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CANBERRA Doctor

Informing the Canberra medical community since 1988

Artificial intelligence in daily practice
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What can doctors expect this term of govt?

The newly re-elected Labor Government is promising more GP bulk-billing, an expanded array of services at nurse-led Walk-in Centres and more healthcare staff working at the top of their scope as part of its agenda to make healthcare in Canberra more accessible and sustainable.

AMA ACT President Dr Kerrie Aust congratulated Labor on its seventh consecutive election win and acknowledged some of the Government's achievements in the last term, including the successful opening of the new Critical Services Building and investments to improve the culture at Canberra Health Services.

Nevertheless, she said doctors were concerned that some of the Government's policies could impact the quality of health services in Canberra. Furthermore, she said it was disappointing to see a lack of strategic policy around developing Canberra's hospital system to attract and retain medical staff.

"Recruitment and retention of medical staff is arguably the biggest issue facing Canberra's health system and one that is crying out for big picture thinking," she said.

Dr Aust is looking forward to continuing to work with the Government on health policy. "I'd like to think the AMA will continue to have a really positive relationship with Government, putting our concerns on the table and having them addressed," she said.

ACT Labor and the Canberra Greens both scored relatively poorly in the AMA ACT's 2024 Health Report Card, which evaluated each parties' health policies. Both Labor and the Greens scored just 55/100, compared to 79/100 for Independents for Canberra and 63/100 for the Canberra Liberals. The scores largely reflected policy differences on supporting GPs and integrated care and clearing the elective surgery waiting list.

General practice

Labor and the Greens both put GP bulk-billing front and centre of their health platforms, with Labor promising to create an $11 million

Continued page 4

WHAT HAS ACT LABOR PROMISED?

- 800 additional health workers
- More bulk-billing GPs
- $1 billion new Northside Hospital
- A new EA that supports competitive remuneration
- More medical student training places in the ACT, with priority for local students
- 70,000 elective surgeries over four years
- GP diagnosis and treatment of ADHD
- More nurse prescribing & pharmacist prescribing
- $4 million professional development and wellbeing fund for GPs
- Explore possibility of nurse sedationists and nurse endoscopists
- Remunerate clinicians for their time to undertake VAD training
- More services at Walk-in Centres
- Explore potential for a Rapid Access Clinic, so unwell patients can receive rapid review without needing to go to ED – GPs able to refer directly
- Robotic surgery
- More cardiologists
- High-risk breast cancer clinic at North Canberra Hospital
- Expand the Child and Adolescent Mental Health Service and the High Care Paediatric Unit at the University of Canberra Hospital
- Phlebotomy workforce in ED at Canberra Hospital
- Expand community paediatric hub at Molonglo
- Specialist dementia care area at North Canberra Hospital
- Increase capacity at Clare Holland House and expand at-home palliative care

President's Notes

WITH PRESIDENT,
DR KERRIE AUST

With the ACT 2024 election behind us, I would like to thank everyone who engaged in setting AMA ACT's election campaign advocacy agenda, including those of you who came along to our Politics in the Pub events. Some positive policy ideas were put forward from the different parties on the back of those activities.

I'm glad to have a strong working relationship with politicians on all sides of politics and will continue to work productively with the Labor Government to advocate for the best interests of our health system and our community.
I would also like to take the opportunity to wish outgoing mental health minister Emma Davidson all the best and thank her for her engagement on mental health matters for our community.

Looking ahead

AMA ACT held our planning meeting in October, where we set the agenda for the next two years. We are grateful to everyone who provided feedback in the leadup to our meeting via our member engagement survey, and will be releasing our strategic plan before Christmas.

ANU medical school

As an ANU medical school graduate who has maintained a close relationship with the school, I know the concern many of you are feeling about the recently announced restructure and the broader funding challenges for the University.

While we understand the changes are necessary to make the school financially viable, it is also vital for Canberra to have an appropriately resourced medical school. The school must be supported to maintain a high level of clinical teaching as the foundation for Canberra's future health workforce, and AMA ACT will continue to advocate that this remains a priority at both the local and Federal level.

Giving doctors a voice in the ACT

In the last couple of months, I've been involved in many consultations on behalf of our members. These have included providing feedback to the ACT Government Walk-in Centres, on the DHR, on implementation issues with the new Variations in Sex Characteristics legislation, on the new birthing centre proposal, and on the importance of transparency about waiting lists.

I've met with David Pocock and his team to discuss issues with JMO training and attracting more doctors to Canberra. I've also met with advocacy groups to discuss issues ranging from wound care, to harm minimisation, to supporting the mental health of men in our community.

Some of you will also have heard me speaking on doctors' behalf on AM and FM radio on topics including the protected industrial action, addressing workforce shortages, the junior doctor experience, hospital waiting lists and IV fluids.

> "I'm grateful to have heard from so many of you about your experiences."
>
> **Dr Kerrie Aust**

In all these discussions, I have your faces and your stories in mind. I'm grateful to have heard from so many of you about your experiences and cannot emphasise enough the importance of members reaching out to me directly, or to our AMA ACT office, to share your concerns so that we can put forward a strong voice for doctors in the ACT.

Parkrun and drumming: part of the fun at September's Drs4Drs Safe Space event.

Member engagement

Now is the time to renew your AMA membership if you haven't already. We have a great team of doctors involved, but can do so much more with more members.

That's why I'm a big fan of our 'member-get-a-member benefit'. For each doctor you refer who becomes a new member, you can get 25% off your membership (up to four members, for the next renewal period). To renew or find out more please phone 02 6270 5410.

Doctors can get more out of their membership by joining one of our AMA ACT committees and by joining our Whatsapp feedback groups (Doctors in Training, GPs and Advisory Forum). For more information or to be added to a group please contact ceo@ama-act.com.au.

End of year

A reminder that we have invited our members to join us for the AMA ACT's Graduation Breakfast for class of 2024 ANU medical students on Friday 13th December at the Hellenic Club in Woden, 8.30am. This an opportunity for our graduating students and their families to be welcomed to the AMA Medical family and celebrate this important milestone. More details are on the AMA ACT website.

I know the last few months of the clinical year is tough for many of us, especially our junior doctors in the hospital system.

Please remember that Drs4Drs ACT is here for you. The telephone helpline operates 24/7 and you'll be put through to a doctor who will listen to you and not judge you.

Drs4Drs ACT: 1300 374 377

VALE

The President, Dr Kerrie Aust, Board members and staff of AMA ACT extend their sincere condolences to the family, friends and colleagues of

Dr Geoff Stubbs

GREG SCHMIDT
Senior Workplace Relations Advisor, AMA ACT

Enterprise bargaining update: doctors urged to maintain the pressure

AMA ACT is increasingly confident public sector doctors will receive a better pay offer as a result of a number of industrial actions currently underway.

Partial work bans

As of Friday, October 18, medical practitioners began implementing partial work bans as previously communicated to the ACT Government by AMA ACT. These actions include a ban on recording non-clinical data, a ban on attending meetings not related to patient care, and a ban on unrostered overtime.

To further our campaign for a better Medical Practitioners Enterprise Agreement, we will also be initiating limited stop-work actions, as approved by our Protected Action Ballot earlier this month.

It is crucial for medical practitioners to participate in industrial action only if they are:

- Acting under a written Bargaining Authority granted to AMA ACT, or

- An ASMOF member (coverage provided by ASMOF membership)

Participation in protected industrial action is only valid under the auspices of either ASMOF or AMA ACT. If you do not fall into either category and wish to join the protected industrial action, please contact the AMA ACT office on 02 6270 5418.

Binding arbitration a possibility

Additionally, ASMOF has submitted an application to the Fair Work Commission (FWC) for an Intractable Bargaining Declaration. Should this be granted, it would indicate that there is no reasonable prospect for an agreement between employer and employee parties for a new Medical Practitioners Enterprise Agreement. AMA ACT has already expressed its support in writing for this application, and we will present our oral arguments at the FWC hearing scheduled for November 12.

If granted, this declaration may lead to a binding arbitration process between employer and employee representatives, including AMA ACT. While this will be a comprehensive process, we anticipate it will yield favourable outcomes focused primarily on salaries and allowances for medical practitioners. The arbitration results would function as a de-facto enterprise agreement until a new Medical Practitioners Enterprise Agreement is established.

Patient safety paramount

We believe that the combination of protected industrial action and the potential for arbitration by an independent body will encourage the ACT Government to engage in negotiations with a more favourable offer regarding salaries and allowances.

In the meantime, it is vital that we maintain pressure on the employer through a variety of actions that disrupt processes without compromising patient safety.

Should anyone encounter difficulties with management due to their participation in protected industrial action, please reach out to me immediately at 02 6270 5418. ■

How does the ACT government's pay offer compare?

Proposed ACT Salary is this percentage of the corresponding state/territory pay

Key Classifications	Proposed ACT Pay Points	NSW	NT	QLD	SA	TAS	VIC	WA
Intern	$83,427	110%	95%	95%	102%	96%	100%	100%
Resident Year 2	$106,081	108%	100%	104%	110%	107%	111%	106%
Registrar 1	$119,327	108%	101%	95%	98%	91%	95%	104%
Senior Registrar 1	$166,194	106%	103%	117%	112%	97%	101%	99%
Specialist Year 1	$196,453	105%	95%	96%	86%	94%	77%	102%
Top End Specialist Salary	$264,161	105%	91%	93%	88%	88%	65%	93%

Green cells *(>100%) mean that the ACT salary on offer is HIGHER than other jurisdictions.*
Red cells *(<100%) mean that the ACT salary on offer is LESS than other jurisdictions.*

Continued from cover

fund to support GP bulk-billing practices, and the Greens promising to establish four bulk-billing GP clinics. These policies scored only 3/10 in the AMA's report card.

Dr Aust commented: "General practice has been systemically under-funded at the Federal level, and while I appreciate that these policies are aimed at addressing the gap for patients, I'm not confident the incentives on offer will be enough to cover the costs of actually providing care. Any funding also needs to be recurrent to provide certainty for practice owners."

Labor has promised to establish a $4 million Professional Development and Wellbeing Fund for GPs, which it says will go to attracting GP Registrars in the ACT, supporting the wellbeing of the GP workforce and creating opportunities for GPs to participate in research, education and professional development.

> "I'm not confident the incentives on offer will be enough to cover the costs of actually providing care."
>
> **Dr Kerrie Aust**

This policy scored 7.9/10 in AMA ACT's Report Card – the highest of any Labor policy.

Fragmentation

The Government's flagship primary care policy remains nurse-led Walk-in Centres, despite the model not having been independently evaluated after more than a decade since its inception.

Labor has promised more nurses at the clinics, including advanced mental health nurses, and more services such as X-ray. They've also promised to establish four new health centres for specialised health care across Canberra. Furthermore, they said they will expand the Women's Health Service to more locations, offering full health checks, cervical screening, support during menopause, nutrition advice and counselling.

Dr Aust commented: "We really would have liked to see more support for existing general practices to deliver these services, which is well within GPs' scope of practice, and reduces fragmentation of care."

The health policy rated most highly by AMA ACT this election was for an independent evaluation of the Government's nurse-led Walk-in Centres. This policy was put forward by the Canberra Liberals as well as by Independents Thomas Emerson and Fiona Carrick and scored 9.8/10 in the Report Card. Both Mr Emerson and Ms Carrick say they will use their new seats in the Legislative Assembly to call for greater transparency on this and other issues.

Expanded Scope of Practice

There is a strong theme of 'expanded scope of practice' in Labor's 2024 health platform, including registered nurse prescribing, pharmacy prescribing and a potential role for nurse sedationists and nurse endoscopists to improve endoscopy access in the ACT.

Nurse and pharmacy led prescribing are unpopular with doctors, given the risks of missed diagnosis and inappropriate prescribing, including inappropriate antimicrobial use and antibiotic resistance.

Labor has said it will work to expand pharmacists' scope of practice to include treating patients for conditions such as acute otitis media, acute minor wound management, acute nausea and vomiting, gastro-oesophageal reflux, mild-to-moderate acne and mild, acute musculoskeletal pain.

Dr Aust commented: "While doctors see the value of working together with our colleagues in pharmacy and nursing through models that promote collaboration, we are very concerned about patient safety when Government is asking non-medical staff to make diagnoses."

Labor's health policy platform also supports a move toward GP diagnosis and management of ADHD, given long waiting times to access psychiatrists, neurologists and paediatricians in the ACT. This policy scored 7.1/10 in the AMA ACT Health Report Card. ■

Junior docs' win brings overtime transparency

An estimated 2,200 doctors who have worked as junior doctors in the ACT over the last eight years are expected to be eligible for a slice of the $31.5 million settlement reached in the landmark ACT Junior Doctors' Class Action on September 18.

All junior doctors employed by the ACT Government and Calvary Health Care (now North Canberra Hospital) will receive a letter in the mail about the settlement in the coming weeks. Doctors can also head to the Gordon Legal website to register.

Speaking on *ABC Radio Canberra* on the day the settlement was announced, AMA ACT President Dr Kerrie Aust said it was an "absolute win".

"While it's a real shame that it had to go through a legal process in order to change, it has actually resulted in junior doctors being consistently paid for their overtime within the Canberra Hospital Health Services," Dr Aust said.

Dr Aust paid tribute to the courage shown by Dr Ying Ying Tham, the lead plaintiff in the ACT class action.

"As a junior doctor, you are so reliant on the referees and being perceived as a team player in order to get through to that next part of the training program," Dr Aust said. "That power imbalance and that 'I don't want to rock the boat' and 'I don't want to be seen as the problematic person' are really challenging."

Dr Aust said she hoped that bringing greater transparency to the overtime issue would enable better workforce planning.

"When you've got data about the hours that people are working, then you can start to make sure that you've got the workforce planning strategies in place to make sure that you've got enough people to meet the demands."

She added: "You know, as doctors we talk about the importance of nutrition and exercise and mental downtime and social connection. Do we actually give our junior doctors a chance to do that?" ■

AMA ACT is here to help members with overtime issues. For support, contact AMA ACT Senior Workplace Relations Advisor, Greg Schmidt on industrial@ama-act.com.au

To register to be part of the class action settlement head to gordonlegal.com.au/services/class-actions/act-junior-doctors-class-action/

Teen's clear warning on vaping wins long-running competition

Telopea Park School Year 8 student, Amira Burton has won the seventeenth annual 'Art In, Butt Out' competition with a clear message that smoking and vaping kill.

Minister for Population Health Emma Davidson together with AMA ACT President Dr Kerrie Aust announced the winning entry.

'Art In, Butt Out' is an initiative of the AMA ACT and its Tobacco Task Force that sees Year 8 students from around Canberra put their design and marketing skills to the test to come up with a poster aimed at reducing the number of young people who smoke or vape. ■

Amira Burton with her winning poster, together with Dr Kerrie Aust, Minister Emma Davidson and Teopea Park School arts teacher Liesl Brenzel.

Urgent review of Walk-in Centres needed: GPs

The ACT's nurse-led Walk-in Centres are undermining general practice in the Territory, a survey of more than 70 GPs suggests, as AMA ACT continues to call for an independent review of the model.

AMA ACT surveyed GPs in Canberra about their interactions with and perceptions of the ACT Government's five nurse-led Walk-in Centres (WiCS) and received 75 responses. Three-quarters of GPs perceived the care at WiCs as 'fair to poor' quality, with none perceiving it as excellent. Most respondents felt WiCs did not complement their services, with the exception of extended hours.

Concerningly, 68% said WiCs undermined the quality of care provided by GPs in Canberra. This was through fragmenting patient care (92%), duplication of services (71%), differences in care standards (63%) and communication issues (51%).

60% OF GPS FEEL WALK-IN CENTRES DO NOT COMPLEMENT THEIR SERVICES

In addition, 44% said they had seen their own workload increase as a result of WiCs.

Several GPs provided suggestions for how the model could be improved, including facilitating two-way communication between GPs and WiC nurses, and enabling GPs to refer patients directly to the service for wound care.

Fragmentation

Many GPs expressed concern that patients often received care from WiCs instead of their regular GP, complicating follow-up and management of health conditions.

One GP commented: "Particularly for children the lack of continuity is risky. There should be a requirement they see their GP after a certain number of visits perhaps."

Quality of care

GPs raised significant concerns about the diagnostic skills of WiC staff, particularly with complex or undifferentiated cases, leading to instances of misdiagnosis and inadequate treatment plans. Six respondents highlighted missed diagnoses, including "missed sexual assault/pregnancy/STI", "missed fractures" and cases of "incorrect antibiotic prescribing". GPs also mentioned that "red flags [are] missed" and that "broad differentials [are] not considered."

The exception to these quality-of-care concerns was wound care. 8% of respondents mentioned that WiCs were great resources for wound care, particularly for redressing of wounds and suture removal.

Communication problems

Communication problems with the centres were a major bugbear for GPs. Some 30 out of 74 respondents mentioned burdensomely long discharge summaries, suggesting WiC nurses might benefit from additional training in how to communicate relevant information succinctly.

One doctor wrote: "A top to toe examination is documented for an UTI. It is hard to read the 3-8 page discharge summaries and extract the actual pertinent information".

GPs expressed a desire to be able to "pick up the phone and talk to a nurse" at the WiC to discuss individual patient care and give feedback.

Several GPs said they wished the WiCs would call patients' usual GP rather than referring to emergency department, saying they were happy to fit in urgent presentations.

44% OF GPS HAVE SEEN THEIR WORKLOAD INCREASE AS A RESULT OF WALK-IN CENTRES

68% OF GPS FEEL WALK-IN CENTRES UNDERMINE QUALITY OF CARE

Data is from the results of an AMA ACT survey sent out to GPs.

Cost-effectiveness

Many GPs questioned the cost-effectiveness of WiCs, citing high taxpayer costs – although the exact cost per service remains undisclosed.

Several respondents suggested that redirecting resources from WiCs to support GP-led care would yield better health outcomes and improve overall healthcare efficiency – for instance, integrating nurses and allied health professionals into existing general practices.

One GP warned that if the Government continues to expand WiCs as promised, general practice viability will decrease. "There is every chance that once they build the Inner South Walk In Centre, that I will close my practice," they wrote.

Feedback and evaluation

There was consensus on the need for systematic evaluation of WiCs to assess their impact on healthcare costs and patient outcomes. Several respondents also called for avenues for GPs to provide direct feedback to WiCs.

As one GP wrote: "There is no mechanism for feedback, and frankly there have been red flags missed – because there are no doctors involved." ■

Med school restructure may have flow-on effects: director

The director of ANU's medical school has warned that the university's capacity to engage with and support Canberra's health system may be impacted by the recently announced ANU restructure.

Speaking in the wake of news that the School of Medicine and Psychology will be moved into the College of Science from next year, Professor Paul Fitzgerald told *Canberra Doctor*: "The loss of a dedicated college of Health and Medicine may reduce the capacity of the university to engage with and support the local health system."

"The leadership of the new colleges in which the health and medicine related schools are placed are going to have to commit meaningfully to ensure this is not the case," he said.

Professor Fitzgerald said students could be reassured about the ongoing high quality of medical education at the school.

"There has been no indication that any proposed changes will directly impact on the delivery of the ANU medical program and we intend to continue delivering high quality medical education within the School of Medicine and Psychology at ANU."

In a statement released on October 3, ANU Vice Chancellor Professor Genevieve Bell announced a proposal to dis-establish the ANU College of Health and Medicine and incorporate the School of Medicine and Psychology into the College of Science – renaming it the ANU College of Science and Medicine from January 2025.

Professor Bell explained that the proposed restructure was part of a suite of changes designed to ensure the long-term sustainability and financial viability of ANU as a high-quality, world-leading institution. She noted that many universities around the world are currently facing substantial financial challenges.

Professor Bell said the University needed to reduce recuring operating costs by $250 million over the next 15 months.

"This will be achieved through reductions in salary and non-salary costs," she said. "This decision has not been taken lightly. All attempts are being made to minimise the number of redundancies, however some job losses will be unavoidable."

It is understood the proposal will result in the loss of considerable expertise from the university in medically focussed grant and other administrative support.

The proposed changes come just two years after a restructure that integrated the schools of Medicine and Psychology at ANU.

It also comes on the back of significant staffing changes at the school, with Professor Russell Gruen stepping down in September after almost six years as Dean. ■

> "The loss of a dedicated college of Health and Medicine may reduce the capacity of the university to engage with and support the local health system."
>
> **Professor Paul Fitzgerald**

International Medical Graduates

Set up to ~~fail~~ succeed: how to do IMG recruitment well

BY SARAH COLYER

Twelve years ago, a landmark Federal Government inquiry drew attention to the myriad challenges faced by International Medical Graduates (IMGs) working in Australia. The inquiry's aptly named 'Lost in the Labyrinth' report, published in March 2012, detailed the confusion and frustration many IMGs experience trying to navigate an unclear regulatory environment and practice medicine in an unfamiliar culture, with little-to-no-support. It offered 45 recommendations to make the system fairer and more efficient.

It seemed there was momentum for change. National registration had recently come in, with the Medical Board of Australia replacing state and territory boards in 2010, and there was scope for a coordinated effort to fix up the IMG mess.

However, toward the end of 2012, something extraordinary happened that ejected IMG issues from the political agenda. The medical intern crisis hit. Suddenly there were not enough training places for graduating Australian medical students, and state and territory governments were left scrambling to create new training positions.

Dr Usha Parvathy, an IMG who has been a champion for IMGs in Australia for two decades, remembers 2012 as an unfortunate turning point for IMGs in Australia.

"Around 2012, IMG funding was withdrawn in NSW as it was believed there would be a tsunami of local graduates," she says.

At the time, Dr Parvathy was in her sixth year of working to support IMGs through Australia's first IMG Unit at Hunter New England Health (HNE Health). The unit was set up by Professor Kichu Nair, who directs the Continuing Medical Professional Development Unit at HNE Health.

"Our philosophy was to set IMGs up to succeed, because we realised that a lot of IMGs were not coping," Dr Parvathy says. "Through the unit we were able to support IMGs with targeted orientation, education and mentoring for their first 6-12 months in Australia."

The program has developed over the years, and is now a beacon to health services around the country who are looking to better support their IMGs. However, since 2012, the work has received no funding. It is supported by HNE Health but in reality, relies on the goodwill of many dedicated doctors who volunteer their time and expertise.

Meanwhile, the IMG workforce in Australia has continued to expand, defying the expectations of a decade ago. Now 30-40% of doctors in Australia are IMGs, and many health services are recruiting more IMGs than ever before.

While the Medical Board of Australia, the specialist colleges and the Australian Medical Council have introduced various reforms over the years to make the system clearer and fairer for IMGs, there is still a dearth of support for these vulnerable doctors on whom our health system increasingly depends.

Dr Pavarthy says it's high time the Federal Government "owned" the IMG issue. "Uniformly, everyone involved in this work believes there should be a national program to support IMGs," she says. "There should be a one-stop contact for every IMG who arrives so that they are clear about how to proceed with their career."

> "For too long, we have just been setting these IMGs up to fail."
>
> **Dr Usha Parvathy**

"Recruiting IMGs is excellent and great, but no international medical graduate is going to fly on their own without at least 6-12 months of significant support. Even our domestic graduates get 12 months of supervised practice.

"So where is that support coming from? Who is going to help them? And do we have the capacity for that? These questions need to be answered before we just go around recruiting a lot of people."

Dr Usha Parvathy.

Unsung heroes

It is impossible to seek to understand the issues affecting IMGs in Australia without coming into contact with Dr Parvathy and Professor Nair.

Since the 1980s, the two doctors, originally from India, have been deeply involved in helping IMGs like themselves settle into life in Australia, pass their exams and make a valuable contribution to the Australian healthcare system.

Professor Nair says he is proud to call himself an IMG. "Once an IMG, always an IMG," he says, adding: "Without IMGs, Australia's health care system would not work—they are the unsung heroes."

Professor Nair and Dr Parvathy both sat the AMC clinical examination in the 1980s, at a time when overseas trained doctors had to pass the test before practising in Australia (nowadays, IMGs who pass an initial multiple-choice questionnaire can be granted limited registration while they work to pass the clinical exam). See box on P9 for more information.

While Professor Nair and Dr Parvathy both passed the clinical exam first time, most IMGs do not – the pass rate is extraordinarily low, between 35% and 45%, for a test that currently costs $4,391. To Dr Parvathy and Professor Nair this figure is a tell-tale sign that the system through which IMGs are recruited, on-boarded and assessed needs fixing.

"For too long, we have just been setting these IMGs up to fail," Dr Parvathy laments. "When service-provision comes ahead of safety it affects everything else."

In 1989 Professor Nair became the first AMC candidate to work as a senior examiner for the AMC. It's a role he's continued in to this day, and one that's given him the capacity to introduce pioneering reforms to the IMG assessment process.

Most significantly, Professor Nair led the establishment of Workplace Based Assessment (WBA), as an alternative to the AMC Clinical Exam in 2010. From HNE Health, WBA has spread around Australia and is now offered at around 25 health services nationally. For more information on WBA, see box below.

Recruitment red flags

It's unfortunately common to hear Australian-trained junior doctors express frustration at having to pick up tasks that an IMG working alongside them has been unable to complete. Dr Parvathy knows the situation all too well.

> "Without IMGs, Australia's health care system would not work—they are the unsung heroes."
>
> **Professor Kichu Nair**

"Someone who has done 5 years in ICU in Mumbai can't come here and work like a local grad who has had 5 years in ICU," she says. "When they come here, their supervisors find they're not able to work at that level. The supervisors are frustrated and the local grads have to take the jobs and fill in positions such as night shifts, because they're not safe to be left on their own."

However, Dr Parvathy stresses that it doesn't have to be this way. The issue, she says is making sure the right IMGs are recruited to the right positions, with the right support.

"It's very important when recruiting IMGs, to be very clear about what support systems are in place," she says.

Dr Parvathy says it's safer for all IMGs to be recruited at level one supervision – as much supervision as possible.

She also warns against recruiting senior specialists to work as JMOs. "If someone has worked as a cardiologist overseas, where they were basically regarded as a 'demigod' in their country, and they are recruited to work as a JMO in Australia, that's a red flag," she says. "They've lost the skills required of a JMO."

Other red flags include recency of practice and whether or not the candidate has Australian referees, Dr Parvathy says. "With international referees, there is a tendency to mark them excellent in every box, and often you need to call them to find out the details," she warns.

The problems associated with poor recruitment are compounded when those candidates attempt the AMC Clinical Examination.

Professor Nair explains: "You can have an experienced surgeon who has come from overseas, whose knowledge is very specialised, being assessed on paediatrics and mental health – things they haven't studied closely since medical school."

Professor Kichu Nair.

Orientation and on-boarding

Through the IMG Program in Newcastle, Dr Parvathy has helped hundreds of IMGs over the years to find their feet living and working in Australia. Indeed, the program is so successful that health services around the country send representatives to masterclasses run by Dr Parvathy and Professor Nair.

The IMG Program provides three full days of orientation for IMGs each year, with subjects including communication, Australian culture and slang, the Australian healthcare system, clinical skills, safe handover and multidisciplinary teams.

Dr Parvathy explains that understanding the culture of the Australian healthcare system is a huge challenge for many IMGs coming from dissimilar systems.

"Most of them come from countries where they do not have a multidisciplinary team to support them," she says. "Many of them are not used to having a nurse unit manager as the boss of the ward, and they often don't understand the variety of work done by staff such as physiotherapists,

Continued page 8

What is Workplace Based Assessment?

Workplace Based Assessment (WBA) is top of the wish-list for many IMGs working as junior doctors, when it comes to things that could be done to improve the existing system.

The model involves 30 assessments at the workplace over a 6-month period from 30 different assessors. Candidates are tested in paediatrics, women's health, accident and emergency medicine, surgery and mental health, as well as being assessed on subjects including record-keeping, communication and team work.

At HNE Health, where the WBA is complemented by Dr Parvathy's comprehensive IMG orientation and support program, the WBA pass rate is 99%.

Professor Nair is adamant this is not rubber stamping: "All the assessors are calibrated by the AMC to know what to look for when making their assessments, and they don't know what the other assessors have found."

The Lost in the Labyrinth report called for an independent evaluation of the WBA model. Although this has never been undertaken, the AMC and the Medical Board both told *Canberra Doctor* they have full confidence in the WBA Program, which the AMC closely monitors.

Professor Nair's research shows one of the great benefits of WBA is that doctors who pass tend to stay in the hospital system where they completed the training. "The investment pays off for the health service, because it means they have a safe doctor who is going to serve the community for the next 20-30 years," he says.

The cost to the health system of WBA is around $16,000 per candidate over a 6-month period, 2012 figures show. Professor Nair says different health services charge candidates varying amounts to help recover the costs, ranging from around $12,500 to $15,000.

It's a fee many candidates are prepared to pay – there are around 150 candidates on the waiting list for HNE Health's WBA program, which takes 40 candidates per year.

Professor Nair says WBA is eminently superior to the clinical exam. "Workplace Based Assessment involves real patients and real doctors in real hospitals," he notes. "The candidate is enculturated into the hospital system as they move to different departments for their assessments and receive immediate feedback from their assessors."

The biggest challenge to establishing WBA is not so much finding the money as finding the people willing to drive it, he says: "You need a committed leader to establish the program and get through the rigorous AMC accreditation, but I'm always happy to help."

International Medical Graduates

Continued from page 7

occupational therapists and speech therapists."

In addition to orientation, Dr Parvathy says HNE Health is now working to develop a wider range of supports for IMGs – a type of concierge service.

"These doctors arrive with no rental references, no referees when they need a bank loan, no access to Medicare for their family, no help getting their children into Australian schools," she said. "There is clearly a lot more we can do to help them settle in."

The elephant in the room, Dr Parvathy says, is racism. "As an IMG, you do have to work extra hard to prove that you're competent and safe."

"It's so difficult at the beginning for these doctors, with culture and language barriers, and often a feeling that they can't speak up. They really need the people around them to have the patience to support them during that period.

"But at the end of the day, I always tell the IMGs that once they've proven themselves, they've got as good a chance as anybody else to make it to the place where they want to go." ■

> "There is clearly a lot more we can do to help them settle in."
>
> **Dr Usha Parvathy**

What is Canberra doing to support our IMGs?

At Canberra Health Services today, 35% of junior doctors are IMGs – a rate that has been steadily increasing over the last five years. What's more, CHS is actively looking to increase its recruitment of IMGs. That's part of the reason why they recently brought on emergency physician Dr Shakeeb Bani Yaseen as Director of Education and Training for International Medical Graduates and Hospital Non-specialist Doctors and GP Dr Marisa Magiros as Prevocational Medical Education Officer for International Medical Graduates.

Dr Yaseen tells *Canberra Doctor*: "Our objective over the next few years is to establish a dedicated team focused on providing comprehensive support for IMGs within our organisation. This initiative aims to attract physicians to the ACT from around the globe."

Dr Yaseen and the team meet regularly with IMGs to address any concerns they have, and run fortnightly education sessions aimed at helping IMGs pass their Australian Medical Council (AMC) requirements.

From this November, CHS will also deliver a two-day dedicated IMG orientation program that will run at least twice a year. The program is strongly influenced by Dr Parvathy's work – with a focus on communication, consent and the various hierarchical systems, as well as providing guidance on practical matters such as housing, obtaining a driver's license, banking and immigration issues.

"I believe this will aid in the recruitment and retention of these doctors and improve patient safety," Dr Yaseen says.

> "This initiative aims to attract physicians to the ACT from around the globe."
>
> **Dr Shakeeb Bani Yaseen**

Dr Yaseen also indicates that Workplace Based Assessment may be coming to Canberra soon. "To achieve [our goal], we continue our structured teaching program, conduct regular orientation sessions three times annually at both at the Canberra Hospital and North Canberra Hospital, and develop a robust work-based assessment program," he says.

A CHS spokesperson confirms that WBA is "under consideration, subject to local and national demand, resourcing and capacity".

"There are a number of benefits and challenges to a Work-Based Assessment for IMGs," they say. "While it has the benefit of evaluating performance in the real world, assessing doctors directly in everyday clinical practice, changing from the current arrangement to this model of assessment would be a time and resource heavy undertaking."

One Canberra IMG who asks not to be named tells *Canberra Doctor* it would make a big difference to have Workplace Based Assessment: "I think for the RMOs, the biggest challenge is to pass the clinical exam and enter a training pathway. It's very difficult to find time to study for the clinical AMC exam, especially as I have kids.

"Workplace based assessment would be very beneficial for all the IMG junior doctors. It's much less stressful as it's a series of assessments over a long period."

Overall, this IMG doctor has positive things to say about working in Canberra.

Dr Shakeeb Bani Yaseen.

"It's quite a friendly work environment. I've had no issues working here with anyone in Canberra Hospital. Every senior doctor is quite friendly to me and they are willing to teach me and to work together as a team."

However, with no allocated leave time, they've been unable to make it to any of the IMG training sessions. "I'm just too busy," they say.

An innovative job-readiness program

NSW Health has developed an innovative program to upskill IMGs before they apply for positions as medical officers.

The IMG Clinical Readiness Program is for IMGs who have completed the AMC MCQ but do not yet have Australian medical registration. They must have English language proficiency and recency of practice within the previous 3 years in any country.

Participants in the 12-week program are not paid and are referred to as Medical Support Officers (MSOs). The program includes an intensive about the Australian healthcare system, communication techniques and simulated clinical learning as well as location orientation.

Participants spend 10 weeks in supervised clinical practice on a ward, with the opportunity to practice history-taking and clinical examinations and perform simple procedures under supervision.

Dr Parvathy says the program has been highly successful in making IMGs-job ready. "Last year, out of 8 participants who came to our health service, 5 got jobs," she says.

The program is ongoing, with the current cohort having started in September.

For more information visit **health.nsw.gov.au/workforce/medical/Pages/icrp.aspx**

To What Extent Has the ICRP program Impacted on IMG Readiness to Work in NSW Health?

100%	of MSOs said their placement experience has increased their confidence in communicating with patients
90%	of MSOs said their placement experience has increased their confidence in undertaking patient clinical handover
96%	of MSOs said their placement experience has increased their ability to complete discharge summaries
100%	of MSOs said their placement experience has increased their history and examination skills

Data from the IMG Clinical Readiness Program Pilot Evaluation Report, April 2024. A total of 49 Medical Support Officers responded to the survey.

Understanding the different IMG pathways

Competent Authority pathway

The Competent Authority pathway is for IMGs with qualifications in medicine and surgery from the UK, Canada, the USA, New Zealand or Ireland. These doctors can apply for provisional registration. Following satisfactory completion of 12 months of supervised practice they may be eligible to apply for general registration

Specialist pathway

IMGs with recognised qualifications in medicine and surgery who have satisfied the requirements to practise in their field of specialty in their country of training, can apply for assessment under this pathway. There are two pathways within the Specialist pathway:

1.Specialist recognition
The IMG applies directly to the relevant specialist medical college who assesses comparability against the criteria for an Australian-trained specialist in the same field of specialty practice. The outcome of the specialist medical college's assessment will determine the relevant registration type. The relevant specialist medical college will require the IMG to undertake a period of supervised practice before recommending that the IMG be granted recognition as a specialist.

2.Area of need
The IMG applies directly to the specialist medical college who assesses their qualifications and relevant experience against the specified requirements of a position in a confirmed area of need. Area of need is determined by the relevant state or territory health authority. This pathway does not lead to specialist registration.

Expedited Specialist pathway (new)

This new fast-track pathway to specialist registration opened on 21 October 2024 and has been developed at the request of Australia's health ministers in response to workforce shortage.

Specialists with a qualification on the Board's Expedited specialist pathway: accepted qualifications list can apply directly to the Medical Board/Ahpra for specialist registration, rather than be assessed individually by a specialist college. In the initial period, this includes GPs with qualifications from Ireland, New Zealand and the UK. This list will be expanded from December to include specialists with qualifications in anaesthetics, obstetrics and gynaecology, and psychiatry.

Specialists on the Expedited Specialist pathway must meet English language, criminal history and recency of practice standards. They will be supervised for six months by an Australian-registered specialist, have an orientation to Australia's health system and do mandatory cultural safety education.

Standard pathway

The Standard pathway is the most common pathway. IMGs who have a primary qualification in medicine and surgery awarded by a recognised training institution can apply for assessment under this pathway.

The Standard pathway has two alternative processes leading to the award of the AMC Certificate, which is necessary for general registration:

1.AMC examinations only
Assessment is by the AMC Multiple Choice Examination (MCQ) and the AMC Clinical Examination. Since October last year all AMC Clinical Exams have been conducted online, as a result of the closure of the National Test Centre in Melbourne. A new test centre is under construction in Melbourne and is expected to begin offering exams in March 2025.

2.Workplace Based Assessment (WBA)
Assessment is by the AMC MCQ and workplace-based assessment of clinical skills and knowledge. There are very limited places for WBA.

Candidates can apply to the MBA for limited registration after completing the MCQ and receiving an offer of employment. They then must complete 12 months supervised practice and pass either the AMC Clinical exam or complete WBA to receive the AMC Certificate. They are eligible for three renewals of registration, allowing them to be registered for four years while working toward the AMC Certificate.

What happens if a candidate does not obtain the AMC certificate before their limited registration expires?

They can make a new application for limited registration. If the Board grants registration, it might decide to impose conditions on registration, such as completing a multi-source feedback and demonstrating progress when they next apply for renewal of registration.

International Medical Graduates

How a new AMA working group is standing up for IMGs

DR MAHA SELVANATHAN
Chair, AMA IMG Working Group

Many years ago, after completing my medical studies in Russia and my internship in my home country of Malaysia, I took the path of many other overseas-trained doctors by moving to Australia.

As I had already completed my training, I thought the hard part was over. What I thought would be a reasonably straightforward process of gaining employment as a doctor in Australia turned out to be anything but that.

I was faced with bureaucratic hurdles and red tape, I had to make several trips back home to complete various paperwork, and I endured many setbacks before finally making my way out the other side of the maze to employment.

I know just how hard it is for international medical graduates who are trying to navigate that seemingly never-ending maze.

In the decade-plus since I first started working as a doctor in Australia, I am afraid to say I have seen very few, if any at all, improvements to the visa and employment processes for international medical graduates (IMGs).

And that is just the process of becoming a doctor. Once that maze is completed, overseas-trained doctors face many challenges in the workforce, including exploitation, discrimination and difficulties establishing themselves in the community without a support network.

In response to these challenges, the AMA has created an IMG Working Group, and I am proud to have been elected as chair after the group's inaugural meeting in June 2024.

This is something I am extremely passionate about, and I hope this working group can be a real catalyst for change.

Australia is a very attractive destination for IMGs, and I would not hesitate to recommend this country for other overseas-trained doctors looking to advance their career. Australia is suffering a considerable workforce shortage, especially in rural areas, such as Armidale where I have worked as a GP for a decade. In many cases, IMGs are highly sought after to help address doctor shortages in these areas.

Rural healthcare is extremely rewarding, and as someone who has worked in Armidale for many years now, I am a strong advocate for it. It is challenging, of course, but extremely satisfying and rewarding.

Generally speaking, being a doctor in Australia provides great job satisfaction, better pay and conditions compared with other countries, and there are many opportunities to continue learning and improving.

But there are certainly major issues that must be addressed, and the AMA's IMG Working Group is dedicated to unearthing and pursuing solutions to these problems.

Support needed

Australia is dependent on overseas-trained doctors to fill workforce gaps, but there's no support system or safety net they can fall onto. IMGs are often placed into a job in a community with no orientation or guidance, and it can lead to burnout.

By establishing an IMG Working Group, the AMA is telling all overseas-trained doctors in Australia that they are extremely valued here, and that someone is looking out for them.

The AMA has long advocated for IMGs, but this working group will ensure this support is further solidified and that new policies and reforms will be pursued.

Visa processes and employment practices need review.

Reforming pathways

Reforming the pathways to employment for overseas-trained doctors is an obvious place to start. All too often I hear about the red tape preventing IMGs from starting a career in Australia, and I've experienced it myself. I have a friend who is trained as a neurosurgeon but is currently working at a supermarket. These kinds of stories are all too common.

> "I look forward to being at the front of the AMA's efforts to improve outcomes for all overseas-trained doctors."
>
> **Dr Maha Selvanathan**

Visa processes and employment practices must be reviewed and efforts must be made to ensure IMGs have equal opportunities that lead to long-term employment, particularly in rural and regional areas.

Ending exploitation

Exploitation is one big issue we are urgently working to address. When seeking work in Australia, many overseas-trained doctors will look past low wages and poor conditions, either because they have already struggled immensely to get their foot in the door in Australia's health system, or because they are simply unaware what the benchmarks are.

Resources must be made available for IMGs to assist them when seeking work in Australia. Primary health networks (PHNs), general practices, medical colleges, local governments and other medical stakeholders all have important roles to play in ensuring IMGs are welcome in Australia.

Some of these problems were discussed at the AMA's Rural Medical Training Summit held in Canberra last year. PHNs can play a greater role in supporting IMGs and establishing support groups to connect overseas-trained doctors if they are feeling bullied, exploited or otherwise struggling with their wellbeing.

We want to ensure that once overseas-trained doctors arrive in Australia, that they stay here and enjoy their time here. In Armidale, we had 6-8 doctors leave town two years ago, and this large gap has not yet been filled.

Australia can be a fantastic destination for overseas-trained doctors, but it is disheartening more is not being done to ensure IMGs have opportunities to thrive and enjoy life here.

As the IMG Working Group chair, I look forward to being at the front of the AMA's efforts to improve outcomes for all overseas-trained doctors and I hope I can encourage more IMGs to engage with the AMA at state, territory and federal levels to ensure we can create a better system for all. ■

BOOK REVIEW

The Culture Map: an enlightening and entertaining read

DR MARISA MAGIROS

Australia is one of the most culturally diverse countries in the world with 27% of Australians being born overseas and 49% of Australians having at least one parent who was born overseas.

My father was born in Greece and my mother in Australia, with her parents coming from the same Greek Island of Kythera as my father. I was born in Australia and spent 4 years growing up in Kythera, ages 2 to 6, attending school locally and learning English by correspondence before returning to Australia to start Year 1 in 1981. I'm used to navigating cultural differences between Greece and Australia and have had to broaden these skills when working both overseas and in Australia and living with an Irish husband.

Think back to your own family or travel experiences or if you've been in a situation where someone has said 'yes' but they really mean 'no'. *The Culture Map* by Erin Meyer superbly uncovers these cultural norms and differences which are most evident when seen from the outside, such as when travelling overseas.

Humorous and enlightening

The Culture Map presents a simple framework and practical applications for understanding cultural differences in human interactions, utilising Meyer's 10 plus years of research and practical experience to detail the impact of cultural differences on business systems. This book is an absolute joy and truly enlightening read. Full of well-chosen and well-articulated anecdotes which beautifully, and often humorously, illustrate the points being made, it is a "must" read.

The ability to recognise, understand and proactively manage cultural differences is relevant to medical training, clinical care and personal relationships. This book provides a systematic, step-by-step approach to understanding the most common communication challenges that arise from cultural differences and offers measures for dealing with them more effectively.

The process begins with recognising the factors that shape human behaviour and methodically analysing the reasons for that behaviour. This allows the application of clear strategies to effectively solve cross-cultural misunderstandings or to avoid them altogether.

Communication differences

Subtle differences in communication patterns and the complex variations in what is considered common sense from one country to another have a tremendous impact on how we understand one another, and ultimately on how we get the job done.

As stated in the book: "If you go into every interaction assuming that culture doesn't matter, your default mechanism will be to view others through your own cultural lens and to judge and misjudge them accordingly. You need to have an appreciation of cultural differences as well as respect for individual differences. Both are essential."

We also need to consider organisational, individual and professional differences. Cultural patterns of behaviour and belief frequently impact on our perceptions, cognitions and actions.

Cultural relativity

Meyer outlines eight scales to show how cultures vary along a spectrum from one extreme to its opposite and the importance of relative differences. The 8 scales are: communicating, evaluating, persuading, leading, deciding, trusting, disagreeing and scheduling. These have been mapped for 67 different countries.

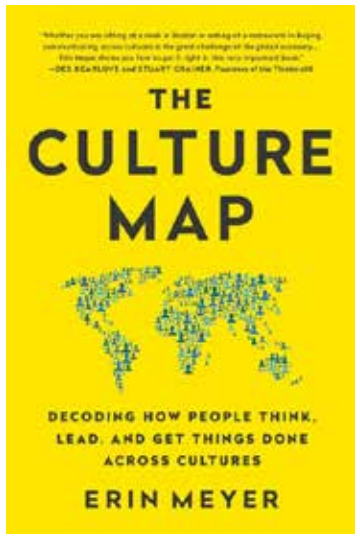
The culture sets a range of acceptable or appropriate behaviours in that country and within that range, each individual makes a choice – culture and personality both at work.

When examining how people from different cultures relate to one another, what matters is not the absolute position of another culture on the scale but rather the relative position of the two cultures. It is relative positioning that determines how people view one another. Cultural relativity is the key to understanding the impact culture has on human interactions.

As one person quoted in the book states: "The culture of my country has a strong character that was totally invisible to me when I was in it and part of it."

I recommend *The Culture Map* – be prepared for many "aha" moments!

Dr Marisa Magiros is a GP at the University of Canberra Medical and Counselling Centre. She is also Prevocational Medical Education Officer for International Medical Graduates (PMEO IMG) at Canberra Hospital, Medical Director Drs4Drs ACT and a board member of AMA ACT.■



Meyer outlines 8 scales to show how Cultures vary on a spectrum.

Dr Magiros will present on the communication and feedback scales from *The Culture Map* to CHS International Medical Graduate doctors at the first IMG Integration Program being held November 7th and 8th.

Artificial Intelligence

AI scribes and your practice: what to consider

TRACY PICKETT
Legal and Policy Advisor, Avant

A new era is unfolding in clinical practice with the introduction of artificial intelligence (AI) scribes.

If your practice is preparing to use an AI scribe, having a change framework that addresses both concrete factors (legal requirements, processes and systems) and more intangible elements (culture and communications) could be invaluable. We suggest seven key steps:

1. Start with the big picture

Start by clarifying how the AI scribe will support your practice and achieve your goals.

For example, if the motivation for using an AI scribe is to save time in clinical notetaking, make sure you understand the nature of the notes it produces. Some practices have found AI scribes generate excessive notes or they leave out important information. All output from an AI scribe must be reviewed by the doctor for accuracy, so actual time saved may be reduced.

Being clear about your reasoning will also help to explain the change to staff and patients.

2. Address your compliance and regulatory obligations

Non-negotiable considerations include whether the AI scribe will allow you to satisfy your legal and professional obligations.

Privacy and confidentiality

The legal obligation to protect patient privacy attaches to the practice as well as the doctor.

Therefore, you need to understand enough about how the AI scribe works to be confident the practice will be able to comply with privacy and security obligations.

Check how and where data is processed and stored, and how it will be retained by the scribe. If the AI scribe generates documentation such as reports or referrals, consider whether practice processes need to be updated or amended to prevent a breach of patient confidentiality.

Outline in the practice's privacy notice and policy that you are using a third-party AI scribe, and provide patients with information from the service provider about the management of their information.

Patient consent

Because an AI scribe 'listens' to the consultation between doctor and patient, it would be considered a listening device under state and territory listening devices legislation. In the ACT, it is an offence to use a listening device to record a private conversation to which the person is a party without consent – this means that you must obtain and document patient consent before an AI scribe is used in a consultation.

If the AI scribe retains an audio recording, find out whether the recording is immediately deleted or if it is held for a period of time, where the recording is held and whether you can access it.

3. Support safe patient care

Your practice's patient cohort and approach to patient care should be considered when choosing an AI scribe. It will also help identify potential concerns to address in your communications with patients.

Generative AI such as AI scribes currently fall outside the Therapeutic Goods Administration's medical device regulatory processes. You need to be satisfied that the AI scribe is fit for its intended purpose in your practice. For example, check how the AI scribe will 'understand' accents or languages other than standard English spoken by your patient cohort.

4. Assess cultural changes

AI use can be polarising. In your practice, do you need to reach a consensus decision, or can individuals choose whether to use it?

Some practices offer doctors the option of opting-in to use AI scribes. If not all doctors choose to use AI scribes, be clear about how patients are informed about this. The practice will want to avoid patients receiving mixed messages if one doctor dismisses AI and the next is using it enthusiastically.

5. Consultation considerations

Doctors need to be aware of, and work within the AI scribe's limitations. While AI scribes can save time, they are not a complete solution to record-keeping.

The notes produced will not capture non-verbal cues or signs and may miss important information or misinterpret information that is discussed. In some cases it may also be inappropriate for doctors to verbalise all their observations, for example recording concerns about the cause of a patient's injuries.

AI scribes may be unable to interpret inconsistent information, for example a patient who says they have no allergies, then later mentions an adverse reaction to a medication. Some scribes may try to fill gaps or extrapolate findings, which could lead to a misleading record.

Doctors are ultimately responsible for ensuring the record accurately reflects the consultation. Any AI-generated outputs should be treated as drafts and doctors should review

and check the draft to ensure that:

- the record is correct
- the AI has captured and correctly interpreted relevant details
- the tool has not raised an inaccurate diagnostic issue
- the record captures sufficient detail to justify any Medicare item numbers billed for the consultation.

6. Review systems and processes

Introducing AI requires a review of existing technology, systems and processes to consider what may need to change.

One important consideration is how well an AI scribe will integrate with your existing software. If the integration is not seamless, consider whether switching between programs could increase the risk of errors, for example due to cutting and pasting between systems.

7. Communicating change to staff and patients

Spend time planning and communicating the change effectively from the start, and bear in mind that staff may have strong views about AI and what it may mean for their jobs.

Assume that staff will need to be trained on how to use any AI that you introduce, as well as how to communicate with patients about it.

Consider how you plan to introduce the change to patients, and how you will document and record patient consent.

Discussing this as a team and preparing responses to potential patient concerns will help staff feel more confident and minimise the risks of upset patients. ■

Further reading

Avant.
Artificial intelligence (AI): what you need to know. 2024.
www.avant.org.au/artificial-intelligence-what-you-need-to-know

Australian Health Practitioner Regulation Agency.
Meeting your professional obligations when using Artificial Intelligence in healthcare. 2024.
www.ahpra.gov.au/Resources/Artificial-Intelligence-in-healthcare.aspx

Australian Medical Association.
AMA position statement on AI in healthcare. 2023.
www.ama.com.au/articles/artificial-intelligence-healthcare

Artificial intelligence: impressive or over-rated?

Have you been using AI as a tool in clinical practice? How have you found it?

Canberra psychologist Nesh Nikolic uses Heidi Health as a note-taking assistant and says he's found it "unbelievably impressive".

After obtaining permission from clients, Nikolic opens the app to record the consult. When the dialogue ends, the program generates clinical notes in a matter of seconds. Data is categorised into easy-to-read sections such as 'Current Presentation', 'Past Medical History', 'Obstacles, Setbacks and Progress' and 'Risk Assessment and Management'.

"The lovely part about using AI is I've never felt as connected with my clients," he says. "Usually, about 20% of my cognitive power is in note-taking, but when AI is writing everything down for me, I can face the patient and be fully engaged with them."

"I then carefully check what Heidi has generated, and make any corrections because at the end of the day I am the author and need to be confident it represents what happened in the consultation.

"I don't usually include direct speech quotations in my own clinical notes because I can't be certain I get the patient's wording right, however when I read back the patients' words in Heidi's report, it jogs my memory for what the patient said."

Canberra GP and AMA ACT board member Dr Marisa Magiros has experience using Lyrebird Scribe, which is integrated into Best Practice.

"It's fantastic," she says. "You need to check it to make sure it's correct, and to add your own notes, but I do like having it as an assistant."

"When I'm doing a clinical examination, if I say out loud the things I'm doing, such as 'blood pressure' or 'heart rate', it will record that information. However, when it comes to psychological symptoms, I will often need to add those things afterwards. For instance, 'patient crying and in distress'."

"Overall, using Lyrebird does save me time, even though I need to review the notes generated before accepting them as accurate. You can also 'train' the system to make changes."

Nevertheless, Dr Magiros says she usually still quickly types her own dot points 'problem list' during a consultation, because the Lyrebird report is not available in real-time. "I like to see the notes as I go," she explains.

At the University of Canberra Medical and Counselling Centre Dr Magiros sees a large number of international students from diverse backgrounds. She says the software has not struggled with different accents. ■

Nesh Nikolic uses Heidi Health as a note-taking assistant and says he's found it "unbelievably impressive".

SHARE YOUR VIEWS

We'd love you to drop us an email describing your experiences using AI at editorial@ama-act.com.au. We'll include your letter in the next *Canberra Doctor* and send you an iconic Canberra scrub cap as a token of our thanks.

NEWS IN BRIEF

MBS changes postponed

Changes to MBS chronic disease management items, which were due to come into effect in November, have now been deferred until 1 July 2025 to allow for extra consultation.

AMA welcomed the Department of Health and Aged Care's decision to allow more time for consultation, which follows lobbying from the AMA and other groups.

The government's decision to pursue a restructure of MBS chronic disease management items was based on a key recommendation arising from the MBS Review.

There has been some very positive work to these items, align them better with clinical practice, reduce red tape and reward longitudinal care.

However, it became obvious that more time was needed to settle the detail as well finalise an appropriate rebate structure. ■

Infant formula marketing restrictions

The AMA applauds the Federal Government's recent decision to develop mandatory marketing guidelines for infant formula products, following calls from the AMA and other health groups.

AMA President Dr Danielle McMullen said: "The government's commitment represents a critical moment for Australia as we move towards enforceable legislation that regulates the marketing of infant formula, which has become even more aggressive and irresponsible with the rise of social media.

"Infant formula remains a safe and healthy alternative for parents who are unable or, for various reasons, choose not to breastfeed, but the marketing tactics used to promote the products must be regulated. Marketing of infant formula products in Australia risks creating confusion about the overwhelming benefits of breastfeeding."

The AMA has long called for Australia to adopt the World Health Organization's (WHO) International Code of Marketing of Breast Milk Substitutes, which aims to stop the aggressive and inappropriate marketing of breast-milk substitutes, including infant formula and 'toddler milks'. ■

Health checks for late-career doctors

AMA ACT has made a submission to the Medical Board of Australia on proposed health checks for late-career doctors, warning against a model that is complex and overly burdensome.

The submission follows extensive consultation and feedback from AMA members on the proposed checks, and direct engagement with the Medical Board Chair, Dr Anne Tonkin. It highlights the AMA's long engagement on the proposal, dating back to the early 2010s when a model akin to revalidation was proposed. AMA's strong advocacy and engagement with the Expert Advisory Group in 2017 led to revalidation being rejected.

The submission emphasises AMA's advocacy for doctors to have regular health checks across all career stages with their regular GP, but warns that overly-burdensome mandatory health checks could dissuade doctors from remaining in practice, reducing access to experienced mentors for younger colleagues and limiting patient care options. ■

To read the full submission visit **ama.com.au.**

Vale

‘Val embodied the best humane qualities a GP can have’

Dr Valerie Hill OAM, well-known and long-term Canberra GP died peacefully on 8 May 2024.

Val was born Valerie Joy Mynott in Sydney, on 5 September 1929, the third child and only daughter of Harry and Laura Mynott.

The family, unlike many Australians, were spared some challenges of the great depression because her father was employed with the Sydney County Council. Valerie attended school at St Georges Girls High School where she excelled. At that time bicycles were highly prized and many families could not afford them, so Val proposed a deal to her parents, that if she came dux of

Dr Valerie Hill graduated MBBS in 1953.

the school could she get a bicycle as a reward. Her parents agreed thinking it would not happen, but they were wrong, as she topped the year and got a bicycle.

Val entered the medical faculty at the University of Sydney, and graduated MBBS in 1953. The post-war years had large numbers of returned servicemen in university intakes, and there were around 600 entrants in her year, of which about 37 were women. In fact there were so many graduates that not everyone could get an internship placement in Australia, and some had to go to New Zealand or Canada.

Val did her internship and residency in 1953 and 1954 in Goulburn. At that time there was a large trauma caseload from road trauma from the busy two-lane Hume Highway which ran straight through the city. In Goulburn, Val met her husband John Hill, who was a solicitor and they married in 1954. Their first child Anthony was born in 1955, followed by Diana in 1961, and Jenifer in 1963.

John decided to study medicine, and Val worked in Earlwood, a suburb of Sydney, supporting the family. They lived in Arncliffe between 1955 to 1960 with Val's parents, who were a great help with childcare.

After John's graduation they bought a house in Lurnea, in Southwestern Sydney, and converted the living and dining area of the three-bedroom weatherboard house to a surgery and waiting room, while the family lived in the rest of the house.

Moving to Canberra

In 1969 Val and John and the young family moved to Canberra, and bought a practice from Dr Bruce Forde in O'Connor. In 1977 Val and John divorced, and Val opened a practise upstairs from the Pharmacy at O'Connor Shops, where she stayed for 20 years. In 1994, she joined a practice in Lyneham with Dr Mike Shihoff and Dr Robyn Jenkins, and worked there until her retirement in 2005.

Val's practice was always busy, at a time when female GP principals were in a minority. Val studied formal counselling and marriage guidance counselling, and sexual health counselling. She assisted with teaching the sexual health counselling module in Family Planning Association doctors courses. She was held in high regard by the social work department at Canberra Hospital for her specialised skill combining traditional GP work and counselling.

Val was an early member of the AMA, and was awarded life membership after 50 years, in 2005. Val was an active long-term member of the Medical Association for Prevention of War, and the Medical Women's Society.

A role-model to younger doctors

Val's medical work was characterised by her caring, compassionate, listening style and her door was open to everyone, including "drop-ins". She frequently worked through lunch time, and would ask her patient if they minded if she ate her lunch in front of them. She had many patients who were also medicos, and welcomed GP trainee registrars, who learned from her reflective listening style. She was a great role-model for younger doctors starting their working life. Val encouraged her patients to take responsibility for their own health, and could be blunt when challenging patients to take charge, but it was always done with kindness.

It was never dull sitting in her waiting room, after doing the cardiac stress test of climbing the stairs to her rooms, and listening to the stories her long-term receptionist Betty would relate. She practised what she preached,

Dr Valerie Hill accepted her declining health with patience and grace.

adopting a vegetarian diet, walking and swimming regularly, and she was a great cross-country skier. One often met her jogging through the Aranda bushland close to where she lived in Cook. Val was never happier than when she was out in the Australian bush, or admiring birds from her balcony close to the reserve. Val was a conservationist and preferred to use recycled paper for her patient notes, which didn't have to be of a uniform size.

Val was a devoted mother to her three children, who say she was always present for them, supporting them, and a delighted grandmother of 5, caring for them in their early years, as well as her own mother who came to live with her towards the end of her life. Val is survived by her son Anthony and daughter Diana, 5 grandchildren and many nieces and nephews. Her daughter Jenifer predeceased her. In the final 18 months of her life she welcomed and adored her first great-grandchild.

After retirement in 2005 she accepted her declining health with patience and grace and was lovingly cared for by her children. She never lost her love of reading medical magazines which were dotted around her house.

Val embodied the best humane qualities that a GP can have, and was awarded a Medal of the Order of Australia in 2006 for her contribution to medicine and counselling. Her citation read “For service to the community of the Australian Capital Territory as a general practitioner and family counsellor.”

Vale Dr Valerie Joy Hill OAM.

Written by Dr Denise Kraus, Anthony Hill and Diana Hill

4 September 2024 ■

PAGE 18 QUIZ ANSWERS:

1) Dr Constance Stone,1890 – a year later, her sister Clara also graduated in medicine **2)** Dr Benjamin Spok, rowing **3)** Dr Brian May, lead guitarist, PhD in astrophysics **4)** False **5)** India’s first female physician 6) Dr Marie Bashir **7)** Dr Jeannette Young **8)** Dr Jacqueline Small, Dr Nicole Higgins **9)** Doctor, engineer, and the first black woman in space – on Space Shuttle Endeavour, 1992 **10)** Posterior knee, throat

Relational communication: the basics

VICKI DE PRAZER
Associate Director
UC medical and counselling centre
(Senior Psychologist)

Among their diverse range of skills, doctors need to be able to communicate with clarity, connection and compassion. They need to be able to convey news to patients that can range from exhilarating to catastrophic. What's more, they need to be able to communicate their knowledge and expertise confidently when speaking with colleagues, specialists and allied health professionals.

All this is what's come to be known as 'Relational Communication' – the subset of communication which focusses on the expression and interpretation of messages within relationships. It includes the gamut of interactions from vital relational messages to mundane everyday interactions.

Relational communication situations are often made more challenging for doctors by the limited time they have available, the critical nature of the communication, the overlay of ethical and professional expectations and the compliance and receptiveness of the person they're talking to.

Tools for reflection

When reflecting on a professional conversation and trying to understand what went wrong or right, it can be helpful to consider the impact of the following four domains on communication:

The Psychological context

Psychological context refers to our mood, values, habits, history, expectations and beliefs. The quality of any communication experience will reflect your Emotional Intelligence, your awareness of self and others, your biases, organisational awareness, empathy, confidence and insight and the ability to understand and manage your own and others' emotions. These skills evolve over time with deliberate reflection and active practice.

The Relational context

The Relational context refers to the nature of the relationship you have or seek with the individual or team you are communicating with. You will communicate differently with a child and an adult, a family member or a colleague, someone you admire or someone you don't respect, someone you trust or someone you fear or mistrust.

The Situational context

The Situational context refers to factors such as the goals of the communication, planned or spontaneous, differing expectations, the environment, nature and level of knowledge and expertise, differing communication skills, power, hierarchy, technology and who else is present.

The Cultural context

The Cultural context refers to the impact on communication of formal or informal styles, customs, values, beliefs or norms of a particular culture. Culture can refer to an organisation, a profession, a team, an ethnic or religious group or nationality.

Bringing it all together

A single communication experience might be impacted by elements from all four contextual domains. Reflecting on your positive and negative interactions might mean considering what you and they brought the 'communication experience' including your moods, expectations and biases, your goals, the nature of your relationship, whether it was a professional or informal context, your communication style and cultural background and the medium (oral, written, face-to-face or online).

Well-developed communication skills will improve your professional effectiveness and the quality of your personal relationships. It is also important to note that in all areas of health AHPRA acknowledges that relational communication skills are an essential component in the delivery of high-quality care, intervention and training and facilitate the ethical exchange of expertise. ■

Vicki de Prazer presenting on relational communication at the most recent Drs4Drs Safe Space event.

Tips for effective interpersonal communication

- Practice active listening
- Use clear, concise language
- Maintain eye contact
- Be mindful of your body language
- Show empathy
- Ask open-ended questions
- Give constructive feedback
- Adapt to communication styles
- Use affirming words
- Be patient
- Express gratitude
- Recognise non-verbal signals
- Practice self-disclosure
- Stay open-minded
- Manage emotions
- Use humour wisely
- Clarify misunderstandings
- Respect differences
- Be assertive, not aggressive
- Practice paraphrasing

Source: examples.com

Scrub Turkey brings joy to healthcare

Iconic Australian scrubs brand Scrub Turkey has joined together with *Canberra Doctor* to offer a $150 voucher for the best submission to our student issue, due out in December.

Scrub Turkey is the creation of Healthcare Uniforms Australia owner Heike Ciesla and her daughter, Elke, a designer. Together they launched the brand during the Covid-19 pandemic to inject some fun and colour into the healthcare industry at a time of unprecedented challenges.

Inspired by Aussie flora and fauna, Scrub Turkey is on a mission to make #funscrubfridays as bright and colourful as possible. In the past four years, Scrub Turkey has collaborated with 6 independent Australian Artists to produce over 15 wonderfully colourful and unique scrub prints.

Every print has a story. For example, the 'Monster Mash' design (pictured) was created by 7-year-old artist Ollie, who uses art as a way of escaping his time spent in the hospital receiving treatment for embryonal rhabdomyosarcoma.

Recently Scrub Turkey worked with Tasmanian Health to create a custom wombat print to celebrate the launch of their new paediatric unit named The Wombat Ward.

Scrub Turkey scrubs are printed on their signature cotton-rich stretch fabrication, known for its comfort and breathability. With Heike's 25+ years of uniform design experience, she understands that a good scrub doesn't just look good, but it feels good too. ■

To explore Scrub Turkey's unique range of printed scrubs, head to **www.scrubturkey.com.au**

WIN

If you're a medical student it's not too late to submit your original work for inclusion in the next edition of *Canberra Doctor* and be in the running for a $150 Scrub Turkey voucher.

Contributions can include essays, opinion pieces, short-stories, poetry or photographs of original artworks. Written entries should be no longer than 1000 words.

Please attach a photo of yourself, provide your postal details and share your medical school name and year.

Entries should be emailed to editorial@ama-act.com.au by Sunday 10 November.

Australian medical history

1920 Congress a window into medical thinking a century ago

BY BILL COOTE

The 1920 Australasian Medical Congress convened in Brisbane from the 21st to the 28th of August 1920. This was before the emergence of national speciality colleges and societies. The records of the Congress provide an insight into medical thinking and medico-political tensions in the years after World War 1.

The first Intercolonial Medical Congress, an initiative of the South Australia branch of the British Medical Association (BMA,) convened in 1887 in Adelaide. The next Congress convened in Melbourne in 1889 to mark Queen Victoria's golden jubilee. Congress sessions were then held every three years, in Sydney in 1892, then Dunedin, Brisbane, Hobart, Adelaide, Melbourne, Sydney and in 1914 in Auckland. The war led to deferment of the Brisbane Congress until 1919 and the influenza epidemic caused a further delay until 1920.

In her PhD Thesis The History of Medical Organisation in Australia, submitted to the University of Sydney in 1967, Amy McGrath notes that Australian doctors had seen the political successes in the UK of the united British Medical Association (BMA) and the political and educational influence of the British Medical Journal. She portrays the Congress as a manifestation of the ambition of many Australian medical practitioners to have a national organisation. Congress meetings provided an opportunity for the medical profession to hear of advances in medical practice and to debate issues of national significance.

Who attended the Congress?

In 1920 there were 4,020 registered medical practitioners in Australia and 460 attended the Congress (plus 12 New Zealanders).

The Congress was dominated by practitioners holding senior city hospital appointments. The 83 Victorian attendees included just 6 doctors from outside Melbourne; of the 77 from Melbourne, 36 had a Collins St address.

Advances in medical practice

It is a truism of medical history that surgery was revolutionised by the development of anaesthesia and adoption of Lister's antiseptic practices. A 1920 *MJA* article by Dr Dunlop of Newcastle, "Surgery As it Was Practiced Thirty Years Ago", mentions an extensive range of conditions. One does not need to know much about surgery to appreciate the advances made in the decades before 1920. A few of his recollections make the point: "In those days the surgeon wore a white coat and apron"; "there was no bone or reconstructional surgery as we know it today, but joints were excised, jaws removed"; "how many little children died of intussusception simply because we did not know how much a child could stand in the way of operative interference?"; "there were few cases of ectopic gestation reported and they were mostly fatal… laparotomy was the last resort;" "The abdomen, that region of mystery and surprise, gave a lot of trouble to the surgeons."

Developments in bacteriology associated with Pasteur, Koch and Ehrlich gave doctors knowledge on which to base effective preventative strategies and treatments, even in this pre-antibiotic era. The English medical historian Pelling suggests: "Bacteriology created a new source of scientific authority for medicine, and made an enormous difference to its reputation for effectiveness in both prevention and cure."

1920 Australasian Medical Congress in Brisbane.

Enhanced status of the profession

In his 1980 book The Rise of the Medical Practitioner in Victoria, the economic historian TS Pensabene describes the growth in the prestige and status of the medical profession between 1880 and 1920.

The enhanced status of the profession is perhaps evidenced by official support for the 1920 Congress. The Governor-General travelled to Brisbane to perform the "ceremonial opening" on the Monday evening. As well as the Governor General, the Governor of Queensland, the Premier, the Mayor of Brisbane, the Chancellor of the University and the Anglican and Catholic Archbishops attended.

> "More needs to be done to inculcate in the minds of members of the medical profession on this side of the world a feeling of close association."
>
> **Editorial in the *Medical Journal of Australia*, 1920**

A pattern of significant State Government support had developed at earlier Congresses in Melbourne and Sydney and this continued in 1920 in Brisbane with "the loan of University premises, Government shorthand writers and financial support from the State Government" including "the production of proceedings by the Government printer". These proceedings (titled Transactions) were produced as a bound book (of 672 pages).

There was significant media coverage of Congress deliberations. *The Queenslander* wrote an editorial on the Congress, noting the World War had "a galvanising influence on medical, surgical and general scientific research" with developments "capable of application to ordinary civilian life". *The Sydney Morning Herald* and *The Melbourne Age* had daily reports on Congress deliberations – more reports than on the Olympic Games underway in Antwerp in the same week.

Political power

Pensebene also describes how the enhanced status of the profession led to enhanced political power. That power consolidated under the BMA, supported by its journal the *Medical Journal of Australia* (MJA).

Contemporary reports refer to the Congress as a continuing entity, with the 1920 Congress referred to as the 11th session. However no formal organisation "owned" the Congress. At the closing meeting of one Congress the venue for the next session would be agreed and a prominent medical practitioner from that city would accept the position of President with the responsibility of coordinating arrangements for the next Congress session.

At the 1920 Brisbane Congress Dr WF Taylor was elected president. An obituary described Taylor as "a distinguished medical man and a notable citizen". He was born in London and settled in Brisbane in 1872. He was a Member of the Royal College of Surgeons and held a Diploma of Public Health from the Royal College of Physicians. In 1920 Taylor was Honorary Surgeon in charge of the Eye, Ear and Throat Department of the

Dr WF Taylor was elected President.

Continued on page 17

Out and about

Dr Aust meets the team at Clare Holland House

AMA ACT president Dr Kerrie Aust had the pleasure of visiting the Palliative Care Team at Clare Holland House in October, including the inpatient palliative care team, home-based palliative care team, and the PEACE team that support residential aged care.

The peaceful building set on the foreshore of Lake Burley Griffin is a place that will always hold special meaning for Dr Aust, who's own mother was one of the first patients when the building opened in 2001.

Dr Aust reflected: "The team today continues to provide high quality care, as evidenced by the patient and family feedback highlighted in the entrance-way."

Dr Aust had the opportunity to speak with Nurse Practitioner, Peter Jenkins, as he talked about the opportunity to care for people at the period of life when time is so precious, exploring their goals of care early in a way that is meaningful to each patient.

Dr Emma Sharp, a Senior Registrar who plans to stay on after she finishes her training, spoke about how palliative care gives her the opportunity to treat the whole person, not just the disease.

Dr Sivaraj Rajadorai reflected on the 'superbly collegiate team' at Clare Holland House that intentionally supports one another.

Dr Aust recalled the days she spent at Clare Holland House with her mother. "Those moments that I cherish were by her bedside as she showed me the swans bringing their cygnets to her door to visit, or sitting under the willow and watching the sunset. I will always be grateful to those that cared for her in her final days."

The ACT Labor-led government has promised further expansion of the service over the coming years, to continue to support the end-of-life care needs of our community whether they wish for their final days to be at Clare Holland House or in their home. Referrals to the palliative care service can be sent via HealthLink. ■

Dr Sivaraj Rajadorai, Dr Emma Sharp and Paul Jenkins.

Dr Kerrie Aust and Dr Sivaraj Rajadorai.

EVENTS

Dr Kerrie Aust at a 'Voices of Bean' Politics in the Pub event, where she was invited to speak.

AMA ACT Treasurer Dr Jason Gluch (L-R) with pathology collectors Kathy Burdett, Alyssa Zarebski and Courtney Patc from Capital Pathology and CEO of Sonic Australia Dr Ian Clark at the annual PSA Testing event in Parliament House on October 10. Led by Pathology Awareness Australia, male parliamentarians, senators, media representatives and staff rolled up their sleeves for prostate-specific antigen (PSA) testing on the day.

Continued from page 16

Brisbane Hospital. He was also Medical Officer of Health for the City of Brisbane and a member of the Queensland Parliament.

The last formal Item of business considered at the 1920 Congress was a motion that "Future Congresses shall be Congresses of the British Medical Association". This was passed and subsequent congresses were held under the auspices of the BMA until the formation of the AMA in 1961.

Medical Journal of Australia

The Medical Journal of Australia commenced publication in 1914 and in the first 6 months of 1920 ran editorials promoting the Brisbane Congress. Later in 1920 it published extensive reports on conference debates.

An editorial of February 28, 1920 states: "More needs to be done to inculcate in the minds of members of the medical profession on this side of the world a feeling of close association and a desire to create a really united Australasian medical profession.... The Australasian Medical Congress has established for itself a permanent reputation."

Another editorial predicted the Congress "....will be a unique reunion for Army Medical Corps men, for those who participated in the greatest adventure of all time and who lived for months and years under the most abnormal conditions, devoid of even rude comforts and of even moderate safety." p389

Circulars outlining travel and accommodation arrangements were sent out with the *MJA*. Readers were assured that "The medical world and his wife will be in good hands in Brisbane." ■

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Palliative care charity launched

A group of Canberra-based doctors and individuals have launched a new charity to help bridge the gap in understanding and access to palliative care for immigrants and multicultural communities.

Dr Betty Ge, Dr Ganes Pranavan, Professor Walter Abhayaratna, Dr Kerrie Aust, Dr Sharmila Sambandam and Dr Rochelle Venturi at the PBH launch evening.

'Paalam the Bridge to Humanity' (PBH) has a pilot project in the ACT working with multicultural communities from the subcontinent. Additionally, the organisation is working to improve palliative care infrastructure and support in Sri Lanka and regional India.

The founders include medical oncologist Dr Ganes Pranavan (director), anaesthetist Dr Senthan Ponniah (deputy director) and palliative care physician Dr Raj Rajadorai.

A Sri Lankan themed gala event to launch PBH was held at Woden's Hellenic Club in August, raising $25,000. Most of the funds will support the construction of a dedicated palliative care ward at a major cancer hospital in Sri Lanka, while $2,500 was also donated to Palliative Care ACT. ■

Free peer support network grows

The old-style hospital tea room where staff could trade stories about their experiences and look out for one another has been reborn online in the form a Federally-funded peer support network.

Hand-n-Hand Peer Support is a free and confidential service for doctors, nurses and allied health professionals which matches peers who have similar professional experiences. Peer support is offered online or over-the-phone, and can be done individually or in small groups.

In contrast to other peer support programs, Hand-n-Hand participants are matched with facilitators who do not work for the same organisation as them, in order to make it easier to discuss subjects that may be sensitive in a workplace.

The service was set up in 2020 by Queensland-based psychiatry registrar, Dr Tahnee Bridson, to enable doctors and nurses to better support one another during the pandemic. It now has around 80 peer support facilitators signed on, the vast majority of whom are doctors. Facilitators are all volunteers who have received training from psychologists and psychiatrists.

Participants are triaged to ensure the service is right for them, with those requiring clinical support steered toward other services, such as Drs4Drs.

Among some of the well-known doctors on the Hand-n-Hand board are Dr Kym Jenkins, the past president of the Royal Australian and New Zealand College of Psychiatrists, Professor Brett McDermott, director of Child and Youth Mental health Services Tasmania and former AMA NSW President Dr Michael Bonning

Drs4Drs ACT 24/7 Help Line: 1300 374 377

For more information about Hand-n-Hand Peer Support, including how to become a participant or facilitator please visit the website **handnhand.org.au**

THE QUIZ

By Dr Antonio Di Dio

1. **Who was Australia's first female medical graduate?**
2. **Which world-famous paediatrician and 1972 politician won an Olympic gold medal in 1924? In what event?**
3. **Who was the doctor in the great band Queen? In what field?**
4. **In Scooby Doo, Velma is a medical student. (T/F)**
5. **Who was Anandi Gopal Joshi (1865-1877)?**
6. **Which amazing doctor became governor of NSW in 2001?**
7. **Which amazing doctor is the current governor of Queensland?**
8. **Who are the current presidents of the college of physicians and the college of GPs?**
9. **Born 1956, who is Dr Mae Carol Jamieson?**
10. **Where would you find your popliteal space and your thrapple?**

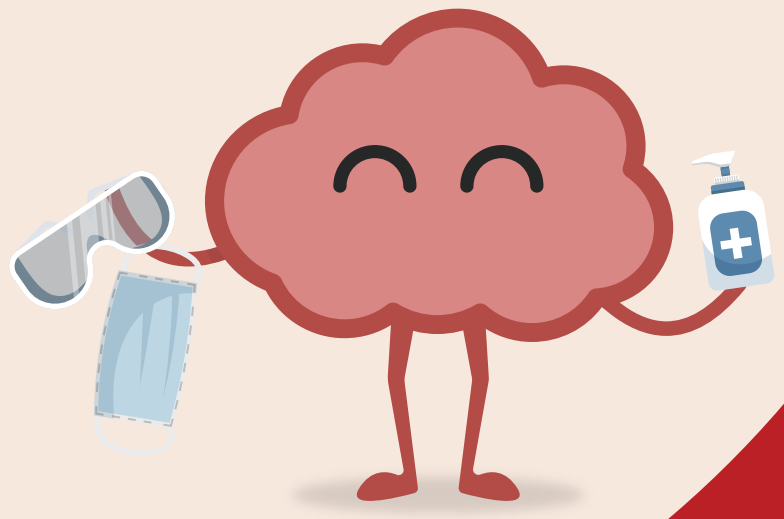
Find the answers on page 14

Hand-n-Hand Peer Support

It’s PPE for your mind.

We support the mental health and wellbeing of all health professionals, students and people in health care in Australia and New Zealand.

- Emotional and wellbeing assistance
- Connect through shared experience
- Facilitator and participant are equals



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