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# THE NSW doctor

AMA NEW SOUTH WALES

THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION OF NSW

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# From the Editor

AMA (NSW) recently participated in the NSW parliamentary inquiry about homelessness amongst older people aged over 55 in New South Wales. In preparing our submission, we canvassed the opinions of our Council of General Practitioners.

The insight provided by this group was matched by the passion many felt about this social issue. It was also surprising how many in this committee already were involved with specialty homelessness services.

It speaks to the commitment of doctors to step outside of their practices and immerse themselves in social issues that directly intersect with health.

You can read an excerpt of our submission on p17.

As an association we are looking forward to tackling these issues, along with much needed health policy reform.

We'll be focusing on our election priorities in the lead up to March 2023. The strength of the AMA (NSW) lies in the breadth of its membership. This is reflected in our Council, which informs AMA (NSW)'s election priorities. While focused on individual areas such as rural and regional health, doctors-in-training, public and private hospitals and general practice, we will be looking at policy solutions that bring together different parts of the system so that it works more collaboratively and cohesively.

We look forward to sharing our election priorities in more detail in these pages in the coming months.

**Andrea Cornish, Editor**

# Have we lost trust in trusts?

## We haven't, you just need to navigate the legislation.

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# BUILDING A BETTER HEALTHCARE SYSTEM

**DR MICHAEL BONNIING**
PRESIDENT, AMA (NSW)

**AMA (NSW) is looking forward to tackling wider health system change to create a model of healthcare fit for the future needs of NSW residents.**

**IT IS AN HONOUR** to take over from Dr Danielle McMullen and a privilege to serve in the leadership team of AMA (NSW) alongside Dr Kathryn Austin, who was elected to Vice President.

I joined the AMA as a student during my first week of medical school. I've always been motivated by the idea of collective action – thoughtful people pulling in the same direction. I also strongly believe doctors need to have a say in the system they work in.

My involvement with the AMA has grown since medical school. I served as AMSA President and then Chair of the Federal AMA Council of Doctors in Training from 2010-2012 before becoming AMA (NSW) Chair of Council and a Non-Executive Director since 2015 and I've been a Federal AMA Councillor since November 2021.

I'm passionate about doctors' mental health and wellbeing and I have served as a Non-Executive Director of beyondblue from 2008 to 2014 and as an inaugural director of the Doctors' Health Service.

As President, I'd like to first and foremost reconnect with the profession by meeting with doctors in their places of work and understanding the priority for our advocacy. I campaigned on the expansion of outpatient clinics in public hospitals to remove the current inequity of access to timely and appropriate specialist consultation knowing that will make a meaningful difference for patients and reduce emergency presentations. I am heartened that one of my initial priorities in palliative care has received substantial funding but there remains significant need for commitment of co-commissioning of services to integrate and best use our health system funding.

We have less than 12 months until the NSW state election and a prime opportunity to shape health policy for a better future.

NSW's 2022/2023 Budget was a strong commitment to health and a recognition that health costs are higher than inflation. But we need more than investment. We're asking the Government to also implement a long-term plan that accounts for our growing and ageing population, which is increasingly presenting with complex chronic health conditions.

We want solutions that target the pain points we're currently experiencing, but also act as a circuit breaker on the causes of this pressure. We need to look at not only the treatment of disease, but the prevention of disease. The more people we can stop from ending up on hospital the better off patients and our healthcare system will be.

AMA (NSW) Council recently sat down to discuss our priorities for the coming election. We concluded that our four main focus areas will be: Rural and Regional Health; Doctors-in-Training; Public and Private Hospitals; and General Practice.

Over the coming months, we'll be building on our election platform and communicating these priorities to members. I remain ever optimistic that the AMA is the most effective voice for constructive change in the health system and to articulate doctors' concerns about community issues affecting health. dr.

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# THE COST OF A HEALTHCARE CRISIS

**FIONA DAVIES**
CEO, AMA (NSW)

**Whilst necessary to highlight the pressure on our health system, we need to find a means of maintaining the public's trust and confidence.**

**IN MY YEARS OF WORKING** with the AMA, there has rarely been a time in which the word crisis has not been associated with health. I have supported doctors through the catastrophic system collapses which have dominated the news cycle for months. These experiences undermine the trust of the community in both doctors and the hospital system. The fallout from such situations always makes me wary of the way in which we manage and highlight crisis in healthcare because so often – beyond clicks on a newspaper website – there isn't much that really changes on the ground.

I have been reflecting on this more recently as our health system faces what feels genuinely like the largest and most significant downturn I have seen. A spiral not just caused by COVID but instead by the collapse of so many aspects of our health system, particularly in the general practice and aged care sectors. I was recently privileged to visit a regional hospital ED. It was a regular weekday afternoon and it felt like a warzone. The exhausted doctors commented on how every day was now a crisis level day with ambulances lined up and patients waiting for care. They observed that it was the impact of two things – the closure of some general practices and the fact that there are no longer aged care beds available to send patients to. Both involved only fairly small events, a few GPs retiring, a few aged care facilities struggling, but the impact was huge. We are hearing this story across rural and regional NSW and increasingly in metropolitan areas. This collapse is not unexpected – I have been hearing the "in five years" projections for some time – but it remains shocking to discover how fragile our health system is.

The challenge in advocacy comes back to how to get change and highlight this crisis without undermining the trust and confidence of the community. This is even harder in a news cycle that lives on crisis and moves on so fast.

The approach we are taking at the AMA is to tell the stories and to share the experiences of our doctors and of our patients. These stories and experiences are coming back around with so many in the community having a lived experience of the difficulties of accessing healthcare and the crisis coming to their family. It's not as sensational as the splashing of critical incidents but it is the real, lived experience of what a healthcare crisis really means and why fixing it remains so important. dr.

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Overseas model shown.

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# PART OF THE SOLUTION

**After witnessing how poor working conditions for doctors-in-training were contributing to underpayment, burnout and fatigue, Dr Sanjay Hettige committed his training years to advocate for change.**

**ANGER.** That's what Dr Sanjay Hettige felt as an intern finally seeing first-hand how poor the hospital systems were when it came to looking after doctors.

"It was eye opening to me," said Dr Hettige.

"I have a lot of friends who have jobs outside of medicine and I started to compare our working conditions, treatment, and what we had to deal with on a day-to-day basis to theirs. Having that perspective drove me to want to be a part of changing a damaged system," he stated.

Currently the DIT Representative on the AMA (NSW) Board of Directors and Co-Chair of the AMA (NSW) Doctors-in-Training Committee, Dr Hettige has been a strong advocate for DITs throughout his medical career.

Dr Hettige has been a member of the AMA since he was a medical student and was previously the NSW Representative on the AMA Council of Doctors-in-Training (AMA CDT).

"It just felt like a natural fit for me to be a part of the AMA," Dr Hettige said.

"Seeing that there were so many issues to be dealt with that could improve working conditions for doctors-in-training made me passionate to be in the role I am in today. I always think that the best way to create change is through collective

"I always think that the best way to create change is through collective action."

action and seeing what the AMA (NSW) Doctors-in-Training Committee had already achieved over the years felt right for me."

Dr Hettige believes doctors shouldn't have to deal with all the issues in the system that make their work so much harder.

"As doctors, we're there to care for our patients and make a difference, it shouldn't be so difficult to do so," he said.

Even through the COVID pandemic, Dr Hettige continued advocating for better working conditions for doctors-in-training. Despite such a rapidly changing environment, the AMA and the DITC rose to the crisis.

"COVID meant that we had to be reactive; we had to quickly change what we were doing advocacy-wise and deal with the problems in front of us such as the pausing of JMO rotations and lack of PPE. I think everyone was on the same path. We knew it was going to be challenging, but we were ready to respond to the different obstacles that were thrown to us on a day-to-day basis."

Among his proudest achievements is being a part of the team that established the Hospital Health Check (HHC) in NSW. The HHC has been pivotal in eliminating the barriers that make it harder for DITs to claim unrostered overtime. The survey has also led to an expansion to the list of pre-approvals for UROT and the creation of the online claiming system.

"Doctors should get paid for the work that they do. It just seems wrong that it wasn't happening, and I think this simple idea improves working conditions immensely because you're getting valued for the work you actually do."

Dr Hettige said that seeing the problem, speaking up about the problem, and then fixing the problem by taking high quality data from the HHC to the Ministry that revealed the extent of the problem has resulted in real change.

"Doctors should get paid for the work that they do. It just seems wrong that it wasn't happening, and I think this simple idea improves working conditions immensely because you're getting valued for the work you actually do."

He aims to advocate on more doctor-in-training issues such as safe working hours, night-shift standards, fatigue standards, and making sure bullying and harassment numbers in hospitals are reduced.

In addition to his involvement in medico-politics, Dr Hettige is a second-year radiology registrar at Nepean Hospital.

"I did struggle with time management skills at first as I had a big problem with saying yes to everything. But being surrounded by other amazing DITs who are just as passionate as me for advocacy really helped," he said.

"I've always been someone that wants to take the opportunity to do what I'm passionate in, and I think as a doctor sometimes you can feel like you're too busy to do these things. When you're passionate about something and surrounded by the people that understand the position you're in, you can create the time and make it work." dr.


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HOW AN AUSTRALIAN DOCTOR IS TRAINING FOR HISTORIC 110-DAY TREK

# From MANLY to ANTARCTICA

**Anaesthetist Dr Gareth Andrews, alongside Dr Richard Stephenson, are preparing for an epic 260-kilometre adventure across Antarctica.**

**THE GOLDEN SANDS** of Manly are a world away from the frozen interior of Antarctica, but the beach provides an ideal training ground for Gareth Andrews.

The 40-year-old consultant anaesthetist at St Vincent's Hospital in Darlinghurst pulls four-wheel-drive tyres along the sand for up to six hours, several times a week, to simulate the 200-kilogram sled he will drag across 2600 kilometres of snow and ice later this year.

Dr Andrews said the training regime - a crucial part of the preparation for the 110-day trek across Antarctica - attracts the odd stare as well as unsolicited advice.

"You've misinterpreted the wheel -

that's my favourite one," he said. "You should just buy a car mate, which is a common one."

Dr Andrews is also working out at the gym and eating eight meals a day to add 10 kilograms to his already muscular frame ahead of The Last Great First, which he will undertake in October with fellow medic Dr Richard Stephenson.

Dr Andrews drinks spoonfuls of olive oil to boost his calorie intake, but still has to eat every two or three hours.

"It's really difficult when you're an anaesthetist and stuck in theatre all day and not able to get out for a food break," he said. "The eating is a full-time job."

The doctors were invested as members and ambassadors of Scouts Australia in Canberra by Governor-General David Hurley.

They follow in the footsteps of Antarctic explorer, Sir Douglas Mawson, who was awarded the Silver Wolf scouting medal in 1915.

Both men credit their adventurous spirit to their childhood in the scouts. Dr Andrews, who grew up in Scotland, said he learnt to use a compass,

abseil down a cliff, paddle a canoe and tie knots as a scout.

"I think scouts can open the eyes of young people everywhere to an outdoor world of fun and adventure whilst learning incredibly valuable life skills, and I want my kids to have that opportunity," Dr Stephenson said.

The Last Great First expedition will be an unsupported, coast-to-coast ski crossing of Antarctica.

Dr Stephenson, an emergency doctor at Dunedin Hospital in New Zealand, and Dr Andrews will burn 7000 calories a day, hauling sleds containing all their food and equipment across the frozen Antarctic landscape.

"If successful, it will be one of the greatest feats of human endurance ever achieved," he said.

It is also risky. British explorer Henry Worsley died in 2016 while attempting a solo, unaided crossing of Antarctica that was inspired by Sir Ernest Shackleton's doomed expedition a century earlier.

Drs Andrews and Stephenson expect to encounter howling winds up to 200 km/h, frequent polar storms and temperatures as cold as -40 degrees during the expedition.

They will begin at sea level on the edge of the Ross Ice Shelf, skiing about 25 kilometres a day into headwinds as they climb 2850 metres through the Transantarctic Mountains to the South Pole before finishing at Gould Bay.

The training is designed to give the adventurous doctors the strength and endurance to pull a 200-kilogram sled or haul it out of a crevasse while withstanding the inevitable wear and tear on their bodies.

However, the pandemic was an obstacle, with both men forced to put the expedition on ice to focus on their work as doctors.

Dr Andrews was living in Wales in 2020, which he said was hit hard by the COVID-19 crisis: "There was no capacity for anything else apart from going to work to treat patients and be there for your colleagues and family."

On days off, he dragged tyres up and down the laneway outside his house in Cardiff, staying within the five-kilometre limit imposed during lockdown.

The logistics of the expedition are mind-boggling – nothing has been left to chance when it comes to equipment, clothing and communications, which explains the $1 million cost of the expedition, which Drs Andrews and Stephenson hope will attract sponsors.

"Weight is everything, so we literally cut labels off clothes, snap handles off our toothbrushes," Andrews said. "We try to minimise weight as much as possible."

Each day of the expedition will be meticulously planned – up at six o'clock to eat breakfast and pack up the tent before 10 hours of skiing from 8am to 6pm.

Dr Andrews said evenings will be consumed with setting up camp, communications and boiling water - no easy feat in subzero temperatures


– and perhaps an hour of reading, writing or listening to music before a strict 10pm bedtime to ensure eight hours of sleep.

"Gareth and I have spent a lot of time in tents together already," Dr Stephenson said. "We know we work really well as a team and perhaps, more importantly, get on really well even when the going gets tough."

With no supply drops, the duo must carry 110 days' worth of food on their sled, eating specially prepared dehydrated meals or, as Dr Andrews put it, "food in a bag. Just pour boiling water on it and off you go."

A hearty menu of spaghetti bolognese, lasagne, curries, dahl and chocolate pudding will fuel the expedition, although Andrews estimates the duo will each shed about 20 kilograms during the three-and-a-half month trek.

There will be no hot showers either, with the doctors relying on alcohol hand rub and wet wipes to maintain personal hygiene and avoid illness.

"Coughs, colds, getting infections are really detrimental and can even be expedition-ending," Dr Andrews said.

Toilet stops will be done "very quickly", he said. "There's no secret formula."

They will also have to carry out any rubbish except for human waste. "In the grand scheme of things, in the immensity of Antarctica, the impact of our human waste will be vanishingly small," Dr Andrews said.

Both men believe the psychological challenges will be as intense as the physical demands of the expedition.

"Just the ability to get out of the tent every day and perform at your best even though you know it's going to be really tough," Dr Andrews said. "It's going to be cold, and your sled is really heavy, and you're really tired."

But a decade of arduous expeditions to the North Pole, and across Greenland, Iceland and Svalbard gives Dr Andrews confidence in their physical stamina and mental fortitude.

"Over three-and-a-half months, you're going to have some bad days and some good days," he said. "It's how we manage those as a team together that will get us through."

For Dr Andrews, the hardest days will be missing wife Andrea and his kids Lucia, five, and two-year-old Arthur, but he said: "It's always a fleeting thing."

Dr Stephenson said separation from his family is the hardest aspect of the expedition: "If we can stay strong psychologically we put ourselves in a much better position to meet the physical challenges and push through when the going gets tough."

The duo will collect climate science data during the expedition such as surface pressure, temperature, magnetic field information, ice surface data and even cloud patterns that Stephenson said is "surprisingly difficult" for satellites to record.

"We will be traversing areas very rarely or never before crossed by humans and even with modern remote sensing technology there simply isn't a way of gathering truly accurate data without the instrumentation physically on the ground that we will be carrying with us," he said.

However, Dr Andrews said: "It's not lost on us that it's a selfish pursuit, and we're putting ourselves in harm's way."

"Both Rich and I have beautiful families and young children and they're the centre of our world," he said. "But this journey has been with Rich and I for 10 years and our adventuring, it makes us the people we are. I truly believe it makes us better husbands, better fathers, better people." dr.

**Reprinted from *The Sydney Morning Herald*, Written by Andrew Taylor**

# VALUING HEALTH IN NSW


**NSW delivered a strong 2022-23 Budget, but without a long term plan to address the crisis in our health system it won't meet the needs of doctors and patients.**

**STATE GOVERNMENTS** across Australia increased their health budgets for 2022-2023. As the largest jurisdiction in the country, NSW handed down a record $33 billion in health spending demonstrating a strong commitment to health and a recognition that health costs are higher than inflation.

Prior to the release of the Budget, AMA (NSW) called on the State to address workforce shortages, medical salaries, and health expenditure for non-COVID care.

We were pleased to see the Budget included a $4.5bn commitment to boost workforce numbers, a lift to the public sector wages cap, and $408m to fast-track elective surgery.

It was clear from our surveys of both senior doctors and doctors-in-training that insufficient resourcing was contributing to high levels of doctor burnout.

The budget announcement included a promise of 10,000 additional FTE staff to hospitals, NSW Ambulance and health services across the State

over the next four years. While this is welcomed, AMA (NSW) recognises the challenges in recruiting and training such a large number of health workers.

The State Government's announcement to introduce a suite of incentives to attract and retain health workers to rural NSW was also welcomed, but AMA (NSW) strongly urged the Government to extend similar measures to doctors to shore up severe workforce shortages in the bush.

Doctors are central to the provision of healthcare, and we need to ensure that measures aimed at building our regional health workforce are extended to all clinicians.

Having a strong health team will help attract doctors to work regionally. Extending extras such as study leave, accommodation, and training allowances to doctors will complement this strategy and strengthen the delivery of healthcare in regional and rural areas. For instance, doctors-in-training who train in regional areas are not provided with supports, including accommodation, when they rotate to metropolitan hospitals.

While overdue, the boost to the wages cap will help doctors keep up with inflation pressures. However, AMA (NSW) is urging the Government to update doctors' contract conditions.

Visiting medical officers, staff specialists, and doctors-in-training have been working under awards that have not been updated for years – for instance, the award for doctors-in-training has not been updated since the 1980s.

AMA (NSW) has called on the State to provide a sustained investment in health to address the capacity issues that threaten the system.

We need to see a long-term plan from Government that accounts for our growing and ageing population, which is increasingly presenting with complex chronic health conditions.

Wards are full with patients who have nowhere to go – they might be waiting for an aged care placement, community mental health, or disability support. This creates bed block, which has a downstream effect on emergency departments. EDs are overcrowded, which means ambulances aren't able to transfer patients. Patients who could be treated in primary care are going to hospital because they are unable to get a GP appointment, due to the GP shortage. Each part of the system is under stress and when one piece falls, the rest topples like dominoes.

Payroll tax threatens the financial viability of medical practices across NSW and risks exacerbating the challenges patients already face, particularly in rural and regional NSW, in accessing healthcare services.

The latest Bureau of Health Information's quarterly report (October to December 2021) found overall activity returned to near pre-pandemic levels and triage category 2 presentations continued a gradual upward trend over the past five years. Meanwhile demand for ambulance responses was high, with more ambulance responses than any final quarter on record, and almost 95,000 patients were on the waiting list at the end of the quarter, with 10,770 patients waiting longer than clinically recommended.

It is clear that emergency departments are full and ambulances are ramping, while elective surgery waiting lists are blowing out.

## PAYROLL TAX

The biggest disappointment in this year's Budget was the Government's failure to act on payroll tax.

We have also been calling on the NSW Government to provide a payroll tax exemption for general practices and it is disappointing that NSW failed to utilise the one mechanism at its disposal to address this punitive tax.

Considering NSW is projected to return to surplus in 2024-25, it is mind-boggling that the State would risk the financial stability of general practices for what amounts to such a relatively small amount of revenue to NSW.

A payroll tax bill of thousands of dollars – particularly if applied retrospectively, could force some practices to close their doors permanently. Given the GP shortage and the crisis we're facing in regional healthcare access, failure to address this tax is disconcerting.

Primary care is the cornerstone of our healthcare system and yet, often taken for granted.

Payroll tax threatens the financial viability of medical practices across NSW and risks exacerbating the challenges patients already face, particularly in rural and regional NSW, in accessing healthcare services.

Payroll tax has implications for all medical practices, but general practices have the potential to be hardest hit. The financial stability of general practice has been under threat for years and recent payroll tax decisions will push some practices to consider whether they can continue to remain open.

NSW is already facing a GP-shortage, particularly in rural and regional Australia. Payroll tax will exacerbate challenges to healthcare access if some practices are forced to close their doors.

Healthcare professionals have worked tirelessly and with little financial reward to assist the NSW Government with the vaccination roll-out and to protect the health of the community throughout the pandemic. dr.

# OVER 55 & HOMELESS

**AMA (NSW) recently contributed to the NSW Parliamentary inquiry into homelessness amongst people aged over 55 in New South Wales. COVID-19 has exacerbated many of the factors that contribute to homelessness, which is turn is leading to increased rates of homelessness in NSW and putting additional strain on services. Women in this demographic are particularly vulnerable.**

THE FACTORS THAT INCREASE the risk of an individual becoming homeless have intensified during the pandemic. The impact of COVID-19 on people's mental and physical health combined with a significant lack of affordable housing and an increase in domestic violence, has created a 'perfect storm' for those at risk of homelessness.

There are increasing numbers of people aged over 55 experiencing homelessness. The Australian Institute of Health and Welfare found the number of older people experiencing homelessness was double the annual growth rate of the Specialist Homelessness Services (SHS).

People at most risk of homelessness include women, Indigenous Australians, individuals in a single person household or single-parent household, those on low income or unemployed, and people receiving income support payments.

Older women are now the fastest growing cohort to experience homelessness in Australia, with a 31% increase in homelessness among older women between 2011 and 2016.

Women over the age of 55 are at greater risk of financial hardship and housing insecurity due to systemic factors, including lack of superannuation, the gender pay gap, age discrimination in the job market, part time employment status, and employment history gaps due to childbearing and raising a family. Life events such as the death of a spouse, illness and divorce can trigger homelessness for this vulnerable group. This demographic is the fastest growing group of homeless people in Australia. Research published in 2020 found 240,000 women aged 55 or older and another 165,000 women aged 45-54 are at risk of homelessness.

It is clear from the evidence that homelessness has a significant impact on an individual's health.

Being homeless can exacerbate an already existing condition or put an individual at risk of developing a new condition, including poor oral health, chronic disease, skin and foot problems, infectious diseases such as tuberculosis, hepatitis C and HIV infection, substance abuse, and mental illness.

People experiencing homelessness present frequently to hospitals which places a significant burden on the public health system.

While hospitals are able to deal with acute health issues, it is expensive care that does not address the other factors that can contribute to homelessness.

Furthermore, it is a preventable cost to the health system that could be avoided if barriers to healthcare access for people experiencing homelessness were to be improved.

Research has found services that specialise in providing patients with a medical service that can manage complex multi-morbidities, mental illness and drug and alcohol issues, as well as trauma-informed care can be particularly effective.

Combining these medical services with case managers who can help people secure social housing, or support for NDIS packages is an important part of that service. These specialised services address some of the personal and relationship barriers previously examined that can prevent individuals from accessing traditional health sector service models.

There are many examples of specialised services that have a track record of success in assisting patients experiencing homelessness.

These services have been effective at providing assistance to people who are most vulnerable in the community; however, there is a need to ensure funding is sufficient to meet the growing need in communities.

While specialised services have proven to be effective at providing healthcare access to people experiencing homelessness, there is additional need to adequately support general practice.

General practitioners are often the first port of call when people experience physical and/or mental ill health. As a result, GPs are well positioned to provide early intervention to patients who are at risk of homelessness.

## Aligning health and social care via general practice

Addressing homelessness is part of healthcare. As outlined in the paper from Stanford and Wood: “Addressing homelessness is, itself, an important form of healthcare, not a separate ‘non-health’ issue.”

For those experiencing homelessness, or at risk of homelessness, a general practice is a safe place and if it is also a place where there is consistency of practitioner and practice health staff. This allows for better outcomes and care that is comprehensive.

## Medicare and block funding to support general practice in provision of care

In addition to experiencing a physical or mental health condition, people at risk of homelessness who present to general practice may also be experiencing a drug and alcohol problem, mental ill health, trauma, and/or family violence as well as housing instability. They may also experience lower levels of literacy and therefore require support in filling in forms for Government financial assistance and housing assistance.

Solving these complex conditions is time consuming and requires a team-based approach to healthcare. Remunerating practice health staff to assist with health assessments for patients at risk or, or experiencing homelessness, would allow for tailored care that encompasses the patient’s whole-of-health needs.

Older women are now the fastest growing cohort to experience homelessness in Australia, with a 31% increase in homelessness among older women between 2011 and 2016.

The criteria for health assessment item numbers currently does not cover homelessness as a reason for initiating a health assessment. Health assessments allow practice nurses to be engaged as part of the MBS rules. Creating a health assessment item number that could be used be utilised by the general practice team, including but not limited to practice nurses, would give general practices greater flexibility in providing care to this cohort.

The criteria for health assessment item numbers currently does not cover homelessness as a reason for initiating a health assessment. Health

assessments allow practice nurses to be engaged as part of the MBS rules. Creating a health assessment item number that could be used be utilised by the general practice team, including but not limited to practice nurses, would give general practices greater flexibility in providing care to this cohort.

Alternatively, we recommend funding practices to provide enhanced services through block funding which can be applied to the practice team as appropriate (eg. For phone outreach, emails, texts).

## Building capacity and capability in general practice

Coordinating social and health services from mainstream general practice can be challenging. Equipping general practitioners with the tools and education to better meet the needs of these complex patients will increase the system's capacity to assist people experiencing homelessness.

The continued use and expansion of HealthPathways is valuable in supporting this capacity building. This is valuable resource for GP teams that are less familiar with, or have less exposure to, assisting people experiencing homelessness.

Access to specialised drug and alcohol advice also gives greater confidence to general practitioners who feel under-equipped to deal with the complexity of issues that people experiencing homelessness can present with.

In addition to ensuring referrals services are easily accessible, there is a need to adequately resource these services so that they are more responsive.

## Models for provision of complex care

There currently exists models where GPs can refer families with complex care needs for assistance by linking to appropriate services. The Western Sydney Kids Early Years (KEYS) Network is a new approach that aligns health and social goals and is designed to deliver cohesive, coordinated services. It relies on multi-sector collaboration. While KEYS was developed to assist children aged five and under and their families, the model could be adapted to serve patients experiencing homelessness.

A second model that currently exists is the Neighbourhood Health Hub, which links patients to many of the same services but for a broader cohort. These service structures serve as vehicles to achieve an objective rather than being service providers in their own right, but all start from the fundamental premise that patients should be linked with a usual practice.

We have identified four principles underpinning the successful provision of care to individuals experiencing homelessness, or at risk or homelessness:

1. Encourage/support patients to register with a usual general practice
2. Support general practices to provide appropriate care
3. Support the use of broader practice teams
4. Minimise fragmentation through better care coordination and communication

More generally, Government could improve access to general practice by addressing some of the financial and practical barriers currently exist.

## Bulk Billing

People who are at risk of homelessness are typically financially disadvantaged and unable to access medical services that are not bulk billed.

The MBS rebate has not kept pace with the costs of providing services. As a result, many practices have been forced to adopt a private billing model resulting in out-of-pocket costs for patients. The Productivity Commission's Report on Government Services 2022, shows in 2020–21 just 67.6% of patients had all GP services bulk billed.

Recent figures found the bulk billing rate is down 1.2% in the December quarter of 2021 from the previous quarter (89.6%). Further to that, the average patient contribution per GP service peaked in Q3 of 2020–21, at $42.79.

The Commonwealth Government must close the gap between the indexation of Medicare schedule fees and the indices for CPI, average weekly earnings, and the AMA fees.

## Workforce

Australia's GP shortage also contributes to reduced access to healthcare services. Fewer doctors-in-training are choosing general practice as a specialty. Applications for GP training dropped by 22% between 2015 and 2020. Meanwhile, unfilled rural training places increased from 10% (65 places) in 2018 to 30% (201 places) in 2020.Almost 40% of the GP workforce is over 55. As older general practitioners retire over the next five years the situation is expected to worsen. A lack of available medical services has put pressure on appointment availability. A two to three week wait for an appointment is not uncommon, particularly in rural and regional areas. Government action to improve the appeal of a career in general practice is needed, including adjustments to remuneration for registrars and improvements in entitlements. Policies to accelerate recruitment into areas of need, particularly rural and regional NSW must also be implemented. dr.

# ANNUAL WAGE ARRANGEMENTS

LISA BENNELL

AMA (NSW) WORKPLACE RELATIONS ADVISOR

**Are you considering annual wage arrangements for your practice? Here is what you need to know about the new annual wage arrangements in the Health Professionals and Support Services Award 2020.**

**ON 9 MAY 2022,** provision was made for an annualised wage arrangement under the Health Professionals and Support Services Award 2020 (HPSSA). An annualised salary is payment made by an employer to award-covered employees that is all inclusive of award entitlements. It is important to note that an annualised salary cannot be less than the minimum entitlements an employee is entitled to under the HPSSA and National Employment Standards (NES).

### Who does this apply to?

Under the HPSSA, full time employees can agree to be paid an annual wage instead of a weekly or hourly pay rate if classified as:

- Support Services employee – level 8 or 9
- Health Professional – level 2, 3 or 4

Part time and casual employees cannot have annual wage arrangements under this award.

### What can be included in the annual wage arrangement?

The annual wage arrangement can compensate an employee for their award minimum:

- Wages
- Any applicable allowances, such as the uniform or laundry allowance
- Overtime, penalty and shift rates for a limited number of hours
- Leave loading

The arrangement needs to be in writing and outline:

- The annual wage to be paid
- The award entitlements included in the annual wage
- How the annual wage has been calculated, including any assumptions used in the calculation
- The maximum (or 'outer limit') penalty hours and overtime hours the employee can work in a pay period or roster cycle without extra payment.

Employers must provide their employees with a copy of the annual wage arrangement. The Fair Work Ombudsman website has a template that you can use.

### What record keeping is required?

It is important to be aware that implementing an annual wage arrangement is not a matter of 'set and forget'. You still need to keep and maintain records.

Employers need to record the employees:

- Start and finish times
- Unpaid breaks

Employees then need to sign the record of hours (either personally or electronically) at the end of every pay period or roster cycle. These records are required for the annual conciliation.

### How do overtime and penalty rates work?

An annual salary does not mean an employee is not paid for overtime or penalty rates. If an employee works for more than their agreed maximum (or outer limit) overtime or penalty hours in a pay period or roster cycle under an annualised salary arrangement, they need to be paid for the additional hours worked at the overtime or penalty rate in the award.

### What is annual reconciliation?

Employers are required to undertake a reconciliation of an employee's annual wages:

- Every 12 months after the arrangement starts, and

- When the arrangement or employment ends.

If the amount paid to the employee is less than the award payments that the employee would have been paid under the award, the employer is required to pay the difference within 14 days.

### How do annual wage arrangements cease?

An annual wage arrangement may end at any time by written agreement between the employer and employee. If either party wishes to cease the arrangement, they can do this by providing 12 months' notice.

### TOP TIPS

Annual wage arrangements may not be for everyone. If you are considering it for your practice, then here are some tips.

- When drafting a salary arrangement, make sure that you specify each entitlement the salary is intended to cover. Otherwise, there is a risk that the clause may be unenforceable in respect of each entitlement you wanted to cover.
- When determining the outer limits and setting the salary, be realistic, rather than optimistic. Make sure it is clear how the annualised salary was calculated, including identifying each separate component.
- Ensure you keep accurate records of hours worked and regularly review the records to ensure the employee is being properly compensated. You may wish to appoint a person responsible for monitoring annual wage arrangements.
- Where an employee works more than their agreed maximum overtime in a pay period, those extra hours should be paid at the appropriate award rate.

### Need help?

**The AMA (NSW) Workplace Relations Team can help and can be contacted via email at workplace@amansw.com.au or calling (02) 9439 8822.**

# INFORMED FINANCIAL CONSENT

**Failing to disclose information or obtain proper consent (including financial), may give rise to a professional conduct complaint.**

**THE DOCTOR-PATIENT** relationship is a partnership that is built on shared decision-making.

Informed Financial Consent refers to the dialogue between a medical practitioner and a patient that enables the patient to understand and consent to the potential:

- fees for a medical service (procedure or treatment) that is to be performed
- costs for protheses and devices that may be used during the procedure
- applicable Medicare and private health insurance rebates that apply to the procedure or treatment
- variations in fees and costs that may occur.

**Informed Financial Consent applies to medical services that:**

- attract a Medicare rebate and / or are insured by the patient's private health insurer
- are self-funded by the patient.

Informed Financial Consent should be provided to and acknowledged by patients in writing prior to their procedure or treatment so patients are aware of what the likely out of pocket expenses may be. For emergency procedures or treatment this may not be possible and if it is not, the information should be provided as soon as possible afterwards.

Patients should, where practicable, be afforded the opportunity to ask


questions about the likely costs of a procedure / treatment and may choose to seek a second opinion from another practitioner.

As a part of providing Informed Financial Consent, medical practitioners may also provide information to the patient about the potential fees of other medical practitioners (such as anaesthetists and assistants) who may be involved in providing the proposed services.

Medical practitioners are required under the Health Practitioner Regulation National Law to disclose to patients any direct financial interest they may have in the facility or facilities where the procedure or treatment is to be provided, and / or in devices that may be used.

While there is no legal obligation to provide Informed Financial Consent, doing so is sound ethical and professional practice and assists to minimise the risk of patient complaints. It is important to remember that failing to disclose information or obtain proper consent (including financial), may give rise to a professional conduct complaint. A patient who may have otherwise been unlikely to complain about a medical service may be more likely to do so if they are surprised following a procedure or treatment regarding the fees charged. Providing Informed Financial Consent also makes it more likely that a patient will settle their accounts with the medical practitioner.

A medical practitioner may delegate part or the whole of the Informed Financial Consent process to practice staff. That said, it is important that the medical practitioner is available to answer any questions patients may have of the practitioner.

Informed Financial Consent is not a one-way conversation. Patients should ask questions and let the medical practitioner (or practice staff) know when they do not understand what is being conveyed to them. Patients are also responsible for contacting other medical practitioners involved in their care regarding their fees and contacting Medicare and their private health fund to confirm the rebates payable.

Further information regarding billing and Informed Financial Consent can be found on the Federal AMA website. If you have any queries or require assistance, **please contact the Workplace Relations Team at workplace@amansw.com.au or (02) 9439 8822.** dr.

**Contributed by AMA (NSW)'s Director of Workplace Relations, Dominique Egan and Workplace Relations Paralegal Sarah Morian**

# VMO CONTRACTS:
## SEEK ADVICE BEFORE SIGNING

**When provided with contracts within weeks or days of the commencement of the next quinquennium, VMOs are under pressure to simply sign and return their contract without properly considering the documentation provided to them. Here's what to do...**

**RECENT ISSUES** with appointment documentation at several Local Health Districts demonstrate the importance of seeking advice before signing Visiting Medical Officer Service Contracts. The Workplace Relations Team at AMA (NSW) are well-placed to review VMO contracts and to advise VMOs accordingly.

### AMA (NSW) contract negotiations – recent wins

AMA (NSW) successfully negotiated changes to the appointment documentation at Nepean Blue Mountains Local Health District and Western Sydney Local Health District. We acknowledge those VMOs who raised issues with AMA (NSW) and assisted the negotiations. Achieving change was possible with the support of VMOs at the Local Health Districts.

In the most recent round of VMO reappointments we have seen increasingly lengthy letters of appointment, some of which have incorrectly set out certain issues or purported to incorporate matters that are not appropriate for VMO arrangements.

AMA (NSW) also identified concerns regarding the lengthy schedules that have been included in some contracts.

### What should a VMO contract include?

The NSW Ministry of Health has issued Model VMO contracts, which provide for the entitlements and conditions as set out in the VMO Determinations. These are available on the Ministry of Health's website, and we encourage VMOs to familiarise themselves with them to identify any discrepancies in contracts that may be issued to them.

The relevant VMO Determination, either the Public Hospital (Visiting Medical Officer Fee-for-Service Contracts) Determination 2014 or the Public Hospital (Visiting Medical Officer Sessional Contracts) Determination 2014) form part of the terms and conditions of the VMO Contract.

In addition to the VMO Contract, VMOs also must comply with relevant NSW Health Policy Directives.

The particulars of each VMO's arrangement are set out in the schedules to the VMO contract. The matters to be addressed in those schedules should be the following:

- The clinical privileges granted to the VMO
- The Hospital or Hospitals where services are to be provided
- The budget for services to be provided by the VMO – this is most commonly expressed as an agreed number of hours
- The remuneration payable
- The on-call commitment – usually expressed as the obligation to participate on the on-call roster
- The classification of the VMO as a Specialist or Senior Specialist

The lengthy letters of appointment and

contract schedules that AMA (NSW) took issue with included matters that were not consistent with the terms of the Determinations and / or applicable NSW Health Policy. Those issues included (but were not limited to) purporting to restrict the rights of VMOs to take leave, restricting the number of Requests for Admission a VMO could submit, budgeted hours that were not consistent with the services to be provided, and seeking to address various matters such as intellectual property rights and performance reviews other than according to NSW Health Policy.

AMA (NSW) will continue to advocate for consistent appointment documentation across the State. This will ensure a more streamlined process and ensure all VMOs are contracted on the same terms.

### When should VMO Contracts be issued?

There is no prescribed timeframe within which a VMO contract should be issued.

AMA (NSW) will be advocating for Local Health Districts to be better prepared and issue contracts well before the commencement of the new quinquennium. VMOs in NSW are routinely appointed for five-year periods (the quinquennium). The VMO re-appointment process commences in the penultimate year of the quinquennium. Despite this, VMOs are frequently provided with contracts for the next quinquennium within weeks or days of the commencement of the next quinquennium, and in some cases after the quinquennium has commenced. This places VMOs under pressure to simply sign and return their contract without properly considering the documentation provided to them.

VMOs are always entitled to seek advice and while it is less than ideal, if a Local Health District is late in issuing contracts, then the appropriate course is for existing contract terms to be extended to afford VMOs the opportunity to consider the offer made and the terms of the contract before signing.

### Annual review of hours and services

AMA (NSW) is calling on Local Health Districts to abide by their contractual obligations including meeting with VMOs on an annual basis to review the VMOs budgeted hours and assess whether there needs to be an adjustment in the hours allocated under the contract to meet service need requirements. Many VMOs report to AMA (NSW) that the hours allocated under the contract are regularly exhausted well before the anniversary date of the contract and this results in considerable delays in payments being made to VMOs for services provided. The annual review provisions under the VMO contract should mean that variations in hours and services can be regularly assessed and addressed, thereby creating greater certainty for the VMO and the LHD as well as ensuring timely payment for the provision of services.

Please contact the AMA (NSW) Workplace Relations Team when you receive your next VMO contract and we will review the contract, or if you have any concerns with your existing contract, **please contact us at workplace@amansw.com.au or by calling (02) 9439 8822.** dr.

**Contributed by AMA (NSW)'s Senior Workplace Relations Advisor, Juliette Paterson and Director of Workplace Relations, Dominique Egan**

# Why do more doctors choose Doctors' Health Fund?

Your health and wellbeing are protected with quality cover provided by one of Australia's fastest growing health funds. Designed exclusively for doctors and their families, there are several reasons why you should join Doctors' Health Fund.

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AMA NEW SOUTH WALES

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# Lifting our game; providing **equitable hospital stroke services** for all Australians

**The Australian Stroke Coalition is inviting hospitals with stroke units to participate in a certification scheme to recognise hospitals that have the essential elements of stroke unit care.**

ACCESS TO A DEDICATED hospital stroke unit makes the biggest difference to outcomes in patients who present with stroke. But currently, not all Australians have access to a hospital which provides specialized stroke services.

If we want to improve the way people receive the best treatment for stroke, this needs to change.

The Australian Stroke Coalition (co-founded by Stroke Society of Australasia and Stroke Foundation) characterises a 'stroke unit' as a facility in which medical, nursing, and allied health professionals with expertise in stroke provide coordinated care in a geographically co-located environment.

Provision of these services differ from state to state and depend on the budget priorities of each hospital and state government. Having a robust way of recognising which hospitals have the essential elements of stroke unit care is an important first step to ensure the quality of care and patient outcomes, but the information can also be used to positively influence the whole system.

Results from the Stroke Foundation's 2021 National Acute Services Audit show that not all Australian hospitals are meeting the requirements outlined in the Australian Stroke Services Framework and Acute Stroke Care standards.

While more than 80 per cent of patients who had been in dedicated stroke units left hospital with a comprehensive discharge plan, of those who did not receive their care in a specialised unit only 62 per cent were discharged with bespoke recovery advice.

We believe that meeting agreed national standards is an important step in ensuring all Australians receive the same level of care, regardless of where they live.

That is why the Australian Stroke Coalition (ASC), which is co-chaired by Stroke Foundation and the Stroke Society of Australasia and includes representatives of those working in the stroke field, is launching a pilot project to implement a certification scheme for stroke units.

Participation will be voluntary. Our aim is to develop a certification scheme which hospitals with stroke units can agree to participate. The spirit of the scheme arises from the collective will to lift our game. We want to emphasize here that this is never about penalizing the services which currently fall short.

To get underway, we are recruiting a part-time Senior Project Officer who will coordinate the pilot project over the next 12 months. When we roll the project out to participating stroke units, there will be clear guidance on participation, and the expected impacts and outcomes.

Australians have access to some of the best healthcare in the world, and in the past 25 years the way stroke is treated has evolved substantially. But we can always do better. We can save more lives, and we can ensure survivors of stroke have even better outcomes.

Almost 30,000 people experience stroke each year. We look forward to working with Australian stroke units to ensure they have the processes in place, and the appropriate resourcing, to deliver the optimal level of care to patients with stroke. dr.

**ABOUT THE AUTHORS**

**By Professor Bernard Yan, President, Stroke Society of Australasia and Kelvin Hill, National Manager Clinical Services, Stroke Foundation**

# ORCHESTRATING CHANGE at all levels

DR ASHNA BASU

PSYCHIATRY REGISTRAR AT TWEED HOSPITAL AND PRESIDENT OF THE MEDICAL WOMEN'S SOCIETY OF NSW

**Three easy and powerful ways to create change from any position in the hierarchy and bring others along the journey with you.**

**I OFTEN HEAR** people speak wistfully about all the ways they'll change the system once they're a consultant, once they're the boss, once they're at the top. And in an institution like medicine, top-down change is absolutely crucial. But I think we lose valuable moments to effect change if we think only in terms of what we can achieve at the top of the ladder, rather than the improvements we can make on the way up.

In every conversation, every opportunity, there is scope to effect positive change. I remember an AMA National Conference a few years ago where I ran into a senior clinician I had met at the same conference a year before, and she told me our discussions about race and medicine have informed her thoughts and actions ever since. That being said, having those conversations and calling people in when there's a power dynamic can be daunting, and isn't always an option.

It's not easy to try and change an institution when you're at the bottom of the pecking order, but here are a few simple and accessible ways to make a difference, and be the change you want to see:

## 1. Share relevant opportunities

Opportunity begets opportunity and creates a snowball effect. That initial opportunity often comes from a place of privilege, so I think it's important to pay it forward. I've found that there are so many clever, hardworking people around who either don't know about opportunities, or don't think they're suitable to apply.

So, when I come across an opportunity, a scholarship, an essay competition – I stop and think, who do I know who would be suitable for this? Whether I know them well, or only vaguely through a friend, I take it upon myself to send them the details, let them know why I think they'd be perfect to apply, and offer to assist with the process or – where relevant – act as a referee.

Sometimes I'll be asked to speak on a panel for a topic with which I have no expertise – rather than saying no, think about recommending someone you know would be great, especially if they have lived experience in the area.

## 2. Use your position to platform others

When arranging an event, or a panel, think about your speakers and topics carefully. You are the curator – take this moment to share different stories, elevate voices that have often been ignored, and ensure that people have their horizons widened.

In platforming stories and messages that are oft dismissed, you inevitably end up with a more interesting and popular event because people are increasingly tired of hearing the same old stories – it's a win/win.

## 3. You don't have to do it alone

Individual actions are powerful and necessary, but collective action is important, too. Find your people and become a community collectively creating the change you want to see. For me, that's groups like the AMA, Medical Women's Society of NSW, Psychiatrists for Racial Equity in Mental Health Australia, Australian Indigenous Doctors' Association, and Doctors for the Environment. dr.

# WHEN IS IT AN **EMERGENCY?**

**A NEW STUDY** found that Australians often 'get it wrong' when determining when to call an ambulance for certain conditions.

The most common errors in judgement were situations where a child has suffered a scalp haematoma (67% incorrectly thought an emergency response was not required); potential meningococcal infection (57%); box jellyfish sting (40%); paracetamol overdose (37%); and mild chest pain (26%).

The study, conducted by Edith Cowan University, looked at data from more than 5000 participants across Australia. They were asked how they would respond to a series of 17 medical scenarios, including some that warranted emergency treatment.

It found men are more likely not to seek emergency treatment when they needed to, compared to women.

"We have a serious issue across the nation with overcrowding of EDs and ambulance ramping so maximising the best use of emergency healthcare services, staff and infrastructure is critical," said Senior Lecturer and Researcher Dr Brennen Mills.

"However, we want to make sure people are not afraid to attend an ED or call for an ambulance when the situation is warranted.

"To develop targeted interventions, we need to better understand which symptoms are not well recognised as potential emergencies and the kinds of people who are less likely to engage with emergency healthcare services for whatever reason."

The paper 'Ability of the Australian general public to identify common emergency medical situations: Results of an online survey of a nationally representative sample' was published in the journal *Australasian Emergency Care*. dr.

# Report finds workers comp system is failing

**THE COST OF ADMINISTERING** the NSW workers compensation system has increased, while return to work rates have declined, according to a new report by the McKell Institute.

The report, *It's Broken*, found since 2015/16 there has been a 12% decline in the number of people with illness or injury returning to work after four weeks.

The qualitative study of 106 workers compensation recipients also found participants routinely experience financial hardship, stress, and even suicidal ideation.

According to the survey, 73% had experienced suicidal ideation as a result of their workers' compensation claim.

In the four years since iCare was established, expenses increased 61%; while Board and Committee fees more than quadrupled between 2013 and 2021. dr.

# INSURANCE NOT MEETING NEEDS FOR UNDER 30S

**Young Australians are willing to buy health insurance, but lower cost products aren't meeting their needs, according to a new survey.**

**The Compare Club survey found people aged under 30 are 155% more likely to request psychology extras in their cover, but access is limited to more expensive policies. Almost half (45%) said they expect health funds to support their mental health.**

**Other highly sought benefits include pregnancy cover, general dental treatments and physiotherapy.** dr.

AMA(NSW) HOSPITAL HEALTH CHECK

**Thank you to all doctors-in-training who completed the 2022 survey. We are now compiling the results and look forward to presenting these to members in the September/October edition of *The NSW Doctor* magazine.**

# AMA (NSW) Exclusive Member Benefits

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

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### 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.

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### Accor Plus

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

### Alfa Romeo

Alfa Romeo® Program allows members to take advantage of incredible discounts across the Alfa Romeo® range. Go to www.alfaromeo.com.au/fleet or and use your Preferred Partner Login.

### AMA Training Services

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

### BMW

Members can enjoy the benefits of this Programme which includes complimentary scheduled servicing for 3 years/60,000 km, preferential pricing on selected vehicles and reduced dealer delivery charges.

### Booktopia

Australia's largest independently- owned online bookstore. We stock over 650,000 items and have over 5 million titles for purchase online. Booktopia carries a wide range of medical books in stock, including textbooks that are prescribed across all medical faculties in NSW and essential texts used by doctors.

### Chubb

Doctor-in-training members of AMA (NSW) are covered by our accident journey insurance policy if they are injured travelling to or from work.

### Dell Technologies

AMA (NSW) members can now save on Dell's outstanding business class technology products! Through the partnership of AMA and Dell Technologies, members have access to an array of valuable benefits.

### Emirates

Emirates offers AMA members great discounts on airfare around the world: 8% off Flex Plus fares or flex fares on Business and Economy. 5% off Saver fares on Business and Economy class. The partnership agreement between Emirates and Qantas allows codeshare.

### Hertz

As an AMA (NSW) member, receive the below exclusive rates and benefits when you rent with Hertz in Australia.*
10% off the best rate of the day on weekdays and 15% off the best rate of the day on weekends.

### Jaguar Land Rover

AMA (NSW) Members can now enjoy the benefits of the Jaguar Land Rover Corporate Advantage programme, including: Free scheduled servicing for 5 years/130,000 kms, 5 Year Warranty, reduced new vehicle delivery costs, and more.

### Jeep

Jeep's® Preferred Partner Program allows members to take advantage of incredible discounts across the Jeep® range. Go to www.jeep.com.au/fleet and use your Preferred Partner Login.

### Qantas Club

Make your flight experience more enjoyable with access to the Qantas Club Lounge. AMA members save on Qantas Club fees.

### Sydney City Lexus

Lexus Members can enjoy the Lexus Corporate Program Benefits including 3 year/60,000kms complimentary scheduled servicing, reduced delivery fee, priority ordering and allocation, complimentary Service loan car & complimentary pick-up/drop-off, Lexus DriveCare providing 24-hour roadside assistance.

### Samsung Partnership Program

We've teamed up with our partners Samsung to give you access to incredible savings across the Samsung mobile and wearable range. Members of the Australian Medical Association are entitled to amazing offers, limited time deals and great perks through an exclusive AMA / Samsung online portal.

### Solahart

Solahart do Solar Panels, not just Solar Hot Water. We continue to build here locally in Sydney 68 years on. AMA members receive 10% off retail price of any of our Solar Power or Solar Hot Water Systems. Please mention your AMA membership. Not in conjunction with any other discount offer.

## CLASSIFIEDS

### MEDICAL PRACTICE / ROOMS FOR SALE SYDNEY CBD

Located in the World Square development in George Street, Sydney. The owners are retiring from practice. Currently configured for two but could be up to four consulting rooms, waiting area, secretarial space and store room plus secure parking for two cars.
The rooms are available for lease or for sale.

**Contact 0404 860 796**

### SPECIALISTS NEEDED AT VARIOUS CENTRES LOCATIONS -

#### EARLWOOD / RAMSGATE BEACH / BANGOR

- Due to our expansion of services, we are looking for Gastroenterologists / GIT Endoscopists, Paediatricians, Psychiatrists, and Surgeons in any specialties to join us.
- Flexible options, e.g., room rental +/- secretarial support with dictation.
- Full team of onsite GPs, non-GP specialists, allied health, and nurses support.

**Please contact: Prof Lim 0499 098 461**
**evp@specialistmedicalservices.com.au**

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