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AMA VICTORIA

SPRING 2025

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Dr Sarah Whitelaw on The Pitt

Insights from members recognised for their commitment, vision and leadership

GROSS out! Six months of Getting Rid of Stupid Stuff in Victoria

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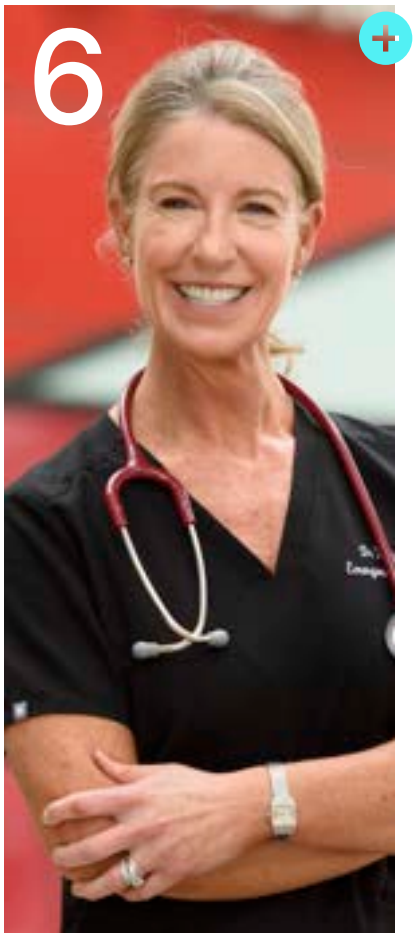

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News

AMA Victoria throws support behind an AMAV member in his advocacy to keep a public swimming facility open in West Heidelberg.

President of AMA Victoria, Dr Simon Judkins spoke to The Age about the importance of readily accessible hand sanitisers for healthcare workers in hospitals after two incidents prompted WorkSafe to issue a safety alert to healthcare services about the risks of hand sanitiser misuse and recommendations that health services remove bottles from areas where vulnerable people may be present.

AMA Victoria spokesperson, Dr Jill Tomlinson spoke to the ABC about the need to release the findings of a women's pain inquiry so the urgent work of addressing problems identified in the delivery of women's healthcare can be addressed.

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Why it was so hard to watch The Pitt

DR SARAH WHITELAW
EMERGENCY PHYSICIANS SPECIALITY GROUP REPRESENTATIVE, AMA FEDERAL COUNCIL

It took me four months to watch The Pitt. I kept pausing mid-episode, knowing I might cry.

As an emergency physician, I've never seen my work so accurately portrayed – the clinical cases, the colleagues and the system issues that define emergency medicine.

The Noah Wyle-led hospital drama has earned critical acclaim for its realism, and I'm often asked about the show: "It's only like that in America though, isn't it?"

I've shocked quite a few friends now by explaining almost everything you see in the show is happening right now in EDs across Australia – the overcrowded waiting rooms, the occupational violence, and the shortage of inpatient beds.

The clinical accuracy is striking, even if compressed into a single shift for TV. Sadly, so is the burnout and moral injury among staff, especially senior emergency physicians who feel helpless watching patients slip through the cracks of an underfunded system.

I viscerally felt the familiar vigilance required for potentially critically ill and dying patients stuck in waiting rooms, lined up in corridors or ramped in ambulances, and the pressure to find space where none exists.

What is missing from the screen, for obvious reasons, is the thousands of hours of non-clinical work, like the continuous research, training and study required to lead a large ED team.

Delayed transfers from ED to inpatient beds have been linked to excess deaths. The UK Royal College of Emergency Medicine found one extra death for every 82 patients waiting over 6-8 hours. In Australia, over 1.4 million patients waited more than four hours in EDs in 2023-24, with 90 per cent of those waiting 18-plus hours.

That is a significant number of excess deaths, and might partially explain why emergency physicians suffer the highest rates of burnout among all specialties and why main protagonist Dr Robby (Wyle) finds Dr Jack Abbot (Shawn Hatosy) on the hospital roof in the first episode.

The show's realism owes much to its medical consultants, including Australian Dr Mel Herbert. They've insisted on clinical accuracy – no added melodrama or blood, just what we manage every day.

COVID's lingering shadow is present too. Though our experience was different, putting N95s back on after wearing them every shift for almost three years stirs unresolved memories.

The show does well to capture the relentless pace of emergency medicine – case after case with no decompression, although the characters seem to have more time for individual patients. In reality, we divide our time much more thinly between multiple patients.

The characters also never seem to write notes, jostle for a computer, wrangle a fax or wait for a page to be answered.

What is missing from the screen, for obvious reasons, is the thousands of hours of non-clinical work, like the continuous research, training and study required to lead a large ED team. But the camaraderie, dark humour and coping strategies are all there. So is the pressure on doctors-in-training, many of whom must balance parenting, financial stress and the pressure of exams.

Also heartbreaking in its accuracy is the scene where Dr Collins (Tracy Ifeachor) suffers a miscarriage and then continues her shift. I'm sure this will resonate with so many Australian female doctors.

I paused the show many times, overwhelmed by memories of patients. I think my tears were from relief, that somewhere they're all still there – deep in my heart and my mind. At times, I've worried they weren't, that my coping strategy was to just move on unaffected.

My lovely director once asked if I was okay after a neonatal death in my care. I was surprised – both by being asked and because I had nothing to say. I felt fine – we had managed the case as well as we could, and we needed to get back on the floor because it was busy.

I've wondered about us as a profession, and all first responders. What does the job do to us that means we can move on so quickly? How do we snap back into being partners, friends, parents and carers for the other people in our lives?

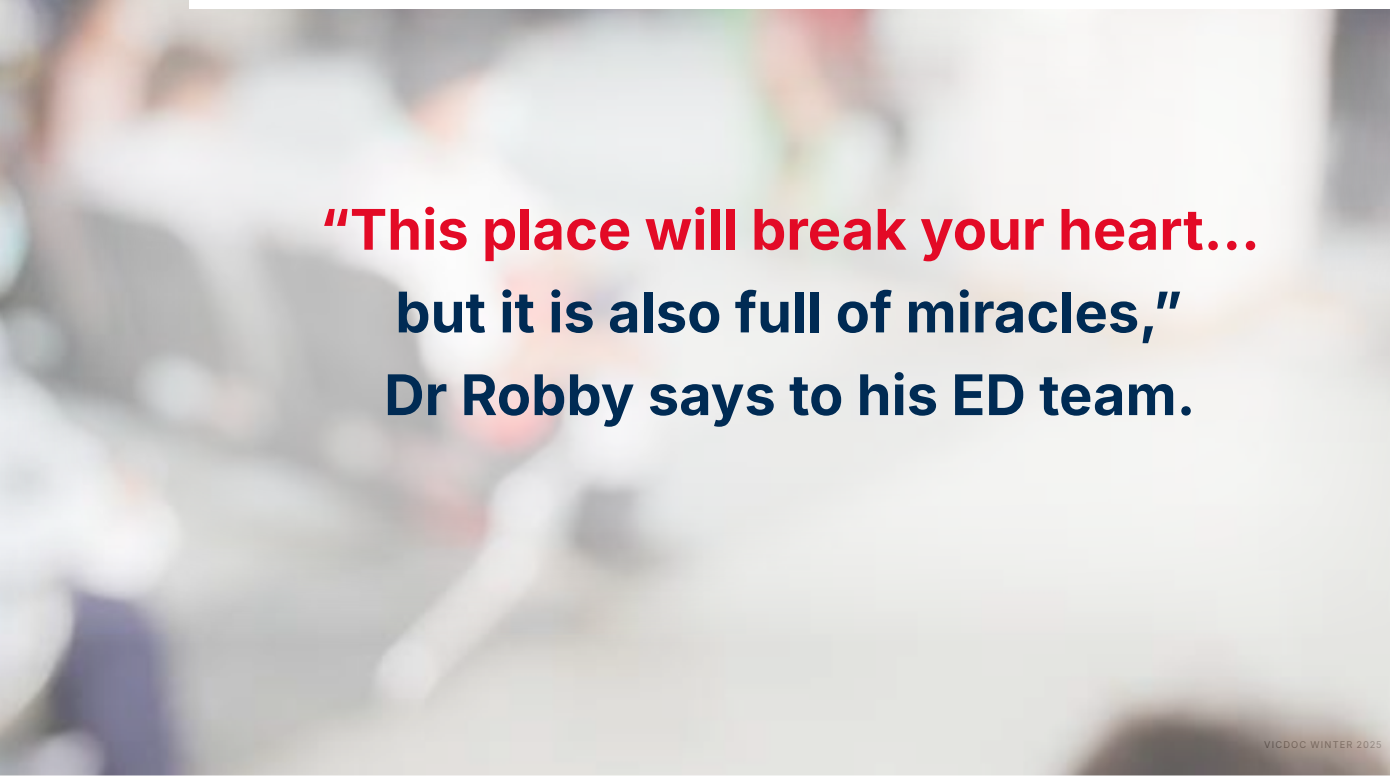
I'm nowhere near the level of burnout as Dr Robby, but I have been, and I see it in our specialty.

A sabbatical, long service leave and coaching helped me rediscover my love for emergency medicine. It also helped me accept that I can't fix the system while I'm on shift – that's what my work with the AMA is for.

I don't think I could continue my clinical work if I didn't have the opportunity to try to improve the system issues that affect all our patients.

Despite the chaos, The Pitt is also a love letter to patients – to their grace, patience Sand resilience. It honours our pride in our teams, our commitment to care and the strength of our diversity. It celebrates the satisfaction of bringing order to chaos and the importance of leadership.

Being an emergency physician is one of the best jobs there is, but I've never been able to explain why, or why it contributes so significantly to who I am as a person, even when I know it doesn't define me.



"This place will break your heart... but it is also full of miracles," Dr Robby says to his ED team.

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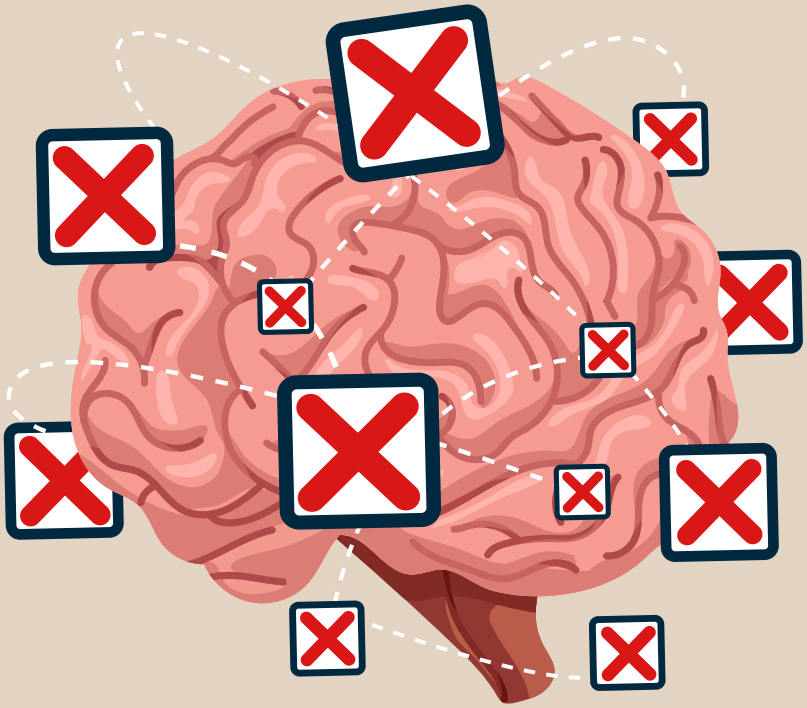

GROSS out

The results are in! We asked you to share real-world examples of stupid stuff – policies, processes, and red tape that waste your time, drain resources and take doctors away from patient care – and you delivered. A new report charts GROSS' reach and impact since its inception at AMA Victoria.

> **Ineffective, duplicate mandatory annual training modules that doctors must complete across different health services, even when the content is identical.**
>
> MEMBER

> **Needing to open five different computer programs just to conduct an outpatient clinic.**
>
> MEMBER

Read the report here

The Getting Rid of Stupid Stuff (GROSS) initiative has been underway at AMA Victoria, in partnership with ASMOF Victoria, since February 2025.

A structured, clinician-led framework to identify and remove inefficiencies, the initiative's aim is straightforward: to eliminate bureaucracy that adds no value so resources can be redirected to the front line.

It also aims to empower health professionals and help health services identify and eliminate inefficiencies and boost worker morale and productivity.

A new report, Six months of GROSS: turning member frustrations into system reform, charts the campaign's impact and reach since its inception. It shows how in just six months, GROSS has shifted from an idea to a recognised work program with visible traction inside government and the health system. It has reframed everyday frustrations as systemic problems worth fixing and put practical solutions in front of decisionmakers.

"

Reusable items are stamped "single use only," unnecessarily increasing waste and costs.

MEMBER

The inspiration for GROSS in Victoria

GROSS was spearheaded at AMA Victoria by Immediate Past President Dr Jill Tomlinson, who made lessening the administrative burdens placed on all medical practitioners one of the goals of her tenure. Inspired by GROSS' impact elsewhere, Jill harnessed it to her vision for the future of Victorian healthcare.

"My vision is for a system where clinicians are empowered to focus on patient care without being weighed down by unnecessary administrative burdens. Technology will work seamlessly to support clinical care, allowing patients to receive more personalised attention and enabling doctors to experience greater professional satisfaction," said Jill in May 2025 as she reflected on her presidency.

AMA Victoria's GROSS campaign is based on a grassroots program that was developed at Hawaii Pacific Health in Honolulu in 2017. There, its primary focus was on meaningless paperwork, particularly in clinical documentation. Staff were invited to identify low-value or unnecessary tasks in their workflow and propose practical solutions. Results included measurable time savings, improved morale and visible action from managers in response to frontline feedback.

GROSS has since been adopted by organisations including the Cleveland Clinic (USA), Queensland Health, Melbourne's Western Health – and most recently, AMA Victoria.

"For years, members have raised concerns about the steady build-up of compliance tasks, duplicated processes and low-value reporting requirements. These burdens are well-known to government, but there has no formal mechanism for identifying, prioritising and resolving them. The prevailing culture has been to work around and put up with it, rather than fix it," says AMA Victoria's President, Dr Simon Judkins, who picked up the GROSS baton when he began his tenure, in May 2025.

"The Victorian GROSS initiative was launched to change that dynamic, not simply to highlight frustrations but to create a structured, repeatable process for eliminating them. By combining member-driven examples with a coordinated push to decisionmakers, we're aiming to make red-tape reduction a system priority with direct benefits for workforce morale, retention, and patient care."

"

Referrals to hospital outpatient paediatric clinics must be signed and submitted by a GP, even after a hospital admission. This wastes GP time and public funds.

MEMBER

"

Most medical records programs don't allow a simple 'send to GP' function, delaying communication and adding administrative burden.

MEMBER

What AMA Victoria members shared

To keep the momentum going, we asked AMA Victoria members to share real-world examples of stupid stuff – policies, processes, and red tape that waste time, drain resources and take doctors away from patient care.

And you delivered! More than 40 members responded to the call out with examples of the kinds of stupid stuff Victorian healthcare could do without.

Submissions arrived via the petition, social media, email and direct calls. Nine major themes have consistently emerged from across specialties and workplaces. Standout examples of stupid stuff shared by members and highlighted in the report include ineffective, duplicate mandatory annual training modules that doctors must repeatedly complete, often across multiple health services, duplicate compliance demands such as doctors having to complete working with children checks despite Ahpra registration already involving rigorous national checks and a growing trend that sees clerical work shifting to clinicians – think doctors faxing forms and ordering supplies. Healthcare's ongoing reliance on faxing for communication of patient information and documents is another concern.

"These are not isolated irritations – they are daily frictions that have shaped GROSS' advocacy priorities and informed the issues now on Ministers' desks," says Simon.

What GROSS achieved in its first six months

By August 2025, our petition calling on the Victorian Government to implement GROSS across all Victorian health services has reached more than 1,160 signatures. The campaign has been mentioned in the State Parliament and had radio and digital media coverage.

GROSS has progressed from gathering examples to securing concrete commitments from government, agencies and health service leaders on a set of priority issues identified by members.

"In its first six months, GROSS has grown from a targeted campaign into a recognised reform agenda," says Simon. "It has been raised in Parliament, covered across mainstream and professional media, and endorsed in principle by the Minister for Health, senior Department of Health officials and Safer Care Victoria. Early wins such as work to develop a statewide approach to recognising prior learning in mandatory training, and active consideration of exemptions from duplicative WWCC requirements show the campaign is gaining traction."

Beyond these flagship issues, GROSS has opened new areas of work. Safer Care Victoria has agreed to explore practical mechanisms for clinicians to report inefficiencies in real time, with options including a simple, direct reporting channel within each health service. Credentialing reform (particularly reducing the repeated onboarding and paperwork faced by junior doctors moving between services) has been acknowledged as a priority, though one that will require sustained, longer-term work to resolve.

The GROSS approach has also been applied to processes outside the hospital system. Discussions with WorkSafe Victoria have identified rules and requirements in the workers' compensation system that could be streamlined without loss of safeguards - for example, unnecessary medical appointments created by outdated certification rules.

"These developments reflect a shift from GROSS being viewed as an advocacy idea to being treated as a live work program with agreed next steps," says Simon.

"While system-wide reform will take time, specific inefficiencies are now on the desks of Ministers, departmental executives, and agency heads, with clear lines of accountability for progressing them. The task ahead is to convert these commitments into workable reforms with firm rollout timelines, and to maintain the loop between member experience, advocacy, and change until the stupid stuff is gone."

Can you help us get to 2,000 signatures. Sign the petition!

Do you have an example of stupid stuff you've been meaning to share? It's not too late! The call-out remains open and visible so new examples continue to shape our work program and discussions with government. **Sign the petition to Get Rid of Stupid Stuff in healthcare.**

Themes highlighted by member submissions to GROSS

Theme	Members report	Why it matters
Duplicative mandatory training	• Near-identical annual modules repeated at each health service • Specialists required to complete basic courses	• Disrupts clinics and theatre lists • Minimal educational value Undermines trust in professional competence
Low-value mandatory training	• Specialists mandated to complete BLS/ALS and similar modules despite advanced qualifications and CPD requirements	• Provides little or no educational benefit • Diverts senior clinicians from care • Signals mistrust in clinical
Duplicative regulation	• All Ahpra-registered doctors required to hold WWCCs to work in Victorian hospitals • Duplication not required for teachers or police; Queensland exempts doctors	• Adds cost and paperwork without improving safety • Signals mistrust in existing professional regulation
Onboarding and credentialing repetition	• Same HR, payroll, and accreditation forms resubmitted every term or rotation • Additional rounds for locum shifts	• Wastes clinical time • Delays patient care
Clerical work shifted to clinicians	• Faxing forms, ordering supplies, processing invoices, booking transport, cleaning clinical spaces	• Pulls highly trained staff away from patients • Increases frustration and burnout risk

Theme	Members report	Why it matters
Environmental waste	• Reusable items labelled 'single use only' without justification • Disposable products replacing washable alternatives • Excessive packaging • Unopened consumables discarded • Automatic printing • Unnecessary linen changes	• Increases costs • Creates avoidable environmental impact • Undermines sustainability commitments
Digital system friction	• Siloed patient data • Missing headers on results • Multiple logins • Insecure referral tools • Persistence of paper requisitions • Duplicate entry of training/ immunisation records	• Slows care • Increases error risk • Reduces efficiency of existing systems
External bureaucracy	• Excessive WorkCover certification • CME reimbursement claims processed manually • Multiple logins for basic government processes	• Diverts time from patient-facing work • Delays payments
Specialty-specific burden	• Inconsistent laws across borders • Absence of national forensic risk database • Meetings without tangible outcomes	• Specialty inefficiencies compound general system pressures

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Celebrating Commitment

Five AMA Victoria members recognised for their commitment, vision and leadership talk to Vicdoc on what makes them tick.

*

AWARDED:
AMA VICTORIA JUNIOR DOCTOR
OF THE YEAR 2025

"

It's time to build a culture where discrimination, bullying, and racism are no longer tolerated.

Dr Gaby Bolton

Dr Gaby Bolton (MBBS) is an anaesthetic registrar at Monash Health. In 2024 Gaby was nominated for a Shout Out award for her selflessness in being the lead applicant in a landmark class action against Peninsula Health for unpaid overtime which, resulted in a Federal Court ruling that the health service had breached the Fair Work Act. In 2025, Gaby received the AMA Victoria Junior Doctor of the Year Award, recognising her remarkable strength and dedication to junior doctor wellbeing. She is also a past recipient of the Postgraduate Medical Council of Victoria's Wellbeing Champion Award for her leadership and wellbeing initiatives during COVID.


RAL COURT OF AUSTRALIA
edical Officers' Federation v Peninsula Health [2023]
FCA 939
VID 115 of 2021
BROMBERG J
11 August 2023
INDUSTRIAL LAW – representative proceeding pursuant to Pt IVA of the Federal Court of Australia Act 1976 (Cth) – junior doctors class action – application for relief under the Fair Work Act 2009 (Cth) – alleged breaches of enterprise agreements – claim for unpaid entitlement to unrostered overtime – meaning of the phrase "authorised hours" in applicable enterprise agreements – whether authorisation may be constituted by a request, requirement or other approval given by the employer – whether authorisation impliedly given may engage the payment obligation imposed by the relevant enterprise agreements – whether only an authorisation given by the employer consistently with a mode or process (policy) adopted by the employer will suffice to engage the payment obligation – whether, as a matter of fact, unrostered overtime was impliedly "authorised" by the employer – employer policies dealing with overtime relevant to whether, as a matter of fact, authorisation may be implied – policies that are unknown or not applied unlikely to have a bearing on authorisation – whether estoppel is available as a defence to a claim of unpaid entitlements under an enterprise agreement – principles for proving loss in an underpayment claim in the absence of precise evidence of hours worked – application allowed in part – common questions determined
Copyright Act 1968 (Cth) s 36(1)
Evidence Act 1995 (Cth) ss 60, 81 and 136
Fair Work Act 2009 (Cth) Pt 2-4, ss 50, 545, 546(3), 547
Fair Work (Registered Organisations) Act 2009 (Cth)
Fair Work Regulations 2009 (Cth) reg 3.33(2) and reg 3.34
Federal Court of Australia Act 1976 (Cth) Pt IVA, s 21
Health Services Act 1988 (Vic)
Workplace Relations Act 1996 (Cth)
ACE Insurance Ltd v Trifunovski (2013) 200 FCR 532

The generational underpayment of doctors, the lack of recognition of their time and the impact of this is still not well recognised.

As a junior doctor, you can feel like you don't belong anywhere, and you're not in a very safe or stable place in terms of job security. Acceptance into specialty training programs is incredibly competitive, and you don't want to do anything or say anything that will make things more difficult for your career progression. So, we bear the brunt of being at the bottom of a still very hierarchical system, where juniors are sometimes pushed around and expected to work extra hours, and to make medicine your entire life. Going through the junior years in this way is almost considered a rite of passage, and that's how the system has run for years and years.

My class action and the other class actions is something more powerful than us as individuals.

I had a lot of support from ASMOF and AMA Victoria, and from the lawyers involved and the department I was working in at the time, which is the main reason I was able to go ahead. It wasn't ever really about the money, but about principle – what's right. I realised early on that I was not as affected as some of my colleagues; unaccredited surgical registrars seem quite affected by this. No-one should be overworked to the point of burnout or go unrecognised and unremunerated because the system or their seniors don't consider the essential work that they're doing is important or necessary.

It took a lot out of me. I spent literally hundreds of hours pulling together evidence and preparing for trial.

The timing was very unfortunate. I was due to sit my specialty exams about six weeks after the trial, and the trial preparation and then of course being on trial, including three and a half days of giving evidence and being cross-examined, was incredibly draining. It was only when it was all behind me and I was able to refocus and pass those exams. That was in 2024. I had hoped it would only take me one year and one attempt, but it's taken me three years and four attempts, and much more money than I would like to have spent on that. I've had to overcome a strong sense of failure and self-doubt.

Medicine needs to better represent and reflect us as a society.

People often assume I'm a nurse because of my gender. It's not offensive that they think I'm a nurse, it's offensive that they think I'm a nurse because I'm a woman. This is another systemic issue we need to overcome; women are just as able and entitled to be doctors as men. We also

need to normalise seeing people of colour practicing and leading in medicine. You really can't assume anyone's role because of their gender or cultural identity; those days are gone.

I wanted to be a veterinarian. But when I learned that it involved euthanising animals, I found it too sad.

So, I turned my attention to medicine instead. Looking back, I can see it had always been part of my world as mum had a lot of health issues when I was growing up. She had several major surgeries. is of visiting my mum after surgery and seeing someone across the corridor having their tracheostomy removed. It didn't upset me; I found it quite interesting. I probably have the right disposition for medicine, the curiosity and the ability to compartmentalise some of the tasks and experiences it demands of you.

I was interested in surgery, but quickly found that the other side of the drape was much more interesting.

I found anaesthetists quite welcoming; I met people with personalities like mine. There's a saying about the 'ROAD' to happiness in specialties, with road being an acronym for radiology, ophthalmology, anaesthesia and dermatology. They're widely seen as the specialties that offer a good work-life balance and give you the capacity to support yourself and your family in a relatively comfortable way. There are a lot of women in anaesthesia; in my cohort of medical school, 60% were female.

When Dr Jill Tomlinson nominated me for the Shout Out award back in 2024, it was hugely affirming.

It was affirming to know that she has seen me and my effort with the class action as worthy of recognition. Anyone who doesn't fit the traditional profile of a doctor – in my case, a woman – can be made to feel like an imposter in medicine. And some of my experiences with the class action amplified that. Being cross-examined was not an easy experience. The Junior Doctor Award is also very affirming; I'm grateful for the recognition from my fellow junior doctors. Would I do it again? Yes. I've always had that strong sense of social justice and an awareness of the importance of contributing to the greater good. That's not always going to be comfortable or easy, but it's always going to be important.

FINALIST:
AMA VICTORIA JUNIOR DOCTOR
OF THE YEAR 2025

"

Emergency medicine is, for me, the epitome of equity and inclusion.

Dr Matt Bray

Dr Matt Bray (MBBS, MPH&TM) is a Senior Emergency Medicine Registrar at the Royal Melbourne Hospital and a proud Australian of Rotuman heritage. Committed to health equity and international collaboration, Matt's work spans clinical care in the pacific, not-for-profit governance, college roles, and advocacy for communities impacted by colonisation and climate change. His contributions have earned him a Global Voices UN Research Fellowship, participation in the US State Department International Visitors Leadership Program, and board roles in health and cultural organisations. In 2025, Matt was a finalist for the AMA Victoria Junior Doctor of the Year Award, recognising his leadership and dedication to social justice in medicine.

Coming from a bicultural background with a family that is spread across the pacific, i initially imagined myself pursuing a career in diplomacy.

But at the end of high school, my parents encouraged me to pursue medicine. They recognised its timeless noble quality and a real immediacy in your ability to impact people's lives. That appealed to me as an idealistic teenager raised in a community that emphasised social justice and service. Building on that social capital, I've been able to marry my interests and have a broader impact by being active in the realm of public health and in the Pacific. My vision is of a career that spans the Pacific region in an evolving clinical role whilst, on a larger scale, addressing some of the systemic drivers to inequitable access to healthcare for First Nations and Pasifika peoples.

In 2017, i took a break from training and worked voluntarily on the island of Rotuma in Fiji, where my family is from.

I was there as a medical officer, practising community medicine on a tiny, remote island alongside my cousin. Being able to care for people in the place my identity is rooted was incredibly fulfilling. My days were a blend of medical work and cultural connection: walking to the clinic each morning, caring for elders, speaking in language, playing volleyball with hospital staff in the afternoons, and swimming on beaches where my ancestors have fished for millennia. There were challenges, too. Working in a small community with limited resources, where you are both personally invested and professionally responsible for critical decisions, was demanding. Learning to navigate that was a significant part of maturing as a doctor.

My background, and my time in Rotuma, deepened my awareness of how culture, history, and identity shape people's experiences of health and healthcare.

In Australian EDs, I've witnessed how patients from culturally and linguistically diverse backgrounds, especially First Nations communities, can feel unseen or misunderstood. For me, the concept of 'cultural literacy' speaks to our responsibility as clinicians and systems to make the effort to connect with patients in the fullness of their personhood and respond with humility. It's not simply about avoiding harm, but about creating spaces where people feel safe, heard, and valued. Whether through governance roles, advocacy work, or simply listening more intently in clinical encounters, I've tried to contribute to building a system that's more equitable and more responsive to diverse communities.

My path through medicine hasn't followed the typical timeline, and that's okay.

I'm a senior registrar now, but it's taken longer than the expected route. I've stepped away from training at different points: to work overseas, complete a Master of Public Health, or simply pause for my own wellbeing. Earlier in my career, I worried that taking these detours meant I didn't belong, or that I was falling behind. But I've learned that medicine shouldn't be a rigid track and feel these experiences outside the traditional path have made me a better doctor and a more grounded person. As someone with a bicultural identity, I've felt a responsibility to be visible and authentic in this profession, and to show there's space for people from diverse backgrounds, and for those who choose paths that look different. Representation matters, both for our colleagues and the communities we serve.

I would never have predicted as a medical student that I'd end up in emergency medicine, but after a few rotations, I realised I'd found my tribe.

The strong sense of collective endeavour and the close collaboration between doctors and nurses felt reminiscent of village life. Above all, emergency medicine is, for me, the epitome of equity and inclusion. It's literally the open front door of the hospital, where all are welcome, regardless of their story, status or circumstances. We meet people and their families on what may be the worst day of their lives, in moments of vulnerability and uncertainty. There's a profound privilege and responsibility in being able to offer calm, reassurance, and knowledgeable care, and to quickly build trust and rapport. It's demanding but I can't imagine a specialty that better aligns with my values of service, justice and connection.

From August 2025, I'll be working in Honiara in the Solomon Islands, participating in the Volunteer Emergency Medicine Registrar Program for six months.

The program, facilitated by the Department of Foreign Affairs, the Australian Volunteers Program and the Australasian College for Emergency Medicine, places Australian emergency medicine registrars in EDs in Papua New Guinea, East Timor, Vanuatu and the Solomon Islands. I'll be working in a capacity strengthening role alongside local doctors, contributing to training, quality improvement and providing an extra set of hands. It feels like a natural continuation of my journey: a chance to learn, build relationships and help strengthen systems in a region that's part of my identity. It's another step in weaving together my clinical skills, my heritage and my commitment to making healthcare fairer for everyone, no matter where they come from.

NOMINATED:
AMA VICTORIA
PATRICK PRITZWALD-STEGMANN AWARD

"

Sometimes being kind requires effort, but it's an effort well worth taking.

Prof Geoff Hebbard

Prof Geoff Hebbard (MBBS, BMedSci, PhD, FRACP) is a gastroenterologist and was the Director of Gastroenterology at the Royal Melbourne Hospital (RMH) from 2002 until March 2025. At the RMH he contributes to the management of patients with disorders of gut brain interaction, has been pivotal in the establishment of the Nurse Endoscopist Program, and has mentored dozens of trainees. In 2020 Geoff was awarded the Outstanding Clinician Award by the Gastroenterological Society of Australia. In 2025 he was nominated for the AMA Victoria Patrick Pritzwald-Stegmann Award, which recognises a doctor who has made an exceptional contribution to the wellbeing of their colleagues and the broader medical community.


The Royal Melbourne Hospital
Prof Geoff
FLU
2025

As soon as I stopped wanting to be an astronaut, I wanted to be a doctor.

Right back to my early teens, I was interested in medicine. My mother would drop me at the library a couple of times a week, where I found myself drawn to the medical section, particularly books about the history of medicine. It really cemented my interest. People tend to go into specialties where they feel that their personality fits in, and specialties tend to select people who they feel will fit in. I think gastroenterologists are relatively friendly. We're also quite down to earth; you can't talk about poo all day and be up yourself.

I'm a great promoter of expanding the role of nurses.

Just over 10 years ago we set up a Nurse Endoscopist Program, training nurse practitioners to do endoscopy and colonoscopy, to follow-up polyps and manage patients taking part in the National Bowel Cancer Screening Program. We've got hepatology and inflammatory bowel disease nurses, as well as outpatient and endoscopy coordinators. The specialist nurses can advise patients, organise scripts and be a first point of care if they become unwell. They are a highly skilled and stable workforce, forming a very valuable addition to the team.

The challenge in the public system is always resources.

There's a limited pie and getting resources to fund services can be frustrating. One of our biggest challenges has been our endoscopy service. The range of therapeutic procedures has grown over the past decades, but within a limited template of theatre space and resources. This problem has been recognised, and we now have access to external sites but ultimately, we need a more stable solution.

One of the public health challenges we're going to face more of is, how does the community pay for medical care?

As medical costs increase at a faster rate than inflation, we need to ensure that our resources are distributed fairly and evenly. One measure of this is variation in care. An example in gastroenterology is the variation in rates of colonoscopy between the wealthiest and poorest postcodes in Australia. While some areas are being underserved, we need to ensure that we apply the relevant guidelines to our practices if we want to avoid a managed care scenario. Another challenge will be integrating AI into medical practice to assist documentation and patient management. AI has enormous potential to increase efficiency but also comes with significant risks – a brave new world with Dr Google on steroids!

As I take more of a tree change in my career, I'll be doing more work.

We have Epic as our electronic medical record system, which facilitates information sharing between the Parkville Precinct – that's the Children's, RMH, the Royal Women's and Peter Mac. It allows for a lot of user configuration, so hospitals can build the functionality that they want rather than having to go to Epic and ask them to build it. I have completed several training certifications and developed patient registries. I've completed a hip fracture registry, an inflammatory bowel disease registry and a GI bleeding registry and am working on one to track outcomes from our Enhanced Recovery After Surgery program.

Australian healthcare really needs to work on secure messaging between practitioners.

Somewhat incredibly, fax is still a common and sometimes the only relatively secure way of transmitting patient information. I still receive a lot of faxes, and the hospital sends enormous numbers of them. It would be beneficial to have a centralised and secure communication system for medical professionals, as the current reliance on multiple platforms can create inefficiencies.

I think one of my greatest achievements is my contribution to gastroenterology training in Victoria.

When I came to the RMH in 2002 gastroenterology training in Victoria – although good – was disjointed, with little coordination between hospitals. Over the years we've been able to evolve this into a cohesive, cross-institutional process where training is coordinated by the heads of gastroenterology departments across Victoria and Tasmania. This includes an educational program, regular meetings to discuss trainee progress and a match for advanced trainees, both continuing and new. We have a selection process that we think is as fair as it can be to get people in and through their training.

I encourage trainees to keep an open mind and not ignore opportunities that don't fit with their current notion of what they want to do.

Even if you think you know where you're going, you need to take the opportunities that arise because often, they're good opportunities. Stay kind to everyone you interact with within the health system. Medicine is not always kind to our patients or to our colleagues. Sometimes being kind requires effort, but it's an effort well worth taking.

AWARDED:
MEMBER OF THE ORDER OF AUSTRALIA (AM)

"

There are a lot of people working out there in the bush who are doing a great job.

Dr David Iser OAM

Dr David Iser OAM (MBBS(Hons), PhD, FRACP, FRACGP) is a general practitioner and rural health educator with more than 40 years' experience, primarily in rural environments. He began practising in Foster (South Gippsland) in 1981. He was named a Victorian Rural Doctor of the Year in 2008. He is a former senior lecturer and head of Monash's School of Rural Health, a dedicated trainee supervisor, and has served as a Royal Australian College of General Practitioners examiner. David has been based in Barwon Heads since 2021 but continues to serve Foster and surrounding communities. In 2025 he was awarded a Medal of the Order of Australia (OAM) for services to medicine as a general practitioner.

It meant a lot that someone who's strongly connected in my community nominated me for the OAM.

When you're in a small town, you're never really a true local unless you've been part of the community right from birth. I've delivered a lot of babies and then watched them grow up and then delivered their children. I think I've even delivered three generations. I guess through all this, I have become a true local. There are a lot of people working out there in the bush who are doing a great job, especially in remote areas where people are dedicating their lives to this kind of work. I'm just one of many.

I spent time working with the Aboriginal Health Service in Alice Springs, then decided I'd work in the country.

I figured if you have to do everything, you can probably cope with anything. Foster was reasonably isolated in those days. I came to Foster in 1981 to work with a solo practitioner, Dr Robert Fleming, who did everything. He'd do an anaesthetic, then turn around and do the surgery himself; I learned a great deal from him. I completed my anaesthetics training and later furthered my surgical skills. It was a challenge, and I enjoyed the challenge, so we stayed. Over the years, I adjusted to what the community needed and continued my knowledge in obstetrics, gastroscopy and endoscopy.

I worked extremely hard, as a lot of country doctors do.

I'd often be kept out at night; sometimes I'd leave home on a Saturday morning and not get back until Sunday night. That must've taken a toll on my wife and family, but they were always extremely supportive. And I can't have made it look too bad, because two of our daughters decided to do medicine and the third has married a surgeon. Living in a small town, our children understood the importance of patient confidentiality early. We'd go away every five years. I'd work locally, and our children attended local schools or sometimes my wife homeschooled We were able to experience other places and ways of life together. We spent time in Papua New Guinea, England and Canada and closer to home, in Broome and Thursday Island.

In a rural setting, sometimes distance can be the difference between life and death.

I remember one woman back in the mid-nineties who was six weeks post birthing and haemorrhaging badly. She suffered an enormous amount of blood loss; it was very dramatic. I'd given her all the blood I had in the hospital and was giving bimanual

compression – that was the only thing keeping her stable. In those days there weren't any organised retrieval services, so I escorted her to Melbourne by air. I rang one hospital who said they had no beds. So, I rang another, who also said they didn't have any beds. I just had to plead with them until they took her. They operated and successfully stemmed the bleeding, and she was able to go home to her family. Later, when I asked why they took her even though they were full and the doctor said, "I could just hear it in your voice. You were desperate."

Simple things can be real game changers in medicine.

Take the development of Troponin for a heart attack. When I first arrived in Foster, people that had chest pain without ECG changes were often sent home and might pass away over the weekend. But now with investigations such as Troponin and CT scans, Ischaemic Heart Disease can be detected much earlier, then fast-tracked into the cardiac stream very quickly. The other major leap I've seen is advances in cancer treatment. Years ago, certain diagnoses meant there was not much we could do for someone, and I'd feel very miserable explaining to they had a particular diagnosis that we didn't have anything to offer for to them. This kind of thing can send shockwaves through a small community.

There aren't the same demands on rural GPs as there used to be, but it seems to have gotten harder to get gps to work in rural areas.

These days, a lot of the after-hours work in Foster and surrounds gets redirected to a nearby 24-hour emergency department. And then there's VirtualED, which I think works quite well. Years ago, we'd have between five and seven doctors working down there every day. More recently we've been down to between three and five. At a government level, the system of fee for service needs upgrading. GPs must get reasonable remuneration for the work they do – as everyone knows, that hasn't kept pace. Being a rural GP is incredibly satisfying, and over the years I've taken great pleasure in supporting students and junior doctors to work out if it's right for them. Happily, it has been a good choice for many, and I'd really encourage more good doctors to consider working in a rural setting. I honestly don't think you'll regret it.

APPOINTED A MEMBER
OF THE ORDER OF AUSTRALIA (AM)

"

In medicine, we often cling to tradition, even when the data clearly show that something newer or better exists.

Prof Alistair Royse AM

Professor Alistair Royse AM (MBBS, MD, FRACS, FCSANZ) is a leading cardiothoracic surgeon and educator who has played a central role in advancing coronary revascularisation and clinical ultrasound training in Australia. He is Director of eLearning Technologies at the Melbourne Medical School, University of Melbourne, Co-Director of both the Ultrasound Education Group and Mobile Learning Unit, and a consultant cardiothoracic surgeon at the Royal Melbourne Hospital. In recognition of his contributions to medicine as a surgeon, researcher, and educator, Alistair was appointed a Member of the Order of Australia (AM) in 2025. He was also awarded the Sir Louis Barnett Medal by the Royal Australasian College of Surgeons in 2023.


GENERAL THORACIC SURGERY
GENERAL THORACIC SURGERY

Much of my surgical career has focused on advancing Total Arterial Revascularisation (TAR), a technique that uses only arterial grafts for coronary artery bypass surgery.

Unlike the conventional approach – typically using one internal mammary artery and supplementary saphenous vein grafts – TAR offers significantly greater long-term patency. Arteries are naturally suited to high-pressure, high-flow environments. Veins, on the other hand, are low-pressure vessels not designed for arterial circulation. Around half of all vein grafts fail within 10 years, due to accelerated atherosclerosis. In contrast, our research shows that arterial grafts – particularly radial arteries – are extremely durable, with very little evidence that they will ever fail.

In one memorable case, I operated on a patient 27 years ago using five arterial grafts. This patient is still alive and well.

A recent coronary CT angiogram showed that all grafts remained completely patent and normal. That sort of result would be almost unheard of with vein grafts. Basically, we expect the arterial grafts to remain normal indefinitely. We've shown a 22% relative survival benefit with TAR compared to conventional mixed grafting strategies. Despite this, TAR remains underused globally. Victoria embraced the approach in the late 1990s, but most of the world still relies on single-artery techniques with vein grafts. That reluctance to adopt change is frustrating – but also an opportunity.

To help shift international practice around coronary artery bypass surgery forward, I'm leading the Total Arterial Trial.

This is a $5 million project funded by the Medical Research Future Fund. The patients are randomised to receive no vein grafts (TAR) or one or more vein grafts (non-TAR). In practice, most patients in this country will receive only one vein graft in the non-TAR arm. They then receive a CT coronary angiogram at three months and at two years to look at perfect patency. The trial aims to generate the kind of rigorous evidence needed to influence global surgical guidelines. A trial of this kind can only be performed at scale in Australia, as roughly 30% will receive TAR, 47% multiple arterial grafts and the remainder conventional single arterial grafts – a tenfold difference to international practice, where 90-95% of coronary surgery will involve a single arterial graft and supplementary vein grafts.

One of the key skills in surgery is adaptability. Angiograms give us a roadmap, but intraoperative findings often differ.

Coronary vessels may be more diseased than anticipated. That means I may need to change graft targets on the fly, adjust angles, and perform more complex reconstructions than initially planned. Being able to respond fluidly in real time is essential. I've been fortunate to work with some outstanding mentors, particularly the late Professor Brian Buxton, who had an enormous impact on my career. Brian was not only technically gifted – ambidextrous and incredibly precise – but he also had an open mind and was receptive to change.

I advise those considering cardiothoracic surgery to think carefully before committing.

It's not for everyone, so you've got to come in eyes wide open. You need to be genuinely excited about the things we're doing, but you also want to be very confident that it's right for you. The training pathway is long – usually involving three years of pre-registrar work, often followed by unaccredited surgical time before entering the formal six-year training program. It's physically and mentally demanding, and it suits people with stamina, dexterity, and a genuine interest in high-stakes, precision work.

In the late 1990s, I teamed up with my brother to create distance education courses in clinical ultrasound.

My brother is Professor Colin Royse, an anaesthetist and expert in cardiac ultrasound. At the time, the courses we created were quite novel. We used DVDs to deliver interactive training content, long before online education became common. Those early efforts helped establish the University of Melbourne as the leading provider of ultrasound education for doctors in Australia. Even today, we remain at the forefront of that field.

Despite how far ultrasound has come, it's still underutilised.

For example, very few clinicians routinely use ultrasound to examine the chest; they still rely on stethoscopes. But ultrasound is a clear technological leap forward – faster, more accurate, and more informative. I believe it should be a standard part of undergraduate training and one day hopefully embedded in routine clinical care. That belief informs my work with the Mobile Learning Unit, where we focus on scalable, digital-first training models. We need to equip the next generation of clinicians with both the knowledge and the tools to use this technology effectively.

Find out more about the AMA Victoria mentoring program

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Spotlight on congenital syphilis

Earlier this year, AMA Victoria awarded the Sir Richard Stawell Memorial Prize for a paper exploring the rise of syphilis in women of reproductive age and congenital syphilis in Australia. Since then, the Chief Medical Officer has declared syphilis a Communicable Disease Incident of National Significance in Australia. We caught up with one of the paper's authors to learn more about this highly preventable occurrence.

“Around 2018-2019, congenital syphilis became a big concern in Australia,” says Dr Belinda Hengel (PhD), an infectious disease researcher with the Surveillance and Evaluation Research Program at the Kirby Institute, University of New South Wales.

“Cases of congenital syphilis started to increase dramatically. Congenital syphilis is entirely preventable if people have access to adequate antenatal care and testing and treatment, so there shouldn’t be any cases.”

This is quite the comeback for a disease that is so potentially eradicable, and that has been earmarked for elimination at various points in history.

In 2025 Belinda accepted AMA Victoria’s Sir Richard Stawell Memorial Prize on behalf of the authors of Notification rates for syphilis in women of reproductive age and congenital syphilis in Australia, 2011-2021: a retrospective cohort analysis of national notifications data, which was published in the Medical Journal of Australia in July 2024.

A global resurgence

Syphilis is one of the most frequent sexually transmissible infections, even though effective treatment is readily available. In 2022, the WHO estimated around eight million new cases of infectious syphilis were diagnosed around the world, along with an estimated 700,000 cases of congenital syphilis.

In Australia, the infectious syphilis notification rate more than tripled between 2011-2021.

“In 2010 it was thought we could eliminate infectious syphilis in Aboriginal and Torres Strait Islander communities,” says Belinda, whose work focuses on reducing the impact of infectious diseases, including sexually transmissible infections and respiratory infections in populations at risk.

However, the following year it started to increase in those communities in northern Australia and then in gay and bisexual men who have sex with men in major cities.”

In the following years jurisdictional surveillance officers then noticed cases increasing among heterosexual women aged 15-44 in major cities and metropolitan areas, along with a parallel increase in cases of congenital syphilis.

Belinda noted anecdotally that research elsewhere has observed that congenital syphilis is more common among people negatively impacted by the social determinants of health.

“That's the group where we mainly see infectious syphilis and those congenital syphilis cases. Our health system and models of care aren't perhaps reaching those people that most need access to the services for testing and treatment.”

Consequences of untreated syphilis in pregnancy

In most cases (50-80%), syphilis in pregnancy leads to severe adverse outcomes. Congenital syphilis is the second leading cause of preventable stillbirth.

"What we found in the cases over that 10-year period is around 23% were stillborn. Another couple of percent died soon after birth. Some were born completely asymptomatic. A large percentage were born with lifelong abnormalities."

With the right surveillance, detection and treatment, adverse outcomes are entirely preventable.

"We need to understand more about the circumstances and the situations that these pregnant people are facing in their lives that create barriers to accessing care. We need to rethink models of care so that every pregnant person has access to the care they need to have a healthy baby in that pregnancy."

Declaring syphilis a Communicable Disease Incident of National Significance in Australia on 7 August 2025, the Chief Medical Officer (CMO) noted 6,566 cases of infectious syphilis in 2023 – a record high. That same year there were 20 cases of congenital syphilis, which resulted in 10 deaths.

As of 6 August 2025, Australia had already recorded 3,546 cases of infectious syphilis and 11 cases of congenital syphilis, leading to 4 infant deaths. In 2025, the CMO expects notifications among women of reproductive age are expected to be similar to 2023.

The great imitator

Syphilis was first recorded in the late fifteenth century. Among many other names, it has been called the 'the great imitator' as early symptoms are easy to miss and syphilis can often mimic other infections.

The term 'syphilis' was introduced in 1530 by Girolamo Fracastoro, a physician-poet in Verona. Fracastoro was inspired by the myth of Syphilus – a shepherd who refused to worship Apollo, who then cursed the population with a "hideous" disease.

Famous people widely believed to have had syphilis include mob boss Al Capone, writer Oscar Wilde, and Ugandan military dictator Idi Amin. Genetic studies indicate the disease originated in South America and there is some evidence that Christopher Columbus's crew became infected with the disease and took it back to Europe.

In the 15th-19th centuries, syphilis was widespread and often fatal without treatment. Mercury and arsenic compounds were common but toxic therapies, until penicillin was introduced in the 1940s.

Innovations in testing

While treatment for syphilis is well-established and effective, traditional tests can present a barrier to care. The gold standard test is a blood draw that gets sent to the laboratory. Waiting and returning for the result and any recommended treatment can be a barrier for people experiencing inequity.

Developments in point of care testing have potential to overcome this barrier by providing a test result to the patient at the time of testing.

"There's a relatively new finger prick test that can be done by the clinician at the time they're seeing the patient, which has been proven useful across multiple settings, in terms of getting a rapid result and then being able to take steps towards treatment," says Belinda.

However, the test can't tell the difference between a past infection that's been treated and a new infection.

"As the epidemic has been underway for more than a decade now, this test is arguably only useful if you've got access to a good syphilis testing history. There are some developments that are happening in new point of care tests that may be able to tell the difference between an old and new infection, as well as other tests that have been approved by the WHO in the triple elimination space for pregnant people, that would test for syphilis, HIV, and hepatitis B in one test."

Frequent testing can help reduce congenital syphilis

Reducing infectious syphilis in the population can help prevent congenital syphilis. For GPs and other healthcare providers, taking steps to ensure any pregnant person has adequate access to antenatal care and is tested for syphilis is crucial.

If a person tests positive, treatment is usually just a penicillin shot, with dose determined by the stage of infection.

"One of the things that has changed since this paper was published in July 2024 is that previously, the test was recommended just once during pregnancy, at the first antenatal screening," says Belinda.

"Now the Communicable Diseases Network Australia and RACGP recommend most jurisdictions around Australia test two or three times in pregnancy, to try to catch it if it does pop up. In areas where remote Aboriginal and Torres Strait Islander communities have had this outbreak since 2011, they're ideally testing five times throughout pregnancy."

Read the Victorian Department of Health's guidelines for syphilis to make sure you're across best practice.

Prescription for digital resilience: Why responsive business insurance is a must for modern medical practices

Whilst the main priority of a medical practice is caring for patients, keeping the practice safe and secure comes a close second. With so much of your practice running online, from appointment bookings to patient records, having the right business insurance package is more important than ever.

Cyber Insurance: Your digital lifeline

Fact: medical practices are attractive targets for cybercriminals. You are dealing with sensitive and confidential personal and health information, and that data needs serious protection, including immediate defence and recovery when a determined cybercriminal penetrates your IT infrastructure. A cyberattack can lead to costly disruptions, legal nightmares and damaged reputation.

That's where cyber insurance comes in. It's designed to help cover:

- Data breaches and ransomware attacks
- System breakdowns that lead to lost patient information
- Legal fees and the costs of notifying affected patients
- Recovery support and tech help if you're targeted

It's like having a tech-savvy emergency team on standby ready to intervene when an unauthorised breach of your IT security occurs.

For anyone who looks at their already thorough practice insurance pack and thinks they shouldn't bother with cyber insurance, consider this: for a building and contents you'd have no hesitation in obtaining comprehensive insurance policies along with security systems, alarms, deadlocks and grills. Your commitment to reducing risk for digital assets and exposures, is just as crucial. It is undeniable, cyber-attacks are on the rise across all segments of business and particularly so for small and medium enterprises in the healthcare sector.

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The takeaway

Cyber incidents are growing fast, and the statutory regulations and penalties relating to managing patient data are clear and onerous. Similarly, exposure to theft, accidental damage, business interruption, equipment breakdown and numerous other medical practice risks continues to evolve. Investing in solid business insurance - with cyber protection front and centre - sets your practice up for long-term stability and peace of mind. Having PSA Insurance by your side means you'll get the advice you need with less fuss, more confidence and the feel-good-factor that they're investing in the future of the profession.

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Deepfake doctors selling lies

DR DANIELLE McMULLEN
AMA PRESIDENT

I first discovered a fake social media profile impersonating me when a family member called to ask if I really believed in what I – the fake version – was selling.

I felt a rush of emotions: confusion, concern, and disbelief. How could this be allowed to happen?

All online scams are insidious, but they become particularly dangerous when they involve healthcare.

Since discovering the fake Dr McMullen on Facebook, I have made several attempts to have her removed. Unfortunately, my efforts have been futile. It feels like an endless game of whack-a-mole – and the scammers are winning.

It seems I got off relatively lightly, though. Other prominent clinicians, including Dr Norman Swan and former AMA president Professor Kerryn Phelps have had their identities misused in 'deepfake' videos that promote unproven health products.

The companies behind these products use artificial intelligence technology to replicate the appearances and voices of reputable health professionals with astonishing accuracy.

A fake Dr Swan was shown calling scientific evidence "stupid" while selling supplements claiming to treat heart disease, diabetes and obesity.

Professor Jonathan Shaw, one of the world's most cited researchers, appeared in a deepfake ad urging people to stop taking prescribed medication in favour of an unproven alternative.

"If you know me, it's clearly fake," said the real Prof Shaw in the Winter 2025 edition of Vicdoc. "But for members of the public, it was unfortunately very convincing."

These scams aren't just a health risk – they're a financial one too. Vulnerable Australians are being tricked into buying products that don't work, or don't even exist.

Deepfake technology is becoming more convincing by the day. We now live in an age where every video must be questioned: is it real, or is it AI-generated? And if it's AI generated, is it sanctioned or a scam?

Believe it or not, 'AI influencers' are now a thing. 'Mila Zelu', an AI-powered social media "influencer", has amassed more than 160,000 Instagram followers by sharing fake, AI-generated content of herself at events such as Wimbledon.

When we talk about AI here at the AMA, we talk about its potential to transform healthcare, offering innovative solutions to long-standing challenges (with appropriate guardrails, of course).

From faster diagnostics to slashing administrative burdens, AI is unlocking new possibilities.

Machine learning is improving medical imaging and data analysis, while predictive models are enhancing preventive care. AI-powered apps and wearables are already monitoring patient vitals in real time.

Many GPs are using AI tools to transcribe consultations and assist with notetaking.

While the performance of these tools varies and caution is needed when using them, their potential to free up time for patient care is undoubtedly significant.

These examples barely scratch the surface of the potential of AI in healthcare. But with great potential comes great risk.

Patient privacy and data security are critical concerns, especially as AI relies on extensive datasets to function effectively. We have taken a leadership role in advocating for a regulatory framework that balances innovation with safety. In submissions to bodies such as the Therapeutic Goods Administration, we've outlined principles for responsible AI integration – with clinical oversight always at the core.

We've been clear: AI should support – not replace – clinician judgment. Regulations must ensure that final decisions remain in the hands of healthcare professionals, preserving the human element in care.

These are the important issues we should be discussing more – not deepfake scammers. But we must respond to the reality we face, and fortunately, we are nimble enough to tackle multiple challenges at once.

I recently wrote to Hon Anika Wells, Minister for Communications, urging the Federal Government to act on deepfake content promoting harmful treatments. We're calling for clear, enforceable regulations on health-related advertising online, including:

- mandatory identification of the individual or company responsible for any online material promoting a medical product or service
- an accessible portal for individuals to report fake or misleading AI-generated or other content
- unsubscribing mechanisms to allow users to opt out of unsolicited medical advertising
- takedown requirements mandating platforms remove harmful content within a specified period after a complaint is lodged
- enforcement powers, including the ability to issue infringement notices for non-compliance.

This is not a problem we can ignore or leave to tech companies to solve on their own. We need strong, enforceable regulations that keep pace with the technology. We need accountability from platforms that profit from engagement irrespective of truth. And we need public awareness so Australians can better recognise and report harmful content when they see it.

The AMA will continue to advocate for a digital environment where innovation serves the public good – not deception. It's time for government, industry, and the community to come together and draw a clear line: health misinformation – including when powered by AI – has no place online.

Harper Bernays Charitable Trust

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- **Capital gains resulting from the investments are tax free**
- **Structured giving without the burden and cost of administration**
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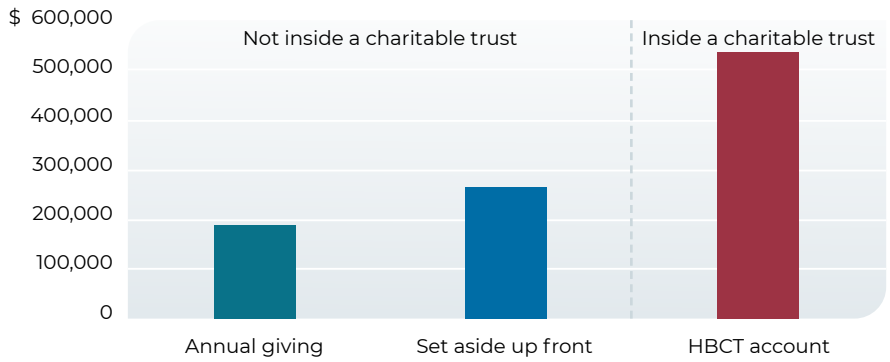

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WAKELIN PROPERTY ADVISORY PARTNER

What separates investment-grade suburbs from the rest

After several muted years, Melbourne's property market is showing renewed signs of life – and investors are beginning to take notice. With interest from both local and interstate buyers picking up, competition is intensifying this spring selling season.

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Click here to listen to Jarrod's podcast

Register for more insights into the property market

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For those looking to make a smart move, understanding what makes a strong investment property is key.

Below, we break down the core attributes of high-performing suburbs – and the features that help drive long-term capital growth and rental demand.

3 capital growth drivers

Strong underlying **land value** is a shared characteristic of great investment locations. Land is always a premium in top performing investment areas – it's hard to come by, and certainly not easily accessible.

Scarcity value is also a major driver. A scarce property is generally a property type that's fairly common within its area. For example, a period terrace house in Carlton is well recognised, highly sought after and finite in existence.

The third aspect is **multifaceted demand**. These are properties and locations that are attractive to more than just one buyer profile, which can include families, downsizers, upsizers, investors and renters alike. The competition between these buyers ensures strong demand and prices.

Infrastructure and services

Proximity to **public transportation** is a big factor. Whether it be commuting to work, travelling to entertainment events, or journeying to school – being close to trains, trams and buses is always desirable.

Access to **quality education facilities** is also a major driver, encompassing both primary and secondary, as well as private and public school options.

Public open space is another characteristic that's highly sought after. There's a reason Victorian license plates for many years were labeled with the 'Garden State' slogan. We love our open spaces, whether it be parks, ovals, beaches or rivers. This was reiterated and amplified during the pandemic lockdowns.

A nearby village that offers a local community feel is highly sought after. This has become increasingly so in recent times, as old shopping strips that became rundown in the 80s and 90s are rejuvenated by the cafe culture developing throughout the suburbs. Some great examples are Rathdowne Village in North Carlton, Burke Road in Camberwell and Ormond Road in Elwood.

Employment opportunities are also a factor. Infrastructure that provides large numbers of jobs, such as hospitals, is an attractive proposition. It definitely creates strong demand from a tenancy point of view.

Specific **suburb draw cards** make a big difference too. In the Bayside suburbs, the beach provides a big pull for many buyers. While in the inner northern suburbs like Fitzroy and Collingwood, the pub culture is very popular.

Consistent housing style

It doesn't have to be Victorian or Edwardian, but a consistent or a very specific style or housing type, can be a major attraction for buyers.

That may well be period in style, but it can also be more recent, such as the converted warehouse apartments in suburbs like Collingwood and Fitzroy.

Moving into the suburbs; areas like Reservoir are well appreciated for mid-century architecture houses, while Bayside suburbs like Elwood are known for their good sized mid-century and art deco apartments.

Proximity to CBD

This has likely eased somewhat since the pandemic, with remote work making office commutes less routine. Still, it remains a major factor for many who continue to head in – even if only two or three days a week.

Proximity to the CBD also brings with it great lifestyle benefits, whether it be the arts precinct, sport and entertainment, or restaurants and nightlife.

Overall, it helps underpin strong renter and homebuyer demand alike.

Take home message

Remember, not every property will score a 10 out of 10 on all fronts. However, hitting as many targets as possible will ensure multifaceted demand from both buyers and renters alike.

Thus, driving strong capital growth and rental income, for wealth creation now and into the years to come.

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AMA Victoria

AMA Victoria President Dr Simon Judkins (R) and Vice President Dr Geoffrey Toogood (L) met with Health Minister Mary-Anne Thomas MP for a wide-ranging and constructive discussion.

The meeting was primarily focused on the mental health and wellbeing of doctors. We highlighted the new Work Health and Safety obligations that come into effect from 1 December, and discussed how these can serve as one lever to improve culture and safety across health services. Other levers include ensuring appropriate resourcing so doctors are not left working unsafe hours or in chronically understaffed environments, and reducing administrative burden through our Getting Rid of Stupid Stuff campaign.

We also discussed challenges facing particular health services, where doctors have voiced serious concerns around culture, consultation and resourcing. In addition, we spoke about workplace safety in emergency departments - where violence and weapons have become a daily reality for staff, and where the absence of a consistent statewide security framework leaves doctors and nurses exposed. The Minister acknowledged the seriousness of the matters and indicated that further progress is expected to follow.

We thank the Minister for her constructive engagement and look forward to continuing to work together on these issues in the months ahead.

↪ **Jillian Tomlinson**
Great to see

↪ **Tom L.**
Brilliant Geoffrey Toogood

↪ **Dr Daniel Garcia**
Thank you and keep up the good work Simon and Geoff.

↪ **Annelise Staples**
Great work

Jillian Tomlinson
Immediate Past President, AMA Victoria I was delighted to attend the Australian Medical Association (Victoria) Fellows Dinner at the Windsor Hotel.

It was a privilege to be in the company of so many leaders who have shaped and continue to shape our profession – including multiple past AMA Victoria and AMA Federal Presidents, current AMA Victoria President Simon Judkins, Vice President Geoffrey Toogood, and AMA Vice President Julian Rait.

The evening was a true reflection of what makes AMA Victoria strong: camaraderie, passion, unity and enthusiasm. These values continue to underpin everything we do as we advocate for doctors and patients across the state.

It was also a wonderful opportunity to share ideas on the current and future state of health in Victoria and beyond – conversations that inspire and remind me why this work matters.

↪ **Simon Judkins**
President AMA Victoria
Agree....excellent evening recognising the enormous contributions many have made to AMA, our health systems and providing health care to the Victorian community (and, in many cases, beyond..). In the next few weeks, I'm meeting with Victorian DiTs to gain the perspectives and ideas...and hopefully engage a new group of healthcare leaders who will help shape our future!

↪ **Lorraine Baker**
Thanks Jill for your continuing engagement in health advocacy and sharing your own insights as well as others. It was a wonderful opportunity to collectively hear (thanks Tony and Mukesh for facilitating an impromptu "round table") the wisdom of others from past experience of the medico-political system from the 1960's to today and comprehend at some level the extraordinary shifts in health care systems and the positive and negative effects of the changes to Medicare, private health insurance, medical training, technology and their impact on health outcomes.

As well - enjoying moving around between courses to share experiences from our personal lives, demonstrating that career engagement and advocacy do not preclude the enjoyment of life with family and friends.

↪ **Harry Hemley, AM**
Great evening
Stimulating discussion
Thanks to all

↪ **Geoffrey Toogood**
Vice President AMA Victoria Fabulous evening with such a wealth of knowledge and experienced group of people.

↪ **Veronica Sparagis**
What an honour this experience would have been for you, and a privilege to hear from such great leaders and advocates

Take home message

AMA Victoria's leadership educator and coach Dr Anna Clark (PhD) and Director of Professional Development and Careers Mardi O'Keefe presented the session 'Psychological safety – Not just a buzzword' as part of the #AMA25 National Conference in Adelaide

The session covered how psychological safety contributes to team collaboration and outlined practical skills and behaviours for creating psychological safety in your teams and workplaces.

Thank you to all who attended, we hope you found the session useful and thought-provoking.

AMA Victoria

AMA Victoria and ASMOF Victoria met with the state government and hospital representatives to present the log of claims for the new enterprise agreement for Victoria's public hospital doctors.

Backed by the voices of AMA Victoria and ASMOF Victoria members and months of preparation, we're bringing a clear message: it's time for fair pay, safe hours and a system that works for doctors and patients. Let's get to work.

AMA Victoria

In June, Dr Simon Judkins had his first meeting with Victorian Health Minister Mary-Anne Thomas as AMAV President, with a wide-ranging discussion on regional health pressures, access block, workforce challenges and broader system reform. They touched on issues such as regional staffing, strengthening digital infrastructure, and the importance of primary care. The wellbeing of doctors in training, including job security and better support, was also a key focus.

A positive first conversation on a range of challenges facing the health system.

AMA Victoria

Congratulations to the outstanding women inducted to the Victorian Honour Roll of Women for 2025.

Among the 24 new inductees are AMA Victoria members Professor Kelly-Anne Phillips and Dr Linny Kimly Phuong. Kelly-Anne and Linny have been awarded the title of 'Change Agents' for their outstanding achievements and contributions to the community.

Professor Kelly-Anne Phillips was the first woman to become a Professor of Oncology in Victoria. Her research and advocacy have influenced international health policy, shaped clinical care in breast cancer prevention and treatment and reduced the burden of breast cancer for women and their families.

Dr Linny Kimly Phuong is a respected paediatric infectious diseases physician, researcher, public health communicator and community advocate. In 2011, Linny founded The Water Well Project, a volunteer-led charity providing free, culturally tailored health education to communities from migrant, refugee and asylum seeker backgrounds, reaching more than 30,000 people.

Linny is also the host of AMA Victoria's The Doctors' Room podcast - The Leadership Series. In this series, special guests Prof Rob Moodie, Dr Rangi De Silva, Dr Stephen Warrillow, A/Prof Kerryn Ireland-Jenkin, Dr Georgia Behrens and Dr Robyn Silcock discuss a range of themes including introversion, vulnerability, finding your purpose, empowering women and carrying t he mental load.

Listen now on Spotify: https://open.spotify.com/
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AMA Media

@BoultonMaria, @walabheart and Dr Lorraine Baker have been admitted to the AMA Roll of Fellows in recognition of their exceptional contributions to the medical profession. @ama_qld @AMA_ACT @amavictoria

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KENNEDYS LAW PARTNER

A caution for medical experts

BY ANJALI WOODFORD (PARTNER) AND
HAMISH MCDOWELL (LAW GRADUATE)

"

An expert plays a crucial role, ensuring that reasonable standards are met, helping identify errors and defending good patient care.

Although there are perceived financial incentives, being a medico-legal expert comes with other sacrifices, namely time away from work and other personal interests. An expert plays a crucial role, ensuring that reasonable standards are met, helping identify errors and defending good patient care. In doing so, experts need to be impartial, rigorous and ensure their opinion is grounded in current practices.

The recent NSW case of *Busa*[1] emphasises the key role of medical experts in helping Courts to reach fair and evidence-based decisions, as well as the importance of engaging well-known and reliable experts who are likely to give well-reasoned and balanced opinions.

Background facts

The patient underwent a 'tap and inject' procedure on his left eye at Sydney Eye Hospital in 2015, for suspected endophthalmitis. He alleged excessive needle taps (up to eight times) by the registrar and a failure to properly document the procedure. The patient suffered vision loss in his left eye, ongoing pain and psychiatric injury.

Findings

The doctor gave evidence that he performed no more than three taps in line with training and usual practice, there were no medical records of the procedure and other medical records demonstrated that no structural trauma occurred due to the procedure.

The plaintiff relied upon the expert evidence of Italian ophthalmologist, Dr Pietro Morelli, whilst the defendant engaged vitreoretinal specialist, Dr Gurmit Uppal, and general ophthalmic surgeon, Dr Geoffrey Cohn. The Court found no breach of duty and held that the doctor did not perform more than three taps, favouring his reasoning over the account of the plaintiff and his sister, and that the procedure was carried out in a manner that was widely accepted in Australia as competent professional practice.

Even if breach had been established, the Court held that the patient would have failed to establish causation. Namely, vision loss was inevitable due to the severity of the patient's pre-existing eye condition (advanced retinopathy and infection) at the time of the procedure.

The Court gave limited weight to Dr Morelli's evidence for the following reasons:

(a) The Expert Witness Code was not acknowledged until Dr Morelli's fourth report;

(b) Dr Morelli failed to set out the assumptions, material facts and documents which he had relied on when preparing his report[2];

(c) Dr Morelli changed his opinion on whether the plaintiff suffered from endophthalmitis, without identifying what documents he relied on to change his opinion; and crucially

(d) Dr Morelli had never practised as an ophthalmic surgeon in Australia, and therefore did not possess the necessary qualifications to opine on professional practice standards in Australia.

Key takeaways

The case of Busa highlights the importance of engaging experts that can comment on the standard of care expected in Australia, particularly in circumstances where there is a paucity of clinical records. Further, the case demonstrates the indispensable contributions medical experts can make in assisting Courts to deliver just outcomes.

[1] *Busa v South Eastern Sydney Local Health District Trading as Sydney Eye Hospital (No. 2)* [2025] NSWSC 130

[2] *Busa v South Eastern Sydney Local Health District Trading as Sydney Eye Hospital (No 2)* [2025] NSWSC 130 [177].

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