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THE NSW doctor

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AMA NEW SOUTH WALES

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RESPONDING TO CRISIS

Climate change is impacting our health system. If we are going to respond to 21st century problems, then we need to employ 21st century solutions.

Dr Kean-Seng Lim
PRESIDENT
AMA (NSW)

AS I WRITE THIS, Sydney is facing its worst day on record for smoke haze. People are being urged to stay inside and keep their windows and doors closed. Schools have cancelled outdoor activities, sporting groups have cancelled games, and workers have been forced to abandon work sites.

Air pollution is reaching unprecedented levels in the city. Across the whole Sydney basin, ultra-fine particle pollution was at 'hazardous' levels. This presents major health challenges for people with asthma and other pulmonary or cardiac conditions.

While the Federal Government continues to deny there is a direct link between greenhouse gas emissions and the fires that have ravaged the nation, the NSW Environment Minister Matt Kean was uncategorical about the weather conditions, telling attendees at the Smart Energy Summit in Sydney that this is "exactly what the scientists have warned us would happen."

He added, "This is not normal and doing nothing is not a solution."

FROM BAD TO WORSE

Experts are predicting that – unless we receive substantial rain – the 'mega-fire' on Sydney's north-western outskirts will likely burn until the end of January or early February.

January is typically one of the hottest months of the year in Australia, and January 2019 was the country's hottest month on record, since record-keeping began in 1910.

What does all this mean for the health of Australians?

There is robust evidence to show hot weather increases mortality in Australia, with air pollution exacerbating this relationship.

Extreme heat conditions are associated with substantial increases in hospital admissions and deaths. There were 374 excess deaths during the 2009 Victorian heatwave, which represented a 62% increase in all cause mortality. Additionally, there was a 46% increase in ambulance emergency cases over the three hottest days; and a 34-fold increase of cases with direct heat-related conditions.

Projected increases in heatwaves will result in increased heat-related deaths and hospital admissions. Without strong mitigation, temperature-related deaths are expected to rise by 14% and 100% in 2050 and 2100, respectively.

IMPACT ON HOSPITALS

Can our hospitals handle the expected increases from a heatwave? The latest Hospital Quarterly report from the BHI shows a health system that is already under immense pressure.

The July to September quarter was the second time in 2019 that NSW public hospitals set an all-time record for the number of emergency department presentations. To better illustrate this, picture the entire population of Brisbane presenting to our ED departments from January to September.

Quarter on quarter, we are consistently seeing presentations to emergency departments climb over 750,000. There are no 'horror flu seasons' to blame this on. This is the consequence of an aging population that is increasingly dealing with complex, chronic conditions. And it will only be exacerbated by health effects of heat waves and air pollution.

Funding for hospitals is always a necessity, but stop-gap measures are only helpful in the short-term. If we are to reduce the demand on our hospitals, we need a better understanding of how patients in NSW use the different services in the health system. Once we have a clear picture of the patient journey we can take steps to minimise potentially preventable hospitalisations.

GOING FORWARD

If we are to tackle the future healthcare challenges, then we must work smarter. Innovative strategies that integrate the health system and make better use of data will help us achieve that aim. dr.

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WHAT HAPPENS WHEN STEPHEN DUCKETT HAS A BAD DAY?

Once again Stephen Duckett wheels out another tired 'greedy doctor' headline. But focusing on the fees of a minority of medical professionals does little to lift the discussion about health.

Fiona Davies
CEO
AMA (NSW)

THE ANSWER is nothing. When Stephen Duckett has a hard day at the think tank there are few consequences. When he goes home at night he can relax – with a cookie in hand – and tell himself 'at least nobody died today'.

So-called 'greedy doctors' don't have that luxury. Every day they make decisions that have huge impacts and long-lasting consequences for the patients they treat. Doctors take on a huge responsibility in caring for patients. Should doctors be paid well for the risks and liabilities they face? Is it 'greedy' to expect that after spending 15 years of your life studying and training to one day become a specialist, that you should be able to charge a fee that you feel reflects your expertise and knowledge?

I've spent the last 20 years of my life working for doctors, and I can safely say I've met hundreds of medical professionals in that time. While doctors are individuals, they tend to share quite a few commonalities. Almost every single one has chosen this career because they want to help people. Doctors recognise the unique privilege they have in being present at some of the most critical points in a patient's life – the birth of a child, a cancer diagnosis, the death of a parent… these are the moments that shape and define people's lives. Being involved in these moments doesn't just happen. Doctors study and train for years on end, making hundreds of little and big sacrifices along the way. They miss meals, bathroom breaks, kids' birthdays and important milestones. And yes, they get paid. No one is suggesting sainthood. But it is insulting to use a 'greedy doctor' headline (only to qualify that statement in the 17th paragraph by indicating this refers to a 'small minority of specialists') to push one's policy reform agenda.

A think tank shouldn't have to use clickbait to sell its ideas.

The AMA has consistently called out doctors who charge exhorbitant fees. But to paint doctors as 'greedy' masks the problem that the Government's indexation of Medicare rebates has never kept pace with the rising costs of medical practice. On average AWE and CPI increase by 3% per year. Practice costs rise by the same amount. By comparison, Medicare rebates only increased by 1.7% on average per year. Very clearly, this discrepancy is a major contributing factor to gap fees.

If we want to address out of pocket costs, then there needs to be greater discourse on Medicare rebates. dr.

fiona.davies@amansw.com.au

Hospital HEALTH CHECK 2019

The results are in from our **third annual Hospital Health Check** survey, which asked doctors-in-training to rate their workplaces. Did your hospital make the grade?

THIS YEAR, the AMA (NSW) Hospital Health Check (HHC) was completed by nearly 2,000 doctors-in-training, which is a significant improvement on previous years.

In fact, it's almost double the number of people who completed the inaugural survey in 2017.

There are some exciting results to report from this year's results, namely that overall A ratings have been awarded for the first time in the NSW HHC's three-year history.

In even better news, not one, but two hospitals – Wagga Wagga and Belmont – were given this grade.

This is especially pleasing for Wagga Wagga – given the hospital's strong performance in past HHCs, where it has consistently been awarded Bs.

It's a testament to the hard work and the priorities being made at Wagga Wagga that the doctors-in-training have responded the way they have.

It's also excellent news for Belmont, which improved from an overall C to an A in the space of 12 months.

Given that the most common overall grade continues to be a C, it's worth emphasising just how strong an improvement that is.

At the other end, the lowest overall grade given to a hospital this year was a C, which is an improvement for the three hospitals given an overall D last year.

And even though Wollongong was given a D for the wellbeing of its DITs, it has increased its standing from the F it

2018 UROT worked

74%

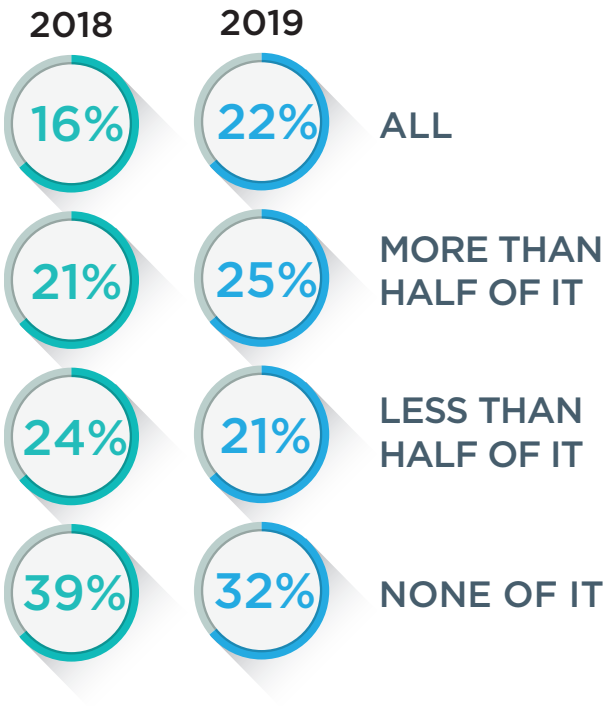
of respondents reported **working more than 5 hours** of unrostered overtime in an average fortnight

2019 UROT worked

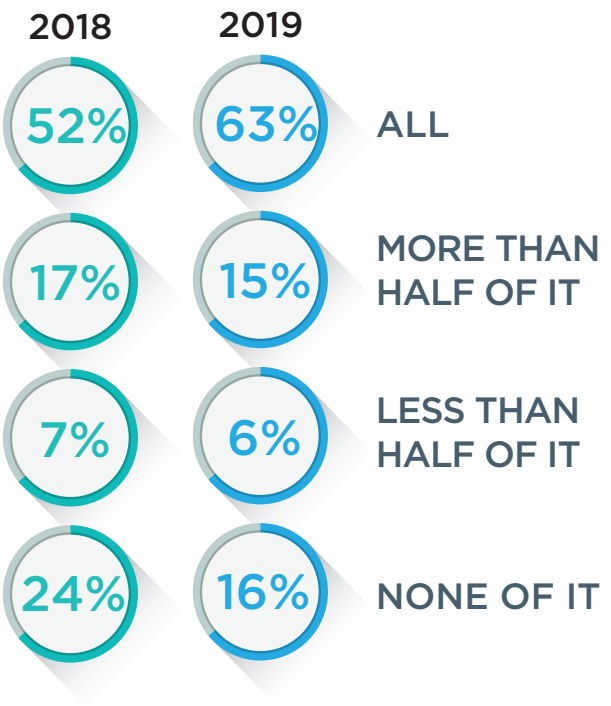
67%

of respondents reported **working more than 5 hours** of unrostered overtime in an average fortnight

Overtime claimed



Overtime paid



was awarded last year.

The lone F given out this year went to Tweed Hospital in the Wellbeing category. While disappointing – and something AMA (NSW) will be looking into – this is still an improvement over 2018 results which awarded three Fs across the Wellbeing and Overtime and Rostering categories.

The biggest upturn in grades was seen in the Overtime and Rostering category. In 2018, there were 10 Ds and an F awarded in that category; this year the lowest grade was a D – given to Blacktown.

The biggest mover in the Overtime and Rostering category was Canterbury Hospital, which received an F in 2018, and jumped to a C in 2019.

Additionally, the first ever A rating in Overtime and Rostering was given to Belmont.

This year's across the board improvement is very encouraging given that state-level advocacy only recently made it much easier for doctors-in-training to claim their unrostered overtime.

Previously, DITs were only able to apply for unrostered overtime without prior approval if it resulted from the following:

- Medical emergency
- Transfer of a patient
- Extended shift in theatre
- Patient admission / discharge

They can now apply for unrostered overtime without prior approval in the additional following circumstances:

- Late ward rounds

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We know that more overtime is being claimed and more is being paid.

We are looking forward to the results of similar surveys in 2020 which should show further improvements in DITs' access to overtime payments.

Despite these positives, the HHC has uncovered a discrepancy between men and women claiming overtime payments. While 28% of men claim all of their unrostered overtime, only 19% of women do the same.

We also know that in surgery, women are twice as likely as men to claim none of their unrostered overtime worked – even though surgery trainees are, on the whole, more likely to claim their unrostered overtime than other DITs.

We encourage all doctors-in-training to be claiming their unrostered overtime but particularly female DITs.

Because of this, we've approached the Health Minister and he's agreed to chair a committee on gender equity in medicine. We want it to look at issues beyond just this one, but we know that getting paid for unrostered overtime worked is a very important issue for doctors-in-training and that makes it a high priority for us.

The other problem highlighted by answers to the Overtime and Rostering questions is one of specialty.

Radiology, psychiatry, and anaesthetics trainees are the most likely of all training groups to claim none of their overtime.

Where only 11% of general surgical trainees claim none of their unrostered overtime worked, more than three-quarters of radiology trainees, and about two-thirds of psychiatry and anaesthetics trainees claim none.

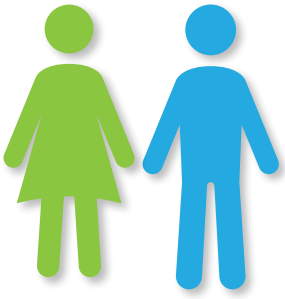
These figures point to a strong difference in culture between surgery and non-surgery specialties – particularly these three – that needs to be addressed. dr.

"The HHC gives us solid data that we can use for advocacy. Anecdotes can be useful, but when used in combination with data, this information provides us with a powerful tool to create change at a NSW Health level."

Dr Sanjay Hettige
Co-chair, AMA (NSW) Doctors-in-Training Committee

Women don't claim as much overtime as men

Overall



19%
of **women** claim all of their overtime

28%
of **men** claim all of their overtime

Surgery

Surgical trainees are more likely to **claim all their overtime,** but **men claim more**

2X
as many **women surgical trainees** claim no overtime

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Dr Raoul Pope, MBChB, FRACS

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RPA HOSPITAL CHOIR
Working in Tune

RPA's choir program is more than just a gathering of like-minded musicos, it's about improving wellbeing, building community, and making connections with colleagues.

WHEN Dr Isabel Hanson and music director Liz Lecoanet approached Royal Prince Alfred Hospital's Executive to pitch their idea for a hospital choir, they presented research about why choirs are beneficial. And then they got them to sing.

"We asked everyone in the Executive to close their eyes, to breathe together and then we did a vocal warm up that led into singing "Hey Jude" by *The Beatles*," says Dr Hanson, who explains that the best way to convince people of the benefits of singing is to get them to experience it for themselves.

"You don't need to be a good singer to reap the benefits," she says. "It's the act of community, breath work, and deep listening that makes you feel quite elevated and refreshed."

The RPAH Choir gathers together once a week from 5.45pm to 6.45pm in the Resident Medical Officers' Association common room to sing a variety of melodies, including pop songs, rock ballads, musical theatre, and African tribal songs. Participants are also encouraged to bring in requests.

The choir has about 70 members and operates on a drop-in basis. There are no auditions to join and people aren't required to make a specific commitment.

The choir is part of RPA's MDOK program, which offers a full suite of workshops, events and activities to support the health and wellbeing of medical professionals.

Dr Hanson and Ms Lecoanet felt the choir would be a good way to bring people from across the hospital together and reduce stress.

"Singing is one of the great social connectors," Dr Hanson says. "It exists in most tribal societies and major religions for a reason. It is the combination of being physically in a room with other people, breathing together, and expressing sound while listening to those around you that builds a sense of community and belonging."

Top photo (L-R): Dr Bethan Richards, Ms Liz Lecoanet, Dr Isabel Hanson, and Dr Sean Lubbe. Bottom photo: The RPA Choir practicing in the RMOA Common room.

While the group does perform, the main goal is to create an all-staff choir that bridges relationships across the hospital. So far – it's working.

"We recently did an assessment on the wellbeing benefits and we found that 100% of people had met someone new that they previously hadn't interacted with before in the hospital. But what was really exciting was 75% of participants had been interacting with [a choir member] in their workday job and found some aspect of their work easier because they now knew that person from choir."

Based on the choir's success at RPA, there are plans to roll out similar programs at other hospitals within the Sydney Local Health District. dr.

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3...2...1 – GO!

For those starting your internship, welcome to the big show! AMA (NSW)'s JMO Advisor, Jennifer Price gives interns her top tips for making it through the first year.

Jennifer Price
JMO ADVISOR
AMA (NSW)

STARTING your internship is a very exciting time. A culmination of many years of hard work. It is also a time when many feel nervous and anxious. After years of working with new interns, I have collated some top tips for starting out.

Ensure your commencement paperwork is complete There is a lot of paperwork to finalise before you can commence. Ensure it is completed before you start. It may not seem important but once you commence you want your focus to be on the role you are undertaking. You don't need to be worrying about obtaining a provider number or confirming your banking details in addition to all the other tasks you will now be responsible for.

Make sure you are registered with AHPRA You would be surprised how many interns I have seen over the years who have overlooked ensuring their registration with AHPRA has been processed and/or kept current. Let me be clear, you cannot work without this. No matter what you've heard, or what your colleague has told you, you cannot work as a doctor without this. Save yourself the stress and ensure it has been processed and is current.

It is a transition This is the time when you move from medical student to doctor. It is new, it is exciting, and it is nerve-racking. Many interns feel they are an imposter for the first few weeks. This is normal and the feeling will pass. Trust that you have been trained for this role and know that there are many people, both in and out of the hospital system, who are able to and want to support you.

You will get quicker It takes time to learn all the hospital systems and processes. Even learning the location of wards and services can be difficult if it is a new hospital. This will all become second nature in time.

Be professional Be on time, know your roster, dress professionally, respect your colleagues. You are now in the workplace and being respectful and courteous goes a long way to making your day to day life easier.

Ask for help You are not working alone. There is a whole team around you. If you are unsure of a patient situation speak with your consultant, your registrar, nursing staff or your DPET.

Work as a team Some days you will be very busy, other days it may be one of your colleagues. If you work together you can lighten the load for each other. Be respectful to other medical staff including doctors, nurses and allied health staff. Know that everyone is working together for the best outcome of the patient.

Build a support network Some of you won't need to move for your internship, others will. Ensure that whichever category you are in you have or find people who can support you. This may be your family, a group of friends, or your workmates. Ensure you have your own regular GP, it is important not to self-diagnose. In the hospital system your DPET and JMO Unit can provide you with support and assistance. Know that there are other external supports available as well including the Employee Assistance Program (EAP), Doctors Health Advisory Service (DHAS), and the JMO Support Line, who can provide confidential support.

Take time out It is a busy time and can be stressful. Take your annual leave and use your Allocated Days Off (ADOs). Make sure you take time out to do things that make you happy and help you to relax. Spending time with family and friends, going to the gym, reading a great book can all help to release some stress and fill your happy reserves. Don't get caught up in focusing on work only.

Enjoy This is the first year of your career life. You have worked hard to get here. Own it and be proud. dr.

Jennifer Price has extensive experience with NSW Health, managing the recruitment processes for both junior medical staff and nursing staff. For more than 10 years she has specialised in junior medical officer management, overseeing the appointment of junior staff, managing rosters, providing award interpretation and policy advice for doctors-in-training, overseeing industrial issues, managing payroll concerns and providing pastoral support.

Homecoming

From rookie to returning veteran, **Ms Dominique Egan** joins AMA (NSW) for a second time to apply her health law expertise in house for members.

MS DOMINIQUE EGAN'S appointment as Legal Counsel to AMA (NSW) is a homecoming of sorts. Early in her career, she was hired as a legal advisor in what was then a shared position between TressCox and the AMA. Twelve months later she went to work for TressCox full time.

"I'm really looking forward to coming back to the AMA," Ms Egan says. "Throughout my 20 years in private practice, AMA (NSW) has been one of my clients and so I've always worked closely with the organisation. This is an opportunity to continue to assist medical practitioners with legal and regulatory issues that arise in their practices but in a slightly different way than I've been able to do in private practice, and assist more with advocacy, legislative and policy reform."

Prior to Ms Egan's initial appointment with AMA (NSW), she worked as a paralegal at the Crown Solicitor's office and then moved into private practice. At the time, she was looking to try a different area of law and had an open mind. When the position came up with the AMA, she jumped at the opportunity.

"My first impression of the AMA was that it was a dedicated team of people working to improve working conditions for members of the medical profession. At the time there were a number of very experienced and senior staff, from whom I learned a lot. There were also a lot of younger professionals here as well, so it was a great time to be here and I learned a lot about how the health system works in NSW, which provided a great foundation for the rest of my career."

Ms Egan has since established a reputation as a prominent lawyer in the area of Health and Aged Care Law.

Over the last two decades, she has worked on behalf of medical and aged care associations, health and aged care facilities, health practitioners and allied health practitioners, medical defence organisations, and insurers, as a partner at TressCox Lawyers, HWL Ebsworth, and Meridian Lawyers.

As a health law specialist, she has expertise in health law and policy, unfair dismissal claims, legislative reform and compliance, employment and industrial matters, professional conduct (disciplinary) claims against health practitioners, Workplace Investigations and mediations, commercial matters, Medicare investigations and Professional Services Review inquiries and coronial inquiries.

Her current role with the AMA (NSW) will involve providing legal advice to the CEO, Board and Council. She will also provide advice to members on medico-legal and employment matters, as well as providing policy advice, including secretariat support to the Professional Issues Committee, and providing advice to AMA staff on legal and related issues. Ms Egan will also mentor and support the Professional Services team.

"I'm pleased to be able to provide advocacy and support for practitioners in private practice and those working in the hospital system…doctors do a wonderful job providing treatment and care for patients, but it is a highly regulated industry, and for good reason. But I think all of those things that practitioners have to negotiate once they start practising can be difficult to navigate and they need the support and services that AMA can provide to help them to do that."

She says her previous experiences have taught her to celebrate the 'little wins along the way that add up', and that one of the most challenging aspects of helping medical practitioners can also be the most meaningful.

"The hardest part of the job is that it does take a toll on medical practitioners when things go wrong, perhaps through no fault of their own. Supporting people through that and trying to help them get through it is very rewarding."

Going forward she sees the increasing competition for the health dollar as one of the biggest issues facing the profession. "It will continue to change medical practice – particularly private medical practice. I think that's a challenge about the provision of services in both the private and the public sectors – how that will be funded and by whom will add to the complexity of the practice of medicine."

Ms Egan will join AMA (NSW) from the 13 January 2020. dr.

PAYROLL TAX: Toll on rural health

Dr Simon Holliday
GENERAL PRACTITIONER
HEALTHHUB TAREE

Faced with a crippling tax assessment, Dr Simon Holliday decided to fight back – not just for himself, but to protect other rural and regional practice owners in NSW.

Taree general practitioner, Dr Simon Holliday, has spent hundreds of hours and over $50,000 in legal advice fighting Revenue NSW's payroll tax assessment of his regional practice.

In 2016, the state revenue office determined that the net earnings of five past or present contractors and Dr Holliday, as practice owner, were all subject to payroll tax over the previous five years.

He disputed the assessment upon legal advice and, the following year, the tax office dropped the assessment on one year, one contractor, and on Dr Holliday.

This second assessment left him with a liability of $140,000, and a warning that if he contested this assessment, he would face an additional 20% penalty.

Dr Holliday, a general practitioner for 30 years in the regional community, described it as a major blow.

"And we were treated with such contempt," he says, adding that there was complete indifference from the agency about the impact this tax would have on the delivery of healthcare services in the area.

"Nobody cares whether somebody is hurt on this matter. And nobody cares if fewer disadvantaged people will be able to access healthcare. Nobody cares if farmers who are struggling with the drought can't access a health service, nobody cares about Closing the Gap with Indigenous people. This is not the issue for state revenue – that's not their problem."

RED FLAGS

Rural general practices struggle with medical recruitment. And like many rural and regional practice owners, Dr Holliday relies on international medical graduates to staff his surgery.

"It's a very competitive task to get IMGs, they can pick and choose, and they want a guaranteed minimum when they start, they want education, and they want to get the best deal they can."

Most IMGs prefer to be employed on a contractor basis, he adds.

In Dr Holliday's case, the IMG contractors' earnings were directed to the practice bank account before being released to the IMGs, net of practice fees. For their first few months, the IMG contractors were guaranteed a minimum sum.

"This was because naturally all are concerned the position may not be as lucrative as that described during recruitment," Dr Holliday says.

This arrangement is not unusual among rural and regional practices. However, it did pique the interest of the state tax revenue department, which determined that if bulk-billing monies flowed to the practice account, they became the property of the practice before being paid to the contractor.

Dr Holliday believed this determination undermined Medicare.

"Medicare pays the rebate to the patient. With what is known as bulk-billing, the patient can pass their rebate to the doctor who looked after them. Medicare law is clear the money

is not paid to a third party."

Faced with the complexities of tax law, trust law and contract law, many practice owners who have faced similar tax assessments have rolled over. But Dr Holliday decided to appeal the case to the Civil and Administrative Tribunal.

"My barrister said to me, you've really taken one for the team. And I did feel that we had to fight this one," he says.

For Dr Holliday, several principles were at stake.

"If practice owners faced a 5.75% impost on the earnings of contractors, many may become unviable harming both the public, and the public purse," he says. "The State Government has much invested in reducing presentations to emergency departments, improving suicide-risk detection, keeping the mentally ill out of jail, reducing traffic accidents and reducing the unequal health and mortality outcomes of regional populations. Losing GPs could set all these programmes back."

He adds that the 5.75% tax levied by Revenue NSW disadvantages NSW practices in recruiting relative to other states, and also penalises practices that train GP registrars.

"I hoped the Tribunal hearing would be a chance to apply a brake to the Treasury's blinkered approach to regulatory functioning."

He was disappointed that none of these matters had any relevance to the hearing. The case only addressed the statute law and Common Law. Regardless, he was predominantly vindicated by the verdict.

The magistrate determined bulk billed money is money paid to the patient for their medical services, and if the doctor accepts the support payment then the patient can assign it to the doctor, they don't assign it to the practice. Bulk billed monies cannot be construed as services in relation to work. That removed almost 94% of all monies the tax department had assessed Dr Holliday for.

Despite the win, the ordeal isn't completely finished for Dr Holliday. The tax department issued him with a bill for $18,500, plus $5000 in penalty taxes. While he paid the first sum, he has contested that the $5000 penalty tax is unreasonable, given that more than 90% of the previous assessment was thrown out.

If they insist on the penalty tax, Dr Holliday says he is prepared to go back to the Tribunal.

Dr Holliday likens the payroll tax to Centrelink's robodebts.

"This is a big issue where we've got out of control tax revenue departments who their job is to generate revenue and not worry about the impact on health services or communities – their job is to raise revenue."

Despite the emotional toll this has taken on his life, Dr Holliday has no plans of retiring. He has restructured his practice and moved to a new location within the town.

He became a doctor because he believed – and still believes – it is genuinely an important service and has some intrinsic value.

"It's a very special thing to be able to help people through difficult times."

And in rural or regional NSW, particularly in areas where people are facing drought or fires, or even both, the connection between doctors and their community is even closer.

"You engage with your community in many different ways," Dr Holliday says. "They might be the teacher of your kids, but you're also in community groups together and you may have looked after their mother, and their wife's brother lives next door to you.

"General practices aren't the glamour end of health. Hospital-based medicine is probably more prominent and where more funding is directed. But I think general practice is where the main grunt of healthcare occurs. And people really do appreciate having somewhere they can bring their fears and troubles and distress." dr.

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CASE SUMMARY: PAYROLL TAX DECISION

The Tribunal determined the bulk billed fees were not payments to the Practice in Dr Simon Holliday's case. Future payroll tax cases will be decided on the particular facts and circumstances of each case.

MANY MEDICAL practices engage with medical practitioners on a contractual basis. Pursuant to the provisions of the Payroll Tax Act, some contractor arrangements may be subject to payroll tax.

Section 35 of the Act provides that amounts paid or payable by a business owner or the putative employer during a financial year for, or in relation to, the performance of work relating to a relevant contract are taken to be taxable wages paid or payable during that financial year.

Subject to a limited number of exceptions, a relevant contract is defined in the Act to include a contract under which a person (the designated person) during that financial year, in the course of a business carried on by the designated person, supplies to another person services for, or in relation to, the performance of work.

In 2018, Dr Holliday's general practice, which engaged with medical practitioners on a contractual basis and paid the medical practitioners a percentage of their billings, appealed a determination by Revenue NSW that the amounts paid to the medical practitioners were assessable for the purposes of payroll tax. The matter was determined by the NSW Civil and Administrative Tribunal and has been remitted to the Commissioner for re-determination.

FACTS

- General practitioners were engaged by the Practice to provide general practice medical services on behalf of the Practice.
- The terms of the contract included the following:
  - > GPs were to provide general practice medical services and such other medical services as may be agreed from time to time.
  - > Four weeks' notice of termination was required.
  - > GPs were engaged as independent contractors and responsible for taxes and other compliances.
  - > The GP was solely responsible for controlling the manner in which services are provided.
  - > The Practice paid the GP fees. A GP was guaranteed minimum earnings for the first 13 weeks. Thereafter the Practice paid the GP 71.5% of the GP's gross earnings (inclusive of GST).
  - > The GPs were obliged to provide services for a minimum 10 x 4 sessions per week.
  - > The GPs were entitled to four weeks' unpaid leave of absence each year.
  - > The GPs were required to maintain Professional Indemnity insurance at their own expense.
- Medicare and DVA payments were made to the GPs as a consequence of the assignment of benefits by the patients to them. The GPs directed Medicare / DVA to make the payments to a clearing account managed by the Practice. For patients who were not bulk-billed, payments were made directly to the Practice.
- Most patients were bulk billed.
- The Practice treated amounts received for medical services as income and payments to contractors were treated as expenses.

FINDINGS

- The Practice conducted the business of a medical centre at which GP services were provided. The Practice required the services of GPs to carry on the business.
- The accounting and taxation treatment of the receipts provided some indication of the character of the receipts but it was not determinative of the outcome.
- The Medicare and DVA entitlements paid by the practice to the GPs did not fall within the meaning of a relevant contract for the purposes of the Act.
- The Practice took on the role of collecting what the GPs were entitled to from Medicare/DVA, the GPs did not assign their entitlement to Medicare / DVA benefits to the Practice.
- Payment for medico-legal reports and payments from cash paying patients did not fall in the same category as the Medicare and DVA payments.

The matter was remitted to the Chief Commissioner of State Revenue for reassessment in accordance with Tribunal's reasons.

Each case will be decided on the basis of its facts and circumstances. In this case, bulk billed fees were found not to be payments from the Practice to the GPs, but fees assigned by patients to GPs that were collected by the Practice. The finding in this regard did not extend to fees when patients were not bulk-billed. dr.

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UNDERSTANDING CONTRACTS

Dealing with contracts can be very complex. The Professional Services Team can assist members with contract reviews and offers template private practice contracts.

Lyndall Humphries
SENIOR ADVISOR (EMPLOYMENT LAW) PROFESSIONAL SERVICES

A CONTRACT is a legally binding agreement between two or more parties that the law will enforce. There are four main elements of a legally binding contract: offer, acceptance, intention to create legal relations, and consideration.

Contracts can be verbal or written. A contract does not have to be in writing to be enforceable, but a written contract creates certainty between the parties and will be easier to enforce.

The following types of contracts are common in private practice:

- service fee agreement
- independent contractor agreement
- lease agreement
- employment agreement

Aside from employment agreements which are governed by employment law, these contracts are generally commercial agreements and the parties can negotiate on contractual terms within the limits of applicable laws and regulations (e.g. health, commercial and contract laws).

Key contractual terms

- **Parties**: This term properly identifies the contracting parties by their names or legal entities, ABN (if appropriate) and contact details.
- **Term:** This term specifies whether the engagement is ongoing (unless terminated in accordance with the contract), for a fixed term (ending on a specified end date) or for a maximum term (ending on a specified end date unless terminated earlier in accordance with the contract).
- **Services:** This term details the services provided. The nature of the services will depend on the type of contract and who is providing services, i.e. whether the practitioner is providing services to the practice or the practice is providing services to the practitioner.
- **Fee:** This term specifies payment for services and the method and timing of those payments. Practices usually pay a percentage of gross receipts/billings or a specified hourly/daily rate.
- **Insurance:** This term identifies the insurance obligations of the parties.
- **Indemnity:** This term allocates legal responsibility/liability between parties.
- **Termination:** This term specifies when and how the parties can end the contract. For fixed or maximum term contracts, the contract will automatically terminate on the specified end date. For maximum term and ongoing contracts, this term will state the period of notice that the parties must give to terminate.
- **Restrictive covenants:** An exclusivity clause may seek to prevent the practitioner from practising for a competing practice in a specified area while the contract is in operation. A non-compete clause may seek to prevent a practitioner from practising in a specified area or for a specified period after termination. A non-solicitation clause may seek to prevent a practitioner from soliciting patients, clients or employees for a specified period after termination of the contract.
- **Confidential information:** This term requires parties to keep information confidential. There may be specific provisions that relate to patient records.
- **Dispute resolution:** This term sets out the processes for resolving any dispute between the parties. The parties may be required to appoint a mediator if the dispute cannot be resolved within a specified period.
- **Entire agreement:** This term makes clear that the contract constitutes the whole agreement between the parties. This ensures contractual certainty and may limit liability for misrepresentation and other potential claims.

Negotiations

The contract should accurately set out the agreement and expectations of the practitioner and practice principal. You should not be pressured or coerced into signing a contract. If you are unsure or uncomfortable with the terms of the contract, don't sign it. Once you enter into the contract, it will become a legal binding agreement. You can't make changes to a contract unilaterally. Changes can only be made with the agreement of both parties.

A dispute is less likely to arise if both parties are happy from the outset. If the contract is not clear or certain or if you can't agree on a term, you should discuss it with the other party to clarify the matter and try and reach agreement. There is often some negotiation that takes place before agreement is reached. You should review any amendments carefully to ensure that any revised contract reflects the terms negotiated and agreed. dr.

PROVIDING SUPPORT FOR MEMBERS

Our team of workplace relations and industrial experts can provide comprehensive individual support to assist doctors with a variety of workplace matters such as contracts, employee entitlements, policy and training issues, registration, compliance with Fair Work Act and regulation, people management, and much more.

ANDREW CAMPBELL

MANAGER, INDUSTRIAL RELATIONS

I'M AN INDUSTRIAL RELATIONS and health policy specialist with a background in employment law and independent contractor arrangements. I manage all aspects of the engagement of senior doctors in public and private health facilities in NSW. I review and interpret contracts and industrial relations instruments to provide support for a wide variety of hospital matters. I also provide members with collective support regarding issues such as hospital best practice, workforce engagement, Medical Staff Council operations, and escalation pathways within the health system.

LYNDALL HUMPHRIES

SENIOR EMPLOYMENT LAWYER

I'M AN EXPERIENCED EMPLOYMENT LAWYER. With 15 years' experience in employment law and workplace relations, I provide proactive and practical advice and training on a range of matters relating to the workplace, including employment contracts, Awards, employee entitlements, performance and conduct issues, discrimination, bullying and workplace investigations. I have a particular interest in the health industry and can assist members in navigating their way around the complexities of their employment arrangements.

JESSICA RANKIN

PROFESSIONAL SERVICES TEAM LEADER

I AM AN ENTHUSIASTIC MANAGER supporting our team of advisors to assist with your workplace, policy and training issues. With a background in human resources across health and government, I understand the complexities and unique issues facing doctors. Every day, our team answers a wide range of general questions from members: fees and billing issues, paying practice staff, employee rights and obligations, consumer complaints, VMO entitlements, privacy issues, subpoenas and court processes, etc. My aim is to reduce your workplace and business stressors and free you up to focus on the practise of medicine.

ANNABEL RAFTERY

POLICY AND PROFESSIONAL SERVICES ADVISOR

I'M AN APPROACHABLE AND AMBITIOUS policy advisor with a background in public health. I have worked exclusively in the health industry in a range of roles and have unique insight into how the healthcare system operates in NSW. I can assist members with their training, College, registration and policy-related enquires. I also work closely with the Ministry of Health to convey and drive change on issues that matter to our members.

LISA BENNELL

HR ADVISOR

I'M AN EXPERIENCED HUMAN RESOURCES professional with extensive skills in a variety of areas. Having spent several years managing teams, I appreciate and understand the issues facing employers. I am passionate about working with doctors and assisting with their workplace issues, whether that be people management, award interpretation or compliance with Fair Work Act and regulations. I have a very pragmatic approach to resolving issues and enjoy taking the time to educate others on their workplace obligations.

FELICITY BUCKLEY

HR ADVISOR

I'M A DEDICATED ADVISOR with human resources and industrial relations experience across a number of industries. I am well placed to provide our members with assistance on a variety of matters and work closely with a range of stakeholders to provide timely support to doctors. I have expertise in Award interpretation, people management, staff entitlements and contracts. I look forward to assisting you with your individual matters and helping to drive change within the healthcare sector.

BARBARA ROBINSON-TAN

HR ADVISOR

I'M A KNOWLEDGEABLE ADVISOR with a background in human resources management. My years of experience across various sectors, including health and community services, are an asset in responding to member enquires. I have worked with both Award and Award-free employees covering a range of issues throughout the whole employment lifecycle. I'm interested in current workforce issues and management practices and look forward to assisting members with their enquiries.

By Russell Price
Director at Specialist Wealth Group

The Protecting Members' Interests First (PMIF) Bill – *Will it affect you?*

Recent legislation passed that may have an impact on your superannuation and personal insurance, such as the Life, TPD or Salary continuance insurance you hold within super.

It's called, Putting Members' Interests First (PMIF) legislation and it passed through the Senate on 19 September 2019 with amendments and received Royal Assent on 2 October 2019. This reform addresses the two remaining requirements – super account balances less than $6,000 and members under 25 years of age, that were not passed as part of the Protecting Your Super (PYS) package. (The PYS legislation included changes to fees, the transfer of inactive low-balance accounts to the Australian Taxation Office (ATO) and cancelling insurance for inactive members)

The aim of the laws is to protect low balance super accounts from being eroded by insurance premiums for insurance that may not be wanted or needed. As part of the law, superannuation providers are required to complete the following activities:

1. Identify members with insurance in their super with an account balance below $6,000 on 1 November 2019;
2. Notify the affected members by 1 December 2019 that to keep their insurance, they'll need to notify us in writing before 1 April 2020 or make contributions to bring their super balance to $6,000;
3. Cancel insurance on 1 April 2020 for existing members identified above whose account balance has not reached $6,000 by 1 April 2020 – unless they have elected to keep their insurance.
4. From 1 April 2020, stop offering default insurance for new members under 25 or members with an account balance of less than $6,000.

As a result of this legislation, if you have insurance through a super fund that you have elected to keep (perhaps due to your health new cover may not have been available to you), that is not your main superannuation fund, meaning, it has a low balance, then please be aware you may lose this insurance and safety net.

Your superfund will write to you if you are in this predicament and you will need to communicate with your superfund by the 1st of April 2020 if you wish to maintain this insurance. If you are unsure, or have any questions, please contact us at Specialist Wealth Group and we can assist you by investigating into your circumstances.

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TOP TIPS TO BE TIP TOP IN 2020

A new year brings new opportunities. CJU Medical Marketing's Managing Director, Caroline Ucherek, looks at what doctors can do to keep their medical business growing and improving.

Caroline Ucherek
MANAGING DIRECTOR
CJU MEDICAL MARKETING

MEDICAL MARKETING should be designed to build your reputation and set you apart in the marketplace. The strategic plan and roll out for a sole practitioner and the marketing campaigns and tactics for a large GP practice or multi-site specialist provider are entirely different. But the true essence of marketing and the key to a successful strategy remains the same: To understand your customers' needs and develop a plan that meets those needs.

Your marketing strategy should address two things:

- **Growth/Acquisition** – consider what are your practice's key indicators for growth, and set regular reviews in place
- **Retention** – this should focus on loyal patients / referrers

Brand Power

We mostly think of a brand as being a logo – but that's just a small part of it. It is the embodiment of your practice – your customer's first experience from their initial contact with your practice to the last interaction they have with your service. It includes the way the phone is answered, how a patient is treated at reception, what information they are given and how they are given it, how the reception looks and feels, including the décor, and your marketing collateral. Your "brand delivery" and the "brand experience" is well underway before you have even met the patient. To better gauge the effect of your brand on the patient's experience, consider implementing a mystery shop. This will give you an unbiased review and help reveal areas that need improvement.

Listening To Patients

Encouraging feedback, listening, and responding to patients are key contributors to long term success. This can best be done via patient surveys, monitoring online reviews, and measuring important patient statistics.

Almost 40% of medical practices don't have a formal feedback strategy. Yet performed thoughtfully and with adequate follow-up, the results of patient surveys can immediately affect your practice's business results.

Before undertaking any questionnaire, it is important to prioritise its objectives in order to ensure the survey itself is manageable for the person completing it and it delivers information that is actionable.

Your Online Presence

Having a comprehensive website is now a necessity. There is no one-size-fits-all website, each medical practice has its own unique qualities and your website design should take these into account.

Online business listings also open the door to Google reviews. Your digital reputation is very important and it is vital to be an active participant in the management of reviews you may receive.

How you respond will depend on the review. If the review is an administrative complaint, you may choose to have your practice manager respond – the key is to respond in a timely and positive fashion.

If the complaint is clinical in nature, you may wish to make a general response acknowledging the patient's concern, but then try to take the conversation offline.

If the comment is unreasonable, you may consider ignoring it. But even if you choose not to respond, it's a good idea to keep monitoring the situation.

Above all, ensure you avoid breaching the Medical Board Code of Conduct, and you do not breach patient confidentiality.

Data, Data, Data

Your practice management software is one of the most valuable marketing tools you possess. Regular reviews of your data (monthly at a minimum) with a focus on key indicators will highlight any significant fluctuations – positive or negative. Data to examine should include:

- Percentage of new patients
- New referrers
- Referrers by volume
- Referrers by revenue

CJU Medical Marketing is a specialist full-service marketing agency working exclusively within the medical industry. dr.

A toolkit for GPs IN NSW

Women's Legal Service NSW has launched an updated GP Toolkit for responding to domestic violence, with important information on strangulation and changes to tenancy laws.

Helen Campbell, Executive Officer of Women's Legal Service NSW

ACCORDING to figures released by the NSW Bureau of Crime Statistics and Research last June, domestic violence-related assaults were up by 6%.

Although the jump is concerning, experts were quick to add that the figures reflect an increase in reporting due to greater public awareness, rather than an increase in violence.

"Of greater concern is that on average one women per week is killed by a current or former partner in Australia. Already there have been 48 deaths this year," says Helen Campbell, Executive Officer of Women's Legal Service NSW.

Doctors have a vital role to play in reducing domestic violence, Ms Campbell adds. Over 1 in 5 women make their first disclosure of domestic violence to their GP. It is estimated that every week, a general practitioner sees up to five women who have been abused by their partners, of which the GP may not be aware. Research indicates one in 10 women attending general practice have been afraid of their partners in the previous 12 months, and one in three women have experienced fear of a partner over their lifetime.

To help medical professionals identify and respond to patients and their children, the Women's Legal Service NSW created the GP Toolkit, 'When she talks to you about the violence'.

This easy to use, concise and accessible resource guides doctors on what to look for, how to talk to your patients about it, safety planning, useful referrals and how to make notes and protect privacy. It also addresses how to respond if your patient is the perpetrator, or if both parties are your patients, and your obligations in relation to children.

The GP Toolkit was first launched in 2014 but was recently updated to include information on strangulation and changes to tenancy laws.

"It is now recognised in law and in police operating procedures that non-fatal strangulation is a strong indicator of escalating and potentially lethal violence," Ms Campbell says.

The kit includes detailed information about detecting and recording symptoms, as well as advice about ongoing monitoring for subtle and delayed symptoms.

In addition, there have been recent changes to tenancy laws to allow a victim of domestic violence to end a tenancy early without penalty.

Evidence is required to do this, which in many cases will be reports or apprehended violence orders from police.

"However, many women do not want to get police involved, but do want to get away to a safer place. In this situation a doctor can make a declaration for the patient to use in support of her application to end the tenancy. This declaration does

not require proof of any particular event and is based on the doctor's statement of belief in good faith that the patient has disclosed that she is experiencing, or in fear of, violence from her partner," Ms Campbell says.

To provide a declaration, the medical practitioner must have consulted with the victim of domestic violence in the course of their professional practice. The victim can be the tenant or the tenant's dependent child.

Some minor changes to these laws commenced on 26 November 2019. The changes include a clarification that medical practitioners are authorised to collect, hold, use and disclose personal information about a relevant domestic violence offender in order to make a domestic violence declaration for their patient.

Medical practitioners can proactively help a victim escape domestic violence in a rented home by telling patients about the protections available to them.

As explained in the GP Toolkit, domestic violence is broadly defined as an abuse of power within a domestic relationship, or after separation, and does not have to be physical violence. There is more detail in the toolkit about the types of domestic violence your patient may be subject to.

Most victims of domestic violence are women. Research indicates women are at greater risk of violence from their partners during pregnancy, or after separation. According to the 2016 Personal Safety Survey, nearly half of women who had experienced violence by a previous partner and who were pregnant during that relationship, experienced violence from their partner while pregnant.

"In any situation of domestic violence, we know how valuable the victim's relationship with her doctor is to accessing support and seeking safety," Ms Campbell says.

"There is evidence showing how highly trusted and valued the confidential doctor-patient relationship is. And we know how much doctors want to help, and to see a safe outcome for their patients. Sometimes this can be frustrating as many victims may be afraid to leave, lack self esteem and be unsure of what to do, or for a variety of reasons not follow through on suggested referrals to support services."

According to Department of Communities and Justice, on average, a woman may leave her abuser seven to eight times before she breaks away for good.

Ms Campbell adds, "Patience is essential, as it can take several attempts to make a successful escape. Continuing to show that you believe and support your patient in whatever she decides to do, or when she decides to do it, is vital. The Toolkit will help with setting out and implementing a safety plan over a period of time."

You may be able to help patients experiencing domestic violence access financial support through the victims support scheme and/or the Centrelink crisis payment. The Toolkit explains time limits and what doctors can provide by way of documentation to assist patients in making these applications.

The toolkit is available free of charge, you can download it or order copies to be posted to you on the Women's Legal Service NSW website https://www.wlsnsw.org.au/newly-updated-gp-toolkit/. dr.

Insight
DR GEORGE THOMSON

His career has taken him around the world. Not only did he gain a lifelong love of New York, but learned techniques that helped shape ophthalmology in Australia.

IN 1970, with three children (one of whom was only one month old) Dr George Thomson and his wife relocated from Australia to New York.

Dr Thomson had successfully secured a research fellowship under Dr Richard Troutman – a pioneer of microsurgery in cataract and corneal surgery and Professor of Ophthalmology at Downstate University in Brooklyn. He was also head of the ophthalmological surgical department at the Manhattan Eye and Ear Hospital.

"The reason I was able to go was I inherited an apartment right next to Central Park, just across from the skating rink on 59th Street," Dr Thomson recalls.

Despite being told by his predecessor that the apartment would be furnished, all they found when they arrived were cocktail glasses. Welcome to New York.

STARTING OUT

Dr Thomson always wanted to be a doctor. His father was a surgeon and physician, and that early exposure to medicine had piqued his interest.

A graduate of Homebush High and former State swimming champion, Dr Thomson was gifted both academically and athletically – participating in North Bondi SLSC, swim coaching, water polo and boat racing when he wasn't studying.

After graduating from medicine in 1963, he did his first-year residency at Wollongong Hospital in 1964, during which time he married his wife, Pamela. The following year, they moved to Adelaide for his second-year residency at the Royal Adelaide Hospital.

The doctor he related best to was a neuro-ophthalmologist, and Dr Thomson's interest in ophthalmology grew from there.

In 1967-68, he did a teaching fellowship in the Anatomy Department of Adelaide University and prepared for the primary ophthalmology exams. During this time, he took the ECMFG which would allow him to work in the US, and he celebrated the birth of his first daughter.

He moved back to Sydney to take the primary at Sydney University and did his training at Sydney Eye Hospital. After 18 months as a registrar, and 18 months as a clinical superintendent he obtained the second part of his post-graduate exams and had two more daughters.

It was at this point that the opportunity to train in New York came up. He describes the experience as a milestone in his career.

"Microsurgery hadn't really reached Australia at that stage – it was being used in a very limited way," he recalls. "I was lucky enough to be trained in it."

During his fellowship in New York, Dr Thomson gained experience in corneal grafting and corneal refractive surgery. He also worked in the Manhattan Eye Bank (the first eye bank in the world), collecting and preparing donor corneas for surgery.

After nearly two years in New York, Dr Thomson returned to Australia. He did some locuming and then joined a group ophthalmic practice in Parramatta. He was also on staff at Lidcombe Hospital and assisted with the design of the operating theatres in the new surgical wing.

Drawing on his experience overseas, Dr Thomson was central in overseeing the placement of the first ceiling mounted microscope in Australia at Lidcombe, which included closed circuit television and was a valuable teaching tool.

He was also on staff at Parramatta Hospital, which relocated to the Westmead Centre in 1978. Three years later, Dr Thomson set up a solo practice.

Dr Thomson was also very involved in the Royal Australian and New Zealand College of Ophthalmologists, serving as the chair of the cataract implant and daycare committee, conducting workshops in cataract removal followed by intraocular lens placement.

"This was in 1978 and the first in Australia. It started a revolution in cataract surgery. Now nearly 100% of cataract surgery is done this way," he says.

In addition, Dr Thomson led several workshops in cataract removal techniques and one on Radial Keratectomy.

He served as the assistant editor of the RANZCO Journal, a committee member of Ophthalmic Research Association of Australia, Secretary of the Ophthalmic Association of Surgeons, and Consultant to the TGA on ophthalmic devices.

He became a foundation member of the Australian Society of Cataract and Refractive Surgeons in 1969 and remained on the organising committee until 2009.

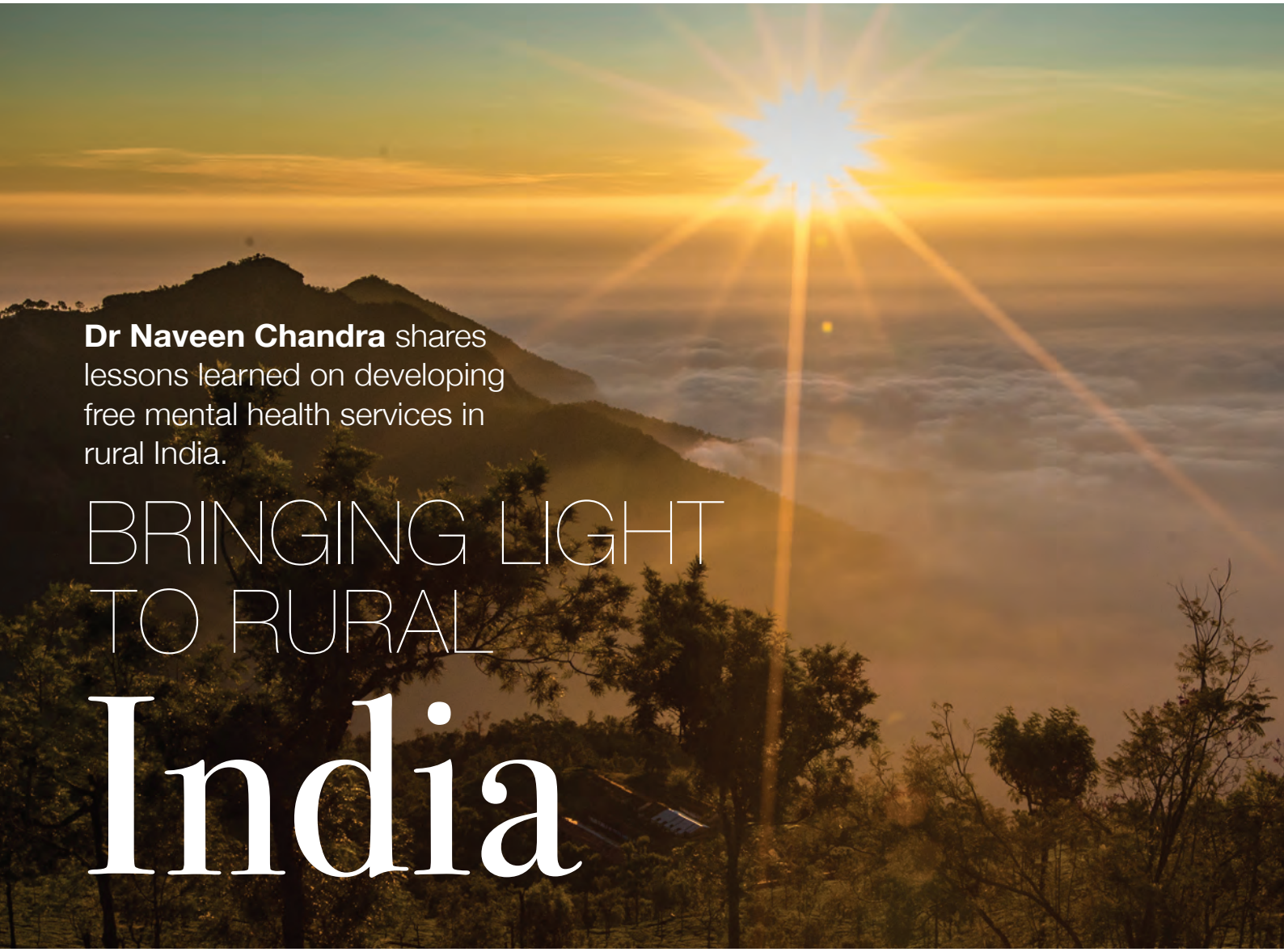
In 1978, Dr Thomson joined the American Society of Cataract and Refractive Surgery, and in 1995 was made a member of the International Intraocular Lens Society.

He has also served as an Ophthalmic Consultant to the Sydney Eye Bank.

"Ophthalmology has moved enormously since I started doing it. The progress has been incredible. These intraocular lenses – I was lucky enough to be a pioneer in that, and really what I feel is my biggest contribution to ophthalmology." dr.

50 YEAR MEMBER

AMA (NSW) is featuring distinguished doctors who have been AMA members for 50 years. Due to the success of these popular profiles, *The NSW Doctor is* pleased to make this a regular addition in the magazine.



Dr Naveen Chandra shares lessons learned on developing free mental health services in rural India.

BRINGING LIGHT TO RURAL India

JUST OVER a decade ago, psychiatrist Dr Naveen Chandra fulfilled his life-long dream to give back to the country of his birth and provide much-needed mental health services to rural areas in South India.

He established free psychiatric centres in three villages that previously had no mental health services available.

"This dream did not always seem attainable," he says. "When discussing my idea for the project with friends in the early days, some discouraged me saying it would never work out due to government red tape and low public cooperation."

His plan was to work six months a year on the project in India and spend the other six months in Australia with his family, while working as a locum.

In 2007, he approached several colleagues to probe their interest in volunteering overseas. While many supported the idea, they were unable to commit to the project.

Dr Chandra then approached the managing director of Nitte Education Trust (NET), a non-government organisation in South India.

"I was very fortunate to have Mr Vinaya Hegde as a generous sponsor for my project," Dr Chandra says. "When I put together my proposal, he readily accepted it and unconditionally supported me with resources and connections to the local university."

Having identified a helpful partner and a target area for the project, his first task was to identify the prevalent mental health issues that affect rural India.

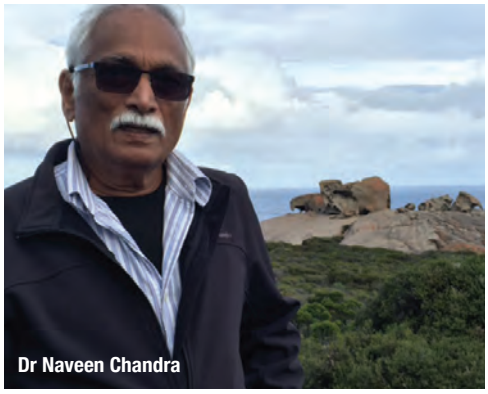
Based on the General Health Questionnaire, he prepared a survey in the local language relevant to the local conditions and beliefs.

"It is important to adapt these questionnaires to ensure validity and understanding," he says.

They utilised nursing students, who did door to door visits at every house in the village. The results gave Dr Chandra a clear picture of the mental health issues affecting residents in the area.

He then approached the superintendent of the local community hospital who agreed to give Dr Chandra two rooms in the out-patient department for his clinic. It was here that Nitte Rural Psychiatric Centre started.

"With the support of my wife, Sharitha, I started seeing psychiatric outpatients. She


Dr Naveen Chandra


Dr Chandra at the centre


Centre picnic


Learning at the rehabilitation centre


New hospital built in conjunction with Nitte Education Trust


Making greeting cards

did the administrative work for the clinic and I did the consultation and treatment. We used the hospital pharmacy and were able to access free medicine. Meanwhile, NET supplied medicines that were not available in the hospital."

Dr Chandra then successfully petitioned NET to appoint a social worker, who assisted them in starting two satellite psychiatric centres in nearby villages. The local Rotary Club offered Dr Chandra the use of their hall, where they established their rehabilitation centre, 'Thudar', which means 'light' in the local language.

They launched community programmes, including an outpatient department, with psychiatrists in attendance for five days. Dr Chandra says this accessibility was important for acute patients.

At the centre, patients make greeting cards and jewellery, and participate in yoga, games, information talks, and picnics. Lunch is provided and patients are given an incentive allowance to encourage attendance. As several patients could not afford the bus fare to attend, Dr Chandra enlisted the Nitte Engineering College bus to pick up patients free of cost.

Unfortunately, the college buses and private buses would not pick patients up from remote villages, which made it difficult for those patients to attend Thudar. However, with the help of donations they managed to buy a van for the centre.

He also started a 24/7 telephone line manned by volunteers – who were trained by a colleague during a weekend workshop. This was less successful, he says, due to a cultural reluctance to disturb staff from their sleep and to discuss problems over the telephone.

SPREADING AWARENESS

Unable to support paid staff, he asked friends and relatives to visit the villages in person and distribute brochures about mental illness to help spread awareness of the centres. In addition, he presented talks in the villages, local clubs, schools and local government centres educating the public about mental illness.

One of his more innovative methods of raising awareness of mental illness was through the creation of a street play team, named 'Parivarthana', which means 'transformation' in the local language.

"These voluntary actors performed plays

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about schizophrenia, depression and alcoholism, specifically in marketplaces, bus stands, public places, etc. These plays were successful in getting our message across, and we found it the best way to communicate with the population, as many of the rural older population were illiterate."

He also printed fact sheets in the local language about different psychiatric illnesses. He found patients were pleased that he was giving them information about their illness, as "many conveyed that their doctors had no time to explain the illness in such detail," he says.

PROGRAMS AND SERVICES

Dr Chandra started an alcohol detox program at the government hospital with the help of Prof Suresh Kamath, a staff member of the hospital. After the patients were discharged, they ensured they were followed up at the clinic by a social worker who counselled the patients as well as their spouses.

He also organised home community visits by a social worker to assess acute cases and to follow up the chronic patients. This helped to make the service accessible to those who were less mobile due to chronic physical illness or to the ones reluctant to attend because of their psychiatric condition.

CHALLENGES

While Dr Chandra made significant progress in bringing mental health services to a previously unserviced rural area in India, he faced several difficulties – many related to staffing.

"We tried to computerise our case histories but did not succeed due to technical problems and not having regular staff members," he recalls, adding that staffing became a more significant consideration as he prepared to return to Australia. Fortunately, two private psychiatrists agreed to carry on with his work at Nitte.

Attracting doctors to work in remote areas was another difficulty, which he solved by training community nurses to identify mental illness.

Opening of the new building by Prof Deva of Malaysia

As with any project, finding the funding necessary to get it off the ground and keep it running was a significant challenge.

"To support the project, I organised a charity lunch in Sydney, and with the help of support and donations from family and friends, I am proud to say that we raised 2,700,000 Indian Rupees. This was alongside the jewellery that Sharitha made and sold to support the project."

MOVING ON

When the Nitte Psychiatric Centre had enough funds to build a new centre, Dr Chandra approached NET's Mr Hegde who suggested that they build a larger centre and offered a contribution to help them do it. The centre was called 'Vakil Perodi Shambha Shetty Memorial Psychiatric and Medical Centre', after Dr Chandra's father and opened its doors in 2013. The psychiatric outpatient section, Thudar rehabilitation centre, dental department, medical OP and minor operation theatre for surgery are now housed in this building.

Over the years in which Dr Chandra was establishing and running this project, he held three international psychiatric conferences: 'Rural Psychiatry – Road Least Travelled' in 2009, 'Mind the Gap' in 2011 and 'Beyond Symptoms Control' in 2015. Dr Chandra says the feedback received was overwhelming and delegates got a first-hand insight into problems in the rural areas and service models that may work in these contexts.

It was during his last visit at the end of 2015, that he felt that he had done as much as he could from a volunteer perspective. Subsequently, he decided that it was time to hand over the centre to Nitte University.

Currently, the centre has around 5,000 patients on its books and treats about 200 outpatients a week. The Thudar rehabilitation centre has 12-15 regular patients and has placed 10-12 patients on part-time or full-time employment.

"I am proud to say that I have been able to set the centre up so that it will serve the rural psychiatric population of the area for several years to come," he says.

"In summary, from my experience, a successful rural project needs as a minimum: a supportive sponsor, convenient transport, knowledge of local language and culture, support of the local community, connections to local institutions, a follow up plan for the future, and the ability to raise funds. One major issue will always be encouraging staff to work in rural areas. Incentives like rural allowance or accommodation and employing local people, if available, is always a good option. We trained the community nurses and volunteers as there were no doctors in these remote areas. The project was a great success which exceeded everyone's expectation, including my own.

"I hope this will help people understand, although it is hard, it is not impossible to do voluntary work in a rural area, sometimes it is where it is needed the most." dr.

Dr Naveen Chandra
MBBS, MRC Psych, FRC Psych







DIT AWARDS 2019

AMA (NSW) and ASMOF (NSW) held the DIT Awards on 21 November to recognise outstanding doctors-in-training and their managers and teachers. Congratulations to our winners and finalists.

DIT MANAGER OF THE YEAR
Winner
BIANCA FIELD
Medical Administration Co-Ordinator
John Hunter Hospital

TEACHER OF THE YEAR
Winner
DR LISA DARK
Consultant Neurologist and General Physician, Tamworth Rural Referral Hospital
Finalists
Dr Marina Vamos
Dr Madhavi Jayachandra
Dr Paul Chee

REGISTRAR OF THE YEAR
Winner
DR WENJIE ZHONG
Urology Registrar
Wollongong Hospital
Finalists
Dr Anosh Sivashanmugarajah
Dr Scott Craythorn
Dr Carolyn Wijaya

JMO OF THE YEAR
Winner
DR BHAVI RAVINDRAN
JMO, Hunter New England Health
Finalists
Dr Hari Sritharan
Dr Lauren Shephard
Dr Jaffly Chen

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1. Winner Dr Lisa Dark. 2. Winner Dr Wenjie Zhong with Phil Minns. 3. Finalist Dr Anosh Sivashanmugarajah with Dr Kean-Seng Lim. 4. Winner Bianca Field with Dr Anthony Sara. 5. Finalist Dr Lauren Shephard. 6. Winner Dr Bhavi Ravindran. 7. Finalist Dr Hari Sritharan with Dr Kean-Seng Lim. 8. Finalist Dr Madhavi Jayachandra. 9. Finalist Dr Scott Craythorn.

VALE: A/PROF ANDREW KEEGAN

THE MEDICAL profession is mourning the loss of distinguished colleague and former president of AMA (NSW), Associate Professor Andrew Keegan.

A/Prof Keegan passed away on 11 December, a year after being diagnosed with an aggressive brain cancer.

Inducted in 2010 into the AMA Roll of Fellows, A/Prof Keegan is remembered for his dedication to his profession, which he served with distinction.

A/Prof Keegan grew up in Wentworthville and graduated with MBBS (Honours) from the University of Sydney in 1980. He was elected to AMA (NSW) Council in 1999 and served on the Hospital Practice Committee and the Finance and Organisation Committee, as well as Chair of the Hospital Practice Committee.

In 2004, he stood as Vice President of AMA (NSW) and then served as President of the organisation from 2006 to 2008. His presidency coincided with both the Nile inquiry into the Royal North Shore Hospital and the subsequent Garling Inquiry into the NSW Health system. A/Prof Keegan was a significant voice during both, which helped shape the medical profession within NSW and across Australia.

A/Prof Keegan was also an important figure in the medical indemnity crisis and led initial negotiations regarding major amendments to the National Registration Scheme with the NSW Government.

He was a gastroenterologist with a distinguished record in practice, publications, teaching and presentations, and a member of the Gastroenterological Society of Australia, a Fellow of the American Gastroenterological Association, the International Society of Biomedical Research on Alcoholism and the Australian Society for Biochemistry and Molecular Biology.

He worked as a visiting consultant gastroenterologist/hepatologist at Nepean Hospital and Nepean Private Hospital.

A/Prof Keegan was very involved in medical education and health administration and served as an Adjunct Associate Professor, Sydney Medical School Nepean at the University of Sydney.

Among his many local appointments, he was Chair of the Nepean Hospital Medical Staff Council and of the Wentworth Area Health Service Medical Staff Council.

In addition, he served on the Gastroenterology Executive of the NSW Agency for Clinical Innovation.

A/Prof Keegan was known for his love of Rugby Union and was a dedicated member of the management committee of Sydney University's Rugby Club for many years. dr.

BOOK REVIEW: Frontline Patient Safety

DR GLEN FARROW takes a practical approach in his guide to preventing serious adverse events. *Frontline Patient Safety* is written for anyone practising in wards, emergency departments and intensive care units, and is essential reading for new doctors.

Dr Farrow argues that despite the many safety systems that have been implemented, the root cause of many serious adverse events continues to be poor clinical decision-making. As a consequence, *Frontline Patient Safety* emphasises individual strategies – not safety systems; and responsibility – not blame. He writes, "What struck me recently was that in reviewing 250 serious adverse events over a six-year period, the same mistakes were happening time after time. While healthcare has become safer, serious adverse events are still occurring at significant rates, despite the focus on a systems approach to quality and the no-blame culture promoted throughout healthcare."

Dr Farrow presents the reader with 20 pragmatic strategies and illustrates the chapters with stories from his own clinical work as a general and paediatric surgeon and his work as a doctor with the Australian Defence Force (ADF), as well as his experiences military parachuting. He's included a few lessons from some of the mistakes he's witnessed, and other lessons he's learnt the hard way. Dr Farrow was Director of Clinical Governance and Medical Administration for Sydney Children's Hospitals Network from 2012 to 2019. He has previously held executive medical roles at Royal North Shore Hospital, Greater Southern AHS and St Vincent's Hospital. dr.

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BMA CHALLENGE CUP 2019

The last event of 2019 was one of the biggest and best turnouts the AMA (NSW) Golf Society has ever had, as golfers contested for the prestigious BMA Cup.

Dr Ian Meakin

Dr Ross Glasson

Mr Stephen Nielsen

THIS YEAR saw a record field of 62 players turn out at Terrey Hills Golf Club to contest the 84th BMA Challenge Cup on a superb summer morning. The Cup was presented to AMA by Dr H Rutherford Darling MS FRCS as a token of his appreciation of the courtesies extended to him during his teaching visit to NSW. It has since established a wonderful tradition among the golfing members of the AMA.

As always, Terrey Hills Golf Club was in pristine condition and, as the scores reflected, was at its competitive best.

The competition is traditionally a Par event and the results are as follows

Albert & Mary Shepherd Trophy
Dr Ian Meakin
BMA CUP Winner
Dr Ross Glasson +2
BMA Cup Runner Up
Mr Michael Burke +1
Sponsors Cup Winner
Mr Stephen Nielsen +2
Sponsors Cup Runner Up
Mrs Nicole Bowman +1
2BBB Winners
Drs Ian Meakin & Peter Cohen
2BBB Runners Up
Dr John McCarty & Mr Peter Cribb
Mens Longest Drive
Dr Tom Pennington
Ladies Longest Drive
Ms Doey Choi
NTPs
Ms Doey Choi & Dr David Pennington

Congratulations to all the prize winners. Special mention must be made of the ultimate winner, Dr Ross Glasson. Ross has been a great supporter of the AMA (NSW) Golf Society over many years and rarely misses an event.

On behalf of AMA (NSW), Medical Secretary, Dr Robyn Napier, extended Seasons Greetings and wished all present a bright and prosperous New Year.

Our 'hard luck story' of the day goes to Prof Brian McCaughan, who after a sterling and courageous effort on the course, missed out on the 2BBB by one point. Next time Brian.

A special guest on the day was a brilliant young player from Concord Golf Club, Ms Doey Choi off a handicap of Plus 3. Still an amateur at this stage, but will be a name to watch in the not too distant future in the Ladies professional ranks.

Once again, the members recognised the magnificent organising skills of the Society's organiser, Claudia Gillis, and thanked her for all her hard work throughout the year.

The Golfing Calendar for 2020 will be published as soon as possible, but in the meantime, **the Autumn Cup will be held on Thursday 12 March 2020 at Concord Golf Club with a morning tee off.**

Any inquiries about the Golf Society may be directed to Claudia at AMA (NSW) (amagolf@amansw.com.au)

Good golfing and best wishes to all members and their families for 2020. dr.

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Anita Fletcher
Manager, Medical Careers Service

"I got the job at Westmead Hospital! Your input from the Hospital interview last time was also very helpful and it definitely helped me get more prepared for this interview. So I have you to thank for it. This AMA (NSW) Careers Service is definitely awesome."
RMO, Westmead Hospital

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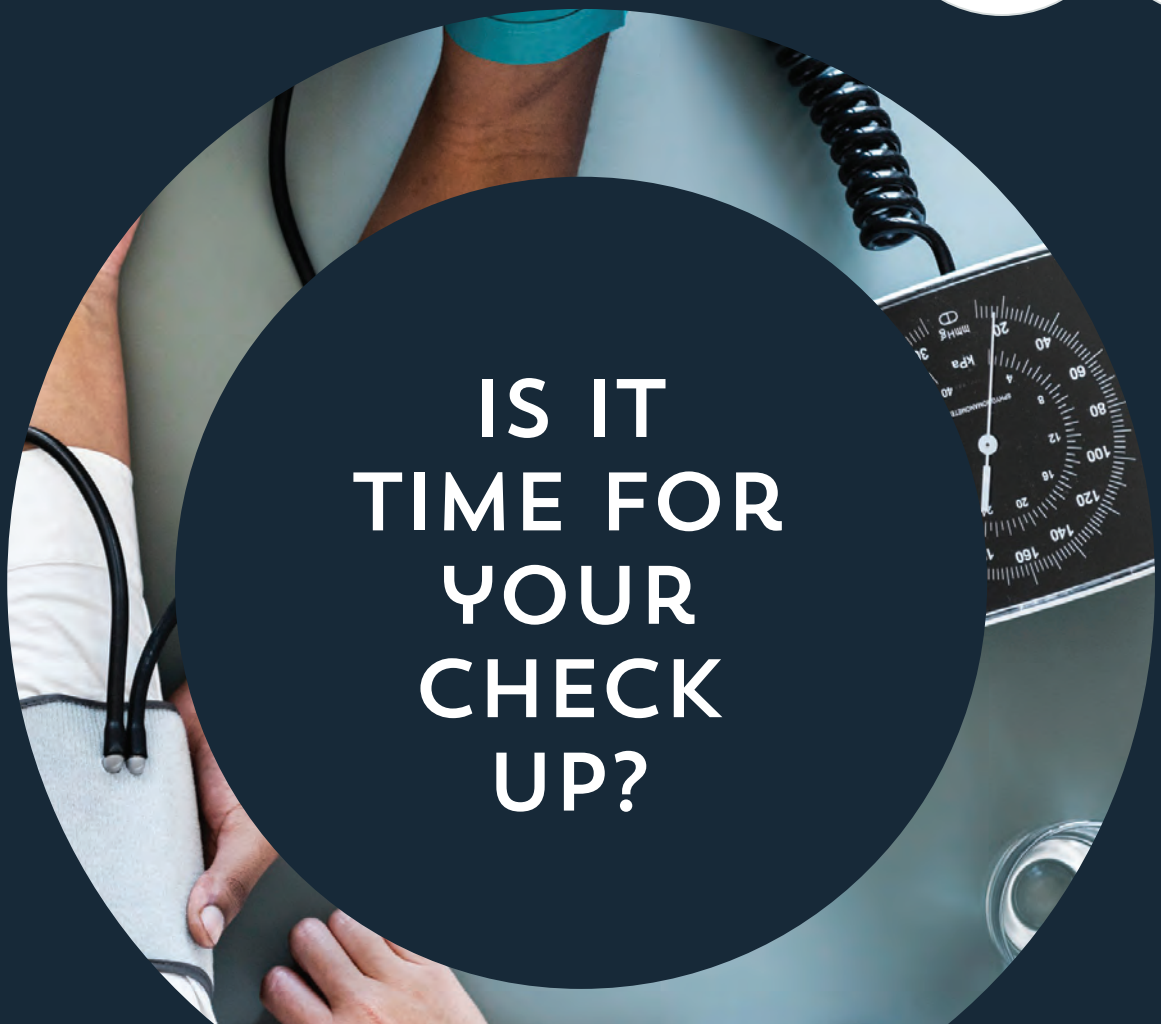

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❶ A business must be a Qantas Business Rewards Member and an individual must be a Qantas Frequent Flyer Member to earn Qantas Points with MIGA. Qantas Points are offered under the MIGA Terms and Conditions (www.miga.com.au/qantas-tc). Qantas Business Rewards Members and Qantas Frequent Flyer Members will earn 1 Qantas Point for every eligible $1 spent (GST exclusive) on payments to MIGA for Eligible Products. Eligible Products are Insurance for Doctors: Medical Indemnity Insurance Policy, Eligible Midwives in Private Practice: Professional Indemnity Insurance Policy, Healthcare Companies: Professional Indemnity Insurance Policy. Eligible spend with MIGA is calculated on the total of the base premium and membership fee (where applicable) and after any government rebate, subsidies and risk management discount, excluding charges such as GST, Stamp Duty and ROCS. Qantas Points will be credited to the relevant Qantas account after receipt of payment for an Eligible Product and in any event within 30 days of payment by You. Any claims in relation to Qantas Points under this offer must be made directly to MIGA by calling National Free Call 1800 777 156 or emailing clientservices@miga.com.au ❷ 75,000 bonus Qantas Points offer only available to registered Australian medical practitioners who first insure with MIGA as a new client in a fully insured category, as a doctor in private practice, for cover commencing on or after 1 December 2019 and on or before 31 January 2020, and who pay in full by 31 January 2020 or enter into a direct debit arrangement with MIGA by 31 January 2020 and have their first instalment successfully deducted. MIGA Terms and Conditions for bonus Qantas Points for Fully Insured are available at www.miga.com.au/qantas-bonus-tc-pp. You must be a Qantas Frequent Flyer member or Qantas Business Rewards member to earn bonus Points. ❸ Insurance is issued by Medical Insurance Australia Pty Ltd. MIGA has not taken into account your personal objectives or situation. Before you make any decisions about any of our policies, please read our Product Disclosure Statement and consider your own needs. Call MIGA for a copy or visit our website.