WOMEN IN MEDICINE

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AMA VICTORIA

AUTUMN 2023








Women in medicine:
In their own words

The invisible minority:
How can we #EmbraceEquity
for all women in medicine

Medical internship:
The intern diaries

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AMA VICTORIA

IN THIS ISSUE

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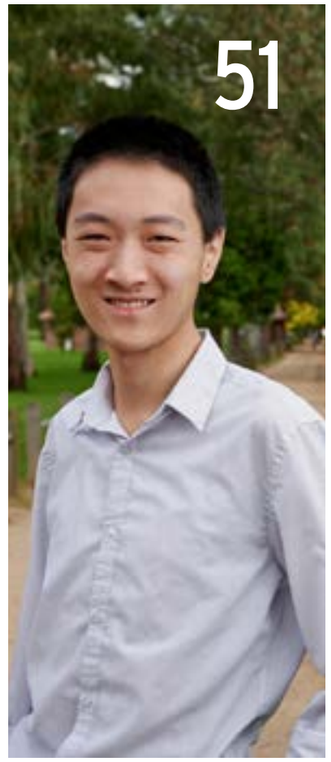

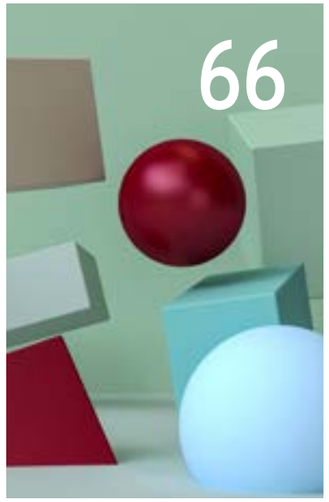

REGULARS

FEATURE

OPINION

WHAT'S NEW

YOUR AMAV

NEWS, VIEWS + REVIEWS

AMA VICTORIA EXPLAINS BENEFITS OUTWEIGH RISKS IN THE SHARING OF HEALTH INFORMATION BETWEEN HEALTH SERVICES

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AMA VICTORIA RESPONDS TO THE DELAY OF SURGERY FOR CANCER PATIENTS AT MELBOURNE'S PETER MACCALLUM CENTRE

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IN REVIEW: READ | WATCH | LISTEN

WOMEN AT WAR

Netflix limited series

'Women at War' is a Netflix limited series set on the French-German border during World War I. The eight-part series explores the destinies of four archetypal women – a mysterious Parisian prostitute; a soon-to-be widow propelled to the head of the family factory; the Mother Superior of a convent and a feminist nurse wanted by the police for performing illegal abortions. It pivots through all the themes of a compelling drama – love, conflict, death, lust, loss and power struggles, along with plenty of heaving bosoms and gore, thanks to the setting of many scenes in a brothel, and a chaotic and woefully unhygienic army hospital. You'll likely find yourself rolling your eyes at many of the medical scenes (such as the dashing male doctor participating in a life-saving operation on himself), but the overall pace, empathy and unfolding pathos make it a worthy watch.

DIGITAL MINIMALISM

Cal Newport

In today's interconnected age, modernisation and digitalisation go hand in hand, don't they? 'Digital Minimalism' is a thoughtfully considered refutation of all our common excuses (I have to keep up with the pregnancy of a distant relative!) by Georgetown University computer science expert, Professor Cal Newport. Referencing industry insiders like an ex-product manager at Facebook, Newport elegantly shows why and how the powerful forces driving the digital age, who claim they help us to communicate and network, might in fact be looping us into a more sinister net from which extracting ourselves will be the ultimate challenge.

THE REST IS HISTORY

Hosted by: Dominic Sandbrook and Tom Holland

Irreverent and charming, 'The Rest Is History' podcast attempts to tackle the whole sweep of human history, from Australia before colonisation to the reign of Liz Truss, from Alexander the Great to Vladmir Putin's Russia, and (mostly) everything in between. Hosted by popular historians Dominic Sandbrook and Tom Holland (not Spiderman, as the latter frequently and humorously notes), The Rest Is History has developed a dedicated and loyal following for its approach which is at once quirky and informative. At over 300 episodes and counting, the podcast's archives are well worth exploring. Episodes on the Jeremy Thorpe scandal', 65. A very British Scandal', 45. Top 10 Eunuchs', and '257. Australia: The Mystery of the Somerton Man' are fabulous.

NEW RESEARCH: SILENT PANDEMIC

THE PATH FOR CURBING ANTIMICROBIAL RESISTANCE

Click here to read report

A recent report outlines the challenges Australia and the world need to overcome to avoid being thrust back into a pre-antimicrobial age where simple infections are deadly and some surgeries are too risky to perform.

Australia is seeing a growing 'silent pandemic' of antimicrobial resistance (AMR) – when bacteria and other microbes become resistant to the drugs designed to kill them, such as antibiotics, usually from misuse or overuse.

The report, Curbing antimicrobial resistance: A technology-powered, human-driven approach to combating the 'silent pandemic', was developed by the Australian Academy of Technological Sciences and Engineering (ATSE) and initiated by CSIRO, Australia's national science agency. It calls for greater national coordination and a focus on streamlining commercialisation processes for new antimicrobial resistance solutions and technologies.

Branwen Morgan, Lead of CSIRO's Minimising Antimicrobial Resistance Mission, said AMR was recently designated one of the top 10 public health threats facing humanity by the World Health Organization (WHO).

The report drew on the expertise of more than 100 multidisciplinary experts across government, academia and industry and looked at a range of potentially impactful technologies such as integrated surveillance and sensing solutions, point-of-care diagnostics, vaccination technologies, antimicrobial surfaces and air sterilisation technologies.

ATSE CEO Kylie Walker said Australia has the potential to be a global contributor in the development of technologies to combat AMR and should aspire to be a world leader in its management.

What's On —

1–31 MARCH

FND Australia Awareness Day

National Epilepsy Awareness

15–19 MARCH

World's Greatest Shave

20–26 MARCH

National Advanced Care Planning Week

26 MARCH

Purple Day

1–30 APRIL

IBS Awareness Month

7 APRIL

World Health Day

11 APRIL

World Parkinson's Day

ENQUIRY

BY WOMEN + FOR WOMEN

DR KATE DUNCAN

THERE IS NO POINT IN TRAINING WOMEN IN MEDICINE, ALL THEY DO IS GO OFF AND GET MARRIED! COMPLETE WASTE OF TIME AND MONEY.

These remarks, coming from a senior academic, greeted me as a nervous 17-year-old first year medical student at Monash. He went on to point out helpfully that most men wouldn't want to see a woman doctor anyway. His born-in-the-1920s view of the world had obviously never been troubled by the idea that female patients might not wish to see male doctors.

When it was also pointed out that I was selfishly occupying a precious medical school place that might otherwise have been awarded to some bright young man who would make a long and worthwhile career in medicine, I made two resolutions: the first – that I would work to the age of 65 before retiring, regardless of marital developments or reproductive adventures, and the second – that I would outlive him and the others of his ilk. And I have done precisely that.

My graduating class was 19% female. This may seem strange to present-day students, but it was a higher proportion than in many of the previous years. Melbourne University first admitted women as medical students in 1890 and the statistics ran to single digit percentages for decades. This might give some idea of the background against which I pursued my medical career. What a relief it was when I finally reached the clinical years and discovered the Queen Victoria Medical Centre where, in the 1960s, Monash had established its Departments of Obstetrics & Gynaecology and Paediatrics.

The Queen Vic, as it was affectionately known, had been founded by the Victorian Medical Women's Society (VWMS). Dr Constance Stone and the first six female graduates from Melbourne University formed the VMWS in 1886. The new graduates, having been grudgingly tolerated as students, found very few opportunities for appointment to training positions or hospital posts. They took steps to solve this by starting a clinic, initially from a church hall, then evolving into a hospital, partly funded by the Queen Victoria Memorial 'Shilling Fund'. This medical service was staffed entirely by women doctors from its inception, up to the 1950s when male doctors were first appointed to the staff. Its motto: "Pro Feminis, A Feminis" (By Women, For Women).

The hospital occupied various sites over its history, starting in the Wesley Church Hall and including a building in William Street which subsequently became

REWARDING ASPECTS OF WORK IN A DIFFERENT MEDICAL SETTING

PHOTOGRAPH SUPPLIED BY THE QUEEN VICTORIA'S WOMEN'S CENTRE ARCHIVE

the Peter Mac and later The Mint. After WWII, the hospital moved into the site bounded by Swanston, Lonsdale, Russell and Little Lonsdale Streets which had formerly been the original Royal Melbourne Hospital. It remained there, with the Monash University departments added, until 1987 when it was closed and 'moved' to become the Monash Clayton, Hospital

Much is being said, these days, about the importance of role models in development and education. When adolescents or young adults see people in senior and authority positions, with whom they can identify, it can be a boost to confidence and self esteem and make building a career seem possible. The Queen Vic of the 1970s had senior female consultants and heads of unit in general and thoracic surgery, plastics, neurosurgery, obstetrics, gynaecology, anaesthetics, medicine, paediatrics, pathology and radiology. Their male colleagues were accustomed to working within this environment and treated women as equals to a far greater extent than at the other teaching hospitals. Mind you, having worked with Dame Joyce Daws, (thoracic surgeon), Dr June Howqua, (physician), and Miss Elizabeth Lewis, (neurosurgeon), amongst others, I feel it would have taken a brave man to do anything else.

I will always be grateful for having had the opportunity to study and train with such a wealth of senior and experienced clinicians. Teachers, mentors and role models with a vast pool of knowledge and willingness to share their expertise. I'm sure Queen Victoria would have been proud to know how well 'her' hospital has served the people of Victoria.

INTERNATIONAL WOMEN'S DAY FEATURE








WOMEN IN MEDICINE:

IN THEIR OWN WORDS

Eight healthcare industry leaders reflect on medicine, gender, equity and womanhood.

SERIES **VANESSA MURRAY**

PHOTOGRAPHY **ERNESTO ARRIAGADA**

PROF MARIE BISMARK

PUBLIC HEALTH PHYSICIAN,
PSYCHIATRY REGISTRAR,
+ HEALTH LAWYER

Marie is a public health physician, psychiatry registrar, and health lawyer. In addition to her clinical work, Marie leads the Law and Public Health Unit within the Centre for Health Policy at the University of Melbourne, where her research focuses on the interface between clinician wellbeing, patient safety, and medical regulation.

Marie completed a Harkness Fellowship in Healthcare Policy at Harvard University in 2005 and is an experienced company director. Her current governance roles include serving as a non-executive director of the Royal Women's Hospital, Summerset retirement villages, and GMHBA health insurance. Marie has three children aged 23, 21 and 19.

CAREER

MY CAREER HAS WOVEN BACK AND FORTH BETWEEN CLINICAL MEDICINE, HEALTH LAW, AND GOVERNANCE.

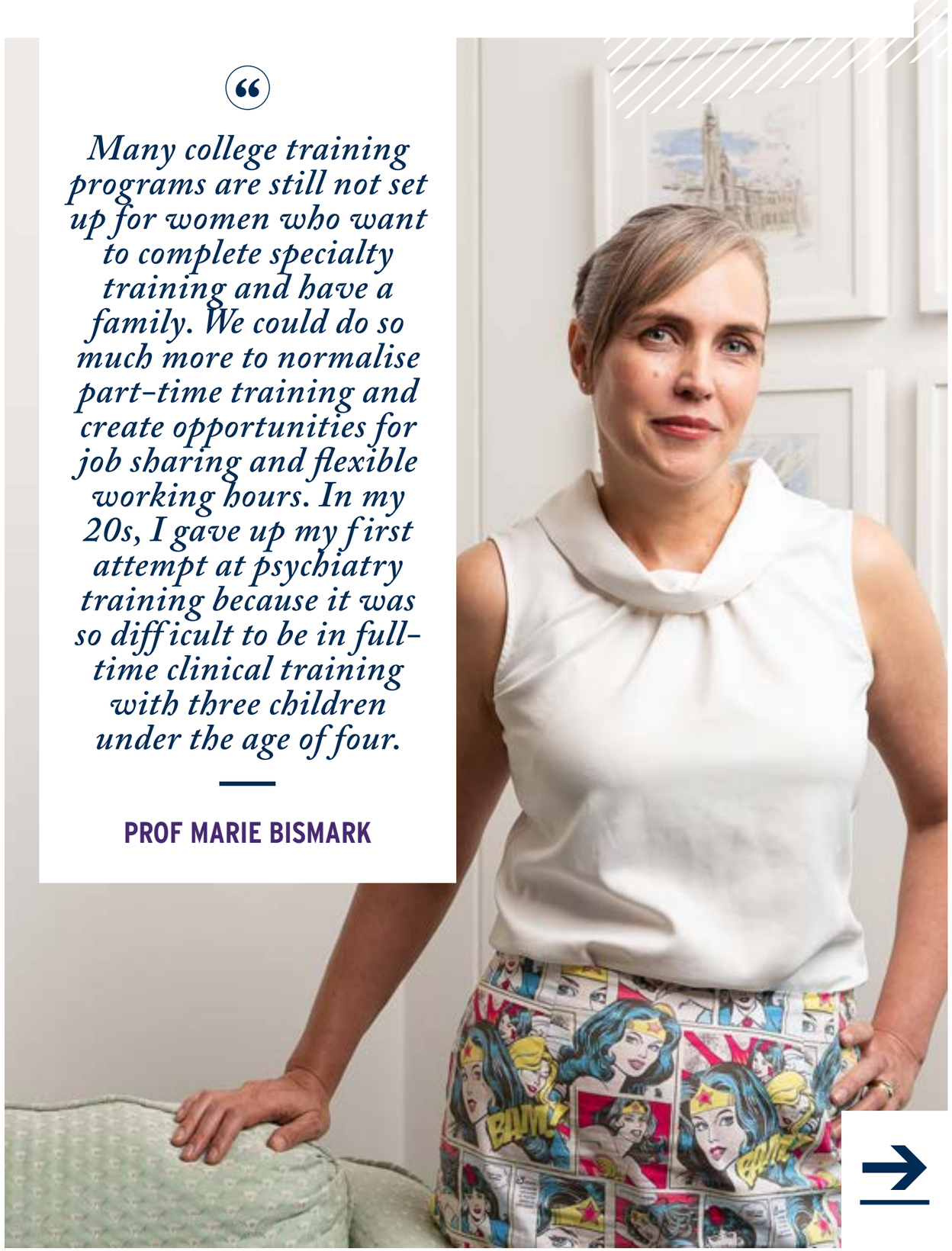
After leaving high school, I was undecided between medicine and law, so I enrolled for both thinking that it would quickly become apparent which one was the career for me. I ended up completing degrees in law and medicine concurrently, and 30 years later I still haven't made up my mind. After initially training in public health medicine, and then working as a lawyer, I returned to specialty training in psychiatry at age 43. I'm happiest when I'm combining clinical work with research and leadership roles.

I CHOOSE TO WORK IN AREAS OF MEDICINE THAT ARE OFTEN UNDERFUNDED AND UNDERAPPRECIATED.

During the pandemic, I chaired the Clinical Quality Committee at Summerset, where we were responsible for protecting the safety of over 7,000 elderly residents and 2,000 aged care staff. Aged care can be a competitive sector, but improving the quality of care is important for everyone, so we worked collaboratively to establish a national benchmarking scheme for New Zealand's aged care providers. An Australian project that I'm especially proud of is the Cornelia Project. It's a wonderful initiative of The Royal Women's Hospital to provide pregnant women who are experiencing homelessness with safe accommodation and compassionate healthcare.

Many college training programs are still not set up for women who want to complete specialty training and have a family. We could do so much more to normalise part-time training and create opportunities for job sharing and flexible working hours. In my 20s, I gave up my first attempt at psychiatry training because it was so difficult to be in full-time clinical training with three children under the age of four.

PROF MARIE BISMARK



PERSONAL

WOMEN STILL CARRY MOST OF THE BURDEN OF BEING PRIMARY CARERS FOR THEIR CHILDREN.

Many college training programs are still not set up for women who want to complete specialty training and have a family. We could do so much more to normalise part-time training and create opportunities for job sharing and flexible working hours. In my 20s, I gave up my first attempt at psychiatry training because it was so difficult to be in full-time clinical training with three children under the age of four. My children, Finn, Stella and Zoe, are young adults now, but support for part-time trainees hasn't changed very much since they were born.

WE NEED TO TALK ABOUT THE REALITY OF SEXUAL HARASSMENT AND ASSAULT OF DOCTORS BY DOCTORS.

Sexual misconduct within the medical profession happens across a whole spectrum, from sexualised comments through to sexual assault or rape. I still remember the distress and shame that I felt, many years ago now, when I knelt down to get a patient file and the male surgeon I was working for said, "It's good to see a woman on her knees. It always makes me hopeful." There is still a real fear of negative repercussions for women, including women doctors, if they report sexual misconduct in the workplace. Particularly because the people that you're working for, who may be the perpetrators, are also the people who are writing your letters of reference, making recommendations to training programs, or who might be employing you in the future.

OUTLOOK

IN FEMINISED PROFESSIONS, PEOPLE ARE OFTEN DOING IMPORTANT WORK THAT THEY CARE DEEPLY ABOUT, BUT THEY'RE NOT BEING PAID FAIRLY.

You see those disparities in status and remuneration across all areas of healthcare: the professions and specialties that are male dominated are consistently paid more. And then equally skilled roles, where most workers are women, are paid much less. Aged care is a good example. Just as most aged care residents are women, so too are the people working in aged care. Many residents have multiple comorbidities and require complex care. Aged care nurses provide a hugely skilled service but are terribly underpaid for it. Women are less likely than men to ask for pay rises, and less likely to be granted them if they do ask. Advocacy for equal pay isn't happening to the extent that it should be.

SOMETIMES ONE ENCOURAGING CONVERSATION CAN CHANGE A PERSON'S LIFE.

I'm at this lovely stage of my career now where I've transitioned into being able to support other people's careers. I've achieved a lot of the things that I want to achieve, and I'm grateful to all the people who encouraged me along the way. So, my focus now is on supporting other clinicians and academics who are coming through. I am enjoying mentoring and supervising and holding the ladder to help other women reach their goals. Sometimes it's simply a matter of letting people talk about their hopes and dreams out loud. It makes it more real.

DR JASMINA KEVRIC

SURGICAL ONCOLOGY (BREAST) FELLOW PETER MAC

Jasmina is the Surgical Oncology (Breast) Fellow at Peter Mac, where she manages predominantly female patients with breast cancer. Her practice involves operating, presenting at multidisciplinary meetings, teaching and research, and of course, spending time with her patients at breast clinic. She is also the mother of a two-year-old daughter (Sophia). Jasmina was aged just 14 when she arrived in Australia on a refugee visa in 2001 from her homeland of Bosnia via Germany, off the back of the civil war that occurred between 1992 and 1995. In 2008, she co-founded social change not-for-profit Footprints Enterprise, and in 2022 received AMA Victoria's Doctor of the Year Award. Jasmina's career in medicine was inspired by witnessing firsthand the bravery and altruism of medical relief teams as they tended the wounded on the streets of her war-torn city, Brcko.

CAREER

BEING ABLE TO SUPPORT WOMEN THROUGH SOME OF THE WORST EXPERIENCES OF THEIR LIVES GIVES ME A GREAT SENSE OF ACHIEVEMENT.
At the same time, it's incredibly humbling to be part of their journeys, and I learn something from my patients each day.
I chose breast cancer as a specialty as early in my medical school years, my mum found a breast lump. Luckily it turned out to be benign, but I remember the initial stages of anxiety and uncertainty. That experience has helped me understand what breast cancer patients go through, and I use it to better support the women in my own practice.

THERE ARE A LOT OF PATIENTS, ESPECIALLY WOMEN, WHO FOR A VARIETY OF REASONS, FIND IT HARD TO ACCESS THE KNOWLEDGE AND CARE THEY NEED.
I also find that women struggle to advocate for themselves. They often have their families and all their responsibilities on their minds. Female patients often report that certain symptoms are dismissed by clinicians and that they feel they have been treated differently because of their gender. This of course leads to poor patient outcomes. It's incredibly important for us as clinicians to empower them to raise any concerns, and then we need to be able to act on those concerns. And I think it starts with our personal practices.

PERSONAL

I REALISED I WANTED TO BE A DOCTOR DURING MY CHILDHOOD IN BOSNIA, WHEN I WAS EXPOSED TO TRAUMA SURGERY.
We would hear the missiles and find cover in the bunkers. When the missile strikes were over, we'd resurface to find, once again, the devastation and bloodshed around us. I would see the doctors come and work on people in the streets, and I saw how much of a difference they made in such a terrible environment.

WHEN I CAME FROM AUSTRALIA, FROM BOSNIA, I COULDN'T SPEAK ENGLISH.
Within six years I was able to pick up the language, go through my VCE and then enter medicine. And I often look back and reflect on how much drive and determination and hard work can achieve. It's something I often look back on to give me the resilience that I need going forward.

OUTLOOK

I THINK AS DOCTORS WE GET TO THE POINT WHERE WE NEGLECT OURSELVES BECAUSE WE HAVE PUT EVERYTHING AND EVERYONE ELSE AHEAD OF OURSELVES.
In my campaigning for refugee rights in Australia, I invested so much time and effort into that, that sometimes I neglected my own wellbeing. But now I'm aware that I can't give 100% unless I'm fully functional and rested. Now I can take breaks and holidays and recharge, and I think it's incredibly important that we as doctors take advantage of that for ourselves.

UNLESS WE HAVE A SYSTEM THAT ACCOMMODATES PROFESSIONAL WOMEN AND THEIR NEEDS, WE WILL CONTINUE TO DISADVANTAGE OUR PATIENTS.
I recently finished my surgical training, and I had a period of two months' leave, and I wanted to work during that time. I applied for local positions but said I could only work from 8 to 5 because of childcare drop offs and pickups. I wasn't given the opportunities because the hours were 7 to 7, but the jobs remained unfilled for weeks – at a time when we had such a large staff shortage! More flexibility for doctors and medical professionals is ultimately in the best interests of our patients. We need more women in powerful positions who can refocus and shift away from medicine's patriarchal culture.

COMING TO AUSTRALIA FROM A REFUGEE BACKGROUND, I'VE ALWAYS BEEN DETERMINED TO LEAD THE WAY FOR OTHERS TO PURSUE THEIR OWN GOALS AND ASPIRATIONS.
That pushes me to make something of my life and now as a parent, I want to show my daughter that she can achieve anything she sets her mind to. I feel that to show her this, I really must walk that path myself. Of course, like everyone I have my ups and downs, but it's this dream to open doors for others that never really dies.

> *More flexibility for doctors and medical professionals is ultimately in the best interests of our patients. We need more women in powerful positions who can refocus and shift away from medicine's patriarchal culture.*

DR JASMINA KEVRIC

DR NISHA KHOT

CLINICAL DIRECTOR OF
OBSTETRICS + GYNAECOLOGY
PENINSULA HEALTH

In August 2022, Nisha was appointed as the Clinical Director of Obstetrics and Gynaecology at Peninsula Health. She also holds board memberships of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Rural Doctors Association of Victoria and Multicultural Centre for Women's Health and chairs the Specialist International Medical Graduate Committee and Gender Equity & Diversity Working Group at RANZCOG. Nisha is especially interested in the experiences of migrant and rural women, and in campaigning for their active inclusion in decision making processes. She is also a mother to a 21-year old daughter and a 14-year-old son.

CAREER

WHEN I WAS A MEDICAL STUDENT, I WAS VERY INTERESTED IN PATHOLOGY. BUT OBSTETRICS AND GYNAECOLOGY WAS MORE AVAILABLE TO ME, SO I PURSUED THAT.
I hated it for the first six months! But I persisted and have grown to be absolutely committed to and passionate about supporting women and families as they navigate pregnancy and birth. Despite many years of practicing obstetrics, I continue to feel very privileged to be a part of the birth not only of a newborn but also of a mother and a family.

I CAME TO AUSTRALIA 10 YEARS AGO AS AN INTERNATIONAL MEDICAL GRADUATE, OR IMG.
This is a descriptive term for medical graduates who have been trained in another country. The term tends to be used in countries where the local population and hence the medical profession is predominantly Caucasian. Most IMGs do not like the term; it's a way of 'othering' us that is very unnecessary. There is also a subtext in that the term IMG is most often used to describe non-Caucasian doctors, leading to further alienation.

IN AUSTRALIA, THE HEALTHCARE YOU CAN ACCESS IS VERY MUCH DETERMINED BY GEOGRAPHY.
We all pay the same taxes, but we don't have access to the same health services. This is a big issue for people living in rural areas, who face a double whammy of poor access to healthcare and lower socio-economic status. I would like the standard of healthcare available in rural areas to match that available in urban areas. Why shouldn't it?

The UN estimates that achieving full gender equity is still centuries away! There are many, many things that need to change and we can't and shouldn't wait for hundreds of years. We must move beyond women just surviving to women thriving in every way.

DR NISHA KHOT

PERSONAL

MY GRANDMOTHER WAS A VERY AMBITIOUS WOMAN IN THE TIME BEFORE WOMEN IN INDIA COULD BE AMBITIOUS, SO SHE PASSED HER AMBITIONS ON TO HER DAUGHTERS AND GRANDDAUGHTERS.

She found herself on the wrong side of the border between India and Pakistan on the eve of partition in 1947. She bravely joined the wave of migration that headed across the border, to make a new life. Both her daughters went to university, and as the oldest granddaughter, I grew up with her plan for my life, which was to be a doctor.

I HAD TO START MY CAREER FROM SCRATCH WHEN I MOVED FROM INDIA TO THE UK, AND AGAIN WHEN I MOVED TO AUSTRALIA.

This is because the UK and Australian medical systems only recognise specialist doctors who are trained within their own systems. It's very western-centric and there are many hurdles to be overcome before a doctor can practice as a specialist. I'm proud that I was able to start over in not one but two countries and build my career to a senior leadership level.

OUTLOOK

I WOULD LIKE TO LIVE IN A WORLD WHERE WE DIDN'T NEED A DAY LIKE INTERNATIONAL WOMEN'S DAY, BUT SADLY, WE DO.

The UN estimates that achieving full gender equity is still centuries away! There are many, many things that need to change and we can't and shouldn't wait for hundreds of years. We need pay parity between men and women. We need to work seriously toward eliminating violence against women. We can't do this without men stepping up and being allies and champions. We must move beyond women just surviving to women thriving in every way.

MANY OF THE DECISIONS MADE FOR WOMEN OF COLOUR IN AUSTRALIA ARE MADE WITHOUT THEIR INPUT.

This is an issue because the solutions being developed are not always a good fit. Without the input of people with lived experience, it's unlikely that solutions will ever be a good fit. I am a big fan of 'Nothing about us without us', and I am working very hard in all my areas of activity and influence to ensure there is a seat at every table for women of colour.

PLEASE DON'T EVER DISCOURAGE A PERSON – ESPECIALLY A WOMAN, OF COLOUR FROM APPLYING FOR ADVANCEMENT.

At various points in my career, I was advised by senior medical leaders to not apply for graduate training programs or leadership positions. The subtext was that as an IMG and a woman of colour there wasn't any point; that I wouldn't be admitted. Well, here I am, proving that this is incorrect. I would like my legacy to be showing other migrant women and women of colour that they can do whatever it is they want to do, including taking on senior leadership positions.

A/PROF MAGDALENA SIMONIS

GENERAL PRACTITIONER

Magdalena has been in full-time general practice in the Melbourne CBD for three decades and is a researcher with the Department of General Practice and the Safer Families Centre of Research Excellence at the University of Melbourne. A leader in her field, a sought-after speaker and a participant in numerous roundtables, steering committees, and advisory groups, Magdalena was the 2022 recipient of the AMA Victoria Patrick Pritzwald-Steggman Award, which celebrates a doctor who has made an exceptional contribution to the wellbeing of their colleagues and the community. Magdalena's career choices have been influenced by her roles as a mother and carer, which drive her commitment to advocating for greater gender equity for women.

CAREER

I DIDN'T GET INVOLVED IN RESEARCH UNTIL QUITE LATE IN MY CAREER. IT EVOLVED OUT OF A NEED TO ADDRESS GAPS IN RESEARCH AREAS, AND A DESIRE TO ADVOCATE.

In order to advocate more effectively, evidence-based research is a necessity. Where it didn't already exist, I decided to undertake research myself to understand what was happening. When this was translated into meaningful figures and statistics, it made the message more impactful. One of the first areas that brought me into research was female general cosmetic surgery, which came to me through my general practice.

YOUNG WOMEN WERE COMING TO ME REQUESTING GENITAL MODIFICATION.

Some teenagers presented with their mothers, concerned about the appearance of their genitals. As presentations started to increase around 2010, my concern led this to become a consuming topic from 2012 through to 2017. My interest expanded to include body dysmorphic disorder, sexist advertising and gender equity in health. I supervised students who won awards for their research in the area, as did I. My research was published in BMJ and I was invited to present internationally.

HAVING A FAMILY HAS REALLY RESTRICTED MY CAREER OPTIONS.

I have two children, Artemis and Alexander, who are now young adults. I worked full-time throughout most of their childhoods, and my husband was often absent as he worked internationally, so I restricted my work to being home-based and Melbourne-based. This limited my ability to take up some of the opportunities that I was offered such as international roles and speaking opportunities or to apply for an international scholarship, which of course I would've loved.

PERSONAL

MY MOTHER LEFT MY FATHER IN THE DAYS BEFORE GREEK WOMEN LEFT THEIR HUSBANDS.
My heritage is Greek, and my parents' marriage was an arranged one. It was an unsuccessful match and my mother absconded to safety with three young children. I was eight, my sister was 15 and my brother was 10. It was a hard time. She was a single mother with three young children and spoke fragmented English. She worked three or four jobs, so she wasn't home much. But my mother never complained. She was never bitter. She just got on with the present. Her stoicism really had an impact on me; she was my rock.

HIGH SCHOOL WAS AWFUL FOR ME. THE KIDS WERE VERY RACIST AND TO EVADE THE TAUNTING, I'D HIDE IN THE LIBRARY.
This worked to my advantage as I immersed myself in books. When at home, my routine revolved around helping to prepare the meals, my own study, as well as helping mum with her English (CAE) Council of Adult Education study and cleaning the house. From the age of seven, I knew that I wanted to be a doctor and drew inspiration from watching M*A*S*H every night.

I LOVE MY KIDS AND LOVE BEING A MOTHER BUT BEING A FULL-TIME WORKING MUM WAS TOUGH.
I remember finishing work, rushing to pick the kids up from school with that lump my throat, knowing that I was going to be late and worrying that my kids were going to be standing in the playground on their own. When I see young working mothers with their children now, I think "Thank goodness I'm not doing that anymore!"

OUTLOOK

WHEN YOU'RE A CLINICIAN, BEING ATTUNED TO FAMILY VIOLENCE IS A CONSTANT PART OF YOUR PRACTICE.
When you ask those extra questions around how things are going on at home, your female patients will often divulge stuff they otherwise wouldn't. Give them space by pausing, looking at them intently and saying, "Looks like there's a lot on your plate. Can you tell me how things are at home?" This often leads to a deeper understanding around their condition.

TO ACHIEVE GENDER EQUITY, WE NEED MORE MEN TO PARTICIPATE IN THIS CONVERSATION.
Gender equity primarily aims to empower women by addressing existing systemic imbalances. However, men will also benefit from achieving gender equity in society because I think that just as women have been forced out of roles, men have been forced into certain roles too. Not all men are comfortable living the life that they're living. Some would like less travel, more time with family.

WE NEED TO HAVE A FLEXIBLE, FLUID APPROACH TO CAREER DEVELOPMENT AND EMPLOYMENT.
At the heart of this is childcare; adequate, funded childcare and an employment culture that looks at people as contributors to society, not just contributors to the business or industry they're in.

> *Gender equity primarily aims to empower women by addressing existing systemic imbalances. However, men will also benef it from achieving gender equity in society because I think that just as women have been forced out of roles, men have been forced into certain roles too.*

A/PROF MAGDALENA SIMONIS

PROF ROSEMARY ALDRICH

CONJOINT ASSOC PROFESSOR
UNIVERSITY OF NEWCASTLE
+ AFFILIATE PROFESSOR
DEAKIN UNIVERSITY

Rosemary was appointed to lead the Grampians Public Health Unit in January 2021, following nearly four years as Chief Medical Officer at Ballarat Health Services. Rosemary was a journalist before becoming a doctor and subsequently a public health physician with fellowship qualifications in medical leadership and management. Her key interests include health system strengthening through attention to equity considerations, coalition building, governance, and by bringing systems thinking to enable stakeholder-driven solutions to prevention and population health challenges. A Conjoint Associate Professor at the University of Newcastle and an Affiliate Professor at Deakin University, Rosemary is also currently a student in Griffith University's Climate Change Adaptation program. She has two adult daughters and one granddaughter.

CAREER

I'M CURRENTLY THE DIRECTOR OF THE GRAMPIANS PUBLIC HEALTH UNIT (GPHU), ONE OF VICTORIA'S NINE LOCAL PUBLIC HEALTH UNITS.

In my role I work in close partnership with clinicians, civic and health leaders, and the people of our region to protect our population's health and prevent disease. In 2021, together we managed to keep COVID-19 case numbers low while achieving a >95% double vaccination rate in all local government areas. In 2022 the GPHU's brief expanded across the breadth of health protection, health promotion and disease prevention, and population health.

BEFORE I BECAME A DOCTOR, I STUDIED COMMUNICATIONS AND THEN WORKED AS A JOURNALIST IN TELEVISION, NEWSPAPERS RADIO AND ADVERTISING.

I became interested in promoting health through mass communication. After working for a year in health promotion, I began medical school and, having no science background, I didn't expect to love it as much as I did. I started my Masters of Public Health while I was a medical student. My 2006 PhD combined all study to that point: I researched how language used by politicians characterised Australia's First Nations people in ways that influenced government policy and health outcomes for decades.

> *As an intern my consultant said he thought women shouldn't be doctors. As a heavily pregnant registrar and the only female at a crowded medical morning handover that same consultant called on me to describe the efficacy of the oral contraceptive pill.*

PROF ROSEMARY ALDRICH

PERSONAL

LIKE MANY WOMEN, THERE WAS A POINT WHEN MY CAREER ASPIRATIONS LOOKED INCOMPATIBLE WITH A CARING FOR A FAMILY.
I was working as a registrar in microbiology and infectious diseases in Newcastle in 1991 and seven months pregnant with my first child when Professor of Medicine Michael Hensley, also a public health physician, suggested I train in public health medicine with him when I returned from maternity leave. He invited me to nominate my start date, and the number, days and hours of my work. Having a role shaped to accommodate me was extremely unusual. As a public health registrar, I worked mainly in communicable diseases and child public health, and was also interested in all aspects of health system functioning. Over time I've cobbled together diverse family-friendly clinical, research, teaching, governance and leadership roles.

AS A MEDICAL STUDENT AT A SCHOOL WHERE THERE WERE MORE FEMALES THAN MALES IN MY YEAR, IT DID NOT OCCUR TO ME THAT GENDER WOULD BE AN ISSUE.
But at times it was. As an intern my consultant said he thought women shouldn't be doctors. As a heavily pregnant registrar and the only female at a crowded medical morning handover that same consultant called on me to describe the efficacy of the oral contraceptive pill. Periodically there have been other occasions when gender-based comments or assumptions have been made which reflect, I think, a mostly unconscious bias about gender roles. Although my organisation's lead in the pertinent area, about a decade ago I was replaced in a matter because, I was told, a male needed to lead a particular conversation. I've had to explain that a male consultant lauding a female consultant for her "passion" in a meeting (rather than her expertise, skill or leadership) can sound patronising. Subtle biases are still potent which is why we need to keep talking about them.

OUTLOOK

PUBLIC HEALTH MEDICINE PRACTICE CAN CHANGE HOW MEDICAL SPECIALISTS TOGETHER THINK ABOUT THE PREVENTION AND MANAGEMENT OF DISEASE, ABOUT WAYS TO REDUCE THE NEED FOR HOSPITALISATION ACROSS A COMMUNITY, AND IN DESIGNING NEW MODELS OF CARE.
While many public health physicians are employed in departments of health, public health units and academic centres, many possess another specialty also and bring public health considerations to that other specialist practice. I trained later in medical leadership and management. When I came to Ballarat, I was credentialled in both medical administration and public health medicine – to my knowledge the first public health physician credentialled in a health service in Victoria. With both hats I was able to scope and establish the Ballarat4Kids program, a whole of city approach to child health and wellbeing, now a coalition of 35 multi-sector organisations working to create an environment in which all children can thrive.

IN THE SERVICE OF OUR COMMUNITIES, PUBLIC HEALTH MEDICINE AND CLINICAL MEDICINE ARE BOTH CRITICAL TO DELIVERING HEALTH AND WELLBEING.
Public health physicians protect and promote health and prevent disease by working with communities to attenuate the impacts of socioeconomic determinants on their health, while working with clinicians and others to ensure that our health and social care systems deliver value and meet community needs.

DR INES RIO

GENERAL PRACTITIONER

Ines is a specialist general practitioner with postgraduate qualifications in public health, law, obstetrics, venereology, and governance. Her special interest areas are maternity care, child health, women's health and the care of marginalised women and children. Ines is also a GP obstetrician and head of the General Practice Liaison Unit at the Royal Women's Hospital, Chair of North Western Melbourne PHN, a member of the TGA's Advisory Committee on Vaccines, a member of the Department of Health's CALD Communities COVID-19 Health Advisory Group, and an Executive member of AMA Federal GP Council. She is committed to quality, effective, efficient, equitable and integrated health care services and the central importance and role of general practice and primary care in this provision. Ines is also a mother to a 24-year-old daughter and a 22-year-old son.

CAREER

I'M IN THE PRIVILEGED POSITION OF DEVELOPING SOMEBODY'S TRUST, IN ME AND IN THE SYSTEM OF CARE I REPRESENT.

I work in a community health centre in an area populated mostly by people with very low socioeconomic status who are often from CALD and refugee backgrounds. Depending on where they've come from and the sorts of systems they've been involved in, their experience with authority, including health professionals and systems, has not always been positive. And they're often in very difficult circumstances, with complex needs over a variety of health, social, family, housing, employment, education and justice areas. There's a high prevalence of domestic violence, chronic disease, mental health problems, and often a low sense of personal agency.

BEING A GP HAS BEEN GOOD FOR MY HEART, AND GOOD FOR MY HEAD.

I graduated as a doctor when I was 23. I stayed in the hospital system for about five years, and started my physician training, but realised I was interested in everything. I then spent time as a registrar in paediatrics, obstetrics and psychiatry. Ultimately, I wanted to work with patients and their families over time. I wanted to understand the context of their world and deal with people as a whole, not just bits of them. That led me to become a GP, and I've found it incredibly emotionally and intellectually satisfying.

PERSONAL

AS A WOMAN, I'VE HAD THE PRIVILEGE OF HAVING A COMPLEX LIFE WITH MULTIPLE, DEEPLY PROFOUND RELATIONSHIPS.

I'm talking about my relationship with my partner, but also my relationship with others. Being a woman has fostered a multifaceted life of work, caring for people around me, including my children and parents, and having several close friendships that I really value and invest in. I've come to understand these are important elements of health, and of a rich and full life. I see health in that holistic way, and I think, in part, that comes from my life as a woman.

WHEN YOU'RE A YOUNG WOMAN, AND YOU'VE GOT WORK AND YOU'VE GOT KIDS, YOU JUST PUT ONE FOOT IN FRONT OF THE OTHER, DON'T YOU?

I went back to work when my daughter was two weeks old. It wasn't my preference, but those were the days without widespread paid maternity or parental leave. I was in general practice at the time, but if I'd still been employed by a hospital, I'd have been entitled to three months' paid leave. This affected my financial ability to take leave when I was having children, purely because I was a GP. And that continues to be the case. Even today, GP registrars currently don't have an employer-based maternity scheme. At best they may be eligible for the minimum Federal Government's paid parental leave program. It's no doubt affecting recruitment into general practice. Its patently unjust, inequitable and untenable.

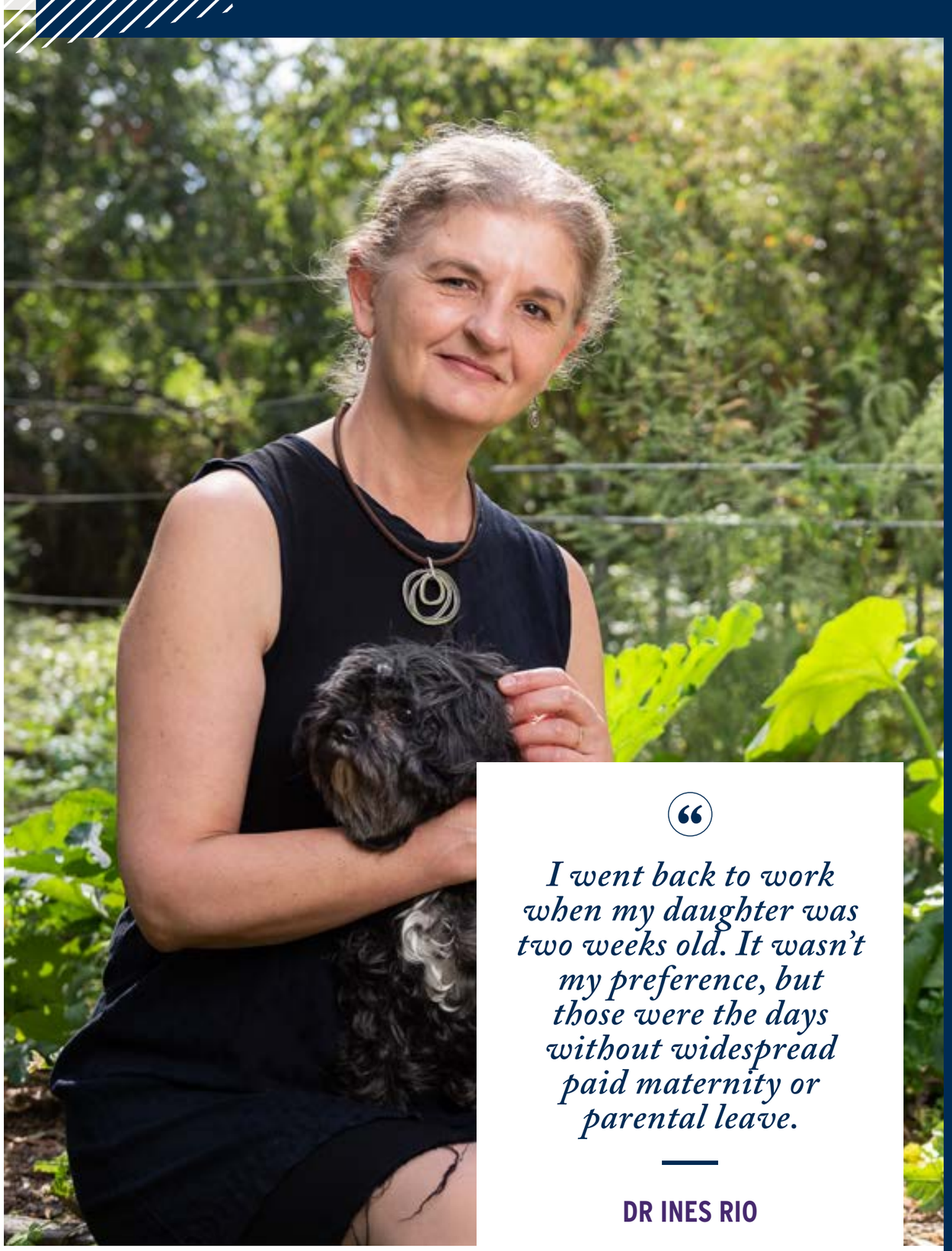
OUTLOOK

THE DIFFICULT PART OF MY JOB IS NOT WHAT HAPPENS IN MY ROOM; BUT GETTING MY PATIENTS THE SERVICES THEY NEED OUTSIDE MY ROOM.

We need more services in general practice to help us deliver comprehensive GP-led, patient-centered medicine. We need dieticians, diabetes educators, physiotherapists, pharmacists, social workers, social prescribers, and psychologists. We need public hospitals to see and treat people in a timely way. They need performance indicators with consequences, for example publicly available, real-time referral to treatment times. And if outpatients can't see people or can't perform surgery within a prescribed time, such as 30 to 60 days, we need to be able to use private services. This is what happens in Denmark. If the public system can't respond in a timely way, the government pays the private system to see people, with no out of pocket expenses for the person.

WE NEED SYSTEM REFORM TO MAKE GENERAL PRACTICE A MORE SUSTAINABLE, MORE EFFECTIVE PIECE OF THE HEALTHCARE PUZZLE.

Currently, general practice is remunerated on "sausage medicine"; doctors are remunerated best for seeing people every five to six minutes. It's not good care for patients and its dissatisfying for GPs. Twenty-minute medicine, which is my average patient time, and the average for most females GPs, is very poorly remunerated. We need reform around general practice to incentivise good quality medicine that acknowledges the time and care patients need, that gives us the time to listen, to be curious and to enjoy our consultations.



"I went back to work when my daughter was two weeks old. It wasn't my preference, but those were the days without widespread paid maternity or parental leave.

DR INES RIO

DR NEELA JANAKIRAMANAN

PLASTIC + RECONSTRUCTIVE SURGEON

Neela is a reconstructive plastic surgeon with a focus on complex hand and wrist surgery.

Her private practice is in Melbourne, and she is the current Acting Clinical Lead of plastic surgery at Eastern Health. She chose her specialty after completing a medical school elective at an NGO hospital which specialised in reconstructive orthopedics in Cambodia and seeing first-hand how surgery could change lives. Neela has also done significant pro bono work in refugee health, and a is a writer and commentator. She is a regular contributor to Women's Agenda and other publications, and her bestselling debut novel, The Registrar, was published in July 2022. Neela has three sons aged six, 10 and 13.

CAREER

MEN TEND TO COME AND SEE ME FOR THEIR SURGERY WHEN THEY CAN'T DO THE THINGS THEY WANT TO DO, WHILE WOMEN COME AND SEE ME WHEN THEY CAN'T DO THE THINGS THEY NEED TO DO.

I've noticed that women often put up with their pain and give up a lot of hobbies and interests that give them joy because they're busy often taking care of other people. Whereas men tend to prioritise themselves and their own wellbeing and interests much sooner. They might come in when they can't play golf, for example. The other place I really see gender differences is when it comes to WorkCover claims. Women's pain, disability and dysfunction is often dismissed by employers, insurers and independent medical examiners. I find myself writing more letters than I would like, calling out those kinds of biased assessments.

In 2019, I was involved in operationalising the Australian Medivac legislation for Refugees in offshore detention.

We coordinated over a thousand Australian doctors to participate in the health assessment of asylum seekers in Manus Island in Nauru. It's notable that most of the volunteers were women. I think women see the broader social responsibility aspect of projects and endeavours like this. Our leadership team were all women, and the working groups, were all led by women, though I would acknowledge the many men who also volunteered their time and expertise.

I was told repeatedly that there was no way to be a good registrar and a good mother. I had six weeks off work and then didn't breastfeed or express at work with my first child, because I was told that I wouldn't get breaks during long cases. A lot of that has changed. The female network is much stronger and many structural protections now exist. But if I can be blunt, some attitudes haven't really changed and to achieve genuine equity, they need to.

DR NEELA JANAKIRAMANAN

PERSONAL

I WAS BROUGHT UP IN A HOUSEHOLD WHERE MY PARENTS NEVER DIFFERENTIATED BASED ON GENDER.

There was never a moment where I didn't think I could do whatever I wanted. At school I would be taken to women in science events and I was perplexed as to why they existed because of course, women could be scientists and mathematicians or whatever else they wanted. It wasn't until I was in my twenties that I started to understand structural barriers and how they applied me and my own career progression.

I was the second woman in plastic surgery training in Victoria to have a baby during training – ever.

I was told repeatedly that there was no way to be a good registrar and a good mother. I had six weeks off work and then didn't breastfeed or express at work with my first child, because I was told that I wouldn't get breaks during long cases. A lot of that has changed. The female network is much stronger and many structural protections now exist. But if I can be blunt, some attitudes haven't really changed and to achieve genuine equity, they need to.

OUTLOOK

I THINK MEDICINE IS VERY SEXIST. THE ORIGINS OF WESTERN MEDICINE ARE PATRIARCHAL; WOMEN WERE NURSES AND MEN WERE DOCTORS.

Women were excluded from the planning and establishment of healthcare systems. In fact, we still don't regularly conduct clinical trials on female subjects because of the menstrual cycle might alter the results. We understand illnesses by the symptoms men get, and miss diagnoses in women. Only 12 per cent of surgeons in Australia and New Zealand are women. In orthopaedic and cardiothoracic surgery, that figure is as low as five per cent. Our surgical instruments were designed by men for men, so if you have smaller hands, they are harder to use.

We know that there is a hierarchy of advantage and disadvantage, and that women of colour are situated towards the bottom of that pyramid.

Privilege is not about whether or not life is easy or hard for you, it's about whether or not there are demographic characteristics that you can't change that contribute to how you are perceived, judged, and supported within the systems we live and work in. I am a woman of colour but I belong to a model minority and I acknowledge that there are many who face greater discrimination within the healthcare profession. We need to think about how we give value to things, such as being 'Australian trained' or the assumptions we make about people, such as how they speak English. Healthcare workers should reflect the communities we serve.

DR MADHURA NAIDU

INTENSIVE CARE REGISTRAR

Madhura is an intensive care registrar and a trainee with the College of Intensive Care Medicine, in training to become an ICU consultant. She has previously worked in a variety of clinical specialties in multiple centres, including St. Vincent's Hospital, Melbourne. She is also the Victorian State Representative for the Australian Federation of Medical Women. In January 2021 she was elected to the role of President of the Victorian Medical Women's Society, and is the youngest woman ever elected to the role. She is interested in intersectional feminism, gendered medicine and digital health. Madhura does not plan to have children.

CAREER

I WANTED TO BECOME A SURGEON WHEN I FINISHED MEDICAL SCHOOL, BUT I BURNED OUT.

I was in unaccredited training and working extremely long hours and it became very difficult for me to see the end of the road. I took a couple of months off to decide what I wanted to do. Then I did a rotation in anaesthetics and then another rotation in ICU. I decided that ICU is more in line with what I am interested in and what I can really see myself doing in the future, so I pivoted. I love the humanity of medicine in critical care.

Women are often not taken seriously when they say they're in pain. I've certainly seen that in my practice; medicine is very gendered.

Incredibly, we're only just starting to recognise and accept that women possibly or even probably react to pain in a different way or have different needs. There is a lot of research to show that a lot of the things that we do in our clinical practice is based on evidence or research that was predominantly conducted on male patients. The classic example is the different ways women present with heart attacks. Traditionally we look out for chest pain, but women can present with symptoms of indigestion. And then the risk is, their diagnosis gets overlooked. We might dismiss a woman's response to pain as overly emotional, whereas when a man tells us he's in pain, we think it's serious. We think, we have to get on top of it! We need to shift our perspectives - gender influences, and is influenced by, the physical, psychological and social lives of our patients; we have to be more intentional in our practice of medicine.

PERSONAL

I'VE MET WONDERFUL WOMEN THROUGH THE VICTORIAN MEDICAL WOMEN'S SOCIETY, INCLUDING SOME PROFESSIONAL ROLE MODELS WHO HAVE HELPED ME TO LOOK AT MEDICINE AND GENDER MORE HOLISTICALLY.

Being a part of the society and getting to know other women has really opened my eyes to the real issues that affect women in both the professional and personal worlds. Some of the issues I've become more attuned to are quite simple, like how people speak to me. Communication can be full of microaggressions. In the past I haven't had the language to put those concepts into words. I think some women go through life without realising how sexist some of the interactions they experience are. Having the language has made me feel more able to combat things like this.

There are a lot of assumptions made around child rearing in medicine. But actually, I don't think I want to have kids.

A lot of my friends and colleagues around my age are pregnant or thinking of getting pregnant. It's definitely a situation that impacts them. They worry what their employer is going to think. But it's something they shouldn't have to worry about. I had male colleagues question my ambition to do this training, because they assumed I'd need to take time off when I got married and had kids. They'd say, this job is very demanding, and it's you — the woman — who will have to take care of your kids. That's a big assumption to make; that viewpoint needs to change. This kind of outdated thinking not only impacts women; it also impacts men who might want to take time off for childcaring.

OUTLOOK

I'M ON THE FENCE ABOUT THE RELEVANCE OF INTERNATIONAL WOMEN'S DAY.

On the one hand, I think it's good because we need organisations to mark the day. We need women and their experiences to be in the front of people's minds and we need change to happen. On the other hand, sometimes I think it's a bit of a lip service type situation, where people might say let's celebrate it, and then the next day they go back to being sexist or non-inclusive.

It's important that we provide space for women in leadership positions.

I know that some people are against the whole idea of having a quota system or actively recruiting and promoting women, but I think it's really important because we talk a lot about gender equality and gender equity, but real change comes from the top down. And until we have women in true leadership positions where they are at the table and able to have a voice and make decisions, we'll never be able to progress and actually achieve gender equality.

> *Communication can be full of microaggressions. In the past I haven't had the language to put those concepts into words. I think some women go through life without realising how sexist some of the interactions they experience are. Having the language has made me feel more able to combat things like this.*

DR MADHURA NAIDU

THE INVISIBLE MINORITY:

HOW CAN WE #EMBRACEEQUITY FOR ALL WOMEN IN MEDICINE?

Significant progress has been made in the representation of women in medicine. But how can we ensure that women are both represented & diverse in the future medical workforce?

OPINION **MONIQUE WISNEWSKI**
MSCV CHAIR

Growing up, gender had never been a driving factor in any life decision I made. In fact, now in my final year of medical school, I'm yet to encounter a significant barrier posed by my gender. Instead, I've fought many barriers of a different kind, in the form of socioeconomic disadvantage. So, while the significance of being a woman in medicine isn't lost on me, I find myself wondering where else we can #EmbraceEquity.

In the 129 years since Iza Coghlan and Grace Robinson became Australia's first female medical graduates, significant progress has been made in the representation of women in medicine. In terms of sheer numbers, medicine has become a female dominated industry, with females now comprising ~52.8% of Australian medical students. Of course, we're still seeing gender inequality in various specialties and positions of leadership, with ongoing issues surrounding flexibility of training programs and the gender pay gap. But progress is being made, more so than for other marginalised groups.

Approximately two thirds of Australian medical students hail from the top socioeconomic quartile of our population. In contrast, In contrast, low socioeconomic status (SES) students make up less than a tenth, despite representing 17% of undergraduate university students overall. Unfortunately, the medical education and training system is heavily biased against these students at every stage of the training pipeline, from medical school to specialty colleges. This is despite the heavy emphasis placed on equity for other marginalised groups such as First Nations and rural candidates, for which there are numerous access schemes, scholarships and support programs in place.

Consider Appadurai's theory of aspirations as a capacity. Low SES and first in family students are less likely to have the guidance, opportunities or 'hot knowledge' to navigate the complex admissions process, partake in the desired extracurriculars, or even consider medicine as a viable career option. Meanwhile, affluent students more often tap into their social networks to land invaluable application advice and work experience, attend high performing schools promising high Australian Tertiary Admission Rank and pay for University Clinical Aptitude Test and interview coaching to skew the very measures put in place to reduce the bias in their favour. While shifts towards graduate entry programs has helped, it doesn't completely level the field and there is something to be said about the impact, costs and 'lost time' in the industry associated with undertaking an additional degree.

For the few who make it into medical school, the transition to university is often a difficult and isolating process, with many forced to either move out or commute long distances without the level of government support afforded to rural students. Likewise, scholarships are few and far between, and seemingly the first to disappear when funds are tight. The intensive structure of medical courses pushes students out of part time work and towards 4-6 years of financial dependence, which for those without parental support is a recipe for long-lasting emotional and physical burnout. Thus, when it comes time for specialty college applications, these students who are often forced to turn down opportunities due to cost or in favour of working to make ends meet find themselves playing catch up with research, volunteering and leadership endeavours.

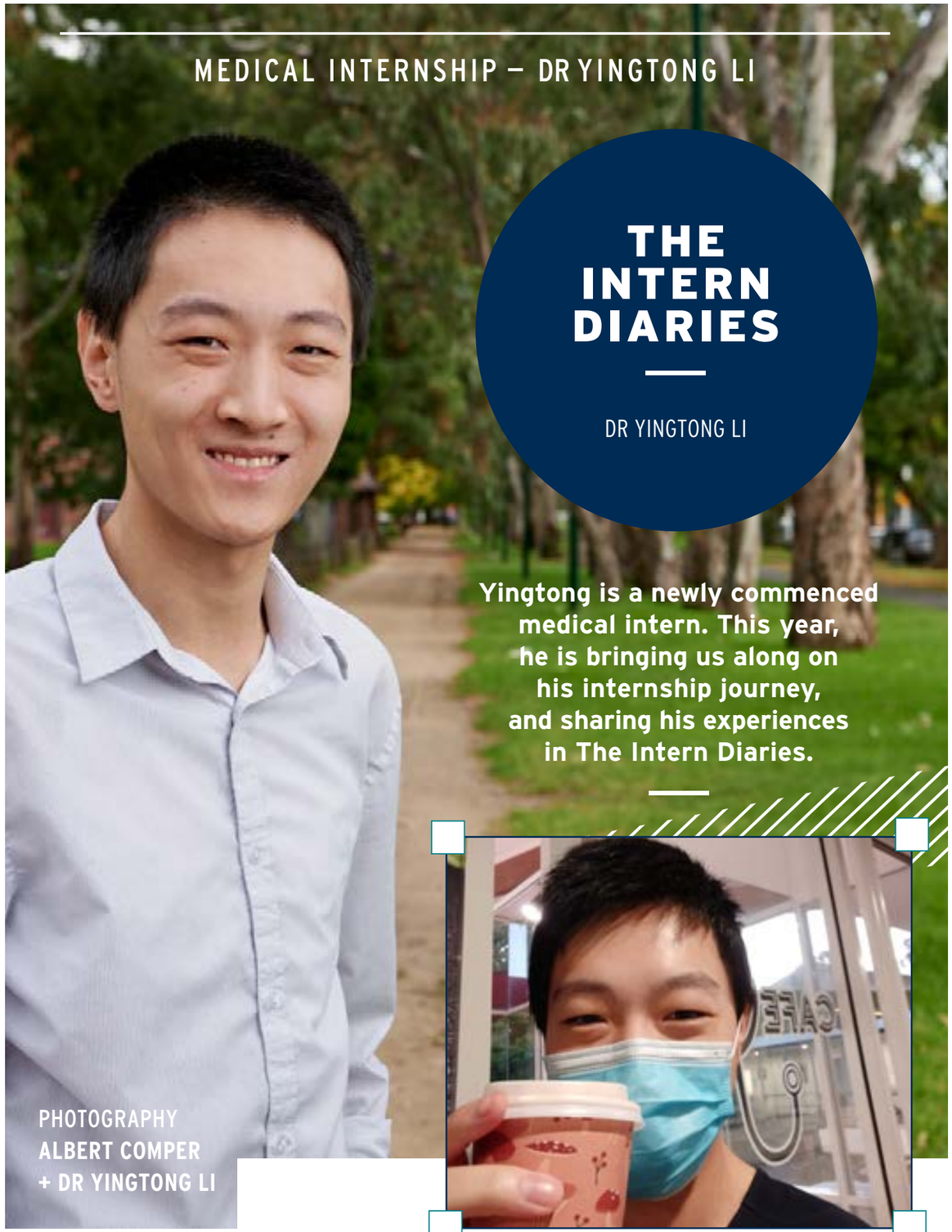
SO HOW DO WE PROMOTE SOCIOECONOMIC DIVERSITY IN OUR MEDICAL SCHOOLS?

Associate Professor Annette Mercer believes that early and continued support is the key. Having been heavily involved in UWA's now discontinued Broadways program, she explains that by engaging with underrepresented high schools, bringing students together, providing logistical support throughout the (then) UMAT, interviews and university transition, and reserving a small number of places in the course for Broadway students (without lowering the entry requirements) the program was able to see many disadvantaged students become doctors. The participants performed as well as their peers, with one alumni, Dr Catherine Nguyen, awarded the AMA gold medal for achieving the top aggregate marks over the four years of her degree. She, like many medical students from lower SES areas, planned to return to her community; many of which make up the outer metropolitan areas which traditionally see medical workforce shortages.

Our outer metropolitan and low SES communities desperately need quality doctors who can staff their hospitals and clinics and effectively connect with their patients.

Socioeconomically disadvantaged populations are at greater risk of poor health and tend to be less involved in medical decision making, hence making up a large number of admissions and representing a vulnerable population in our hospitals. Supporting a new generation of doctors who are diverse beyond the frame of gender provides an invaluable opportunity to better distribute the medical workforce and ensure that all patients can be cared for by doctors who understand their experiences and values. To achieve this, we need medical schools and specialty colleges to recognise the barriers faced by low SES students and work to break them down in the same way as for other underrepresented groups. It may be by tweaking admission processes to be more equitable towards low SES students, implementing programs like UWA's Broadway program, better distributing scholarship funding or a combination of all three. Perhaps one day soon, every young girl can look in the mirror and see a future doctor, regardless of the size of her piggy bank.

Perhaps one day soon, every young girl can look in the mirror and see a future doctor, regardless of the size of her piggy bank.



THE INTERN DIARIES

DR YINGTONG LI

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

PHOTOGRAPHY
ALBERT COMPER
+ DR YINGTONG LI

> *I looked out the window of the twin-engine turboprop, stethoscope and clipboard in tow, waiting for the propellers to whir to life, to take me away to my secondment where I'd start my first ever rotation as an intern. I clutched my boarding pass, my gaze falling to the text neatly printed on the top line – a familiar name, preceded by an unfamiliar prefix: one "Doctor" Yingtong Li. A rising sense of apprehension welled in my chest.*
>
> *Was I really ready for this?*

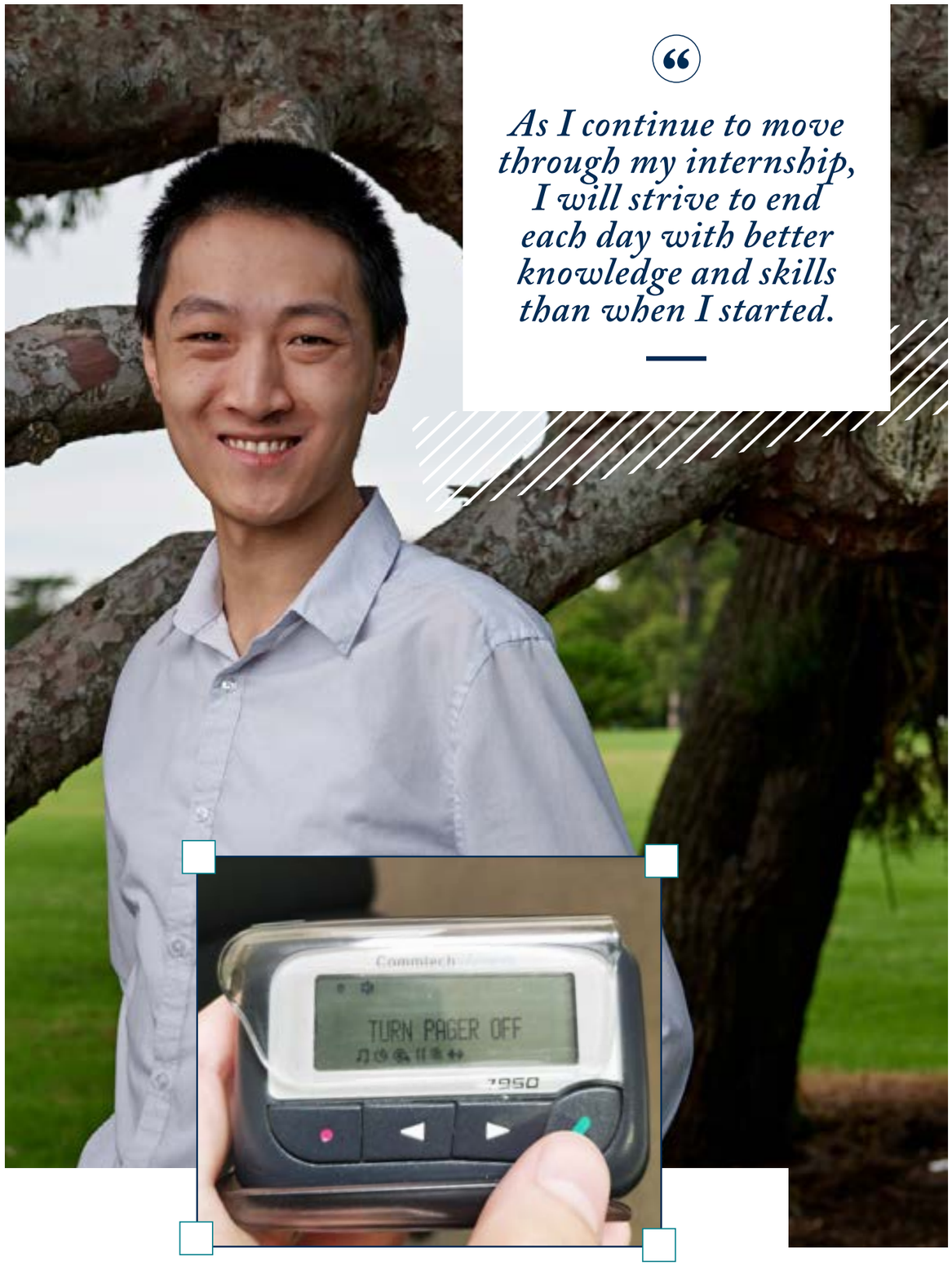
That's how I would have liked to start this article, had it been true. Three years ago, I felt uneasy and disquieted at the idea of being halfway through medical school. I didn't imagine graduation and starting an internship could feel anything other than surreal and apprehensive.

But now, after having been sidelined from placement during a global pandemic, and (for me) a year away from clinical medicine, I feel satisfied with what I've achieved in medical school, and ready to be moving forward. "Sorry, I can't do that, I'm just the medical student", once a reassuring fallback, has become tiring, while "Sure, put their feet up, recheck the blood pressure and I'll come review them" is, for now, new and exciting.

It is refreshing to be able to take what I've learned and apply it to patient care – even if it is just to rechart an insulin order.

This is not to say, however, that I have felt confident per se starting my internship. In the grand scheme of things, I am acutely aware that I know very little. This had weighed on my mind, and I had anticipated that knowledge gaps would be my biggest challenge moving into internship. As an example, the first time I prescribed a medication on my own initiative was for a stable ward patient with essential hypertension and persistently elevated blood pressure – a scenario that I'm sure to most VICDOC readers is quite unexciting. From medical school, I of course had "book knowledge" of first-line antihypertensives and their textbook indications – but how hypertensive is hypertensive enough for me, a newly minted intern, to prescribe someone a medication for possibly the rest of their life? For learning opportunities like these, I've been grateful to have supportive residents, registrars and consultants – indeed, it was actually my consultant who talked through the hypertension case with me!

> *It is refreshing to be able to take what I've learned and apply it to patient care – even if it is just to rechart an insulin order.*



> *As I continue to move through my internship, I will strive to end each day with better knowledge and skills than when I started.*

In this context, I have been pleasantly surprised to find that knowledge gaps have not been the major hurdle I expected. Rather, the major challenge I did not anticipate has been time management and task prioritisation. In most industries, junior entry-level staff tend to have fixed responsibilities assigned to them. In my previous jobs as a junior in the service industry, I performed one well-defined role at a time while my manager rotated me through different responsibilities.

When I became a manager and gained responsibility for delegation and balancing workload, I delegated tasks to my juniors – the well-known Eisenhower matrix, which categorises tasks by urgency and importance, says to delegate tasks downwards that are 'urgent but not important'.

Likewise, as a medical student, I worked on one job at a time that I volunteered to do, or that my intern offered to me – typically jobs that were relatively simple or non-critical. But now, as an intern, I carry the pager and screen all the tasks that come through on it. Despite being the most junior doctor on the team, I find myself having responsibility for divvying work up between myself and the residents, and escalating registrar-level tasks. Rather than delegating tasks downwards to juniors, I am distributing tasks among my peers, and referring matters upwards to my seniors. Whereas as a medical student I only needed to focus on what I was doing, I now find myself needing to appreciate what everyone on the team is doing, in order to divide the work effectively. This has taken some practice, and some getting used to.

Perhaps the most humbling and sombre reflections of internship so far have come from one major increase in scope of practice between medical school and internship – prescribing.

Research shows more than half of hospital discharge prescriptions contain a medication error. I wish I could say I've not contributed to that statistic.

Unfortunately, I've committed my share of textbook prescribing errors, including prescribing penicillin for a patient with an allergy, prescribing a modified-release opioid as immediate-release, and inadvertently converting a PRN medication to a regular prescription. I'm thankful that in each case these mistakes have been detected and patient harm has been averted.

All this is a reminder that, in between all the paperwork and service provision, internship is also a time of transition and growth. I will inevitably have many basic questions to ask, and many basic mistakes to commit, and it is best that this happens while I have a supportive team to guide me. I will savour each moment of uncertainty as an opportunity to learn – now I know how to prescribe amlodipine – and reflect on each mistake as a time for growth – I have not made the same medication error twice.

As I continue to move through my internship, I will strive to end each day with better knowledge and skills than when I started.

WORKPLACE RELATIONS

NATIONAL HEALTH REGULATOR

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

The Australian Health Practitioner Regulation Agency (AHPRA) has been much in the news recently. Sometimes referred to as the medical regulator, AHPRA notionally regulates the 15 Australian health professions of which nurses and doctors constitute the majority of the 820,000 members. In reality AHPRA regulates only half that number as NSW never joined the national scheme and Queensland later opted out.

OPINION **DR KERRY BREEN AM**

AHPRA was established hastily in 2010. It has not won the confidence of the community or the health professions. It probably never will because of the flaws in the national law that underpins the scheme, the unworkable size of a very large bureaucracy which is now beyond the reach of the nine health ministers responsible for the scheme, and the fact that it will never truly be a national scheme. In criticising the scheme, I emphasise that I am not criticising the staff of AHPRA who are trapped in its dysfunctional structure.

In its nearly 13 years of existence, AHPRA has been the subject of four Federal parliamentary inquiries, a Victorian parliamentary inquiry and an independent review by a consultant chosen for the task by the health ministers. Added to this list is the 'rapid review' now ordered by the Federal Health Minister. The CEO of AHPRA has recently announced proposals for reforms directed primarily at issues surrounding sexual misconduct by health professionals. This announcement is ironic for Victorians as the proposed reforms represent a return to unique Victorian initiatives that were abandoned by AHPRA in 2010.

The structure of the national scheme made up of AHPRA and the 15 health professions boards is impossible to accurately describe in a few words. Although the role of AHPRA vis-a-vis the 15 health profession boards is portrayed as co-regulatory, AHPRA controls all the funds, holds all the strings and employs most of the staff. Each board has to apply annually to AHPRA for continuation of funding.

When the national scheme was first announced, the interim agency responsible for establishing it claimed that its efficiencies would lead to reduced annual registration fees and that the scheme would maintain all the positive aspects of the existing state-based systems. Both claims proved to be untrue for Victoria. Annual registration fees almost doubled overnight. The valuable Victorian Doctors Health Program came close to collapse through lack of funding. The Victorian Medical Practitioners board's unique free support service for patients who made allegations of sexual misconduct by doctors was abandoned. And any control or influence of the Victorian health minister on the regulation of Victoria's health professionals suddenly became remote.

With time, flaws in the national law on which the scheme is based have become evident. These include a mandatory requirement that treating doctors must notify AHPRA if a doctor under care may be ill and impaired, a requirement that is self-defeating as it inhibits ill doctors from seeking medical care. The national law is difficult to amend as any changes have to be agreed by the health ministers, then put to the Queensland Parliament and later adopted by the other state and territory legislatures.

It is unclear to most doctors whether they are regulated by AHPRA, the Medical Board of Australia or both organisations. It is also unclear which organisation takes precedence should disagreements prove unresolvable.

AHPRA employs all the investigative staff; few of these have personal knowledge or experience of working in health care. As a result AHPRA has struggled to separate the less serious from the more serious complaints and to identify vexatious complaints. More recently AHPRA has added a layer of clinical advisers as an admission of this problem.

What did Victorians lose through joining the national scheme? In regard to the regulation of its doctors, they lost a Medical Practitioners Board composed of nine medical practitioners, two community members and a lawyer, a board accountable directly to the Minister for Health. They lost an innovative approach to handling allegations of sexual misconduct that included the appointment of a female investigating officer with degrees in law and psychology and an independent service funded by the Board to support distressed complainants during and after all the stressful stages of processing these complaints.

Victoria's doctors also lost much. They lost a board that was visible, approachable, generally trusted and familiar with medical practice in Victoria. They lost the targeted, readable and informative annual reports and regular bulletins. They experienced steep rises in annual renewal of registration fees. They lost medically qualified investigating officers employed by the board; officers with the skills and knowledge to treat complainant and doctor fairly and even-handedly. They almost lost their valued Victorian Doctors Health Program, established in 2000 and funded fully by the medical profession via annual renewal of registration fees. Luckily it was rescued partly because successive Victorian health ministers also appreciated its value to distressed doctors and distressed medical students.

The Victorian Parliamentary inquiry into AHPRA and the national scheme that reported in 2014 recommended that Victoria copy NSW and become a 'co-regulated' jurisdiction, leaving AHPRA with the core role of maintaining a national register. The Victorian community and all of Victoria's health professionals will be well-served if this nine-year-old recommendation is now acted upon.

Dr Kerry Breen AM has been a member of the AMA since 1965. He served on the Medical Practitioners Board of Victoria from 1981–2000 and as its President from 1994–2000.

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.

After a successful 2022, a State Election year where we had a number of our policy proposals adopted and announced by the returned Government, the start to 2023 has continued to be a busy time as issues as diverse as the future financial sustainability of general practice, health service information sharing, the management of human sources, the reform of AHPRA, the future of e-scooters, eating disorder treatment, and mental health reform have all come across the policy desk. The following provides a snapshot of our recent policy and advocacy activities on behalf of members.

COMMENCEMENT OF VICTORIAN PARLIAMENT FOR 2023- POLITICAL ADVOCACY

Since Victorian Parliament commenced sitting for 2023 on 2 February, AMA Victoria has met with senior politicians from the ALP, Liberal Party, National Party, and Greens to advocate for members and the Victorian medical profession on a variety of fronts.

Amongst other issues, we have held discussions on:

- Putting general practice on a more sustainable footing (at the state level, this can be done by incentivising junior doctors to take up a career in general practice through adoption of a single employer model for GP registrars, and, for those already in practice, by abandoning retrospectively applied payroll tax assessments and putting in place a moratorium period for payroll tax liability);
- Concerns regarding the Victorian pharmacy prescribing trial (we conveyed in no uncertain terms our view that this is a retrograde step for Victoria and the health of all Victorians).
- reasserting the importance of the medical model in the mental health reform process (this can be achieved by drawing upon the wisdom/insights of medical practitioners at the clinical coalface, and by re-orientating funding priorities towards acute medically required care).
- Addressing profound structural and cultural issues within the Victorian Institute of Forensic Medicine.
- Proactive planning for the closure of Epworth Geelong Maternity Services.

HEALTH LEGISLATION AMENDMENT (INFORMATION SHARING) BILL 2023

We have recently contacted Victorian MPs from across the political spectrum expressing our support for the Health Legislation Amendment (Information Sharing) Bill, currently being debated in the Victorian Parliament.

In expressing our support for the Bill, we are in no way diminishing privacy concerns, particularly for mental health and reproductive health records. But we do need to acknowledge the current circumstances as comparator; it is a reality that patients' health information is already stored in hackable databases or manila folders by individual health services, and data in the proposed model would be ring-fenced with the strictest of protections.

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

HUMAN SOURCE MANAGEMENT BILL 2023

Recently, the Victorian Government introduced the Human Source Management Bill 2023.

The Bill provides for those who owe a duty of confidentiality – such as doctors to their patients- to be registrable as human sources for Victoria Police in certain circumstances.

It is our preliminary view that the Bill should more clearly define the threshold for exempting medical confidentiality. The Bill should also better address the sensitive nature of the patient-doctor relationship in the registration of reportable human sources. Lastly, medical confidentiality could be officially enshrined in legislation separately to provide another corroborating source for medical conduct.

ROAD SAFETY AMENDMENT (MEDICINAL CANNABIS) BILL 2023

AMA Victoria was recently approached by Victorian parliamentarians for our view on the Road Safety Amendment (Medicinal Cannabis) Bill 2023, proposed legislation that in effect would stop the prosecution of drivers who test positive to THC if they have a legal prescription for medicinal cannabis.

AMA Victoria provided the response that, given that the science is not settled on the effects of cannabis and driving performance, we cannot support this Bill at this time.

VICTORIAN EATING DISORDERS STRATEGY

Post-pandemic, the number of people with eating disorders in Victoria has increased. This has been recognised by recent media coverage. In response, AMA Victoria submitted a response to the Victorian Government's new Victorian Eating Disorders Strategy to help design a system of eating disorder care better suited to new needs.

The overarching perspective of the submission was that Victoria's system of care should be better coordinated and funded and that the specialist services available for eating disorder care should also be expanded.

INDEPENDENT REVIEW PANEL INTO COMPULSORY TREATMENT CRITERIA AND ALIGNMENT OF DECISION-MAKING LAWS

AMA Victoria's Section of Psychiatry recently met with the Independent Review Panel tasked with providing advice/ recommendations to government into compulsory treatment criteria and alignment of decision-making laws in Victoria.

AMA Victoria felt it was a very worthwhile meeting in which the Chair (Shane Marshall AM) provided an excellent opportunity for all of us to contribute and to speak frankly and freely.

The Chair and Panel members were open minded and asked questions that caused us to reflect deeply on some of the more challenging issues being faced by the Panel.

We were particularly appreciative of the fact that our involvement was at an earlier stage of the independent review process, which is not always the case with similar government-initiated consultations.

Our Section of Psychiatry relayed to the Panel that AMA Victoria is happy to assist as its process evolves in the period ahead – whether that be through advice, similar formal meetings, provision of research literature, or dealing with practical real-world issues and challenges.

AHPRA ADVOCACY

AMA Victoria, assisted and advised by the Compliance Committee of AMA Victoria Council, has continued its efforts advocating for the wholesale reform of AHPRA.

Whilst acknowledging that a regulator is essential, the medical profession deserves one that is accountable, fair, efficient, and prompt. The status quo fails on all fronts.

Due to AMA Victoria's advocacy, our AMA Federal colleagues have countenanced the possibility of an inquiry into the regulator. Moreover, we have held constructive conversations with the Victorian Committee of the Medical Board of Australia.

Nevertheless, it remains our view that a paradigm shift of what can be an unaccountable and occasionally capricious regulator is necessary, and that a Royal Commission will ultimately be required to truly reform AHPRA.

AMA VICTORIA CONCERNS AROUND THE USE OF E-SCOOTERS IN VICTORIA AND RECOMMENDATIONS TO GOVERNMENT

AMA Victoria has written to the Victorian Government to raise several key health concerns arising from the e-scooter trial in Victoria in light of its extension to 31 March 2023.

In summary, our letter stated that e-scooter morbidity contributes significantly to Emergency Department overcrowding and thus hospital access block and that, given the current climate, we are of the opinion that more steps need to be undertaken to reduce e-scooter accidents and their healthcare burden.

As always, if members have a policy issue they would like to discuss, or have some feedback about our priorities, please contact our Senior Policy Adviser, Lewis Horton.

DOCS DON'T CHARGE DOCS

DO YOU HAVE A DIFFERENT VIEW? WE WELCOME OPINION PIECES FROM AMA VICTORIA MEMBERS. EMAIL: TARYN SHEEHY

I was 18 years old and in my first year of medicine at Monash, 1966. I was the oldest of five children living in a small three bedroom house off North Road about halfway between the Huntingdale station and the Clayton campus. Many Monash graduates of my era will be familiar with this area. Dad was a concrete contractor.

Money was very tight and visits to the family doctor occurred only in the most extreme of circumstances.

It was my third attack of abdominal pain. The previous two had been written off as food poisoning or gastro. Dad, a veteran of the siege of Tobruk and the jungles of Borneo in the Second World War considered all forms of illness as weakness. Certainly nothing to go to the doctor about!

This attack was worse. Dad wasn't home and mum was worried and rang for an appointment with our family doctor. There was one appointment left at 6:30 PM.

There was no car and no easy way of getting to the surgery which was near the corner of North Road and Warrigal Road in Oakleigh.

There was nothing else to do but catch the North Road bus for the 20 minute trip to see the GP, not a pleasant journey with every jolt of the old bus exacerbating the pain on my right side.

He made the diagnosis as I walked in the door, obviously appendicitis. I'd only met him once the year before and he was aware I was a now a medical student.

He rang and arranged for an ambulance to take me to the Alfred Hospital.

A doctor's fee in those days, prior to Medicare, was a significant proportion of a tradesperson's weekly income. I politely asked if he could send the account to my father.

That's when he uttered these exact words which are as clear to me today as they were to me as an 18-year-old first year medical student.

"Docs don't charge docs."

It's a principle I've always practised throughout my career as do most of our colleagues.

However, both anecdotally and personally, I am aware of a gradual breakdown of this collegiate approach to billing our colleagues.

I hope this small anecdote may give pause to think when considering charging out-of-pocket fees to a colleague or their immediate family.

JOIN THE CONVERSATION

AMAV SOCIALS

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

DR JASMINA KEVRIC
[On The Doctors' Room podcast: 'Inside Internship']: Thank you AMA Victoria for inviting me to share my insights into what makes a successful surgical intern rotation. I hope future interns can take something from this and use it in their everyday practice. #generalsurgery #medicine
→ Kumail Jaffry
Brilliant podcasts Dr Jasmina Kevric, absolutely enjoyed listening to your success story and tips to thrive as a surgical intern!

ADJ PROF KAREN PRICE
[On AMAV and the AMAV Women in Medicine Committee's International Women's Day event]: Thanks @amavictoria for helping me book myself and my doctor daughter into the International Women's Day event. Looking forward to hearing from @Mon4Kooyong on women's leadership, advocacy and all the fun stuff of that. I'm sure I can think of some great questions... Looking forward to this.

AMA VICTORIA
We are here at the Fair Work Commission for the fifth time this year, representing AMA Victoria members and advocating for better working conditions for doctors. Read more about how John Ryan, former Fair Work Commissioner, is fighting for AMAV members: bit.ly/3xYghvK

DR JILL TOMLINSON
[On AMAV and the AMAV Women in Medicine Committee's International Women's Day event]: Join me and special guest @Mon4Kooyong at @amavictoria's International Women's Day dinner on Wednesday 15 March at 6.30pm in Kew – it promises to be a great night! #IWD2023

FED FACTS

HEALTH & SAFETY

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

REPRODUCTIVE HEALTH AND SAFETY ALWAYS AHEAD OF CONVENIENCE, SAYS AMA

Reproductive health and safety must be prioritised across the health system, the AMA told a Senate inquiry into universal access to reproductive healthcare.

In February, AMA Vice President, Dr Danielle McMullen, told a hearing of the Senate Standing Committee on Community Affairs that the AMA advocates for safe, accessible and affordable reproductive health services throughout Australia, especially rural and remote areas.

"Importantly, provision of and access to services should be timely, culturally safe, equitable, and affordable," she said.

"Equity of access for all people seeking services is critical. We can and should improve access to reproductive healthcare in Australia.

"However, we must be careful not to confuse convenience with access because the most convenient option is not always the safest option," Dr McMullen said.

The AMA submission to the committee focuses on contraception, abortion, collaborative models of reproductive healthcare, health literacy and equity of access to reproductive health services.

The AMA's submission made the following points:

» There should be equity of access across Australia to appropriate abortion services, which should involve a multi-disciplinary team under the leadership of a doctor. All people should have access to legal and safe abortion and counselling services.
» The central Queensland maternity crisis had shone a light on the parlous state of birthing access services not just in Queensland but across Australia. The AMA is concerned about a growing trend in remote and rural areas where obstetricians, GP obstetricians and rural generalists with accredited advanced obstetrics skills are being relegated to secondary positions within maternity care teams or excluded in favour of midwifery-led care.
» It is disappointing that pregnancy care is restricted to top-level private health cover. The AMA calls for pregnancy cover to be included in Bronze and Silver policies and upwards, matching it to cover of other reproductive policies.
» Doctors have a right to refuse to provide or participate in certain medical treatments or procedures based on a conscientious objection. However, a doctor should always provide medically appropriate treatment in an emergency even it that treatment conflicts with their personal beliefs.
» It does not support oral contraceptives being prescribed in community pharmacies, a position also taken by the independent regulator of medicines in Australia, the Therapeutic Goods Administration.

ACHIEVING EQUITY IN THE WORKPLACE

Dr Anna Clark is AMA Victoria's Leadership consultant, coach and educator, currently offering individual coaching for doctors and directing the AMA's professional development programs in leadership, the Emerging Leader Program and Middle Leader Program.

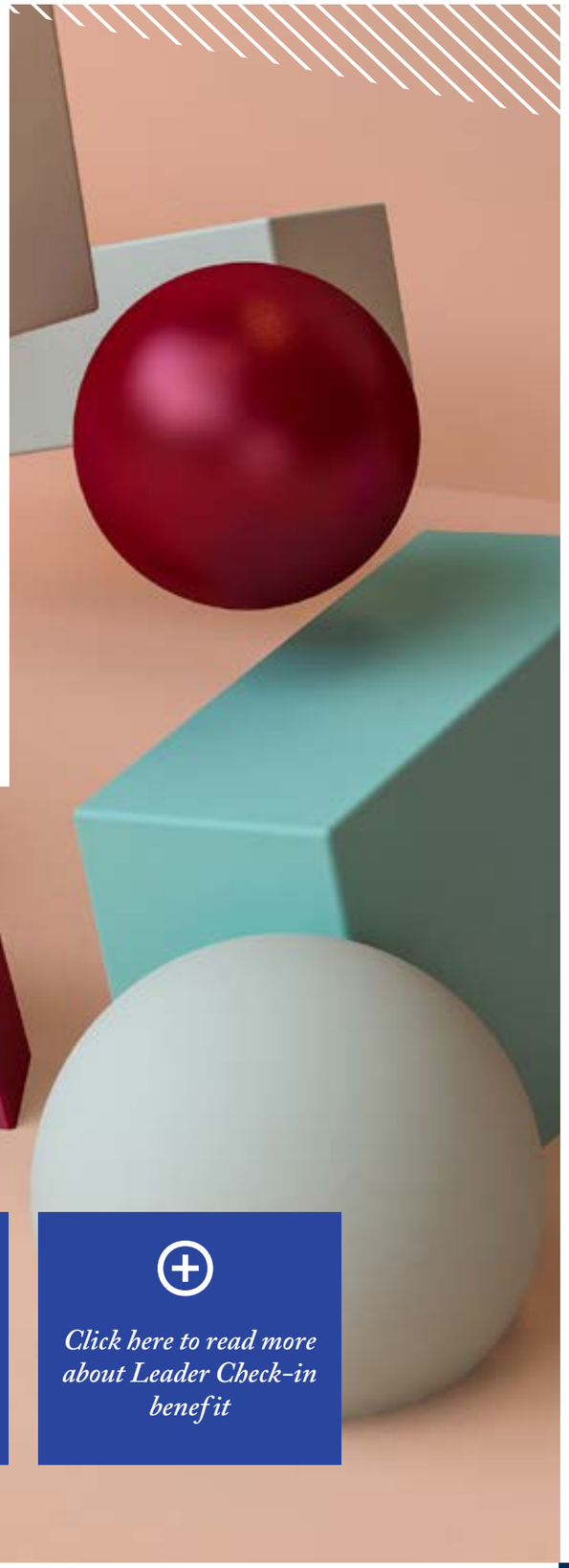
Equity is more than equality. Equality refers to providing the same treatment and opportunity for all. Equity goes beyond this, recognising that we are not all the same, we don't start from the same place or require the same things to live and work equitably in society. Providing everyone the exact same resource or opportunity, doesn't mean that there is necessarily an equal or equitable outcome, as the starting point and requirements for full participation are different for different people.

There is a popular graphic for illustrating equity that portrays three people standing behind a fence with a ball game taking place on the other side. One person is tall enough to see over the fence, while the other two people need to stand on one or two boxes to see the game. This illustrates that different people have different 'starting points' and need different structures to allow them to participate.

Women face a different set of barriers and challenges at work than men do – with decades of research and statistics showing that these adversely affect their participation, status, take-up of leadership roles and pay. There is not one barrier or challenge, but a systemic set of challenges. Understanding this systemic nature is crucial, because this means that there is not one approach or solution that will work on its own. Rather, we need a multi pronged approach, that is realistic and sustainable over a relatively long time frame.

Providing everyone the exact same resource or opportunity doesn't mean that there is necessarily an equal or equitable outcome, as the starting point and requirements for full participation are different for different people.

Inequity increases across time, with women being less likely to earn promotions, and progress in their careers as men do. Pay close attention to how work is recognised and rewarded in your area. Informally allocated opportunities such as inclusion in research, conferences, presentations, and panels can lead into promotions and other critical opportunities.



Click here for references and resources on this topic

Click here to read our recent Leadership Insights on this topic

Click here to read more about Leader Check-in benefit

WHAT CAN INDIVIDUAL LEADERS DO?
A helpful starting point is to collect data in your context. What does your specific workforce look like? What is the gender breakdown of your department or area by level, role, FTE or fractional appointment or leadership status? Take a gender lens to who takes on additional work or unpaid work, who has caring duties inside and outside the workplace, and who is asked to collaborate on research, conference presentations, committees and panels?

There are 'points' along the career path or progression where women tend to be overlooked, under recognised and promoted, and underpaid for their work:

RECRUITMENT AND SELECTION:
When attracting and recruiting your doctors, be mindful of using and relying on personal networks. Carefully design and structure your selection process, have a diverse selection panel and use a standard process and set of measures to evaluate the skills of the candidates.

NETWORKS AND NETWORKING:
Set strong expectations around the importance of building strong professional relationships and networks. Support new hires to integrate and consider mentors and cross-gender professional relationships.

PERFORMANCE REVIEWS AND FEEDBACK:
Ensure everyone can engage in regular professional conversations with leaders about work and their performance, regardless of their fractional appointments, or on versus off-site arrangement. Ensure that your feedback is regular and is specific regarding any areas for improvement.

PROMOTIONS AND CAREER OPPORTUNITIES:
Inequity increases across time, with women being less likely to earn promotions, and progress in their careers as men do. Pay close attention to how work is recognised and rewarded in your area. Informally allocated opportunities such as inclusion in research, conferences, presentations, and panels can lead into promotions and other critical opportunities.

WORK IN ADDITIONAL TASKS, COMMITTEES, AND OTHER UNPAID WORK:
Extra tasks and commitments that take up valuable time and do not tend to lead to promotions and advancement are a trap for women.

Choose a small number of areas to work on, based on data, that you think would make a difference to gender equity in your workplace. Set goals and create an action plan specifying how to work toward these goals. Consider realistic timelines for small changes and improvements.

While it is important to build your own personal and business case for equity in your context, understanding your own relationship to the issue can also be helpful. For example, as we talk about systemic bias and barriers – what are your own experiences of these? It doesn't matter what they are – there is no 'right' or 'wrong' – rather the point is that it is helpful to know your own experience of your career journey and progression, and acknowledge that you speak from this experience as well as to your values. There is strength in owning your own experience and asking others about theirs.

This is slow and important work. Addressing deeply entrenched systemic issues takes a long time so prepare yourself for the journey. International Women's Day is a reminder that addressing gender equity is not just an annual morning tea, it must be part of our everyday leadership work.

PARTNER CONTENT

SHOULD INVESTORS RE-FOCUS AMID RESURGENT RENTAL YIELDS?

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

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

As we move further into 2023, it's clear the adjustment phase of the market cycle has longer to run, as it rebalances after the record highs of the COVID years. As such, Melbourne's property market is slated for little or even negative capital growth in coming months.

After some hard years, especially through COVID, Melbourne's rental investor market is resurgent.

Melbourne's median unit rental yield was 4.51% in December, up 18.4% over a year, according to the Domain Rent Report.

Meanwhile median house yields also climbed to 3.05%, up 6.8% year on year.

The city saw the greatest decline in new listings, down more than 16 per cent year on year to December, and sitting at a historic low rental vacancy rate, according to the PropTrack Rental Report.

Rental demand is only set to increase in the year ahead, as overseas and interstate population inflows into Melbourne build after the pandemic, driving population growth and housing demand.

Amid ongoing interest rate rises, the resurgent rental market is helping investors offset the increased costs servicing property mortgages.

So given capital growth is likely to remain subdued for the shorter term, should a prospective investor adopt a strategy that seeks to maximise the other source of return – rental income?

Of course, yields vary markedly from property to property, location to location. Yields for multi-million dollar mansions in Melbourne are typically much lower compared to student studio apartments or country homes.

These high yield properties often deliver new owners net positive income from day one even when, not unusually, the loan-to-value ratio is up around 80% and there are the other leasing and maintenance expenses to pay out each month.

So does that promise of some income make high yielding properties the least bad asset to hold in a time of decline? Are they the property market's equivalent of the equity market's unglamorous but safe defensive utility stocks that pay a significant dividend twice a year?

Alas, no. Unfortunately, properties with high yields tend to be more vulnerable than average to economic shocks, not less.

They are often located in areas that struggle economically in the best of times due to a limited and narrow economic base and contain tenants who are more susceptible to bouts of unemployment or transience.

Consequently, in downturns, there is a serious risk of rent arrears and extended vacancies that can bleed dry an investor's cash reserves and capital values that fall harder than elsewhere.

Those properties essentially have high yields as compensation for the high risk the properties present.

In these less certain times for property, I would much prefer to see a risk-averse prospective investor sit on the sidelines than opt for a high yielding asset.

But over the long-term, sitting on the sidelines and not buying growth assets – be it property or shares – is a material risk to one's future retirement prospects too.

Few of us are able to 'time the market' and buy at the bottom. We instead invariably become distracted by the multitude of other issues in our lives and suddenly 10 years have flown by.

So put aside the market cycle. Invest when you have the means.

WAKELIN
PROPERTY ADVISORY

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

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AMA VICTORIA EXCLUSIVE PODCAST

THE DOCTORS' ROOM

LISTEN NOW

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?

A PODCAST FOR MEMBERS WITH DOCTORS FOR DOCTORS

In a special International Women's Day edition of 'The Doctors' Room' we are looking at the puzzling way women often unconsciously impose unnecessary obstacles in front of their goals.

We all know equity can only be achieved when the structural and cultural norms of the workforce meaningfully shift, but awareness of 'unconscious obligations' is a tool all women can use right now, to more fully participate, to be heard, to achieve their potential, powerfully enabling women to keep driving those broader structural and cultural changes to achieve equity.

It's complex, fascinating and empowering once you can recognise the role it may play in your own life. Let's get into it.

CARA CROSS + ROD FELMINGHAM – KENNEDYS

PARTNER CONTENT

TOP #5

HUMAN RESOURCE MANAGEMENT FAILURES

IN MEDICAL PRACTICES

Setting up a medical practice, employing practice staff, maybe taking on some other doctors as well? What could go wrong? Here are five of the most common human resource management fails in medical practices that come across our desks.

NOT TAKING A PROACTIVE APPROACH TO RESOLVE ISSUES EARLY OR SITTING ON COMPLAINTS FOR TOO LONG

—

A good way to turn a workplace issue molehill into a mountain is to do nothing and hope it goes away. When issues such as punctuality, efficiency, honesty, courteous behaviour to patients and other staff or relationships arise, it may be tempting to hope they resolve themselves. Formal performance management – periodic formal reviews, counselling about below-par performance, or even issuing formal warnings if necessary – is uncomfortable, especially in a small practice. However, failure to intervene until a problem has become acute and serious exposes a medical practice to the risk of a claim in the Fair Work Commission, a court, or to a Workcover claim.

REACTING TOO QUICKLY AND NOT MAKING PROPER ENQUIRIES

—

Moving too quickly when an issue arises can sometimes be as bad as not moving quickly enough. Denial of procedural fairness can also be an excellent way to end up in court or a tribunal. When a complaint is made, make careful enquiries. What happened? What is the context? Is the employee given a proper opportunity to tell their side of the story? Acting too quickly, and making a fast decision, can result from sitting on complaints for too long. For example, there may have been grumbling about a staff member's behaviour for a long time, but it has been too difficult to do anything about it. Then you get a moderately serious complaint that you can use as opportunity to get rid of them, so you take it. Denial of natural justice greatly increases the risk you will lose if a claim is brought against you.

FAILING TO UNDERSTAND INDUSTRIAL AWARDS

—

Practice support staff and nurses are covered by Awards under Commonwealth legislation. Awards are the law. They set out minimum terms and conditions that employees are legally entitled to. A common and simple failure is not understanding what your legal obligations are as an employer. Another failure is attempting to avoid managing complex entitlements by paying an "over award" rate, intended to compensate for all award entitlements. The consequences can be costly. If the relationship sours, the unhappy employee leaves (or is dismissed), and seeks legal advice about their situation, where a competent lawyer can often find they have been underpaid. Underpayment claims routinely range between $50,000 and $150,000. Unpaid overtime is often a major component of the claim.

CONTRACT ISSUES

—

Doctors engaged in private practices are not covered by Awards. Whether they are employees or independent contractors, the precise legal obligations of the parties will be largely determined by their contract. If a dispute arises, the answer will in most cases be found in the contract. Not having a written contract does not mean that there is no contract. If the contact is not in writing it will be oral, or implied. Disputes can become protracted, and very costly, if contracts are not in writing, or if the terms of the written contract are not clear or are badly drafted.

OVER-RELIANCE ON PROFORMA CONTRACTS, POLICIES AND LETTERS

—

Documentation of employment relationships and policies can be crucial in any business. If not done properly, employment disputes, occupational health and safety issues and workers compensation issues can arise. Proforma template contracts, policies or letters are rarely adequate, especially if they are not properly adapted to the specific needs of your business. You might not notice the importance of these documents when a problem has not yet arisen, however the only time you really need them is when there is a problem.

Click here to contact Kennedys

Taking a template document and amending yourself can also have unintended legal consequences, ranging from the amendments being legally ineffective, to changing the fundamental nature of a relationship. Australian employment laws are amongst the most complex in the world, so DIY lawyering with documents off the internet is never recommended.

Kennedys

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—

MORE THAN MED

MEDICINE ⊕ PAINTING

Dr Jessica (Jet) Driver O'Keefe

Click here to share an interest or hobby that is away from medicine

"I've always drawn and painted and experimented creatively, but my art making has become much more purposeful in the past six years.

REPORT **VANESSA MURRAY**

Click here for Dr Jessica Driver O'Keefe on Instagram

I'VE ALWAYS DRAWN AND PAINTED AND EXPERIMENTED CREATIVELY, BUT MY ART MAKING HAS BECOME MUCH MORE PURPOSEFUL IN THE PAST SIX YEARS.
This happened after my wife, Steph, gave me the greatest gift to my overall development as a human – regular private tutoring with Sue Jarvis, an incredible artist. I was feeling stunted by words and my inability to articulate my experience of existence in all its forms. Words were a great creative outlet, but they just didn't convey the textures, colours, temperatures and emotions with the accuracy I was seeking. Steph's gift came in response to this frustration. And then came painting.

MEDICINE CAN BE A REAL VACUUM FOR YOUR IDENTITY.
The need to be always operating at 100% in a hugely pressured environment provides fertiliser for this to happen unconsciously. As a result, we are sub-standard versions of ourselves and can quickly become resentful of the careers we've so passionately pursued. People can't keep being great without a way of releasing or recharging.

MY STUDIO IS IN A SHIPPING CONTAINER OUT THE BACK OF OUR HOUSE; IT'S WHERE I COME TO ESCAPE AND RECHARGE.
It's good having a dedicated space. I can spread out; I don't have to clear things away when I'm done. I like to come in here with everything I need and shut the door and shut myself away. It's a multisensory experience. There's the smell of the paints. The visual feast of the colours and materials and artwork taking shape. The touch of the brush. I play music while I work, so there's the sound. I usually paint in the evening, and I'll have a glass of whiskey. There's the taste. I often lose track of time in here, so I can't paint before a shift, or I'll be late!

MY ART PRACTICE IS A WONDERFUL COMPLIMENT TO MY WORK AS AN EMERGENCY DOCTOR.
At work, it's go go go. There's no room for experimentation, failure or "Hmm... what happens if I do... THIS!" That kind of thing can have dire consequences for patients. But in my studio, I have that inconsequential freedom. It's taken me a while to appreciate it – to realise it's okay to go in there without a plan and just see what happens.

SOMETIMES MY MEDICAL PRACTICE FEATURES IN MY ART. THERE IS ONE PATIENT, A MAN WITH JUST ONE LEG, WHO HAD TO WAIT OUTSIDE THE EMERGENCY DEPARTMENT AS WE DIDN'T HAVE ANY SEATS INSIDE.
He was sitting out there, smoking and yarning. He was happy, he was alright. He spoke to a moment in time when there were no beds available. The piece reflects how my perceptions – and the medical community's perceptions – have changed over the years as our resources have gotten tighter and tighter. In my early years I would have been very worried that this man didn't have a bed, maybe even outraged that I was doing his work up in the ambulance bay. But this has become our normal. What that says about us I think we will only be able to appreciate in retrospect.

SO OFTEN, WE PURSUE OR SEEK TO PRESENT PERFECTIONISM IN OUR PUBLIC SELVES – WHAT WE CHOOSE TO CURATE AND PUT FORWARD TO THE WORLD.
I see this happening for my colleagues, we're a bunch of high achievers and we want to be our perfect selves. But my art has helped me to realise there is no such thing as perfect – it's an impossible dream. A finished artwork is often quite far removed from what I had in mind when I started out, and I'm okay with that – I like the product at the end of all this higher brain input that has somehow perverted the process. It reminds me that the notion of control can be so easily and wonderfully thwarted with fabulous outcomes.

ONE OF MY BIGGEST HIGHLIGHTS SINCE I BEGAN PAINTING HAS BEEN CONNECTING AND EXHIBITING WITH THE POLISH ART FOUNDATION.
They are a progressive, inspiring and inclusive bunch, I really like what they do. The Foundation asked me to speak as part of the most recent Border's Exhibition, which I had several pieces in at the Victorian Artists Society Gallery in East Melbourne. I was one of four artists in the artists talk, and I couldn't have been prouder.

MY ADVICE TO OTHER DOCTORS IS ACTIVELY SEEK SOMETHING THAT YOU CAN BE NOT VERY GOOD AT, WHERE FAILURE IS INCONSEQUENTIAL... AND JUST ENJOY IT!
Don't wait for the right time, or the right place or the right inspiration. There is no such thing. Just start and be crap. And enjoy being crap at it. We don't need to be perfect at everything we do or have a goal. Make your goal noticing how much it doesn't matter if you mess up something in this space. Revel in the lack of pressure for perfectionism and the fact it won't play on your mind afterwards. Make all the mistakes you want or need to.

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