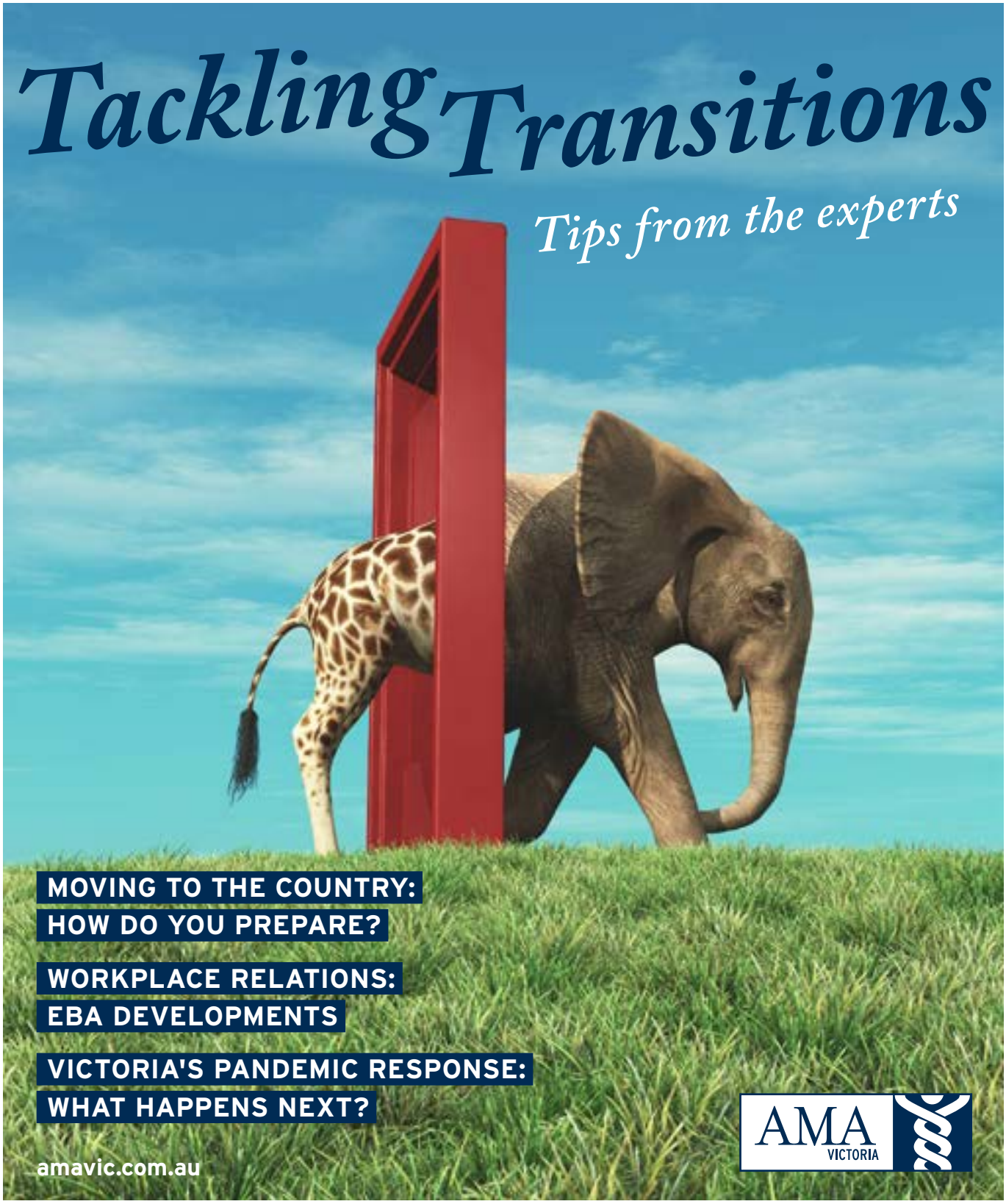
TRANSITIONS

VICDOC

AMA VICTORIA

SPRING 2022



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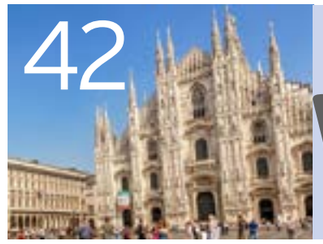

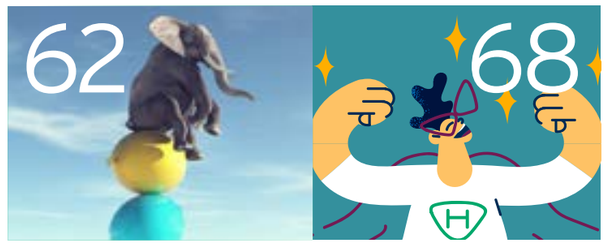

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References to articles available from the editor on request.

REGULARS

FEATURES

A TIME OF TRANSITIONS

DR RODERICK McRAE

AMA Victoria President

Spring is all about 'transitions' and so our new edition of Vicdoc tackles the topic from a range of perspectives.

Whether you are a student preparing to enter the workforce; an intern coping with, but progressing in, working life; whether you are a doctor deciding on a training specialty or moving to a new location; or an older doctor considering retirement; change is a fact of life. It is useful to acknowledge and reflect on the significant role 'transitions' play in successfully navigating the inevitable shifts that occur in life as we move from one stage to another.

As a community, we have experienced so many transitions throughout 2022 including the evolution of our national and Victorian approach to the management of COVID-19; the community re-set post-lockdowns; and a new Federal Government. We have mourned the loss of many people: well-loved Australian icons; highly regarded members of AMA Victoria; and only recently, the end of an era was defined by the passing of Her Majesty Queen Elizabeth II.

For the health system, transition is a continuous imperative. It will need to undergo fundamental change as it attracts the attention of state and federal governments to discuss and plan for the reform it so desperately needs. I hope that we can bring politicians at a state and federal level on this journey with us to understand the deep need to reform our sector across physical and mental health, as well as individualised treatment options; and to appreciate the imperative to cast pure politics aside and collaborate to resolve the deep-seated issues within our health system. This will be the only way we can transition to a system that we can rely upon again; one in which we can work in successfully again, thrive in and through which we can deliver world-class care once again.

STATE ELECTION CAMPAIGN

As you know, throughout 2022, AMA Victoria has relentlessly campaigned for a healthcare-led recovery for Victoria. In the lead up to the state election, this campaign will continue.

In our view, a recovery-encompassing real, planned investment into general practice, medical mental health care, deferred and delayed care and public hospitals- will lead not only medical recovery for Victorians whose health has suffered during the COVID-19 pandemic, but also steady economic recovery through investment in essential health infrastructure and services.

We were pleased that in its 2022-23 State Budget, the Victorian Government unequivocally placed health at the centre. Indeed, the State Government admitted to us that it borrowed our rhetoric that expenditure on health should not be seen as a drain on Victoria's finite resources, but instead as sound economic policy and prudent investment.

This was indeed a great result for our members, for all doctors, and for the community.

However, we are acutely aware that whilst the government has prioritised billions of dollars of new spending on health in the coming years, this does not improve the critical situation healthcare workers face on the ground right now- particularly in public hospitals. This is a crisis which has built up over decades due, in no small part, to a lack of planning – both in terms of recognising increasing demand and capacity constraints and planning effectively for it; and a failure between federal and state governments to co-operate to improve and ready the interconnecting parts of the health system for the demands we face today. Note the recent debacle over management of an announced public holiday!

> *"For the health system, transition is a continuous imperative. It will need to undergo fundamental change as it attracts the attention of state and federal governments to discuss and plan for the reform it so desperately needs.*

Furthermore, the plight of general practice remains genuinely dire, for which the entire community will suffer. General practice shoulders over 90 per cent of the healthcare burden in Victoria yet receives the least attention from state government. This simply must change, and AMA Victoria is advocating for this change. Funding must be prioritised to create a Division of General Practice within the Victorian Department of Health to ensure that the voice and concerns of general practice, across physical and mental health, are embedded within the very machinery of government, and resources should be directed to improve the interface between general practice and our hospitals, both public and private.

Moreover, AMA Victoria is profoundly concerned at the trajectory of mental health reform in this state: there is about to be proclamation of a new Act recently passed in parliament. Its essence is profoundly anti medical. There must be a fundamental re-orientation of funding priorities towards acute medically required care for serious, urgent, complex, high-risk cases so that those patients who are most in need can obtain the treatment and support they require. "Lived experience" alone cannot help in these most difficult of circumstances.

AMA Victoria appreciates that our agenda is ambitious, but now is the time to double down on a healthcare-led recovery for our state. Victorians deserve no less.

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Medical Association (Victoria) LIMITED
293 Royal Parade Parkville Victoria 3052
T: 03 9280 8722 | F: 03 9280 8786
Country Free call 1800 810 451
amavic.com.au

EDITORIAL:
Editor Taryn Sheehy
TarynS@amavic.com.au
Designer Shelley Heaney
ShelleyH@amavic.com.au
Advertising Frances Morell
FrancesM@amavic.com.au

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NEWS, VIEWS ⊕ REVIEWS

Would you like to share your news, views and reviews? VICDOC is your magazine. We want to hear from you.

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Doctors for the Environment Australia

(@DocsEnvAus)
Advocacy with @amavictoria has made climate change mitigation and sustainability a condition of the Enterprise Agreement (i.e. a condition of employment for Doctors in Training)
#iDEA2022Conf
#ClimateHealth
#TimeToAct

VICTORIAN AMA PRESIDENT LIFTS THE LID ON CONCERNING REALITY IN MAJOR HOSPITALS

President of AMA Victoria told 3AW the state's hospitals are in such crisis that elective surgery reductions are now effectively in place at many hospitals.

Click here to read + listen

AMA PRESIDENT PROFESSOR STEVE ROBSON ON ABC RN DRIVE – NATIONAL CABINET NEEDS TO RELEASE HEALTH ADVICE ON REDUCED ISOLATION PERIOD

Newly elected AMA President Professor Steve Robson spoke to ABC RN Drive about the need for National Cabinet to release health advice on reducing the COVID-19 isolation period.

Click here to read + listen

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

The President of AMA Victoria Dr Roderick McRae told 3AW "scores" of patients are treated in hospital hallways or tents across the state every day.

Click here to read + listen

DRS WARN ANDREWS GOVERNMENT'S MENTAL HEALTH REFORMS FLAWED AND PUT LIVES AT RISK

AMA Victoria spoke to The Age about mental health reforms failing to strike the right balance between protecting acutely ill patients and keeping healthcare workers safe.

Click here to read + listen

SONGS FOR OUR DAUGHTER

Laura Marling

Through the fever dream of the past 2 years, Laura Marling's seventh studio album 'Song for our Daughter' was released and was another revelation. A troubadour of the early 2000s quasi folk scene of England, Marling emerged, as the most talented, immense, and genuine. This album, written in her words about "trauma and an enduring quest to understand what it is to be a woman in this society" is a triumph. Having taken a hiatus to move to Los Angeles to escape recognition and become a yoga instructor, Marling made a triumphant return to music, and we are all the better for it. Influenced by the likes of Mitchell, Dylan, Young, Reed and Cohen, she has also been newly influenced by McCartney. The title track, 'Song for Our Daughter' lacks the typical sentimentality one might expect of such a theme, but is exquisite and haunting, and just like the overall album, full, melodious, stirring, and hopeful.

—

TRAVEL MAN 48 HOURS IN

SBS On Demand

With borders open, you might be wondering where to take your next trip? Join Richard Ayoade (actor, comedian, broadcaster, filmmaker) for inspiration as he presents the definitive guide to 48-hours away. Each episode is presented with a different celebrity and depicts travel for what it really is: the best and the worst of anything you could do. Get ready for wit and hilarity in this engaging television show. And if you have not seen Richard's 2010 debut feature film that he wrote and directed, 'Submarine', I also highly recommend this sublime coming of age comedy-drama.

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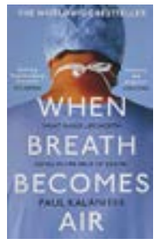


WHEN BREATH BECOMES AIR

Dr Paul Kalanithi

After being diagnosed with inoperable lung cancer at the age of thirty-six, Dr Paul Kalanith wrote an exquisite memoir reflecting on his life and wrestling with the question, "What makes a life worth living?" The extraordinary generosity and intimacy of this novel is breath taking, as Dr Kalanithi journeys from a medical student, "possessed by the question of what, given all organisms die, makes a virtuous and meaningful life" into a neurosurgeon at Stanford studying the very home of identity in the brain; and then finally as a patient, father and husband confronting his mortality with grace and stoicism. It is a moving and life affirming read; both a generous legacy, for Dr Kalanithi's daughter, and a gift for us all.

—

"After being diagnosed with inoperable lung cancer at the age of thirty-six, Dr Paul Kalanithi wrote an exquisite memoir wrestling with the question, "What makes a life worth living?"

When Breath Becomes Air

NEW RESEARCH ON TEMPORARY FACIAL PARALYSIS IN CHILDREN

Most children with a condition that causes a temporary weakness or paralysis of the muscles in the face recover without medication within six months, according to a new study. The research, led by the Murdoch Children's Research Institute and published in Neurology, found the steroid prednisolone does not significantly impact on a child's recovery from Bell's palsy.

Murdoch Children's Professor Franz Babl said while studies had shown steroid use in adults with Bell's palsy helped improve symptoms by minimising facial nerve swelling and damage within the temporal bone, similar research hadn't been available for children. The randomised-controlled trial involved 187 participants, aged six months to 17 years, who presented to emergency departments (EDs) with Bell's palsy.

The study was staged in 11 ED's in the Paediatric Research in Emergency Departments International Collaborative (PREDICT) research network in Australia and New Zealand. They were recruited within 72 hours after symptom onset and received 10 days of treatment with prednisolone or a placebo (no active drug). The study found 57 per cent of those who didn't take any medication recovered facial function at one month, 85 per cent at three months and 93 per cent at six months. For those assigned prednisolone, 49 per cent recovered at one month, 90 per cent at three months and 99 per cent at six months. There were no serious side effects recorded during the trial and the most common adverse reactions were temporary changes in behaviour and increased appetite.

Bell's palsy, which causes half of the face to droop, is the third most common condition causing a sudden change in nerve function in children. In most cases the exact cause of the facial weakness is unknown but may be related to a viral infection. "The lack of evidence on the use of steroids in children with Bell's palsy in children has led to variable practice in their treatment," Professor Babl said. Discovering that early treatment with prednisolone doesn't hasten recovery will help GPs, emergency physicians and paediatricians in their discussion with affected families and make better informed decisions."

Click here to contact Bridie Byrne Murdoch Children's Research Institute

What's On

21/9

World Alzheimer's Day

21/9

World Heart Day

1–31/10

Breast Cancer Awareness Month

1–7/10

Borderline Personality Disorder Awareness Week

10/10

Mental Health Day

1–30/11

Movember

ENQUIRY

MEDICINE + BUSINESS

“Doctors are the champions at managing transitions

DR SARAH LEWIS

AMA Victoria Board Member

Where are you currently working as a doctor and what does it involve?

I work as a GP at Port Melbourne Medical. As the owner and Practice Principal there are many clinical and managerial aspects to my role.

I am consulting 2.5 days per week and spending 2.5 (or more!) days per week doing the behind the scenes work that keeps the Clinic functioning and maintains high standards; including setting up and running our GP Respiratory Clinic, creating the clinical protocols and processes for our large-scale vaccine clinic, changes to the day to day running of the Clinic due to the pandemic and working with our clinic nurses to constantly improve how we do things.

What prompted you to study Medicine and become a doctor?

Like a lot of doctors, I grew up in a medical family. My mother was a GP, working in an underprivileged community and making a real difference. Medicine was always what our family did, and I was educated on why it was such a great career and saw the benefits it offered my mother and the flexibility she had. Prior to starting my career as a doctor, I knew I wanted to have a career where I was lucky enough to earn a living doing work in line with my values. It has not disappointed.

Who has inspired you in your professional life?

My inspiration comes from many people, both medical and non-medical. Throughout my career, I have been lucky to have been inspired by doctors who have demonstrated teamwork and leadership as well as excellent clinical skills. I consciously attempt to emulate those positive character traits and be supportive to those around me. I am constantly impressed by the amazing women in medicine. I am part of a female ‘clinic-owners’ group in Melbourne and these women’s achievements are outstanding. I know clinic owners who were told they would never manage to open a clinic and have managed to do so successfully. Their willingness to help each other and lack of competitive behaviour is heartening.

We are not taught about the business aspect of medicine during our degree and seeing how my non-medical husband runs the business side of our clinic is also inspiring. He recognizes growth areas, considers the patient experience, recognises and mitigates risk areas and does so much more in the business. He has inspired me to look at the business of general practice through a different lens and it is an exciting and rewarding journey.

You have recently joined the AMA Victoria Board. What motivated you to do this? What do you hope to achieve?

I have been a quiet member of the AMA for some years. The last 2 years have been some of the most challenging as well as the most rewarding in my career. Unfortunately, it became (more) apparent during the pandemic that many people do not understand general practice and what we do, until we do not or cannot do it!

Like a lot of GPs and practice owners, I feel frustrated about the direction of frontline medicine. There are many

headwinds impacting us, and we need to unite and be more of a political force to ensure high quality clinical practice continues, whilst ensuring patients have access to affordable, timely and quality healthcare. The safety and wellbeing of those working in the health sector is also vital. For too long, we have watched as the entire system falters and things get progressively worse. In Victoria, we need to work together with the RACGP, ACCRM and other relevant groups as a united body, to advocate for change through all layers of government.

It is vital that we are consulted and the impact of government decisions on GPs and other doctors is considered. We’ve seen the chaos that ensues when a press conference announcement is made, with no chance to prepare for the onslaught of phone calls and abuse at our lack of preparation. I have been part of some Victorian Government working groups during Covid and have managed to have changes implemented that are crucial to our workflows as GPs, including having forewarning for upcoming announcements. Being involved in discussions and being able to explain how we work and how decisions affect us has meant a better end-use experience to the front-line health care workers and their patients.

Why do you think the AMA is important?

The AMA is a great established body to represent doctors, and I feel that recently there is an increased desire and energy to make real change. This change will not just benefit doctors, but all patients too. The AMA is there to represent its members, and I encourage GPs to join. Have a voice and be part of the change.

The theme of the Spring VICDOC is ‘transitions’. Can you talk about a transition in your life and how you managed it?

Doctors are the champions of managing transitions. Our early hospital years have us out of our comfort zones by changing our clinical rotations multiple times per year. I have transitioned through interstate moves, job changes, parenting and clinic ownership.

However, the biggest transition I have experienced was the major changes we had to make in response to the pandemic. I went from a GP happily working away at my practice to what felt like an army commander preparing for battle. Right from the start, my husband and I decided our goals were to keep everyone safe, retain our workforce and still manage to safely see our patients. We met these goals and are proud to have not had any cases of staff catching Covid at work, and have not had to let any staff go, even when our business, like most, suffered a downturn during lockdowns.

Within a short time of the pandemic being called, we were contracted by the Federal Government to open a GP Respiratory Clinic. This resulted in us converting our newly built and just opened specialists’ rooms into a dedicated Respiratory Clinic. We have now assessed and swabbed over 60,000 patients, saved many lives and prevented many serious illnesses.

Changes to how we use our building was one thing but having to become the leaders of a team tackling the response head on was something else entirely. At the height of the Covid assessments and vaccinations we were running a team of 55 and operating 7 days a week.

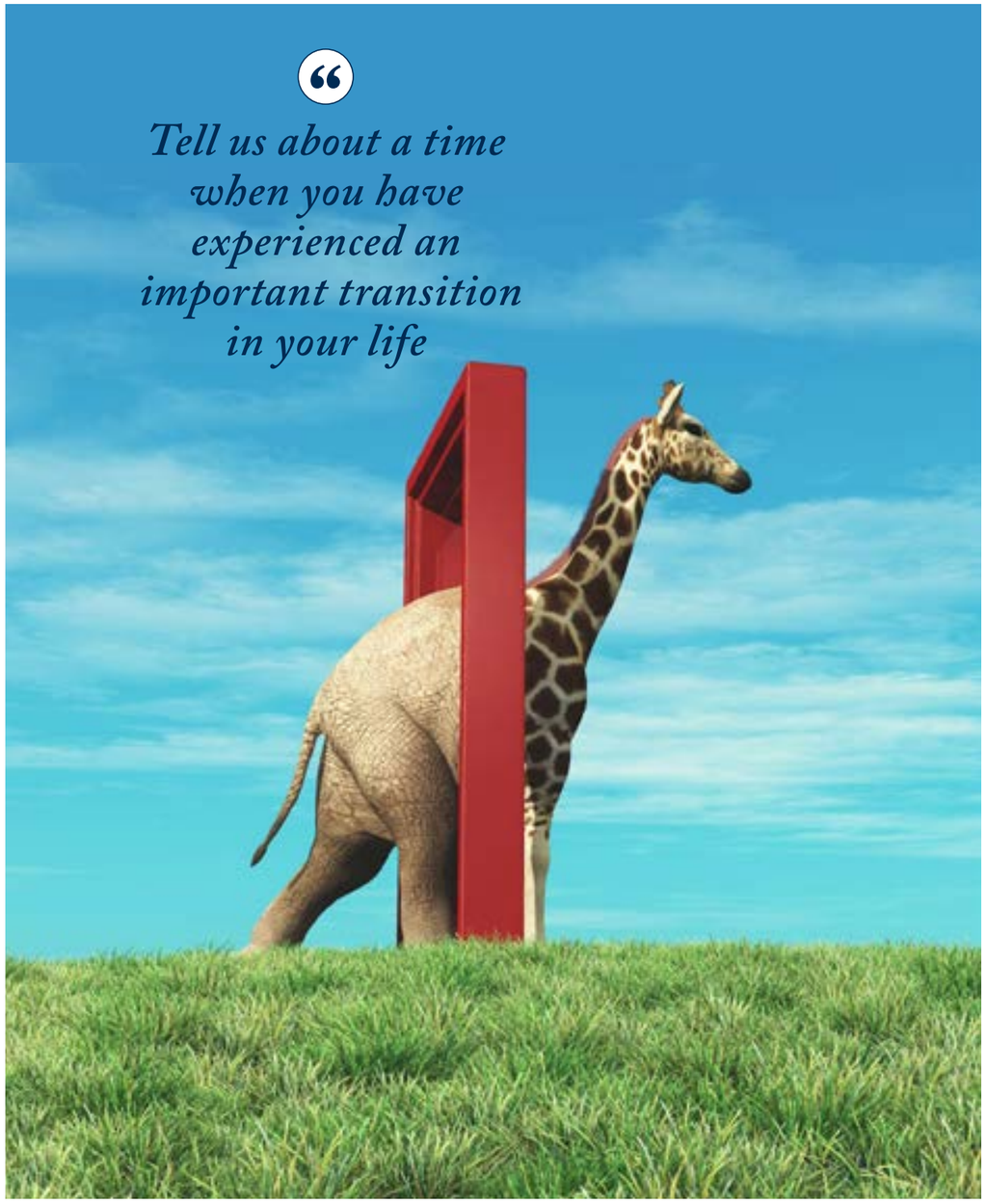
Since March 2020, we have had many transitions, depending on the current situations, and having a flexible and responsive team has been a godsend. Almost every area of our business had to go through some sort of transition – be it patient screening, waiting areas, PPE, telehealth, working from home… the list goes on.

I never in my wildest dreams thought I would be challenged in the way we have been over the last two and a half years. I have learned a lot about myself, and I have new skills and capabilities I never thought I would.

UNCERTAINTY + CERTAINTY

Would you like to take part in Second Opinion?
vicdoc@amavic.com.au

Tell us about a time when you have experienced an important transition in your life



DR CARMEN BROWN

FACOG, FRANZCOG
Consultant Obstetrician / Gynaecologist

I suppose my biggest transition was the decision to leave my home country of the USA and practice medicine in New Zealand and now Australia.

I have had the honor of meeting so many people along the way that have helped shape me into the clinician I am today.

I came to New Zealand not knowing much about the benefits of Midwifery led care and didn't have a really good understanding of how collaborative care models worked.

Being open to new structures and engaging with patients, midwives and specialists gave me the opportunity to become a more well rounded clinician. Seeing the interaction of systems and patients through three countries and a myriad of health care structures has turned me from a relatively passive observer to a passionate and vocal activist when it comes to health care inequities and safe maternity care for all women.

Although the transition from one country to another is usually a period of uncertainty and upheaval, I've been super lucky so far!

DR CILLA J. HAYWOOD

MBBS (Hons) FRACP PhD
Geriatrician / GP / Obesity Physician

Warning — the below is about miscarriage

—

My partner and I met when I was 33. After suffering a miscarriage at the age of 36, I struggled to get pregnant again. It took me a while to accept that I needed IVF. That was a real surrender to a process which was stressful, expensive and unpredictable. I very luckily got pregnant just before I turned 39. I dared not attach myself emotionally to the pregnancy until well after the halfway mark. Having suffered with depression before, I feared developing postnatal depression. I had a perinatal psychiatrist ready to go. Having my son nearly 4 years ago marked the beginning of a transition that I am still going through today. I am far less hard on myself, and I appreciate the small, joyful moments much more readily. In my career, I am much more brave and willing to take on work that challenges me and entails a risk of failure. I still worry about what people think of me, and have fear of failure or not being good enough, but it affects me less and less as time goes on. The struggle to become a mum increased my confidence. I hope that our profession and the AMA can support new mums to achieve their career aims.

DR SEAMUS HORAN

Doctor in Training
Secretary of the Doctor in Training Subdivision

Transition 1: ironed shirt, new shoes, brimming with anxiety. Where do I find general surgery? What is general surgery? Eventually your (much brighter) co-student finds the team. Round finished; you follow the team off the ward – where to? Clinics? Theatres? You arrive at Zoukis and the registrar looks at you, "what do you drink?". "Me? Really? ...I'll have a hot chocolate please".

Transition 2: stethoscope around neck, a useful tool you know how to use and wear everywhere. Boots which no longer give you blisters, with a shine that's started to fade. It's 3pm and the medical ward round has wound up. You walk the extra steps to the good café and your consultant nods towards you,
"I'll have a mocha thanks".

Transition 3: the round ends, the consultant and registrars head to theatre and the team start jobs. No such luck on this team. You look at your bank account. You head to the staff cafeteria and one button later: Nescafe's finest.

Transition 4: haven't slept in a week. No time for washing – oversized scrubs again today (I really should return the dirty ones...). Better get to Zouki's before it closes for the night. "One double shot latte thanks".

—

VICTORIA'S COVID-19 RESPONSE

IMPORTANT CHANGE NEEDED

The COVID years have been tough and whether our health system has learned enough to improve our responses to the inevitable future demands will require some fundamental transitions.

REPORT **PROF. M. LINDSAY GRAYSON**
PROF OF INFECTIOUS DISEASES,
DEPARTMENT OF MEDICINE,
UNIVERSITY OF MELBOURNE

PHOTOGRAPHY **ALBERT COMPER**

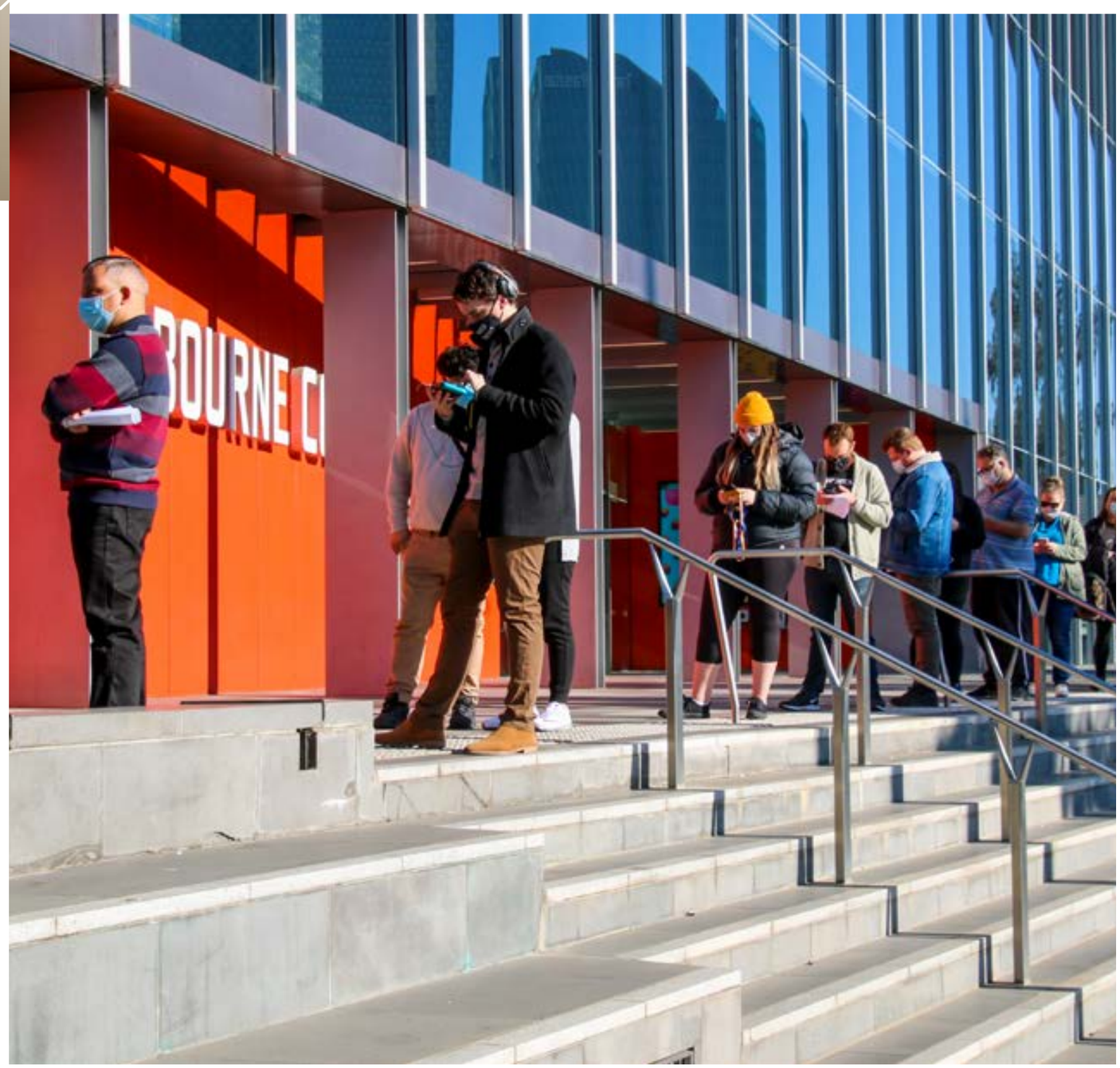
By any measure, the past two and a half years (what I will call the "COVID years") have been a tough time in Australia, for the community and the healthcare system. However, I think most of Australia would agree that Victoria has been impacted more than other states in terms of overall societal impact.

> *Of the many questions one could ask, the two most important are: What have we learned from Victoria's response; and when there is a new infectious diseases outbreak, will our public health response be any different?*

As a society, we would be foolish not to review how we have responded – not to lay blame for any mistakes, but instead identify how our public health and political systems could do better.

Firstly, by all objective measures, Victoria entered the COVID pandemic with the worst funded and most dysfunctionally structured Department of Health (DOH) in Australia. Unlike other states, Victoria had a Chief Health Officer who was solely responsible for public health and was low down the DOH organisational structure; a part-time Chief Medical Officer (CMO) who was in a separate department and solely responsible for hospital-based healthcare, and no defined medical structure to provide coordination between all facets of the state's healthcare response (including general practice, community health, vaccination policy and aged care). Until recently, Victoria had many fewer doctors (per capita) working in the DOH than other states and although this has lately improved, these positions are still mostly on short-term insecure contracts, such that staff retention has been a critical problem.

Because of poor COVID source-control and slow contact tracing, COVID spread more extensively than in other jurisdictions. In response, Victoria used blunt societal containment measures such as repeated lockdowns, the "ring of steel" around Melbourne and curfews to restrict people movements and COVID transmission.



The failure of the Federal Government's COVID vaccine policy in terms of vaccine selection, purchase and contracts; communication and roll-out are a shameful reflection on our broken system of federal healthcare and combined with a poor public health structure in Victoria, saw Victoria heavily impacted. Combine this with Australia's crazy system of federally-controlled, but locally administered aged-care policy, it is no surprise that Victorian aged-care residents (and their families) bore the brunt of COVID policy impacts.

The Victorian COVID-19 Hotel Quarantine Inquiry (HQI) was notable for many reasons. Firstly, it was chaired by Her Honour Jennifer Coates, who had previously as a Victorian Coroner, overseen the 2007/8 Broughton Hall salmonella enquiry that highlighted the dysfunction in the federal-state-local Council response to infectious diseases outbreaks in aged-care facilities. Secondly, the HQI highlighted the poor coordination between federal and state DOHs in terms of accurate public health and infection control communication and messaging, and the inconsistencies in public health policy and implementation both within Victoria and between states. The HQI findings clearly outlined why Victoria failed in its public health and political response to COVID.

Once COVID vaccines became readily available, the impact of the previous 18 months of poor communication and negative publicity associated with the Astra-Zenica vaccine complications (the clotting effects of this type of vaccine were well known prior to COVID) and the power of social media to spread misinformation among a fatigued and increasingly disgruntled and distrustful community meant that the state needed to resort to mandating COVID vaccination. Messaging about the usual positive effects of vaccination and its societal benefits was now lost and replaced by the fog of politics, spin and coercion. The absolute disgrace of having a mob of angry anti-vaxxers desecrate the Shrine of Rememberance will forever live in my memory as a symbol of how far our society had fractured and how poor our response to COVID has been.

The final straw, was the intense political focus on wresling the pandemic powers from the Victorian CHO, Professor Brett Sutton in late 2021 to the Victorian Government. Imagine if all the political effort that was applied to get the last deciding vote to enact this legislative change had been applied to COVID policy? How different Victoria might be. Instead, the Health Minister announced a near-abandonment of COVID control measures 10 days before Christmas (and then the Boxing Day Test) – roughly two COVID replication cycles before the largest family gathering event (and sporting event) in the year. The subsequent explosion in cases and deaths was inevitable. Governments may want to control pandemic health policy, but it seemed like nothing had been learned from the previous two years of pain.

Firstly, we need a consistent effective standard of public health across all states. Currently it is not only the quality of public health that varies, but even the list of notifiable infectious diseases that differs between states. To achieve consistency, Australia needs a Centre for Disease Control (CDC) that defines minimum standards; provides a central source of reliable, accurate disease information; collaborates with state DOHs to ensure effective implementation of public health policy and links with existing infectious diseases research institutes to maximise research output.

How does Victoria and Australia transition to a better system of healthcare?

Secondly, greater transparency is required in health. In general, Australians respond well to truthful, accurate health information that is not polluted by political spin – it is the latter that makes them distrustful and allow conspiracy theories to gain traction. As an example, enhanced information about the current COVID cases and hospitalisation data would be welcome.

- What underlying diseases do these patients have?
- How many were only vaccinated with Astra-Zenica vaccine (now known to have poor efficacy against current COVID variants)?
- How many had a delayed presentation and therefore may have missed the opportunity to receive oral antivirals?

Such transparency would greatly improve education initiatives and trust. To achieve this, politics and spin needs to be removed. The creation of an independent CDC could help with this.

Finally, an emphasis on empowering personal responsibility and behaviour in our patients is required. Clear, authoritative communication and targeted education that is tailored to different populations within our society is crucial. Just look at the improved efficacy of indigenous vaccination programs when messaging was locally designed and initiated. These programs are the future and need coordinated support.

The COVID years have been tough and whether our health system has learned enough to improve our responses to the inevitable future demands will require some fundamental transitions.

Click here to read AMA Victoria's submission to the 2020 Inquiry into the Victorian Government's Response to the COVID-19 Pandemic

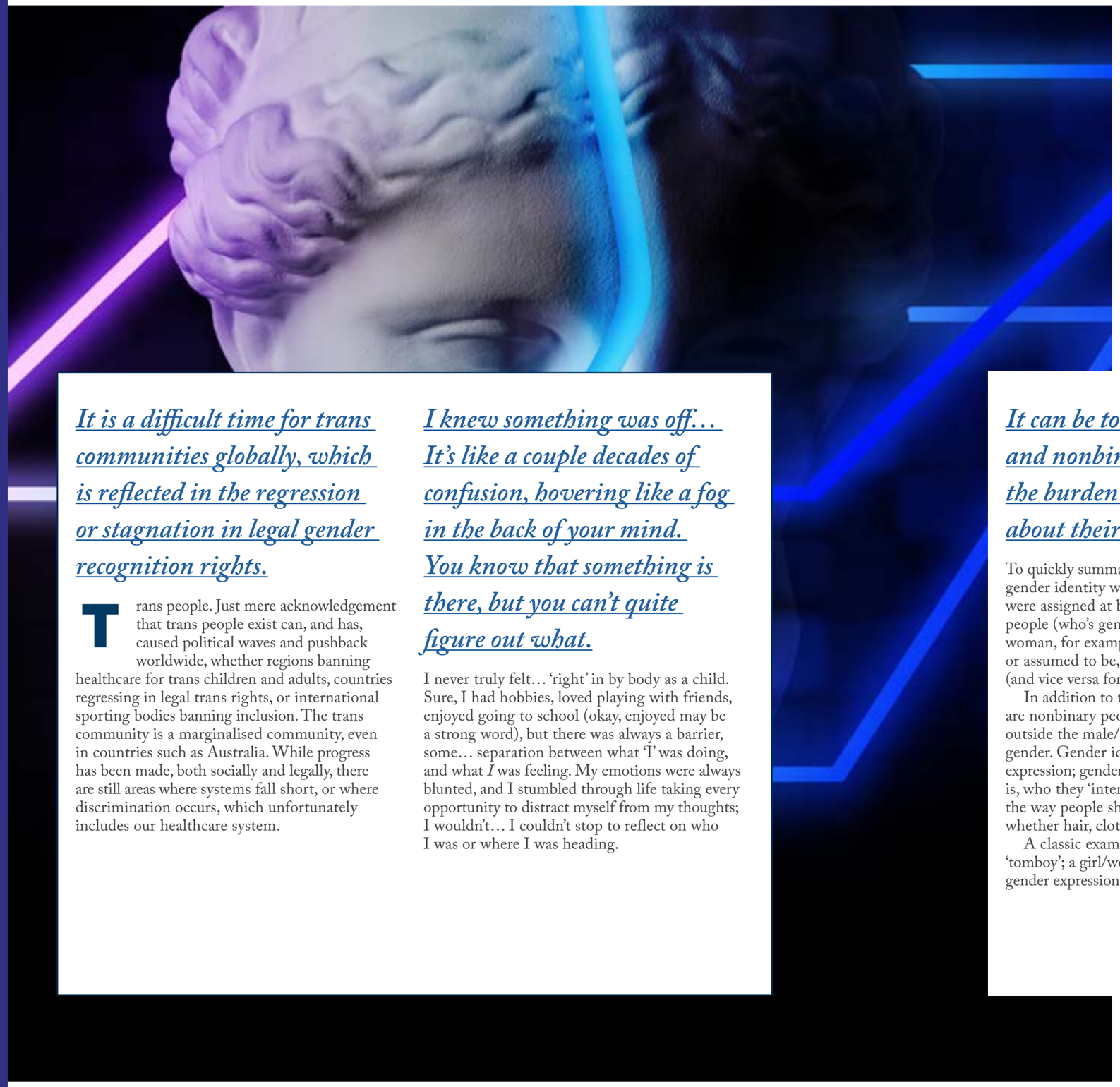
REPORT **DR ARIA NASTEKA (SHE/HER), CRITICAL CARE HMO3, BALLARAT BASE HOSPITAL, AMAV DOCTORS-IN-TRAINING SUBDIVISION**

TRANS PEOPLE:

A MARGINALISED COMMUNITY

FAR TOO OFTEN FAILED BY THE HEALTHCARE SYSTEM

When I first heard about 'transgender people', I found myself strangely drawn



> While progress has been made, both socially and legally, there are still areas where systems fall short, or where discrimination occurs, which unfortunately includes our healthcare system.

It is a difficult time for trans communities globally, which is reflected in the regression or stagnation in legal gender recognition rights.

Trans people. Just mere acknowledgement that trans people exist can, and has, caused political waves and pushback worldwide, whether regions banning healthcare for trans children and adults, countries regressing in legal trans rights, or international sporting bodies banning inclusion. The trans community is a marginalised community, even in countries such as Australia. While progress has been made, both socially and legally, there are still areas where systems fall short, or where discrimination occurs, which unfortunately includes our healthcare system.

I knew something was off… It's like a couple decades of confusion, hovering like a fog in the back of your mind. You know that something is there, but you can't quite figure out what.

I never truly felt… 'right' in by body as a child. Sure, I had hobbies, loved playing with friends, enjoyed going to school (okay, enjoyed may be a strong word), but there was always a barrier, some… separation between what 'I' was doing, and what *I* was feeling. My emotions were always blunted, and I stumbled through life taking every opportunity to distract myself from my thoughts; I wouldn't… I couldn't stop to reflect on who I was or where I was heading.

It can be tough for transgender and nonbinary people to bear the burden of educating others about their lived experience.

To quickly summarise, transgender people have a gender identity which differs from the one they were assigned at birth, in contrast to cisgender people (who's gender identity matches). A trans woman, for example, may have been assigned, or assumed to be, 'male', but is in fact a woman (and vice versa for trans men).

In addition to trans men and trans women there are nonbinary people, whose gender identity is outside the male/female binary classification of gender. Gender identity also differs from gender expression; gender identity is the gender someone is, who they 'internally' are, gender expression is the way people show who they are externally, whether hair, clothing, jewellery, makeup, etc.

A classic example to demonstrate is a 'tomboy'; a girl/woman with a more masculine gender expression.

Look in the mirror and tell me. What it is like to be free. How do I grasp reality. When I don't have an identity?

When I first heard about 'transgender people', I found myself strangely drawn. People could 'change' their gender… and that was okay? I fell down a rabbit hole of reading, watching, learning. It took a few months, but it would finally click. As the realisation hit, I felt an immediate rush of warmth, joy, and relief: "I AM TRANS!!". Then the reality of the situation slowly descended, replacing the joy with a sense of dread "I… am trans".

Transgender people have a gender identity which differs from the one they were assigned at birth, in contrast to cisgender people (who's gender identity matches)

> *There need to be better efforts, at the individual, organisational, and policy-making level, to create environments of support, which will make vital differences in improving the lives of trans people.*

375 Transgender People Murdered In 2021-'Deadliest Year' Since Records Began.

Discrimination and violence against trans, and all LGBTIQA+, people remains depressingly prevalent. Trans people in the US are 4 times as likely as their cisgender peers to be a victim of violent crime; while data is limited in Australia, it is known that the trends here echo that of the US, with higher rates of family violence, sexual assault, physical assault, and verbal abuse.

Additionally, 33% of trans people report employment discrimination, with the unemployment rate of trans people also 3 times the national average. Trans children also face many difficulties; they are more likely to experience homelessness, family conflict, and child abuse, and shelters for children are often poorly trained and equipped to provide a space for those who are trans. The legal and government systems, instead of providing respite, continue to provide further stressors. Conversion therapy for LGBTIQA+ people in Victoria was only criminalised this year, despite the known trauma that arises from these practices, which many trans people will be carrying with them. Surgeries necessary for the alleviation of gender dysphoria are also only available privately, meaning that many may not be able to receive healthcare they need; despite a federal government petition which received almost 150,000 signatures, no moves to publicly fund these surgeries have been made.

Whether societal, legal, or otherwise, the minority stress this community experiences leads to worse mental health outcomes. 73% of trans people in Australia report depression in their lifetime, 67% anxiety, 63% previous self-harm, and 43% suicide attempts.

Trans people will carry these burdens, this trauma, with them when they approach the healthcare system; discrimination and abuse within this system is, however, another disappointing reality. 15% of Trans people have experienced verbal abuse within a healthcare setting, 6% 'unwanted sexual contact', and 2% have been physically attacked. Approximately 20% of trans people have been refused healthcare, 8% refused healthcare because they are trans.

Finally, more than half 'had to teach [their] doctor or healthcare provider' in order to receive appropriate care. All this leads to avoidance of the medical systems; 41.3% of trans people in Australia avoid emergency departments because they are trans.

The [Trans, gender diverse, and non-binary] community is a high priority...

There is evidence that mental health outcomes improve significantly when individuals are able to acccess gender-affirming hormones. Trans affirming care is associated with far better health outcomes for trans people. Trans children who receive affirming care have far lower rates of depression and anxiety, approaching levels of their cis peers, which is also the case when trans adults receive gender affirming care. One particular striking statistic is that trans youth who have at least one accepting adult are 40% less likely to report a suicide attempt; healthcare professionals can be avenues of support, healthcare professionals should be avenues of support.

There is serious discrimination, marginalisation, and inadequate education regarding trans people, within not only the general Australian community, but also healthcare settings, leading to ongoing trauma and avoidance. There need to be better efforts, at the individual, organisational, and policy-making level, to create environments of support, which will make vital differences in improving the lives of trans people.

My primary experience of my body now is relaxation and comfort.

It has been 2 years since I first realised I was trans, and well over a year since I started receiving gender affirming care. I would not trade this knowledge or care for the world. I feel calm and peace, but also feel… alive. Before, I would look in the mirror and feel confusion, distance, and discomfort. Now when I do so I feel… joy.

—

RURAL TRANSITIONS

HOW DO YOU PREPARE

A career in medicine is full of transitions: from high school to medical school to clinical placements to internship; and then residency, specialty training and fellowship. It can sometimes feel like you are always changing roles, locations and needing to figure out where you fit in.

JASMINE DAVIS

President Australian Medical Students' Association (AMSA)

Get to know the community you are entering

Jasmine is a penultimate year student at The University of Melbourne studying a combined Doctor of Medicine and Master of Public Health. Jasmine is passionate about a career in rural health, originally growing up in regional Victoria and having completed all of her studies as part of the Rural Clinical School program at Melbourne University.

> *In a country as geographically diverse as Australia, we have the added challenge of physical relocation also occurring alongside such transitions.*

As a medical student from regional Victoria and a member of my rural clinical school, I have undergone a number of relocations during my time at university; and with a desire to go into a career in rural generalism, I anticipate a number of additional geographical transitions in my career to come.

Shifting to live and work or complete placement in a regional, rural or remote community often comes with its unique challenges and benefits. The way in which we approach such a move, whether it be from metropolitan to rural or between rural sites, can have implications on the overall experience of your placement or rotation.

This piece hopes to provide some advice on how you can best prepare for and embrace the beginning of a new term or life rurally, collating advice I have received from rural doctors and mentors throughout my student years.

Investing time early in the creation of friendships and relationships with colleagues will make your experience richer and more valuable
—

1 GET TO KNOW THE COMMUNITY YOU ARE ENTERING
—

Once you find out where you are moving for your placement or rotation, make sure to find out as much as you can about the location, community and local surroundings. If you are a student, the best way to do this is to chat to students who have previously been placed in the rural area and ask them about their experiences. It is also worthwhile chatting to any educators or doctors who work in the area about their experiences and why they love working there. If it is possible, visit the community as a tourist prior to moving there to get to experience the local sights and surroundings.

2 BRING EVERYTHING YOU MAY NEED
—

Sometimes, the hardest part about constantly moving for rural rotations is the packing. What you need to bring will really depend on the distance your home is from the rotation, how long the rotation is, and the kind of facilities provided to you by the health service, or the place you are staying. Important things I have forgotten across my placements include bedding, phone charger, clothes for placement, and plastic containers for leftover food. If you find yourself far from home with forgotten items, ask other students or doctors in the accommodation, or try and get things from the local op-shop so you don't end up with two of everything!

3 SEEK OUT COLLEAGUES EARLY
—

A key part of any transition into a new team and community is finding those people who you really click with and work with well, and people who you can debrief with about your experiences. As a student, it is frequently easy to find the other students on placement with you. Spend some time at the start of your rotation getting to know them if you haven't already. Go out for dinner and try a local restaurant together, create a local trivia team, or mixed netball team. Investing time early in the creation of friendships and relationships with colleagues will make your experience richer and more valuable; and will be incredibly useful should you find yourself in need of someone to whom you can talk.

4 EXPLORE
—

When you get time off, make sure you do as much exploring as possible! Ask the staff at the hospital or clinic for activities to do on the weekends. Rural Australia is incredibly beautiful, and you are often not far away from a breath-taking hike, a gorgeous winery or a beachside town. Make the most of your rural time and see as much as you can, whilst supporting local businesses.

5 CONTINUE TO LOOK AFTER YOURSELF
—

Sometimes going rural can be tough. You may miss your family, friends, and the familiarity of wherever your home base usually is. Make sure in the period of transition into your rural placement or rotation, that you continue your usual routine as much as possible. This means getting in touch with a local gym and continuing your classes if that's what you did back home, and it also means making sure to get sleep and eat well. Talking to your friends and family as much as possible can also really help with the transition, and make sure to just be kind to yourself if you aren't finding you fit in and love it straight away. Be patient, look after yourself and make the most of the time you have on the placement.

6 SHARE YOUR EXPERIENCE
—

If you enjoyed going rural, tell people about it! We need more students, doctors in training, and specialists to experience rural practice, and stay there. The more you share about your experience, the more we can do to dispel some of the fears people have about making the transition to become a rural doctor. Rural clinical school has been a career affirming experience for me, and I hope it is the same for you. Whether you want to be rural long term or not, sharing your experience can help others take the step to a potential future career in rural Australia. —

starting a private practice fact sheet

bongiornogroup

setting yourself up for success

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other considerations

1. Ownership structure
- Legal structure (sole practitioner, trust, company, etc)
- Legal agreements and documents
- Finance considerations

2. Organise business set up
- Register your business name
- Set up ABN and TFN
- Secure premises – buy or rent
- Set up business bank accounts
- Organise merchant facility (credit card, EFTPOS, etc)

3. Website and communication
- Register your business domain name
- Develop logo and visual imagery
- Source website design, content creation, and hosting
- Create email addresses, signature blocks, etc.
- Online appointment bookings and SMS reminders

4. Stationery
- Design and templates for letterhead, invoices, referrals, etc.
- Business cards, next appointment cards

5. Rebate systems
- Health insurance rebate systems – Medicare and PHI

6. Practice team
- Set up work cover and other insurance
- Registration of PAYGW + GST
- Employee contracts and forms

7. Client facilities
- Waiting room, décor, promotional material
- Seating, accessibility (disability, prams, etc)
- Bathroom facilities

8. Office and rooms
- Phones, computers, furniture
- Printers and photocopier

9. Hardware & software
- Xero accounting or similar
- Practice management & billing
- Genie, Clinic to Cloud

The Bongiorno Group specialises in financial wealth and tax advice for healthcare professionals. We will make your transition to private practice as seamless and thorough as possible, ensuring you're adhering to the ATO guidelines. We'll help you get it right from the beginning and continue supporting you to enjoy the benefits of working in private practice. Want to have a chat with one of our expert advisers? Book an AMAV member complimentary meeting today.

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THE POLICY DESK

AMAV ADVOCACY

If you have a policy issue you would like to discuss, or have some feedback about our priorities, please contact LewisH@amavic.com.au

A particularly eclectic array of issues has come across the policy desk over the past few months including mental health reform, vaping regulation, and payroll tax.

MENTAL HEALTH REFORM

AMA Victoria has recently, both publicly and privately, voiced concerns over the direction of mental health reform in Victoria, particularly as manifested in the Mental Health and Wellbeing Act, passed by the Victorian Parliament on 31 August.

AMA Victoria recognises and respects the commitment of the Victorian Government to implementing all recommendations of the Royal Commission into Victoria's Mental Health System Final Report within the broad timeframes specified by the Commission.

However, we have significant concerns over the rushed development and parliamentary passage of this Act.

As opposed to the perfunctory consultation process performed by the Victorian Department of Health prior to the legislation being passed, it is AMA Victoria's view that important legislation of this nature should be developed over significant periods of time, particularly from medical experts in the fields of impact, and that a rushed process is not conducive to optimal outcomes and may have unintended consequences of harm.

Beyond issues of process, our substantive objections to the legislation include:

- Wording in the legislation that restrictive interventions offer "no inherent therapeutic benefit to the person", and the continuing objective to eliminate these practices within 10 years (it should be noted, however, that in response to AMA Victoria's forceful advocacy, the Government abandoned efforts to legislate a firm ban on these practices).
- Police-like powers to mental health staff.
- Language of the Act itself (for example, definitions around 'Electroconvulsive therapy' and 'Patient').

More generally, we have also raised with government the issue of excessive bureaucracy and administration- or 'treatment red tape'- attaching to rash reform of legislation. Members have noted that, as it stands, the system is still struggling to catch up and deal with the huge impost and administrative burden of the 2014 Act, and they have concerns that what has been legislated will only double-down on this.

VICTORIA DISHONOURABLE RECIPIENT OF DIRTY ASHTRAY AWARD

AMA Victoria recently wrote to Health Minister Thomas to inform her that Victoria, lamentably, received a Dirty Ashtray Award at the recent AMA National Conference for the state's lack of effort in preventing vapes being sold to children.

The letter noted that inadequate priority has been given to implementing and most importantly doing nil to enforce existing state laws, and ensuring compliance with these laws, to prevent the sale of illegal e-cigarettes to children, teenagers, and young adults in Victoria.

Moreover, it noted that retailers of tobacco products in Victoria are currently not required to be licensed and this makes it very difficult to enforce existing laws, and ensure compliance with these laws, regarding the sale of tobacco products and e-cigarettes.

The letter concluded by calling on the Victorian Government to require all Victorian tobacco retailers to be licenced to protect young people from the enormous harm caused by all tobacco products and for more resources to be allocated to enforcement of the laws that are on the books.

INDEPENDENT COVID REVIEW

AMA Victoria recently provided a submission to a private review into Australia's response to the COVID-19 pandemic COVID Review Submissions | e61.

Our submission was grounded principally in the Victorian experience, and particularly the structural issues within Victoria's health system, namely the devolved governance of the state's hospitals.

The submission noted that there are certain advantages associated with decentralisation, but that the pandemic had only stood to magnify the weaknesses inherent in the system, with these weaknesses including governance, accountability, transparency, communication, general practice integration, and (primarily early in the pandemic) a lack of clinical knowledge within the Victorian Department of Health.

On a more positive note, the submission highlighted recent steps taken by the Government that resulted in state engagement and investment into general practice to address COVID-19, some of which has been revolutionary (including directly funding general practice). The submission noted that AMA Victoria's hope is that this is just the beginning of greater State Government engagement with general practice.

PAYROLL TAX AND MEDICAL PRACTICES

AMA Victoria continues to advocate to the Victorian Government expressing significant concern regarding recent developments in payroll tax – originating from the Optical Superstore decision of the Court of Appeal in Victoria, most recently the Thomas and Naaz case in the NSW Civil and Administrative Tribunal.

We have conveyed to the Victorian Government that the standard business procedures caught by these decisions are incredibly common throughout Victoria and are now essentially the standard for how medical care is supported outside hospitals and that imposing payroll tax in this manner would necessitate many general practices abandoning bulk billing and charging gap fees to Victorian patients to remain a sustainable and viable business.

Accordingly, AMA Victoria continues to urge the Victorian Government to abandon retrospectively applied current payroll tax assessments on medical practices relying on the reasoning in Optical Superstore and like cases, and to reform payroll tax law to prevent this from happening further.

Beyond the realm of political advocacy, we continue to receive questions/queries from members on what the implications of these developments could be for them and their practices Accordingly, we are collaborating with Tax and Accounting Partner, the Bongiorno Group, and Legal Partner, Kennedys, to develop guidance for members to assist them in avoiding falling afoul of mistargeted laws.

UNRESOLVED ISSUES AT GOULBURN VALLEY HEALTH

AMA Victoria continues to call for the serious workplace culture issues at Goulburn Valley Health (GV Health) perpetuated by the executive management of the service to be addressed.

Over the years, AMA Victoria members have often contacted us to report mistreatment at GV Health. However, in recent times, there has been a rapid escalation in the number of calls and disputes being brough to our attention. An alarming number of practitioners have been the subject of disputes arising from management action and have departed GV Health on poor terms. Despite requests for action by AMA Victoria to the health service, it appears that it is doing nothing to improve the situation.

In addition to shining a spotlight on this important issue, we are assisting members lodging formal complaints to the AHRC and VEOHRC detailing unaddressed incidences of discrimination perpetuated by senior figures at the service by reviewing their applications.

VIDEO

HTTPS://WWW.YOUTUBE.COM/WATCH?V=3DHDK9LI8W8

McKELL ROUNDTABLE PANEL EXAMINES POST-PANDEMIC HEALTHCARE IN VICTORIA

A recent McKell Institute-hosted policy roundtable featuring AMA Victoria President, Dr Roderick McRae, examined the key post-pandemic issues facing the Victorian healthcare system and the possible policies that Government could adopt to address the urgent concerns of healthcare worker fatigue, the backlog of non-pandemic related surgeries, and the need for new financial models to assure the system's economic sustainability.

The panel's discussion highlighted the interconnection between healthcare worker well-being, enhanced patient care, overall system performance, financial sustainability, and technology.

There was considerable panel discussion about the impact of the pandemic upon healthcare workers and how government can best support those on the frontline of healthcare going forward. This led to a review of a wide array of issues, including the collection and use of patient data and how a combination of data and technology can help relieve overworked healthcare professionals while fostering improved patient outcomes and better managing the overall healthcare supply chain.

Dr McRae stated that "one thing I want to say (coming) out of this crisis, we have got to do stuff differently... I can't overstate (how) stressful it is it because it's a crisis and it seems such a shame to waste it". He noted that while vaccination efforts have been good and vaccination efforts must continue, better efforts are needed to make sure that "healthcare workers, medical, nursing people going into people's homes" have the required personal protective equipment to safeguard themselves.

FED FACTS

AWARDS ⊕ CELEBRATION

AMA National Conference
International Convention Centre
Sydney Australia
July 2022

Two AMAV members inducted into the AMA Roll of Fellows

A/PROF JULIAN RAIT OAM

Associate Professor Julian Rait is an eminent Ophthalmologist who joined the AMA in 1982 after graduating with a Bachelor of Medicine, Bachelor of Surgery from the University of Melbourne.

In 2018, A/Prof Rait was awarded the Medal of the Order of Australia for service to Ophthalmology and to the development of overseas aid.

Following two years' service as President of AMA Victoria, in May 2020 A/Prof Rait agreed to continue in the role for a further year in order to lead Victorian advocacy on behalf of the medical profession during the COVID-19 pandemic. Members' concerns were rapidly communicated to state and federal health authorities and his daily advocacy to ensure there were systemic and organisational changes in the Victorian Health Department and to protect the public and healthcare workers including appropriate PPE, working conditions and support in Victorian hospitals, certainly saved lives.

A/Prof Rait became Chairman of the AMA Federal Council in August 2020.

He has also been Chairman of AMA Victoria and Chairman of the Council of Private Specialist Practice for the Federal AMA (since 2016), advocating for private health insurance reforms and helping to secure improvements to private health insurance on behalf of private specialists and the AMA.

Through his participation in the Federal Government's second medical indemnity review, A/Prof Rait secured both continuity of government support schemes and improvements to the regulation of the medical indemnity insurance industry.

The outstanding contribution of A/Prof Rait has left an enduring legacy from which the Australian Medical Association will benefit for years to come.

DR SARAH WHITELAW

Dr Sarah Whitelaw is a highly respected emergency medicine physician who trained in Queensland and is a Staff Specialist at the Royal Melbourne Hospital.

Dr Whitelaw joined the AMA as a medical student in 1993 and became President of the Australian Medical Students Association in 1996. Dr Whitelaw led the students' campaign on major national policy issues including the backlash against the Federal Government's decision to restrict Medicare provider numbers to doctors who had completed postgraduate training.

As Chair of the AMA Council of Doctors-in-Training in 2000-2001, Dr Whitelaw was a strong and fearless campaigner on issues concerning junior doctors such as training, safer hours and fatigue. She contributed to the medical indemnity crisis campaign in that year, arguably the most challenging issue the medical community has ever faced. There is no doubt that Dr Whitelaw's contribution to AMA in these earlier years helped strengthen the influence of medical students and doctors-in-training.

Dr Whitelaw's impact during the COVID-19 pandemic has been significant. She has advocated for issues such as stronger personal protective equipment and conditions for health workers, an operational approach to hotel quarantine, and a stronger system-wide approach from Victoria in responding to the pandemic. More recently, she has been pivotal in advocating for whole-of-system reform to deal with unprecedented pressures on the health system Australia-wide as an emergency physician on both the AMA Victoria and Federal Councils.

Dr Whitelaw's outstanding contribution has lifted the profile of many important policy issues and driven positive change from which the medical profession and the AMA will benefit for years to come.

Victorian doctor wins AMA's Women in Medical Leadership Award

Dr Dr Kym Jenkins (right) receiving award from Dr Helen McArdle (Chair of the AMA Committee on Equity, Inclusion and Diversity)

DR KYM JENKINS

A Victorian doctor whose work has resulted in many thousands of doctors receiving support has won the Australian Medical Association's annual Women in Medical Leadership Award.

Dr Kym Jenkins received the award from Dr Helen McArdle (Chair of the AMA Committee on Equity, Inclusion and Diversity) at the AMA's National Conference for her outstanding dedication and commitment to advancing women leadership, quality care and contributing to medical politics.

"Dr Jenkins has dedicated herself throughout her career to improving the working conditions and wellbeing of doctors in all their career stages," Dr McArdle said.

"Her dedication in this area is unparalleled. Through her work as the founding Medical Director of the Victorian Doctors Health Program, Dr Jenkins has helped establish a critical standalone clinical support service for doctors' health in Victoria that has served as the model for doctors' health services nationally.

"Dr Jenkins then used her experience from the program to serve as the chair of the Expert Advisory Group of the Doctors' Health service leading significant change in doctors' health services nationally."

Doctors Health Service coordinates the delivery of advisory and referral services to doctors and medical students across the country by state-based providers.

Dr McArdle said that while Dr Jenkins most profound advocacy efforts have focused on doctors' health and wellbeing, her advocacy efforts stretched beyond this to include migrant and refugee health, women's health, domestic violence and mental health more broadly.

"More recently Dr Jenkins has been pivotal in helping the AMA as a founding executive member and treasurer of the Hand-n-Hand Peer Support network, which has provided support to medical practitioners and other healthcare workers throughout the COVID-19 pandemic.

"Dr Jenkins, who is also a former President of the Royal Australian and New Zealand College of Psychiatrists and former chair of the Council of Presidents of Medical Colleges, is a true advocate for women in healthcare leadership who embodies the character of this award."

Dr McArdle said the eight outstanding nominees for the award should be very proud of their achievements.

"I'd like to thank each one of these amazing doctors for their dedication and commitment to advancing women leadership, quality care and contributing to medical politics."

Leading through Advocacy

A chat with Dr Kym Jenkins who recently won the Australian Medical Association's Annual Women in Medical Leadership Award

DR KYM JENKINS

Consultant Psychiatrist

WHAT HAVE BEEN THE HIGHLIGHTS OF YOUR CAREER SO FAR?

—

The highlights for me have been getting into medical school and being the first person in my family to go to university and then making the decision to change tracks and move from general practice into psychiatry. Certainly, getting my FRANZCP and taking my children with me! And finally, being elected RANZCP President and Chair of CPMC and feeling the responsibility of the trust that my colleagues had put in me.

WHAT HAS DRIVEN YOUR DEDICATION TO PROVIDING SUPPORT SERVICES FOR DOCTORS' HEALTH AND THEIR OWN WELLBEING?

—

I feel privileged to have worked with and looked after so many inspirational doctors who have overcome adverse circumstances or battled through health problems to still provide the best possible care for their patients. Medicine is an inherently stressful occupation however I have witnessed so many doctors struggle unnecessarily due to undue pressures in the healthcare system, industrial concerns, interpersonal issues and professional conflict.

WHAT DO YOU THINK IS FUNDAMENTALLY IMPORTANT IF WE ARE TO IMPROVE THE WELLBEING OF DOCTORS BOTH NOW AND IN THE FUTURE?

—

Of fundamental importance is decreasing the stigma around help seeking and the need for workplaces to facilitate the seeking of help and receiving care. Additionally, the focus of doctors' health services has been to look after those who are already struggling.
It is necessary to broaden our approach to be preventative. Equally, all of us, whatever level we work at or whatever stage we are at in our careers, must take responsibility to ensure we are not agents contributing to poor health for our colleagues.

CAN YOU TELL US ABOUT YOUR WORK IN MIGRANT AND REFUGEE HEALTH, WOMEN'S HEALTH, DOMESTIC VIOLENCE AND MENTAL HEALTH?

—

Over the past few years, I have undertaken pro bono work with the Asylum Seeker and Refugee Centre (ASRC) and other important organisations that advocate for the needs of this vulnerable group of people. I see and assess the mental health of people who have experienced all sorts of unimaginable traumas and are seeking asylum in Australia. It is hard to be involved in this area and not feel the need to do more.

I was additionally privileged to participate and then become Chair of the Migrant and Refugee Health Partnership (MRHP). MRHP has developed a curriculum framework for training of all clinicians when working with migrants and refugees, now adopted by nearly all the medical colleges. Another significant project was working with the Commission on Safety and Quality in Healthcare to produce the NSQHS user guide for health services providing care to people for migrant and refugee backgrounds.

WHAT WOULD YOU SAY TO OTHER YOUNGER DOCTORS (PARTICULARLY WOMEN) WHO WANT TO GET INVOLVED IN ADVOCACY?

—

Advocacy is not just about lobbying at a high government level. In fact, we all advocate for patients everyday however, if there is an issue you care about or want to change, put your hand up to volunteer with existing advocacy groups.

Be patient in your advocacy. Change takes time and you need to prepare the ground and seeds will have to be sown. Watch the political climate and wait for the right time to try again. Be prepared to be flexible. Taking a sideways route might be more effective than tackling an issue head on.

TRAVEL:

TAKING TO THE SKIES AGAIN

PROF RICHARD O'BRIEN

Clinical Dean,
Austin Clinical School,
University of Melbourne

Overseas travel and international conferences are back. Professor Richard O'Brien attended the face-to-face European Atherosclerosis Society Meeting in Milan this year and describes the thrill of the return to travel along with the rich rewards gained from face-to-face connection with colleagues.

For anyone considering travelling to a conference, I say go for it and re-discover the pleasure of travel

—

"Benvenuti a Milano," came over the plane's loudspeaker. I sat in my seat with a mixture of excitement and anticipation. Readjusting my face mask and eagerly waiting the disembarkation command, I wondered, 'would Milan be as I remembered?'

Flash back two years to 2019. This had been my year for overseas travel. I'd made two trips to Europe – one for a conference and one for a friend's wedding – and multiple voyages around Asia. After recently being elected president of the Asia Pacific Society of Atherosclerosis and Vascular Diseases, I was flying every other month for meetings and speaking commitments. I vividly remember flying back from Singapore on the first day of December, planning my return and running the maths on how many frequent flyer points I would need for a 2020 European holiday.

Then of course, overseas travel ended quite abruptly. Borders closed, planes were flown off to the Nevada desert, and travel plans for 2020 – and then for 2021 – evaporated. I was soon running a different calculation in my head – how I could make the most of walking the dog within a 5km radius. International scientific organizations made a quick pivot to 'virtual' conferences. This certainly helped reduce the feeling of isolation, but somehow the prospect of staying up until 2am to watch a keynote lecture on video with no opportunity to interact with colleagues left me a little cold.

It was therefore with some considerable excitement that I made the decision to attend the face-to-face European Atherosclerosis Society Meeting in Milan this year. Always a great meeting academically, this would be a chance to catch up with colleagues I hadn't seen in person for almost three years. A nasty surprise came when I discovered the price of flights to Milan – clearly, I wasn't the only one with the idea of heading to Europe! Thank goodness we were allowed to roll over our CME money during the pandemic (thanks AMAV!).

Departure day came with a mixture of excitement and anxiety: my well-worn travel routine long forgotten; I had this constant nagging feeling that I had missed something. I did remember my vaccination certificate but had failed to put liquids in a plastic bag. No problem – most of my fellow passengers had also forgotten how to travel. The security staff, obviously now used to this, were eternally patient.

So, as I sat there, having made the most of the inflight entertainment and food, I fixed my facemask into place and prepared my belongings. 'Would Milan be as I remembered?' It was, after all, the early epicentre of the pandemic, with hospitals overrun and a terrible death rate. However just prior to my arrival they had removed the last of the covid restrictions.

As I made my way off the plane into the Italian spring, I noticed that life appeared very normal. The weather was fabulous, tourists thronged the Piazza del Duomo and elegantly attired Milanese sipped Aperol Spritz' at street side cafes: I instantly wished I had booked a longer stay than just the few days of the conference.

The meeting itself was marvellous. There was palpable excitement at the opening ceremony despite the conference being 'hybrid'. Turns out a huge contingent had travelled to Milan, obviously keen to get together in person, just like me. Indeed, I was a little surprised to find that Australians were not the only ones grounded for two years: most of my European colleagues had not been on a plane since the pandemic began.

The lectures were excellent, but the real highlight was the personal interactions with colleagues. I had 'off the record' discussions at the conclusion of committee meetings, discovered what people had been doing for the last two years when chatting over lunch, and made plans for collaborative research over dinner.

This, I was reminded, is why I'm happy to travel halfway around the world to attend a conference. The IT gurus who tell us that the modern meeting platforms are just as good as being there simply don't get it. It's a well-worn adage but we are, after all, social animals. The pandemic is not over and who knows what future twists it will take. However, for anyone considering travelling to a conference, I say go for it and re-discover the pleasure of travel.

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PROPERTY ADVISORY

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BEHIND THE WALLED GARDENS:

MELBOURNE'S PRESTIGE PROPERTY SALES NETWORK

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

Gaining entry into the city's prestige property off-market sales network, doesn't just take high levels of cash and equity, it also relies on warm relationships and firm connections.

For those with the required wealth and means, investing in the top five per cent of Melbourne's market – above $5 million – can yield extremely attractive capital gains.

However, the relative scarcity of property sold above $5 million, particularly in tightly held enclaves with proven capital growth, means savvy buyers must be in the know.

Those unfamiliar with off-market networks need to understand how the market works and the subtle and not so subtle nuances of negotiating within this unique environment.

Opportunities in off-market networks tend to open up when markets tighten. Vendors may be reluctant to go through a highly public auction process, if they perceive there is a high risk of failure or if they are a high profile individual and want a confidential sale.

Similarly, when the top sector of the market is flat, dealing privately through a reputable agent can be a way for a vendor to achieve a reasonable price sooner, rather than waiting for the typical four week auction period plus a settlement time of 60 days or more.

There is a key proviso for buyers wanting to buy a property using off-market networks. They must recognise that like most networks, off-market property networks operate on the reputation and mutual trust of the participants.

That means a buyer must have the financial capacity to buy the properties available through the network and have a reputation for following through on commitments.

Buyers who make firm, but fair offers on properties through an off-market network gain respect and are likely to be contacted again.

Conversely, those who gain a reputation for low-ball offers or refuse to accept a fair price, are likely to find themselves ostracised by the network very quickly.

Most crucially of all, any buyer who reneges on a deal is unlikely to be approached again.

The usual entry point for buyers to off-market networks is to register their interest with three to four top agencies in their target areas, communicating to the agents what their key requirements and price brackets are.

Agents often tend to work through buyer advisory firms, as this means both parties are realistic about current market values and key requirements, such as due diligence, timing and privacy.

While becoming a member of off-market networks presents exclusive buying opportunities, it's important to remember that premium prices don't automatically equate to long term value. Just like any other, the prestige market also has its share of sub-standard property.

As is the case with all property purchases, comprehensive research, independent advice and a firm grasp of market fundamentals should always underpin your decisions – no matter the price tag.

FOR MORE INFO:

(03) 9859 9595

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Click here to listen to Jarrod's podcast

Register for more insights into the property market

JOIN THE CONVERSATION

AMAV SOCIALS

Digital communications specialist Lily Pavlovic

Prof Marie Bismark (@mbismark)
Thank you to @amavictoria employment relations team for the amazing support they provided during a very difficult time. I've only ever contacted the AMA a few times in my career but whenever I do, they're worth their weight in gold.

Australian Medical Association
And the Dirty Ashtray Award goes to (drumroll). Retailers who illegally sell vapes to kids and two states for lack of enforcement QLD and Vic #DirtyAshtray #AMANatCon The AMA was joined by AMA Queensland President Dr Maria Boulton and AMA Victoria President Dr Roderick McRae who accepted the certificates or the awards on behalf of the state governments and of course our #AnonymousVapeSeller

Michael Myers
Professor of Clinical Psychiatry
[On the article 'Overcoming the barriers which stop doctors from seeking support']: "Well done. Another benefit of having your own GP is role modelling that helps you when/if you treat other physicians yourself."

Simon Gibbs
Consultant Haematologist
[On the VICDOC article 'Spirit of humanity']: "Cheryl is an Angel on Earth. Thank you for looking after all of us who are burnt out or have anxiety, depression, PTSD etc."

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LinkedIn: Australian Medical Association (Victoria)

INTERACT WITH US

Monash University School of Rural Health

https://fb.watch/fvIcuHz1Wj/

The newest episode of the Doctor What? Doctor Where? podcast is here – Leadership from the Start.

We've heard from doctors all over regional Victoria that training and practicing in rural health lets them get more hands-on experience. Combining that with AMA Victoria's Emerging Leader Program is a brilliant combination to establish your early career.

That's what Dr Thang Dao is doing as an Intern at Latrobe Regional Hospital who has just wrapped up the first stage of the Emerging Leader Program, sponsored by our Gippsland Regional Training Hub.

INTERNSHIP:

SENIOR STUDENT

↓

JUNIOR DOCTOR

YINGTONG LI

Final year medical student + Chair of Medical Student Council of Victoria

“

Two years ago, on the night of a social function celebrating being halfway through medical school, I recall clearly the disbelief I felt at being closer to the end of medical school than the beginning. Now, with an offer of internship in hand, it still feels surreal that in a mere few months *I* will be the one my medical students will be directing their questions to.

The responsibility of making decisions – decisions which could cause substantial patient harm if made incorrectly – is a heavy one
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Over the last weeks and months, final-year medical students across Victoria have started receiving offers to join the medical workforce as interns in 2023. Personally, and commonly among my peers, the feeling is of both apprehension and optimism. After disruptions due to COVID-19 (and in my own case, intermitting to undertake a year of research), I have come to value my clinical opportunities in the hospital. I am ready to be of more help to my team: I feel prepared for the responsibility of ordering a urine culture from the ward round plan, without waiting for a doctor to co-sign my order. “Sorry, I’m the medical student, you’ll have to ask the doctor” is sometimes beginning to wear thin.

At the same time, the responsibility of making decisions – decisions which could cause substantial patient harm if made incorrectly – is a heavy one. Of the questions which I see posed to my interns and residents, those which I could confidently and correctly answer account, as would be expected, for a slim minority. Apologies in advance, to my residents and registrars, who will be fielding many simple questions from me as I find my feet! In this regard, we all will assuredly be grateful for the support and understanding of our doctor-in-training colleagues and senior medical supervisors, while we grow over the next year as our interns and residents did before us.

The transition from a medical student to a junior doctor also brings new challenges beyond the academic practice of medicine. Workplace relations, rostering, payroll, leave – none of these are in the medical school curriculum, but all junior doctors deal with these topics, some potentially for the first time. Bullying, harassment and wellbeing also take on new complexity as employment, assessment and training progression interweave in a intricate tapestry of professional relationships.

To complicate matters, we enter the medical workforce at a time when the discussion around many of these issues is changing. Junior doctor class action lawsuits regarding unrostered overtime have thrust patient safety and doctors’ wellbeing into the public limelight. We have gone through the bulk of our clinical placements in a setting where junior doctors have actively and visibly pushed for change to structures which endanger patients. At information sessions for prospective interns, health services are now invariably asked to discuss their policies surrounding unrostered overtime. Students want to work for health services which share their value of patient safety and doctor wellbeing.

Similarly, the renegotiation of the Victorian enterprise agreements for doctors-in-training and specialists has created opportunity for students, as soon-to-be doctors, to have healthy discussions about our conditions at work – and ultimately to reflect on our role as advocates in shaping a healthcare system which does right by our patients and colleagues, rather than simply accepting a status quo which may be lacking.

In navigating the transition from senior students to junior doctors, we will assuredly be looking to each other, and to our senior colleagues, for support and guidance. As medical students, when it comes to academic and social issues, placement concerns or student advocacy, we are all familiar with the support provided by our student representatives and medical student societies. As junior doctors, we likewise ought look to our peers and professional association as a vehicle to support external advocacy and member-facing support. I look forward to joining my fellow graduates, and our senior colleagues in AMA Victoria, as we continue to advocate for our patients and peers.
—

In navigating the transition from senior students to junior doctors, we will assuredly be looking to each other, and to our senior colleagues, for support and guidance.

CAREER:

PARENTHOOD + A PROFESSIONAL LEADERSHIP POSITION

Part of leading a healthy and sustainable workforce is supporting employees to have a full and meaningful life outside of work as well

Around 85% of employees become parents at some stage, mostly occurring when people are in their 30s. As if this transition isn't sufficiently challenging, this is often precisely the time when people take on more senior leadership positions.

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

The transition to parenthood is neither a women's issue or a leadership issue. It is an issue relevant to us all. Raising families and looking after a healthy workforce is a community responsibility.

People of all genders have their own challenges in thinking about and starting a family. The demands of leadership vary and people have their own journey through the transition to parenthood. That said, it is important to think carefully about how parenthood impacts women compared to men. For women starting a family brings very specific and personal challenges: fertility treatments, pregnancy, childbirth and caring for a newborn. This work requires personal, physical and emotional labour. While many women who undertake this work have support from partners, family and friends, some women do not have such support.

UNDERSTANDING THE NATURE OF THE TRANSITION

In my leadership coaching work, I have worked with many people at various stages in this transition. For example, pregnant women about to go on parental leave and fathers wanting to extend time out of the workforce to look after their children.

A crucial aspect of these mini-transition points within parenthood is working out one's identity, and how that identity includes both professional and family elements.

In many ways this is about the new story you are creating for yourself. "I also want to be a parent" can be a seismic shift. It's moving the tectonic plates of who you are and how you see yourself, and likely this happens very privately first. Getting comfortable with different and sometimes competing priorities is important personal work. It's part of crafting a personal and professional narrative that makes sense of why you are doing what you're doing.

Traditionally these have not been questions on the leadership agenda – this work has been relegated to 'private life', and raising a family usually relegated to the sidelines and to outside the professional realm. Things are changing. People going through all life stages and experiences should be supported to be part of the workforce.

I am transitioning to parenthood

> We need to support each other at various life stages, whether this be caring for others or caring for ourselves
>
> —

THINK ABOUT WHAT YOU NEED

—

Think about what has changed in your situation and the implications these changes might have on how you work. For example, in a transition to parenthood there are specific things that may need accommodation, for example:

» Attending medical appointments
» Needing more rest times or short breaks
» Time off for sudden, unexpected events

Think about what changes might be helpful and supportive for your needs now, even though these may change over time.

DECIDE ON WHAT TO COMMUNICATE AND SHARE WITH COLLEAGUES

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Private and sensitive information can feel hard to share. Not all colleagues and workplaces may be supportive. Navigating lack of knowledge and stigma around pregnancy and family is still very real.

Thinking about what you want to tell others is about creating and managing boundaries. For example, "Do I need to tell my boss why I have medical appointments?" Perhaps it feels right to simply say, "For health reasons I need to attend a few extra appointments this month." This is personal and there is no right answer. Think about what you are comfortable sharing and find the right words to share and manage these boundaries.

FIND AND PRACTICE THE RIGHT LANGUAGE TO USE

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Think about who you might share with, along with when and why. Building literacy for your situation is important. This transition is a new place, and we are usually not adept at talking about these things at work. It can feel difficult and even inappropriate for some people. Some workplaces might still not be good at these conversations either – so it might be challenging. Individuals beginning this transition can feel vulnerable for many reasons. It can feel immensely vulnerable being pregnant or trying to be pregnant, and there can be difficult and confronting stereotypes around women, family and career. Figuring out who you will share your information with, when and why can be a positive first step.

BUILDING NETWORKS OF SUPPORT

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While you might not share everything straight away, sharing something with one or two colleagues who you trust provides powerful support at work. So, think carefully about your colleagues. Who do you trust to share something this personal? Who can support you – as a role model, mentor or ally? Who would be willing to support navigating a period of leave and more flexible work arrangements – especially if this is not well accepted in your workplace?

Support outside of work is also helpful – friends, family, online groups and forums. It can be supportive to hear and share stories with others in similar situations. This is especially true in the event of trauma. The coming of children is usually assumed as a time of joy but sometimes these events can also be traumatic or challenging. It can be helpful to be with and talk to people who have been in the same place, as difficult as that is.

I am a leader supporting a team

> Leaders are looking to step up and support their employees to ensure that life outside work is supported and sustainable
>
> —

Click here for leadership insights

CHECK YOUR SELF: WHAT ARE YOUR OWN EXPERIENCES AND POTENTIAL BIAS?

—

If you have experienced the transition to parenthood, this will likely inform how you think about it and navigate it with others. Were you able to share the challenges of this transition at work? Was your workplace supportive? What were the positive and negatives aspects of the experience for you? If we can be aware of our past experiences and how they impacted us; and we know the assumptions or biases we bring to the workplace, we are better placed to positively support our team members.

RESPECT PRIVACY + CONFIDENTIALITY

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As managers, we are interested in our colleagues and their career intentions. These are relevant to leadership pipelines and workforce planning. It's also important to be mindful of the boundaries between personal and professional life, and what is in and out of bounds. Strong professional relationships are best served when leaders are engaged and caring, but also able to hold their role and not intrude into personal matters. Know that your team members will share more with you if they can trust that you will respect privacy and confidentiality, and not push for more information.

ASK PEOPLE WHAT THEY NEED

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Your responsibility is to look after your team and ensure that the work of the team is done effectively and efficiently. Creating a psychologically safe workplace is part of this work. Asking people what they need from you is an open and supportive way to communicate that you care. Ask yourself – do I think my team feels comfortable to talk to me about sensitive issues and ask for support when they need it?

POSSIBLE SOLUTIONS IN TERMS OF WORKPLACE PRACTICES + POLICIES

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Workplace policies, especially flexibility, can go a long way in supporting employees navigating challenging times. Oftentimes there can be small 'tweaks' to someone's work set-up and responsibilities that can support different needs – such as the transition to parenthood – over a relevant timeframe. Workplaces are required to comply with any Enterprise Agreement and Fair Work Act entitlements but may also have policies that add to these entitlements for flexible work work from home and various types of leave and while the transition from parenthood doesn't fit this list these types of leave can provide a relevant framework.

Other flexible work arrangements include:

» Time off for appointments
» Working from home / reduced hours (If this could be negotiated for a fixed period for part of the role, however for many clinical roles this can be difficult to support).
» Temporary change to role and responsibilities When we are supporting people in challenging situations, and providing accommodations for a team member, we need to be flexible and innovative. We can frame ideas and suggestions in terms of a trial period that will be reviewed.

We want team members to talk to us about what they need to do their work well. We don't want them withdrawing, taking sick leave or leaving a job or the profession because they feel they can't do it without those conversations. Sometimes a desired or ideal solution won't be possible, but that doesn't mean it can't be put on the table and considered. Solutions come from open discussions, and a diversity of perspectives, knowledge and opinions. We need a healthy, diverse workforce including parents and carers. Our leadership toolbox needs a strong set of skills to support life transitions.

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JOINING A MEDICAL PRACTICE AS AN OWNER

Joining an existing medical practice as an owner is a big step, both in terms of your medical career and your legal responsibilities. It is important to properly understand what you are signing up to.

NICHOLAS BLACKMORE, PARTNER, KENNEDYS

BECOMING A PARTNER

Partnerships require new entrants to sign a deed which provides that you will comply with the terms of the partnership agreement. The partnership agreement sets out the terms on which the partners agree to operate the partnership, including the distribution of profits and losses, the rights and obligations of partners to each other, termination rights, and what happens when a partner leaves. If you are joining an established partnership, it is usually offered on a "take it or leave it" basis. Nevertheless, it is always a good idea to seek legal advice, to ensure you understand what you are getting into.

The most important point for new partners to understand is that, by joining a partnership, you are jointly and severally liable for the debts and liabilities of the partnership. This means that if the partnership runs up a debt, you will be personally liable for that debt. If the partnership is sued and insurance does not cover that liability, you will also be personally liable.

BECOMING AN ASSOCIATE

Like a partnership, an associateship is built around an agreement, which governs the terms on which the associates agree to operate the associateship. Unlike a partnership, the associates in an associateship do not carry on a joint business. They run their practices independently and do not share income or profits. Their cooperation is limited to sharing premises and clinical and administrative support services. The legal effect of this is that they are not liable for each other's actions, debts or liabilities.

However, practitioners in an associateship arrangement should be aware that the associateship model is relatively untested by Australian courts. The idea behind an associateship is that the practitioners run their practices separately. However, if the practice is run more like a partnership – particularly in relation to sharing of expenses and joint decision-making – a court may determine that the practice is, in fact, a partnership.

BECOMING A SHAREHOLDER

Other practices are run by a company in which the practitioners are shareholders and directors. The service company owns the practice assets and manages the business, and provide clinical and administrative support services to each doctor. While more expensive to set up, this model has the advantage that the company is a separate legal entity from its shareholders. The company's debts and liabilities can generally only be satisfied from the assets of the company. From the shareholder's perspective, the only money at risk is the amount they paid for their shares.

Most companies have two documents which govern how the company is run. The constitution sets out the basic mechanics of the company: how shares will be issued, how directors will be appointed, how directors and shareholder meetings will be held and so on. The shareholders agreement sets out any more elaborate arrangements that the shareholders wish to put in place: for example, in a medical practice where the shareholders are also practising doctors, the shareholders agreement may provide that a shareholder must sell or redeem their shares if they cease working at the practice.

CONCLUSION

Regardless of the business structure, it is important when joining a medical practice to properly understand what you are signing up to. It is always a good idea to seek your own legal advice regarding the business structure.

Level 9 360 Elizabeth Street Melbourne VIC 3000 Australia T (03) 9498 6699

Kennedys

EMERGING LEADER PROGRAM

Click here to enrol

AMA Victoria's flagship leadership development program for emerging leaders in medicine is back in 2022 with registrations now open for our second intake commencing on Saturday October 8, 2022 and we would love for you to join us.

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

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

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

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

AMA VICTORIA

RETIREMENT

PERSPECTIVES ON A CAREER IN COUNTRY PRACTICE

In 1985, Dr Nola Maxfield arrived in Wonthaggi with her husband believing it would be a six month stay. Today, she is removing her stethoscope after serving this community as a rural generalist GP for 40 years. As she now transitions to retirement, Nola reflects on her career, her passion for rural general practice and life beyond medicine.

INTERVIEW **TARYN SHEEHY**

Are there things you are enthusiastic about that can be developed? What are the new ways that you can continue to connect and contribute and do the things that you might not have had time for in the past.

Get out there and try it. Find the community that is the right fit for you and where you feel supported.

NOLA MAXFIELD

Photograph taken after chemotherapy in 2021

PRACTICING IN A REGIONAL AREA

Having grown up in Drouin (a rural town in Gippsland), I fit the model of people who return to rural areas to practise. When I went to university, I was not sure that I would go back, but once I graduated and started working, my perspective changed. My husband spent the second half of his secondary education in a rural community as well, and together we decided we wanted to raise our family in a rural community. Whilst we certainly had friends in Melbourne, we figured that we could still stay in touch with them and our friendships wouldn't suffer, so off we went. We had an initial period in northern Victoria and that was not the right fit for us, whereas Wonthaggi felt right. It was only meant to be a six month stay, and here we are still four decades later. That is the key to living and working regionally or rurally. You must find the community that is the right fit for you. We enjoyed living and working in the town. People were friendly and it was a lovely area to be and that never changed.

CAREER HIGHLIGHTS

I have really enjoyed living and working in a town and being part of that community. It has been deeply satisfying to treat generations within families, sometimes all at the same time!

When I arrived in Wonthaggi, we were the only practice in town and provided a wide range of care which was challenging but also extremely rewarding. We worked as a team with a 24 hour/7 day a week surgical on-call roster for which I did the anaesthetics or obstetrics.

The hospital was staffed by the doctors in the practice. So, this was also demanding work but there were always people available if I was experiencing difficulties. Everyone would come in and help if they were needed, whether they were on call or not. I always knew my colleagues would support me and I did the same for them.

We were a teaching practice with medical students from Monash University (and from most universities from around Australia) who came to us initially for an entire year of general practice and then rotated out to do other specialty work. Recently, this reduced to six months. Over the years, we have had interns as part of the now ceased prevocational GP placement program which everyone in the practice loved. We have had other junior doctors at second and third year out and GP registrars.

When I arrived, the practice employed nurses and that was unusual back in those days. We oversaw the expansion of the practice with nurses undertaking chronic disease work, women's health, and diabetes education. Additionally, we employed various allied health people when we had enough spare rooms. Our practice grew as the community grew.

Trauma cases were a particular challenge back then. With the establishment of trauma centres in Victoria, these patients go straight to the Alfred Hospital; and it has been positive to see a reduction in road trauma more broadly over the years with the safety measures that have been introduced. This positive change has been a direct result of advocacy and lobbying by the AMA and other groups pushing for better safety outcomes.

When it comes to advocacy, I feel proud to have been involved in medical politics and grateful that I could do all of it from Wonthaggi. I was the President of both the state and national Rural Doctors Association at various times and on the AMA Council of Rural Doctors as the Victorian representative. I was also then on Medicare Locals and the Primary Health Networks. I did all of that whilst still being based in my own town. I appreciated being able to reach out and visit people in all the other states in a variety of roles but also remain grounded in Wonthaggi.

ADVICE TO YOUNG DOCTORS CONSIDERING PRACTISING IN REGIONAL OR RURAL VICTORIA

Get out there and try it. Find the community that is the right fit for you and where you feel supported. The camaraderie between people in regional and rural areas is particularly special and help is only a phone call away. There are so many guidelines and other forms of assistance for you; and you will be challenged medically and professionally rather than referring cases off to someone else around the corner. This builds your confidence, and it does feel that you are making a difference to patients' lives. We are certainly still close to our friends in Melbourne, so you need not worry about missing social activities. If we want to go to shows, then we make a day trip or a weekend of it. Above all country Victoria offers so many beautiful areas if you are into bushwalking or into water sports. It is a gorgeous place to live.

CONTINUED FUTURE ADVOCACY REQUIRED TO IMPROVE RURAL AND REGIONAL HEALTHCARE

In rural general practice, the financial rewards are not as great compared to other members of the medical profession. The bulk billing rebate has not kept pace with inflation, and it is now at a level where it is impossible to run a quality practice and bulk bill everyone. Unfortunately, many people in rural communities are from lower socio-economic backgrounds and cannot afford to pay some of the full private fees. It is exceedingly difficult to bill these patients when you know their situations.

So, the federal government really needs to invest in that area.

Also, the medical profession needs to respect general practice and rural general practice particularly. It is often perceived as an easier career option when in fact, it is not. I can see why young doctors might believe that being a specialist in a big city hospital attracts prestige and money. The medical profession needs to change this. Our universities need to demonstrate it - because medical students and graduates spend a lot of time in big city hospitals and they think that is what medicine is about but a lot of the important work actually happens in the community and in primary care and I don't think we see enough of that when we're being educated.

TRANSITIONING TO RETIREMENT

Prior to COVID, I had a retirement plan. I wanted to pull back my hours. I reduced my days in general practice to 3 days a week and I planned to stop my VMO work at the hospital, along with the on-call work, and doing births in the middle of the night. I wanted to slowly transition into retirement, although I had no definite idea about when the point of retirement would be reached.

However, life happens when you are making other plans and during COVID, I was diagnosed with breast cancer. Treatment caused me to stop work completely and afterwards, I did not feel inclined to go back. I discovered that my post-treatment energy levels were low and unpredictably, I found that I did not miss medicine as much as I had expected. This really surprised me because it had been my whole life for 40 years. I had the realisation that I was moving on. I thought, "I have done all that. It is behind me and now it is time to do something else." So, on reflection the cancer diagnosis and treatment were the turning point. It made the decision for me and my thoughts and readiness for retirement naturally evolved from there.

ADVICE FOR DOCTORS CONSIDERING THE TRANSITION TO RETIREMENT

Transitioning to retirement can be overwhelming of course but it can help doctors approaching this time to think about the range of skills they have. Are there things you are enthusiastic about that can be developed? What are the new ways that you can continue to connect and contribute and do the things that you might not have had time for in the past.

For me, being a grandmother and spending time with my grandchildren is important and I have the time to do that now. As I get more energy, I will explore what I can do volunteering within the community as well.

I have met other retired people, and I have the time to invest in and develop new friendships. Together, we have been making sure that we keep our bodies and brains active. I am relearning how to play the piano, attending French classes, and doing seniors ballet!

It's a new chapter and one that I intend to enjoy as much as I can.

WORKPLACE RELATIONS

THE NEW EBA: AN EV⊕LUTION NOT A REVOLUTION

GRANT FORSYTH

Workplace Relations Director
CEO of ASMOF Victoria

One of AMA/ASMOF Victoria's Workplace Relations team core tasks is negotiating terms and conditions of employment, mostly through collective bargaining but also through negotiations of individual contracts. The team has most recently completed bargaining for our two biggest Enterprise Agreements for public hospital doctors: one that covers Doctors in Training (DiT) and one that covers Specialists. The agreements will cover all health services in Victoria who directly employ their doctors.

The two agreements are negotiated every four years and are a result of extensive consultation with members and analysis of current terms and conditions by AMAV's Workplace Relations team. We use this consultation and analysis to create a priority list of conditions that need updating or the introduction of new conditions to keep pace with current legislation and industrial norms.

Feedback from members during this round of bargaining highlighted the need for improved and more easily enforceable conditions rather than focusing on salary increases. For example, we have introduced new on call conditions for DiT's that will see them paid for each hour they work during on-call instead of a flat rate for up to 16 hours of on-call. This will see a significant change in on-call rostering patterns, and we expect it to also create better work life balance for DiT's.

We have also introduced a rural attraction and retention bonus for doctors who complete a year's employment in a rural health service. While these are cost items for the government, for us they are fundamentally about getting resources in the right place at the right time. A comprehensive breakdown of the changes to both agreements will soon be available on our website.

If the new Agreement is approved by the majority of doctors and the Fair Work Commission, the process of transitioning to the new terms and conditions will begin. AMA/ASMOF Victoria and the health services will work together to implement the new clauses. AMA will meet with every health service to talk through their implementation plans and monitor their progress. From experience this initial phase can take several months. AMA/ASMOF has recently increased its workplace relations team numbers with a view to having more resources available to implement and enforce these agreements successfully and proactively.

Together we bargain, divided we beg

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“Feedback from members during this round of bargaining highlighted the need for improved and more easily enforceable conditions rather than focusing on salary increases.

If you have a workplace relations issue you would like to discuss, please contact amavic@amavic.com.au

During this time AMA/ASMOF will be running a series of education webinars, developing fact sheets, trialing podcasts, and running face to face meetings to talk through the most significant changes and how they can be enforced. This transition phase is when one or two unexpected consequences of changes occur (that one or other of the parties did not foresee) and so there are likely to be some clauses that will need to be taken to Fair Work in order get an independent view of how the clause should be interpreted. This is common and happened with the current agreements in relation to Clinical Support Time and Continuing Medical Education Allowances for Specialists.

The State Government has also committed to a ministerial review of workloads and out of hours work for doctors, a very topical issue. This review is to take place within 6 months of the agreements being approved. We hope this will see further improvements to conditions outside of the agreements, with any such improvements incorporated into the next agreement's log of claims so that they are enforceable in the future.

Bargaining for new terms and conditions should be viewed as an evolution not a revolution. In a negotiation it is rare that one party gets everything that they want – in fact, every outcome is a compromise. Even after significant industrial action there will always be a compromise reached. For example, currently fractional (part time) doctors are paid a different hourly rate than full time Specialists and we are trying to move all specialists to the same rate of pay. While all parties agreed in bargaining that the situation is incongruous, the cost of such a change was seen as too high to afford all in one go. It was agreed to make a small change straight away and then use the Ministerial review process to work out the cost of moving all doctors across to the fractional rates and plan how to make it happen.

If you have been reading this article thinking, that sounds great, but I don't work in the public system so that doesn't help me, you are correct if you are a self employed GP but if you are not and you are paid as a contractor or even as an employee at a private hospital this transition to new terms and conditions will have a flow on effect. The public system is the biggest employer of doctors in the state and as such has the critical mass to set the benchmark for terms and conditions for other employers who recognize that they may have to match it if they want to keep their doctors.

AMA/ASMOF is constantly looking for ways to better improve working conditions for doctors and we already have the beginnings of a log of claims to continue to build on the improvements made during this round of bargaining. We can only achieve good outcomes in bargaining if we have active and engaged members so I would encourage you all to be part of the next negotiations by attending any meetings and giving us your feedback.

Together we bargain, divided we beg.

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DEALING WITH PROBLEMATIC STAFF

DOESN'T HAVE TO BE A PROBLEM

During the past four years, AMAV has been adapting a new approach to dealing with problematic employees in private practices.

The approach adopted by AMAV is based on an acceptance that we are dealing with a relationship involving real people

REPORT **JOHN RYAN**
SENIOR WORKPLACE RELATIONS ADVISOR

"We recently used the services of AMAV's 'Be Firm. Be Respectful. Be Generous.' process. It was handled solely by AMAV in a most professional manner with a satisfactory outcome for all parties involved.

AMAV Member

Traditional HR approaches to dealing with problematic employees has required employers to performance manage the employee until termination occurs. The traditional HR approach is all about avoiding an unfair dismissal claim or being able to defend the termination of employment if an unfair dismissal claim is made.

The approach adopted by AMA Victoria is based on an acceptance that we are dealing with a relationship involving real people.

All relationships have a beginning, a middle and an end. The ending of relationships can be messy or they can be amicable. What is sought, is an ending of the relationship that is amicable.

OUR 'BE FIRM – BE RESPECTFUL – BE GENEROUS' PROCESS

Implementing our 'Be Firm – Be Respectful – Be Generous' process requires care and attention and needs to be carried out by a person who can ensure that the employee is being treated respectfully throughout the process.

Whilst the process is simple enough that any employer doctor or their practice manager could undertake the process, AMAV always cautions our members and their practice managers from trying to do this.

It is generally easier and more effective to get AMAV to do this for you. AMAV charges a fee for the service but the benefit in using AMAV is that we can bring a level of calm professionalism to the process which allows the employee to focus on the process rather than on the person delivering the message. The new approach involves four elements.

1

COME TO A FIRM DECISION ABOUT THE EMPLOYMENT RELATIONSHIP

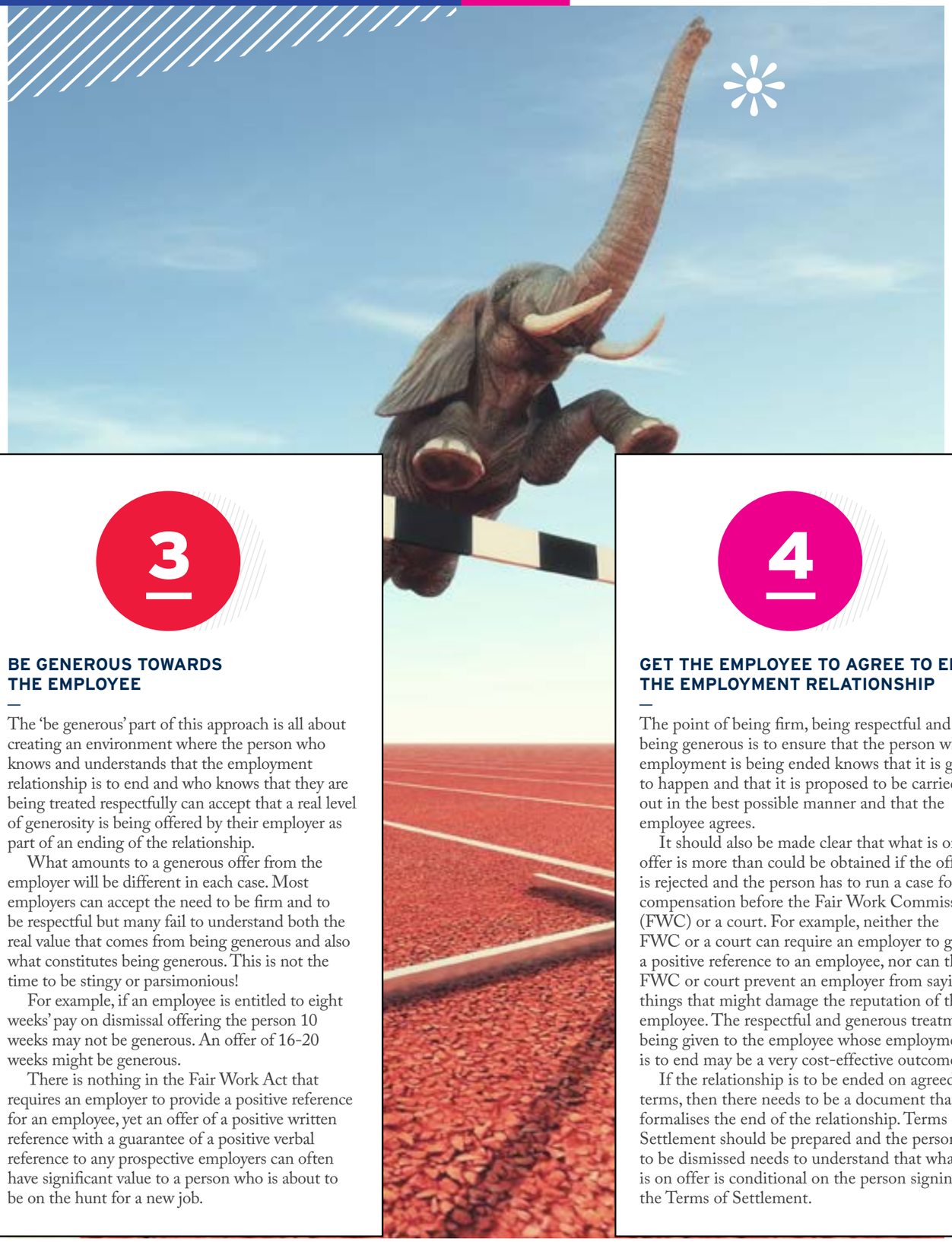
The first question that every employer should ask as soon as any employee becomes problematic is: Do I want to continue the employment relationship with this employee, or do I want to end the employment relationship with this employee?

This double-sided question forces the employer to make a decision in relation to the relationship it has with an employee. The employer's decision will simply reflect its views about the nature of the relationship.

If an employer comes to the view that the employment relationship should end; then end it!

The 'be firm' part of this approach is to hold to your decision that the relationship is to end. It's the relationship that is to end and nothing more than that. Don't be like the parents whose relationship has completely and irrevocably broken down but who stay together 'for the children'. They often inflict more damage on each other and on their children than if they had separated as amicably as possible and as early as necessary.

Our 'Be Firm. Be Respectful. Be Generous.' Process



> *I would not hesitate to recommend this service to any practice.*
> *AMAV Member*

2

ALWAYS TREAT THE EMPLOYEE WITH RESPECT

The 'be respectful' part of this approach requires the employer (or whoever is acting for the employer) to genuinely respect the human dignity of the employee to be dismissed. The employee has a name, a family, feelings, emotions, a sense of their place in society, a sense of their value as a worker, a group of friends including workplace friends and all the other attributes that make up being a real person. They are not simply a set of numbers or values in a human resources spreadsheet.

The conversation with this person must be open, honest, and direct. It is a conversation about the ending of a relationship. It is not a conversation about blaming the person, or accusing the person, or belittling the person.

Remember always that the person being dismissed must be able to explain their loss of employment to their family and friends and in some cultural groups they will have to explain themselves to their community leaders.

3

BE GENEROUS TOWARDS THE EMPLOYEE

The 'be generous' part of this approach is all about creating an environment where the person who knows and understands that the employment relationship is to end and who knows that they are being treated respectfully can accept that a real level of generosity is being offered by their employer as part of an ending of the relationship.

What amounts to a generous offer from the employer will be different in each case. Most employers can accept the need to be firm and to be respectful but many fail to understand both the real value that comes from being generous and also what constitutes being generous. This is not the time to be stingy or parsimonious!

For example, if an employee is entitled to eight weeks' pay on dismissal offering the person 10 weeks may not be generous. An offer of 16-20 weeks might be generous.

There is nothing in the Fair Work Act that requires an employer to provide a positive reference for an employee, yet an offer of a positive written reference with a guarantee of a positive verbal reference to any prospective employers can often have significant value to a person who is about to be on the hunt for a new job.

4

GET THE EMPLOYEE TO AGREE TO END THE EMPLOYMENT RELATIONSHIP

The point of being firm, being respectful and being generous is to ensure that the person whose employment is being ended knows that it is going to happen and that it is proposed to be carried out in the best possible manner and that the employee agrees.

It should also be made clear that what is on offer is more than could be obtained if the offer is rejected and the person has to run a case for compensation before the Fair Work Commission (FWC) or a court. For example, neither the FWC or a court can require an employer to give a positive reference to an employee, nor can the FWC or court prevent an employer from saying things that might damage the reputation of the employee. The respectful and generous treatment being given to the employee whose employment is to end may be a very cost-effective outcome.

If the relationship is to be ended on agreed terms, then there needs to be a document that formalises the end of the relationship. Terms of Settlement should be prepared and the person to be dismissed needs to understand that what is on offer is conditional on the person signing the Terms of Settlement.

STANDARD TERMS OF SETTLEMENT CONTAIN THREE IMPORTANT PROVISIONS

- A mutual surrender of most rights to take any further legal action against the other side for anything relating to the employment relationship.
- A mutual undertaking not to say or do anything which harms the reputation of the other side.
- A mutual undertaking not to disclose the Terms of Settlement or any of the circumstances leading to the ending of the employment relationship.

Click here to contact Workplace Relations

AUSTRALASIAN DOCTORS' HEALTH CONFERENCE 2022

1-3 December 2022, Adelaide, Australia

THE THRIVING DOCTOR: TOWARDS HARMONY, PRODUCTIVITY, LONGEVITY

Australasian Doctors' Health Conference 1—3 December 2022 Adelaide, Australia

Click here to register

Calling all doctors, medical students, health leaders and the many people across Australasia working to create a healthy medical profession. This conference is your opportunity to explore with others the ways in which we can all thrive, as individuals in our personal and professional lives, in our workplaces and the wider health system, with a focus on new frontiers in research and best practice.

This international conference has a firm focus on sharing positive ideas and solutions that enhance the health of doctors and students. This is very timely and so important to the profession itself, our health system and our patients in the wider urban and rural community.

Conference registration offers a hybrid conference model, which will consist of a full in-person conference program and exhibition at the Adelaide Convention Centre, coupled with streaming of the program from the two plenary rooms to enable both in person and remote delegates to attend these sessions. The hybrid session enables us to welcome a larger community who may not be able to attend in person due to travel, health, or other restrictions. Day registration and discounts for medical students and early bird discounts are available until 29th August.

The program includes pre-conference workshops on Thursday 1st December such as a writer's workshop, creative doctors (art, music, wine making and comedy), introduction to medical research and burnout- words, meanings actions. The main program includes renown international speakers such as Dr Tait Shanafelt MD who is the Centre Director and Chief Wellness Officer at Stanford Medicine and Dr Helen Garra Medical Director from the NHS Practitioner Health. There are also a range of impressive Australian speakers as well as submitted workshops, oral presentations and posters which will include research and initiatives related to the conference theme.

The trees in the logo for the conference are symbolic of those doctors who are able to draw nourishment from their personal roots and professional environments, survive, thrive and extend themselves to reach their potential, whilst protecting and nurturing the next generation of doctors to do the same.

CAREER TRANSITIONS

LEARNING FROM SUPERHEROES

If you're embarking on a career or life transition, here are four things to consider in order to make 'like a superhero' and be in-control of how you show up

REPORT **LISA STOCKMAN**

When I met Hannah, she'd been working as an inner-city specialist in a well-established, busy practice.

After years of practicing in her area of specialty and 18 months of feeling a little stale, she decided to actively pursue her passion – mentoring junior doctors and entering the medical education space. Once she'd made the decision, she was both relieved and fearful: How would this career change impact her future? Would she continue to have job security? Would she be successful? Would she again feel fulfilled, purposeful?

As with any major life transition, change can be scary and anxiety provoking. The feelings of letting go, of losing control, uncertainty, inviting in or responding to unknowns, can be unsettling. However, during times of change, one thing you can control is how you show up: physically, mentally and more specifically through your professional brand and style.

Change presents a unique opportunity to do things differently – to reinvent yourself and show up exactly how you choose to at this stage in your professional and personal life.

Therefore, in working with Hannah to help her navigate her career change we adopted the superhero principle. All superheros wear capes – or some form of uniform, costume or armour that not only makes them look powerful, but shows others they are in charge, in command and confident. Before that outfit change, our heroes are mere mortals!

As a personal stylist, one of my objectives when working with a client is to style them in a way that represents who they are and who they want to be, giving them the confidence to achieve anything they set out to do.

In four sessions working with Hannah, we defined her style goals, edited her wardrobe, shopped for her 'uniform' and organised new corporate headshots.

This process empowered her, enabling her to confidently step into her new career, projecting an image that aligned with her professional brand and eliminated the daily stress of knowing what to wear.

If you're embarking on a career or life transition, here are four things to consider in order to make 'like a superhero' and be in-control of how you show up:

WHAT IMAGE DO YOU WANT TO PROJECT TO THE WORLD?

Style is a way of saying who we are without having to speak. So, when I asked Hannah what she wanted her style to say about her in her new role, some of the words that came up were – professional, approachable, knowledgeable and well-put together.

When thinking about what you want to project, consider both your work persona and your off-duty persona. Is it the same? Think about your field of expertise, your personality and most importantly words that align with your values.

WHAT CLIENTS WOULD YOU LIKE?

In Hannah's case, in her new role as mentor and teacher, she wanted to set an example of how medical professionals could present themselves.

Think about your ideal clients or patients. This is important because you want your professional brand to be something that a potential client or patient can feel comfortable with. You want them to feel like you understand them, their needs and their issues. You want your brand to build their trust.

WHAT DO YOU THINK YOUR CLIENTS / PATIENTS REMEMBER VISUALLY WHEN THEY THINK OF YOU AND YOUR SERVICE?

It's important here to think of what specialty you're in and the expectations your clients would have of you. If your professional brand matches these expectations, rapport and trust is more easily earned.

In medicine, your patients expect to meet a hygienic, clean and tidy professional.

When your patients' expectations of your personal brand are matched or exceeded by those you project, the focus then becomes on you, your experience and what you deliver.

DEVELOP A UNIFORM

The clothes we wear have a proven effect on how we feel about ourselves and how we perform. It is referred to as 'enclothed cognition' and describes the systematic influence clothes have on the wearers' psychological processes. Research suggests this is only the case when we attribute meaning to what we wear. By choosing a 'uniform' we believe represents the image we want to project, we can present our best selves and live this as our truth.

A uniform also eliminates the daily decision around what to wear. Hannah's uniform consisted of a blazer, non-iron shirt, pants and stylish loafers. The blazer was a key wardrobe item which added instant professionalism – her superhero cape.

When developing your own uniform, find images of style that represent the words you want to project. Save the images on your phone for reference when shopping. Also consider your lifestyle and the type of core items you need to facilitate your new career.

Of course, there is a lot more to a successful career transition than just what you wear. It's about putting yourself out there in your new field. Speaking up, contributing to relevant groups, conferences, papers and building your network online and in-person.

Ultimately, a successful career transition is one that projects to the world the most accurate view of who you are, what you stand for and the value you bring. Dressing to be the best version of yourself will give you the confidence to communicate your brand with the people who matter.

MEDICINE FROM A DIFFERENT PERSPECTIVE

J MALIOS

General Practitioner

With a 50-year career as a recently retired GP in a practice I established working alongside associate GPs and allied health professionals. I have been fortunate to have experienced a diverse career that has included occupational health, medicolegal medicine, administrative and educational roles.

Early in my GP career I developed an interest in occupational health and medicolegal medicine when after consulting numerous patients presenting with shoulder injuries coming from the one workplace, I asked to attend the workplace and after common sense advice we were able to reduce the number of injuries which was pleasing, not only for the workers/patients, and also welcomed by the employer.

This commenced a pathway in the management of work-related injuries. I subsequently managed work related injuries at various worksites and at a dedicated work injury clinic and developed an interest in the medicolegal aspect of injuries and my opinion was sought in various advisory roles.

I have had general medical educational roles with the RACGP and with medical undergraduates as an honorary lecturer at Monash University. I have also been a regular presenter for employer groups, insurers, legal and medical conferences, particularly regarding aspects of injury compensation including impairment assessments.

In 1992 I was appointed as a sessional conciliator for the newly established Accident Compensation Conciliation Service, a role that involved mediating work injury disputes and reviewing both treating doctor's and medicolegal reports. The insight of what happens when the medical information that we obtain in our consulting room, is put into a medical report for administrative reasons, together with the training I received as a Conciliator, was an important learning stage in my career.

I continue to have a clinical role as a medical advisor to a multinational organisation and I am on the list of medical practitioners who can be appointed to a Medical Panel. I have previously held positions as the Deputy Convenor and then Convenor of Medical Panels. I regularly undertake impairment assessments following disputed assessments for work injuries and Wrongs Act claims

I was a founding member of Thalassaemia and Sickle Cell Association of Australia (TASCA) and am currently involved in a voluntary role as a medical advisor and as a member of the management committee. I am a consumer advocate in the Australian division of the Primary Aldosteronism Foundation and an Associate Investigator on a proposed clinical trial for improved diagnosis of primary aldosteronism in primary care (CONSEP trial)

HOW LONG HAVE YOU BEEN AN IMPAIRMENT ASSESSOR, AND WHY DID YOU GET INVOLVED?

In 1985 the Victorian government introduced the Accident Compensation Act a major reform of workers' compensation legislation. Included in that legislation was a requirement to assess the impairment of injuries. Long-term consequences of injuries had previously been assessed as "industrial loss" for which there was no standard methodology, and the introduction of impairment assessments was intended to provide a standardised methodology for assessment.

I commenced doing impairment assessments when the Second Edition American Medical Association Guides was utilised as well as an additional disability and handicap rating. Training of medical practitioners to undertake impairment assessments was not a legislative requirement and I attended the early courses and organisational meetings that were offered that time.

In 1998 I was invited and joined the Committee overseeing the training program for impairment assessors and I am currently the Independent Medical Practitioner representative on the AMA Training Course Management Committee. Impairment assessments are now also utilised with the Transport Accident Act and the Wrongs Act, and completing the accredited course, is now a legislative requirement to be an impairment assessor

WHY WOULD A CLINICIAN BECOME AN IMPAIRMENT ASSESSOR, AND WHAT DO YOU THINK IS THE RIGHT STAGE IN A DOCTOR'S CAREER TO COMMENCE THIS WORK?

As medical practitioners we manage injuries that can be subject to legal consequences. The clinical assessment of an injury in a normal medical consultation does not necessarily communicate the full impact of that injury in a manner that a legal or administrative process can determine the consequences.

Learning and becoming proficient using the AMA Guides to assess impairment, not only provides a much-needed service for the community but also allows the medical profession to work towards providing fair and equitable resolution of disputes.

It has been traditional to consider that medico legal assessments are a role that clinicians undertake as part of a retirement pathway. I believe it is important for current, active, and experienced clinicians to become involved in medico legal assessments, as it is important to maintain medical currency and impetus for change and improvement when needed.

IN YOUR EXPERIENCE, WHAT ARE THE MOST REWARDING AND CHALLENGING ASPECTS OF BEING AN IMPAIRMENT ASSESSOR

In medical practice particularly in a busy general practice, I have always found it rewarding to venture outside of the consulting room and understand the environment and circumstances of our patients. This led me to the workplaces assisting with return-to-work programs and becoming involved in the administrative and legal process that ultimately has a major impact on our patient's well-being.

Becoming an impairment assessor offers the clinician an opportunity to enhance their skills and gain understanding and appreciation of a different aspect of medical care including how legal process provides compensation for injuries. Apart from providing a set of skills to add to a practitioner's practice, it can also be a pathway to additional opportunities for a practitioner's career.

HOW IMPORTANT HAS THE PRACTICE OF IMPAIRMENT ASSESSMENT BEEN IN YOUR PROFESSIONAL CAREER, AND HAS IT HELPED YOU GAIN MORE RECOGNITION IN YOUR AREA OF EXPERTISE? WHY?

What commenced as a need to understand why patients were presenting with similar shoulder injuries, has led me to a satisfying and diverse medical and medicolegal career and the opportunity to have a leadership role and involvement within our medico legal system.

IMPAIRMENT ASSESSMENT TRAINING

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

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

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

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

Please enquire at: training@amavic.com.au

IMPAIRMENT ASSESSMENT TRAINING COURSES

Click here for VIC

Click here for NSW

VALE

ASSOCIATE PROFESSOR JOSEPH EPSTEIN AM FIFEM

TRIBUTE WRITTEN BY:
PROFESSOR ANNE-MAREE KELLY
AND PROFESSOR PETER CAMERON

Few people have had such a varied and inspiring professional career as Joseph Epstein

~ Associate Professor Joseph Epstein ~
Emergency physician, surgeon, College president, academic mentor, agent provocateur, philosopher, politician, photographic historian and raconteur.

Few people have had such a varied and inspiring professional career as Joseph Epstein. Joe was a surgeon, emergency physician, one of the founding fathers of the Australasian College for Emergency Medicine (also later serving as its President), founding signatory of the International Federation for Emergency Medicine, director of the State Retrieval Service in Victoria and advisor to ministers and governments. In addition, he was an enthusiastic and generous teacher, wise mentor, inspirational leader, trusted advisor, force of nature, radical, philosopher and raconteur.

Born and raised in Melbourne of Jewish immigrant parents who narrowly escaped Poland before the war, Joe was intent on making the world a better place. He initially trained as a surgeon, where he observed the shortfalls of consultant-based medicine, and he used this knowledge to focus on the development of the new specialty of Emergency Medicine.

Joe described Emergency Medicine as a Janus-faced specialty, with one face towards the community and the other towards hospital-based healthcare. He was fascinated by its complex challenges and spent much of his professional life exploring them. In particular, he saw the opportunities to improve healthcare that working at this crossroads of the health system provided.

It may be hard to believe but within living memory, care in what was then called 'casualty' was delivered (for the most part) by junior doctors, with little training, experience or supervision. Despite their best efforts, the term 'casualty' became associated with second rate medical care. Joe and a small band of like-minded doctors in Australasia decided to change that. The path to establishing a specialist college for emergency medicine in Australasia was difficult, but successful. It was not just about training a specialist workforce for emergency departments. It was also about standard setting, monitoring quality and performance, advocating for system change and being a voice for the vulnerable. The older, established medical colleges were not supportive and found the idea of a new specialty threatening. However, the public and governments demanded safe and effective care for emergencies. This could only be delivered through a specialty college and the College finally gained recognition by the medical councils of Australia and New Zealand in 1992.

The College that we see today owes a lot to Joe's vision, energy and persistence. Fittingly, Joe was honoured at the recent International Conference on Emergency Medicine held in Melbourne where delegates from around the world acknowledged his contribution to improving care for emergency patients everywhere.

The College that we see today owes a lot to Joe's vision, energy and persistence
—

In addition to his work at state and national levels, Joe was an inspirational local leader and mentor at Footscray Hospital (and its later incarnation Western Health). For many years, the west of Melbourne was neglected. Its people were poor, working class, immigrants and of little political 'value'. They also had high rates of chronic and preventable illness and workplace injuries. Joe was a champion for them and stayed with them despite attractive career opportunities at larger, more prestigious hospitals. He advocated for a greater share of health funding and more and better hospitals and services so that specialist care could be delivered where people live.

Above all Joe was a doctor. He cared passionately about people – each individual's real-world struggles, their fears, their pain, and their hopes. In particular, he would spend time and really listen to them.

Joe was a skilled influencer, but not in the social media sense. He used his charm, charisma and sharp intellect to open doors and inform and persuade those in positions of power on both local and national issues. His intellectual agility, precise use of language and careful preparation rarely saw him leave such meetings without progressing his cause.

Joe prided himself on his use of language and the power of individual words. In the early stages of emergency medicine's development, the word "casualty" was one of his pet hates. Unlike the UK College, in Australasia, the correct description of our work prevailed in the nomenclature. He also fought long and hard to make ACEM a college (and later IFEM) "for" emergency medicine (for advocacy) rather than "of."

Joe's concern for First Nations people, particularly expressed through the ACEM Foundation, has contributed to significant increases in awareness of health inequity in emergency care and efforts to increase the number of emergency clinicians of First Nations heritage.

In addition to his work at state and national levels, Joe was an inspirational local leader and mentor at Footscray Hospital (and its later incarnation Western Health). For many years, the west of Melbourne was neglected. Its people were poor, working class, immigrants and of little political 'value'. They also had high rates of chronic and preventable illness and workplace injuries. Joe was a champion for them and stayed with them despite attractive career opportunities at larger, more prestigious hospitals. He advocated for a greater share of health funding and more and better hospitals and services so that specialist care could be delivered where people lived.

At Footscray Hospital, Joe was a long serving ED director and senior clinician. More importantly, he established Western Health as a leader of emergency medicine practice and education for both doctors and nurses and nurtured the diverse and dedicated team who work there. His mentorship has led to Western Health trained clinicians taking up senior leadership positions throughout the health system, carrying on his legacy of providing the best care for all, no matter what their personal circumstances. We are but two among them.

Joe was a staunch believer that quality of care and research were inextricably linked. He influenced young emergency physicians and the College to foster research to improve patient care. It is no accident that there is a Joseph Epstein Centre for Emergency Medicine Research. He also believed that to work effectively with, and influence, other specialist groups emergency medicine had to establish academic credibility through research. The Centre carries on Joe's philosophy of rigorous inquiry and change driven by evidence.

Above all Joe was a doctor. He cared passionately about people – each individual's real-world struggles, their fears, their pain, and their hopes. In particular, he would spend time and really listen to them. All those who worked with him, know of a time when he went above and beyond. For example, one holiday period he found a place in detox for a young man whose father had brought him to ED distraught and not knowing what else to do. Then, after his shift he drove the young man there and saw him settled and safe.

Emergency medicine flowed through Joe's veins. His passion and energy for emergency medicine as a specialty for doctors and nurses and his care and advocacy for his patients were second to none. Personally, for both of us, he was an exceptional mentor and friend. There will never be another Joe.

—

PEER VISITOR PROGRAM

PERFECT MATCH

About the Peer Visitor Program

Retired doctors, Dr Ron Speechley and Dr Brendan Steele, had not met or worked together before they were matched through the AMAV Peer Visitor Program. They have found they have much in common as they have kept in contact for almost 18 months, despite the COVID-19 lock downs, to enjoy conversation and companionship.

Brendan believes that volunteering enhances his own quality of life and fits well with his personal values and approach to his career in medicine.

REPORT **KAY DUNKLEY**
AMA VICTORIA COORDINATOR OF DOCTOR WELLBEING

Do you know an older doctor who would enjoy having a visitor?
—
Contact AMAV

DR BRENDAN STEEL

Brendan initially worked at St Vincent's, Prince Henry's and the Royal Women's Hospital before starting out in general practice in Pyramid Hill in Victoria for 5 years. He then returned to obstetrics and gynaecology at the Queen Victoria Hospital in Adelaide followed by 12 months at the Odstock Hospital in Salisbury UK and 6 months at Addenbrooke's Maternity Hospital in Cambridge UK. Brendan then spent 21 years in full-time obstetric and gynaecological practice in Gippsland and obtained his FRACGP in 1983 and his FRACOG in 1987. Brendan says he enjoyed both general practice and obstetrics and gynaecology, although he primarily worked in the latter specialty. Prior to retiring in 2020, Brendan worked as an obstetrician and gynaecologist in Melbourne for 10 years at Sandringham Hospital, Cabrini and Jessie MacPherson and also spent some time working for the Victorian Doctor's Health Program supporting his medical colleagues.

Brendan is the founding member and a long-term volunteer with the AMA Victoria Peer Visitor Program. He really enjoys the one-on-one friendships he has with his older peers and values the opportunity to give back to the older doctors who have given so much to the Australian community through their work as doctors. Brendan says he gets a lot of satisfaction from being a visitor. He notes that many of the older doctors he has visited have outlived their close friends and partners and feel isolated. He believes that the common bond of medicine and joint understanding of life experiences enhances the relationships formed through the program. Brendan believes that volunteering enhances his own quality of life and fits well with his personal values and approach to his career in medicine. He finds visiting an easy flexible activity which can be fitted around work and other commitments.

Now that he is retired Brendan enjoys the opportunity to still be involved with the AMA and medicine in this role. Brendan admits that over his many years of visiting he has grown more comfortable with the aging process, declining health and the death of those he visits. He noted that this contrasted well to his work in obstetrics bringing new life into the world.

DR RON SPEECHLEY

Ron originally graduated from Sydney University in 1956 and Brendan from Melbourne University in 1974. They have both seen a lot of change in the way medicine is practiced and how healthcare is provided. They have worked in similar areas of practice including general practice and obstetrics and gynaecology in both metropolitan and regional areas. In addition, Ron worked in medical administration as a medical director and in emergency medicine in regional Australia.

This ability to practice in various roles in many locations provided Ron with a great deal of satisfaction in his 73-year career prior to retirement. Ron sagely notes that over his lifetime there has always been a shortage of doctors and a problem attracting doctors to regional areas. Ron's view, which may not be popular with more recent generations of doctors, is that there is a need for a full-time commitment to clinical medicine to resolve wthe current workforce shortages.

In his long career Ron has worked in many locations in NSW and Victoria, including Sydney, Melbourne and Hobart and spent time in the Shepparton area as well as Bega and Orange. His career pathway also included working in the UK at the Newcastle General Hospital and while travelling in the USA he visited large hospitals with obstetric and gynaecology units like The John Hopkins Hospital in Baltimore. Ron did not allow a brain tumour which caused permanent damage to his eyesight interfere with his professional career and after time in medical administration was able to return to clinical practice in the emergency department.

Ron has had two visitors previously through the Peer Visitor Program when he was living in Shepparton and enjoyed their company. During the time of his current match with Brendan Ron has relocated from living independently in his own property in Melbourne to living in a supported care environment which has been a challenging transition
—

MEDICINE + AUTONOMY

What tips do you have about being a doctor and living well ?

Email: vicdoc@amavic.com.au

Paediatric and Adult Otolaryngologist, Ear Nose and Throat, Head and Neck Surgeon Dr Eric Levi reflects on the concept of 'autonomy' in medicine — how much autonomy is enough for doctors to thrive?

Click here for Stethoscope article

How much autonomy is enough autonomy for us as doctors?

20%

—

Autonomy is something we give to our patients. That's the bedrock of medical ethics – respect for patient autonomy over their health and their choice of treatment. As doctors we make diagnosis and we offer our recommendations, but the ultimate decision on treatment is in the hands of our patients (except in very few select situations where the patient is unable to do so).

Let's put the mirror up to ourselves now. Do we offer ourselves autonomy? Are we given autonomy in our day to day practice as clinicians? Does your department head or supervisor of training allow you some autonomy in your work?

All through medical school and surgical training, I have been trained to think in a certain way and act in a certain way. All of our training is about principles, rules, regulations, protocols, policies, and they're all good – to a certain dogmatic degree – for the sake of our patients. As a surgical trainee years ago, I felt my life ruled by my pager and on-call roster. I had loss of autonomy. I did not see my family much due to relentless call backs. I lost my social network due to frequent relocations through training. I lost my hobbies as they are displaced by the time demands of training, work and study. This rigorous training is necessary to a degree, but is also erosive to the individual personal autonomy.

As consultants, many of us have better control over our days, but we are also merely cogs in the wheels of the complex healthcare system with many jurisdictions and administrators determining our day to day work. As we spend our days chained to computers on wheels click-click-clicking the EMR, the song "I want to break free" by Queen sometimes echoes in our heads, or maybe just in my head (sorry if you are not from that awesome generation).

Autonomy is not absolute freedom. Autonomy is the freedom to decide what is good for us. Yes, there is a sprinkle of selfishness in there if autonomy is taken to an extreme and intrude on others' autonomy. We are clinicians and of course we have to abide by rules and principles when we treat patients and work in teams. But perhaps the lack of freedom to do what we really want to do because of the numerous mundane non-clinical work displacing the essentials is what is causing personal distress in us. Multiple studies have shown that bureaucracy and non-clinical tasks are the things that cause emotional distress and burnout in many of us.

How much autonomy is enough autonomy for us as doctors? As it turns out, there is a number. And that number is 20%. From Dr Tait Shanafelt [1]: Evidence suggests that doctors who spend at least 20% of their time focused on the dimension of work they find most meaningful are at dramatically lower risk for burnout. Although each 1% reduction below this threshold increases the risk of burnout, there is a ceiling effect to this benefit at 20% (eg, spending 50% of your time in the most meaningful area is associated with similar rates of burnout as 20%). This suggests that doctors will spend 80% of their time doing what leadership needs them to do provided that they are spending at least 20% of their time in the professional activity that motivates them. This activity could involve caring for specific types of patients (eg, immigrant health) or patients with a given health condition (eg, becoming a disease expert) or activities such as patient education, quality improvement work, community outreach, mentorship, teaching students/residents, or leadership/administration."

Interestingly, high performance organisations such as Google and Apple recognise this and apply this principle of allowing staff members to have a degree of flexibility in their work. What about us? We trained to be clinicians and that privilege comes with certain responsibilities such as teaching, research, leadership, administration, and other non-clinical duties. Let's be honest, some of us are better at one thing than another, and in reality that's probably because some of us prefer one thing over the other and find one particular thing to be more meaningful than another. What if we gave each other the gift of autonomy and allow each other some freedom within the boundaries of our responsibilities to do work which we uniquely find most meaningful. Just 20%! How will that affect our job satisfaction, job effectiveness and patient care?

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MORE THAN MED

MEDICINE ⊕ STORYTELLING

Dr Neela Janakiramanan

REPORT **KAY DUNKLEY**

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WHEN DID YOU DECIDE TO PURSUE MEDICINE AS A CAREER AND WHAT FACTORS PROMPTED THAT DECISION?

I decided to pursue medicine in my mid-teens. My grandfather was a GP-surgeon in rural India. He built his clinic and family home in the same location and his waiting room was a pergola in the back garden. By the time I was born, he had given up obstetrics, but he still performed minor surgery like tonsillectomies and vasectomies. I watched my first operation – a tonsillectomy – when I was eight! (With the consent of the patient!)

My parents actually didn't encourage me to pursue a career in medicine, if anything they discouraged it – pointing to many of the issues we still face in medicine, discrimination, harassment, long working hours, challenges to work-life balance. I strongly considered a career in journalism as I loved writing (which, to be honest, faces many of the same issues), but in the end I was really inspired by how important my grandfather was to his community, and how much of a difference he made to people's lives.

WHAT LEAD TO YOU SPECIALISING IN RECONSTRUCTIVE PLASTIC SURGERY? WHAT IS THE MOST SATISFYING ASPECT OF YOUR WORK?

It's hard to explain exactly why we choose what we do. In part, it was the nature of the work that I found intellectually satisfying, in part it was mentors that inspired and supported my career. A majority of my work now is complex hand and wrist surgery, for which I have done multiple post-training fellowships, including overseas. This is an area I did choose because of the wonderful collegiate community, but also because restoration of upper limb function is deeply satisfying. I love it when people come and say to me that they need their hands because... and what follows is the most important thing to them, the thing their identity is woven up in. It might be work, or a hobby or caring responsibilities. And being ble to undertake work that allows people to return to that thing is really satisfying.

YOU WRITE REGULARLY FOR WOMEN'S AGENDA AND HAVE JUST RELEASED YOUR FIRST NOVEL THE REGISTRAR. HOW LONG HAVE YOU BEEN WRITING AND WHAT PROMPTED YOU TO START WRITING?

I was having a coffee with a journalist friend in 2017 and got a text message from my son's GP practice, asking me to confirm an appointment for the following day. The thing was, I had never taken my son to the GP, and we had tried on multiple occasions to have my husband listed as the primary parent. This is no criticism of the GP practice, but just an example of how implicitly gender roles are reinforced in society. My husband also works full time but has always been a bit more flexible in his work and has thus borne more of the parenting tasks and emotional labour of keeping a household running, and yet has faced specific challenges because no one expects it to be him. I told this story to my friend and she asked me to write about it. On a whim, having not written for years, I did, and she sent it to her editor at Women's Agenda, and it kind of went everywhere.

Since that time, I've written small bits of commentary, often about gender or health equity. Having a day job allows me some privileges when it comes to writing – I don't have to write every day and I'm not trying to earn an income from my writing, so generally I only write when I'm interested in something or moved to. Not everything I write sees the light of day! I've written and thrown out plenty, as I'm still very much learning the craft.

The novel arose from an almost overwhelming need to tell the story. I had just learned that a former colleague had died, and I sat down and wrote the first three chapters of a first draft that evening (two of those three were later cut, proving that writing is actually rewriting, repeatedly!)

YOUR NEW NOVEL *THE REGISTRAR* FOCUSES ON THE CULTURE OF MEDICINE AND THE IMPACT OF THIS, ESPECIALLY ON DOCTORS EARLY IN THEIR CAREER. WHAT WOULD YOU LIKE TO SEE CHANGE AND HOW COULD THIS BE ACHIEVED?

I think that storytelling is a really powerful to understand the human experience and impact of things that we more often hear about as facts or statistics. There are so many issues with the culture of medicine, and overall I would like to see it be a profession that is physically and emotional safer and more inclusive.

This needs people to understand not only facts but rather the stories, as this is what changes hearts and minds. As acclaimed author, Zadie Smith, argues in her essay titled 'Fail Better', storytelling is not just about the responsibility of those telling tales to try their hardest, to avoid sleepwalking through not only cliched sentences and misformed paragraphs, but whole misconceived stories, but also the responsibility of the reader, the listener to understand that this is a two-way street. That understanding, done properly, is as tough as telling. She compares the reader/listener to a music performer handed sheet music rather than the audience. The composer might have written a beautiful score but it is the skill of the musician, hard-won, that translates it into something beautiful.

I don't have solutions to these problems. They might look like different things to different people in different places. But I do think the starting point is all of us, especially those in positions of power and authority to approach the issues our colleagues and patients face with curiosity, courage and genuine effort.

WHAT IS YOUR KEY MESSAGE ABOUT WELLBEING FOR DOCTORS IN TRAINING AS THEY JUGGLE WORK, STUDY AND PERSONAL COMMITMENTS?

Please seek assistance and support, especially if you are struggling. It is not a failing to find things difficult.

Share an interest or hobby away from medicine

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Email: vicdoc@amavic.com.au

As you read this book you will recognise many familiar situations and characters

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'Brenda, it's up to you how much you take our welfare seriously.' Daphne holds her ground under Brenda's withering gaze. 'We've sat in meeting after meeting telling you what we need is better staffing, reliable parking, safe hours, appropriate teaching, better supervision and support, adequate sleep and meal breaks, all all you've offered is fruit and decorative plants and lectures and, now, whale meditation.'

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REVIEW BY KAY DUNKLEY

OUR REVIEW

The Registrar
Dr Neela Janakiramanan

"This book is a must read for not only doctors and medical students but also family members and friends. It should also be compulsory reading for all health ministers and hospital administrators.

Although fiction, the experiences of Dr Emma Swann as a first-year surgical registrar could easily take place in in any major teaching hospital in Australia. As you read this book you will recognise many familiar situations and characters. Some readers may find some of the scenes all too familiar. Commentary on twitter notes that this book can be too real for comfortable reading although it is compelling.

The pace of the book closely resembles the pace of surgical teams in a hospital. With a constant sense of urgency, the book is hard to put down once you start reading as you become immersed in the unfolding plot. Aptly, the story shows the high demands of a career in surgery and the pressure this puts on the personal lives of doctors in training and surgeons with very little time for personal life and relationships.

An overarching theme in the book is the wellbeing of doctors. One passage focuses on the need for attention to be paid to the needs of doctors rather than offering classes in relaxation, decorative plants and fresh fruit. This paragraph clearly notes the importance of workplace entitlements, supervision, training and support to ensure the wellbeing of doctors.

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Australian Medical Association Victoria
293 Royal Parade
Parkville Victoria 3052
T: 03 9280 8722
F: 03 9280 8786
Country Freecall: 1800 810 451
E: amavic@amavic.com.au

amavic.com.au