

RENEWED CONFIDENCE

# V I C D + C

AMA VICTORIA

WINTER 2024



## VOICES FOR CHANGE

Points of growth,  
with A/Prof Kerry  
Ireland-Jenkin

Restoring confidence,  
with Dr Jill Tomlinson

Understanding the  
Ahpra process,  
with Prof Steve Robson

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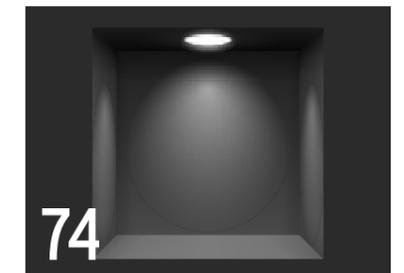


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## NEWS + REVIEWS

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AMA Victoria President Dr Jill Tomlinson welcomes the changes to GP payroll tax after years of advocacy.

#1



Dr Jill Tomlinson, President of AMA Victoria, tells the Herald Sun she would seek clarity after letters from the Victorian Minister for Health were sent to Victorian health boards ordering them to stick to impossible budgets. Dr Tomlinson stated she wants to know how each health service's funding has been costed to ensure delivery of projected future activity, high-quality patient care, safe staffing levels and the delivery of award entitlement for the entire healthcare workforce.

#2



Dr Jill Tomlinson, President of AMA Victoria, responds to media at the press conference to announce the new GP payroll tax changes with Victorian Treasurer, Tim Pallas, following years of advocacy.

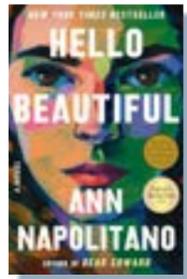
#3



AMA Victoria President Dr Jill Tomlinson responds to a second incident of faulty equipment at Austin Hospital explaining her concern that the failures are investigated and identified as soon as possible so that action can be taken to safeguard their ongoing reliability and protect patient safety.

#4





**HELLO BEAUTIFUL**

*Nonfiction by Ann Napolitano*

In her latest novel, bestselling author Ann Napolitano presents a poignant family drama centred on the lives of Julia Padavano and her three inseparable younger sisters. When William Waters, a man who carries the scars of a troubled past, finds solace in Julia and her family, he finds a sense of long yearned for belonging. However, as the story unfolds, the hidden wounds from William's past begin to surface, leading to a devastating rift that tests the strength of the family's bonds. Napolitano masterfully explores themes of family, sisterhood, love, and loss. Her characters are richly drawn, and their relationships are depicted with nuance and depth. The novel delves into the complexities of understanding ourselves and each other and highlights the importance of gaining perspective to confront the difficult truths in our lives.



**BOY SWALLOWS UNIVERSE**

*Netflix drama series (2024)*

The series is based on Trent Dalton's 2018 semi-autobiographical debut novel of the same name. Set in 1980s suburban Brisbane, it's an entrancing blend of gritty realism and magical surrealism, charting the tumultuous youth of Eli Bell, whose life is shaped by his affectionate yet troubled family (poverty, alcoholism, drug addiction, family breakdown) and its interactions with the criminal underbelly of the Australian crime world. Boy Swallows Universe transcends the conventional coming-of-age narrative with an evocative and wildly inventive exploration of love, fate, and survival. Like the book, the seven-part series is equal parts gruesome, gritty, poignant and beautiful, and stars an eclectic cast of well-known and new faces including 13-year-old Felix Cameron in the lead role, Travis Fimmel, Bryan Brown and Phoebe Tonkin. Australian cinematography at its best.



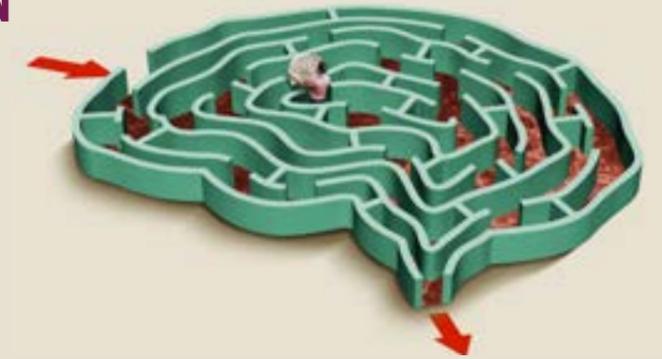
**AWAYE!**

*ABC Radio National podcast*

Part radio and part podcast, AWAYE! is a diverse and vibrant exploration of Aboriginal arts and culture from across Australia, hosted by Rudi Bremer. Some of AWAYE!'s productions are quite short, like November 2023's sharing of the Yindjibarndi word for country, by Wimiya Woodley. Others are longer segments that make up part of an almost hour-long full episode, like Returning, a deep dive into writer Kirli Saunders' exploration of the weight of colonisation – "a burden that can affect the way we interpret the things around us; like climate disasters, to our own sense of self, like who we love and how." AWAYE! is released weekly on Saturdays at 6pm and is repeated at 9pm Tuesday and 1am Thursday (that's the radio part). Podcasters can listen anytime via the ABC Listen app.

REVIEWS VANESSA MURRAY + TARYN SHEEHY

**BACTERIAL INFECTION MAY IMPACT BRAIN AND MENTAL HEALTH OF FUTURE GENERATIONS**



**F**lorey researchers discovered that paternal infection, which alters RNA molecules in sperm, can lead to changes in offspring brain development – including behavioural changes relevant to anxiety and depression.

Exposure to stress and substance abuse are known to influence the health and quality of sperm epigenetics.

Now, a study published in Brain Behavior and Immunity, led by Professor Anthony Hannan, and conducted by Dr Huan Liao with The Florey's Epigenetics and Neural Plasticity Group, investigates how bacterial infections too can affect sperm genetics and impact the health of future offspring. Through mimicking bacterial infection in a preclinical mouse model, the team found that the infection led to significant changes in RNA molecules in sperm.

The effects of these changes included behavioural changes similar to anxiety and depressive-like behaviours, and were seen not only in direct offspring, but also grand-offspring.

Professor Anthony Hannan and the team had previously modelled viral infection and its effect on sperm epigenetics and offspring brain function. However, the study's results differed when it came to paternal bacterial infection.

Dr Huan Liao, Research Officer at The Florey, said this recent study illuminates the profound impact of paternal exposures on offspring across multiple generations.

"These discoveries underscore the intricate links between environmental exposures and heritable changes, paving the way for new insights into epigenetic inheritance and its long-term effects on health and disease."

Different types of infection, and the immune system's response to these infections, can influence genetics delivered through sperm in different ways, thus its effect on the development of future generations also may vary.

Professor Hannan said this understanding of the impact of infection on epigenetics, and the role of epigenetics in brain function and immunity, is critical at a time when infectious diseases are on the rise.

"With pandemics of infectious diseases predicted to become more frequent, this research has major implications for human health, including that of future generations."

Email Kathryn Powley for more information.



## POINTS OF GROWTH

A/Prof Kerryn Ireland-Jenkin has broadened her focus from gynaecological pathology towards organisational leadership. She shares insights from her evolution as a leader, her experience of crisis leadership and the importance of fostering psychological safety.

BY VANESSA MURRAY

A/PROF  
KERRYN  
IRELAND-JENKIN

**A** /Prof Kerryn Ireland-Jenkin has been a member of the senior medical staff at Austin Health since 2006. Kerryn's achievements include successfully consolidating statewide perinatal autopsy services at the Victorian Perinatal Autopsy Service (VPAS) at the Royal Women's Hospital (RWH) and managing the Austin Health Pathology Network through COVID-19 and a regional expansion. Since May 2023, Kerryn has been the Medical Director of the Medical Workforce Unit and Deputy Chief Medical Officer at Austin Health. A Fellow of the Royal College of Pathologists of Australasia, a graduate of the Australian Institute of Company Directors, and Associate Fellow of the Royal Australasian College of Medical Administrators, Kerryn has qualifications in clinical leadership and business administration.

In 2014, after establishing herself in the field of gynaecological pathology, Kerryn was ready to step into a leadership role. She studied with the Australian Institute of Company Directors and studied with Deakin University.

Then, towards the end of 2015, Kerryn had the opportunity to head the newly created VPAS and RWH.

Kerryn filled this role for VPAS' first three years of operation, working with a team across its three Victorian hubs to successfully consolidate statewide perinatal autopsy services, including developing a governance framework and government liaison.

"This was a relatively small clinical governance role, but it was a significant learning opportunity for me," says Kerryn. "It was the first time I'd reported directly to hospital executive level and had a liaison role with the Department of Health. I also presented directly to the Senate inquiry into Stillbirth Research and Education in Canberra."

### LEADERSHIP IN TIMES OF CRISIS

Kerryn's next role was as Medical Director of the Austin Health Pathology (AHP) network; her first time leading people outside of gynaecological pathology. Here, Kerryn, with her leadership team, united and led a network that expanded to comprise laboratories in the Hume, Loddon Mallee and Goulburn Valley regions, with a team that grew by 100% (from roughly 200 to 400 personnel) in a short space of time.

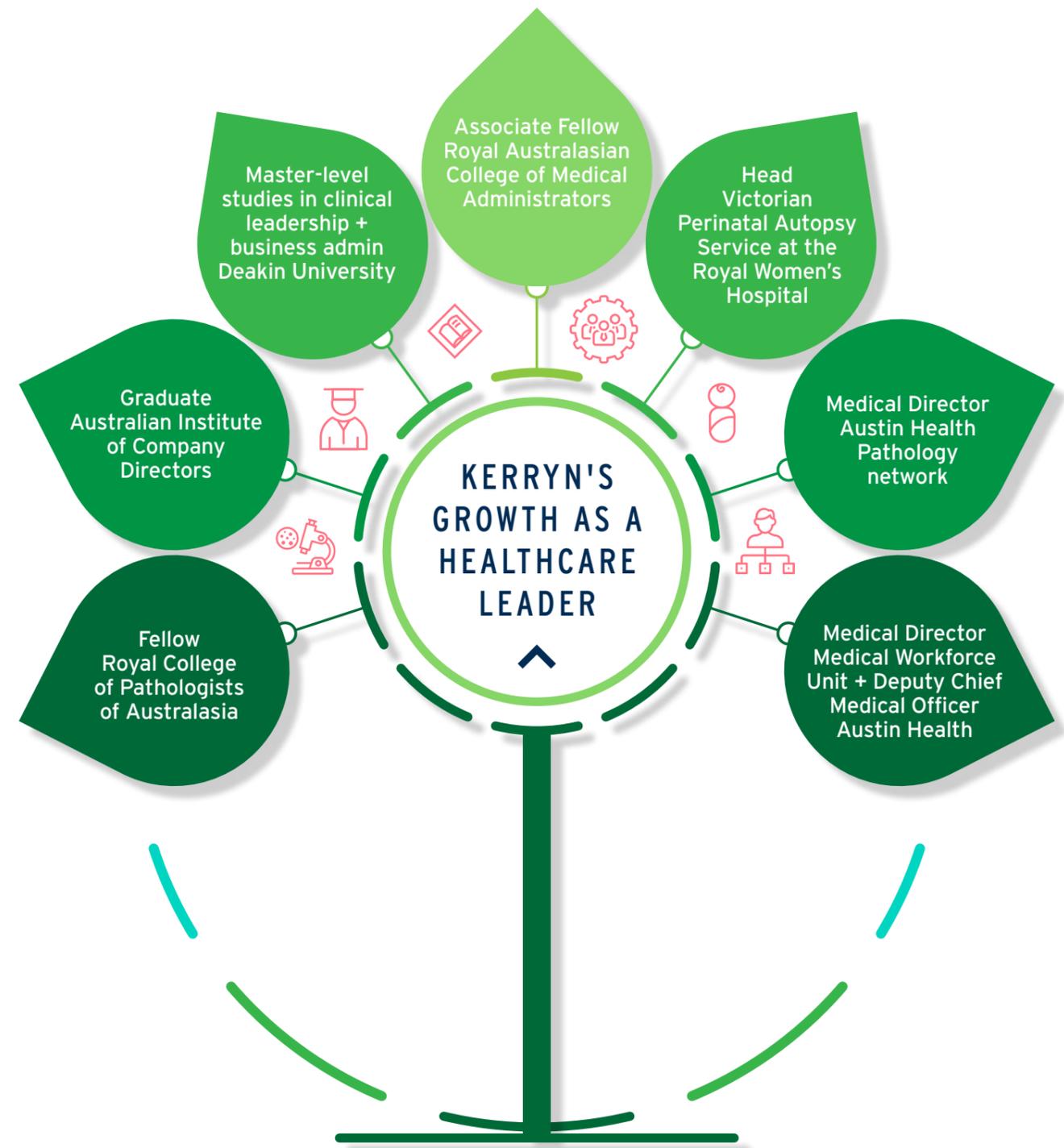
The role came with a double dose of crisis management; the initiation by fire that was taking on the management of a pathology service at the beginning of COVID-19, and then, in October 2022, significant flooding in 31 Victorian local government areas – including many the service operated in or serviced.

"COVID-19 presented some real challenges. We had to learn how to safely deliver testing, whilst also undergoing significant network expansion. There were many adaptive and technical challenges that required developmental learning. But, as a team we were able to successfully fulfil the needs of the Austin Health pathology network."

During the floods in 2022, when some of the other pathology providers reduced services regionally, the need to keep the public service running became even more necessary – and Kerryn's team problem solving became intensely practical and logistical.

"The way we managed to keep our entire service open during the floods was a credit to our whole team and the relationship that we built with the regional health services. We had situations where some of the smaller hospitals were cut off by road and we had to make air drops and pickups at some difficult to access locations so that they could continue to operate."

### ORGANISATIONAL LEADERSHIP



## PSYCHOLOGICAL SAFETY IN TEAMS



*I quickly recognised that it was my job to empower and enable experts there by building psychological safety and reducing barriers and silos. This approach certainly creates a greater sense of certainty and safety in challenging times.*



*Supporting people to feel completely safe to speak up and raise issues in a safe and respectful way isn't just the right thing to do, it's critical to success.*



### NURTURING PSYCHOLOGICAL SAFETY IN TEAMS

The role presented multiple points of growth for Kerry, particularly around her approach to engagement and collaboration. Finding ways to bring staff on the journey was fundamental to the service's successful growth and service delivery.

"I was an introvert by nature. And one of the missing pieces of the puzzle for me as a leader of a big, rapidly expanded team doing such important work in very trying social and physical circumstances was that I needed to communicate more. My team needed me to be right out in front for them."

"My approach included communicating uncertainty with confidence, and bringing higher level executives into the visible communication, so that the team knew they were seen, and that their needs were understood. It was also about leaning into our shared values more. I now actually test as an extrovert, so it has completely changed me."

Kerry also realised that she needed to optimise her teams' sense of psychological safety.

"I was leading departments within pathology that were very different to where I'd come from. I recognised my role was to empower and enable experts there by building psychological safety and reducing barriers and silos, and to create a greater sense of certainty and safety in challenging times."

The notion of psychological safety was developed by Harvard Business School professor Amy Edmondson in 1999. It pivots on the notion that when a team experiences high psychological safety, its members feel safe to speak up and take

interpersonal risks without fear of negative repercussions. It's widely accepted that when psychological safety is present in workplaces it creates a more innovative, stronger community.

Kerry nurtured her team's psychological safety by approaching their issues with curiosity, ensuring their issues or requirements were seen and addressed, using 'we-centric' language to increase connection and a sense of unity, and working closely with line managers to ensure they were taking a similar approach.

"Supporting people to feel completely safe to speak up and raise issues in a safe and respectful way isn't just the right thing to do, it's critical to success. Building that in our team meant we were able to mitigate a number of risks around COVID-19 and our expanded service delivery and start to see challenges as opportunities."

Since May 2023, Kerry has been Medical Director of the Medical Workforce Unit and Deputy Chief Medical Officer at Austin Health. In this role, she focuses on managing junior and senior medical staff and medical education, fostering organisational culture, and focusing on retaining Austin Health's reputation as an employer of choice.

"Ultimately, I've learned to be more confident in the way I approach relationships and to work more productively in challenging environments by becoming adept at negotiation. If you work in a large organisation, there's the opportunity to work with people from a variety of disciplines and backgrounds, and often we're all trying to solve very similar problems. That's exciting."



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WINTER EDITION FEATURE

# VOICES FOR CHANGE



Thoughts, reflections and insights on how to improve systems, service delivery and patient outcomes in Victoria from eight public healthcare leaders.

SERIES VANESSA MURRAY

## REBUILDING CONFIDENCE

**A/PROF  
INES RIO**



MBBS MPH MHLTH&MEDLAW  
FRACGP FAICD

A/Prof Ines Rio is a specialist general practitioner at North Richmond Community Health, Chief Medical Officer at Monash University, and GP obstetrician and Head of the General Practice Liaison Unit at the Royal Women's Hospital. She is Chair of North Western Melbourne Primary Healthcare Network, Director of Sexual Health Victoria, and member of the TGA's Advisory Committee on Vaccines, the National Women's Health Advisory Council and Department of Health's CALD Advisory Group. Ines is passionate about the central role of general practice and primary care in the provision of quality, effective and equitable healthcare for all Australians.



**VICTORIA'S HEALTHCARE SYSTEM IS SOLID, BUT WE NEED TO IMPROVE HOW WE WORK AND PROVIDE CARE.**

We are fortunate to have a highly trained, multidisciplinary workforce, a national universal healthcare system, and strong research and education institutions. However, there are plenty of opportunities to restore confidence in the system and improve our provision of care. Fragmented communication and planning, especially between GPs and hospitals, poses a significant challenge to the continuity of care and patient safety. Interactions between hospitals and GPs are not helped by outdated, non-interoperable technologies. Such disjointed communication compromises patient safety and erodes patient trust and trust between healthcare sectors. Its inefficiencies and ineffectiveness cost the community and providers dearly.

**AN IDEAL HEALTHCARE SYSTEM APPROPRIATELY RESPONDS TO HEALTHCARE NEEDS.**

We need to create a system that prioritises equity, efficiency and integration. It needs to revolve around the care a patient needs in a GP-led, patient-centred medical home model, ensuring longitudinal, comprehensive, and accessible care. This model emphasises proactive outreach to address the needs of marginalised populations and those falling through the gaps in traditional healthcare delivery. To be successful, this model must be underpinned by seamless integration of IT systems, direct communication channels between GPs and hospitals, the ability for GPs to obtain timely advice, and transparent performance indicators to improve coordination and patient outcomes.

**WE MUST EMPOWER GENERAL PRACTICE BY INVESTING IN SUPPORT, REMUNERATION, AND IT INFRASTRUCTURE.**

Developing more shared care models between hospitals and GPs, and supporting GPs to provide what they can enables more patient care close to home, more efficiently and cost effectively. Hospitals should be funded and expected to enable this, along with training, upskilling and supporting GPs. An example of this is long-acting reversible contraception (LARC). GPs want to be able to insert them, however there's a limitation in accessible training to upskill GPs. If GPs were provided with free training and appropriate remuneration to insert LARCs, more would happen in general practice.

**AN INTEGRATED IT SYSTEM WOULD MAKE A MEANINGFUL DIFFERENCE TO PATIENT CARE.**

Streamlined communication and collaboration between healthcare sectors is critical to a GP-led, patient-centred model's success. The State Government needs to implement interoperable e-communication platforms between general practice and hospitals and standardise referral processes; facilitating efficient information exchange, clinical handover and care coordination. While referrals can be done and sent electronically directly from common GP software, many hospitals still don't have the ability to receive electronic referrals, with some still relying on outdated fax machines, causing significant clinical risks. GPs also need information to be provided electronically and directly into clinical software. Many coroner reports have made recommendations on this, yet progress is patchy and service specific, rather than government and quality standard mandated.



*We are fortunate to have a highly trained, multidisciplinary workforce, a national universal healthcare system, and strong research and education institutions. However, there are plenty of opportunities to restore confidence in the system and improve our provision of care.*

**FUNDING MODELS NEED TO BE ENHANCED TO BETTER SUPPORT PATIENTS.**

Patient-centred multidisciplinary models are applied successfully overseas. They are supported by different types of funding models, which include fee for service as the foundation, but also incentives for quality and providing care for people with complex care and social needs. Strengthening Medicare is making small steps towards this. Investing in general practice ultimately saves money but more importantly, patients benefit from more accessible, holistic and timely care. How can we get hospitals to appropriately fund timely and expert advice for GP clinical queries? This investment would ensure GPs can address more in the community, while also ensuring the right care and investigations are in place before we transfer patients to a hospital or specialist outpatient setting. We also need transparency from hospital systems about how they're performing in terms of communication, planning, access and equity. When we measure the right things, we can incentivise the right things.

**MEANINGFUL CHANGE IS POSSIBLE WHEN THE HEALTH SYSTEM WORKS COLLABORATIVELY.**

Initiatives that I and others have put forward that require cross-healthcare sector commitment, such as equal pay and leave for GP registrars, patient registration models, mixed funding models and electronic prescribing, have gained traction. As an advocate for healthcare reform, I am encouraged by the progress we've made towards improving access to sexual and reproductive health services, shared maternity care, shared care in cancer and chronic care. While Victoria's healthcare system stands on solid ground, it also faces challenges that demand concerted efforts from all stakeholders. Embracing a GP-led patient-centred medical home model, enhancing communication and collaboration, and addressing access and equity issues are critical steps in rebuilding confidence in our healthcare system and ensuring equitable access to quality care and outcomes for all.

**ABE  
ROPITINI**

///  
EXECUTIVE DIRECTOR  
POPULATION HEALTH,  
VACCHO

Abe Ropitini is an Indigenous man of Ngāti Kahungunu and Ngāti Maniapoto (Aotearoa New Zealand) and Trawlwoolway (Northeastern Tasmania) descent. He has been Executive Director of Population Health at the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) since 2020, working on the Aboriginal community controlled sector's response to the COVID-19 pandemic, the implementation of the Mental Health Royal Commission's recommendations for Aboriginal social and emotional wellbeing, and overall advocacy for Aboriginal health. With a background in medical anthropology and global health, and a deep interest in Indigenous ways of being, knowing and doing, Abe is currently undertaking a PhD in Medical Anthropology at La Trobe University.



**OUR PURPOSE IS TO BE A STRONG VOICE FOR THE ABORIGINAL COMMUNITY CONTROLLED HEALTH SECTOR IN VICTORIA.**

This includes advancing the commitments under the National Agreement on Closing the Gap. It has four priority reforms, each crystal clear in what the government must do. We spend a lot of time working on the second priority reform; building the community controlled sector. This was a commitment to transfer resources and power across to Aboriginal Community Controlled Organisations (ACCOs). ACCOs have boards elected from a membership of local Aboriginal community members, so they operate within a governance model of local community control. We have 33 of these services in Victoria, collectively making up VACCHO's membership. Our job at VACCHO is to support our member organisations to remain strong and sustainable, and we are a fearless advocate for their aspirations.

**THE NATIONAL AGREEMENT ON CLOSING THE GAP AND THE TRANSITION OF RESOURCES AND POWER TO THE ABORIGINAL COMMUNITY CONTROLLED SECTOR IS WHAT'S OWED AFTER THE RECENT HISTORY OF THIS COUNTRY.**

The violent impact of colonisation dismantled the preconditions for health and wellbeing in Aboriginal Communities. The National Agreement recognises what is owed to Aboriginal Communities in the effort to restore that stolen prosperity. In healthcare, Aboriginal people need to lead that restoration, and that's embodied in community controlled services. Unfortunately, government needs constant reminding of that mandate, and of the clarity of its commitments under the Agreement. They are still trying to dictate the terms of their relationships with ACCOs, and it's undermining the practice of community control. So, in some areas progress has stalled.

**PRODUCTIVITY COMMISSION REPORTS SHOW THE MACHINERY OF GOVERNMENT IS NOT RECOGNISING AND RESPONDING TO THE MANDATE OF THE NATIONAL AGREEMENT ON CLOSING THE GAP.**

Too often, government support is fragmented, short-term, and subject to overly prescriptive and controlling terms and conditions. ACCOs are constantly caught between accountability to their community and the siloed and inefficient machinery of government. When ACCOs are provided with flexible and consolidated funding to pursue their self-determined aspirations, their outcomes are incredible. They develop innovative models of care based on trust and cultural safety, where high quality medicine is combined with wraparound support to address the social determinants of health. It's a strengths-based approach, with multidisciplinary teams providing family-oriented, trauma-informed, integrated health and social services.

**AT VACCHO, WE'VE BEEN CHANGING NARRATIVES ABOUT ABORIGINAL HEALTH.**

The narratives about Aboriginal health that you're most likely familiar with are characterised by an overwhelming emphasis on deficits. Low income, low health literacy, complex trauma, co-morbidities, and so on. It's an utterly disempowering way of talking about – and to – Aboriginal people. It's also misleading. The reality is that people are aspirational. Year on year, more reasons emerge for Aboriginal people to embrace and celebrate their identity. We're seeing a real hunger for connection, community, and belonging. That's an incredibly powerful source of strength, from which we're developing optimistic narratives of health and wellbeing.



*Year on year, more reasons emerge for Aboriginal people to embrace and celebrate their identity. We're seeing a real hunger for connection, community, and belonging. That's an incredibly powerful source of strength, from which we're developing optimistic narratives of health and wellbeing.*

**ONE SIMPLE WAY MEDICAL PRACTITIONERS CAN INCREASE THEIR CULTURAL COMPETENCY IS BY BUILDING MUTUALLY BENEFICIAL RELATIONSHIPS.**

Relationships are everything. Every major hospital in Victoria has an Aboriginal health team of local community members whose presence makes hospitals more culturally safe, and accessible for Aboriginal people. If you're working in a hospital setting, I encourage you to introduce yourself to your Aboriginal Health Liaison Officers. Get to know them. Turn up when they hold their NAIDOC events. There are also opportunities to undertake professional development in cultural safety through organisations like the Australian Indigenous Doctors' Association.

**AT VACCHO, WE'VE BEEN ADVOCATING FOR THE DECOLONISATION OF MEDICINE.**

The medical profession has its own unique culture, with innate ways of being, knowing and doing. Its origins

are in Eurocentric, hierarchical, competitive, and male-dominated fellowships where other people – women, Indigenous people, and people of colour – have had to fight to create space for themselves. We're just getting started in decolonising the structures that exclude Aboriginal people. Within the ACCO sector, we've flipped the script. A medical professional's legitimacy, authority and trustworthiness depend on their ability to detach from medicine's culture and adjust to Aboriginal ways of being, knowing, and doing. Are they good at listening? Do they practice humility and embrace team members' strengths? Are they advocates against racism and structural inequity? These are not soft skills – in fact, decolonising medicine requires us to think of them as basic qualifiers. After all, the role of a doctor is one of service, and high-quality medicine in any setting cannot be practiced without trust.

**DR  
DEBRA  
BLACKMORE**

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MBBS FRACGP

Dr Debra Blackmore is a GP and First Nations ally who has spent her medical career working across Aboriginal health and community health. Debra has worked at the Victorian Aboriginal Health Service (VAHS) since 2018. Before that she worked in Aboriginal health in the Kimberley in Western Australia. Debra has also worked overseas in humanitarian settings in Liberia, Somalia, Nigeria, Afghanistan and Bangladesh. She is committed to delivering trauma-informed, individualised primary healthcare in a way that meets the needs of all people in our communities, including those experiencing disadvantage and marginalisation through historical and systemic barriers to accessing healthcare.



**A STRONG SYSTEM IS ONE THAT'S ACCESSIBLE TO ALL. IT'S CULTURALLY SAFE AND OFFERS DIGNITY TO PEOPLE.**

It's adaptable and trauma-informed and incorporates and acknowledges the social determinants of health – understanding that people's health and health literacy is affected by factors like the places they live, the work they do, and the education they have. As medicine has become more specialised, it has focused on biology and deals with individual problems in a vacuum. We need good multidisciplinary care where there is clear communication between teams, providers and government and between community and providers because, if we don't understand where the strengths and challenges are in the community, it's hard to develop services that respond appropriately and effectively.

**THE ADVERSE AND LONG-TERM EFFECTS OF COLONISATION AND RACISM ON COMMUNITIES NEEDS TO BE ACKNOWLEDGED.**

At VAHS, we support many who are survivors of the Stolen Generation and their descendants, and those who have been impacted by intergenerational trauma. They continue to be impacted by racism and institutional bias, which impacts mental health and wellbeing and chronic disease and creates barriers to accessing care.

**ONE OF THE STRENGTHS OF WORKING IN AN ABORIGINAL COMMUNITY-CONTROLLED ORGANISATION IS THAT FLEXIBILITY IS BUILT INTO THE SYSTEM WE PROVIDE CARE FROM.**

This means I can spend more time with a client who presents distressed, whereas many private practice models might not have the capacity to meet people in that way. Our system is set up to be supportive and responsive, with wraparound services. If somebody comes in in crisis, we have

access to community engagement officers who can support and connect them with services. We've got drug and alcohol support workers and access to mental health support.

**MY CLINICAL TIME IS SPENT FACE-TO-FACE WITH PATIENTS IN THE SERVICE, AND ON COMMUNITY OUTREACH VISITS.**

I do home visits once a fortnight to Elders all over Melbourne. We travel to them when they're not able to get into the service. Through COVID this became very important, as many community members felt vulnerable coming in and being potentially exposed. There's also a palliative care arm. Meeting the community in their homes as well as in our service gives a deeper sense of connection and trust, which allows for more flexible responses in times of acute need.

**WE FORMED MEDICAL ADVOCACY TOGETHER FOR COMMUNITY HEALTH (MATCH) IN LATE 2022.**

This is a group of 40 or so Victorian GPs working in Aboriginal and community health. We've united to raise awareness about and advocate for the important model of care our services provide. We feel it demonstrates how to best deliver care for all, especially the more marginalised in our community, and for people experiencing the most barriers in accessing healthcare. And yet, funding for such services is decreasing. We also raise awareness about research and training needed in general practice and community health to better meet the needs of the communities we care for. The reality is that most medical practitioners come from privileged backgrounds and have little exposure to the adverse effects of the social and political determinants of health. Better training would support GPs to work more effectively across the spectrum of delivering care and reduce system harm.

**THERE'S A LONG HISTORY OF A LACK OF TRUST IN THE SYSTEM FOR THE ABORIGINAL AND FIRST NATIONS COMMUNITY.**

This is an overlay that existed pre-COVID and requires a lot of work to overcome. We need to start having some honest conversations. Getting politicians and the people who are managing budgets to talk with clinicians on the ground and with the community must be a starting point. It's been clearly identified that Aboriginal and community health services provide a model of care that is unique and beneficial, especially for those who often experience the most disadvantage and face the most barriers in accessing healthcare.

**THE ABORIGINAL COMMUNITY-CONTROLLED MODEL OF HEALTHCARE AND COMMUNITY HEALTH TRULY GOES TO THE HEART OF HOLISTIC SOCIAL AND EMOTIONAL WELLBEING.**

It's a privilege to be able to work and learn in this space and to see resilience and strength despite a system that has endeavoured to destroy a culture. There is more flexibility to take time to see patients and address complex needs. This is not the case for many models of general practice care. Our model of care has been set up in a way that I am salaried. This allows my colleagues and I to focus on patient wellbeing and work in a trauma-informed and strengths-based way to care for people.



*It's been clearly identified that Aboriginal and community health services provide a model of care that is unique and beneficial, especially for those who often experience the most disadvantage and face the most barriers in accessing healthcare.*

**DR  
AJIT  
SELVENDRA**  
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MBBS FRANZCP

Dr Ajit Selvendra has been a senior consultant psychiatrist in the Victorian public hospital system for many years. He also has an academic appointment and works in private practice. After training in Melbourne, he undertook further studies at St. George's Hospital in London and has provided specialised training to mental health workers overseas. Ajit is Chair of the AMAV Section of Psychiatry, the AMA representative to the RANZCP State Committee, is involved with the AMA Federal Mental Health Committee, and oversaw AMAV's submission to the Royal Commission into Victoria's Mental Health System.



## WE ARE IN A PERIOD OF CHANGE AND TRANSITION IN THE VICTORIAN MENTAL HEALTH SYSTEM.

Difficulty accessing appropriate care when you need it has been written about extensively, especially the difficulties people experience accessing acute care and hospital beds when they were most unwell. With statewide underfunding of the mental health system over a couple of decades, the system had limited resources and patients were treated and relatively quickly referred back to their GP. Their GP then had limited ongoing specialised support or access to a psychiatrist. In this context, many patients later deteriorated again resulting in a return to the public sector system in a revolving door fashion. This pattern is still observed.

## MY INVOLVEMENT IN THE AMA AND VARIOUS OTHER COMMITTEES LARGELY DEALS WITH SYSTEMIC ISSUES AND INFRASTRUCTURE AROUND THE MENTAL HEALTH SYSTEM.

I get to work with very intelligent and capable people who have exceptional insights into the system with innovative and very effective solutions for the challenges that we face. I have the chance to develop this information and provide feedback to others about this; how things look on the ground, the potential the impact of higher-level and government decisions, and advise how models and approaches can be optimised and tweaked to get the best outcomes for patients and the best use of resources.

## THERE WAS A ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM THAT RESULTED IN SIGNIFICANT GOVERNMENT FUNDING TO SUPPORT IMPLEMENTATION OF ITS REFORMS.

A large range of stakeholders and interest groups participated, and there were a range of wish-lists proposed. However, a number of AMA members have expressed concerns that in this process there has not been enough focus or utilisation of actual expertise from clinical experts and staff who have significant experience working in this area. Despite AMA's advocacy raising this issue very prominently, I still don't think we have the balance right. If the models and systems developed by the current reform process are not optimal and clinical staff on the ground are not effectively supported to do their work properly then patients will continue to slip through the cracks, and we will struggle to attract and retain the skilled staff and expertise that hold the system together.

## A NEW VICTORIAN MENTAL HEALTH AND WELLBEING ACT WAS LEGISLATED IN 2022.

Then, on 1 April 2024 a further stage of implementation was applying some provisions in the Act to specifically designated hospital emergency departments. The Act has increased documentation, oversight and escalation requirements and the workforce and hospitals have had to develop more infrastructure around this. AMAV is actively monitoring this implementation, its effectiveness and outcomes while also providing feedback to the department.



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## AMAV'S MEMBERS HAVE IDENTIFIED SIGNIFICANT CONCERNS ABOUT THE DIRECTION THE OVERALL SYSTEM WAS TAKING.

In the second half of 2022, AMA Victoria was involved in a range of higher-level discussions around the statewide reform process. This was also a period of overwhelming patient need and staff exhaustion after COVID-19 and its impact. This was an important and intense time, where we were well advised by internal AMA expertise and higher-level committees and were able to effect change and a refocusing.

## AN EFFECTIVE INTERFACE BETWEEN THE PUBLIC HOSPITAL SYSTEM AND THE PRIMARY CARE AND PRIVATE SECTORS WOULD BE VERY HELPFUL IN TAKING THE BURDEN OFF THE SYSTEM.

After acute treatment and stabilisation in the state funded public mental health system, in most cases patients are transitioned back to the general practice and private sectors. As the Medicare MBS system funding didn't keep up with inflation and rising costs over prior decades, access to private psychiatrists became difficult and now

access to GPs is becoming more difficult. This is resulting in out-of-pocket costs and difficulty for patients, especially those with longer-term mental health-related disability and financial problems.

## MOVEMENT TO AN ONGOING CONTINUITY OF CARE MODEL WOULD HELP TO IMPROVE PATIENT OUTCOMES FOR THOSE WHO HAVE LONGER TERM ILLNESS.

While some people have a single episode or milder mental illness, many people have ongoing impairment and a greater illness impact. Specialist expertise and support should be available at all stages of peoples' care to get them better and then help keep them better. This would also demand that we ensure specialised clinical support and effective clinical governance for multidisciplinary teams and for GPs in primary care. Ongoing funding should also be directed towards increased acute beds, acute care and specialist tertiary services. These topics seem to be less popular during discussions in the current climate but are going to be even more important with Victoria's predicted population growth over the coming years.

**GRANT  
FORSYTH**

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**DIRECTOR WR AMAV  
CEO ASMOF**

**Grant Forsyth is Director Workplace Relations at AMA Victoria and CEO at Australian Salaried Medical Officers Federation (ASMOF) Victoria. Grant applies understanding of the Fair Work Act, HR, OH&S and other industrial legislation to lead AMAV and ASMOF Victoria's member advocacy. Grant has a background in banking and industrial relations and has been with AMA Victoria since 2016. Since 2019, he has led Workplace Relations' coordinated advice and support to members and long-term advocacy campaigns and strategies.**

**THERE ARE A FEW WAYS TO LOOK AT THE IDEA OF A STRONG HEALTHCARE SYSTEM.**

There's what a strong system looks like for health services' consumers, for the government, for various interest groups. Ultimately, I approach it from the perspective of the people working in the system, but it's important not to lose sight of all the parties and stakeholders involved. A strong public healthcare system has enough doctors and other employees so that doctors can meet their basic human needs. It includes job security and professional advancement as well as fair pay for fair work.

**OUR MINISTERIAL REVIEW IS ARGUABLY OUR STARTING POINT FOR REBUILDING CONFIDENCE IN PUBLIC HEALTHCARE IN VICTORIA.**

Our submission focused on numerous systemic shortcomings that are impacting doctors at individual and collective levels. We highlighted the short-term nature of employment for doctors in training, and the ongoing issues that raises. We asked for better incentives and conditions for doctors working in rural and regional areas, for specialists' pay to be equalised, and for greater transparency about pay from the 76 health services in Victoria.

**THE DEVOLVED NATURE OF VICTORIA'S HEALTH SYSTEM MEANS WE HAVE 76 PUBLIC HEALTH SERVICES, OFTEN WITH THEIR OWN WAY OF DOING THINGS.**

In other states, like New South Wales, there's just one employer, with one set of terms and conditions and HR policies. In Victoria, health services can have vastly different policies. This is bureaucratic, confusing and unfair for our members. To protect and support them, we have developed two strong enterprise agreements: one for doctors in training and one for specialists. The agreements cover 38 health services in Victoria that employ their doctors directly. Victoria's devolved system has forced class actions against 12 health services who are in breach of the Doctors in Training Agreement. In 2023 we won the first of these class actions against Peninsula Health, so we're making progress. We expect that if the State Government does not settle the cases, we will end up taking action against all 38 health services.

**WE WANT TO SEE LONGER TERM OR ONGOING CONTRACTS FOR DOCTORS IN TRAINING, TO INCENTIVISE BETTER EMPLOYER BEHAVIOUR AND CONDITIONS.**

Doctors in training in the public system are on short, fixed term contracts, which means they must reapply for their jobs multiple times before they qualify. It's very destabilising, with doctors often afraid to raise issues or rock the boat lest they're not given a good reference. Another issue is that workplaces are less inclined to make positive changes or support the professional development of short-term staff, because there's no incentive to invest in them. We've been able to remove maximum term contract restrictions from the Doctors in Training Agreement and specifically encourage longer term employment.

**WE'RE ALSO LOOKING TO REDUCE OVERRELIANCE ON AND IMPROVE INTEGRATION OF INTERNATIONAL MEDICAL GRADUATES (IMGs) AND LOCUMS IN REGIONAL AND RURAL SETTINGS.**

Many regional and rural doctors are contractors and not employed under the enterprise agreements. There's no line of sight about the cost of resourcing those health services or the usual protections afforded an employee, like recourse to the Fair Work Commission. And then, there is no real incentive, support or career progression for a doctor who works in rural Victoria compared to a doctor working in metro Melbourne, so those regional and rural hospitals find it difficult to attract doctors with experience in the Australian system, and rely on IMGs. The support for IMGs is pretty poor; they're left to sink or swim. We think that there is a lot more work that needs to be done to support our IMGs professionally and in the communities they live in.

**THE ROLE OF SPECIALIST COLLEGES IN THE AUSTRALIAN HEALTHCARE SYSTEM IS ANOTHER AREA WE THINK COULD BE FAIRER.**

Currently, the colleges set a lot of the standards for a trainee to aspire or get past, but they're not an employer. They have a massive influence on the system and on workers – particularly doctors in training – but they sit outside the system and there's very little accountability. This was another area of focus in our Ministerial Review where we asked for greater oversight, equity and fairness of policies and procedures. We have also recently employed a relationship manager at AMAV who will focus on building connections and relationships with the colleges, so we can better advocate for our members in that space.



*We highlighted the short-term nature of employment for doctors in training, and the ongoing issues that raises. We asked for better incentives and conditions for doctors working in rural and regional areas, for specialists' pay to be equalised, and for greater transparency about pay from the 76 health services in Victoria.*

**DR  
SARAH  
WHITELAW**



MBBS FACEM FRCEM  
AD EUNDEM DIP IMC  
RCS ED GAICD

Dr Sarah Whitelaw is an emergency medicine physician and medical specialist at the Royal Melbourne Hospital, Victorian Doctors Health Program board member, chair of the AMA Equity, Inclusion and Diversity Committee and Emergency Medicine Craft Group representative to the AMA Federal Council. Sarah is a member of the Australian Women in Healthcare Leadership project's Steering Committee, represents the Federal AMA on the project, and is an honorary clinical senior lecturer at the University of Melbourne. Having worked in multiple geographically and culturally diverse EDs under different administrative health systems.

Sarah has a strong interest and background in trauma care, medical education, medico-politics and quality improvement.



**A STRONG HEALTHCARE SYSTEM STARTS WITH THE SOCIAL DETERMINANTS OF HEALTH AND KEEPING PEOPLE HEALTHY.**

We are always going to have people who become unwell and injure themselves, so we need a strong community care system, including general practice, and an excellent acute care system. These need to integrate seamlessly to support people to move out of acute care and back into the community. We need to remove artificial barriers and work together because we all bring our perspective of what's best for our community and what's best for our patients. We need to be allowed to have that integrated focus and to work together without any barriers.

**WE PROVIDE A WORLD-CLASS LEVEL OF CARE IN OUR ACUTE PUBLIC HOSPITAL SYSTEM, BUT THERE IS GROWING FRUSTRATION.**

Our health workforce receives world-leading training, strives for excellence and delivers the highest standard of care. But more people are unable to access the system and have to wait longer, whether that's for elective surgery, outpatients, or access to appropriate rebates for general practice care. It is not in any of our interests for patients to end up sicker or to experience more complications while they're waiting. This vicious cycle creates a burden on the system, contributes to an increased need for emergency care and hospital admission and costs more. Many staff are exhausted. If we continue to limit resources and push productivity and efficiency, we're going to continue to see an exodus.

**MORE INVESTMENT IN PUBLIC HEALTH AND PREVENTATIVE HEALTH WOULD HELP TO KEEP PEOPLE HEALTHIER.**

The current system focuses our health resources on treating people when they're sick and injured. We need to support general practice to decrease preventable hospital admissions while also investing in acute care to manage the needs of people who are living for longer with more complex chronic healthcare requirements. More emphasis on keeping people healthy is imperative.

**MOVING BEYOND ARTIFICIAL DIVIDES BETWEEN FUNDING AND RESPONSIBILITY WILL BENEFIT PATIENTS.**

We need to focus on facilitating collaboration and working as one system. Patients despair at falling through the cracks of federal or state responsibility. In my AMA role as representative to the Federal Council, I have been involved in the Federal AMA campaign to clear the hospital logjam. This campaign has made a significant impact on stopping the blame game between federal or state governments in accepting responsibility for the public health system and collaborating to improve it. I'm proud of what we have achieved. It's incredibly important for our hospitals, our patients and our workforce, and will positively impact the rest of the Australian healthcare system too.

**THE SYSTEM AND CULTURE HEALTHCARE PROFESSIONALS WORK IN HAVE AN ENORMOUS IMPACT ON THEIR ABILITY TO DELIVER EXCELLENT CARE.**

Improving culture and professional behaviour means ensuring the workplace environment and working conditions allow people to work effectively with colleagues and deliver excellent care. We cannot get the best from people who are overworked, under-supervised, unsupported or not given appropriate resources. People need to be paid overtime and provided with adequate notice about when and where they will be working. They need to be able to access their leave, housing and childcare, and complete their training while participating in their communities and family life. We share a common goal to deliver excellent care, work collaboratively and effectively with our colleagues, communicate well and be compassionate and patient. We can only achieve this if the environment and culture of medicine and our health system support us.

**EMERGENCY MEDICINE IS UNDER ENORMOUS STRAIN – MAINLY BECAUSE WE CAN'T MOVE PATIENTS TO THE WARDS.**

We're very good at delivering emergency medical care, but 20% of our workload is taken up by patients who need inpatient care. Being unable to move patients out of ED when their emergency care is finished is stopping us from offloading ambulances and getting to our undifferentiated patients who are waiting for us. One of the key things emergency physicians do is advocate for our colleagues in other areas of the hospital and in primary and community care to access the resources they need to provide timely care in their environments. Being able to move patients into adequately resourced inpatient units and out of hospital safely – particularly our elderly patients care and those with disability – will free up our emergency departments for those who actually need acute care. It's all interlinked, which is why we need to work together and advocate for each other.



*We are always going to have people who become unwell and injure themselves, so we need a strong community care system, including general practice, and an excellent acute care system.*

**DR  
SARAH  
RICKMAN**



**MBBS FACEM  
GRAD DIP  
CLINICAL EDUCATION**

Dr Sarah Rickman is an emergency physician and medical educator at Austin Health, and Medical Director for the Postgraduate Medical Council of Victoria (PMCV). Sarah is skilled in emergency medicine, clinical supervision and program development. She has had hospital roles including IMG supervision, supervisor of intern training and clinical lead for the implementation of the National Framework for Prevocational Medical Training. Sarah champions education and support for junior doctors, and has become a leading voice in addressing the challenges they face within the healthcare landscape and advocating for a sustainable healthcare workforce.



**A STRONG HEALTH SYSTEM PUTS THE PATIENT FIRST, BUT ALSO RECOGNISES THE IMPORTANCE OF STAFF AND OTHER VOICES.**

We need to integrate the valuable perspectives and experiences of our frontline workers into decision-making for our healthcare system to be sustainable for the long term. Without this, systems level decisions can have a degree of disconnect, resulting in less buy-in from the staff. In our quest to develop a robust healthcare system, we cannot underestimate the importance of balancing patient care with staff wellbeing. If we don't look after staff, patient care will be affected. This means looking for ways to ensure staff feel respected, valued and supported for their work and contribution.

**WORKFORCE LONGEVITY, ESPECIALLY FOR JUNIOR DOCTORS, IS OFTEN OVERLOOKED, AND YET IT PLAYS A VITAL ROLE IN A FUNCTIONAL HEALTHCARE SYSTEM.**

Junior doctors are our future workforce, so we need to set them up to continue to thrive in a career that feels worthwhile and for which they feel valued. Workforce sustainability often focuses on large systems approaches, but we also need to support individuals to make their own work sustainable in the long term. From my perspective, there are two parts to workforce sustainability. There's a numbers-based component, making sure we have enough people coming through to fill the positions, but focusing on numbers is not enough – we cannot manage with only inexperienced and junior staff in our hospitals. We also need to build up a group of people who are committed and will remain for the long haul. We need to see our junior

staff as more than just service providers; as our future senior decision makers and leaders. These are the people who need to feel valued, invested in and supported to continually develop. Setting a culture where junior and senior staff are actively expected to take time for learning conversations recognises this. This is an area I am passionate about – supporting and teaching others but also improving things that aren't working. My role as Medical Director allows me to contribute to making the system better.

**EFFECTIVE COLLABORATION AND STREAMLINED COMMUNICATION ARE VITAL FOR SUSTAINING THE HEALTHCARE WORKFORCE.**

Victoria's healthcare system thrives on a systems-based approach and a culture of innovation. However, challenges like funding constraints and inter-hospital coordination gaps persist. Addressing these weaknesses is paramount for strengthening healthcare foundations and ensuring resilience amidst evolving demands. Reimagining funding models to prioritise patient care and incentivise collaboration would reinforce healthcare system resilience. There are coordination challenges across Victorian hospitals and a need for enhanced collaboration and funding model changes to support patient care and centralisation to improve efficiency. At PMCV, we're working on building our networks of educators from different hospitals. We should always be asking, are there projects that we can work on together, or systems or processes that could be centralised?



*In our quest to develop a robust healthcare system, we cannot underestimate the importance of balancing patient care with staff wellbeing. If we don't look after staff, patient care will be affected.*

**PRIORITISING TRAINING, EDUCATION AND MENTORSHIP CULTIVATES COMPETENT PROFESSIONALS READY TO TACKLE EVOLVING CHALLENGES AND DRIVE INNOVATION.**

This year, one of my major areas of focus is on implementing the revised National Framework for Prevocational Medical Training. The framework provides a foundational structure for enhancing supervision standards and fostering continuous development for junior doctors. Sustaining support beyond initial training phases remains critical. This initiative, part of a nationwide rollout, extends support beyond the traditional one-year internship, offering two years of feedback and growth opportunities. The focus is on a more generalist approach, providing comprehensive support during the crucial early career phase. We need to find a way to redress the balance between service provision and supervision and education. This means moving from a service provision first approach to an approach that recognises that without adequate education and supervision, service provision will eventually suffer.

Current pressures often squeeze out valuable education and supervision time, instead of encouraging investment in mentorship and education to yield a self-reinforcing cycle of support and quality supervision.

**SENIOR DOCTORS ARE INDISPENSABLE IN SHAPING THE FUTURE OF HEALTHCARE THROUGH MENTORSHIP AND EXPERIENCE.**

A strong healthcare system also facilitates the ongoing transfer of knowledge and guidance to ensure continuity and excellence in patient care while nurturing the next generation of medical professionals. Recognising the invaluable contributions of senior doctors and fostering intergenerational collaboration is vital for workforce sustainability. We need to be very careful that in front-loading senior decision-making we don't forget about the need to continue to build future capability. If we follow that too strongly, then we're saying we only want senior decision-makers; we don't want anyone inexperienced. That's not sustainable.

**DR  
MARGREET  
STEGEMAN****MD FRANZCOG  
MASTER CLIN ED**

Dr Margreet Stegeman is a gynaecologist, founder and director of the Shepparton Women's Health Centre, and the Deputy Director of Medical Education in the Department of Rural Health at the University of Melbourne. Originally from the Netherlands, she arrived in Australia in 1999 and completed her specialty training at the Royal Women's Hospital, Melbourne. She has lived in Shepparton in 2003 and has been in full-time private practice since 2012. In 2016 she established the Shepparton Women's Health Centre. She has a Master in Clinical Education and is an examiner for the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.



**IN MOST FAMILIES, WOMEN ARE STILL AT THE HEART OF HEALTHCARE, SO THEY'RE OUR PRIORITY AT THE WOMEN'S HEALTH CENTRE – BUT WE'RE ALSO HAPPY TO SEE MEN AND CHILDREN.**

We have a physiotherapist, a psychologist, a female surgeon who's mostly interested in breast surgery, one gynaecologist, one paediatrician, and six GPs. They're supported by three nurses, a practice manager and administration staff. It's fantastic to run my own practice and make our own decisions. If something is not running well, we ask, 'How can we do this better?' and start to make the changes we want to see. Here we are quite flexible. My leadership style is more transformational than transactional; I try not to micromanage anybody.

**SOCIOECONOMICALLY, SHEPPARTON IS NOT AS PROSPEROUS AS SOMEWHERE LIKE MELBOURNE. LIFE CAN BE CHALLENGING.**

Endometriosis, menopause, fertility and perinatal health – particularly mental health – are major issues for women in our catchment. There are not enough specialists, including gynaecologists, and the public waiting list is very long. We also get referrals from surrounding towns like Deniliquin, Echuca, sometimes even Seymour and Kilmore. This means it can be very difficult for women to access the care they need in a timely fashion, especially if they're not privately insured or don't have the funds. Sometimes women have to travel an hour or even an hour and a half to get checked. That can also present a barrier.

**FROM A BUSINESS PERSPECTIVE, WE EXPERIENCE FINANCIAL CONFLICT WITH EVERY CONSULTATION BECAUSE A PRACTICE JUST CANNOT SURVIVE ON BULK BILLING.**

Medicare is so unbelievably difficult for GPs. In specialist care it's much more straightforward. You just have two main items: a new patient or a review. But a GP, with every little step, they need to think, can I bill for that? Our GPs have a lot of knowledge about Medicare. I come from a country where healthcare is on individual patient needs, not external financial drivers. I think this would be better here in Australia, but that would demand a complete overhaul of the whole system.

**HEALTH HAS ALWAYS BEEN LOOKED AT FROM A MALE PERSPECTIVE; TRADITIONALLY, ALL OUR LITERATURE AND EVERYTHING THAT WE LEARN ABOUT DISEASES IS BASED ON HOW MEN PRESENT.**

How we treat them is also based on results from male research participants. So, we often don't know how women respond to medications or treatments. Now there's a quota, saying that you must have a proportion of women in your research. The quota came about in 2016, when a group of experts from nine countries designed the SAGER (Sex And Gender Equality in Research) rules, an international set of guidelines for more gender balance in research. So, this is changing. The medical students have to do a research project, and we make it female-focused. One recent research project was based on how women felt they were treated by our GPs based on their BMI.

**WE NEED PERINATAL SUPPORT AND MENTAL HEALTH CARE FOR OUR DOCTORS, AND WE NEED CHILDCARE AND SCHOOL ACCESS FOR DOCTORS IN RURAL AREAS.**

There are not enough schools here, particularly high schools, to support professional families to stay. There are long wait lists and there is no guarantee their children will get in. It used to be that professional people that came to Shepparton could always get their child into one of the schools, but that's not the case at the moment. Our GPs and other healthcare professionals are very valuable for our community, but if they can't get their children into good schools, they will leave.

**BEING ABLE TO DO OUR ENTIRE TRAINING RURALLY WOULD BE VERY GOOD FOR RURAL HEALTH.**

By creating opportunities to do your entire training as a specialist rurally, rural areas would be less likely to lose skilled doctors and other healthcare professionals back to the cities. Making this happen involves more funding, but also a shift in attitude from the training colleges and urban clinicians, who sometimes seem to think that urban areas are the only ones that can deliver good healthcare. As an aside, I'd also like to see more gender-bias awareness training for the men in our profession, because they don't realise they're biased, and often are.

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*By creating opportunities to do your entire training as a specialist rurally, rural areas would be less likely to lose skilled doctors and other healthcare professionals back to the cities.*



*Click here to book  
a complimentary  
meeting*

## EMBRACING CHANGE: WHY REGULAR TAX MEETINGS INSTIL CONFIDENCE

**In today's ever-evolving financial landscape, the ability to face change with confidence is essential. Regular meetings with your accountant are important for strategic decision-making and adapting to changes in the tax system.**

These meetings provide a valuable opportunity to tailor strategies for navigating tax complexities efficiently. Topics covered may include:

### STRATEGIES FOR MAXIMISING YOUR TAX SAVINGS

With your accountant, you should be delving into personalised tax-saving strategies tailored to fit your unique financial situation. By examining your income, expenses, investments, and deductions, your accountant can uncover potential tax breaks and credits you might have missed. Through proactive tax planning, you have the potential to strategically reduce your tax bill, amplify your savings and hold onto more of your hard-earned cash.

### KEEPING YOU IN THE LOOP ON TAX UPDATES

Tax laws are constantly evolving, making it challenging for individuals to stay abreast of the latest changes and regulations. Your accountant can guide you through the maze of tax rules, informing you about new laws that could impact your finance and ensuring you avoid costly mistakes by remaining compliant.

### PAVING THE WAY FOR SOUND FINANCIAL CHOICES

A tax planning session isn't just about minimising your tax liabilities, it's also an opportunity to strategise for the future. Your accountant can shed light on the tax implications of major financial decisions, whether it's launching a business, purchasing property, or plotting out retirement. By considering tax ramifications upfront, you can make savvy choices that align with your long-term financial goals while optimising your tax position.

### NAVIGATING COMPLEX TAX SITUATIONS

The tax landscape can be tricky, with complex issues being not an uncommon occurrence. Whether it's tackling international tax matters, managing investment portfolios, or dealing with estate planning, your accountant can be your compass, ensuring compliance with tax laws and guiding you toward decisions that safeguard your financial interests.

### KEEPING YOUR DUCKS IN A ROW

By proactively assessing potential tax risks and addressing compliance matters, individuals and businesses can steer clear of unnecessary or avoidable penalties. Additionally, this process can pinpoint areas for improvement in record-keeping and documentation, ensuring that your financial information is accurate, comprehensive, and in line with regulatory requirements.

Regular tax planning catchups with your accountant are an investment in your financial well-being. At the Bongiorno Group, we're committed to empowering our clients to make savvy decisions and flourish in a financially secure future.

For further information or to book a complimentary meeting, please phone **03 9863 3111** or email **amav@bongiorno.com.au**



# RESTORING CONFIDENCE

Our advocacy priorities for 2024-25 focus on the theme of Restoring Confidence: Practical Solutions to Address Victoria's Healthcare System Challenges. These priorities build upon the initiatives we have been pursuing since May 2023. AMAV President, Dr Jill Tomlinson, talks us through them.

BY VANESSA MURRAY

WITH  
DR JILL  
TOMLINSON

AMAV PRESIDENT





*The Victorian healthcare system delivers high quality care, but workforce pressures and the impact of the pandemic has left the medical workforce with low morale and extremely stretched resources.*

Victorians want a healthcare system that provides quality, accessible safe healthcare. We have lived through unprecedented times, and there is much work to be done to restore confidence and improve workforce morale,” says AMA Victoria’s President, Dr Jill Tomlinson.

“The Victorian healthcare system delivers high quality care, but workforce pressures and the impact of the pandemic has left the medical workforce with low morale and extremely stretched resources. The continued expectation that we can do more with less, the increasing complexity of care, increasing cost of living pressures and access issues are contributing to despair and burnout among doctors.

“General practitioners lament the fragmentation of team-based general practice care by initiatives including pharmacy prescribing and priority primary care clinics, and the challenges of accessibility and affordability for their patients. Psychiatrists experienced significant challenges with communication around the implementation of the Mental Health and Wellbeing Act 2022 and

are concerned that care delivery is being limited by workforce and bed constraints despite increasing demand for services.”

AMA Victoria is committed to enhancing Victoria's healthcare system by focusing on key areas including sustaining general practice, improving public hospitals, advancing digital health, supporting mental health, advocating for progressive public health measures, prioritising rural and regional health, lessening the administrative burdens placed on all medical practitioners, and addressing equity and diversity issues.

Restoring Confidence provides AMAV’s advocacy template for the year ahead. It focuses on three key areas or leading themes (general practice, public health services and mental health), and five contributing themes (digital health and technology, equity and diversity, regional and rural healthcare, administrative burden, public health).

“General practice is the most efficient part of our healthcare system and the workforce and funding crisis in general practice heightens the difficulties of

## RESTORING CONFIDENCE

managing patients who have increasingly complex care needs. We desperately need to bolster the general practice workforce through improvements in recruitment and retention; improve accessibility and affordability of quality primary care for Victorians; and reduce avoidable hospital presentations and admissions. We need to improve working conditions for public hospital doctors including in psychiatry, and address recruitment and retention factors, particularly in regional and rural areas.”

“Given the straitened state fiscal climate and the reality that much advocacy in 2024 will be directed at preventing cuts rather than proposing new expenditure, we have deliberately not used the term ‘budget

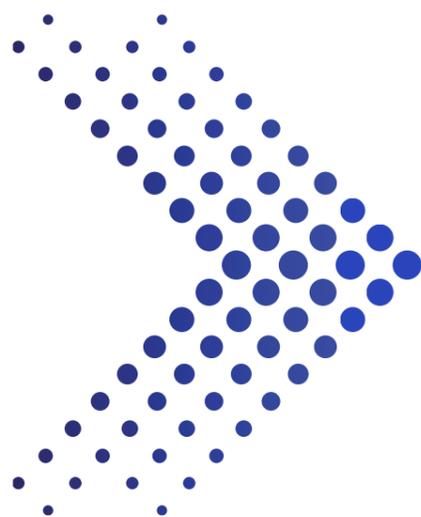
submission’ this year. Instead, we’ve created series of priorities that encapsulates the policy and advocacy initiatives AMAV has been pursuing since May 2023. This deliberately presents nothing we haven’t discussed many times with government,” explains Dr Tomlinson.

“The 2024-25 priorities reinforce our messaging and are supported by many tangible, achievable solutions, which we strongly recommend the Victorian Government take up to resolve persistent issues, improve the healthcare system and usher in a more resilient and responsive era – one that advances a Victorian healthcare system that empowers doctors and enriches patient care.”



*AMA Victoria is committed to enhancing Victoria's healthcare system by focusing on key areas including: sustaining general practice, improving public hospitals, advancing digital health, supporting mental health, advocating for progressive public health measures, prioritising rural and regional health, lessening the administrative burdens placed on all medical practitioners, and addressing equity and diversity issues.*

## ADVOCACY PRIORITIES AT A GLANCE



LEADING THEMES
We are advocating for...
<b>PUBLIC HEALTH SERVICES</b>
<p><b><u>Improvements to working conditions for public hospital doctors:</u></b></p> <ul style="list-style-type: none"> <li>» restructuring health system governance</li> <li>» job security enhancement</li> <li>» adequate staffing levels</li> <li>» improved gender equity</li> <li>» improved implementation of employment terms and conditions</li> <li>» fair remuneration for unsocial hours</li> <li>» streamlined credentialing process</li> <li>» rural and regional infrastructure investment</li> <li>» carer support provisions</li> <li>» support for IMGs</li> <li>» increased transparency in workforce planning</li> <li>» oversight of specialist colleges</li> <li>» doctor to patient ratio standards</li> </ul> <p><b>Reasonable and swift resolution of Doctor in Training class actions</b></p> <p><u>Providing clarity regarding MBS billing in public health services</u></p> <p><u>Transparency and appropriate consultation in reform of Victorian health services</u></p>

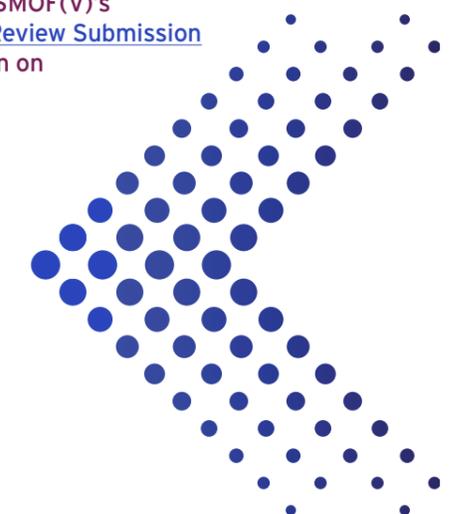
## RESTORING CONFIDENCE

LEADING THEMES	
We are advocating for...	We are advocating for...
<b>GENERAL PRACTICE</b>	<b>MENTAL HEALTH</b>
<p><b><u>General Practice Support and Recovery Strategy interventions:</u></b></p> <ul style="list-style-type: none"> <li>» <a href="#">Single Employer Model trial in 2025</a></li> <li>» <a href="#">extension of GP Registrar Incentive Payments</a></li> <li>» <a href="#">payroll tax clarity and certainty</a></li> <li>» removal of red tape</li> <li>» <a href="#">reduced expectation for forms to be completed gratis</a></li> <li>» improved transfer of care</li> <li>» support and recognition for GP reduction of avoidable hospital readmissions</li> <li>» Continuation of the vital Chief General Practice Advisor position within the Department of Health</li> </ul> <p><b>Expanding Victorian virtual specialist consults</b> to improve community access to specialist opinions</p> <p><b>State-initiated primary care measures (e.g. <a href="#">pharmacy prescribing</a>, <a href="#">Priority Primary Care Centres</a>)</b> to not further fragment GP-led, team-based care</p> <p><u>Timely access to vaccines</u></p>	<p><b><u>Continuation of mental health service funding,</u></b> given the burden of the Mental Health and Wellbeing Act and noting that mental health services were unable to be delivered at projected levels last financial year due to workforce and bed constraints</p> <p><b><u>Improved communication from the Department of Health</u></b> about implementation of the Mental Health and Well Being Act, and <a href="#">Restrictive Interventions</a> and <a href="#">Compulsory Assessment and Treatment</a> policies</p> <p><b><u>Solutions to enhance recruitment and retention</u></b> in the mental health workforce, particularly those that address increasing rates of occupational violence and a lack of senior leadership</p> <p><b><u>Reasserting the importance of the medical model in mental health reform</u></b></p> <ul style="list-style-type: none"> <li>» co-design of policy</li> <li>» embedding clinician executive decision-making authority within the Department</li> <li>» funding for appropriate remuneration to enable experienced clinicians to participate in such processes</li> </ul>

CONTRIBUTING THEMES		
We are advocating for...		
DIGITAL HEALTH + TECHNOLOGY	EQUITY AND DIVERSITY <sup>1</sup>	REGIONAL + RURAL HEALTHCARE <sup>1</sup>
<p>Improved transfer of care particularly discharge summary content and delivery, and referrals and information sharing</p> <p><b>Embedding protected time to perform clinical handover</b> at the point of hospital discharge</p> <p><b>Virtual care measures</b> that support emergency care and general practice</p> <p><b>Lifting digital maturity</b> in health services across Victoria</p> <p><b>Improving health information sharing</b></p> <p><b>Reducing red tape</b> through digital improvements</p>	<p><b>Availability and analysis of gender data</b> within the workforce</p> <p>Addressing the <b>gender pay gap</b></p> <p>Facilitation of participation, cultural safety, and <b>inclusion of doctors from diverse backgrounds</b></p> <p><b>Carer allowances or supports</b></p> <p><b>Needs-based adjustment of medical school and training programs</b> to provide pathways to specialties with shortfalls</p> <p><b>Better support for IMGs</b>, especially in rural settings</p> <p><b>Recognition of prior learning</b> from College training programs</p> <p><b>Inclusion, fair selection and support for medical students with disability</b></p> <p><b>Increase flexible training opportunities</b>, including part time stand-alone positions</p> <p><a href="#">Improved racial literacy of healthcare workforce, and Ahpra</a></p> <p><a href="#">All trainees able to sit/apply to sit College and Fellowship exams while on parental leave</a></p> <p><a href="#">Fair and equitable registration fees</a></p>	<p><b>Rural infrastructure Investment</b></p> <p><b>Student training and recruitment investment</b></p> <p><b>Increase medical student intake from rural areas</b></p> <p><b>Increase rural exposure</b> for metro students</p> <p><b>Increase pay, allowances or subsidise expenses</b> for doctors and students training or practising rurally</p> <p><b>Ensure clinical services are adequately equipped</b></p> <p>Require colleges to <b>recruit trainees based on rural experience</b></p> <p>Provide <b>more rural training opportunities</b></p>

CONTRIBUTING THEMES	
We are advocating for...	
ADMINISTRATIVE BURDEN	PUBLIC HEALTH
<p><b>Reduction in duplication</b>, unnecessary paperwork and <b>streamlined workloads</b> for healthcare workers</p> <p><a href="#">Eliminate automatic rejection of unnamed referrals by public hospital outpatient clinics</a></p> <p><a href="#">Substantial reduction in organisational expectations for doctors to provide pro bono services in completing forms and reports without payment</a></p> <p><a href="#">Improvements to Ahpra's notifications process</a></p>	<p><a href="#">Supervised injecting facility in the Melbourne CBD</a></p> <p><a href="#">Drug checking (pill testing) accessibility</a></p> <p><a href="#">Pharmacotherapy services (opioid replacement therapy)</a></p> <p>More accessible <b>chronic pain services</b> for women and men</p> <p><a href="#">Progression of the aims of the Victorian Sustainable Healthcare Unit</a> including developing sustainability KPIs, embedding sustainability metrics into procurement contracts and developing a roadmap for net zero healthcare emissions targets</p> <p><a href="#">Reduction in vaping related harms</a></p> <p><a href="#">Improved regulation and public safety, and reduced harms around e-Scooters</a></p>

<sup>1</sup> Please see AMAV/ASMOF(V)'s [Ministerial Review Review Submission](#) for more information on these initiatives





# Making the chance of growing a family more affordable for every Australian



**Dr Julie Whitehead**  
Clinical Director (VIC),  
Fertility Specialist, Obstetrician  
& Gynaecologist  
MBBS, FRANZCOG, MMed



**Dr Amy Feng**  
Fertility Specialist,  
Obstetrician & Gynaecologist  
MBBS, FRANZCOG,  
MSurg (Adv Gyn)



**Dr Stephanie Sii**  
Fertility Specialist,  
Obstetrician & Gynaecologist  
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### Affordable and Accessible IVF

Adora Fertility has helped create over 11,000 babies through IVF since 2014. We provide affordable IVF without compromising on quality. By referring your patient to one of our highly qualified specialists, they will receive a tailored approach to their fertility treatment plans with medications sensitive to their needs. We bulk-bill the majority of Medicare eligible expenses resulting in out-of-pocket costs which are typically less than \$2,000 for a fully stimulated IVF cycle. We now offer IVF with a known donor allowing us to help more people grow their families in more ways. Give your patients the best chance of conception without the financial sacrifice.



# INTERGOVERNMENTAL COLLABORATION CAN SAVE LIVES

In the realm of healthcare, collaboration is not merely a virtue; it's an imperative. Particularly in a federated nation like Australia, where responsibilities are divided between federal, state and territory governments, intergovernmental collaboration is the cornerstone of effective healthcare planning.

BY PROFESSOR STEVE ROBSON

Australia's health system is rightly the envy of the world, but there is much room for improvement, especially when it comes to intergovernmental collaboration – that crucial cooperation between state and federal governments.

Australians are also a highly mobile population, and healthcare systems can be difficult to navigate in different jurisdictions.

This is why it is so important for the AMA to be advocating for doctors' interest on both fronts – in the federal arena and in state and territory jurisdictions.

The AMA is a strong advocate of intergovernmental collaboration in healthcare to create an efficient and strong system across the country.

A key issue to date is the federal government's vaping reforms, and I was glad to hear all Australian Health Ministers came together at their meeting in Brisbane in April to declare their support for coordinated action on vaping to protect young Australians.

This bodes well for intergovernmental collaboration, which will be absolutely essential when it comes to implementing vaping reforms. The Poisons Acts differ in each jurisdiction, and there are also differences in tobacco and vape licencing arrangements, penalties and enforcement.

The Australian Centre for Disease Control (CDC) is another area where collaboration between all governments will be vital.

If implemented effectively, the CDC would work closely with states and territories to manage the allocation of public health workforces and resources to tackle emerging and current threats.

It would also complement existing state and territory disease control measures and structures by providing national leadership, coordination, research and decision making.

The AMA has been integral to the formation of the CDC, and we will work hard to ensure it is implemented and resourced properly.

Medical workforce shortages are profound, particularly in rural and regional areas in Australia, where people find it difficult to see a GP and often must drive long distances in search of healthcare.

This is a significant issue requiring collaboration from all governments, and in our pre-budget submission we proposed a [\\$1 billion commitment to establish an independent health workforce planning agency](#).

This agency could supercharge intergovernmental collaboration by providing quality evidence to inform new policies that all governments could act on to help address regional doctor shortages right around the country.

Perhaps one of the most concerning gaps in intergovernmental collaboration right now is data.

There is currently an intergovernmental agreement on data sharing, but this is around how data is shared and protected, not what data is shared and protected. Inadequate data linkage has for too long been a weakness that has limited our ability as a nation to inform policies across the country.

Two areas of significant concern at the moment relate to road safety and homelessness.



*The AMA is a strong advocate of inter-governmental collaboration in healthcare to create an efficient and strong system across the country.*

In December, we updated our position statement on road user safety and [called on the federal government](#) to mandate a requirement for state and territory governments to start sharing road safety data.

During the 12 months to March this year, 1286 people lost their lives on Australian roads – an 8.2 per cent increase from the previous 12-month period.

It is disappointing that something as simple as a national data set to provide better understanding of the causes of crashes is not available.

By having these crucial insights and data, investments can be guided to where they are need most – in effective road safety and transport infrastructure policy. Something so simple could save so many lives, and reduce the death and trauma that doctors, ambulance officers and nurses are confronted with every day on our roads. But sharing such data requires buy-in from not only the federal government, but all state and territory governments.

Homelessness is another area where intergovernmental collaboration could save lives.

It is shocking that so many Australians experiencing homelessness are dying at an average age of 44, as a [year-long investigation](#) by The Guardian revealed. If it wasn't for journalists scouring a decade's worth of non-public death reports to state and territory coroners and conducting extensive interviews, this shameful national tragedy may never have been fully uncovered.

The AMA sees great benefit in creating a national reporting framework to provide consistent data and provide a complete picture on the very real issue of homelessness deaths in Australia.

The AMA is serious about intergovernmental collaboration, and while we are glad to see strides made in certain healthcare areas, there is still much to be desired.

With just a bit of political will from our governments, Australia's already world-leading health system could be made even stronger and many more lives could be saved.

## DO YOU NEED MORE FROM YOUR FAMILY'S HEALTH COVER?

Our personal lives are full of milestones, many of which centre around the health needs of our family. When it's time to consider whether your private health cover is meeting the growing health needs of your family and is providing the best value possible, there's a few things to consider.



*Click here to find out how to switch*



### THE PRICE OF HEALTH COVER

Health insurance is community rated so your age, health status or claims history cannot influence the price of your health cover, and everyone pays the same amount regardless of the frequency of which they need to access health services. This system ensures equality and fairness for Australians when it comes to protecting their health with insurance.

The price of health cover varies for other reasons, such as the number of services it covers, the state or territory, and government initiatives such as Lifetime Health Cover loading and the Australian Government Rebate on Private Health Insurance.

Premiums are generally higher for policies that cover more services. In 2019, the Australian Government introduced tiers to categorise hospital cover: Gold, Silver, Bronze and Basic. While these tiers have standardised the inclusions of hospital cover, it is up to individual health funds to set the price of these policies. That means a Gold policy with one health fund can have a different premium to a Gold policy with another health fund, even when they cover the same services.

### VALUE MEANS MANY THINGS, IN ADDITION TO PRICE.

Value for money when it comes to your health insurance doesn't just include the cost of your premium. While price is an important consideration when managing a family budget, paying less may not necessarily mean you are receiving the right amount of value for your family. When assessing the value you receive from your health cover, other factors such as the level of medical gap cover your health fund offers, the service experience and the health fund itself and their values, all contribute to how your health cover can support and meet the health needs of your family.

### IF YOU DO SWITCH, IT'S EASIER THAN YOU MIGHT THINK.

In Australia health insurance is 'portable'. This means you can switch health funds at any time and in most instances, you won't have to re-serve waiting periods already served on your existing policy. If you're upgrading your cover, you will need to serve waiting periods for any new services, and these can range from two months to 12 months. This is why planning for the additional services you may need can be beneficial to ensure you have served any waits before you need to access these services. When you switch, all this information is transferred directly between health funds, so you don't need to worry about any of the paperwork.

We all want to get value from our health insurance, and there are important considerations when deciding on what this means for your family and what is the best option for your current and future needs.

**With competitively priced Gold hospital cover, market leading medical gap cover and no preferred providers for extras, Doctors' Health Fund is made for doctors, the medical community, and your families. Plus, join on any hospital and extras by 30 June and receive up to 15 weeks free<sup>^</sup> across your first two years and skip the two-month waiting period on extras so you can claim for services like dental and optical straight away.<sup>^</sup> Made for better value for your family, [see how your cover compares today.](#)**

<sup>^</sup> Offer and policy T&Cs apply, see our website. Existing Avant members receive 15 weeks over the first two years, non-Avant members receive 8 weeks free in the first year. Check eligibility in the full terms and conditions at [doctorshealthfund.com.au/silvertogold](https://doctorshealthfund.com.au/silvertogold) Private health insurance products are issued by The Doctors' Health Fund Pty Limited, ABN 68 001 417 527 (Doctors' Health Fund), a member of the Avant Mutual Group. Cover is subject to the terms and conditions (including waiting periods, limitations and exclusions) of the individual policy, available at [www.doctorshealthfund.com.au/our-cover](https://www.doctorshealthfund.com.au/our-cover).

# UNPACKING BIASES

**Alex Ikanovic, President of the Medical Student Council of Victoria, explores and unpacks the typical medical student's biases about working in rural and regional areas.**



Attending a medical school with a strong focus on rural and Indigenous healthcare meant that the notion of person-centred and public health medicine were always front of mind.

However, I'll confess that prior to attending medical school, while I was across my school's mission statement and values, a core part of me had reservations about working regionally and in remote settings. So, in typical 'medical student fashion', I looked to the literature to cement my own prejudices (confirmation bias, anyone?).

But instead, I was reassured by the notion of 'rural amenity'. It posits that a location's attractiveness comprises two components – a tangible environment, and a psychosocial one. And while COVID-19 may have contributed to the resurgence of the Australian 'sea-change' sentiment,

discourse among my peers still frequently cited more practical considerations when discussing their apprehension around transitioning rurally. Namely that, beyond the supportive infrastructure for recreational activities and work-life balance is a scepticism for true employment prosperity. For students, I believe this translates to a misconception around vocational training program viability which has failed to be demystified during their tertiary education.

Even so, with scant data present in the literature to support a correlative association between the District of Workforce Shortage (DWS) classification and rural amenity, I believed that there still lay valuable upstream determinants of workforce retention – and therefore policy development – which were being sorely overlooked.

I turned to my school's curriculum instead. A concept that was ubiquitous throughout my degree's teachings was the social determinants of health model. At a glance, this is a framework which aims to classify the enablers and barriers to health equity. For a visual learner like me, an analogy which frequently stood out was the deep-seated notion that as healthcare professionals, we somewhat habitually act as the ambulance at the bottom of a cliff, rather than being the individuals who develop the cautionary signage at its precipice. In a way, I believe these considerations to almost hold true when it comes to discussions surrounding incentivisation strategies for rural and regional workforce sustainability.

I concluded that policymakers have, unfortunately, played the role of the ambulances for too long, with poorly placed solutions to these amenity reservations, such as the Bonded Medical Program. With some students foregoing any regional and rural exposure in their tertiary training, it's unsurprising that a 2017 audit demonstrated that less than 1% of 10,000 bonded participants had completed their obligations since the Program's inception in 2001.

Upon further reflection, I began to consider the microcosm which was my medical school – a passionate and motivated group of individuals who are seemingly more inspired to serve more regional, remote, and Indigenous communities than the average medical student or graduate. Had we somehow organically struck an appropriate balance between clinical exposure and relevant teachings that meant students were actually motivated – without incentivisation – to serve these communities in need?

As the last four years of my degree passed, I've continued to reflect on this topic. I've raised many more questions

of my own: Have we been too myopic in our assessment of the drivers of rural workforce aversion? Were we inadvertently wasting many of our resources in funnelling students whose apprehension could not be overcome through mere incentivisation? Or perhaps had we just started to shift the balance in a meaningful way with some of the more novel strategies which are yet to have enough throughput to justify their implementation?

Some key observations I've made over my four years at a rurally-focused school which may help navigate the optics associated with rural amenity. Firstly, the rural retention rate was higher in students of regional and rural origin. Secondly, students at a regional clinical school found themselves considering practicing there more so than when they commenced medical school. Thirdly, those with a keen interest in general practice or rural generalism were looking forward to moving rurally pre-vocationally – with this final element largely fostered through encouraging and supportive university interest groups.

What we can glean from this is that, in the interim, instead of waiting for other sectors of Australia's government to play catch-up when it comes to rural amenity, schools should look towards more sustainable forms of student recruitment, that accurately reflect motivators for rural workforce retention. As, while the throughput isn't currently enough to substantiate a paradigm shift, the upstream determinants of retention are certainly more than just speculative. This holds especially true for my own medical journey, as I've seen just how transformative a great combination of grassroots interest groups and a specially-tailored curriculum can be for demystifying students' rural amenity-based apprehensions.

## 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*

### VICDOC POLICY DESK

As always, it has been a busy time in policy for AMA Victoria's policy and advocacy team, with issues as diverse as payroll tax, the reform of health services in Victoria, and Ahpra concerns finding their way across the policy desk in recent months. Here are the highlights:

### MEETINGS WITH HEALTH AND MENTAL HEALTH MINISTERS

AMAV has recently held productive meetings with the Victorian Health and Mental Health ministers, addressing a range of critical topics:

- » *Health Services Plan*: dialogue on reforming health services addressed issues such as efficiency, accessibility, and quality of care. Emphasis was placed on ensuring that reforms align with the needs of both patients and medical practitioners.
- » *Support for General Practice*: discussions encompassed various forms of support, including payroll tax certainty and clarity, aimed at ensuring the sustainability of general practice in Victoria.
- » *Ministerial Review*: conversations surrounding the Ministerial Review were focused on assessing current policies and practices to identify areas for improvement and optimisation.

- » *Class Actions*: emphasising the concerns of junior doctors related to working conditions and unpaid overtime, AMAV urged for a prompt settlement of these actions.
- » *Medical Workforce Wellbeing*: discussions addressed the challenges faced by medical practitioners, including burnout, mental health, and work-life balance, all of which are crucial for maintaining a resilient and effective healthcare workforce.
- » *Implementation of Mental Health and Wellbeing Act*: discussions centred on strategies for effectively communicating and implementing this legislation.
- » *AOD Issues*: discussions on prevention, treatment, harm reduction, and support services, including pharmacotherapy access and a CBD injecting facility.
- » *MBS Billing Practices*: discussion regarding MBS billing practices addressed the need for compliance with the NHRA and other requirements.

AMAV is committed to continuing dialogue and collaboration with the Victorian Government on these pressing matters. AMAV's goal is to advocate for the best interests of our members, the medical community, and the health of all Victorians.

### PAYROLL TAX REFORM: A POSITIVE RESULT FOR VICTORIAN GENERAL PRACTICE

General practice is vital for keeping Victorians out of hospital. After listening to advocacy from the sector, the State Government has announced changes that deliver certainty and clarity to Victorian general practices. While AMA Victoria acknowledges that there will be costs associated with this transition for practices that are not currently paying payroll tax on GP contractor wages, it is positive news for general practices, general practitioners and Victorians.



*More: AMAV Hub*

### HEALTH SERVICES PLAN UPDATE

AMA Victoria has endeavoured to keep members informed of our ongoing efforts to advocate for transparent communication regarding the Victorian Government's Health Services Plan. This initiative, as described by the Government, aims to consider the optimal design and governance of the public health system, with a focus on improving care for all Victorians by enhancing collaboration among public health services. The goal is for reform to address the fragmented delivery of healthcare by promoting a more integrated approach, streamlining patient journeys, ensuring continuity of care and reducing the inefficiencies caused by the current decentralised system.



*More: AMAV Hub*

### AHPRA- REGISTRATION FEES FOR HEALTHCARE PRACTITIONERS ON PARENTAL LEAVE

AMA Victoria has written to Ahpra regarding registration fees for healthcare practitioners on parental leave. Specifically, the letter addresses Ahpra's refusal to provide any registration category or mechanism to reduce fees to assist practitioners on parental leave, despite requests for change.

The letter argues that Ahpra's fee-setting policies fail to consider principles of equity, emphasising the need to accounting for each person's different circumstances. It contends that fee setting with consideration of principles of equity requires allocation of resources and opportunities such that an equal outcome is achieved. Specifically in regard to parental leave, the principles of equity mean that practitioners who take a period of parental leave should be offered a mechanism to reduce fees, given the reduction in income associated with parental leave, the lowered risk from practitioners who are practicing less for a defined period, the obviously gendered nature of the impact and the legislated requirement that the scheme function "to enable the continuous development of a flexible, responsive and sustainable Australian health workforce".

The letter challenges Ahpra's assertion that it is constrained from providing fee reductions, pointing out the agency's broad discretion in fee-setting and the absence of specific legislative barriers.

Furthermore, the letter critiques Ahpra's suggestion for practitioners on parental leave to apply for non-practising registration, citing practical and financial obstacles.

In summary, the letter urges Ahpra to revise its fee-setting policy to reflect equity principles and calls for transparent clarification on why reduced fees for parental leave practitioners have not yet been offered.

We have offered to meet with Ahpra to discuss these matters, and to discuss the positive impacts on equity, inclusion, and diversity within the healthcare workforce that would result from Ahpra and the Medical Board embedding the principle of equity in its fee setting arrangements.

We will update members on Ahpra's response.



### AHPRA – CONCERNS REGARDING NOTIFICATIONS PROCESS

AMA Victoria has contacted Ahpra regarding concerns about the notifications process.

A significant challenge is that the medical profession does not perceive that the notifications process is conducted in a "transparent, accountable, efficient, effective and fair way".

AMA Victoria informed Ahpra that members report that:

- » The notifications process is commonly perceived as a "black box".
- » Terminology used by Ahpra in the notifications process is unclear to external parties.
- » Practitioners do not receive realistic, regular and informative updates around accurate expectations of timeframes and outcomes.

- » There is a lack of clarity on how the internal process of assessment of a notification proceeds.
- » IMGs are particularly vulnerable when receiving a notification because they are not familiar with the supports available and are very concerned about the impact on employment opportunities, their visa and ability to stay in Australia.
- » The notifications process does not appear to consider the factors affecting "shared decision making" conducted by a doctor who is under supervision, such as an intern or an IMG.
- » Where delays in resolving notifications leave a doctor unable to work, this can leave them without income and create recency of practice issues. The impacts of this can be unfair and inequitable.

AMAV asked Ahpra to acknowledge these concerns and provide advice on what actions can collectively be taken to address and resolve them.

### AHPRA – RACISM AND RACIAL LITERACY

AMA Victoria has contacted Ahpra regarding what active steps Ahpra and the Medical Board of Australia are currently undertaking to ensure:

- » the development of a culturally safe and respectful health workforce
- » adequate levels of racial literacy within Ahpra notifications staff.

In this communication, AMAV underscored the AMA's staunch opposition to racism and all forms of discrimination, including bullying, bias, and persecution, whether direct or indirect. Additionally, the letter emphasised the detrimental impact of racism and discrimination, which can exacerbate the health burden faced by medical professionals and their patients.

### AHPRA – SEEKING CLARITY REGARDING WITHDRAWN AND RESTRICTED RIGHT TO PRACTICE

AMA Victoria has contacted Ahpra to seek clarity on the expectations of Ahpra and the Medical Board in relation to medical practitioners' declarations and disclosure requirements about withdrawn or restricted right to practice.

This query arises following an Ahpra *Nursing and Midwifery Board Fact Sheet* from April 2021 which clearly articulates that there is not a requirement for nurses to declare in the circumstances described and that Ahpra would not pursue for failure for a nurse to do so unless and until their right to practice has been withdrawn or restricted based on their conduct, professional performance or health. That Fact Sheet clearly clarifies the expectations in Ahpra's *Notice of Certain Events* document for nurses and midwives, but AMAV is not aware of clarity on whether this applies to medical practitioners or whether Ahpra and the Medical Board have the same expectations for medical practitioners.

AMAV continues to await clarification from Ahpra.

### ENSURING INCLUSIVITY AND OPPORTUNITY FOR TRAINEES ON PARENTAL LEAVE: ADVOCACY REGARDING EXAMINATION SITTING AND APPLICATIONS WHILE ON PARENTAL LEAVE

Beginning in 2023, AMA Victoria, spearheaded by President Dr Jill Tomlinson, has advocated to change the policies of certain colleges excluding trainees who are on parental leave from applying to sit and sitting fellowship examinations. In our view, policy change that allows trainees who are on parental leave to apply to sit and to sit for fellowship examination would promote a culture of inclusivity, diversity, and equal opportunity.

AMAV's efforts resulted in [RANZCO](#) and the [AOA](#), respectively, reversing (RANZCO) and amending (AOA) policies which prevented trainees to apply to sit, and to sit examinations while on parental leave.

Most recently, as a result of Dr Tomlinson's advocacy, we are delighted to advise that the RACGP has confirmed that they have changed their [Fellowship Examination policy](#) so that it is in line with AMA policy on flexible training.



### MEDICARE BILLING FRAUD CLAIMS

AMA Victoria is aware of the further Medicare Billing fraud claims aired on ABC's Four Corners program in April. Last year an [Independent Review of Medicare Integrity and Compliance](#), commissioned by Federal Health Minister Mark Butler, found "legislation, governance, systems, processes and tools are currently not fit for purpose and, without significant attention, will result in significant levels of fraud." The Medicare Integrity Report was authored by Dr Pradeep Philip, who attended our March 2024 Council meeting as part of AMA Victoria's ongoing work to address systems problems in Victoria related to Medicare Billing compliance systems problems including duplicate payments and rejection of unnamed GP referrals.



## INQUIRY INTO VAPING AND TOBACCO CONTROLS

AMA Victoria has provided a submission to the [Victorian Parliament's inquiry into vaping and tobacco controls](#).

Noting that the regulation of vaping and tobacco products remains a significant concern for medical practitioners and their patients, the submission outlines concerns regarding the regulation of vaping and tobacco products, stressing the health risks associated with their use, especially among youth. It highlights trends in vaping and tobacco use, noting increases in vaping, particularly among young people, while tobacco smoking rates have been gradually declining. Additionally, the submission details that tobacco smoking imposes significant costs on healthcare and the economy, while vaping is seen as a cheaper alternative, albeit with health risks such as lung disease and nicotine addiction.



*More: AMAV Hub*

## REPORTING RESTRICTIVE INTERVENTIONS COMMENCES

Legislative changes requiring Designated Mental Health Services (DMHSs) to report the use of restrictive interventions, including chemical restraint, in Emergency Departments (EDs) and Urgent Care Centres (UCCs) to the Chief Psychiatrist, came into effect on April 1st.

AMA Victoria has [consistently](#) kept members informed of its meetings with the OCP, the Department, and the Mental Health Minister's Office to discuss the implementation of the Mental Health and Wellbeing Act in these areas. AMAV's goal was to ensure that this process occurs as seamlessly as possible, with early reports – or lack thereof – indicating that the lessons from the Act's initial haphazard implementation in designated psychiatric wards in September 2023 were heeded.

## E-SCOOTER UPDATE

AMAV has [previously](#) informed members of its advocacy on e-scooters, recognising them as a sustainable mode of transportation. However, AMAV has also highlighted the significant contribution of e-scooter-related injuries to Emergency Department overcrowding and hospital access block. Given this concern, AMAV has contended that it is necessary to undertake further steps to mitigate e-scooter accidents and reduce their healthcare burden.

In this context, AMAV welcomes (and indeed likely had some influencing in shaping) the Victorian Government's recent [announcement](#) to extend the current e-scooter trial for the next six months. This extension aims to explore additional safety and compliance measures before implementing permanent regulatory settings later this year. The goal is to ensure that e-scooters become safer for all road users.

AMA Victoria remains committed to collaborating with the government to improve e-scooter safety for all road users and pedestrians.

## SAFESCRIPT REVIEW

AMA Victoria has provided feedback to the Department of Health/Deloitte's review of the SafeScript real-time prescription monitoring system, expressing support for its ongoing use.

However, our submission highlighted the following as areas for improvement:

- » Inclusion of medications like methadone in SafeScript: concerns were raised about methadone not being monitored, leading to issues during times when regular avenues for prescription access are closed.
- » Lack of information: challenges were noted in verifying crucial medication details, especially during after-hours or when pharmacies are closed, impacting emergency settings.
- » Accessibility and connectivity issues: dependence on reliable internet and phone services posed challenges for prescribers, particularly in settings with limited connectivity. Issues with hospital ICT systems further hindered SafeScript's effective use.

AMA Victoria will keep members update on the progress of the review, including its final recommendations.

## VCAT – MEDICAL REPORT TEMPLATE – GUARDIANSHIP LIST FORM – UPDATE

AMAV has previously informed members about concerns raised by AMA Victoria regarding what we perceive as a common practice at VCAT. This practice involves 'requesting' medical practitioners to complete a form titled "Medical Report Template - Guardianship List" while remaining silent on the payment of fees and unclear on legal protections for practitioners.

We noted that this practice is unfair, inappropriate, and, in the absence of explicit legal protection on the form,

potentially exposes doctors to unnecessary legal risk.

To address these concerns, we have been working with VCAT to develop a revised form, now updated on VCAT's website.

The updated version explicitly states that providing VCAT with a medical report means a practitioner is considered a witness with legal protections as defined by the VCAT Act. The revised form also makes it clear that medical reports can be provided in alternative formats, and includes a section for practitioners to note costs incurred, though VCAT still refuses to pay for practitioners' time.

AMAV has advised members that while, ultimately, VCAT has the authority to request a report (as stated in the revised form), members are not required to provide a medical report unless specifically directed by an order from VCAT.

This initiative is one of several being pursued by AMAV to reduce the administrative burden on GPs and other medical practitioners.

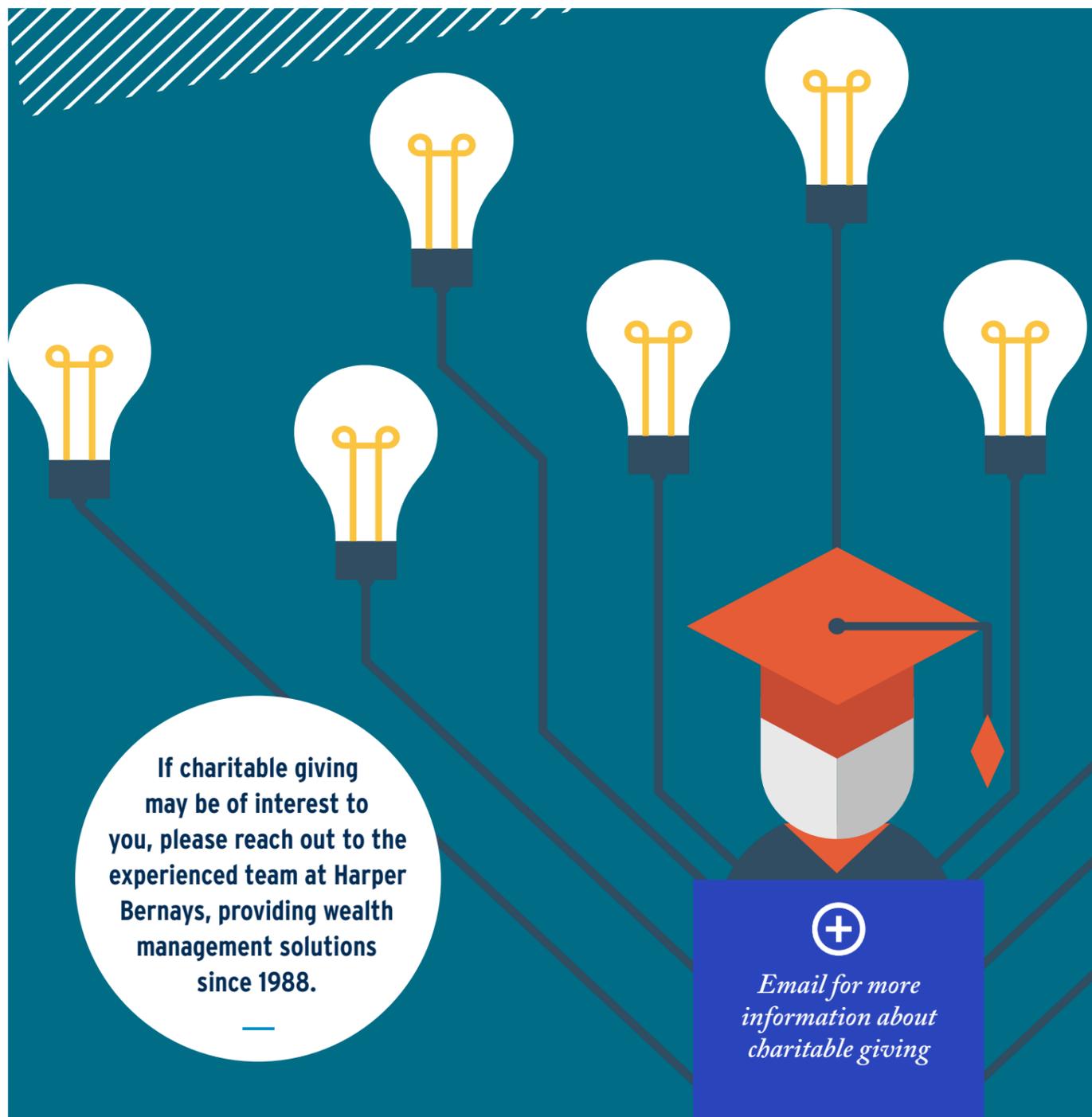
## VACCINE ORDERING UPDATE

AMA Victoria has [previously](#) written to members regarding the current availability of flu and COVID vaccines. We relayed that many practices have expressed frustration, stating that they have been unable to place orders for weeks, resulting in numerous instances of turning away patients due to insufficient supplies. We further informed members that we reached out to the Victoria Department of Health to explore ways in which we can collaborate more effectively to achieve the crucial goal of enhancing vaccine access.

The Department has subsequently advised that National Immunisation Program (NIP) influenza vaccine ordering limits have been lifted, marking a significant success for AMA Victoria's advocacy.

# DRIVING CHANGE THROUGH EDUCATION

**Jack Middleton MBE was a doyen of the electrical contracting industry. He had a passion for mentoring and had a strong commitment to education, both for his own family, and for those in the electrical contracting industry.**



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Jack completed an apprenticeship with Norman Bell & Co (later part of GEC and subsequently, O'Donnell Griffin), in July 1945. He then started his own business, and in 1946 formed a partnership with Lionel Kennedy. With their partnership, one of the great names in the history of electrical contracting in Queensland was born – Kennedy and Middleton.

Over three decades the company became a substantial force in electrical contracting. It was publicly listed on the stock exchange in 1977 – Kennedy and Middleton Industries Limited. In 1979, a tie up with Barker and Taylor created Kennedy Taylor, a national contractor with branches and manufacturing facilities in Brisbane, Melbourne, and Sydney. The company was a substantial employer and trainer of apprentices. Jack retired from Kennedy Taylor in 1984.

In the 1986 Queen's Birthday Honours list Jack was made a Member of the Order of the British Empire (MBE).

Sadly, Jack died in November 2013. At Jack's celebration of life event, an electrician who Jack had nurtured as a young apprentice more than 50 years before said, "Jack was a great mentor during my time as an apprentice, and he was the best boss I ever had."

Following Jack's death, his family established the Jack Baxter Middleton Scholarship with Queensland University of Technology (QUT) to honour his memory and his lifelong commitment to education and training, and to foster the education of future leaders in industries related to electrical engineering.

The scholarship, first awarded in 2017, quickly established itself as a prestigious scholarship. It is awarded annually to an outstanding engineering student completing first year undergraduate studies and moving into an electrical engineering speciality.

The inaugural recipient of the scholarship was Somayeh Hussaini. Somayeh's parents were from Afghanistan, and she was born in Iran. The family were displaced at this time, and registered with the United Nations to become refugees. Somayeh learned English at a community centre for refugees in Malaysia and after just one year began teaching others.

Somayeh and her family were accepted by Australia in 2013. When they arrived in Brisbane Somayeh started school for the first time, beginning in Year 10. Her maths teachers encouraged her to go to an engineering camp for high school students, where Somayeh became very interested in mechatronics engineering. She applied and was accepted to study a Bachelor of Engineering (Mechatronics Engineering) at QUT. After her first year of study, Somayeh received the inaugural Jack Middleton Scholarship in 2017.

Since then, Somayeh has gone from strength to strength, and graduated with first class honours. She is currently undertaking her PhD studies at QUT Centre for Robotics in perception and localisation for robotics and autonomous vehicles. Somayeh is a strong advocate for young women studying STEM, especially those from migrant backgrounds.

The Middleton Family are actively engaged with the award of the scholarship, as well as building and nurturing relationships with alumni. They are delighted with the career path and development of its first recipient.

The family has endowed an account within the Harper Bernays Charitable Trust to underwrite the funding of the scholarship in perpetuity.



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# UNDERSTANDING THE Ahpra PROCESS

**PROFESSOR  
STEVE  
ROBSON**  
—  
AMA PRESIDENT

**80%**

of notifications are made by patients or their relatives or advocates

**7.2%**

of notifications are made by fellow practitioners

**78%**

of cases Ahpra has managed to resolve in under six months

## THE AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

**W**hen an Ahpra notification is made against a medical practitioner, it can understandably be an extremely distressing and confusing experience.

The whole process is often described as a “black box”, where there is a vacuum of information and transparency about what happens with each notification.

It can also be a very lengthy process, leading to significant mental health issues for doctors who feel they have a dark cloud hanging over their heads for an extended period.

It is important to know that if you receive a notification, you are not alone. Most doctors will receive at least one notification against them during their careers, with around five % of doctors receiving one each year. While over 60% are resolved with no findings against the practitioner and only 0.7% result in cancellation or restrictions to registration, the uncertainty and lack of understanding about the process can make it worse than it should be.

Limiting the impact of the notification process is one of the AMA's main goals in our advocacy and work related to Ahpra. Improving understanding by shining a light into the black box is one of the ways we aim to do this.

In March, we hosted a member-only webinar with Matthew Hardy, National Director of Notifications at Ahpra. Mr Hardy pointed to several improvements to the Ahpra process that he directly attributed to the AMA's long-standing advocacy and continued engagement with Ahpra.

For example, having a single case manager assigned to each case, having more doctors involved in assessing notifications, and placing a greater focus

on practitioner health and wellbeing throughout the notification process are all direct results of AMA advocacy.

Mr Hardy acknowledged the Ahpra notifications process is a vexed issue for many doctors, but the first step of understanding the process is acknowledging that the National Law, which is a creation of all the state and territory health ministers and has been passed separately by the parliaments of each jurisdiction, says a notification is classified as any concern about a practitioner's health, conduct or performance.

These parameters are extremely broad, and it's important to understand there is not necessarily a high threshold for a notification to be made, but Ahpra is obligated to accept a notification if it meets just very basic requirements. This means the assumption that only serious matters can be reported to Ahpra is incorrect.

Mr Hardy also shared some illuminating statistics that should put to bed some misconceptions about the notifications process.

For example, more than 80% of notifications are made by patients or their relatives or advocates, and just 7.2% are made by fellow practitioners. Of all notifications made, just 10.4% are mandatory, which may arise out of concerns about a practitioner's health status, drug or alcohol misuse or sexual misconduct.

In its most recent reporting period, Ahpra has managed to resolve 78% of cases in under six months, which is a considerable improvement on where things were before, and they have ambitions to resolve the vast majority of cases within three months.

## AHPRA

Ahpra takes “no further action” in 70% of cases it deals with.

When it comes to vexatious notifications – these accounted for less than 1% of all notifications.

In March last year, an Ahpra commissioned study identified 16 deaths and four instances of attempted suicide or self-harm among practitioners who were subject to regulatory notifications within the four-year study period from January 18 to December 2021. This is 20 cases too many. Strong actions are needed to address the distress and harms caused by the notification process.

Following the release of this study, the AMA wrote to all health ministers to call for the following measures:

- » mandate, either through a Ministerial Directive or changes to the National Law, that Ahpra has a duty of care to the Registrant and in particular a duty to minimise the mental health impacts and financial effects on the health practitioner who may be subject to a notification
- » require Ahpra and the Medical Board of Australia to offer confidential support by an independent mental health professional to any health practitioner under investigation
- » require all investigations to be completed promptly – with an average target of less than six months except in exceptional circumstances
- » ensure that a practitioner has the right to be personally present and to be legally represented during all stages of the investigative process – with the practitioner or their legal representative having the full and unfettered right to support their case.

While Mr Hardy acknowledges it is “almost an impossible task to avoid a notification” at some point in your career, he stressed Ahpra is not focused on punishment and the statistics show being the subject of a notification is by no means a career ending event.

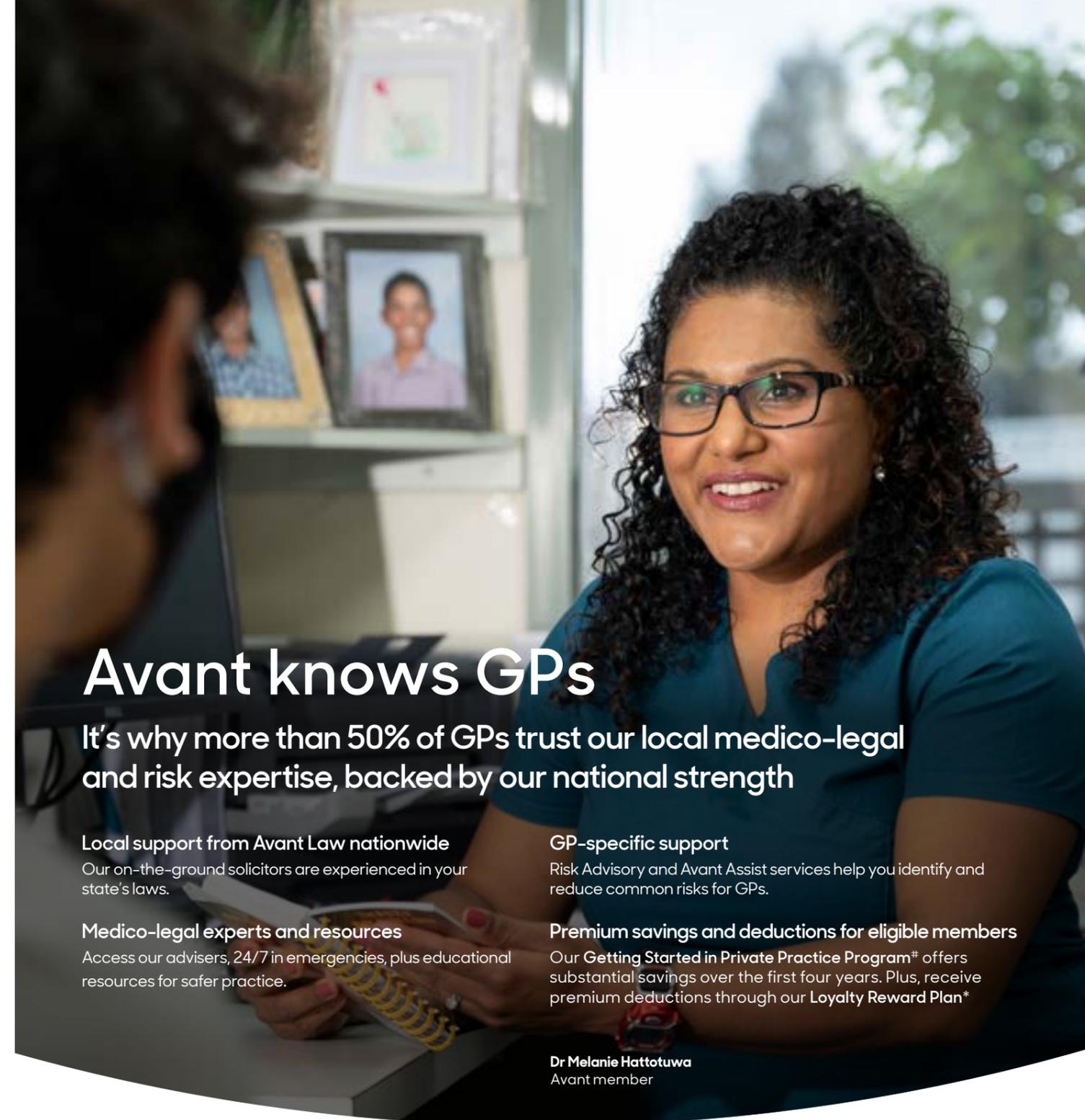
He also pointed out that many patients who make a complaint say they would complain directly to the practice in question if they knew they had an internal complaints procedure.

While AMA advocacy over several years has led to significant improvements in the Ahpra notification processes, there are still improvements to be made and we will continue to work with Ahpra and the Medical Board to achieve them.

The AMA will continue to engage with Ahpra to ensure notification processing times continue to come down – with vexatious or frivolous notifications being identified and dealt with at the earliest opportunity.

The real challenge is with the health ministers who oversee the National Law and direct Ahpra in the work they do. The AMA continues to advocate for amendments to the National Law to improve the treatment of registrants.

If you do receive a notification, it is important to note there is help available. The Drs4Drs service is available 24/7, providing free, safe, supportive and confidential assistance. If you are struggling under the weight of an Ahpra notification, there is no need to suffer in silence. If you missed the AMA’s webinar with Matthew Hardy, National Director of Notifications at Ahpra, you can watch a replay here: <https://www.ama.com.au/ama-rounds/29-march-2024/articles/revisit-weeks-member-only-ahpra-webinar>



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# AS THE DAYS BECOME DARKER, LET'S PUT A VALUE ON NATURAL LIGHT

As we head into Melbourne's colder and darker months, the value of natural light becomes ever more apparent.

We all love a property with sunlit rooms and conventional wisdom intones that such a property will be more valuable than a darker one, all other things being equal. But when selecting a property, what weight should an investor attach to good natural light, and is some light better than another type of light?



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Let's start with a brief look at the mechanics of sunlight. As a southern hemisphere land, the sun sits in the north of the Australian sky, travelling an arc each day from the east at sunrise to the west at sunset. Consequently, north-facing rooms receive more unshaded light over the day than their south-facing counterparts. This advantage is accentuated on winter days due to the sun's lower trajectory in those months, leaving many south-facing locations in shade much of the time.

Estate agents' sales literature will rave about properties with north-facing gardens because experience shows that buyers gravitate towards a well-lit outside area and adjoining entertainment rooms. In some respects, the 'north-facing garden' has become short-hand for an ideally sunlit property. The reality is more complex than that.

There are some rooms where good sunlight is more important than others – bathrooms for instance. Having a shave in a sunlit bathroom is a breeze compared to using artificial light, and no doubt it is the same for women when applying makeup. In contrast, no one worries about a dark loo! As well as light, the sun also brings heat. In winter and spring, sunlight streaming through a window can be delightfully warming. But on a hot summer's day, a sunlit room can feel as hot as a glass house. Typically, the sun's heat is most intense and persistent in the afternoon and even well into the evening during the longest days of the year. Rooms with north-west facing rooms can swelter in these conditions.

Often you want light without heat, such as in bedrooms and living spaces. You certainly do not want western light upon a wall where artwork hangs as the hot, bright, sustained heat and light denigrates canvasses over time.

So, when assessing a property, investors (and particularly home buyers, for that matter) will want to consider the floor plan and look at the orientation of various rooms, rather than just the aspect of the garden or the front of the property.

Saying all that, if a property receives a reasonable amount of light over the course of a cloudless day – be it northern, easterly, or westerly light – don't reject it because the aspect isn't perfect.

Little or no sunlight can be grounds for rejecting a property for both investment and home-buying purposes and can mark down the value of a property by several tens of thousands of dollars. The issue is more prevalent with apartments and especially high-density apartments in high-rise blocks.

Rejecting a property because it is gloomy is often an open-and-shut case. As soon as you walk into the property it is clear that the place is beyond redemption.

Occasionally, there is a property where the problem can be remediated. Options include installing more windows and skylights, replacing solid wooden doors with glass-filled ones, hanging mirrors to reflect light into dark corners and using pale colours for walls and floors. Note that the options are usually far more limited in an apartment than in a house.

Sadly, in practice, it is rare to find a truly gloomy property where remediation sufficiently improves the light quality and does it within a reasonable enough budget to justify the expense.

In today's market, some buyers may be tempted to compromise on 'light' to secure a well-located property at what looks like good value.

That is invariably a mistake. The property may appear cheap, but it will underperform. So, if on first inspection your gut tells you a property is too gloomy, trust your instincts and move on.

## GET INVOLVED

# AMAV SOCIALS



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

### Dr Eleanor Chew OAM

[On [AMA Victoria's petition](#) for fair and equitable healthcare registration fees]: Thank you for promoting this cause. So important to support our healthcare workers.

### Victorian Psychologists Association (VPA)

[On [AMA Victoria's petition](#) for fair and equitable healthcare registration fees]: Thank you AMA Victoria for progressing this campaign. This directly impacts our psychology members. We strongly support the campaign.

### Aaron Barnes

[On [AMA Victoria's petition](#) for fair and equitable healthcare registration fees]: Great cause and needs attention thanks for bringing to awareness.

### Dr Katherine Miller MBBS (Hons) FRACP

[On [Victoria not achieving its elective surgery waiting list targets for five years](#)]: Watching my patients move into residential aged care because they can no longer walk, due to long waiting list times has to be one of the most heartbreaking parts of my job. Thank you for advocating.

### Michael Myers

[On Crazy Socks 4 Docs Day]: A very special day of the year felt all over the world. We honour all healthcare professionals for their commitment and service. And we remember those lost and their families. Special thanks to Dr Geoff Toogood for his candour, focus, inspiration and leadership.

### Emily Amos

[On the results of [a survey](#) by hundreds of doctors by Australian Salaried Medical Officers' Federation (ASMOF) Victoria]: "You cannot change what you do not see".

As confronting as these figures are I am hopeful for the change that can come from knowing them.

### David Tse

[On the results of [a survey](#) by hundreds of doctors by Australian Salaried Medical Officers' Federation (ASMOF) Victoria]: If a hospital setup a system to make it difficult to claim hours worked, it's wage theft. I have never known a politician or a hospital CEO to go without, and you're far more important. Contact the AMA if you feel you're not getting paid properly.

### Tilak Dissanayake

[On [Dr Rosalind \(Ros\) Terry's pioneering story](#) published in the previous issue of Vicdoc]: Great work Ros, I remember you at the Alfred ED those days!! You come from a great school too!!

Dr Lakshinie Gunasiri [On [Dr Sarah Arachchi's article](#) on the additional barriers faced by women of colour in medicine and the power of role models]: Timely topic and inspirational!



### Kay Dunkley

(@M\_Kay\_Dunkley) #crazysocks4docs it is "Crazy Socks 4 Docs Day" and we need to keep working to reduce stigma for those working in health care who experience mental health issues. The suicide rates for health care workers are too high. Keep on campaigning @gdtoogood @amavictoria @amapresident



### AMA Victoria

Before heading to the operating theatre, AMA Victoria President Dr Jill Tomlinson dons her best and brightest odd socks for #CrazySocks4Docs Day. Crazy Socks 4 Docs Day is held to support doctors' wellbeing by bringing attention to the impact of stigma on healthcare workers who need to seek help for their mental health.

Join us in raising awareness, advocating for lasting change and turning talk into tangible action: [amav.me/crazysocks4docs](https://amav.me/crazysocks4docs)

### AMA Victoria

AMAV staff have worn their boldest and brightest socks in support of #CrazySocks4Docs Day today. Thank you to all members who have been contributing to conversations about doctors' wellbeing and working towards eliminating stigma for health professionals experiencing mental health issues. Remember that if you need assistance (today or any day), you can call these free and confidential services:

- » Lifeline: 131114 (for urgent assistance)
- » Victorian Doctors Health Program (VDHP): 1300 330 543 (24/7)
- » AMA Victoria Peer Support: 1300 853 338 (8am-10pm)



## DO YOU NEED CONFIDENTIAL SUPPORT?

Talk anonymously and confidentially with a medical colleague by phone for support for a range of issues.

AMAV PEER SUPPORT  
8AM-10PM EVERY DAY  
1300 853 338



*Learn more*

## WOULD YOU LIKE TO MEET WITH A VOLUNTEER MEDICAL COLLEAGUE?

The AMAV Peer Visitor Program currently has vacancies for older doctors who would enjoy some companionship from a volunteer medical colleague. Our volunteer visitors come from a range of backgrounds and include doctors and medical students.

AMAV PEER VISITOR PROGRAM



*Learn more*

# TAKE NOTE: THE LEGALITIES OF CONSULTATION TRANSCRIPTION SOFTWARE

As speech recognition and language processing technology improves, new software has recently come onto the market which automatically transcribes patient consultations into structured clinical notes. We have recently had a number of queries about the legalities of using this software in a medical practice.

REPORT NICHOLAS BLACKMORE, PARTNER KENNEDYS



*It is critical that practitioners who use consultation transcription software obtain consent from all persons who are present in the consultation – not just the patient – before using that software.*

There are two main issues to consider when using this type of consultation transcription software:

- » the need to obtain consent to the recording of the consultation under surveillance devices laws; and
- » the collection and handling of personal information under the Privacy Act.

#### SURVEILLANCE DEVICES LAWS

All Australian states and territories have laws regarding the recording of private conversations. The detail of these laws vary by state or territory, but generally speaking, it is a criminal offence to record a conversation without the consent of all of the parties to that conversation. In some states and territories, it is also an offence to possess, use or communicate such a recording, or any material derived from such a recording.

While consultation transcription software appears to produce clinical notes of the consultation almost immediately, it does so by making an audio recording of the consultation, which is sent to the servers of the software provider. That recording is then processed using artificial intelligence to produce the notes, which are sent back to the practitioner. While the audio

recording is generally deleted soon after that processing is complete, this process does amount to recording a conversation, and communicating that recording, for the purposes of surveillance devices laws.

As such, it is critical that practitioners who use consultation transcription software obtain consent from all persons who are present in the consultation – not just the patient – before using that software.

Most States and Territories allow the consent to be express or implied, verbal or written. However, given that failure to obtain consent constitutes a criminal offence, we recommend obtaining express written consent wherever possible.

For patients, this can be done through a new patient form. It is fine to obtain this consent once for all future consultations (provided that this is made clear on the form), but it is also important to bear in mind that the patient can withdraw their consent at any time, either for a particular consultation or for all future consultations. It may be more difficult to obtain consent from relatives or other people who accompany the patient in the consultation – this is probably best done at the start of the consultation, before the recording function is turned on.

The wording of this consent is also important. In several states and territories, consent needs to be obtained not only to the recording of the consultation, but also to the subsequent communication of that recording and of the clinical notes made by the software.

#### PRIVACY ACT

Most medical practitioners will already be familiar with the Privacy Act 1988, which governs the collection and handling of personal information, and applies to all Australian healthcare providers. As consultation transcription software records personal information about patients (and potentially other people in the consultation) and that personal information is sent to the provider of the software for processing, practitioners need to ensure that their use of this software complies with the Privacy Act in several respects.

Firstly, the practitioner's or clinic's privacy policy (under Australian Privacy Principle 1) and collection statements (under Australian Privacy Principle 5) should mention that the practitioner or clinic may disclose patient personal information to the software provider in the course of using the transcription consultation software (although it is not necessary to name the specific software provider or the specific software used).

Secondly, you should read the software provider's privacy policy and terms of service and ensure that you are satisfied that they will:

- » only use the personal information they collect for the purposes of generating the clinical notes and for no other purpose;
- » not disclose the personal information to any subcontractors or other third parties (or if they must, will ensure those third parties do not misuse that personal information);
- » delete (or at least anonymise) any personal information as soon as possible after they have generated the clinical notes; and
- » keep any personal information they do hold secure using appropriate security measures, such as encryption and access controls.

Thirdly, you should find out:

- » where the software provider is located, and whether it is subject to the Privacy Act or a similar data privacy law in another country; and
- » where the software provider stores the personal information it collects. It is important to note that if the software provider stores personal information outside Australia, then you may be responsible for notifying the Office of the Australian Information Commissioner and the affected individuals in the event that it suffers an eligible data breach. Your privacy policy may also need to state which countries the service provider will store patient's personal information in.

VALE DR STEWART BOOTH

# A LEGACY OF COMMUNITY CARE

Dr Stewart Booth was a GP, rural healthcare leader, and long-time AMA member who lived and worked in Swan Hill for more than 40 years. We had the honour of speaking with Stewart before he passed away earlier this year.

BY VANESSA MURRAY



## A LEGACY OF COMMUNITY CARE

**“HELLO VANESSA!” THIS IS HOW DR STEWART BOOTH ANSWERS THE PHONE WHEN I CALL HIM, RIGHT ON TIME, JUST A FEW DAYS BEFORE HIS PASSING.**

He tells me he’s had a “pretty good innings” and is keen to chat and share a few thoughts on the state of rural healthcare before he goes. Even though he’s a bit breathless and becomes tired as we talk, he’s chipper, and I get a sense of the man who fell in love with a community and way of life.

Stewart grew up in Pascoe Vale, Melbourne, and was the first medical person in his family. He had an older cousin who had severe polio, which inspired his interest in care and his ambition to improve healthcare for people from an early age.

He graduated from Melbourne University in 1976, became a fellow of the College of General Practitioners in 1980 and was further recognised when he became a Fellow of the College of Rural & Remote Medicine in 1998. At medical school, he enjoyed all his rotations but settled on being a procedural GP as it meant you got to talk to people, and you got to do a bit of everything.

“I decided the best solution was to go to a medium-sized country town where you could do all these things. I thought I’d better get some obstetrics training first – which I was a bit scared of, if I’m honest – so I did a six-month term at the Royal Women’s.”

Given he went on to serve as honorary director of obstetrics at Swan Hill District Health and delivered dozens of babies – including many by caesarean – this detail is as surprising as it is sweet. It’s also testament to his dedication and

determination to serve the Swan Hill community as best he could. And his best turned out to be rather outstanding.

He first settled in Sea Lake, a single-doctor town some 70 kilometres west of Swan Hill. It’s wheat belt country, and he admired its farmers (many who were veterans) greatly. He was able to develop his skills in surgery, anaesthetics and obstetrics here.

“At first, I’d travel to Swan Hill with patients I’d referred, and assist the physician or surgeon to perform a procedure. I was keen to be trained up and they were keen to train me up, and eventually it got to the point where they were assisting me.”

Stewart also met his wife, Gaye, in Sea Lake. Together they have seven children (four from Gaye’s previous marriage and three from Stewart’s) and 23 grandchildren.

After Sea Lake came Swan Hill itself, where Stewart lived from 1994 until his death on 23 January 2024.

Stewart was appointed as visiting medical officer at Swan Hill District Health in 1994. He was a GP at Swan Hill Medical Group and served as honorary director of obstetrics at Swan Hill District Health until July 2011, showcasing his expertise in the field of obstetrics and delivering many babies during his long career. He also provided his services as a GP anaesthetist, making himself available all hours to support emergency care needs as they arose.

Stewart went into semi-retirement in 2023 and planned to fully retire in 2024. He was looking forward to spending more time with his wife Gaye and their family, and to focusing on his health.

## A LEGACY OF COMMUNITY CARE



*A privilege to have had four generations of care provided by him to our family. A highly respected doctor who my grandmother worked alongside, to then ensuring both my grandparents had the best care in their later stages of life. Delivering my parents' four babies. This was not an uncommon theme for a wonderful family doctor.*

*Bec Delmenico*

But sadly, Stewart passed away a few days after we spoke, aged 71. His death came as a shock to the community he'd spent a lifetime serving, and there was an outpouring of grief from across the Swan Hill region, with hundreds recalling "generations of care" in local families.

"RIP Dr Booth. It will be hard to find a family in this area that hasn't had the privilege of his care and expertise over many years. It was so shocking and sad to hear of his passing. It will be felt by many," posted Carrie-Ann Robins on social media.

"A privilege to have had four generations of care provided by him to our family. A highly respected doctor who my grandmother worked alongside, to then ensuring both my grandparents had

the best care in their later stages of life. Delivering my parents' four babies. This was not an uncommon theme for a wonderful family doctor," posted Bec Delmenico.

One of his patients called for a municipal or state funeral, while another suggested the new emergency department being built at Swan Hill District Health be dedicated to Dr Booth.

"Dr Booth's impact on our community has been profound, leaving an indelible mark through his commitment to quality health care across our wider community," Swan Hill District Health said in a statement.

Vale, Stewart.

## STEWART'S ADVICE ⊕ REFLECTIONS

### ON SPOUSAL SUPPORT AND ACCESS TO CHILDCARE

"If you're a doctor in the country it's really important to have a supportive spouse. I've often seen colleagues who love the country, but their partner doesn't. They might be planning to be a specialist in Melbourne or Sydney, and that doesn't gel with the other partner wanting to live or work in the bush. It's an area of rural generalism that probably hasn't been looked at as closely as it could be. I think if we had a circumstance where there was spouse support, it would help to attract GPs to rural areas. We also need better and more reliable childcare for working parents, then seamless access into primary school. We had one doctor have to leave because she couldn't find what she considered adequate childcare."

### ON POLICY AND MEETING THE NEEDS OF RURAL COMMUNITIES

"I honestly think a mistake was made back in the 1990s, when they greatly reduced the number of medical school places in Victoria on the grounds that we could recruit overseas-trained doctors. Initially they came from the UK and South Africa, and then more commonly, from sub-Asia and Eastern Europe. While some of them are excellent doctors, they don't tend to want to settle in rural areas long-term. They move to Melbourne or Sydney the moment they're free to practice anywhere and I can't blame them for that, but it seemed a short-term solution when they started it, and that's been going on for 40 years now.

It's made general practice much less exciting for young graduates, and it's letting our rural communities down."

### ON HIS VISION FOR THE FUTURE OF HEALTHCARE IN SWAN HILL

"My aspiration would be to have a group of younger GPs in one or two practices that are keen to be brought up to extra skills through the hospital, particularly in A&E, obstetrics and general medicine. A&E is especially important as the Swan Hill Hospital has to reply on locums – that's not sustainable. They would work in the clinics but also spend some of their time covering the hospital. Then there would be another group of GPs who do GP stuff and provided some outreach services to surrounding towns, as we have a patient load that comes from an 80-kilometre radius. Some of that could involve Telehealth – preferably by video, as it's too hard to get a handle on your patient over the phone."

### ON RURAL GENERALISM AS A CAREER

"You get to be what I call a proper doctor, where you're caring for multiple generations of a family. You're caring for little patients that you've delivered, whose mother you'd looked after through her pregnancy. You'd been treating the grandparents for various chronic disease processes, and you'd probably have the great grandparents in care in one of the nursing homes. My view is that it makes for a very satisfying professional and personal life. Sometimes the two impinge on each other, but it's a good life."



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