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THE NSW doctor

THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION (NSW)

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Changing of the **guard**

With new health ministers at both the State and the Federal level, now is the perfect time to set a fresh course for better healthcare.

A NEW PREMIER and a new Health Minister in NSW offers a chance for the Government to do a stocktake on health and set some new directions. We have seen a period of investment in infrastructure which has been welcome and necessary, and building new hospitals needs to continue. We have also seen relentless pressure on hospital administrators to achieve efficiency gains, especially in emergency departments. Pressure on administrators, of course, translates to pressure on clinicians to deliver more for less. Despite all of this focus, even to the point of emergency department waiting times being one of the former Premier's priorities, improvements in performance have been modest. This is very enlightening, but should also give cause for reflection.

NSW public hospitals are, by any standards, very efficient places. Unfortunately, demand for both emergency care and elective surgery continues to grow at higher than anticipated rates. The reasons for this are unclear, and not explained by population growth alone. I suspect the Medicare rebate freeze is really biting, with access to general practice becoming more difficult, especially after hours. A patient seeing their GP early in the course of an illness is the best way to prevent that illness becoming worse. Avoiding the GP, for whatever reason, runs the risk of the illness progressing to the point of requiring hospital care. The Commonwealth is probably content to continue to underfund general practice and shift the cost to state hospitals, but it ends up costing the taxpayer much more overall. More importantly, it is bad for patients.

The other cost of the relentless pressure on public hospitals is the human one. I am increasingly concerned about the effect this pressure is having on both medical and non-medical colleagues who seem to spend more of their time on administrative functions, and by consequence are always rushing to get their patient care, teaching and training roles covered. Most people I know spend a lot of time at night and on weekends preparing talks, answering emails, and getting their research and other academic activities done. As a profession, we are at risk of large scale burn-out. I also hear a lot from colleagues that, although the vast majority of patients are very grateful for the care they receive, some are very quick to complain if they feel an outcome is less than perfect. Given the importance we all place on doing our best for every patient, this can be very distressing.

So, perhaps our new Health Minister will be persuaded that the best investment in health is in the human resources that keep our hospitals and public health services running at such high standards, and that it is time, once again, to look at how well those resources are distributed across our State, how accessible care close to home is for our patients, and how we can best use technology to modernise and improve healthcare.

While we are on the topic of new Health Ministers, it is disappointing that our new Federal Minister Greg Hunt has dismissed the idea of a tax on sugar-sweetened beverages so early in his tenure, despite an increasing number of experts in the field calling for it as part of a strategy to address Australia's epidemic of obesity and overweight. Similarly, the Minister for Rural Health, our own colleague Dr David Gillespie, would also have us believe that this is simply a matter of personal responsibility. Gentlemen, the personal responsibility approach is clearly failing, and it's failing under your watch. If we, as a society, had taken a similar flat-earth approach to tobacco control, we wouldn't have tobacco use levels close to the lowest in the world.

The Federal Coalition's obesity strategy, and it's whole public health agenda, is in need of a major reworking. AMA would be happy to help, Minister Hunt. dr.

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Prof Brad Frankum President, AMA (NSW)

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A time of **sadness** and **reflection**

While the profession reels from the loss of so many colleagues in such a short timeframe, we need to focus on what we can learn from these tragedies and how we can change our system for the better.

2017 is only a few months in and yet it has already been a time of sadness for the medical profession. As members will have seen from news coverage and our own publications, we have seen the loss of two more young and talented doctors this year, following on from the suicide of another physician trainee in 2016.

These deaths leave us all searching for answers and wanting to make things better. We received an overwhelming response to the email from Prof Brad Frankum about the issue of doctor suicide. It is clear that nobody in the medical profession is untouched from the pain of losing a colleague or a friend. Some of the responses to the email remind us of how long we have been struggling with this issue. Many of the doctors involved in the AMA talk about first becoming involved to assist in a health and welfare issue after the loss of a colleague. One reflected in an email that they had done a significant amount of work in 2008 on a major JMO wellbeing project and how saddened they were to feel that it had not been effective. I was able to remind her that we will never know who was touched by her work and that she should never feel that her efforts did not make a difference.

Understandably, much of the feedback – particularly from our younger members – is about how we all need to do more to prevent doctor suicide. This is absolutely true. However, we need to learn from the work of the past and build on it to go forward, not go over old ground.

Two key themes are emerging very strongly from the feedback. The first relates to the incredible demands on our public hospital doctors. Our hospitals have seen year-on-year growth in demand. Doctors-in-training are working under intense pressure and their senior doctors and supervisors are also being pushed with service delivery, meaning there is no time for proper teaching or mentoring. Hospitals must be about more than just churn and service delivery.

The other key theme from the feedback was about the failure of mandatory reporting with regard to treating doctors.

Mandatory reporting is a controversial issue. It came in on my watch as we faced the public furore around Graeme Reeves. It was seen as a political solution to a major lack of public confidence in doctors speaking up against their own. We worked to get the bar for reporting as high as possible and under the law, there are very few things that a treating doctor would actually have to report. However, the problem is not the law, it is the perception of the law. That perception and fear is now so entrenched and so widespread that we know that doctors will continue to avoid seeking help unless there is a change. Our colleagues in WA achieved such a change in their State law some years ago and the AMA has been advocating for this amendment nationally for some time. We will be redoubling our efforts to advocate on this issue.

Sadly, suicide has not been the only affliction on our profession. Following the tragic death of Dr Ann Formaz-Preston in a cycling accident in December, we have had at least two other members experience serious cycling accidents. My love and thoughts go to their families. dr.

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Dr Chloe Abbott: champion for young doctors

AMA (NSW) would like to recognise the passing of one of the profession's brightest young doctors: Dr Chloe Abbott.

A PASSIONATE advocate for the profession and her patients, Dr Chloe Abbott has been widely mourned by colleagues, friends and family in the weeks following her death in January.

A fourth year doctor-in-training, Chloe was most recently working at St Vincent's Hospital. Not only was she an extremely talented and dedicated doctor, Chloe was an exceptional spokesperson on numerous issues faced by doctors-in-training.

Chloe previously served as the ACT representative to the AMA Council of Doctors-in-Training and Chair of the ACT Doctors-in-Training Forum. More recently, she was appointed to the role of Deputy Chair at the AMA Council of Doctors-in-Training meeting held in July 2016.

Chloe was also one of the founding members of the group Medical Student Action on Training.

At a national level, Chloe achieved meaningful political change. At numerous meetings and in several published articles, Chloe called for action on the training pipeline crisis.

"The AMACDT continues to advocate for the growing number of junior doctors who anxiously approach bottlenecks in the system that have been predicted for years, yet consistently not acted upon by governments with short terms and visions regarding the health system," she wrote.

Her energy and enthusiasm were critical to the success of the intern crisis campaign. Several young doctors now have jobs as a result of her professional advocacy on this issue. The ripple effect of her advocacy, of course, means more Australians will now have access to better healthcare.

Never afraid to stand up for patients' rights, Chloe took the time to meet with politicians during the Federal Election to express her concerns regarding the ongoing Medicare Freeze. She challenged politicians to examine the long-term impact on the health system if patients – unable to see their GP – would then present to emergency departments.

Chloe was also a persuasive voice on the issue of the "academic medicine crisis". She wrote:

"As competition for places has intensified, academic research experience has become an increasingly significant point of difference for trainees, but this is yet to be reflected in many pathways currently available in Australia. Instead, trainees are burdened with meeting their clinical training requirements while simultaneously attempting to pursue academic research, often leaving them in difficult financial circumstances – the remuneration of these endeavours is significantly less than a full-time medical trainee income."

She added: "The successful implementation of the UK Academic Foundation Program, which has fostered the development of an optional pathway which incorporates academic research in the first two years of a medical career, provides a potential model for Australia, particularly given the growth in medical graduate numbers and the limited opportunities to expand training places."

Chloe's willingness to extend herself is no doubt a reflection of her personal conviction that change would not come without action. She previously wrote:

"As a mentor once said to me, 'No one is going to advocate for the rights of medical professionals, except for medical professionals', a message I believe that every doctor should keep in mind in the unstable climate we face as a profession in years to come."

Chloe's achievements in her professional life are only outmatched by her personal connections. A talented and respected doctor, who was also a beloved daughter, partner, sister, step daughter, grandchild, niece, friend and colleague to many.

Vale Dr Chloe Abbott. dr.

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Lifting the stigma of mental illness

Depression, anxiety and other mental health issues do not automatically equate to impairment, writes Dr Eliza Milliken, who supports a more frank discussion of these issues in the medical profession.

SINCE THE END of my residency 18 months ago I have attended four funerals. Each was for a woman who took her own life. Two of whom were my friends and colleagues in basic physician training.

In this sad context I have been reflecting on the discussion about junior doctors' mental health. This discussion feels long overdue and has been prompted by shocking revelations about bullying, sexual harassment, lack of access to leave and a suicide rate in the medical community unacceptably above the national average.

When we talk about doctors' mental health there is often a heavy focus on workplace stress and exam pressure. However, I fear that blaming 'the system' alone risks an oversimplification.

Losing four people has shown me that each individual battle with mental illness is different. Some are intensely private with their struggles. Some more open. Many find training intensely stressful and I would be one of them.

Nevertheless, training is only one part of a bigger life. Work pressure as cause of death is perhaps the simplest narrative and if we accept it in the absolute it absolves us of the need to enquire further and ask more complicated questions. It lets us position ourselves as victims of the system instead of individual agents inside it who influence its culture.

Factors that contribute to high rates of mental illness in the medical community are legion. We are high achievers with high standards. Professional exams and key performance indicators inherently invite comparison with our peers. We work long and difficult hours and are exposed to the suffering of our patients which can leave us feeling powerless and defeated. We need sane working hours so we can reliably see our loved ones (or even sleep). But, I think there is also great opportunity for change in our personal attitudes to mental health.

I fear many colleagues have kept quiet about coping with depression, reasonably worried about how it might be perceived. A beyondblue enquiry into mental health in the medical profession identified stigma as a major source of harm. We must also open ourselves to a more frank discussion about mental health and remember that depression, anxiety and other mental health issues do not automatically equate to impairment.

Our peers have made an intimidating multitude of achievements in the fields of medicine, sport, political activism, research and social justice. It saddens me that we can still treat the mental illness of our colleagues as shameful, when in fact these feats were achieved through the adversity. The fact that we can achieve so much despite our struggles is something to be celebrated, not hidden.

I have had quiet conservations about the stress of work and training with colleagues. They were quiet because we didn't want to be seen as a weak link. I now see how foolish that was and want to go forward with honesty and openness about how dark this job can sometimes feel.

We need to help each other and we need to be kind to those going through personal and professional battles. I worry that searching for simple, one size fits all answers to these events will leave us as empty as we are now. For myself, I know no one can give me a simple answer that reconciles these events, there is no one thing to blame. There is only loss.

Ironically it was the 'system' that I think gave the best advice. As I tried to reassure our network director I would 'get over it' soon and come back to work, he gently corrected me: "You'll never get over it, but it will get easier ... take all the time you need." dr.

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Dr Eliza Milliken Junior Doctor

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Call for clinical **supervision**

The need for increased pastoral care in our professional lives could be met by an expanded view of the current supervision model, suggests Dr Rebecca Lee.

FOLLOWING THE suicide of one of our colleagues, it is only right that we examine the culture of medicine and seek answers. Others have written brave and heartfelt pieces about their experiences. There has been a call, and a response, for the provision of greater resources for mental health for doctors. It is clear that there is a need for better pastoral care and support for professionals.

As revealed in the National Mental Health Survey of Doctors and Medical Students, "the general work experience for Australian doctors is stressful and demanding." Additionally, that there are high levels of emotional exhaustion, cynicism and low professional efficacy reported, all three of which are indicators of burn out. Young doctors and female doctors, in particular, report higher levels of work stress and appear to have greater levels of general and specific mental health problems. These surveys pinpoint the early years of training, during the transition from medical school to postgraduate training, as critical periods of mental distress.

I cannot speak on behalf of all junior doctors, as we each have a different experience of medicine. Nor do I intend to go over the multifaceted reasons why change is needed. My intention is only to put forward the idea of clinical supervision for junior doctors as a means of improving the support structure for junior doctors.

The AMA position statement provides an outline for the provision of supervision of postgraduate medical trainees. The need for increased pastoral care in our professional lives could be met by an expanded view of this current supervision model. There are many models of clinical supervision in use, and the use of clinical supervision in psychiatry training and for all mental health clinicians is well established.

The purpose of clinical supervision is to provide a professional relationship between two clinicians with the aim of providing a safe and trusting relationship in which the supervisee can reflect on clinical practice. It is different from the informal structure of mentoring relationships or the more formal and feedback-oriented supervisor roles that we are all familiar with. It is an entirely professional and supportive relationship, set up within the clinical framework and designed to help develop the clinical and emotional skill set of the trainee by encouraging them to reflect on their clinical encounters, their interactions with colleagues and to guide them in their personal development. Some of us are intuitive, self-reflective and insightful by nature and others of us need help to nurture these qualities. Turning our attention to clinical supervision and to extension of the existing skills and expertise of supervisors could well be important. It is time that we allocated resources to the promotion of these personal and professional skills and to the support of clinicians.

There are many models of clinical supervision, and whilst no single model stands out as universally applicable, it is my hope that we could expand the current models of supervision that we employ. I wonder whether an expanded definition of clinical supervision could lower the rates of cynicism and emotional exhaustion described by junior doctors in the beyondblue surveys. If so, it is a solution that could have far-reaching benefits for each of us and for our patients. dr.

> *"We could build upon the existing skills and experience of our mentors and supervisors to meet the needs of junior doctors."*

‘LOG ON’ to better mental health

President of the NSW Medical Students’ Council, Ashna Basu, breaks down the benefits of iCBT for the medical community.

AN OFT-CITED beyondblue report shows medical students report higher rates of distress and burnout than the general population, and 19.2% have experienced suicidal thoughts in the past 12 months. Only 56% of students with depression sought treatment, and just 37.4% for anxiety; this number drops to less than 10% for doctors. Students perceived that the medical community still stigmatises doctors with mental health conditions, and the perception that they would be viewed as incompetent or suffer repercussions on their career was a major barrier to seeking treatment. Additional barriers included fear of impact on their registration, confidentiality concerns, lack of time, and cost.

We have dedicated so many resources to raising awareness, to starting conversations, to deconstructing the stigma surrounding mental illness. But seeing the benefits of those efforts requires massive cultural change, which takes time. What happens in the interim? What happens to the people who fall between the cracks? We need a treatment option that can operate outside of those barriers.

For many years, the conventional wisdom was that cognitive behavioural therapy (CBT) had to be delivered face-to-face for that human connection. This year, I started doing research at St Vincent’s Clinical Research Unit for Anxiety and Depression (CRUfAD). CRUfAD specialises in internet-delivered CBT (iCBT). The courses are sophisticated, illustrated modules which follow the story of patients being treated, while simultaneously teaching you skills to manage, and treat, your illness.

The advent of iCBT has changed the game when it comes to access to, and distribution of, treatment. It can be clinician-guided and prescribed by your GP, or taken in self-help form where you register yourself. It’s been a boon for the general community in terms of convenience, privacy and cost, and the same benefits can – and should – be realised by the medical community. The cost of an iCBT course varies; some are free, some cost up to $60 – significantly less than the cost of seeing a therapist. You can do it at home, on your phone, virtually anywhere in the world. More importantly, it’s been shown to be equally as effective as face-to-face therapy.

But, of course, we’re all data nerds, so I won’t expect you to take my word for it. There’s a wealth of evidence demonstrating the efficacy of iCBT, and over 30 randomised control trials conducted by CRUfAD alone. I’m currently updating a meta-analysis done in 2010 looking at the efficacy of any iCBT program worldwide in major depression and the anxiety disorders. Spoiler alert: it’s pretty effective. The results indicate there was no significant difference between iCBT and face-to-face-therapy. These results confirmed those of the original meta-analysis, and concur with the literature more broadly.

Clearly, we need to work on the stigmatising culture that surrounds mental illness, particularly in the medical community. But in the interim, we need to find solutions – because if only half of our students and a tenth of our doctors feel comfortable and able to seek treatment, we are failing them. dr.

Ashna is a 5th year medical student at UNSW, and the President of the NSW Medical Students’ Council.

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NSW WELCOMES NEW INTERNS

Almost 1000 interns found a placement in the NSW Health system – a third record-breaker year in a row.

DESPITE A NATIONAL internship shortage, more medical graduates than ever secured an internship in NSW in 2017. Official numbers reveal 1000 interns found a training position – up from 983 the previous year.

While it's good news for NSW, there continues to be an undersupply of doctors in rural and regional Australia as the overall number of medical students coming through the ranks exceeds available internship and vocational training positions.

The Australian Medical Students' Association (AMSA), which represents 17,000 medical students, continues to advocate on behalf of those students who have missed out on a placement this year.

"It is disappointing for someone to work so hard for up to seven years of medical school, only to be unable to formalise their qualification as a doctor," AMSA President, Rob Thomas said.

"In 2016, there were 3648 graduates with only 3413 total internship positions being made available. With increased medical student numbers, these figures are set to worsen."

Medical graduate numbers have more than doubled in the past 10 years, but internship and vocational training positions have not caught up to meet this oversupply.

AMA President, Dr Michael Gannon said the current situation is ludicrous.

"Now we've got the ridiculous situation where we've got people who are trained in Australian medical schools, understand our system, are proficient in English, and understand our unique health system – but there's not enough internships for them," Dr Gannon told 3AW.

"One of the points that we keep making to the Government is that, while they need to invest in the training programs, the internship's even more important than that, because if you don't satisfactorily complete your intern year, you're not fully registered as a doctor."

In NSW, this year's interns embarked on the next stage of their career in January. The AMA (NSW) / ASMOF (NSW) Alliance welcomed this latest crop of doctors by going out to hospitals across the state to meet them. Alliance doctors and representatives visited Concord, Gosford, Hornsby, John Hunter, Orange, Port Macquarie, RPA, Westmead, as well as Royal North Shore, St Vincent's, Nepean, Wagga Wagga, Coffs Harbour, and Tamworth. They also spent time at Lismore, Tweed, St George, and Blacktown Hospitals.

These meetings were a valuable opportunity for interns to hear about the benefits of Alliance membership, upcoming events, and advocacy that the organisation conducts on behalf of doctors-in-training, as well as activities conducted by The Alliance's Doctors-in-Training Committee.

Dr Tessa Kennedy, chair of the Doctors-in-Training Committee, echoed concerns about the training pipeline crisis, but added DITs face many other challenges.

"As medical graduate numbers have surged in recent years we've seen increased competition to enter all specialty training programs, leading to increasing numbers of graduates stuck in unaccredited training purgatory," she said.

"As well, greater competition and recurrent job uncertainty as we work through short contracts adds extra stress for DITs, and makes us more vulnerable to workplace bullying and harassment. This is especially the case if we feel like we can't complain, or that putting up with inappropriate behaviour is just part of the job. Fortunately, this culture is starting to change."

Dr Kennedy adds many junior doctors are also concerned about maintaining a work/life balance.

"We have heard from a lot of members wishing to improve the flexibility offered in training programs – while some programs offer the option of less than full time training and try to support trainees who become mums, dads, and have other life stuff happen along the way, many of us still uproot our lives every term change to move to another part of Sydney or the State (or even country!) "on rotation" for the better part of a decade.

"A common theme seems to be a desire to make medical training more compatible with life, so doctors can lead lives as full and healthy as their patients; to start trying as hard to look after ourselves and each other as well as we do our communities."

In an effort to better meet the needs of junior doctors, the DIT Committee is launching monthly meetings – these

will alternate between mixed business meetings discussing a range of issues relevant to DITs and more in-depth themed meetings that will put a spotlight on a single issue.

The first themed meeting will focus on junior doctor mental health, as part of the committee's broader agenda to promote doctor wellbeing, a key focus for 2017.

Dr Kennedy adds, "Along with the Federal Council of Doctors in Training, our NSW DITC will continue to advocate for more specialty training places, particularly in regional and rural areas that have the capacity to provide quality training, as well as maintaining or improving teaching, mentoring and support. We are also advocating for better workforce planning – trying to figure out how many GPs, dermatologists, anaesthetists and other specialties we need across the country, and pushing for a national training survey to monitor the paths and progress of trainees. This is particularly important to get a better idea of how many unaccredited registrars are out there.

The DIT Committee is also launching a new initiative, the NSW Hospital Healthcheck, which will compare different hospitals on a range of metrics relevant to DITs, from leave provision to term choice, parking to overtime and pay, among other issues. This will provide comparative data to help us target our advocacy efforts where needed, to highlight where problems exist, but also where things are going well – and what other sites might learn from how those doing well.

"The DITC will also start to link more closely with your RMO associations, who understand your local issues best. We want to help share both troubles and triumphs experienced by JMOs across the State, connecting our ideas and unifying our voices." dr.

Note: 992 intern positions were filled in the NSW Prevocational Training Networks, plus two job shares. NSW also supports a further six intern positions in Bega (2) and Goulburn (4), which are filled via the ACT intern training network.

THE ABCS OF DITS

Dr Tessa Kennedy, Chair of the Doctors-in-Training Committee, shares intel on The Alliance and how to survive your internship.

What is a DIT?

A DIT stands for "doctor-in-training". It refers to any doctor who is not yet a specialist, and is planning to pursue a specialty training pathway of any kind. So, interns, residents, registrars, fellows... all of you!

What is The Alliance?

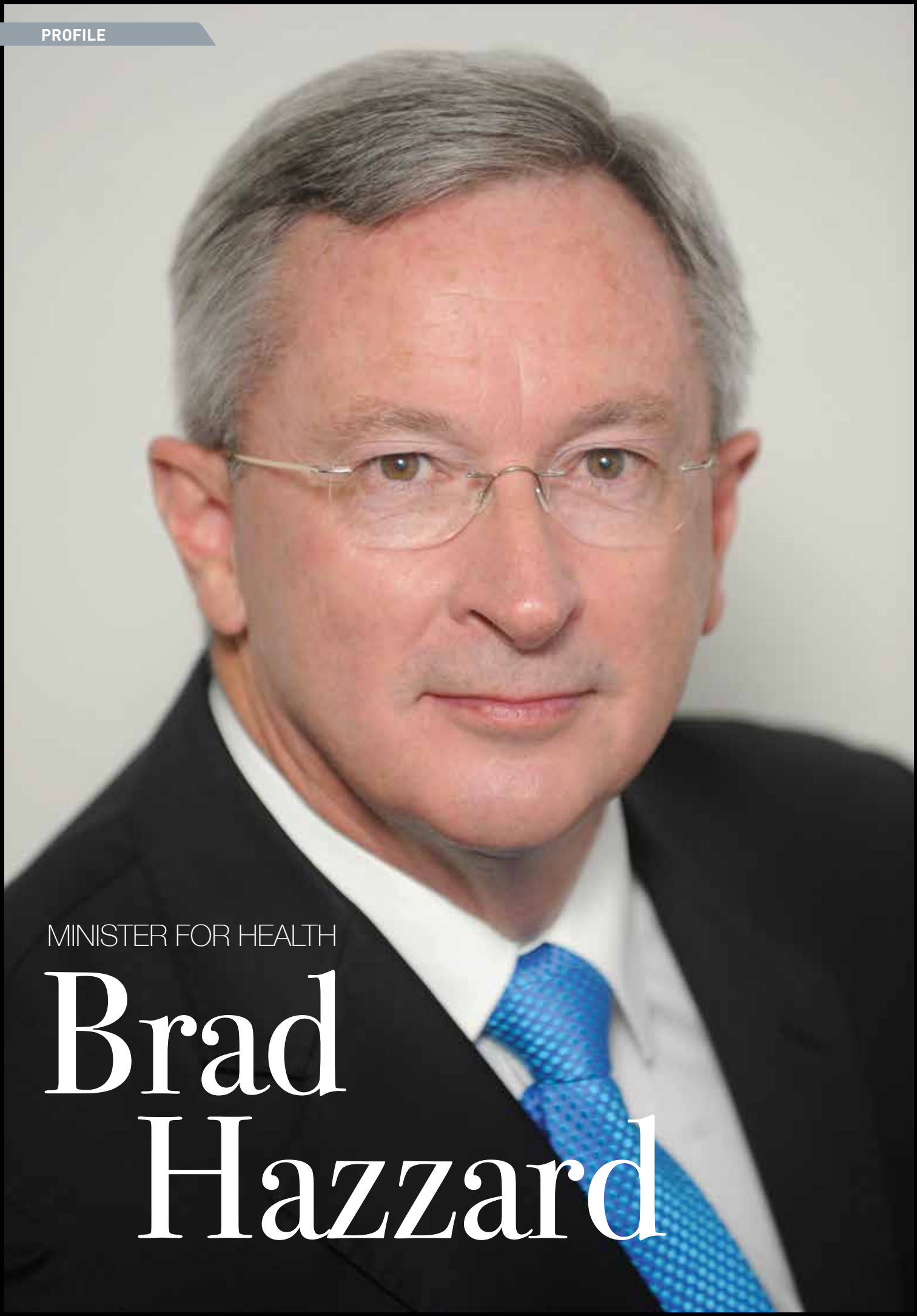
AMA (NSW) + ASMOF (NSW) = The Alliance. Your one-stop shop for pretty much everything you need to get through medical training that you can't find at your home hospital, in a highly caffeinated beverage, or some lovingly filled Tupperware from your mum.

What advice can you give new interns?

1. Repeat after me: there is ALWAYS time to eat and pee, and you must make time to sleep.
2. Ask for help if you are unsure – that will help you to first do no harm.
3. Never stop learning – even if it's 10 minutes a day reading over a new topic, never stop asking how and why.
4. Compassion can endure more than empathy – care for your patients, understand where they are coming from, but don't walk in their shoes and cry their tears. It's exhausting, and you will burn out.
5. Look after each other. We are all on the same team, and no one understands the trials of being a DIT better than another DIT.

If you are interested in joining the DIT Committee, coming to a meeting, or just want to ask a question, feel free to email me:

ChairDITC@amansw.com.au



MINISTER FOR HEALTH

Brad Hazzard

The NSW Doctor spoke with the State's new Minister for Health, Brad Hazzard, to get his view on the challenges that lie ahead.

IF POLITICS WERE like baseball, veteran politician, the Hon. Brad Hazzard is stepping into the health portfolio like a relief pitcher - it's the bottom of the ninth, bases are loaded, with the Visitors one run away from smashing the Home team.

As the date draws closer to the June 2017 funding cliff, medical professionals are anxiously watching to see how Mr Hazzard will handle the Commonwealth's changes to the health funding model, which is projected to cut $4.7 billion out of the budget allocated to public hospitals up to 2024-25.

Mr Hazzard, who was sworn in as NSW Health Minister in January 2017, told *The NSW Doctor* he was concerned about the health funding changes, but was speaking with other State and Territory Ministers to consider how they might work together.

"I've also had contact with the Federal Health Minister and I'm very confident that they might see their way clear to supporting the States in our endeavours to deliver better health for our communities," he said.

And while both Ministers are relatively new to their respective portfolios, Mr Hazzard said his previous political encounters with his Federal counterpart, The Hon. Greg Hunt have been positive.

In terms of mitigating the impact from Federal funding shortfalls, Mr Hazzard suggested the sector needed to look for greater efficiencies.

"It's a challenge for all of us in the health system to look at alternative paths to achieve the very best for the patients. I would certainly encourage the medical profession to look at their own practices with fresh eyes to see if there are other ways to achieve really good outcomes for the patients of NSW in a cost effective way," he said.

How much the system can tighten in the face of increasing population demands however, will be the biggest challenge, Mr Hazzard admits.

"I'm a former Planning Minister as well as Attorney-General and I'm very aware that NSW is expecting another 2 million people in the next 25 years. Approximately 60-65% of those are our own children. So we have to cater for a very substantial increase in our population across different geographical demographics and somehow our health system has to become far more fleet of foot and adaptable to meet those challenges."

At the time *The NSW Doctor* spoke with Mr Hazzard, the Minister was just one week into the job. In light of the challenges facing the health sector, he said his first priority was to listen and learn from medical professionals at the front line.

And what had he heard so far?

"Like all big systems, it has problems. To try and get that system working in a more connected way is a challenge, particularly because 7.5 million people live not just in the city but in the regions. The regional areas have some very big challenges and there are a variety of views as to what resources should or should not be allocated into regional areas. In an ideal world, from a patient's point of view, we would have level five hospitals everywhere, but that is not a practical possibility."

Minister Hazzard is no stranger to tough political portfolios. He comes to the Health Ministry after spending nearly two years as Minister for Family and Community Services, during which time he introduced sweeping changes in light of a number of scandals, including the alleged rape and drug overdose death of a teenager dubbed Girl X within the group foster home system.

Under a radical State Government plan to decrease the number of kids languishing in group homes, Minister Hazzard revealed natural parents would have two years to prove they could provide responsible care for their children, after which time agencies would remove the children from group homes and find permanent homes for children.

The move would dramatically increase the rate of adoptions and guardianships.

Mr Hazzard also served as Attorney General in 2014-15 and Minister for Planning and Instructure from 2011-14.

Much of his political career in the NSW Parliament has been served on the front bench. To date, he has held 17 portfolios in opposition, while maintaining a strong local presence in his electorate of Wakehurst.

A lifelong resident of Sydney's Northern Beaches, Mr Hazzard started his working career as a science teacher at North Sydney Boys High School.

While working as a teacher he studied Law at the University of NSW and later completed a Master of Laws at Sydney University. For a short period, Mr Hazzard considered a medical career, having been accepted into University of Newcastle's medical program.

"They deferred my entry for 12 months because I had done science, and I was studying law when I actually got into medicine. At the time I decided having done two degrees it might be actually time to get a real job and do some work," Mr Hazzard said.

Despite his career path forking into another direction, Mr Hazzard said his interest has never waned.

He's a passionate advocate for mental health, adding that it's an issue that's been kept in the dark for too long.

"The other very substantial issue for our community is obesity," he said.

"I think the fact that the AMA are prepared to lead the discussions on that is a major positive. Doctors, nurses and medical professionals are some of the most respected people in the community. We all look to those with medical expertise to give us guidance when we need it." dr.


THE
BIG

SPECIAL FEATURE OBESITY

IS OBESITY A DOCTOR'S PROBLEM?

More than half of Australians have a body weight that puts their health at risk. Are we failing our patients?

IT'S EASY to point fingers when the subject of obesity comes up. Some say it's the government's fault. The failure to have a national obesity plan, combined with a lack of sports programs, nutritional education, cycle paths, and public transportation are the reasons Australians are getting bigger. Others say we only have ourselves to blame: we eat too much, too often, don't exercise and live sedentary lifestyles.

And some blame doctors for not weighing patients at each consultation; taking the time to talk about weight and, if appropriate, recommending appropriate lifestyle behaviours and a healthy diet.

Recent studies have shown doctors aren't weighing three out of four patients. The study of more than 270,000 patients between 2011 and 2013 found just 22.2% of patients had their weight recorded by their GP and only 4.3% had their waist circumference measured. The *MJA* study also found doctors had problems identifying obesity, difficulty discussing it with patients and did not have the appropriate training to manage it.

So, as Dr Karen Hitchcock suggests in her book *Fat City*, is obesity a doctor's problem?

Like many health issues, doctors are at the coal face of obesity. We have a particular role to play in the prevention and early intervention of this epidemic.

But what makes obesity substantially more difficult to treat is that it is much more than just a health issue. Yes, eating too much and moving too little can cause weight gain. But embedded in the issue are genetics, psychological factors, social-economic and behavioural issues.

And what about the patients who resent being told by their doctor that they are overweight? Many people feel "fat-shamed" if they come in for consultation on a completely unrelated matter and their doctor forces them up on the scale. Twitter's #fatsidestories abounds with hundreds of stories where patients have felt emotionally abused by doctors during consultations.

The other 'elephant in the room' is the issue of overweight/obese doctors. An Australian Health Survey published by the ABS in 2015 found nearly 60% of Australian doctors are overweight or obese. Are patients going to accept advice from a health practitioner who is clearly struggling with the same issue? Not according to the *International Journal of Obesity*, which found doctors who are overweight are seen as less credible than "normal weight" doctors, and patients are less likely to follow their advice.

And weight bias goes both ways. Studies show that individuals with obesity are perceived as lacking self control, unmotivated to improve health, noncompliant with treatment, and personally to blame for their weight. A report from the Australian Diabetes Society found this sometimes results in less desire from doctors to help overweight/obese patients compared with "normal weight" patients.

In this special edition of *The NSW Doctor*, we examine a few of these issues more closely and hear from the experts about potential solutions. There are no easy answers, but obesity is just too big to ignore. dr.

WHY ARE WE STILL

Despite decades of healthy eating and exercise messaging, the prevalence of overweight and obesity continues to increase. Professor Kylie Ball examines some of the reasons why and potential solutions.

FEW PEOPLE would be surprised to learn that the epidemic prevalence and serious health threats posed by obesity have earned it a description as "one of the most important medical and public health problems of our time." What might be surprising is that this description was issued in 1979, by Professor Emeritus George Bray, one of the world's longest-serving leading obesity researchers.

It is hard to understand why, almost 40 years later, we have seen so little progress in our attempts to tackle this issue. With the proliferation of four decades' worth of healthy eating and exercise messages, surely we know and hear more about managing our weight than ever before. Yet despite this, the prevalence remains at its highest ever. In Australia, 11.2 million adults - 63.4% of the adult population - and 27.4% of children aged 5-17 years are classified as overweight or obese according to their body mass index (BMI). Certain groups in the population – those facing socioeconomic disadvantage, or living in regional areas, for example, are at disproportionately higher risk.

WHY HAVE WE FAILED TO ADDRESS OBESITY?

Unfortunately, knowledge and awareness alone are insufficient for dealing with the obesity epidemic, which has been described by the United Nations as a "wicked problem" – one that is highly resistant to resolution, due not only to the sheer numbers affected but also the widespread, changing, interconnected

and competing aetiological drivers.

Responsibility for obesity is often attributed primarily to individuals themselves (or to parents, in the case of young children), which can lead to a tendency to blame individuals for their 'failure' to maintain a healthy weight. In fact many factors combine to increase the risk of obesity. While some of these are characteristics or behaviours of individuals – skills, values and priorities related to nutrition and physical activity, for example – other contributing factors are less amenable to individual control. Financial hardship and poverty, food insecurity, prevailing social or cultural norms, lack of social support, work and other psychosocial stressors, time poverty and competing demands, poor physical or mental health, excessive exposure to food marketing and supplies of cheap energy-dense foods, sedentary workplaces, urban sprawl and long commutes, and lack of access to health-promoting foods or physical activity options in local neighbourhoods have all been implicated in obesity risk.

IS THERE ANY HOPE?

The good news is that there are success stories. At Deakin University's Institute for Physical Activity and Nutrition (IPAN), we have followed more than 4,000 women and children living in disadvantaged neighbourhoods to investigate how some manage, despite their increased risk, to stave off obesity. Key predictors of this 'resilience' to obesity included confidence, self-control and skills that facilitated healthy eating and physical activity, but also social and physical environments that were supportive of these behaviours.

The National Weight Control Registry in the USA is tracking more than 10,000 individuals who have lost significant amounts of weight and kept it off for long periods of time. Just under half of the participants lost weight on their own, and the other half did so through some sort of formal program. Almost all (98%) reported that they modified their food intake in some way to lose weight, and 94% increased their physical activity, mostly by walking more. More than three-quarters of participants reported eating breakfast every day; 75% weighed themselves at least once per week; and 62% watched less than 10 hours of TV per week.

WHAT CAN HEALTHCARE PROFESSIONALS DO?

Healthcare professionals can play a key role in assisting clients to achieve and maintain a healthy weight. Lifestyle change remains the cornerstone of weight management – that is, increased physical activity, reduced energy intake, and incorporating behaviours such as eating a healthy breakfast and weekly self-weighing. Psychological and behavioural interventions including cognitive behaviour therapy, stimulus control techniques, self-monitoring, and behaviour modification techniques such as goal-setting can all be useful components of a weight loss approach. But weight management support cannot be delivered in a vacuum – it needs to be holistic, tailored to individuals' circumstances, barriers and broader environmental risk factors. This will require assessing the contexts in which individuals are living. For example, the healthcare professional might frame a discussion around questions such as:

- How confident are clients to engage in weight-management behaviours?
- What is stopping them?
- How can they overcome these barriers?
- What are the supports available in their homes, workplaces, peer groups, local neighbourhoods?
- If needed, can the healthcare professional facilitate access to ongoing psychological support, or support for stress management, or time management, or financial assistance, or strategies to garner social support (e.g. involving families or others in treatment)?
- Can they encourage or assist the client to explore their local environment for opportunities (does the supermarket stock affordable, quality fresh produce? Are there safe walking/bicycle tracks, parks or public open spaces to exercise in? Are there other weight, food or exercise support groups?) and even to advocate for these if they are lacking?

Finally, weight management is typically a long-term undertaking, and the importance of ongoing support, review, and assistance in dealing with relapse cannot be understated.

Achieving and maintaining a healthy weight is challenging in modern societies, but it is not impossible. Healthcare professionals can play a key role in supporting clients with their weight management efforts by remaining cognisant not only of the specific behaviour changes required, but also of the broader contextual drivers of the obesity epidemic. dr.

Alfred Deakin Professor Kylie Ball is a National Health & Medical Research Council Principal Research Fellow in the Institute for Physical Activity and Nutrition (IPAN) at Deakin University. Her research focuses on the epidemiology and prevention of obesity, particularly amongst vulnerable groups such as those facing socioeconomic disadvantage.


SPECIAL FEATURE OBESITY
THE BIG PROBLEM
facing little kids

Childhood obesity is a sensitive topic for healthcare professionals. Dr Shirley Alexander explores the challenges and solutions to this increasingly prevalent health issue.

OVERWEIGHT and obesity affects one in four school-aged children and one in five pre-schoolers in Australia – rates which rank us amongst the top Westernised societies, just behind the US and UK. Prevalence is even higher in certain subgroups including the Indigenous community, those with intellectual disabilities and children from very low socioeconomic backgrounds. Children with obesity are at increased risk of both immediate and long term physical and mental health issues, and without intervention their obesity will continue to affect them in their adult life. There have even been suggestions that this current generation may have a shorter lifespan than their parents, a situation not experienced for the past 200 years. Yet despite presenting to healthcare professionals more frequently than children within normal weight status, very few children with obesity are offered any form of intervention. Why would this be the case?

The reality is that the majority of healthcare professionals find childhood obesity a difficult and sensitive topic to broach. Healthcare workers are not immune to stigma and bias, both explicitly and implicitly. Research gives insight into the challenges that doctors and other health professionals face in the management of childhood obesity, and the word "lack" repeatedly raises its head. Lack of time, lack of resources or support services (including lack of bariatric surgery for severe obesity), lack of effective interventions, lack of parental and/or patient motivation and lack of reimbursement are some of the more common reasons cited to account for reduced initiation of treatment.

Inadequate training in childhood obesity means that many feel unable to provide the necessary care and lack of recognition of the weight status of a child (by both parents and health professionals) compounds the situation. For many, raising the issue is a significant barrier with concerns about offending parents, especially as presentations to health professionals are not usually for weight concerns per se – even though the presenting condition may well be exacerbated by excessive weight gain. But excessive weight is a significant health risk and there are few, if any, other adverse health conditions that would not be brought to the attention of the patient/parent and addressed in order to improve patient wellbeing.

What can be done to address the challenges within paediatric bariatric care? Certainly as causes and consequences of childhood obesity are multifactorial and complex, a multipronged approach is needed across the spectrum – preventative measures on the one hand concurrently with treatment for those already affected. Education and training of healthcare professionals in the assessment and management of childhood obesity is essential along with developing standardised models of care and health pathways to facilitate management and enable improved and greater equitable access to care. A family-wide approach to sustainable behavioural change in the areas of activity and nutrition is the aim of most treatment programs, this being shown to be the most effective intervention. Many clinicians, researchers and policy makers have been strong advocates for action within the childhood obesity realm for several years and their efforts are being realised. Since the inception of the NSW Premiers Priorities on tackling childhood obesity, in NSW at least, there has never been a better time to take on the challenges and break down many of the aforementioned barriers. Collaboration between much-needed new, and already well-established, multidisciplinary clinics is paving the way to improved patient care. Development of educational packages, such as Weight4KIDS, and access to community intervention programs, such as Go4Fun, are changing the paediatric bariatric medicine landscape. Translational grants are being utilised to determine what works at the coalface. And the RACGP is dealing head-on with the issue of obesity in both adults and children through its recently formed Obesity Management Network and by including bariatric medicine in its training curriculum.

It is encouraging to see so much happening in this space. Although there is some suggestion that prevalence rates may be plateauing, there is still much work to be done with no time to rest on our laurels, as of major concern is the continued and increased rise in the number of children with severe obesity. Encouraging a culture whereby assessment of growth is core business of paediatric care, and using every opportunity to encourage healthy lifestyle practices independent of weight status, will contribute markedly to de-stigmatising a condition that disadvantages those affected in so many ways. Childhood obesity is highly prevalent and dealing with it is everyone's business. dr.

> *"This current generation may have a shorter lifespan than their parents, a situation not experienced for the past 200 years."*

Dr Shirley Alexander is a paediatrician and Department Head of CHISM and Weight Management Services at the Children's Hospital at Westmead. For the past eight years she has been working within a multidisciplinary team helping families with children and young people who have obesity.

SPECIAL FEATURE OBESITY

For the love of THE GAME

A pioneer of sports medicine, Dr Jeni Saunders has worked with some of the country's top athletes. She shares her insight on exercise, sports and the country's burgeoning obesity crisis.

DR JENI SAUNDERS has always been somewhat of a sporting polymath. While pursuing her undergraduate medical degree (from 1970 to 1977) at the University of New South Wales, she served as the Secretary of the UNSW Sports Association; the Secretary, Treasurer and President of the UNSW's Women's Basketball Club; a member of the UNSW Water Polo Club; Member of the UNSW Hockey Club; the UNSW Squash Club; and a Foundation member of the Women's Cricket Club.

What she discovered during this early and intense participation in sport was that, while the treatment of acute injuries was reasonably good, there was a dearth of treatment and advice for non-operative injuries.

As a result, she began a literature search to work out treatments for atraumatic, repetitive microtrauma injuries.

"The answers were there, but not necessarily put together," she said. "I realised then that there was a gap in provision of medical services to keep people active."

Thus began her passion for sports medicine. A career choice that has taken her into the locker rooms of the country's top rugby teams and beyond. From footy fields to snow fields, Dr Saunders has helped Australia's elite athletes stay at the top of their game.

In the 1970s, sports medicine was still in its infancy. After graduation, Dr Saunders spent three years working in the hospital system before establishing her own sports medicine clinic.

In addition to running her own practice, Dr Saunders became the first woman to set foot in a professional Rugby League dressing room. She served as the team doctor for the St George Rugby League Football Club for almost a decade.

As her reputation grew, so did Dr Saunders list of elite clients. She has since accompanied several National teams, including Women's hockey, swimming, track and field, volleyball and netball to overseas and world competitions. She has also served as a medical officer at the Olympic Games (Barcelona and Athens), as well as the Commonwealth Games. In addition, Dr Saunders works closely with NSWIS winter sports athletes.

> *Not only has Dr Saunders broken down barriers in the sporting world, but she has been instrumental in developing formal post-graduate education programs for sports medicine.*

Not only has Dr Saunders broken down barriers in the sporting world, but she has been instrumental in developing formal post-graduate education programs for sports medicine.

"It wasn't long before I came in contact with a few other similar-minded people," she said.

Dr Saunders taught the initial post-graduate course run by the Royal Australian College of General Practitioners and started accepting RACGP registrars for six-month specialty-learning placements.

At the same time, Dr Saunders became a Founding Member of the Australasian College of Sports and Exercise Physicians (ACSEP).

"Shortly after this, I joined UNSW to teach in their Sports Medicine Masters Degree courses. This was very satisfying as I was able to work on the clinical aspects of the teaching as well as assist my colleague with curriculum development."

The development of the ACSEP College and her subsequent work to gain recognition for ACSEP as a specialty college remains one of the highlights of her career, Dr Saunders said.

"This entailed a very large amount of work over many years but I am proud

that we can continue to work to a high standard and maintain and continue to improve all aspects of our college standards."

In addition to her work with the College, Dr Saunders volunteered with the Westpac Rescue Helicopter and served as medical director. Later she became a founding Director of CareFlight – a medical evacuation, rescue and retrieval helicopter service based in Sydney.

Dr Saunders has also been an instrumental member of Sports Medicine Australia, the peak national organisation for the prevention of lifestyle diseases through sports medicine and sports science and injury prevention. She joined as a student and later became active in NSW as a Council Member, Treasurer, Secretary and then became a National Councillor. More recently she re-joined the NSW Council to serve as Vice President.

While she still works with elite athletes, the majority of her patient demographic now consists of average Australians who wish to remain active, and a small percentage who are re-commencing activity.

Given the importance of physical activity in reducing the obesity crisis in Australia, Dr Saunders has a unique viewpoint on what the country needs to do to combat this epidemic.

"The answer is multifaceted, as not just one thing will change this," she said, adding there needs to be an easier way to get incidental exercise and access to walking tracks/bike paths.

"This is an urban planning issue and should be a very high priority."

Dr Saunders also sees an increased emphasis on food education as being an important way to reduce childhood obesity.

"The vegetable gardens and cooking program in schools is one way to do this. More access to community gardens can help those in built up areas (gardening is also an exercise so double points for this one) as well as education into eating a simple balanced diet." dr.

DR JENI SAUNDERS OBSTACLES TO EXERCISE

What do you think are some of the biggest obstacles patients face when starting a fitness program?

Probably the main obstacle is picking an exercise they are not suited to. Not everyone will enjoy the gym or a personal trainer. There may be more fun (and therefore adherence) on choosing alternative activities such as dance, walking, cycling, bowling, or tennis. Best to aim for a mixt of aerobic activities as well as some strength ones.

The other issue patients have is starting off too keen and trying to do too much. It is best to start alternate days and gradually build up. This will allow for the body to recover and gradually build strength and endurance to allow for more frequency and more intensity.

A good tip in designing exercise programs is to ask what the person enjoyed as a child. Perhaps rekindle the love of swimming, or tap dancing, or table tennis. There are now many programs catering for older participants (not just children).

Can you counteract a sedentary work/life with three workouts a week?

Yes, you can, however it is recommended that you do some physical activity on most / all days of the week. The current recommendation for adults is for 150 – 300 minutes of moderate physical activity per week or 75-150 minutes of vigorous physical activity per week. Strength training is recommended on two days per week to maintain muscle strength and bone health.

SPECIAL FEATURE OBESITY

TIME FOR **CHANGE**

Momentum for sugar tax builds, as experts from across Australia call for a national obesity plan and regulatory reform.

COMMERCIAL INTERESTS shouldn't trump the health of future generations, says leading obesity expert, Laureate Professor Nick Talley.

Professor Talley, who chaired the recent National Health Summit on Obesity, is calling on the Commonwealth Government to adopt a coordinated six-point plan for action on obesity.

The plan not only recognises obesity as a disease, but recommends a tax on sugar sweetened beverages (SSBs) and a reduction of unhealthy food marketing to kids.

Prof Talley outlined the plan in the February edition of *MJA*, which also included a persuasive argument from Professor Stephen Colaguiri on the need to adopt a tax on sugar sweetened beverages.

Prof Colaguiri addresses the argument that a tax on SSBs is a nanny-state response to the obesity crisis.

"Such thinking calls into question government intervention to control tobacco and alcohol or promote road safety through seat belts and speed restrictions."

He also acknowledges that strong government leadership is needed in the face of industry opposition.

A similar call for a sugar tax was made by 100 experts from 53 organisations who developed their own 47-point plan to address obesity.

Dr Gary Sacks, a senior research fellow at the Global Obesity Centre at Deakin University, led the study. In addition to recommending the development of an overall national strategy, the study called for a tax on junk food, especially sugary drinks, to make them more expensive, and a reduction of advertising and marketing of those products to children.

The study also recommended a junk food ban from schools and sports venues and a crackdown on using junk food vouchers as rewards for sporting performance and fundraising.

The experts found wide discrepancy between State and Federal food labelling, advertising and health policies and are recommending a National Nutrition Policy.

AMA (NSW) President, Professor Brad Frankum, also recently made a compelling case for a tax on sugar sweetened beverages in a video posted to Facebook. The video was viewed more than 20,000 times, shared 83 times and elicited 34 comments.

Not only does Prof Frankum call for a tax on SSBs, but urges money generated from the tax be spent on a national obesity plan, which includes nutritional education and sports programs.

To date, these calls for a sugar tax have been met with resistance by the Federal Government. The Department of Health's issued a press release on 20 February: "Obesity and poor diets are complex public health issue with multiple contributing factors, requiring a community-wide approach as well as behaviour change by individuals. We do not support a new tax on sugar to address this issue."

Prof Frankum responded that the Federal Health Minister is letting the people of NSW down by dismissing a sugar tax so readily.

"A tax on added sugar is not about raising the prices of people's grocery bills, in fact, it would help as part of an overall education strategy.

"The sorts of things it would ideally be applied to are things like sugary drinks, which are not a necessary part of anyone's diet," he said.

"Knowing that a tax applies to something because of its unhealthy added sugar content would help people in identifying poor food choices," he added. dr.

PERSONALISED HEALTH CARE – EVOLVING HEALTH CARE NEEDS THROUGH THE CYCLE OF LIFE

Doctors, practice managers, registered nurses and other medical industry professionals from around Australia are invited to attend the *Annual AMA Queensland Conference* in Rome.

The program will feature high-profile European and Australian speakers on a range of medical leadership and clinical topics. RACGP points will be on offer.

To find out more about the conference program or to register, please contact:

Neil Mackintosh, Conference Organiser
P: (07) 3872 2222 or
E: n.mackintosh@amaq.com.au

Download a conference brochure from the events calendar at www.amaq.com.au

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DOCTORS' CYCLING TEAM

AMA (NSW) would like to support the Amy Gillett Foundation in its bid to make bike riding safer by sponsoring a team of doctors to participate in the Wiggle Amy's Gran Fondo cycling event, which takes place September 2017 on the Great Ocean Road. If you're interested in joining the AMA (NSW) peleton, please contact Andrea Cornish on andrea.cornish@amansw.com.au or (02) 9902 8118.

PROFESSIONAL SERVICES

Helen Winklemann
Director, Professional Services

Sticky issues for VMOs

EVER BEEN left scratching your head wondering why a V-Money claim was rejected? Lately, we've been talking to a lot of VMOs about their experiences with the V-Money system, and helping them work through some of its hidden tricks and traps. In the process, we came across one particularly sticky issue which isn't to do with V-Money, but which has led to a number of VMOs missing out on V-Money payments. More significantly, it may also have left unwitting VMOs exposed to potential medico-legal and professional liability for procedures they didn't perform, on patients they didn't believe were under their care!

THE ISSUE

How would you feel if your V-Money claim was rejected because a patient you believed was public had subsequently been reclassified as private? In theory, this should never happen as the rules under the *National Standards for Admitted Patient Election Processes* seem quite clear:

- patients are to be classified and treated as public until a valid election is made for private treatment,
- once made, elections can only be altered in the limited ranges of "unforeseen circumstances" and
- even if unforeseen circumstances *do* arise, any consequential change in the election only applies from the date of the change (ie, it isn't applied retrospectively or "backdated" to the date of admission).

However, where the patient *defers* their election and subsequently changes that election, some hospitals are seeking to deny V-Money claims. This seems to be most common with anaesthetics and emergency procedures, however it can also be an issue with other specialties.

The key problem is where a registrar (validly) performed a procedure between the time of admission and the time the election was made, on the basis the patient was believed to be public. If the patient later makes a valid - but deferred – election to be private, the VMO generally won't be able to claim V-Money; and they also won't be able to seek payment from the patient, their insurer or Medicare because they didn't actually perform the procedure themselves. This scenario also clearly raises significant professional and medico-legal risks in relation to the care of a patient for whom a VMO is retrospectively deemed responsible.

The AMA has raised this issue a number of times. Our clear position is that if there is uncertainty around the classification, the patient must be treated as public and the VMO claim paid.

SO WHAT CAN YOU DO?

✔ **DO** hold your hospital administration to account. Check whether they have practical and appropriate procedures in place to ensure all patient elections are completed at or before admission, unless there is a legitimate reason for the delay as contemplated by the National Standards (eg, emergency admissions after hours in hospitals where staff are not available to organise the completion of the election form until the following working day; or patient inability to make a valid election at the time of admission due to severe pain, dementia, etc). If the hospital is using apparent loopholes to justify deferred elections, ask them to explain this to you and scrutinise their responses.

✗ **DON'T** just assume you've made a mistake and let rejected V-Money claims slide. If initial elections are changed from public to private, follow this up and ask for what you're owed. But also remember the proverbial canary in the coalmine: a V-Money rejection may be the first warning sign that your hospital's admission procedures aren't working as well as they should; so find out as much as you can and – if you need help - raise your concerns with us for further review against the National Standards. dr.

By Jane Eldridge and Helen Winklemann

PS.

V-MONEY CLAIMS The AMA has assisted a number of members in querying V-Money claims. We have been concerned by the practice of LHDs refusing to pay claims while matters are being investigated, sometimes for a period of months. We believe that under the Determination, there is an obligation on the LHD to pay the disputed claim and then investigate, rather than withholding the payment. We will be reporting on this further in coming months. **Find out more about Professional Services at: www.amansw.com.au/professional-services/**

AMA NEW SOUTH WALES

Notice Of Annual General Meeting

Notice is hereby given that the Annual Meeting of the Australian Medical Association (NSW) Limited will be held at 7pm on Tuesday 9 May 2017 in the Conference Centre, Ground Floor, AMA House, 69 Christie Street, St Leonards.

AGENDA

- To receive and adopt minutes of the Annual General Meeting, 10 May 2016.
- To receive and consider the Report of the Board of Directors.
- To receive and consider the Financial Report for the year ended 31 December 2016, the Statement of Financial Position at that date and the Auditor's Report thereon.
- To call for nominations for the Positions of Officers of the Association.
- To appoint a Returning Officer for the election of the Officers of the Association.
- To transact any other business in conformity with the Constitution of the Association.
- Address by the President.
- To consider, and if thought fit, to pass Special Resolutions:

NOTE: A member entitled to attend and vote at the meeting is entitled to appoint a proxy to attend and vote instead of the member. A proxy must be an ordinary member or in the case of a company, the Nominated Representative of an ordinary member of the Association. To be valid, a proxy form duly completed and signed must be received at the office of the Association at Level 6, AMA House, 69 Christie Street, St Leonards, not less than 48 hours before the time for holding the meeting. Proxy forms must be obtained from the office of the Association at Level 6, AMA House, 69 Christie St, St Leonards.

TO AMEND THE CONSTITUTION AS FOLLOWS

- The addition of clause 35.2 which will create a dedicated position on Council for a representative from AIDA. The Clause will state that representative from AIDA will be invited to join the Council and if that invitation is accepted, will be appointed at the first meeting of the Council following an election of the Council.
- A consequential amendment has been made to clause 36.1 such that the reference to clause 35 is now a reference to 35.1.
- Amendment to clause 40.1 to remove the requirements to regarding casual vacancies, under the current Constitution, where there are more than 2 positions vacant on council, the third or subsequent position cannot be filled as a casual vacancy. This will allow for any vacacancy within the term of Council to be filled as a casual vacancy.
- Amendments to the provisions for appointment of the DIT Director to the Board. The relevant clause will now provide (at Clause 42.4) that the Doctor in Training Director will be appointed by the Council from those Doctors in Training Committee members who are nominated by the Doctors in Training Committee for the position.
- As a consequence of the amendment to clause 42.4, clause 42.5 has been deleted.

By Order of the Board
Fiona Davies,
Chief Executive Officer

AMA (NSW) congratulates members

AMA (NSW) is proud to count a number of Australians who received Australia Day Honours as members.

AO – OFFICER IN THE GENERAL DIVISION:

Professor Stephen Colagiuri – for distinguished service to medical research in the field of diabetes and endocrinology as an academic, clinician and author, to global health policy formation, and to professional bodies.

Emeritus Professor William Gibson AM (retired) – for distinguished service to medicine, particularly in the area of otolaryngology, as a clinician, to the advancement of cochlear implant programs, and to professional medical organisations.

MEMBER (AM) IN THE GENERAL DIVISION:

Dr Roberta Chow – for significant service to medicine as a clinician, and to pioneering developments in the use of laser therapy techniques for chronic pain management.

Dr Patrick Charles Cregan (deceased) – for significant service to medicine and healthcare delivery in NSW, and to clinical advisory and governance roles.

Professor Albert Hoi King Lam – for significant service to medicine, particularly to paediatric radiology, as a clinician, and to child health education.

Professor Lynette Margaret March – for significant service to medicine in the areas of rheumatology and clinical epidemiology, as an academic, researcher and clinician.

Associate Professor Geoffrey Painter – for significant service to medicine in the field of ophthalmology, and to international relations, particularly to eye health in Asia and the Pacific.

MEDAL (OAM) IN THE GENERAL DIVISION

Dr Michael Armstrong – for service to medicine, and to the community.

Dr Sally Fiona Bonar – for service to medicine, particularly to orthopaedic pathology.

Dr Ann Ellacott – for service to medicine, to community health, and to education.

Associate Professor Gayle Fischer – for service to medicine in the field of dermatology.

Dr John Terence Flynn – for service to medicine, and to medical administration.

Clinical Professor Gregory Ronald Fulcher – for service to medicine, and to medical administration.

Clinical Professor Robert Bernard Howman-Giles – for service to nuclear medicine, and to professional organisations.

Dr Jennifer Kay King – for service to medicine in the field of obstetrics and gynaecology.

Dr John Graham – for service to medicine as a gastroenterologist.

Dr George Simpson – for service to medicine, and to the community of Wauchope. dr.

THE SPOUSE **CONNECTION**

At the end of every year, a huge majority of medical families start their well-rehearsed routine of packing up and moving to a new location for training.

The challenges that come with moving to a new place where we have no roots or support are lessened with connections that I've made through the Australian Doctor's Spouse Network (ADSN). Cofounded by Kenna Jefferson and Amanda Low in 2013, ADSN is a way to connect the trailing spouses of Australian and New Zealand medical trainees as well as international families here on fellowship. The medical spouse faces many unique challenges, especially during their partner's training. ADSN is a platform that offers advice, support and connects the spouse with others that understand their situation. This is achieved by creating an online community with chat groups, blogs, local advice from doctor's spouses, Facebook posts with helpful information, online articles and resources, and hosting spouse and family meet-ups during the year. ADSN can be found online at www.australiandoctorsspousenetwork.com
Facebook: www.facebook.com/AustralianDoctorsSpouseNetwork
Closed Facebook Group: www.facebook.com/groups/ChatADSN

Please note the term spouse refers to a person, irrespective of sex or gender, who is in a personal relationship with a doctor on a permanent and domestic basis.

Tania Tobin lives in Newcastle with her husband Luke, an Anaesthetic Registrar, and their two young children. dr.

Australian Medical Association (NSW) Limited

ELECTION NOTICE

2017 ELECTION OF COUNCIL

Phil Lewis, Elections Australia Pty Ltd will be the Returning Officer for the 2017 election of the Council of the Australian Medical Association (NSW) Limited.

NOMINATIONS

N.B. No member or Nominated Representative shall nominate for more than one class (position) on Council.
Nominations in writing are hereby invited for the following positions on Council:

SPECIAL INTEREST GROUP

ONE (1) to be elected from each of the following classes:

- Physician Class
- Surgeon Class
- Ophthalmologist Class
- Psychiatrist Class
- Pathologist Class
- General Practitioner Class
- Radiologist Class
- Anaesthetist Class
- Obstetrician/Gynaecologist Class
- Salaried Doctor Class
- Rural Doctor Class
- Doctor-in-training Class
- Student Member Class

ZONES

ONE (1) to be elected from each of the following classes:

- Northern Metropolitan Zone Class
- Southern Metropolitan Zone Class
- Central Metropolitan Zone Class
- Western Metropolitan Zone Class
- North Western Metropolitan Zone Class
- South Western Metropolitan Zone Class
- New England and North Coast Zone Class
- Illawarra and South Coast Zone Class
- North West Zone Class
- South Zone Class
- Hunter and Central Coast Zone Class

UNRESTRICTED GENERAL MEMBER CATEGORY

In the "Unrestricted General Member Class", a further ELEVEN (11) to be elected from any of the above classes (with the exception of the Student Member Class) provided that at least three (3) of those eleven (11) shall be general practitioners.

STUDENT MEMBER CLASS

ONE (1) to be elected from the Student Member Class.

With the exception of the Student Member Class, candidates and their nominators must be Ordinary Members, or in the case of a company, the Nominated Representative of an Ordinary Member. Candidates must be members of the relevant class of the Association and must be financial members of the Association as at the date of the closing of nominations, i.e. 12:00 noon AEST, Wednesday, 5th April 2017. Candidates must be nominated by one (1) other member of the relevant class who must be a financial member of the Association.

In respect of the Student Member Class, candidates must be Student Members of the Association and must be nominated by one (1) other Student Member of the Association.

CLOSE OF NOMINATIONS

NOMINATION FORMS OF CANDIDATURE MUST BE RECEIVED BY THRE RETURNING OFFICER NOT LATER THAN 12 NOON AEST, WEDNESDAY, 5TH APRIL 2017.

THEY MAY BE RETURNED VIA: EMAIL: ROCE2017@amansw.com.au

HAND DELIVERED: TO LEVEL 6, 69 CHRISTIE STREET, ST LEONARDS NSW 2065. (Must be handed to receptionist and signed in.)

POSTED: TO THE RETURNING OFFICER, PO BOX 121, ST LEONARDS NSW 1590

FAX: TO THE RETURNING OFFICER - 02 9438 3760

A candidate may only withdraw his/her nomination in writing prior to the close of nominations.

Should more than the required number of nominations be received, a draw will be conducted to determine the order of candidates' names on the ballot paper at Level 6, 69 Christie Street, St Leonards NSW 2065 at 11:00am AEST, Thursday, 6th April 2017. Candidates or their representatives are invited to witness the draw.

VOTING

If the election is contested, a ballot will be conducted, closing at 12 Noon AEST, Thursday, 4th May 2017. Members of the Australian Medical Association (NSW) Limited, financial as at 12:00 noon AEST, Wednesday, 5th April 2017 entitled to vote in that class or classes that are contested will be sent material to enable them to vote by Internet, if they have a valid email address registered with the AMA (NSW). Members who do not have an email address will be sent voting material by post. Any contested Student Member election will be by Internet Voting only.

The method of voting to be observed for this election will be "First Past the Post". Any enquiries concerning this election should be directed to Elections Australia Pty Ltd, telephone 02 9416 9627

Phil Lewis, Returning Officer for the 2017 Australian Medical Association (NSW) Limited Election.

Australian Medical Association (NSW) Limited

ELECTION NOTICE

2017 ELECTION OF COUNCIL - Candidate information sheet

Each candidate may, before the close of Nominations **(12 Noon AEST Wednesday, 5th April 2017)** in the election, submit to the Returning Officer for approval a Candidate Information Sheet. Details supplied by candidates will be included in the Candidate Information Sheet which will be sent out with the ballot voting material if a ballot is required. The Returning Officer may reject any material contained in a Candidate Information Sheet which is false, misleading, defamatory or otherwise inappropriate.

ONLY INFORMATION PROVIDED WITHIN THE BOXED AREA BELOW WILL BE DISTRIBUTED. IT WILL BE REPRODUCED AS RECEIVED, i.e. IT WILL NOT BE RETYPED.

Therefore, ensure you either print or write all information clearly. Alternatively, a typed statement may be affixed inside the boxed area. Information MUST be restricted to the defined space allocated, and annexures will NOT be accepted. If scanning/emailing/faxing this form, it would be advisable to post the original to the Returning Officer at the address at the bottom of the form, immediately after emailing/faxing.

(CANDIDATE SURNAME) PLEASE PRINT CLEARLY

(CANDIDATE GIVEN NAMES)

Information in support of candidature:

No information beyond this line.

(SIGNATURE OF CANDIDATE)

(DATE)

Completed candidature Information Sheets may be lodged with the Returning Officer, Elections Australia Pty Ltd by 12 noon AEST Wednesday, 5 April, 2017 via; **Email:** ROCE2017@amansw.com.au. **Hand Delivered:** to Level 6, 69 Christie Street, St Leonards NSW 2065. (Must be handed to receptionist and signed in.) **Posted:** To the Returning Officer, PO BOX 121, St Leonards NSW 1590. **Faxed:** To the Returning Officer 02 9438 3760. Copies of the Blank Candidate's information Sheet or Nomination Form can be obtained from the AMA website (www.amansw.com.au) or by Emailing ROCE2017@amansw.com.au

Australian Medical Association (NSW) Limited

ELECTION NOTICE

2017 ELECTION OF COUNCIL - Nomination Form

With the exception of the Student Member Class, candidates and their nominators must be Ordinary Members, or in the case of a company, the Nominated Representative of an Ordinary Member. Candidates and their nominators must be members of the relevant class of the Association and must be financial members of the Association as at the date of the closing of nominations, i.e. 12:00 noon AEST, Wednesday, 5th April, 2017. In respect of the Student Member Class, candidates must be Student Members of the Association. **No member or Nominated Representative shall nominate for more than one class on the Council.**

I, the undersigned, being a member of _____ Class and a *financial member (or *Student Member) of the Australian Medical Association (NSW) Limited hereby nominate: *Delete whichever is inapplicable

_____
(SURNAME) PLEASE PRINT CLEARLY (GIVEN NAMES)

of _____
(PRIMARY PRACTICE ADDRESS) (POSTCODE)

of _____
(RESIDENTIAL ADDRESS) (POSTCODE)

( ) _____ ( ) _____ _____ _____
(PRACTICE PHONE NO.) (HOME PHONE NO.) (MOBILE PHONE NO.) (DATE OF BIRTH)

_____
(EMAIL ADDRESS)

as Candidate for the Council of the Australian Medical Association (NSW) Limited

representing _____ Class

FULL NAME OF NOMINATOR	ADDRESS	SIGNATURE
1. _____ (NAME)	_____ (PRIMARY PRACTICE)	_____
	_____ (RESIDENTIAL ADDRESS)	

NOTE: This nomination must be made by one (1) member of the relevant class of the Association (other than the candidate) who must be a financial member of the Australian Medical Association (NSW) Limited. In respect of student members the nomination must be made by one (1) student members of the Association (other than the candidate).

I, being a member of the _____ Class and a *financial member (or *Student Member) of the Australian Medical Association (NSW) Limited do hereby consent to the nomination. *Delete whichever is inapplicable

_____ _____
(SIGNATURE OF CANDIDATE) (DATE)

IMPORTANT: CANDIDATE'S NAME ON THE BALLOT PAPER
For the purposes of uniformity only one given name is included on the ballot paper. Recognised abbreviations or derivatives of given names are acceptable e.g. Bill for William, Jim for James, Rose for Rosemary, but nicknames are not e.g. Blue, Rocky, Bunny.

_____ _____
(SURNAME) (GIVEN NAMES)

My Affiliated Local Association or Special Group (only if applicable) is _____

Completed Nomination Forms must be lodged with the Returning Officer, Elections Australia Pty Ltd, not later than 12:00 noon AEST Wednesday, 5th April, 2017. They may be returned to the Returning Officer via; **Email** ROCE2017@amansw.com.au. **In person** Level 6, 69 Christie Street, St Leonards NSW 2065, **Post** to the Returning Officer PO Box 121 St Leonards NSW 1590 or **Faxed** to the Returning Officer - 02 9438 3760.
If you have any questions please email these to **ROCE2017@amansw.com.au** or phone **Phil Lewis Returning Officer on 02 9416 9627.**

METROPOLITAN ZONES

1. One (1) member of Council shall be a member who carries on his or her profession in the Northern Metropolitan Zone (Northern Metropolitan Zone Class), which comprises the Local Government areas of:

- Hornsby
- Manly
- Willoughby
- Ryde
- Ku-ring-gai
- Mosman
- Lane Cove
- Pittwater
- Warringah
- North Sydney
- Hunters Hill

2. One (1) member of Council shall be a member who carries on his or her profession in the Southern Metropolitan Zone (Southern Metropolitan Zone Class), which comprises the Local Government areas of:

- Canterbury
- Kogarah
- Rockdale
- Sutherland
- Hurstville

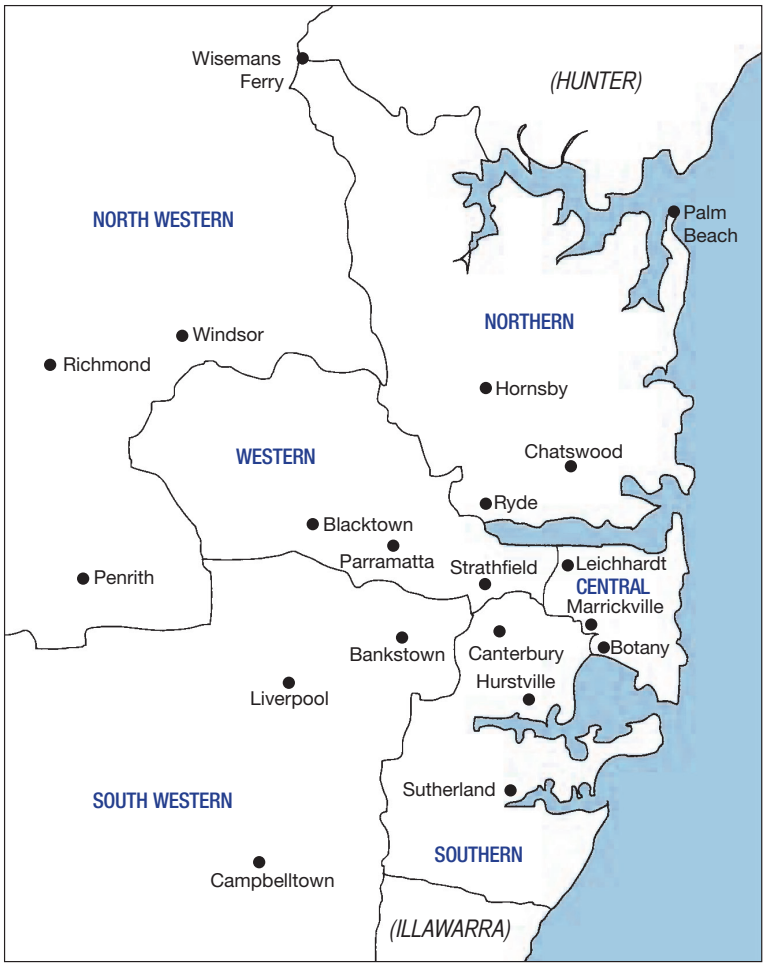
3. One (1) member of Council shall be a member who carries on his or her profession in the Central Metropolitan Zone (Central Metropolitan Zone Class), which comprises the Local Government areas of:

- Sydney City
- Waverley
- Randwick
- Leichhardt
- Woollahra
- Marrickville
- Botany Bay

4. One (1) member of Council shall be a member who carries on his or her profession in the Western Metropolitan Zone (Western Metropolitan Zone Class), which comprises the Local Government areas of:

- Parramatta
- Holroyd
- Blacktown
- Auburn
- Strathfield
- Burwood
- Ashfield
- Canada Bay
- The Hills

(that part of The Hills Shire Council area, south of Annangrove Road)



5. One (1) member of Council shall be a member who carries on his or her profession in the North Western Metropolitan Zone (North Western Metropolitan Zone Class), which comprises the Local Government areas of:

- Penrith
- Hawkesbury
- Blue Mountains
- The Hills

(that part of The Hills Shire Council area, north of Annangrove Road)

6. One (1) member of council shall be a member who carries on his or her profession in the South Western Metropolitan Zone (South Western Metropolitan Zone Class), which comprises the Local Government areas of:

- Camden
- Bankstown
- Liverpool
- Fairfield
- Campbelltown

INTERPRETATION

a) A reference to a member or Nominated Representative being engaged in a particular branch or specialty of the medical profession or to a member or Nominated Representative carrying on a particular type of medical practice shall mean a member or Nominated Representative who is primarily engaged in that branch or specialty of the medical profession or in carrying on that particular type of medical practice.

b) A reference to a member or Nominated Representative carrying on his or her profession in a particular Zone shall mean a member or Nominated Representative who carries on his or her profession primarily in that Zone.

c) "Salaried Doctor" means a member who is engaged not less than 50% of his or her professional time in carrying out duties as an employee otherwise than in private medical practice and includes an academic and a member who is primarily engaged in conducting research.

COUNTRY ZONES

7. One (1) member of Council shall be a member who carries on his or her profession in the Hunter and Central Coast Zone (Hunter and Central Coast Zone Class), which comprises the local Government areas of:

- Muswellbrook
- Gosford
- Lake Macquarie
- Port Stephens
- Maitland
- Dungog
- Singleton
- Wyong
- Newcastle
- Cessnock
- Gloucester
- Great Lakes
- Upper Hunter

8. One (1) member of Council shall be a member who carries on his or her profession in the Illawarra and South Coast Zone (Illawarra and South Coast Zone Class), which comprises the Local Government areas of:

- Bega Valley
- Eurobodalla
- Shoalhaven
- Wollongong
- Shellharbour
- Wingecarribee
- Wollondilly
- Kiama

9. One (1) member of Council shall be a member who carries on his or her profession in the New England and North Coast Zone (New England and North Coast Zone Class),which comprises the Local Government areas of:

- Moree Plains
- Armidale – Dumaresq
- Bellingen
- Kempsey
- Tenterfield
- Nambucca
- Byron
- Glen Innes
- Tweed
- Tamworth
- Coffs Harbour
- Narrabri
- Lismore
- Inverell
- Gunnedah
- Guyra
- Greater Taree
- Walcha
- Port Macquarie – Hastings
- Richmond Valley
- Ballina
- Kyogle
- Liverpool Plains
- Gwydir
- Uralla
- Clarence Valley

10. One (1) member of Council shall be a member who carries on his or her profession in the South Zone (South Zone Class), which comprises the Local Government areas of:

- Wentworth
- Bombala
- Carrathool
- Coolamon
- Leeton
- Berrigan
- Wagga Wagga
- Greater Hume
- Narrandera
- Albury
- Goulburn-Mulwaree
- Gundagai
- Snowy River
- Queanbeyan
- Deniliquin
- Young
- Jerilderie
- Wakool
- Hay
- Temora
- Urana
- Murray
- Tumut
- Boorowa
- Harden
- Upper Lachlan
- Lockhart
- Griffith
- Cooma-Monaro
- Tumbarumba
- Junee
- Yass
- Palerang
- Conargo
- Balranald
- Cootamundra
- Murrumbidgee
- Corowa

11. One (1) member of Council shall be a member who carries on his or her profession in the North West Zone (North West Zone Class), which comprises the Local Government areas of:

- Broken Hill
- Parkes
- Oberon
- Wellington
- Coonamble
- Bathurst
- Cowra
- Brewarrina
- Blayney
- Orange
- Mid-Western Regional
- Bland
- Lithgow City
- Weddin
- Bogan
- Gilgandra
- Warren
- Cobar
- Bourke
- Cabonne
- Forbes
- Lachlan
- Dubbo
- Walgett
- Warrumbungle
- Central Darling
- Narromine

INTERPRETATION

d) Doctor in Training" means an employed member who is undertaking a course of post graduate training and who does not otherwise fall within any of the classes referred to in paragraphs (a) to (k) of Clause 35.1of the AMA (NSW) Constitution.

e) "Rural Doctor" means a member or Nominated Representative who is engaged in a private medical practice in one of the Zones referred to in paragraphs (s) to (w) inclusive of Clause 35.1 where the practice at which that member or Nominated Representative is primarily engaged in carrying on his or her profession is not in a Town or City which has a Base Hospital.

New golfers welcome

The AMA (NSW) Golf Society is back in full swing. Please join us for another exciting year of golf.

Are you a golfer? Why not come along to our next event and try us out! We always welcome new players. You don't need to be an AMA (NSW) Golf Society member to play, but you do need an official slope rating. Our next event is the Presidents Cup, 21st July at Stonecutters Ridge Golf Club. If you would like to register for our events or if you have any queries about the AMA (NSW) Golf Society, please contact **Claudia Gillis on amagolf@amansw.com.au or ph: 02 9439 8822.** dr.

Volunteer with Palms Australia

Strong Relationships, Mutual Development, Better Health Outcomes

Sharing and developing skills with medical staff in African, Pacific or Asian communities builds health services sustainably.

To find out more, speak to Christine on 02 9560 5333 or email: palms@palms.org.au

www.palms.org.au

Active Funds vs Index Funds

By Russell Price
Director at Specialist Wealth Group

Keeping costs down are a key to wealth. Some of the most significant costs are hidden in your portfolio and are caused by product selection and your adviser's bias towards actively managed funds.

Although most advisers recommend actively managed funds, in reality, the net return of active funds are consistently below most passive (index) funds or well-constructed direct share portfolios.

Index funds vs managed funds

With managed funds, you buy units in an investment with other people. The money is pooled and a manager decides where to invest, based on parameters set down by the fund, such as asset class, geography, industry and so on. Most funds allow the manager to invest into any assets within the fund parameters that the manager thinks will provide the best return.

This active investment approach usually results in increased trading costs and tax. In addition, the costs of research increases the active manager's fees. Not only does the manager need to outperform the market, but the return has to be better than the market for your net return to be worthwhile.

An index fund on the other hand takes a more passive investment approach and doesn't bet on an individual fund manager's capability to consistently (and safely) outperform the market. It invests in the assets that make up its market index.

For example, an Australian Share Index Fund will invest into all the companies that make up a share index, such as the ASX200. The index fund will invest in each company in the same proportion as that company's proportion of the market as a whole. If BHP makes up 8% of the market, an index fund will invest 8% of its money into BHP.Which market you invest in will depend on your objectives and should be determined by your adviser and yourself. An index fund will cost around 0.05 - 0.50% (compared with an active fund costing about 1.0 – 2.5%).

Do Active Funds Perform Better?

The mid-year 2016 SPIVA (Standard & Poors' Index Versus Active Funds) Scorecard shows that, over the last 5 years, 91% of actively managed International Share Funds have underperformed the S&P Developed Large/ Mid Cap Index (the average return of all companies in that sector).

And it isn't much better for the Australian fund managers. Over 5 years:"

- 91% of active International Share managers underperformed against their index.
- 69% of active Australian Share managers underperformed against their index.
- 88% of Australian Bond funds underperformed.
- 92% of Property funds failed to beat the index.

The additional layer of fees

In most cases you are probably paying an ongoing fee for that adviser to monitor the portfolio.

The problem with an active investment approach is that it needs constant monitoring and adjusting. The reason for this is that fund managers lose key staff, underperform, close, etc. In addition to this, economic conditions change and the fund's parameters in which the manager is allowed to invest may not suit the new economic conditions. This causes most active funds to substantially underperform.

This active portfolio usually results in a worse return than the index – a return further reduced when the fees of the fund are taken into account.

The cost of portfolio advice?

Your adviser can provide a range of ongoing support other than a portfolio recommendation, such as insurance, budgeting, superannuation and debt management.

But what you pay should be based on how good your adviser is at picking the right mix of assets and how actively they manage the portfolio.

If your adviser charges a fee for their ability to build a portfolio, they should be accountable for the performance of their portfolio. Your adviser is probably not used to being held accountable for the performance of their expensive portfolios.

In other words, what you pay for ongoing investment advice should depend on performance of your portfolio (after fees) when compared to the benchmark index.

The bottom line is this: many advisers' ongoing fees are based on portfolio management so make sure they are providing a return that covers the extra costs, when compared to a suitable benchmark.

So what do you do?

I am yet to see a portfolio review (except ours) that shows a return that takes into account the adviser's ongoing fee compared to an appropriate benchmark.

So if you have an active managed fund portfolio, ask your adviser to provide a report that compares the performance of your portfolio with the benchmark index for each asset class or market you are invested in.

Check the returns are net of investment management fees. You then need to subtract your adviser's fees for portfolio management. If your net return is below the benchmark by more than 0.2%, then you are underperforming most index funds.

If this gets too confusing, email me a portfolio summary and I will do a free review for you.

Contact an adviser at Specialist Wealth Group on 1300 008 002 to discuss your portfolio today.

SPECIALIST WEALTH GROUP

A warm welcome to all of our **new members** this month

Get more from your membership today and utilise our medico-legal and industrial relations team for advice, our preferred partner advantages, member services and events throughout the year. To find out more phone our membership team on 02 9439 8822.

Dr Phillip Malouf
Dr Noah Freelander
Dr Kelvin Cheung
Dr Brian Seckold
Dr Anna-Kristen Szubert
Dr Stephanie Gorham
Dr Michelle Alexander
Dr Vivian Lee
Dr Udit Nindra
Dr Claire Francis
Dr Anthony El Hosri
Dr Monish Maharaj
Dr Leon Ong
Dr Annabelle Wood
Dr Kasia Kulinski
Dr David Graham
Dr Lucinda Tran
Dr Mohammed Uddin
Dr Jack Mitchell
Dr Erin Cunynghame
Dr Adrina Varda
Dr Jeremy Ong
Dr Anthony Zandes
Dr Jessica Mills
Dr Lucy Burgess
Dr Luke Brunton
Dr Ivonne Lichtenberg
Dr Patrick Chung
Dr Jack Cecire
Dr Sarah Lamb
Dr Peter Kilby
Dr Varitsara Mangkorntongsakul
Mr Joshua Anderson
Dr Chloe Boateng
Dr Nishath Khan
Dr Marley Pulbrook
Dr Susan Jacob
Dr Suchitra Mantrala
Dr Adam Mackie
Dr Gorokgoda Gunaratne
Dr Darshana Patil
Dr Dakshika Gunaratne
Dr Ahmet Erol Paterson
Dr Andrew Dunn
Dr Dimitri Christy
Dr Alex Raffles
Dr Jeffrey Van Gangelen
Dr Dushyant Tripathi
Dr Sebastian Rodrigues
Dr Sean Smith
Dr Catriona Lonie
Dr Michael Ward Jones
Dr Amitee Ryan
Dr Mohammed Al-Khalili
Dr Gulshan Islam
Dr Tasneem Mayat
Dr Malalage Waruni Peiris
Dr Tony Ratajkoski
Dr Chyna Kwek
Dr Aneesha Gill
Dr Nathan Leung
Dr Inhae Jeong
Dr Josie Lim
Dr Alicia Steller
Dr Edward Teo
Dr Erica Leaney
Dr Sofia Dominguez
Dr Patrick Aouad
Dr Wei Shyan Soon
Dr Elizabeth Chong
Dr Shiamalan Thanaskanda
Dr Mei Shan Sheila Koh
Dr Susannah Lyes
Dr Nandini Singh
Dr Estelle White
Dr Xizi Duo
Dr Michael Fitzgerald
Dr Lauren Gray
Dr Lasitha Delungahawatte
Dr David Cooper
Dr Jack Mackey
Dr Kimberly Vallester
Dr Sherrin Hannah
Dr Richard Lin
Dr Bahadir Demirdes
Dr Lucinda Wynter
Dr Lyndal Edwards
Dr Elizabeth Walsh
Dr David Airey
Dr Jinhang Luo
Dr Lawrence Lanesman
Dr Lauren Tang
Dr Astrid Alawattegama
Dr Ho Chu
Dr Anna Almulla
Dr Jordan Weastell
Dr Johnny Efendy
Dr Neil Ferguson
Dr Dinuke De Silva
Dr Mariana Sheales
Dr Chatika Premaratne
Dr Ee-May Chia
Dr Suzanne Cartwright
Dr Meena Rattan
Dr Avedis Ekmejian
Dr Joseph Rizk
Dr John Beer
Dr Sharron Flahive
Dr Isobel Lang
Dr Emily Agius
Dr Sang-Hee Lee
Dr Sara Berry
Mr Michael Taylor
Dr Sanjidah Mostafa
Mr Edgardo Solis
Dr Rathna Prasad
Dr Aveena Dhanjee
Dr Henaka Ralalage Samaratunga
Dr Kathleen Leaper
Dr Samantha Thomas
Dr Samuel Eather
Dr Emily Hedditch
Dr Kartik Vasan
Mr Muditha Nanayakkara
Dr Blair Burke
Dr Jake Chia
Dr Michael Hagarty
Dr Alexandra Bolger
Dr Sujinyaa Sriskandan
Dr Xi Zhang
Dr Tristan Scott
Dr Louise Thomas
Dr Praneel Kumar
Dr Dominic Vickers
Dr Jessica Bowen
Dr Burcu Saglam
Dr Samoda Mudalige
Dr Joanna Mills
Dr Corinne Fulford
Dr Melanie Diver
Dr Daniel Guilfoyle
Dr Anita Puvanendran
Dr Merran Cooper
Dr Aimee Tran
Dr Siobhan Clayton
Dr May Zaw
Dr Dominic Douglas
Dr Jayanand Mahendra Raj
Dr Yan Joyce Ming
Dr Damon Shorter
Dr Dinesh Thadani
Dr Kelly Needham
Dr Wenfei Kwok
Dr Justyn Huang
Dr Seema Padencheri
Dr Katharine Kline
Dr Loi Lam
Dr Kenny Parra
Dr King Fai Leung
Dr Carolyn Russell
Dr Alexander Kirwan

AMA (NSW) would like to acknowledge Dr William Thomas Hudson Scales, who at age 98, has been a member for 74 years. Congratulations!

Dr Kallie Shaw
Dr Shilpa Dahal
Dr Max Leibenson
Dr Cigdem Kaya
Dr Junedahemad Shaikh

Dr Dan Li
Dr Michele Fiorentino
Dr Anna Di Marco
Dr Clyne Fernandes
Dr Isabella Sukkar

Dr Dillon Cheah
Dr Laura Anthony
Dr Likhitha Sudini
Dr Thomas Suo
Dr Emily Sutherland

Dr Amirsalar Rashidianfar
Dr Shirley Kam
Dr Madeleine Didsbury
Dr Mei Shan Sheila Koh
Dr Nathan Biddle
Dr Ronny Schneider
Dr Andrew Lange
Dr Shantiban Shanmugam
Dr Malcolm Cooper
Dr Laura Thomson
Dr Jillian Neve
Dr Emily Le Fevre
Dr Danny Lam
Dr Benjamin Trevitt
Dr Wai Kwok
Dr Jasjit Walia
Dr Kevin Rourke
Prof Mohamed Khadra
Dr Muthusamy Kaneson
Dr Raja Chaganti
Dr Fiona Cleary
Dr Minjoo Jeong
Dr Raany Rahme
Dr Anusha Saxena
Dr Salman Siddiqui
Dr Robert Pocklington
Dr Andrew Luo
Dr Zijun Ge
Dr Jasmine Wintour
Dr Jeremy Yeo
Dr Natasha Stark
Dr Luke Chen
Dr Hardeep Salaria
Dr Ji Do
Dr Jessica Yabsley
Dr Connor O'Meara
Dr Bridget Prior
Dr Bernadette Tomes
Dr Patrick Lau
Dr Christina Mullany
Dr Olumuyiwa Komolafe
Dr Craig Mooney
Dr Daniel Jones
Dr Moe Thinn
Dr Neville Sammel

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

Dr Ross Thompson
Dr Chloe Abbott
Dr Brian Hoolahan
Dr Joseph Malouf

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Avis Budget | Avis Budget is the official car rental partner for AMA (NSW) offering discounted rates. Contact AMA member services for the details.

BMW Corporate Programme | Members can enjoy the benefits of this Programme which includes complimentary scheduled servicing for 5 years/80,000 km, preferential pricing on selected vehicles and reduced dealer delivery charges.

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