

# V I C D O C

AMA VICTORIA

SUMMER 2022

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## NEWS, VIEWS + REVIEWS

### AMA VICTORIA RESPONDS TO THE ANNOUNCEMENT OF A POTENTIAL PHARMACY PRESCRIBING TRIAL IN VICTORIA

See AMA Victoria's communication to members on this issue here.

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### AMA VICTORIA BOSS SAYS 'HUNDREDS' OF CONCERNING HOSPITAL EXPERIENCES ARE HAPPENING EVERY DAY

AMA Victoria President, Dr Roderick McRae spoke with 3AW's Neil Mitchell about the state of the Victorian hospital system, emphasising the need for major structural reform.

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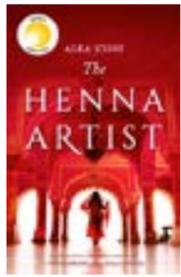
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**THE HENNA ARTIST**

*Alka Joshi*

Lakshmi is a sought-after henna artist living in Jaipur in the 1950s. Having escaped her past, she is building a strong reputation with sophisticated, wealthy clients and close to attaining the independent life of her dreams. Everything Lakshmi has worked for however is threatened when her past catches up with her. As she fights to maintain her status in India's challenging caste-system, Lakshmi must decide who she is and what her future will be.

The first in a trilogy, this book by Alka Joshi, was released in 2020 to acclaim. Whilst there's no word on an official release date, Netflix is adapting the book into a TV series coming soon. So, if you like to read the novels on which some TV series are based before watching them on your screens, this one is a must.



**THE PHANTOM OF THE OPERA**

*The Arts Centre Melbourne*

The Phantom is back. Performing to packed, enthusiastic audiences at Melbourne's Arts Centre, many dressed up for the occasion, this is theatre at its best. Set in the late 1800s, Phantom of the Opera is a tragic love story set in an opera house haunted by the shadowy Phantom who trains a young, naive singer, Christine. Josh Piterman is spellbinding as the tormented Phantom and perfectly matched by Amy Manford's exquisite Christine. Costumes, lighting, and visual effects are spectacularly executed with the entire show carried magnificently by its sweeping 27-piece orchestra. There has been much written about why audiences feel for the violent and murderous Phantom. This stirring production brings the audience so close to the Phantom and his pain, that we too can only be captivated by the music of the night.



**THE DOCTORS' ROOM**

*AMA Victoria Podcast*

Keep a look out for the upcoming launch of AMA Victoria's podcast, 'The Doctors' Room'. This is an exclusive member only podcast brought to you by AMA Victoria with doctors, for doctors. We discuss the issues you tell us you want to hear about and provide information that is relevant and useful for you. The first series of episodes focus on two topics: 'Inside Internship' and 'Enterprise Agreement Explainers'. When these drop, interns will learn from senior doctors how to thrive during their intern rotations and all public hospital doctors will have a better grasp on their rights in the workplace under the recently approved, new enterprise agreement. With many more episodes to come, there will be something for all AMA Victoria members here. An exciting new chapter in the way AMA Victoria connects and serves its members.



*'The Doctors' Room' is an exclusive member only podcast brought to you by AMA Victoria with doctors, for doctors.*

**GP EXPERIENCES + CHALLENGES OF TREATING DOCTOR-PATIENTS**

*Claire Hutton (PhD candidate, Department of General Practice, Monash University), Dr Chris Barton, Dr Penny Round*

In order to function well, doctors need to look after themselves. Indeed, medical boards recommend that doctors have their own (independent) general practitioner (GP), but many do not. Doctors also often delay seeking medical care for themselves, for a range of reasons, including discomfort about the role reversal such a step requires. Guidelines consistently state that doctor-patients should be treated like any other patient, but this appears to be difficult to put into practice.

Once doctors do seek medical care, there is some evidence that the treating doctor can struggle to provide optimal treatment. Treating doctors often experience anxiety about errors and the likely scrutiny from the medical, and wider community. They can also make assumptions about the doctor-patient's level of knowledge, and they are at times influenced by strong medical cultural beliefs about doctors' invulnerability to illness.

Many, if not most, doctors will at some point find themselves treating fellow doctors. Doctor-patients will of course need and present at all levels of care. We have chosen to focus on general practitioners for this qualitative study, as this is the entry point to the medical system in Australia.

The aim of this study is to develop a theoretical and conceptual model that makes sense of Australian GPs' experiences and challenges and approaches to care for a patient that is a fellow medical doctor. We will explore how GPs feel about seeing doctor-patients, and what they like and/or find challenging about this. We will also look at whether GPs believe they treat doctor-patients differently to other patients and if so, in what ways and for what reasons, and what this means for provision of care.

The findings from this study will inform the development of a questionnaire to be disseminated to GPs across Australia to test the model that is suggested by this qualitative work and whether it can be generalised to primary care doctors broadly. Developing a clearer understanding about the challenges in seeing doctor-patients, may assist in helping doctors to become more at ease and effective in caring for their own.

We plan to interview 15-25 GPs who have some (even if minimal) experience with treating fellow doctors. Interviews are semi-structured, audio-recorded and will take 45-60 minutes.



*Click here to participate, either face-to-face or by Zoom*



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# SENSE OF PLACE + MEDICINE



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**DR KEVIN MACDONALD**

*Retired Occupational Physician  
AMA Victoria Retired  
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### Far North Australia

*To the West:* the ancient Kimberley with breathtaking views of our galaxy and moon, the inevitable questions arise of just how did the universe and galaxies form and evolve, how old, how big and what is the finale.

*To the East:* the ancient Daintree Rainforest and Barrier Reef with an incredible biological diversity which also begs the question of life: how it started, evolved and prospered.

*Lizard island* is 250 km north of Cairns by light plane, a granite island surrounded by reefs. Cook walked to the top of the hill to try and find a passage out of the reefs. The excellent marine research centre is a fascinating visit.

*Snorkelling* off the beaches over massive clams and corals and tropical fish is easy in a wetsuit for buoyancy and UV protection although not without difficulty getting on and off for older bodies. The variety, colour and huge number of fish species is always amazing and we must never forget that this is a whole ecosystem dependent on healthy coral.

First Nations people have inhabited these areas for millennia. Our obligation to maintain and preserve these unique natural monuments is pressing.



**DR SABINE WAGNER**

*Doctor in Training  
AMA Victoria WIM  
Committee*

With the fast pace of life in general, I have always found that it's upon re-visiting a place after a period of time that I begin to understand what it meant to me. That I feel a nostalgic glow and start cherishing the memories I had there. There are definitely many such places like this for me – which I feel extremely grateful for. However one that really springs to mind is Glasgow, where I went to university. One place in particular (and I know this is going to sound really weird) was my local convenience store. I went there for the last time on my graduation day to buy a bottle of water seeing as it was a (rare) warm day. Suddenly I started to remember all my pre-study session visits to buy essential snack supplies. My late-night stops on the way home from a night out to buy instant noodles with my flatmates. It was open 24/7, just around the corner, there when we needed it most. The food may have been junk, but the memories it facilitated were priceless.



**DR LINDA SCHACHTER**

*Respiratory & Sleep  
Physician Chair,  
AMA Victoria WIM Committee*

After my uncle was unable to go, I was incredibly lucky to be invited by my travel agent aunt on a cruise from Iceland to Holland. After an extraordinarily long plane flight that took us through Helsinki, we landed in Reykjavik, Iceland. The first night that we arrived in the middle of their summer, we were told that it was unseasonably warm with 4 degrees expected for the night.

I was keen to see the northern lights and despite being absolutely exhausted, jumped on a bus to travel to the middle of nowhere to see if they would appear. At about 1am, with a wind chill factor of about -10 degrees, we started to see the northern lights. Thousands of small green specks lit up the sky and it was truly amazing.

The next day was a trip to a thermal spa. While reclining in warm water at 38 degrees, the temperature was 10 degrees out of the water. Life guards wearing fur lined thermal jackets supervised tourists reclining in bathers in the thermal springs.



*Far North Australia  
Glasgow  
Iceland to Holland*

A bar in the middle of the springs was a highlight with a mimosa the perfect way to start the day. A plunge into ice cold water kick started the system. Interestingly some people actually find this enjoyable.

A tour of the area was amazing with a trip to Geysir which had thermal water shooting 50m into the air every 5 minutes out of a small pool. Other sites that we visited included glaciers and beautiful waterfalls.

Another highlight was lunch of tomato soup with tomato beer (also tomato ice cream if you are so inclined) in a hot house as food has to be grown differently due to the weather.

Then back to the ship, and with a send off of a band and a canon (who knew that they still did this?). So with music and a loud bang, we were off to Cork across the North sea and to the next part of our adventure.

Iceland is truly a special place and should be on everyone's must see list.



*At about 1am, with a wind chill factor of about  
-10 degrees, we started to see the northern lights.*



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## TOOLS OF TRADE: EXPLORING THE AMA COLLECTION

A fascinating exhibition of medical artefacts gives insight into the day-to-day lives of doctors and healthcare in the 1800s.

REPORT VANESSA MURRAY

The exhibition, Tools of Trade, is a carefully curated selection of more than 20 everyday objects that doctors used in conducting their medical practice such as stethoscopes, medical kits and microscopes. Many were used by early doctors of the Port Phillip District and date to the mid-late nineteenth century.

“These items are significant as they give us insight into the day-to-day lives of doctors and how they carried out their profession, but also reflect science and technology of the time,” says curator Jacqueline (Jacky) Healy.

The monaural stethoscopes on display might look outmoded to us now, but at the time they were state of the art – and not without controversy.

“Before the invention of this type of stethoscope, doctors would roll up a paper tube and use it as a funnel. Many doctors thought this was quite adequate and didn’t like the new devices. We selected these for inclusion as the stethoscope is an enduring symbol of the physician’s trade,” explains Jacky.

Made primarily of wood, with one end larger than the other and a hollow cavity in between, monaural stethoscopes enabled a physician to listen to a patient’s chest without having to place their ear improperly close (important especially regarding women patients) and are the precursor to today’s binaural stethoscope design.

And then there are the amputation kits. While older versions are ornate and crafted from materials like wood, bone, and ivory, more versions are far more utilitarian – either purely metal, or with a metal blade which could be detached from its handle.

“This shift in form from decorative to utilitarian reflects a hugely important development in medical science of the time – germ theory. They show us that people began to understand that germs existed and posed risks, and that medical instruments needed to be made of non-porous materials that could be thoroughly and properly cleaned,” says Jacky.

Similarly, the Burroughs & Wellcome medical kit on display shows how doctors conducted their business at this time, and how health care was accessed in society.

“Hospitals were for the poor – if you were more well to do the doctor came to you. Supplies like these were an essential part of a colonial era doctor’s kit, as they travelled to their patients and needed to be able to prepare and dispense prescriptions on the spot.”

» 01/ Top left: This foetal stethoscope dates from circa 1890. Made from wood and ivory, it stands roughly 20cm tall and was used for foetal heart rate monitoring. Where the stethoscope has a flat bell ideal for hearing heartbeats through the chest, the fetoscope has a rounded bell, which is more sensitive for hearing a baby’s heartbeat through a woman’s belly.

» 02/ Top right: This complete antidote case dates from circa 1900 includes bottles of zinc sulphate, potassium bromide, dialysed iron, chlorai, magnesii sulphas (epsom salts), calcined magnesia, tannin, oil of turpentine and dialysed iron, along with a small vial of egotin (bonjean), along with a syringe needle, rubber hose and a cylindrical glass tube.

» 03/ Below: This surgical instruments kit was manufactured by W. Pepys sometime between 1750 and 1863. It contains various instruments with either ebony or ivory handles and is an example of the type of kit in production and use before the advent of germ theory.



*These items are significant as they give us insight into the day-to-day lives of doctors and how they carried out their profession, but also reflect science and technology of the time.*





» 04/ Left: Most of the instruments are missing from this amputations and general operations case, but still present is an 11-inch (28 cm) amputation knife and two full curve needles, all with wooden handles.

» 05/ Below: This enema apparatus and case was made in Melbourne by J. Jones, a surgical instrument maker based in Lonsdale Street. Comprised of a metal enema syringe with a bone handle, it is accompanied by one oesophageal tube, and two bone pipes.



The items in Tools of Trade are from the much larger AMA Collection, which was amassed and retained by AMA Victoria and then loaned to the University in 1994, when its museum closed. It was bequeathed to the University of Melbourne in 2011. It contains more than 5,000 artefacts, including instruments, photographs and correspondence, and is still being catalogued by Jacky, students and colleagues.

The exhibition and the AMA Collection are also reflective of wider histories – those of western medicine, colonisation, the AMA and the University of Melbourne.

Port Phillip District was a district of the Colony of New South Wales from 1836 until 1851. It achieved independence from New South Wales in 1851 and became the Colony of Victoria.

The very next year, in 1852, AMA Victoria (then the Victorian Medical Association) was founded by former members of the Port Phillip Medical Association. Just a decade later in 1862, the Melbourne Medical School at the University of Melbourne was founded.

It's no coincidence that the AMA Collection was gifted to the University of Melbourne the year before its 150th anniversary, which fell in 2012.

"AMA Victoria has a longstanding and very positive relationship with the University of Melbourne. AMA members were founders of Melbourne Medical School, and we are thrilled the university appreciates and can protect the Collection," says Chair of AMA Victoria's Heritage and Archive Committee, Dr Gerald Segal.

Gerald points out that "history never stops" and says an important part of his role is to document significant items, documents and occurrences for future posterity.

The AMA Collection is now part of the University's Faculty of Medicine, Dentistry and Health Sciences' larger collection, which comprises more than 17,000 items that encompass Aboriginal and Torres Strait Islander healing practices and the history of teaching, learning and research at the University of Melbourne, and health sciences in Australia and internationally.

Jacky and her colleagues spent several months curating and setting up the exhibition and bringing some of the collection to life.

"The AMA Victoria collection has greatly enhanced the Medical History Museum's historical material," says Jacky. "We're cataloguing it thematically, and when we want to explore a particular topic it's the first place we look."



*The exhibition opened on 8 November 2022 and will be open to state council members at AMA Victoria's next State Council meeting in March 2023. All members will be able to view the artefacts on at least one other occasion in the intervening period (to be announced).*



*Click here to view the Medical History collections, including parts of the AMA Collection*

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*Dr Lyn-May Lim, Psychiatrist*

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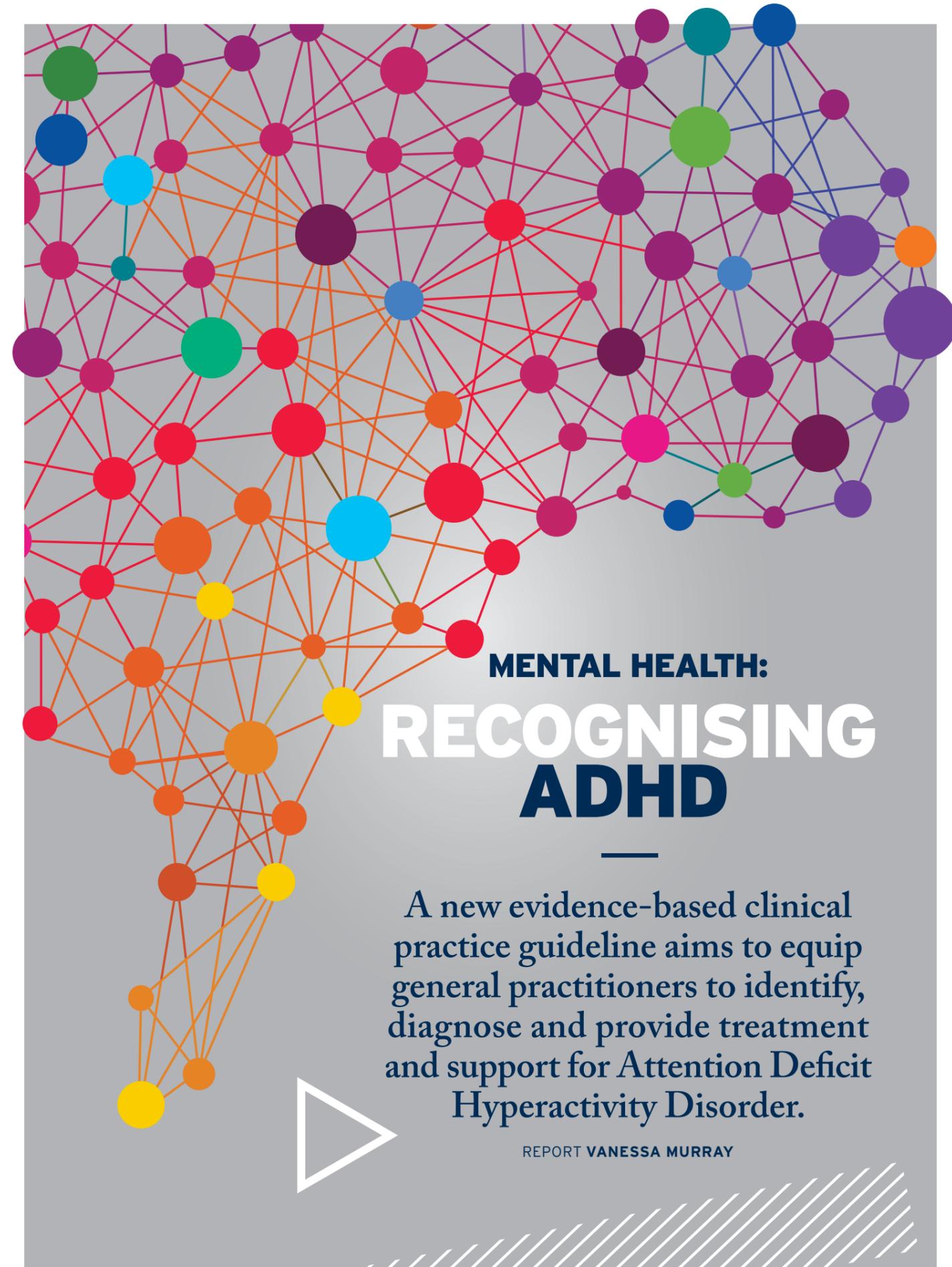
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## MENTAL HEALTH: RECOGNISING ADHD

A new evidence-based clinical practice guideline aims to equip general practitioners to identify, diagnose and provide treatment and support for Attention Deficit Hyperactivity Disorder.

REPORT VANESSA MURRAY

**T**he Australian Evidence-Based Clinical Practice Guideline for ADHD was released by the Australian ADHD Professionals Association (AADPA) in October 2022

and is Australia's first clinical guideline about Attention Deficit Hyperactivity Disorder (ADHD).

Associate Professor John Kramer is Chair of the RACGP's ADHD, ASD and Neurodiversity Specific Interest Group. He says the guidelines are the first national guidelines for 20 years, and that a lot has been discovered about ADHD in that time.

"We're getting better at picking up on ADHD, but it's not being taught to medical students, GPs in training or paediatricians or psychiatrists in training. So, it's very possible to be in practice – even as a paediatrician or a psychiatrist – and to have had very little formal exposure during training. They're being forced to learn on the job, so we need to spread the word around," said Associate Professor Kramer.

#### ADHD AFFECTS OVER ONE MILLION AUSTRALIANS

ADHD is a neurodevelopmental condition with differences in brain and cognitive development. Symptoms include difficulties with focusing and sustaining attention and hyperactive and impulsive symptoms, which are greater than expected for a person's age or developmental level.

It affects over one million Australians and is the most common mental health condition in children, impacting around 6-10 percent of children and 2-5 percent of adults – including women, who have historically been underdiagnosed. A lifelong condition that persists into adulthood for most people, if left untreated ADHD can result in significant functional impairments with poor long-term outcomes.

On top of its toll on individuals and their families, the condition has a considerable social and economic burden, estimated by Deloitte Access Economics to be \$20 billion per year in Australia alone.

Effective non-medication and medication treatments for ADHD can reduce symptoms and improve function and participation, resulting in better personal outcomes and a reduction in community and economic costs.

Given these factors and a rise in referrals for ADHD diagnosis, GPs need to be able to identify, diagnose and provide treatment and support for ADHD.



*Effective non-medication and medication treatments for ADHD can reduce symptoms and improve function and participation, resulting in better personal outcomes and a reduction in community and economic costs*

“

*We're getting better at picking up on ADHD, but it's not being taught to medical students, GPs in training or paediatricians or psychiatrists in training. So, it's very possible to be in practice – even as a paediatrician or a psychiatrist – and to have had very little formal exposure during training. They're being forced to learn on the job, so we need to spread the word around.*



## THE ROLE OF GPs IN ADHD DIAGNOSIS AND TREATMENT

GPs are critical in managing the ongoing care and support needs of people with ADHD.

Their comprehensive involvement in and oversight of individual and family health and wellbeing across the lifespan means they are uniquely placed to support individuals with lifelong disorders, including ADHD.

Paediatricians, child and adolescent psychiatrists and psychologists typically diagnose ADHD in children and adolescents, while psychiatrists and psychologists typically diagnose ADHD in adults. Often, the commencement of diagnosis and treatment for ADHD is facilitated by a GP working together with the person's paediatrician or psychiatrist. It is important for GPs to have referral pathways to these clinicians with expertise in ADHD.

The GP's role can include recognising symptoms and facilitating diagnosis and treatment. Dispelling myths around ADHD and its various treatment pathways is especially valuable in supporting people to access and continue accessing what they need.

## TREATMENT FOR ADHD CAN BE BOTH NON-PHARMACOLOGICAL AND PHARMACOLOGICAL

Non-pharmacological treatments include cognitive-behavioural interventions and ADHD coaching, and where appropriate, GPs can make referrals to psychologists, coaches and other allied health clinicians who have expertise in ADHD. They can also help people with referrals to treat co-occurring conditions and will often be asked to confirm a condition and document what reasonable adjustments may be required in education and workplace settings.

Medications for ADHD can be prescribed by paediatricians, psychiatrists and general practitioners. Supporting GPs to develop their skills in prescribing ADHD medications, including stimulant medication, is an identified need in the guideline.

"Given the delays and lack of access to ADHD medical specialists who can prescribe stimulants, it is critical that more GPs develop competencies in this area," says Associate Professor Kramer. "We also know that accessing healthcare from GPs is more affordable, especially for those on low incomes, which makes GP training particularly important because ADHD has implications for poor health outcomes."



*We know that accessing healthcare from GPs is more affordable, especially for those on low incomes, which makes GP training particularly important because ADHD has implications for poor health outcomes.*



*Now that the guideline is completed, AADPA is working on education packages for clinicians. Click here to access the guideline and associated resources online.*

## FIVE TIPS FOR ADHD DIAGNOSIS + TREATMENT

1

*People usually don't 'grow out' of ADHD*

For most people, symptoms usually persist into adulthood and require continuous treatment. Transition periods between adolescent to adult services need to be carefully managed to ensure the person can access ongoing treatment.

2

*Look out for the inattentive subtype*

The inattentive presentation of ADHD does not include hyperactive-impulsive symptoms, so may not be as easily identified.

Being aware of it is critical to ensuring affected people – including women – are correctly diagnosed and supported.

3

*Co-occurring conditions are common*

Most people with ADHD have other co-occurring conditions which may require treatment and support.

4

*Girls and women also have ADHD*

In adulthood the gender ratio declines from 2-3 boys for every one girl, to ADHD being equally prevalent in men and women.

5

*People with ADHD can be highly intelligent and successful in many parts of their lives*

This does not mean they cannot have ADHD. Many people with ADHD will not be recognised until early adulthood, or later.



## ENVIRONMENT:

# THE URBAN + RURAL HEALTH DISPARITY

Growing up in regional Queensland, I always felt like an outsider. At the time, it was hard to see why. It is only now, as a student in the city studying public health, do I understand why: narratives often revolve around those holding power.

OPINION EEELEEN TEY

Urban Australia has forgotten that it created the rural health disparity – and both rural and urban Australia will suffer for it

*It is clear rural health care must be improved – not only because health is a fundamental human right, but because worsening rural health standards will worsen urban health too.*

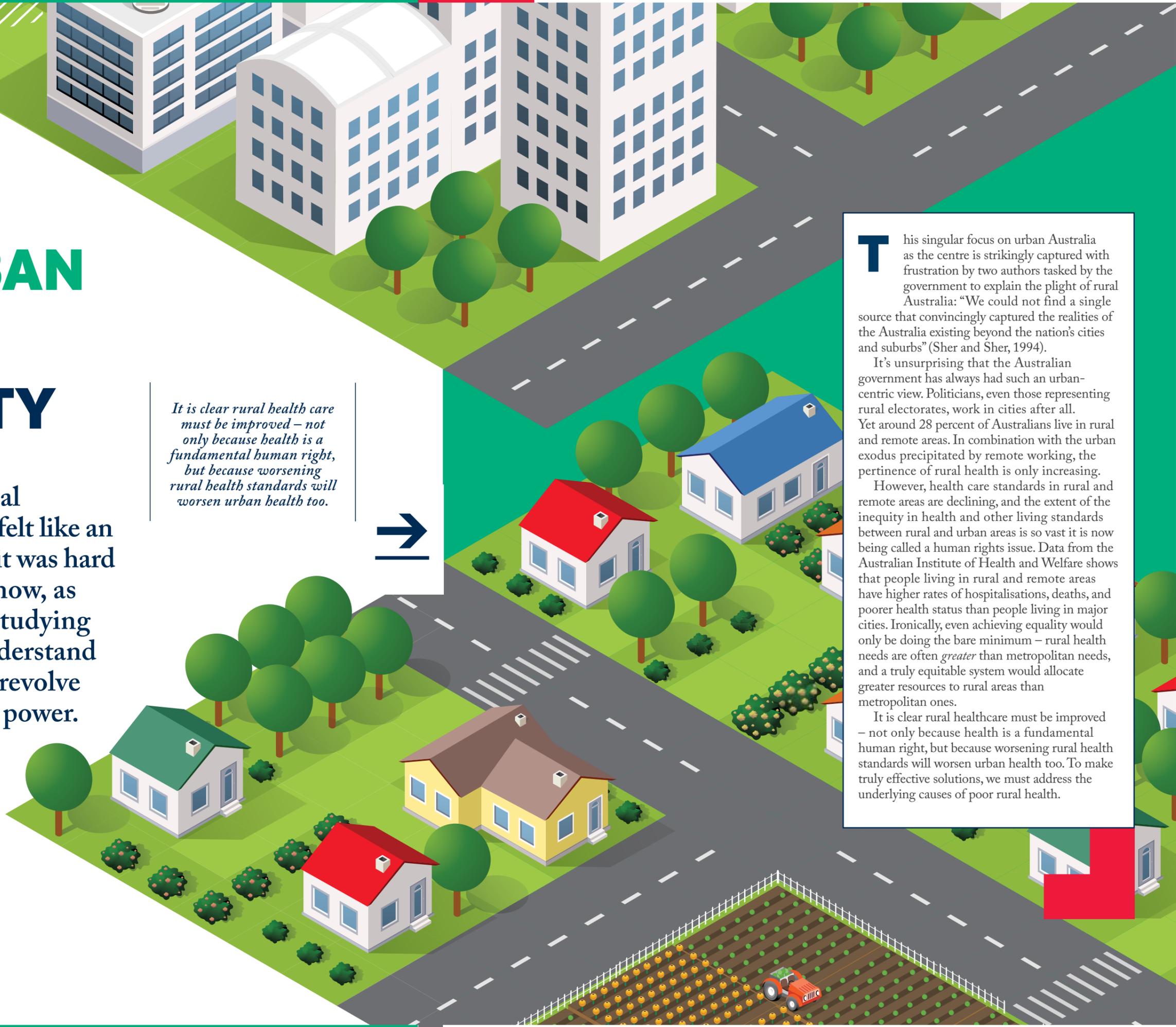


This singular focus on urban Australia as the centre is strikingly captured with frustration by two authors tasked by the government to explain the plight of rural Australia: “We could not find a single source that convincingly captured the realities of the Australia existing beyond the nation’s cities and suburbs” (Sher and Sher, 1994).

It’s unsurprising that the Australian government has always had such an urban-centric view. Politicians, even those representing rural electorates, work in cities after all. Yet around 28 percent of Australians live in rural and remote areas. In combination with the urban exodus precipitated by remote working, the pertinence of rural health is only increasing.

However, health care standards in rural and remote areas are declining, and the extent of the inequity in health and other living standards between rural and urban areas is so vast it is now being called a human rights issue. Data from the Australian Institute of Health and Welfare shows that people living in rural and remote areas have higher rates of hospitalisations, deaths, and poorer health status than people living in major cities. Ironically, even achieving equality would only be doing the bare minimum – rural health needs are often *greater* than metropolitan needs, and a truly equitable system would allocate greater resources to rural areas than metropolitan ones.

It is clear rural healthcare must be improved – not only because health is a fundamental human right, but because worsening rural health standards will worsen urban health too. To make truly effective solutions, we must address the underlying causes of poor rural health.





Most research focuses on the direct causes of poor rural health: health professional shortage, lower income and employment levels, lower educational levels, higher average age, and a lack of geographical healthcare access.

However, this research fails to look at the original urban-centric policies that caused these issues. In the 1980s, the Australian government began to adopt neo-liberal policies that rolled back its intervention in the market, emphasising individual responsibility and prioritising the free market. However, rural communities – with their smaller businesses and populations – were disadvantaged by this shift while urban areas benefitted. This is for three main reasons: a dynamic market for services is less likely to exist in rural regions and hence competition is less likely to result in more competitive businesses, job losses have significant consequences in rural communities as alternative employment prospects are limited, and small businesses are unlikely to achieve the economies of scale that competitive markets favour.

One study for example shows how Australia's National Competition Policy (NCP) and compulsory competitive tendering in Victoria potentially led to "the economic hollowing of country Victoria" (Ernst et al., 1998). Testifying to this, a 1998 submission to the Productivity Commission by the Grains Council of Australia warned that, if the NCP were to continue without any adjustments for rural Australia, Australia's grain industry would suffer and rural Australians as a result. However, the NCP continued, and a 1999 Productivity Commission review of the NCP found that the program indeed favoured metropolitan areas more than rural and regional areas. A 2005 review at the program's conclusion found again that it had had negative influences on economic activity and employment in a number of smaller regional areas while those living in major cities recorded the greatest increases in incomes. The Commission bluntly acknowledged that it was "inevitable" that reforms designed to remove sources of inefficiency in the economy would create "losers" and "winners" – with the "losers" being regional areas who suffered job losses and reduced incomes.

In combination, these policies whittled away rural incomes and resulted in an oft-seen downwards spiral in rural regions, where unemployment and reduced incomes made it even harder for rural areas to attract new employers or employees. Additionally, perceived lack of opportunity in rural areas incentivised young people to leave for Australia's cities, and these reduced populations reduced the availability of amenities. It also reduced government support for hospitals via the casemix funding model, which funds hospitals based on the number of patients treated and activities conducted. Reduced hospital capability itself began a downwards spiral that challenged hospitals' viability as it meant that complex patients were transferred to larger hospitals – further reducing the need for funding. This has resulted in the unattractiveness of rural areas to health professionals that we see today. These professionals commonly cite disincentivising factors such as poor hospital infrastructure and a lack of opportunities for children and partners.

A more insidious factor was also at play: rural-urban power differentials. The longstanding urban-centric narrative of Australia consisting of powerful urban centres orbited by rural communities discreetly led to the de-prioritisation of rural Australia in Australian policy. Additionally, economic restructuring in the late 20th century from agricultural, mining and manufacturing to service-based sectors, the deregulation of the financial system, as well as the increasingly market-based system gave metropolitan cities further financial and labour-force advantages that translated into power and influence. Concurrently, rural capacity to advocate for increased funding and services declined with growing disadvantage.

Urban health is ultimately linked to rural health. An erosion in rural healthcare capacity ultimately results in overloaded metropolitan cities and hospitals. This is already happening in Canada, where Ontario's urban hospitals have become overwhelmed by dislocated rural patients. A 1998 research paper on the decline of rural Australia damningly predicted this very scenario, saying: "metropolitan Melbourne and half a dozen regional centres will in future service the needs of ever-declining rural populations" (Ernst et al., 1998).



*To draw people back into rural towns and improve socioeconomic and educational status, we need to turn our focus to diversifying rural jobs and skills and building towns with a future.*



## SO – WHAT CAN BE DONE?

We can remedy the effects of increasing urbanisation through market forces by shifting our rural health policies back towards reasonable levels of government intervention. Government initiatives for rural healthcare currently revolve around enforcing people to work rurally – for example via bonded medical places and rural training pathways – or increasing monetary incentives for rural work. However, this does nothing to break the fundamental cycle of decline in rural hospitals and towns. To draw people back into rural towns and improve socioeconomic and educational status, we need to turn our focus to diversifying rural jobs and skills and building towns with a future. We need to set up rural businesses in a way that sets them up for a service-based future. We also need to turn to a different model of care for rural hospitals – moving the burden of care from centralised hospitals to decentralised rural health centres that allow healthcare to be tailored to local needs. Lastly, while certain rural hospitals have transitioned from an activity-based funding model to block funding, rural GPs need to be given the same type of funding to truly give traction to the decentralised approach.

Ultimately, we need to move away from an urban-centric narrative towards one that recognises the importance of rural wellbeing for Australian wellbeing. In doing so, we can finally move from the margins the rural voice so that it is no longer that of an outsider.





I didn't realise how tough it would be working long hours and being pregnant, and how that would impact me



**DR SARAH ATACHCHI**

*As told to 9Honey's Maddison Leach*



**PREGNANCY DIARIES:**

**AS A DOCTOR, I FEARED THE WORST WHEN I FELL PREGNANT**

Ever wonder if other women experience pregnancy the same way you do? In this diary entry, mum and paediatrician Sarah Arachchi admits everything she'd seen as a doctor only made her more worried during her pregnancy.



As a paediatrician, I've seen a lot of pregnant women in my time, so I definitely had an idea of what to expect when I fell pregnant the first time. But I didn't realise how tough it would be working long hours and being pregnant, and how that would impact me.

I remember going into the obstetrician's office at around 14 weeks and he told me I had high blood pressure. I was like, what? I've looked after women with high blood and I knew all of the risk factors but it was quite a shock. I was working so hard at the hospital, I didn't realise that it had impacted on my blood pressure.

I really had to take a step back after that. The team supported me and I didn't have to do super long hours or late shifts, which really did help. But I had to stop and think, 'I have to take care of this baby because no one else is going to'.

I was working in the hospital doing lots of walking and I was on my feet a lot in a busy ward. There were a lot of illnesses and I got the flu. It was terrible, I was in bed for a week and I couldn't breathe properly and had really bad chest pain. I went to the hospital and because I have asthma, I was wiped out for a whole week.

And because I was pregnant it was worse. My coworkers said I needed to take time off, but I felt so guilty about that. In pregnancy, you don't realise how compromised you actually are and that you're more prone to picking up other infections.

Later on in the pregnancy, I was offered a job but I turned it down because I didn't want to come back to work at six months postpartum. I wanted to spend more time with the baby.

At around 30 weeks, I pushed a really heavy IV trolley and I didn't think about it. The next day I was in hospital with pelvic pain and had to have an ultrasound

because they worried that I'd been bleeding. Luckily it was all fine, but these are things that I never thought about.

The other issue with being a doctor is you know too much; you know about all the complications that could happen, like preterm delivery. I don't think it's normal but a lot of doctors do think like that.

I had all these unnecessary fears based on what I've seen. I've looked after babies in NICU, I've resuscitated babies. You see the worst side.

When I had my first son, I had an emergency C-section and that was probably what took me the most by surprise. I've been on the other end of that procedure and when babies are born, I'm the doctor that they hand the baby to so I've seen the procedure hundreds of times. But it's so different when you are the one lying on the table.

The weird thing was afterwards, I didn't expect the pain. I remember saying to the obstetrician, 'I feel like I was cut open with a knife'. And he goes, 'Yes you were'.

I didn't expect to feel so isolated in that situation, even though there were doctors and nurses doing what they needed to do around me. It was a weekend too, so I had to wait in recovery and I was separated from my son for almost an hour or maybe longer. I was shivering and I didn't have the baby with me.

Even for me as a paediatrician, I never saw that side. I'd get the baby, the mum would be closed up and then we'd focus on the baby. You do think about the mum, but I focus more on the baby so I didn't expect it.

You grow this human being inside of you for so long and you have this imagination of what birth is going to be like. And then when it's different, it's really hard to comprehend. I think a lot of women feel like something was almost taken away from them.

Then for my second pregnancy, I actually started bleeding from 24 weeks which was unexpected. I had to limit my activity and I got hospitalised for a week at around 30 weeks. I just had to do bed rest in the hospital for a whole week because I was bleeding.

For that birth I had to do a caesarean again, but the best thing was I had an elective caesarean and I knew what it was going to be like. I had my hair done, I had my nails done, I had everything done and I was ready so it was much better.

Yes, it was painful, I knew it was painful, but I was more prepared for it. My son was put on my chest straight away and I was able to breastfeed him straight away. I think the first experience definitely shaped the second and I made better choices the second time around.

My experience as a doctor was different to a lot of other women and that really shaped my pregnancy. There was a lot of fear but there was also a lot of joy as well. The kicks and the kicking and feeling that something is alive inside of you, that was amazing. I loved that all the beautiful things about being pregnant.

**The best piece of advice**

**I can give is to be prepared.**

**Talk to your friends, talk to**

**women who have had**

**different experiences.**

Everybody knows someone who's had a C-section. And don't think that your birth plan will go perfectly, you can have a hope for something, but then you need to have a backup plan if it doesn't work. Have a support network and know where you can go for help."

JOIN THE CONVERSATION

# AMAV SOCIALS



*Digital communications  
specialist Lily Pavlovic*



**Matt from Bongiorno**  
([matt\\_from\\_bongiorno](#))

This week #MitchMcKeown and I spread our wings and gave a new media platform a run. @youramavic invited us to do a #podcast on Salary Packaging to help recently graduated medical students prepare for their Internship. It's fair to say we think we nailed it – watch out @willandwoody Watch this space for the actual podcast #bongiornogroup #accounting #tax #insurance #finance #finanicalservices #financialplanning

**Anthony Dunin**

[On the article 'whole person healthcare for health professionals']: "We are human too, just like our patients."

**Goran Petrovic**

[On the article 'whole person healthcare for health professionals']: "...Have seen a lot more emphasis on health over the years amongst our colleagues. Health doesn't discriminate."

**Dr Tahnee Bridson**

"This #worldmentalhealthday I'm excited to announce I'll be a guest speaker at the 'Flourish – Women in Medicine' event. I'll be talking about all things mental health and doctors wellbeing."

**Kay Dunkley**

Wonderful networking during the @amavictoriawomen in medicine flourish event.



**Rob Phair**

"Great to see a #ClimateEmergency clause in the new @amavictoria EBA which allows engagement, education and #ClimateActionNow discussion. This is reportedly the first of its kind in an industrial agreement and places #ClimateAction front and centre as a matter of employment."

**Jasmine Davis**  
(**AMSA President**)

"[Flourish by AMAV Women in Medicine] was a great event. Thanks @M\_Kay\_Dunkley and @amavictoria – taking time out as a #womaninmedicine to prioritise well-being and career development is so important! Hope there are many more in person catch ups..."

**Simon Mathieson**

[On the article What is the difference between incivility, bullying, harassment and discrimination?]: "...It's great to see incivility and its impact included here. I can't tell you how many staff I have lost to its effects. It's great to see the Australian Medical Association advocating for change and while supports are really important, prevention must also be prioritised."

**Jasmine Davis**  
(**AMSA President**)

"Thanks to Australian Medical Association (Victoria) for the opportunity to write a piece for the latest VICDOC edition on 'Transitions' – sharing my thoughts on #rural transitions and how students can best prepare for rural terms."

**Doctors' Health in Queensland**

[On the article Leadership insight #14: The power of the 'check-in']: "Start small and grow big. There is power in these small steps. They are the foundations of conversations and professional relationships that can then support the navigation of bigger, more challenging conversations that are done well and are productive."

**Jannette Langley - Labor for Gippsland**

"[The Climate Change clause in Victorian doctors' enterprise agreements] is fantastic to see. Hopefully more agreements have this introduced."

**Dr Tahnee Bridson**

[On the AMAV Women in Medicine Flourish event]: "Thank you @M\_Kay\_Dunkley and @amavictoria for putting on a fantastic event. Was great to be back in person."

**Dr Lanka Wijewardena**  
(**Heal with Buddhism**)

[On the AMAV Women in Medicine Flourish event]: "Thank you AMAV for this amazing opportunity. I am really excited to be part of your great effort to look after doctors' wellbeing."

**Doctors' Health in Queensland**

[On the article 'loneliness and social isolation']: "The lasting solution to emotional loneliness is to establish and maintain a healthy support system of friends and family..."



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## INTERNSHIP:

# REFLECTIONS ON THE TRAINEE'S ENVIRONMENT

As medical trainees, our environment dictates much of our professional lives. From the university environment of preclinical medicine to the hospital and clinic environments of clinical rotations, we become familiar with transitioning through many different environments.



**LEE YINGTONG LI**

*Chair of the Medical Student Council of Victoria, and a 2023 medical intern*



**W**ith each rotation, we often have only a few weeks to get to know a fresh set of people, places and protocols, before moving to the next. Looking back on medical school, the environments I've experienced have led me to some insights I'll take with me into my future.

The environments of my medical education so far have been diverse and varied. Sometimes a spacious open-plan office with generous windows and a view of the park; more often a small, cramped room in the back of the ward. Sometimes busy with doctors rushing to and fro; other times quieter. The settings of medicine have perhaps been even more varied since COVID-19, with the addition of telehealth clinics and online teaching as settings for study and work. What I have found, though, is the feature of the environment which impacted my experience the most has been the people. The environments that energised me were ones where I was surrounded by people who were passionate about their work, were invested in learning, growth and excellence, and had compassion for each other as well as their patients. This has weighed significantly in my mind, perhaps even as the most important factor, in deciding what to specialise in and where to train.

At the same time, this has given me perspective on my own role in creating a positive work environment. As a final-year student, and next year as an intern, I have my own junior medical students to supervise. Medical students appreciate that the learning one has in a supportive environment, where doctors know your name, talk to you and get you involved, is vastly different to the experience one has waiting outside curtains, hiding at the back of the ward round and being generally ignored.

It's important for me to play my part, then, in creating a positive learning environment for those

I supervise. The environment of one's work is an important factor for many students and doctors in training, including my graduating final-year colleagues, judging by the focus of health services' intern information sessions and panels. While the usual questions about training pathways and rotations feature, and we are all looking for different things in our internship sites, there is always attention and commentary given to junior doctors' wellbeing and support, and attitudes towards bullying and harassment. Indeed, with junior doctors' mental health and AMA Victoria's class action lawsuits in the news, it is fair to say the work environment of doctors has reached the public consciousness.

Now I am certainly only at the very beginning of my medical career, and there will assuredly be many more environments to see. Yet at the same time, there is a sense in which the earliest years of rotational training are the ones with the most variety. As we progress through training, our terms grow longer, our roles more stable and our experience more specialised, which gives one pause for thought. For example, with my own intern year roster freshly in hand, and with plans for the future, it appears 2019 may inadvertently turn out to have been my last experience, ever, of the environment of adult specialty medicine. I am glad that, on that rotation, I did pay attention and learn what I ought to – it would be a shame, and a detriment to the care of my future patients, had I let that final opportunity lapse. It is a reminder, though, that my next experience of any rotation could be the last, and I'll not know except in hindsight. What this suggests, I think, is the value of savouring each experience, and making the most of everything in each environment we find ourselves in. It is an attitude I'll be sure to take with me as I continue in my medical career.



*The environments that energised me were ones where I was surrounded by people who were passionate about their work, were invested in learning, growth and excellence, and had compassion for each other as well as their patients.*

AMA HOUSE

# 'FLOURISH' AMAV WOMEN IN MEDICINE

18 October 2022



Speakers:  
Dr Tahnee Bridson,  
Dr Patrick Johnson,  
Dr Dominic Barbaro,  
Sarah Thorburn,  
Vanessa Smith,  
Dr Lanka  
Wijewardena

Lakmini  
De Silva



*I was overjoyed to attend and chair 'FLOURISH', our first meeting organised by AMA WIM and AMA Victoria back at AMA House. The attendance was great, and everyone was very excited to be back meeting face to face. It was wonderful to see a broad range of members from medical students to retired members.*

REPORT DR LINDA SCHACHTER  
CHAIR OF AMA WIM COMMITTEE

The aim of this meeting was to give members some ideas of the support available to those who are struggling at this difficult time working and studying in healthcare.

The speakers included Dr Tahnee Bridson, the founder of Hand-n-Hand Peer Support. Tahnee is a psychiatry registrar who described her difficulties being unwell during her training and the lack of support she encountered during this time. In response to her struggles, she set up Hand-n-Hand peer support, a group offering peer support to all healthcare workers.

There are currently 97 peer support groups offering hundreds of healthcare workers peer support through multiple issues.

I was so motivated by Tahnee and her journey, that I have volunteered to be a facilitator!

Dr Patrick Johnson, Medical Director of the Victorian Doctors Health Program also spoke. He explained that this confidential program has been set up to help doctors with mental health issues, stress, substance use problems and other medical problems that affect doctors' abilities to work and function. This program currently includes psychiatrists, GPs and psychologists. Patrick is looking to expand the program and expedite treatment in other areas.

Dr Dominic Barbaro, President of the Victorian Medical Benevolent Association, was in the audience and spoke briefly about providing financial aid to those in need.

Sarah Thorburn and Vanessa Smith from Bongiorno Group spoke about financial health and the differences in women's financial needs across their working lives, including during maternity leave and retirement. Questions about superannuation, home ownership and financial independence were also interesting and started a robust discussion. One question about homelessness in middle aged women brought up the vulnerability of women.

Dr Lanka Wijewardena, the Founder/CEO of Heal with Buddhism was the last speaker and spoke about Buddhism and its value in wellbeing of individuals and society. Lanka led the group in a relaxing meditation.

Lots of delicious food was provided by caterers Asylum Seeker Resource Centre Catering. Looking forward to many more functions together.



## LEADERSHIP TIPS:

# PREGNANCY+ TRANSITIONS

In the spring issue of VICDOC, I wrote about how leaders can support the transition to parenthood. In this edition, we focus on the specific skills leaders can develop to support doctors who are planning a pregnancy or juggling a pregnancy at work.

REPORT DR ANNA CLARK (PHD)  
AMA VICTORIA LEADERSHIP CONSULTANT + COACH

  
*Click here for Spring issue of VICDOC*



Phases of pregnancy are physically, physiologically, & emotionally demanding. They are also short. Supporting people in these times is an investment in our workforce.

**WHAT DO WE KNOW?**  
—  
We know that pregnancy and planning for pregnancy is a personal time, meaning that we can't necessarily have open and transparent conversations about what's going on. Many people can be guarded about their pregnancy early on.  
We also know there can be stigma around pregnancy in a professional environment. For example, assumptions can be made that the pregnant person no longer prioritises their work or career, that they are uncommitted and less competent, compounding the problem of talking openly about pregnancy at work.  
Phases of pregnancy are physically, physiologically, and emotionally demanding, and this takes a toll on our energy levels and resources. Time and rest can therefore be required suddenly by the pregnant person, without the ability to share the reasons why.  
Further, planning a pregnancy and the pregnancy itself has uncertain timelines. There is uncertainty about when a pregnancy will begin, if it runs to term, and the exact nature of how parents will take parental leave and manage caring for their baby.

**HOW CAN LEADERS SUPPORT PREGNANCY AT WORK?**  
—  
Strong leaders understand the importance of building strong and sustainable workforces, and retaining talent and experience, and they plan to accommodate the changing needs of their staff.  
Leaders can use their knowledge of possible and likely challenges pregnancies face in the work environment and use workforce design skills and interpersonal communication skills to support change, flexibility, and sensitivity.



*Leaders need to view their team members as people – with lives beyond work.*



*Click here for individual coaching*

**LEADERS CAN:**

**1/ REFLECT ON HOW WE WORK WITH UNCERTAINTY & CHANGE**

In a robust and healthy workforce, employees feel that their workplace can accommodate short term changes and modifications to support employee needs. For example, if someone needed to suddenly attend early medical appointments, or was for a time unable to work on the COVID ward, that this could be talked about without fear of negative consequences.

**Leadership skill**

Practice a change-ready mindset; talk about how 'we' (as a team) can adapt to new situations and be flexible and agile to meet change and uncertainty. COVID has been a great teacher in this area – we can learn from recent experiences of adaptation to meet changing scenarios and predictions. This will help with workforce engagement – earning commitment and dedication, and support learning and growth. When employees feel valued and feel that leaders are looking out for them and their future, they too can also plan for the medium and long term and feel that it's worthwhile to invest in growth and development. While parents-to-be may not be willing to talk openly about the challenges of pregnancy, they can see that their workplace can handle additional demands, and that needing changes is not a major risk to their job.

**2/ BUILD SOLID AND COMPETENT TEAMS WITH CLEAR ROLES & RESPONSIBILITIES**

Clear team structure and roles support workforce planning. It helps with selection and recruitment, with professional development, and creates muscle for team-level flexibility to accommodate changes in responsibilities and duties. Workplaces have many types of flexibility and need for short-term leave (e.g., study leave, conference leave, long service, carer's leave for partners, families, aging parents, sick leave, family holidays). Sometimes there may be also a need to accommodate leave for pregnancy requirements.

**Leadership skill**

Ensure you have an accurate map or plan of you team, department, or area. Who is working in your area? What is their role? What responsibilities are attached to this role? Are there duties or roles that aren't covered or accounted for? Who is showing talent and engagement in particular roles or tasks? When and if people leave or move into another role – who is in the pipeline or succession plan? Many senior leaders are working on the strategic planning that supports well designed collaborative teams that can deliver a robust and sustainable service. This strategic thinking and planning means leaders have strong knowledge of their workforce and can organise cover for roles in a productive way.

**3/ IMPROVE YOUR ABILITY TO HAVE PROFESSIONAL CONVERSATIONS AROUND PERSONAL & PRIVATE MATTERS**

Leaders need to view their team members as people – with lives beyond work. In early career, cementing technical expertise and training requirements likely coincides with forming intimate relationships, friendships, and professional networks. The mid-career phase often includes starting and raising a family. Later it's aging parents and perhaps one's own changing health and lifestyle needs. When leaders can hold all of this in mind and include it in their planning for the present and future, workforces can grow and thrive, as long term investment in good people make the short term 'work arounds' more than worth it.

**Leadership skills**

Develop a holistic perspective your own career and have the self-knowledge and awareness to reflect on your own experience of juggling the personal and professional. While not every leader has been pregnant or raised a family, everyone has times in their lives, and personal or private challenges, that go better when their workplace can support them. This awareness also helps us manage any assumptions or bias that could influence our thinking and judgement, supporting us to be open to listening and understanding what a team member might need to support their current role or career progression.

**SUMMARY**

Leaders need to nurture and develop healthy and sustainable workforces. Many of the skills leaders bring to this task are their interpersonal and team communication skills. Remember that the conversations you have to support pregnancies are not about pregnancy per se – they are about work, and how we organise ourselves and our resources to work the best we can together and deliver the best healthcare service we can.

Personal life events and transitions – like a pregnancy – can bring challenges to this; challenges because they can arrive suddenly and involve an individual who may need their responsibility or time commitments changed. But this is life. The work of leadership is to support healthy and sustainable workforces around this.



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

SPRING  
**LUNCHEON  
FOR RETIRED  
DOCTORS**

29 September 2022

The Retired Doctors Group, through its informal social lunches with a guest speaker is a great way to enjoy the comradery of old and new colleagues

“  
*Our guest speaker was Mr John Hasker AM who spoke about The Sinking of the HMAS Sydney (II) in November 1941. John, now retired, was a Civil Engineering graduate from the University of Melbourne in 1960.*

REPORT DR JEAN DOUGLAS  
RETIRED GENERAL PRACTITIONER  
AMA VICTORIA RETIRED  
DOCTORS COMMITTEE

**F**ifty eight doctors, partners and friends attended our successful Retired Doctors' Luncheon at Young and Jackson's Hotel in the city during September. Our guest speaker was Mr John Hasker AM who spoke about The Sinking of the HMAS Sydney (II) in November 1941. John, now retired, was a Civil Engineering graduate from the University of Melbourne in 1960. John told the group about his cousin Dr John Reid Hasker (Jack), Surgeon Commander, the Senior Medical Officer on the HMAS Sydney when it was sunk by the German raider cruiser Kormoran after a short battle off the coast of Western Australia. John had only a basic knowledge of Jack when he was contacted by a Geelong journalist for comment after the wreckage of the Sydney was found in 2008. John was curious to research his cousin's short life as not a lot had been passed down. Families so rarely discussed their war experiences and losses. He discovered that Jack Hasker was 41 years old and single when he was lost in the Indian Ocean with 644 other naval seamen. He was born in Ballarat. His father, Thomas, was a bank manager with the Bank of NSW in country Victoria. After being transferred to Warrnambool this became the family home for many years. He attended Geelong Grammar from 1915-1918 then to Trinity College at Melbourne University where he graduated in Medicine in 1925. He was a sports all-rounder at school and university. After graduation his residency was at the Bendigo Hospital. In May 1928 he joined the Australian Navy and as a career naval officer served on a number of navy ships and bases such as Cerberus, Adelaide, Penguin, Swan and Hobart. He was posted to the HMAS Sydney on a number of occasions early in 1941 as the Senior Medical Officer. John recalled hearing Dr John's sister Meg speaking about being visited by him whilst on leave shortly before his ship left for Western Australia. This would have been the last time he saw his family. Much controversy about the sinking of HMAS Sydney can be found. No documentation remain from the ship with German logs and diaries the only recordings of the battle. Despite much discussion within the Australian government over many years, the wreckage of both the Sydney and the Kormoran was found in 2008 by David Mearns, a private underwater shipwreck hunter. John and his daughter Lisa were fortunate to be invited to Western Australia in 2008 to travel on the HMAS Manoora to the wreckage site with 280 other family descendants. John discussed hearing stories from other relatives of Jack's medical practice on board ship: retold by their kin who left the ship before it sunk. There was no doubt he was a well-respected and caring ship's doctor. The other doctor lost was Surgeon Lieutenant Commander Francis Harrison Genge, a NSW doctor stationed at Flinders Naval Base as well as dentist Surgeon Lieutenant Mervyn Townsend brother of Professor Lance Townsend, the noted Obstetrics and Gynaecology academic from the University of Melbourne. It was a privilege to have John as our guest speaker and John felt very privileged to meet many friends and colleagues from his school and Ormond College days who attended the lunch.

## PRIVATE PRACTICE:



# ARE YOU CONSIDERING ESTABLISHING YOUR OWN PRIVATE PRACTICE?

To discuss your next commercial property decision in conjunction with your future financial plan contact the Bongiorno Group

There are a number of general and professional factors to cover to ensure you get it right. Julian Muldoon, Director and Founding Partner of 1Group Property Advisory provides us with some key considerations to think about when it comes to this big decision.

There's an incredibly important aspect of starting a private practice which is often not given the time and energy commensurate with its importance. We are talking about finding the right location AND securing the right property for your private practice.

Unfortunately, many doctors get this part wrong. And that's not surprising, as it's complex and not something to learn 'on the fly'. Each parameter counts and every decision is final.

### WHY IS LOCATION STRATEGY IMPORTANT?

Choosing the right location is such a vital decision and a critical step in launching (or relocating) your practice. Getting it right can mean huge upside for you and your business. We're talking about:

- » Successful launch of the practice – being profitable quicker
- » Security of tenure and market share
- » Attracting the right doctors and other team members
- » Wealth creation for you

But on the other side of the coin, overlooking something in your strategy can lead to you wasting your time, energy and regretting the decision for years to come. We have found that a lot of doctors can get caught up in what seems convenient or right, rather than aligning their location strategy to what's optimal for the target market or their business model. So, here we will provide you with a few key things to look out for when developing your location strategy so you can avoid some common pitfalls.

## GENERAL CONSIDERATIONS

No matter the property, there are usually some common aspects to consider. Now this is not an exhaustive list and there is more to it, but a few things to keep in mind include:

### Zoning and planning overlays

- » The site must be zoned appropriately and it's important to know whether the size and scale of the project would be supported by council.

### Parking

- » Are there adequate parking spaces for patients and staff?

### Accessibility

- » You want a site that is going to be easy to find, park at and enter
- » Will patients have a good experience locating your practice and navigating the building?
- » Is the site accessible and convenient for the doctor/s?
- » Is it compliant?

### Property

- » How well does the building convert to healthcare use?
- » What are the expected project costs? Are you over capitalising?

## PROFESSIONAL CONSIDERATIONS

Now, depending on your profession, there are likely some specific things to consider, to give yourself the best chance at success.

### Potential practice location – what should I consider?

- » Other medical practices
- » Other health services
- » Pharmacies
- » Hospitals
- » Aged care services
- » Community facilities
- » Transport infrastructure
- » Pathology and diagnostic services

Consider this list. Depending on your field, some of the suggestions there may be vital, or they may be irrelevant. Either way, it goes to show the sort of things you should be thinking about and the vast number of moving parts and integration points.

Other professional considerations might also include:

### Target market / Demographics

- » Who is your core client?
- » Where do they live, where do they frequent? What else do they need that you can leverage off?
- » Your location would likely be different if your target market is the older population versus if it were young families
- » Looking at demographics can reveal incredibly important information about your market and what they value
- » What sort of income and work statistics are prevalent in the area? This is particularly important depending if you bulk bill or have patients that primarily use private health and pay per visit

### Competition

- » What competition is nearby?
- » What other complimentary medical services/businesses are nearby?
- » Is there enough target market to share between your competitors and your new practice in your 'catchment area'?
- » With dental, veterinary and primary health businesses, it's best to try and 'own' a catchment area
- » Where are the service gaps?
- » Does the area have sufficient patient numbers to share around or very high population growth to support the new services

As you can see, it's quite involved. There's so much to think about and little margin for error, which is where engaging partners like 1Group Property and the Bongiorno Group can play a big part in formulating a solid and successful plan.



Click here to book an exclusive AMA Victoria member complimentary meeting

By: The Bongiorno Group with Julian Muldoon, Director, 1Group Property Advisory. This general advice has been prepared without taking account of your objectives, financial situation or needs, you should consider the appropriateness of this advice before acting on it. If this general advice relates to acquiring a financial product, you should obtain a product disclosure statement before deciding to acquire the product.

# EMERGING LEADER PROGRAM



Click here  
to enrol



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

AMA Victoria's flagship leadership development program for emerging leaders in medicine is back in 2023 with registrations now open for our first intake commencing on Saturday 6 May 2023 and we would love for you to join us.

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

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

For any queries,  
please call us on  
03 9280 8797 or  
email us at  
[careersadvisor@  
amavic.com.au](mailto:careersadvisor@amavic.com.au)



## RESOLVING PRACTICE DISPUTES

Kennedys

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Melbourne Victoria 3000

Australia

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*Disputes arise even in the most successful practices, and often amongst partners or colleagues who have otherwise worked harmoniously. Topics that commonly cause conflict include decisions about premises, the sale or acquisition of a practice, the accounting treatment of profits and expenses, and the impact of the retirement or under-contribution of a partner. What can your practice do to minimise the disruption that is commonly caused by these disputes?*

### GIVE YOUR PRACTICE AGREEMENTS A 'HEALTH CHECK'

Ensure that your practice agreements contain the 'rules' for how important decisions will be made and any disputes resolved.

Have your agreements evolved with your practice? Do they reflect the operational realities of your business?

What are the decisions that will require a special vote of all of the partners? Examples include a decision to re-name or relocate the practice, introduce a new practice area, or acquire or sell property.

Do your agreements set out what must happen when a partner decides to leave the practice or a new partner joins, or how an interest in the practice will be valued?

Good agreements will reduce the possibility of conflict escalating and provide certainty when a quick or unpopular decision is required.

### CHAMPION GOOD GOVERNANCE IN YOUR PRACTICE

Even in a small practice, effective systems and processes are essential. Utilise the skills of your practice manager to establish and champion governance in your practice.

Set agendas for your meetings, meet regularly, and record discussion and outcomes in accurate minutes. In the event of a dispute, these records will be the most reliable evidence of what has occurred.

Provide proper notice of meetings and conduct meetings in accordance with the requirements of your practice. This will reduce the likelihood of a decision being attacked or 'unwound' because of a process irregularity.

Many disputes arise because a partner is 'kept out' of information. Provide all partners with free and equal access to practice accounts and records. If you believe it is necessary to exclude a partner in order to protect your practice, seek legal advice.

Keep your practice accountant independent, so that all partners have confidence in the accounts when a dispute about financials arises or a valuation is required.

### ACT QUICKLY WHEN A DISPUTE ARISES

Most disputes can be resolved without the need for court proceedings. This is especially so when early steps are taken to confine and address a problem.

Your practice agreements should prescribe a mechanism for resolving disputes that do not require urgent legal intervention.

Waiting too long to address a problem inevitably makes the problem bigger and more difficult and costly to resolve.

Where a dispute is broad or intractable, identify matters that might be capable of interim resolution while bigger issues are dealt with. For example, it might be possible to preserve disputed funds in a trust account for a period of time, while broader negotiations occur.

A network of trusted professional advisers who understand your practice and can work together to support your business if difficulties arise is invaluable.

AUTHOR JANE KUPSCH  
PARTNER KENNEDYS (MELBOURNE)

# MEDICARE + OP-ED



**PROF STEVE ROBSON**

*AMA President*



*It's perhaps Australia's most treasured piece of public policy. The green and gold card is practically part of the Australian identity. It's completely understandable, therefore, that when allegations of \$8 billion being wasted in fraud are made, national attention is swift and condemnation fierce. If only it were true.*



The suggestion that \$8 billion (around 30 percent) of the spend on Medicare is being defrauded has been shown to be based on anecdotes, simplistic analysis and opinion, rather than any rigorous data or comprehensive statistical analysis. This goes some way to explaining the utter puzzlement of the medical profession, and the federal government (as the holder of Medicare data) for that matter, at the suggestion.

But it's completely understandable that Australians responded this way, when presented with these figures as "facts".

We've seen Medicare used as a political football before – through five years of a Medicare freeze as a savings measure – pushing costs away from government and onto patients.

And we're seeing pressures on general practice like never before, with increasing out-of-pocket costs as the Medicare patient rebate falls further and further behind.

Clearly change is needed. Doctors and the community know this.

From the AMA's perspective, to achieve this change it's critical we do three things.

Firstly, we do need to increase the funding to Medicare. At the beginning of the year the patient's rebate for a regular GP consult was \$39.10. After indexing it in July, it is now \$39.75. That's not going to do much in an inflation environment of around 7 per cent. Something is broken here.

Secondly, we need to continue to stamp out any fraud, mistakes, and wastage – something the AMA (with the wider profession) has dedicated a significant amount of its resources to over many years.

Over 700 clinicians gave up their time to be part of a five-year effort to review the entire Medicare system, through the MBS Review. You don't do that if you're not interested in protecting the system from misuse.

In recent years we have backed legislative reforms to increase Medicare audit and compliance powers, making it easier for government to tackle allegations of Medicare fraud. The specific cases being quoted in the media are largely those that have been detected under the current compliance and audit regime, showing the system is working. We've been regularly consulted on the Department of Health's education program – helping to shape letters to practitioners on Medicare by using the Department's advanced data analytics to support practitioners who genuinely struggle to understand often complex Medicare rules.

Where issues of fraud appear, we've worked with the government's compliance and risk program, alerting them to issues, and supporting efforts to quickly address any inappropriate and unethical use – including where necessary through referral to the Professional Services Review. The AMA always has, and always will, have a strong stand on our role as stewards of the system. It's also why we implored health ministers to ditch a plan that would have seen cosmetic surgeons able to use patient testimonials on social media. We need tighter controls on cosmetic surgery, not a TikTok free for all.

Thirdly, much of the recent debate has centred on how complicated, confusing and convoluted the system is. We'd agree. It's why the AMA is running a campaign called "Modernise Medicare", focussed on reforming the system to fund coordinated, multi-disciplinary care under one roof.

You shouldn't have to bounce around the health system to see a doctor, a nurse, an allied health specialist. It's a travesty those with chronic wounds can't afford bandages to take to the GP, because we don't fund it as a nation. We don't fund GPs to make it sustainable to be open after hours, while also expecting them to devote huge amounts of their time to completely unfunded healthcare delivery, because the 'system' hasn't kept up with Australian's healthcare needs.

It's no surprise Australians' needing health care miss out, become sicker and end up caught in the hospital logjam.

One of the very few areas of the recent media coverage we do agree with is that there is more work to be done.

Doctors go to work every day with the express purpose of caring for other people, healing them and making them well. Recently in theatre I worked to save the life of a woman who had lost 12 litres of blood – more than twice her blood volume. This is the job doctors quietly go to work and do every day. That's what doctors want to focus on.

It's no surprise then that hundreds if not thousands of hard-working dedicated doctors have been dismayed by recent media stories.

There are important issues to be debated relating to the health system, including the pressures placed on that system by an ageing society, rising chronic disease rates and the long tail of COVID-19 in the community. I can only hope we have the political will to invest in Medicare as it is needed, and the opportunity to have a truthful public debate about these issues.

## A RENTAL PROPERTY CHECKLIST:

# RELAX ON YOUR HOLIDAYS

The end of year is quickly approaching, and we are all looking forward to the summer break, but first, there's a number of important matters property investors should attend to in the weeks ahead.

Preparation will minimise the chance of a rental property-related issue spoiling your summer break.

REPORT JARROD MCCABE DIRECTOR,  
WAKELIN PROPERTY ADVISORY



Let's start with the most important item: ensuring you're protected should a costly incident occur.

The long break brings seasonal risks. Our hot summer climate can ruin investments: think bush and grass fires, violent hailstorms and flooding. There is also a change in human routines in summer which can make properties vulnerable to crime: homes left vacant for weeks, and windows left open.

It's not exciting but check that the appropriate insurance policies are in place. It's a relatively simple exercise if you own an asset such as a house where there isn't common property. The rental provider insurance should incorporate building cover, contents cover for fittings and furnishes owned by the investor and public liability.

With apartments, there is a division of responsibility. The apartment owner is responsible for contents insurance, whilst the owners' corporation takes care of building and public liability insurance. Nevertheless, it is prudent for a unit owner to check with the owners' corporation manager that these insurances are in place and based on a recent valuation of the buildings.

Note that damage to permanently attached fittings such as kitchen cabinetry, gas ovens, sinks, baths and toilets is usually covered by the owners' corporation building insurance, rather than content insurance.

Be warned that policies do not typically cover upkeep nor accidents caused by poor maintenance – say damage to a wall due to a lack of sealant in a shower.

That's one reason to also check in with your property manager as well in the coming weeks.

Find out if there are any pressing maintenance issues that need addressing before the break and what procedures they have in place for dealing with out-of-hours calls.

It is also worth suggesting that they write to your renter about security of the property over the break if they are going away – ensure the building is locked-up, and that arrangements are made to ensure mail doesn't build up and bins are not left out.

You may also fear that a renter gives you notice to vacate in coming days. Don't fear. It would not be bad news as January and February are typically a good time of the year to find a new renter; however, not so to find tradies. Like the rest of us, many tradies take holidays in early summer, and those who are willing to work will charge a premium to do so.

This makes it crucial that any required maintenance or repairs are carried out before the break, or at least the due diligence should be conducted to ensure maintenance can hold off until after the holiday period.

It's worth taking the time to run through any potential problems. While some urgent repairs can't be predicted, it is often possible to spot signs of wear and tear that point towards problems ahead and which could pose a frustrating incursion on the renter's accommodation requirements and your holiday time.

Work with your property manager, who can check in with your renter, to identify any prospective issues that can be dealt with before the festive period such as landscaping and garden maintenance, as well as ensuring smoke alarms and security aspects are all in working order. Other areas might need a contingency plan put in place.

Whatever the issues, once they have been flagged and accounted for, you're giving yourself, the renter and property manager, the best possible chance of a restful festive season and summer break ahead.

WAKELIN  
PROPERTY ADVISORY

Wakelin Property Advisory is an independent buyer's agent specialising in acquiring residential property for investors. [www.wakelin.com.au](http://www.wakelin.com.au)

### FOR MORE INFO:

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Click here to listen to Jarrod's podcast



Register for more insights into the property market

# WORKING TOWARDS WELL WORKPLACES

REPORT VANESSA MURRAY

**M**uch of AMA Victoria's work is focused on making whole-of-system improvements that will benefit doctors in training and specialists at individual and collective levels – including to the workplace environment.

When we think about 'environment', we often think about climate and nature. But all the places and spaces we pass through and spend time in constitute our environment (or environments) – from the built environment that make up our streets and architecture, to the home and work environments in which we spend much of our time.

The work environment comprises the setting, physical conditions and culture of the workplace – all important elements that can impact our day-to-day productivity, sense of wellbeing, professional relationships, personal health and of course, our patients.

From AMA Victoria's perspective, the notion of work environment also takes in the overarching system in which each workplace exists: the Victorian healthcare system. This is increasingly where the organisation is placing its focus

– and where it believes it can affect the most significant and impactful changes.

"We are refocusing from a 'well person' to a 'well workplace'. This means shifting away from making it the individual's responsibility to take care of themselves, towards identifying larger, systemic and cultural issues and taking collective action to address them," says Grant Forsyth, Workplace Relations Director, AMA Victoria; CEO of ASMOF Victoria

"It's no good putting on free lunches and yoga classes when our members are faced with a workload that makes finding time to take a toilet break challenging – that's the reality of the working environment for many doctors," explains Grant.

Grant leads a team of six at AMA Victoria, which receives around 200 calls from doctors in training (DiT) and specialists every month, many of which are stress related. A union background has enabled Grant to evolve AMA Victoria's approach to complaints and advocacy from the individual to the collective.

"We want members to know that when they speak up about their rights they can

make a difference to their own experience, and that of others, without jeopardising their careers. It's easiest to fix things as a collective. So now, when members call us about an issue, one of the first things we ask is, is there anybody else in the same boat?"

Over the past few years, AMA Victoria has achieved significant workplace environment wins for members and for the broader medical profession, such as advocating for and ensuring N95 mask fit-testing in the early months of the COVID-19 pandemic.

"At the start of the pandemic, we did a lot of work to get the Victorian Government to agree to compulsory fit-testing of N95 masks. When COVID-19 began, very few if any health service were doing this; it was a monumental task to get the hospitals and the government to agree that to be effective, masks needed to be properly fitted," says Grant.

"Our work in this space now means there's a requirement that when you start at a health service, you get a mask fitting so that you know what mask you should be using, and so that you're properly protected."

“*We are refocusing from a 'well person' to a 'well workplace'. This means shifting away from making it the individual's responsibility to take care of themselves, towards identifying larger, systemic and cultural issues and taking collective action to address them.*”

AMA Victoria has also made significant gains in the Enterprise Agreement for Doctors in Training. These include increasing the notice period for rosters from 14 to 28 days; securing equal access to paid parental leave if both parents are doctors in the Victorian public system; requiring hospitals to pay DiT for an hour's pay for every overnight call they take; and making further progress towards introducing longer term contracts.

Improving the work environment for specialists is also a focus – most notably through overtime gains for fractional doctors in the Enterprise Agreement for Specialists. Two big focuses here are on equity of pay and entitlements between fractional and full-time doctors. To this end, AMA Victoria has reached agreement on the establishment of a ministerial review that will take place early next year.

AMA Victoria is also progressing the DiT class action, which is a legal action against most Victorian health services for underpayment of overtime. Victoria has 37 health services covered by the DiT

Enterprise Agreement, and each will have proceedings brought against it. So far, actions have been submitted against 10 hospitals. If successful, affected DiT stand to be back paid for up to six years' unpaid overtime.

"Many of these changes are arguably coming from the bottom-up, not the top-down," says Grant. "In the past few years, we have observed a dramatic increase in the number of junior doctors who are willing to speak up about workplace bullying, stress and burn out."

The new agreements were approved on 27 October (Specialists) and 2 November (DiT) and the process of transitioning to the new terms and conditions is now underway. AMA/ASMOF Victoria will meet with every health service to talk through their implementation plans and monitor their progress.

**Doctors in training and specialists, can you help to improve your workplace environment?**

**Become actively engaged with AMA Victoria by attending meetings, responding to surveys, or contacting the Workplace Relations team directly**

*Together we bargain, divided we beg*



*If you have a workplace relations issue you would like to discuss, please contact [amavic@amavic.com.au](mailto:amavic@amavic.com.au)*

# ARE YOU A GP WHO TREATS OTHER DOCTORS?

We invite you to participate in our study, exploring GP experiences and challenges when your patient is a fellow doctor.

Participation involves an interview (around an hour) with a researcher, face-to-face or Zoom, at a time/location suitable to you. GPs will receive a \$150 gift voucher in recognition of your time.

*Project ID: 35690 Project title: gp experiences and challenges in treating doctor-patients*



*Click here to contact  
Claire Hutton  
for more information*

## OVERVIEW OF KEY 2022 ENTERPRISE AGREEMENTS WORKPLACE WINS

CLAUSE	EVOLUTION	MAIN WINS
<b>OVERTIME PAY FOR FRACTIONAL SPECIALISTS</b>	Historically, there has been no standard for being paid overtime; a fractional specialist had to negotiate this at the department or hospital level themselves, with varying degrees of success. The new agreement now explicitly states that a doctor must be paid for additional hours. The quantum still needs to be negotiated.	<ul style="list-style-type: none"> <li>» Fair pay for work done out of hours</li> <li>» Acknowledgement that time worked should be paid for Specialists will know what they're entitled to</li> <li>» Employers will rethink their approach to over-engaging specialists</li> </ul>
<b>REMOTE RECALL FOR DIT</b>	Under the previous agreement, a doctor could work a whole on call shift and be paid one figure – a fixed fee to cover that entire time. Going forward employers will be required to pay an hour's pay at overtime rates every time a doctor is recalled remotely.	<ul style="list-style-type: none"> <li>» Fair pay for work done out of hours</li> <li>» Employers will need to keep track of overnight consults</li> <li>» Greater transparency of workload</li> <li>» Less burn out</li> <li>» May incentivise employers to roster another doctor on overnight</li> </ul>
<b>RURAL ATTRACTION AND RETENTION PAYMENT</b>	For many years AMA/ASMOF have been petitioning for some form of payment included in the agreements to financially reward doctors who choose to work and live in rural locations, and to encourage doctors to consider it as an option.	<ul style="list-style-type: none"> <li>» All rural health services are covered by the clause</li> <li>» Payment made at the end of contract or year to encourage the completion of terms</li> <li>» Improved staffing levels, particularly towards the end of the calendar year</li> </ul>
<b>INCREASED PARENTAL LEAVE AND SHARED LEAVE FOR 'EMPLOYEE COUPLES'</b>	All employees who have given six months continuous service will now be entitled to parental leave. The new clause increases the paid component to 14 weeks for primary carer leave and two weeks for secondary carer leave. An employee couple can choose to share the 16 weeks as they see fit.	<ul style="list-style-type: none"> <li>» More paid time off</li> <li>» Better flexibility for parents</li> <li>» Service requirement for access to the entitlement halved</li> </ul>
<b>CLIMATE CHANGE MITIGATION AND SUSTAINABILITY</b>	A new clause that provides for acknowledgement of continuous improvement and education around climate-related health topics.	<ul style="list-style-type: none"> <li>» Use of Continuing Medical Education and conference leave to attend any relevant conference</li> <li>» Requires engagement of doctors by Health Services on Sustainability</li> </ul>

Solely funded by members, AMA Victoria is a fearlessly independent body and the only organisation with a right to represent you if things get rough in the workplace. Always prioritising the protection of your professional relationships, your career and reputation, our experienced team stand ready to help.

The only independent body for doctors

# JOIN AMAV 2023



## ENTER TO WIN

As a thank you to our members our wonderful Partner, Dell Technologies is sponsoring an end of year prize draw. One lucky member will win a Dell 14 Portable Monitor - C1422H | Dell Australia valued at \$467.50.

**TERMS AND CONDITIONS:** The Competition is open to residents of Australia who are members of AMA Victoria on 12 Dec 2022. To qualify for entry to the Competition, the member must email [francesm@amavic.com.au](mailto:francesm@amavic.com.au) with their full name and member number to be delivered by 11:59pm AEST on 31 December 2022. 1 entry per member only. Commencement time: 09:00am Australian Eastern Standard Time (AEST). Commencement date: Monday 12 December 2022. Closing time: 11:59pm AEST. Closing date: Saturday 31 December 2022. Draw time: 11:00am AEST. Draw date: Friday 6 January 2023. Draw location: AMA Victoria House, 293 Royal Parade, Parkville, Vic, 3052. **WINNER NOTIFICATION, PUBLICATION AND DRAW:** The winner will be notified via email within 14 days of the draw. The winner will be contacted via the email address which is associated with the member within the membership database. The winner's email address, phone number and postal address will be provided to Dell Technologies. Dell Technologies will contact the winner to arrange delivery of the prize within 28 days of the draw.

To enter please email [francesm@amavic.com.au](mailto:francesm@amavic.com.au) with your full name and member number by 11:59pm AEST on Saturday 31 December 2022



*Did you know that AMAV members receive ongoing discounts from Dell year round?*

*To find out more click here.*

Winner will be drawn on Friday 6 January 2023 and notified. Please see full Terms and Conditions below.

AMA Victoria will be closed from 5pm 23 December 2022 and will reopen 9am 3 January 2023

  
AMA Victoria would like to wish you a safe and happy holiday

# WHAT IS AN ENTERPRISE AGREEMENT?

*Whilst the legal regulation of terms and conditions of employment in Australia is complex, the main types of regulation can be understood as a hierarchy.*

REPORT CARA CROSS  
ROD FELMINGHAM KENNEDYS

## 1. THE FAIR WORK ACT

At the top of the hierarchy is the Commonwealth Fair Work Act 2009 (Cth) (FW Act). All Victorian employees are covered by the FW Act and, except for some limited Victorian public sector employees, are entitled to the minimum National Employment Standards it provides, such as four weeks annual leave, unpaid parental leave, payment for public holidays, and notice of termination.

## 2. AWARDS AND ENTERPRISE AGREEMENTS

Next in the hierarchy are Awards and Enterprise Agreements. Neither Awards nor enterprise agreements can include terms and conditions of employment that are less favourable to employees than are the minimum standards set out in the FW Act.

### Awards

Awards are made by the Fair Work Commission (FWC) to allow for more detailed regulation of specific and limited industries and occupations. Awards include, for example, classification structures for employees in the industry, rates of pay for each classification, various allowances, shiftwork arrangements, consultation provisions, and other matters relevant to the specific industry it covers.

### Enterprise agreements

Enterprise agreements are not made by the FWC, but once they are approved by the FWC they have the same force as an Award. Enterprise agreements are negotiated between employer and employee representatives, and agreed by the employer and a majority of employees. The enterprise agreements covering Victorian public hospital doctors are negotiated by AMA Victoria, ASMOF, the Victorian Hospitals Industrial Association, and the Victorian Government.

Where there is an enterprise agreement in operation, it completely displaces the operation of an Award. For example, the FWC has made an Award that covers public sector doctors - the Medical Practitioners' Award 2010 - but in practice it does not apply in Victoria, because all doctors in the public sector are covered by an enterprise agreement. In approving enterprise agreements, the FWC applies a "better off overall" test to ensure that the terms and conditions of the enterprise agreement are not less favourable for employees than the terms and conditions of the Award that would otherwise apply.



*Employer non-compliance with an enterprise agreement is a very serious matter.*

**Kennedys**

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## 3. CONTRACTS

The lowest level of the hierarchy is the contract of employment. Employers and employees routinely enter into written contracts of employment that set out their agreement about their respective rights and obligations in relation to a particular job. If an Award or enterprise agreement covers the employment, a contract can include agreed terms and conditions of employment that are more favourable than the Award or enterprise agreement. If a contract includes terms and conditions that are less favourable than those in the enterprise agreement, those terms are not enforceable and the enterprise agreement will prevail.

As a simple example, a doctor could have a written contract with a public hospital that included a lower rate of pay than they were entitled to under the enterprise agreement. Despite having signed the written contract, they would still be legally entitled to the higher rate under the enterprise agreement (and could be entitled to claim against the hospital for underpayment).

## MAKING SURE THAT YOU GET WHAT YOU ARE ENTITLED TO UNDER THE ENTERPRISE AGREEMENT

Enterprise agreements, especially in the Victorian public sector, are long and complex legal documents. Interpretation of the interrelated provisions of an enterprise agreement is often not straightforward.

If you think you are not being given your correct entitlements under the enterprise agreement, a very good option is to seek advice from AMA Victoria.

If, after having sought advice, you are reasonably sure that your employer is not complying with the enterprise agreement, your first step should be to politely make enquires. Hospitals also find application of enterprise agreements to be less than straightforward at times, and they can make mistakes. Not all non-compliance is deliberate, or "wage theft". If the issue is not satisfactorily resolved by discussion, request assistance from AMA Victoria.

## ENFORCING ENTERPRISE AGREEMENTS

Employer non-compliance with an enterprise agreement is a very serious matter. It is a breach of the FW Act, and exposes the employer to financial civil penalties. An employer's failure to comply with an enterprise agreement can be dealt with either in the FWC, or by making an application to the Federal Court.

Enterprise agreement dispute resolution procedures enable disputes about employer compliance to be referred to the FWC. The FWC may have power to resolve a dispute by arbitration.

To take a dispute to the FWC under such a dispute resolution procedure, you must be an employee of the employer at the time the dispute is notified. If you have been underpaid, for example, but you do not notify a dispute until after you have left the job, the FWC cannot deal with the dispute, but you can still enforce an underpayment claim in a court. Underpayment claims need to be brought in a court within 6 years from the date when the payment was due.

## ENFORCING AN ORDER OF THE FWC

If an employer does not comply with an order of the FWC in dealing with a dispute, only a court has power to enforce compliance.

The Federal Courts have full power to enforce enterprise agreements and to impose penalties for non-compliance.

## OTHER CONSIDERATIONS

Having an argument with your employer over your employment entitlements can be very uncomfortable. While the FW Act contains strong protections for employees, in practical terms, it is important to consider the impact it could have on the viability of the employment relationship to sue your employer for a contravention of an enterprise agreement, such as underpayment. Such a step should not be commenced without obtaining advice that considers all of your interests holistically.



EXPRESSIONS OF INTEREST

# AMAV MENTORING PROGRAM

AMA Victoria welcomes expressions of interest from members to be **mentors** and **mentees** in our 12-month supported and structured mentoring program. The program is a free membership benefit and is designed to support your personal and professional development as a doctor. It is particularly relevant during times of career transition or whilst you are finding your balance and professional identity. The program helps you set and achieve your goals. AMA Victoria undertakes matching to ensure there are no conflicts of interest and to maximise the value of the mentoring relationship.

The program has been running since 2015 and utilises the Mentorloop platform. It continues to consistently score above the industry average satisfaction ranking in feedback from the mentors and mentees.



Click here for more information about the AMA Victoria mentoring program

To express interest please email [mentoring@amavic.com.au](mailto:mentoring@amavic.com.au)

HERE ARE SOME RECENT COMMENTS FROM PARTICIPANTS



*As I described before, a really good fit and a candour that flows both ways that will benefit the relationship greatly. I am so grateful for this [opportunity]*

MENTEE, AUGUST 2022

*I look forward to my monthly catch up with [my mentor]. He provides really helpful advice around navigating the next steps in my career pathway.*

MENTEE, OCT 2021

*Excellent match in terms of interests and personality. [My mentor] has been a very thoughtful, helpful and inspiring mentor*

MENTOR, SEPTEMBER 2021

*[My mentor] is a very supportive and engaged mentor, with similar interests!*

MENTEE, OCTOBER 2022

*[My mentee] is thoughtful, reflective and hopefully gains some value from our meetings – a wonderful example of the clinician of the future.*

MENTOR, NOVEMBER 2021

*Despite being very different people, [My mentee] and I have established a terrific rapport and use our differences to stimulate debate that can help [my mentee] – and also me – to think about issues from multiple perspectives. [My mentee] has advised me that this is extremely helpful to him and I am pleased!*

MENTEE, JULY 2022

*My mentee is a very thoughtful and mature doctor – I have really valued being able to meet with him – we met today and I hope to meet face-to-face in the next couple of months.*

MENTOR, MARCH 2021

## PEER SUPPORT PROGRAM:

# MOVING FORWARD

Mr Chris Haw is a Retired Orthopaedic Surgeon and was a Peer Support volunteer



*Being a Peer Support volunteer has provided me with the opportunity to give back to the profession and use my experience and knowledge to support the next generation of doctors.*



REPORT KAY DUNKLEY  
AMA VICTORIA COORDINATOR  
OF DOCTOR WELLBEING



About the Peer Support Service



1300 853 338  
8am - 10pm  
365 days

Chris graduated from medical school in Edinburgh in 1964 and achieved his Edinburgh Fellowship in Orthopaedics in 1972. The positive impact of orthopaedic surgery on quality of life prompted Chris to choose this as his specialty. Chris subsequently migrated to Australia and received his Australian Fellowship in 1978. He started work as an orthopaedic surgeon at Western Health, then known as Footscray Hospital, in 1978. In the 1970s the orthopaedic unit at Footscray was a small ward and looked after all age groups, including babies. Often babies and young children would be up in gallows traction in their cots to reduce dislocated hips. At the time open surgery on babies' hips was also common. A lot of patients treated in traction systems would spend months in the hospital.

When Chris first started at Footscray Hospital, the on-call rosters were one month long and involved a lot of emergency surgery during the night. Footscray Hospital received many serious trauma cases prior to the establishment of the Level 1 trauma centres at The Alfred and the Royal Melbourne Hospitals in the late 1980s. The cases brought to the Footscray Hospital included severe injuries such as multiple fractures resulting from major car accidents. This was very demanding and exhausting for the surgeons involved, who responded to these calls many nights in a row while on-call, and then returned to operate and attend outpatient clinics during the day. Chris was head of the Orthopaedic Unit at Western Health for 25 years, taking over from Kevin King in 1985. In this role he oversaw significant growth of the unit and the hospital, a significant increase in research and many new developments in orthopaedic techniques. Chris was also the Footscray Football Club's orthopaedic surgeon for several years.

Chris was very active in the Australian Orthopaedic Association, in particular the training program. Today there are many orthopaedic surgeons practicing in Melbourne who have spent time training under Chris' supervision. Chris is a recipient of a lifetime achievement award from the Royal Australasian College of Surgeons for his services to the community of the western suburbs.

Chris volunteered to become involved in the AMA Victoria Peer Support Service in 2009 as he began to wind back his clinical and leadership commitments. He reports "Being a peer support volunteer has provided me with the opportunity to give back to the profession and use my experience and knowledge to support the next generation of doctors. As a surgeon who has supervised many trainees and seen the difficulties they experience, I was keen to use my familiarity with the training program and the hospital system to support doctors in training as I can relate to their situation. While a lot of the work in peer support is listening and providing empathy, it really makes a difference to be a doctor supporting a doctor as we have a mutual understanding as peers." Chris also noted that orthopaedic surgery does not have a good reputation for psychological support but he really values the satisfaction he received from supporting his colleagues and helping them plan a way forward when they are facing difficult situations.

As the Peer Support volunteers remain anonymous and keep a low profile about their role it is only now that Chris has stepped down from his role in the Peer Support Service that AMA Victoria can acknowledge the work undertaken by Chris and by his fellow Peer Support volunteers. Volunteers participate in a roster, making themselves available to take calls, between 8am and 10pm every day of the year. Doctors and medical students calling the service generally are experiencing stress about a broad range of issues. It can be hard for doctors to reach out for help, hence the anonymity of the Peer Support Service which enhances confidentiality.

In retirement Chris has a large garden to maintain, he will continue to play golf regularly, spend time with his family and travel more.

Peer Support Training is provided and the next annual intake of volunteers is expected to take place in mid-2023. The role is best suited to experienced doctors who have the flexibility to be on duty and take calls during the day.

The Peer Visitor Service is proudly sponsored by VMIAL, the name behind PSA Insurance.



# LONELINESS + ISOLATION



*Loneliness is that negative feeling that arises when our social needs are not met. As social beings, we rely on safe, secure social surroundings to survive and thrive. When we begin to feel lonely, we feel vulnerable, which can take a toll on both our physical and mental health.*



**AMAV Peer Visitor Program provides companionship to older doctors who may be feeling isolated after retiring or moving to an aged care facility**

**L**oneliness is a function of our need for companionship and belonging, and left unaddressed, it can detrimentally affect our self-worth. The presence of loneliness reflects the absence of connection, not the absence of people. That's why we can feel lonely even in a crowd. In fact, being in the middle of a crowd can make us feel even lonelier if none of the members of our known support network are present, and we feel unable to connect with others around us. We can also experience loneliness when we feel that our support network isn't providing the support that we need at a given moment in time. Loneliness can leave us questioning our value to others and where we belong.

Feeling lonely isn't a mental health problem, but the two are strongly linked. Having a mental health problem can increase the chance of feeling lonely and isolated. This can be due to stigma and a lack of understanding by others, which makes it hard to build relationships based on acceptance and trust. Also mental health issues such as social anxiety can make it harder to interact with others. Feeling lonely can also have a negative impact on mental health, especially if these feelings have lasted a long time. Some research suggests that loneliness is associated with an increased risk of certain mental health problems, including depression, anxiety, low self-esteem, sleep problems and increased stress.

**THERE ARE 3 TYPES OF LONELINESS:**

**EXISTENTIAL LONELINESS**

Existential loneliness is related to the nature of existence and particularly, a lack of meaning in life. It is a sense of personal incompleteness. Loneliness tends to stir up negative feelings, and while those can be helpful in terms of self-exploration, they are also something to which we are averse and want to avoid as much as we can.

**EMOTIONAL LONELINESS**

This type of loneliness arises from a feeling that we lack relationships or attachments. For example, when everyone has a romantic partner in our group except us. Emotional loneliness can be felt when we need someone to talk to about something going on in our lives, but feel that there is no-one available to contact. We might feel lonely for a partner who has moved out of our lives. We might be lonely for a close friend, a parent, a sibling, or a partner who is absent.

**SOCIAL LONELINESS**

This type of loneliness occurs when we don't feel a sense of belonging to a group beyond ourselves. We might even feel social loneliness even when we have a romantic relationship with a partner we treasure. If we don't have a wider circle of social support, we may feel that we don't have a group with whom to belong. When we walk into a party and don't recognise anyone familiar, a feeling of social loneliness may wash over us if we don't typically feel comfortable approaching new people. If we don't feel that our presence is valued in a wider circle, we might experience social loneliness.

**DOCTORS AND MEDICAL STUDENTS ARE MORE LIKELY TO FEEL LONELY IN THE FOLLOWING CIRCUMSTANCES:**

- » Starting out at university, after leaving a secure school environment
- » If you are older than your peers or at a different stage of life or have caring responsibilities, such as children, when your peers do not
- » On a rotation away from usual supports such as family and friends
- » After failing an exam if everyone you know has passed
- » When working from home

- » When relocating for work, especially when you have to move house to unfamiliar locations and leave behind your usual contacts and supports
- » If you experience discrimination and stigma because of your gender, race or sexual orientation, especially if you are in a minority group
- » When experiencing bullying or bad behaviour.
- » After an error or incident if you do not have someone you feel safe with to talk about the event
- » When retiring and losing the social contacts you had at work
- » When experiencing loss and bereavement.

**ADDRESSING LONELINESS**

Loneliness tends to stir up negative feelings, and while those can be helpful in terms of self-exploration, they are also something to which we are averse and want to avoid as much as we can.

Existential fears, including the fears of isolation, death, meaninglessness, and freedom, are experienced by virtually all of us at some point in time. Recognising the fear and using it as a motivator to live more fully and more in the moment can help us immerse ourselves in the present, which might help us recognise that we are among a vast sea of individuals struggling against these fears just as we are.

The lasting solution to emotional loneliness is to establish and maintain a healthy support system of friends and family. While we can't make instant friendship happen or find a soulmate overnight, we can maximise our chances of deepening a friendship by reaching out to friends and being willing to be the one to suggest a meet-up or get together. Accepting invitations to socialise in a group is a good way to broaden our network exponentially as group members will introduce us to others.

Letting someone know we need to talk can open the door to a deeper bond, so long as we don't overburden others with our needs. Showing interest in others and asking them about their interests is essential to develop rapport.

Other ways to reduce loneliness are to be open to socialising with a range of people of different backgrounds and life experiences and having broader interests and hobbies outside work or study and joining clubs or activities with others with those interests. Pets can be great companions too and if a pet requires regular walks or obedience classes this will provide opportunities to meet other pet owners.

# HEALTH COVER TIPS



It is time to book in any final appointments to use up any benefits before the year is up

Your private health insurance policy will operate all year round so long as your premium payments are kept up to date. However, there's 3 things to consider with your health cover as we draw closer to the end of the year and into another holiday period.

### 1. MAKING THE MOST OF YOUR EXTRAS BENEFITS IF THEY RESET ON 1 JANUARY

Health insurance extras benefits usually reset at the end of the calendar year on 1 January or at the end of the financial year on 1 July depending on the health fund. If your extras limits are due to reset on 1 January and you have some remaining, it's time to book in any final appointments to use up these benefits before the year is up.

### 2. LOOKING AFTER YOUR HEALTH NEEDS WHILE TRAVELLING

If you're travelling overseas for the holidays, keep in mind that private health insurance and Medicare

only cover health services within Australia. Travel insurance can help cover medical costs while overseas and is strongly recommended to ensure you're not left significantly out of pocket. More information on health care planning while travelling can be found at [servicesaustralia.gov.au](http://servicesaustralia.gov.au)

You may also have the option to suspend your health cover while overseas depending on the length of your travels. Different health funds have different rules, and your suspension may have tax implications, so it's important to make a detailed enquiry with your health fund to understand any conditions.

Travelling domestically? Your private health insurance policy will operate as normal regardless of the state or territory you visit. If you're moving to another state permanently, you will need to contact your health fund to update your personal details to reflect your new address.

### 3. RELIEVING FINANCIAL PRESSURES ACROSS THE HOLIDAY PERIOD

The holiday period can be an expensive time especially during this period of high inflation. If you're looking for ways to save without compromising what you're covered for, reviewing your payment frequency, increasing your hospital excess if you don't have near-future plans for elective surgery\* or claiming the Australian government private health

insurance rebate as a premium reduction, are ways you could see immediate changes in the amount you pay to your health fund. As you're not bound to a contract with your health cover, you should be able to make these changes straight away. It's important to speak to your health fund for more information and to understand what's available to you.

\*By increasing your excess, you will be required to pay more in the event you are admitted to hospital as a private patient. If you change your mind, waiting periods can apply when reducing the excess on your policy. Please refer to your health fund to understand any policy implications. IMPORTANT: Private health insurance products are issued by The Doctors' Health Fund Pty Limited, ABN 68 001 417 527 (Doctors' Health Fund), a member of the Avant Mutual Group. Cover is subject to the terms and conditions (including waiting periods, limitations and exclusions) of the individual policy, available at [www.doctorshealthfund.com.au/our-cover](http://www.doctorshealthfund.com.au/our-cover). This publication is not comprehensive and does not constitute legal or financial advice. It is intended only to provide a summary and general overview on matters of interest. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances. Information is only current at the date initially published.



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MORE THAN MED

# MEDICINE + NON-FICTION WRITING

Dr Henry R. (Harry) Lew OAM

REPORT VANESSA MURRAY  
PHOTOGRAPHY ERNESTO ARRIAGADA

“

*Fascinated by art and history, Dr Henry Lew OAM has written numerous non-fiction books to great acclaim, particularly exploring the lives of figures whose stories would otherwise be lost.*

—



**I CAN TRACE MY EARLY LOVE OF WORDS BACK TO MY FATHER'S 1951 CAR NUMBER PLATE.**

—  
I started learning letters and numbers from number plates at a very early age; my father's was the first one I learnt. Within a matter of eight weeks, I'd learned probably a hundred number plates, and knew all my letters and numbers. When I arrived at prep aged five, they immediately put me up to grade one. I finished school at 16 and I finished medicine at 22, and I owed all of this to my father's original number plate. So, when I bought my first car in 1974, I asked if my father's number plate was still available. It was, and I've had that number plate ever since.

**ALL MY WRITING IS NON-FICTION. MY FIRST TWO BOOKS WERE ABOUT TWO AUSTRALIAN MODERNISTS WHO I DISCOVERED ON THE SAME DAY, IN 1976, AT A GALLERY IN ARMADALE.**

—  
It was showing a collection of modern British works, and one of the paintings that I liked best was by a painter called Horace Brodzky. I recognised Brodzky as a Russian Jewish name and imagined the artist left during the Russian Revolution, went to Paris, and started painting there in the French style. But the gallery owner, Chrisopher Deutscher, told me Brodzky was born in Melbourne in 1885. I was surprised to learn an Australian artist of that era was painting in that way. Then he showed me a similar work by another contemporary Australian modernist, Derwent Lees. A few years later when I was a fellow in Leeds, England, I found works by both artists in the Leeds Art Gallery. I started looking into them and realised that they exhibited in numerous mixed exhibitions with the who's who of modern art, names like Manet, Monet, Pissarro, van Gogh, Gauguin, Cézanne, Picasso, Modigliani, Dali, Man Ray, and even

Jackson Pollock. Nobody in Australia was interested in their art, so I started collecting it. Then I decided to write about them.

**I'VE ALWAYS BEEN A BIT OF AN OUTSIDER, WHO EXPERIENCED DIFFICULTIES AT OPHTHALMIC MEETINGS, BECAUSE I WAS A VERY LATERAL THINKER, WHO STARTED DOING THINGS MANY YEARS BEFORE COLLEAGUES, BOTH HERE AND ABROAD, ALSO EVENTUALLY STARTED DOING THEM.**

—  
All through medicine I also read a lot of non-medical stuff. I was very interested in history, art and art history. One of the disadvantages of medicine is that you can spend your whole life doing really good work, but the only people who ever appreciate you when you're gone are your patients. Whereas, if you produce some books on interesting topics, they will be a legacy that you'll leave behind for your children and your grandchildren, and maybe for other people who discover those topics in the future and also become interested in them. Writing gave me something else; it built me as a person.

**THE ONLY THING THAT OUR RETINAS PICK UP WHEN WE ARE LOOKING AT THINGS IS STRAIGHT LINES. AND THESE STRAIGHT LINES SEND IMPULSES TO OUR BRAINS, WHICH ANALYSE THEM.**

—  
Most of our vision is created within the brain from these signals delivered by the retinas as a result of our previous experience looking at things. At one point it occurred to me that if the retina only responds to lines, and an artist can appreciate this, all an artist has to do is put the right lines in the right colours and right tones in the right positions on his canvas, and our brains will do the rest.

**MY PARENTS WERE HOLOCAUST SURVIVORS. MY FATHER IS THE MAIN REASON I WROTE *THE STORIES OUR PARENTS FOUND TOO PAINFUL TO TELL* (2008) AND ITS QUASI-SEQUEL, *LIONHEARTS* (2012).**

—  
I was visiting my father one night when he was aged about 90. He told me he'd read Rafael Rajzner's Holocaust memoir for the first time in 50 years and had been crying all day. He was upset because it was written in Yiddish, in a very small edition, and he was worried it was going to be lost. A few years after he died, I set about having it translated into English. Today *The Stories Our Parents Found Too Painful To Tell* can be found in the libraries of every major Holocaust museum in the world. Before my father died, I managed to convince him to go to the Melbourne Holocaust Museum and give a testament on video. It was six hours long. It inspired me to write *Lionhearts*, based on his testimony, but which not only told his story, but also that of 20 of his friends. He was long gone when these two books came out, but I think he would've been thrilled with them both.

**MY NINTH BOOK IS DUE OUT IN EARLY TO MID 2023. IT'S CALLED *AUSTRALIAN GENESIS AND EXODUS*, AND IN IT, I REVISIT BRODZKY AND LEES.**

—  
I've been collecting their work for 40 years now, and I've acquired much more information about them [than I had when I wrote my first two books]. *Australian Genesis and Exodus* is about their lives and families and their mutual friends and acquaintances. It's a much bigger book than the original ones, *Brodzky* (1987) and *In Search of Derwent Lees* (1996), combined.

» (previous page) The large painting behind Harry is signed John Lawry after Brodzky and Lees. It is circa 2000–2001 and was entered in the Moran Prize around 2001.

The painting is principally based on Brodzky's painting *Self-portrait in the Café Royal* which appears on the cover of Harry's book, *Brodzky* (1987) which is visible below it in the photograph. Horace has been removed and replaced by Harry in his Heidelberg Repat theatre gear. Harry's Crock-Pericic comido (combination indirect ophthalmoscope/magnifying loop) is on the table next to his left hand; his ophthalmologist's doctor's bag is next to him on the seat; and the textbook *Controversy in Ophthalmology* lies on the bag's open lid. The window in the room has been replaced by Lees' painting *Chateau Royal, Collioure* which appears on the cover of Harry's book *In Search of Derwent Lees* (1996) and likewise is visible below the painting in the photograph. Harry is reading his third book *The Five Walking Sticks* which has the Brodzky painting *The Return* on its cover.



*Click here to visit  
Harry's website*



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