A Conversation About…Shaping the Future of Care with GP Registrars and Psychiatry Trainees

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Ava Carter (00:18):

Welcome to this episode of MHPN Presents A Conversation About. Today we're going to chat about the psychiatry trainees and GP registrar experience. This conversation will traverse governance, clinical and future forward considerations. I'm Ava Carter. I'm one of the board directors for the RANZCP or Royal Australian and New Zealand College of Psychiatrists and a recent fellow of the college. By way of beginning, I'd like to introduce my guests. I've got Rebecca Loveridge here. Rebecca, welcome.

Rebecca Loveridge (00:46):

Hi Ava. It's great to be here. I'm a gp. I fellowed April last year and I'm also a board director for the RACGP through my role as chair of the RACGP gps in training faculty.

Ava Carter (00:59):

Brilliant. And I've also got here Chris Dickie.

Chris Dickie (01:02):

Thanks Ava for inviting me. I am a current GP Registrar, almost about to become a fully qualified gp. I sit on the board of General Practise Registrars Australia where I'm also the president of the organisation.

Ava Carter (01:14):

Brilliant. It's been a really wonderful experience getting you guys together and talking about this podcast. I really wanted to get us together mostly because it's such an unusual experience and such a creative pathway in terms of medical careers to be able to do one of these board director positions and there's not many of them about, and when I was talking to Daisy Brooke, who's the amazing CEO of MHPN, we were thinking how do we get this sort of experience to the broader community and what it's like to be a board director, but more importantly how it actually helps different parts of the healthcare sector. So I'm really looking forward to this conversation, talking about lots of different things, but not just from a medical perspective, but also about how it affects our healthcare colleagues all around Allied health and all around the different parts of the community that we work in. So I was thinking with all the recent issues that have been happening in the colleges, there's exams going on all the time and there's different sorts of elections. I was wondering, Chris, what's it been like being part of the GPRA and how did you get into what you do in terms of accreditation and your board work and the teaching as well that you do?

Chris Dickie (02:26):

Yeah, so I've always been interested in how systems work and how we can support colleagues and others. So I've always been quite involved in different advocacy spaces. So when I became a GP registrar, I quickly became aware of the GP registrar's Australia, GPRA and the things that we were doing in advocacy spaces and educational spaces and it's some work that I really enjoy. I've done similar things. I've worked with Bec before, and the gps and training faculty over RACGP and I've worked with you at the Canberra Regional Medical Education Council where we look to see around accreditation of junior doctors. So I think it's a really good way to develop skills personally, but also really like that giving back and making things better for other people.

Ava Carter (03:04):

That's so true. It's really nice when you can do a job that's so enjoyable but actually affects so many other people. Bec, you've been on the GP board for quite a while now, haven't you?

Rebecca Loveridge (03:14):

Yeah, I think I joined as chair of the faculty end of 2023, so it's been a year and a half now that I've been on the board of the RACGP.

Ava Carter (03:22):

Amazing. I mean even I don't really know exactly what it's like to be a board director on the RACGP. Can you give some of our listeners a little bit of an idea about what the organisation does and what it aims to do?

Rebecca Loveridge (03:33):

Yeah, the Royal Australian College of General Practitioners is one of two GP representative bodies in Australia. The other one being the Australian College for Rural and Remote Medicine and RACGP is sort of the bigger of the two. We train 90% of Australia's gps. Our board is a representative board, so there's

huge GP voice running the organisation and setting the direction. The GPS in training faculty chair, which is myself at the moment, sits on the board and we provide that expert GPS in training perspective to those strategy and governance issues. We help to set the direction of the college and we are the future of the profession as I often say, and so I think it's really important that we have a seat at that table

Ava Carter (04:14):

That's brilliant. With the psychiatry college in 2021, we had a big change of the way the college itself looks at and engages with trainees and that's how the trainees came to the table. I mean my predecessor Dr. Pramudie Gunaratnei was brilliant. She was the inaugural, I guess trainee on our board and I have been there since 2023, similar to you the last two years in that position and I'm about to finish in May. At our AGM, we'll have another appointed director, Dr. Ashna Basu, come on and do some brilliant work. I was wondering what sort of impact do you think it's had in having a trainee on the board and in such a high position? Not the first college, the psychiatrists aren't the first college to do it, but certainly not every medical college has it.

Rebecca Loveridge (04:59):

Yeah, I think you're right and I think it's really important that all key stakeholders are represented at the highest level of governance and so I think that all specialist training colleges probably should think strongly about having a trainee on their board. I think that as I said before about having a seat at the table and having an opportunity to provide that GPs in training perspective to everyone whilst the representative board has gone through GP training, it was a number of years ago for some of them and things change, the landscape changes, training changes, healthcare changes. So I think having someone that's really close to the ground and I consider myself as a fellow of only one year to be pretty close to training still just means that you're up to date with what the issues are. And you're also a bit more in contact with current registrars or people considering general practise training just by association you're a bit more of a near peer.

Ava Carter (05:52):

That's so true. You can be 10 years out and depending on what that was like when you were training 10 years ago, you can be still with the trainee times or it can be completely different.

Rebecca Loveridge (06:03):

Exactly right. I think the pace of changes in medical understanding is so quick and the information comes to the table and it's easy to age out, which is how I describe myself. I'm getting close to ageing out of my position.

Chris Dickie (06:16):

I think that's quite an interesting contrast thinking back and think both Bec yourself and Ava, sit on boards of your colleges where there's quite broad representation across people at different career sectors, which is quite different to my board. GPRA's board is made up of five member directors who by virtue of how member directors are or have to be gps and have to be within five years of fellowings or quite close to that point, and then some appointed directors who usually have specific skill sets, so we

might have expertise in governance or finance or legal kind of aspect. So we've got a slightly different type of board and some of us at a different career stages. It's quite interesting thinking around how all of our different boards work slightly differently.

Ava Carter (06:51):

One of the things that it's really interested me in the specialist colleges is some have people with lived experience or peer workers or allied health workers on them and some don't. I mean our college doesn't at the moment, but I mean from a personal viewpoint, I think it's a really important thing. You're providing all this care to the community. The voice of the community really should be there in my personal opinion and that's something that I think our college is trying to work towards as well eventually. It may not be something that you want to talk about or can talk about openly, but I'd be interested in your thoughts on peer workers lived experience specialists on boards in general if you can't talk specifically about your college.

Chris Dickie (07:29):

So I think that's true in so many things that we do in medicine and life in general now., so I think whether that's research or board work or designing systems or all sorts of different things, that people with lived experience is really important and that might be people with lived experience of psychological problems, might have people that have lived experience like basically all of Australia does have seeing a GP or it might be people of lived experience of a system. So things like being a GP trainee still is having lived experience of that system. So thinking around what decisions we're making and who they're affecting and trying to include those people where we can I think is really important.

Rebecca Loveridge (08:03):

So similar to Chris, I think it's really important to have the consumer voice represented at the RACGP. We don't currently have a consumer advocate have a formal position on the board, but we do have presentations from external organisations scheduled throughout our board calendar and we have had consumers come and present their perspectives on those schedules. I guess the other thing is that the thing about being a GP is that we have really high patient contact and we see a lot of people every day. We see a lot of consumers every day and having so many GPS on the board means that vicariously we can draw on consumer experiences so whilst they're not there having a seat at the table per se, I think that with so many gps on the board, if you amplify that by the number of patients they see a day, a week, a year, you're getting a lot of experience vicariously through that. But I think that we're working towards, similarly to the college of psychiatrists, working towards having a bit more of a formal representation.

Ava Carter (09:02):

It's really interesting. I think the idea of seeing patients and being able to bring their view to the work that we do in medical administration and medical leadership is really important. I mean it's probably not maybe in my view the most ideal way to do it, but I certainly think if we start changing the narrative on how you actually utilise your position in terms of bringing your own views about what the specialty needs to be doing but also what your patients tell you every day, I mean that's advocacy isn't it, and so

important because who else is going to be able to speak for all those tens of thousands of people that we see every year? We're not doing it as well alongside them. I hadn't really thought about the number of voices that we have access to and to have them sitting beside us as you think about each decision that you make. That's a really potent one. Bec, I really like that idea just to visualise all those different stories together.

Rebecca Loveridge (09:51):

Well, I think it came obvious to me at our last board meeting, we were reviewing a position statement on raising the age and I work clinically as a GP in the youth custodial system. So for me that was very much what my day-to-day clinical work is and it was highly relevant and so when I was at the board thinking about this position statement, all I could really do was think about my patients who I work with and the ones who are under the age of 14 and whether or not they should be incarcerated. So I guess I've had a recent experience which has really brought that consumer perspective on the board to the forefront.

Chris Dickie (10:24):

Yeah, I agree. I think we're so informed by our patients and their kind of lived experience, but also I find it works other way around a little bit as well as far as some of my patients really love hearing about the kind of things the organisation is involved in doing or what things you do outside of your clinical work. I think it can be really good way to discuss things with patients, explore their understanding of health systems and think around ways that we could make things better that we might not always see ourselves.

Ava Carter (10:47):

It's that idea of health literacy within the community and how we can impact that given all that's happening. I mean we're not going to talk about politics that'll just derail us all, but I was thinking about our college is very keen on the investments that are being reported about mental health care and any sort of investment into mental health care is something that will support whether that's psychology, AI, Medicare, rebates for gps doing mental health care plans. I was wondering thoughts on medicare reform and the broad ideas that you guys are having within your own organisations about how that could help.

Chris Dickie (11:21):

I think a lot of what we've talked around already feeds into that. I think a bit like we're talking around co-designing and involving consumers in processes, it's very similar in things like medicare reform, so that needs to involve consumer groups and it needs to involve medics and other health professionals to make sure we really get the best out of Medicare. There's a lot of potential in Medicare reform, but really thinking through it carefully and working together as much as we can I think gets the best outcome for everyone.

Rebecca Loveridge (11:47):

I guess my perspective on that is similar once again and in the bigger picture it's also about broader health system reform and Medicare is a small part of the overall health budget and I think looking at

where we can get the most efficiencies and the best outcomes for patients and healthcare workers and reduce burnout, administrative burden, improve patient access, improve patient outcomes, I think that it's a really big picture problem and Medicare is only a small part of that and only one of the solutions that we need to be looking to personally. I think that having access to a GP who knows you well is really important and I've lived that again myself because my GP who had been my GP since I was in the womb, so preconception, she retired at the start of last year and I have gone through that experience of not having a GP who knows my whole medical history and whilst I've had great care and I've been lucky, it has been stressful just to have that person who was my support for so long.

Ava Carter (12:49):

It speaks to I guess how much the primary care providers actually do in terms of holding each patient's history and their care and all that knowledge alongside the local pharmacist and alongside the local nursing staff that work in the GP clinic. All that knowledge is not lost per se, but it dissipates doesn't it? When the GP retires, I mean I had a similar experience when I was in Queensland doing my first degree, which was dentistry. I had a really great GP who knew me from three, four years old, all the vaccine history, everything. And mine was a little bit annoying because they went overseas and the annoying part about it was I had to figure out all the vaccinations that I'd had and all those sort of things because at that time I had absolutely no clue about what the process was and how you actually check all your vaccines. I hadn't done medicine at that point, so I was really naive to all of that. So that really struck home to me how important having a good record with your GP was and having good connections there and that was an experience, probably an experience lots of people have when they go back and go, oh, did I get that vaccination at that point or do I have that certificate? I've got no idea. Who did I see back then?

Rebecca Loveridge (13:57):

Yes, absolutely. I think as a GP it's both a blessing and a curse, but I consider that you're kind of the care coordinator a lot of the time and so do you hold a lot of things for patients, as you said, Ava.

Chris Dickie (14:07):

I think that highlights the importance of communications as part of medical professionals and health professionals in general, kind of that communication with people both outside your practise, whether it's allied health or specialists, but also I'm really lucky in my practise I have psychologist, I have a social worker, I have multiple nurses, and the ability to see notes and coordinate care becomes much easier when you have access to those notes, but also good communication between you and that worker. So it's not always possible that that's in the same practise, but hopefully you can build good lines of communications with your local physio. For example. I don't have one in my practise, but I know who that is and we can speak to each other quite happily if we need to about patients. I think that's really important.

Ava Carter (14:41):

So having that multidisciplinary team care is so much more beneficial than doing anything siloed. I mean I really like that we talk about it a lot, but to see it when it works well is actually quite something. So I'm

not a GP and I'm only just a recent fellow of the college of psychiatrists. How is it when you're trying to interact with specialists and I mean your specialists in family care and really specialists in that coordination of care, how do you find that process of making sure that you know what the specialist wants to do and does it work for the patient? Does it work for you guys?

Rebecca Loveridge (15:15):

It's complex. It's complex to answer and it's really, at least in my experience, it changes so much depending on the context of where you're working as well. Like I said before, I work in a prison at the moment and so those people are unentitled to Medicare, so we're working outside of that system and they're very complex patients with complex social histories most of the time, and so coordinating their care is a whole different ball game. And then previous to that, I was working in Aboriginal medical service in rural Victoria. Then the issue became access to specialists, so their choices of who people could see were so highly limited and there was a lot of telehealth, and Ava you probably know about the telehealth psychiatry services and I'm sure you have thoughts on those and the variable quality of what patients can access and the cost associated with that. So I actually haven't worked in metro private GP practise before to comment on what most people would know as the routine general practise. I'm not sure, Chris, if you have any thoughts.

Chris Dickie (16:12):

Yeah, so I work in slightly rural, so I'm just outside of Canberra working, so we have reasonable access to specialists in Canberra or up to Sydney if we need to. But again, it comes back to that kind of public versus private and the cost associated accessing healthcare can be good, but if we're focusing on the MDT, so overall I think we get reasonably good communications between us as GP specialists and as other non-Gp specialists and with allied health and nursing staff that I work with in other practises, it definitely can be challenging sometimes and there's a whole range of reasons for that and sometimes a patient turns up to you on the same day that they've seen a specialist so understandably don't have a letter yet. But I think overall it works well. Like any communication system, there's always a room for improvement and I can do better things for us as healthcare workers and also for our patients.

Ava Carter (16:59):

They talk about artificial intelligence a lot in communications and things like electronic medical records and at least at the moment from some of the board directors CPD continuing professional development that I've been doing. They talk a lot about AI in that field, but also the issues of confidentiality. I mean some clinics that I'm aware of across Australia, even the world are using AI to scribe patient interviews and things like that. I was wondering your guys' thoughts on that process, were you exposed to any of that in your training versus now when you're working as specialists?

Chris Dickie (17:33):

So I'm kind of exposed to it quite a lot. I've not used it much myself. I've used it a little bit certainly and probably plan to use it more and more because I do find that note taking scribe aspect of it, a potentially useful and helpful area that yeah, I can be involved in. I think we do need to focus on those kind of privacy aspects and the medical legal aspects and I think the medical indemnity organisations now are

having more and more information for us to help us inform us as clinicians where it's appropriate to use things and how to use things and making sure we're using tools that are kind of approved in some way. I think that's slightly different as a trainee compared as a specialist. So there's a degree of working as a trainee with your supervisors and with your colleges to make sure that it's appropriate for you and your stage of training and for how your training should look depending on what point in training is different tools, whether that's AI or other tools become more or less appropriate for you depending on you yourself, the system that you work in and the organisations you work for.

(18:29):

So I think it's about having those open conversations to make sure it's the right thing for you and for your patients and being really open with your patients to consenting them appropriately for the use of any tools like this.

Rebecca Loveridge (18:39):

I think as well, noting everything Chris said about confidentiality and privacy, I think that if those things are ticked off and you're using the tool appropriately, especially for the complex mental health consults, I think that there's so much potential within the AI scribe realm and I think having the opportunity to be able to face the patient talk to them without looking at the computer, without worrying about documenting things and just being able to have a natural free flowing conversation with them and not worry about all of that is something that I really look forward to hopefully becoming a reality in the future and being able to use it every day. I just think that that would be so much of a better experience for the patient. Me constantly flicking back if they say something important and I really want it to be a quote, making sure that I get the quote down without making it really obvious that I've decided that that's the thing that they said that's really interesting and I need to type it. So it can be hard to document appropriately in those complex consults. I think

Chris Dickie (19:42):

It kind of empowers you to be able to do that. So I try and do that as much as I can. I try not to look into my computer and particularly for complicated or difficult conversations, I probably do focus on the patient, but then you spend quite a lot of time afterwards catching up on your notes and trying to remember those exact quotes and things that you say. So I think it's a tool that helps empowers to do our job better. It's not something that changes what we do particularly. It shouldn't influence anything we're doing, but it's there as a scribe that just makes our life a little bit easier and allows us to focus on our patients.

Rebecca Loveridge (20:07):

I can't remember who, somebody globally mentioned that doctors were going to be one of the things that were taken away from ai. I'm sure it was someone controversial possibly in America, and I think that as Chris just said, I really see that AI is so useful for scribing or documenting, but I don't see AI as a threat personally to any kind of formulation or diagnostic assessment because that human element and Ava, you mentioned the therapeutic relationship, AI at least as we currently have access to it and as best we can predict where it might go in the future is not going to be able to come for that aspect of medicine. The art of medicine, I think being from a generation that was raised with technology, not

having to learn how to use a computer other than just by growing up and having the dexterity of being able to type.

(20:55):

I think that these new technological developments that are coming in are one area where having a trainee director on the board can be really valuable because not to generalise, but I think perhaps that the trainees do have a bit more of a finger on the pulse of these really new developments compared to the average gp. There are definitely really tech savvy people out there who know far more than I do, but if we're talking about the averages there, I do think that even more so than me now, the current trainees probably have access to things that I am unaware of and the Gen Z is going to be more progressive than the millennials and so on and so forth, and that will continue. So having a trainee on the board I think is really important to make sure that you're staying as current as possible.

Ava Carter (21:38):

That's such a good point. Not to generalise at all, there's some more senior staff specialists and gps that are fabulous at all the technology, but I would say in general, I think it's probably more so the younger generations that take these sort of technologies and run with it. I will say that I'm not one of the younger tech savvy new fellows. I've certainly got lots more respect for the young stage one trainees. Just in general for a little bit of an insight, we've got what we call the trainee advisory council, one of the committees that I chair as part of my portfolio, and some of those trainees are just incredible. Their ability to use technology and have it flow so seamlessly is really, really amazing. And they're doing it not just in their clinical care, but some of them are developing apps and some of them are doing stuff with all of this AI to make their lives at home easier and their training programme, and it's just really, really quite something.

Chris Dickie (22:34):

I see it a little bit like when we moved from kind of paper records to more computer-based and electronic medical records, there's a whole lot of challenges that came with that, not only in head of what's the right thing to do, but how people use that system that have never used that system before. But that was always going to happen. It was always going to change. And I think the position that we're in just now is was always technological changes, sorry, happening, they are happening. They're going to be used. We just need to think around as medics, as healthcare professionals, how we do that to the best, further our roles and to help patients as well. These are tools that can do both of those things as long as we're doing them right.

Ava Carter (23:07):

That's very true. Centering it back on, how do we do it right for the patient? How do we make sure that essentially really, like you said before, Chris, where shortening the administrative burden so that we can be more present in the consult room. I was wondering, just hearing you guys speaking just before about some of the different skill sets, different people with different backgrounds bring, what's it been like for you guys in terms of your experience of, I guess medical admin, medical leadership and management through your roles in your different board positions?

Rebecca Loveridge (23:40):

I guess for myself, I've found being on the board to be a really super valuable experience and I learn so much every day from the other board directors and I find them all very inspiring and I think it's also really important as a GP to have other interests. Unfortunately, I don't think that it's sustainable to be a full-time GP in a consulting room, just not the way that the health system is currently set up anyway. So I find that having that nonclinical outlet to be really valuable to my practise as a GP and the opportunity to mentor other people on the GPS in training faculty council, I could take credit for Chris's GPRA in presidency for that point. So I think it is really a good opportunity to foster my own leadership skills, but also leadership skills in other people as well.

Chris Dickie (24:36):

I think that's so true. We learned so much from our non-clinical position, so I've been very lucky. So currently not only am I on the board and have a president role there where I've learned so much from my board and from our CEO and other members of staff that we have, but I was quite lucky before starting GP training, I did a few nonclinical jobs. I worked as a medical administration registrar for a senior executive, sat involved in government briefings and high-level meetings. I did another non-clinical job that involved strategy development, so a lot of consultation strategy things. I think all of these nonclinical jobs help. I really do feel like they help my clinical work as well. It helps me have really good understanding of the wider systems and how those work. It keeps me up to date with the research with things and it gives me things to talk about with my patients that my patients find interesting as well sometimes. And like Bec says, for me that mixture of nonclinical and clinical time is a really good way for me. Avoiding burnout, it keeps me interested in different stuff and stops me being burnt out by doing one thing all of the time.

Rebecca Loveridge (25:32):

I really love Chris, how you ever so subtly demonstrated all of your experience, which is in fact why you are GPRA president. It has nothing to do with me. Just it was seamless, a plus.

Chris Dickie (25:42):

I think definitely the time we worked together is definitely helpful Bec.

Ava Carter (25:46):

I think you set the scene for Chris to be able to stand on the shoulders of Giants, Bec. I think that's always a plus. Well, this has been wonderful. I've just been reflecting on all the things that I guess we've done. I've worked with Chris quite a bit in the accreditation space and seen him working in that medical admin role with those senior executives. It looked like it was a lot of fun, but also something stressful. But at the same time, it sounds like Chris has given you a lot of different perspectives to bring to the consult room and be able to relate to people and all the different things that our patients do. And Bec, it sounds like you've had a very broad and very varied experience as chair of your faculty on the GP board. Any last thoughts or comments? Because I'm aware that our audience is a lot of allied healthcare workers, a lot of non-doctors, but at the same time sometimes it's nice to think about the different things that we do as trainee doctors and specialists in training and how we can help raise the voice of

allied health. Thoughts on that, what maybe the next part of your careers might look like. I've got some ideas about how I will contribute to that space, but open the floor to you guys on some last points there.

Chris Dickie (26:54):

So I think for me it's around thinking around what healthcare systems are like. All of us got into healthcare in general for that patient interaction. That's kind of why we got into medicine or allied health or nursing. But there's so many things that impact that one-on-one consult that you have. So if you're interested, there's opportunities, whether it's through board works or other organisations consultations. There's so many ways that you can get involved to do things if you're interested and even if you're not, just knowing all of these things that go on in the background that have an impact on your day-today life. So people are advocating for you at government levels to make sure there's appropriate fundings for healthcare or people working on systems to make sure that trainees have the right kind of system to get through things. So I think there's opportunities there if you want them, but if not, being aware of things for me in the future. I think my goals at the moment, I'm waiting for my fellowship hopefully any day now. Pretty much the paperwork in and I'm getting married this year. So those are the two priorities this year and future. I think a mixture of clinical and nonclinical work. What that'll look like as far as advocacy, research, teaching, I think is still to be decided. But I find all of those interesting and exciting. We'll see what happens.

Ava Carter (27:56):

Amazing. Bec?

Rebecca Loveridge (27:57):

Yeah, thanks Chris. Thanks, Ava. I think in terms of the allied health realm, the RACGP sits on a number of committees and external groups that have allied health membership as well, and we contribute to a heck of a lot of government advocacy bodies and that kind of thing. So it's not stuff that I'm directly involved in as a board director, but I do know that our college has a lot to say in those spaces and does engage really well and really broadly. So I think that the RACGP is actually doing a pretty good job in that area. I think for myself, similarly to Chris, who really knows what the future holds, I think as a new fellow, you've just finished training for me, it was 14 years from when I first started university to when I followed as a gp, so it was a long journey and I decided to celebrate that by having a baby. So I've got a seven month old almost eight months now, and so I am very busy between him at home and my clinical work and my board work. I am just sort of treading water almost. And so I think the future is very uncertain. I don't know which direction things will go, but I'm loving life at the moment and I'm loving opportunities like this podcast as well.

Ava Carter (29:15):

That's what's important. Loving life, loving the new bub, seven months old. Wow, that's young and exciting and new and everything's happening all at once.

Rebecca Loveridge (29:22):

Yes, yes. That is the way I tend to do things.

Ava Carter (29:24):

Yeah, it's a similar experience for me, I guess with all the stuff that our Royal College does and seeing what the future holds in 2025 feels like a big fellowship year for me and Chris as well, waiting to see all the different things and wonderful opportunities that will happen through that process. I think mine was a teeny bit longer. I think I've done 15 and a half years with my undergrad to now, but it's been a hell of an experience and one I would definitely do again. I think it's been really a privilege to be able to study medicine and do all the different types of work that I've done in medical admin and the board work and with Allied Health. I think one of the things that I'd really love to see, at least in my own practise, is having a team of allied health specialists around me, because that's something that I've really learned a lot from the public system in training is you can't have a really good outcome without a really strong multidisciplinary team. And I saw it when it worked really well, and I also saw it when we didn't have that, and that's something that I'm going to take with me into being a fellow is making sure that I don't forget that and that I promote that for all of our patients. But I'd really like to thank you guys for being here and joining us on this episode of MHPN presents a conversation about the GP and psychiatry trainee registrar experience. You've been listening to me, Ava Carter -

Rebecca Loveridge (30:39):

And me, Rebecca Loveridge, and -

Chris Dickie (30:41):

- Me, Chris Dickie.

Ava Carter (30:43):

Lovely. We've covered a lot of territory. We've talked about artificial intelligence in the medical record and medical admin space, Medicare reform very briefly, but not too politically. We've talked about multidisciplinary team care as well as peer worker and lived experience on different boards. And I would say just before we finish that, if there's anybody in Allied Health listening at the moment, there are so many opportunities for people who have those subspecialty backgrounds on boards, on different organisations. There's the Australian Institute of Company Directors website that if you sign up to, you can see all the different opportunities for exactly these types of lived experience, specialisations and knowledge, and there's so much opportunity for that in organisations these days. I would jump on it if you are thinking about doing it. It's a really wonderful experience and really broadens your perspective on life in general. To stay up to date with MHPN Podcasts, please make sure you subscribe to the MHPN presents. Thank you for your commitment to multidisciplinary care and lifelong learning.

Host (31:44):

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