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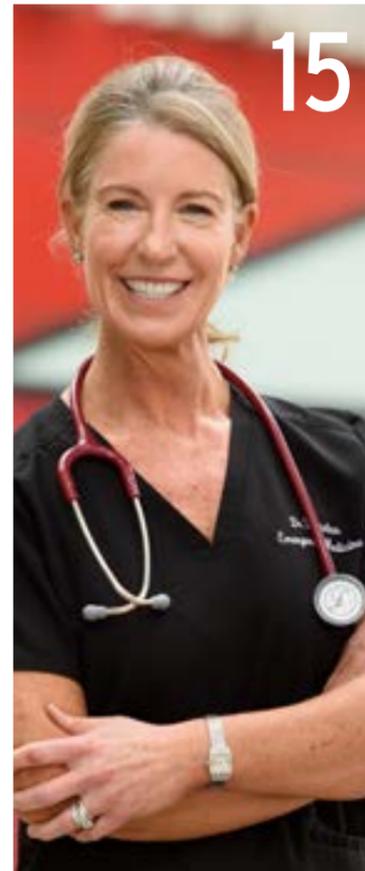
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## NEWS + REVIEWS

VICDOC + C

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AMA Victoria president DR Jill Tomlinson spoke to ABC Morning's about the need for the Victorian Government to return to the negotiating table over unpaid overtime for doctors in training.

[+](#) *Click here to read*

AMA Victoria's Dr Jill Tomlinson calls for greater government transparency on patient deaths following revelations dozens of Victorian babies died after failings and missed opportunities in their mothers' care.

[+](#) *Click here to read*

This is Dr Kim Hansen, the Chair of the AMA Queensland Ramping Roundtable, remaining unflappable even when a magpie photobombs a live interview.

[+](#) *Click here to watch*

Dr Sarah Whitelaw, AMA Victoria Councillor speaks to The Age about measures to improve e-scooter safety.

[+](#) *Click here to read*

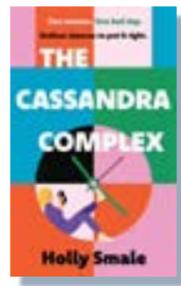
IN REVIEW: READ | LISTEN | RESEARCH



**WILD THINGS**

*Nonfiction by Sally Rippin (2022)*

As Australia’s highest selling female author, Sally Rippin can be trusted to spin a good yarn. And while most of her more than 100 books are fiction for children and young adults, this one, *Wild Things*, is all fact. Intended for parents, it explores how we learn to read and what can happen if we can’t. Rippin speaks from a very personal position: her own experience as “a parent who did everything the wrong way” with her son, Sam, who was diagnosed with dyslexia and ADHD at a relatively late age. Rippin blends insights from education, medical, learning and disability experts with her own observations and anecdotes to deepen her understanding of her son’s experience, and how the Australian education system does (and doesn’t) support kids who learn differently.



**THE CASSANDRA COMPLEX**

*Fiction by Holly Smale (2023)*

Fiction with neurodiverse main characters can offer insights into the internal world and experiences of people living with diagnoses such as autism. In Holly Smale’s touching book, *The Cassandra Complex*, the main character, Cassandra, is autistic, and discovers she can time travel. With endless opportunities to go back in time to correct situations where she has misinterpreted people, missed social cues, or said the wrong thing, surely she can save her job, friendships, and romantic life – right? But fitting her ‘circular’ self into a ‘square box world’ proves a huge challenge, and in Cassandra’s quest to do everything right, life becomes even more confusing. Cassandra is forced to confront some big questions about what it means to see and experience the world differently, how to be okay with being yourself, and ultimately how to bravely forge your own path.



**WOMANICA**

*Podcast hosted by Jenny Kaplan (2023)*

If you’re after a daily hit of womanly inspiration, then look no further than this fabulous podcast. Each weekday *Womanica* offers up a brisk and informative five-minute biography of a woman from history. It’s hosted by Jenny Kaplan, co-founder of Wonder Media Network and a former award-winning journalist recognised in Forbes’ 30 Under 30 in Media list for 2022, it’s well worth a listen. Some noteworthy examples are Charlotta Bass, the first Black woman to run for vice president of the United States, Dr Chris Longman the first known Chinese-American woman to become a doctor, and Burmese politician, diplomat, author, and Nobel Peace Prize laureate Aung San Suu Kyi. The only downside is that most of the women it covers are American, though there are a few exceptions.

Reviews by: Vanessa Murray and Taryn Sheehy

IN REVIEW: READ | LISTEN | RESEARCH



**L**a Trobe University researchers have identified a protein that is integral to gut health, providing an important lead in the search for a treatment for people with Inflammatory Bowel Disease (IBD).

Research published in *Communications Biology*, shows for the first time that in mice, the removal of the protein BECLIN1 causes a condition with similarities to IBD.

The study shows that removing BECLIN1 causes problems in the internal “trafficking” pathways of the epithelial cells which line the intestine, leading to a disruption of the protective barrier the cells create.

This disruption can allow bacteria to enter the intestinal wall, which in turn causes the extensive inflammation associated with IBD.

The research opens new possibilities for investigation into new treatment avenues for the disease, which currently affects more than 100,000 people in Australia alone.

Lead researchers Associate Professor Erinna Lee and Associate Professor Doug Fairlie, from the La Trobe Institute for Molecular Science (LIMS) and the Olivia Newton-John Cancer Research Institute (ONJCRI), said this is the first time BECLIN1 has been implicated as a potential factor in IBD, which includes conditions such as Crohn’s Disease and Ulcerative Colitis.

This research also demonstrates the essential role BECLIN1 plays in endocytic trafficking.

“This was unexpected, as BECLIN1 is best known for its involvement in another cellular process called autophagy that does have a known and strong connection with IBD,” Associate Professor Fairlie said.

Endocytic trafficking ensures proper functioning by moving the cell’s internal elements, known as “cargo”, to the right place at the right time.

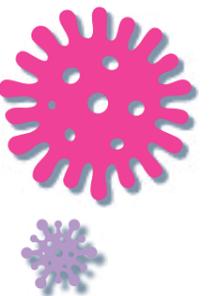
In this study, another protein called E-CADHERIN, was identified as being an important cargo that relies on BECLIN1 for its correct localisation within the cell.

“This makes sense because E-CADHERIN is essential for enabling epithelial cells to stick together. If E-CADHERIN is not located correctly within the cell, then the epithelial barrier lining the gut breaks down and bacteria can penetrate the intestinal tissue, leading to a potent inflammatory response,” Associate Professor Fairlie said.

Current treatments for IBD are only able to address the disease’s symptoms by reducing inflammation and treating infection, but this study could open the way for the development new treatment options.

This research was done in collaboration with scientists from the University of Melbourne, the University of Queensland, the Garvan Institute of Medical Research, and the UK-based Francis Crick Institute and the Institute for Liver and Digestive Health. For further info email:

[S.Smethurst@latrobe.edu.au](mailto:S.Smethurst@latrobe.edu.au)





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INTRODUCING DR DESIREE YAP

We are thrilled  
to welcome  
Dr Desiree Yap AM  
to the AMAV Board

**MEET OUR NEWEST  
AMAV BOARD  
MEMBER**

INTERVIEW VANESSA MURRAY

## ADVOCACY + CULTURAL CHANGE

**Desiree is a Specialist Gynaecologist with demonstrated commitment to advocacy and cultural change with extensive Board experience. She is a past Board member and Chair for Women's Health Victoria, as well as a Past President of Victorian Medical Women's Society, the Australian Federation of Medical Women and is currently on the Board of Pelvic Pain Victoria. She completed a three-year term as Vice President of the Medical Women's International Association Western Pacific Region (July 2019-22) serves on the Council of AMA Victoria and has served on the State Committee of RANZCOG. Desiree has a Master in Public Health and Tropical Medicine. In 2020 she was appointed Member of the Order of Australia for significant service to women's health and medicine. Desiree is a recent graduate of the Australian Institute of Company Directors and is on the Steering Committee of the Australian Women's Health Leadership Project. Here are the takeaways from our recent conversation.**



**DR  
DESIREE  
YAP**

**SPECIALIST  
GYNAECOLOGIST**

## ON GOVERNANCE AND ACCOUNTABILITY

“Governance means different things to different people – I think of it as the system by which an organisation is controlled and operates, and the mechanisms by which it, and its people, are held to account. I am interested in membership-based organisations and advocacy and want to ensure an organisation is run in the best interests of its membership. In terms of AMAV, I would like to help work out how to best address the issues I know many members, including myself, are concerned about, and ensure the AMA is an organisation non-members decide is worth joining and belonging to. A happy, engaged, large membership increases the voice of an organisation and strengthens its advocacy and policy influence.

## ON LEADERSHIP AND INFLUENCE

“My major leadership goals are to constructively apply myself in places where I can contribute to meaningful change and improvement for our patients and my colleagues. Advocacy for women’s health services, medical students and doctors of all ages and stages, and optimising health systems is important to me. There is a need to balance available resources and optimise systems on the grounds of good evidence. This achieves better care for patients, and more personally and professionally satisfying for healthcare providers. Equipping doctors to constructively upwardly manage their workplaces and building the capacity of advocacy bodies such as the AMA and other medical organisations are other priorities.

## ON WOMEN'S HEALTH AS AN ECONOMIC DRIVER

“It is a fundamental principle of public health that the healthier your population is the more productive your population is. We all gain from this – women as well as men. One thing to consider in discussions of women’s health as an economic driver is on women’s paid work, not their unpaid work. Unpaid work comprises labour like unpaid household work, childcare, shopping, and volunteer and community work. Women and girls work incredibly hard to care for others. Often this unpaid work isn’t seen as real work at all. But it is work. We know that women coming into paid work is great for the economy, but it begs the question, who’s going to do the unpaid work? Researchers have estimated that if we put a price on unpaid care work, it would be worth nearly US\$11 trillion a year.

## ON PATRIARCHAL POWER STRUCTURES

“The word ‘patriarchy’ is so loaded, isn’t it? A lot of people are immediately triggered by that word – often in vastly different ways. Patriarchy simply describes a system of power structures that favour men. There is a notion that women need to speak up and do all the work to improve their lot. However, if the world changes for women, it inherently changes for men. Imagine a hall full of people where the seats are ranked from the stage backwards. Premium at the front, then standard, and the cheapest seats are the ones behind the pillars. Now, if you want to get to the front of the hall but it’s full, then somebody at the front has to give up their seat and move back. And if you want to get up on the stage, someone is going to have to get off. It doesn’t matter how much women lean in, if men won’t give up their better seats, or the seat allocation system isn’t made fairer, then there is no change. Not surprisingly, most people with good seats want to keep them. They’ve got a lovely seat – why would they give it up?



*A happy, engaged, large membership increases the voice of an organisation and strengthens its advocacy and policy influence.*

## ON CULTURAL BIASES AND CHANGE

“Organisations, systems and political priorities need to recognise and be explicit about their own cultural biases and agendas. After all, a male dominated society is just a type of culture – and culture dictates power structures. Recognising unconscious biases and implementing practices to combat unhelpful biases is critical. Implementing policies and practices to support constructive improvement is required, and resistance to change must be anticipated. Changing the paradigm so those who perceive themselves as the ‘losers’, appreciate that there are wins in change for them too is important. People are often afraid of change, but good leadership helps people embrace change as a positive thing.

## ON INTERNATIONAL WOMEN'S DAY

“In general, it’s women who turn up to International Women’s Day. Why are men not engaged? Given that men have most of the power to change things, having women sitting in an echo chamber saying the same things brings solidarity, but no meaningful change. Over my lifetime, change has been disappointingly slow. We had the pipeline theory debunked as a myth and leaning in has left women feeling like the failure is theirs. For me now, there is something about the way International Women’s Day continues to be pitched that still implicitly other women. We also implicitly other ourselves. We don’t want systems to support women; we want to have transparent unbiased mechanisms that support justice, fairness and equity for all. Despite some progress, and despite how some people feel, the evidence demonstrates that cisgendered white men are still the primary beneficiaries of our healthcare system.



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DR SARAH WHITELAW

## ADVANCING WOMEN IN LEADERSHIP

The Federal AMA is one of five lead partners on the Advancing Women in Healthcare Leadership (AWHL) project.

BY VANESSA MURRAY



Learn more about the Advancing Women in Healthcare Leadership project



Learn more about the Advancing Women in Healthcare Leadership Program

WOMEN MAKE UP 75% OF AUSTRALIA'S HEALTHCARE WORKFORCE.



Women make up 75% of Australia's healthcare workforce, but just 45% of medical deans, 45% of public hospital board chairs, 39% of private hospital CEOs and 38% of state and federal chief medical or health officers.

This declining scale of women in healthcare leadership indicates that currently, the Australian healthcare sector is not supporting its workforce to meet its full potential, and that despite considerable effort and table talk, pervasive gender inequity and barriers to advancement remain in Australian healthcare.

To work towards overcoming this, a robust Monash University-led team set about establishing the Advancing Women in Healthcare Leadership (AWHL) national initiative.

The AWHL was first funded by the NHMRC in 2019 with nine partners, and has grown to include 21 professional, medical and nursing colleges, industrial bodies, leading health services, government and academic partners. It is based at the Monash Centre for Health Research and Implementation (MCHRI), with Professor Helena Teede as Chief Investigator.

The Federal AMA is proud to be one of the initiative's 21 partners, and one of five lead partners. AMA Victoria Board Member Dr Desiree Yap AM and Dr Sarah Whitelaw are Steering Committee Members, and Sarah also represents the Federal AMA to AWHL.

"I'm much more aware now of the evidence base for actual improvement in both patient care and quality of care, but also the benefits to organisational performance associated with that increase in diversity, particularly at a leadership level. It's not just morally right, it's not just going to benefit people like me who have similar experiences or similar challenges as they progress through their career; it's important for our patients, our facilities and our communities, in terms of organisational performance and the quality of healthcare being delivered," says Sarah.

Together in co-design with partners, AWHL focuses on generating a knowledge base and delivering multi-faceted organisational and individual level interventions to measurably improve career progression for women in healthcare, to deliver gender equity, and to improve health outcomes.



DR SARAH WHITELAW

EMERGENCY MEDICINE PHYSICIAN

**AWHL'S RESEARCHERS WORK ACROSS FIVE KEY RESEARCH THEMES AND PRIORITIES.**

**1**

**ORGANISATIONAL CHANGE MANAGEMENT**

Working with organisations to design and implement evidence-based interventions to advance women in healthcare leadership.

**2**

**NURSING LEADERSHIP**

Understanding and overcoming barriers unique to the career advancement of women in nursing.

**3**

**COLLECTIVE ACTION WITH MEMBER ORGANISATIONS**

Identifying the role of member organisations in gender equity and women's career advancement in healthcare and working together for change.

**4**

**LEADERSHIP DEVELOPMENT**

Determining the essential components required in leadership development programs for women in healthcare.

**5**

**EXPLORING INTER-SECTIONALITY**

Exploring the intersection of other identities, such as race and ethnicity, because women's experiences are not the same and we need to look beyond gender alone.

**THE WORK IS BEING COMPLETED WITHIN AND COLLECTIVELY ACROSS PARTNER ORGANISATIONS, CAPTURING AND SHARING LEARNING FOR BROAD SCALE-UP AND IMPACT VIA A FOUR-PHASE COPRODUCTION APPROACH.**

**1**

**KNOWLEDGE GENERATION**

Evidence synthesis  
Qualitative research  
Priority setting

**2**

**INTERVENTION DEVELOPMENT**

Working groups  
Development workshops

**3**

**IMPLEMENTATION SUPPORT**

Researcher in residence  
Capacity building program  
Evaluation and impact

**4**

**SCALE UP**

Implementation resources and toolkits  
Policy translation and guidance

“The AWHL concept is about developing an evidence base and running interventions with organisations and seeing what works and what doesn't work,” says Sarah.

“The methods and outcomes are familiar and approachable in that they're quantitative and measurable rather than purely qualitative. That means a lot of AWHL's resources are structured in an evidence-based way. I think when you're communicating with colleagues about why these things are important, being able to draw on and present an evidence base that's like what they would look for and expect to see when considering any other organisational or systematic change is highly relevant – and effective.”

Resources include evidence-based infographics on topics like merit, privilege and inequity organisational change management, and leadership development. There are recordings and podcasts, links to publications by or about AHWL, and links to further useful information and reading. All are available online.

A JAMA Network publication from Mar-23 explores how organisational practices and conditions work together to advance women in healthcare leadership was explored through the experiences of women in leadership roles. The paper identifies four interrelated elements that create the necessary conditions for an organisational culture to advance women in healthcare leadership:

- » Identifying and actively addressing systemic barriers
- » Challenging gendered assumptions and expectations of leadership behaviours
- » Providing mentorship to shape career opportunities
- » Determining how these conditions all contribute toward raising women's credibility to enable internalising a leadership identity.

Another January 2024 publication in The Lancet presents a systematic review and meta-synthesis of barriers to advancing women nurses in healthcare leadership.

**THE KEY BARRIERS HIGHLIGHTED WERE RELATED TO:**

- » Role modelling and leadership development (ability)
- » Multiple complex and interacting factors, including gender stereotyping, perception of professionalism, human relations policies, and gender bias (motivation)
- » Systemic issues, such as organisational setting, structure, and support (opportunity).

The project's approach takes care to recognise that women are not a homogenous group, and that it's important to understand the impact of intersecting social identities on women's journeys to leadership in healthcare.

It also recognises that the meritocracy that underpins advancement and career profession in our current healthcare system (as in many other systems) legitimises and perpetuates privilege and may entrench gender inequity and unfairness. This means that women face bias, greater barriers and overall, less opportunity to lead.

The initiative also includes an embedded national Women in Leadership Program. In 2023 the program enabled 30 women, many in rural areas, to attend Monash's Women in Leadership Program to transform careers and improve the care of our most underserved populations. In 2024 the Program is being offered five times, in in-person and online formats, with a scholarship program offering 15 women the opportunity to attend the program at a heavily discounted rate.



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# WOMEN IN RURAL GENERALISM

Six women GPs working in rural, regional and remote parts of Victoria on professional life away from the city, being part of a regional community, and how rural generalism can be improved.

SERIES VANESSA MURRAY

**DR  
CECILIA  
XIAO**

—  
BSC MBBS MBA  
MSC FRACGP

Originally from Singapore, Cecilia lives in Geelong and is a GP at Ocean Grove (southwest Victoria).

She gained nursing qualifications from the National University of Singapore, before deciding to pursue a career as a doctor in Australia.

Cecilia gained her undergraduate medical degree from the University of Tasmania. She completed the first year of her internship in Hobart then studied in Oxford (UK) for a year before returning to Australia to complete her training. Cecilia is the Co-Deputy Chair of the National GP in Training Faculty and teaches first year clinical medicine one day per week at Deakin University.



**EVEN THOUGH I WENT TO MEDICAL SCHOOL IN AUSTRALIA, I HAVE TO FULFILL THE SAME MORATORIUM AS IMGs.**

As an international medical student graduate from a local medical school, I must fulfil the same moratorium as International Medical Graduates [IMGs] until 2028. This is the main driver for my current focus on rural generalism. I think many international students who study in local medical schools are discouraged to consider GP training because of a perceived lack of support and social networks in rural Australia.

**WHEN I RETURNED TO AUSTRALIA IN LATE 2020 VICTORIA WAS IN LOCKDOWN AND IN NEED OF DOCTORS.**

I had decided on GP training when I completed my studies in Oxford and returned to Melbourne amidst COVID lockdown to work at Eastern Health. Choosing a training region was quite challenging as I was not familiar with Victoria, but I thought Geelong, which is along the Bellarine Peninsula, would fulfil my desire to live near the coast and meet moratorium requirements. I am grateful for the close-knit medical community, great professional network, and many friendships I have forged in the last few years.

**I ALWAYS IMAGINED I'D PURSUE OBSTETRICS AND GYNECOLOGY OR GASTROENTEROLOGY, BUT GENERAL PRACTICE HAS BEEN AN EPIPHANY.**

I enjoyed procedure-based disciplines as a junior doctor, but the excitement soon faded due to exhaustion and trade-off for work life-balance. After speaking to a few GPs, I was impressed with the potential of special interests and procedures that I enjoy while speaking to people, building relationships, and having a little more predictability and routine.

**A REGIONAL OR RURAL GP NEEDS TO BE OPEN-MINDED.**

You've got to be open-minded, curious, and willing to take on an adventure. Don't sweat the small stuff, be flexible and work with limited resources. You never know what to expect and things can change from moment to moment.

**WHERE I'M LOCATED, IN GEELONG AND OCEAN GROVE, THERE IS A HUGE POPULATION BOOM.**

I might be biased, but I think the Bellarine Peninsula is the prettiest part of Victoria. It has a growing population of people looking for a sea change, with lots of young families, retirees and plenty of new buildings and social changes. That said, the inherent challenges that we face in the regional areas do persist. For example, despite having three hospitals in Geelong – two private and one public – there are long wait lists. Where I work in Ocean Grove is half an hour's drive from Geelong, and my patients are looking at wait times up to 24 months for some specialties.

**MY GP TRAINING IN COLAC PREPARED ME TO SURVIVE WORKING ANYWHERE IN AUSTRALIA.**

Unexpectedly, I was called upon to work longer hours than ever before – or since. As a GP registrar in Colac, I was required to work as a GP at a private clinic and provide VMO service to the local hospital. This meant working normal clinic hours between 9 to 5, urgent care after hours, and answering overnight calls from the nursing homes and hospital. All of which fall on the GPs who are on the rotating roster as the hospital was unable to attract general medical and ED specialists to meet the demand. This is not uncommon in many rural areas in Australia, but it also means working as a GP in such areas requires extended skill sets and commitment.



*I am grateful for the close-knit medical community, great professional network, and many friendships I have forged in the last few years.*

**IF YOU'RE SINGLE, THE PERSONAL SIDE OF LIFE AS A RURAL OR REGIONAL GP CAN BE CHALLENGING.**

This is especially so if you're in your thirties and want to have a family one day. While it is challenging for doctors to uproot their family to go rural, it is just as difficult to find a partner if you are single. Rural training and work are exciting and rewarding, but often take more than a few years of commitment. So, if you haven't sorted out your family plans or your love life, you've got to take that into consideration. If you're considering cryo-preservation – egg or embryo freezing – there are only two IVF units here in Geelong, whereas there are at least a dozen in Melbourne, so it might be worthwhile to plan ahead. I think it's helpful to consider not just the regional move itself, but what is it in life that is set out for you there.



A portrait of Dr. Christie Rodda, a woman with short dark hair, wearing a teal top and a watch, standing outdoors in front of a building. The background is slightly blurred, showing a street scene with a white car and a building with a balcony.

**DR  
CHRISTIE  
RODDA**

MBBS(HONS) DRANZCOG FRACGP

**Christie is a General Practitioner at Beechworth Surgery in Beechworth (northeast Victoria), and Chair of the RACGP Doctors for Women in Rural Medicine Committee. Christie gained her undergraduate medical degree at Monash University in 2005. She completed her GP training in 2014 and has been in a group practice in Beechworth part time since 2010. She also spends one day a week working in the emergency department at Wangaratta Hospital and has a seat on the Rural Faculty of the RACGP. Her husband is a local winemaker, and she has three children aged 14, 12, and 11.**

**RURAL GENERALISM OFFERS AN INCREDIBLY BROAD SCOPE OF PRACTICE.**

I loved everything I came across when I was studying medicine, from paediatrics and obstetrics to general medicine and surgery. The ability to practice all of that as a rural GP really appealed to me. As an intern, I had the most amazing ‘make you or break you’ rotation at Bairnsdale Hospital. Back then, one intern ran the hospital overnight. This included the ED and all the wards with two GPs backing you up over the phone if needed. Seeing those old school country GPs doing everything from delivering the babies to the anaesthetic to the ED, and then back in their rooms seeing patients the next day was incredibly inspiring. After that rotation, I was set on going to go down the rural general practice pathway.

**MY ROLE AS CHAIR OF THE RACGP DOCTORS FOR WOMEN IN RURAL MEDICINE COMMITTEE ENABLES ME TO GIVE BACK TO THE PROFESSION.**

The Committee is a very targeted and effective for me to help support our profession, to show younger women doctors just how rewarding rural general practice is and help them navigate a rural GP career. I'm passionate about strengthening the profile of general practice and generalism and of course the benefits and joys of being a female rural GP, as well as tackling and overcoming some of the challenges that can go with that.

**MY PERSONAL EXPERIENCE IS ONE OF FEMALE-LED GENERAL PRACTICE.**

In my 14 years here at the practice, we've had more women in leadership, education and supervisory roles. I've been trained by women, supervised by women, and mentored by women. I have had and continue to have some fantastic male mentors and colleagues, but overall, I've had more women guide me than men. In our group practice we're getting closer to a 50-50 split, but in recent times we've had more female GPs.

**THERE ARE CHALLENGES FOR WOMEN ACROSS ALL SECTORS OF THE MEDICAL PROFESSION.**

I experienced sexism in my early years in a hospital environment, but I've been fortunate that I've not experienced it directly in my practice from colleagues or supervisors. It remains a huge issue in medicine though. Systemic structures and policies such as part time training, on call arrangements and parental leave entitlements are issues frequently highlighted in discussions amongst my rural female colleagues. Lack of access to childcare is a huge problem across the board, but it's amplified in rural areas where we have even less access to childcare and sometimes also the difficulty of being away from family supports. Women still shoulder the bulk of the burden of care for children, older parents and family members with disability, so that is a significant concern.



*I loved everything I came across when I was studying medicine, from paediatrics and obstetrics to general medicine and surgery. The ability to practice all of that as a rural GP really appealed to me*

**THE DATA TELLS US THAT FEMALE DOCTORS ARE MUCH MORE LIKELY TO HAVE A PROFESSIONAL PARTNER THAN MALE DOCTORS, WHICH CAN DEMAND COMPROMISE.**

Although that statistic is probably changing with time, it can mean a lot of juggling when there are two careers to think about. As an example, when you've got a partner in a role or profession that is geographically limited or limiting, you must factor that in to how you negotiate working in a rural environment. I experienced that, as my partner is a winemaker. I would have loved to work in the Northern Territory, but there's not much need for winemakers there! So that put limitations on where we, as partnership, were able to work.

**WE KNOW THAT IN THE FUTURE, WOMEN WILL MAKE UP A SIGNIFICANTLY LARGER PROPORTION OF AUSTRALIA'S GP WORKFORCE THAN MEN.**

The RACGP's 2022 General Practice Health of the Nation report shows that the number of women GPs in training has surpassed men, at 58% of women compared to 39% of men. This highlights Australia's progress towards gender equality, but there's more work to do. One of our key concerns is that women GPs tend to spend longer with their patients, because they see more people with complex needs. But Medicare pays less per minute for longer consultations, meaning women GPs and their patients are being unfairly penalised. This needs to change. It's time for the government to invest in Medicare patient rebates for longer consultations because this trend is not going away.





**DR  
BEC  
LOVERIDGE**

BCOMM MD

**Rebecca (Bec) has been a GP Registrar at Dhauwurd-Wurrung Elderly and Community Health Service Inc, an Aboriginal medical service, in Portland (southwest Victoria), since January 2022. Rebecca is the newly elected Chair of the RACGP's GPs in Training Faculty, a rural GP trainee under the Remote Vocational Training Scheme (RVTS), the RACGP's RVTS Representative – GPs in Training Faculty, Registrar Liaison Officer with the RVTS and the GP Registrar Representative – GP Advisory Group with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).**



**PORTLAND HAS A LARGE FIRST NATIONS POPULATION.**

In Portland there's a large population, but not enough GPs. Where I work, we see non-Indigenous patients as well as Indigenous patients, but our priority is to service First Nations patients. There are limited universal bulk billing services in town, which means there's a high demand for our services. Some days I'm the only doctor in the clinic, so I've got to be ready for anything.

**IN MY EXPERIENCE, IT CAN TAKE LONGER TO BUILD TRUST WITH FIRST NATIONS PATIENTS.**

Patients might come and see me about an earache or something that's causing them a lot of immediate grief; something they need fixed right now. But when it comes to longer term problems or more sensitive problems or things that can cause shame, it takes longer for that to come out. It's partly because they're waiting for the right time, but it's also because they need to accept me as a trusted person to be brought into that extra inner circle.

**IN FIRST NATIONS COMMUNITIES, THERE ARE CONCEPTS OF 'WOMEN'S BUSINESS' AND 'MEN'S BUSINESS'.**

As a female doctor, I can tell you a lot more about women's business than about men's business! That's because culturally, women patients are generally most comfortable discussing their 'women's business' with a female doctor. Women's business includes things like cervical screening tests, breast screening, child rearing, menstruation, and menopause. The extra layer of the general GP workforce shortage means that if there's no female doctor, those issues might not get addressed. For the five years before myself and another woman doctor joined this clinic, there was usually only a male doctor in the clinic.

**FROM A COST PERSPECTIVE, THE WORK GPs DO IS INCREDIBLY VALUABLE; WE ARE THE MOST COST-EFFICIENT PART OF THE HEALTHCARE SYSTEM.**

GPs touch the most patients – both literally and figuratively! We do our utmost to keep people out of hospital, that's our job. But the government is grossly underfunding primary care. There are good initiatives for providing care to First Nations people; without those initiatives, services like mine wouldn't be able to exist. But in rural areas more generally, the severity of people's healthcare needs and the lack of doctors and other healthcare workers is a big problem. Money isn't everything, but more funding would really help to improve things. To attract someone out of a metro area to a place like Portland, for the same amount of money and more work, that's a hard sell, isn't it?

**I GREW UP IN THORNBURY, MELBOURNE, BUT I'VE ALWAYS BEEN INTERESTED IN RURAL WORK.**

I come at it from an equity of access perspective. In general, with Aboriginal and Torres Strait Islander patients, it's the same healthcare issues as in the non-Indigenous population, only amplified. We often see earlier onset of illness, and more severe illness. It's extremely important that health services in rural and regional areas like the one I work in exist, and that there's enough staff to see people when they need to be seen. That's an ongoing challenge.

*As a female doctor, I can tell you a lot more about women's business than about men's business! That's because culturally, women patients are generally most comfortable discussing their 'women's business' with a female doctor.*



**RURAL WORK HAS BEEN CHALLENGING FOR MY FAMILY.**

My husband and I moved here together but he has had to return to Melbourne. It wasn't working out for him to work remotely, and he couldn't find work in his field here in Portland. He doesn't work in healthcare and there just weren't any opportunities here that were a good fit. So now he works full-time in Melbourne and comes here for one week out of every month. I really like working in community, but I'm not sure how sustainable that's going to be for us.

**ONE OF THE BIGGEST AREAS THAT WE'RE WORKING TOWARDS AT THE GPs IN TRAINING FACULTY IS HAVING PAID PARENTAL LEAVE INCLUDED IN OUR TRAINING PROGRAM.**

Right now, it isn't and obviously that affects both men and women, but it affects women more. Without paid leave, registrars might delay starting a family until they're done training. And what if, when the time comes, they can't get pregnant because of their age? That's a real risk, and it's discouraging people from leaving the hospital system to start GP training – because hospital doctors get paid parental leave. As Chair I sit on the RACGP Board, so it's a voice for the Faculty right at the top – advocating for GPs in training, medical students and junior doctors considering being a GP.



**DR  
BRITTANY  
BUTTON**

MBBS BA BBIOMEDSC  
CDCH GCHH

**Brittany (Britt) is a GP-registrar-in-training at Active Health in Portland (southwest Victoria). A dual trainee with ACRRM and RACGP, and an affiliate lecturer with the Deakin University Rural Community Clinical School, Britt has special interests in palliative care and medical education. Britt graduated from Deakin University MBBS in 2019 after completing placements in the Barwon South West region. Britt lives in Portland with her partner and (nearly) two-year-old son and works part-time.**

**I WAS VERY INTERESTED IN DOING MEDICINE IN THE PLACES WHERE THERE IS A NEED FOR ME.**

I was relatively unwell as a teenager with a chronic illness, and my interactions with the health system solidified my desire to get involved. And then, I've always had a real interest in doing good in the world in places where people might necessarily go. I started medical school with the assumption that I was going to be a specialist, general practice and rural health were not on my radar. However, I became aware that it was a part of medicine that had a workforce shortage. My first clinical placement was at a rural community clinical school here in Portland. I did a complete 180 on general practice and rural generalism, and fell in love with the town, the people at my clinic and what rural generalist GP work can really do. It's absolutely my happy place and the work I do really matters here.

**I ENJOY THE CONTINUITY OF CARE THAT RURAL GENERALISM AND RURAL GENERAL PRACTICE ALLOWS.**

In urban medicine, people are complaining that it's the end of the GP era and that you don't have a GP for life anymore, but rurally, we still have a lot more hold on that experience of cradle to grave care. Of course, being in a small town can present other challenges in this setting. With my patients I call it 'the filing cabinet'; I might be seeing the grandmother, the mother, and the daughter, and I'll know things about the daughter that the daughter might not have told me yet because the grandmother has told me, and so on. With that there's capacity to get beyond the surface level of the problems that people are facing in life. There's a lot more opportunity to change things.

**I HAVE SON, VINCENT WHO IS ALMOST TWO. BEING HIS MUM IS THE MOST IMPORTANT ROLE IN MY LIFE.**

I feel very supported by my supervisors, my clinic and even my patients to be a mum first. I usually start off talking about Vincent in my new patient consults; I'll tell them about Vincent and say, "I work part-time, and I will be the best doctor I can be for you when I'm here. But you need to be comfortable seeing other people because if Vincent's sick or you can't get in with me because I'm booked out; Vincent comes first. If you're looking for someone who's going to be free every single time you need to see a GP every time, then I'm not going to be the right GP for you. We need to find you someone who works full time and doesn't have children." I tell my patients that I'm proud and thrilled to be the number one doctor in their life, but I can't be the only doctor in their life. And people get that.

**NEITHER GP REGISTRARS NOR CONSULTANT GPs ARE OFFERED PAID MATERNITY LEAVE.**

And that's interesting given that being a registrar is still technically a salaried position, and the lack of paid parental leave is in contrast with what equivalent doctors of the same training would be getting in the hospital. This is a real barrier for many female doctors considering general practice training. They might have an interest in general practice, but I've certainly got lots and lots of colleagues and friends who've decided to stay in the hospital system for their baby making years because financially as female doctors, we're often now the breadwinners of their family while also being a primary carers. It is a constant juggle and the lack of paid parental leave for GPs is placing a sad and unnecessary barrier to people choosing to pursue general practice.



*My first clinical placement was at a rural community clinical school here in Portland. I did a complete 180 on general practice and rural generalism, and fell in love with the town, the people at my clinic and what rural generalist GP work can really do. It's absolutely my happy place and the work I do really matters here.*

**I TEACH FOR THE MEDICAL SCHOOL THAT I WAS ONCE A PART OF; IT'S PHENOMENALLY REWARDING.**

I enjoy teaching, but in addition I'm future proofing myself and my own clinical care too, because I'm confident I've got at least two doctors coming up through the ranks who I taught, and who I trust completely. Even though there had been a small community medical school here for about 10 years prior to my arrival, I was the first student to stay and make a life in the community. Since I made the decision to stay and join the teaching program, there's been a groundswell of people staying. So much of building a pipeline of doctors to your communities is getting that first person – students need to see it to want to be it.

**VICTORIAN SINGLE EMPLOYER MODEL TRIAL**

Victoria is commencing the design of a Single Employer Model (SEM) trial for rural generalist registrars. The SEM, which is designed to remove immediate economic barriers and enhance training conditions (including parental leave entitlements) for GP Registrars toward Specialist General Practice fellowship, is an initiative for which AMA Victoria and ASMOF Victoria have long campaigned (please see page 79 for more information on the Victoria SEM).



**DR  
RUTH  
CHANTLER**

—  
MBCHB MRCGP FRACGP  
DRCOG DFSRH PGDIP  
GRADCERTHLTHPROFED

Ruth has been a GP at the Macleod Street Medical Centre in Bairnsdale (east Victoria) since 2008.

Originally from the UK, she has always been interested in rural medicine. Ruth has a Graduate Certificate in Health Professional Education and is a Teaching Associate at Monash University, and an Examiner and Senior Regional Medical Educator with the RACGP. She splits her time 50-50 across her clinical practice and her teaching, and lives in Bairnsdale with her husband and two children.

**IT WAS NEVER MY PLAN TO WORK IN RURAL AUSTRALIA LONG TERM.**

I first came here in 2008. After completing my GP training in the UK, I went to a careers fair in London. I hadn't heard of Bairnsdale! But it appealed as it's close to the beach, bush, snow and skiing. It seemed like somewhere I could have a lot of experiences outside of work. I stayed for 18 months then returned home, but I didn't settle very well returning eight months later – I'd met a local. It's been life changing. Now I have Australian children and in-laws, the whole lot! I have been subject to the 10-year International Medical Graduate moratorium, but that hasn't been an issue for me.

**I MISS HEALTHCARE BEING FREE FOR EVERYBODY AT THE POINT OF ACCESS IN THE NHS.**

This makes getting medications, referrals, treatments a lot easier for people, especially people experiencing socioeconomic hardship. The NHS referral pathways are much clearer too – it's a bit of a one stop shop, particularly for possible cancer diagnoses. Here there are more steps and processes to facilitate a referral in a regional area. I've got to think about geography, cost accessibility and do more clinically with the patient before they see the specialist. That said, I think Medicare and Australia's mixture of private and public makes patients place more value on the healthcare they receive.

**I THINK RURAL GENERALISM IS SUITED TO SOMEBODY WHO'S WILLING TO HAVE A GO.**

Overall, I've had a lot more autonomy over my workload here, than I had in Britain. My regional practice was welcoming and very flexible. They encouraged me to try my hand at teaching, and in my first year I was able to arrange my working week so that I had Fridays off to go and explore. Clinically you can have a go at everything, and a decent amount of it may be outside of your comfort zone to begin with. You must be aware of your boundaries, because you're more likely to encounter the same people in lots of different roles – as a patient, as a colleague, as a parent at school and as a team member in your sports club – in a regional setting than in the city.

**I THINK ACCEPTING PATIENTS HAVE A HEALTHCARE TEAM IS A MINDSET SHIFT WE SHOULD ENCOURAGE IN GENERAL PRACTICE.**

Many patients express a preference to see a female practitioner. We have just four female practitioners in our practice, and there are several more in the local area. Increasing our available appointments can be a challenge as many of us have children and are working less as a result or are diversifying to other interests. This can translate to challenges in accessing preferred GPs for patients. But I think patient expectations need to shift. The idea of having one GP for life is very traditional, so we need to gently encourage our patients to accept and understand there are going to be other people in their healthcare team.

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*The idea of having one GP for life is very traditional, so we need to gently encourage our patients to accept and understand there are going to be other people in their healthcare team.*



**THERE ARE SIGNIFICANT WAIT TIMES FOR CHILDCARE AT THE MOMENT, WHICH IS A BARRIER TO WOMEN RETURNING TO WORK.**

There's been an incredible amount of building and growth in Bairnsdale over the last 10 years. There are new homes and people arriving, but the services needed to support that population growth – like childcare – are not growing at the same rate. There can also be significant frustrations with referrals like paediatrics or ENTs or psychiatry, as we don't have local specialists. Patients have to travel at least an hour to see them, and they also have significant waiting times.

**AS A MEDICAL EDUCATOR WITH THE RACGP, I'M INVOLVED IN TRAINING REGISTRARS TO BE GPs, FROM START TO FINISH.**

This involves a mixture of workshops, with face-to-face learning and teaching about the art of general practice and various clinical subjects. I'm involved in some registrar support. So, I work with registrars who need assistance with their learning. I also support supervisors and practices locally as well. We have Monash University medical students come to our practice on 18-week placements, and it's great when some of them come back later as local interns. Unfortunately, learners can sometimes experience negative messaging before moving to the country – that there will be lesser opportunities for you and your career or your family or your child's education or opportunities. I try to show that's not the case!



**DR  
REBECCA  
McGOWAN**

MBBS FRACGP  
DIPOBSRANZCOG  
DIPFORENSICMEDICINE

Rebecca has been a specialist rural GP for more than 35 years. She lives, farms and works in the community she grew up in, in the Greater Albury-Wodonga area (northeast Victoria). With qualifications in obstetrics and forensic medicine, Rebecca has run breast screening programs and was a forensic medical officer for 12 years. In 2015 Rebecca co-founded LifeVest Health Promotion Programs, a consultancy that aims to increase peoples' health literacy. A member of Doctors for the Environment Australia and a climate change activist, she lives with her husband and has two adult children who live away from home. In 2024 Rebecca ceased GP practice altogether and is now focused on LifeVest fulltime.

**I'M VERY PASSIONATE ABOUT EDUCATION AND IMPROVING HEALTH LITERACY IN THE COMMUNITY.**

That's what my business, LifeVest, is all about. I work with big companies, in particular rural manufacturing factories. We've been presenting about health literacy online and in person for the past five years, and prior to that we ran it in pubs for two years. We ran it based on a book club model; we did a different topic every month, with an overarching focus on teaching people how to navigate the health system to improve their own health outcomes.

**I'M A BORN AND BRED FARM GIRL – I'VE WANTED TO BE A DOCTOR SINCE I WAS 12.**

I saw my mum and my aunts being treated in a very patronising, dismissive way by older white male doctors. And I remember thinking, that's not right. We have a couple of sayings in our family: 'be the change you want to see' and 'bloom where are planted'. So even though I trained and worked away in places like London and Melbourne, I knew I wanted to come back to my area and help country women like my mum and aunts get a better deal from health.

**I THINK GENERAL PRACTICE IS IN A TOTAL DOWNWARD SPIRAL AND I DON'T SEE MUCH OF A CONVERSATION ABOUT IT, PARTICULARLY FOR WOMEN.**

It is the elephant in the room and how it's affecting women GPs is a real deficit in the conversation. I've just made the very tough call to leave general practice; if circumstances were better, I would've stayed until I was 65. I have four women colleagues of a similar age who have also made the call to leave. Many of my colleagues describe general practice as a toxic environment and are voting with their feet. Then there's a gender pay disparity, where practices are increasingly owned by non-medical people and men, and women GPs like me are working on a percentage. And there are no benefits: no maternity leave, no holiday leave, no super.

**THE REAL REWARDS OF BEING A RURAL GP IS BEING ABLE TO REALLY HELP PEOPLE AND FAMILIES AND A WHOLE COMMUNITY TO THRIVE.**

I have a lot of four generation families that I've looked after and even a couple of five generation families. When you work rurally for a long time, people see you as an integral part of their family and their life. And you are really part of the community. Love and care are a big part of general practice – the love and care you have for your patients, and the love and care they have for you. The other real advantage is that your skills are well utilised. A lot of rurally trained GPs are very, very good at their jobs. In that way, the job satisfaction is great.



*Love and care are a big part of general practice – the love and care you have for your patients, and the love and care they have for you.*

**AFTER I HAD MY FIRST CHILD, I WENT BACK TO WORK AT THREE MONTHS; AT SIX WEEKS OLD WITH MY SECOND. AND THEY WERE BOTH CAESAREANS!**

A lot of women GPs are the main income earners for their families, and there's always that worry you might lose your patients if you stay away for too long. Fortunately for me, I have a very supportive partner; we've always done 50-50. When I went back to work after having my children, I worked mornings and he worked afternoons. We'd pass on the way home. We live half an hour out of town, so we'd pull over and I'd literally breastfeed the baby in the car on the side the road, then take her home.

**THE NUMBER ONE HEALTH CRISIS FACING RURAL WOMEN IS CLIMATE CHANGE.**

I have worked a lot with women and their families who have been devastatingly impacted by fires and floods. This became especially obvious after the Black Summer bushfires of 2019-2020 here in our local area in the Upper Murray. I've experienced this personally; in a previous season our own farm got burnt out. I saw fire impacting women in multiple ways. It impacts pregnant women, it impacts breastfeeding, it impacts lung health. The 'safe places' women and their children get evacuated to aren't always safe; domestic violence rates go up. Elderly patients without air conditioning are more susceptible to heat stroke. We need much more government funding to provide genuinely safe places for women and children.

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2024 AUSTRALIA DAY HONOURS

# MELBOURNE GP AWARDED OAM

AMA Victoria member and GP  
Dr Christine (Chris) Longman's services to medicine across 40+ years in the field were recognised in the 2024 Australia Day (26 January) honours and awards. Congratulations Chris!

BY VANESSA MURRAY



**W**hen Chris received an email informing her that she was the recipient of a Medal of the Order of Australia, she thought it was spam.

“I’m flabbergasted that someone’s thought I’ve done such a good job and decided to nominate me. It was very unexpected – in fact, I thought it was spam and nearly deleted the email! GPs work hard and do a lot of the bread-and-butter care for the community, so it’s lovely we’re getting recognised in this way,” says Chris, who turns 70 next year.

The award recognises an individual’s excellence, achievement or meritorious service and contribution to society. And Chris has done this in spades – so many, in fact, that the award specifically recognises her services ‘through various roles’.

Those roles include 40 years in general practice in Yarraville, being a medical educator, working to support our GP training practices and their supervisors. Chris also spent 11 years as a sessional medical officer at Western Hospital’s Drug and Alcohol Service and worked at the Dame Phyllis Frost Correctional Centre. She also spent eight years as a sessional medical officer in the Gestational Diabetes Antenatal Clinic at Sunshine Hospital.

Chris is also an Honorary Senior Fellow in the University of Melbourne’s Department of General Practice and Primary Care, has been a doctor on call for the Victorian Doctors’ Health Program, and has been active writing letters through Amnesty International Human Rights since 1981. She has also founded a local Amnesty International group.

Chris was inspired to become a GP by a lifelong fascination with the human body and says general practice has been her great love.

“To this day I retain an absolute scientific fascination with the human body – with its physiology and how its systems work. And I’ve always loved the human contact and the engagement with families and knowing people over long periods of time that comes with being a community GP.”

“I still meet registrars that I worked with as far back as 1987, who are now fantastic GPs. That was in what was then called the Family Medicine Program. It was really a formal training program for doctors for general practice. I would visit them and observe their consultations for half a day and offer feedback. I visited so many practices and got to know so many registrars and their supervisors.”

In 1995, Chris became involved in addiction medicine.

“There have always been substance use and abuse problems in our communities, but at that time in Footscray, heroin was becoming a real problem. Western Hospital had just set up its Drug and Alcohol Service, so I went and visited them. They persuaded me to do the training to prescribe methadone, and then they offered me a job,” says Chris.

“It was a great time. I met people on the fringes, who had often had a raw deal from life. They could be very difficult; sometimes drug seekers’ behaviours were very unpleasant, but it helped me to see the behaviours as survival tactics, and signs of someone in trouble. I hope I made some difference.”



**DR  
CHRIS  
LONGMAN**

—  
GENERAL  
PRACTITIONER



*To this day I retain an absolute scientific fascination with the human body – with its physiology and how its systems work.*



*Chris thinks general practice is facing big challenges as a result of the 10 year freeze of the Medicare rebate, and the feminisation of general practice, whereby the greater number of female GPs has broadened the scope of general practice but also brought challenges.*

In 2007, Chris undertook a Master of Medicine by research in the Department of General Practice at the University of Melbourne. Her research explored the motivations, experiences and retention of GPs who chose (or didn't choose) to become opioid substitution therapy prescribers.

Chris reflects that being a GP can be quite solitary, and that she especially enjoyed the teamwork that she experienced in her role at the Western Hospital Drug and Alcohol Service.

The team I worked with had a strong culture of looking after each other. I also worked with many allied health professionals such as case managers, social workers, psychologists and specialist nurses, and it was helpful to learn other ways of doing things."

Chris thinks general practice is facing big challenges as a result of the 10 year freeze of the Medicare rebate, and the feminisation of general practice, whereby the greater number of female GPs has broadened the scope of general practice but also brought challenges.

She cites some of her main professional influences over the years as Professor John Murtagh, Associate Professor Mike McDonough, Professor Meredith Temple-Smith, Dr Russell Soppitt, Professor Neil Spike and Dr Caroline Johnson.

Going forward, Chris will be concentrating more on family and being a grandmother, playing the clarinet (which she took up at 60), and her volunteer roles in several local community organisations, and some teaching at a refugee health clinic. In 2024, she will work one week per month as a GP in a rural Victorian practice.



#### CHRIS ON THE FEMINISATION OF GENERAL PRACTICE

"In recent years there has been a significant increase in the number of women entering general practice. And we know the nature of women's practice is enormously different. We have longer consultations; it's much more emotionally intense. There's a lot more mental health and that tends to take it out of you. To add to that, women are still the child bearers and are more likely to work part time, so the payment issues are significant for them when they don't get maternity leave pay, superannuation and so on. It is great to see more male GPs and other partners taking parenting leave as well. Lastly, general practice is quite a solitary career. I'll go to work and work a whole day and possibly not even see my colleagues. And if you do, you're in such a rush you can hardly have a chat.



#### CHRIS ON THE MEDICARE FREEZE

"The freeze on Medicare over the last 10 years has been a huge problem in that the number of medical graduates deciding to train for general practice has dropped right off. We just cannot always provide good service on bulk billing to patients. It is financially challenging to undertake long consultations which are often what is best for the patient. I admire GPs who work in bulk billing clinics despite the Medicare limitations. Then there's the massive amounts of paperwork that needs to be done outside of consultations – we don't get paid for doing that either. I'd like to see rebate increases for long consultations.





A PIONEER FOR WOMEN

**BREAKING  
BARRIERS  
IN MEDICINE**

*The Trailblazing Journey  
of Dr Rosalind Terry*

In an era when women's foray into medicine was uncommon, Dr Rosalind (Ros) Terry emerged as an inspiration. Born in 1940, she was not only the first in her family to attend university but also a trailblazer for women in the medical field. Her journey, rich with challenges and triumphs, is a testament to her unwavering belief, determination, and the invaluable support of her advocates. It all started with a bold step by her mother, who secretly arranged for her to sit a scholarship exam for Methodist Ladies' College (MLC) in Melbourne. This is her pioneering story, as told recently to Kay Dunkley.

WRITTEN BY KAY DUNKLEY  
EDITED BY TARYN SHEEHY  
AND VANESSA MURRAY

## DR ROSALIND TERRY

### THE FIRST GIRL IN HER FAMILY TO GO TO UNIVERSITY

Raised in Melbourne and Geelong, Ros's enjoyed school, particularly math. Despite her father's scepticism about higher education for women, Ros's mother arranged for Ros to sit a scholarship for MLC without his knowledge. Having left school at age 14 to become a dressmaker, despite being dux, her mother was determined to ensure Ros had the academic opportunities she had been denied. When Ros subsequently won the scholarship, her father capitulated only on the basis that, "This is worth a lot of money, so we had better not waste it."

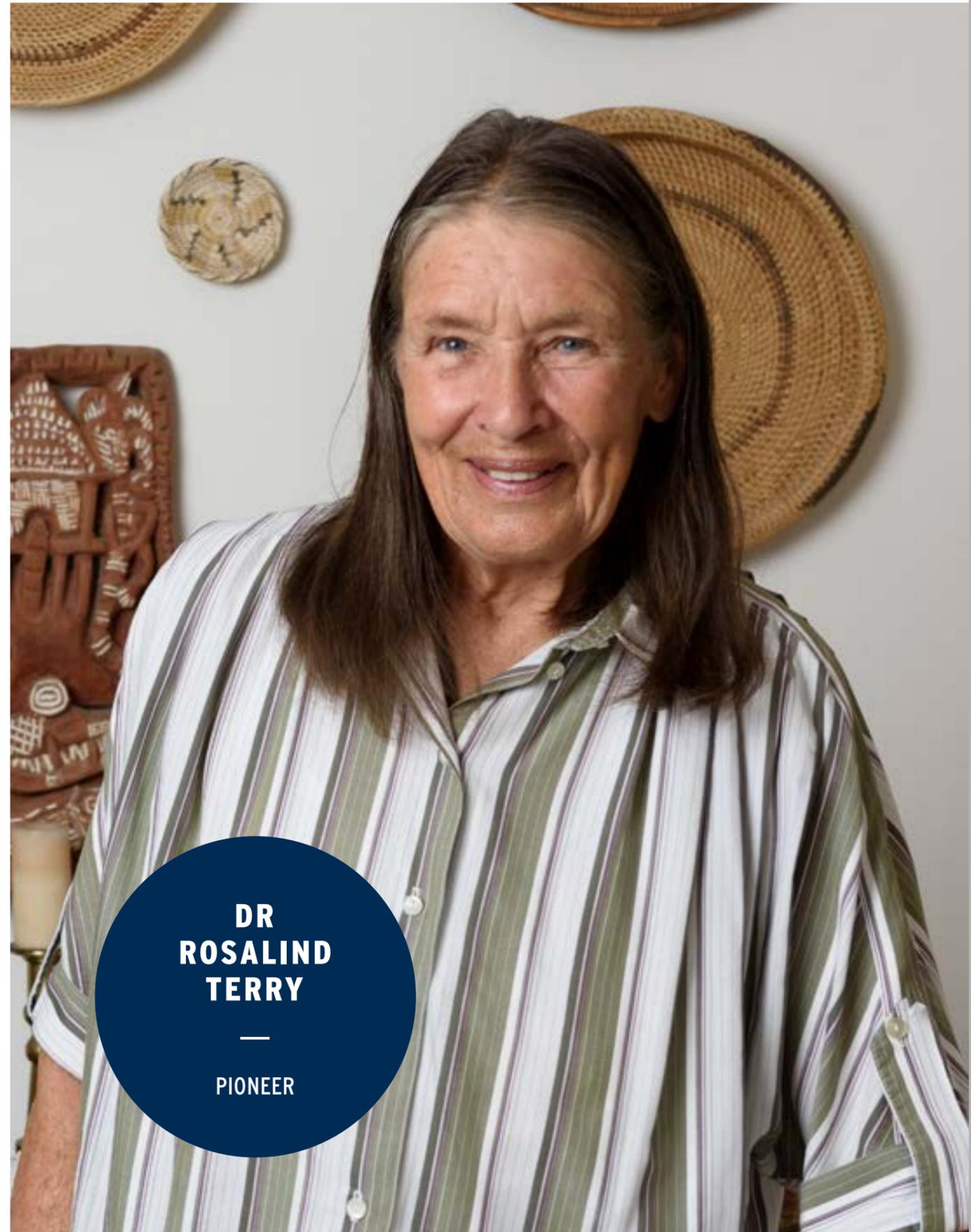
Ros subsequently won scholarships throughout her secondary schooling and successfully completed her matriculation at MLC. In her final year, however, her father remained stubbornly unsupportive of her university aspirations. "Nobody in the family has been to university and a girl is not going to be the first," he stated.

Despite her father's reluctance, he finally allowed her to undertake a three-year science degree in 1957, when Ros won a Commonwealth scholarship to attend the University of Melbourne. While studying, she won a fees scholarship, allowing her to live at the University's Women's College. This period marked a significant shift in her life, eliminating the exhausting three-hour commute from home; and allowing her to blend work and study seamlessly, working in the Microbiology Department at the University while also completing a Master of Science majoring in Microbiology.

### ENCOURAGEMENT TO ATTEND MEDICAL SCHOOL

Ros then moved to the United States for three years, accompanying her first husband while he studied a higher degree in theology. In Chicago Ros worked as a biochemist and in Madison Wisconsin in the veterinary laboratory headquarters. While in Chicago her supervisor noted Ros's potential for a career in medicine. She encouraged Ros to pursue this in America; believing in Ros' potential so strongly that she personally flew to Washington in the hope she might be able to organise a visa extension for Ros to study medicine in the United States, but without success.

Back in Australia, Ros received similar encouragement while working in the veterinary laboratories in Launceston Tasmania. Her new supervisors emboldened Ros to pursue medicine – but if Ros were going to become a doctor, there would be no straightforward way to do it. With no medical school in Tasmania, she returned to Melbourne. And with second Commonwealth scholarships disallowed and her marriage having ended; she had to do this on her own.



**DR  
ROSALIND  
TERRY**

—  
**PIONEER**



*During her inaugural Division of Surgery meeting, when Dr Henry Windsor, a luminary known for Australia's first heart transplant, queried the room about her anticipated arrival by asking "Does anyone know if she's coming?" Ros asserted her presence with a calm yet firm, "Yes, I am here." This simple declaration is symbolic of a profound moment for Ros, as well as for aspiring female surgeons.*

**MEDICAL SCHOOL**

So, Ros did just that. In 1969, she commenced studying medicine at the University of Melbourne, attending classes during the day, and supporting herself working in the laboratories at the Royal Melbourne Hospital until midnight.

Ros triumphantly emerged from the halls of Medical School in 1973. Most memorably, she received a belated validation from her father. He marked the milestone with a family dinner at the prestigious Windsor Hotel, offering his long-awaited acknowledgment and pride. Ros worked her last night in the laboratory at Royal Melbourne finishing at midnight and returning at 8.00am to commence as a medical intern on the wards.

**SYDNEY'S FIRST EVER FEMALE SURGICAL REGISTRAR**

In a bold move after two years at the Royal Melbourne Hospital, Ros set her sights on a groundbreaking path in surgery. She confronted a stark reality though: Melbourne's hospitals did not allow women to enter surgical training. Undeterred, Ros charted a new course to St Vincent's in Sydney, etching her name in history as Sydney's first female surgical registrar.

At St Vincent's, although Ros was well supported by the Sisters of Charity and the nursing staff, she still encountered resistance. Her pioneering spirit was put to the test by sceptical patients who had never seen a female surgeon, and by peers unaccustomed to sharing the surgical stage with a female colleague. During her inaugural Division of Surgery meeting, when Dr Henry Windsor, a luminary

known for Australia's first heart transplant, queried the room about her anticipated arrival by asking "Does anyone know if she's coming?" Ros asserted her presence with a calm yet firm, "Yes, I am here." This simple declaration is symbolic of a profound moment for Ros, as well as for aspiring female surgeons.

St Vincent's second year of surgical training included a six-month placement in Papua New Guinea. Although it was controversial to send a woman, Ros was keen to gain this experience and be treated like all other surgical registrars. The move to Papua New Guinea proved to be lifechanging for Ros as she met her future husband and her 6 month stay extended to 10 years.

**REMOTE MEDICINE IN LAE, PAPUA NEW GUINEA (PNG)**

Remote medical and surgical practice in Lae was diverse. Although the nurses spoke English, Ros became proficient in the local version of Pidgin English and was thus able to talk more easily with patients. The setting required a wide breadth of medical practice, so Ros had to be prepared for all possibilities including life threatening emergencies with limited or no back-up. This was a place where surgeons juggled multiple roles, often topping up anaesthetic for their patients during long unpredictable trauma cases; and where nurses would manually 'bag' patients throughout procedures, when there was no power.

There were weekly plane trips to remote clinics in mountainous locations. Unpredictable sudden weather changes sometimes prevented a return flight, so Ros always needed to be prepared for an overnight stay.

Ros recalls splinting and bandaging a baby with talipes in a mountain village and fondly remembers how the local children loved to watch her undertake the procedure every two to three weeks for many months. Their teacher knew better than to try to keep them in school when Ros visited. One day, she arrived to be welcomed by children running to greet her, as she disembarked from the plane, calling out "Our little boy is walking!"

Ros introduced the bikini line cut during caesareans. Pelvic disproportion was a significant issue in the local population due to the improving nutritional status of the mothers and subsequent larger babies. At that time, the male obstetricians and gynaecologists performed midline cuts but nurses working at the hospital saw the benefits of Ros's approach and requested Ros when they needed caesareans.

Ros also treated widespread injuries from coconut tree accidents, trauma from road accidents on the narrow winding roads in the mountains around Lae, and farming and boating accidents.

Her role extended beyond human medicine. When an unknown disease impacted the local crocodile farm killing multiple crocodiles, Ros conducted an autopsy and took multiple specimens from a dead crocodile. These specimens were then sent to Australia for analysis so the disease could be diagnosed, and the remaining crocodiles treated.

Additionally, as there was only one veterinarian in Lae, sometimes people would bring their sick animals to Ros when the vet was away. Ros' love of animals and broader experience in veterinary laboratories in the USA and Tasmania meant she was well equipped to treat the sick animals.

## DR ROSALIND TERRY

### CHIEF MEDICAL OFFICER ON NORFOLK ISLAND

After a decade in Lae, Ros and her husband travelled the world for six months and then Ros took the post of Chief Medical Officer on Norfolk Island. The next two years marked a happy reintegration with a shift back into Western medical practice, speaking English and eating European food again.

Ros lived in the Government Medical Officer's House in Quality Row, an old house with extra rooms for visitors who frequently came to stay. Ros loved the beautiful scenery and felt safe walking anywhere at any time.

Without mobile phones or pagers and sharing on-call duties with an assistant medical officer every second day, Ros had to stay close or keep the hospital informed of her whereabouts. She was responsible for all emergency surgery with the anaesthetic provided by the assistant medical officer, who also managed all straightforward vaginal births, with Ros performing all caesareans.

### FIRST FEMALE SENIOR EMERGENCY PHYSICIAN AT THE ALFRED

In 1990, after more travel in the UK and USA, Ros returned to Melbourne, after a time settling in South Yarra. She now embarked on the next chapter of her career. After initially undertaking surgical assisting Ros had a pivotal role in the establishment of the Emergency Department at Werribee Mercy Hospital, this time with the support of the Sisters of Mercy. Then after initially working as a locum she secured a

permanent role at the Alfred Hospital, where she became the hospital's first female senior Emergency Department physician. When Ros turned 70 years of age, she asked her boss if there were any rules requiring her to retire and he replied, "I don't know, and you are not going to retire yet".

At The Alfred, Ros contributed not only through her skills in trauma management, general medicine, and surgery but also through the warmth of her camaraderie and her dedication to teaching. She became especially known for imparting practical skills to colleagues including the first nurse practitioners. Ros is still treasured by those who worked with her at The Alfred.

### AN ACTIVE RETIREMENT

In her retirement, Ros' influence in the medical community has continued. She has generously devoted time to volunteering with the AMA Victoria Peer Visitor Program visiting isolated elderly doctors. Ros has been a member of both the AMA Victoria Board and the Board of the Victorian Medical Benevolent Association. She has also had active involvement in groups such as the AMA Victoria Women in Medicine Committee and the Victorian Medical Women's Society, which underscore her commitment to elevating and supporting women in the medical field. Ros however notes that women are still under-represented in leadership roles and certain specialties.

Ros continues to enjoy the company of her peers on outings and at dinners organised by the AMA Victoria Retired Doctors Group.

“

*Thank you, Ros for your extraordinary achievements and your incredible contribution to healthcare and society. Your journey is not just a personal triumph but a legacy that has paved the way for other women to follow in the medical profession.*



PARTNER – HARPER BERNAYS

# GIVE WHILE YOU LIVE

The early life,  
inspirations  
and philosophy  
of philanthropist  
Dr Laurie Cowled

DR  
LAURIE  
COWLED

PHILANTHROPIST



“

*The simple act of giving brings Laurie much joy, and her big heart and open hands are inspiring to others to aim high and follow their dreams.*

Growing up on a sheep property in rural NSW during the Depression, Laurie Cowled aspired to become a ballerina, an actor, or an artist.

Opportunities were limited in the country, and further education for girls was commonly viewed as unnecessary. Despite the challenges of her rural upbringing in a time when women were not always supported to achieve their potential, Laurie enjoyed a long and successful career in the banking industry. Yet her childhood ambitions were unfulfilled.

Laurie's career was interspersed with much travel overseas. In her youth she travelled with her sister Ruth, who was building a promising career in costume and set design. The sisters based themselves in London and travelled around parts of Europe, later joined by their parents. Sadly, Ruth died at the age of 25 from an aneurism.

Ruth's tragic death affected Laurie profoundly, with Laurie describing it as a nightmare that ended her youth. Laurie met her husband Ron, later in life – in her forties. The pair courted for more than ten years before eventually marrying and did not have any children. They did well financially separately and together from property in Sydney and later in Noosa, where they moved to. Ron sadly died in 2005. Prior to his death, the couple had made the decision to donate everything

to charity when they had both died.

Following Ron's death, Laurie decided there was no time like the present and embarked on a new career as a philanthropist, under the strong ethos of 'Give while you live'. Her gifting reflects her personal interests and values, and those of the people she loved.

Advised that her giving was best done in a structured way, Laurie decided to establish a Foundation in perpetuity.

One of her early gifts was donating the proceeds of a block of land in Noosa Waters to Queensland University of Technology (QUT), with QUT agreeing to match the donation dollar for dollar. The gift set up a series of scholarships that support young female recipients from rural backgrounds experiencing socio-economic hardship to continue their studies.

One, the Ron Macnamara Rural Nursing Scholarship, was established in the name of her late husband. It honours his interest in medicine and fosters further education of female advanced practice nurses above the Tropic of Capricorn in northern Australia.

Laurie also established a Women in Leadership scholarship, for a female graduate of QUT's Business School to attend an international leadership event of experience – with the recipient again required to have a rural background.

## GIVE WHILE YOU LIVE



*Since generously turning her attention to philanthropy in 2005, Laurie has made major contributions to the further education of hundreds of young Australians.*

### LAURIE HAS ESTABLISHED MANY OTHER SCHOLARSHIPS WITH OTHER ORGANISATIONS, WHICH INCLUDE:

#### NATIONAL INSTITUTE OF DRAMATIC ART (NIDA)

through the Ruth Cowled Memorial Scholarship (in memory of her sister, Ruth), the Ruth Cowled Design Fund and the Laurie Cowled International Scholarship for Costume.

#### FOUNDING THE COOTAMUNDRA DISTRICT COUNTRY EDUCATION FUND,

which over the years has supported many young people. This project is one of Laurie's proudest achievements and is very close to her heart, supporting young people from the area she grew up in.

#### UNIVERSITY OF TECHNOLOGY SYDNEY (UTS)

a scholarship and PhD bursary for indigenous female students. Laurie's personal interest and research into indigenous education has convinced her that women, as the primary influencers of children, provide the strongest pathway to spreading the impact of education to the next generation. Laurie also committed a large contribution towards the construction of the UTS Indigenous Residential College – the first of its kind in Australia.

#### THE COWLED POSTGRADUATE SCHOLARSHIP IN BRAIN RESEARCH AT NEUROSCIENCE RESEARCH AUSTRALIA (NEURA)

which supports Australian female PhD students, to study Alzheimer's and other brain diseases, which fosters the careers of very talented female researchers for years to come.

#### AUSTRALIAN BALLET SCHOOL

in honour of her unfulfilled childhood dreams, providing annual scholarships to cover tuition fees, which has included helping a dancer becoming the second Indigenous ballerina with the Australian Ballet.

Since generously turning her attention to philanthropy in 2005, Laurie has made major contributions to the further education of hundreds of young Australians. By focusing her energy on supporting young country and Indigenous women she has enabled them to realise their hopes and dreams. Recipients include nurses, ballerinas, set designers and women who have degrees in diverse disciplines.

The ripple effect of the access and inclusion enabled by targeted philanthropy like Laurie's is demonstrated by family members of recipients taking up tertiary studies, and by communities then benefitting from women returning with valuable skills.

Laurie particularly enjoys connecting personally with her beneficiaries and follows the careers of many of the recipients well beyond the end of their scholarships.

She enjoys seeing their delight at receiving a scholarship she has enabled or watching the results of years of study and hard work in a ballet performance or theatre production.

Laurie is a previous nominee for the Qld Senior Australian of the Year award. This sentence from her nomination sums it up beautifully:

"The simple act of giving brings Laurie much joy, and her big heart and open hands are inspiring to others to aim high and follow their dreams."



*Click here to learn about charitable giving*



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**PROF  
ZOE WAINER**

—  
DEPUTY SECRETARY,  
COMMUNITY +  
PUBLIC HEALTH



*Learn more about  
the Inquiry into  
Women's Pain*

PUBLIC HEALTH LEADERSHIP

# IN-DEPTH WITH PROF ZOE WAINER

**Prof Zoe Wainer has been the Deputy Secretary, Community and Public Health in the Victorian Department of Health since June 2021.**



*Learn more about  
the Women's  
Health Survey  
+ the Victorian  
Government's  
Women's Health and  
Wellbeing Program*

**Z**oe has a clinical background in cardiothoracic surgery and surgical oncology and a strong interest in public health and health administration. She has been actively engaged with implementing the principles of value-based healthcare through roles, particularly her roles as Medical Director and Head of Public Health and Director of Clinical Governance at Bupa, and as Chair of the Board of Dental Health Services Victoria. Zoe is an Honorary Enterprise Professor in the Department of General Practice and Primary Care at Melbourne Medical School (University of Melbourne). Zoe is a former AMAV member, Vice President and Non-Executive Board Member. Here Zoe reflects on her pathway to public health leadership, her perspective on healthcare delivery and her focus on women's health.

**Q: HOW IS THE VICTORIAN GOVERNMENT APPROACHING AND IMPROVING WOMEN'S HEALTH?**

**A:** It's an exciting time to be focusing on women's health in Victoria. We have a National Women's Health Advisory Council that I sit on, which is chaired by Assistant Minister Ged Kearney. And we have a Victorian Women's Health Advisory Council, chaired by the Minister of Health Mary-Anne Thomas and supported by the Parliamentary Secretary of Women's Health, The Hon Kat Theophanous. There are multiple initiatives in the Women's Health and Wellbeing Program which are already rolling out, but the Government's commitment is a four-year program so we have a huge path ahead of us to 2027. My team and I are thrilled about this investment in women's health and working towards a real step change to improved access, addressing barriers for equity and better health outcomes.

**Q: HOW DOES THE PROGRAM SUPPORT WOMEN WHO ARE HEALTHCARE PROFESSIONALS, AND HEALTHCARE LEADERS?**

**A:** We have invested \$2 million in women's health scholarships to uplift women in clinical leadership roles. And we have \$4 million for research into women's health; that's around supporting not only taking the research into women's health, but also female researchers. My own experience tells me that it's important to have women doing research; we tend to see where and how and why women are missing. There's probably more thinking to do about how we engage and support women medical and clinical leaders in that space. Beyond the women's health scholarships, if you look at the Executive Board around the table of the Department of Health, we are predominantly female. So, we are there, and we are seeing and supporting women into leadership roles. I'm both a clinician and a public servant and I'm very proactive about supporting and mentoring women into leadership roles.

**Q: WHAT DID YOU LEARN THROUGH THE WOMEN'S HEALTH SURVEY?**

**A:** The Women's Health survey has given us an incredibly valuable insights into how Victorian women and girls experience their health and care. Not surprisingly, 70.8% of respondents go to their GP for trusted and reliable information. One in four women reported being impacted by the financial burden of healthcare, while one in three had health conditions that impacted their ability to work and keep a job. And concerningly, two in five live with chronic pain that adversely effects their health and wellbeing. The experience of pain came up repeatedly

throughout the survey, and since the release of its findings the Premier has launched the Inquiry into Women's Pain, where we're listening deeply to the women who experience pain and the clinicians who care for them and understand how our system can do better by them. We are wanting to lift the voice of lived experience to improve health outcomes at a system level – and thinking about how our response can deliver on the Department of Health's vision for Victorians to be the healthiest people in the world. How do we change and support our system and doctors and clinicians, and their patients and communities to be able to address women's pain and how it's impacting their ability to enjoy their lives, their health and wellbeing, and contribute to the community more broadly?

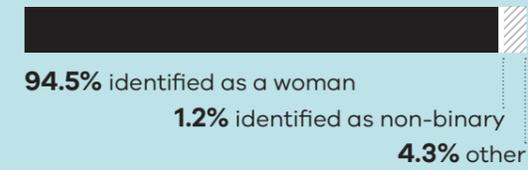
**Q: HOW IS THE VICTORIAN GOVERNMENT GOING TO SAFEGUARD AND IMPROVE HEALTH OUTCOMES FOR RURAL WOMEN?**

**A:** We know geography and rurality for women is more likely to lead to worse health outcomes and barriers to accessing care. How do we create different ways of delivering care that allows women to access confidential care and not have geography be a barrier? How do we think about and use the new models of care that have arisen out of COVID, to increase access for women in rural and regional areas? As we design the system moving forward, we're very focused not just on rurality, but on equity more broadly. For example, we know Aboriginal and Torres Strait Islander of women face different and more challenges, as do CALD communities. These are things we're very focused on and will continue to focus on as we shape the future of healthcare.

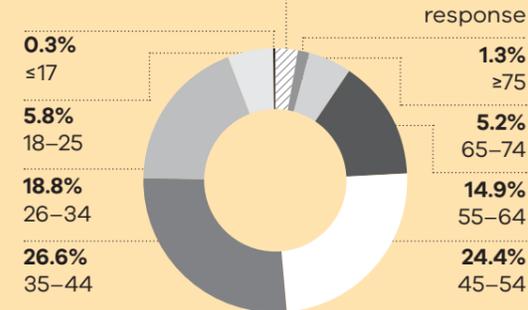
**Demographic insights**

We heard from **1,772** Victorians

**Gender identify**



**Age range**



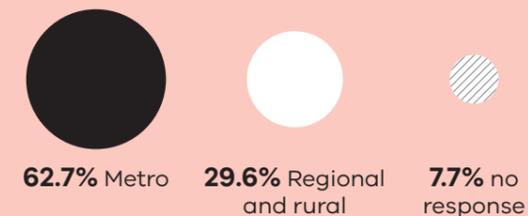
1.2% identified as Aboriginal and/or Torres Strait Islander

13.4% identified as LGBTIQ+

14.2% were of CALD backgrounds

20.6% were living with a disability

**Geographical representation**



**What we heard**

2 in 5 live with **chronic pain** (that adversely affects their health and wellbeing)



10% 1 in 10 asked that clinicians improve their knowledge and clinical skills surrounding women's health



1 in 4 women were impacted by the financial burden of healthcare

1 in 3 had health conditions that impacted their ability to work and keep a job

1/2 had health and wellbeing impacted by at least one of the following:

- mental health
- menstruation
- pregnancy, birth and postnatal care
- sexual and reproductive health

1 in 3 impacted by perimenopause or menopause

1 in 5 did not have the social connections they needed to support good health and wellbeing

Sourced from p.7 Listening to women's voices – Results of the Victorian Women's Health Survey 2023

**Q: WHAT HAS MOTIVATED YOU TO BECOME A PUBLIC SERVANT AND HEALTHCARE LEADER?**

**A:** I loved my clinical work, but I became very driven to create change and have an impact at a system level. I began exploring how I could contribute my skills, understanding, experience, and background to my community more broadly. This led me to seek opportunities in leadership in healthcare. I first moved to the role of Deputy Director of Medical Services at the Peter McCallum Cancer Centre. I also had an opportunity and deep privilege to work in global health and cardiac surgery, and spent time in Tonga, East Timor and Fiji. I had the opportunity to contribute to public health in East Timor and joined the Bracks Timor-Leste Governance Project as health advisor. I've also spent time as a Senior Advisor to the Department of the Prime Minister and Cabinet, chaired the Board of Dental Health Services Victoria, and spent six years in six different roles at Bupa, including as Director of Clinical Governance. When the role of Deputy Secretary arose in the Department in June 2021, I leapt at the opportunity to contribute to the health and wellbeing of Victorians.

**Q: HOW ARE YOU APPROACHING THE FUTURE OF HEALTHCARE?**

**A:** Our system is at a tipping point; we know that incremental change is no longer enough. We really are going to have to think quite differently and develop, design, implement very different solutions to healthcare moving forward. I believe the principles of value-based healthcare is key to those changes. In 2015 I completed the Harvard course on value-based healthcare. It encouraged critical analysis of how we structure and think about our health system. It also encouraged awareness of which health outcomes matter to patients – not just what the government wants,

or what the hospital directors want, or what the doctors want, but what does the patient want? This patient-centered approach got me thinking about outcomes quite differently, and now, one of the ways I approach my career and decisions is to make the most of opportunities – whether in the private or public sector – where I can contribute my skills to my community.

**Q: HOW CAN HEALTHCARE PROVIDERS MAKE SURE THEY'RE DOING THEIR BEST WHEN IT COMES TO WOMEN'S HEALTHCARE?**

**A:** I remain passionate about understanding what the barriers to better health outcomes for women are, and how we can bring our clinical workforce on that journey. An article in the Medical Journal of Australia in 2018 showed that if you're a woman in Australia and you present to an ED with a severe heart attack, or a STEMI as we call it, you're half as likely to get the care you need as a man, and twice as likely to be dead in six months. This is quite well known, and we keep reporting the data, but we are yet to see a meaningful change in health outcomes. It is also critical that we support our doctors and clinicians to look out for and understand unconscious bias as it may be impacting the quality of their practice and ultimately the health outcomes of their patients and support them to ask questions. When they have a woman in front of them, do they know the difference between the outcomes for men and women with this condition? Are they able to give her the care she needs? I'm not aware of many – or even any – medical schools in Australia that are currently mainstreaming sex and gender in their curriculum. It certainly wasn't being taught when I was at medical school – so I think that seems like a natural starting point for improving how clinicians look at gender, and in doing so better understand and diagnose their patients.

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**DR DANIELLE McMULLEN**  
—  
AMA VICE PRESIDENT

# WHY IT'S IMPORTANT TO INVEST IN WOMEN

  
*Click here if you have a workplace relations issue you would like to discuss*

## Extensive research shows having a greater diversity of people in the workplace leads to better outcomes – in any industry.

**D**iversity is particularly important in leadership positions, where women are sadly under-represented in the healthcare profession.

Despite making up 75 per cent of the healthcare industry workforce, women hold 45 per cent of public hospital board positions, 39 per cent of private hospital chief executive roles and 38 per cent of chief medical or health officers at state, territory and federal levels.

Female specialists also earn 16.6 per cent less than their male counterparts, while female GPs earn 25 per cent less than male GPs on average.

The theme of this year's International Women's Day is: "Count Her In: Invest in Women. Accelerate Progress". It recognises "when women are given equal opportunities to earn, learn and lead – entire communities thrive".

The thing I like about this theme is that it places importance on inclusion and equal opportunity for females in all stages of their life.

Young girls must have equal access to education, and women must be given every opportunity to progress in their profession and take on those all-important leadership positions.

A more diverse leadership can go a long way in addressing many challenges in medicine, including bullying and harassment and issues with training and supervision.

Many women are all too familiar with the myriad barriers preventing them from progressing in their medical careers. They know medicine can be akin to a treadmill and there's this fear that if you jump off the treadmill, it's very hard to get back on where you stepped off.

That is why the AMA works hard developing policy proposals that create greater flexibility in medical workplaces and training environments. We need to build a culture of flexibility in medicine where people can do a variety of things, whether it's raising children or pursuing further education, and still come back to leadership roles.



*That is why the AMA works hard developing policy proposals that create greater flexibility in medical workplaces and training environments. We need to build a culture of flexibility in medicine where people can do a variety of things, whether it's raising children or pursuing further education, and still come back to leadership roles.*

The AMA's partnership with the Advancing Women in Healthcare Leadership is driving forward evidence-based organizational and systemic change.

I have seen a very big shift over the many years I have been around the AMA. The number of women in our councils and committees across the country is growing. We still have a way to go, but we have been really striving to create more opportunities for women, and the AMA is a very flexible organisation to be involved in.

Our Equity, Inclusion and Diversity Committee develops specific policies around gender equity and other issues of inclusion, and the Council of Doctors in Training has a very keen focus on making sure our policy output always promotes equity and diversity in training settings. These are just a few of the ways the AMA is investing in women and accelerating progress.

We are also advocating for better working conditions for GPs. There has been a lot of coverage lately about general practice, where there is no systemic access to paid maternity leave and even in our hospital systems, people struggle with the amount of paid leave available.

There's also our advocacy on the Medicare Benefits Scheme (MBS). We know female doctors tend to spend longer with patients and bill fewer services, but the MBS is not set up to support this type of care.

Because, in part, of this MBS imbalance, there exists a gender pay gap in medicine, which is why the AMA is pushing for greater support for longer consults.

Also at the patient level, women suffer more from a lack of investment in Medicare item numbers for female-specific medical procedures.

Investing in women looks like many different things – and as we mark International Women's Day today, I feel proud the AMA knows what it takes to truly invest in women.

# MIDDLE LEADER PROGRAM



Click here to enrol

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

AMA Victoria's flagship leadership development program for senior doctors in middle leader roles is back in 2024. Registrations are now open for our first intake, commencing Friday 10 May 2024. We'd love for you to join us.

Excellence in healthcare requires expert collaboration within and between diverse teams of highly specialised healthcare professionals. Middle Leaders play a significant role in developing a culture of collaboration and performance through their influence on both senior and junior roles. Join this program

to increase your knowledge of effective leadership and learn practical skills you can apply immediately in your current role. The program comprises four modules delivered in person at AMA House over two days (Friday, 10 May, and 14 June), complemented by an online launch and tutorial. Additionally, participants will

engage in structured peer learning groups, fostering a collaborative environment. The program concludes with a personalised touch – a one-on-one, hour-long coaching session. The learning atmosphere is intentionally crafted: small group settings, highly interactive, inclusive, and safe.

SHREYA MAGO, MSCV

# SEEING IS BELIEVING

**Shreya Mago, Advocacy Officer  
with the Medical Student  
Council of Victoria, reflects on  
intersectionality, inclusion  
and being a woman of colour  
in healthcare.**

## INTERSECTIONALITY

In one of my first surgical rotations, I learnt that seeing truly is believing. Despite the diversity I noted in medical school and the hospital as a whole, I had also noted that certain pockets of the hospital – leadership positions, surgery – seemed to house a more homogenous subset. Yet, when I met the senior registrar of the surgery team, my previous observations and the known statistics suddenly felt less relevant. The senior registrar of the general surgery team was my idol. She was cool, kind, collected and a great surgeon – and I was in awe. In fact, I think every one of my female colleagues left that rotation inspired, and more accurately, fangirling over this surgeon. After that, no matter our individual interest in surgery, the possibility and path were wide open.

We notice when we see people like us, particularly in positions which we aspire to. And we also notice when we are missing. As a woman of colour, when I look towards doctors in leadership roles, most don't look like me. And the statistics back this up – the diversity in medical school, of sexuality, race, gender or otherwise, isn't reflected in leadership positions later on.

This lack of diversity is also apparent in other aspects of medicine. For example, many are aware of the historical gender imbalance of participants in clinical trials. Although some areas still lag, there has been considerable headway made in achieving adequate representation of women in trials. However, this underrepresentation is not only a gender issue. A recent publication from the Lancet Regional Health Americas suggests people from diverse ethnic backgrounds continue to be disproportionately underrepresented in clinical trials, with only modest improvement over time. While data on

the intersection of these two identities in clinical trials is rarely reported, given the underrepresented proportions of women and ethnically diverse people, we can comfortably infer that women from diverse ethnic backgrounds are even less likely to be adequately represented.

Adequate representation of the people that make up our populations in research is essential to the provision of effective healthcare to the entire population. However, uplifting marginalised groups in silos – as has historically been done – can result in the prioritisation of certain subgroups while leaving others behind, particularly those who may fit into additional marginalised identities. Additionally, addressing lack of diversity one population at a time, as opposed to attempting to overhaul bias within a system as a whole is surely inefficient.

Intersectionality recognises that human beings possess multiple identities, each of which overlap and intersect to influence their individual experience of the world. Intersectionality isn't about forming increasingly granular categories of individuals, but instead considers all individuals, and it is extraordinarily relevant to all aspects of medicine. Indeed, just one search reveals a multitude of articles in many reputable journals discussing the need for a shift towards an intersectional framework, for medical research, medical education, health policy and so on.

For example, in clinical research, multiple intersectional frameworks have been proposed which outline inclusivity guidelines for research trials, as well as outlining identifying data which should be collected to further understanding of how different characteristics of patients may intersect and impact health, experiences and treatment responses.

SHREYA MAGO, MSCV



*Intersectionality isn't about forming increasingly granular categories of individuals, but instead considers all individuals, and it is extraordinarily relevant to all aspects of medicine.*

It is here that I see a gap in my medical school learning. While we have learnt about issues such as healthcare access in specific populations, or the general provision of culturally safe care, teaching of intersectionality as a concept is notably lacking. Indeed, Rehman et al. suggest that currently, intersectionality and its many facets of applicability are covered at best superficially in medical education.

There has been a new emergence of research and framework proposals suggesting methods of introducing formalised intersectionality teaching into medical education. As we await this introduction into the curriculum, I hope that we – particularly my own generation of future healthcare leaders – become increasingly cognisant of how we can consider and implement the theories of intersectionality in our everyday practice and policies. Samra et al. state, "dismantling the power

structures in medicine... requires complex thinking that goes beyond focusing on one dimension at a time – e.g., patriarchy or racism". Indeed, whenever we think of improving our system, we must think of all the people in the setting. Only then will our advocacy, research and healthcare reach everyone.

Intersectionality is important in understanding the experiences of healthcare professionals with differing and intersecting identities. It's important in providing clinical care to all patients of diverse identities. It's important in ensuring clinical research is applicable to everyone. It's important in ensuring our health policies serve all groups of people. It's important to learn in medical school, because we are the future of medicine and the medical system. And it's important on International Women's Day because when we talk about women, we must talk about all women.

THE POLICY DESK

# AMAV ADVOCACY



*Click here if you have a policy issue you would like to discuss, or have some feedback about our priorities*

It has been a busy start to 2024, with a range of issues spanning general practice sustainability, mental health reform, parental leave, and matters related to Ahpra, among others, all making their way across the policy desk.

Despite their varied nature, our advocacy efforts on these matters collectively embody a cohesive vision: the restoration and enhancement of confidence in the Victorian Health System, benefitting both medical practitioners and their patients alike.

Here are the highlights.



## AMAV ADVOCACY

### GENERAL PRACTICE

On 29 February, AMA Victoria met with the Victorian Treasurer, the Hon. Tim Pallas MP, to discuss the well-documented financial and workforce challenges currently faced by Victorian general practice. These challenges include, but are not limited to, the pressing issue of payroll tax.

During the meeting, the Treasurer recognised the pivotal role of general practice in the Victorian health system and acknowledged the concerns expressed by many practices regarding payroll tax. He has committed to ongoing constructive collaboration with the sector to offer certainty and reassurance.

In support of this commitment, the Treasurer announced that a \$10 million co-designed scheme would be developed to aid the delivery of general practice services, and the establishment of a General Practice Support and Recovery Working Group (involving officials from Treasury and the Health Ministers Office in addition to representatives from AMAV and other representative bodies),

to develop the scheme. Furthermore, in the immediate future, ex gratia relief will be provided to practices facing payroll tax compliance issues, contingent on a demonstration of good faith in compliance efforts, and financial hardship. In this context, the Treasurer explicitly expressed no desire for practices to close and no targeting of general practices by the State Revenue Office.

Given that AMAV has been advocating for [a General Practice Support and Recovery Strategy for Victoria](#) since October 2023, this was a most gratifying announcement and a testament to the strength of our advocacy and influence.

This positive development follows recent announcements by the Victorian Government regarding the Victorian General Practitioner (GP) Trainee Grants Program and a Single Employer Model trial for GP Registrars in 2025 (see more on this later in the article).

While specific details of the Treasurer's announcement are yet to be revealed (these are expected to be

communicated in the coming weeks), we are committed to ensuring that our advocated priorities are incorporated for the benefit of practices, practitioners, and patients. This includes not only addressing the payroll tax issue and exploring Single Employer Model trials, but beneficial data sharing, mitigating disruptions caused by state-initiated pharmacy prescribing measures to GP-led team-based care, addressing intersections with Priority Primary Care Centres and the Victorian Virtual Emergency Department, and improving GP/hospital transfer of care arrangements.

### PAYROLL TAX

AMAV Victoria has continued to raise the matter of payroll tax on medical practices in meetings with Government and Department of Health throughout summer, and most recently with the Department of Health Secretary, the Premier's Office, and the Treasurer. We are meeting quarterly with the State Revenue Office (SRO) on this issue.

While AMAV continues to advocate for a political resolution to this issue,

we are concurrently meeting with the Victorian SRO to discuss administration of laws, with the goal of transparent and open interpretation and compliance.

### VICTORIAN SINGLE EMPLOYER MODEL (SEM) TRIAL

Victoria is commencing the design of a SEM trial for rural generalist registrars. The Department of Health is designing the trial with broad sector stakeholder input to ensure the trial is optimised for Victoria, financially sustainable, responsive to local area need and focused on attracting, developing, and retaining the rural generalist workforce. Subject to Commonwealth approval, the aim is for a two-year trial for up to 15 rural generalist registrars in up to three trial sites, with an anticipated start date of February 2025.

The SEM, which is designed to remove immediate economic barriers and enhance training conditions for GP registrars toward Specialist General Practice fellowship, is [an initiative for which AMAV and ASMOF Victoria have long campaigned.](#)

## THE POLICY DESK

We are pleased to see our advocacy efforts rewarded and look forward to working closely with the Victorian Government and Department of Health to ensure the trial's effectiveness for Victorian GP registrars, practices, and patients.

### VICTORIAN GENERAL PRACTITIONER (GP) TRAINEE GRANTS PROGRAM

The Department of Health has released the long-awaited guidelines for the Victorian Government's GP grants program. AMA Victoria has long campaigned for such an initiative, which will deliver \$30,000 top-up payments for eligible trainee GPs, ensuring they do not take a significant pay cut when entering GP training. It will also cover the costs of trainee GP exams in their first year, investing \$10,000 per trainee.

Subsequent to the Government's initial November 2022 announcement of the program, and in the context of a lack of information provided by the Department throughout 2023, last year AMAV met with the

Victorian Government regarding whom would be eligible for the payment, and it was eventually decided that a trainee would need to have applied, enrolled and been accepted on or after 27 November 2022 into a GP training program in Victoria and have commenced training in 2023. We acknowledge the disappointment of those who initially believed that they were eligible and have urged the Department to ensure that such information is communicated more effectively and expeditiously in future.

[These guidelines outline the grant's eligibility criteria, payment instalment dates and application process.](#) We will continue advocating for the retention and extension of such initiatives.



## AMAV ADVOCACY

### MENTAL HEALTH

Meeting with Victorian Mental Health Minister

In late 2023, AMAV held a cordial and constructive meeting with the Mental Health Minister, the Hon. Ingrid Stitt MLC.

During the meeting, several key issues were discussed, including:

#### 1. Mental Health and Wellbeing Act implementation concerns

- » Concerns were raised about the lack of initial guidance to medical practitioners for implementing the Mental Health and Wellbeing Act.
- » Different and, at times, contradictory communications from various health services about the requirements of the Act were discussed.

#### 2. Resourcing and workforce issues

- » Challenges in retention and recruitment were addressed, including the increasing rates of occupational violence in public hospitals (i.e., tension between OH&S and the Mental Health and Wellbeing Act).

- » The meeting touched upon the rise in administration and bureaucracy, as well as the attrition of senior staff leading to poorer outcomes for genuinely unwell individuals.

#### 3. Challenges within the Department

- » Structural issues within the Department were identified as an area of concern.
- » Substandard communication practices from the Department and a lack of updates on the status of projects related to Seclusion & Restraint and Compulsory Assessment & Treatment were discussed.

AMAV Victoria has been offered regular meetings with the Minister. We are hopeful that in 2024, we can collaborate more directly with the Government and the Department to rebalance the trajectory of mental health reform. Our aim is to ensure that the voice of the medical community is heard and incorporated.

### MEETING WITH THE OFFICE OF THE CHIEF PSYCHIATRIST (OCP) AND MENTAL HEALTH REFORM ADVOCACY PRIORITIES

In late February, AMA Victoria met with the OCP to discuss the implementation of the Mental Health and Wellbeing Act (the Act) in Victorian health services. Specifically, our focus was on the Act's implementation in designated Victorian Emergency Departments starting from 31 March 31, 2024.

Noting the challenges of the initial implementation of 1 September 2023, we are keen to work with the OCP, the Department of Health, and the Victorian Government to improve communications to the medical workforce in the lead up to 31 March so that we can proactively address member concerns.

AMAV Victoria strongly believes that such steps will be beneficial in reducing workforce anxiety that will otherwise arise from a relative information vacuum – a view that we articulated to the OCP.

## THE POLICY DESK

On a broader scale, AMAV is advocating for a continuation of mental health service funding (i.e., for mental health funding not to be withdrawn from health services). This consideration considers the additional burden of the new Act and details from the Department's Annual Report, indicating that mental health services were not able to be delivered last financial year at the projected levels due to workforce/bed constraints.

Furthermore, we are urging the Department and the OCP to reduce duplication, i.e. unnecessary paperwork, and bureaucracy, and streamline workloads for healthcare workers.

We are also advocating for solutions to enhance the recruitment and retention of individuals in the mental health workforce, particularly addressing concerns about senior leadership positions, for example directors of psychiatric inpatient units in hospitals and directors of community psychiatry positions – individuals capable of creating the vision to sustain a service.

Additionally, AMA Victoria is actively advocating on:

- » ADHD access for adults and children
- » CBD safe injecting facility
- » Drug checking (pill testing)
- » Pharmacotherapy (opioid replacement therapy) services
- » Improving cultural safety in the mental healthcare workforce.

AMAV Victoria will be meeting with Mental Health Minister Stitt in March to discuss these matters further.

### AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY (AHPRA)

Meeting with Ahpra to discuss notifications about medical practitioners in relation to social media posts regarding the conflict in Israel and Gaza

In January 2024, AMAV and AMA Federal met with Ahpra and Dr Anne Tonkin AO, Chair, Medical Board of Australia, to discuss notifications about medical practitioners in relation to social media posts regarding the Middle East conflict.

In the current situation, we are aware that Ahpra has conducted inquiries into the received complaints. However, it is relevant to note that all investigations have (so far) concluded without necessitating a formal inquiry.

Our discussion with Ahpra extended to how these outcomes are being communicated to medical practitioners. We will continue to discuss this with Ahpra, AMA Federal and other state AMAs over the coming weeks and work to provide clarity for doctors and other health professionals.



## AMAV ADVOCACY

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

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

to medical practitioners or whether Ahpra and the Medical Board have the same expectations for medical practitioners. We await clarification and will continue to follow up.

### DOCTORS IN TRAINING CLASS ACTIONS

AMA Victoria has met with multiple state MPs and the media to discuss Victoria's doctors in training class actions, led by ASMOF Victoria and supported by our organisation.

ASMOF Victoria and AMAV are seeking to raise awareness about the current class actions and why changes are needed. Fundamentally, we seek to remind Victorians and the Victorian Government that junior doctors are young professionals who work incredibly hard to care for sick Victorians and deserve to be paid for the hours they have worked. This is not just about money – many junior doctors have reported being tired, making mistakes, suffering from poor mental health, being constantly stressed and much more.

On 28 February 2024 Peninsula Health withdrew its appeal against the 2023 Federal Court ruling, which found the health service to be in breach of its obligations by failing to pay then intern Dr Gaby Bolton for unpaid overtime. This decision solidified a crucial Victorian precedent, ensuring the ruling stands. This is a triumph for junior doctors across Victoria who are advocating for rightful compensation and opens the door for thousands to claim what they have rightfully earned.

As more class actions unfold across Victoria, AMAV and ASMOF Victoria hope that this precedent encourages health services to seek fair resolutions outside the courtroom, recognising the value and dedication of all our medical staff.

AMA Victoria remains steadfast in supporting doctors, championing their rights, and advocating for a healthcare system that truly values its doctors. Together, we are not just fighting for what is owed; we are shaping a fairer future for all Victorian doctors.

## THE POLICY DESK

### WORKCOVER AND THE TAC

In January 2024, AMA Victoria met with the Hon. Cindy McLeish MP, Shadow Minister for WorkCover and the TAC, to discuss our concerns regarding the Workplace Injury Rehabilitation and Compensation Amendment (WorkCover Scheme Modernisation) Bill 2023.

We acknowledge that the Victorian Workcover system is fundamentally broken, and that the Government is seeking to make change that will create a sustainable system. However, AMAV cannot support measures that reduce worker access to WorkCover supports, such as the introduction of an additional hurdle requiring the establishment of a permanent impairment of at least 20% under the relevant Guides after 130 weeks, and the termination of employee eligibility for weekly benefits for stress and burnout.

It is AMAV's view that these changes are incongruous with the purposes of the scheme, and deleterious to the welfare of workers and the health system more broadly.

### ADVOCACY REGARDING EXAMINATION SITTING AND APPLICATIONS WHILE ON PARENTAL LEAVE

Australian Orthopaedic Association (AOA) Following advocacy to the AOA commencing in July 2023, AMA Victoria was pleased to receive communication from the Australian Orthopaedic Association recently regarding the issue of trainees being unable to sit or to apply to sit the Fellowship examination while on parental leave. The Training Committee has resolved to amend the AOA 21 Training Program Requirements to allow eligible trainees on an approved interruption of training for the purposes of parental leave to sit, be approved to sit and/or sit the exam while on interruption. The AOA Board have ratified this decision, has now been reflected in policy and will be in effect going forwards.

### ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTICE (RACGP)

AMA Victoria met with the RACGP last year to advocate for changes to RACGP training policy that would allow RACGP trainees to apply to sit, and to sit examinations while on parental leave. Advocacy to RACGP to achieve this change so that RACGP policy reflects AMA policy in this regard is ongoing.



# AVOID THE 7 SELLER SINS

With record interest rate rises spooking buyers over the last 18 months, a significant proportion of would-be vendors have chosen to hold off putting their property on the market.

However, with interest rates predicted to stabilise and potentially soften sometime this year, many owners will be anticipating more favourable selling conditions.

But before they embark on a sales campaign, it's critical they know how to avoid the seven seller's sins. Note these are mistakes that I see at every point in the property cycle.



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**1 GREED.** This is the vendor who wants too much for their property, regardless of market conditions. They can't recognise when they have secured a great deal and are always wanting another 5 to 10% more than they are going to get. Invariably, negotiations break down and they eventually agree to a similar (or worse) offer several weeks or even months later.

**2 SLOTH.** This actually covers a couple of poor behaviours. It's the procrastination when key, time-sensitive decisions need to be made. It's also being too lazy to present the property as well as possible when it is open for inspection.

**3 PRIDE.** An overly-proud vendor is one who treasures their privacy more than obtaining an optimal sales outcome. They want to dictate unreasonable terms such as only allowing a property to be open for inspection when it suits them, trying to exclude sticky-beak neighbours from attending opens, and selecting a sub-optimal method of sale because it doesn't suit their lifestyle. They jeopardise a promising offer by refusing early access to the property for the putative owner to allow prospective tenants through or by being inflexible on the settlement period.

**4 WRATH.** This isn't so much about vendors who fly into incandescent rage at the drop of a hat – though we've all met them! It's more a lack of dispassion in their dealings. It's the vendor who takes every piece of candid advice from an adviser about their property as a personal affront. Rather than respecting the honesty and expertise of the professional, they become offended and obstructive. They end up being represented by the obsequious and mediocre, which rarely ends well.

AS WELL AS THESE FOUR CLASSIC SINS,  
HERE ARE THREE MORE MODERN ONES:

**5 DETACHMENT.** It's the vendor who isn't truly engaged in the process. Their behaviour suggests they don't really care if they sell or not. Putting aside the money they could be wasting and the sheer inconsideration of not respecting the efforts of others, it often turns out that the detachment is more short-sightedness than insouciance. When self-inflicted failure finally occurs these aloof sinners are often jolted out of their fog of indifference and become quite upset.

**6 UNTRUSTING.** We've all developed a healthy scepticism when interviewing potential candidates to undertake important work for us, and that includes engaging an estate agent. It's naturally right to test those claims and promises pitched to us in an interview and to thoroughly check credentials before hiring. What isn't healthy is to remain eternally mistrustful. A successful sales campaign requires a vendor to empower their agent to do the best job. Vendors who don't listen to their advisers often fail.

**7 WILFUL IGNORANCE.** Whilst one should trust one's advisers, it is incumbent on a vendor to have a reasonable grasp of the specific property market they are planning to engage with. Without this knowledge one can't establish a healthy partnership with the advising estate agent. It won't be possible to ask the intelligent questions that will help the agent to shape the best campaign. In the most extreme circumstances, wilful ignorance risks being shafted by an unscrupulous operator. In this day and age it isn't hard to become enlightened. At a minimum, keep track of recent sales of similar properties in your locale.

# DOCTORS ARE NOT IMMUNE TO MENTAL HEALTH ISSUES

Research from Beyond Blue reveals that the prevalence of mental illness is higher amongst doctors and medical students than mainstream society.

DR DOV DEGAN  
NEPHROLOGIST & GENERAL  
MEDICINE PHYSICIAN



Doctors are not immune to mental health issues. In fact, research from Beyond Blue reveals that the prevalence of mental illness is higher amongst doctors and medical students than mainstream society. Despite this statistic, it is still not widely discussed in the medical community. A multitude of factors contribute to the burden of disease including stressful careers, unpaid work hours, workplace bullying, insufficient provision of training positions and jobs, 'type A' personalities and patient complaints.

"Physician Burnout" has been formally recognised as a condition by the World Health Organisation in 2019 and is a state of mental exhaustion caused by the doctor's professional life, characterised by emotional exhaustion, depersonalisation and reduced sense of accomplishment of success. It is not a medical condition but is an occupational phenomenon. Clinical signs of burnout include low mood, irritability, lack of energy, poor motivation and the very real phenomenon of compassion fatigue. This can lead to clinician disempowerment and career dissatisfaction.

A survey in the United States during the COVID-19 pandemic revealed a burnout prevalence of 63% with a reported 70% dissatisfaction in work-life balance. Those who experienced burnout had a three to four-fold increase in job dissatisfaction with intention to leave their jobs. The cost of burnout is substantial with an estimated \$4.6 billion dollar annual burden to the US healthcare system due to factors such as reduced hours, physician turnover and expenses associated with

hiring replacement staff. Burnout has not surprisingly been associated with twice as many patient safety incidents, reduced productivity, increased absenteeism, and a rise in doctors wanting to reduce their work hours or leave the field entirely.

Unfortunately, there have been numerous doctors, nurses and medical students who have taken their lives in our profession. These suicides represent tragic statistics which are often not widely nor openly discussed. These are not just case numbers but represent the tragic loss of lives of our colleagues and friends. The COVID-19 pandemic resulted in daily announcements of mortality figures but the mental health endemic does not give rise to media attention. A death by suicide is no less worthy of substantiation than a death by coronavirus. The issue of mental health and its causative factors merits greater attention and research by the medical community, just like any other organic illness.

I have a lived experience of mental illness which I have openly disclosed in order to try and reduce the stigma that it plays amongst doctors. I am in the unique position of having experienced both sides of the fence as an inpatient and a medical practitioner. From the doctor's perspective, I am disappointed by the discrepancy with which patients with mental illness are sometimes treated compared to those who are unaffected. The time taken to explore comorbid psychiatric problems is rarely comparable to physical issues. In addition, the training time in medical school dealing with mental health issues is limited leading

to practitioners who are ill-equipped at managing affected patients, especially those with lower prevalence disorders such as schizophrenia, bipolar disorder and personality disorders.

From the patient's perspective, I have unfortunately been on the receiving end of stigma from colleagues and hospital staff. I have not always been well-supported by my senior employers, peers and unfortunately some psychiatrists. My illness and episodes of hospitalisation during earlier years of training have been gossiped about in the medical community and I am certain that this would have been handled far more professionally had I suffered a physical illness. It has affected selection in specialty matching positions through employer bias. Having a mental illness has not affected my intelligence nor general competency as a doctor but I have had to advocate hard for myself in the face of stigma, and I continue to do so to this very day. On a positive note, my difficult experiences dealing with the mental health system and stigma from colleagues has allowed me to be a more empathic and holistic clinician when caring for my patients. More importantly, mental health challenges have not stopped me from reaching my career aspirations.

Accessing treatment through the mental health system was not always easy. When I was first hospitalised as a medical student, I found it interesting that amongst my peers of around 200 medical students and tutors, lectures and colleagues, no-one was able to successfully access services to help me. These inefficiencies with reporting, escalating and providing help to medical students and doctors in distress is ubiquitous across healthcare organisations even today. I believe that hospital organisations are well-intentioned

but our staff simply do not have the training nor established systems in place to effectively deal with doctors in distress. This requires urgent attention in order to create safer work environments for medical students and doctors.

In 2015, I became a mental health advocate for SANE Australia and Beyond Blue. I shared a national video campaign of my story which received an overwhelming and supportive response. Open disclosure has allowed for widespread dialogue about these issues. Countless doctors, nurses and medical students have contacted me, often in anonymity, to share their personal struggles as they do not feel comfortable discussing this at work due to stigma. This demonstrates the power of vulnerability and sharing which fosters a culture of open communication and human connection. It also highlights that the medical profession is ready to have these important conversations about mental health – we just need catalysts.

Mental health can no longer be an additive. We need to move beyond simple initiatives such as annual mental health days and start initiating important conversations at a systemic level to foster real culture change. It is critical that we learn to speak openly about our own difficulties and struggles, which includes our clinical mistakes. Many people have commented that I am brave for openly disclosing my personal struggles. I want to see a medical profession where open disclosure is so commonplace that it is considered the norm. Mental health affects all of us, regardless of whether we receive a diagnostic label, and we need to give this issue the attention and credit it deserves so that we can influence a real culture change in medicine and how it is perceived for future generations.



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*Mental health can no longer be an additive.  
We need to move beyond simple initiatives  
such as annual mental health days and start  
initiating important conversations at a  
systemic level to foster real culture change.*

## JOIN THE CONVERSATION

# AMAV SOCIALS



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(@newscomauHQ)

[A hospital that failed to pay more than 1500 junior doctors for overtime is appealing the historic class action, in a fresh blow for workers.](#)

→ **Dr Jill Tomlinson**  
(@jilltomlinson)

Both @amavictoria and ASMOF Victoria continue to urge the Department of Health and Health Minister @MaryAnneThomas to instruct @PeninsulaHealth to settle this & other class actions by doctors in training against Victorian health services. #wagetheft

→ **David Tse**

Don't let hospitals get away with wage theft! It's a hospital, there is always an emergency. It doesn't mean hospitals should be able to set up a system so you're not paid overtime. Follow it up with AMA if you're expected to work for free. No hospital CEO would work for free.

**Royal Australian College of GPs (RACGP) President**  
(@RACGPPresident)  
Great news!  
[@MaryAnneThomas has announced new grants of up to \\$40,000 to encourage future doctors to train as GPs. As @DrAnitaMunoz told @rileyrobyn08 this will help secure the future of the GP workforce. It's a positive step forward. #GPWorkforce](#)

→ **Dr Jill Tomlinson**  
(@jilltomlinson)

The @amavictoria team have also appreciated the opportunity to help shape this important initiative. Looking forward to continuing to work together in 2024 on initiatives that support the entire Victorian GP workforce, and achieve better outcomes for all Victorians.

**Ian McPhee**  
(@iGas2)

[On AMAV's Emerging Leader Professional Development Program]: Great initiative. There will be an unprecedented need for strong leadership within medicine, at all levels, in the years to come.

**AMA Victoria**

"So tired and still so much to do!" There is a common theme in the conversations we're having with doctors and medical leaders: I'm just exhausted; and there's still so much to do. The tiredness is evident. And the items still on the to-do list are real too. So, how do we manage it all?

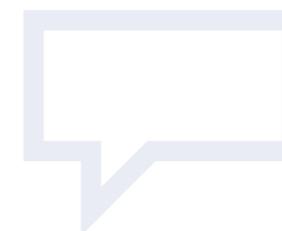


## AMAV SOCIALS



**Jason Chuen**  
(@ozvasdoc)

A memento of a bygone era – when my dad requalified as a doctor in 1969 Australia he joined @amavictoria and the Medical Society of Victoria, receiving this badge which was screwed to our car license plate. I guess it was basically a parking permit for hospitals or home visits.



**Evelyn Konstantopoulos**  
Our Women in Medicine Committee is hosting the Australian Medical Association (Victoria) International Women's Day dinner on March 12th this year.

Featured Speakers:

Dr. Nisha Khot – Clinical Director of Obstetrics and Gynaecology at Peninsula Health and Vice President of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists



Dr. Mrin Nayagam – Clinician/GP and a former Practice Principal/Owner of an award winning practice in Victoria, Former Board Member RACGP/Victoria Faculty, currently practicing as a GP/Subcontractor (part time), Triple award winner for excellence in teaching – Monash Department of General Practice 2014, 2015, 2017, Inaugural Chair of Women in General Practice in Victoria, mentor for junior GP auspiced through the AMA and Author of "Silver Linings – True Stories of Resilience from a General Practice"

**Aditya Veer Singh Sood**  
As a dedicated professional and advocate for diversity and excellence in healthcare, I'm looking forward to gaining valuable insights from Dr. Mrin Nayagam at [AMAV's] upcoming International Women's Day event. Excited to uncover pathways to success and celebrate the achievements of women in the medical field.

**NSW State Insurance Regulatory Authority**  
We have partnered with Australian Medical Association (Victoria) to deliver training for health practitioners who want to become an assessor of permanent impairment. These programs are a pre-requisite for assessing permanent impairment in both the NSW workers compensation and motor accident schemes. Find out more here: <https://www.iatnsw.com.au/>

→ **Roshana May**  
Training should always be accessible and available to anyone who wants to learn about the Guides for the evaluation of permanent impairment.

**AMA Victoria**  
[AMA Victoria president Dr Jillian Tomlinson says AMAV is looking to advocate to the state and federal government to support equal access to healthcare for rural communities.](#)

→ **Jennifer Collier**  
We definitely need a focused strategy to support specialist training in regional Victoria. Let's make use of all the amazing resources out there!

**AMA Victoria**  
Victorian doctor and AMAV board member Dr Geoffrey Toogood won the lived experience category in the 2023 Australian Mental Health Prize. Read more about Geoff's achievements in the latest edition of #VICDOC: [amav.me/vicdoc](http://amav.me/vicdoc)

→ **Whitney Luxford**  
Congratulations!! Inspiring and well deserved!

**Christopher Jones**  
As doctors, we need to start thinking about our own wellbeing; we're like the mouse running round and round the wheel... nobody cares how exhausted we get; someone else will take over when we fall off... 2024 is the year we start looking after ourselves. Targets, deadlines and patients can wait.

**AMA Victoria**  
AMA Victoria's team is out on site at hospitals across Victoria to welcome 2024's interns. We look forward to meeting you and being a part of your internship experience. Whether you have questions, need support, or just want to say hello, we're here for you! Stay tuned for updates and advice as we kickstart your medical career together. #FutureDoctorJourney



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# BREASTFEEDING FACILITY AUDIT RESULTS

AMA Victoria is committed to supporting doctors who are nursing to express or feed in the workplace. Late last year our Workplace Relations team requested information about compliance with the breastfeeding clauses from health services signatory to the Enterprise Agreements.

REPORT DR JENNY HELLSING

Feedback from our members about their workplace breastfeeding experience is welcome. If the facilities available to you are inadequate for your needs or in breach of the Enterprise Agreement, please reach out to us for advice.

### PROVISION OF A PLACE TO EXPRESS OR FEED

“Health Services will also provide a comfortable place, other than a bathroom, that is shielded from view and free from intrusion from co-workers and the public, which may be used by a Doctor to express breast milk or breastfeed a child in privacy.”<sup>1</sup>

### PROVISION OF STORAGE FACILITIES

“Appropriate refrigeration will be available in proximity to the area for breast milk storage. Responsibility for labelling, storage and use is with the Doctor.”<sup>2</sup>

The audit was voluntary and took place in August and September 2023. Of the 34 Victorian health services that are signatories to the Enterprise Agreements that we invited to take part, 26 (76.5%) responded. Disappointingly, eight services did not respond.

Working whilst lactating is a situation many parents navigate when returning to work after parental leave. Although it is unlawful to discriminate against people who breastfeed, the Fair Work Act 2009 does not contain specific breastfeeding provisions.

To work towards overcoming this shortfall for AMAV members, the Specialists and Doctors in Training Enterprise Agreements include specifications around breastfeeding. The Agreements specify that health services must provide an appropriate place for doctors who are nursing to express or feed.

#### WHAT WE LEARNED

“Our analysis of the information we received shows that facilities are, or can be, made available at all responding health

services. However, the quality and extent of these facilities and their furnishings vary greatly and do not always meet best practice recommendations or satisfy the requirements of the Enterprise Agreement,” says Jenny Hellsing, Workplace Relations Adviser at AMAV, who oversaw the audit.

“For example, rooms that cannot be locked and curtained-off areas that are also accessible to the public and patients do not provide a space that is free from intrusion. Hand and equipment washing facilities located at a distance from the breastfeeding room may fail to provide adequate hygiene facilities and pose a potential infection control risk to lactating parents and their babies. A single facility within a vast building is not necessarily easily accessible and flexibility regarding location may be required by some doctors,” says Jenny.

“We encourage all health services to review their breastfeeding facilities in line with best practice guidelines and the requirements of the Enterprise Agreements. Proof of accreditation as a Breastfeeding Friendly Workplace with the Australian Breastfeeding Association is welcome.”

1. Section 46.2 - Medical Specialist Enterprise Agreement 2022-2026; Section 74.2 - Doctors in Training Enterprise Agreement 2022-2026

2. Section 46.3 - Medical Specialist Enterprise Agreement 2022-2026; Section 74.3 of the Doctors in Training Enterprise Agreement 2022-2026

### WORKPLACE PRIVACY, SAFETY, COMFORT OR SUPPORT

<p><b>23, or 34%</b></p> <p>said they have a dedicated room or space set aside for breastfeeding</p>	<p><b>7, or 10%</b></p> <p>said the room can be accessed by swipe card</p>
<p><b>24, or 35%</b></p> <p>said they have a room or space set aside for breastfeeding, but that is also intended for other purposes such as a staff tearoom, parent room, quiet space or prayer</p>	<p><b>7, or 10%</b></p> <p>said the door to the breastfeeding room could be locked</p>
<p><b>13, or 19%</b></p> <p>said they do not have a designated space, but one can be made available on request</p>	<p><b>7, or 10%</b></p> <p>said there was a sign that could be out on the door for privacy</p>
<p><b>2, or 3%</b></p> <p>said they have a designated space that is protected by a curtain or screen (not a door)</p>	<p><b>30, or 44%</b></p> <p>said they have a dedicated fridge for storing breastmilk only</p>
<p><b>30, or 44%</b></p> <p>said the space is for all staff</p>	<p><b>15, or 22%</b></p> <p>said they do not have a dedicated fridge for storing breastmilk; doctors must use a shared staff fridge</p>
<p><b>7, or 10%</b></p> <p>said the space can also be accessed by patients, volunteers and/or members of the public</p>	<p>Not all the responses we received were detailed enough to infer the degree of privacy, safety, comfort or support provided. Percentages have been rounded up or down to the nearest whole number.</p>

### THE 26 RESPONDING HEALTH SERVICES

Twenty-six health services responded. Responses were given about a total of 68 distinct locations. Some health services provided details for multiple locations. We have noted the number of locations in brackets after the service name.

<b>1</b>	Albury Wodonga Health (Wodonga Hospital only)	<b>14</b>	Mildura Base Public Hospital
<b>2</b>	Alfred Health (4)	<b>15</b>	Peninsula Health (13)
<b>3</b>	Austin Health (3)	<b>16</b>	Peter MacCallum Cancer Institute (7)
<b>4</b>	Bairnsdale Regional Health Service	<b>17</b>	South West Healthcare
<b>5</b>	Barwon Health (2)	<b>18</b>	Swan Hill District Health (2)
<b>6</b>	Bass Coast Health (2)	<b>19</b>	The Royal Children's Hospital
<b>7</b>	Bendigo Health Care Group	<b>20</b>	The Royal Victorian Eye and Ear Hospital (2)
<b>8</b>	Central Gippsland Health Service	<b>21</b>	The Victorian Institute of Forensic Mental Health (trading as Forensicare)
<b>9</b>	Eastern Health (8)	<b>22</b>	The Royal Women's Hospital
<b>10</b>	Echuca Regional Health	<b>23</b>	St Vincent's (2)
<b>11</b>	Goulburn Valley Health	<b>24</b>	West Gippsland Healthcare Group
<b>12</b>	Grampians Health (5)	<b>25</b>	Western District Health Service
<b>13</b>	Melbourne Health (2)	<b>26</b>	Western Health (3)

We will be following up with these **8 non-responding health services** directly: Calvary Health Care Bethlehem Limited, Dental Health Services Victoria, Latrobe Regional Hospital, Mercy Hospitals Victoria, Monash Health, Northeast Health Wangaratta, Northern Health, Portland District Health



## RACIAL AND RELIGIOUS TOLERANCE ACT

A standard has been set in Victorian legislation that in some circumstances statements made regarding race or religion can be unlawful. *The Racial and Religious Tolerance Act 2001 (Vic)* makes it unlawful to incite hatred against/ serious contempt for / revulsion or severe ridicule of a person on the ground of:

- » race of the person or class of persons (s 7); or
- » religious belief or activity of the person or class of persons (s 8).<sup>7</sup>

In *Chief Commissioner of Police v Police Appeals Board* [2012], the Victorian Supreme Court clarified that “vilification” must involve conduct of a “quite serious nature”.<sup>8</sup> In *Catch the Fire Ministries Inc and ors v Islamic Council of Victoria Inc and anor* (2006), the court interpreted the provisions to include inchoate or preliminary conduct, whether or not the conduct has caused the kind of third party response it is calculated to encourage.<sup>9</sup> The effect of vilification must be assessed from the view of a reasonable member of the class of persons to whom the conduct is directed.<sup>10</sup>

Under s 9 of the Act, the person’s motive and dominant ground for engaging in any conduct is irrelevant.<sup>11</sup>

Currently, there are limited precedents on the application of the Act. The leading precedent is *Catch the Fire Ministries Inc and ors v Islamic Council of Victoria Inc and anor* (2006) which dealt with alleged religious vilification in relation to statements by Pastors and subsequent publications by a Christian association

on the religion of Islam. The Victorian Supreme Court of Appeal ultimately found contravention of the religious vilification provision and upheld the previous orders of corrective advertising and prohibition of republication of vilifying material.

A contravention of the Act does not create any civil or criminal liability unless the act is considered as serious vilification.

It would not be necessary for a social media post to contravene the Act for the Board to take disciplinary action against a doctor. The MBA could initiate disciplinary action if it determined that statements or comments made on social media breached the Code of Conduct by reflecting or promoting personal views about issues that may be offensive to a group of people or may impact on someone’s sense of cultural safety or could lead to a patient or members of the community feeling judged, intimidated or embarrassed.

<sup>1</sup> See ‘Social media: How to meet your obligations under the National Law’ at <https://www.ahpra.gov.au/Resources/Social-media-guidance.aspx>.

<sup>2</sup> See ‘Social media: How to meet your obligations under the National Law’ at <https://www.ahpra.gov.au/Resources/Social-media-guidance.aspx>.

<sup>3</sup> *Ellis v Medical Board of Australia (Review and Regulation)* [2020] VCAT 862 at [15].

<sup>4</sup> At [87].

<sup>5</sup> *Fidge v Medical Board of Australia (Review and Regulation)* [2022] VCAT 1137 at [70].

<sup>6</sup> At [71].

<sup>7</sup> *Racial and Religious Tolerance Act 2001 (Vic)* ss 7-8.

<sup>8</sup> *Chief Commissioner of Police v Police Appeals Board* [2012] VSC 105 at [50].

<sup>9</sup> *Catch the Fire Ministries Inc and ors v Islamic Council of Victoria Inc and anor* (2006) 15 VR 207 at 212.

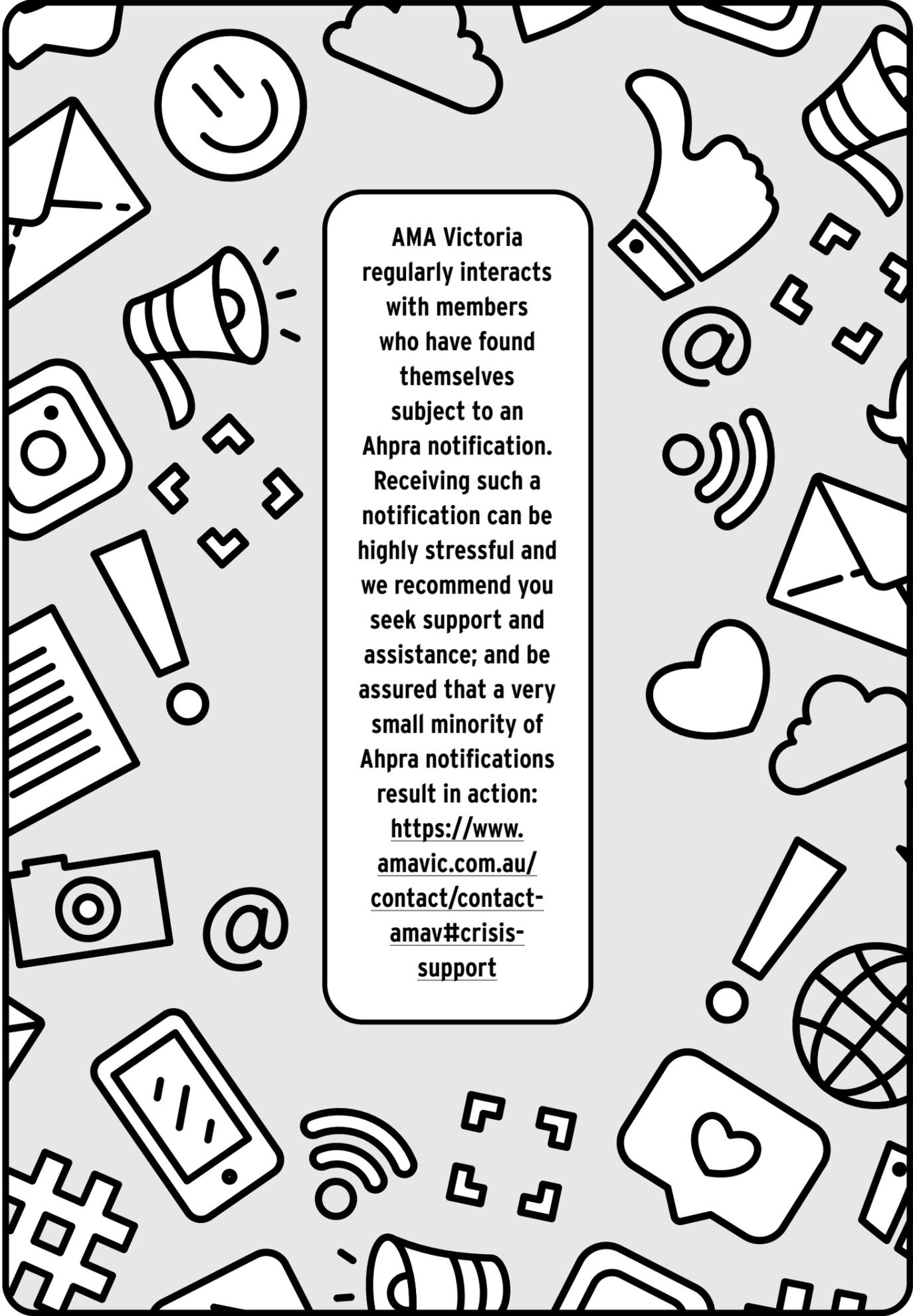
<sup>10</sup> At 231-214.

<sup>11</sup> *Racial and Religious Tolerance Act 2001 (Vic)* s 9.

Kennedys

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AMA Victoria regularly interacts with members who have found themselves subject to an Ahpra notification. Receiving such a notification can be highly stressful and we recommend you seek support and assistance; and be assured that a very small minority of Ahpra notifications result in action: <https://www.amavic.com.au/contact/contact-amav#crisis-support>

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