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CANBERRA Doctor

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ACT Govt snubs GPs, again

The ACT Government's relationship with general practice continues to deteriorate, amid revelations Federal funding earmarked to establish an 'Urgent Care Clinic' will go toward existing nurse-led Walk-In Centres, with no doctor involvement.

ACT's five Walk-In Centres will become Urgent Care Clinics, Chief Minister Andrew Barr announced in October, with more than $7 million of Commonwealth money used to employ additional non-medical staff at the centres and buy extra equipment to expand the scope of services they provide.

The announcement defies advice from senior doctors as well as from the AMA and the RACGP and comes amid ongoing tension between the profession and the Government over a new payroll tax on GP earnings.

AMA ACT President, Professor Walter Abhayaratna said the latest development was another example of the ACT Government failing to understand general practice's role underpinning the Medicare system.

"We have worked really hard to keep the lines of communication open with Government, helping them to understand that collaborative GP-led primary care is the best value investment to keep patients out of hospital," Professor Abhayaratna said.

"General practice is really struggling from chronic underfunding at the Federal level, and yet, at every opportunity that the ACT Government has had to support general practice it has made a decision in the opposite direction."

GPs wiped from plan

Urgent Care Clinics were the centrepiece of Labor's health policy at the May 2022 election, with $135 million allocated to establish more than 50 clinics over four years.

In the model proposed by the Federal Government, the clinics were to be GP-led, and on the eve of the election, ACT Senator Katy Gallagher told Canberrans the clinics were "a key part of our plan to strengthen Medicare by making it easier to see a doctor".

Each state and territory Government was tasked with developing its own model, with the aim of providing short term, episodic care for urgent conditions that are not immediately life-threatening.

In March 2023, Canberra Health Services issued a proposal to implement an Urgent Care Clinic by placing a GP into an existing CHS Walk-In Centre. The AMA ACT and RACGP warned in a joint response that the model was not GP-led and created potential workload and indemnity risks for the one doctor who would be "hidden away in the back office". They raised concern that alternative models had not been explored, including augmenting the existing GP-led After Hours Locum Medical Service (CALMS) or funding an existing GP clinic to expand its service.

Weston Creek Walk-in Centre, currently one of the ACT's five Walk-In Centres.

However, in October Chief Minister Andrew Barr announced a final model that completely wiped GPs from the picture. Instead, the money would fund 3 new Nurse Practitioners, 3 new Advance Practice Nurses, a physiotherapist, radiographer and

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President's Notes

WITH PRESIDENT, **PROFESSOR WALTER ABHAYARATNA**

Dr Graeme Thomson (fourth from right) receiving his life membership of the AMA, alongside [L-R] Dr Igor Policinski, Dr Antonio Di Dio, Abigail de Waard, Dr Tanya Robertson, Professor Walter Abhayaratna, Dr Kerrie Aust, Dr Andrew Miller and Dr Betty Ge.

First there was payroll tax. Now there is the shameful shafting of GPs from the Urgent Care Clinic model. It's hard to overstate how disappointing the ACT Government's attitude to general practice is.

The Federal Government's Urgent Care Clinic program is no panacea for emergency department waiting times, but it was at very least, meant to improve patient access to doctors after-hours in an out-of-hospital setting. States and territories were given a unique opportunity to invest Federal funds in improving the accessibility of existing GP-led services to keep patients out of hospital.

This ideal should have been seized upon by the ACT Government, given the well-known GP-access problems here in Canberra. Models could have been explored putting more nurses into existing general practices. The GP-led CALMS clinic could have been supported to provide expanded services at no cost to patients.

Instead, the Government decided to rebrand its Walk-In Centres as Urgent Care Clinics and employ a few more non-medical staff and buy some extra equipment, in a model that competes with already struggling general practices.

There is no doubting the expertise and commitment of ACT's nurse practitioners, but the limited evidence available suggests nurse-led centres are a very expensive model of care, where patients very often have to be sent back to emergency or to a general practice.

Indeed, at the hospital we are seeing an ever-increasing number of Category 3 and 4 patients with chronic disease – a tell-tale sign that Canberra's primary care ecosystem, including struggling general practices and siloed nurse-led care, is not working.

The only proven way to keep patients out of the emergency department is to make GP-led care more accessible. While the ACT can't undo decades of Medicare underfunding of general practice, it has had two important opportunities to support general practice this year and it is squandering them both.

Payroll tax help

AMA ACT continues to negotiate with the ACT Government over its new payroll tax on GP earnings, and notes that the Queensland Government has recently announced that the tax will not apply to patient fees paid directly to a GP.

In the meantime, we recently ran a Payroll Tax Webinar to help GPs understand their obligations. Hosted by specialist accountants Cutcher & Neale, the webinar is available on the AMA ACT website.

Farewell Dr O'Connor

The legendary Dr Simon O'Connor, whose famous 'Talley and O'Connor' textbooks have been a sacred text of medical students around the world for decades, has announced his retirement.

Dr O'Connor is another of Canberra's unsung medical heroes, having worked as a consultant cardiologist here since the 1980s. I have had the pleasure of being an examiner alongside Dr O'Connor for many years through the Royal Australasian College of Physicians where I have often appreciated his razor-sharp wit and incredible insight. We wish Dr O'Connor all the best upon his retirement and will sincerely miss having him around.

Congratulations Dr Thomson

Congratulations Dr Graeme Thomson, who was recently awarded life membership of the AMA after 50 years. Dr Thomson, a GP who has also worked as a VMO, acknowledged the ways AMA has supported him in the background and the foreground. He made specific reference to AMA's negotiating for better employment conditions for doctors, and its leadership on difficult issues in medical-politics, to the benefit of the whole community. It was an honour to present Dr Thomson with his life membership (see picture).

Education and research

The latest string of warnings from the colleges regarding training accreditation for some of Canberra's hospital departments is troubling. This is not an individual unit problem; it's a system issue.

We have so many brilliant doctors and health care staff here in Canberra, but I fear we really don't let them reach their full potential. We need our health system leaders to keep expanding their vision for what we can be, and create structures and processes that support education and research – not just service delivery. Get that right, and doctors will pay it back by staying here in Canberra.

Diary event

The next Drs4Drs ACT Safe Space event is scheduled for Sunday 26 November at AMA offices in Barton, 9am-2pm. These events are always a great opportunity to build the supportive network of medical colleagues we have here in Canberra, and access resources that support a sustainable career in medicine. I encourage all readers to consider coming along. Tickets available at **trybooking.com/CMPKF** ■

Students highlight vaping harms

Minister for Health Rachel Stephen-Smith together with AMA ACT CEO Peter Somerville were delighted to present students with awards at a ceremony for the long-running Art In, Butt Out competition in October.

Now in its 16th year, Art In, Butt Out is an initiative of the AMA ACT and its Tobacco Task Force and sees year 8 students from around Canberra design a poster to persuade their peers about the harms of smoking and vaping.

This year's winner was Canberra High School Year 8 student, Rose Tong (pictured), whose colourful poster showed three teenage girls chained to a shadowy vape, in a stark warning about the addictiveness of vaping.

Ms Stephen-Smith told the students: "Very worryingly, for the first time in 20 years we have seen an increase in smoking rates amongst young people aged 14-17 years in Australia. Researchers believe that young people are becoming dependent on nicotine through vaping and are then starting to smoke as well."

Ms Stephen-Smith stressed that vapes should not be considered harmless. "The particles that people vape, and those around them breathe in, are of an ultra-fine size that is difficult to visualise," she said. "Because they are so small, they penetrate deep into the lungs and can transfer via the bloodstream to every organ in the body."

AMA has been a strong advocate for greater regulation of vaping, and is pleased the Australian Government has recently introduced a number of reforms, which are also supported by the ACT Government. These include banning the sale of all e-cigarettes in retail settings.

Mr Somerville thanked all the competition entrants for the high quality of their work. "This is a powerful competition because the public health messages being created are designed by teenagers, for teenagers," he said.

Art In, Butt Out is supported by the Cancer Council ACT, Winnunga Nimmityjah Aboriginal Health Service, Canberra ASH and the Heart Foundation as well as the ACT Government and AMA ACT. ■

COVER STORY

ACT Govt snubs GPs, again

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sonographer and a raft of new equipment, and there would be no doctor involved.

Extraordinary disappointment

AMA President Professor Steve Robson and AMA ACT President Dr Kerrie Aust have expressed their "extraordinary disappointment" over the final model in a letter to Federal Health Minister Mark Butler, urging him not to lose control of the implementation of Labor's election commitment.

"The current network of nurse- practitioner led clinics are not well integrated with other primary care services locally, leading to fragmentation, duplication, and extra costs," they wrote. "While we recognise nurse practitioners as being highly skilled health professionals, the model proposed reinforces a siloed approach to care."

Professor Robson and Dr Aust said the ACT Government's lack of understanding of the role and importance of general practice had become "obvious in recent months in the commentary of the Chief Minister with respect to payroll tax".

Payroll tax

Payroll tax has emerged as a new threat to general practice viability around the country in the wake of a decision by the NSW Court of Appeal to apply the tax to GP earnings. After strong AMA advocacy, GPs in Queensland were recently granted a reprieve, with the Revenue Office advising that Medicare benefits and patient fees would not be subject to payroll tax when paid directly by a patient to a doctor for a medical service.

After AMA ACT and RACGP advocacy, the ACT Government has agreed to rule out back-taxing practices for payroll tax. However, going forward, GP earnings will be subject to the 6.85% tax, which applies to wages paid over $2 million. The only exemption is for practices that bulk bill at least 65% of their patients.

GPs have told AMA ACT they're already operating on exceedingly slim financial margins, and that the new tax leaves them with the difficult choice between further increasing patient fees or reducing their service. ■

DIGITAL HEALTH RECORD

Canberra's DHR turns one

It's almost a year since the DHR went live across Canberra's public health system, triggering more than 2000 help requests daily in the initial weeks. Thankfully, things have settled; the DHR team now receives around 200 help requests daily, and says it has a 90% closure rate in 24 hours.

Associate Professor Rohan Essex, a Canberra ophthalmologist and Chief Medical Information Officer for the project told *Canberra Doctor*: "It's been a wild ride, but I'm very confident it was the right strategic decision for the territory."

He noted NSW Health has chosen to go ahead with the same system. "It's a vote of confidence in what we've done with the DHR in Canberra," he said. "It will be exciting when south-east NSW is on the same system as ours because we'll have far greater interoperability for those patients who come from south-east NSW – which is about a third of patients managed in Canberra Health Services."

So what are the ongoing issues? Here's what Associate Professor Essex had to say:

New configurations

"We've had a lot of work to do recently configuring the system for the Calvary to North Canberra Hospital transition. We are also now embarking on quite a bit of work to support the new clinical services building at Canberra Hospital. That is taking up a fair bit of our resources."

Data and reporting

"We have had to rebuild all our national submissions for elective surgery waiting lists and admitted patient care. That's proving to be more challenging than we anticipated and we've had to apply for extensions from the Department of Health.

"The good news is that once we've got the reports built, they should be automated from that point on. I'm excited to get some full visibility of the whole patient journey from referral to appointment or surgery."

Optimisations

"We are still working closely with clinicians on customising and optimising the system to suit their needs. Most of our core workflows are now pretty stable and mature – things like outpatient visit, inpatient workflows, the operating theatre. We are now focusing on the edge cases as well – issues affecting the smaller specialties and opportunities for improved efficiency with system use."

Refresher training

"I'm reasonably confident that the vast majority of our clinical workforce, including the VMOs and part-timers, have become comfortable in performing their basic workflows. A big focus

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Father and son differ on DHR

Dr Andrew Miller and Dr James Miller are father and son doctors. Andrew works in private practice as a consultant dermatologist and sees public patients at outpatient clinics, while James is a junior doctor at the Canberra Hospital. Andrew says the DHR has made life harder, but James thinks it's an amazing tool.

ANDREW MILLER

"I'm only at the clinic intermittently but I would say that at every clinic we hit a problem. A lot of it is problems with ordering pathology and prescribing. We all carry prescription and pathology pads and if we can't get the software to work, we just write it out on paper. We might log a concern but we don't waste time.

"One of the things we've had issues with is registrars appearing on the system like consultants. Consultants get dropped off and not put back on. The problem of data entry and lost results is gradually getting better but it's taking a lot longer than anyone thought it would.

"Workflow is worse than it was before the DHR. I have to enter information into the DHR the way it wants and tick all the right boxes. There's lots of clicks. It adds about 10 or 15 clicks to the end of each consult. It won't let me sign out until I've done it all. It might be good for health system managers wanting to look at stats, but it's a pain in the bottom for the clinician."

JAMES MILLER

"I think the DHR is amazing. It is such a good system from a junior doctor standpoint. It provides an electronic record of medications, but also when they've been given, as well as vital signs and things like that.

"The productivity gain particularly around patient reviews after-hours for junior doctors is amazing. If you get a call from a nurse, in the old days you had no idea what the patient was in hospital for and you would hear the nurse flicking through paper files to get their admission note; whereas with the DHR I can look up the patient and initiate a plan before I've even got to them.

"The medication prescription side of things is really good as well because you can create your own custom lists and things like that. Some specialists have set up treatment orders. A good example is a heparin infusion. If someone senior has set it up, as a junior doctor you can just order that set and you know that it's safe and guidelines-driven.

"The clinicians who like it less tend to be the consultants, and I think that's partly because the system is not so great when it comes to outpatients. For inpatients however, the DHR is amazing and it's just going to get better because it has its own self-generating momentum for collaborative continual improvement."

between now and the end of the year is on refresher training and ensuring people stay up-to-date with their optimal use of the system and any new features.

"We've had to do a lot of work to retrain and support surgeons affected by the fires that affected the North Canberra Hospital operating theatres at the end of 2022. A lot of those surgeons only had a week or two to use the system after they were trained, and they've only just got back into the theatres."

Links to general practice

"DHRLink allows GPs to see the entire medical record of the patient, with medications, problem lists, all the clinical notes and pathology results. We are currently running a pilot at three practices, with a view to offering it to all general practices next year, and possibly some non-medical practices as well.

"One requirement is for patients to give written consent to GPs to access their chart. Over 36,000 patients have provided this consent, but we are looking at changing the way we capture consent to make DHRLink a more useful tool."

Pathology results

"Many of the problems we had in the beginning with DHR communication to external software have been resolved. We have a solution for pathology results where we are sending PDF summaries through the DHR digitally to general practice software. We are working towards a text-based message rather than an image-based message for cumulative pathology results and hope that will be in place by the end of the year."

Individualised support

"I am acutely aware that there is still a number of clinicians who are unhappy with the transition to the Digital Health Record. I would encourage any members to reach out if this sounds like you – there is a lot we can do to help, including individualised support, training and system personalisation. Your feedback will help us make the DHR better for all. The DHR support team genuinely want to make the system as good as it can be for clinicians and for our patients." ■

Dates set for VMO contract arbitration

While some progress towards a new VMO contract has been made at the recent mediation session held between AMA ACT, the ACT Visiting Medical Officers Association (VMOA) and the ACT Government, hearing dates for arbitration have been scheduled for the last week of November. Consequently, a decision on the new VMO contract is not expected until early in the new year.

While the recent mediation resolved a number of minor matters and made progress on others, the major issues, including the new contract rates, remain outstanding.

AMA ACT and the VMOA continue to work together representing VMOs, as the arbitration of outstanding claims kicks off next month.

Amongst the matters resolved at the mediation, or on which progress was made include:

- Use of act.gov.au email addresses for contact purposes. The Territory will not require VMOs to use an ACT Government email address as the relevant contact email.
- Daily rates for locums. Revised wording being considered to the effect that the agreed daily rate will not be less than the sessional hourly rate when averaged across all days worked in a fixed period.
- Introduction of a new Schedule 6 to register variations to the contract.
- Access to ACT Govt electronic systems with @act.gov.au email address. Clarification that use of @act.gov.au email address is for accessing ACT Government electronic systems (i.e. 'logging in') and there is no further requirement for use.
- While Digital Callback will continue to be a feature of the contract, consultation is occurring on the guidelines for its use.
- Liability coverage has been clarified and updated to ensure consistency and clarity. Cross Border indemnity cover for VMOs has also been confirmed subject only to the treatment being provided under the contract while the VMO is on-call or as otherwise required by the Territory.

Progress was also made on issues of parking, public holidays and the Continuity Bonus with further work to be undertaken prior to the arbitration hearing.

Outstanding Issues

Although progress has been made on several issues, the key issues, including sessional and Fee for Service rates, remain to be arbitrated.

In addition to rates, other important issues remain that include support for continuing education, three-year contracts, choice of sessional or fee for service or hybrid contracts, and no reduction of workload (unless agreed) for the duration of a VMO's contract.

Rates

Both AMA ACT and the VMOA have claims in regard to the rates payable to VMOs under the new contract. AMA ACT's claim is that FFS VMOs should be remunerated at AMA Fees List rates, with a phasing in of the rates to occur over the life of the contract.

For sessional VMOs, rates should be adjusted by the most recent increase in the AMA's Medical Fees index (MFI). The MFI is used to adjust the AMA Fees List rates each year.

Finally, if we are not successful with the AMA Fees List rates claim, the AMA ACT has proposed that FFS rates should also be increased by the MFI. ■

For further information please contact AMA ACT at industrial@ama-act.com.au or on 02 6270 5418.

DOCTORS IN TRAINING

Pain points for junior doctor training identified

The barriers that junior doctors face in accessing training were recently discussed at AMA ACT's Council of Doctors in Training (CDT).

The feedback was that interns and residents are generally well supported by the Director of Prevocational Education and Training (DPET), however in the later years of training, junior doctors have had mixed experiences at department levels. Some departments have exceptional leadership when it comes to training and development, whereas others have 'journal clubs' that exist only on paper – they are almost always cancelled due to clinics running overtime.

Areas of concern were the lack of support for unaccredited registrars and Senior Resident Medical Officers (SRMOs) and for International Medical Graduates (IMGs).

Below is a summary of some of the challenges and potential solutions.

Interns and residents

Interns and residents come under the oversight of DPET, which provides regular structured and centralised teaching. Every week, trainees at the Canberra Hospital have 1 hour of 'protected' teaching and 1 hour of 'unprotected' teaching.

Over the past few years the DPET has worked hard to enforce the hour of protected teaching time, and have tried to communicate to nurses and departments that interns and residents should not be expected to be contactable during this time. This has certainly improved access to training, however all junior doctors have experience of being paged during this time as there is no one to cover for them.

CDT would like to see the hospital encourage interns and residents to drop pagers off at rostering or DPET during training. Unprotected teaching time could also be converted into protected teaching time which would increase attendance.

Unaccredited registrars and SRMOs

Gone are the days of entering straight into training programs after internship and residency. Now, most doctors will spend some time as an unaccredited registrar or SRMO before being successful at applying to a college training program. Unaccredited registrars and SRMOs have no centralised teaching program and no training oversight. Whether they are permitted to join accredited registrars in training opportunities varies from department to department. Often unaccredited registrars and SRMOs are relied upon to do clinics and other tasks that may be considered low-value in terms of training and development, so that accredited registrars are freed up to attend high-value opportunities such as surgical training.

This group of junior doctors are among the most likely to be taken advantage of out of any doctor at the hospital. They are eager to maximise their work experience so they can attain a position on a college training program and are reluctant to complain as they rely on the endorsement of senior doctors.

CHS has acknowledged this group as needing additional support. Starting from next year, a new position has been created which it says will provide education and career advancement support for all doctors across CHS. This is likely to be a very challenging role, as this position will cover a mix of different registrars from the surgical specialties, obstetrics, and medicine. One particular concern is that if unaccredited registrars are granted protected training time, will accredited registrars or consultants cover for them or will clinics be cancelled?

Other jurisdictions have tried some innovative solutions. In Victoria, unaccredited registrars have up to 4 hours rostered time a week where they're paid to do education/research activities but do not need to be at the hospital.

Accredited registrars

Accredited registrars come under the oversight of their college, which accredits their training position at the hospital. However, it is well known that some departments in Canberra are at risk of losing their accreditation. This is typically because they are so short-staffed that trainees need to sacrifice training opportunities such as theatre time to attend hospital clinics and perform other tasks of lower educational value.

Another issue for registrars is accessing non-clinical time to complete the research requirements for their college. In situations of staff shortage, this non-clinical time is the first thing to go from the roster.

Many of the go-to solutions are fraught. Typically, departments rely on unaccredited registrars so that accredited registrars can get to training/theatre, however in some departments the culture is so poor that unaccredited registrars don't want to work there. Struggling departments often rely on locum consultants. These doctors often don't know the registrars well and have their own reputation to protect, which often means they give trainees less hands-on experience.

Canberra Hospital has recently advertised for SRMO positions who will do two terms in an area of their choice and then two terms in an area of the hospital's choice to help deal with planned and unplanned leave on the wards.

International Medical Graduates

Approximately 1 in 3 residents at the Canberra Hospital are overseas trained. The number of overseas trained junior doctors is expected to further increase as Australia looks to expand the areas of automatic registration recognition (UK, NZ, South Africa, Canada and the US) and accepts increasing numbers at the registrar level. These doctors often face language barriers and are unfamiliar with the hospital system. Intensive investment in support of this group of doctors is urgently needed. ■

Wage theft class action gathers momentum

Around 2,200 doctors who have worked as JMOs in the ACT since 2016 have recently received formal notification about a class action to recover wages for unrostered unpaid overtime, which could result in payouts of up to $40,000.

Hayden Stephens and Associates and Gordon Legal have been contacting doctors urging them to register their interest in the ACT class action. Similar class actions are underway in Victoria and NSW.

Victoria's win

The ACT class action follows a landmark victory for junior doctors in Victoria, with the Federal Court handing down a decision in August that employer Peninsula Health breached its obligations under the Enterprise Agreement by not paying a doctor for her unrostered overtime.

Mr Hayden Stephens told *Canberra Doctor*: "It's the first wage theft case of its kind in Australian legal history where a health department has been forced to recognise the true working hours of a junior doctor."

Under the Enterprise Agreement in Victoria, a doctor is entitled to payment for their unrostered overtime in circumstances where the work that they perform is authorised. A central issue in the court case was the interpretation of "authorisation".

The Court determined that the overtime duties performed by the lead applicant, Dr Gaby Bolton, were authorised because they were both necessary and required, even though they may not have been at the express direction of a supervisor. Dr Bolton did not have a record of her hours, but the court largely accepted her best recollections.

Peninsula Health lodged appeal papers in October to challenge the decision. While different employment regimes exist in each state and territory, Mr Stephens said the Federal Court decision was extremely important for doctors in the ACT because of the similar nature of duties carried out by junior doctors and the circumstances in which those duties are performed outside rostered hours.

The ACT

In the ACT, lead applicant Dr Ying Tham has brought proceedings against both the ACT Government as the operator of the Canberra Hospital as well as Calvary Hospital. Junior doctors who have worked unpaid unrostered overtime at either hospital over the last six years are automatically included in the class action unless they choose to opt out. A trial is expected to go ahead in late 2024.

Calvary Hospital has taken the unusual step of filing a counter claim, signalling its intension to recover any compensation awarded to Dr Tham on the basis that she failed to keep her own time records. Mr Stephens said it was an unusual step, not taken in any other actions underway and, in his opinion, designed to intimidate doctors from adding their voice to the campaign.

Culture change

Mr Stephens said the problem of excessive hours and unpaid unrostered overtime among junior doctors was "widespread and systemic".

"Doctors often work unrostered unpaid overtime for necessary clinical and administrative tasks such as discharge summaries, completing medical records or conducting a handover," he said. "Those hours can stretch to 10-15 hours on average per week, with even more for doctors who work in some surgical departments."

Mr Stephens said if successful, the class actions could lead to payments between $10,000 and $40,000.

He praised the lead applicants, including Dr Bolton and Dr Tham, for their "tremendous courage to do what's right".

"In hospitals there is a power imbalance between junior doctors and senior doctors and heads of department," he said. "To bring a claim for underpayment is a huge step especially when these same senior doctors are often the gatekeepers of your future progression and career opportunities.

"In that environment, there is a real sense that you can't speak up, and you keep your head down and do what you need to do. But as we have seen, doctors are speaking up and with the success in Victoria, in big numbers."

Mr Stephens said although some senior staff were resistant to reforming hospital culture, there were notable exceptions. He said some consultants had urged junior doctors to record their unrostered overtime to expose problems of burnout and understaffing. Anecdotally, some health services have also told junior doctors they'll authorise any overtime they claim in the wake of the class actions.

Mr Stephens said keeping a record of unrostered hours worked could benefit a doctors' claim, although the absence of records was not a bar to participating in the class action. ■

Hayden Stephens and Associates wants to hear more from ACT's junior doctors about their experiences of unrostered unpaid overtime. It takes only a few minutes. All conversations are strictly confidential. To register your interest in the class action visit: haydenstephens.com.au/act-doctors-in-training

Getting to know and love your Modern Award

GREG SCHMIDT
Senior Workplace Relations Advisor, AMA ACT

Industrial Awards have been a feature of the Australian employment landscape for many decades, containing enforceable standards for minimum pay rates, hours of work, overtime payments and other conditions.

"Modern Awards" is the name given to awards created by the Fair Work Commission and authorised under the *Fair Work Act 2009*. Compared to many of the Awards that they replaced, Modern Awards generally are simpler and easier to understand – although the process of "plain English" simplification is an ongoing task.

Coverage

Most ACT workers will be covered by a Modern Award, unless an Enterprise Agreement has been approved for their workplace. Depending upon the particular award, managers may or may not be covered by the award.

The Modern Awards that apply to most ACT medical practices will be:

- *Health Professionals and Support Services Award 2020 (HP&SS Award)*, and
- *Nurses Award 2020*

In addition, the *Medical Practitioners Award 2020* may apply to some medical practitioners who are employees in some (but not most) medical practices.

The part of the Modern Award that tells you who it covers is Clause 4 – Coverage. Coverage by a particular award requires identification of both the employer (by reference to their industry) and the employee (by reference to their role). So, while both receptionists and nurses might be employed by a medical practice (operating in the "health industry") the specific roles require that two different Modern Awards will apply.

Wages

Each Modern Award has a "Minimum Rates" clause (generally found at around Clause 15 or 16) that sets out the minimum wage rates for each classification level in the Award. Employers cannot pay less than the specified amount but there's no restriction on paying more. So, if the Modern Award specifies that the minimum weekly wage for a full-time Level 3 Support Services employee is $983.40, there's nothing stopping a practice from paying $1000 or $1100 per week for the role. This may be necessary if you are having trouble attracting staff in a competitive market.

Hours

The Modern Award contains a clause setting out the span of hours during which ordinary time hours can be worked. In the case of the HP&SS Award, that's Clause 13. For private medical practices, it states that ordinary hours can be worked up until 9:00pm Monday to Friday, and Saturdays between 8:00am and 4:30pm *(different hours may apply to different types of practices)*.

Suppose that the practice wants to run its Thursday evening clinic up until 10:00pm. The two admin staff that are working that evening will have to be paid at overtime rates for any time worked after 9:00pm (that comes from Clause 25 – Overtime). That's OK, but it introduces an extra complication for whoever is calculating the payroll.

Individual flexibility

The Award allows for an alternative way of handling this. Every Modern Award has a clause allowing for Individual Flexibility Agreements (it's Clause 5 in the HP&SS Award). An Individual Flexibility Agreement provides an ability to change the way that particular terms of the award will be applied, in a way that doesn't disadvantage the employee. A practice might, for example, agree with an employee that ordinary hours can be extended until 10:15pm on Thursdays, and overtime will not be paid. In return, the worker might be paid a higher base hourly rate, or perhaps a fixed allowance in lieu of overtime.

There are rules (of course) about setting up an Individual Flexibility Agreement with an employee. A couple of the main ones are that it must be a genuine agreement (that the employee is able to refuse) and the employee must be better off overall. This means that an Individual Flexibility Agreement is not a way for the medical practice to pay less to the employee – the benefit to the employer will take another form. This might be simplicity of payroll, or the ability to keep the practice open later and see more patients.

In conclusion, a Modern Award almost certainly applies to employers and employees in the ACT, unless an Enterprise Agreement applies instead. The Modern Award sets out minimum wage rates and conditions of employment – the employer can be more generous than the Award terms, but can't provide less than the Award requires. This means that allowances, overtime and other Award provisions still apply *even if* the employer is paying above-award wages. Having said that, an Individual Flexibility Agreement made with an employee can allow a package of benefits to be provided to an employee that makes them better off overall, but also provides a worthwhile benefit to the employer. ■

The AMA is available to assist members with advice on Modern Awards and other aspects of the management of staff. Our Workplace Relations Support Line is (02) 6270 5418.

Why AMA membership matters

This year has presented a number of fresh challenges for doctors in the ACT, from the Government's takeover of Calvary Hospital to its decision to impose a new payroll tax on GP earnings.

With each challenge, AMA has been here for doctors, gathering the profession together to understand and respond to the issues. As always, AMA has shown itself to be a strong and respected voice to government and has won some important concessions and assurances.

AMA would like to thank all its members for their support in 2023 and highlight the many ways they have contributed to important work on behalf of the medical profession.

We invite you to join today

joinama.ama.com.au

AMA ACT's work in 2023 has included:

- safeguarding employment conditions for doctors with the takeover of **Calvary Hospital**
- assisting and advocating for GPs in the context of a new **payroll tax**
- bargaining for an improved **VMO Contract**
- bargaining in **Enterprise Agreement** negotiations
- assisting members with **pay issues** and **employment concerns**
- providing practical advice on **staffing issues**
- running **training and careers** events for medical students and young doctors
- holding the ACT Government to account for the challenges faced by **Doctors in Training**

Federal AMA advocacy has also been linked with several wins in 2023, including:

- $3.5b to triple **bulk billing incentive** payments on specified GP consultation items
- $50 million for a **wounds consumable** scheme in general practice
- **60-day dispensing**
- **single employer model** pilots for GP registrars across Australia
- dumping of plans to privatise **Aged Care Assessment Services Teams (ACATs)**

Getting the most out of your membership

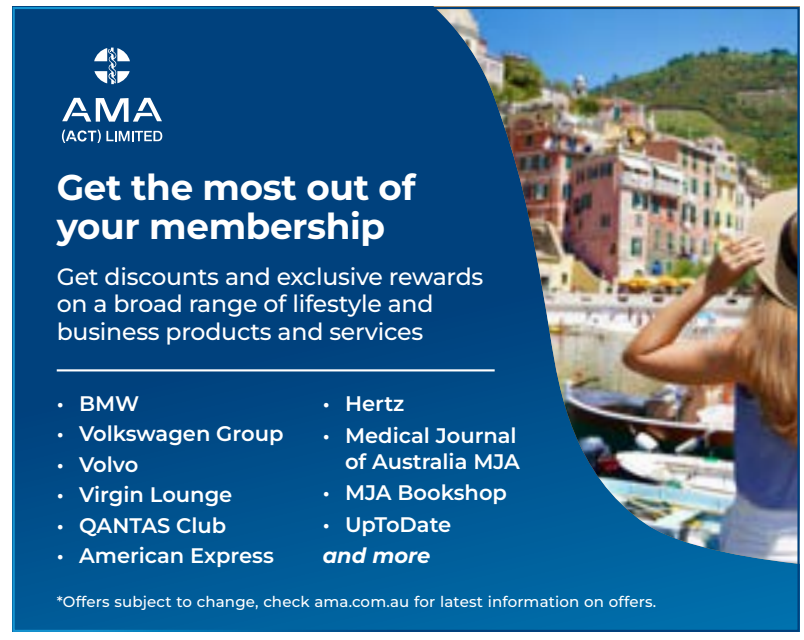
Doctors can get more from their membership by joining AMA meetings in person and online throughout the year. For junior doctors, our Council of Doctors in Training is a supportive group that meets regularly to discuss issues at the coalface of medical education and inform AMA's advocacy and industrial relations work. For senior doctors, there are opportunities to get involved in providing medical care to fellow doctors through AMA's partnership with Drs4Drs.

AMA members receive a subscription to the highly respected *Medical Journal of Australia* and access to AMA's membership portal which provides networking, peer mentorship and professional opportunities. A range of exclusive discounts are also available to AMA members through our membership rewards program partners.

Discounts available

With more members, we can do more to promote and protect the professional interests of doctors and the healthcare needs of our patients and communities. First-time members who join in November will receive 14 months membership instead of the usual 12 months.

If you're already a member, why not encourage a colleague to join? For every new member you refer, you'll receive an additional 25% discount on your annual membership fee. Refer four new members and you'll have free membership for a year. ■



BMW benefits for AMA members

AMA members can access exclusive benefits when purchasing a vehicle through Canberra BMW.

AMA members receive complimentary BMW Service for up to 3 years or 60,000kms in addition to reduced delivery ($1,850 excluding taxes). Benefits are extended to members' spouse or de-factor partner.

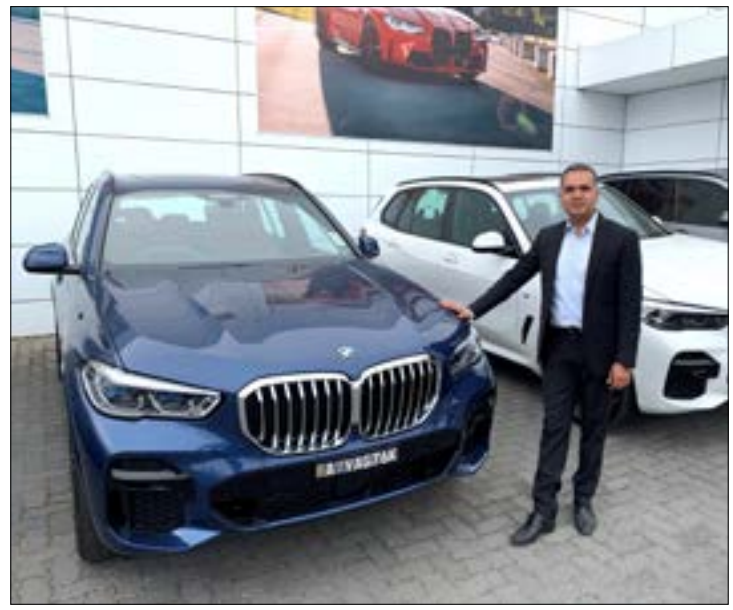
In addition, all AMA members will receive 5 years unlimited kilometre warranty, 3 years BMW Roadside assistance and competitive finance rates across a range of products through BMW Financial Services.

"For our valued AMA members, we proudly offer an exclusive 3-year service package," said Corporate Sales Manager, Tabish Ali (pictured). "This is a true testament to worry-free ownership.

"We're also delighted to extend a generous $5,000 trade-in bonus on select X5 models (conditions apply)," he said. "You'll want to act swiftly because this offer is available only while our stock lasts."

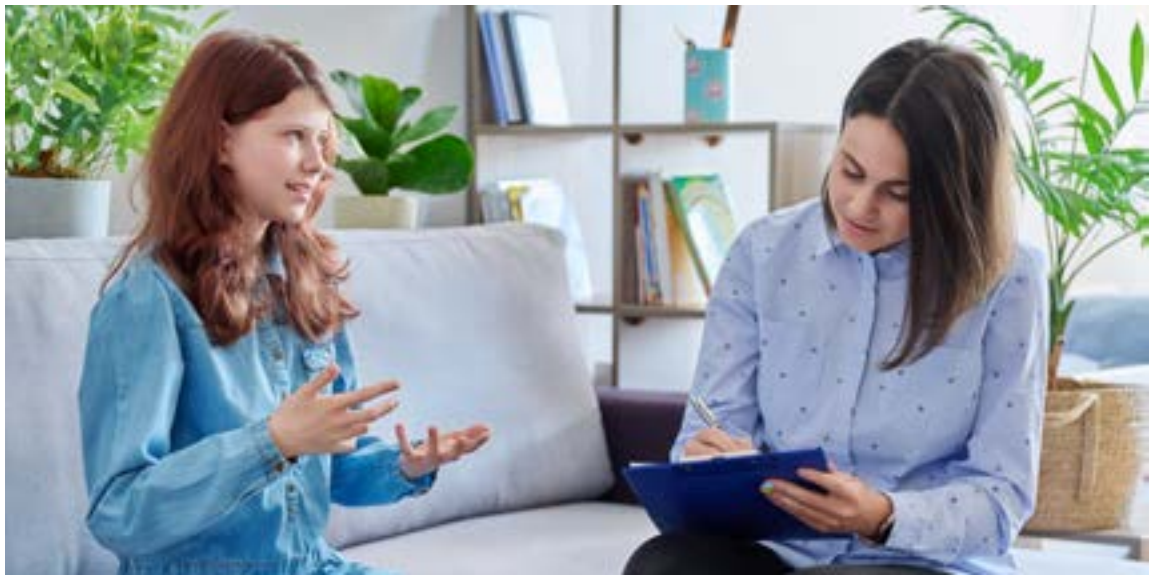
Tabish is pictured with 2023 BMW X5 xDrive30d M Sport. With its powerful 3.0L diesel engine, sports automatic transmission and all-wheel-drive system, this luxury SUV is suitable for both city driving and off-road adventures. ■

To access this offer with BMW, contact reception at AMA ACT to request a membership confirmation letter: reception@ama-act.com.au



Gillick competent or not? Determining maturity of a minor for medical care

DANIEL SPENCER
Medico-legal Adviser,
MDA National



A 12-, 13- and 15-year-old walk into a consultation room. No punchline, but a regular challenge for GPs in determining who is and who is not a 'mature minor' for the purpose of medical treatment.

One of the more common medico-legal queries received by medical defence organisations relates to the clinical management of young persons and to what extent they can make treatment decisions without parental involvement.

There are nuances in every circumstance, and each case requires its own careful assessment.

Put simply, if a child is a mature minor (or '*Gillick* competent'), they are entitled to the same confidentiality about their health information as an adult patient.

Consenting to treatment

Case law guidance in this area comes from the UK case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 which is authority for the position that a child can consent to their own treatment if they "achieve a sufficient understanding and intelligence to enable [them] to understand fully what is proposed".

While a minor may be considered Gillick competent for one procedure, such a finding should not be routinely applied to all treatment. Each presentation/issue must be assessed individually.

Depending on the specific circumstances, consent to medical treatment of a patient less than 18 years of age may be provided by:

- the patient
- the parent or legal guardian
- a court
- other agencies (e.g. in NSW, the consent of the Guardianship Tribunal is required for 'special medical treatment' which includes sterilisation, vasectomy or tubal occlusion in someone aged 16 years or younger).

While young people under 18 years require an assessment of capacity to consent, it is generally accepted that those aged 16 or older do have the capacity to consent. In some jurisdictions, laws allow for those 14 years and over (NSW) and 16 years and over (SA) to consent to their own treatment.

The Office of the Australian Information Commissioner allows a presumption that an individual aged 15 and over has capacity to control who accesses their health record; Services Australia provides access to a Medicare Card from the age of 15; and MyHealthRecord presumes a 14-year-old can control access to their record.

No consent is required in emergency situations if it is impractical to obtain.

Access to records

While queries in this space often relate to a young person's capacity to consent to treatment, they also arise where parents seek access to their children's records. An example is where a parent may wish to know whether their daughter (patient) is taking the oral contraceptive pill.

If the patient is considered *Gillick* competent, a parent or guardian will not have a right of access to the health information of their *Gillick* competent child and any request for access to records should be refused, subject to any of the exceptions under the Australian Privacy Principles, such as if there is a serious risk to health or safety by not disclosing.

One pragmatic option for GPs in these circumstances is to encourage the patient to discuss their treatment with their parent(s) if doing so appears to be in the patient's interests. But it is ultimately up to the patient as to whether to do so. GPs may also wish to encourage an enquiring parent to discuss their request with their child (patient).

Confidentiality

While some parents may hold the view that they ought to be aware of any treatment their (under 18) child is receiving, if patients under 18 feel that their confidentiality may be breached, it can stop them from seeking help. Private time with their GP can help facilitate confidence in talking about personal matters which may otherwise remain unspoken.

GPs should consider asking parents to leave a consultation if the child patient is considered a mature minor, to provide the opportunity for the patient to disclose what is on their mind, and provide a complete, and unedited, history.

It is important to explain to a mature minor your confidentiality obligations and the limited circumstances that may arise requiring you to breach this confidentiality.

When documenting that you have assessed a mature minor to have capacity, it is important to include in your assessment that you deem the patient as able to understand the information given and the broader consequences of the decisions they are making. Providing specific examples in your notes of why you have determined this is helpful in supporting your opinion and assists others who may be involved in the care. ■

This article is provided by MDA National. They recommend that you contact your indemnity provider if you need specific advice in relation to your insurance policy or medico-legal matters. Members can contact MDA National for specific advice on freecall 1800 011 255 or use the "contact us" form at **mdanational.com.au**

Checklist for GPs

The following is a non-exhaustive list of factors to be considered when determining whether a child is a mature minor:

1. Age and maturity
2. Circumstances of presentation
3. Medical and social history
4. The nature, consequences and implications of the proposed treatment and the patient's ability to understand these
5. Degree of independence
6. Family or other social dynamics
7. The type and sensitivity of the information to be disclosed
8. The complexity and nature of the treatment (eg. elective, therapeutic or emergency, minor or major).

Voluntary patient enrolment – good for GPs or a waste of time?

DR SIMON TORVALDSEN
Chair, AMA Council of General Practice

Voluntary patient enrolment (VPE), billed by government as MyMedicare, commenced in October. What does it mean for GPs and patients? Is it going to deliver any benefits? Are there hidden risks?

In principle, there are advantages to VPE. It enables something not previously possible – identification of a patient's nominated primary GP. Most patients can identify who their regular GP is, but government and health departments have had no idea.

There are plenty of tasks that can and should be performed by the patient's regular GP rather than anyone else – such as chronic disease management, care plans, chronic wound care, etc. Note that the proposal involves a nominated GP, but it includes any other practitioners and staff working within the same practice.

While there is some advantage to VPE in terms of better data to government, the main advantage is in providing an opportunity for targeted funding to a nominated GP for care best provided by the regular GP. It can also serve to prevent inappropriate care, such as when a patient goes into a practice once for an acute need and ends up with a care plan.

What is it not? It is NOT a mandatory, capitated system like in the United Kingdom. The AMA would never support this, and we have made this very clear to government. There are many ways to do patient enrolment and there is no intention to copy the flawed UK model. Rather, the Australian model is voluntary (patients can still visit any other GP for consultations) and, instead of capitation, the plan is to use enrolment to 'unlock' access to extra item numbers and additional funding packages.

There will be no payment purely for enrolling a patient, which some may consider a potential flaw in the plan. However, Government insists sufficient benefits will flow from enrolment to render any administrative payment unnecessary. Something the AMA intends to hold them to.

There are a few other flaws in the model as currently proposed, although not fatal ones.

The enrolment process, at least initially as designed by Services Australia, is a rather clunky one. I have put pressure to integrate it with our practice software, and to also ensure obtaining consent for those in residential aged care facilities (RACFs) is practicable.

The major problem, however, is how remarkably little incentive there currently is to enrol most patients. You will gain access to extended telephone consults for enrolled patients – but how often will most of us need this, at least in metro areas?

There will also be a payment scheme for looking after hospital 'frequent flyers' – a nice idea, but again a very small group.

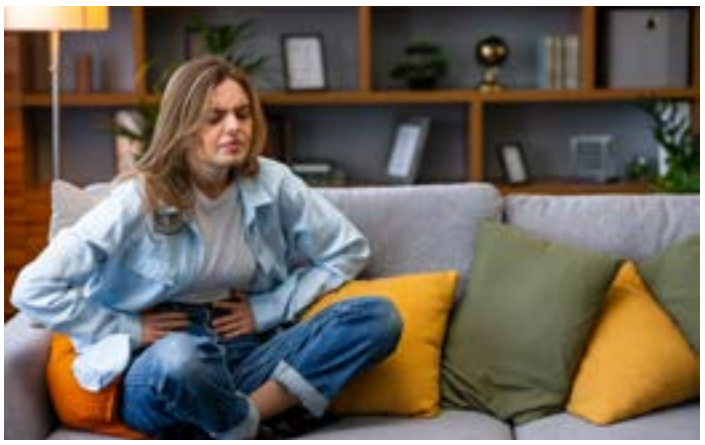
Next year, there will be additional block payments for looking after patients in RACFs – most welcome, but yet again a relatively small group. Enrolled patients will only be able to get care plans from their nominated GP – but those not enrolled will still be able to obtain them from any GP.

I think some of this is deliberate, and there is an intent to pilot enrolment with relatively small numbers and expand from there. That may be okay, but if not done well and appropriate additional incentives are not added, the program risks stalling, disenchantment and failure. This would be a shame, as in fact it can deliver significant benefit for us and our patients as well as cost-effectiveness for government – and, as proposed, carries little risk of devolving into a capitated system or other major problems.

My message at present is to watch this space – and consider enrolling patients who will potentially benefit. Longer term, MyMedicare should deliver significant benefit to patients and their GPs, and be far more than just a bureaucratic nuisance.

Of course, the devil is always in the detail, and that is why you have the AMA to engage on this. Government is consulting with us, and the AMA is working productively to ensure MyMedicare does deliver real benefits, and that these do ramp up over time as promised. ■

> "Longer term, MyMedicare should deliver significant benefit to patients and their GPs, and be far more than just a bureaucratic nuisance."



UTI surge at EDs following pharmacy prescribing

New figures show the number of urinary tract infection (UTI) cases presenting at emergency departments has blown out since pharmacists have been allowed to autonomously diagnose and prescribe UTI treatments in Queensland.

Health Minister Shannon Fentiman released figures about ED presentations across Queensland's 16 Hospital and Health Services showing 36,911 ED presentations between 2022 and April 2023 were due to UTIs.

This is up from 24,620 in 2020, the year pharmacists were first allowed to diagnose and sell antibiotics to patients without undertaking a basic urine test or seeking any medical oversight.

AMA Queensland President Dr Maria Boulton said the UTI pharmacy prescribing pilot has not reduced the number of presentations to EDs. "In fact, UTI presentations have increased since the flawed pilot began," she said.

"This is not a criticism of our hardworking pharmacist colleagues, who we work with every day to get the best outcomes for our patients. It is a criticism of short-term, short-sighted political band-aids that will not resolve our health workforce shortages.

"We continue to call on all levels of government and all sides of politics to work together to recruit, train and retain our own healthcare workforce, and to scrap dangerous experiments with patient health." ■

Survey on antidepressant withdrawals

Mental health specialists are asking Australians who have stopped taking antidepressants, or are trying to stop, to share their real-life experiences through completing a brief online survey.

"More than 50% of people who stop taking antidepressants will experience withdrawal effects," said University of Adelaide Professor Jon Jureidini, who is leading the study.

"For up to half of those people, the withdrawal effects are severe. They can include symptoms such as depressed mood, anxiety, fatigue and brain zaps, which can be misdiagnosed as a return of an underlying mental health condition.

"By investigating real-life experiences with withdrawal, we hope to obtain a better understanding of what resources people might need to help them stop the medication safely and easily." ■

The survey can be accessed at bit.ly/3QOG3JL

DRS4DRS ACT
Australian Capital Territory

The 24/7 Drs4Drs ACT Helpline is 1300 374 377

Responding to trauma in the workplace

Many healthcare organisations have recently adopted the value of "trauma informed care", at least in principle. While it's great to see the issue getting compassionate treatment, it's important to disentangle the 'symptoms' associated with Post Traumatic Stress Disorder (PTSD) from 'disorder'. Truly informed and inclusive workplaces will make space to accommodate people who are working through their response to trauma, and will avoid actions that feed disorder.

NESH NIKOLIC
Strategic Psychology

Symptoms

About 20% of people who experience actual or threatened death or serious physical injury experience ongoing symptoms consistent with a diagnosis of PTSD. However, many of these symptoms, such as flashbacks, nightmares and distress at certain cues, may be viewed as protective responses to past trauma when considered from an evolutionary perspective; it is safer to believe that every rustling bush hides a snake or a bear, than to make the mistake that it's just a bunny.

Disorder occurs when the physical and psychological responses associated with past trauma impede on a person's ability to function. For instance, if after a car accident, a patient resolves not do drive again. Or, if a person believes they can't return to a workplace after a traumatic event.

Treatment

The gold standard therapy for PTSD is exposure, aimed at adjusting a client's response to trauma so that it no longer interferes with their ability to function. An example is the psychologist setting driving challenges for a client who has had a car accident and is distressed when travelling on freeways. I have sat in the passenger seat beside such patients, encouraging them to veer toward the middle barrier until their anxiety is '3 out of 10' and then veer away. On future occasions we would aim for a '4' or '5 out of 10'. After repeated exposure, they are able to get closer to the barrier, however there is a natural point when they will go no further, demonstrating that their anxiety is a truly protective instinct. With this approach, patients can regain confidence with driving.

Workplace challenges

What about in the workplace? Exposure therapy can certainly work for people who are experiencing unwanted symptoms after a traumatic incident at work. However, it is unfortunately not uncommon for patients to believe they simply "cannot" return to work. Sometimes they are encouraged in this thinking by managers and even by their treating health care providers.

I once wrote a very extensive treatment plan to get a client back into a workplace where they had experienced vicarious trauma. The idea was they would spend manageable increments of time in an environment that brought on their unwanted feelings. They started with only a couple of minutes and progressed to 5 minutes one week, 10 minutes the next, and so on. The client was going well for a number of weeks, then unfortunately a manager scolded them for being in the area, stating they weren't allowed, and it set the client back to square one.

Too many times have I seen workplaces inadvertently trigger the severity of a worker's response to trauma through such secondary insults. It is not uncommon for managers to tell staff they cannot be at work or cannot speak with colleagues while investigations into an incident are underway. The worker is left isolated and unsupported in their time of need, exacerbating their response to the trauma.

A caring approach

Trauma-informed care must begin with an appreciation that people can continue to be in the workplace, even while they are working through their response to a terrible event. It requires supportive and nurturing managers, who will not rush a person back into full duties, nor block them from turning up.

People who have experienced trauma need to be heard and taken seriously. They need their feelings to be validated, even if their story isn't. And they need the people around them to promote an expectation that with time, their responses to the trauma will no longer be a barrier to them living the life they want to lead. ■

Doctors learn how to help each other

What's your personality type as a doctor? At a recent workshop to help doctors provide better medical care to fellow doctors, delegates were urged to first understand their own personality type and its associated risks.

Common personality types are the 'obsessional', 'avoidant' and 'dependent' doctor.

Dr Roger Sexton AM, Medical Director of Doctors' Health SA, outlined three common personality types at September's Doctors Health Alliance workshop. First, there is the 'obsessional' doctor, who prides themselves on being thorough but is prone to anxiety and depression. Second, there is the 'avoidant' doctor who doesn't like to clash with the patient, who can become a target of doctor shoppers. Third, there is the 'dependent' doctor, who is much-loved and takes a broad interest in their patients' lives, but at the risk of becoming too deeply involved.

Dr Sexton said knowing ones' personality and associated risks was essential to doctors developing an effective 'operating manual' to sustain them through a life in medical practice. He encouraged doctors to take a step back and look at the way they spend their time, considering for example, starting the working day later after checking emails, and going for a walk in the middle of the day. He also urged doctors to review the mix of work they were doing (eg. clinical, academic, advocacy and teaching), given evidence that those who spent less than 20% of their time on work they loved were at increased risk of burnout. Most importantly, he urged all doctors to get themselves their own GP.

Consultation tips

Dr Helen Wilcox, Medical Director of Doctors Health Advisory Service WA acknowledged the reasons doctors often don't have their own GP, such as fear of being perceived as ignorant, fear of being reported to the medical board and a feeling they could manage their own care better by themselves.

Among her many valuable insights, she urged doctors to make each consult with a fellow doctor "compassion heavy and judgment free", with confidentiality like a "concrete bunker".

Doctors might need to make themselves available outside of normal hours for the doctor-patient, Dr Wilcox said, noting that a common stated barrier for doctors not having their own GP was "waiting room tension", or being seen to be asking for care, potentially alongside their own patients.

Medicolegal advice

Delegates had an opportunity to ask medicolegal experts from Avant their questions regarding mandatory reporting. Dr Marjorie Cross, who was a participant, told *Canberra Doctor*: "The standout for me from Avant was the emphasis on only reporting if there is clear evidence of harm to patients and never to do it without advice from colleagues and your medical defence organisation."

Moral injury

Presenters Dr Margaret Kay and Dr Kathryn Hutt helped delegates understand the nature of "moral injury", which is where people experience a "betrayal of their own moral beliefs". This typically occurs in high stakes situations, where an individual feels they were harmed or failed to prevent harm. It is often associated with sadness and anxiety, guilt and shame and loss of faith in the system, or humanity more generally.

Dr Kay and Dr Hutt said moral injury is increasingly recognised as a mental health issue affecting doctors, in addition to depression, anxiety, burnout, vicarious trauma and PTSD. They urged all doctors to have their own 'personal wellbeing plan', similar to a bushfire survival plan. This includes being aware when one's mental health is "moving into the yellow zone" – for instance, when someone is drinking more or avoiding socialising – and when it is "catastrophic" – a "leave now" situation, requiring immediate help through a GP, Drs4Drs and sometimes a medical defence organisation. ■

The Doctors Caring for Colleagues Workshop was a Doctors' Health Alliance initiative held at AMA ACT offices in Barton as well as online. For help, call the Drs4Drs ACT Helpline 1300 374 377

COMPETITION

$100 prize for student edition

Medical students with a flair for writing or visual arts are invited to submit their work for the annual student edition of *Canberra Doctor*, due out in December.

Written work should be 500-1000 words, and can include works of fiction or non-fiction. Poetry, short stories, essays and book reviews are all welcome. Students are also welcome to submit images of their original visual artworks in JPG form.

Pieces may be about medicine, although that's not essential. The only requirement is that they be entertaining, amazing or thought-provoking.

The student with the best entry, as judged by AMA ACT staff, will receive a $100 gift card. Works previously submitted elsewhere may be entered, provided you are the owner of the work.

Entries should be sent to editorial@ama-act.com.au by November 21.

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LIFE OUTSIDE OF MEDICINE

Canberra's doctors show their colours

What is there to do in Canberra when you're not working? The possibilities include things you've probably never imagined, as Canberra Doctor found out when we asked readers to submit photos of their life outside of medicine.

Dr Liz Fraser, a GP in Watson sent a photo of herself "blue titting".

If you're not familiar with the concept, Dr Fraser is happy to explain:

"While I'm working, I dream of #bluetits. Here I am, in a muddy puddle which is one of the dams below Mt Majura, on a sunny morning in mid-winter. Water temp was probably around 10 deg. My walking buddy and I love to get out and about in the bush at least once a week, especially if it involves a swim in icy water. Blue-titting is super-fun. Did you know that there is a world-wide organisation that promotes cold water swimming? Sunshine makes everything better too, 'specially in Canberra's winter. Sometimes I sneak a dip in before or after a session in GPland."

If blue titting doesn't sound like your cup of tea, how about unicycling, traditional drumming or rock climbing? Thanks to Dr Liz Fraser, Dr Rod Lambert, Dr Graeme Thomson and Dr Kwee-Lian Lim for sharing some of their inspirational and amusing photos. For their efforts, they will each receive an iconic Canberra scrub cap thanks to Drs4Drs ACT. ■

From top: Dr Liz Fraser dreams of blue titting; Dr Rod Lambert loves to ride his unicycle around various ACT bike tracks and trails; Dr Graeme Thomson enjoys playing flute and drumming with the Folkloric & Ghawazee Performance Troupe; Dr Kwee-Lian Lim counts rock-climbing among her many hobbies.

Graduation breakfast: all welcome

Canberra Doctor's favourite event of the year is coming up: AMA ACT's Graduation Breakfast. All doctors are invited to this feel-good morning to celebrate this year's ANU Medical Graduates, alongside their family members and friends.

The event includes breakfast at Hotel Realm, with guest speakers from the Canberra medical community. Graduates who join as an AMA Graduate Member on the day go into a draw to win a prize from one of our sponsors.

This event is FREE to attend for all 2023 ANU Medical Graduates and AMA members. For everyone else, the cost is $40 pp.

Details

8:30am - 10am, Friday 15 December 2023

Hotel Realm, 18 National Circuit, Barton ACT 2600

Tickets

RSVP by Wednesday 13 December 2023 (or until sold out)

Spaces are limited, please secure your place by booking online at:

trybooking.com/events/landing/1124819

Send us your Kris Kringle Zingers

Every good office Christmas party needs a Kris Kringle, or Secret Santa as some of you call it. The best Kris Kringle gift keeps the laughs going well into the new year. So, here's our reader challenge as the silly season approaches: share with us a gift idea valued at less than $20 which is guaranteed to spread joy around the office. Maybe it's one you've given or received before. Photos are welcome. Your ideas will be published in the next issue of Canberra Doctor. Don't forget to give us your postal address so we can send you a **funky Canberra scrub cap** to keep or re-gift. **Email editorial@ama-act.com.au**

REGISTRATION CHANGE IS COMING IN 2024

In order to comply with the new CPD registration standard, all Australian doctors must join an Australian Medical Council (AMC) approved CPD home by 1 January 2024.

Under the Medical Board of Australia's *Registration Standard: Continuing professional development* (the Standard), doctors will no longer be able to self-manage their CPD.

Download our informative guide on the upcoming changes, find out whether or not you will be impacted, and what you need to do.

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$880 (full-time) **$660** (part-time)

Junior Doctors

AMA Members
$220
Non-AMA Members
$440 (full-time) **$330** (part-time)

Welcome Home

At CPD Home, **we understand**. We understand the new Standard and that non-compliance means your medical registration is at risk. We understand how best to support you to stay compliant each year.

Our platform is the only AMC accredited CPD home outside of a specialist college. We boast a catalogue of Australia's broadest range of CPD activities, and offer full support to all doctors to help them achieve their CPD compliance with ease.

Trust the AMA's CPD Home, accredited by the AMC, to guide your CPD journey.

Email: enquiries@cpdhome.org.au
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