

THE NSW

doctor



THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION OF NSW

A full-page background image of a rural landscape. A dirt road winds through a green field towards a line of trees. A large, leafy tree stands prominently on the right side of the road. In the background, there are rolling hills and mountains under a blue sky with scattered white clouds.

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Contents

12

ADVANCED TRAINEES

Improving the quality of provisional training

6

RURAL REGIONAL REMOTE HEALTH

How can we improve health outcomes across NSW?

10

WAGGA WAGGA STROKE UNIT

How to provide world class care in a regional centre

15

PROFESSIONAL COURTESY

Should you charge your colleagues?

17

COLLECTIVE VOICE

Together we are stronger

Regulars

3

President's Word

5

From the CEO

19

Workplace Relations

23

Policy

25

Golf

27

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President's Word

BACK TO BUSINESS



DR DANIELLE MCMULLEN
PRESIDENT, AMA (NSW)

Many of us are probably still a little fatigued from the previous 12 months, but it feels so good to turn the corner into 2021.

FIRSTLY, I WANT TO welcome the Interns of 2021. Your enthusiasm and energy will be very welcome – particularly in hospitals that are feeling a little worse for wear from the previous 12 months. Congratulations on completing your final year in such trying times. We have been exceptionally lucky in NSW (and I figuratively knock on wood here – given that I am writing this a few weeks before it lands in mailboxes and anything can happen...), but the stress and anxiety of the past 12 months has taken its toll on everyone.

Many of our members have not taken leave over the holidays – or taken a shorter amount of leave – in order to facilitate elective surgeries for patients who were bumped earlier in the year.

We can now see that elective surgery figures are ticking up again. The Bureau of Health Information figures, released in December for the third quarter of 2020, revealed that the number of elective surgical procedures performed in NSW during July to September was 64,668 – up 4.2% compared with the same quarter the previous year.

More elective surgical procedures were performed in that quarter than in any quarter over the past five years – and double the number performed in April to June.

Despite this acceleration in activity, more people were on the waiting list for surgery at the end of the quarter compared with the same time last year – and those patients were more likely to have waited longer.

The number of people on the waiting list on 30 September was 95,052 – up 11.8% compared to the same quarter last year. Of those people, 8193

had waited longer than the clinically recommended time for their surgery – up from 844 in 2019.

From 1 July, there has been a return to 100% activity, with some LHD's operating up to 115% activity.

It will take many more months to clear this backlog and we recognise the pressure this has on members. Please remember to look after your own mental health and wellbeing at this time.

There will be a similar significant increase in activity for general practitioners, as many prepare for the roll-out of the COVID-19 vaccine.

We are working with NSW Health to ensure that roll-out is as well-planned as possible. We anticipate that distribution will be challenging, and we will keep you informed along the way.

Initial vaccine roll out is likely to be in small numbers to a very specific group of people. This may be managed in specialised vaccine centres. As broader population vaccination rolls out, we are advocating strongly for these to be delivered through general practice – the existing distribution network has proved its safety, efficacy and efficiency delivering the national immunisation program and should be the centrepiece of a COVID vaccination.

I hope you all had a restful holiday season. We're ready at the AMA to get back out and meet as many of you as possible, and continue to work on the issues that matter most to you. Please be in touch with us anytime. **dr.**







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From the CEO

WHAT BUSINESS IS IT OF YOURS?



FIONA DAVIES
CEO, AMA (NSW)

As your professional association, the AMA is always ready and willing to get involved in issues that impact doctors and patients.

IN A RECENT, rather terse, exchange with a Government organisation, the person on the other end of the Zoom meeting said to me, “What business is it of yours to interfere in [Dr X’s] case? What gives you the right to tell us what we should be doing?”

It was this moment that I wished the meeting had been face-to-face so I could draw myself up to my full 5’2” height.

With all the dignity I could muster I said, “It’s my business because it matters to my doctors and anything that matters to my doctors is the AMA’s business.”

This is why, in any given year, we deal with seemingly disparate issues – from tunnels to border closures, climate change to rates of pay for administrative staff, Medically Supervised Injecting Centres to services and resources for hospitals. If it affects our members, then it’s our business.




We sincerely hope for 2021 that less of our business will focus on COVID and that we will be returning to a focus on our health system. COVID has provided the opportunity for people to understand the value of good health and good healthcare. It has allowed walls to be built and walls to be taken down. It has exposed some of the weaknesses of a delicately balanced and interconnected system that exists between general practice, private specialist practice, private and public hospitals.

We know what happens when this balance is upset – most notably at Blacktown Hospital in recent weeks. The hospital is under pressure from growing patient demand and declining utilisation

of private health insurance, particularly in areas such as obstetrics. And while private health insurers have developed some models which they believe will be more attractive to patients, those models reduce the autonomy and potentially the satisfaction of doctors.

In one positive piece of news for the end of 2020, we were pleased to see SIRA recognise the contribution of doctors and index workers compensation fees to reflect the AMA List of Medical Services and Fees. The decision followed many months of lobbying and significant work by State and Federal AMA to highlight the appropriateness of the AMA Fees List and the contribution of doctors to the care of injured workers.

We don’t expect this battle to go away – blaming doctors for poor return to work rates is simply too easy to do. However, we will continue to stand up for the work of doctors in caring for patients injured at work – just as we will continue to stand up for our doctors on all the issues that matter most to our members. **dr.**

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IMPROVING HEALTH OUTCOMES

in rural, regional &
remote NSW



Feature

Barriers to healthcare access in rural, regional and remote NSW are multifactorial, but tackling workforce challenges must be a priority if we are going to improve outcomes in these areas.

FROM THE beautiful beaches of the North Coast to the rolling fields of the Riverina Murray, rural, regional and remote NSW has much to offer. But beneath the beauty lies some stark realities for residents, including shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas.

An Upper House Inquiry was established last September to look into the health outcomes and access to health and hospital services in rural, regional and remote NSW.

In addition to examining health outcomes, the committee is investigating patient experiences, wait-times and quality of care for people living in these areas, and how these measures compare to metropolitan communities, including examining service availability, barriers to access and the quality of available services.

Furthermore, the Committee is analysing NSW Health's planning, systems and projections in determining the provision of health services, as well as capital and recurrent funding.

The review also includes a look into staffing challenges, ambulance services, access and availability of oncology treatments and palliative care.

Submissions to the Inquiry close mid January.

To help inform our submission, we surveyed members about their experiences and conducted research interviews with individual members and the Medical Staff Councils of rural, regional and remote hospitals.

We had a huge response from members, which spoke to the passion and dedication many members have for working in rural, remote and regional

Australia and their commitment to seeing improvements in healthcare for their patients.

The challenges faced in rural, remote and regional areas across NSW are not uniform. Healthcare service and access is highly varied across the State in many respects, but residents face similar issues of disadvantages relative to their metro counterparts in relation to their health and welfare.

HEALTH OUTCOMES

Many health outcomes are worse for regional and rural populations. Regional and rural communities also have a proportionally higher Indigenous population, whose health risks and outcomes across all measures are significantly worse than non-Indigenous Australians.

These disparities include:

- Higher incidence of death from all causes, resulting in a lower overall life expectancy with the greatest gap in life expectancy experienced by the Indigenous population
- Higher incidence of low-birth weight neonates and perinatal mortality
- Increased incidence of death, injury and disability amongst the Indigenous population and young adults in regional communities due to higher rates of violence, accidents and suicide
- Higher incidence of many chronic conditions that together with later diagnosis and limited treatment options impact survival rates of patients

WORKFORCE

The number of medical practitioners has increased in recent years on average across Australia. The number of medical

Feature

practitioners registered and employed in NSW in 2019 was 31,817, according to Health Workforce Data.

The NSW Rural Health Plan: Progress Report (2017-18) indicates there was a 15.8% increase in medical practitioners between 2015 and 2017.

However, as indicated by the significant number of regional areas that are classified as 'Districts of Workforce Shortage and/or Areas of Need' there continues to be considerable service shortages across the State.

It is not possible to accurately ascertain distribution of the specialist workforce by speciality from published statistical measures, which makes assessment of the (in)adequacy of the workforce difficult to quantify.

It is understood that NSW Health, together with Colleges, are currently improving data collection and transparency in relation to the specialist workforce and unmet need, a task that is critical for targeting specialities and communities and as a benchmark to assess the success of existing and future policies.

The low number of specialists in regional areas is particularly concerning, as these areas are not only serving their own populations but also rural and very remote areas.

By contrast, the number of GPs (including GP proceduralists) per 100,000 population is slightly higher in regional areas, reflecting their broader scope of practice and provision of services to smaller populations over larger distances.

The Rural Doctors Network gathers statistical data for GP workforce planning and policy development.

According to the RDN, as of 31 December 2018 there were:

- 2,061 rural NSW GPs (excluding registrars)
- 2,562 rural NSW GPs including registrars in 651 practices in Australian

Standard Geographical Classification – Remoteness Area (ASGC-RA) 2-5

- 515 rural NSW GPs who are Visiting Medical Officers (VMOs) in rural hospitals in MMM 2-7
- 266 GP vacancies registered with RDN in rural towns

The RDN NSW points out that despite an increase in the number of rural GPs over the years, the average hours of patient contact has decreased as more doctors are working part-time and doctors have gradually reduced their hours. There are growing concerns about an aging GP population. About 33% of GPs are over 55.

Replacing doctors as they retire will be a significant challenge, which is compounded by the fact that these doctors often take an active and critical role in training registrars and medical undergraduates.

Regional and remote areas are also heavily reliant on international medical graduates, and more transient workforce short term placements, visiting staff and FIFO workers.

RECRUITMENT AND RETENTION

It is imperative that we explore initiatives to ensure that regional practice is an attractive option.

The majority of current initiatives focus on the important issue of provision of primary care services to rural and remote populations, with fewer initiatives targeted specifically towards either the regional workforce or non-GP specialists.

Programs that have specifically targeted regional areas include expansion in GP Training and Specialist Training Program placements (STPs), as well as the creation of academic centres such as the Rural Clinical School (RCS) and University Departments of Rural Health Program (UDRH).

Survey Feedback

"The situation now is worse than when I was a registrar. The rural generalist training scheme will benefit hospitals, but not general practice, where most people are cared for. What country people need most is more qualified GPs (fellows). I have seen many initiatives in my time but none have worked. The federal government needs to pay more to fellowed GPs through Medicare, such as an increased rebate on the Medicare levy, to recognise the increased complexity of the work and to reward the fact that we live in places no other doctors wish to (i.e. a higher hourly rate). I am of this opinion despite the fact that I am a proceduralist (obstetrics and anaesthesia)."

– Survey respondent

What can be done?

Through our consultation with members, AMA (NSW) identified these solutions.

SOLUTIONS

- **Supporting the rural and regional pipeline:** Recruiting rural/regional students and creating opportunities for rural/regional immersion throughout medical training has provided a long term but effective strategy to maintain and increase the rural and regional

Feature


medical workforce, especially the GP workforce. Some advances have also been made in developing the specialist pipeline, such as increasing STPs. However, further STPs and more generalist training options are needed to cater for the numbers of junior doctors wanting to train and practise regionally.

- **Bundled initiatives:** Not all doctors with a rural background will practise in regional/rural areas, and because of the smaller number of medical students with a rural background, the majority of regional/rural doctors have an urban background. This emphasises the fact that multiple bundled initiatives – professional, organisational, personal and financial – that target other key driving factors in a doctor's choice of geographical location, such as regional training and support, streamlined recruitment processes, succession planning, reviewing family needs, and financial initiatives, are required to recruit and retain doctors in regional and rural settings.
- **Critical mass:** Building and retaining 'critical mass' (multiple doctors with the same specialty in a popular location) is imperative for recruitment and retention. A critical mass ensures seamless high-quality services to the community and partly counteracts the professional, organisational, and social disadvantages or remoteness.
- **Appropriate infrastructure:** The non-GP specialist workforce is in many ways a more difficult problem than the GP workforce, requiring adequate infrastructure and hospital appointments. Adequacy of health infrastructure, including availability of long-term certainty of theatres and lists, diagnostic services, access to specialist

drugs, specialist nurses and staff, access to private hospitals as well as connections to metropolitan colleagues, are all key issues for recruitment of specialists and maximising their benefit to their community.

- **Engagement and planning:** Doctors on the ground are often keen to be involved in succession planning and recruitment and more broadly in planning and service delivery decisions. Engagement of clinicians by hospital administration in workforce planning is critical to the success of recruitment and retention drives in regional and rural areas.
- **Standardised contracts and working conditions for VMOs:** Members have highlighted the inadequacy of standard contracts. These contracts do not take into account 24/7 on-call requirements of some specialists who have no back-up. This makes it difficult to attract new specialists to the area. LHDs need more flexibility to be able to address these individual demands.
- **Improving Health IT:** There are several practical concerns with the existing rural eMeds EMR program. The current software has not kept pace with versions available in metro LHDs. The limited features and support create delays in treatment and an inability to access information after hours.
- **Rural / regional bonding:** It was consistently expressed by our members that there is a lack of surgical specialists as well as nursing staff. High need exists for specialists, such as rheumatologists, neurologists, dermatologists and psychiatrists. Rural / regional bonding for some advanced training positions or enhanced

Medicare funding for areas of need to attract specialists to rural areas might alleviate some of these shortages.

You can read AMA (NSW)'s full submission to the NSW Parliamentary Inquiry into Regional, Remote and Rural Services after submissions close on 15 Jan 2021 here: <https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2615> 

Recruitment and Retention of Nursing Staff

Our members identified issues with retaining experienced nursing staff. Some LHDs reported that nurses and operating assistants have been given casual, or part time contracts – despite years of service – which makes it very difficult for them to obtain home loans. One member indicated that during a recent recruitment, four anaesthetic nurses to Port Macquarie were put through a three-to-six month training program (to meet ANZCA standards), but upon completion of training no further hours were promised. Only one of those four nurses has remained, the others were forced to accept other jobs for economic reasons. Offering casual or low permanent hours makes it difficult to recruit from metropolitan areas, as moving to a regional area requires a significant commitment and there are fewer opportunities to pick up work at other nearby facilities.

Feature



Associate Professor Martin Jude



RECOGNISING REGIONAL ACHIEVEMENT

Whilst healthcare improvement is needed in rural, regional and remote areas of NSW, Wagga Wagga Base Hospital is demonstrating it can provide world class care to residents.

THE STROKE UNIT at Wagga Wagga Base Hospital recently became the first in Australia to receive a prestigious World Stroke Organisation Angels Gold Status Award for meeting the highest standards in stroke treatment.

Head of the Wagga Wagga Hospital Stroke Unit, Associate Professor Martin Jude, said that one of the hospital's key achievements was ensuring more than 70 per cent of eligible patients receive clot busting therapy (recanalisation) within 60 minutes of arriving at the hospital door.

"This is an outstanding result, for our team and for patients being treated for stroke."

Feature



Kim Malkin, Australian Lead, Angels Initiative, Dennis Jewell (patient), A/Prof Martin Jude, Katherine Mohr, Gary Bingham (patient), Samantha Dagasso, Regional Angels Program Manager

A/Prof Jude described the achievement as ‘fantastic’ but says they did not participate in the initiative to win the award.

“Auditing data is core business for a stroke unit,” he said. “If you’re not auditing your performance, you’re not doing the right thing.”

A/Prof Jude explained that Wagga’s Stroke Unit has been regularly providing its data to the Australian Stroke Clinical Registry, but this is the first year the World Stroke Association has included the audit data from Australia in this initiative.

The Angels Initiative is a partnership between the World Stroke Organisation, European Stroke Organisation and Boehringer Ingelheim.

The purpose of the program is to optimise the standard of treatment in stroke centres worldwide and improve patient outcomes by setting global benchmarks for best practice stroke care.

The Angels Initiative Medical Project Manager in Australia, Kim Malkin said Wagga Wagga was the first Australian hospital to achieve an Angels Award Gold Status and the objective was to ensure all hospitals reach these global benchmarks.

“To achieve gold status a hospital must demonstrate a range of outcomes. This includes more than half of all eligible patients with stroke receiving treatment within 60 minutes of hospital arrival – at Wagga Wagga they’ve been able to do even better,” she said.

Australian Stroke Clinical Registry (AuSCR) lead, Professor Dominique Cadilhac from The Florey Institute and Monash University, congratulated Wagga Wagga Base Hospital on their achievement.

“This award acknowledges the leadership and dedication of Martin and his team, while underscoring the importance of high quality, standardised data collection and review of performance to improve stroke care,” she said.

A/Prof Jude has been working in Wagga Wagga since 1995 and running the stroke service for the past 12 years.

Wagga Wagga Base Hospital has the only dedicated stroke unit in the Murrumbidgee Local Health District, serving a population of nearly 250,000 people across a 125,000 square kilometre catchment area.

A recent report by the Stroke Foundation highlights that people living in regional Australia are 17 per cent more

likely to suffer a stroke than those living in metropolitan areas.

In stroke care, “the greatest battle is against time,” A/Prof Jude says. “With each minute that goes by more brain cells are lost and the risk of disability and death increases.”

“In regional Australia we not only have higher rates of stroke but have to contend with the challenges of rapid access to expert care over long distances.”

The hospital, where up to 450 admissions to its stroke unit occur each year, has implemented a range of procedures to ensure patients receive optimum care.

“We recognised that stability of staffing and the depth of skill across our unit was critical,” A/Prof Jude said.

“We have invested in education and training starting with Ambulance, Emergency Department, radiology and all members of the stroke unit team, meaning stroke symptoms are recognised rapidly and we’re able to deliver the right treatment at the right time.”

He is hoping this award reassures residents that – despite living in regional NSW – they are receiving quality healthcare.

“There’s a misconception that quality care doesn’t exist outside of Sydney. But we’re hoping this takes some of that fear away and is motivating for staff as well. We also want junior doctors to feel confident that they can have a good career working in regional locations.”

He says Wagga Wagga Base Hospital has what he calls a ‘Goldilocks’ advantage. It’s just the right size to get on with the job at hand.

A/Prof Jude says the lesson for other regional healthcare centres looking to emulate their success is to focus on continuity of staffing.

“You also need to be brave enough to look at your performance and take the good news with the bad. And if there are challenges, see where you can improve.”

dr.

ADVOCACY for advanced trainees

AMA is working at both a State and Federal level to improve the quality of vocational training.



THE AMA Specialist Trainee Experience Health Check, released in late November, reveals the challenges and stressors faced by advanced trainees.

The Health Check compares the specialty training experience across 11 Colleges, ranking them from A+ (excellent) to F- (unsatisfactory) in four areas:

- Communication and Engagement
- Examination and Assessment
- Supervision and Teaching
- Workplace Environment and Culture

No College achieved higher than a B in any area, while the lowest mark was D-.

Almost 10,000 respondents completed the survey, which revealed the stressors doctors face as they complete their training.

“Australia has a world-renowned system of specialist training and our medical Colleges are doing a fantastic job in preparing doctors for independent

specialist practice. However, the Health Check shows that there is room for improvement,” said AMA President, Dr Omar Khorshid.

“This includes areas such as exam feedback, providing access to mental health services, addressing bullying, discrimination and harassment, access to study leave, and supporting employment at the end of training.”

The survey found 32% reported receiving useful exam feedback while almost half (45%) indicated they did not.

Meanwhile 66% reported having access to protected study time or leave.

The survey found that one in five respondents experienced bullying, discrimination or harassment, while 36% reported its occurrence. Once reported, it was followed up half of the time. About a quarter of respondents (27%) indicated they witnessed bullying, discrimination and harassment, while only one-third

reported it and 41% followed up on these issues.

With regard to employment concerns, almost half (45%) of respondents agreed they were concerned about their ability to secure employment at the end of their training.

Access to mental health services was also highlighted as another area for improvement, with only 38% indicating they were supported in this area.

To help address doctors’ mental health and wellbeing, AMA partnered with other medical groups and mental health leaders to launch its Every Doctor, Every Setting: A National Framework in October 2020.

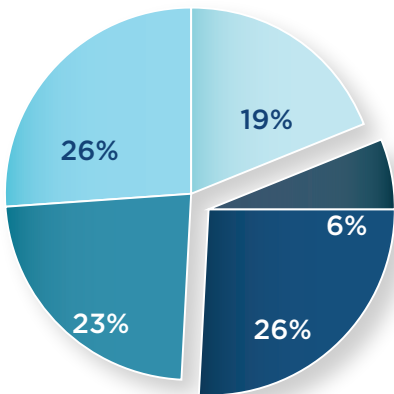
NSW ADVANCED TRAINEES AND FELLOWS

Concerns from advanced trainees and fellows about workplace conditions and career options following completion of

Feature

Exam Feedback

32% reported receiving useful exam feedback.



** AMA Specialist Trainee Experience Health Check*

training sparked AMA (NSW) to also survey its members.

Preliminary results from this survey suggest more than half of respondents (55%) do not have a rest policy in the event they are called to come into work at night, with several respondents commenting that they are expected to come in and work the next day as rostered, after coming in overnight. Others indicated there wasn't a formal policy in place but informally they could take the morning off to rest or leave work early the next day depending on clinical load.

Respondents were divided in their responses on how often they are required to come in when on call. About 18% said 'always' while another 18% indicated 'never'.

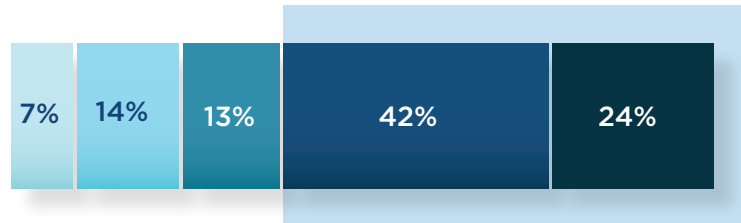
Almost 60% indicated they are 'always' paid for callbacks, while three-quarters (74%) indicated they are 'never' paid for remote clinical appraisals.

The majority of respondents (85%) said they are pursuing a public appointment upon completion of their fellowship, but almost 40% said they are 'not at all confident' they will achieve that.

More than a third indicated they will pursue work in private practice and 28% are interested in doing an international fellowship.

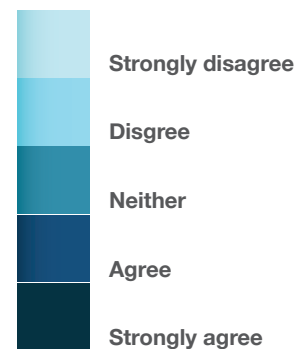
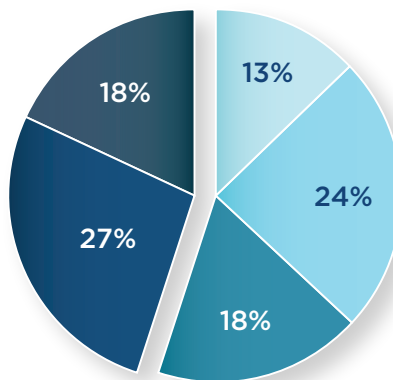
Study Leave

66% reported having access to protected study time or leave.



Employment Concerns

Almost half (45%) of respondents agreed that they were concerned about their ability to secure employment at the end of their training.



** AMA Specialist Trainee Experience Health Check*

Nearly all respondents (79%) felt they must undertake additional education to receive a public hospital appointment.

One respondent commented, "Thank you for looking into AT and fellow welfare. AT training can be very tough with a lot of exploitation occurring due to the desire for career advancement/public appointments."

Paid paternity was another issue cited by respondents, as was part-time flexibility.

"Paid paternity leave is standard in most other industries (banking, law, etc)... paternity leave affords working mothers the opportunity to return to work sooner."

Another respondent commented, "[I] currently have a 12-month-old with another on the way and I'm studying for fellowship exams. I am working part time while my wife has to work full time due to

her training and workplace inflexibility. My department's roster is underfilled (always is!) but recently I've been informally informed that they will be reviewing the sustainability of allowing part-time employment for trainees. Nothing formal but this is concerning given that there is no way I can work more, study and afford childcare and in addition, it's highly unlikely I will be able to get a 1.0 FTE staff specialist job even if I had the flexibility to work that much. Bottom line, I feel there is a background attitude that trainees fill the roster and that's it – with no acknowledgement of exam pressures or even that we might have lives outside the hospital at the age of 30!"

AMA (NSW) will be examining these survey results in further detail to determine advocacy for advanced trainees and fellows. **dr.**



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SHOULD DOCTORS CHARGE OTHER DOCTORS?



DR MICHAEL STEINER
AMA (NSW) COUNCILLOR,
FORMER PRESIDENT

Waiving fees for colleagues is more than just a professional courtesy. All medical practitioners have a responsibility to look after the health of colleagues and to lower barriers to doctors' wellbeing.

AMA (NSW) was recently contacted by a long-standing member about his experience with a local general practitioner. Both he and his wife attended appointments with the general practitioner and were required to pay a gap fee following the consultation.

The member who raised the issue had

never billed a colleague or their family over many years of practice. While not a rule, this is common practice for many doctors.

The money was not the issue. But rather, the member was concerned about what this signalled for the profession as a whole.

While he recognises the economic complexities of current practice, his worry is that professional courtesy and respect for colleagues appears to gradually becoming lost.

Professional courtesy is not unique to medicine but has long been associated with medical practice. In addition to marking the mutual respect for another's commitment, training and expertise as a medical professional, providing care at no cost (or reduced cost) to colleagues was originally adopted as a means of discouraging doctors from treating themselves or their families. This long-standing tradition is referenced back to the Father of Medicine, Hippocrates.

English physician and ethicist, Thomas Percival wrote a classic essay in 1803 that reaffirmed the importance of providing complimentary professional care between physicians and surgeons, and their immediate family members.

In 1847, the American Medical Association included this concept in its Code of Ethics. However, in 1994, it revised this position – advising members that waiving fees for colleagues was not an ethical requirement and that physicians should use their own judgement when extending this professional courtesy. The reversal of opinion reflected the complexities of health remuneration in America, which includes co-pays and insurance-only billing.

While this may be the situation overseas, medical practitioners in Australia have greater flexibility.

The AMA (NSW) Ethics Committee agreed with the member that failure to extend complimentary care to colleagues appears to be a sad and lamentable reflection of a few medical practitioners where more than good manners are becoming lost.

The real failing is actually the impact on doctors' health. Now, perhaps more than ever, we must be looking at ways to lower barriers for medical colleagues to access care. The global pandemic has affected everyone, but frontline healthcare workers have been among the hardest hit.

Research by Mental Health Australia revealed more than 70% of healthcare workers surveyed said the COVID-19 restrictions had a negative effect on their mental health and wellbeing, while 67% said working in healthcare during the pandemic had been bad for their home life.

Healthcare workers reported several health impacts including prolonged tiredness and fatigue, sleep problems, and mood swings.

Almost half of all survey respondents (49%) said they have not sought specific mental health support.

Many doctors are reluctant to seek help often due to not wishing to impose on colleagues. While cost is unlikely to be a prohibitive factor in itself, professional courtesy is always appreciated, in all its forms. Removing barriers for doctors to access care not only benefits the whole profession, it has wider benefits. If we can look after each other, then we will be in a better position to look after our patients. **dr.**

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LEADERSHIP IN CRISIS



DR ASHNA BASU
DOCTOR-IN-TRAINING

One of the greatest lessons from the pandemic was the importance of having a strong organisation to represent doctors.

THE COVID-19 pandemic rendered people helpless, anxious and uncertain. People were unsure how to help as the world was plunged into chaos and their families and communities faced an invisible enemy. In some ways, as healthcare workers we had a clear role during the pandemic – a way we could roll up our sleeves and actively make a difference – but even we felt helpless at times. Every day there was a new, sometimes conflicting, directive. We had no control over when we could wear PPE – let alone widespread access to equipment.

As junior doctors, we encountered the usual learning curve and stresses,

compounded with the prospect of frozen rotations and cancelled exams, with resultant uncertainty around training and progression. And while we were luckily able to work in-person and see colleagues daily, the (much-needed) lockdown rules prevented us from gathering in groups to talk through everything.

But it wasn't just junior doctors who felt a sense of powerlessness. We were at the mercy of decisions made by Government. And while elements of Australia's response are to be lauded, there were also errors. We've done pretty well, comparatively, because good decisions were made. But we've also done well in spite of suboptimal or slow decisions.

The decisions around PPE, lockdown, quarantine, screening and testing were made by Government and expert advisory groups, while individual healthcare workers on the ground had to bear the consequences, ie ED doctors who were told they weren't allowed to routinely wear masks, because that wasn't the policy (yet); GPs who were left in the lurch without access to adequate PPE; doctors who saw patients with COVID-like symptoms, but couldn't test them because, even though they had travelled overseas and had all the symptoms, they hadn't come from China or Iran.

We were the ones who would risk getting the infection in order to treat those in need, the ones who risked bringing the virus into our homes and infecting our loved ones. And it felt like we weren't adequately prepared or protected. We had to contend with a daily flood of emails, and wade through the information to see how it would affect our work, and lives. As Advocacy and Wellbeing Officer for our RMOA, I wrote a small daily WhatsApp newsletter for my hospital to try and summarise relevant

information, allowing people to switch off from the onslaught of notifications, emails and breaking news alerts sending our phones crazy when we were trying to focus on work.

We watched horrified, as the Victorian Government toyed with letting the Melbourne F1 Grand Prix go ahead whilst lambasting (and publicly naming!) a COVID-positive GP who followed their guidelines. We had Facebook groups, and we circulated petitions. We tweeted, and we messaged furiously in WhatsApp chats.

The pandemic has taught us the importance of community. We learned how essential it is that a community comes together and agrees to stay home to protect each other. We saw how our community ensured that vulnerable folk received groceries and essential items, and how they thanked us for our work. Individuals had no hope of staving off the pandemic alone – but a community, united, could make sure there was no fuel to fan the flames of infection.

Doctors need a community too – and not just the informal ones we make with our friends and colleagues, but a formal organisation that lobbies on our behalf. The AMA, both state and federal, worked tirelessly to convey doctors' concerns to the government – lobbying for PPE, for fit testing, for a lockdown. The AMA provided the kind of advocacy power that can only be achieved when you have strength in numbers. Pragmatically, we will always be more successful when we come together as one voice – rather than dispersed doctors who despair alone.

If we speak together, we become so loud that we can't be silenced, or ignored. We become so powerful that we galvanise people into action, and enact changes that protect both our patients, and ourselves. Together, we are strong.

dr.



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SUPPORTING MEMBERS IN 2021



DOMINIQUE EGAN
DIRECTOR OF WORKPLACE
RELATIONS, AMA (NSW)

As we move into a new year, we are analysing the impact of the pandemic and how AMA (NSW) can support members as we refocus and rebuild in the coming months.

COVID-19

Just like all of you, my imaginings of what last year would look like and what I might see and do in my first 12 months as Director of Workplace Relations at AMA (NSW) were quickly forgotten as COVID-19 presented a number of unforeseen and immediate challenges across the public and private health systems.

As 2021 begins, our members in the hospital system continue to have to navigate COVID-19 and the changes this has brought to rostering, training,

examinations, access to leave, where work is being done, how they will be paid for services provided, and a final push to get through as much wait list reduction work as possible.

The Workplace Relations Team continues to support our members to negotiate their workplace arrangements during this busy time.

REVIEW OF VMO DETERMINATIONS

COVID-19 has not only presented challenges for our members and the health system but has also provided AMA (NSW) and its members with the opportunity to learn from how our health system has responded and what might be able to be done better. The Workplace Relations Team is currently looking closely at the VMO Determinations and whether the arrangements under those Determinations have kept pace with the changing nature of medical practice, service delivery and the workforce. In particular, we are looking at where and how services can be delivered to public patients. If you are a VMO in the public hospital system and are interested in becoming a member of our focus group, please email workplace@amansw.com.au.

PRIVATE HOSPITAL ARRANGEMENTS

COVID-19 has provided the opportunity for AMA (NSW) to have greater engagement with private hospitals. This is a dialogue that AMA (NSW) will continue in 2021 as we support and advocate for our members in the private hospital system which in many ways is becoming more regulated, but without many of the protections and supports for those medical practitioners providing services in the public hospital system.

DOCTORS-IN-TRAINING

The Workplace Relations Team has really enjoyed being able to return to providing individual workplace relations services to our doctors-in-training members following the dissolution of the Alliance. We continue to be here to support DITs with their workplace issues, COVID-19 and non-COVID-19 related. We will be taking the next couple of months to undertake a detailed review of the Hospital Health Check, parental leave entitlements, night shifts and workforce availability across all sites, but in particular, those outside metropolitan areas.

PRIVATE PRACTICE

Last year was challenging for members in private practice. In my 20 years working with doctors, never did I foresee a time when medical practitioners would be facing so many difficulties to keep their practices open. We have supported our members in navigating telehealth, elective surgery close downs, Job Keeper and to keep across the Public Health Orders and Government COVID-19 requirements and best practice.

On top of everything else, Revenue NSW advised it was changing its approach to payroll tax following the Optical Superstore decision. We are continuing with our communications to members to help them understand whether this may affect them and encouraging them to see a review of their existing arrangements.

Webinars have allowed us to keep in contact with our members, and our first virtual Private Practice Masterclass was a success. While we are looking forward to a return to face-to-face events as soon as possible, we will continue with webinars to ensure we reach as many of our members as possible. **dr.**

LOOKING BEYOND JOBKEEPER



LYNDALL HUMPHRIES
SENIOR EMPLOYMENT LAWYER,
WORKPLACE RELATIONS,
AMA (NSW)

Employers should be preparing for a future post JobKeeper. This includes making plans around staffing that may not have been necessary or may have been deferred while the JobKeeper scheme has been in effect.

MANY BUSINESSES have been able to stay afloat and continue employing staff throughout the COVID-19 pandemic largely thanks to the Federal Government's JobKeeper scheme and the accompanying JobKeeper changes to the Fair Work Act 2009. Private practices are no exception. We have heard from members who have been grateful recipients of recent support measures.

According to the Treasury, the first phase of JobKeeper announced in March 2020 supported more than 3.6 million workers and around 1 million businesses, with payments totalling nearly \$70 billion for the 13 JobKeeper fortnights to 27 September 2020¹.

The second phase of JobKeeper announced in September 2020 required a re-test of business eligibility. The Treasury indicated that more than 1.5 million workers and around half a million businesses had applications processed at the start of the second phase, meaning that around 450,000 fewer businesses and around 2 million fewer employees qualified for JobKeeper in October 2020 than in September 2020².

Participation in the second phase of JobKeeper was lower than forecast by the Federal Government, suggesting that business is improving and the economy is recovering. According to the ABS, Australian economic activity rose 3.3% in the September 2020 quarter³. You may have noticed an uplift in activity at your practice after the NSW Government lifted the ban on elective surgery from 1 July 2020 or as COVID-19 restrictions have been further eased.

The second phase of JobKeeper is set to end on 28 March 2021, along with the temporary JobKeeper provisions in the Fair Work Act which have given

employers more flexibility to modify their employees' working arrangements while covered by the JobKeeper scheme.

On 9 December 2020 the Government introduced a Bill proposing significant amendments to industrial relations. Amongst other changes the Bill seeks to extend certain JobKeeper flexibilities for a further two years for the retail and hospitality industries, being those industries hardest hit by COVID-19. At the time of drafting this article, there was no such proposal to extend JobKeeper flexibilities beyond the scheduled end date for the health industry.

While businesses have taken significant steps to adjust to the new normal, employers should be preparing for a future post JobKeeper. This includes making plans around staffing that may not have been necessary or may have been deferred while the JobKeeper scheme has been in effect.

Flexible working arrangements

There is no doubt that the COVID-19 pandemic has placed flexible working arrangements under the spotlight. Particularly during lockdown, employers were required to consider flexible working arrangements they may not have contemplated before.

After the flexibilities enabled by the temporary JobKeeper provisions cease, some employees can continue to request flexibility in the workplace. Some employees will still have the right to request flexible working arrangements, such as changes to hours, patterns or locations of work (including working from home).

The Fair Work Act enables employees who have worked with the same employer for at least 12 months to request flexible working arrangements if they:



- are the parent, or have responsibility for the care, of a child who is school aged or younger
- are a carer (under the Carer Recognition Act 2010)
- have a disability
- are 55 or older
- are experiencing family or domestic violence, or
- provide care or support to a member of their household or immediate family who requires care and support because of family or domestic violence.

Casual employees can only make a request for flexible working arrangements if they are a long term casual with a reasonable expectation of continuing employment on a regular and systematic basis.

It is important to note that an employer must respond in writing within 21 days and can only refuse a request on reasonable business grounds. Such grounds can include if it would be too costly for the employer, be impossible or impractical to change other employees' working arrangements or have a significant negative affect on productivity or customer service. Sometimes employers and employees are able to consult with each other to agree a mutually acceptable solution.

Changes to terms of employment

The temporary JobKeeper provisions in the Fair Work Act have enabled qualifying employers to give eligible employees a JobKeeper enabling direction or agreement to reduce hours or days of work, change duties or work location or change days or times of work. These flexibilities have been aimed at providing employers with flexibility to manage the workplace during the COVID-19

pandemic.

If a JobKeeper enabling stand down direction is in place, it will end if the employer or employee no longer meet the eligibility requirements, if the direction is withdrawn, revoked or replaced or it will otherwise stop applying after the temporary JobKeeper provisions cease.

After this point, the situation pre-JobKeeper will prevail. In accordance with basic contract principles, the terms of a contract must be agreed. This means that a party to a contract cannot unilaterally change its terms. Any changes to existing terms and conditions of employment must be agreed. This applies to any change to agreed hours, days, times of work, pay and position.

Consultation regarding change

Some of our members were not eligible for the first stage of JobKeeper and many of our members were not eligible for the second. Even with Government support, many private practices have suffered an immense financial blow and others have had to consider shutting down.

Many of our members have had to make, or consider making, difficult decisions about staffing and operational requirements as they deal with the economic impact of COVID-19. These decisions have not been easy and have often been a last resort to maintain practice viability. Some of these decisions relate to a reduction in hours, days and pay. Other decisions have resulted in redundancies.

When it comes to change, it is important that employers consult with employees in accordance with the consultation provisions in applicable modern awards. Such changes include a definite decision to make major workplace changes that are likely to have

significant effects on employees (such as a decision to make an employee's position redundant or undertake an organisational restructure) or a proposed change to an employee's regular roster or hours of work (before these changes are agreed).

Failure to comply with consultation provisions may lead to adverse consequences such as penalties for breach of a modern award or exposure to unfair dismissal in the case of redundancy.

AMA (NSW) Workplace Relations Team

Since the start of the COVID-19 pandemic, we have heard from members who have been dealing with considerable financial strain. We understand the impact of COVID-19 on business has been very stressful. We are here to support our members through these challenges.

If you need assistance with workplace flexibility, change or any other matter, contact the AMA (NSW) Workplace Relations Team by emailing workplace@amansw.com.au. You can also access our Workplace Relations resources on our website, including our guide "Working through COVID-19: Consultation and Redundancy". This article is current as at 15 December 2020. [dr.](#)

1. The Treasurer, "JobKeeper Update", <https://ministers.treasury.gov.au/ministers/josh-frydenberg-2018/media-releases/jobkeeper-update-0> (accessed 15 December 2020).
2. Ibid.
3. ABS, "Economic activity increased 3.3% in September quarter", <https://www.abs.gov.au/media-centre/media-releases/economic-activity-increased-33-september-quarter> (accessed 15 December 2020).

ARE YOUR CASUAL EMPLOYEES ENTITLED TO PAID LEAVE?



Employers have been seeking clarity around this question for some time now, and answers will finally be given when the High Court makes a decision that will help to remove the confusion around the definition of casual employment.



Need help?

Please contact our Workplace Relations Team on
02 9439 8822 or by email
workplace@amansw.com.au

IN WELCOME news for private medical practices and other employers across Australia, on 26 November 2020 the High Court of Australia granted Workpac special leave to appeal the decision of the Full Court of the Federal Court in *Workpac v Rossato*.

Current state of play

The Full Court decisions of *Workpac v Skene* and *Workpac v Rossato* have caused widespread confusion and uncertainty for employers. In these cases, employees who were engaged as casuals and paid a casual loading were found not to be casual employees and were successful in their claims for permanent entitlements.

Employer concerns

Many of our members have been concerned about the potential for “double dipping”, where they pay the employee a casual loading and may later be ordered to pay the employee permanent entitlements e.g. paid annual leave, paid personal/carer’s leave, paid compassionate leave and payment for public holidays.

Employers, industry and Government have also been alarmed about the potential cost impact to business, particularly small businesses that are already struggling to deal with the financial challenges caused by the COVID-19 pandemic.

Watch this space

The High Court decision may not be delivered until late 2021, but it will provide some much needed clarity on the interpretation of the common law around casual employment. Until then, the decision in *Workpac v Rossato* represents the current position on

casual employment, subject to current legislation and any legislative reform.

Meaning of casual employment

For the time being we should look to the Full Court for guidance on the meaning of casual employment. It has established that the essence of casualness is the “absence of a firm advance commitment as to the duration of the employee’s employment or the days (or hours) the employee will work”. Other key indicia of casual employment include irregular work patterns, uncertainty, discontinuity, intermittency of work and unpredictability.

To provide certainty about obligations and rights, the Government has proposed that the Fair Work Act 2009 (Cth) be amended to introduce a statutory definition of “casual employee” which incorporates the key common law principle that a casual is someone who has no firm advance commitment to ongoing work.

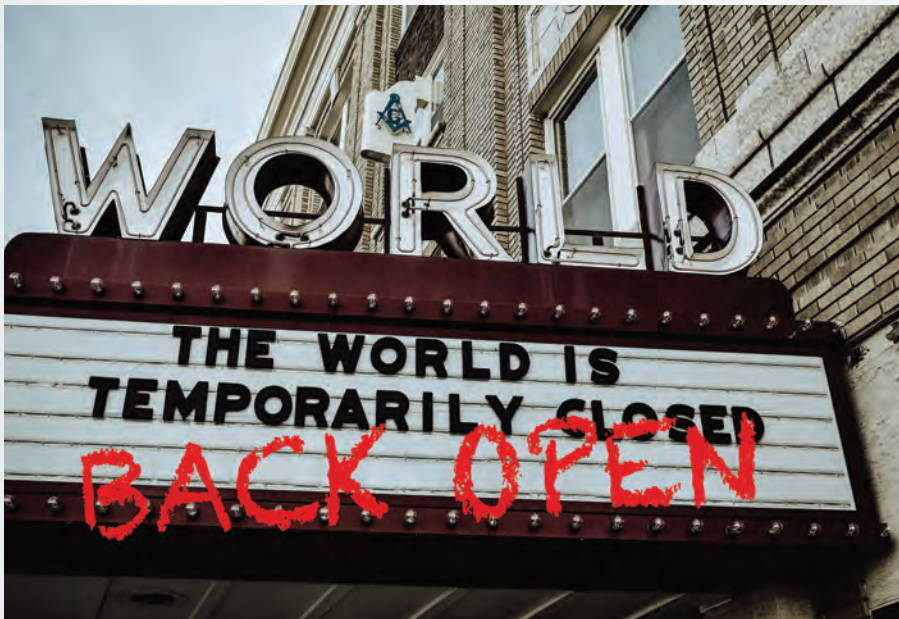
What does this mean?

The issue of long term casual employment is not a new one for private practice. Until the Fair Work Act is amended and the High Court provides clarity on the issue, there are several things you can do to minimise the risk of an underpayment claim against you or your practice:

- Correctly identify whether an employee is a casual or permanent and issue the correct type of employment contract
- Separately identify any casual loading
- Review the days and hours of work of your casual employees
- Consider whether to convert casuals to permanent employment noting the casual conversion clause in Modern Awards **dr.**

This article is current as at 15 Dec 2020.

HEALTH POLICY PERSPECTIVE



Whilst the pandemic took precedence in 2020, there was a flurry of policy activity towards the end of the year and in early 2021.

AMA (NSW) has been busy formulating policy responses to a number of Government inquiries. Here is a breakdown of several health-related issues being examined in more detail by Parliamentary Committees and the AMA (NSW) response to these inquiries*.

MANDATORY DISEASE TESTING

The Standing Committee on Law and Justice in the NSW Legislative Council established an inquiry into the Mandatory Disease Testing Bill 2020 in late November.

The Bill proposes to establish a scheme whereby a person can be ordered to

provide a blood sample for testing if, by deliberate action, the person's blood has come into contact with a health, emergency and public sector worker, and the worker is at risk of contracting a blood-borne disease as a result.

The Bill would allow law enforcement officers to use 'reasonable force' to assist in taking blood. It also comes with a penalty of 100 units or imprisonment for 12 months (or both) for failing to comply with a mandatory testing order.

It's not the first time AMA (NSW) has been asked to participate in policy formulation on this issue.

AMA (NSW) acknowledges that the impact of potentially serious blood borne viruses (BBVs) such as Hepatitis B, Hepatitis C and HIV continues to be an issue of public health significance. We also recognise that because such infections can be serious, emergency services personnel are deeply concerned about the risk to themselves.

However, AMA (NSW) has repeatedly

stressed that the rationale for mandatory testing of people whose body fluids may come into contact with emergency or public sector workers is not evidence-based.

Clinical evidence shows that the risk of Hepatitis B, Hepatitis C and HIV transmission from a known positive source through blood and saliva to unbroken skin and skin-to-skin contact is zero.

There have been no cases of saliva being a transmission route for HIV in Australia.

We also highlight that the standard workplace procedure is to treat all blood and bodily fluids as potentially infectious.

So in circumstances where a risk assessment has determined there is a risk of transmission of BBVs, emergency services personnel would be advised to follow potential bloodborne virus exposure management protocols.

AMA (NSW) strongly supports emergency services workers have access to immediate assessment, counselling and management by a health care professional after exposure to potentially infectious bodily fluids.

Testing of the source person (whether that be mandatory or voluntary) should not change the management of a potential blood-borne virus exposure.

This is especially important given that testing for HIV and other BBVs has a window period during which an infection cannot be detected.

A negative result is not conclusive. If significant exposure such as a needle stick injury or blood splash to broken skin, mouth or eyes has occurred, it is critical that Post Exposure Prophylaxis (PEP) treatment is commenced no later than 72 hours following exposure.

Given that testing and results should not change the protocol that should be followed in cases where significant exposure has occurred, and that testing of the source person should not be considered conclusive, AMA (NSW) does not support mandatory testing as an effective, reliable and necessary legislative reform.

Policy

AMA (NSW) acknowledges the stress emergency services personnel experience following exposure to blood and bodily fluids and potential for transmission of BBVs. It is vital that emergency services personnel are given prompt assessment, counselling and management by a health care professional.

AMA (NSW) highlights that mandatory testing presents significant practical and ethical challenges.

Informed consent is part of doctors' duty of care to patients and is necessary before performing any medical procedure. Under NSW Health's Your Health Rights and Responsibilities, patients have the right to withhold consent.

There are other practical issues for attending health professionals should the source person not consent to testing and 'reasonable force' must be used – how is this applied and what risks does this pose for medical staff?

Mandatory testing also removes the source person's autonomy over their health information. Medical professionals are very protective and vigilant about the privacy of health information of patients. Furthermore, mandatory testing contributes to the stigma and discrimination of people living with HIV, Hepatitis B and C. This has the downstream effect of limiting the ability of health services to engage people at risk or living with blood borne viruses.

Lastly, AMA (NSW) is concerned that the Bill applies to children between 14 and 18. The risk of infection from minors in this age group is extremely low – there were only three infections among children in this age group in the previous year.

Summary

Mandatory testing will not necessarily reduce stress for emergency services personnel who are exposed to a person's blood or other bodily fluids.

Should exposure occur, emergency services personnel should follow procedures for management of a potential blood-borne virus exposure.

Based on this, AMA (NSW) does not

conclude that the benefits of mandatory disease testing to emergency services personnel outweighs the extreme impact on the rights of the source person to consent to medical tests and disclosure of their health information.

CHILD PROTECTION AND SOCIAL SERVICES SYSTEM

The number of children 'lost in the system' is increasing year on year. In 2019, more than 77,000 children assessed by the Department of Communities and Justice to be at risk of significant harm were not followed up. That is a 41% increase from four years ago.

The Joint Committee on Children and Young People launched an inquiry into how the current child protection and social services system responds to these vulnerable children and their families.

The Committee is reviewing the respective roles and responsibilities of health, education, police, justice and social services and is assessing optimum evidence-based prevention and early intervention responses for vulnerable children and families.

The availability and adequacy of current funding for prevention and early intervention services will also be considered.

AMA (NSW) is advocating for investment in specialised training for evaluation and management when child abuse or neglect is suspected, particularly for vulnerable populations including Aboriginal and Torres Strait Islander children, children from CALD backgrounds and children with disabilities.

Cooperation and coordination between medical practitioners in different disciplines and medical practitioners and experts in other professions is important in effective prevention and management of child abuse and neglect, as such AMA (NSW) endorses an integrated strategy and response.

COERCIVE CONTROL IN DOMESTIC RELATIONSHIPS

The NSW Government established a

Parliamentary Joint Select Committee to hold a public inquiry to examine coercive control.

The Discussion Paper details key issues to inform their consideration of legislative reform and what can be done to improve how the justice system addresses it.

As many frontline health workers are involved in responding to people involved in domestic and family violence, AMA (NSW) will be looking at training and service delivery in the health sector to individuals subject to coercive control and other education and awareness measures, as well as note-taking for legal purposes and the role of medical practitioners to provide documentation for criminal proceedings.

THE CRIMES LEGISLATION (OFFENCES AGAINST PREGNANT WOMEN) BILL

Premier Gladys Berejiklian and Attorney General Mark Speakman released an Exposure Draft Bill for public consultation on a suite of reforms to recognise the loss of an unborn child as a result of a third-party criminal act.

The draft bill makes good on the Premier's pledge look at this legislation in the 2019 election campaign after abortion law reform was finalised.

AMA (NSW) will be looking at the proposed legislation in relation to issues associated with personhood.

A balance needs to be reached between protecting the rights of women and doctors and being able to hold people who would harm women to the point they lose pregnancies to account.

AMA (NSW) notes that a new bill from the Government would not be the same as previous ones introduced by Reverend Fred Nile and as such would consider it on its merits.

Please note that at the time of writing AMA (NSW) was still finalising its submissions to these inquiries. To read our submissions in full, please follow the Parliament of NSW - <https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiries.aspx>.* **dr.



BMA CUP CHALLENGE



LAURIE PINCOTT
FORMER CEO AMA
(NSW)

The BMA Cup is the highlight event of the golfing year for the AMA (NSW) Golf Society, which by tradition is a par event – one of the most difficult golf formats.

FORTY SIX players gathered early morning at the magnificent Terrey Hills Golf Club to contest this year's BMA Cup. The weather was cool for a summer's day and playing conditions were excellent. Terrey Hills, as always, looked after our group superbly with breakfast before tee off and an excellent lunch following play. Although the greens were lightning fast they rewarded those who could read the undulations. The COVID-19 rules were stringently enforced by the Club, for which the management were to be congratulated.

As AMA Golf Society members know the BMA Cup is the highlight event of the golfing year. By tradition the competition must be a par event, which is regarded as the most difficult of the golf formats.

The Golf Society wishes to thank the sponsors of the prizes for the day, Mr Scott Chapman of Ebsworth, Lawyers and Drummond Golf, Taren Point, and Dr Reuben Jackson.

Results presented a few surprises but at the same time rewarded disciplined play.

The winner of the 2020 BMA Cup was none other than the Society's President, Dr George Thomson with a score of Plus 3. For the uninitiated, that is an excellent score on a championship course.

Runner up was one of the Society's great supporters, Dr Merv Cross with Plus 1. As always, Merv gave us all a long explanation as to how his score could well have been two or three better. Tradition dictates that we all agree vigorously.

The Sponsors Trophy, which is open to guests and non-AMA doctors, went to another loyal supporter, Dr Greg Crosland with a score of Plus 1. Greg is also a winner of a previous event a

“Although the greens were lightning fast they rewarded those who could read the undulations.”

few years back, the AMA International Shield, which was held in New Zealand. Runner up for the Sponsors Trophy was Mr Glenn Cooper with a score of Square. Glenn is another well known supporter of the Society.

Nearest the Pins for the ladies went to Nicole Bowman and Nerida Campbell while the men's were taken out by Mr Hutch Ranck and Mr Don Harris.

Longest Drive for the men went to Dr Reuben Jackson while the ladies was won by Dr Diana Hart.

The 2BBB Competition was won by Dr Greg Crosland and David Cocks with a brilliant score of Plus 10. Runners-up were Rick Dent and David Cocks with Plus 9.

A very well deserved congratulations go to them all. Great golf.

The other major result announced on the day was for The Shepherd Trophy and it was won by Dr Ross Glasson. Ross was unable to play on the day due to recent shoulder surgery, but made the effort to attend the lunch to proudly receive the Trophy. In accepting



Dr George Thomson - BMA Cup winner



Dr Merv Cross - BMA Cup runner up



Dr Ross Glasson - The Shepherd Trophy

the Trophy, Ross reminisced about his years as a member of the AMA and the wonderful years he held the office of National Treasurer of Federal AMA, mentioning Bruce's unbridled support of the profession in the face of relentless pressure from both State and Federal Labor Governments.

Dr Robyn Napier, on behalf of the Society, extended Seasons Greetings to all present and their families for a joyous and Happy Christmas and a bright and prosperous New Year hoping that nothing would be as bad as 2020.

In winding up the day's events, Society President, Dr George Thomson informed

the gathering that after many successful years, the Golf Society would be winding up. The announcement drew a great deal of comment from the members present.

So, from this writer and the Golf Society, it would appear that "au revoir" would be the appropriate farewell." **dr.**



Dr Greg Crosland - The Sponsors Cup winner



Dr George Thomson and Dr Robyn Napier received Honorary Life Membership for their service to the Golf Society. The awards were warmly supported by the membership.

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