

V I C D ⊕ C

AMA VICTORIA

WINTER 2021

A NEW CHAPTER

» CLASS ACTION
HOW DID IT COME TO THIS?

» MENTAL HEALTH REFORM
MEDICAL EXPERTISE ESSENTIAL

» RURAL MATERNITY
A CALL TO ACTION



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Dr Wilga Kottek
Anaesthetist, VIC

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References to articles available from the Editor on request.

15	18
22	26
30	32
40	42
46	50

CONTENTS



COVER IMAGE:
DR RODERICK McRAE
AMA VICTORIA PRESIDENT
PHOTO: JOE ARMAO/THE AGE

REGULARS

- 04 FROM THE PRESIDENT
- 07 NEWS, VIEWS + REVIEWS
- 52 FED FACTS
- 55 YOUR WELLBEING
- 56 MORE THAN MED

FEATURES

- 15 AN OPPORTUNITY FOR CHANGE
- 18 THE CLASS ACTION
- 22 SABOTAGING PATIENT CARE
- 26 EQUITABLE WORKING CONDITIONS
- 30 MENTAL HEALTH REFORM
- 32 EXTRAORDINARY LEADERSHIP IN EXTRAORDINARY TIMES
- 40 IMPAIRED ASSESSMENT
- 42 ADVERTISING + PUBLIC ENDORSEMENT
- 46 RURAL MATERNITY
- 50 INDIGENOUS HEALTH

KEEPING DOCTORS CONNECTED IS VITAL



DR RODERICK McRAE

AMA Victoria President

I am honoured and humbled to be given the opportunity to be President of AMA Victoria.

I grew up in Melbourne's south eastern suburbs and attended Monash University's medical school. Whilst there I became involved in the local Medical Student Association, following which, as a graduate in 1985, I joined the Australian Medical Association and became active in the (then) RMO subdivision (now the doctors-in-training subdivision), eventually becoming Chair of that group. When the AMA created a national doctors-in-training role I was elected to it and over six years helped lay the foundations for today's current Federal Council of Doctors-in-Training. I am a consultant anaesthetist in a tertiary Melbourne teaching hospital, overlapping with a private practice.

I still remember how stressful those doctors-in-training years were, and how too often, learning to be a doctor felt like a fight to prove myself superhuman, on so many fronts. I know many doctors share these feelings and the system that promulgates this must change – for the sake of both the doctors and patients. It's why the doctors-in-training class action is one of the most important steps we can collectively take to reform the workplace, both for those working in the system now and for those to follow. I look forward to continuing to strongly support this cause to drive the real structural reform we so desperately need, hand-in-hand with our current cohort of doctors-in-training.

It's fair to say my early experiences certainly sparked an enduring passion for workplace issues and industrial relations. Some of our younger members might not know how very close the medical profession came during the early 1990s to being absorbed into, and represented by, one healthcare super union. I fought hard then

to create a stand-alone union specifically for doctors, operated by doctors, and won. I am proud that here in Victoria, decades later, the medical profession is well represented - both at the bargaining table with the State Government and, more broadly, by AMA Victoria and conjointly with ASMOF Victoria, which represents all doctors working in the public health system across our state. I intend to carry on these traditions by representing and engaging with all doctors – listening and fearlessly taking your concerns to those in power who need to hear them.

As Chair of Federal Council from 1999–2001 and again from 2009–13, and as Vice President of AMA Victoria for the past three years, I am across the great many issues all doctors face in trying their best to deliver the highest quality of healthcare, under enormous, increasing pressures and expectations.

Problems for general practitioners, who are funded by the Federal Government but deliver care within a state-run health system, have never been more acutely evident than during this past COVID-19 year. Whilst it is extremely frustrating that this has not been resolved before now, the pandemic has uniquely shone a spotlight directly on this problem. The fact is that general practice is the spine of Victoria's protective COVID-19 vaccine administration. It has provided us with an opportunity to highlight to the State Government that it needs a meaningful two-way relationship with general practitioners and that it needs to collaborate with general practitioners to include their views and needs in planning and building an effectively integrated, efficient health system in Victoria.

It does finally appear that the Victorian Government is starting to listen and "get it", but there is so much more work to be done.

I will continue to personally hold the Victorian State Government accountable to this during my two-year term as President and I will also ensure, along with our AMA Victoria Board members, that the concerns of our Victorian-based general practitioners are also communicated to AMA Federal when requiring advocacy to the Federal Government.

Similarly, many issues are before private, non-general practitioner specialists, where much also falls to AMA Federal but AMA Victoria punches above its weight with influence at AMA Federal. We understand the implications for effectively small businesses and the impacts of pandemic management, including ceasing their ability to functionally operate. We have advocated for telehealth, likely to continue in perpetuity, and improvements related to private health insurance, but have opposed US-style managed care. This requires a consistent membership approach.

AMA Victoria must find ways for its members to connect with each other, build networks, share information and support each other. Whilst I regret online meetings will be a reality for some time yet, I am convinced AMA Victoria must keep connecting doctors from all walks of the profession. This is our true, hidden, value proposition – connecting regional and metropolitan-based doctors, private specialists with doctors-in-training; public hospital specialists with general practitioners – and we can best achieve this through our subdivisions. It will be a challenge, but over the next two years I am determined to resurrect our subdivisions and I am very open to your ideas on how best to achieve this. I am eager that, when it is safe, we can depart Zoom meetings and have the subdivisions physically meet, safely, with all sections of our medical profession interacting to inspire and support each other.

Over the next two years, as we weave our way through the COVID-19 global pandemic, members' occupational health and safety and industrial relations issues, as well as the safety of the community, will be front of mind for me and the AMA Victoria Board. Our chronically fatigued public health system (both physical and mental) suffers due to underinvestment over many years whilst the population has doubled, resulting in an acute public health system crisis and workforce issues that must be addressed, and which existed even prior to COVID-19.

I look forward to working with the other six members of the AMA Victoria Board to address these issues and more. It is a marvellous Board, with a mix of skill and experience, old hands and emerging future leaders. Very pleasingly, in line with our Constitution, a majority of women will lead our organisation.

I remain optimistic for the future of the medical profession as we all work together for others, as the ultimate public servants.

Dr Roderick McRae
AMA Victoria President

Dr Roderick McRae is an anaesthetist, intensive care physician, lawyer and bioethicist.

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NEWS, VIEWS + REVIEWS

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

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



NEW AMA VICTORIA BOARD

The new Board of AMA Victoria was elected prior to the AGM on Tuesday 25 May. The Board comprises a mix of previous directors and some new members as follows:

- » Dr Roderick McRae
President (2 yr term)
- » Dr Sarah Whitelaw
Vice President (1 yr term)
- » Dr Jill Tomlinson
Chair of the Audit, Risk and Compliance Committee (1 yr term)

- Directors without Portfolio:
- » Dr Enis Kocak (2 yr term)
 - » Dr Simon Judkins (2 yr term)
 - » Dr Alice Mizrahi (1 yr term)
 - » Dr Pearly Khaw (1 yr term)

Congratulations to the successful candidates.

AMA VICTORIA NOMINEE TO AMA FEDERAL BOARD

The AMA Victoria Board recently called for nominations from members for the position of AMA Victoria Nominee to the Board of Australian Medical Association Ltd, the governing body of AMA Federal.

Following the receipt of a number of high quality nominations, the AMA Victoria Board has appointed Dr Gary Speck to the position. Congratulations to Dr Speck and thank you to those members who nominated.

AMA SOCIAL



Join VMWS's free and confidential database to find out how you can make medicine work for you.
<https://vic.afmw.org.au/part-time-training/>



VCCC Alliance
Thanks to @amavictoria President Dr Roderick McRae for throwing his support behind the #gotcancer getvaccinated campaign on @TheTodayShow

Dr Sonia Fullerton ping @amavictoria - this resource will be very useful for doctors especially in regional #Victoria #palliativecare <http://pcas.org.au>

ADVOCACY PRIORITIES FOR THE YEAR AHEAD

We are pleased to share with our members AMA Victoria's State Budget submission, highlighting our priorities for 2021-22. Many of the funding requests outlined in our submission reflect our advocacy over the past three years, while those centred around addressing the acute health system crisis continue to be an urgent priority.

We look forward to constructively engaging with all political parties and the broader community on these important health issues in the lead-up to the State Budget and beyond. Our members and the Victorian community will be kept informed about the performance of the State Government in improving the health of Victorians through building and maintaining a world-class health system.

[CLICK HERE TO VIEW](#)

HOSPITAL HEALTH CHECK CONFIRMS CHRONIC ISSUES REMAIN

Despite the unprecedented circumstances triggered by the COVID-19 pandemic, the results from this year's Hospital Health Check (HHC) survey show a continuation of the chronic underlying issues reported by Victorian doctors-in-training (DiTs) in previous years. Unpaid work and fatigue due to working conditions continue to be major issues for DiTs. AMA Victoria is seeking urgent action from health services and the Victorian Government to rectify these issues.

The HHC quantifies issues experienced by Victorian trainees working in the public hospital system. The survey helps AMA Victoria identify workplace and cultural issues within public hospitals across the state. It also provides a way for AMA Victoria to monitor progress and improvements made by health services.

AMA Victoria sends report cards to each health service and requests written responses as to actions they are taking to make improvements. These responses are shared with members.

BREAKTHROUGHS

REPORT + READ + WATCH + LISTEN

REPORTS **BARRY LEVINSON**
REVIEWS **VARIOUS**



REPORT

Launch of world-first digital platform to support Australians living with young onset Parkinson's

More than 20,000 Australians aged under 50 years who are living with young onset Parkinson's are able to benefit from the recent launch of a world-first digital support platform.

Developed as a 'living lab' model, the Young Onset Parkinson's eXchange (YOP-X) is a free app and resource hub uniquely shaped by the first-hand knowledge and experiences of Australians with young onset Parkinson's. Available to patients, the YOP-X app can be downloaded for free from the App Store or Google Play, while carers, GPs and NDIS-contracted providers can access resources through the accompanying YOP-X website.

Dr Fiona Kerr, cognitive neuroscientist, founder and CEO of the NeuroTech Institute, and member of YOP-X project working party, said the YOP-X app will prove a critical support tool for those affected by young onset Parkinson's.

"Patients must not only face times of debilitating motor impairment, but must also contend with non-motor symptoms, including anxiety, depression, apathy and sleep disorders that can substantially compromise quality of life. The combination of information and support provided by the YOP-X app offers patients a holistic approach to addressing changes involving their work, relationships, sleep, physical ability and mental health," Dr Kerr said.

When the YOP-X Project commenced in January 2020, comprehensive scoping exercises highlighted a lack of resources, support and information for people with young onset Parkinson's both in Australia and internationally.

"YOP-X provides patients with easily accessible information, videos on various topics, including strategies to address their mental health and wellbeing, exercises designed to increase their strength and balance, and a series of educational videos by a relationship therapist," explained Research Lead, Wellbeing & Resilience Centre, South Australian Health & Medical Research Institute Mr Joep van Agteren.

The YOP-X website equips GPs and NDIS-contracted providers with the knowledge they require to better meet, and optimally fulfil, the needs of their clients living with neurological degenerative conditions.

The app allows the GP visit to be more informed, as it includes data collection and self-assessments that can be discussed together. In addition, data collected by the app can be emailed directly to the GP or the patient's treating specialist at any time.

YOP-X also includes an Australian-first tool – the NDIS Wallet, providing a fast track for patients to collect and collate information relevant to their NDIS applications, acting as a valuable workforce tool for NDIS staff and health professionals alike.

Visit www.youngonsetparkinsons.org.au for more information.

"YOP-X app will prove a critical support tool for those affected by young onset Parkinson's."
Dr Fiona Kerr



EMOTIONAL FEMALE

Yumiko Kadota
Published by Viking

Dr Yumiko Kadota was every parent's dream: model student, top of her class in medical school and on track to becoming a surgeon. A self-confessed workaholic, she regularly put 'knife before life', knowing it was all going to be worth it because it would lead to her longed-for career.

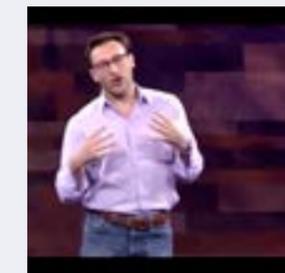
But if the punishing hours in surgery weren't hard enough, she also faced challenges as a young female surgeon navigating a male-dominated specialty. She was regularly left to carry out complex procedures without senior surgeons' oversight; she was called all sorts of things, from 'emotional' to 'too confident'; and she was expected to work a relentless on-call roster – sometimes 70 hours a week or more – to prove herself. Eventually it was too much and Yumiko had to quit.

Emotional Female is her account of what it was like to train in the Australian public hospital system, and what made her walk away.

DID YOU KNOW?

—#1—

The AMA is rated as Australia's most ethical member association



TALK

Leading with Empathy
Simon Sinek

Simon Sinek argues that leaders need two things – empathy and perspective. He says that the real job of leaders is not to be in charge, but to take care of people in their charge.

Empathy is being concerned about the person, not their work output. Sinek says we should support people to be their best by taking the time and care to understand where they are coming from. He explains that when something is going wrong at work (performance, behaviour, mood), we should recognise that we don't know why. We don't know everything that is going on in people's lives. So let's start from a place of perspective-taking and care, and ask, "Are you OK? Can you share with me a little bit so I can understand and help?" Leaders need to practise empathy and create an environment where people can speak up.



PODCAST

Speakola
Tony Wilson

Speakola is the home for great speeches on the web. Melbourne author Tony Wilson is the founder and curator of *Speakola*, which now hosts more than 2000 speeches, some famous – think Churchill, Obama, Gandhi – some not so well known.

In each podcast episode, Tony interviews someone who has written, delivered or studied a great speech to reveal the stories behind the scenes, to provide context to the historical moment, or in the case of eulogies, birthdays and other common events, to inspire people to hit new creative highs.

Tony also plays a 'speech of the week' to honour great words by great orators. Released fortnightly.

 [Click here for the Speakola podcast](#)

4150

Online participants in the AMA Victoria Medical Careers Expo

—117—

Number of Peer Support Service calls received in 2020

ENQUIRY

AT THE TABLE

Ten questions about the rewarding aspects of AMA Victoria Presidency.



ASSOCIATE PROFESSOR JULIAN RAIT OAM

Reflecting on his three years as AMA Victoria President, from May 2018 to May 2021.



01 What achievement are you most proud of as President?

Our Board gender quota given the outcome of our most recent Board election.

Mental health care reforms arising from the Royal Commission into Victoria's Mental Health System.

Renewed focus on our ageing health infrastructure with the funded proposal (\$1.5 billion) to rebuild Footscray Hospital.

02 What have you learned as President?

The relevance of the AMA as being a highly respected advocacy group.

The importance of focusing on the public policy issues rather than personalities.

How well the profession performs in a crisis.

03 What has been the most challenging aspect of the role?

Managing my time given all the demands of the media and members during the pandemic.

Keeping up with the medical literature and being able to communicate accurate and evidence-based information to the public and to the profession.

Lack of transparency from governments and their inability to learn from mistakes.

04 Would you do anything differently if you had your time again?

Write more opinion pieces explaining the science surrounding COVID-19.

Meet more members.

05 Were there any surprises?

My conversation with the Federal Health Minister, Greg Hunt, that was shared with the Prime Minister and contributed to the formation of National Cabinet.

06 Has the role changed you?

I am more patient and understanding of the challenges faced by various parts of the profession.

07 How would you describe the support from members?

I valued the advice of many medical leaders, especially those in the specialist colleges who supported me throughout my time as AMA Victoria President.



08 What, in your opinion, are some of the future challenges for the medical profession and for the AMA?

Maintaining adequate funding and restoring the primacy of general practice in Australia's healthcare system.

Ensuring that rural and regional medicine is encouraged as a career path.

Improving the working lives and wellbeing of all doctors-in-training.

09 In your time as President of AMA Victoria, what have you come to appreciate about the AMA that you didn't know before?

It's a force for positive change in public policy.

It prevents many disasters of which the membership are mostly unaware.

10 What is next for you?

Chair of Council of AMA Federal, which will enable me to still contribute to public policy.

Contribute to advocacy for the blind and vision impaired via my Board role with Vision Australia.



Click here to listen to A/Prof Rait's farewell at our AGM

SECOND OPINION

ASK THE EXPERT

“
How do you manage work-life balance and your wellbeing?
 ”



DR KYM JENKINS

*Interim Medical Director VDHP
 Chair CPMC
 Past President RANZCP*

To be honest I don't think much about work-balance. However, to lead a fulfilling life I know I need enough sleep and need to be as physically and mentally healthy as possible. Despite writing this late at night I've never studied after 10pm, and even when training or doing exams, I always had a day off each week to do something outside medicine.

What I find refreshes and recharges me has changed with time but has always included time with family and friends, I love being active outdoors, I enjoy sailing, skiing and hiking. Over the years I've not been good at listening to my body when it tells me to slow down, however during the pandemic I've come to realise more the value in being able to find time for being quiet and still.

“To lead a fulfilling life I know I need enough sleep and need to be as physically and mentally healthy as possible.”



MR ERIC LEVI

*Ear, Nose & Throat,
 Head & Neck Surgeon*

I often need to remind myself of the big picture. I work for my patients, not the institution. My work matters, yet I am more than my occupation. My work brings satisfaction, but my family brings meaning.

I am replaceable at work but not replaceable at home. I write. I journal. I eat, drink and be merry. I read books and watch movies. I walk. I engage in social and spiritual communities. I say no to things. I try not to be possessed by possessions.

I don't think I'll ever get the work-life balance perfect, because every season of life is different. Tomorrow will be better.

 *Check out Mr Eric Levi's website*

“My work brings satisfaction, but my family brings meaning. I am replaceable at work but not replaceable at home.”

Mr Eric Levi



DR DAN WILSON

*Rural Generalist & GP Obstetrics Trainee
 Chair, AMA Victoria GPs in Training Subdivision
 Chair, AMA Federal GPs in Training Advisory Committee*

I use my lived experience of coming back from burnout or near burnout (more occasions than I'd like to say) to continue to craft a balance between life and work. My tips for achieving wellbeing are:

- 1) **Learn to recognise your limits and boundaries.**
 Also know that it's okay to not be okay sometimes, but reach for help.
- 2) **Learn to accept defeat.**
 Many readers will be high achievers and with many personal and professional goals. Discover a way to come to terms with defeat (or coming up short) and move on to a means to achieve it later or drop altogether.

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



- 3) **Speak up and get connected.** Don't suffer alone when struggling to balance work commitments and personal commitments. Speak with friends, family, your manager, a colleague, your GP or anyone you trust can help support you through.
- 4) **Discover joy.** Whether its physical activity, leisure reading, reuniting with friends or just vegging out on the couch, dedicate time to switching off from work and make joy part of your everyday routine.

I'm not expert at it, but I've learned to recognise when I'm feeling the pressure, and have a support network of colleagues and friends that know when to tell me to stop, pull back and reinvigorate that joy.



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*Whilst stocks last. For information on the availability and prices of the C-Class Special Edition models, features, optional extras and/or colours available, contact your authorised Mercedes-Benz Retailer. ¹Corporate programme is available to approved corporations who meet the eligibility criteria and is available on selected new passenger cars only. The programme requires a minimum commitment over 24 months. ²Purchase of a Compact vehicle will attract a discount of \$1500.00 off the Manufacturer's List Price. Purchase of a Non-Compact Vehicle will attract a discount of \$2000.00 off the Manufacturer's List Price. Refer to the Terms and Conditions of the Mercedes-Benz Corporate Programme and Fleet Support for further details regarding which vehicles are considered to be 'Compact Vehicles' and 'Non-Compact Vehicles.' ³Available to customers who purchase a vehicle under the Corporate Programme on or after 1 January 2020. Access (including ongoing access) to Corporate Rewards is contingent on the customer holding a valid membership with the Mercedes-Benz Corporate Programme. Member Benefits is not a representative or agent of Mercedes-Benz and Mercedes-Benz accepts no legal responsibility for the Member Benefits website, any information supplied, or any goods or services provided by Member Benefits. ⁴Not applicable to all models.



HEALTH AND ECONOMIC BURDENS

— AN OPPORTUNITY — FOR CHANGE

It is incumbent on government and services to consider the changes we need in our healthcare system to **best address our challenges**. And we need to make and embed those enhancements now.

REPORT DR INES RIO
AMA VICTORIA GP SUBDIVISION



Although Australia's response to the coronavirus pandemic has not always been perfect, we still have much of which to be proud. The human and economic cost has been high, but not nearly as high as it could have been. And it has shown us time and again what we are capable of; from the millions who endured the many effects of lockdown to the tireless efforts of healthcare workers; there are many success stories from 2020.

However, there is no doubt we will be left with ongoing health and economic burdens that need acknowledgement and addressing. We have seen cancer diagnosis fall, fewer presentations to general practice for cardiovascular events, preventative health screening and chronic disease management, and more presentations for distress and mental health concerns.

All of these can be expected to have flow on effects in the next few years. Cancer stage progression, more end organ effects from vascular diseases and diabetes, and the impact of poor mental health on the wellbeing of individuals, families, and communities. It is incumbent on government and services to consider the changes we need in our healthcare system to best address such challenges. And we need to make and embed those enhancements now.

As a GP, I often tell registrars that clinically I almost always know what to do or can readily find out what to do. It's getting it done that is the hardest part. Which service will accept this patient? How long will they wait for an outpatient appointment? What happened at the hospital? Who can help me help the patient to increase their physical activity, get involved in social activities or get stable and safe housing?

So, what do we need to progress on? I think the following are crucial areas of system development that would make the care people receive improve overnight:

REFERRAL TO TREATMENT TIMES

The AMA has long argued for referral to treatment times for public specialist outpatient services. This is well established in the United Kingdom (see my article from 2019). Yet, I still have no idea when I refer patients to hospital how long they will wait for an outpatient appointment. And as any GP who needs to use public outpatients for their patients knows, this can be many, many months and even years. As we are likely to see increased demand on specialist outpatient services in the next few years, my patient and I need to know this so we can choose and modify management as needed. The Victorian Government should require this of all outpatient services in all public hospitals.

CENTRAL REFERRAL POINT FOR SPECIALIST OUTPATIENTS

It is becoming increasingly complex to know which health service does what and which 'catchment' of patients they will accept. Who does gastric banding? Who will do a breast reduction for pain? Who offers an allergy service? Who has a short wait time; who has a long one? What maternity service will accept a woman with a multiple pregnancy?

Hospitals in a region should link up and develop a central point for electronic referrals (yes, electronic please). This way referrals can be better managed according to the services and the wait times. It's been done in Western Australia for over a decade.

CONTINUUM OF CARE AND CENTRAL REFERRAL POINT FOR MENTAL HEALTH

The cost of mental illness in Australia is \$600 million a day, and only likely to grow with the ongoing fallout from the pandemic and recent drought and bushfires. I have argued previously that the problem in many areas is not so much the lack of services, but rather the difficulty for patients, families, and GPs and other care providers in finding a way through the maze of different providers and a lack of coordination between services.

From where I sit, a successful system development has been the HeadtoHelp service in Victoria. Announced by the Federal Government last August as a measure to support Victorians struggling through a protracted lockdown, it is run by Victoria's six Primary Health Networks. It consists of a state-wide single point intake service where patients, families or GPs and other health professionals can refer all but the most acutely unwell person.

The central intake service is staffed by experienced mental health professionals who (along with a referring GP if a GP has referred) make an initial assessment and determine the level of care required and then connect that person to the service.

- ▶ GPs still have no idea when they refer patients to hospital how long the wait will be for an outpatient appointment.
- ▶ It is becoming increasingly complex to know which health service does what and which 'catchment' of patients they will accept.
- ▶ The cost of mental illness in Australia is \$600 million a day and only likely to grow with the ongoing fallout from the pandemic and recent drought and bushfires.
- ▶ You can contact or follow Dr Rio via:
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Twitter: @InesRio1
LinkedIn: Ines Rio

If the past year has taught us anything, it is that when pressed, we can adapt our systems rapidly and effectively to meet a crisis.

[Click here to follow Dr Rio on Twitter](#)

At lower level acuity it may be mental health coaching, cognitive behavioural or talking therapy and mindfulness apps and social connection, at low-to-medium it may be referral to a psychologist or social worker for more structured psychological therapies. At medium acuity, it may be referral to more targeted supports including dedicated HeadtoHelp mental health hubs that have multidisciplinary teams that include mental health nurses, psychologists, social workers, alcohol, and other drug workers and at higher acuity, it's commonly referral to the regional hospital run mental health services.

This should be expanded, with HeadtoHelp also having access to psychiatrists and drug and alcohol medical specialists. This could then provide a 'single door' for most people into the vast majority of mental health services resulting in streamlined access and a greater continuum of care that meets the person's needs. It should also be extended (both the central intake model and the hubs), so that it is a permanent part of the system and continues to evolve in response to feedback from patients, families, GPs, and performance indicators. With the State Government considering its actions in response to Victoria's mental health Royal Commission, the time for this is ripe.

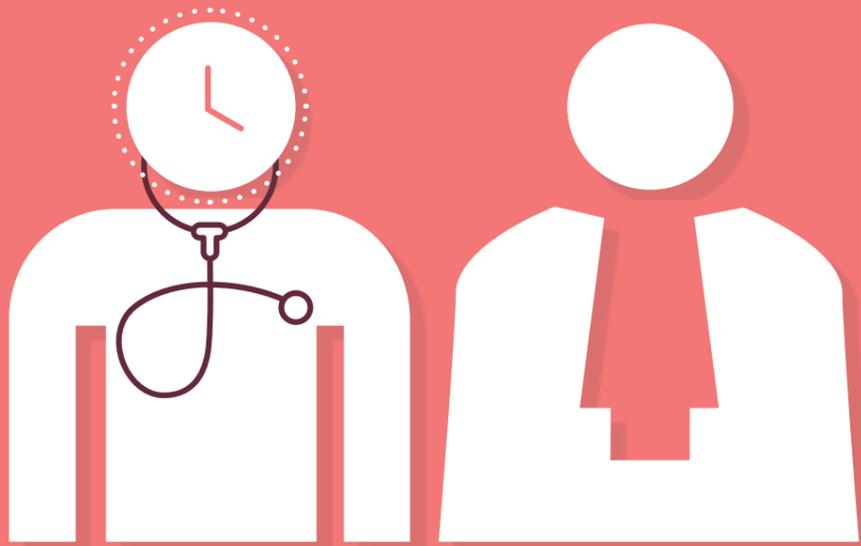
The COVID-19 pandemic is a key moment for Australian health, and provides an opportunity we must take. If the past year has taught us anything, it is that when pressed, we can adapt our systems rapidly and effectively to meet a crisis. Just as Victoria has evolved in leaps and bounds on systems for contact tracing in COVID-19 when it was apparent there were many failures, it is time to recognise failure in these other areas and make these measured changes which will have major positive impacts.

UNROSTERED OVERTIME: HOW DID IT COME TO THIS?

I know how easy it is to make a potentially catastrophic error, or miss something important, when deliriously exhausted during a shift.

It's hoped the launch of the current class actions will empower all Victorian doctors to collaboratively take action to change a deeply ingrained culture of ignoring, dissuading or punishing junior doctors who claim their unrostered overtime.

REPORT DR KARLA VILLAFANA-SOTO
AMA VICTORIA DOCTOR-IN-TRAINING SUBDIVISION
WORKPLACE RELATIONS ADVISER



- ▶ Anyone who has been a junior doctor in Victoria since January 2015 is eligible to register to find out more information about the class action.
- ▶ The process is completely confidential and you will not be pressured to proceed further if you don't want to.



A deeply ingrained culture of ignoring, dissuading or punishing junior doctors who claim their unrostered overtime (UROT) remains widespread in Victoria. Despite an Enterprise Agreement that describes in detail how junior doctors can claim their UROT, we work in a system that hypocritically prevents it.

There is much hope that the launch of the current class actions (so far against Peninsula Health, Monash Health and Latrobe Regional Hospital) will motivate Victorian health services to acknowledge overtime worked by junior staff, address the barriers faced by junior doctors when claiming un-rostered overtime, secure compensation for unpaid hours and drive positive change for the future.

Having worked in the Victorian public hospital system for several years, the thought of a loved one deteriorating in hospital and needing urgent medical or surgical attention terrifies me.

I know how easy it is to make a potentially catastrophic error, or miss something important, when deliriously exhausted during a shift which includes interruptions with referrals or questions every two minutes; when I'm the only doctor directly responsible for hundreds of patients after-hours, whilst dehydrated and rushing to attend to half a dozen competing priorities, on top of many more non-urgent tasks that are also piling up.

I also know the bitterness of having to make families wait for many hours before I have a chance to answer their questions about a patient who has a poor prognosis. The dread of facing relatives who have been waiting for over an hour for me to certify that their loved one has passed away, while I tended to medical emergencies elsewhere in the hospital. The guilt of letting my nursing colleagues down by not attending to their important but less urgent requests for many hours. The frustration of never being able to catch up on endless discharge summaries, despite staying back late every single evening and working as quickly as possible all day with no time for lunch. The uselessness of booking in any catch-ups with friends on a weeknight, because they will probably have finished by the time I get there.

I know the heartache of seeing a very competent intern come in to work on a day off to write discharge summaries, explaining to me that he would not dare claim because he was made to feel it was his fault for being too slow to finish them during his rostered hours; the shame of knowing that things have not changed to any significant degree since I was an intern seven years ago.

I know that all junior and senior Victorian doctors reading this will have experienced these things too. Worse than everything already mentioned, I have known too many times how deeply painful it is to muster up the courage to flag a dangerous workload by submitting a claim for the hours I've worked, only to be summoned to a meeting with my head of unit to be asked – directly and/or indirectly – why I'm claiming, since no other junior doctors ever claim. Perhaps what they are really asking me is why I am putting them in the difficult position of being asked to also stand up to a system that punishes them for approving those claims.

Junior doctors may incorrectly make villains of consultants who sigh disapprovingly, raise an eyebrow and shift uncomfortably when the junior tremblingly puts a claim form in front of them. Juniors could be forgiven for thinking that the consultant is angry at them, when actually they are worrying about being punished themselves. These class actions were put in motion to empower consultants, as well as junior doctors.

Our plea to junior doctors is this: please claim all of your UROT this coming week, and every week until you finish your training. It is about leaving a written record of the workload on your team, to allow the hospital to identify where rostering shortages exist. The first step is to find the UROT claim form and print it, in order to identify what information you'll need to keep a record of each day.

Anyone who has been a junior doctor in Victorian since January 2015 is eligible to register to find out more information about the class action. By registering, you will find out what you may be owed in unpaid wages. The process is completely confidential, and you will not be pressured to proceed further. The number of registrations submitted will determine the strength of our campaign to change out-dated practices and protect junior doctors and patients.



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A SYSTEM SABOTAGING PATIENT CARE

REPORT SURGICAL REGISTRAR
AMA VICTORIA MEMBER

A surgical registrar, who has registered to join the class action, outlines some of the challenges they have experienced, caused by unreasonable and unhealthy working conditions in the public hospital system. All doctors who register for the class action can remain completely anonymous, as this registrar has opted to do.



My phone jars me awake. I pick up the phone and look at the time before answering the call: 0030.

“Hello, this is ‘X’ speaking, registrar,” I mumble into the phone.

“Oh hi, I’m so sorry to bother you, but I wanted to discuss a patient with you – is now a good time?”

I resist the urge to point out that I was asleep, so **no, it wasn’t a good time**, and instead reply, “Sure, what’s the story?”

“Well, we have a patient here in ED, a 48-year-old woman with really bad abdominal pain. She’s requiring a lot of analgesia. The bloods aren’t back yet, but I was wondering if you think we should order a CT scan on her?”

I pause for a minute to remind myself that this must be a junior ED doctor, who presumably was feeling overwhelmed with her situation enough to feel more comfortable calling me, the sleeping on-call registrar (who will return to work for another 4-12 days straight with more overnight on-calls sprinkled in between) than speaking to any of her own awake senior colleagues in the department for simple advice. I respond that if she is concerned that the patient is unwell, and may have a surgical issue, then yes, a CT scan was warranted, but if she was unsure, it would be helpful to have a senior member of the department who was there with her review the patient to make a decision. She bid me a quick thank you and hung up the phone, while I sighed and tried to go back to sleep before needing to wake up at 6am for rounds.

As most registrars know, nights on-call can be peppered with calls like this, where the lines between urgent and non-urgent are often blurred. While frustrating, these nights are not inherently unsafe in the presence of a well-staffed team with a fair and even roster that has enough redundancy to account for necessary post-call days off in the context of a particularly busy night. This helps registrars avoid feeling the need to come to work on little to no sleep, potentially compromising patient care and safety and being ineffective in their role. Unfortunately, this is not the case in certain hospitals, and is often more prevalent in regional and rural hospitals where staff recruitment and retention are already an issue.

As a registrar with experience working in both metropolitan and regional centres, the expectation that regional rotations would be busy and challenging were founded by stories about understaffed teams, difficult personalities and payroll inaccuracies. Certainly, the most challenging aspect of the

role was the fact that the team was chronically understaffed at multiple levels.

For the high patient acuity and turnover, one HMO per team and a new intern, was certainly not enough to ensure patients were appropriately managed, along with the need for:

- 1) adequate communication, both to patient and family and other members of the healthcare team
- 2) paperwork such as transfer letters and discharge summaries being completed in a timely manner
- 3) non-clinical jobs such as journal club and audit presentations being completed monthly
- 4) attendance to structured teaching.

Chronic understaffing meant unpaid overtime was required to complete basic job duties, leading to burnout, frustration, and distress. On occasions, investigations would be missed, there was inadequate communication, and interpersonal conflicts between team members would arise, compromising patient care and doctor wellbeing.

At the registrar level, the chronic understaffing meant we would frequently come to work with just 2-4 hours of sleep, expected to complete another 12-hour workday or risk further overloading our stressed and overworked registrar colleagues. Due to the way rosters were organised, the most junior registrar would often shoulder most of the on-call duties during the week, and in the case of surgical registrars, this would compromise their ability to actually attend theatre and learn to operate.

It was a reasonable indicator that the roster of our department was unusually challenging when senior members from other departments felt the need to feed us because they knew we rarely had time to eat at work and

check-in on our mental health to ensure we were coping. It was particularly frustrating when issues like these were repeatedly raised to heads of department and executive members, only to be met with platitudes and promises, but ultimately no actions.

In order to protect trainees and patients from a system destined to sabotage staff trying to provide the best care they can to patients at the most vulnerable point in their lives, changes need to be made to ensure the system becomes more sustainable. This can be achieved by:

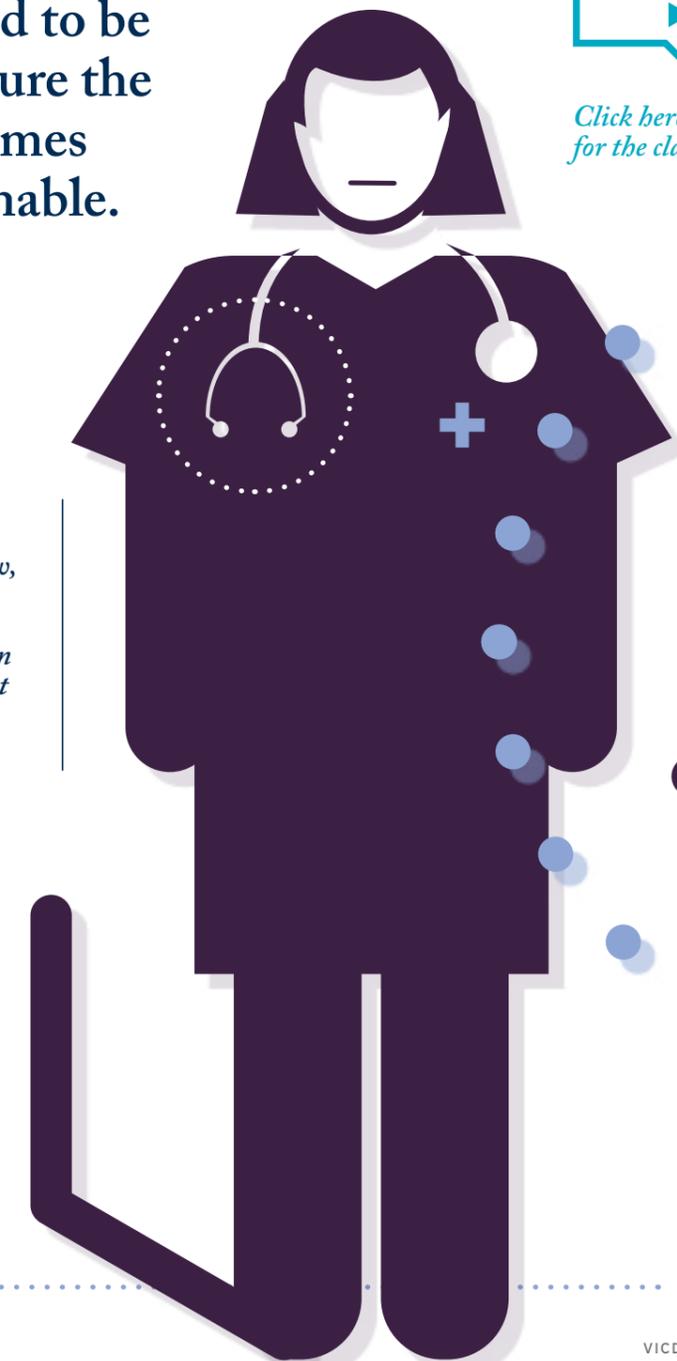
- 1) improving staff to patient ratios and workloads to ensure patients receive the care they need in a timely manner
- 2) ensuring healthcare staff receive adequate rest between shifts so that their decision-making skills and the quality of care they provide are not compromised
- 3) providing allowances in the roster for regular teaching to facilitate continuing upskilling and maintenance of clinical competencies to improve patient care
- 4) a transparent and non-punitive system for ongoing feedback between staff and hospital executives and workforce so that changes can be tailored to the health service.

Regional and rural healthcare offers so much potential for doctors hoping to broaden their skillset and challenge themselves in a professional environment requiring creative and lifesaving thinking in a facility with reduced resources. It can be, and should be, a rewarding experience for all. Unfortunately, this will not be the case as long as issues such as chronic understaffing leading to unsafe working conditions persist, and it will ultimately be our patients who suffer from the consequences.

In order to protect trainees and patients from a system destined to sabotage staff trying to provide the best care they can to patients at the most vulnerable point in their lives, changes need to be made to ensure the system becomes more sustainable.



As most registrars know, nights on-call can be peppered with calls, where the lines between urgent and non-urgent are often blurred.



- ▶ Chronic understaffing meant unpaid overtime was required to complete basic job duties, leading to burnout, frustration, and distress.
- ▶ Regional and rural healthcare offers so much potential for doctors hoping to broaden their skillset and challenge themselves in a professional environment



Click here to register for the class action

SEEKING EQUITABLE WORKING CONDITIONS

REPORT VICTORIAN PGY3 DOCTOR
AMA VICTORIA MEMBER
INTRODUCTION DR INES RIO

There is a culture among junior doctors to “grin and bear it”, rather than speak up about the issues that affect us.

After hearing of recurrent concerns in conditions and pay for GP registrars, in 2018 the AMA Victoria GP Subdivision passed a motion calling for GP registrar equity in conditions and remuneration compared with non GP registrars.

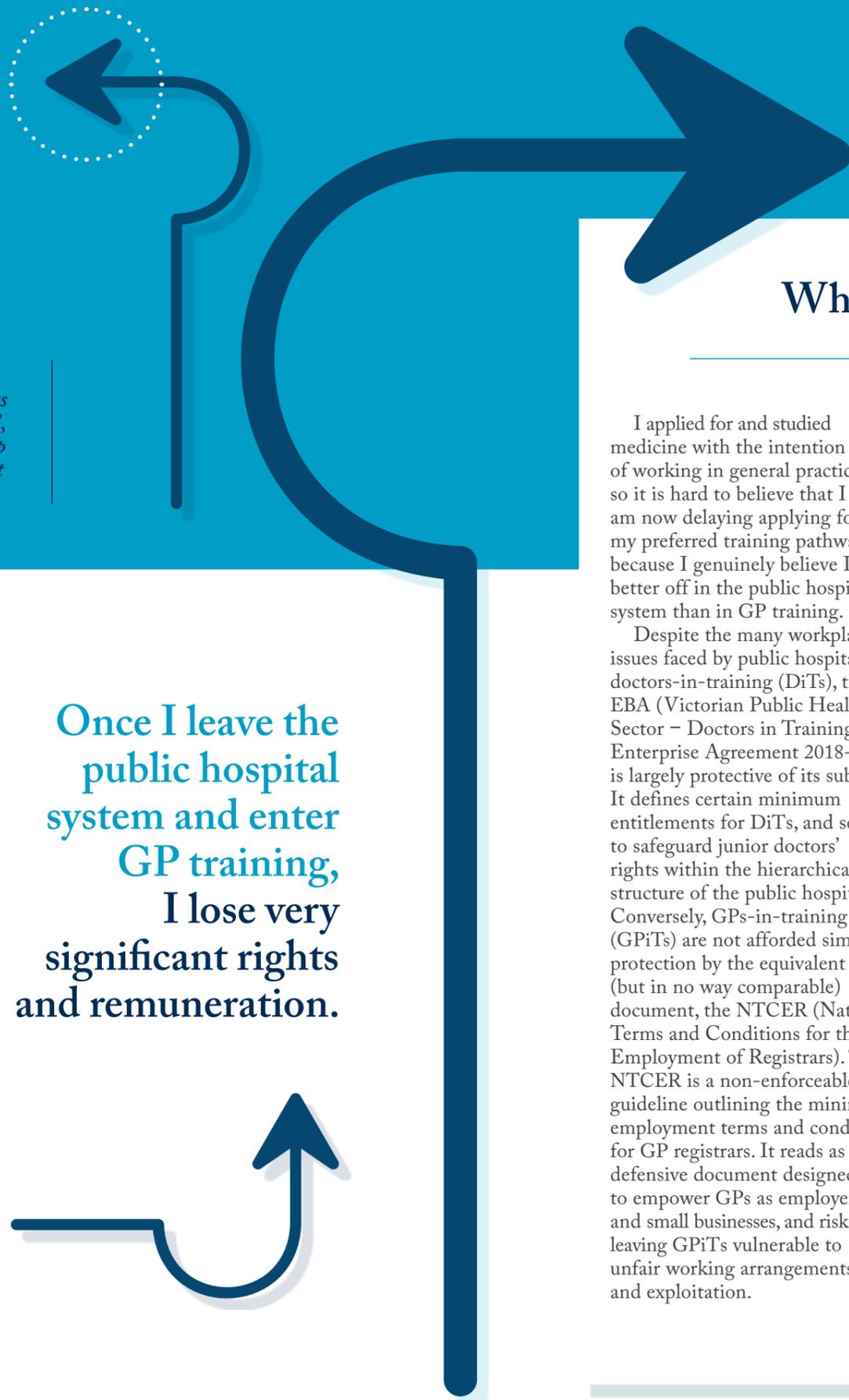
On behalf of the subdivision, I then shepherded this to the AMA Federal GP Council, who along with the Federal Council of Doctors-in-Training, supported the principle. This was then supported by over 95 per cent of delegates when passed as a motion at the 2019 AMA Conference.

AMA Federal has since been actively advocating for GP registrar equity in pay and conditions. However, this cannot come out of the pocket of general practice. It must be funded by government.

It is a fundamental element of ensuring a viable general practice and the reorientation of resources required for general practice. There is an overwhelming evidence base that this rebalancing would result in more equitable, more comprehensive, more affordable and better healthcare outcomes.

There have been recent reports that over 30 per cent of GP registrars now do second jobs in order make up for the lost income in moving from hospital to general practice settings. The following article was written by a friend's daughter. She wants to enter GP training, but for the moment the barriers are just too much.

Dr Ines Rio



▶ GPiTs are not afforded similar workplace protection to public hospital DiTs.

▶ The AMA is advocating for a single employer model to improve the remuneration and rights of GP registrars.

Why I am deferring GP training

I applied for and studied medicine with the intention of working in general practice, so it is hard to believe that I am now delaying applying for my preferred training pathway because I genuinely believe I am better off in the public hospital system than in GP training.

Despite the many workplace issues faced by public hospital doctors-in-training (DiTs), the EBA (Victorian Public Health Sector – Doctors in Training Enterprise Agreement 2018-2021) is largely protective of its subjects. It defines certain minimum entitlements for DiTs, and serves to safeguard junior doctors' rights within the hierarchical structure of the public hospital. Conversely, GPs-in-training (GPiTs) are not afforded similar protection by the equivalent (but in no way comparable) document, the NTCER (National Terms and Conditions for the Employment of Registrars). The NTCER is a non-enforceable guideline outlining the minimum employment terms and conditions for GP registrars. It reads as a defensive document designed to empower GPs as employers and small businesses, and risks leaving GPiTs vulnerable to unfair working arrangements and exploitation.

There is a culture among junior doctors to “grin and bear it”, rather than speak up about the issues that affect us. This is why junior doctors find ourselves in unsafe clinical situations for which we are ill-equipped; why we work excessive amounts of overtime; and why we go through the onerous task of reapplying for 12 month employment contracts every year. But staying silent does not facilitate change, and change is what is needed for GPiTs and the NTCER.

I am a PGY3 resident currently working in a tertiary public hospital in metropolitan Melbourne. Having had my first child at the end of medical school, I applied for and was allowed to complete my internship part-time over two years as part of a job-sharing arrangement. I have since worked full-time in an effort to gain experience in a range of areas that I see as important and relevant to a future career in general practice, and I am due to take several months' maternity leave for the birth of my second child in the coming months. I have to stop myself from writing, “I am lucky to have been afforded flexibility” in favour of writing, “I am covered by an award that has entitled me to fair and flexible working arrangements”!

However, the situation in general practices is far more dire. Once I leave the public hospital system and enter GP training, I lose very significant rights and remuneration. I commit to several years of even worse job insecurity (due to six-month employment contracts for GP registrars), a substantial salary reduction (and an end to penalty rates and salary packaging privileges), hazy/non-existent parental leave entitlements and a reduction in leave flexibility.

My experience is not unique. My concerns are shared by other prevocational doctors looking to enter GP training, current GP registrars and recently fellowed GPs. I am hopeful the AMA's advocacy for GP registrars in remuneration and rights compared with hospital registrars via a single employer model might mitigate some of these issues which undoubtedly contribute to the declining interest in GP training. Further, I hope the GP training policy and workplace landscape develops to provide the incentives needed for general practice to be the specialty of choice for more trainees, and for a greater recognition of the vital role GPiTs play in our healthcare system. I and others wait with anticipation for this, so that we can enter and complete training in our preferred speciality of general practice.

Once I leave the public hospital system and enter GP training, I lose very significant rights and remuneration.



TRANSFERRING MONEY FROM OVERSEAS INTO AUSTRALIA



Transferring money into Australia has tax implications, so it's important to seek professional advice.

Australian tax law is a complex web of rules and reporting requirements that is constantly being tweaked and reshaped.

This makes it challenging to keep abreast of the ins and outs that keep you on the right side of the Australian Tax Office (ATO). The complexity only increases when you're an Australian resident who receives income from overseas.

IS MONEY FROM OVERSEAS TAXABLE?

Moving your money into Australia is easy enough, but it can be a challenge to know precisely what payments you need to declare.

Keep in mind that every transfer of money into and out of Australia is monitored by AUSTRAC, the federal agency responsible for combatting international money-laundering and other abuses of our financial system.

AUSTRAC passes all the data it collects onto the ATO, even if it's not suspect, and the ATO then follows up with the taxpayer in respect of that overseas income.

For these reasons, it's important to obtain professional advice on your tax affairs so you don't inadvertently fall foul of the law.

To figure out whether money from overseas will be taxable in Australia, you'll need to consider its source. It's likely that you'll need to report an international money transfer derived from:

- » income from an overseas business or property
- » salary or wage from an overseas job
- » foreign investment income (eg. interest and/or dividends received)
- » an overseas pension or superannuation.

INCOME TAX TREATIES

Australia has signed income tax treaties with 46 foreign nations and these agreements provide Australian tax credits on overseas income where taxes have already been paid. This means that you won't be doubly taxed when you transfer that money into Australia.

ARE THERE ANY OTHER EXCEPTIONS?

The following sources are unlikely to have any tax implications and may not be required to be declared as income.

- » gifts
- » inheritance
- » windfalls (eg. lottery win)

- » an initial amount of money transferred when you first moved to Australia (eg. if you sold your house in the UK before immigrating to Australia and then moved the proceeds from the sale to Australia to help buy your new home).

WHAT RECORDS ARE REQUIRED?

It's essential that you keep full and accurate records of all overseas transactions so you can answer any questions the ATO may ask. These records include copies of relevant bank statements from the country where you've transacted so you can provide documentary evidence about the source of your funds.

HOW CAN I TRANSFER MONEY TO AUSTRALIA?

The most common method of transferring funds is through a money transfer to your Australian bank.

It's best to choose a reputable money transfer provider that is regulated and authorised by the Australian Securities and Investment Commission and has an Australian Financial Services Licence number.

REPORT **Jim Tsirtsakis**

BBus (Acc), DipFP, CFP®

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Director, Bongiorno Group



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SUCCESS OR FAILURE



EXPERTISE ESSENTIAL TO MENTAL HEALTH REFORM

The success or failure in fundamentally transforming Victoria’s mental health system depends upon successful implementation of the Royal Commission’s recommendations and medical expertise is essential to successful implementation.

REPORT DR AJIT SELVENDRA
CHAIR, AMA VICTORIA SECTION OF PSYCHIATRY

► Recommendations of investment in the mental health workforce and increased investment in infrastructure are critically needed.

► The report failed to go into detail regarding how the recommendations are to be implemented.



[View AMA Victoria's State Budget Submission](#)

The Final Report of the Royal Commission into Victoria’s Mental Health System was tabled in the Victorian Parliament in early March and AMA Victoria’s Section of Psychiatry acknowledges the Commission’s involvement of the AMA during the two-year process.

We agree with the Chair of the Commission that the current system has, “Catastrophically failed to live up to expectations”, and we hope that Premier Daniel Andrews’ assertion that the report will serve as, “A blueprint for the biggest social reform in a generation” achieves its potential. Victorians deserve no less.

For a state that has recently had the lowest per capita expenditure on mental health in Australia, this report recommends a significantly increased investment in public mental health services across Victoria, and provides a genuine attempt to ensure that funding given to mental health stays within mental health. The Section is particularly pleased with the report’s recommendations of investment in the mental health workforce and increased investment in infrastructure (both physical and IT) – all of which are critically needed.

Nevertheless, we note that the report failed to go into detail regarding how the recommendations are to be implemented. Ultimately, the report’s success or failure in fundamentally transforming Victoria’s mental health system depends upon successful implementation of its recommendations, and medical expertise is essential to successful implementation. The Section expressed concern that the implementation could potentially be captured by the loudest voices in the room focused on prevention, but without grounding in medical or scientific evidence.

For instance, regarding the creation of up to 60 community-based mental health and wellbeing services across the state; whilst undoubtedly a worthy initiative, if these centres are not clinically informed, they could represent a potential lost opportunity

and lost dollars for the Victorian taxpayer. Ensuring clinical governance, oversight and frameworks to ensure optimal care, safety and functionality amidst innovation and change is essential. Models allowing continuity of care, such as the psychiatric outpatient clinic which provides longer term specialist support for people managed in primary care, as well as providing an opportunity for expert assessment of new cases, is one such example.

We recently met with Mental Health Reform Victoria to discuss our reflections on the recommendations and how we would like to be engaged in the implementation process. We expressed our view that there was a general apprehension in the medical community over implementation (for example, regarding the role of the ‘hubs’ in intervention and treatment and what role clinicians will play), and made it clear psychiatrists have a strong desire to be involved early in the implementation process, and not to be merely consulted towards the end as some sort of ‘box ticking’ exercise. We also touched upon the need to avoid duplication of existing services, the critical importance of further workforce investment, and the need to have better integration of mental health care with the NDIS.

Our views on the Final Report have also been reflected in AMA Victoria’s recent State Budget Submission. Whilst welcoming the State Government’s commitment to funding mental health reform, our submission noted that to truly transform mental healthcare in Victoria, funding must also be prioritised for acute care and continuity of care. This would ensure that those most urgently in need receive the treatment and support they require, and those who have recently improved can move on with their lives without a rapid discharge to unsupported primary care that often results in an inevitable deterioration and a revolving-door experience of public mental health services.



[Click here to view the final report of the Royal Commission into Victoria's Mental Health System](#)



EXTRAORDINARY LEADERSHIP IN EXTRAORDINARY TIMES

REPORT STEVEN BURRELL
AMA VICTORIA CEO

AMA Victoria farewelled its former President, A/Prof Julian Rait at its AGM on 26 May 2021. This is an excerpt from a speech given by AMA Victoria CEO, Steven Burrell.

Elected as President of AMA Victoria in May, 2018, Associate Professor Julian Rait truly provided AMA Victoria with extraordinary leadership in extraordinary times.

It was 50 years earlier in May 1968, that Julian's GP father took him to an AMA national conference in Sydney. Julian was introduced to Dr Christian Barnard, the South African cardiac surgeon who had performed the world's first human-to-human heart transplant six months earlier.

Julian more recently reflected on the impact of that moment – when he realised the power of scientific research and technology to transform the medical profession. He much admired the AMA, even then, as an organisation that encouraged great ideas and could have a positive influence on the health of Australians.

That belief has underscored his time as President of AMA Victoria. He has used his powerful platform fearlessly, advocating for robust policy ideas for the medical profession and for better health outcomes for all Victorians.

In 2018, one of Julian's first tasks as a newly elected President was to develop a state election advocacy agenda.

Following careful consultation with members, Julian launched AMA Victoria's, 'Key Priorities for the Victorian Health System' – a detailed document that argued the case for investment in mental health; regional and rural health; our public hospital system; drug and alcohol support; and investment in a robust palliative care system for all Victorians.

Whilst publicly promoting this agenda, it became obvious that Julian's instinctive media capabilities, natural communication skills and frank advocacy style would serve AMA Victoria and the community well. He executed strong media campaigns throughout his term, capturing government attention and

motivating action. For example, his advocacy for the redevelopment of Footscray Hospital was followed by a \$1.5 billion pledge from the Andrews Government. Equally, his advocacy for greater investment into the mental health sector played a significant part in securing the State Government's commitment to reform the broken mental health system.

In those first hectic months of his presidency, Julian wasted no time campaigning to improve the workplace for doctors and ensure support for the health and wellbeing of medical professionals.

His meetings with health sector stakeholders, left him astounded though.

There was clearly a reluctance – and at times complete indifference – on the part of health services to fully implement pay and conditions arising from the 2018 Enterprise Agreement.

Julian eventually concluded that AMA Victoria had to be bold – culminating in its most recent public support for the current doctor-in-training class action – a significant step for the organisation, creating a ripple effect of interest from other AMAs across the country and driving the necessary momentum required for structural reform.

As President, Julian also emphasised the need for a two-way relationship between the State Government and general practitioners; to build GPs into the state's health system more holistically and to more successfully integrate care and reduce the burden of preventable and chronic disease.

Julian's impact was not only in the policy and advocacy space.

As Chair of the AMA Victoria Board, Julian was clear, strategic and determined. His mission to stabilise and then improve AMA Victoria's financial position and to improve its operational performance and governance, led the Board and Council to implement important changes including a governance review and the first change to the AMA Victoria Constitution within the past decade, including the introduction of a 40 per cent quota for female representation on the AMA Victoria Board.



Then, at the close of 2019, as Julian's presidency entered its final quarter and, as he quite possibly started to ponder his next steps, there emerged on New Year's Eve an atypical pneumonia whose cause was then unknown which had been detected in Wuhan, in the Hubei Province of China.

It was the first black cloud on the horizon which turned out to be one of the biggest storms to hit the health system, our economy and Australian society in a century.

And so, instead of stepping back, there began reacceleration; and a tireless, sustained often breath-taking daily advocacy effort by Julian, focused on the COVID-19 pandemic.

Members' concerns about a lack of facilities, resources, testing and protective equipment were rapidly communicated to state and federal health authorities in an all-out effort to support the medical profession and protect the community from this once-in-a-lifetime pandemic.

Best practice and accessible respiratory protection and infection control for health workers across all healthcare settings became Julian's unrelenting priority, as we raced to flatten the first and then the second waves.

Julian's sustained daily advocacy was awe-inspiring: energetic, strategic, focused and determined. Some of it was in the media. Much of it was behind the scenes. A little known fact is that a conversation with the Federal Minister for Health, Greg Hunt, inspired the formation of National Cabinet. Mr Hunt publicly

credits Julian with backgrounding him on how the Spanish flu nearly fractured the Australian federation a century earlier and how important it was to ensure co-operation between the states.

Minister Hunt briefed the Prime Minister on this conversation and National Cabinet was formed. Regardless of the multiplicity and complexity of the issues that required attention, Julian grasped topics quickly as members' concerns flooded in.

Julian always consulted a broad, cross section of members. He co-ordinated responses from practitioners and collaborated with experts to develop a deep understanding of the issues.

He has always proudly asserted this as the ultimate power of the AMA – the only organisation in Australia that can take the opinions of the entire medical profession and present a cogent view to inform government thinking.

Julian's work for and impact on AMA Victoria has been significant. He has strengthened the AMA Victoria brand without a doubt, leaving a much stronger organisation and an enduring legacy from which members will benefit for years to come.

STATUTORY DUTY OF CANDOUR

REPORT ANJALI WOODFORD & LAURA SKAZLIC, KENNEDYS

The Victorian Government will introduce a statutory duty of candour in 2021 to aid in strengthening quality and safety in healthcare delivery.

HISTORICAL FRAMEWORK

In 2016 the Review of Hospital Safety and Quality Assurance in Victoria published *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care (Targeting Zero)*. One of the recommendations included: “That a statutory duty of candour be introduced that requires all hospitals to ensure that any person harmed while receiving care is informed of this fact and apologised to by an appropriately trained professional in a manner consistent with the national Open Disclosure Framework”.

“All hospitals” is defined as public health services; public hospitals; multi-purpose services; denominational hospitals; private hospitals; and day procedure centres. There is also a consideration that it should include individual doctors; registered community health centres and healthcare organisations.

In 2017 an Expert Working Group was appointed to provide advice on legislative reforms arising from *Targeting Zero*. Sixty-one submissions were received and the Expert Working Group provided 27 recommendations, which were accepted in principle.

STATUTORY DUTY OF CANDOUR?

The proposed statutory duty of candour requires clinicians and hospitals to provide patients with:

- an apology
- an explanation of the facts about what occurred
- a description of the response and improvements employed.

The statutory duty is intended to apply to incidents with an incident severity rating (ISR) of 1-2, defined as ‘severe harm or death/moderate harm.’ The duty will not replace the current principles of open disclosure

under the Australian Open Disclosure Framework. Rather, it is a complementary legal obligation to strengthen commitment to open disclosure.

The Expert Working Group has recommended *Victorian candour and open disclosure guidelines (Guidelines)*, to outline requirements for compliance.

PROTECTIONS

The Expert Working Group acknowledged that for a statutory duty to be effective, legal protections for apologies are required. An apology would not constitute an admission of fault or liability in civil or disciplinary proceedings. This is already a provision under s 14I and 14J of the *Wrongs Act 1958 (Vic)*.

The Expert Working Group emphasised that clinical incident review processes are valuable quality and safety improvement processes. Thus, it is not subject to Freedom of Information requests and cannot be used in court. However, under the proposed reforms, reports will be offered to patients, family members and carers, consistent with candour and open disclosure.

POTENTIAL CONCERNS

A potential concern for clinicians is being reported to the Australian Health Practitioner Regulation Agency (Ahpra) on the basis that the duty is viewed as a breach of professional standards. The Expert Working Group’s recommendations aim to eliminate these concerns.

The State Government sought comments from the public and stakeholders by 9 April 2021 and will consider the feedback for drafting the bill and developing the Guidelines. The Guidelines will be released for public comment. Upon implementation, we encourage clinicians to seek guidance from their MDOs regarding coverage under their policy when working in private and public sectors.

Click here to view AMA Victoria’s submission to Safer Care Victoria.

Is your practice covered for COVID-19 vaccines?



As COVID-19 vaccines are rolled out nationally, your practice faces increased risks around vaccine safety and complications, administration and patient consent. Complaints, actions of non-medical staff, and lapses in training or privacy around vaccine management, could expose your practice to legal action.

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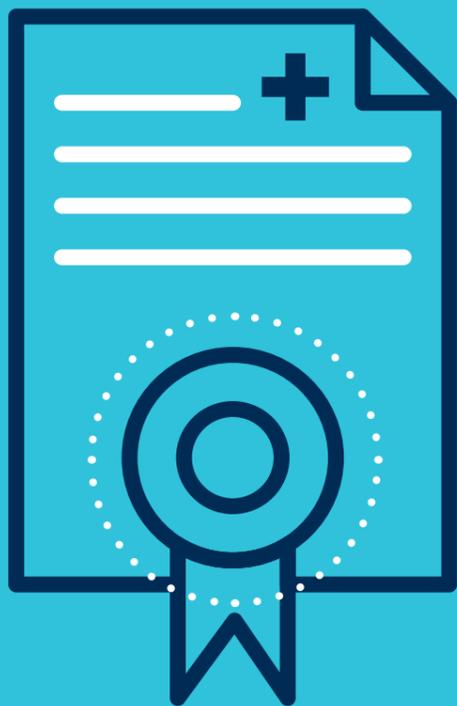
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MEDICINE FROM A DIFFERENT PERSPECTIVE

DID YOU KNOW:
Our members can access a 5% discount for the courses delivered in Victoria.

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



ASSOCIATE PROFESSOR VINCENT COUSINS

Otolaryngologist head and neck (ENT) surgeon

Firstly, can you give us a brief overview of your medical career?

I've been an otolaryngologist head and neck (ENT) surgeon since the mid 1980s in both private and public practice and was previously Head of Unit at The Alfred Hospital. I'm also an Adjunct Associate Clinical Professor at Monash University's Department of Surgery. My particular interest has been diseases of the ear and related conditions.

I have included medico-legal assessments as a routine part of my practice since the 80s.

I am a facilitator for the Otolaryngology Modules of the AMA impairment training courses and am co-author of the *Guidelines for the Assessment of Impairment from Compensable Hearing Loss for the State of Victoria* (2017).

How would you define the role and responsibilities of an impairment assessor?

This is a well-developed, standardised method to assessing the physical and/or psychological impairment from occupational injury, road trauma and other causes that assists in rehabilitation and provides compensation to those affected.

How long have you been an impairment assessor, and why did you get involved?

Since the 1990s. All medical specialties need to have an active group of practitioners involved in impairment assessment.

Why should a clinician become an impairment assessor and when do you think is the right stage in a doctor's career to begin this work?

The proper assessment of physical and psychological injury must be performed by Individuals with medical training and requires both generalists

and specialists that manage the full range of conditions of all body systems that may be affected. Experienced medical practitioners who are actively involved in routine patient care are those best placed to assess illness and injury and the impairments that result from them. The earlier years of specialist practice is a good time to start.

In your experience, what is the most rewarding aspect of being an impairment assessor?

Seeing claimants assessed impartially with accurate and fair outcomes.

What is the most challenging aspect?

Assessing claimants with multiple system injuries in my own specialty and across specialties which is more often seen in those who have been involved in serious transport accidents.

Why is impairment assessment work important and what role does it play in society?

The system we have in Victoria provides a reliable and repeatable manner of assessment by experienced and well-trained medical practitioners leading to the provision of rehabilitation and fair compensation to injured individuals in the community. This assists in their resumption of as a normal a life as possible in their particular circumstances, including return to work if relevant.

How do interested doctors become an impairment assessor?

Complete the core and specialty module(s) of the AMA Impairment Assessment Training and register with the relevant statutory bodies, including WorkSafe and TAC.

IMPAIRMENT ASSESSMENT TRAINING

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

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

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

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

Please enquire at: training@amavic.com.au



Impairment Assessment Training in Victoria

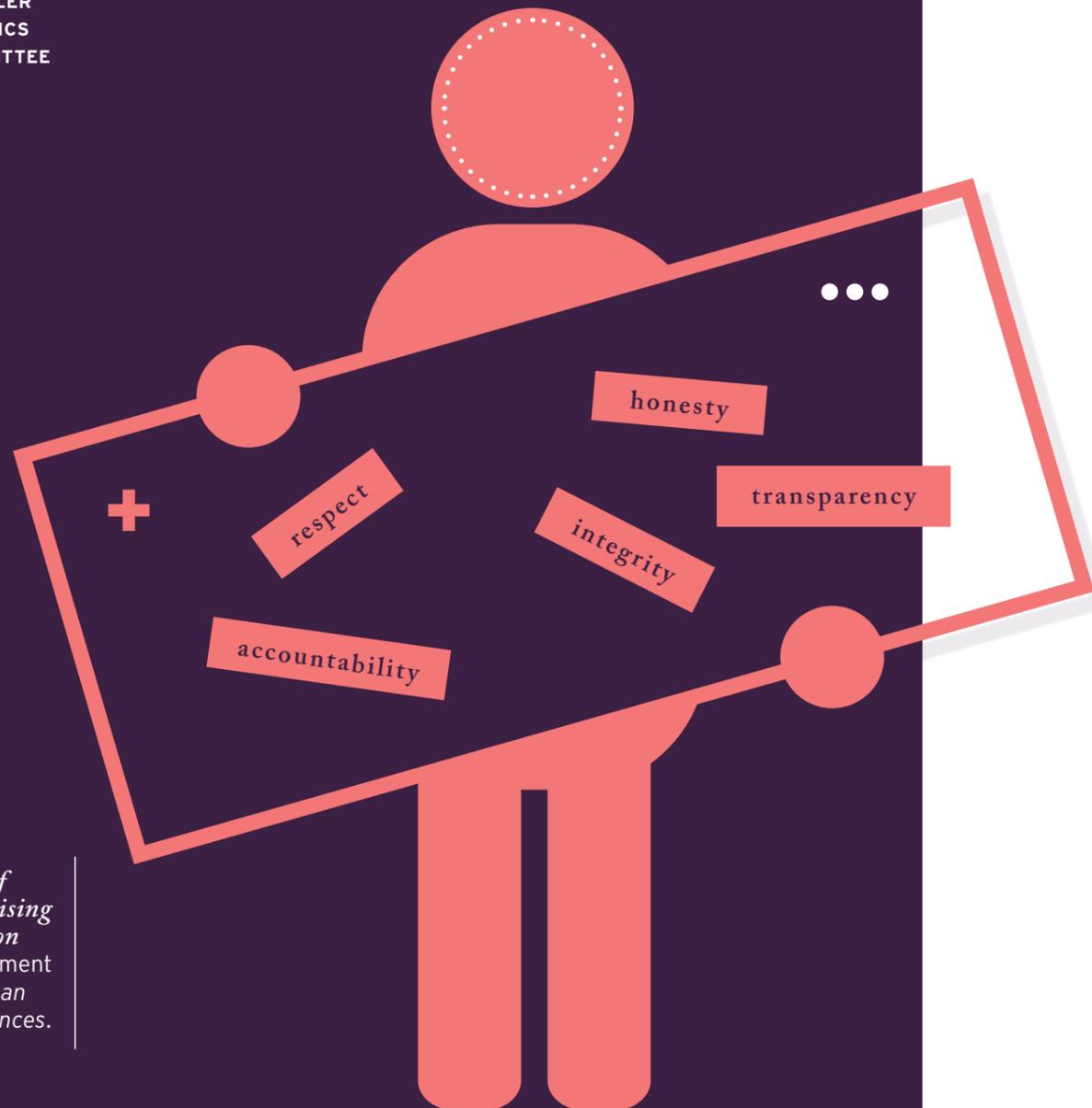


Impairment Assessment Training in New South Wales

ADVERTISING + PUBLIC ENDORSEMENT

Advertising by doctors should be guided by ethical values.

REPORT DR ANDREW J MILLER
CHAIR, AMA FEDERAL ETHICS
AND MEDICO LEGAL COMMITTEE



A good example of inappropriate advertising is outlined in section 7 of the position statement – pathologising human conditions and experiences.

Doctors have a legitimate interest in advertising their medical services, however, inappropriate advertising practices have the very real potential to harm both individuals and the wider community.

In recently updating its policy on advertising and public endorsement by doctors, now referred to as the *Position Statement on Advertising and Public Endorsement 2020*, the AMA's Ethics and Medico-Legal Committee (EMLC) concluded that the line between appropriate and inappropriate advertising is increasingly blurred. This can lead to confusion for doctors in how to meet their ethical, legal and professional obligations and potentially result in harm to patients.

The AMA's updated policy will support members by referring to a range of legal obligations and professional standards set by entities such as the Australian Health Practitioner Regulation Agency (Ahpra), the Medical Board and the Therapeutic Goods Administration while providing additional ethical guidance to support doctors to advertise in the interests of patients and the wider community.

Advertising by doctors should be guided by ethical values including respect, honesty, integrity, transparency and accountability. They should facilitate – not undermine – informed patient choice, relevant medical referral and the community's trust and confidence in the medical profession.

Inappropriate advertising practices can be coercive and exploitative in nature (possibly unintentionally), leading some individuals to use products or services indiscriminately or unnecessarily, potentially resulting in physical, psychological and/or financial harm. Further, inappropriate advertising feeds the perception that doctors are greedy and self-interested, caring more about their own personal and financial interests than patients' interests, damaging community trust and confidence in the integrity of the medical profession.

A good example of inappropriate advertising is outlined in section 7 of the position statement – *pathologising human conditions and experiences*. This refers to advertising practices that portray human conditions and experiences as pathological conditions requiring medical treatment in situations where this is not medically indicated. For example, advertising that promotes unrealistic body images, targeting common features of the human lifecycle such as wrinkles, skin laxity, breast ptosis or baldness that are not actually pathological in nature nor in need of medical treatment, exploits individuals' vulnerabilities, contributes to poor mental health and encourages unnecessary medical consumerism.

▶ The line between appropriate and inappropriate advertising is increasingly blurred.



[Click here to read the Position Statement on Advertising and Public Endorsement 2020](#)

While doctors should clearly not be involved in these inappropriate advertising practices, there are less obvious forms of advertising that can nonetheless prove ethically (and sometimes professionally and legally) problematic if not managed effectively. For example, social media increasingly lends itself to innovative and unique ways to advertise medical services to potential patients, colleagues and other third parties. The 'real time' nature of social media allows doctors to post up-to-date information such as changes to practice arrangements which can benefit patients by enabling them to make informed decisions about the appropriateness of the services.

The interactive nature of social media can also enable doctors to engage directly and publicly with patients and others on doctors' own social media platforms. For example, by allowing individuals to post comments or questions on a doctor's Facebook page, comments that appear (deliberately or inadvertently) to entice or persuade others to use the doctor's service can be considered a form of advertising even if the doctor did not solicit the comments. Not only is this ethically problematic but Ahpra may consider such comments to be testimonials which are distinctly banned under section 133 of the National Law. Some confusion in this area has arisen in relation to enforcement, due to the obvious proliferation of advertising on some social media platforms that seems to infringe this regularly, but goes uncorrected.

As the opportunities to advertise in new, innovative and dynamic ways continue to grow, the AMA's *Position Statement on Advertising and Public Endorsement 2020* will assist members to not only meet their legal and professional obligations but to maintain a strong ethical focus to advertise in the interests of patients and the wider community.

The position statement outlines the ethical principles to guide doctors' advertising practices, refers to relevant legal obligations and professional standards, and addresses advertising in a range of contexts including advertising of medical services; social media advertising; publicly endorsing products and services; participating in media reports, magazine articles and advertorials; and pathologising human conditions and experiences.

The *Position Statement on Advertising and Public Endorsement 2020* can be found on the AMA Federal website.





BUY OR SELL FIRST?

NAVIGATING 2021's PROPERTY REBOUND

So far 2021 has seen a ground swell of property transactions, as demand and prices rebound from last year's COVID-19 downturn. The strong market activity is likely to entice many property owners to think about selling, and then in turn, make another purchase.

"Should I buy first or sell first?" is a question often asked by owner-occupiers planning to move. The conventional wisdom is to play it safe and sell first and buy second, as holding two assets with very high debt for a prolonged period is considered a bigger danger to finances and nerves than the potential inconvenience of renting for a while. But there is a case for the less risk-averse approach of buying first and selling second, particularly in rising markets like we see across much of the nation now.

Judge correctly that prices are moving up and the participant can be tens of thousands of dollars better off by buying in the cheaper current market and selling in the more expensive future one compared to the net outcome of a sell first, buy second strategy.

There are tried-and-tested ways to minimise the risks associated with holding two properties. For instance, it's possible to lease out one of the two properties, earning rent to offset most if not all the holding costs until market conditions improve sufficiently to offload the property on more favourable terms.

Price trends are not the only factor to consider when deciding transaction order. How similar are the asset types that are being switched? If quite different, then the rule of thumb is to buy or sell the more unusual property first as this transaction will probably take longer.

This approach reduces the likelihood and length of time of either holding two properties and extra debt or holding no properties and having to rent an interim home. For example, it is usually easier to buy or sell a well-maintained three-bedroom suburban house (where the market is liquid), than a large country mansion of a very particular architectural style with several bedrooms and living rooms and a tennis court (where the market is illiquid). If the homeowner was switching between these types of properties, then the focus should be on transacting the country mansion first.

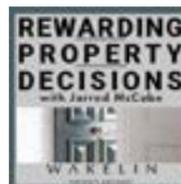
Putting aside the order of transactions, prospective homeowner switchers should make contingency plans to either rent for a while or take out bridging finance.

Hopefully, they are the fortunate ones who can coordinate transaction settlement timings perfectly, but having an artificial must-buy or must-sell deadline just to achieve this end risks delivering various panicky outcomes: buying the wrong replacement property, paying too much or selling too cheaply.

REPORT **Jarrold McCabe** Director
Wakelin Property Advisory

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

For more property insights listen to Jarrod's podcast, Rewarding Property Decisions.



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MATERNITY CALL TO ACTION

When a maternity service is lost from a rural town, this has catastrophic consequences, not only for mothers and babies, but also for our communities at large.

REPORT DR MARCO GIUSEPPIN
CHAIR, AMA FEDERAL COUNCIL
OF RURAL DOCTORS

The loss of a maternity service means that women must travel long distances to access care. This may be for something as simple as an antenatal appointment.



▶ The AMA, RDAA, RACGP and ACRRM have long seen eye to eye on the need to develop rural generalist medicine in Australia.

▶ Maternity services attract broadly skilled rural doctors with the capacity to work in both primary and hospital care.



One of the privileges of my role is to be able to represent the AMA on rural health issues in Canberra.

In March I was privileged to be a guest of the Rural Doctors Association of Australia (RDAA), and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) at Parliament House to discuss the future of rural maternity services. The AMA, RDAA, and the two rural generalist training colleges (RACGP and ACRRM) have long seen eye to eye on the need to develop rural generalist medicine in Australia.

The local health system is, and will remain, the basis on which vibrant rural communities are built. It is absolutely essential that these systems are built by rural doctors for the benefit of their communities. In larger rural communities, the appeal of locally based maternity services is clear. When a maternity service is lost from a rural town, this has catastrophic consequences, not only for mothers and babies, but also for our communities at large.

The loss of a maternity service means that women must travel long distances to access care. This may be for something as simple as an antenatal appointment. It will almost certainly be required for delivery. It is difficult for many who live in the city to envision or imagine the consequences of having to uproot an entire family at 34-36 weeks gestation to move to a larger centre to deliver their baby safely. This is a particular travesty in our First Nations communities who have gradually had their rights to birth on country removed from them as services are wound back.

Not only are there direct consequences for women, but communities as a whole benefit from a functional maternity service. Maternity services attract broadly skilled rural doctors (rural general practitioners, rural generalists and specialists) with the capacity to work in both primary and hospital care. They also require an operating theatre to be available in the event of a crisis during labour. The running of these services requires a critical mass of skilled doctors, nurses and midwives. This is an incredibly valuable resource that can be called upon whenever difficult situations arise in a rural town.

In their zeal to overcentralise services, governments of all stripes have suggested that rural birthing is “unsafe” and can only be performed in larger metropolitan and regional centres. This has been disproven by data time and time again. Rural clinicians are regularly ignored in the planning of local services in favour of centralised opinion and edict from our cities. It is, at its core, a most egregious example of geographic narcissism that has real consequences for our communities and our patients.

Governments claim they cannot recruit doctors, nurses, and midwives. Once again, these skilled clinicians do exist. We will be seeing more of them as the National Rural Generalist Pathway (NRGP) gains steam. Where our focus must be is in making these services and these positions attractive for the skilled clinicians they require.

To have a baby is a human right. To have quality healthcare in rural Australia is a human right. Childbirth does not respect geography, but it is time our governments do.

IS THE DRINKING WATER SAFE?

In many remote or very remote communities bore water is often the primary source of drinking and household water.

The fact that Indigenous people live without safe drinking water is unacceptable and it should not be the case that people in remote communities are out of sight, therefore, out of mind.

REPORT DR OMAR KHORSHID AMA FEDERAL PRESIDENT
TASKFORCE ON INDIGENOUS HEALTH

Having access to safe drinking water is a fundamental human right. Water remains a critical issue for many communities across Australia, particularly those who were at risk of losing their water supplies at the height of the recent drought. As devastating as losing water supplies might sound, many Aboriginal and Torres Strait Islander communities live without safe drinking water every day. In prosperous countries such as Australia, it is often assumed that safe drinking water is accessible to everyone – but it is not.

In many remote or very remote communities bore water is often the primary source of drinking and household water, but it is often contaminated and fails to meet the standards of the Australian Drinking Water Guidelines. Water chemistry analysis in some communities indicates that the nitrate and uranium content far exceed recommended levels for drinking.

The burden of inequity in terms of access to safe drinking water in Australia disproportionately affects remote areas, and these areas often have a larger population of Aboriginal and Torres Strait Islander people. The fact that Indigenous people live without safe drinking water is unacceptable and it should not be the case that people in remote communities are out of sight, therefore, out of mind.

Aboriginal and Torres Strait Islander people in remote communities represent an important part of Australia's heritage and local, state, territory and federal governments must take urgent action to address the water crisis facing many remote communities. Not only is access to safe drinking water a human rights issue, it is also an important public health issue. The lack of water and affordable healthy food in rural and remote communities is strongly linked to the epidemic levels of diabetes and renal disease among Aboriginal and Torres Strait Islander people.

Sugary drinks are more readily available than low sugar drinks, and in some communities, they are more accessible than running water. In a recent study published by the Australian National University, concerns about the safety and quality of drinking water in rural and remote areas have led residents to avoid tap water and instead buy bottled water, cordial or other sugary drinks.

It is unfathomable that in Australia, there are some communities that do not have access to safe drinking water – this is essential for good health and wellbeing. While most of us enjoy free, safe drinking water from the tap, those who can least afford it often have to pay just to ensure they are not drinking water sourced from rivers, streams, cisterns, poorly constructed wells, or water from an unsafe catchment. It is an issue that demands immediate attention and action by all levels of government – without it, the health gap between Aboriginal and Torres Strait Islander people and their non-Indigenous peers will remain wide and intractable.

The AMA sees an interim policy opportunity for the Commonwealth Government through Outback Stores to ensure that bottled water is affordable and available, especially where the supply of drinking water to homes and communities may be inadequate. Over the long term, governments must invest in the appropriate infrastructure, such as proper treatment facilities, water storage facilities and distribution systems to meet the water needs of communities.

Access to safe drinking water is an important policy issue for the AMA and is something that we will continue to advocate for – all Australians have the right to permanent and free access to safe drinking water regardless of where they live.



- ▶ All Australians have the right to permanent and free access to safe drinking water regardless of where they live.
- ▶ Sugary drinks are more readily available than low sugar drinks, and in some communities, they are more accessible than running water.

FED FACTS

GP'S PLAY CRITICAL ROLE IN MATERNITY CARE

Involving GPs in maternity care leads to better outcomes for mothers and babies. Releasing the AMA Position Statement on General Practitioners in Maternity Care, AMA Federal President Dr Omar Khorshid said all people thinking about starting a family or having another baby should consult with their GP.

The AMA position statement outlines how to ensure GPs are involved in maternity care and are able to provide continuity of care to mothers and babies from pre-conception and through all the important milestones in the mother and baby's lives.

"We know that best-practice maternity care is provided by a multi-disciplinary team of health professionals led by an obstetrician or GP-obstetrician in partnership with a patient's usual GP, and includes midwives, nurses, physicians, allied health professionals and Aboriginal health workers," Dr Khorshid said. "To support high-quality care for mothers, it is critical that their regular GP is involved in their care regardless of the model chosen."

As part of ensuring safe access to maternity services in Australia, it is also time for government to act to stem the loss of comprehensive maternity services in parts of rural Australia. "The closure of rural maternity services not only reduces access to safe and effective maternity care for the almost 30 per cent of Australian women who live outside of major cities, but also undermines skills of GP obstetricians and rural generalists, nurses and midwives."

"Australia has world-class maternity services and if we are to maintain this record, more needs to be done to ensure women have access to high-quality, collaborative models of care that involve obstetricians and GP-obstetricians working in partnership with a patient's usual GP and other members of the healthcare team."

Click here to access the AMA Position Statement on General Practitioners in Maternity Care.

Highlighting some of the advocacy areas AMA Federal has been working on for members recently.

GOVERNMENT URGED TO FUND GP AGED CARE VISITS AND NURSING HOME INFRASTRUCTURE

The AMA is calling for increased funding to support and encourage more GPs to visit patients in nursing homes as well as greater investment in nursing home facilities to make it easier for GPs to deliver the care that people in nursing homes deserve.

"AMA members have signalled their intention to reduce nursing home visits and even cease them altogether and this is the last thing we want right now, when we know our older loved ones are suffering from a lack of medical care inside nursing homes," Dr Khorshid said.

"Instead we should be attracting more doctors into aged care by supporting them to take the time away from their busy practices and visit patients in nursing homes. That way GPs can continue their relationships with their elderly patients who move into aged care. We are calling for increased Medicare funding so that GPs can work with nurses to deliver the quality and quantity of care that older Australians expect, and deserve, in a way that is sustainable for the health system."

"We've estimated this to cost \$145 million in 2021-22 and \$643 million over four years to 2024-25 in our new modelling. It's a relatively small ask when we've identified over \$21 billion of savings that can be made in addressing preventable hospital admissions from aged care," Dr Khorshid said.

Details of \$21 billion in potential savings identified by the AMA are contained in our latest report: 'Putting Health Care Back Into Aged Care'



*Click here for our
latest report: Putting
Health Care Back
into Aged Care*

EMPOWERING DIT ADVOCACY WITHIN THE AMA IN 2021

REPORT DR HASH ABDEEN
AMA FEDERAL COUNCIL OF DOCTORS IN TRAINING

Over the past six months the AMA Federal Council of Doctors in Training (AMACDT) has undertaken a dramatic restructure to better increase our grassroots engagement and representation. This redesign is aimed at supporting increased diversity in our representation as well as proving an opportunity for more AMA DiT members to be involved in our advocacy and policy development.

So, what does our new structure look like? We have three special interest groups (SIGs) and two advisory committees aimed at DiTs who have specific advocacy passions and expertise and tailored to accommodate the busy life of working DiTs.

- 1) Our Prevocational SIG, chaired by Dr Ben Maudlin and Dr Cassie Spanos, is focusing on the complex issues of the unaccredited registrar space, and looking at best practise standards to supporting this growing group of trainees. They have provided important stakeholder feedback on the AMC Review of the National Framework for Prevocational Training (previously the National Intern Framework) and are considering further developing career tools and support mechanisms for prevocational doctors.
- 2) The Wellbeing SIG, chaired by Dr Nicola Campbell and Dr Tahnee Bridson, is focusing on three key issues including researching the evidence base behind interventions for support for DiTs, addressing bullying and harassment in medicine, and further a project that will map the current support services available for DiTs.
- 3) Our Industrial SIG, chaired by Dr Chris Wilson and AMA Victoria Workplace Relations Adviser Dr Karla Villafana-Soto, is developing pathways to ensure DiTs can easily access information about their enterprise bargaining agreements on a national level to allow a comparison of conditions for DiTs who might be moving interstate. It will also assist with state and territory award negotiations and we are combining data from the individual state and territory Hospital Health Checks (HHC) to form a national HHC to act as a comparator.



- 4) The AMACDT Policy Advisory Committee (CPAC), chaired by Dr Ekta Paw and Dr Bhavi Ravindran, forms the backbone of our policy development and review processes.
- 5) The creation of our GPs in Training Advisory Committee (GTAC) chaired by AMA Victoria's GPs in Training Subdivision Chair Dr Dan Wilson, means we now have exceptional representation and engagement from our AMA GPs in Training members. GTAC is currently discussing and advocating for improved GP registrar employment conditions, including portability of workplace entitlements, pay parity and parental leave for GP registrars, and further GP education and training issues, including the transition to college-led training.
- 6) Our Communications and Engagement Team (CET) chaired by Dr Charlotte Durand and Dr Sonia Chanchlani, aims to communicate all of the advocacy that we are working so hard on in the background to support to DiTs. One of our initiatives is the creation of our new Federal AMACDT Instagram page. Please join the newly created AMACDT Instagram page for more regular updates from the CDT team – www.instagram.com/amacdt/
- 7) AMACDT also hosts a quarterly Trainee Forum where of all your 16 Binational Specialist Medical College Trainee Committee Chairs and Representatives meet to discuss the many issues related to vocational training including education, training, assessment and trainee wellbeing.

Finally, I encourage you to please reach out if you feel that you have a passion for any one of our teams above, or if you have any questions or queries – we encourage everyone from those who are new to the advocacy space, to those with seasoned skills.

And as always, your feedback is welcome. You can reach me at cdt.chair@ama.com.au

Clean energy now powering more Victorian hospitals

Over recent years there has been a shift across the healthcare sector with many Victorian hospitals moving away from traditional coal-fired grid electricity to introducing solar power to assist in the generation of their energy supply.



As large power consumers, not only have grid electricity costs continued to skyrocket for hospitals over the last 10 years, but a resulting 7 per cent of Australia's total carbon footprint is now estimated to be attributed to the healthcare sector, with hospitals a major contributor.

High electricity costs coupled with widespread recognition of the need for sustainably produced power, are the driving forces behind many Victorian hospitals seeking long-term alternatives, with the integration of solar power readily considered one of the most economically viable sources of renewable energy.

Energis has proudly delivered successful solar projects for hospitals and healthcare facilities across both metropolitan and regional Victoria; including the 780KW system installed for Bairnsdale Regional Health Service, notably one of the largest rooftop solar systems on a hospital in the southern hemisphere.

Check out the birds eye view and video testimonial below from the Bairnsdale Hospital 780KW and Castlemaine Health 200KW solar power projects delivered by Energis!

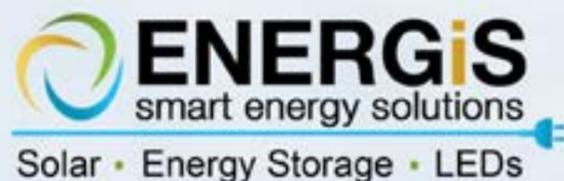


If you would like to know more about how solar power can benefit your medical practice, hospital or healthcare facility, contact Energis for a consultation and Free Sustainable Energy Assessment today!!

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YOUR WELLBEING

New
bewell.besafe
online resource



A new online resource has launched to support every Victorian in the healthcare system, whatever their role and wherever they work.

The Victorian Department of Health has launched a new resource to provide healthcare workers with the most up to date advice, information and tools to help them be well and safe at work.

"We all know how much Victorian healthcare workers do to care for other Victorians," said Chief Medical Officer, Prof Andrew Wilson. "But we need ways to help us take care of ourselves. If we are safe and well, others will be safe and well."

"So we have created 'be well be safe', an online space with the most current evidence, guidance and information about infection control, PPE, mental health and wellbeing. It's a program designed with our frontline workers to be shared. And it's designed to keep us all well and safe."

The team behind **bewell.besafe** is consulting experts and scanning for useful and useable information to share more widely. All healthcare workers are invited to share feedback, ideas for new topics or connections, working tips and examples of best practice from their workplace.

Already, content on **bewell.besafe** has covered topics such as fit testing, COVID-19 vaccination rollout, PPE supply volumes and tips on facemask skincare.

The importance of wellbeing has been a popular topic and featured healthcare workers from around the state on what they're doing to support their own mental health and general wellbeing.



Click here to learn more

MORE THAN MED

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

Sing with Fred!

Helping people communicate with loved ones through healing song, especially those in aged care and nursing homes.



REPORT DR ALFRED ZERFAS

I was a public health doctor and epidemiologist who worked for agencies such as UNICEF, universities and governments in low-income countries in emergencies, nutrition, maternal and child health, surveys and research.

On 'retirement' aged 70 in 2006, I returned to Australia and started making videos and presentations on health-related issues, but with no particular purpose. A few years ago, at a retreat, I met an amazing person who became my (tor)mentor! She made me realise it was OK to be different. She also encouraged me to explore my core values, which identified me as a 'stand-up comedian'. I realised I love to sing and make people smile, which led to the program 'SingwithFred!'

I like to help people communicate through song with loved ones, especially those in aged care and nursing homes, where singing is encouraged as part of the program for residents. Happiness and memory can be rekindled by song. Music therapists form a recognised part of healthcare for the aged, at-risk groups and those with mental illness.

Recently I have conducted meetings over Zoom. My aim is to help in the choice, content, delivery, timing and wording of songs, provide ongoing follow-up for recipients and invite celebrities to show ways in which they use song to help themselves and loved ones. My aim is to enrol 100 people in 6-12 months leading to a major event.

SingwithFred! offers an added dimension both in the preventive and therapeutic aspects of therapy for mental health using family and friends with their elderly relatives. I plan an evaluation in a pilot clinical trial with controls including those using current therapy matched by setting and location.

In time, this research will seek funding, involving an academic institution with special reference to interested doctors and healthcare therapists.



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