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THE NSW doctor

AMA NEW SOUTH WALES

THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION OF NSW

AMA (NSW) CHAIR OF COUNCIL DR MICHAEL BONNING

MAKING A DIFFERENCE *in a time of uncertainty*

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Dr Andrew Zuschmann
Obstetrician and gynaecologist, NSW

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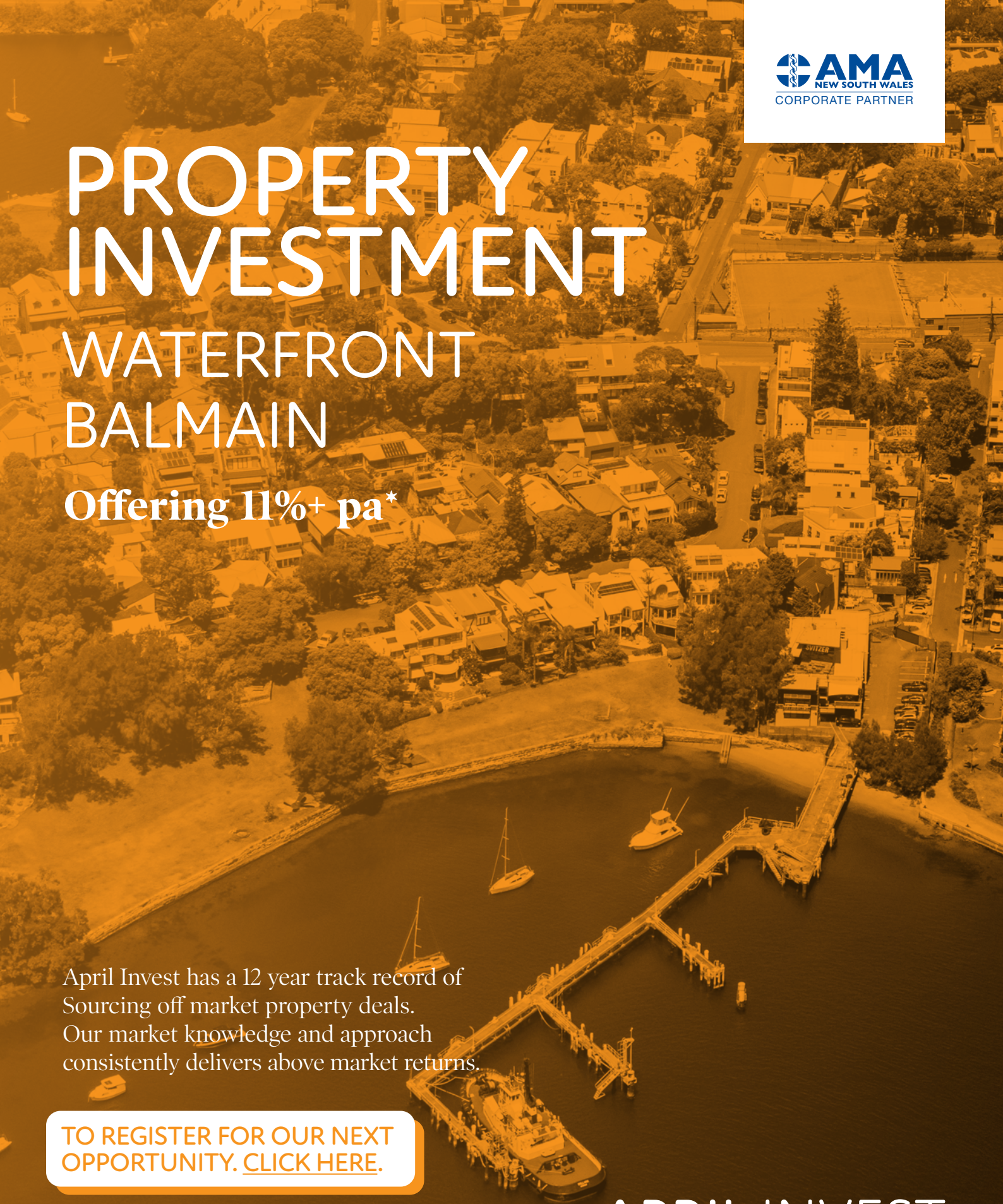

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From the Editor

In NSW, we have developed a new tradition – the 11am briefing.

It's the moment of the day when everything else stops and everyone tunes in to listen to the Premier and Dr Kerry Chant.

It's amazing how quickly one's focus narrows during an outbreak.

Other plans, other concerns, other issues tend to dim, and everything hangs on the daily number – or rather the number of cases that have been active in the community, which has become the new barometer.

This single-minded focus is a natural consequence of our shrinking worlds. Confined to our homes, our worlds now revolve around a new set of rules of what we can't do.

I think that's what I love about this issue so much. In this edition we feature AMA (NSW) Chair of Council, Dr Michael Bonning, whose medical career has taken him across the globe. His story is a reminder of what adventures are possible beyond COVID, but more importantly it highlights what one can achieve when you put service beyond self.

We're also pleased to feature Dr Daniel Nour, who launched a GP-led mobile health service for Sydney's homeless community last year. His tireless commitment to grow Street Side Medics is inspirational, and another reminder that beyond the four walls of home, beyond the 11am briefing, is a world that keeps spinning and has needs that have nothing to do with COVID. And despite how all-encompassing this pandemic might seem now, one day we'll stop thinking about what we can't do, and start thinking about what we can do.

Andrea Cornish, Editor

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BRACING FOR IMPACT

DR DANIELLE MCMULLEN
PRESIDENT, AMA (NSW)

The latest COVID outbreak feels like we're back where we started. But unlike March 2020, we've had time to prepare our health system should the number of cases rise. We should also have learned experiences from overseas. I hope those lessons are reflected in our response.

ONCE AGAIN, I find myself wishing I could write about something other than COVID. Writing this column is a bi-monthly exercise, but each and every time it comes up, it seems there has been a new development in the pandemic that is hard to ignore.

NSW is facing the most difficult challenge we've had to date in the COVID-19 crisis. Coupled with a variant that is more easily transmissible, is a population that is under-vaccinated – thanks to both a plagued rollout and some vaccine hesitancy.

The State is now scrambling to get on top of this outbreak and day by day the worry of doctors increases about what the impact on our hospitals will be if it's too late.

Unlike March 2020, we've had time and opportunity to prepare our health system should the number of cases rise. We should also have learned experiences from overseas. I hope those lessons are reflected in our response.

What we continue to struggle with is capacity.

The latest Bureau of Health Information results for January to March 2021 clearly reveal a hospital system that is under pressure. Emergency department presentations have rebounded to pre-pandemic levels, with a 6.2% increase in Triage category 2 (emergency) presentations.

The number of emergency department patients treated within the clinically recommended time frames fell 1.7 percentage points from the same quarter the previous year, while the number of patients who spent four hours or less in the emergency department was down 3.0 percentage points compared to the same quarter in 2020 – this was the lowest percentage of patients who spent four hours or less in the ED for any quarter over the past five years.

We're seeing an increase in patients who require emergency care and a corresponding decline in our ability to treat patients within the clinically recommended timelines.

AMA (NSW) has called for greater resourcing of our hospitals to address these problems and the AMA has recently released a blueprint for a new funding approach. This blueprint, calling on the Commonwealth to increase their contribution to 50%, was just part of a brilliant document outlining AMA's Vision for Australia's Health – I encourage you all to read it.

To build the best possible health system for our future, we need both resourcing, and strong senior clinician engagement.

AMA (NSW) recently closed our Senior Doctor Pulse Check survey, which had more than 1000 respondents. The results are sobering. One of you noted, "I have been on the staff of my hospital for 40 years and have never known it to be more dysfunctional and for morale to be lower than it is now."

Almost 70% said they do not feel valued by their hospital. More than 80% of doctors indicated they are experiencing workplace stress, with a significant number citing excessive workload and lack of resources as being contributors to this stress.

AMA (NSW) will be evaluating these results in more detail and outlining our response to Government accordingly. We are currently producing a report to be released next month.

In the meantime, stay safe Sydney. And let's work to get this under control (and keep it out of regional areas). Together, we'll get through this. dr.

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Overseas model shown.

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MAKING A DIFFERENCE IN A TIME OF UNCERTAINTY

FIONA DAVIES
CEO, AMA (NSW)

Throughout the pandemic, AMA (NSW) has continued to work to support doctors and their practices. We're here for you.

ONE OF THE DIFFICULTIES in my job is that I often end up interacting with doctors (and indeed non-doctors), during difficult times in their lives or their careers.

It's not uncommon to start discussions with, "I wish we were not meeting like this."

Despite these often-difficult conversations, these interactions are often the most rewarding.

Being able to support our doctors is at the core of what we do.

In situations where people feel they are overwhelmed, I often encourage them to find the things that they do feel they can control and hold onto it.

In these uncertain times, we wanted this edition of *The NSW Doctor* to serve as a reminder of the amazing things that can be done as a doctor. Our members have unique abilities that allow them to make a difference in people's lives every day – and that is something worth holding on to.

Doctors have an extraordinary ability not just to care for the patient in front of them but for the community at large. It's a good time to remember those ambitions and to think of the projects and priorities you want to be working towards.

Throughout the pandemic, AMA (NSW) has continued to support doctors and their practices. We have provided advice on matters such as vaccinations to QR codes and everything in between.

Our dedicated Workplaces Relations Advisors are an excellent source of support, and you can reach them by phone or email at any time.

Finally, I would like to remind all of our members of the importance of taking care of yourselves and taking care of each other.

In my interactions with doctors – either in person or online – the sense of fatigue is evident.

We have had months of cancelled plans and disappointed families and people who have worked longer than they should without taking leave.

While a "staycation" is not much fun for anyone, it can be particularly unfulfilling for doctors where the demands of patients and calls tend to intrude when you are not able to say, "I am away."

So, now more than ever, remember the supports available to you, check in with each other, allow a little additional patience and tolerance and hold on to the things that matter to you. dr.

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ADVENTURES *in Medicine*

Dr Michael Bonning caving in Iceland

Before COVID, AMA (NSW) Council members often started Council meetings with a little game they liked to call, 'Where in the world is Michael?'

Profile

DR MICHAEL BONNING, chair of the AMA (NSW) Council, is notorious for dialling in from far-flung locations around the world.

"I once did a Board meeting walking down in the Himalayas from Tengboche, Nepal," he recalls.

"I always felt as long as I had phone signal I could probably dial in from anywhere."

Between working as the chief medical officer of Inspired Adventures and spending 12 years as a medical officer with the Royal Australian Navy, Dr Bonning has traversed across Southeast Asia, the Middle East, North and South America, the horn of Africa, most of Europe, Pakistan, India, several Scandinavian countries … if you throw a dart at a map, there is reasonable chance he's been there.

COVID might have grounded Dr Bonning to Australia, but it hasn't stopped him from leading hiking expeditions – in May, he took a group across the Larapinta Trail in the Outback to raise funds for Interplast Australia, a non-profit organisation that provides plastic and reconstructive surgery in countries across the Asia Pacific region.

When he's not trekking across deserts and some of the world's highest peaks, Dr Bonning works as a general practitioner at Balmain Village Health, as well as the Inner West Respiratory Clinic and the vaccination service at Sydney Olympic Park.

In addition to serving as Chair of the AMA (NSW) Council, he currently sits on the Board of GP Synergy as Deputy Chair, is a Community Panel Member of Ad Standards, the medical advisor for DermaSensor, Adjunct Fellow of Macquarie University, and Non-executive director of Postgraduate Medical Council of Queensland.

"I find general practice has so much inherent opportunity in it. It allows me to do so many things and it's a great platform to step into other parts of healthcare, technology, advocacy, military service – it all connects together."

General practice might provide the vehicle for these pursuits, but Dr Bonning credits his drive to his family, particularly his twin sister.

"We grew up together, played sport together, went to school across the road from one another, and both of us are intrinsically driven…

"We do very different things, but we do push each other along and we want to see each other succeed," he adds.

▲ Above: Dr Bonning (orange jacket) climbing Mount Aconcagua in west-Central Argentina

Whereas his sister went into finance, Dr Bonning was drawn to science. He completed his undergraduate degree in science at the Queensland University of Technology in 2005.

Inspired by the military service of his grandparents, he applied for the Royal Australian Navy's Graduate Medical Program and subsequently

enrolled in the University of Queensland's medical school.

Throughout med school, Dr Bonning was heavily involved in student politics, and in 2007 he was elected President of the University of Queensland Medical Society (UQMS) in his third year of medical school and then President of Australian Medical Students' Association (AMSA) in his final year. He also served as Chair of the Ashintosh Foundation, the charitable society of UQMS.

"I'm a joiner. I'm someone who likes to be part of a big organisation because when you work with others and you have a shared purpose, you can achieve a lot more than any individual."

His commitment and enthusiasm for medico-political advocacy and his academic achievements did not go unnoticed. Dr Bonning was awarded the Dr Magdalene Brodie Memorial Prize for Paediatrics and made Valedictorian of his graduating class in 2008.

During this period, Dr Bonning says he was both encouraged and inspired by Professor John Pearn, a paediatrician and former Surgeon-General of the ADF, as well as past-patron of UQMS.

"He always encouraged and supported my goals in medicine and the military."

He received a leadership award during his stint at HMAS Creswell and recalls the proud moment of being made Commanding Officer for the Ceremonial Sunset, a naval tradition of saluting and lowering of the Ensign at sunset.

"I still have the sword used to command the platoon from that day … and giving the order to fire a cannon was cool too."

Beyond medical school and officer training, Dr Bonning continued to serve as medical officer with the Royal Australian Navy and was involved in fleet operations including border protection, as well as counter terrorism and counter drug smuggling operations in the Middle East, and humanitarian and training missions in Southeast Asia and the Pacific Rim.

▲ **Dr Michael Bonning in service with the Royal Australian Navy**

He helped organise medical and healthcare support for dozens of nations who brought ships to Australia for the International Fleet Review.

He also had the opportunity to mark the ANZAC Centenary on the Greek Island of Lemnos near Gallipoli.

Despite these highlights, there were challenges during his service with RAN and Dr Bonning is open about the psychological burden he carried while conducting border protection activities, acknowledging he struggled morally and with his own mental health.

"The purpose of a sovereign navy is to defend borders, protect shipping, prevent smuggling, and to keep the waterways safe. But to intercept and turn back or detain people who are trying to escape places that are not as nice as Australia… it's just

through simple luck that I was born in Australia and therefore have privilege and opportunity that few others in world history have ever had – and to stand there and be someone that turns other people who may be in less fortunate situations around is hard."

He adds, "At no other time in my service did I feel there was a conflict between being a medical officer as well as having a Hippocratic oath to uphold, but that was a difficult time."

Being a medical officer onboard a military vessel also comes with its own unique clinical challenges.

Dr Bonning describes the medical and logistical challenges of being 900 miles from land and dealing with a patient with acute appendicitis; and in another scenario, flying a patient with intracranial pathology by military helicopter to New Caledonia and trying to coordinate care with doctors who only speak French.

Coupled with these obstacles is that all of these patients are colleagues and friends.

"The thing about being a military doctor, especially a navy doctor, is you are essentially a small-town GP because you know everyone."

Dr Bonning specialised in general practice, with additional training in high altitude physiology, diving medicine, aeromedical evacuation, and emergency management in remote environments.

His medical career afforded him learning opportunities that lent itself to expedition medicine. Or as he describes it, "you get taught in how to manage yourself in an environment where things fall apart under pressure and without support."

Dr Bonning started working with Inspired Adventures, a philanthropic travel company that connects worthy causes with people seeking adventures, in 2014.

Since it was founded in 2001, the organisation has raised $38.6m for 300 charities and taken fundraising trekkers around the globe, including treks in Mt Kilimanjaro, the Great Wall of China, Nepal, the Inca Trail and more.

▲ **Kayaking in Voss, Norway**

He says he was drawn to Inspired Adventures because it connects people with causes that they support and for many people, having a humanitarian motivation often pushes them to their outer limits.

"When people trek on behalf of an organisation or a cause that is bigger than themselves, they put themselves out there to do things they never thought they could and that is incredibly rewarding to see."

THE POWER OF PEOPLE

Dr Bonning joined AMA on 24 January 2005 – he remembers that day as it was the second day of O Week during his internship.

"As I've said, I'm a joiner. I joined the AMA, I joined my medical student society, I joined AMSA, I joined the military…I'm a huge believer in collective action – or the will of an organisation supported by thoughtful people who are all pulling in the same direction for a better, healthier future."

Central to his motivation for participating in medico-political advocacy is the belief that doctors need to have a say in the system they work in.

"Engaging doctors to help construct the medical system they work in is absolutely essential for the system to work," he says.

According to Dr Bonning, the value of having a professional association like the AMA is its shared sense of purpose and collegiality.

"Sometimes these jobs we do can be a bit lonely. I've had my own experience

with loneliness – being the only doctor for hundreds of kilometres – and even within Greater Sydney or NSW you can feel like you are battling on alone in the health system. But there are genuinely friendly people out there to support you and listen and I think everyone needs that."

Mental health awareness has been a prominent feature of Dr Bonning's career – he spent six years (2008-2014) working as the Non Executive Director for beyondblue.

His involvement with the organisation was sparked by a chance meeting with beyondblue founder and former Victoria premier Jeff Kennett, who was invited to speak at the AMSA National Convention in 2008.

On the morning of the presentation, Dr Bonning happened to be on the ground floor of the hotel very early. The convention convenor spotted Dr Bonning and asked him to look after Mr Bennett for breakfast.

"Jeff and I had a fairly robust discussion about the mental health space and by the time we walked to the top of the stairs for him to speak in front of an audience of 1000 medical students he asked me join beyondblue as a director."

Dr Bonning recalls a few weeks later he received a letter of invitation from the organisation which highlighted there was a director's fee.

"I wrote back – I was very apologetic – I said, I'm very sorry but I'm a medical student – I can't pay a fee to be on this Board.

"At my first Board meeting everyone laughed. It was the other way around, they paid me a small stipend to be part of the organisation."

In 2009, Dr Bonning undertook a Churchill Fellowship to study methods of promoting wellbeing within the medical profession and in 2010, beyondblue conducted a $2m world-leading study on doctors' and medical students' mental health and wellbeing.

The research from that study became the basis for a reform agenda which has been taken forward by the profession.

Dr Bonning subsequently became involved in advocating for funding for the Doctors Health Advisory Services in Australia and as a Board member of Doctors Health Service which was charged with distributing that funding for services in the States and Territories.

When asked if he could cure one thing immediately, Dr Bonning doesn't hesitate.

"We know there is an epidemic of loneliness. Lots of people like to be alone. But there is a difference between being alone and being lonely and I think we are caught in a growing wave of loneliness, and I think the pandemic has probably made that worse. And being a GP, a significant number of people come to see me because they are lonely."

As Chair of AMA Council, his focus is on ensuring that Council has exposure to emerging issues such as the impact of technology, the role of private equity, value-based healthcare and overseas organisations taking an interest in Australian healthcare.

"The biggest issue facing doctors at the moment is the rapidly changing interface of healthcare with virtual care. Doctors need to work to ensure standards of quality in care are maintained and the positives of virtual care are made available to everyone in the community." dr.

> "Engaging doctors to help construct the medical system they work in is absolutely essential..."

FAST FACTS

- **Best hike in Sydney:** Jerusalem Bay
- **Next on the bucket list:** Climb Denali in Alaska
- **When the borders open I will:** …take my parents overseas
- **If I had one more hour in my day I would…** fit in an hour of tennis if I could
- **If I wasn't a doctor, I'd be a…** a talkback radio host or a podcaster – I just like talking to people

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STREET SIDE MEDICS

Street Side Medics is tackling the healthcare needs of Sydney's homeless community by overcoming barriers to access.

DR DANIEL NOUR is a full-time PGY2 resident at Royal North Shore, but it's his passion project – Street Side Medics – which takes up most of his time.

"I don't necessarily need to go to every clinic, but it's pretty hard to get me not to go. I love it."

Street Side Medics is a not-for-profit organisation which provides a GP-led mobile outreach medical service for people that are either experiencing homelessness or are vulnerable.

The clinic operates out of a van that has been custom-fitted as a medical service with two different stations – a medical support officer station which acts as a triaging station and a GP station.

The mobile clinic, which was launched by Dr Nour last August, operates alongside well-established homeless services and shelters, and provides care to the growing homeless community in Woolloomooloo, Parramatta, Manly and Brookvale.

Street Side Medics recently procured a second van donated by LSH Auto Australia but is in desperate need of volunteers to help them expand their outreach.

They currently have about 145 volunteers, of which about 25 are medical professionals. But the clinic is centred around general practitioners.

"It's a GP led service, so we really rely on them. The only thing that has limited our growth is trying to get more GP volunteers," Dr Nour says.

The commitment doesn't need to be onerous.

"Really all you need to do is come to the clinic for three hours and that's it – we do the rest. Some GPs say they'd really like to commit every fortnight or every week – we can always work around their schedule, but it's a minimum of 3 hours a month."

How does it work?

Street Side Medicine takes its van to existing food services and homeless shelters three nights a week. The mobile clinic has a no-turn-away policy and provides a walk-in service for the homeless, who know where and when the van will be every week.

▲ **Dr Daniel Nour and his team of volunteers for Street Side Medics**

"This allows us to improve the catchment of patients and build rapport with them as we attend to their acute and chronic healthcare concerns," Dr Nour explained.

There are two teams of volunteers. The team outside the van, which usually consists of a social worker, physiotherapist, dietician and other general volunteers, approach individuals to see if they have any health issues. Inside the van, there is a general practitioner and a nurse, or other medical practitioners.

The van is set up with all the common facilities necessary for a general practice, including medical examination, basic pathology, and minor surgical procedures.

In the past 12 months, Dr Nour says they have seen "some weird, wonderful and amazing medicine" – people making do with what they have.

But Dr Nour adds, "most confronting are the health issues that have been neglected for many, many years that were easily preventable or somewhat treatable. We see people with diabetes that has gone untreated

for years and the complications associated with that.

"And there are more subtle things like thyroid issues, skin cancers … I remember a guy who came to me with haematuria – blood in his urine, and he said, 'I figured it was just because it was getting cold.' So, one of the things that we're trying to change is health literacy."

Dr Nour recently treated a 29-year-old man who has been homeless since age 13. The man had a severe phobia of being indoors due to childhood trauma, but he came to the van to ask for some wound dressings. After chatting with the man, the doctor on duty discovered he is a Type 1 diabetic and hadn't been using insulin for the last four months. His blood sugar was 33 but his ketones and PH were normal. As a result of his fear of being indoors, he refused to go see an endocrinologist. After dressing his wounds, the team found out which medicine he normally takes and asked him to come back next week. When the man returned, they gave him the medicine and a glucometer. The team worked with an endocrinologist to develop a plan and organised a telehealth consult. The endocrinologist recommended a Freestyle Libre Sensor to help him keep a track record of his blood sugar. Since then, the man's wounds have healed, his blood sugar levels have dropped and he's on a much better trajectory. They've also referred him to an ophthalmologist for his diabetic retinopathy.

"We've built good rapport with him, and he trusts us enough that we've made a referral for the endocrinologist and the ophthalmologist to see him in clinic. That is big achievement for him."

The success of Street Side Medics is dependent on trust and respect, Dr Nour says.

"That underpins the whole service – having doctors who care, genuinely care. Every single person in the organisation is a volunteer. Every single one. They come because they want to be there, and they come because they care. And that translates into the way they communicate with the patients.

"A lot of times they come in and they might not tell us about three quarters of the problems that they're having. But they get to know us, they appreciate the way that they are spoken to, the care that they are provided – they build trust. Not only with the doctor but with the service. And they tend to come back with more healthcare concerns."

Dr Nour was motivated to start Street Side Medics while undertaking an elective at the Imperial College of London. He recalls coming to the aid a homeless man having a seizure. After speaking with the man's friends, they indicated the man – who doesn't drink or do drugs – had had several seizures over the previous months, but usually in the back lane.

"And I remember thinking, why hasn't anyone taken him to see a doctor or a GP? And this one lady, I'll never forget her face, saying 'Daniel', and this is her words not mine, 'Daniel, the NHS barely cares about you, let alone us'."

Upon returning to Sydney, Dr Nour conducted his own research into healthcare services for people experiencing homelessness and found that barriers include lack of awareness of available services, prohibitive costs, lack of transport, the level of documentation required, stigma and embarrassment, previous negative experiences, and distrust.

"The only real way to alleviate those barriers is, in my opinion, to take the service to them and be an opportunistic service.

"There really is no GP-led mobile outreach service and there certainly is none that have the capability of ours … I look at people's risk factors for diabetes and I can actually tell you within five minutes if you have diabetes. And if you do have diabetes, I can actually give you the medication so we can start treating it.

"This gives people positivity – we know what's wrong and we're starting to fix it."

> "Most confronting are the health issues that have been neglected for many, many years..."

The Street Side Medics van is located in Parramatta every Sunday between 4.30pm-6.30pm, Manly every Monday between 5pm-7pm, Brookvale every Monday between 7.15pm-8.30pm and every Tuesday at Woolloomooloo between 7.30pm-9.30pm.

Medical practitioners interested in volunteering with Street Side Medics are encouraged to email: volunteer@streetsidemedics.com.au or call 02 8324 7531. dr.

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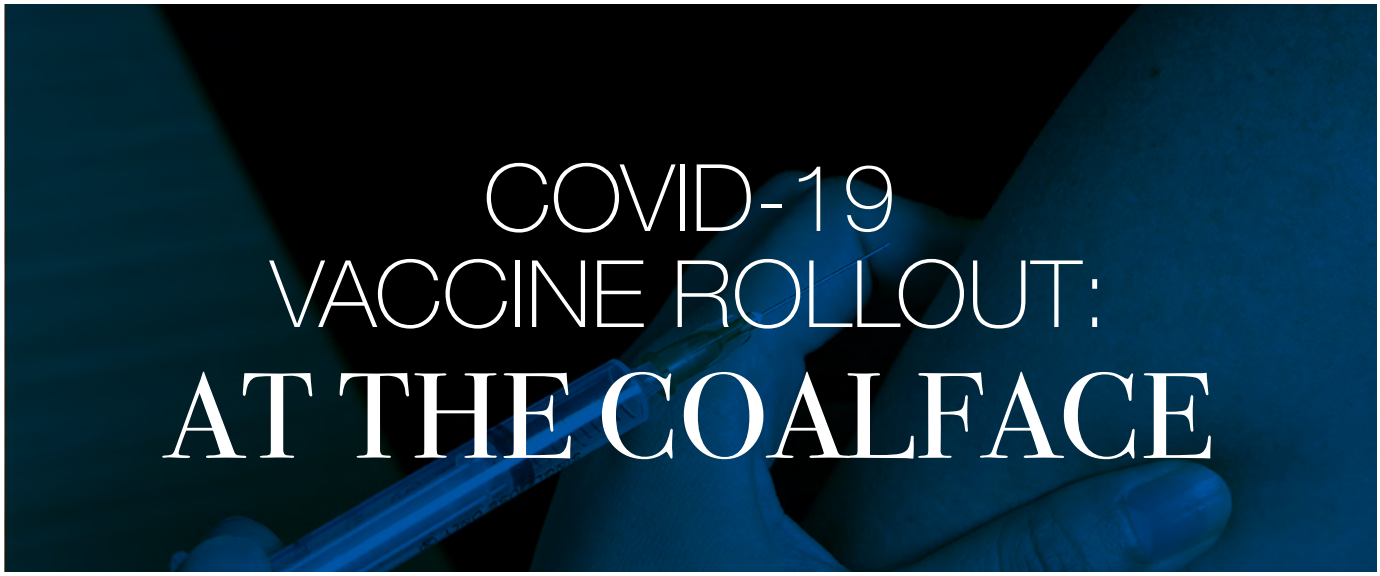
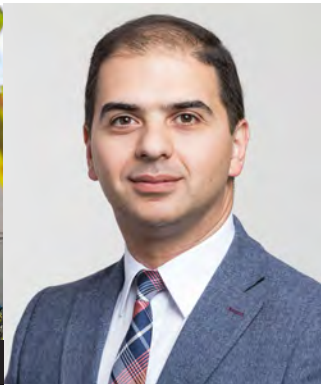


COVID-19 VACCINE ROLLOUT: AT THE COALFACE

The vaccine rollout has been bumpy ride thus far, but *The NSW Doctor* recently chatted with general practitioners who have tried to make it as smooth as possible for their patients.



Dr Charbel Badr, Hunters Hill Medical Practice

FOR MANY, Australia's COVID-19 vaccine rollout has felt like a game where the rules change as you go. While we can all see the prize of vaccinating our population against this potentially deadly and easily transmissible disease, getting to that point has been equal parts challenging and frustrating.

Despite these obstacles, GPs across the country have been active and willing participants in the program.

Hunters Hill Medical Practice

For Dr Charbel Badr, who runs Hunters Hill Medical Practice, there was never any question about the practice being involved in the rollout.

"Our practice ethos is to provide multidisciplinary care to patients in the community, so we were always going to provide the vaccine. It shouldn't be just about the money. Even if the rebate was lower we would do it anyway, because we want our patients to be able to access it. Especially our patients who are older and can't drive to somewhere like Chatswood or Homebush."

When the Government put the call out for EOIs, Dr Badr and his team spent more than 100 hours preparing the clinic. Preparations included:

- Converting an upstairs education area to be used as a vaccine hub;
- Creating appropriate signage;
- Establishing a pre-vaccination waiting area with social distancing;
- Creating a post-vaccination waiting area, with social distancing and a staff member to monitor patients;
- Placing timers in the post vaccine area to alert patients when 15 minutes is up;
- Printing Government resources such as consent forms and post vaccination materials;
- Printing vaccination cards for patients to use as a physical record and to keep track of their next appointment;
- A four-hour staff education workshop and dry run of their vaccine clinic;
- Flowcharts for reception, with pathways depending on whether the patient was new or a current, and retrieving medical records from their usual GP if needed;
- Running vaccination information on their waiting room TVs;
- Creating a website specific to their vaccine clinic, which allows patients to download the consent form and/or new patient forms prior to their appointment.

Dr Badr says feedback from patients has been positive.

"I think it also gives patients confidence when they see a process

and a protocol in place – they don't feel like this is something new."

Initially the clinic received only 50 doses of AstraZeneca a week, which was disappointing, given their readiness to vaccinate more patients.

"The first few weeks we had lots of staff capacity, lots of room capacity, lots of patient demand, but no vaccine."

The early days of the vaccine rollout were a bit chaotic, with many patients calling, some getting upset and staff struggling to find them appointments."

"We tried to control it in those first few weeks by concentrating on our most vulnerable people, but as soon as we opened up the appointments online, they would fill in automatically and some of them would fill in with patients from far and wide."

He adds, "From a continuity of care perspective that created a bit of a mess. Because somebody from Ashfield could come and get their vaccine here, and some of my patients could be going to the Northern Beaches – so just in terms of continuity and medical records – that was a bit difficult."

The system is working quite smoothly now, but his main criticisms of the rollout is poor supply at the beginning, the Government's decision to develop a COVID vaccine specific ordering and delivery system (as opposed to using the system already established for flu vaccines), poor education and messaging.

"All in all, it's a new program and it's going to have some teething issues."

Bridgeview Medical Practice

Drs Thava Seelan and Shanthini Seelan are the principals of Bridgeview Medical Practice, located in Toongabbie. The Western Sydney practice caters to a large multicultural community and has a mixed patient base with a significant number of older patients and vulnerable patients with chronic disease.

Drs Shanthini and Thava Seelan, Bridgeview Medical Practice

"We have been eating, breathing and living COVID vaccinations for the last couple of months," says Dr Shanthini Seelan.

Bridgeview started vaccinating its patients in April and initially received 50 doses per week, but they began planning for the rollout months before.

Dr Thava Seelan says the practice held collaborative planning sessions with the practice's doctors, as well as administration and nursing staff, completed training modules and created a 'COVID team' which meets regularly to discuss updated COVID vaccine information and guidance.

The practice utilises two buildings and has converted an adjacent auditorium to be used as its vaccine clinic. The clinic has been modified to meet the specifications outlined by Government and includes multiple cubicles to allow vaccination of five patients at a time. Whilst they are currently administering 300 doses per week, they have capacity to ramp up to 500 doses per week.

Thava says demand for the vaccine was initially very high but noted increased vaccine hesitancy after media reports of patients experiencing the rare side effect of thrombosis with thrombocytopenia syndrome surfaced.

"However, many of our patients showed delayed acceptance following our positive approach and messaging around the importance of vaccination," he says.

According to Shanthini, the Government's decision to use general practitioners to roll out the vaccine was a "master stroke of genius".

"You cannot do something like this without getting the GPs involved – you need the relationship we have with our patients," she says.

"We are not dealing with the mainstream Australian public here – we are dealing with people with varied experiences of the healthcare system … it's a very unique relationship that we have with them."

In addition to the supply issues that plagued the rollout at the beginning, the doctors' other concerns included the loopholes that have allowed people who were not eligible for Pfizer to receive that vaccine at the state hubs, and lack of communication and transparency.

"GPs have been called the protagonists, we've been lauded as the saviours, but we would really appreciate some strong support, because we have really invested a lot in this – time, energy, and money," Shanthini says. dr.

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Should doctors risk their lives when responding to a disaster?

Doctors must balance their duties to individual patients with their duties to protect themselves, other patients, staff, colleagues and the wider public from harm.

ON 5 MARCH 2021, Amnesty International announced that at least 17,000 health care workers globally have died from COVID-19 over the last year, forcing doctors both in Australia and around the world to confront the very real question of whether they are willing (or should be expected) to put their own lives at risk to treat real or potential COVID-19 patients.

The AMA's Position Statement on Ethical Considerations for Medical Practitioners in Disaster Response 2014, currently under review by the Ethics and Medico-Legal Committee (EMLC), briefly addresses doctors' risk of personal harm when responding to a disaster.

The position statement affirms that doctors must balance their duties to individual patients with their duties to protect themselves, other patients, staff, colleagues and the wider public from harm, highlighting that during 'ordinary' clinical practice, these duties do not generally come into conflict, but during a disaster, tensions between these duties may very well eventuate.

The current pandemic has turned this potential eventuality into a stark reality for doctors in Australia and worldwide where doctors must weigh up their duty to treat individual patients infected with COVID-19 with their duty to ensure they do not develop COVID-19 themselves and become unable to work or risk infecting other patients, staff or those in the wider community.

In addition to the professional duty to reduce risk of personal harm, doctors also have their own personal duties and interests in not becoming infected and risking sickness or even death or spreading the virus to their own family members and friends.

So what level of risk of personal harm should doctors accept? While there is a general expectation within the community that doctors will accept a certain amount of personal risk when responding to a disaster, this risk is not unconditional or without reasonable limit. The current position statement says that doctors are entitled to protect themselves from harm and should not be expected to exceed the bounds of 'reasonable' personal risk.

But the global pandemic has made it clear that 'reasonable' risk is highly subjective, and the level of risk that governments, employers, patients and their family members and others expect doctors to accept when responding to a disaster may not be 'reasonable' to the medical profession or to individual doctors or their loved ones.

Globally, professional regulators and associations set varying standards regarding the expectations of doctors in relation to risk of personal harm when responding to disasters.

For example, the Medical Board's Good Medical Practice states that: *Treating patients in emergencies requires doctors to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other patients under your care; and continuing to provide that assistance until your services are no longer required.*

The UK's General Medical Council is more explicit in their own Good Medical Practice, stating that: *58 You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making other suitable alternative arrangements for providing treatment.*

While the American Medical Association's Code of Medical Ethics, Opinion 8.3 Physicians' Responsibilities in Disaster Response & Preparedness, advises that: *Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life. However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.*

While the expected standard of doctors' risk of personal harm may be addressed differently in these examples, at least they are all consistent that what is unreasonable is for doctors to be placed at risk of significant harm because of inadequate or inappropriate safety and protection, and advocacy to improve that protection is an important duty for medical professionals and those who control any aspect of workplace safety. Doctors with apparently less agency or power, such as doctors-in-training or those in temporary employment, must be protected from any implied or overt obligation to practice in conditions that are not as safe as it is reasonably practicable for them to be.

Employers, managers and workplace safety regulators have a duty to ensure that corners are not cut, and peer group or management pressure is not acting to decrease safety for any doctor.

Doctors' willingness to risk significant personal harm when treating patients in disasters has also experienced a temporal shift. Where doctors once entered the profession seemingly willing to sacrifice their own lives to care for patients, as exemplified in the American Medical Association's Code of Medical Ethics in 1847, which directed: *and when pestilence prevails, it is their duty to face the danger, and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives.*

Many of today's doctors are not so willing to lay their lives on the line and will need to consider their own personal morals and values when deciding how much risk is reasonable to them.

As the EMLC examines this issue during our policy review, we will identify a range of factors that doctors should consider when determining what constitutes a reasonable risk of personal harm and what they can do to mitigate their personal risk. While it is not unreasonable for doctors to accept a certain amount of personal risk when responding to disasters, that risk is not unconditional and we will continue to advocate that governments and the wider community have an obligation to protect doctors and reciprocate and support doctors (and their family members) who suffer harm when caring for patients. dr.

ABOUT THE AUTHOR

Dr Andrew J Miller is the Chair of Federal AMA Ethics and Medico-legal Committee and Immediate Past-President of AMA WA.

RURAL MEDICINE, OVER GOVERNANCE, AND DIPLOMATOSIS

What is needed urgently is a discussion amongst our profession about the how we ensure that those who practice safely are not left out.

AS THE National Rural Generalist Pathway begins to gather steam, it is imperative to look at how a Rural Generalist fits into a complex system of medical education, credentialing, and Continuing Professional Development (CPD).

If we look at the Collingrove Definition of a Rural Generalist, that is, a practitioner who is predominantly a GP but with skills in emergency care and one or more advanced skill disciplines, we are then forced to ask the question – how do we prove that these clinicians are up to the job? How do we ensure that they meet the standards and ongoing professional development required to provide quality care to our rural and remote communities?

How do you, as a clinical governance professional, resolve this issue?

At first glance, one looks at this issue and thinks the solution is simple – "There's a diploma for that!" – the last five years have seen the proliferation of diplomas from various subspecialty colleges. These include diploma qualifications in Obstetrics, Emergency Medicine, and Prehospital and Retrieval Medicine, with upcoming diploma qualifications in Anaesthesia and Psychiatry in the works. Each of these qualifications is "renewable" and comes with their own separate College membership and CPD requirements. Hospital credentialing bodies then proceed to make the diploma the "minimum" standard for practice in a given field – problem solved!

This solution sounds fantastic on paper, however underlying the concept are issues that demand and warrant attention.

The first issue is that of grandfathering: How do you address those already in practice in a particular field? This is an issue that tends to disproportionately affect early career doctors (usually 1-10 years post fellowship) who face the prospect of needing to "retrain" to do a job they are already doing safely. How do you manage those with experience and current CPD but without the piece of paper? If you throw up roadblocks in this process, a large proportion of newly minted Rural Generalists will leave or opt to retrain in non-RG specialties.

The second issue is that of CPD and fees. How many Colleges should a rural generalist maintain membership with in order to practice? How many fees should they have to pay? How many months a year must a Rural Generalist spend on CPD for multiple different organisations at a loss to the community they serve?

The "recently fellowed" Rural Generalist cohort is large, as Rural Generalist is a relatively new specialty. In a world where "time" and "case numbers" are assumed to be markers of competence, expectations around CPD and maintenance of skills dictated from and by subspecialists in the city quickly become unrealistic. This is further fuelled by unrealistic concerns from many in the city that Rural Generalists are "after their jobs" when this has not been demonstrated practically.

The end result of this is that these talented Rural Generalists opt for two pathways. Many will return to the centrepiece of Rural Medicine, which is the provision of good General Practice care. A second cohort who enjoy working in the hospital setting will opt to retrain as non-GP specialists in order to avoid the unrealistic, multiple CPD burdens associated with a Rural Generalist skillset. Both of these options are a loss to rural

"An obsession with silos and 'Diploma' qualifications leads to them picking up their bat and ball and moving to greener pastures."

medicine, as these cohorts of talented and skilled doctors lose the ability to practice their full scope as a Rural Generalist. A combination of poor clinical governance practice and an obsession with silos and "Diploma" qualifications leads to them picking up their bat and ball and moving to greener pastures elsewhere.

It is important to note, despite all I have said, that the presence of Diploma qualifications is not necessarily a bad thing. The ability to prove competency objectively is important and will become more relevant as Rural Generalist Medicine matures as a specialty. The two Rural Generalist Colleges approach this problem differently, but this is not necessarily to the detriment of trainees who will enjoy greater choice as to which pathway to pursue. What is needed urgently is a discussion amongst our profession about the how we ensure that those who practice safely are not left out. It is time that we consider alternatives such as a competency-based framework as opposed to "time in an accredited subspecialty position" as the sole criteria for determining who is safe to practice.

If we fail to do this, and instead opt for a combination of misunderstanding and geographic narcissism to drive the process, we stand to lose our pioneering generations of Rural Generalists forever. We simply cannot and must not allow this to happen any longer.

Rural and Remote Australia deserves better. dr.

ABOUT THE AUTHOR

Dr Marco Giuseppin is chair of AMA Council of Rural Doctors (CRD) and a member of AMA Queensland Council. He is a practising Rural Generalist based in Queensland and a retrieval doctor with the Royal Flying Doctors Service.

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A NEW COLLECTIVE BARGAINING PROCESS: CLASS EXEMPTION

DOMINIQUE EGAN

DIRECTOR OF WORKPLACE RELATIONS, AMA (NSW)

From 3 June 2021 small businesses, which includes many medical practitioners, have available to them a Class Exemption to engage in collective negotiations with suppliers and customers.

What is it?

The collective bargaining class exemption is a determination by the Australian Competition and Consumer Commission (ACCC), which allows small, eligible businesses to negotiate with suppliers and customers as a group. Its operation removes the risk of those negotiating from breaching the Competition and Consumer Act 2010 (Cth). A collective bargaining class exemption will be permitted on two bases:

- that the creation of a bargaining group would not substantially lessen competition, or
- that the creation of a bargaining group would result in a public benefit.

What are the eligibility criteria?

For a business or independent contractor to be eligible for protection under the class exemption, their aggregated turnover in the preceding financial year must be less than $10 million. This amount is consistent with the ATO's threshold for what constitutes 'small business entities.'

An aggregated turnover is the sum of a businesses' annual turnover and the annual turnover of any Australian or international business connected or affiliated with that business. If the aggregated turnover has not yet been confirmed, a business or individual may still rely on the exemption on the condition that it reasonably believes its turnover in the financial year prior to it joining the bargaining group, was less than $10 million.

How do I apply?

A one-page Collective bargaining class exemption notice form (the Notice) is to be provided to the ACCC, and any target business the group proposes to negotiate with, before collective bargaining commences or within 14 days of doing so.

You will be required to provide:

- details of the collective bargaining group,
- details of the target businesses,
- what the group proposes to bargain about, and
- details for a contact person.

The ACCC will place the Notice on their public register and provide bargaining groups with a letter confirming receipt.

Once the notice form is complete, the group will be legally permitted to bargain collectively.

Do I need to notify of changes to the bargaining group or targets?

If members of the bargaining group or targets change, a new Notice must be provided to the ACCC before new members of the group are covered by the exemption or negotiations with new target/s commences.

Further, each member of the group must reasonably expect to make at least one contract (either through collective or independent negotiation) with the target described on the Notice, for the class exemption to apply.

How does the class exemption differ from the existing Notification and Authorisation processes?

The class exemption provides bargaining groups with automatic and immediate protection from competition law. In comparison, legal protection through the Notification process commences 14 days after the notification is lodged. Legal protection granted by the ACCC through an Authorisation, may occur at any time within its discretion, provided that a final determination is made within 6 months of the application for Authorisation.

Is there a fee payable?

As opposed to the Notification and Authorisation process, the Class Exemption does not require the payment of a fee for providing the notice form.

Does this affect existing Authorisations or Notifications?

Where legal protection under an Authorisation or Notification already exists, that protection continues to apply until expiration. Upon expiry, businesses can either rely on a class exemption (provided they meet the eligibility criteria), seek re-authorisation or re-notify their arrangement.

Does the class exemption give protection in relation to collective boycotts?

The class exemption does not provide legal protection for collective boycotts. As such, as a part of, or in addition to, negotiations with one or more targets, the group cannot collectively decide not to provide or obtain goods or services from a target business.

There are penalties for engaging in collective boycott activity.

Does a target business have to negotiate with the group once a class exemption has been granted?

As the class exemption operates on a voluntary, mutual-benefit basis, no business is obliged to join a collective bargaining group.

Similarly, no target business is obliged to negotiate with a bargaining group.

The class exemption does not override any pre-existing legal or contractual obligations between parties.

If you require further information please visit the ACCC's website www.accc.gov.au or contact the AMA (NSW) Workplace Relations Team at workplace@amansw.com.au or by phone 02 9439 8822.

Article co-author, Cassandra Christopher, Paralegal

UNDERSTANDING PROBATION PERIODS AND THE MINIMUM EMPLOYMENT PERIOD

As AMA (NSW)'s Workplace Relations advisor, Felicity Buckley explains, probation periods are not 'get out of jail free cards' for under-performance.

IT IS COMMON for an employment contract to contain a probation period clause. The AMA (NSW) template contracts of employment, which you may already be using, contains one. Probation periods can be helpful tools when establishing workplace expectations with a new employee. However, they are often confused with the Minimum Employment Period and should not be relied upon as a "get out of jail free" card when the employee is not performing as expected.

What is a probation period?

A probation period is a period of time at the start of a permanent employment relationship that is designed to give the employer an opportunity to assess whether the new employee is suitable for the role and the business. The conditions of the probation period need to be included in a clause in the employment contract. It is usually for a length of 3 or 6 months and commonly includes a reduced period of notice of termination, often only 1 week required by either party. It may also stipulate regular formal or informal check-ins between the employee and their manager in this period.

It is likely that this clause will have little practical effect when it comes to ending an employment contract within the set period. Particularly considering the National Employment Standards only require a minimum of 1 weeks' notice of termination in the first year of employment. It is also important to remember that while in probation, employees continue to receive the same entitlements (ie. access to leave) as someone who is not on probation.

What is the Minimum Employment Period (MEP)?

Employees need to have been employed for a minimum of 6 months (or 12 months if the business has less than 15 employees) before they can access an unfair dismissal claim if they are terminated. In theory this means that when terminating an employee within their MEP, employers do not need to follow a fair process or give a reason for termination.

It is important to note that this MEP only applies to an unfair dismissal claim and not a general protection claim. This means that at no point can you terminate an employee for a prohibited reason, such as taking sick leave, making a workplace complaint, or family / carers responsibilities. Because of this, it is helpful to always give an employee a reason for their termination, even if they are within their MEP. It makes it clearer that it was not for any prohibited reasons.

The minimum employment period applies to all employees and is not dependant of having a probation period clause in your contracts. The length of a probation period, or the decision to extend it, will also have no influence on an MEP, it is always 6 months for employers with 15 or more employees and 12 months if you have less than 15 employees.

What are the benefits of including a probation period in my contracts?

Having a probation period clause in your employment contacts allows you to set expectations with your new employee. It is a great opportunity to review their ongoing performance, fix any problems and raise possible issues through regular meetings and catch ups. In turn, the employee can also raise any of their concerns and will hopefully feel supported in their new role. dr.

If you require further information please contact the AMA (NSW) Workplace Relations Team at workplace@amansw.com.au.

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HEALTH LITERACY, MENTAL HEALTH, AND A HOLISTIC LENS

CATHERINE LOUREY

COMMISSIONER, MENTAL HEALTH COMMISSION OF NSW

Being the Commissioner is a humbling experience. Listening to the stories of people who are brave enough to share is also a privilege.

OVER THE LAST two years, the Commission carried out a series of community consultations across the State to listen to the community and learn about their experiences, challenges and hopes. We held more than 60 consultations, service visits and an online survey where more than 3,000 people gave us their views and feedback. This was a diverse group with many having a lived experience of mental health issues, as well as families, service providers, mental health professionals, community workers and community members.

One of the most significant concerns to surface from our consultations, was that people with lived experience of mental health issues said that they wanted health workers to understand their mental health issues better.

Having a holistic understanding of a person's cultural context and environment, as well as their physical and mental health is essential for getting the right support and offering opportunities to improve wellbeing. Improving mental health literacy across the workforce is key to optimising these opportunities. Whereas most health literacy projects are about educating the public to help them understand their own health needs, the Mental Health Commission of NSW is undertaking the Health Literacy Initiative that aims to support the important relationship between a health worker and their client, to achieve the best holistic health outcomes for the person. This focus upon supporting the health literacy of the workforce and creating enabling environments is unique and has been recognised by the World Health Organization.

Health literacy is about people's ability to access, understand, appraise, remember and use health information and health care services. It means understanding the context in which people access information and providing clear communication about how, when and where people can access help so they can make more informed choices about both their health needs.

Health literacy helps a clinician or health worker to tune in to what is happening for someone. It helps the patient tune in and understand their options, too. Achieving that comes back to providing holistic care.

The resources developed through the Commonwealth-funded Health Literacy Initiative will add to the toolkit that health and social support workers use in their work. It's not about creating a new performance standard, but about creating a new set of guides and resources that health and social service workers can draw upon. This health literacy toolkit then becomes more useful as each worker can draw upon it, given their own experience and professional setting, whether in a local health district, primary health network or community-managed service.

Studies vary in their findings but in general it's been shown that people with mental health issues have reduced life expectancy by 20 years in males

and 15 years in females[1].

We know that many health workers practice a whole-of-person approach, but when we also know that people with severe mental illness continue to have a reduced life expectancy, we need to increase our efforts to support workers to get the best overall health outcomes for their clients. If you have a mental health issue and go to a health worker, they should be able to see you as a whole person, and say: 'OK, we have discussed your mental health during this past fortnight, but I've also noticed that lump on your forearm. Have you seen someone about that?' And equally important, if you are seeking advice about feelings of tightness in your chest, then questions about your mood and feelings also need to be explored further.

People often tell us that they have poor experiences with a service in which they are misjudged or are seen through the prism of stigma. As such, some people are hesitant to reach out, even though they may be experiencing physical or mental distress.

What that means is they delay seeking help.

We hope that by improving health and mental health literacy across the health and social care workforce and having a common language, that we can break down stigma, strengthen trust, provide care earlier and improve life outcomes.

The Commission's Health Literacy Initiative has been invited to join the World Health Organizations' global network of health literacy projects.

Resources developed throughout the three-year Initiative will be freely available on the Mental Health Commission of NSW website. dr.

[1] Wahlbeck et al. 2011, "Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders", The British Journal of Psychiatry (United Kingdom: Royal College of Psychiatrists, 2011), 199, 453–458, cited in AIHW, "Physical health of people with mental illness", Australia's health 2020 (July 2020)

Air Pollution

The long-term trend shows air pollution is getting worse in NSW and the impact on residents is determined by where you live, explains Dr Kim Loo.

AIR POLLUTION is harming our health. Yet this flies under the radar for most people, including those in our own profession.

Anthropogenic air pollutant PM2.5 (Particulate matter 2.5 microns) causes premature mortality. An estimated 2600 people die from air pollution in Australia each year.

Once inhaled, PM2.5 can affect the respiratory and cardiac systems. Numerous studies have also shown links between air pollution and an increase in the incidence of type 2 diabetes and slow foetal growth in utero.

Air pollution arises from human activity such as motor vehicles, residential wood heaters, indoor gas cooking, mining, industry, power generation from coal and off-road vehicles. There are 43 stations in the NSW Air Quality Monitoring network. These stations monitor particulate matter PM10 and PM 2.5, NO2, SO2, VOC (Volatile organic compounds) and Ozone (secondary pollutant arising from the photo chemical reaction of NO2 and VOC).

The worst air quality for the state is in Central and Western Sydney and adjacent to Coal fired power stations and mines. These areas have exceeded annual PM2.5 standards for years. They are also areas of socioeconomic disadvantage.

The long-term trend shows that PM2.5 is rising, even with excluding the 2019/20 bush fires.

Pollution from energy generation

We have five coal fired power stations in NSW. The bulk of NSW's energy need is generated from black coal. There is also hydro, wind and solar.

The most recent epidemiological study shows that air pollution from generating electricity led to 279 deaths, 233 being born underweight (less than 2500 grams) and 361 people with new onset diabetes.

The impact of air pollution on birth weight was documented by a Beijing study in 2008, which found 83,000 babies born around the time of the Olympics (when air pollution was reduced by 59%) were heavier by an average of 23 grams.

Domestic heating

Wood smoke from domestic heaters is a serious problem causing an estimated 100 deaths per year in greater Sydney.

Mine dust in the Upper Hunter Valley

Coal workers and surrounding communities are exposed to higher levels of air pollution than other communities.

Children in these communities have a much higher incidence of asthma.

Yet despite the elevated level of air pollutions causing health consequences, there is no improvement

in air quality. The EPA (Environmental Protection Agency) mine dust enforcement workforce in the Upper Hunter is under resourced and needs the capacity to impose larger fines for breeches of environmental conditions. The usual $15,000 fine is ineffectual.

Transport pollution

Urban traffic related air pollution is heterogeneous, with roadside concentrations markedly higher than background ambient levels. Children are especially sensitive to air pollution due to their immature capacity to detoxify a pollutant load, and higher respiratory ventilation rate per Kg body weight. Traffic related air pollution has been documented in Australian research to be associated with increased asthma prevalence and concerning new evidence from Spain has shown an association with slower cognitive development in school children.

What can we do as doctors?

We can make choices in our own lives to reduce our own pollution and emissions generation. Thermally insulate your house, buy solar panels, batteries, and an electric vehicle. Doctors are also encouraged to join the health sector in the advocacy space. I have been in this advocacy space for environmental determinants of health for six years. Clean air, clean water, healthy soils, stable climate, and a healthy ecosystem are inextricably linked to human health.

We have had prolonged drought, bush fires, heat waves and extreme weather. My patients have been impacted by heat waves, bush fire smoke and floods in the past two years. And the mental health impacts have been significant.

Moving to non-polluting energy generation, transport and industries and a more sustainable health care sector are a win win for the whole community.

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dr.

ABOUT THE AUTHOR

Dr Kim Loo is a General Practitioner and a Council member of AMA (NSW), as well as Chair of NSW Doctors for the Environment. She is also a member of the Hills Doctors Association and the Australian Parents for Climate Actionand Hills 4 Climate Action. She is a mother of two children and lives and works in Western Sydney.

Dr Loo has been advocating for the environmental determinants of health for the past six years.

IMPROVED ACCESS TO SPECIALIST TREATMENTS FOR CARDIAC PATIENTS

NSW HEALTH committed $21.6m to improve access to specialist treatments for patients with aortic stenosis in its 2021-22 NSW Budget.

The funding allows complex patients who can't undergo open heart surgery to have a less invasive Transcatheter Aortic Valve Implantation (TAVI) prodecure.

The High-risk TAVI Supra-LHD Service will be available at John Hunter Hospital, Royal North Shore, Royal Prince Alfred, St Vincent's, Westmead, Liverpool and a to-be-determined hospital within South East Sydney Local Health District.

"Importantly the investment will help NSW Health define and strengthen referral pathways for our regional and rural patients into the seven hospitals offering the highly-specialised High-risk TAVI service," said NSW Health Minister, Mr Brad Hazzard said. dr.

EXTENDED TELEHEALTH CONSULTS

THE FEDERAL GOVERNMENT'S decision to reinstate a longer level C telephone consultation item was critical for patients with complex health needs and followed AMA discussions over the past few days with the Minister for Health, Greg Hunt.

"The latest COVID-19 outbreak in Sydney has demonstrated consultations with GPs via the telephone remains critical for patient safety and access during lockdowns," said AMA President, Dr Omar Khorshid.

The AMA supports the Federal Government's Medicare-funded telehealth and strongly believes that it has been one of the most successful measures as part of the response to the COVID-19 pandemic. dr.

MED STUDENTS CALL FOR PAID OPPORTUNITIES

THE NEW SOUTH WALES Medical Students' Council (NSWMSC) calls for workforce positions, and other paid workforce opportunities for the future of medical students, following the release of NSW Health's evaluation report of the Assistant in Medicine (AiM) workforce roles.

NSWMSC worked closely with NSW Health on the development of the AiM program as a component of the NSW Health medical surge workforce in response to COVID-19. Its goal was employing final-year medical students in part-time roles to support multiple medical teams in hard times.

The NSW Health's evaluation discovered that students employed as AiMs were highly skilled in their division and supported Junior Medical Officers in completing clinical tasks, allowing Junior Doctors to spend more time on patient care and clinical procedures, as well as teaching along the way.

The AiM program financially supported medical students at a time where many had lost their jobs or were unable to work due to placement obligations. Additionally, participants say they felt more prepared for internship.

"Medical students often spend long hours on clinical placement, with inconsistent class schedules and study requirements making it difficult for students to support themselves through part-time work," Isaac Wade, President of the New South Wales Medical Students' Council, said.

NSWMSC welcomes the results of NSW Health's evaluation and believes that the success of the program highlights the significant benefits of employing senior medical students in clinical positions for patients, clinical teams, and students. dr.

AMA (NSW) Careers Service

Providing assistance to medical professionals throughout your career. You can access AMA (NSW)'s Careers Service free of charge as part of your membership. We offer ongoing support throughout your career, including CV review and development, assistance with selection criteria and application responses, as well as interview skills and preparation. Online or phone meetings can be arranged depending on your availability.

To make a booking visit us at www.amansw.com.au/careers email us careers@amansw.com.au or call us on 02 9902 8158

"Having Jessica from the AMA Careers Service review my resume gave me confidence that my application was going to be competitive. Then following that with an interview preparation session online made me feel prepared to face interview panels."

Rene L, O&G Registrar

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AMA (NSW) Corporate Partner Benefits

April Invest

April Invest is a Property Investment Fund Manager who buys, manages and adds value to direct property investments within Sydney. Our objective is to help you generate greater wealth and diversify your investment portfolio through additional passive income from the purchase of Sydney office buildings.

Accountants/Tax Advisers

Cutcher & Neale's expertise is built on an intimate understanding of the unique circumstances of the medical profession. Our team of medical accounting specialists are dedicated to helping you put the right structure in place now to ensure a lifetime of wealth creation and preservation.

Health Insurance

Doctors' Health Fund aligns to the values of the medical profession and supports quality health care. The Fund was created by and is ultimately owned by doctors. Contact the Fund on 1800 226 126 for a quote or visit the website: www.doctorshealthfund.com.au

Tyro

At Tyro, we are the champions for better business banking. We've grown to become the largest EFTPOS provider outside of the majors. AMA (NSW) members receive special merchant service fee rates with Tyro's fast, integrated and reliable EFTPOS for business.

Specialist Wealth Group

The Australian Medical Association (NSW) Limited and Specialist Wealth Group Pty Ltd wish to advise members that their commercial relationship came to an end on 30 June 2021.

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

Member benefits

AMA (NSW) Partner Benefits

Alfa Romeo & Jeep

Alfa Romeo's® & Jeep's® Preferred Partner Program gives members significant discounts across both vehicle ranges.

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Receive AudiCare A+ for the duration of the new car warranty, free scheduled servicing for 3 years/45,000km, and more.

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Complimentary scheduled servicing for 5 years/80,000 km, preferential pricing on select vehicles and reduced dealer delivery charges.

Jaguar Land Rover

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Mercedes-Benz

Enjoy the benefits of this Programme on selected vehicles, including Preferential pricing, access to the Corporate Rewards Portal and more.

Sydney City Lexus

Preferential corporate pricing, 3 year/60,000km complimentary scheduled servicing, reduced delivery fee, and more.

Tesla Corporate Program

Complimentary 3-Year maintenance plan and waived delivery fee and energy product purchases for AMA (NSW) members.

Hertz

10% off the best rate of the day on weekdays and 15% off the best rate of the day on weekends.

AMA Training Services

Members receive a $500 discount off first Assisted Study Program term for yourself or nominated staff member.

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Call AMA (NSW) membership team on 02 9439 8822 or go to amansw.com.au and ama.com.au for full list of benefits.

Disclaimer: AMA (NSW) may financially benefit from its relationship with Preferred Partners.

Financial**Paracetamol**

July 2021

Cutcher&Neale
ACCOUNTING AND FINANCIAL SERVICES

Welcome to the July edition of Financial Paracetamol for 2021.

In this edition:

Setting goals for the financial year ahead. As we begin another financial year now is the perfect time to set your financial goals.

What's new in cloud accounting? If you've established your cloud accounting system, growing your 'cloud maturity' is an on-going task.

Employing your spouse. Does your spouse assist you in the day-to-day operations of your practice or your work undertaken as a medical practitioner?

Single Touch Payroll is set to expand! The ATO has confirmed Single Touch Payroll (STP) reporting for micro-employers with 1 to 4 employees and small employers with closely held payees will commence from 1 July 2021.

As always, if you have any questions relating to any of the articles in this edition, please feel free to get in touch with our award winning team.

Jarrod Bramble
PARTNER

Setting goals for the **financial year ahead.**

Happy new financial year!

As we begin another financial year now is the perfect time to set your financial goals.

Setting measurable goals is a powerful tool in helping you reach your full financial potential both now and into the future. Following are a few of our hints and tips to get you started:

Budgeting

Having a budget will increase your chances of success. A successful budget will be monitored on an ongoing basis to ensure it is still on track to reach your overall financial goals.

A simple starting point when looking to prepare a budget is to break down your expenses and outgoings into categories so they are easier to understand.

Understanding where your money is going is a pivotal first step.

Cloud Accounting

Gone are the days of keeping your accounting program on the hard drive of your computer. Cloud accounting allows you to keep mobile, up to date and informed in a very simple manner.

Accounting software not in the cloud can be tedious and time consuming and can take far too much of your time and effort.

One of the biggest advantages of cloud accounting is the ability for your income and expenses to flow straight from your bank account to your accounting system without hours of data entry.

Cloud accounting software enables you to know your financial position at any time.

Get your team right

It is important to have the perfect team of professionals to assist you in setting goals as well as achieving them.

Your accountant should be your first contact and will have the best understanding of your financial position and can assist you in developing your financial goals.

If you are looking to focus on entering the property market, the introduction of a buyer's agent into your team can not only bring skill and knowledge but a hefty time saving as well.

An informed business banker is also an important factor. Your banker should understand the career and income progression of a medical practitioner and in turn your borrowing capacity.

Set a target

Whether it's paying down debt, retirement planning or growing your property portfolio you need to know what you are working towards. Recognising, recording and communicating this target primarily to your accountant will enable them to help you achieve this.

If paying down debt is your area of focus, your accountant will help you determine how much you are able to commit to debt reduction each year and which debts to tackle first.

Final tips… It is worthwhile to take time to make sure your goals are achievable and measurable. Tracking how you are progressing against these goals throughout the year will keep you motivated and gives you the ability to adjust if necessary.

Need help in getting started with your goals? Contact our team today.

What's new in **cloud accounting?**

If you've established your cloud accounting system, growing your 'cloud maturity' is an on-going task– and that includes staying on top of the latest developments in cloud accounting.

Here's our round up of new programs and features to be aware of:

E-Invoicing

E-invoicing is available in Australia. As part of the government's commitment to improve the way businesses interact with each other you are now able to register and utilise e-Invoicing.

Invoices are electronically exchanged between accounting software systems without manual data entry. This means businesses will no longer need to generate paper invoices or PDF documents and send out to customers.

This also means bills can be received straight into your bills area of your accounting system without any data entry required ready to be approved and paid.

Xero Verify

There is a new Multi Factor Authentication App released by Xero for their accounting software called Xero Verify.

You can now authenticate quickly and easily using push notifications rather than generated codes within the app.

Xero have worked on a solution to make the 2-layer security option much simpler and smarter for its customers. This new solution is more seamless than other 2 factor authentication apps making the task so much easier.

The acceleration of open banking

Open banking in Australia allows customers of the big 4 banks to securely share some of their banking data with other accredited banks and soon financial software providers.

You will have the control of which third party can access your data and how this data is then used. This information can include transaction history and account balances and if shared with accounting software providers will hopefully assist with account types that currently have no bank feeds available.

No more providing transaction history files for importing data.

Currently customers of the big 4 banks can request and share their various types of account information with an accredited data recipient who will provide this to other banks and providers to speed up application processes, switching financial institutions, finding products more tailored to your current situation and giving you a better overview of your finances.

Smaller financial institutions are also now offering opening banking access and towards the latter half of 2021, third party software providers can start to include open banking in their product offerings.

If you would like to discuss your accounting software, please feel free to chat to one of our cloud accounting specialists.

Employing **your spouse.**

Does your spouse assist you in the day-to-day operations of your practice or your work undertaken as a medical practitioner?

There may be tax savings to be had by remunerating your spouse for the work they do.

It is important you have the appropriate documentation prepared and adhere to the rules and obligations as an employer.

Paying your spouse or family member a commercial wage for work performed for your medical practice can also mean that you are able to pay additional super contributions above the super guarantee and thereby maximise their concessional super contributions each year.

Some common activities that your spouse could be assisting you with might include bookkeeping, practice management, billings and invoicing, creditor payments and other administration tasks.

You will need to ensure the work arrangements are implemented as you would any employee, including paying them a reasonable amount and making sure that an employee contract is entered in to for the work performed.

You would also need to register for single touch payroll and a superannuation clearing house to meet your employment obligations, but most accounting software programs will assist with this.

Is your spouse assisting in your medical practice? Are you unsure whether paying them a salary is possible? Do you need to get the correct documentation in place? Our team can help!

Single touch payroll is set to expand!

The ATO has confirmed Single Touch Payroll (STP) reporting for micro-employers with 1 to 4 employees and small employers with closely held payees will commence from 1 July 2021.

A closely held payee is an individual who is directly related to the entity from which they receive payments, for example:

- Family members of a family business
- Directors or shareholders of a company
- Beneficiaries of a trust.

STP reporting for micro employers is not the only update, the expansion of STP continues with the introduction of STP Phase 2.

In the 2020 Budget it was announced that the ATO would expand the data collected through STP.

This expansion is mandatory from 1 January 2022.

Interestingly the ATO have recently indicated the role out is largely dependent on the software companies and this may not be a definitive cut-off.

STP Phase 2 is designed to reduce the reporting burden for employers needing to report information about their employees to relevant government agencies and assist the administration of the social security system.

Additional information required to be reported in STP Phase 2 includes:

- Employment Conditions
- Income types and country codes
- Itemisation of allowances
- Salary Sacrificed amounts
- Categorisation of lump sum payments

A lot of this new reporting is reliant on software companies and payroll providers updating their software to accommodate these changes.

Our resident Xero Heroes will be keeping a close eye on STP expansion and the potential impacts it may have on our clients.

If you have any questions relating to STP, please get in touch today!

Upcoming events

Cutcher & Neale are proud presenters on a range of topics to help you along your journey as a medical professional.

To see where we are presenting next, scan the QR code to visit our events page, or visit **cutcher.com.au/events.**

SCAN ME

Federal Budget Summary

In May 2021, the Hon Josh Frydenberg MP, delivered the 2021 Federal Budget. We've reviewed the budget, summarised the key points and outlined how these may impact you as a medical professional. Scan the QR code or visit **cutcher.com.au/budget-2021.**

Key dates

14 July 2021	Issue PAYG withholding payment summaries or income statements
21 July 2021	June monthly BAS due
28 July 2021	June quarter SG due June quarterly BAS due
23 August 2021	July monthly BAS due
21 September 2021	August monthly BAS due

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