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CANBERRA Doctor

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The Government's plans to aquire Calvary have shocked hospital staff and the community. Above: *The Canberra Times*, Thursday, 1 June 2023. Image: Wikimedia Commons

Rush to regain trust after Calvary announcement

ACT Minister for Health Rachel Stephen-Smith has given repeated assurances to healthcare staff at Calvary Public Hospital Bruce that they will have "the same job, in the same team, with the same manager, in the same location, on the same pay and conditions" as the hospital comes under Government control.

Ms Stephen-Smith's shock announcement on May 10 that the ACT Government would compulsorily acquire Calvary Public Hospital Bruce to build a new northside hospital on the site sparked outcry from doctors and the community.

Many hospital staff have expressed anger at the Government's unilateral decision, which came as a surprise to senior Calvary doctors and to AMA ACT. Calvary National CEO Martin Bowles said the Government gave Calvary just two days notice before publicly announcing its plan, arguing the Government had acted in bad faith towards its partner in healthcare for 44-years.

A bill to transfer ownership of the hospital to the ACT Government was passed on May 31 and the Government's current public hospital arrangements with Calvary are expected to terminate in early July.

Some doctors have raised concern that the takeover will change the culture at Calvary, which has a reputation for being less bureaucratic than the Canberra Hospital (TCH). Management is typically closer to the frontline workers at Calvary than TCH, which anecdotally enables faster decision-making and access to budgets.

Prominent Catholics and conservatives have argued the Government's move is an assault on freedom of religion, with some saying the acquisition is driven by a clash of ideology on issues such as abortion and the ACT's looming voluntary assisted dying scheme. They note that Calvary was recently singled out for criticism by an ACT Legislative Assembly Committee Inquiry into Canberra abortion services for its refusal to provide "full reproductive health services".

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President's Notes

WITH PRESIDENT, **PROFESSOR WALTER ABHAYARATNA**

A tale of two governments: the ACT Legislative Assembly (left) and Parliament House (right).

A contrast has emerged in the last couple of months between the Federal Government's engagement with doctors and the ACT's.

The Albanese Government is finally beginning to address some of the harm caused by the Rudd Government's 2013 freeze on Medicare rebates, with an additional $1.5 billion towards MBS indexation in the latest Federal Budget. The Government is also tripling the value of bulk-billing incentives for concession card holders and children aged under 16. This will make bulk-billing of vulnerable patients viable in many general practices across the country, especially rural areas, even if it won't make much difference to practices in capital cities where cost-of-living pressures are most extreme.

In the leadup to the budget, the AMA provided the government with a clear plan to revive general practice through its Modernise Medicare campaign. Many of that campaign's recommendations have been taken up. Importantly, the budget kicks off a wave of reforms which place GPs at the heart of primary care.

Among the budget announcements are:

- $112 million to reform the GP aged care incentive
- nearly $50 million to create a wound consumables scheme for general practice
- $99.1 million in new funding for GP consultations that last for sixty minutes or longer
- A new system of voluntary patient registration – 'MyMedicare' – including funding and access to additional telehealth services, enhanced GP-led care for frequent hospital users and better targeted chronic disease items
- $445.1 million for the Workforce Incentive Program, to enable general practices to engage more nursing and allied health professionals

This last announcement will be keenly welcomed in the ACT, where it may be viewed in contrast to stand-alone nurse-led walk-in centres. Engaging nurses in general practice is a model that enables nurses and GPs to work cooperatively within their scope of practice. It makes care more convenient and accessible for patients, eases pressure on overstretched GPs and keeps patients out of hospital.

Overall, the budget shows the Albanese Government values general practice and takes seriously the pain it is facing. In this edition of *Canberra Doctor*, Associate Professor Louise Stone describes the 'rapid and brutal' collapse of general practice, and she's not exaggerating. Although the latest budget is not enough to rebuild a system that has experienced two decades of neglect, it is the first real health budget we have seen in many years.

What about the ACT?

Unfortunately, while the Albanese Government was preparing general practice for life-saving surgery, the ACT Government failed to even check the patient's pulse. Instead, the ACT Revenue Office has made it clear that Canberra's GPs are in their sights, threatening practices with a 6.85% payroll tax rate.

ACT Health Minister Rachel Stephen-Smith told *The Canberra Times* the Government had "no intention" of softening its "clear" payroll tax rules. "We understand that GPs are under significant pressure in this country, and that's a national issue," she said. "But asking states and territories to wear the cost by exempting a particular group of professionals from payroll tax is something we're not considering at this point."

Does the minister *really* understand the pressure GPs are under? ACT already has the lowest bulk billing rate (under 60%) and highest out-of-pocket expenses of any state or territory in Australia. As Canberra practice owner Dr John Deery recently told *AusDoc*, most ACT practices are running on a profit margin of 5%, and most of that comes from practice incentive payments. If a payroll tax of 5-7% is applied, practice owners only have two options: close or pass that cost onto patients.

To be clear, the Revenue Office in the ACT has never collected payroll tax on GPs' billings. Its latest moves are a new development, triggered by unprecedented investigations by tax authorities in NSW and Victoria into general practices there.

Why have tax offices not previously collected payroll tax from medical practices? Because of an understanding that GPs contract the services of the practice, rather than the other way around. So why should tax offices demand payroll tax now, when practices are experiencing higher costs than ever before?

After strong advocacy from AMA Queensland and the RACGP, the Queensland Government has offered general practices a payroll tax amnesty until 2025. At the very least, that gives practices a chance to find a way to structure their businesses to remain viable. A far more logical step would be for state and territory governments to make GP-billings exempt from payroll tax.

Where does this leave practices in the ACT? Right now there is deep uncertainty and worry among many ACT practice owners and GPs. To them, the gains in this year's Federal Budget are nothing to celebrate, as they are effectively offset by the actions of a Territory Government that has failed to grasp how gravely ill general practice truly is.

All this comes amidst the Government's shocking takeover of Calvary Public Hospital Bruce. Doctors want to work together with governments on sustainable improvements to the healthcare system, but right now in the ACT, they are feeling sidelined and disrespected. The ACT Government has a lot of work to do to restore trust among the people it relies upon to deliver healthcare. It must begin with listening. ■

SHARE YOUR STORY

What would it mean for your practice if the ACT Government imposes a new payroll tax? Email editorial@ama-act.com.au

Complete our quick survey to help doctors' health

Do you have your own GP? AMA ACT and Drs4Drs ACT are asking doctors in the Canberra region to take a few minutes to complete an online survey about how they are accessing medical care and the barriers they have experienced.

Why are we doing this? Because having a GP is one of the best things a doctor can do to take care of themselves – indeed, it's point number one in the section of the Medical Board's Code of Conduct that deals with ensuring doctors' health.

There is no substitute for a trusted independent doctor who can carry out a thorough and independent diagnostic work-up, as many doctors who have missed their own diagnoses will attest. Too many doctors and patients have been hurt when the slippery slope of self-prescribing leads to substance misuse. We are also tragically aware of colleagues who have struggled alone with the burden of mental illness.

Yet, despite all these good reasons to have your own GP, the day-to-day time pressures of a life in medicine can make it hard to get to a doctor. Anecdotally, some doctors have trouble finding a GP who they trust and can access when they need them.

The more we understand about how doctors are accessing – or not accessing – general practice, the more we can help improve the situation. The survey is anonymous, so you can be confident that your honest feedback will be strictly confidential. Thanks in advance for your willingness to participate.

If you'd like help finding a GP for yourself please contact AMA ACT. We maintain a list of doctors who make themselves available to see doctors as patients.

REACH OUT

If you or a colleague need help contact the 24/7 Drs4Drs ACT help line on **1300 374 377**. ■

Help us to better understand how doctors are accessing general practice by taking the confidential survey at:

surveymonkey.com/r/F3RBGGY

GPs wait for funding announcement about free medical abortions

The ACT Government says changes are imminent that will enable GPs and other community health workers to provide medical abortions at no cost to clients.

The Government announced in April that it was making abortions free to ACT residents immediately, in news that came as a surprise to many doctors working in women's health. Residents seeking abortion services were directed to MSI Australia for free access to medical abortions up to nine weeks gestation; surgical abortions up to 16 weeks gestation; and long-acting reversible contraceptives (LARCs) following an abortion.

The agreement with MSI for surgical abortions lasts until 2026, however for medical abortions it is set to end on 30 June 2023, after which time the government said it expects people will be able to access the services for free through primary health care.

A spokesperson for the ACT Health Directorate explained: "The agreement with MSI Australia for free access to medical abortions was put in place as an interim measure to ensure that patients were not inadvertently encouraged towards surgical abortions while the ACT Health Directorate establishes a broader funding model to expand the pool of medical abortion providers in the community, including through primary health care, at no cost to the client. It is anticipated the establishment of this broader funding model will occur before the end of June 2023."

At the time of writing it was unclear how the government planned to overcome jurisdictional funding hurdles related to Medicare to enable ACT GPs to do this.

Dr Tanya Robertson, an AMA board member and GP at the Junction Youth Health Service commented: "While it seems the ACT government's intent is to ensure medical abortion is available with no out-of-pocket cost via GPs, there has not yet been any communication with GPs about how to access funding to provide this service or the delivery of LARC to this cohort."

Dr Robertson added that she would like to see LARC made available for free not only to those who have had an abortion, but to all women.

AMA ACT President Elect Dr Kerrie Aust said most women in Canberra who accessed an abortion through their GP would currently pay around $500. The AMA has advocated for measures to make it more affordable for women to access a medical abortion in general practice if their GP is willing to provide the service.

Dr Aust commented: "Many women in the situation of having an unwanted pregnancy benefit from being able to talk about their options with a doctor they already know and trust."

MSI has advised that it is not experiencing any major delays in service delivery since free access to abortion care began in the ACT. According to the ACT Health Directorate, MSI is meeting the current demand for its services, with next day telehealth appointments, and in-clinic appointments available within seven days for both surgical and medical abortions. ■

Variation in Sex Characteristics law

New law to protect intersex and other patients raises concerns

Doctors could be jailed for carrying out a restricted medical treatment.

It's being championed as a breakthrough for the rights of intersex people, but new legislation that restricts doctors from carrying out medical or surgical treatments affecting the sex characteristics of some young children has raised concerns among some doctors.

The Variation in Sex Characteristics (Restricted Medical Treatment) Bill was passed on 8 June. Chief Minister Andrew Barr, who introduced the Bill, said it formed the basis for a "world-leading scheme to protect the human rights of intersex people in medical settings".

An emotional Mr Barr referred to the "long journey and the traumatic experiences of many people in our community" saying many intersex people have been harmed through past medical treatments they received as children.

Mr Barr said that central to the reform is the fundamental principle that "people, including children, should always be involved in decisions about irreversible and non-urgent medical interventions made to their bodies".

The legislation will apply to any surgical or medical procedure or treatment (including reversible treatments) affecting a child's sexual characteristics if that child has a variation in sex characteristics and is too young to give informed consent (assessed as Gillick competency).

The law makes an exception for 'urgent' situations, where treatment is needed to save the patient's life, to prevent serious damage to their health or prevent suffering or significant pain.

In non-urgent situations, doctors will only be able to carry out a restricted medical treatment on a prescribed individual if they have a general or individualised treatment plan approved by a government-appointed Restricted Medical Treatment Assessment Board.

Doctors could face up to two years in prison for breaking the law, while parents could also be jailed for taking a child interstate to receive restricted medical treatment.

AMA ACT has offered its support for the broad policy objectives of the Act – that individuals with variation in sex characteristics should be protected from harm and be free from external coercion.

However, it remains concerned about several aspects of the law's implementation.

AMA ACT had argued that the Bill's definition of 'urgent' set the bar too high. It is also concerned that the complexities of the scheme, including the additional reporting and record keeping requirements and medicolegal risk, could shift work from the private to the public sector, where there may be insufficient capacity. Furthermore, it is concerned that patients could face increased delays and fees associated with accessing evidence-based care.

> "This committee will be given the authority to over-rule multidisciplinary teams' evidence-based recommendations."

The Royal Australasian College of Surgeons (RACS) has strongly criticised the legislation arguing it encompasses a broad sweep of conditions that should not be regarded as variations in sex characteristics and gives too much power to "a narrow government appointed committee". It says legislators have failed to recognise how medical care for patients with variations has evolved in the last two decades, so that it is now thoroughly multi-disciplinary and patient-centred – involving clinicians, psycho-social experts and parents.

The new prohibitions and penalties will not come into effect for 18 months. In the interim, there will be time to establish the Board and for treatment plans to be prepared, assessed and reviewed. The Government has said the details of how the scheme will operate will be clarified through the accompanying regulation prior to its commencement. AMA ACT is calling on the Government to produce progress reports to show how its concerns are being addressed.

What conditions are affected?

Although commentary about the scheme has focused on the rights of intersex people, the objectives of the Act are much broader. Morgan Carpenter, a bioethicist and executive director of Intersex Human Rights Australia, which has strongly advocated for the legislation, said the legislation was not about protecting an "identity group" but about protecting anybody whose innate sex characteristics don't fit with "expectations of what a boy or girl, woman or man should look or function like".

Sex characteristics are defined broadly in the Act as a person's "chromosomal, gonadal or anatomical sex." These can include the person's hormones that are related to sex, the sexual and reproductive parts of the person's anatomy and the person's secondary physical features emerging as a result of puberty.

The Government has provided a list of included conditions in accompanying draft regulations tabled with the Bill (see box), however it has stressed that the list is not exhaustive.

The list includes several conditions where there is not usually ambiguity about a patient's sex, such as Turner syndrome and Klinefelter Syndrome. Nevertheless, the Government said it included both syndromes based on feedback it received from affected individuals, who wanted more of a say in treatment decisions, particularly as adolescents.

Importantly, the proposed treatment does not need to be related to a person's atypical sex characteristics to be restricted. This means, for instance, that depending on the

location of the hernia, a doctor could not treat an inguinal hernia in a baby with Turner syndrome (a listed condition) until it became urgent.

What conditions are excluded?

The regulations set out a small number of conditions or variations where the Act will not apply – bladder exstrophy, epispadias, hypospadias other than proximal hypospadias with cryptorchidism, polycystic ovary syndrome and undescended testis. These conditions were originally part of the list of 'inclusions' in the exposure draft of the Bill, but were excluded in the regulations after strong resistance from RACS.

A doctor must report an 'exempt' treatment within three months of carrying it out, and must retain records for an extended period. The Government says it will continue to monitor evidence about the appropriateness of the exclusions.

The Act does not apply to pre-birth procedures or to circumcision.

Getting approval

Restricted medical treatments will be prohibited unless they are in accordance with a plan approved by the Restricted Medical Treatment Assessment Board. The Board will include a president and 10 other members – only two of whom will be doctors. The other members will be representatives of human rights, ethics, psychosocial support and people with variations in sex characteristics.

There are two kinds of 'treatment plans' under the Act – general treatment plans, created for a category of patients and initiated by persons the minister has not yet prescribed; and individual treatment plans, brought by an individual patient's doctor or parents/carers.

Each application for a treatment plan will be assessed by a committee of five of the Board's members, only one of whom will be a doctor. The Board will only approve a plan if it is satisfied the child would suffer physical or psychological harm without the treatment or an alternative treatment, and also that the treatment would not restrict the patient's ability to make a decision about their sex characteristics in future compared with alternative treatments.

In making its decision, the committee must "disregard any evidence that the treatment needs to be undertaken to reduce discrimination or stigmatisation or a perceived risk of discrimination or stigmatisation".

If an application is rejected by the Board, there are avenues for appeal – either to the President of the Assessment Board or through the ACT Civil and Administrative Tribunal. However, ACAT can only confirm the Board's decision or remit it back to the Board for reconsideration. One lawyer said this could set the patient on an 'appeal roundabout', with significant fees involved.

Until further details are provided in the scheme's regulations, it is unclear how general treatment plans will be kept up-to-date with the latest medical evidence. There are also concerns that patients could face delays accessing treatment while waiting for an approved individual treatment plan. One paediatrician said this could be a problem for some endocrine conditions such as micropenis, where hormones are given early in life to mimic natural hormonal processes.

Dr Rajay Rampersad, a paediatric surgeon in Canberra who co-authored the RACS submission, commented: "It is not clear how a government appointed committee with only one medical practitioner on the panel could provide expert advice for the care of young people with complex conditions, and yet, this committee will be given the authority to over-rule multidisciplinary teams' evidence-based recommendations."

Dr Rampersad said existing multidisciplinary teams already gave due consideration to the human rights of patients. Nevertheless, he said such teams could be expanded to include members from the human rights field as a "better alternative" to imposing criminal sanctions on doctors and parents.

As an example, Dr Rampersad said the current standard of care for a child with risk of malignancy from an internal gonad would involve a meeting of 20-30 experts from ACT and NSW. "They would go through all the results and potential diagnoses and look through the literature and see what is the actual risk to the patient from what was often a very rare condition," he said. Any procedure would be carried out in NSW, not the ACT.

Claims and counter-claims

Despite RACS's claim that times have changed when it comes to the way doctors care for this vulnerable patient group, Mr Carpenter remains unconvinced.

"There have been claims and counter-claims about changes in clinical practice which lack verification, while we continue to have evidence of practices of concern, so there needs to be regulation of some kind to be able to ascertain exactly what treatment is proposed for an individual, what the evidence for it is and whether it should go ahead," he said.

He noted the Australian Human Rights Commissions' 2021 Report, 'Ensuring Health and Bodily Integrity' recommended legislative restrictions on medical interventions for this patient group.

Mr Carpenter said he was pleased that as part of the new scheme, the Government will establish a Variation in Sex Characteristics Psychosocial Support Unit at the Canberra Hospital with specialist staff to support intersex people and their families.

"The harm caused by unnecessary or unwanted medical intervention in this space has been profoundly damaging to patients," he said.

"I know people who have never had an orgasm and people who have to insert a device into their urethra in order to be able to urinate, due to non-urgent surgery they received without their personal consent.

"We regularly have people reaching out, even in their 50s, having just discovered the name for their diagnosis and discovered they have a community of people with similar experience.

"I hope that legislation will provide an opportunity to reset the relationship between community and clinicians and put it on a footing that has not really been acknowledged before." ■

Included conditions*

- 17-beta-hydroxysteroid dehydrogenase deficiency
- 48XXXX/XXXX Syndrome
- 49XXXXX, XXXXX Syndrome
- 5-alpha reductase deficiency
- Androgen Insensitivity Syndrome
- aphallia
- clitoromegaly
- Complete Androgen Insensitivity Syndrome
- Congenital Adrenal Hyperplasia
- De la Chapelle Syndrome
- Follicle-Stimulating Hormone Insensitivity
- Fraser Syndrome
- gonadal dysgenesis (partial or complete)
- isolated 17,20-lyase deficiency
- Jacobs Syndrome
- Kallmann Syndrome
- Klinefelter Syndrome
- Leydig cell hypoplasia
- Mayer-Rokitansky-Küster-Hauser Syndrome
- micropenis
- Mild Androgen Insensitivity Syndrome
- mosaicism or chimerism involving sex chromosomes
- Non-classical Congenital Adrenal Hyperplasia
- ovo-testes
- Partial Androgen Insensitivity Syndrome
- Persistent Mullerian Duct Syndrome
- progestin-induced virilisation
- proximal hypospadias with cryptorchidism
- pseudohermaphroditism
- Swyer Syndrome
- Triple-X Syndrome
- Turner Syndrome
- XO/XY Mosaics

**Taken from Table 3 of draft regulations tabled with the Bill. The Bill can still apply where a condition is not listed.*

New resources help GPs provide sustainable care for veterans

The Department of Veterans' Affairs (DVA) has produced a raft of new resources to make it easier for GPs to care for veterans, including increasing awareness about programs that offer generous fees to support this work.

Some Canberra practices have recently stopped accepting DVA White Cards. This is because DVA rebates, despite being higher than MBS rebates, are not equivalent to a practices' standard fees, and practices cannot charge a gap fee if they claim a DVA rebate.

Dr Dan Corkery, acting Deputy Chief Health Officer at DVA, said his team had listened to GPs' concerns about the current fee-for-service model, and responded with a range of helpful options. These include:

- Accredited CPD on veterans' health specific issues through the RACGP (including clinical issues, DVA program specifics, billing and administration)
- New training on Veterans' Health/Military Medicine in the RACGP Fellowship syllabus
- Veterans HealthPathways – the first national level health pathways, in partnership with Primary Health Networks (PHN). The pathways are now available in Townsville, with PHNs nationally being invited to adopt them later this year
- Veteran specific health checks, and Coordinated Veterans' Care
- Printable quick guides to provide GPs the basics on DVA cards, eligibility, billing, services and programs

Dr Corkery said: "The main thing is helping practices to move away from providing frequent Level B consultations which are inherently focused on a single issue, towards care plans which can consider multiple issues with a whole-of-person approach. This is both better for the patient and better for the practice."

Dr Corkery strongly recommended to GPs the RACGP CPD module, which is designed to help them make the most of two programs tailored to meet the needs of veterans – the Coordinated Veterans' Care (CVC) Program and Veterans' Health Check program (see box).

He noted that the Australian Government is also investing $33.3 million over 4 years to triple the Veterans' Access Payment from 1 November 2023 – a budget initiative which is directly linked to the Medicare bulk-billing Incentive. This is paid in addition to the rebate for GP services provided to DVA clients.

AMA ACT President-Elect Dr Kerrie Aust welcomed the additional funding in the Federal Budget. She said she hoped the new DVA resources would provide GPs with greater clarity about which consults could be covered by a DVA card, noting this was sometimes ambiguous, especially if a consult involved multiple health issues.

Dr Corkery said that if the primary reason for a DVA client's attendance to their practitioner is for a condition which DVA has accepted liability, or if the client has a Gold Card, then the GP can bill a consultation to DVA for the holistic care of that patient, rather than claim separately across DVA and Medicare. ■

For inquiries, contact DVA on 1800 550 457 or email: cvcprogram@dva.gov.au.

Veterans' Health Check

A one-off Veterans' Health Check is available to anyone who has served at least one day in the Australian Defence Force. An annual Veterans' Health Check is available to anyone with a DVA Veteran Card who moved to civilian life from 1 July 2019. The DVA rebate ranges from $72.70 for a consult of 30 minutes or less to up to $326.35 for a consult lasting more than an hour.

The Annual Veterans' Health Check initiative was launched in July 2019. Since then, as at 31 March 2023, more than 1000 veterans have had one or more Annual Veterans' Health Checks. In the ACT, 60 assessments have been delivered to veteran patients in that time.

Coordinated Veterans' Care

The Coordinated Veterans' Care (CVC) Program funds GPs so they can proactively coordinate care for Veteran Gold Card holders with chronic health conditions and Veteran White Card holders with chronic DVA-accepted mental health conditions.

The aim is to reduce participants' unplanned hospital admissions and improve their health, wellbeing and quality of life. The GP, care coordinator (usually a practice nurse), and veteran collaborate to develop a comprehensive CVC care plan, tailored to the participant's individual health and care needs, and deliver services as per the care plan.

"The CVC Program remunerates at nearly double the rate of a standard consult, and up to $2000 per year," Dr Corkery said.

There are currently over 19,000 participants enrolled nationally, including more than 400 in the ACT. DVA recognises there is potential to increase the participation rate, and is working to promote the program.

CVC Schedule

GP Type	Initial Assessment & program enrolment *	Item No	Completion: 90 days of care/review plan **	Item No	Total year 1	Total year 2
GP with practice nurse	$455.25	UP01	$475.05	UP03	$2,355.45	$1,900.20
GP, no practice nurse	$284.55	UP02	$213.45	UP04	$1,138.35	$853.80

** The initial assessment and program enrolment payment can only be claimed once.*
*** UP03/UP04 can be claimed following the end of the 90 day period, after reviewing the care plan and confirming the patient is eligible for subsequent periods of care.*
Fees are effective 1 July 2022.

The following table indicates the eligibility criteria for Veteran Card holders, and how their treatment entitlements are listed in MyService.

Veteran	CVC Program Eligibility criteria	Definition/description on My Service
Gold Card holder	✓ One or more chronic health conditions ✓ At risk of hospitalisation ✓ Complex care needs ✓ Living in the community	Gold Card – All conditions accepted
White Card holder - with accepted mental health condition (i.e. DVA accepts relates to their military service)	✓ One or more chronic accepted mental health conditions ✓ At risk of hospitalisation ✓ Complex care needs ✓ Living in the community	'Accepted conditions' listed as: '*Condition*', showing date of acceptance and under which legislation e.g. '*Major Depression – Approved under MRCA, 20 October 2018*'
White Card holder – Non-Liability Health Care (NLHC) condition	• Not eligible for CVC • But, all veterans can access mental health care under NLHC	NLHC entitlements listed as: '*All mental health conditions – Treatment only*' or may be listed as a specific condition e.g. '*Anxiety – Treatment only*'

Why have ACT GPs become an endangered species?

ASSOCIATE PROFESSOR LOUISE STONE*

The collapse of Australian General Practice has been rapid and brutal. We are expecting a shortage of over 11,000 full time GPs in the next 8 years. The proportion of young doctors choosing General Practice has plummeted from 50% a few years ago to 12%. I don't blame young doctors for choosing other specialties. They can earn double or triple as a non-GP specialist per hour, and with a $100,000 HECS debt and the current cost of housing, you can't blame junior doctors for prioritising their financial stability.

The GPs who remain are becoming less accessible and affordable. Solid, popular and highly valued practices like Hobart Place General Practice, a practice that served the LGBTIQ+ community for decades, have closed, accepting that they cannot remain financially sustainable.

When a person sees a GP for their healthcare, they use less taxpayer funds than the Walk-In clinics, Headspace, and certainly Accident and Emergency. In a health system where every tax-payer funded dollar matters, it seems short-sighted to bankrupt the most effective and efficient part of the health system.

The cost of care

Many people would say that they choose to use services like Accident and Emergency because GPs charge too much for a consultation. Most Australians, including GPs, believe the cost of care should be low or non-existent for the people who need it most and can't afford to pay.

However, consultations have become much more expensive. The consultation fee has to cover everything in the practice, including rent, salaries for nurses and receptionists, consumables and insurance. All of these costs have skyrocketed in the last few decades, but Medicare rebates have been static. This means there is an increasing gap between the cost of the consultation, and the rebate Medicare will pay.

When a patient is bulk-billed, the doctor accepts the Medicare rebate as full payment. This means a 50% discount on the cost of their care. GPs have subsidised patients for decades, especially when they would otherwise be unable to see a doctor because of their financial situation. Unfortunately the gap has increased so much that GPs are no longer able to absorb this cost.

However, some patients pay more than others. The more complex the consultation, the less Medicare pays. The best rate is for a 6 minute consultation, where the rebate is about $6 per minute. If a doctor sees a patient for 50 minutes (for a very long consultation about complex problems) the rebate is only $2.50 per minute. If a patient sees their doctor for mental health issues, the rebate is even lower, at $1.26 per minute. That works out at about $50 per hour take home pay for the doctor before tax and the longer the consultation, the bigger the gap needs to be to keep the practice viable.

It is natural that some GPs have responded to this government pressure towards shorter consultations by pivoting to "6 minute medicine". I am mystified why we, as a community, would want to discourage thorough care but that is what Medicare is designed to achieve. It uses policy levers to drive the sort of medicine no-one wants.

Where is healthcare headed?

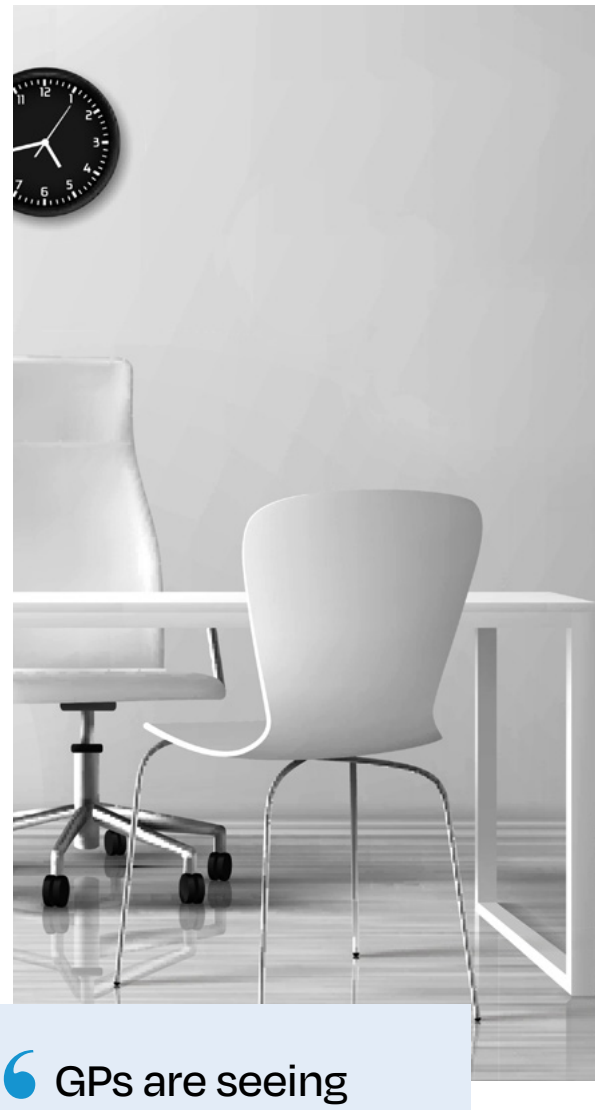
Apart from becoming more expensive, there is no doubt that healthcare is becoming much more complicated and less equitable. Consumers have asked for more choice in the care they receive, and this means we have a broader range of services available. However, as a GP, I am increasingly faced with patients who cannot access any care at all. We cannot say we provide choice if patients are unable to access any of the options that are supposed to be available to them.

Like most Australians, I am also a consumer of healthcare services. I have spent a lot of time inside large hospitals as a consumer, carer and of course a doctor. If there is one thing I've learned, when you are sick, tired and overwhelmed, it is hard to make complex decisions without help.

Anyone who has assisted an elderly relative to navigate the My Aged Care portal will recognise how difficult healthcare processes can be. This portal is inaccessible to many of my patients with cognitive slowing, poor digital literacy or cultural and linguistic diversity. Add in anxiety, dementia or intellectual disability, and My Aged Care provides a barrier to care, not a choice. NDIS is so bewilderingly complex that there is a small industry of NDIS coordinators.

As a GP, it is hard to understand NDIS requirements. My patients with low literacy haven't a hope of navigating this without help. Often help they can't find, can't access or can't afford. We GPs try to fill this gap in care coordination, but it's getting harder to do so without adequate remuneration. Unpaid administration time in General Practice is growing, with many GPs working an extra day a week just to manage the paperwork.

As a GP, I am one of few health services which do not have eligibility requirements. For people who don't know what they need, we are a one stop shop. We are being replaced by multiple services, all serving different needs. This is a lot of unpaid labour for carers and consumers. For patients with multiple illnesses, I shudder to think of the time and energy it will take to consult teams designed to focus on one illness at a time.



> "GPs are seeing the writing on the wall, and choosing safer career options."

But we GPs are smart enough to take a hint. In the last few years, we have been subject to increasing government audits, accusations of fraud (which were proven to be wrong), public violence, appalling professional disrespect and chronic underfunding. GPs are seeing the writing on the wall, and choosing safer career options.

A British colleague of mine with a lifetime of service to the NHS wrote: "as an older person, I want to state that I'm now afraid. I'm scared of dying in pain, dehydrated and unattended, on a trolley in a hospital corridor. I'm frightened that I'll end my days on a ward where the staff, however hard they try, won't have the time or resources to give me the care I need, either to cure me or to relieve my passing." I agree with him.

I believe we are past the point where General Practice can survive. In its place we are facing a fragmented system with complex, overlapping services, and large healthcare gaps. Without General Practice, the system will be more expensive, harder to navigate and less accessible for the patients with the greatest need. How, in a rich and privileged society, did it come to this? ■

*Associate Professor Louise Stone is associate director of professionalism and performance with the social foundations of medicine group at the Australian National University school of medicine and psychology.

This article previously appeared in The Canberra Times.

Is that a valid referral? Know the rules

There is a lot of confusion about what constitutes a valid referral, and an unacceptable amount of time is wasted by patients, doctors and administrative staff trying to make sure they are following the rules. Determined that it shouldn't be so complicated, I've scoured the websites of the MBS and Services Australia to get the definitive word on what constitutes a valid referral. So here it is: the referral rulebook.

DR KERRIE AUST

Does a referral need to be "named"?

No. The Services Australia website* plainly states: "referrals don't need to be made out to a certain specialist or consultant physician". This means that if I write a referral to see Dr Grey (respiratory physician) and the patient decides to see Dr Blue (respiratory physician) the referral is still valid. However, if the patient wants to see a cardiologist for the same issue instead, a new referral should be completed.

The same website also says if you're referring a patient, you should let them choose where to present the referral. This also applies to electronic referrals. In the case on an electronic referral, it may be necessary to send the new provider a referral if the original contained investigations as an attachment to the electronic file that cannot be read on the hard copy that the patient holds.

What does a valid referral contain?

In order for a referral to be valid it needs to contain:

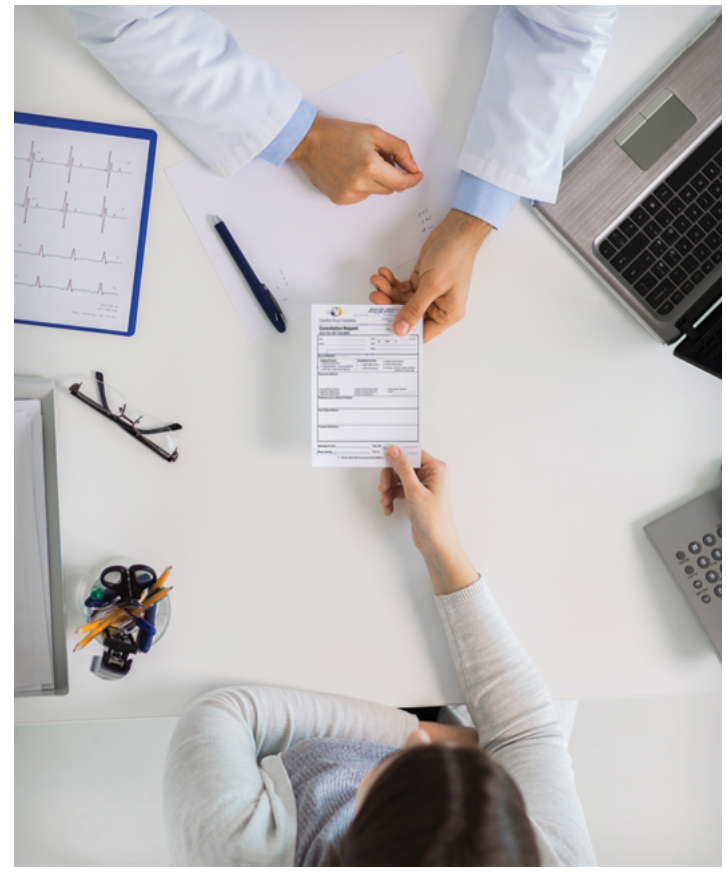
- the patient's name and contact information
- relevant clinical information about the patient's condition for investigation, opinion, treatment and management
- the date of the referral
- the signature of the referring practitioner
- provider number

What does a referral cover?

A referral covers a single course of treatment for the condition specified. This includes the initial assessment and subsequent attendances for continuing management.

What doesn't a referral cover?

A referral doesn't cover any new issues arising, for which the patient might want to see the non-GP specialist. For instance, if I asked Dr Blue to see my patient about their asthma and they subsequently develop obstructive sleep apnoea, I would need to do a new referral for assessment and management of this condition.



How long does a referral last?

A referral from a GP to a non-GP specialist lasts for 12 months. This starts on the date that the non-GP specialist first meets the patient (not the date of the original referral).

Indefinite referrals can be written for ongoing care.

If the referral is from a non-GP specialist the referral lasts for three months from the first appointment.

What if the patient loses the referral?

If a patient loses their referral, the lost (or destroyed referral) is valid for a single consult with the non-GP Specialist. When preparing the account it should be annotated with:

- the referring medical provider's name
- practice address or provider number of the referring medical provider (if known)
- the words 'lost referral'

A new referral should be obtained before a subsequent appointment.

Can referrals be backdated?

No. The specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

Does the GP need to be named in consultant-to-consultant referrals?

It is expected that the patient's GP will be kept informed of the patient's progress. Thus, a referral from a specialist or a consultant physician must include the name of the patient's GPs and/or practice. Where a patient is unable or unwilling to nominate a GP or practice this must be stated in the referral.

What if the patient sees different locums?

Fresh referrals are not required for locum tenens acting according to accepted medical practice for the principal of a practice. ■

*For more information visit servicesaustralia.gov.au/referring-and-requesting-medicare-services-for-health-professionals

Malpractice in Wonderland: ‘damn good stuff’

The directors of this year's ANU Med Revue, including the author Henry Carter (second from right).

HENRY CARTER, DIRECTOR OF THE ANU MED REVUE

I love Med Revue. Maybe too much, but that’s not for me to decide. It’s at its heart a silly little play making fun of medicine – the jokes and costumes are kinda ramshackle and it never really makes sense. But I’m addicted to the whole process.

I’ve had the honour of directing 3 revues (acting as co-director with April Thompson in 2022) and each time the experience has improved. The revue exists as a charitable venture, and Christine Phillips (representing our charity of choice Companion House) brings the house to tears every year explaining the surprisingly vital role the ‘med student’ fund holds in their service. I’m always humbled by the manner in which something that is so fun, and so stupid and so tied-together-by-strings could make an observable impact on the community around it. Watching something so profoundly small and intimate in its humour – like a chuckle between friends over puns about Grave’s Disease building to a roar over red fabric getting an acting credit as ‘Blood’ or a single person laughing over their own joke to a confused audience – barrelling through to successful donation is a stunning thing to watch. A joke doesn’t have to be about the laugh it elicits or the sense it makes, sometimes it’s the reason it was made it all.

But it’s helpful that the revue is damn good stuff. Every single year I am genuinely taken aback by the amount of talent held within my cohort. Every single person I come across in the revue has been able to show a bit of themselves every time they write or sing or dance or perform – irrespective of the necessary quantitative or qualitative markers of genius society normally attends to these things. I was lucky enough as a director to have been delivered genuine world-class talent but I wouldn’t have cared if the play had looked like a Year 2 play – no disrespect to primary school plays. I look for talent in the willingness to participate.

Medicine is hard. People tend to remind themselves, or are in need of reminding, at the end of the revue that the people they’ve watched flail around a stage are medical students. Future doctors. Tired. There are tireless, seemingly endless days of intended study that go into the revue – but the revue-folk are no less studious than the rest. The revue is a focusing object, a looking glass through which the students can choose to turn away from study and turn back when ready – and a unique place to explore their insecurities and build themselves to be the performer that a doctor needs to be. To be vulnerable I credit my ability to one day sit down and counsel a patient on my time spent with the revue.

I know it’s just for laughs. I know it’s all pretty rough and tumble. But on several different levels, tired and talented med students can confer happiness. To themselves, their colleagues, their friends and family, their school, their community. I don’t particularly care if it sounds childish but I love the Med Revue. ■

ANU's 2023 Med Revue was held over three nights in May. It sold almost 800 tickets and raised an estimated $11,000 for Companion House. This year's show 'Malpractice in Wonderland' followed the travails of poor little Alice through her internship nightmare, where the Queen of Hearts was the cardiology supervisor and the Mad Hatter was a bubble-blowing paediatrician. A talented cast of musicians, dancers and actors (all med students) kept the audience in stitches.

COVER STORY

Rush to regain trust after Calvary announcement

Continued from page 1

The minister’s response

AMA ACT met with Calvary doctors in the wake of the announcement and wrote to Ms Stephen-Smith expressing the anger of senior medical staff at being disrespected and excluded over such a significant decision.

The health minister said that while she appreciated the frustration of Calvary staff, it would not have been possible to consult with them given the confidential and commercial nature of negotiations. She added that the transition timeframe was aimed at giving certainty to the workforce and patients.

The Government has argued that the takeover is not about religion, but is necessary to replace Calvary’s aging infrastructure and create future capacity in the public hospital system. It says it made the decision after negotiations with Calvary reached a stalemate.

AMA ACT is working hard to ensure that existing Calvary doctors – both staff and VMOs – are offered ongoing work on the same terms as they currently enjoy. Ms Stephen-Smith has stressed that, for all employees their entitlements would be kept and that no one will be asked to move to another hospital or community-based service unless they wish to.

In open letter to health workers at Calvary Public, Ms Stephen-Smith acknowledged how staff valued the culture of the hospital – “a culture you built”.

“Our commitment is to work with you throughout the next steps, to listen to your feedback and to respond to your concerns,” she wrote. “To the greatest extent possible, your current managers and team leaders will be there to support you, and there will be no change to the way you do things.

“Where teams themselves decide that changes are needed, nothing will happen without speaking to you first and providing you with the information you need to feel informed and assured.”

The Government has advised AMA ACT that there will be no changes to roles, location or structure for Calvary VMOs and staff specialists transitioning to CHS contracts, “other than those in response to emergent need following a consultation process”.

The Government says it will be working with individual VMOs to confirm their current arrangements so they can either consolidate them under one CHS contract or transition them to a new CHS contract. Contracts will last the length of a VMO’s existing contract, unless that is fewer than 12 months, in which case, a 12-month contract will be issued.

AMA ACT has urged the Government to devise a leadership structure that preserves Calvary’s culture as far as it is possible. The Government has appointed a Transition Team to work with Calvary management toward a smooth handover, including establishing a forum for clinical advice and guidance.

An uphill battle

The ACT Government has a mammoth task on its hands transferring around 1800 Calvary staff onto CHS contracts, supplying them with new uniforms and transferring IT systems and records – all within weeks. AMA ACT President Professor Walter Abhayaratna said the Government faces an uphill battle regaining the trust of doctors who feel like they have been ignored.

“Unfortunately, the Government’s actions fly in the face of the culture review it ordered into the public health system back in 2018, which said engaging doctors within the system was ‘a critical success factor’,” he said. “Now that the announcement has been made, the Government must make sure it works with the profession rather than simply imposing structures on them.” ■

Do you work at Calvary? Stay in the loop with developments that affect you by making sure AMA ACT has your correct contact details. Email reception@ama-act.com.au

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8. Refer to the bank/lender cashback terms & conditions.

Mobile clinic brings care to vulnerable youth

Dr Tanya Robertson (right) at the opening of The Junction's new mobile clinic, with Health Minister Rachel Stephen-Smith and Anglicare's Sarah Murdoch.

A new mobile clinic aims to provide increased access to no-cost healthcare for vulnerable youth aged 12-25 in the Canberra region.

The new outreach van is part of Anglicare's Junction Youth Health Services and will be staffed by a GP and youth worker or nurse. Plans have been made for the van to visit Kippax Uniting Care on Tuesdays and PCYC Erindale on Wednesdays from 12.30 to 4.30pm, with additional locations to come.

Dr Tanya Robertson, a GP at Junction Youth Health Service and AMA board member, celebrated the opening of the new van at an event attended by ACT Minister for Health, Rachel Stephen-Smith.

"The clinic on wheels is able to reduce transport barriers and provide a range of primary care services such as sexual and reproductive healthcare, mental health assessments, physical health checks as well as offering social supports in a youth friendly setting," Dr Roberston said.

Funding for the purchase, outfitting and stocking of the van was provided through a grant from the ACT Health Directorate. There are currently over 1000 young people registered with The Junction, and with the current high cost of living, the need is increasing.

For more information about Anglicare's mobile health clinic or The Junction Youth Health Service phone 02 6245 7100

Letters to the Editor

Have Your Say

Submit your letter to
editorial@ama-act.com.au

GPs ready and willing to break down ADHD gridlock

I am a GP who has been practicing in Canberra since 1993. I refer to the cover story about ADHD gridlock that is happening in Canberra as well across the whole country as featured in last month's *Canberra Doctor*.

I write to lend my support to having GPs in the lead role in managing ADHD – equal to paediatricians and psychiatrists – and for our health department to make GPs prescribers of psychostimulants in their own right.

The current triaging system dictates that only paediatricians (in children under 16-18 years of age) or a psychiatrist (for anyone older than 18) can assess and initiate treatment for ADHD patients via the PBS and each state imposes restriction that makes interstate prescribing impossible. This system bypasses the family physician who is always the first clinician the person seeks out and who has an in-depth knowledge and relationship with the patients/families.

The current gridlock means that each patient can wait up to 12 months to access a private specialist service at great expense or up to 2 years by the public system. This system is antiquated and harmful. GPs can improve access and provide timely assessment and management, more efficiently and more cost effectively.

This long latent period is totally unacceptable. The impact of untreated ADHD is far reaching, not only impacting on the person who suffers from it; it also wreaks havoc in their family unit, their school and community as a whole. It's a life-long condition and people with ADHD due to the impaired executive function earlier in their lives are often behind in personality development, and can experience chronic anxiety, impaired self-esteem, sub-optimal educational attainment, poorer vocational prospects and difficulty attaining and maintaining meaningful relationships. Each passing day delay in accessing clinical help means more anxiety, entrenching maladaptive behaviour and more suffering. By allowing the gridlock to continue means that we are complicit in inflicting the suffering on the patients.

Looking at the impact of untreated ADHD in broader economic terms, it leads to less productivity, lower GDP and lower tax revenues for the government. This gridlock should be viewed as a potential national crisis rather than a mere inconsequential inconvenience.

General practitioners are specialists with our own college, which imposes rigorous continuing medical education requirements like all other specialties. We chose to do general practice not because it is easy but because it is hard.

GPs believe in advocating and finding a timely solution to our patients' problems. Many of us possess the intellectual stamina and drive for lifelong learning. The argument that the gridlock can be remedied by training more paediatricians for example, does not hold up against the fact that it would take only a fraction of time to up-skill a GP compared to training a paediatric or a psychiatric registrar to manage ADHD. Less costly at that by far.

I am confident and comfortable at managing ADHD. There are abundant established clinical guidelines and resources. Hardly a day goes by in my work as a GP that I don't see at least 2-3 patients who are already on psychostimulants or waiting to access psychostimulants. I have seen patients erroneously diagnosed by psychiatrists as having borderline personality disorder when they only suffered from ADHD and having psychostimulants really helped them.

It's time for RACGP, RANZCP and RACP and the local Government departments to work collaboratively to dismantle this gridlock and streamline the prescribing processes. In our Age of Enlightenment and in the spirit of inclusivity, there is no place for this antiquated triaging system that is tinged with prejudice and stigma that ADHD is a disease to loath and to fear.

After all, with proper help, sufferers of ADHD today can become the movers and shakers of our society tomorrow in a positive way. They are not hopelessly defective, just neurodiverse.

Remember, our goal in life as clinicians is first and foremost, DO NO HARM.

Dr Annie Lim

More paediatricians not the answer

I cannot allow the comments attributed to Dr Rosier in the last *Canberra Doctor* to go unchallenged. Dr Rosier was quoted saying: "As it stands, I just can't see that GPs have the time and skillset required to do the workup required to prescribe psychostimulant medication to children."

Paediatricians definitely don't have the time as they are currently rejecting ADHD referrals from GPs. Dr Rosier's solution is to plead with the government to find more paediatricians for Canberra and set up a national taskforce. That will not resolve an Australia-wide problem for ADHD patients.

I agree that initial ADHD assessments are very detailed, especially for paediatricians. The referring GP treats families inside communities so he/she already has much of the information needed to make the assessment. GPs are also more available to deal with issues that can arise with dopamine agonists and NRIs.

Paediatricians are in a privileged prescribing position due to government regulation. There is no evidence that their ADHD skillset surpasses that of their GP colleagues who are willing to treat this common condition. In any case, that skillset can be readily acquired.

Denying GPs the autonomy to manage ADHD just disadvantages patients and their families.

Dr Henry Berenson

Bullied by unhelpful thoughts? Acceptance and Commitment Therapy may help

NESH NIKOLIC,
STRATEGIC
PSYCHOLOGY

We all experience unhelpful thoughts from time to time, from the child who believes 'nobody likes me', to the doctor who tells themself they're a failure or a phony. What do you do though, when unhelpful thoughts start to dominate your thinking and get in the way of living a meaningful life?

Health professionals are generally aware of the basics of Cognitive Behaviour Therapy (CBT), which challenges unhelpful thoughts to help a person see a different reality – you 'do' have friends; you 'do' have achievements. However, for every point of positive self-talk, the mind often comes back with a swift rebuttal. For instance, the doctor with impostor syndrome will retort that their achievements, while real, are still less than they ought to be. By the time people come to see a psychologist they've often been fighting a losing battle in their head for years.

A different way of dealing with unhelpful thoughts and feelings comes through Acceptance and Commitment Therapy (ACT). In this approach, the goal is not to remove difficult feelings and thoughts, but to learn to live with them. Sometimes called the 'third wave' of CBT, ACT was developed 40 years ago by American clinical psychologist, Dr Steven Hayes. Although it is widely practiced around the world, including here in Canberra, many health professionals remain unfamiliar with it.

So how does ACT do things differently? Whereas traditional CBT relies on rational thinking, ACT originates from mindfulness practices. Instead of engaging an unhelpful thought, the person acknowledges its existence and then distances themselves from it, through a process called 'cognitive defusion'. For example, rather than thinking 'no one likes me' the client learns to say to themselves 'I am having the thought that nobody likes me'. Rather than saying 'I don't have enough time to exercise' they just observe the thought and effectively say, 'thankyou mind'.

ACT shifts the goal away from symptom-relief to functionality – being able to live a meaningful life. The client is helped to develop a clear view of what's important to them and to live consistently with those values and goals, with the assistance of mindfulness-based strategies.

The principles of ACT include the following:

- **Cognitive defusion**
  The person notices their thoughts, does not judge them and detaches from the content of their thoughts. This allows the person to see their thoughts as separate to themselves.
- **Commitment**
  The person is clear about their values – who and what is important to them – and makes a committed effort toward their goals in order to live a meaningful life.
- **Mindfulness**
  The person is aware of their internal and external worlds. They are able to notice their feelings, thoughts and senses in a grounded manner and from there act deliberately toward their values.
- **Psychological flexibility**
  The person learns to increase their range of perspectives. The opposite of this is psychological rigidity, which often leads people to feel stuck and so act in impulsive or avoidant ways.
- **Functionality**
  Whether the person is able to function according to their goals is more important than whether their symptoms are addressed.
- **Experiential acceptance**
  The person learns to make room for unpleasant feelings or sensations rather than trying to stop them from occurring (experiential avoidance).

So how does Acceptance and Commitment Therapy work in practice?

Consider the person with chronic pain. Often there's nothing that can be done to help them in a physical sense. Therefore, the therapist would help the client 'make space' for pain in their life while focusing on what is more meaningful and functional to them.

Another example might be the young person with school avoidance. Rather than targeting the negative feelings the child is attaching to school, the therapist helps the child to make room for that discomfort in the service of important goals like socialising and attaining academic achievements.

The principles and strategies of ACT are relevant across the full spectrum of mental health conditions. They can be useful as first-line therapy or when conventional CBT fails.

Importantly, ACT says to a person 'You can still live a worthwhile life, despite your symptoms'. This makes it a powerful approach in a world where discomfort – physical, emotional and mental – is a normal part of human experience. ■

Useful metaphors to help patients understand their own mental processing

The radio/email inbox

The mind is constantly chatting like talk radio in the background. The person learns to simply observe the chatter and let it be. In a similar image, the mind is compared to an email inbox – not all emails need to be acted upon, and some thoughts which can look very compelling are spam that ought to be filtered out or simply archived without actioning.

The bully

If a bully is calling out, the worst thing a child can do is argue with them, or the encounter will likely escalate. Likewise, instead of arguing with a thought, the person effectively says 'thankyou mind'. The internal bully does keep coming back, but over time, they bother us less.

The solution machine

The mind is a solution machine. It doesn't care if it's offering helpful or unhelpful solutions and some of its suggestions are downright scary – consider for example, the prevalence of suicidal ideation. Viewed in this way, the individual understands it is unwise to act in accordance with every 'solution' their mind offers up.

The tug of war

The mind is on one side of the rope, while the client is on the other. Can you let go of the rope so that there is no tension and you don't have to fight anymore? After you let go of the rope, you can reorientate to the things that are important to you – meet a friend, go for a coffee, go to work.

Vaping reforms a breath of fresh air

AMA welcomes sweeping reforms on vaping products recently announced by the Federal Government, which are consistent with AMA advocacy.

As part of the 2023-24 budget the government announced it will work with states and territories to stamp out the growing black market in illegal vaping, including to:

- stop the import of non-prescription vapes;
- increase the minimum quality standards for vapes including by restricting flavours, colours, and other ingredients;
- require pharmaceutical-like packaging;
- reduce the allowed nicotine concentrations and volumes; and
- ban all single use, disposable vapes.

The Government said it will also work with states and territories to close down the sale of vapes in retail settings, ending vape sales in convenience stores and other retail settings, while also making it easier to get a prescription for legitimate therapeutic use. ■

AMA calls for end to unjust 'name and shame' powers

A number of changes to the Health Practitioner Regulation National Law recently came into effect, including a concerning new power for AHPRA and the National Boards to make public statements about practitioners prior to completing due process.

The AMA strongly opposed this power from the start due to the serious harm to the professional reputation and wellbeing of any practitioner publicly named when a subsequent investigation exonerated them from any wrongdoing.

While AMA were unable to prevent the Health Ministers from amending the National Law to introduce this power, we have through our submission and discussions with AHPRA and the Medical Board clarified that this power will be used extremely rarely and only in the most serious circumstances posing a threat to public safety.

We have also succeeded in ensuring that practitioners about to be named will be provided at least one business day's prior notice by email and text message or other means of communication (allowing time for an appeal or an injunction); that in the event a statement is revoked, it will be made in the same way as the original statement; and consideration will be given to a request by the practitioner for additional steps to be taken such as issuing a media release.

The AMA will continue to advocate for increased accountability for the use of this power. The AMA's position is that any decision to make a public statement about a health practitioner must be made by the AHPRA CEO or the chair of the relevant board, and anytime the power is used it must be reported and explained to the national health practitioner ombudsman.

We will closely monitor use of the new power and continue to advocate for the removal of the public statements provision. This change was a decision of the Health Ministers who administer the National Law. We continue to call on Health Ministers to reverse these unjust changes to the National Law. ■

Professor Steve Robson, AMA President

King's Birthday Honours

AMA ACT would like to congratulate Canberra's Dr David Hughes for being appointed a Member of the Order of Australia. Dr Hughes, a long-time AMA member, was recognised for significant services to sports medicine as an administrator and elite athlete physician. ■

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AMA ACT Events 2023

Safe Space 3

Sunday 25 June 2023 AMA Federal Office, Level 1, 39 Brisbane Ave ,Canberra

From the health system to the individual doctor – facilitating safe spaces in our lives

A morning of facilitated sessions about system issues in medicine, including setting the advocacy agenda and addressing harassment in medicine. Followed by interactive workshops with activities selected for positive mental health.

Open to all doctors and medical students.
Free event – register online to secure your place: **tinyurl.com/amasafespace3**

Presented by AMA (ACT) and Drs4Drs ACT

Conferences

For a full list of conferences visit mja.com.au/conference-calendar

Please check with individual conference organisers about cancellations or postponements.

14 Jul - 16 Jul	iDEA 2023 Conference, Brisbane, QLD
21 Jul - 22 Jul	2023 AOA NSW Branch ASM, Newcastle, NSW
22 Jul	2023 Sydney Eye Hospital Alumni Meeting, Sydney, NSW
22 Jul - 23 Jul	GPCE Perth 2023, Perth, WA
28 Jul	2023 AOA VIC Branch Winter Welcome, TBA, VIC
04 Aug - 05 Aug	RANZCO QLD Branch Annual Scientific Meeting 2023, TBA
18 Aug - 19 Aug	AOA WA Branch ASM, TBA, WA
01 Sep - 03 Sep	26th Annual Australasian Menopause Society Congress, Queenstown, NZ
08 Sep - 10 Sep	2023 AOA Queensland Branch Hybrid Annual Scientific Meeting, Noosa, QLD
09 Sep - 10 Sep	GPCE Brisbane 2023, Brisbane, QLD

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New program bridges leadership gap for ethnically diverse female doctors

Above: Canberra haematologist and ANU clinician scientist, Professor Dipti Talaulikar. **Inset:** Some of the contributors to the Link & Grow Blog; (Clockwise from left) Dr Talat Uppal, Dr Jennifer Elijah, Dr Ashwini Bennett, Dr Anukriti Mathur.

A Canberra-based network has found a valuable role supporting female doctors from linguistically and culturally diverse backgrounds to develop leadership capabilities.

During the deadly Covid-19 surge in India in April 2021, Canberra haematologist and ANU clinician scientist, Professor Dipti Talaulikar assembled the ANU Covid-19 Peer Support Program to support clinicians in India and across the Asia Pacific region.

The network attracted more than 200 volunteer doctors from Australia and New Zealand and pooled substantial networks of international health professionals from 38 countries. It provided direct clinical support to clinicians through online platforms and advised local authorities on setting up ICUs in remote locations. It also ran weekly webinar series for 25 weeks throughout 2021, where international experts countered misinformation about Covid-19.

As the pandemic subsided, Professor Talaulikar and others were determined that the strengths of the network be put to future good use. "Our volunteer base was unique in being very ethnically diverse, including many doctors from the Indian diaspora who initially joined the network to help their home country," Professor Talaulikar told *Canberra Doctor*.

In January 2022, the network held a conference to determine its future priorities. Together they decided upon a new name – 'the Link' – and agreed on several programs aimed at promoting equity in healthcare.

Link and Grow

Among its new programs is Link and Grow, which provides peer support for ethnically diverse female health professionals. This includes a new national, 6-month facilitated mentoring program. Its first workshops began in May, with 18 mentor/mentee pairs (36 doctors) from ACT, NSW, Queensland, Victoria and Northern Territory.

Professor Talaulikar explained: "Despite the Australian health workforce becoming increasingly diverse, women from culturally or racially diverse backgrounds continue to face barriers relating to both gender and racial and cultural background.

"These barriers contribute to their under-representation in leadership positions and ultimately negative disparate outcomes for patients and healthcare professionals."

Link and Grow aims to build leadership capabilities within minority groups and to shift organisational culture to address these inequities and enhance inclusion.

Ideal mentees in the Link and Grow program are culturally or racially diverse women, who are registrars, or Fellows at early or middle stages of their career. By enhancing their mentoring and leadership skills, it is expected that a large proportion of mentees will be interested in being a mentor in future.

Mentors can be individuals of any gender who are trained in medicine and who are now in leadership roles in the healthcare and health and medical research sector and who are committed to inclusive leadership practices and to allyship. Mentors are not required to identify as culturally diverse.

The program gives mentors the opportunity to hear about the experiences of diverse women and understand how micro-aggressions and casual words and actions alienate diverse women and limit their career growth.

Diversity blog

The Link also hosts a diversity blog, which highlights the achievements of female medical professionals of culturally and racially diverse backgrounds, and has just released the Link and Grow podcast series that highlights the barriers they face.

Professor Talaulikar commented: "Some of the challenges entail child rearing and career interruptions amplified during the migration journey.

"These doctors also face racism and discrimination from staff and patients, and isolation and lack of psychological safety because of lack of diversity and inclusion."

The blog showcases heartening stories of resilience from doctors who became aware of the ways their cultural difference brought strengths to their community and workplaces. ■

Professor Talaulikar encourages more women health professionals from diverse backgrounds to contribute to the diversity blog or to express an interest in becoming a mentor or mentee by emailing **international.health@anu.edu.au.**

To subscribe to LINK or offer financial support, visit: **medicalschool.anu.edu.au/connect/link**

The blog can be found at **medicalschool.anu.edu.au/connect/link/link-grow**

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