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THE NSW doctor

THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION (NSW)

AUSTRALIAN MEDICAL ASSOCIATION NEW SOUTH WALES

SPOTLIGHT:

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Much more than a medical service

Tharawal Aboriginal Corporation exemplifies the necessity for Aboriginal people to shape the services for their community to deliver better health outcomes.

I HAD THE pleasure of meeting Professor Sir Michael Marmot last September as he visited Australia to deliver the Boyer Lecture, and perform a number of media engagements. Sir Michael is one of the foremost public health academics in the world, renowned for his work on the social determinants of health, amongst many other things.

AMA (NSW) organised for Sir Michael to visit the Tharawal Aboriginal Corporation in Airds, Campbelltown while he was in Sydney. Tharawal is a comprehensive, community-controlled medical service serving the large Indigenous community of Southwestern Sydney. It is, however, much more than a medical service. Tharawal includes a preschool, dental clinic, and multiple programs assisting community groups including new mums, people with mental health issues, drug and alcohol programs, and healthy eating.

Tharawal is staffed by a number of dedicated GPs, and always has multiple training GP registrars. There is also a growing number of visiting specialists who perform clinics there, a number of whom are associated with Western Sydney University. I have had the privilege of running an immunology/allergy outreach clinic at Tharawal for a number of years. The aim is to provide Indigenous patients specialist services in a more accessible and culturally appropriate environment than is able to be provided at the local public hospital.

As we showed Sir Michael around, I was struck at the incredible pride the Tharawal staff displayed. There was great passion about how far the service has come and how integral Tharawal is to the local community. One of my friends, who is a Board member at Tharawal, and often quite a shy person, became very vocal talking about a range of challenges faced by our Indigenous community, and the absolute necessity for Aboriginal people to be trusted and supported to shape the services and use the resources available to deliver better outcomes for their people.

Prof Brad Frankum, Prof Sir Michael Marmot, Tharawal Board member Cris Carriage, and Dr Tim Senior

I am personally very proud of Western Sydney University's School of Medicine, which has insisted upon, and facilitated a dedicated five-week full-time clinical attachment in an Aboriginal Community-controlled Health Organisation for every senior medical student since the MBBS course commenced. This is underpinned by the philosophy that all practising medical practitioners in Australia should have at least a degree of competence and skill in Aboriginal health. I felt reassured during the Tharawal visit as two of our medical graduates from Western Sydney spoke to me as GP registrars, having replaced two previous GP registrars who were also Western Sydney graduates. Proof, I think, that producing medical graduates from Western Sydney is starting to make a real impact on the health of our community.

Thanks to the staff and patients at Tharawal for their time, and to Professor Sir Michael Marmot for his interest and dedication to public health. dr.

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Prof Brad Frankum President, AMA (NSW)

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Extraordinary doctors

In the medical profession's pursuit of health equity and justice, some doctors stand out for their work in caring for the community.

BEING THE CEO of AMA (NSW) is a very fortunate job. Aside from getting to work with impressive doctors on important health issues, sometimes you can also be lucky enough to have special experiences like getting to take Professor Sir Michael Marmot to the Tharawal Aboriginal Corporation. Sir Michael (or Michael as he prefers) emailed the AMA last year to advise that he was coming to Sydney for the Boyer Lectures and asked if there might be any AMA people he should meet during his visit. We suggested he might like to travel to Campbelltown to visit Tharawal.

The visit was organised by AMA (NSW) President Brad Frankum and it was an extraordinary experience for both of us to see Tharawal through Michael's eyes and also to see how all of the staff of Tharawal reacted to being visited by one of the world's leading experts in the social determinants of health. I can say without any hesitation that Michael was genuinely moved by his experience at Tharawal. The visit was the motivation for this edition of *The NSW Doctor* in which we cover the extraordinary work of doctors, nurses and allied health staff in caring for our community, particularly those more vulnerable. These doctors are making a real difference and they are an inspiration to us all.

In this edition, we are also proud to announce our new partnership with Specialist Wealth Group, which was established in 2013 and provides holistic, quality financial planning for medical and dental professionals. Specialist Wealth Group provides risk insurance (life insurance and income protection), business and general insurance, and financial advice.

On a much sadder note, I wanted to acknowledge the recent loss of two young doctors, Dr Ann Formaz-Preston and Dr Chloe Abbott.

Ann was an exceptional doctor who had just been accepted into the Obstetric and Gynaecology Training programme. She was killed in a cycling accident just prior to Christmas.

Chloe tragically passed away in January. She was a physician trainee and Vice Chair of AMA CDT. In addition to being a dedicated doctor, she was a much-loved colleague. Our thoughts are with her family and colleagues at this time. dr.

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Fiona Davies CEO, AMA (NSW)

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WORLD FIRST hip vs knee hockey match

IN A HISTORIC year marking the Australian Orthopaedic Association's (AOA) 80th anniversary, the AOA supported a world-first field hockey match between 27 hockey players who have either had hip or knee replacement surgery.

The 'hip vs knee' event matched 13 players with at least one artificial hip and 14 players with at least one knee replacement.

President of the AOA Dr Ian Incoll said that such an event is a celebration of the wonder of movement and provides the Australian orthopaedic community a chance to reflect on the significant contribution hip and knee replacement surgery provides thousands of Australians every year.

"Being able to enjoy the freedom of movement, let alone undertake sporting endeavors, just wouldn't be possible without the significant advancements in prosthesis technology and the superior surgical techniques that have been developed over the past 80 years." Dr Incoll said.

President of Western Hockey Masters and organiser of the event, Simon Thomson said the event was devised when the hockey club became aware of the number of players who returned to play hockey after hip or knee replacement surgery.

"We wanted to address the lack of awareness in the community that it is no longer necessary to suffer lack of mobility with painful hip or knee joints." Mr Thomson said.

So who won? The hips took it 3-1. dr.

LETTER TO THE EDITOR

Talking to a **brick wall**

Mervyn J Cross questions the benefit of talking to Government

AS A GRADUATE of 1965 and a practising orthopaedic surgeon since 1973, I am dismayed at the continuing lack of understanding of the medical profession's attitude to Medicare and health funding. Medicare and health funding are third party payers, and as such are completely focused on decreasing both the number and the cost of "cost generating units". They are simply health funders, and as such are the instruments where patients receive some payments for their health costs. The medical profession and the private hospital system are the only two businesses that are concerned where their "clients" receive the money to settle their accounts.

Health insurance is illegal in Australia, where as health funding on a community basis is described as insurance. The government implemented Medicare as the "Health Insurance Commission", thus attempting to fool the public.

In the mid-1980s, Peter Woodcock and I established Silver Cross as a true insurance, risk rated entity. Carmen Lawrence, the Health Minister at the time, outlawed Silver Cross and in so doing brought travel insurance and other insurances in turmoil, as they too were outlawed. This necessitated sacking her adviser and re-instituting those other insurances.

Our responsibility is to our patients, and the time spent by many of our esteemed colleagues would be better spent on continuing medical education, rather than attempting to convince a brick wall to move.

I was involved originally in many disputes with the government and was a foundation member and second president of The Australian Society of Orthopaedic Surgeons. As President, I abstained from the Relative Value Study concocted by Dr Michael Wooldridge, a decision which eventually was proven to be correct. After much input and time spent uselessly by many of our colleagues it was unceremoniously abandoned.

I resigned my position at Royal North Shore Hospital because of the Wran dispute, but after defeating the Wran Government, those of us who resigned took back our rightful places. I always remained an Honorary and never received any payment for my work in the public system. I took up a position at Sydney Hospital as an Honorary and within a few years we had re-established a working orthopaedic unit. The Government soon closed the unit as we were overspending the prosthesis budget because of our efficiency, doing too many replacements for the public patients.

I joined the Liberal party in late 1970 and became the Chairman of their Health, Welfare and Safety committee. After many hours spending time with the likes of Baume, Tuckey and Porter, I finally resigned as chairman and member of the party. I finally woke up that there is absolutely no point in talking to Government, as their so called principals are readily replaced by policies.

We are an independent and necessary profession; our ideals are based on ethics and care. We are givers of time and expertise. Undoubtedly, there are among us renegades who hide behind the medical shield, but this should not stop us defending our honour and concentrating on the welfare and health of our patients. We should be grateful for their choosing us as their doctor and confidante.

MERVYN J CROSS
OAM MBBS MD FRACS

BUILDING A RESPECTFUL CULTURE IN MEDICINE

NSW Health, alongside AMA (NSW) and 13 other industry stakeholders, endorsed a Statement of Agreed Principles to demonstrate a clear commitment to ensuring our places of work, training and education are places where everybody is treated with dignity and respect.

The Statement of Agreed Principles is an important step towards significant cultural change.

It is based on peer-reviewed literature that indicates the importance of organisational leaders making a clear statement regarding acceptable and unacceptable behaviour.

The Statement is a positive and transparent mechanism by which we, and other stakeholders, provide leadership and agree to work within a set of shared principles to build a better medical culture. It is important that we let our members, students, employees and the community know that this issue is being taken seriously.

The Statement follows NSW Health's strong policy on workplace bullying, which was released in September 2016. The policy codifies NSW Health's commitment to providing a safe and equitable workplace for all staff, where the contribution of everyone is valued and respected.

You can find the full Statement and policy on the NSW Health website www.health.nsw.gov.au. dr.

Dr John Egan: acknowledgement

AMA (NSW) would like to acknowledge Dr John Egan's exceptional service to the profession, and express appreciation for his long-standing membership to our organisation.

A career in medicine means a lifetime of learning and responsibility. Dr Egan has been a doctor and AMA member for 62 years. Now 87, he has maintained his registration since he retired from general practice almost 20 years ago until October when the limited rights registration was no longer available. Dr Egan has always maintained his professional education.

Our healthcare system is built on the commitment of professionals such as Dr Egan, who has dedicated his life to helping others. It is a career that can be physically and emotionally draining, but with the reward of knowing you are making a difference to the lives around you. Dr Egan's contribution as a general practitioner to his patients and community has been greatly valued.

AMA (NSW) thanks Dr Egan for his dedication as a doctor and as a member. dr.

Summer **burnout**

JMOs aren't resigning from contracts early because they're selfish, but because they need a break to survive the stresses of training and working.

THIS TIME of year can be especially stressful for junior doctors. It's normal to feel exhausted and in need of a break after 12 months of hard work and new challenges, but every year the fatigue is compounded by the steady attrition caused by inadequate staff numbers. This is only partly due to staff leave. It has become increasingly common for junior doctors to resign before the end of their contracts in order to facilitate some time off before starting over in new hospitals. Anecdotally, this often occurs between the prevocational resident years and vocational specialty training. Unfortunately, summer also brings an increase in the volume of presentations, especially those related to trauma and drug and alcohol issues. This can create a perfect storm for those of us feeling overwhelmed, causing burnout and with it poorer work performance and doctors requiring sick leave, further exacerbating the lack of staffing brought about by resignations and annual leave.

On New Year's Day, instead of studying for the physicians exam like I should have been, I sat in the sun having a glass of rosé with a friend from medical school who is working as an emergency department resident. He told me he'd called in sick that day to come and drink wine with me. I was horrified (if still mellow), but he explained that he'd been regularly working an extra one-to-two 10-hour shift on top of his normal hours every week for the past month to cover other bone-weary residents calling in sick to an ED already severely understaffed due to resignations. The last shift he worked had involved a distressing, prolonged attempted resuscitation for a middle-aged woman in cardiac arrest. Her distraught family were present throughout. After finally calling T.O.D, my friend tried to take a minute to gather himself only for the consultant to tell him he was needed back on the floor. The waiting room was full and there just simply wasn't time to process events, it would have to be done later on his own time.

Exhausted and a little bit broken, my friend sensibly saw his GP, who advised he needed a break and provided a medical certificate for three days of sick leave. Of course, the residents called in to cover him were subjected to exactly the same pressures that resulted in my friend needing time away from work.

Staff shortages don't just create problems for doctors; there is immense pressure on hospital administration to provide adequate staffing when it simply isn't available. NSW Health has employed measures to combat the yearly exodus. Many NSW Health contracts state that resigning from a previous NSW Health position before the agreed upon end date is grounds to terminate a new contract. How often this is actually enforced is unclear, given that it would likely propagate the problem of lack of staffing to a new network.

It would be easy to say that it is selfish to resign before the end of your contract, leaving your colleagues to shoulder additional workload. However, this ignores the underlying problem. I don't think this phenomenon occurs because junior doctors are selfish, but rather because they're trying to survive the stresses and pressures of training and keep themselves intact. It also doesn't help that the public system fails to engender a sense of institutional loyalty. There are good reasons why junior doctors can no longer undertake the entirety of their training in one institution. Moving networks annually, working contract to contract can be a mutually beneficial arrangement, but it does mean JMOs are not part of a greater whole.

In the case of severe burnout, JMOs are making the difficult decision to burn a bridge with their current institution and recharge before they self-immolate. A culture where the idea of self-care is normalised, rather than one that expects the ability to dig a little deeper to be infinite, will be just as vital for fixing this issue as the actual provision of extra staff. dr.

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Getting **it right**

AMA (NSW) Councillor Sergio Diez Alvarez argues more investment is needed in medical training positions in hospitals, particularly in rural and regional areas, to address the poor geographic distribution of doctors.

THERE has been a lot of talk recently about the state of the medical workforce and an imbalance between GPs and specialists, in particular.

The root cause of this is actually further back in the medical training pipeline.

Our current system is struggling to keep up with the massive influx of incoming university medical graduates.

Medical training is never really over for any doctor. All doctors must undergo continuing professional development throughout their careers, to keep up with the latest treatments.

However, for interns fresh out of university, they still have a long way to climb before they are fully trained.

Depending on the specialty they choose, this can take over a decade. Even for the specialties with the shortest post-university training for full qualification, this education lasts several years.

The recent tsunami of medical graduates resulted from a complete U-turn on efforts made to limit doctor numbers during the 1990s.

Limitations on university degrees were put in place in a short-sighted attempt to limit Medicare spending.

This left us with a doctor shortage, which forced Australia to poach doctors from overseas in order to meet the medical requirements of our population.

Today, this shortage has left the training pipeline with too few senior doctors to adequately cope with the training of the next generation.

This problem is exacerbated in areas outside of major cities. Even though junior doctors are rotated through a variety of hospitals in their training networks, both metropolitan and rural/regional, most training is based in capital cities. This is compounded by the fact that rural hospitals can struggle to attract senior staff.

Before more training positions can be based in rural and regional areas, more needs to be done to encourage senior doctors to work in these areas.

If we can get more viable training positions based in country areas, this will help overcome the problem of poor geographic distribution of doctors.

And I have to specify here that I am talking about training positions in hospitals, not new university courses based in the country. Additional universities teaching medicine courses would just exacerbate our current problems.

Doctors set up practices where they have connections to other doctors, hospitals, GPs, and specialists. If more doctors can be trained in rural and regional areas and have good experiences there, it will be easier to persuade them to stay and work once they are fully trained.

It hasn't helped that with each passing year, the number of university graduates entering our hospitals as interns has been getting larger.

That said, we need all of these doctors to complete their training and become the GPs and specialists our nation requires.

It has been the case that an unlucky few, typically overseas medical graduates, have been turned away from gaining an intern position.

That is only the first hurdle, however. These young doctors need to choose a specialty training program. The huge numbers of doctors-in-training we're seeing is causing massive competition for the available training spots.

It's only natural that a training system under such stress would ultimately lead to a less than ideal distribution of doctors on grounds of both geography and specialties.

When the system is preoccupied with ensuring there are training positions available for everyone, because we do need all of these doctors, of course it will be less focussed on directing them to where they are needed.

Specialties can be dictated for our current doctors-in-training by an individual medical college's ability to provide training.

The bigger colleges often have greater capacity to provide training.

But if, for example, it is possible to train a legion of surgeons when what we really need is more dermatologists, this is not necessarily helpful.

It's vital that we train all these doctors to their full qualifications but it is equally important that we get it right.

The problem is greater than just distribution of GPs and specialists and city doctors vs rural-based ones.

And it's deeper than just the personal choice of individual doctors.

But, if we are serious about fixing these problems – and a good number of others besides – we need to provide greater investment in medical training. dr.

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Chiropractors **and vaccination**

Chiropractor Andrew Shepherd condemns anti-vax colleagues whose views endanger the community and the profession.

Andrew Shepherd with his wife, Sue and daughter, Sofia.

MANY CHIROPRACTORS, such as myself, have publicly stood against the actions of one Melbourne chiropractic clinic which screened the anti-vaccination film *Vaxxed* last year.

My colleagues and I are well aware of the discredited research of Andrew Wakefield and his paper published and later retracted in *The Lancet* in 1998, proposing a causal link between the MMR vaccine and autism. Despite this research being debunked in several large studies since its publication, some of my colleagues continue to believe these myths.

I graduated from Macquarie University in 2008 with a Master of Chiropractic after five years of study and training. During this period I was taught the foundational sciences of physics, chemistry and biology upon which was taught university level anatomy, physiology, neurology, orthopaedics and microbiology. I learned how to use critical thinking, clinical reasoning and the scientific method under the evidence-based practice model to assess, diagnose and conservatively treat musculoskeletal conditions in members of the general public presenting to the university outpatient clinics.

Despite the training in science and subjects such as microbiology we received at university, these chiropractors were openly dissuading patients in their clinics from immunising their children.

Three years after my graduation and having established my own clinic, my daughter was diagnosed with autism at the age of two. Imagine my dismay when former friends and colleagues in the chiropractic profession openly suggested that I was at fault for immunising my child with the MMR vaccine. I continued to work quietly as a rational, evidence-based chiropractor for another three years, networking and building bridges with local GPs and other medical specialists whilst trying to cope with the ever increasing challenges at home of raising a child with autism. Not speaking out. Trying not to rock the boat.

> *Imagine my dismay when colleagues in the chiropractic profession openly suggested that I was at fault for immunising my child.*

Chiropractic has had a long history of being at odds with the medical community for a range of reasons, but largely because a sizeable proportion of the profession continues to believe in biologically implausible, pseudoscientific approaches to healthcare. In 2010, chiropractic was included in the national register of primary healthcare practitioners to be regulated under AHPRA to ensure that the profession adhered to public healthcare guidelines, which include upholding healthcare initiatives such as vaccination.

In 2015, Chiropractic Australia (CA) broke away from the peak chiropractic association, the Chiropractors Association of Australia (CAA) in order to better represent evidence-based chiropractors and to make unambiguous statements about our position in mainstream health-care, including the position of being pro-vaccination.

It is my opinion that those chiropractors who continue to promote an anti-vaccination message and materials to their patients are not only a danger to public health but a danger to the longevity of a profession which is striving to become the mainstream healthcare profession it should be through ethical, evidence-based practice, and university training and research. A zero tolerance attitude to these practitioners should be adopted from the association level up to the State and Federal health ministers. A slap on the wrist for this behaviour is no longer acceptable to the rational practitioners in my profession and nothing less than deregistration, first offence or not, is required for those who break the rules.

We owe the general public that much, at least. dr.

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STOP THE CLOCK

AMA (NSW) created the Stop the Clock campaign to raise awareness of the prevalence of child abuse, as well as highlight the resources available to those affected.

In Australia, a child is abused every 15 minutes

TRAGICALLY, every 15 minutes in Australia, a child is abused. In 2014-15, almost 152,000 Australian children received child protection services – roughly one in 35.

There are many forms of abuse – physical, sexual, emotional and neglect. In extreme cases, victims of child abuse die. And those who live must suffer the impact of that abuse for the rest of their lives.

Doctors are often at the forefront of responding to and treating the consequences of child abuse – or what we often term in medicine as 'non accidental injury'.

Former Federal AMA President, Professor Brian Owler, who helped launched the campaign, said when he first started working at Westmead as a paediatric neurosurgeon, he was appalled at the number of children coming in with non-accidental injuries.

"I was shocked at the number of babies that present through the emergency department with subdural haematomas or bleeding on the brain as a result of being shaken, but also the toddlers that were beaten senseless, with fractured skulls and traumatic brain injuries," he told media.

"At the Children's Hospital each year we probably see 12 or so severe brain injuries that come through our doors, not to mention all of the other cases of physical abuse," he said. "Some of them die in hospital, the vast majority end up with severe disability and are in need of lifelong care."

The AMA estimates about 25 children are killed around the country each year by a parent or step-parent, with another 50,000 abused. Last year, Westmead Children's Hospital referred 569 injured children to the Child Protection Unit.

Together, with other frontline professionals in child protection, AMA (NSW) would like to make a positive impact on the incidence of child abuse.

AMA (NSW) coordinated with the Child Protection Unit at Sydney Children's Hospitals Network, and NSW Health to launch the Stop the Clock campaign in January.

Central to the campaign is the Stop the Clock website (stoptheclock.today) which features a powerful image on its homepage, created by the Joy Agency. The image illustrates the sad reality that in Australia, a child is abused every 15 minutes.

The website also includes a direct appeal from Child Protection Unit social worker, Calli Goninan to children who might currently be experiencing child abuse, as well clear information on where to find help.

Ms Goninan's emotional message to kids is that it's not their fault, and that it's important to tell someone.

In addition, the website includes several video interviews with professionals from the Child Protection Unit at Sydney Children's Hospitals Network who speak about cases of child abuse they have dealt with. These stories help to drive home several key messages to children, such as:

- there is help out there;
- these issues are not something children are expected to deal with on their own
- it's not your fault;
- there are many forms of child abuse, including physical, emotional, sexual and neglect.

Reports, facts and statistics are included under 'Resources' to give website users broader information on child abuse in Australia and its prevalence.

In NSW, anyone with concerns regarding the safety, welfare and wellbeing of a child, young person or unborn child is encouraged to contact Child Protection Helpline on 132 111, or in the event of an emergency 000.

National helpline numbers include Kids Helpline, Lifeline, 1800 RESPECT, Bravehearts Information and Support Line, Translating and Interpreting Service, and Mensline. There is also contact information for the child protection agency in each state and territory, as well as information on Parentline Services in each state and territory.

The website features information for health professionals, with clear guidelines on what to do should you have concerns for the safety, welfare and wellbeing of a child, young person or unborn child, as well as information on how to support Indigenous children.

Medical professionals are not expected to respond to child abuse on their own. Chapter 16A of the NSW Children and Young Persons (Care and Protection) Act 1998 requires professionals from different government and non-government agencies working with children and families, as well as private health professionals, to collaborate in service delivery to promote child safety welfare and wellbeing. It also allows you to share information with other service providers without breaching privacy. dr.

Visit www.stoptheclock.today for more information.

TARGETING RHEUMATIC HEART DISEASE

Federal AMA's Report Card on Indigenous Health aims to completely eliminate RHD by 2031.

AMA PRESIDENT, Dr Michael Gannon called on governments to rid Rheumatic Heart Disease (RHD) from Aboriginal and Torres Strait Islander communities at the launch of the AMA's Report Card on Indigenous Health.

The Report Card, which has been published annually by the AMA since 2002, reveals that Aboriginal and Torres Strait Islander people continue to face some of the worst health outcomes in Australia.

It also identifies a major health problem – RHD, which is an entirely preventable and debilitating condition – and calls on Australian governments to eliminate this disease within a finite timeline.

"From 2010 to 2013, over 700 new or recurrent cases of Rheumatic Heart Disease were reported in Australia, with 94% of cases being among Indigenous people," Dr Gannon said.

More than half of these cases were among children aged 5 to 14 years. According to Dr Gannon, the fact that RHD still occurs in Australia is a national shame. It is a disease of poverty caused by Acute Rheumatic Fever. In a first-world country such as Australia, this preventable disease has all but been eliminated in the non-Indigenous Australian population; however, it persists within many rural and remote Aboriginal and Torres Strait Islander communities.

Indigenous people are 20 times more likely to die from RHD than non-Indigenous people, In the Northern Territory, this rate rises to 55 times higher.

"It is remembered as being a disease of last century – a time before better living conditions and access to health services, and a time before penicillin was introduced.

"But, today, for many Indigenous Australians, Rheumatic Heart Disease continues to be a reality," Dr Gannon said in his speech.

"These high rates speak volumes about the fundamental underlying causes of Rheumatic Heart Disease, particularly in remote areas. We are talking about poverty, poor-quality and overcrowded housing, lack of education, and inadequate primary healthcare.

"We know the conditions that give rise to Rheumatic Heart Disease. And, we know how to address it – this knowledge has been around for many decades. Yet, we have not been able to rid Australia of this serious disease.

"The Closing the Gap measures are an important step forward in some ways in housing, education, and health funding."

The AMA Report Card on Indigenous Health 2016 calls on Australian governments to:

- Commit to a target to prevent new cases of RHD among Indigenous Australians by 2031, with a sub-target that, by 2025, no child in Australia dies of Acute Rheumatic Fever or its complications;
- Work in partnership with Indigenous health bodies, experts, and key stakeholders to develop, fully fund, and implement a strategy to end RHD as a public health problem in Australia by 2031.

AMA is one of the foundation partners in the new END Rheumatic Heart Disease Coalition. Together with the END Rheumatic Heart Disease Centre for Research Excellence, the Heart Foundation, the National Aboriginal Community Controlled Health Organisation, and RHD Australia, the AMA commits to work to eliminate the scourge of RHD from this country. dr.

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HOPE AMONG THE MELEE

If communities and individuals are empowered it is more likely that money spent will lead to progress, writes **Prof Sir Michael Marmot** in this account of his visit to Tharawal Aboriginal Corporation.

IT IS EASY to find accounts of Australian aboriginal health – strictly Aborigines and Torres Strait Islanders – that are lacking in hope. The standard narrative is that billions have been spent, but Aboriginal families are characterised by violence, alcohol, drugs, worklessness and high rates of crime.

Billions have been spent and Aboriginal health is bad compared to the non-Indigenous population – 11 years shorter life expectancy for men and just under 10 years for women. But a different account says that when people's lives are characterised by betrayal of trust and systematic destruction of identity and self-worth leading to powerlessness perhaps it is no surprise that this spiritual sickness can lead to destructive behaviours. Money spent is not irrelevant. But the psychosocial issues are central. My starting position is that if communities and individuals are empowered it is more likely that money spent will lead to progress.

On my recent trip to Sydney to give the first Boyer Lecture for the ABC, the Australian Medical Association wrote to ask how they could help. I said I would like to see examples of doctors in action on social determinants of health. Prof Brad Frankum, President, and Fiona Davies, Chief Executive of the New South Wales Branch of AMA took me to Tharawal Aboriginal Corporation in Campbelltown, a suburb 50 km southwest of Sydney. Sydney spreads and spreads and spreads...

As I understand it, the two names are emblematic of Australian history. The Tharawal people were the original Aboriginal residents of the area. The Colonial Administration established a settlement named after the Governor Macquarie's wife, Elizabeth Campbell. Indigenous people make up over 3% of the Campbelltown population, compared to 1.2% of greater Sydney.

The centre was an inspiration. I was shown around by two enthusiasts, Aboriginal women, who were key in the administration. I was also greeted by one of the doctors, Tim Senior, with a sign that read: Welcome to Fantasyland.

The evening before, on ABC Television's national discussion programme, *Q&A*, I had talked of a fairer distribution of power, money and resources, and was told I was in Fantasyland. This Aboriginal centre was making a difference. It was making fantasy a reality.

Among its many roles is providing medical care. But it is a prime example of what we mean by doctors working in partnership. As I went round the centre, I was shown where the antenatal classes took place, and activities at every stage of the life course: from early childhood to older age.

"Bringing them home" is significant. A psychologist at the centre told me that she works with the psychological consequences for children and the family of a child's removal from home. I asked if she was talking about the stolen generations – Aboriginal children taken from their families between the 1890s and 1970s with the presumed intent of destroying Aboriginal culture. The psychologist said that it is still going on. Children are removed because of family disruption, but the consequences are severe.

There is also a variety of services that deal with the reality of people's needs. Not to mention subsidised fruit and vegetables to make healthy eating more of a possibility.

We then came to the part of the Centre that dealt with drug and alcohol problems. I said to the woman in charge: 'you must have the toughest job in this whole centre?'

'No,' she said, 'I have the most rewarding job.'

She showed me a painting on the wall. The man who painted this had come to the centre with huge problems of drugs, alcohol and domestic violence. By the time he left, the centre had made a huge impact on him. He came back with this painting to say thank you.

I hold no illusions. There are deep-seated structural problems that account for the dramatic life expectancy gap between Indigenous and non-Indigenous Australians. But I challenge anyone to come away from a visit to Tharawal and say it is all hopeless. I saw evidence of community empowerment: a community controlling the services needed for its population. To repeat, funding for services is vital, as are good schools and job opportunities. But here was a centre dedicated to improving things for its own community. Inspiring, indeed. dr.

This article was reprinted with permission from Prof Sir Michael Marmot, one of the world's leading advocates for health equality.


SMOKE FREE
FAMILY
NURTURE
EAT HEALTHY


YOORI

Great expectations

Associate Professor Kelvin Kong spoke with *The NSW Doctor* about his pathway into medicine, his mentors and his desire to see a national approach to curing ear disease.

A LOT OF SIX-YEAR-OLDS like to play at being a doctor, inspecting teddy bears with plastic stethoscopes and testing reflexes with a rubber hammer on their sisters' knees.

But when A/Prof Kelvin Kong was a child, pretend play took a back seat to first-hand experience.

"Medicine has always been fascinating to me. My mum was an early pioneer as an Aboriginal nurse. As a consequence, our house was always filled with people coming around for medical advice. Whether that be our immediate family, our extended family – everyone would come to our place for removal of sutures, vaccinations, immunisations, all those kind of things.

As a result, he says he would fight with his sisters over who would cut the sutures, do the dressings, and any other assistance they could provide.

A/Prof Kong grew up in Shoal Bay, as the son of a Chinese doctor, Tony Kong or Kong Cheok Seng, and an Aboriginal nurse, Grace Kinsella. His parents separated when he was three and his father returned to Malaysia. His mother worked to support Kelvin, alongside his twin sisters Marilyn and Marlene and he was surrounded by a large extended Aboriginal family. His family hails from the Worimi people of Port Stephens.

"The house was always filled with lots of joy, because our house was a hub of activity," A/Prof Kong reflected.

It wasn't until high school that he questioned why so many would come to his mother for medical treatment, instead of going to the hospital.

"Then you start realising that there was a paucity of access to healthcare for our family, extended family and Aboriginal people. Mum was acting as a health practitioner for all kinds of issues. I realised later that the role that she was fulfilling was actually quite enormous."

A/Prof Kong says his mother, who was one of the first Aboriginal nurses in Australia, was an early mentor for him and extremely inspirational.

"Mum was a superstar – she always encouraged education, education, education. My sisters are both doctors as well, and they were actually leading the way for me because I was following in their footsteps. So when you have this mini-critical mass it made it a lot easier."

His sister Marilyn became Australia's first Indigenous obstetrician, while his other sister, Marlene, is a GP.

As for A/Prof Kong, he became the first Indigenous surgeon in Australia, specialising as an ENT. It's a distinction he is somewhat hesitant about.

"It's an awkward situation because one of the things I always say is that there were traditional healers in our society for thousands of years, so I'm the first surgeon in the Western sense, but in a medical sense there were Aboriginal surgeons before me…

"And the second part of this is, I think some of it is thrust upon you in terms of expectation, and I don't mind that so much, but we need to make sure that we are trying to change the system. As an individual there is only so much that you can actually do."

A/Prof Kong is quick to credit his mother and aunties and uncles who supported him throughout his journey.

"I think back to those early days, when I was chasing football dreams and it was my nan who pulled me aside and said, don't worry about that – you've got bigger things to achieve and bigger things for our people. I was in tears after that conversation, but she saw the big picture, as did my mother, as did my aunties and uncles who used to feed me and make sure I had a roof over my head and plenty of time to study – I stand up on their shoulders and appreciate their sacrifice."

A/Prof Kong is passionate about working to improve health inequalities in Australia, and he says the prevalence of ear disease is one of the biggest disappointments in closing the gap.

"I realise I'm very biased towards this – there are a lot of competing interests in terms of closing the gap, which are all very important and I don't deny that for one moment. But I'm really disheartened that hearing and ear health has such a low priority on all of those aspects.

"One of things that really frustrates me is that this is something that is really curable. I'm really pushing for a national approach to ear disease, because we need to bring parity to the Indigenous population."

According to A/Prof Kong research indicates more than 90% of prisoners have hearing loss and suggests the direct link between hearing and learning means more Indigenous Australians are missing out on an education and an opportunity to be productive, contributing members of society.

"If you treat ear disease at an early stage, could we change life trajectories? Absolutely," he says. dr.

THE PITFALLS OF PRIVATISING PRISON HEALTHCARE

Elise Buisson argues good policy should trump good politics in the debate over whether to privatise healthcare in NSW correction facilities.

"Nowhere is the fragmentation of the corrections system more apparent than in the provision of health services."

- Independent Investigation into the Management and Operation of Victoria's Private Prisons (2000)

FOUR YEARS AGO, a renewed set of Guidelines for Corrections in Australia reaffirmed our nation's commitment to the principle of healthcare equivalence. Being incarcerated was not to be a barrier – it was every prisoners' right to receive healthcare equivalent to that which they would receive in the community. The guidelines stressed the importance of continuity of care in protecting this equivalence.

"[A guiding principle is that prisoners are] provided with access to healthcare, to the same standard as in the community, in response to need, with an appropriate range of preventative services, and promoting continuity with external health services upon release."

Fast forward to the first weeks of 2017, and we straddle two possible futures for corrections healthcare. The first, maintaining the status quo; the majority of NSW prisons currently receive healthcare from the same public system that serves the communities prisoners come from and return to. This healthcare is comprehensive, accountable, and integrated both across prison sites and with the external community. The second, throwing the baby out with the bathwater; a move to privatise corrections healthcare along with the rest of the prison system, isolating prison health from the public health system that has been its foundation.

The privatisation of prison healthcare is believed by the NSW Government to represent a move of both innovation and inexpensive service delivery. As the past few years of health policy have demonstrated, healthcare is fast running out of such 'efficiencies' to deliver back to the Government's bottom line. At some point – a point that many would argue we have already passed – savings in healthcare are provided at the expense of patient care.

Corrections health privatisation heralds countless blows to patient care: the absence of a whole-of-system healthcare advocate, as multiple private providers dilute responsibility for the prison population as a whole; the loss of healthcare provision independent of corrections management, which the WHO calls 'a failsafe to detect and protect against prisoner mistreatment'; the risk of eroding patient-clinician relationships, based as they are on the goodwill and passion of public clinicians; the disintegration of medically skilled oversight, as private prison health providers are overseen by the Department of Corrective Services rather than the Department of Health.

Those employed by a private prison health provider face isolation from the public system, working in a single prison site in a professional silo. With this goes the benchmarking of prison health against wider health workforce strategies and the requirement to participate in state public health initiatives. Each of these issues are highlighted in AMA policy,

alongside a recommendation that prison healthcare remain a domain of health – not Department of Corrections – authority.

In an earlier NSW inquiry into prison privatisation, the Department of Corrective Services stressed that privatisation does not represent the contracting out of responsibilities; rather, it should be seen as contracting in additional services. However, fulfillment of those responsibilities is far from assured.

Even the best efforts of private providers face significant barriers. In 2000, at the time of a review of entirely privatised Victorian prison healthcare, no less than eight separate health providers operated in the state. That is eight different note-taking forms and norms, eight different layers of management, eight opportunities for a prisoner, frequently transferred between facilities on short notice, to fall through the cracks.

This compromised continuity of care is particularly significant given the complex and chronic health needs of a patient base. Prisoners seek medical care three times more frequently than the general population, and require specialised care for issues of addiction, as well as higher requirements for psychiatric care. This is to say nothing of the disjoint between the multiple potential healthcare providers inside prisons and the patients' eventual provider upon release – the state.

The present public management of prison health, independent of corrections management, is gold standard.

However, as the year of 2016 so clearly demonstrated, good policy is too often trumped by good politics. That which engages or enrages voters has come to have far more sway in government policy than a carefully considered, comprehensively developed, evidence-based plan. It seems that the future of prison health will hinge on how much medical practitioners and the general public alike make it known that they care. dr.

> *"It is not sufficiently recognised that the prison service is a public service… As with all public services, the extent and the quality of provision depend on a political decision."* - ***World Health Organisation***

WHAT LED YOU TO BECOMING A FORENSIC PSYCHIATRIST?

I was a lawyer working in commercial litigation – young and ambitious, a senior associate aiming for partnership. I decided to start a family, but was concerned I would not be able to balance family and the long hours of a career in litigation. I was looking for an alternative option that would enable my career to stay somewhat on track whilst I had young children. I thought a medical degree would help me return to law with a strong advantage. I had already done a Masters in Law and university lecturing, but did not want to pursue this further. Besides, lots of lawyers (including me) have a fascination with doctors and medicine. I was quite naïve about medicine and once I started the medical program I realised that it was more than a job but a privileged vocation (and a lot of work). I loved psychiatry, and early on it was obvious to me that forensic psychiatry would be a perfect marriage for my combined degrees.

HOW DID YOUR PERSONAL VALUES AFFECT YOUR CAREER CHOICE?

My personal values centre around the belief that we should contribute to society in some meaningful way and that we should strive to do the right thing (whilst acknowledging that this is often complex). In psychiatry, as a doctor, you are in a position of great power and privilege in relation to those who are highly disadvantaged in society. Mental illness impacts on your ability to interpret reality and often impairs your judgment. This results in the need for great trust in those who are responsible for the care and treatment of the mentally ill. Those mentally ill who are unfortunate enough to find themselves before the criminal justice system are even more vulnerable. Their ability to access treatment and navigate the justice system can be highly compromised by their illness. Many mentally ill inmates have committed minor offences such as not having a ticket on a train or public disturbance offences, but are unable to provide an address for bail, for instance, and end up in custody as a result. These people can be extremely vulnerable in the hostile custodial environment and will often not seek out treatment due to their distrust of mental health services. Treating and caring for this highly disadvantaged group can be very rewarding. I believe that being involved in the care and treatment of this group enables me to make a much more significant contribution to society than I could ever do as a lawyer. In addition, I believe that forensic psychiatry is an area where there are many challenges but that it is important and right that we push through those challenges in an attempt to help and support this disadvantaged group.

WHAT ARE THE MOST IMPORTANT QUALITIES OF A FORENSIC MENTAL HEALTH PRACTITIONER?

In my view, it is most important for the forensic mental health practitioner to be able to empathise with the person before them in some way, regardless of what that person has done, or how they present. This enables the practitioner to treat the patient as a person not as an offender. In addition, a forensic mental health practitioner must be able to identify and reflect on the emotions (good or bad) that the person engenders in them to ensure those emotions don't get in the way of the practitioner's ability to properly assess, treat and care for that person. Finally, the treating forensic mental health practitioner, like all doctors, must be able to keep the patient as the centre of the focus of care, regardless of the other tensions (such as resource or systems issues). In expert report writing, it is most important to stay focussed on your own values and make every effort to maintain an independent honest view. I think these qualities are actually very hard to achieve in practice.

WHAT DOES YOUR CURRENT ROLE INVOLVE?

I am employed as a staff specialist in the acute male unit at the high secure forensic hospital and I prepare private expert reports for Court. I have clinical responsibility for forensic patients on that unit. These patients have been found not guilty by reason of mental illness or are unfit for trial. As an expert, I assist the Court by assessing defendants and providing opinions on, for example, the presence of any mental illness, the relationship between their mental disorder and offending conduct and/or recommend treatment/rehabilitation plans. I am also Chair of Medical Staff Council for Justice Health, which is an elected position. The Medical Staff Council reports to the Board of Justice Health on medical matters.

WHAT DOES A SUCCESSFUL DAY FOR YOU LOOK LIKE?

In the hospital setting a good day would be when there are no aggressive incidents on the ward. However, a successful day might take various forms. It might involve facing a serious incident of aggression and working as a team (including the nursing staff, allied health and medical staff) to achieve a peaceful de-escalation of the situation. I have been involved in numerous situations like this, including a patient who armed himself with sharp pieces of plastic from a broken music player, barricaded himself in his room and threatened to cut his own throat or a staff member's throat if they entered the room. Working together with the nursing staff we managed to convince him, through a de-escalation process, to surrender the weapons and cooperate with staff without incident. A successful day has also occurred when a patient with treatment-resistant schizophrenia who had a delusional system for 20 years despite treatment was placed on the right medication (after months of encouragement) and the delusional system resolved in three weeks. He developed insight and after years of distrusting mental health expressed much gratitude for the treatment he had received. It can be very satisfying to be part of a team that works effectively together and to have so many great people by your side.

WHAT IS THE BIGGEST CHALLENGE CURRENTLY FACING THE DELIVERY OF PRISON HEALTHCARE SERVICES?

The biggest challenge in the delivery of prison healthcare services is ensuring access to minimum standards of healthcare in a population with substantial severe physical and mental health morbidity who are housed in correctional facilities often in regional or rural areas with little ability to control their environment or communicate with others and often with limited education, poor communication skills and few to advocate for them. dr.

PRIVILEGE, POWER & *trust*

As a forensic psychiatrist and Chair of the Medical Staff Council for Justice Health, Dr Kerri Eagle supports some of the justice system's most vulnerable and disadvantaged inmates.

PROFESSIONAL SERVICES

Helen Winklemann
Director, Professional Services

EMPLOYING CASUALS: a double-edged sword for private practices

OVER THE YEARS, I've seen a lot of employers fall into the trap of hiring 'casual' employees, believing this would be less risky or more flexible for their business than a 'permanent' or 'fixed term' staffing model. Without a doubt, the casual model does have a lot to offer: for both parties. But when used in the wrong circumstances, without a full appreciation of the pros and cons, or without ongoing management oversight, the legal and financial risks can be enormous. Those risks are magnified for small businesses (like most private practices), because they usually have limited in house HR/management expertise, and the financial and disruptive impact of an unexpected legal claim can be much higher!

Uncertainity = Risk

The heart of the problem is uncertainty, and if there is one certainty in life (and in practice management) it is that legal uncertainty equals business risk.

Unfortunately, there is no hard and fast statutory rule about when a particular employment relationship is 'truly' casual, and the law has different tests that apply in different situations. At the most fundamental level, it comes down to a case by case assessment of a range of factors, such as: how you engage with a particular employee, their working patterns and, most significantly, the extent to which their employment is 'regular and systematic' and they expect to keep working for you in the future.

Did you know?

- ✔ a court or tribunal may find that your 'casuals' are actually permanent, *even if* they've been employed less than 12 months
- ✔ even 'true' casuals can make termination claims under the Fair Work Act
- ✔ long term 'casuals' are entitled to access unpaid parental leave and long service leave
- ✔ casuals may also be entitled to higher penalty or overtime rates at different times
- ✘ you can't just *agree* that someone will be casual – if they're not, they're not
- ✘ fluctuating days of work, or start and finish times, don't necessarily make someone casual
- ✘ just paying a casual loading doesn't make someone casual
- ✘ even if you pay a casual loading, this may not protect you from paying leave entitlements as well (and/or additional penalties and interest if you don't!)

Most workplace relations lawyers could argue for hours about what 'regular and systematic' actually means in a particular case, so expecting a principal doctor or practice manager to work it out for themselves is pretty tough; and if you make a poor judgement call, the law (or the Fair Work Ombudsman) is unlikely to offer much sympathy. As far as the law is concerned, if it looks like a duck and quacks like a duck, it's a duck, even if the duck prefers to be called a goose!

To make things worse, the nature of a particular employee's relationship may change over time (without you consciously doing anything, knowing anything has changed, or knowing when the change occurred). And you won't be able to get a definitive legal answer from anyone unless and until a legal claim is actually made against you and proceeds all the way through to final judgement in court (and who wants to go through all that?).

So how can you protect yourself and your business from the double edged sword of casual employment?

Here are our best tips:

- only use a casual model if your business needs are genuinely uncertain and changeable, with no guarantee/expectation of ongoing work or regular work patterns
- get advice on which model to use before you hire and consider the

options carefully – for example, a variety of template contracts and other information is available for members on the AMA (NSW) website

- don't pick a casual arrangement just because you want to 'try before you buy' – remember that permanent employment is usually subject to a probation period of 6-12 months anyway
- don't set and forget – review each casual employee's work patterns regularly (eg, every three months), to see whether your business needs have changed in that time, or their actual work patterns have become more regular and systematic – if something's changed, discuss it transparently and update their contract accordingly
- if you need to keep a valued staff member, don't let them 'stay a casual' just because they like getting a casual loading – manage hiring decisions according to your business needs and, if you need to incentivise a staff member to stay, find something else of value to offer them
- no matter which model you choose, to minimise uncertainty and limit the risks, ensure you have a well drafted, written contract in place before the employee starts work and update or replace it whenever the relationship changes significantly. dr.

Disclaimer: The views and information provided in this article are of a general nature only and do not constitute legal advice. It is not tailored for your particular circumstances. If you would like specific assistance with issues raised in the article, please contact our professional services team on professionalservices@amansw.com.au. If we are unable to provide specific advice or legal services to you directly (or to do so within your desired timeframes), we would be happy to refer you to appropriate external providers. In that regard, AMA (NSW) has relationships with preferred providers who will generally provide a free initial consultation to our members.

PS. HERE TO HELP YOU!

WHAT'S NEW IN PROFESSIONAL SERVICES?

New contract templates for private practice employees have now been uploaded to our website, and are available for free download by members.

Our next member education seminar will be in Newcastle on Saturday 25 February 2017. **Check amansw.com.au for further details.**

Looking for Robert Johnson

A JOURNEY THROUGH MISSISSIPPI

AMA (NT) President, Associate Professor Robert Parker, took a journey through Mississippi in search of a blues legend.

‘I went down to the crossroad, fell down on my knees
Asked the Lord above ‘have mercy, now save poor Bob, if you please’

SO SANG ROBERT JOHNSON in 1936 prior to his untimely death due to poisoning in 1938 at the age of 27. Johnson’s brief contribution of 29 songs recorded prior to his death later had a profound influence in rock and roll with artists such as Eric Clapton, The Rolling Stones, Led Zeppelin and the new Nobel Laureate Bob Dylan all acknowledging their debt. The “official” site of the Crossroads where Johnson reportedly made a deal with the devil to play the finest blues guitar is at the intersection of Highways 49 and 61 outside of Clarksdale, Mississippi. However, everyone knows that the real truth is out there somewhere. So, what better excuse for a week’s driving holiday in Mississippi between New Orleans and Memphis.

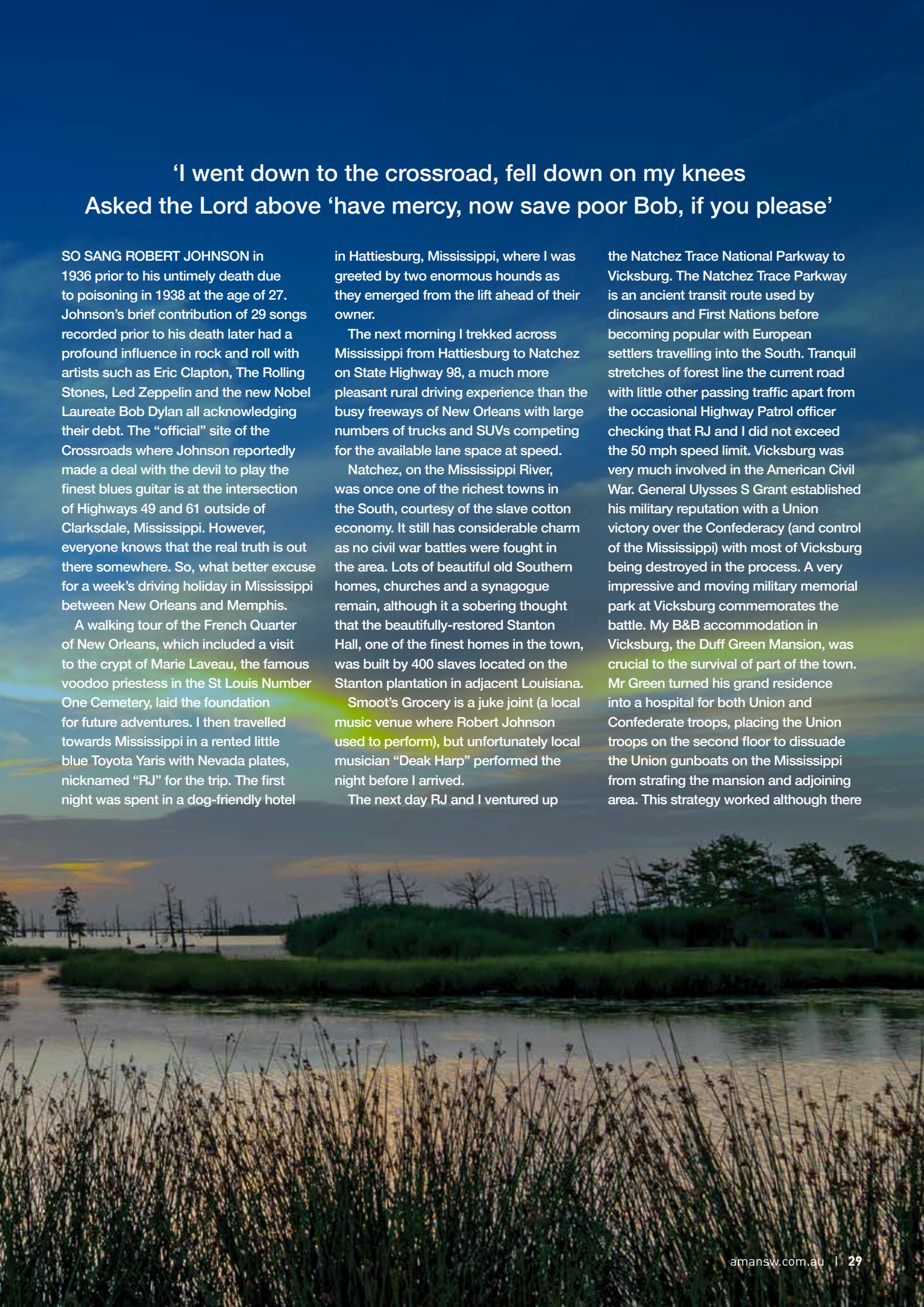
A walking tour of the French Quarter of New Orleans, which included a visit to the crypt of Marie Laveau, the famous voodoo priestess in the St Louis Number One Cemetery, laid the foundation for future adventures. I then travelled towards Mississippi in a rented little blue Toyota Yaris with Nevada plates, nicknamed “RJ” for the trip. The first night was spent in a dog-friendly hotel in Hattiesburg, Mississippi, where I was greeted by two enormous hounds as they emerged from the lift ahead of their owner.

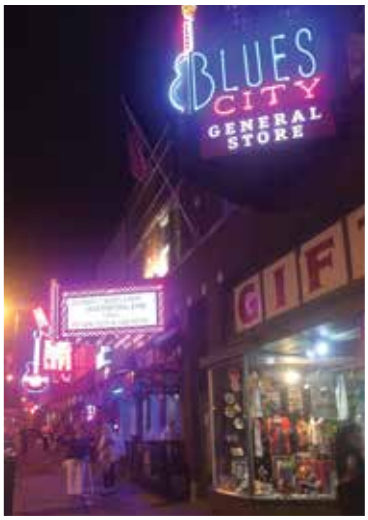
The next morning I trekked across Mississippi from Hattiesburg to Natchez on State Highway 98, a much more pleasant rural driving experience than the busy freeways of New Orleans with large numbers of trucks and SUVs competing for the available lane space at speed.

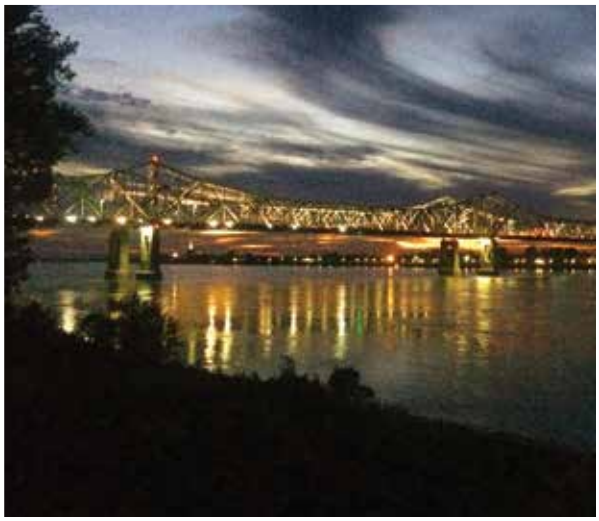
Natchez, on the Mississippi River, was once one of the richest towns in the South, courtesy of the slave cotton economy. It still has considerable charm as no civil war battles were fought in the area. Lots of beautiful old Southern homes, churches and a synagogue remain, although it a sobering thought that the beautifully-restored Stanton Hall, one of the finest homes in the town, was built by 400 slaves located on the Stanton plantation in adjacent Louisiana.

Smoot’s Grocery is a juke joint (a local music venue where Robert Johnson used to perform), but unfortunately local musician “Deak Harp” performed the night before I arrived.

The next day RJ and I ventured up the Natchez Trace National Parkway to Vicksburg. The Natchez Trace Parkway is an ancient transit route used by dinosaurs and First Nations before becoming popular with European settlers travelling into the South. Tranquil stretches of forest line the current road with little other passing traffic apart from the occasional Highway Patrol officer checking that RJ and I did not exceed the 50 mph speed limit. Vicksburg was very much involved in the American Civil War. General Ulysses S Grant established his military reputation with a Union victory over the Confederacy (and control of the Mississippi) with most of Vicksburg being destroyed in the process. A very impressive and moving military memorial park at Vicksburg commemorates the battle. My B&B accommodation in Vicksburg, the Duff Green Mansion, was crucial to the survival of part of the town. Mr Green turned his grand residence into a hospital for both Union and Confederate troops, placing the Union troops on the second floor to dissuade the Union gunboats on the Mississippi from strafing the mansion and adjoining area. This strategy worked although there







is a commemorative cannon ball hole in one of the ceilings.

On to Greenwood where Robert Johnson once had three potential grave locations, being initially buried in an unmarked grave that became a major point of interest after the release of his collected songs on CD in the mid-1990s with more than one million copies being sold. Recent information has reliably placed the grave under a shady tree next to the Little Mount Zion Church, a church built by slaves over 200 years ago as they ferried the timber up the adjacent Tallahatchie River (where Billy Joe McAllister jumped off the Tallahatchie Bridge according to the song by Bobbie Gentry). Sylvester Hooper (www.deltablueslegendtours.com) runs tours out of his store in Baptist Town in Greenwood of the relevant Robert Johnson sites in the area (the grave, the site of the Juke Joint where he was playing when he was poisoned, and the site of the "real crossroad").

From Greenwood, it was on to Clarksdale up Highway 61. Clarksdale has a good Blues Museum (that contains the actual cabin where Muddy Waters grew up), adjacent to the Ground Zero restaurant and music venue part owned by Morgan Freeman. The next day I made a brief visit to Friars Point, a small riverside community, passing the fields of raw and harvested cotton, about 20 minutes north of Clarksdale. Friars Point does not appear to have changed much since Robert Johnson was reported to have a particularly good time there (commemorated in his "Travelling Riverside Blues" and Led Zepplin's "Lemon Song". Then I drove on, past Robinsonville where Robert Johnson first experienced the Blues, and Tunica which houses his marriage registration to Virginia Travis. From there, I travelled on to Memphis where RJ and I parted company. The great music on Beale Street along with visits to Graceland, Sun Records and the excellent National Civil Rights Museum (situated behind the Lorraine Motel, the site of Martin Luther King's assassination) provided a fitting finale to the "Robert Johnson in Mississippi" travel experience. dr.

Associate Professor Robert Parker is President of AMA (NT) and an avid blues fan. If you're am AMA member and you'd like to submit a Travel Column, please contact andrea.cornish@amansw.com.au

How might the latest **superannuation** changes affect you?

By Russell Price
Director at Specialist Wealth Group

With several major changes to Australia's superannuation system due to take effect from 1 July 2017, here's a summary of the main ones. These changes involve a lot of fine detail, so if you think you may be affected make sure you seek qualified advice sooner rather than later.

New $1.6 million cap on retirement balances

This move limits the sum that retirees can invest in tax-free pensions. It will also apply to current pensions, so if you have more than $1.6 million in retirement stream products on 1 July 2017, you will need to roll the excess back to an accumulation phase account where earnings will be taxed at 15%.

This cap will be indexed in line with inflation, in $100,000 increments. The Federal Government estimates this figure will grow to $1.7m by 2020-21.

Also, once the income stream is established within the applicable limits, subsequent earnings will not be subject to the cap. If you intend to set up a pension account before 1 July 2017, take this cap into account to avoid creating additional headaches.

New non-concessional contributions cap

The current limit on non-concessional (i.e. after tax) contributions is $180,000 p.a. or $540,000 over three years. From 1 July 2017 the limit is reduced to $100,000 p.a. or $300,000 within any three-year period.

In addition, people who have reached their retirement balance cap (initially $1.6 million) at the start of each financial year will be unable to make non-concessional contributions.

If you plan on making large non-concessional contributions, perhaps from the sale of property for example, be aware that the current caps apply until 1 July 2017.

Concessional contributions cap reduced

Current annual caps on pre-tax contributions are $30,000, or $35,000 for over-49s. From 1 July 2017 these reduce to $25,000 p.a., irrespective of age. This measure is softened in that, from 1 July 2018, if you have a super balance of less than $500,000, you will be able to carry forward any unused cap for up to five years.As for this financial year, if you currently contribute less than your current cap you may want to increase your salary sacrifice or self-employed contributions prior to July 2017 if appropriate.

Reduced income threshold for additional contributions taxThe annual income threshold above which superannuation contributions are taxed at 30% (rather than the usual 15%) will be reduced from $300,000 to $250,000.

Tax-deductions on super contributions extended to all

From 1 July 2017 all residents under 65, or between 65 and 74 if they meet the work test, will be able to claim a tax deduction for superannuation contributions they personally make. This is a win for workers whose employers don't allow salary sacrifice contributions, and some individuals who are both self-employed and employees. Don't forget that the concessional contribution cap will still apply.

Tax on earnings to be applied to Transition to Retirement (TTR) pensions

The current tax-free status of TTR pensions will be removed, so earnings within the fund will be taxed at 15%. The tax treatment on pension payments to individuals will remain unchanged.

Linked to this, individuals will no longer be able to treat certain superannuation income stream payments as lump sums for tax purposes. Currently such lump sum payments are tax-free up to the lifetime threshold low rate cap ($195,000).

Extended spouse tax offset

Currently, an individual who makes a superannuation contribution for a spouse earning less than $10,800 per year can claim a tax offset of up to $540. The threshold will rise from $10,800 to $40,000, increasing the number of people able to claim the offset.

Removal of anti-detriment rule

Super funds will no longer be able to claim a tax deduction for a portion of a death benefit paid to a dependent. An anti-detriment payment represents a refund of the 15% paid on contributions made by the deceased member over their lifetime. The government claims the current provision is inconsistent with parts of tax law.

Tax exemptions extended to additional retirement phase products

Deferred lifetime annuity products will receive a tax exemption on earnings in the retirement phase, bringing them into line with other retirement income streams.

The importance of advice

These changes will affect us all in different ways, and as they do little to simplify the superannuation system, it's critical to seek expert advice to ensure that you continue to make the most of your retirement savings.

To learn more about how these latest changes may affect you contact an adviser at Specialist Wealth Group on 1300 008 002 or visit www.specialistwealth.com.au

SPECIALIST WEALTH GROUP

BMA CUP 2016

In what could only be described as perfect conditions for golf, the 2016 BMA Cup was held at the NSW Golf Course with an early morning shotgun start.

FIFTY PLAYERS enjoyed the magnificent views from the fairways and the course was in pristine condition. As a championship course, NSW is always challenging and the overall results reflected this.

The event is traditionally a par event and the Cup can only be won by a member of the AMA.

The 2016 winner was Dr George Thomson with Plus 3. This caused great mirth among the players as the event has for many years been held at Concord where George has been a long-time member. However, following cries of 'home course advantage' we moved the 2016 event to NSW only to have a Concord member win. That puts that issue to rest. Well done George.

Runner up with Plus 2 was one of our very popular and great supporters, Dr Merv Cross.

Winner of the Sponsors and Non Doctors Trophy was Mr Hutch Ranck with Plus 4 and runner up Mr Scott Chapman of TressCox, a great supporter of the Golf Society, on Plus 3.

Nearest the Pins went to Dr Chris Browne and Mr Andrew Ball, our Lexus representative.

Longest Drive was won by Mr Andrew Ball. 2BBB winners were Dr Dennis Sundin and Mr Andrew Ball on Plus 10, which is a mighty effort on such a tough course. Runners-up were Mr Scott Chapman and Mr Mike Manak on Plus 9.

The prestigious Albert & Mary Shepherd Trophy was won by Dr Michael Burke with 77 points and runner-up, Dr Rajiv Shah with 73.

The Golf Society wishes to thank contributors to the event for their very generous support, namely, Mr Warren Rennie who donated a golf bag for the winner and printed the programs for the day, MDA National who donated a Kindle and Samsung Tablet, AMA (NSW), also regular donors TressCox, and new contributor, Lexus, who donated a Hunter Valley accommodation with a loan car package.

There is no doubt that these donations assisted greatly with the success of the traditional raffle which raised $685 for the AMA (NSW) Charitable Foundation, bringing the Society's total donations to $4910. All golfers are hopeful that this will warrant a Certificate of Appreciation from the Foundation.

On behalf of AMA (NSW), Dr Robyn Napier extended best wishes for Christmas and the New Year to all members of the Golf Society and encouraged all present to bring along golfing colleagues to future events.

Good golfing to all. dr.

LEFT: Winner of the Sponsors Trophy, Mr Hutch Ranck with Dr Robyn Napier. MIDDLE: Albert & Mary Shepherd Trophy winner, Dr Michael Burke with Dr George Thomson (left) and Dr Robyn Napier. RIGHT: BMA Cup Winner Dr George Thomson with Dr Robyn Napier.

International Shield winner Dr Greg Crosland with Dr Robyn Napier.

International Shield New Zealand

A SMALL but enthusiastic group of golfers contested the 2016 AMA International Shield over six rounds in October at three magnificent courses on the North Island of New Zealand. The courses were, with two rounds at each, Kinloch, Wairakei and Cape Kidnappers. Regular golfers would be well aware of these three courses as they all present different challenges and are a true test of golf. The last round at Kidnappers was the most testing as the infamous Napier Southerly descended upon us at close to 50 knots. The CCR for that round was 30 compared to an average of 36 for the other five rounds. A true test of golf.

The winner of the Shield was Dr Greg Crosland. Greg had a "four-best aggregate rounds" of 143 with Dr Mark Bowman coming in second with 139. The third place went to one of our regular supporters, Nicole Bowman on 134. It must be said that Nicole is constantly in the top placings and has gone close on several occasions. Perhaps 2017? A stand-out performance in putting came from Laurie Pincott who was introduced to the 'claw putting grip' by Dr David Wong. Laurie's only complaint was that David had waited until halfway through the week to come forward with the advice. **Good golfing for 2017!** dr.

VALE

The Golf Society is saddened to learn of the passing during the year of three of our very popular and great supporters of the Society – namely Drs Ramon Bullock, Geoff Driscoll and Jan Myers. The Golf Society extends to the families of these wonderful supporters and individuals our deepest sympathy in their sad loss. We lost them all too soon but we know the tremendous fight each of them put up in the face of very difficult odds.

Dr Ramon Bullock

Dr Geoff Driscoll

Dr Jan Myers

AMA (NSW) Golf Society Calendar of Events 2017

AUTUMN CUP // Tuesday 7th March
Pennant Hills Golf Club

PRESIDENTS CUP // Friday 21 July
Stonecutters Ridge

INTERNATIONAL SHIELD // Early Sept (dates t.b.c)
South Africa

SPRING CUP // Tuesday 24 October
Elanora Country Club

BMA CUP // Thursday 30 Nov
Terrey Hills Golf Club

AMA (NSW) Golf Society
Claudia Gillis 9439 8822 amagolf@amansw.com.au

A warm welcome to all of our **new members** this month

Get more from your membership today and utilise our medico-legal and industrial relations team for advice, our preferred partner advantages, member services and events throughout the year. To find out more phone our membership team on 02 9439 8822.

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Dr Adriana Suker
Dr Adrianna Thomas
Dr Adrienne Campbell
Dr Ahmed Saeed Goolam
Dr Aizat Drahman
Dr Alan Bennett
Dr Alana Sokolowsky
Dr Alana S Bruce
Dr Alex Chung
Dr Alex Goswell
Dr Alex Tridgell
Dr Alexander Miteff
Dr Alexandra Flynn
Dr Amy Hort
Dr Andreas Rauch
Dr Andrew Ung
Dr Andrew Do
Dr Andrew Belford
Dr Anju Varghese
Dr Ankur Srivastava
Dr Anna Granger
Dr Anna Facchetti
Ms Anna Mysliborski
Dr Anthony Restifo
Dr Anthony Marren
Dr Aric Johnson
Dr Arunn Jothidas
Dr Ashleigh Johnson
Dr Ashley Shoppee
Dr Ashradha Ketheeswaran
Ms Audrey Pinna
Dr Aung Min Maw
Dr Avril Friend
Dr Ayesha Akram
Dr Barry Renner
Dr Bashar Alani
Dr Basil Psarommatis
Dr Benjamin Tong
Dr Benjamin Hoadley
Dr Benjamin Kolevski
Dr Benjamin Jay Cunanan
Dr Bhupinder Kumar
Dr Brad Woodford
Dr Brandon Barks
Dr Brett Levin
Dr Candice Jensen
Dr Carolina Mazur
Dr Caroline Powers
Dr Cassidy Campbell
Dr Cathy Cui
Dr Chatwin Lee
Dr Cherynne Johansson
Mr Chi Hang Ho
Dr Chiranjeev Narula
Dr Christene Mikhail
Dr Claudia Buckmaster
Dr Claudio Alarcon
Dr Corinne Fulford
Dr Cristina Penanueva
Dr Cuong Le
Dr Dan Rodricks
Dr Daniel Yeo
Dr Daniel Akrawi
Dr Daniel Akrawi
Dr Daniel Dotta
Dr Darko Pozder
Dr David Hassell
Dr Davina Hiley
Dr Diane Premnath
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Dr Geekiyanage Yasarathna
Dr Geoffrey Chu
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Dr Georgina Burrough
Dr Glendon Inkster
Dr Grace Leo
Dr Gurdeep Singh Bagari
Dr Guy Nelmes
Dr Hamish Watson
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Dr Hany Abdelghani
Dr Harmanpreet Kaur Brar
Dr Harrison Brand
Dr Helmut Yu
Dr Henry Guo
Dr Hilary Cahill
Dr Hongjie Soh
Dr Hope Hoang
Dr Hossein Manuchehri
Dr Hugh Brigden
Dr Hugh Pearson
Dr Hugh Carter
Dr Hugh Stump
Dr Ian Yuen
Dr Irene Chuah
Dr Isobel Yeap
Dr Israel Berger
Dr Jack Garland
Dr Jacob Hampton
Dr Jake Funnell
Dr James Wayte
Dr James Bliss
Dr James Rodway
Dr James Kilpatrick
Dr James Lawler
Dr Jan Zhang
Dr Jane Guan
Dr Jane Manning
Dr Janene Dalrymple
Dr Janice Hui
Dr Janice Taylor
Dr Jared McNeill
Dr Jasmin Smyth
Dr Jayant Rajah
Dr Jenna Iwasenko
Dr Jenny Nguyen-Lam
Dr Jeremy Pulvers
Dr Jessica Jose
Dr Jessica Kracht
Dr Jia Yu
Dr Joanne Wood
Dr Joben Singh

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Dr Yong Kho
Dr Yuen See Choi
Dr Zachary Kesby
Dr Zeynep Oyman
Dr Zhiyong Darran Foo
Dr Zion Chan
Dr Zoe Boyatzis

The AMA (NSW) offers condolences to family and friends of those AMA members who have recently passed away.

Dr Alan Knyvett
Dr Ann Formaz-Preston
Dr Jonathan Halliday
Dr Lionel Hann
A/Prof Amanda McBride
Dr Ramy Mezrani
Dr Winston Summerhayes
Dr Keith Whish

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TressCox Lawyers | Expert legal advice and duty solicitor scheme with one free consultation (referral required).

Sydney City Lexus | Members can enjoy the benefits of the Lexus Corporate Programme, including Encore Privileges. An exclusive offer in conjunction with Qantas is available to AMA members - earn one Qantas Point for every dollar spent on a new vehicle purchase, only at Sydney City Lexus.

Avis Budget | Avis Budget is the official car rental partner for AMA (NSW) offering discounted rates. Contact AMA member services for the details.

BMW Corporate Programme | Members can enjoy the benefits of this Programme which includes complimentary scheduled servicing for 5 years/80,000 km, preferential pricing on selected vehicles and reduced dealer delivery charges.

Emirates | Emirates offers AMA members great discounts on airfare around the world: 8% off Flex Plus fares or flex fares on Business and Economy. 5% off Saver fares on Business and Economy class. The partnership agreement between Emirates and Qantas allows codeshare. Travel with Emirates to experience world-class service and take advantage of their great offers to AMA members.

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Make It Cheaper | As the official energy partner of AMA (NSW), Make It Cheaper would like to run a free bill comparison for you. Their energy health-check compares your bill against the competitive rates they have negotiated with their panel of retailers. Call 02 8077 0196 or email amansw@makeitcheaper.com.au for a free quote.

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