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THE NSW doctor

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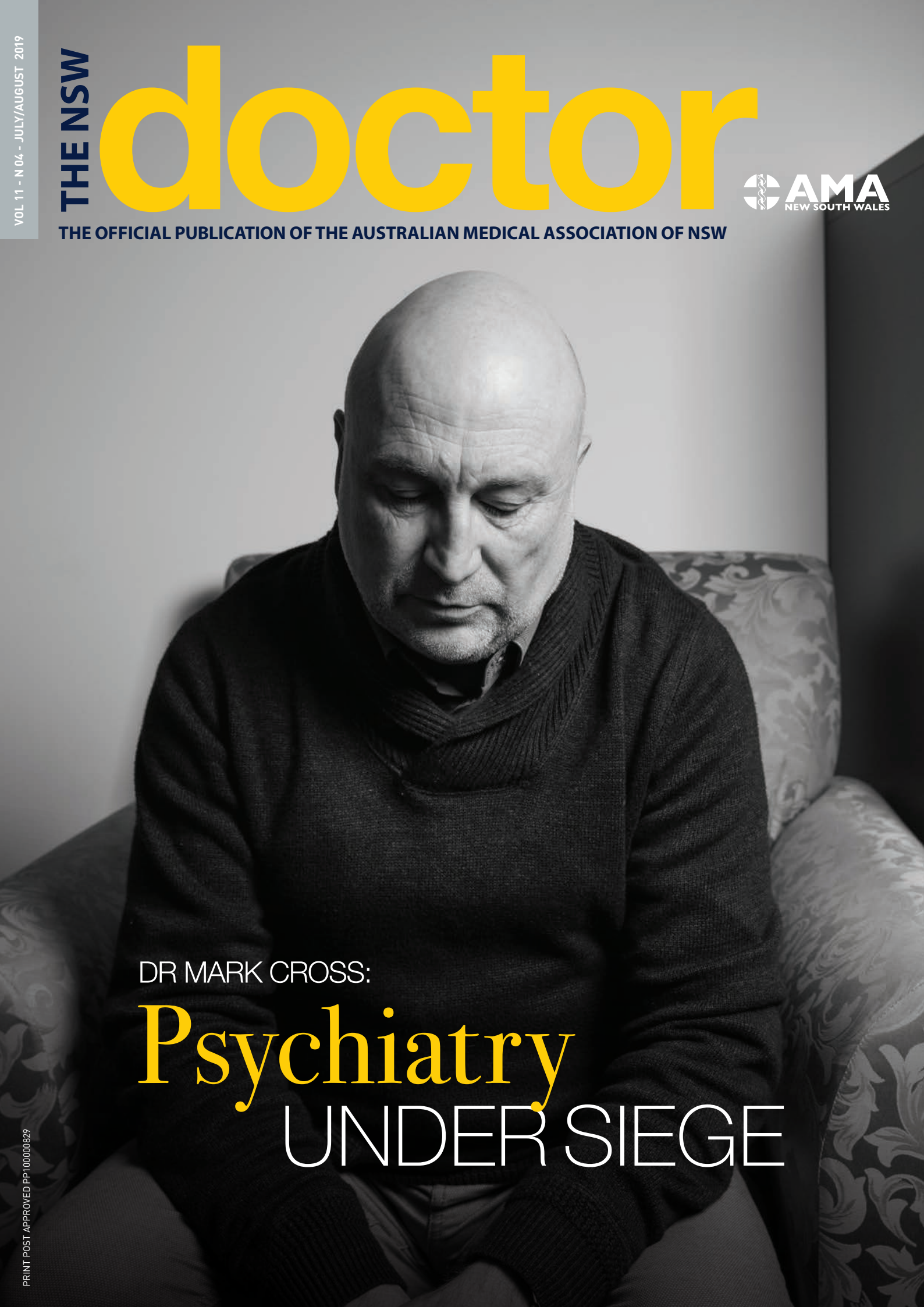

DR MARK CROSS:

Psychiatry UNDER SIEGE

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SAME SOLUTIONS TO OLD PROBLEMS

Budget Day always begs the question, 'is this the most effective use of our money?'.

AS I WRITE this column, the NSW Government has just announced its first post-election Budget. Despite the largest revenue writedown in NSW history, the state will be $802m in the black.

It's a relief to see the Government is boosting front line workers over the next four years, including 3300 more doctors and health professionals. As this edition of *The NSW Doctor* details, the public health system – particularly its psychiatry workforce – is in desperate need of greater resourcing. I note, however, that despite leading psychiatrists warning we have passed the tipping point, there has been no major financial boost to provide care for people with severe psychiatric conditions (severe depression, psychosis, schizophrenia, etc) in public hospitals.

The increase in mental health patients presenting to emergency departments is exasperating the situation in our already overstretched EDs. Our emergency departments are overcrowded. The latest Bureau of Health Information report revealed there has been more than a 40% increase in the number of patients presenting at NSW emergency departments, in less than 10 years. We've just witnessed another all-time record for ED presentations, peaking above 750,000 patients for the first time.

This is not just a reflection of population growth. It also speaks to the rising prevalence of chronic disease and our inability to effectively manage these conditions in the community. If we can treat people at the primary care level, then we can keep them out of hospital and relieve some of the pressure in emergency departments.

We will never be able to build big enough hospitals and emergency departments to deal with this crisis. Unless we can successfully target both the demand and supply problems facing our hospitals, issues of overcrowding that plague both the patient and staff experience will not go away.

Instead we need to think about tackling these issues in a different way. We must refocus our efforts on primary care and helping people better maintain their health before their condition becomes dire.

The State's commitment to reducing overweight and obesity fits into this paradigm shift. The Government's commitment to planning for additional greenspace throughout Sydney, an increase in trees for better air quality, and investment in public transport are good incentives to encourage people to be more physically active.

Expanding the Active Kids program from a single $100 voucher for children to participate in organised sport to two vouchers is also a positive move in terms of the Premier's priorities on childhood obesity.

In addition, I applaud the boost to frontline services staff which will place 100 additional counsellors or psychologists in schools, as well as a $70 million investment into mobile dental clinics at schools in western Sydney, the Central coast and the Mid-North coast. There is also $76 million to increase elective surgery in hospitals, with children given preference. The goal of this funding is to increase paediatric surgeries by 8,000 over four years. This focus on children will pay dividends.

But the State can't tackle preventative health on its own – particularly given the Federal Government has much greater control of primary care. This Budget really highlights the need for better coordination with the Commonwealth.

It also highlights the need to boost total spending on primary care to 10%. With this goal in mind, we will continue to push the Federal Government to increase total spending on primary care to 10% of the total health Budget. It's time for 10. dr.

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Dr Kean-Seng Lim President, AMA (NSW)

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CHECKING THE HEALTH OF OUR PROFESSION

Protecting doctors at all stages of their careers – from doctors-in-training to senior clinicians – is important to the AMA.

LAST MONTH, we launched our third annual Hospital Health Check survey for doctors-in-training. The survey is an important opportunity for AMA (NSW) to find out what junior doctors really think about working in our public hospitals. Each year, we use the results as a platform from which to launch our advocacy for improved conditions for doctors-in-training. Following each survey, we meet with chief executives to discuss how the results impact on their hospital and what they are doing to care for their staff. These meetings provide an opportunity to highlight the commendable things hospitals are doing and provide some positive feedback.

We also use the survey to draw attention to the problems in the system, particularly around unrostered overtime. This continues to be our biggest concern, with doctors reporting being actively discouraged from claiming overtime and/or not being paid when they do. While there is nothing new to this culture, it's a culture we need to change. We know that our senior doctor members are also under pressure and feeling unsupported. Senior doctors and particularly heads of department hold the unfair burden of balancing budgets in a system under serious strain. While paying doctors-in-training overtime won't fix everything, we need to start somewhere to break the cycle of doctors being expected to give more and more for less in return.

Looking after the profession has always been important to the AMA. However, this tenet became even more critical following the challenging media issues which arose last month. From the concern over a lack of accountability in a high charging specialist, to the terrible opinion piece from Nikki Gemmell in *The Australian* about male obstetricians – there has been an attempt to divide the profession and damage doctors' reputations. The AMA has been there to respond to each issue and to remind the community of the incredible work of ordinary, hard-working doctors, as well as highlight the care they provide and the need to support our doctors every day. dr.

fiona.davies@amansw.com.au

Fiona Davies CEO, AMA (NSW)

BREAKING DOWN

Psychiatrist Dr Mark Cross worked tirelessly to break down the barriers and stigma associated with mental health, first on behalf of his patients, and then for his colleagues who continue to struggle to meet the unflinching demands of a broken public health system.

DR MARK CROSS has spent his entire professional career fighting stigma.

As the familiar face on the ABC documentary series *Changing Minds*, Dr Cross was instrumental in providing viewers with an inside look into the locked wards of Liverpool Hospital's mental health unit. The program was ground-breaking – not only for being the first program in television history to shoot inside one of the busiest psychiatric units in the country, but for its non-judgmental portrayal of the stories of patients and staff as they struggled to regain their health.

Now, five years on from when the first episode aired, Dr Cross is working to address the mental health issues faced by medical professionals by documenting his own life-long battles in his book, *Anxiety, expert advice by a neurotic shrink*, to be published next year.

EARLY YEARS

Dr Cross was drawn to psychiatry partly because of his own mental health issues, which helped him feel more compassionate and empathetic to patients.

He also developed a deep personal understanding of discrimination early in his life.

Being gay and coming to terms with his own sexuality in the 1980s in South Africa was challenging. At the time, homosexuality was not only a criminal offence, but it was considered a mental illness.

During his final year of medical school at the University of Cape Town, he recalls one of his professors castigating another openly gay professor during a meeting.

"He stood up and said HIV was God's gift to homosexuality," Dr Cross says. "So that was what we were dealing with at the time."

Despite an atmosphere of discrimination, he graduated medical school in 1990 and did his internship at his hometown district hospital in Port Elizabeth.

"In my internship, I worked many weeks over 100 hours. But we had great onsite accommodation, wonderful camaraderie, kind consultants, and little discharge paperwork to concern ourselves over," he said.

"It was the best year of my doctoring life. The next year, the medical superintendent asked me to take over the 16-bedded psychiatry ward, which we then opened to all races for the first time in South Africa's history in 1992."

With his supervisor 300 miles away, Dr Cross learnt from the nurses and formed the foundation of psychiatry he continues to practice today – a combination of practicality, common sense, and mutually respectful engagement with the people he treats.

He moved to England to further

specialise in psychiatry and worked as a consultant for the National Health Service until he moved to Sydney in 2005.

In Australia, Dr Cross initially worked as the Director of Consultation/Liaison Psychiatry at Liverpool Hospital, before taking over as Clinical Director of Psychiatry in 2006 until September 2014.

The stress of his demanding and unrelenting workload was overwhelming.

"In my management role I was responsible for bed flow. I had to try and move those patients who were admitted under mental health out of the emergency department. There were constant calls from the manager, management flow team, and the mental health flow team. Some days I'd be responsible for 45 beds and we were always short staffed."

"Whilst the series changed my life and is the single most important piece of work I have ever been involved in – I was also at the time stretching myself too far."

He added, "There was a constant pressure to discharge to create beds, but discharging someone to the department of housing emergency queue is not good or kind practice."

Patients often languished for days in overstretched emergency departments waiting for psychiatric assessment and to be admitted to a psychiatric unit that is already at full capacity.

Dr Cross was drinking up to eight cups of sugary coffee, coupled with Coca Cola, to try and maintain the energy needed to get through the day. Then in 2013, he began shooting the *Changing Minds* series.

"Whilst the series changed my life and is the single most important piece of work I have ever been involved in – I was also at the time stretching myself too far."

He resigned as Clinical Director and then moved within the Sydney South West Local Health District to Campbelltown Hospital to work as the Senior Psychiatrist running the only Youth Ward (Public) in NSW in 2014.

He said this move, "brought some relief, although the anxiety related to this decision was immense."

There was still daily pressure to create beds when there was inadequate post discharge, as well as rehabilitation, options.

Dealing with really ill people with complex needs, combined with too much paperwork, high staff turnover and shortages, the sparsity of permanent senior managers, and on call rules which meant phone calls throughout the night, from Friday to Monday, eventually took its toll on Dr Cross.

By 2016, he had had enough of working in the public health service and started working in private practice at Northside MacArthur Clinic in Campbelltown and Northside Cremorne and is a Senior Lecturer at the University of New South Wales (UNSW).

"I was feeling burnt out. I could no longer be part of the mentality of feeling 'under siege'" he said.

While no longer working in the public sector, Dr Cross said the private practice is beneficial to the overall health system, particularly patients in Campbelltown.

"I continually strive for good relationships with the local public systems, and believe we take pressure off an overloaded system."

It also allows him to take better care of his own mental health and wellbeing.

"I still hate paperwork, I am always behind, dictating over weekends, working six-day weeks, at times. But I no longer get bronchitis three times a year, I sleep better, I don't have anticipatory anxiety every weekday morning, and whilst there are pressures, I am more in control of my diary, and my time. I start later to fit in exercise and taking my kids to school."

The change has allowed him to improve his work life-balance, and has given him enough spare time to devote to sitting on the board of SANE Australia – an organisation that supports people with complex mental health issues.

He hasn't ruled out returning to the public sector, but in the meantime, he is passionate about advocating for doctors' health and wellbeing.

Dr Cross believes medical professionals should be more open about their vulnerabilities and issues, without fear of mandatory reporting.

"We should be blazing the way in terms of mental health and work," he said. "We as doctors don't look after ourselves properly. There's such stigma. I still think of my conditions as weakness and we've got to stop thinking of it like that. We have to acknowledge and seek help or we end up killing ourselves, or engaging in high risk activities and our relationships go to pot."

THE OTHER SIDE

There's a scene at the end of Episode One in *Changing Minds* that still resonates with Dr Cross.

"It's a very moving – I've watched it about 30 times and I still cry," Dr Cross said.

One of his patients, an IT specialist with bipolar, was admitted after hitching a high-speed ride on the bull bar of a truck.

After five weeks in the mental health unit, Patrick was deemed well enough to return home. Throughout the program – even after coming down from his mania, Patrick is quite animated. But in a moment of teary emotional reflection Patrick turns to the camera and says, "I think people who have experienced problems and have come through on the other side – that's the sort of person that I want to be in contact with."

It's the kind of insight Dr Cross can appreciate, having made the journey himself.

"I'm now in my early 50s, proud of my commitment, passion and working record. And no longer afraid to be open about myself, and to work towards better systems, and mental health." dr.

PSYCHIATRY: A SYSTEM UNDER SIEGE

Frustration from frontline medical staff grows as workforce shortages and under-resourcing threaten to push the public health system to the brink.

NSW IS FACING A CRISIS in mental health, as dwindling numbers of psychiatrists are left to care for increasing numbers of patients.

Depression is now the fourth highest cause of disability in Australia, and suicide claims twice as many lives as the national road toll.

In NSW, the number of mental health-related presentations to emergency departments increased by 76% between 2004-05 and 2017-18.

And while the burden of mental distress and illness is growing, the number of medical professionals available to help patients is in decline.

"By the time we recognise how serious the situation is, I am concerned we will have passed the tipping point and it will be too late to make the significant changes necessary to turn things around," said Professor Gordon Parker, UNSW Sydney Scientia Professor of Psychiatry and Founder of the Black Dog Institute, when he launched the 2019 Australian Mental Health Prize at UNSW.

"Australia is a global leader in many areas of mental health including community awareness, public advocacy and innovative service delivery, but the pressures faced by mental health professionals in the public sector needs urgent attention," he added.

The specialty is severely under-subscribed, with potential trainees turned off by an overburdened system.

NSW currently has 60 vacant training positions for psychiatric trainees.

"I see so many young psychiatrists enter the public sector with a genuine commitment and wish to help those with serious psychiatric problems but who become profoundly disillusioned. Psychiatrists and trainees in the public sector are often unable to find beds for patients at suicidal risk. They see patients who need close observation prematurely discharged or patients who are discharged into homelessness, rather than public housing."

Professor Parker said it was not uncommon in public hospitals for up to 30 people to be waiting for an acute psychiatric assessment every day without adequate beds available, with mental health disorders one of the leading causes of emergency room delays.

Department of Health workforce projections indicate a future undersupply of 125 by 2030 for the psychiatry workforce.

The modelling is based on an anticipated 2% increase per year (from 194 in 2015 to 234 by 2030) on the first year intake to the program.

The projections also included the high reliance on overseas trained doctors (OTDs) continuing, with OTDs being projected at 55 new Fellows per year. To meet the expected undersupply projected by 2030, the new intake would need to increase from the projected 197 to 200 in 2016 up to 269 in 2025, which equates to an average annual increase of 3.3%.

The NSW Health Ministry and the Royal Australian & New Zealand College of Psychiatrists are developing a workforce plan to improve workforce culture and address burn-out. dr.

GIVING **HOPE**

The 2019 Australian Mental Health Prize is a critical opportunity to recognise and acknowledge those working tirelessly in mental health, said Professor Gordon Parker, UNSW Sydney Scientia Professor of Psychiatry and Founder of the Black Dog Institute at the launch.

Chair of the Australian Mental Health Prize Advisory Group, Ita Buttrose, said the prize is helping to improve mental health care in Australia and ensure mental health stays top of mind for Australians.

"I would like to see this year's prize highlight some of the world-class work being done in the field of mental health, to give hope not only to those with mental illness and their families, but other mental health professionals working in this challenging area."

For more information or to nominate, visit australianmentalhealthprize.org.au. Entries close 30 August 2019.

PROGRESSIVE POLICY NEEDED

Responses to illicit drug use are often informed by broader arguments around **harm minimisation** and **zero tolerance.** **AMA (NSW) urges a balanced approach,** that views addiction primarily as a **health issue.**

AMPHETAMINE possession has risen by 250% over the last decade in NSW. And as usage of meth/amphetamines has increased, so has the number of names to describe it. Batu, speed, crank, tweak, shabu, Christina – are but a few of methamphetamine's existing monikers.

But none of the street names have become as synonymous with the drug as the word 'ice' – an apt description for the highly concentrated crystal form of methamphetamine.

The NSW Special Commission of Inquiry into the Drug 'Ice' was commissioned by Premier Gladys Berejiklian last year to investigate crystal methamphetamine but was expanded in February to cover other illicit amphetamine-type stimulants (ATS). ATS include amphetamine and methamphetamine and a range of other substances, such as methcathinone, fenetylline, ephedrine, pseudoephedrine, methylphenidate and MDMA, also known as ecstasy.

The expanded scope of the Inquiry followed closely on the heels of a spate of drug overdose deaths at music festivals and subsequent calls for harm minimisation measures such as pill-testing.

The inquiry is investigating the nature, prevalence and impact of these drugs as well as the adequacy of existing measures to target ice and illicit ATS in NSW. It is also looking at options to strengthen NSW's response to ice and illicit ATS, including law enforcement, education, treatment and rehabilitation responses.

AMA (NSW)'s response to the Special Commission of Inquiry into the Drug 'Ice' reflects our organisation's view that addiction is primarily a health issue, requiring treatment and support. Furthermore, AMA (NSW) supports a balanced approach to methamphetamine, in which law and order responses to the supply and demand of crystal methamphetamine are offset by efforts to reduce demand for the drug in the community, and for the provision of appropriate health care including referral to treatment and support for users.

There is growing concern within the health sector, as well as the wider community, about the impact of ATS – particularly the more potent forms of these substances. Not only are concentrated forms of methamphetamine associated with greater harms to individuals and the community, but they have greater impact on emergency and primary care services. Methamphetamine users present unique challenges for these treatment services, often presenting in crisis, with acute behavioural disturbances or psychotic symptoms. High doses of ice and frequent use may cause 'ice psychosis' which can cause paranoid delusions, hallucinations, and aggressive and violent behaviour.

A recent review into the safety of staff, patients and visitors in NSW public hospitals found doctors and nurses are reporting an increase in aggressive and violent behaviour. Part of the increase is attributed to alcohol and drug-affected patients, some of whom were experiencing an ice-induced psychosis. Patients with acute amphetamine intoxication are often agitated and aggressive and may require extensive resources, such as sedation.

Methamphetamine addiction is not very well suited to current treatment facilities available in emergency departments,

USE OF AGONIST **TREATMENT** FOR **METH ADDICTION**

Addictions specialist Dr Simon DeBurgh suggests that for addictions in general, agonist treatment is the most rewarding modality for difficult addictions.

"Thus, methadone and buprenorphine are outstandingly successful, and nicotine replacement is the mainstay for tobacco. An agonist 'gives' the user something," he says.

There are treatment facilities in NSW for methamphetamine which offer some agonist treatment using dexamphetamine.

However, Dr DeBurgh says "Political timidity restricts the availability, medication is offered to a minority, and the dose ceiling again is politically determined."

Another contender for substitution medication is lisdexamfetamine, which is a long-acting amphetamine formulation that provides agonist action if it is swallowed but not if it is injected.

Dr DeBurgh says approval of lisdexamfetamine is problematic for patients. "My understanding is that an ice user must show urine screens free of methamphetamine before approval can be granted, and approval will be withdrawn if there is relapse. In other words, patients must show they don't need lisdexamfetamine before they can receive it."

He suggests it could be administered under supervision daily at a community pharmacy much as methadone is commonly dispensed. "This would give a reassuring degree of security and monitoring. Valuable clinical experience could be had in this way and build a basis for rigorous research."

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general practices, or acute hospital admissions. However, clinical and referral pathways are often unclear between the emergency/primary care services and the specialist alcohol and other drug services.

Meth/amphetamines and crystal methamphetamine are addictive and require a tailored treatment response. Rehabilitation takes part in two stages. Recovering must first involve a physical detox, which takes almost twice as long as other drugs (10-14 days). Treatment after the detox may need to be continued for many months. Methamphetamine can cause long-term damage to the brain, which may require specialised treatment and continuous care over a sustained period of time. NSW needs to strategically plan for downstream effects of long-term usage, particularly those with high levels of cognitive dysfunction, who cannot live independently, and have difficulty finding placement in assisted-living facilities.

Traditional approaches include inpatient detox, drug substitution, and residential rehabilitation programs. Counselling, which may include cognitive behavioural therapy and other bahevioural approaches, are seen to be effective in helping people address problems associated with meth/amphetamine use. Other counselling approaches include narrative therapy and solution-focused therapy.

There are also self help approaches and mutual support groups, such as Crystal Meth Anonymous.

The demand for treatment often outstrips its availability. The lag time between problem use and treatment also presents difficulties. Users present to general practitioners and other clinicians typically quite late in the course of their illness, which increases complications and difficulties with follow up and adherence. Counselling can also be cost prohibitive, as can private treatment providers.

Treatment is often more effective when provided early. The Federal Government's $13 million funding injection in 2015 for Addiction Medicine Medicare Benefits Schedule (MBS) items have attracted new trainees to addiction medicine, which will help build a specialist alcohol and other drug sector.

The funding of these dedicated MBS items, combined with efforts to develop and support the range of professionals who are deemed to be 'front line staff', including general practitioners, was an important measure. However, the AMA suggests greater support and resources need to be developed to reach 'occasional' users of ATS, or people who find they are increasingly using ATS. These patients may be more likely to present to general practitioners. As a result, general practitioners need access to clear referral pathways to drug-related services in their area.

More research is needed into methamphetamine pharmacotherapies. Studies show medication-assisted treatment of opioid-dependence is effective and safe. However, there has been little research into the efficacy of substitution therapies for methamphetamine. Greater examination of pharmacotherapies, such as lisdexamfetamine, dexamphetamine, modafinil, bupropion, oral naltrexone and N-acetylcysteine is essential.

The AMA supports the introduction of innovative policy models and trials in a controlled manner, funded and evaluated appropriately that might reduce harms and improve outcomes for users and society at large.

TRIAL OF PILL-TESTING

Debates around pill-testing are informed by broader arguments about harm minimisation versus zero tolerance. Australia's approach to illicit drugs under the National Drug Strategy remains one of harm minimisation, and the country has in place a significant number of measures to reduce the harms caused by drugs. These include Sydney's Medically Supervised Injecting Centre, needle and syringe programs and opioid substitution treatment.

The National Ice Taskforce report emphasised drug treatment over law enforcement measures – a reflection of sentiments expressed by former Victorian Police Commissioner, Ken Lay, and many other law enforcement officers. They acknowledged Australia cannot win the war on drugs through law enforcement measures alone.

Despite this prevailing attitude, the response from NSW Government to drug-related deaths at music festivals has been to increase police presence and medical personnel at music festivals, as well as a trial of Drug Criminal Infringement notices.

AMA (NSW) reiterated its support for consideration of a pill-testing trial as part of a wider harm minimisation strategy at festivals.

Pill-testing is an opportunity to reduce harms associated with drug use through education and outreach. International research suggests pill-testing changes behaviour; negative results have deterred people from consuming drugs and warning their friends.

It also enables the capture of long-term data about substances in the drug market and the potential for a warning system against new, unexpected, or very dangerous drugs and consumption trends.

With proper lab equipment, pill-testing can determine potency – information which patrons can use to modify their consumption and reduce the risk of overdose. dr

The Special Commission of Inquiry into the Drug 'Ice' held public and private hearings throughout May and June in Sydney, Broken Hill, Dubbo, Lismore, Nowra and the Hunter Region.
The five regional areas were identified as experiencing particular harms from ice and other illicit ATS. The Inquiry will hand down its findings by the end of 2019.
For more information, or to view the Issues Papers, visit www.iceinquiry.nsw.gov.au.

TAKING THE **STING** OUT

Medical professionals are unlikely to persuade anti-vaxxers on immunisation. However, there is an opportunity to encourage people who are vaccine-hesitant by establishing a relationship that is built on trust and respect.

THE NATION'S public health departments are on high alert following warnings that Australia could be stripped of its measles elimination status within 12 months if the number of cases continues to rise at its current rate.

As of 9 May, there had been 109 measles cases reported – compared to 103 for the whole of 2018 and 81 for 2017.

The immunisation rate among young children is just below the 95% mark in Australia – which is the magic number needed to achieve herd immunity.

A drop in vaccination rates makes us vulnerable to the spread of diseases such as measles – thus the current outbreak has given rise to public health campaigns on the necessity of immunisation.

But immunisation tends to polarise people, and occasionally this messaging attracts online vitriol against those who decide not to vaccinate, and those who do. We see this almost every day on AMA (NSW)'s Facebook page.

It's unlikely that hurling insults at anti-vaxxers is going to change their minds, any more than insulting comments from that movement would deter firm proponents of immunisation. However, there is an opportunity to encourage people who are vaccine hesitant by establishing a relationship that is built on trust and respect.

AMA (NSW) Vice President and general practitioner, Dr Danielle McMullen, often faces patients who are concerned about vaccinations.

"I hope that by having a therapeutic relationship with my patients that is ongoing and comprehensive, I open the door to discussion around vaccination. I certainly see some examples of that. A few times per year I have patients come in and ask questions specifically around the safety of vaccines for their children."

She recently had a patient indicate she was nervous about vaccinating her teenage boys with the HPV vaccine.

"We explored her concerns in a non-judgmental way, validated her concerns and presented evidence as it stands. I still don't know what she chose to do with the information, but hopefully walked away more likely to vaccinate."

Dr McMullen described another case, where the young parents of a baby expressed their anxiety about vaccination and resentment of pressure to vaccinate by the 'no jab, no play' policy and family tax benefit legislation.

"It takes time to manage these cases, explain common and rare side effects, and to make sure that parents are giving informed consent. It's important to try and help them understand the difference between financial pressures and medical risks. Ultimately, they decided to vaccinate but hearing things like 'my baby had better not get any adverse reaction or I'll be really mad' made me anxious and I took a long time to make sure I had discussed things with them to the point that they understood the decision they were making."

She adds that time can be a luxury for busy general practices, and some patients choose to do their research elsewhere.

"And science isn't always sexy. For some reason at the moment people seem to love the pseudoscience space – people using big long 'sciency' sounding words which promote the counter-position."

The World Health Organisation (WHO) suggests health professionals have a vital role in addressing vaccine hesitancy.

"In the face of emerging hesitancy, health workers remain the most trusted advisor and influencer of vaccination decisions. The capacity and confidence of health workers are often stretched, though, as they are faced with time constraints, limited resources, and inadequate information and/or training to respond to any questions and discuss the risks and benefits."

According to the WHO, several factors contribute to vaccine hesitancy including complacency, lack of convenience, and low levels of trust.

If patients are hesitant, health professionals are urged to use a motivational interviewing method, which creates a conversation around change without attempting to convince the person of the need to change or instructing them about how to change.

Health professionals are encouraged to answer open-ended questions, such as 'what do you think…' 'what did you understand…'?

> The World Health Organisation named **vaccine hesitancy** one of the top **10 threats to global health** in 2019.

Another tool to use is reflection. By repeating what the patient says, or repeating what you think the patient means, you are acknowledging their concerns. For example, is a patient says 'I know vaccinating will help me but I am afraid of side effects,' the doctor could respond, "I understand you want to make the best choice for yourself. What side effects are you concerned about?'

It's important that health professionals affirm the strength of discussion ("It's great that you are starting to think about vaccines") and validate the patient's concerns ("The health of your children is important to you.")

These are just a few techniques suggested by the World Health Organisation. For more information, visit who.int. dr.

FROM THE RED CENTRE TO THE SEA

Dr Eliza Milliken and her partner, Dr Alexander Whitfield, reflect on taking time out from training and the realities of locuming in rural hospitals.

IN THE ERA of year to year contracts, the medical "gap year" has become common practice for doctors-in-training. There are lots of reasons to take time off – travel, time for family and friends, or seeking space to gain career-perspective before returning to the pressures of training. A gap year can also be a positive response to not getting the job you wanted exactly when you wanted it, and a way to turn a disappointment into a windfall.

At the end of 2017, we found ourselves exhausted by the demands of training. Long hours whilst studying for exams and moving house every couple of terms for secondments was draining. Both of us were in supportive networks but even in optimal conditions the job can be demanding. Alexander especially found himself not looking forward to shifts, a feeling that didn't go away after a couple of days off – a red flag for burnout. It was a sign to take some time to focus on our own goals and interests outside of training.

It would be easy (and perhaps more fun) to tell you about the adventures we had in 2018; we travelled to Taiwan and Japan, and got weird in Tasmania at Dark Mofo. We moved to the Northern Territory for a few months, discovering a deep love for the quiet expanse of the desert. We crewed a ship in Liberia with *Sea Shepherd*, working with the military patrolling for illegal fishing vessels, and managed to contract a few exotic ailments and fractured bones in the process. We somehow even managed to chase some academic projects in between times. Of course, we procrastinated a lot, too, and watched a lot of Netflix. We still, despite all our lofty intentions, can't speak French or meditate properly. A year off didn't hinder us in securing the training jobs we wanted. In fact, most departments were interested to hear what we could offer thanks to our broader professional experiences.

However, it wasn't the highlights reel that fuelled our professional development. Locuming can be challenging. Shifts are often in rural hospitals far from home as

these are the most affected by workplace shortages. The lessons we've carried with us into our new roles aren't so much based on the good things as the inequality, glaring injustices and groaning bureaucracy we witnessed in the Australian health system. Realities you are often protected from in tertiary training hospitals. We discovered how dangerous the job can be in small under-resourced facilities when Eliza was physically assaulted by an irate patient in a private hospital with no after-hours security, how First Nations people encounter significant barriers to care when there's no funding to make health spaces culturally safe, how length-of-stay can blow out when there's inadequate imaging and investigation services, and how expensive and logistically difficult retrieval becomes when health is increasingly centralised (as well as how alienating this can be for patients who wish to remain close to family).

For doctors who have been training in metropolitan areas it's easy to underestimate the impact workplace shortages are having on rural and regional Australia. We found ourselves running rural hospitals or being the sole doctors on site, despite lack of local systems or community knowledge. This is common for locums as regional hospitals struggle to recruit full-time staff. In many hospitals your closest help may be whoever is in town that night and the on-call system merely a phone-tree of numbers to try hoping someone answers. Working in these conditions forces you to think about your own responsibility, culpability and safety in a way that being protected inside a teaching hospital does not.

While at times frustrating and not always relaxing, taking some time out from training broadened our horizons and career goals and we would recommend it to anyone wondering what else is out there. If you're burnt-out and unsure what you're getting out of your career, the chance to compare options can give you richer insight into the health system and valuable experience to bring to a permanent role with a renewed sense of purpose. It may also lead more doctors-in-training to positive experiences in rural and remote areas, increasing uptake of permanent positions in these places in the future. Shop around for locum agencies, find hospitals you enjoy working in that you can book semi-regular work in and of course, remember to take some time to forget the job all together! dr.

Co-written by Drs Eliza Milliken and Alexander Whitfield

Careers Service offers tailored support to doctors throughout their careers. *The NSW Doctor* is showcasing the unique stories of doctors who have successfully used Careers Service to further their progress through medicine. Dr Dolapo Sotade shares his journey through medicine.

PATHWAYS THROUGH MEDICINE

I CAME TO Australia at the age of 10 and spent my high school years in rural Queensland. I elected to study medicine as both my parents work in health, and as many readers would know health careers tend to run in families. My father is a general practitioner and my mother is a nurse. I spent part of my childhood living in a medical compound in South Africa and I look back on that time fondly.

I also chose to do medicine as the work offers intellectual challenge and variety, and I believe room for new innovations. I feel there is a true challenge in being able to keep up to date with new technology and advances in medicine. I truly enjoy caring for patients and it is extremely satisfying when patients experience good outcomes. I am in the privileged position as an orthopaedic registrar to use my expertise to care for patients when they are in a time of need.

WORKING RURALLY

I studied medicine at the University of Newcastle and I accepted a rurally bonded place.

In my career, I have worked in both large metropolitan and smaller rural centres, and currently I am working as an unaccredited orthopaedic registrar for Hunter New England Health.

As a junior doctor, I particularly enjoyed my orthopaedic rotations. I was inspired by the enormous impact that routine procedures have on patients. I remember looking after a patient who was wheelchair bound, and with poor quality of life as a result of arthritis of the hip. The patient received a hip replacement and the change was astounding. His mobility and independence returned, and his outlook on life became more positive. Not only did this surgery have a positive impact on the patient, but it had a ripple effect to his whole family. The patient's increased independence took some caring duties off his wife and daughter. The patient was also delighted that he could finally play with his grandchildren at the local park, which was previously impossible to access with a wheelchair. This early exposure to orthopaedic surgery is part of the reason I have continued to work in this area of medicine.

I have always been drawn to regional medicine. There is a great need to attract, train and retain rural doctors so all Australians have equitable access to healthcare. This is particularly important to me as I grew up in a rural area and I would like to make a contribution to rural medicine. Working in regional centres has given me the opportunity to develop my skills in a supported environment. In my current post, my area covers a wide population from affluent to lower socioeconomic, and ethnically diverse, providing a good case mix for training.

As with any job there are stressful and challenging moments. However, on the whole, orthopaedics offers variety of work accompanied by a great deal of personal satisfaction. One aspect of the work which can be challenging is managing patients who have high expectations in an occasionally strained public health system. Often it gets busy, and patients have to wait longer to be seen. It can be difficult managing the understandably anxious or upset patients. With experience, good communication skills, empathy and patience, I feel that you can build rapport and de-escalate these situations.

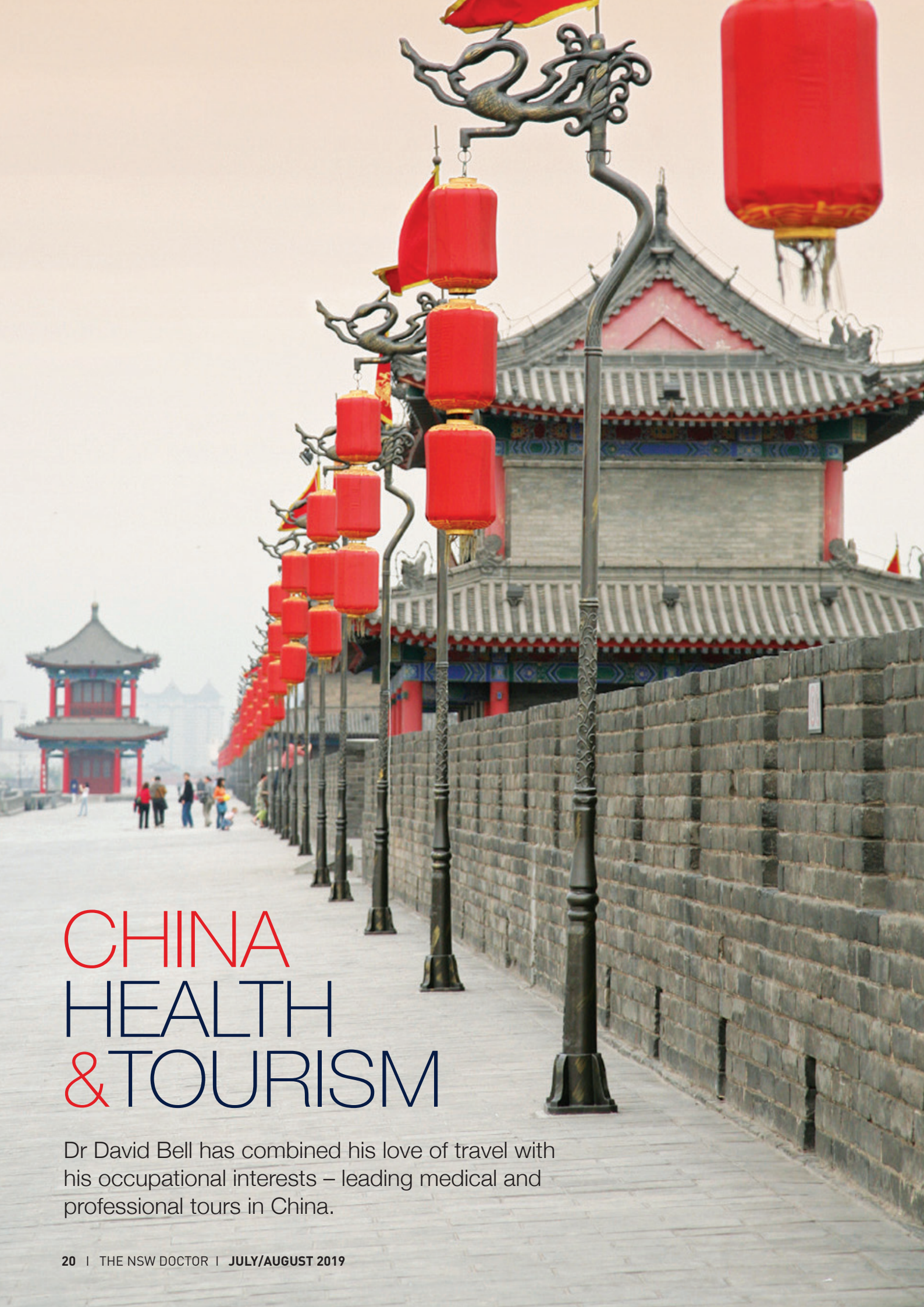
I am currently working towards securing a place on the orthopaedic training program. If I am able to secure a position and finish training I would like to return to regional practice.

CAREERS SERVICE

I met Careers Service's Anita Fletcher at a professional function, and she introduced me to her work as a career adviser. My CV was reviewed, and recommendations were made for improvements. Anita was also proactive in helping me meet leaders in my field, which has been a great professional learning experience.

LIFE ADVICE

My advice to other doctors would be to choose a speciality that you truly enjoy and to create a good work-life balance. We might have certain skills that make us suitable for particular types of work, but this may not be what we really want to do. My advice is to find something you are motivated to do from a clinical, personal or academic perspective. dr.



CHINA HEALTH &TOURISM

Dr David Bell has combined his love of travel with his occupational interests – leading medical and professional tours in China.

FOR MANY Australians travelling to China, their bucket list of places to see might include the Great Wall, the Xian Terracotta Warriors, the Forbidden Palace, or possibly a giant panda sanctuary.

But for some doctors, the desire to visit cultural landmarks is matched by their professional curiosity.

Dr David Bell has done two tours to China as a medical tour leader – taking doctors, nurses and other medical professionals to visit not only the well-known wonders of China, but a behind-the-scenes look at how medicine is done in one of the largest countries in the world.

As a senior medical oncologist at the Northern Cancer Institute in Sydney, with responsibility for the medical oncology unit, Dr Bell is particularly interested in how China treats oncology patients as well as palliative care, and the relationship between traditional Chinese medicine and Western medicine.

During his two-week tour, Dr Bell leads the group to a variety of medical institutions – from world-class teaching hospitals, to traditional Chinese medicine practices, as well as small regional medical facilities, and both traditional and Western pharmacies. Participants have a chance to speak with oncologists, palliative care specialists, researchers, and in more provincial locations – barefoot doctors.

China's economic growth over the last three decades has been meteoric. It has grown from a farming nation into the world's second-largest economy – and socialised medicine has improved healthcare outcomes for its citizens. Life expectancy has risen to 76, and maternal mortality rates have dropped to 19.6 per 100,000 in 2017.

Despite these achievements, the health system is ill-equipped to deal with its burgeoning population. With 1.3bn people, China is the most populous

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country in the world. Dr Bell said the sheer volume of people needing treatment at any one time was staggering.

"Seeing the absolute magnitude of China in terms of the volumes of people – everywhere you look, buildings and concrete and road, cars and smoke, and masses of people – it's a bit overwhelming at times.

"In Beijing hospitals there would be huge line-ups of patients, with many waiting eight hours to have a consultation – just the huge volume of people coming through was extraordinary."

Dr Bell said it was not uncommon to see some avoid queuing by paying someone else to stand in line for them.

The system has a mix of public and private care, but there are is huge inequality in care standards. While the wealthy have access to first-class care in top hospitals, poorer people are subjected to overcrowded hospitals. In small regional areas, sometimes there isn't a doctor there at all.

"There's really the top hospitals, and we actually got a look inside the international hospital which was just fabulous, all the way down to somebody who's had little medical training that's just in a room with a couch and a few medications. It's very diverse," Dr Bell said. "Some of the care is really, really good. There's a lot in the middle and there's a lot still lagging behind."

Dr Bell described their visit to a regional town that had one so-called 'barefoot doctor'.

"The 'barefoot doctor' – who had been trained for two years and would be what we'd call in Australia a 'nursing aide' to provide medical care for approximately 20,000 people. Families would pay something equivalent to $20 a year, and this particular person would do pap smears, vaccination, minor things, and hand out medicines like Panadol and Nurofen."

The integration between traditional medicine and Western medicine is fascinating, he added.

"There often is a variation in the way they approach patients and it's interesting to see the balancing act the country is doing between their traditional approaches and Western medicine."

He said it was not uncommon for Western hospitals to have a small department of traditional medicine as well.

In his experience, older generations of Chinese patients tended to frequent more traditional medical centres. Treatment at these facilities was also available more cheaply.

As tour leader, Dr Bell facilitated discussions during the hospital and medical facility tours, and also conducted de-brief sessions on the tour bus with participants.

While the first tour was mostly participants from Australia, the last one had several doctors from various countries around the world, which made for a richer discussion and more varied perspectives.

The main thing people come away with, he said, is "insight into how other people approach the sort of problems I'm approaching here with Australian patients.

"Their approach to breast cancer, their approach to lung cancer, their access to some of the newer drugs is sometimes surprisingly good and sometimes ahead of Australia… in China if you want something medically and you've got money, you can get it.

"So that was a bit of an eye-opener – that they had access to medicines and treatments before we did in Australia. I think it was looking at that and then looking at the barefoot doctor and seeing they've only got Panadol and Nurofen and that's how you care for 20,000 people – just that variation in treatment is very interesting."

Despite having travelled to China several times, Dr Bell is looking forward to leading his third tour next year. dr.

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[1] Check-ups limited to an examination, fluoride and a scale and clean where the fees are within the range of the usual, customary and reasonable charges.

DHF 271_7/19

VMO PERFORMANCE REVIEWS

Not sure what to expect from your performance review? Andrew Campbell explains the Level 1 and Level 2 review process.

Andrew Campbell
MANAGER
INDUSTRIAL RELATIONS

WHILE annual performance reviews for specialist VMOs don't always occur, Local Health Districts (LHDs) are required to arrange them. With the exception of the penultimate year of the appointment, the reviews are conducted as Level 1 reviews. A Level 1 review requires the VMO to complete the review form and provide this to the reviewer, who would typically be the Department Director. If the performance is assessed to be satisfactory, there should be no need for an interview. If the reviewer requires further clarification on any matters arising during the process, further action such as an interview may be needed.

Level 2 reviews occur in the penultimate year of a VMO's contract. Firstly, a Level 1 review process is completed. Following this, an interview is convened between the VMO and at least two reviewers. The reviewers would ordinarily include the VMO's direct supervisor and the local DMS or equivalent. As part of the review process, the VMO is required to nominate three referees. The reviewers may also seek feedback from medical students and JMOs regarding the teaching and supervision provided by the VMO.

Performance reviews should not be used as an opportunity by the LHD to discuss ordinary hours or the services plan, nor should they be used to raise formal grievances lodged by colleagues. There are separate policy directives in place to deal with these scenarios. For example, if a VMO's colleague has raised a grievance with the Department Director regarding a VMO, the Director should convene a meeting with the VMO to discuss the grievance under the applicable policy directive.

Following each type of performance review, a copy of the completed and signed form should be returned to the VMO for his or her records. Where concerns arise regarding a VMO's performance as a result of a review, action may be taken by the LHD. For example, if it appears that the clinical privileges of the VMO should be changed, the matter may be referred to MDAAC.

When it is time for contract renewal, the LHD has discretion to reappoint a specialist VMO to the same role without advertisement following a successful Level 2 review.

For further information please see NSW Health Policy Directive PD2011_010 or contact Andrew Campbell at 02 9439 8822.

Delayed VMoney claims and the Superannuation Contributions Cap

IT WAS brought to AMA (NSW)'s attention that there is a discrepancy between the NSW Health Superannuation for Sessional VMOs Policy Directive (PD2016_033) and the ATO's superannuation contribution cap. As background, while Sessional VMOs are not employees in the common law sense, they are employees for superannuation purposes by operation of a 2005 ATO ruling. This means that superannuation should be paid on top of ordinary earnings up to the contribution cap ($54,030 per quarter for the 2018/19 financial year).

The Policy Directive states that superannuation is not payable in respect of remuneration paid to a VMO which exceeds the quarterly contribution cap. This is not correct. The contribution cap relates to earnings in a particular quarter rather than payments in a particular quarter. This drafting issue could lead to underpayment of VMOs in cases when a backlog of monthly claims are submitted together. We have flagged the matter with NSW Health.

AMA (NSW) encourages VMOs to submit monthly claims within the 15-day timeframe suggested in the Determination. However, we understand that this is not always possible. It's important to note that after 12 months the LHD may give written notice to the VMO that 50% of the claim will be discounted. The VMO has four weeks to remedy the issue (or seek further exemption due to extenuating circumstances). After 24 months, an entire monthly claim may not be paid.

Should you have any questions regarding superannuation please contact our referral accounting partners Cutcher & Neale at 02 9923 1817.

EMPLOYING NEW STAFF

Here's your guide to recruiting and retaining the right staff for your practice.

Lisa Bennell
HR ADVISOR
PROFESSIONAL SERVICES

MANAGING a medical practice, like any small business, takes time and effort. When things go wrong it can take your attention away from your core role and what you do best – the practise of medicine. It makes sense to get it right from the outset, especially when you are looking to recruit suitable people to help you run your practice.

Here are some practical, yet simple, steps to help you with the recruitment process.

POSITION DESCRIPTION

What job do you want the person to do? What tasks will they need to undertake? What are the key responsibilities? What skills and abilities do they need to perform the role? What qualifications or experience is required? If it is an existing role, is the old position description outdated and in need of updating?

Consider the type of employment you require for this role. That is, whether it is a full-time, part-time, or casual position. What hours are needed to perform the role? Do you need the employee to work on an ongoing, temporary, or as needed basis?

At this point, you should also identify the correct classification for the role under any applicable Modern Award (or enterprise agreement). In the Health Professionals and Support Services Award 2010 and Nurses Award 2010 the classification definitions are set out in Schedule B. The classification will determine the minimum rate of pay for the role. Selecting the correct classification and meeting the minimum rate of pay is ultimately your (the employer's) responsibility.

ADVERTISING

How do you intend to attract candidates to your role? A popular form of advertising is via online employment sites, such as Seek, Indeed and CareerOne, to name a few. These sites allow you to upload your own text for a digital advertisement and in some cases manage responses from candidates. You may also like to consider other means of advertising, such as the local newspaper, community notice boards, personal referral or head hunting.

When advertising your role, use the position description to help outline the requirements of the role including your expectations of previous experience and the nature of employment (full time, part time or casual).

INTERVIEWING

Once you have a shortlist of potential candidates, we recommend you conduct interviews with each applicant to assess their suitability for the role. Prepare for the interview by scripting a set of questions to get a sense of their skills/abilities, past experience and whether they would be a good fit for your business. The same set of questions should be asked of all candidates to ensure equity in your recruitment process. Take care not to ask any questions that may be considered discriminatory. Your questions should focus on the requirements of the role. You may like to review our recent article in the May/June edition of *The NSW Doctor*, 'Avoiding Discrimination in Job Interviews'.

REFERENCE CHECKING

Prior to making an offer of employment, you may wish to check the references of your preferred candidate. Generally speaking, a verbal reference is preferable to a written one. A verbal reference allows you to ask questions of the candidate's previous employer that relate specifically to the role you are recruiting for. Again, it is a good idea to develop a script or standard set of questions when conducting a reference check. Don't be afraid to ask questions about skill level, areas for improvement or particular points of concern; however, be mindful that questions relate to the applicant's ability to do the job and not their personal characteristics.

OFFER OF EMPLOYMENT

Although there is no legal obligation to have a written contract of employment, having one in place is likely to minimise any future disagreement between you and your employee. An employment contract will usually set out the terms and conditions of the employment offer, including the type of employment (permanent, casual, fixed term etc), hours of work, rate of pay, as well as the Modern Award that the employee is covered by. AMA (NSW) provides template contracts of employment for

members, which can be accessed by logging onto the AMA (NSW) website. (If you need any assistance with the template contracts, contact the Professional Services team on professionalservices@amansw.com.au).

Make sure your employee returns a signed copy of the employment contract, ideally before their commencement date, and keep the copy for future reference.

FAIR WORK INFORMATION STATEMENT

All new employees must be provided with a copy of the Fair Work Information Statement before (or as soon as possible after) they start their new job. This statement provides employees with information about conditions of employment, including the National Employment Standards (NES), Modern Awards, right to request flexible work arrangements, freedom of association and workplace rights, as well as the role of the Fair Work Ombudsman and Fair Work Commission. You can read further information about the statement and access a copy on the Fair Work Ombudsman's website.

INDUCTION

Set your new employee up for success by providing a thorough induction. Before commencement pre-arrange access to IT systems and order any new equipment required. Welcome them with a tour of your office space ensuring you meet your Work Health and Safety obligations along the way. Introduce them to other employees and familiarise them with any policies or procedures applicable to your practice.

It's a good idea to prepare an induction checklist and/or training schedule, which can be shared with the employee – there's a lot to remember in those first few weeks. A proper induction will also give you the chance to give an overview of your business and explain your expectations of the role. It's also a good opportunity for new employees to ask questions. An employee who feels included and well informed is more likely to be engaged in the business.

REVIEW

Don't set and forget! Meet with new employees on a regular basis. Check in on how they are going. Do they need any additional resources or training? Are they settling in ok? Ensure they are aware of your expectations. Are those expectations being met? Don't wait to raise concerns. These are best raised quickly during the probation or minimum employment period. When you meet with an employee, make a point of setting a time for a follow up whether it be in the form of a formal meeting or a casual catch up.

SUMMARY

You would be surprised by how many workplace issues could have been avoided if only employers had taken the time to get it right up front. It is sensible to invest some time and effort at the outset to increase your chances of employing the right people in the right roles – after all, these people are often the face of your practice and the backbone of your business.

Looking for additional resources? The Fair Work Ombudsman website provides various resources including best practice guides to hiring new employees plus templates for job advertisements, conducting reference checks and induction checklists. https://www.fairwork.gov.au/ dr.

Disclaimer: *The views and information provided in these articles 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.

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Professional Services offers training and education to doctors on a range of relevant topics. These education sessions are free for members* and $300 for non-members.

EMPLOYER ESSENTIALS

- 9 August 2019 - Penrith
- 13 September 2019 - St George / Sutherland
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✔ Key risks for practice principals under the Fair Work Act, including personal liability

✔ Key strategies for managing those risks, including identifying the key compliance obligations under the Fair Work Act;

✔ Compliance with the two key Modern Awards that apply to employed practice staff; and

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LEXUS
EXPERIENCE AMAZING

MINIMUM WAGES INCREASED BY 3%

The Fair Work Commission (FWC) handed down its annual wage review decision which increased the National Minimum Wage and all Modern Award minimum wages by 3% effective from the first full pay period on or after 1 July 2019.

Lyndall Humphries
SENIOR ADVISOR (EMPLOYMENT LAW) PROFESSIONAL SERVICES

THE FAIR WORK COMMISSION'S recent annual wage review decision affects minimum wages in all Modern Awards, including the two awards that apply to most employees in private medical practices, the Health Professionals and Support Services Award 2010 and the Nurses Award 2010.

Q. Where can I access Modern Award minimum wages?
A. AMA (NSW) prepares Quick Reference Rates Sheets to help members quickly identify Modern Award minimum rates payable to practice staff. These are available for our members to download on the Employer Quick Links page of our website (amansw.com.au). The Fair Work Ombudsman (FWO) also publishes pay guides for all Modern Awards which are available on the FWO website (https://www.fairwork.gov.au).

Q. Who is affected?
A. The increase will affect all private sector employees whose minimum pay rates are set by a Modern Award. This includes most practice nurses, health professionals and support/administration staff in private practices. Some doctors who are employed in the private sector (e.g. private hospitals) may also receive an increase. However, the increase won't affect independent contractors or public sector employees.

Q. What do I have to do?
A. If you employ Award covered staff, you need to check that their pay rates will meet the new Modern Award minimum rates from the first pay period on or after 1 July 2019. If you are not already paying enough to cover the increase, you will have to increase your employee pay rates.

Q. Is it just the base rate that changes?
A. No. Some allowances payable under the Modern Awards will also change as a consequence of this decision. Other allowances will increase by CPI. Further information about changes to allowances will be made available from FWO.

Q. What if I already pay above award?
A. The awards provide "safety net" conditions that underpin your individual contractual agreements with particular employees. So, if you already pay staff above the new Modern Award minimum wages, you may not need to increase their pay at this time.

Q. How are other agreements affected?
A. If you have other agreements in your practice (e.g. Individual Flexibility Agreements, Enterprise Agreements) you will need to ensure affected employees remain "better off overall" when compared to the new Modern Award minimum rates. Likewise, the high income threshold will also change in July 2019, so if you have issued anyone with a formal Guarantee of Annual Earnings under s.330 of the Fair Work Act, you will need to ensure that the guaranteed amount still exceeds the new high income threshold. Where other agreements are affected, you may wish to seek specific advice.

Q. Need help?
A. If you have any questions or would like assistance, please contact our Professional Services team by emailing professionalservices@amansw.com.au. You can read more about the services offered by our Professional Services team on amansw.com.au/professional-services/. dr.

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SHARED DEBT

The Shared Debt Recovery Scheme acknowledges the responsibility of both medical practitioners and the organisation they work under to ensure claims submitted to Medicare are not false or misleading.

Dominique Egan
PRINCIPAL
MERIDIAN LAWYERS

THE SHARED DEBT Recovery Scheme (the Scheme) commences on 1 July 2019 and applies to services provided from 1 July 2018. The Scheme enables the Commonwealth Government to recover repayment of Medicare compliance debts from both a medical practitioner and another party (such as a medical practice), as a result of incorrectly claimed Medicare benefits. The Government will do so by making a shared debt determination.

The Scheme recognises that Medicare billing may be delegated to others and administered through a billing process influenced by organisational policies. In some cases, this may contribute to incorrect claiming of Medicare benefits. Medical practitioners remain responsible for services billed under their provider number. At the same time, this Scheme acknowledges that organisations undertaking billing on behalf of medical practitioners also have an obligation to ensure that claims submitted to Medicare are not false or misleading based on the information available to them.

The Scheme applies in relation to the Medicare compliance audit process. If a medical practitioner under audit informs the Department that they are in an employment, contractual or other relevant relationship with another party and requests consideration of a shared debt, the Department will contact the other party. Documents may be sought from both parties in relation to the debt, the contractual arrangement and other documents relevant to determining whether to share a potential debt. Before making a shared debt determination, the Department will provide written notice to each party that it is considering making a shared debt determination, including the amount of the debt, the proportion of the debt that will be recovered from each party and the reasons, and share any documents provided in relation to the debt. Each party can make submissions in reply before the Department makes its decision.

In order for a shared debt determination to be made, the following three criteria must apply:

- There is a debt recoverable as a result of the making of a false or misleading statement;
- There is a relationship between the medical practitioner and the organisation; and
- The organisation could have controlled or influenced the making of the false or misleading statement, obtained a direct or indirect financial benefit from the making of the false or misleading statement, and/or there are other factors that make it fair and reasonable for a shared debt determination to be made.

The Scheme does not apply in the following circumstances:

- claims adjustments that occur routinely as part of medical practice, where a medical practitioner alerts the Department of Human Services to an error to correct the claims record;
- a voluntary acknowledgement by a practitioner of incorrect payments such as after receiving a letter asking them to review their billing or following a targeted campaign;
- debts arising as a result of inappropriate practice following referral to the Professional Services Review;
- debts arising as a result of a false or misleading statement which can be shown to have been made by someone other than the medical practitioner; or
- debts arising where one party has, without knowledge of the other, engaged in fraudulent conduct in relation to Medicare claims or billing.

How will debts be apportioned?

The Department has prescribed a default percentage that may be applied: 65% to the medical practitioner and 35% to the medical practice or other organisation. That said, the Department will consider whether in the circumstances it would be fair and reasonable to set a different percentage based on:

- the arrangements between the parties for apportioning the benefits paid;
- the proportion of the benefits paid for the services were received by medical practitioner and the organisation; and
- the influence or control the organisation may have had over the billing for the services under audit.

The Department is not bound to any terms or conditions in a contract between the medical practitioner and the organisation where they are providing the services including those that would seek to indemnify either party.

What should I do now?

Understand your obligations:

- Review your contractual arrangements;
- Regularly review claims submitted on your behalf by any third party; and
- If you are contacted by the Department, seek professional advice.

COALITION PROMISES

In the wake of the election, Cutcher & Neale's Stuart Chan explains how the Coalition's promises will affect you.

Stuart Chan
PARTNER - SPECIALIST MEDICAL SERVICES, CUTCHER & NEALE

THE COALITION are providing tax breaks for more than 10 million Australians by simplifying the current system and removing the 37% tax bracket entirely.

In the process, the Coalition are planning to increase the 19% tax rate to $45,000 (previously $37,000) and they have also proposed reducing the 32.5% to 30% resulting in a flat 30% for anyone earning between $45,000 and $200,000.

Those earning $200,000 a year will get a tax cut worth $11,640. See the below graph of what the proposed tax rates may look like.

Instant Asset Write-off

As part of the 2019 budget, businesses with a turnover of under $50 million but more than $10 million can write-off assets against their taxable income. Previously, businesses turning over more than $10 million were excluded from the scheme.

The Coalition also increased the threshold from $25,000 to $30,000, as of 2 April 2019. This is a significant increase in threshold from 2017, which gave a $20,000 instant write-off amount.

Medicare

The Coalition have promised to lift the Medicare rebate freeze. This means Medicare payments to medical practitioners will increase to reflect rising costs associated with public care.

The Federal Budget contained a $1 billion funding boost, including $448.5 million for GPs to better treat patients with chronic diseases, and investments in mental health. It will add 30 new Headspace Centres, build new residential eating disorder treatment facilities nationally, and take new measures to prevent Indigenous youth suicide.

First Home Buyers Scheme

The Coalition recently announced a First Home Buyers Scheme which allowed first home buyers to only supply a 5% deposit and the government would make up the remaining 15%.

This would result in first home buyers saving up to $10,000 by not having to pay lenders mortgage insurance. The scheme is limited to the first 10,000 homebuyers and for single people earning up to $125,000 or couples earning up to $200,000. This could offer an opportunity for the next generation of young Australians looking to purchase their first home. Keep in mind this does not limit itself to young Australians but anyone who has yet purchased their first home.

Key tax policies that are still intact

- You are still eligible to negatively gear
- Individuals and trusts will still benefit from the 50% CGT discount for assets held greater than 12 months
- Franking credits will still be refundable for individuals and super funds
- Tax deductions are still eligible to be claimed on managing your tax affairs
- The non-concessional contributions cap stays at $100,000 and will not be reduced to $75,000
- The threshold for imposing an additional 15% tax on concessional contributions of high-income earners will remain at $250,000 and will not be reduced to $200,000
- Catch up concessional contributions are still allowed for individuals with a total superannuation balance of less than $500,000
- Tax deductions are still allowed for your personal super contributions
- A SMSF can still utilise their fund to organise borrowing arrangement to acquire property
- There will not be a standard minimum tax rate of 30% imposed on family trust distributions

Should you have any questions or want further information, please do not hesitate to contact Cutcher & Neale on 1800 988 522 or medical@cutcher.com.au

PROPOSED TAX RATES FROM 1 JULY 2024

Taxable income	Rate	Tax payable	
$0 - $18,200	0%	Nil	
$18,201 - $45,000	19%	Nil	+19% of excess over $18,200
$45,001 - $200,000	30.0%	$5,092	+30.0% of excess over $41,000
$200,000+	45%	$51,592	+45% of excess over $200,000

NEWS IN BRIEF

Study author, Dr Karen D'Souza with medical student

Rural medical students match **performance** with **urban** peers

DESPITE ENTERING postgraduate courses with lower grades, rural medical students are proving they are just as capable as students from metropolitan areas, according to new study.

The Deakin University study looked at 150 medical graduates, including a quarter from a rural background and found no substantial difference in the academic results between the two groups.

Study co-author Dr Karen D'Souza said the results affirmed that special rural entry bonuses worked.

"We really need more rural doctors, and to do that we have to get more people from a rural background into medicine," she said. "But the selection processes to medical school are highly competitive, with applicants far exceeding the number of places available, potentially disadvantaging rural applicants."

Students from a regional or rural area, or from a disadvantaged background are able to receive bonuses to their GPA and GAMSAT scores when they apply.

Dr D'Souza added that rural students can often be the first in their family to go to university – living out of home and work while completing their first degree. These factors can contribute to a slightly lower GPA. In addition, they're more likely to be financially disadvantaged. dr.

Payment for protheses for NSW workers compensation patients

THE STATE Insurance Regulatory Authority (SIRA) advises from 1 January 2019, all surgical prostheses utilised as part of a surgical procedure in a private hospital must be invoiced using payment classification code PTH009. The expectation is that private hospitals will invoice for prostheses, not the attending surgeon. dr.

Casual vacancies on AMA (NSW) Council

THERE is one unfilled vacancy in the South Zone Class. In accordance with Clause 40.1 of the Constitution, any casual vacancy in the Council may be filled by the Council by appointment. If there is more than one candidate for the position, the Council shall elect, by simple majority, one of the candidates to be appointed to the vacant office. Council is entitled to fill these positions following expressions of interest from a member. If you are interested in pursuing either of these positions, please email Ms Fiona Davies with your CV, at enquiries@amansw.com.au. dr.

In memory: Dr Gregory Rowell

THE MEDICAL community mourns the loss of Dr Gregory William Rowell, who passed away in April aged 59 after a long illness, leaving his wife Kathy and children Stephanie, Galen and Samuel.

Dr Rowell worked as a VMO general paediatrician at Royal Prince Alfred Hospital and Children's Hospital at Westmead and private practice in Stanmore. He trained at the University of Sydney and in paediatrics at Royal Alexandria Hospital for Children where he was chief resident. Dr Rowell was involved in the RACP and served the College in several capacities.

He is remembered for his dedication as a general paediatrician and for his contribution to the profession. As AMA (NSW)'s Physical Craft Group representative, he served as a delegate on several occasions to the AMA National Conference. He also held two Chair positions on the Paediatric Self-Assessment Program Committee and the Paediatric Chair of the NSW/ACT Regional Committee.

In addition, Dr Rowell was an active member of various Committees including the Social Issues Committee, Board of the Continuing Professional Development Committee, Paediatric & Child Health Division Education Committee, the Paediatric Chairs of State, the Regional Committee and the Accreditation Expert Advisory Group.

He was tremendously respected by colleagues for his commitment to patients, his extensive medical knowledge, and keen intellect. He had a passion for politics, music and motor vehicles.

He will be sadly missed by family, friends, colleagues and patients. dr.

Young ophthalmologist **wins prestigious** award

DEDICATED ophthalmologist Dr Chameen Samarawickrama was named one of ABC's Top Five Young Scientists of the Year.

Dr Samarawickrama currently delivers care at both Westmead Hospital and Liverpool Hospital, and was recognised for his work teaching the next generation of doctors, as a senior lecturer at both the University of Sydney and the University of New South Wales. He sits on the Board of the Ophthalmic Research Institute of Australia (ORIA). Dr Samarawickrama is an active and committed member of RANZCO and is Chair of RANZCO's Younger Fellows' Advisory Group.

Dr Samarawickrama is an avid promoter of research in delivering better care and better outcomes for patients.

"I believe that science is the bedrock of excellent patient care and the future of medical innovation, while scientific communication is essential to help patients understand their diseases and the treatments available to them. In ophthalmology this means being better able to help people to keep their sight, their wellbeing and, often, their independence," Dr Chameen Samarawickrama said. dr.

RANZCP RELEASES NEW GUIDELINES ON DIGITAL THERAPY

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed new guidelines on digital therapy, and up-to-date advice on treatment of three common adult anxiety disorders.

Associate Professor Lisa Lampe, a member of the RANZCP Anxiety Disorders Working Group said, "Guided therapy involves providing support for the person as they complete digital therapy modules. It has been known for some time that digital therapy can have high dropout rates; people start the therapy and do not finish. "We know the treatments work if people complete them, but have needed to better understand how to get more people finishing the treatments they start."

She added that digital cognitive-behavioural therapy (eCBT) for the treatment of anxiety disorders is most effective as a collaborative treatment undertaken with the support of a health professional, including the patient's general practitioner, psychologist or psychiatrist. dr.

2019 HOSPITAL HEALTH CHECK SURVEY

WE'RE ACHIEVING REAL CHANGE

The story so far

AMA (NSW)/ASMOF (NSW) Alliance used the **results from the 2017 and 2018 Hospital Health Check** in NSW to achieve real change for doctors-in-training. Your feedback convinced NSW Health to:

- ✔ Remove barriers to claiming overtime
- ✔ Limit rostered shifts to a maximum 14 hours
- ✔ Provide minimum 10-hour breaks between rostered shifts
- ✔ Review rosters and unsafe working hours
- ✔ Work harder to eliminate discrimination in recruitment
- ✔ Review parental leave policies

But there is still more work to do. The 2019 HHC will progress this effective advocacy campaign with updated questions about unpaid overtime, discrimination at work and other things that you shouldn't have to put up with.

Take the Hospital Health Check and be part of the change that improves working conditions for all NSW doctors-in-training.

What's in it for me?

Apart from having your voice heard and helping us change your workplace and conditions for the better, there are **4 x $250 Visa card vouchers up for grabs.**

Take the survey that matters

alliancensw.com.au/hospitalhealthcheck

AMA NEW SOUTH WALES

asmof nsw The Doctors' Union

QUEEN'S BIRTHDAY **HONOURS**

MEMBER (AM) IN THE GENERAL DIVISION

Dr Jonathan CLARK
Camperdown NSW
For significant service to medicine as a head and neck surgeon.

Professor Alan James COOPER OAM
Neutral Bay NSW
For significant service to medicine as a dermatologist and researcher.

Dr Michael HOLLANDS
Castlecrag NSW
For significant service to medical education and professional standards, and as a surgeon.

Professor Constance KATELARIS
Epping NSW
For significant service to medicine in the field of immunology and allergy.

MEDAL (OAM) IN THE GENERAL DIVISION

Dr Michael Thomas BIGGS
Milsons Point NSW
For service to medicine as a neurosurgeon.

Dr Geraldine Frances DUNCAN
Wagga Wagga NSW
For service to rural medicine.

Dr John ENGLAND
Katoomba NSW
For service to medicine as a cardiologist.

Dr Frank FISHER
Mosman NSW 2088
For service to community health.

Dr David McDONALD
East Tamworth NSW
For service to medicine as a paediatrician.

Dr William NARDI
Lismore NSW
For service to medicine in the field of ophthalmology.

Dr Gregory O'SULLIVAN
Clovelly NSW
For service to medicine in the field of anaesthesiology.

Dr George WILLIAMS
Menai NSW
For service to medicine in the field of paediatrics and developmental disability. dr.

Anyone can nominate an Australian for an award in the Order of Australia. If you know someone worthy, nominate them now at www.gg.gov.au

AMA NAT CON 2019: GP REGISTRARS

MORE THAN 200 delegates, observers and media gathered in Brisbane for AMA's three-day National Conference to discuss policy and the organisation's strategic direction for the next 12 months.

AMA (NSW) Vice President, Dr Danielle McMullen spoke during the policy sessions on 25 May and called on delegates to consider how working arrangements for GP registrars could be improved to achieve fair and equitable employment conditions that meet the needs of registrars and supervisors alike.

Dr McMullen argued GP registrars experience a lack of parity in remuneration compared to their non-GP registrar counterparts and are disadvantaged by an inability to transfer leave and other entitlements as they progress through training.

"This year, for the second year running, general practice specialty training was undersubscribed – doctors are turning their noses up at this rewarding and important career pathway. One of the contributing factors, we think, is the inequity in training contracts between general practice and other specialties. To continue providing safe, high quality GP training, something needs to change," she said.

Dr McMullen pointed out GP registrars are required to actively seek a new job every six months, for two to three years. In addition, they must renegotiate a contract every six months.

After substantial debate, delegates at the AMA National Conference voted to lobby Government to adopt a single employer model as an alternative to fee for service arrangements for GP registrars.

The motion reads: That our AMA recommends the Government develop a single employer model as an alternative to fee for service arrangements to deliver equitable remuneration and employment conditions for GP registrars, and between GP registrars, while at the same time meeting the needs of supervising practices. dr.


Dr Danielle McMullen

AMA (NSW) Exclusive Member Benefits

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Health Insurance

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AMA Training Services

AMA Training Services offers HLT57715 Diploma of Practice Management for current and aspiring practice managers. Receive the member discount for yourself or nominated staff off the first ASP term, valued at $500. Three scholarships valued at up to $2,000 each are available for current and future students.

Accor Plus

Members are able to purchase Accor Plus membership at a discounted price. As an Accor Plus member, you will enjoy a complimentary night stay at participating AccorHotels each year and up to 50% savings on rooms and food bills.

Audi

AMA members are now eligible for the Audi Corporate Program, which gives members a range of privileges, including AudiCare A+ for the duration of the new car warranty, complimentary scheduled servicing for three years or 45,000km, and much more.

Alfa Romeo and Jeep

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BMW

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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.

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Receive exclusive rates and benefits when you rent with Hertz in Australia (terms and conditions apply). Weekdays – 10% off the best rate of the day; Weekends – 15% off the best rate of the day; 5+ Days – 15% off the best rate of the day; Prestige Collection – 15% off the best rate of the day.

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Make it Cheaper can run a free energy bill comparison for you and help you find a competitive deal and save. Call 02 8077 0196 or email amansw@makeitcheaper.com.au for a free quote.

Mainly Mobile/Optus

Mainly Mobiles Communications has teamed up with Optus to provide AMA (NSW) members with a great offer: new Optus mobile customers will receive a 10% discount on their new 24-month mobile handset plan; existing Optus mobile customers will receive a 5% discount on their new 24-month mobile handset plan.

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Medical Staff specialises in the recruitment and placement of Nursing Staff, Locum Doctors and Allied Health Professionals in Private and Public Hospitals, Aged Care Facilities, Retirement Villages, Private Clinics, Universities, Schools, Medical Surgeries and Home care services including personal care and domestic help.

Mercedes-Benz

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Nespresso

Receive 10% off Nespresso Professional Zenius Machine, cost $674.10 (Save $74.90), and a complimentary bundle of accessories worth $251, including a Aeroccino4 milk frother, Nespresso Coffee&Co Coffee Dispenser, and a dozen Cappuccino cups and saucers. Valid ABN and business name required to redeem offer.

Nungar Trading Company

Members will receive free Australia-wide shipping or a free tin of Stockman's polish when you purchase a pair of R. M. Williams Comfort Craftsman, Dynamic Flex, Adelaide or Sydney Boots at $430 (RRP $595).Standard sizing. Option of leather sole POA. International Postage POA. Order on www.nungar.com.au and mention this offer in the comments box.

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AMA NEW SOUTH WALES

For more information and assistance please call one of our member services team on 02 9439 8822 or email members@amansw.com.au. Visit our websites www.amansw.com.au or www.ama.com.au

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Dr Andrew Foote
Dr Nalini Thayaparan
Dr Nastasha Polites
Dr Anthony Johnson
Dr Mathew George
Dr Kumar Muthiah
Dr Kenneth Cho
Dr Katherine Ellenberger
Dr Angelique Brescia
Dr Ann-Maree Kurzydlo
Dr Sanjeev Vijayan
Dr Melanie Stevenson
Dr Adam Najem
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Dr Anosh Sivashanmugarajah
Dr Phillip Denning
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Dr Saurabh Gupta
Dr Monier Cosman
Dr Theodore Aroney
Dr Connie Li
Dr Shahnawaz Khan

Dr Quang Ngo
Dr Ritam Prasad
Dr Hayden Lee
Dr Jennifer Ogiji

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

Dr Paul Falk
Dr Alwyne Coster
Dr Janet Anderson
Dr Paul Gan
Dr Nicholas Blair
Dr John Roarty
Dr Gregory Rowell
Dr David Smith

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