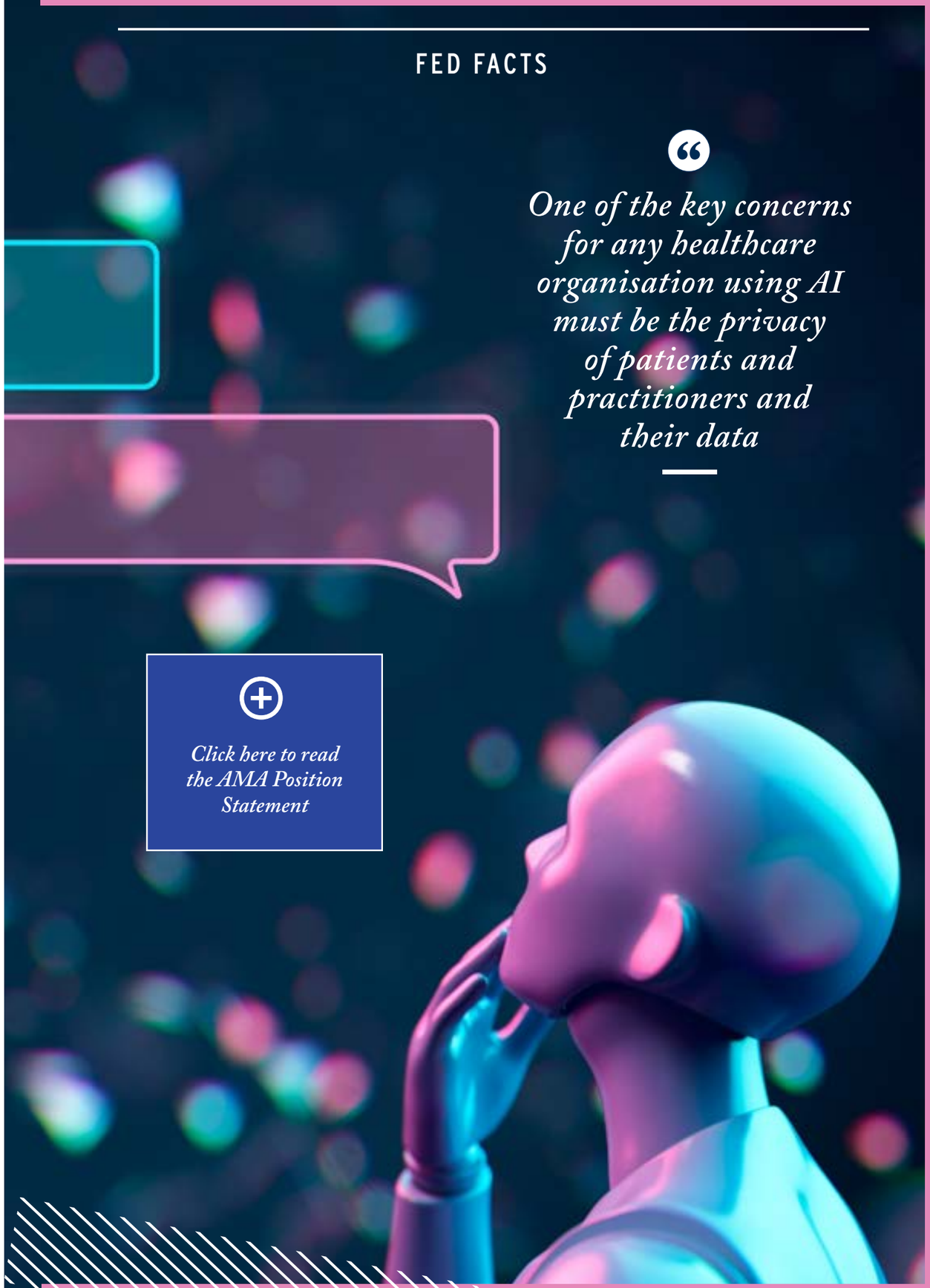
"We need to get ahead of any unforeseen consequences for patient safety, quality of care and privacy across the profession. This will require future changes to how we teach, train, supervise, research and manage our workforce.

"One of the key concerns for any healthcare organisation using AI must be the privacy of patients and practitioners and their data. The AMA's position is very clear about protecting the privacy and confidentiality of patient health information. This is where regulation and oversight is really important; the healthcare sector must establish robust and effective frameworks to manage risks, ensure patient safety and guarantee the privacy of all involved.

"The AMA's position statement shows doctors are engaging with this rapidly evolving field and laying down some guiding principles. If we can get the settings right, so that AI serves the healthcare needs of patients and the wider community, we think it can enable healthcare that is safe, high quality and patient centred."







DOCTORS SUPPORTING DOCTORS

# PEER SUPPORT SERVICE

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

In the demanding and often isolating world of medicine, having the mental and emotional support as and when you need it is important. Recognising this need, in 2008 we established the Peer Support Service, a valuable initiative designed to provide all doctors and medical students with a safe space to seek support from colleagues who are compassionate experienced doctors. The AMA Victoria Peer Support Service is a crucial component of the broader effort to promote the wellbeing of the medical profession.

## KEY FEATURES AND BENEFITS

**Confidentiality:** One of the primary concerns for doctors seeking support is maintaining confidentiality. The AMA Victoria Peer Support Service ensures that conversations remain entirely confidential, allowing doctors and medical students to speak openly without fear of repercussions. All callers remain anonymous unless at immediate risk of harm.

**Experienced peers:** The service connects doctors trained as peer supporters who have a deep understanding of the medical profession's challenges. These supporters have firsthand experience in navigating the complexities of a medical career, making them uniquely qualified to offer relevant guidance and empathy.

**Non-judgmental environment:** Medical professionals often hesitate to seek help due to fears of being judged or stigmatised. The Peer Support Service offers a non-judgmental space where individuals can openly discuss their concerns, fears, and stressors without the fear of criticism.

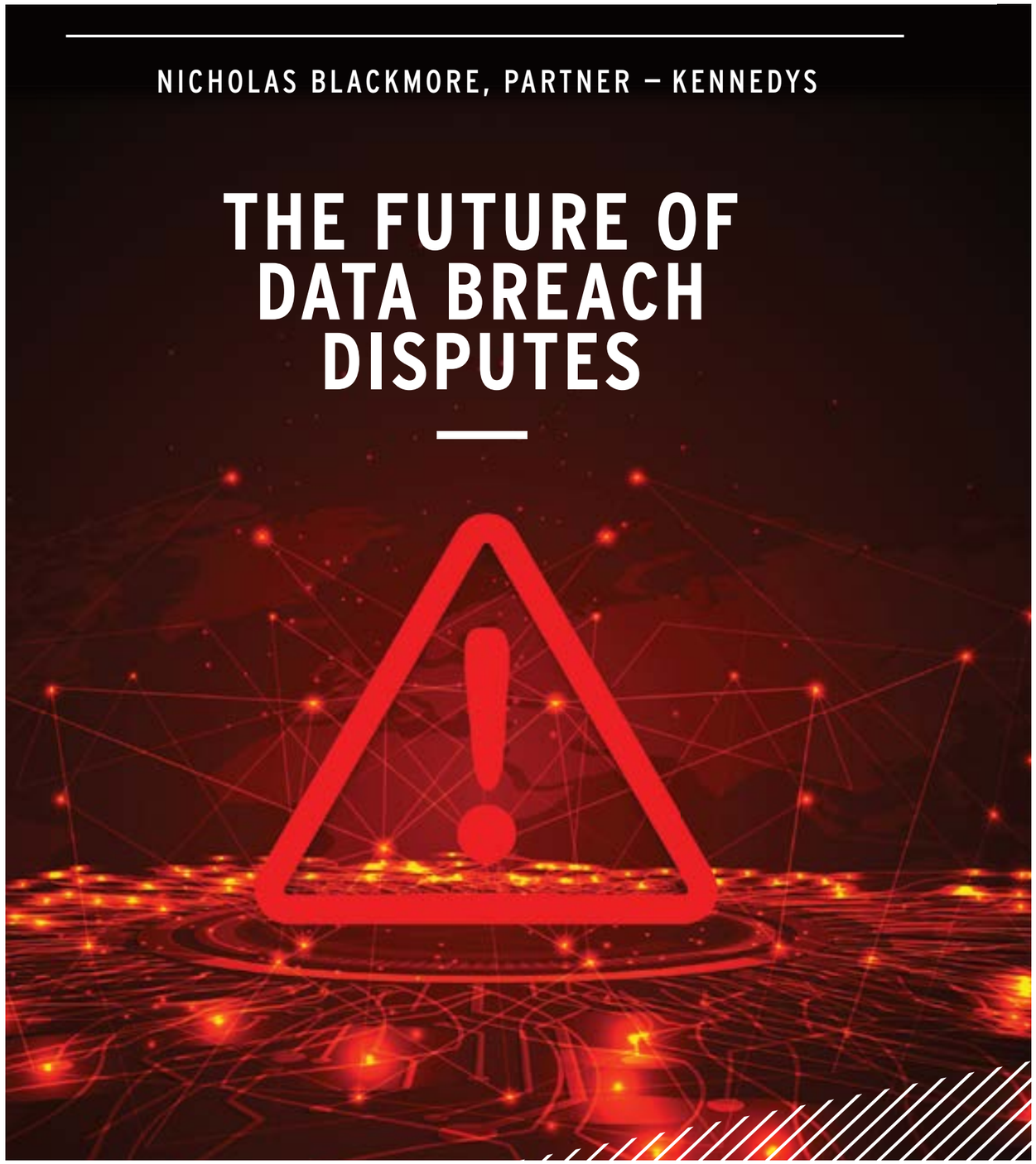
**Diverse range of issues:** The challenges doctors face can span a wide spectrum, including burnout, stress, work-life balance, ethical dilemmas, and personal crises. The AMA Victoria Peer Support Service is equipped to address any issues, ensuring that doctors receive the assistance they need.

**Accessibility:** Recognising that challenges can arise at any time, the service is accessible every day of the year from 8am to 10pm via telephone on 1300 853 338. This availability ensures that doctors have a support system to turn to which is available for extended hours every day.

The medical profession, with its demanding schedules, high stakes and emotional toll, can inadvertently foster an environment where the wellbeing of medical professionals takes a back seat. The Peer Support Service challenges this status quo by placing the mental and emotional health of doctors at the forefront. Remember, seeking support is not a sign of weakness but rather a sign of strength and self-awareness.

NICHOLAS BLACKMORE, PARTNER – KENNEDYS

# THE FUTURE OF DATA BREACH DISPUTES



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The Medibank Private data breach in October 2022 affected the personal information of 9.7 million Australians, including a wide range of sensitive health information. Your practice may not have quite that many patients, but the incident still serves to highlight the importance of cybersecurity for any business which holds large volumes of sensitive health information. The legal impact of the breach, however, is still to come, as the health insurer faces class actions and regulatory proceedings that could change the legal landscape for data breach disputes.

A data breach can cause harm to affected individuals in many ways. The publication of sensitive health information (for example, that an individual had an abortion, is suffering a sexually transmitted disease, or has a mental illness) can cause distress, psychological harm and reputational damage. The misuse of an individual's identity documents can cause financial loss. In some cases, the disclosure of an individual's address can put them at risk of physical harm.

If an individual who suffers harm as a result of a data breach decides to seek compensation, they currently have two options.

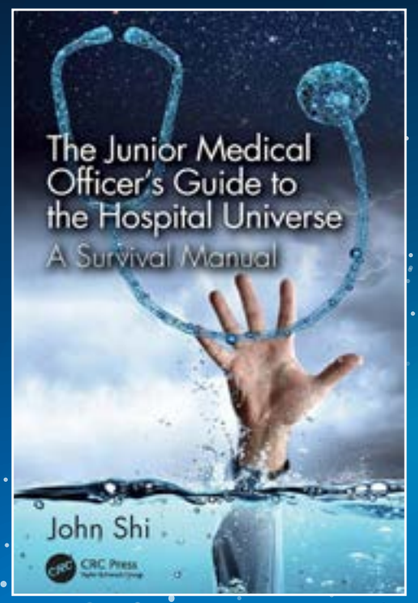
Firstly, they can lodge a complaint with the Office of the Australian Information Commissioner (OAIC). If a class of people are affected, a representative complaint can be made on behalf of that class. The OAIC will investigate the complaint, and if it cannot be resolved by conciliation, has the power to make a determination, which may include an order for compensation.

Secondly, they can commence legal proceedings. If a class of people are affected, a class action can be commenced. Currently, there is no specific cause of action for a data breach, so the plaintiff's main argument will usually be that the business was negligent in failing to adequately protect the personal information they held. The Commonwealth Government is proposing to introduce a specific cause of action for breaches of the Privacy Act later this year.

Until now, representative complaints and class actions have been exceedingly rare in Australia. In the 23 years since the Privacy Act was extended to apply to the private sector, only five representative complaints have been made to the OAIC, and there has never been a class action in relation to a data breach.

However, this may be about to change, thanks to the Medibank Private and Optus data breaches. At the time of writing, Medibank Private is facing two separate class actions from consumers, a class action from its shareholders, and a representative complaint to the OAIC. Optus is facing a consumer class action and a representative complaint to the OAIC.

The class actions, in particular, will be watched closely by lawyers. If they proceed to trial, the parties will argue about a variety of issues that have not previously been considered by an Australian court. Does a business have a duty of care to its customers and employees to protect the personal information it holds, and what is the standard they must meet to satisfy that duty? How can an individual prove that the harm they suffered was a result of this particular data breach? Should individuals be able to claim damages for psychological or emotional harm suffered as a result of a data breach – and if so, is general distress sufficient, or must a specific mental injury be diagnosed? The court's decision on these issues will help establish whether data breach class actions are worth conducting in Australia, and in what circumstances. If the plaintiffs in these class actions are successful, class actions may become a regular response to large-scale data breaches – which will mean that healthcare providers need to take cybersecurity even more seriously, particularly when handling sensitive health information.




*Each chapter is a treasure trove of insights, covering everything from the art of effective communication with patients, families and colleagues to tips for managing ward rounds and keeping up with discharge summaries.*

# THE JUNIOR MEDICAL OFFICER'S GUIDE TO THE HOSPITAL UNIVERSE:

## A SURVIVAL MANUAL

**by Dr. John Shi (2022)**

BOOK REVIEW
KAY DUNKLEY,
AMA VICTORIA DOCTOR
WELLBEING CONSULTANT



The Junior Medical Officer's Guide to the Hospital Universe: A Survival Manual starts within hospital walls and is a valuable tool for all those embarking on their medical career journey. Authored by an experienced doctor in training, this manual is a valuable compass for successfully navigating working in a hospital and surviving as a junior medical officer.

As the author himself notes, the book is about life in medicine, particularly 'admin'. Prepared as a reference book and a very practical guide, this is not a book to sit down and read from cover to cover, but rather one to dip into as needed. There is a detailed list of contents which makes it easy to find relevant information, plus a glossary and an index at the end.

That said, it's an easy and interesting read as the language is authentic and real. Shi does not shy away from a realistic appraisal of the mundane and the challenging nature of being a junior doctor. However, he does emphasise the need for efficiency and provides a lot of advice about techniques to manage repetitive task and stresses the importance of finding time for self-care.

Each chapter is a treasure trove of insights, covering everything from the art of effective communication with patients, families and colleagues to tips for managing ward rounds and keeping up with discharge summaries. Shi includes tips for saving time and covers life admin topics like pay, salary packaging and tax as well as employment entitlements.

One of the book's standout features is its emphasis on teamwork and effective communication within the hospital environment. Shi dedicates ample space to upskilling readers on how to collaborate seamlessly with nurses, allied healthcare professionals, and senior colleagues. It underscores the importance of fostering a supportive and respectful atmosphere.

A minor draw back that readers need to be aware of is that, as Shi is based in New South Wales, he refers to a specific EMR system which is not used by all hospitals in Australia. Likewise, he refers to NSW employment entitlements which may be different in other states and territories of Australia. However, provided readers keep this in mind, it shouldn't detract from the relevance of his overall messages.

Of course, different readers will find some sections more relevant than others, depending on their specialties or experience. However, the author's consistent encouragement of adaptability and resilience through practical techniques to enhance workload management and work-life balance are valuable for all.

This survival manual will be very useful for junior medical officers, for intern doctors as they transition from medical students to doctors and for doctors who have trained overseas and who are unfamiliar with the Australian medical system. It makes a great graduation gift for medical students and I strongly recommend it to all overseas trained doctors entering the workforce in an Australian hospital.

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