VOL 10 - N 05 - SEPTEMBER/OCTOBER 2018

THE NSW doctor

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THE NSW doctor
THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION (NSW)

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The NSW Doctor is the bi-monthly publication of the Australian Medical Association (NSW) Limited.

Printing by Immij Pty Ltd.

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NEW SOLUTIONS TO OLD PROBLEMS

The Western Sydney Diabetes Initiative demonstrates that integrating hospital and community-based services can show benefits.

YEAR ON YEAR, almost quarter on quarter, we see NSW hospitals breaking new records in terms of hospital presentations and admissions. There is no question we need adequate resourcing of our hospital sector, but we should question how we can optimise the use of resources. Paying for more of the same is a great way to lead to more of the same. Sometimes we don't need more, we need different.

Western Sydney is a well-known diabetes hotspot, with recent studies showing that 47% of the population in Blacktown-Mt Druitt have HbA1c screening tests in the diabetic or prediabetic range. Amongst admitted patients, every year there is a 1% increase in patients with a diagnosis of type 2 diabetes. A co-morbid diagnosis of diabetes is associated with up to 25% higher total cost per admission and longer bed stays. In my practice, after the age of 35, up to 90% of patients in some deciles are overweight or obese. We diagnose a new case of diabetes on average every three weeks, with almost 12% of our patient population now suffering from diabetes.

Four years ago, the Blacktown Hospital Diabetes Clinic had a wait time of more than nine months when Professor Glen Maberly embarked on a strategy to make a difference. One of the problems was that the clinic was not able to discharge patients and was swamped with referrals. One of the solutions was to improve the capacity to care for patients in the community. While there are many parts to a whole of system, whole of area diabetes strategy, an innovative part of the solution was a partnership program with the Western Sydney Primary Health Network. This allowed endocrinologists and diabetic educators from the hospital to see patients in consultation with their usual GPs and primary care team in general practices. In our practice, our team of our dietitian, pharmacist, nurse and doctors would engage in the case conference – sometimes in person, sometimes using remote video conferencing.

Across the 19 practices involved in the exercise initially, there was an average improvement in HbA1c for each patient seen of almost 0.9% at the six-month mark, and almost 1% at the three-year review. There were significant reductions in lipid profiles and improvements in eGFR. Across the practices, there were improvements in overall diabetic control. Within our practice, the percentage of patients with diabetes with an HbA1c of <8 has continued to increase from 60% in 2014 to 86% in August this year. The wait time at the diabetic clinic reduced to less than a month, with urgent cases being able to be seen in less than a week at a Rapid Access Clinic.

As with all improvements, the reasons are often multifactorial, and treatment of diabetes is more than managing the condition once diagnosed. Community case conferencing is one part of a broader strategy. At a systems level we need to look at primary prevention as well as secondary prevention and management. There needs to be a layered approach to management with support for patients and providers according to needs and experience. What this demonstrates is that integrating hospital and community-based services can show benefits.

We know a 1% reduction in HbA1C can reduce risks of: diabetes-related deaths by 21%; myocardial infarction by 14%; microvascular complications by 37%; and amputation or death by 43%.

The Western Sydney Diabetes Initiative is a partnership program, with partners across the spectrum of community from State Government departments, LHD, PHN down to local practices, universities and community organisations all with a common objective – to reduce the burden and impact of diabetes in the region.

Sometimes we need to do something different. dr.

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Dr Kean-Seng Lim President, AMA (NSW)

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INDEPENDENCE

AMA (NSW) draws from the experience of Councillors and Committee Members to ensure it is effectively representing the interests of members.

AMA (NSW) represents doctors' interests to the Government – not the other way around.

In this edition of *The NSW Doctor*, we are focusing on some of the issues facing our hospital-based specialist members. Over the past few months, we have seen significant discussion of fees, both in terms of the action of Bupa in changing the nature of the fees payable to doctors in public hospitals and non-contracted facilities, as well as general media interest in the issue of fees.

At AMA (NSW), we are extremely fortunate that we are able to draw on the expertise of our Councillors to respond to the many issues which arise. Our Council has representatives from every medical specialty as well as doctors-in-training and a medical student. They are all active, practising doctors, which means they speak with experience and expertise about the issues facing the profession.

Issues come to the AMA (NSW) Council in many ways. Some are in response to members raising queries, some develop in response to a new policy from Government or the Opposition. In each instance, the way we deal with the issue is the same, we draw on the expertise of doctors and they consider what is in the interest of our patients and the profession. At the heart of our decision-making is the importance of independence – independence of the AMA and the independence of the profession. For this reason, I was proud once again of the leadership of AMA (NSW) who were the only major health organisation to oppose entering into agreement with Government in the form of the Compacts prior to the 2018 budget. It is the AMA's job to build a case for investment in health and then to hold the Government to deliver that investment. Deals, or even the appearance of deals, undermine the confidence of the public, particularly when it comes to really important reforms such as the My Health Record.

While there is value in having a centralised repository of health information for patients, doctors' over-riding concern needs to be the protection and security of patient privacy. No deal is worth compromising the trust doctors have worked so hard to build with patients. dr.

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Fiona Davies CEO, AMA (NSW)

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A BRAVE NEW WORLD

For lifelong Sydneysider Dr Jacqueline Ho, regional secondments have made her a better doctor and an advocate for equitable access to healthcare.

Dr Jacqueline Ho
SURGICAL SENIOR RESIDENT MEDICAL OFFICER

MY HAIRDRESSER remarked that I was "brave" for packing up my bags and starting a new job in the middle of NSW. And yet what this person called "brave" is what many junior doctors call just another part of training.

Across NSW, there are hundreds of doctors-in-training undertaking secondment. Experiences can be anywhere from 10 weeks to six months or more, depending on whether it's part of prevocational training or a formal part of a training program.

Removing doctors from all their major supports is a good way to challenge a JMO's resilience (a word which I hate). And it's not uncommon to see doctors struggle. The 2013 BeyondBlue survey of doctors and medical students showed that doctors from regional, rural and remote areas may be particularly vulnerable to psychological distress.

But far from drawing the short straw, my regional placements have forced me to take greater responsibility, learn how to do more with less, and experience working closely with some great teams.

These rural spots are well sought after – and for good reason. Our metropolitan hospitals are often "top heavy" – there are senior consultants, junior consultants, fellows, senior registrars, junior registrars, senior residents, residents and interns. And as someone lower down on that pecking order, it can be difficult to get a look in. I have literally been the sixth person scrubbed in an elective operation.

It's true when people say you learn a lot more on a rural placement. Maybe it's because consultants aren't running between two or three different hospitals. Or maybe it's because operating lists accommodate for teaching time. Regardless of why, the reality is there are fewer resources and greater opportunities to step up.

My first two secondments were at Wagga and I'm currently at Griffith Base Hospital (which is less well resourced than Wagga). Working in a regional hospital can feel like a different world. All hospitals are affected by chronic underfunding, but regional facilities even more so, and you're forced to make do with older equipment or second-hand CT scanners.

Rurality is one of the most important social determinants of health. Access to healthcare is often limited – due to distance, availability or even health literacy, and so hospitals have higher rates of potentially avoidable hospitalisations. It is not uncommon to see uncontrolled diabetes, morbid obesity, hypertension and low levels of exercise, so patients tend to have a lower life expectancy. These patients deserve the exact same care as any other patient and should be able to access it as close to home as possible.

And yet rural and regional patients can routinely travel one to two hours to receive a surgical review as district hospitals are only equipped with their clinical examination and an istat machine. Despite these barriers to access, patients are grateful for our care and philisophical about their healthcare situation.

One of my patients remarked – 'well sometimes you can travel an hour in traffic in Sydney to see a specialist, and take another 15 to 30 minutes to find parking – whereas here, if you're driving, you're at least getting somewhere far.'

It's important to have this insight into rural, regional and remote health, as the experience helps us become better advocates for our rural patients.

I consider myself lucky to have been able to go on three rotations over the past three years. Each experience has been educational, enlightening and enjoyable. And I've been able to work with some great consultants and great teams. Working in a rural town has definitely made me a better doctor and helped me grow as a surgeon. I have made some great friends and enjoyed old and new hobbies. And, as the 'Cheers' theme song goes, I love working in a hospital where 'everybody knows your name'. I can't wait to come back to work here once I'm qualified. dr.

@simplyjak

PROTECTING CHOICE

At the core of AMA (NSW)'s advocacy around billing is protecting doctors' rights to set their own fees.

DOCTORS' FEES have been in the spotlight for much of 2018 for multiple reasons. AMA (NSW) has had to weigh in on these issues on many occasions and, at times, the policies and protections we advocate for seem at odds.

In February of this year, Bupa announced changes that would have dramatically restricted doctors' access to Bupa's Medical Gap Scheme. Whilst it has always been a doctor's right to set her or his own fee, many doctors choose to utilise gap scheme billing in certain circumstances. This is particularly the case for emergency presentations to hospital, whether that be in a public or private setting. It is also acknowledged that some doctors choose to charge a gap in these circumstances and for many situations, that is appropriate. Bupa's proposed changes would have limited a doctor's choice of billing option dependent not on the service, but rather on geographical location.

AMA (NSW) was one of the first organisations to recognise the significance of this issue and act upon it. Along with Federal AMA, we advocated to ensure that a doctor's right to set her or his own fee is protected. Whilst Bupa has significantly backed down on many of their proposed changes, lack of Medical Gap Scheme access for practitioners working in non-BUPA contracted private facilities remains an issue. This is an area we will continue to work on.

Seemingly at conflict with protecting this access to Medical Gap Schemes, is the requirement for the AMA to provide a balanced argument of why doctors do, in fact, charge gaps in certain

Dr Fred Betros, AMA
Board Member

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circumstances. The airing of the ABC's *Four Corners* – "Mind the Gap" on 28 May, focussed on the issue of patient out-of-pocket (OOP) costs related to specialist doctor billing and private sector health care. The program presented multiple case scenarios that ranged from very large OOP costs related to single surgeon bills, right through to "bill shock" from cumulative, multiple, small to medium OOP costs, associated with long and protracted multidisciplinary management.

The AMA does not support exorbitant charges – fees that the majority of a practitioner's peers would consider to be unacceptable. Statistics reveal that this happens in very few instances. More than 90% of AMA members charge well below the list of fees at the insurers' schedule, using no-gap schemes to minimise costs to patients.

But the AMA does respect a doctor's choice to charge a fee.

On the surface, protecting Medical Gap Schemes and defending doctors' rights to charge a gap seem at odds with each other, but the core issues driving AMA involvement are at the heart of each. The AMA 2017 Position Statement on Setting Medical Fees and Billing Practices states:

As highly trained professionals, medical practitioners are free to place their own value on their professional skills and expertise and determine what they consider to be a fair and reasonable fee for the services they provide.

Doctors should also satisfy themselves in each case as to a fair and reasonable fee having regard to their own costs and the particular circumstances of the case and the patient.

Indexation of the MBS and the private schedules have not kept pace with the costs of providing medical care. This is why patients may have out-of-pocket costs for medical services. The AMA List is indexed annually at a rate that takes into account the cost of providing medical services and is therefore higher than the MBS and private schedules. The AMA List guides members in setting their fees with periodic indexation.

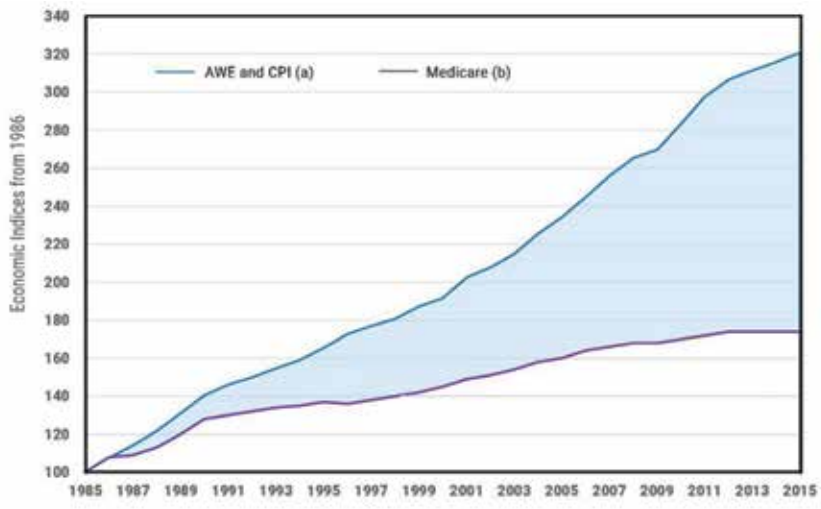
The AMA opposes the introduction of any legislation that restricts the fees that medical practitioners may charge.

The AMA encourages good informed financial consent (IFC) practice and the provision of information about medical fees to patients. Doctors are encouraged to review the AMA's Position Statement on Informed Financial Consent (2015).

The AMA recognises that providing quality healthcare has a cost. As a practising surgeon in the private and public sectors, I am constantly reminded of the expertise, training and substantial risk that is required to provide this level of care. For those who are non-proceduralists, the issues are no less important. The decisions we make every day also carry risk. However, our years of training and experience allow us to make these decisions with confidence, knowing we are doing the best thing for our patients. The responsibilities are significant, and we should be remunerated for this. I believe this is not just the case for hospital specialists, but also for general practice and other outpatient-based services as well. This is obviously difficult to communicate to the wider community as it often seems to be a self-serving cause.

Our aim is to protect the quality of the healthcare we provide by not undervaluing it, but at the same time, we also recognise that practitioners may choose to provide this care without a gap if they so wish. Ultimately, we see it as our role to protect this choice of the doctor and we will always continue to do so. dr.

WHY IS THERE A GAP?



(a) Index comprising of Average Weekly Earnings and Consumer Price Index (70:30) reflecting the average cost structures in medical practices.

(b) Index of Medical fees as determined by the Commonwealth Government.

AMA INFORMED FINANCIAL CONSENT

The AMA encourages good Informed Financial Consent (IFC) practice and the provision of information about medical fees to patients. Patients should always ask their doctor about his/her fees, and the fees of other doctors involved in their care, before going to hospital as a private patient.

The AMA has several resources available for doctors to help patients, including an IFC template form as well as brochures, flyers and a poster. Information such as 'Questions to ask your doctor about costs before you go to hospital' is available for free from the Federal AMA website.

The Medical Gaps Poster is also a useful tool available for download.

To access these resources for your practice and your patients, go to: ama.com.au/article/ama-informed-financial-consent.

AUSTRALIA'S STAR CHAMBER

Huge outcry from medical professionals forced AHPRA to back down from its controversial policy to post tribunal decisions. However, Dr Michael Gliksman argues AHPRA's underlying philosophy remains an issue.

Dr Michael Gliksman
FORMER AMA (NSW)
VICE PRESIDENT

STAR CHAMBER (def): an English court of law from 15th to 17th century, originally established to ensure the fair enforcement of laws against prominent persons that ordinary courts would hesitate to convict. In practice it became synonymous with oppression through the arbitrary use and abuse of the power it wielded.

More than 16,000 of our colleagues signed a petition[1] calling on AHPRA to reverse its proposal to link tribunal actions to online registration details of doctors (and only doctors), possibly in perpetuity, when no adverse findings were made.

Clearly the signatories (myself included) agreed with Avant's assessment that although no adverse finding would be noted on the register, there was real concern the allegation would be given more weight than the finding. After all, how could the Medical Board of Australia chair Dr Joanna Flynn's statement that the move was to help '…build trust between patients and doctors' be understood except as a restatement of the rubric 'where there's smoke there's fire' (even when it's AHPRA rubbing the sticks together)?

AHPRA is constituted on the premise that the best (perhaps only) way to protect the public from medical misadventure is to detect and punish individuals. I believe this, as well as perceived bias, lies behind the opposition AHPRA encountered.

Punish the 'bad apples' – no one opposes that, but don't confuse it with prevention and effective public protection. Is there a better way? The airline industry, focussing on a systems approach rather than simply punishing individuals after the event, has proven there is.

Airline industry regulators use root cause analysis[2] to establish the systemic limitations that allows failure to occur, and then corrects these. It has helped transform the commercial airline industry's safety record from 2379 passenger deaths in 1972 to 59 in 2017, despite the explosion in air travel in the intervening period.[3]

One need not imagine the consequences for that industry if it adopted AHPRA's approach. Commercial airlines would fall from the sky on a weekly basis and beyond punishing surviving aircrew, nothing would be done to prevent recurrences.

Using the root cause method in the health industry requires investigation of all factors involved in the causal sequence, including the role of inadequate resourcing, excessive work demands placed on individuals, and other bureaucratic/systems arrangements that promote error, a task for which AHPRA has shown neither inclination nor competence. Instead, it is individual doctors that are scapegoated for any or (in the case of vexatious complaints) no part they have played in health system failures.

Even the limited prospect for prevention offered by AHPRA's approach is mitigated by its other major failing – its inability to identify the innocent and guilty in a manner in which the profession and public can have confidence. This goes beyond simple bias.

Any decent society places the 'Golden Thread'[4] at the centre of its system of justice. In criminal matters this finds practical expression in the need for guilt to be established beyond reasonable doubt (BRD), a standard of proof designed to minimise the risk of wrongful conviction.

When it comes to the functioning of the various Tribunals judging doctors, the standard applied is the civil courts' balance of probability (BoP); ie: 50:50. Presuming an unbiased approach, this will convict the innocent up to 49% of the time.[5] The consequence of this lottery for the accused but innocent doctor can be devastating - including heavy fines, public humiliation, the destruction of reputation, livelihood and sometimes, the loss of life.

Does AHPRA owe a duty of care to those the subject of its investigations? This is yet to be tested in the Courts but if so, there is no evidence it acts as if so and I can find no section of its Act requiring it do so.

AHPRA's snapping 'The Golden Thread' of the law - the presumption of innocence, as well as the fact that its panels are not bound by rules of evidence, represents the abuse of unequal power more potent than that of which it often accuses our profession.

On 27 July, AHPRA bowed to mounting pressure to rescind its ill-advised policy but like the Bourbons, it has learned nothing and forgotten nothing. Fresh from its defeat it has proposed an even greater outrage.

Proposed changes to the Medical Board's Code of Conduct look much like a gag order, threatening those who speak out with disciplinary action and perhaps deregistration.

Section 2.1 states: "You need to acknowledge and consider the effect of your comments and actions outside work, including online, on your professional standing and on the reputation of the profession. If making public comment, you should acknowledge the profession's generally accepted views and indicate when your personal opinion differs. Behaviour which could undermine community trust in the profession … may be considered unprofessional."

The threat of disciplinary action for expressing an opinion of which AHPRA and/or its advisors disapprove clearly impinges on the ability of doctors (and only doctors) to comment and advocate for some of the most disadvantaged people in our society, or to participate candidly in debate over health-related matters that are not settled science or diverge from the majority.

It limits potentially our right to participate in the discussion of controversial social and medical issues such as asylum seeker policy, abortion, euthanasia, drug policy, public health and gender/sexual politics. Moreover, it highlights AHPRA's ignorance of (or contempt for) the High Court's ruling on the Constitutionally implied right to free political communication.[6]

The original Star Chamber lasted almost two centuries before Parliament summoned sufficient courage to abolish it. Let's hope our legislature is less supine in taking action to reform its modern incarnation. dr.

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3. https://news.aviation-safety.net/2017/12/30/preliminary-asn-data-show-2017-safest-year-aviation-history
4. Lord Sankey in the case of Woolmington in the House of Lords: "Throughout the web of the English Criminal Law one golden thread is always to be seen that it is the duty of the prosecution to prove the (accused's) guilt…" (ie: Innocent unless proven guilty).
5. In medical terms a test with high sensitivity but woeful specificity.
6. Nationwide News Pty Ltd v Wills (1992) 177 CLR 1 ('Nationwide News'); Australian Capital Television Pty Ltd v Commonwealth (1992) 177 CLR 106 ('ACTV'); Theophanous v Herald & Weekly Times Ltd (1994) 182 CLR 104 ('Theophanous'); Stephens v West Australian Newspapers Ltd (1994) 182 CLR 211; Lange v Australian Broadcasting Corporation (1997) 145 ALR 96, 112; Coleman v Power (2004) 209 ALR 182, 232-3 (Kirby J).

TWITTER IN 2018

New rules to fight trolls and control spam are making Twitter a friendlier place. You might be late to the party, but enthusiasts argue there's never been a better time to join…

TWITTER was launched in 2006 – the same year Saddam Hussein was executed, Pluto was downgraded as a planet, and Cyclone Larry hit Queensland.

If it feels like forever ago – that's because it was.

And while you might have dismissed it as a sad place for social media attention seekers, or anonymous trolls with an ax to grind, Twitter is still arguably the best place for breaking news and real-time discussion.

Proponents of the social media platform say it's also changed – for the better – since it was first launched more than a decade ago. In March, Twitter CEO Jack Dorsey announced the social media platform would target disruptive behaviour by trolls that distort and distract from the public conversation. By using new behaviour-based signals into how Tweets are organised and presented in areas like conversations and search, they have limited the impact and reach of abusive and digressive comments.

Wollongong Anaesthetist, Dr Tanya Selak says medical professionals stand to gain huge benefits by participating on Twitter.

"I have met extremely interesting people across disciplines, across countries, and across cultures that I would never have come across otherwise."

She was convinced to join Twitter after hearing the keynote speaker Dr Victoria Brazil at the Social Media and Critical Care conference on the Gold Coast in 2013.

"She talked about tribal culture in medicine. How, for example, in hospitals, the emergency doctors stick together and it's them versus the inpatient team, and the inpatient team versus the GPs. And how we sometimes function negatively across the tribes in the hospital system. That really rang true for me and I believe it's quite a negative aspect of the system. Twitter is one way of crossing those boundaries."

She started by live-tweeting during a medical conference, which she recommends as a great way for people to take their Twitter game to the next level.

"Go to your next medical conference, and just follow the hashtag. And in fact, following conference hashtags is a really good way to get more education and stimulate further reading on current topics."

Through Twitter, Dr Selak says she has been able to connect with doctors from other specialties, as well as boost her own medical education by connecting with doctors from within anesthesiology.

Access to timely information was what initially attracted Dr Lisa Pryor to using Twitter.

As a former journalist, Dr Pryor was used to a newsroom environment where she needed to know what was happening in the world and what news was breaking. But as a doctor, Dr Pryor's usage has slightly changed.

"I also find it's been useful for discovering new research, or what's happening in the health department or health system. It's really timely information that you can access."

She adds that through Twitter she's found a really good support network of doctors, as well as a way of directly communicating with people one might not normally have access to – such as representatives from the Ministry of Health.

And while some think the character limitation (which was doubled from 140 to 280 characters last November), doesn't allow for meaningful exchange, Dr Pryor has found it's possible to elevate the quality of conversation by inserting real evidence into a debate.

"Recently, I linked statistics on mental illness from the World Health Organisation

that are actually different from what's in the media conversation, which helps make the conversation a little more evidence-based."

Doctors' ability to leverage their medical education and expertise is one reason why many feel medical professionals have a duty to participate in online discussions. Dr Ashleigh Witt, who has more than 7,000 followers and is a prolific Twitter enthusiast, created a 12-point list on her blog which detailed her top Twitter rules. Rule number two states, "As health professionals we have a duty to participate in public discussion about health. If we don't the chiropractors, celebrity health hacks and snake oil salesmen of the world will answer our patients' questions for us."

However, medical professionals – perhaps more so than most, put themselves at risk when engaging online.

"As doctors, we are registered to a professional body and therefore if someone is angry with something we've said the first thing they will do is complain to your employer and complain to your registered body. So, you can understand why people would be confronted by that," Dr Selak says.

"But if you just leave social media to people who have nothing to lose, who are anonymous, who create accounts impersonating other people, who have no job, or no registered body, there is an unbalance in the voices that are heard. So, I think it is important. If we just put our heads in the sand, then I think we do ourselves and our patients a disservice because people get very biased views of what the truth is. And as medics, we know a lot about medicine, that's what we're trained for and if we leave a void that will get filled by people perhaps less appropriate."

> "If we just put our heads in the sand, then I think we do ourselves and our patients a disserve because people get very biased views of what the truth is."

Dr Selak says while some people are out there to use your words to further their own agenda, she has learned to control some of the negative aspects of Twitter.

"I have a medical focus. I do keep up with current affairs and I do tweet more broadly. But I am mindful that if you start tweeting about politics you will attract negative content – because clearly with politics, whatever your position is, half the people will have the opposite position.

"You can easily control your content when you have a smaller circle. In fact, some of my tweets which have been very widely spread, in a way those are the ones that attract negativity."

Dr Selak recently tweeted about the Thai Cave rescue acknowledging the efforts of Dr Richard Harris, and the sad fact that while he was overseas his father passed.

"I did a tweet, saying, 'this is medicine – we miss family tragedies whilst helping others', and it was re-tweeted quite widely. And in the beginning, it received very positive comments. But then people started saying, 'oh, you think medicine is the only profession where you miss things'… so pretty much anything you write could be twisted. Especially the larger your following, the more likely that is to happen."

There will always be differing points of view. But when it comes to abusive comments, your online response should be similar to how you might deal with a negative person in real life.

"I've learned it's best not to get into debates with people. Once you've said your piece and they've said their piece, don't keep fighting it out, it's not worth it," Dr Pryor says.

You can always block and report someone to Twitter and medical professionals have the option of engaging with their Medical Defense organization for further advice if they find themselves in a difficult position. dr.

@AMA_NSW

SOCIAL MEDIA RULES FOR DOCTORS

AT THE time of writing, the Medical Board of Australia and AHPRA were proposing changes to the current Code of Conduct, which has the potential to affect doctors' use of social media.

The draft document, Good Medical Practice: A Code of Conduct for Doctors in Australia (June 2018) introduced a new section to the Code, which states:

"The boundary between a doctor's personal and public profile can be blurred. As a doctor, you need to acknowledge and consider the effect of your comments and actions outside work, including online, on your professional standing and on the reputation of the profession.

Doctors' groups expressed concerns that the section is ambiguous and leaves too much room for subjective interpretation. It could also be construed as an attempt to curtail what doctors say publicly, thereby stifling the ability of medical professionals to contribute to public debate.

The AMA's guide to online professionalism for medical practitioners and medical students outlines rules to abide by when engaging online. The guide includes information around protecting patient confidentiality, avoiding making defamatory statements, respecting doctor-patient boundaries, and more. You can access the AMA's online guide here: https://ama.com.au/system/tdf/documents/Social_Media_and_the_Medical_Profession_FINAL_with_links_0.pdf?file=1&type=node&id=35198

WIPING THE PAST

YOUR Twitter account should not be an online record of musings for your grandchildren to enjoy. Given that Twitter's stock-in-trade is breaking news and immediate reactions, comments you made today may be at odds with opinions you hold you in the future. Most people formulate opinions based on the best available information they have at the time, and revise as more information becomes made available – and that's ok. But we live in a world where some people consider it a sport to dredge up old comments, twist them to suit their own agenda, and leave the victim trying to do damage control. The best way to combat this is to take away any potential ammunition.

You can always delete your account and start again, but then you lose all those connections you've built up over the years. If you want a slightly less nuclear option than destroying your profile, you might consider employing a service to wipe your Twitter history. Here are a few options:

TweetDelete – a free web tool which allows you to mass delete tweets that are older than a specified age. Once activated, it will periodically check for new tweets that have expired according to the age you have specified, and it will delete them for you. This service can only work within the latest 3,200 tweets on your account.

TweetEraser – a web-based tool that helps you filter and delete your Tweets. Three options are available: Free Eraser, Standard Eraser (USD 6.99), or Premium Eraser (USD 9.99).

TweetDeleter – a tool that allows you to search for and delete tweets. The service allows you to find tweets based on date, keywords, or tweet and media link types. Free, Premium (USD 5.99/month if billed annually), or Unlimited (USD 7.50/month).

CAN TWITTER KILL YOUR CAREER?

THE SHORT answer is yes – even if you're not famous.

The recent case of former Cricket Australia employee Angela Williamson highlights the friction that exists between being able to express political opinions online and what your employer deems as acceptable.

Ms Williamson was fired after she campaigned for abortion reform on social media.

In the media furore that followed, the sporting organisation stated, "Cricket Australia respects an individual's right to their opinion. However, it expects that employees will refrain from making offensive comments that contravene the organisation's policies."

Ms Williamson, who was employed as a manager of public policy and government relations, was one of the first forced to travel to Melbourne for a termination in February after the state's only abortion provider was closed.

She had used her Twitter account in January 2018, calling the situation in Tasmania a 'disgrace'.

A government staffer who was cyber-trolling Ms Williamson sent an email to Cricket Australia alerting the organisation of her tweet. The government staffer was later forced to resign after it was revealed she was using a fake Twitter account to target critics of the Government.

More recently, Ms Williamson reacted to Tasmania Government's decision to reject a motion to allow for abortions to be provided in public hospitals, tweeting "most irresponsible … gutless and reckless."

Cricket Australia terminated her employment shortly afterwards, citing feedback from the Cricket Tasmania board that they no longer had confidence in her ability to work as a government relations manager.

Ms Williamson has engaged employment law firm Maurice Blackburn to represent her in this matter. dr.

"For speaking up, I lost my job." - **Angela Williamson**

A PLACE TO LAY YOUR HEAD

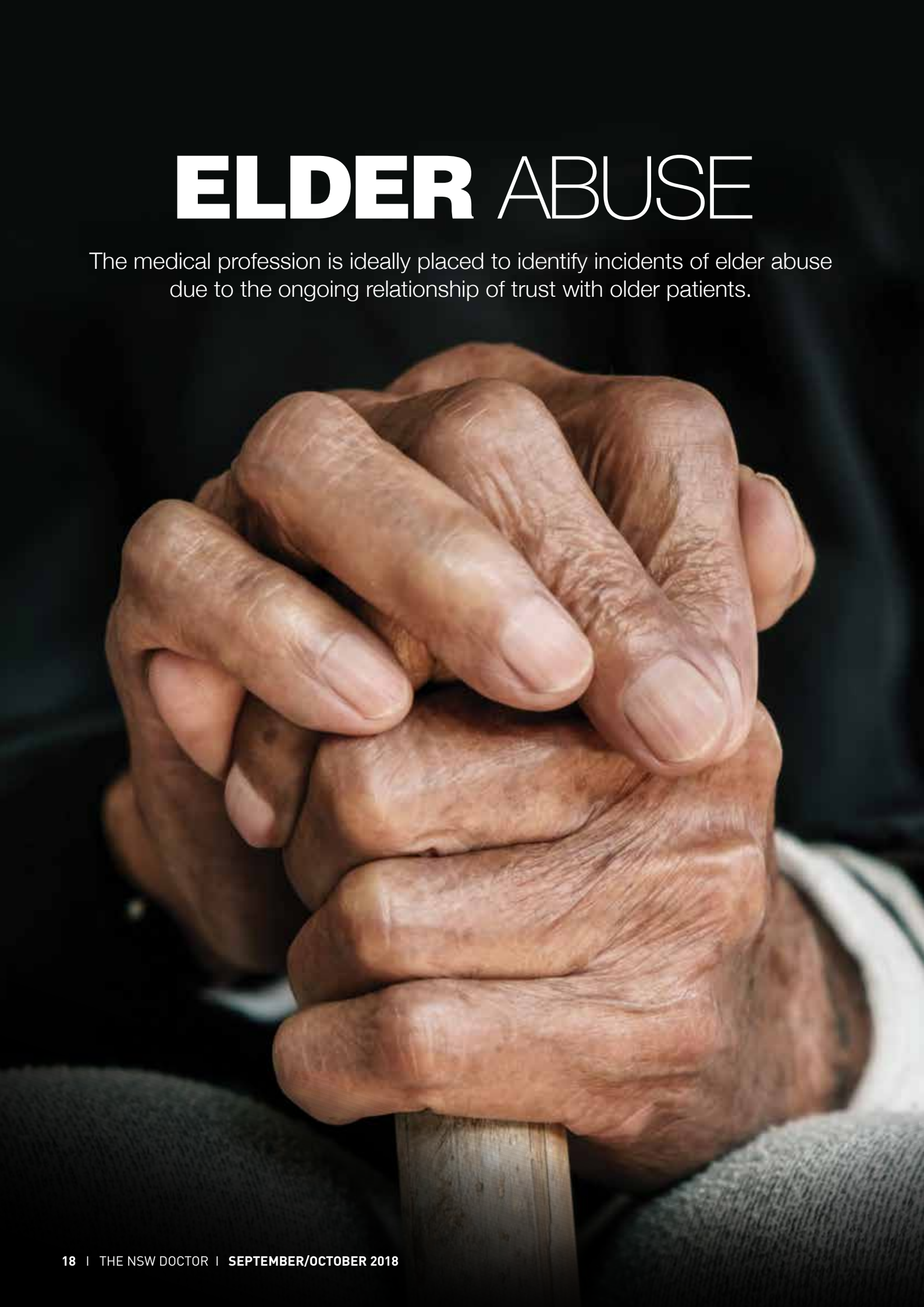
ONE OF Twitter's key selling points is that it gives you direct access to people you may not normally be in contact with – be that Ricky Gervais or Health Minister Greg Hunt.

And sometimes this leads to surprising outcomes. As was the case for Dr Tracey Tay who recently tweeted: "5.33am seems a good time to ask. Is it acceptable for a senior doctor on call to be "sleeping" on the floor of her shared office (literally) because the hospital does not supply any place for us to be horizontal, warm and safe? Note I've even left out "comfortable".

Dr Tay's tweet was shared 238 times, liked by 473 people and elicited 99 comments. She then tweeted a photo of her desk and commented "Nice! And I accept that I could have found a pillow somewhere instead of using my bag." These tweets caught the eye of AMA (NSW) CEO Fiona Davies, who helped organise a senior doctors' on call room at Dr Tay's hospital. This is the magic of Twitter. dr.

ELDER ABUSE

The medical profession is ideally placed to identify incidents of elder abuse due to the ongoing relationship of trust with older patients.



MEDIA reports of a growing epidemic of elder abuse in Australia underscores the importance of this issue and how it impacts upon both the medical and legal professions. This is particularly critical in the lead up to the Commonwealth Government's National Plan on Elder Abuse to be released at the end of 2018. The National Plan was a recommendation of the 2017 Australian Law Reform Commission report *Elder Abuse - A National Legal Response* (https://www.alrc.gov.au/publications/elder-abuse-report).

WHAT IS ELDER ABUSE?

Elder abuse does not have a single, legal definition. The WHO standard is often referred to, which defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person". Elder abuse can include physical abuse, emotional abuse, financial abuse, sexual abuse and neglect.

Older women are significantly more likely to be victims than older men, and most abuse is intergenerational (e.g. involving abuse of parents by adult children), with sons being perpetrators to a greater extent than daughters. Other common risk factors include when the older person has cognitive impairment or another disability, is isolated, or has a prior history of traumatic life events.

There is limited evidence as to the prevalence of elder abuse. The Australian Longitudinal Study of Women's Health (2014), one of the few studies to be conducted, estimated that approximately 8% of a cohort aged 85 to 90 had experienced some vulnerability to abuse. This study also assessed neglect at a rate of about 20%. Anecdotally, Community Legal Centres and Seniors Rights Services in Australia are seeing an increase in the number of elder abuse cases.

THE NATIONAL PLAN

In February 2018, Attorney-General Christian Porter announced that the Commonwealth Government would develop a National Plan to address elder abuse in Australia by the end of 2018.

The National Plan will have five goals: promote the autonomy and agency of older people; address ageism and promote community understanding of elder abuse; achieve national consistency; safeguard at-risk older people and improve responses; and build the evidence base.

In anticipation of the National Plan, the Seniors Rights Service in NSW recently released a report on 29 May 2018 following consultation with, and in conjunction with, community advocates, consumers, leaders and service providers *Abuse of Older People: A Community Response* (http://seniorsrightsservice.org.au/community-response/). This report is intended to set out an agenda from the ageing community to address and reduce the risk of elder abuse. It makes a number of recommendations for Government which are intended to feed into the development of the National Plan.

ROLE OF DOCTORS

The medical profession is ideally placed to encounter and identify early incidents of elder abuse due to the ongoing relationship of trust with older patients. Doctors are often in a position to question a patient if they suspect abuse as they may do for other forms of family violence.

Doctors, however, have been limited in their ability to deal with suspected abuse, particularly when the patient denies abuse or when there are concerns that reporting suspected abuse may either compromise a therapeutic relationship or result in further negative consequences for the patient. Doctors have also had a lack of knowledge about reporting or referral options. The Senior Rights Service Report identifies that there has been a limited amount of work done to date to provide early intervention strategies for those that are on the front line.

It is clear that more training would benefit doctors and all health practitioners who deal with suspected elder abuse. This could include training on how to identify abuse, particularly when the signs are subtle, and information on appropriate referral pathways. Screening tools have already been developed and there is currently a pilot study in NSW that aims to improve detection and support of older patients at risk of abuse (Elder abuse: The role of general practitioners in community-based screening and multidisciplinary action, Australian Journal of General Practice, Ries N & Mansfield E, Volume 4, No. 4, April 2018)

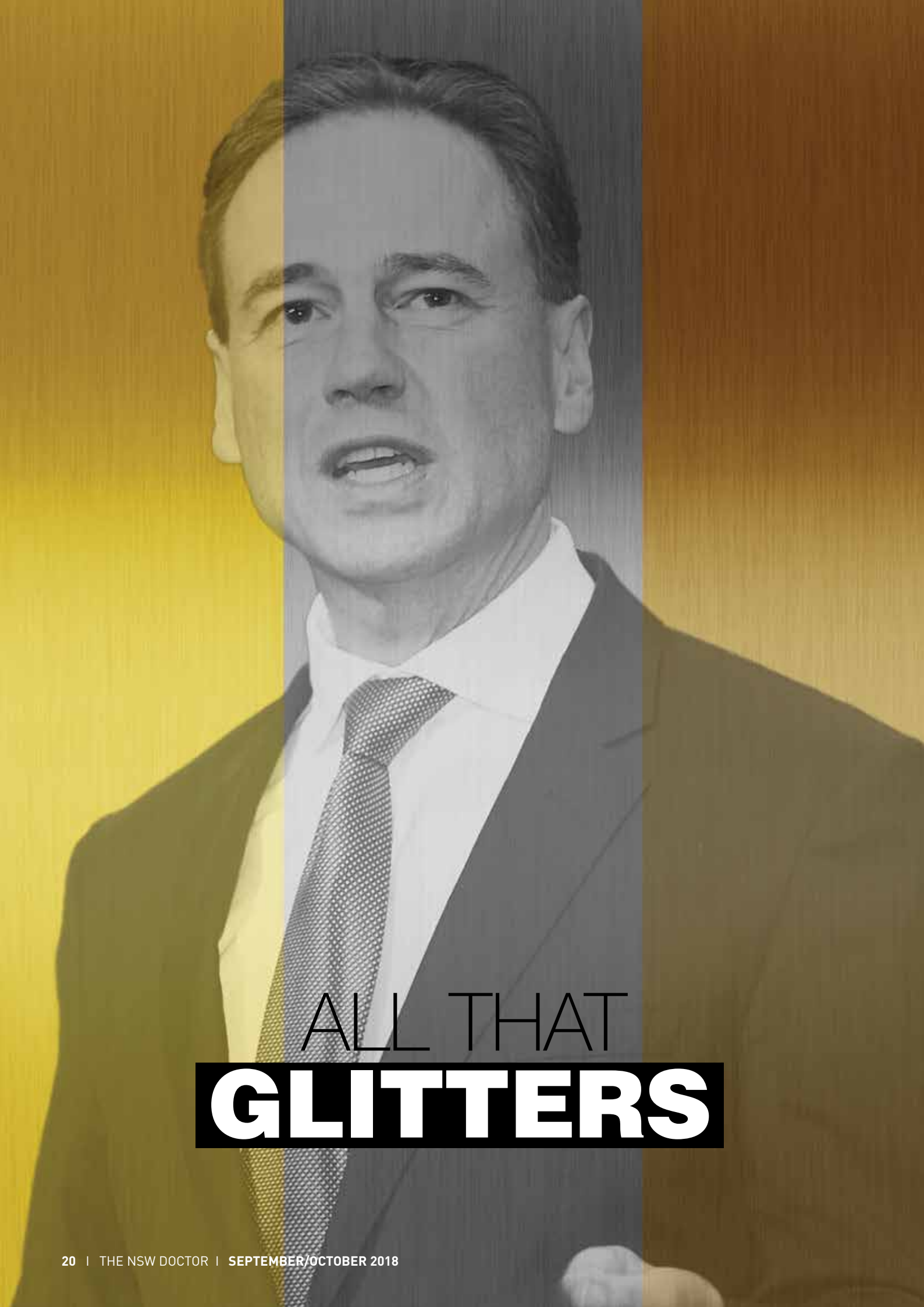
ROLE OF LAWYERS

Lawyers are increasingly advising on all aspects of elder abuse. The most common being financial abuse. Lawyers also need training to ensure that when preparing a will, power of attorney or other legal documents, that the client is competent to make a decision and can provide instructions. It is not uncommon for a lawyer to ask a doctor to assist in the assessment of a client's mental capacity. The lawyer should properly brief the doctor in that situation, so the role of both the lawyer and doctor is clear. The NSW Law Society released in May 2018 a pro forma letter for lawyers to use in requesting assistance from doctors in assessing mental capacity.

WHAT'S NEXT?

It is likely that the landscape with regard to how the Australian community deals with, and responds to, rising incidents of elder abuse will change over the coming years. It is becoming clear that with an ageing population, both doctors and lawyers will have to confront issues relating to elder abuse more frequently. Grappling with these issues now and providing some useful tools will make it easier to help patients and clients when they need help in the future. dr.

Contributed by Karen Keogh, Partner, HWL Ebsworth Lawyers and Kate Scott-Murphy, Senior Advocacy Officer, The Royal Australian & New Zealand College of Radiologists



ALL THAT GLITTERS

GOLD SILVER BRONZE

The Government's plan to clear up consumer confusion over private health cover with its Gold, Silver, Bronze and Basic categories has been met with mixed reviews from doctors' groups.

THE FEDERAL Government recently unveiled its new categories for private health insurance – Gold, Silver, Bronze and Basic – as part of a suite of reforms aimed at making private health cover more transparent and easier to afford for consumers.

Immediately after the announcement, doctors' groups raised concerns about the new reforms.

So what went wrong?

Few would argue with the necessity to make private health insurance simpler for Australians. There is a staggering array of policies and providers to choose from. A CHOICE report released in July last year found 44% of policyholders find it difficult to compare health insurance policies. Of these, 69% found it difficult to compare policies side-by-side.

According to consumer groups, rising premiums, coupled with concerns over value for money, and the opacity of the private health insurance products are to blame for the sickly slide in private hospital insurance coverage, which recently fell to its lowest level since June 2011.

Figures from the Australian Prudential Regulation Authority revealed 45.5% of the population had hospital cover in the March quarter of 2018, down from 47.4% three years ago. In real numbers, 37,000 people dumped their private hospital cover in the last year.

While confronting, the figures are not hugely surprising. Australians have been steadily downgrading or cancelling their private health cover in lock step with premium increases, which in recent years have been greater than inflation and wage growth.

As AMA President, Dr Tony Bartone outlined in his Press Club speech in July, "We are clearly at a crisis point in private health insurance. And the Government knows it."

When the Australian Government first announced its wide-ranging package of reforms back in October 2017, AMA welcomed the changes as a necessary measure to increase transparency and stem the flow of Australians ditching private health insurance. However, it noted that the challenge would be to clearly define and describe the products on offer to deliver consistent levels of covers in each tier.

The AMA has been involved with the Private Health Ministerial Committee, which was set up to provide government advice on the reforms. As part of the process, AMA provided a submission to the Department of Health regarding the draft clinical definitions that support the health insurance categories.

Enter Health Minister Greg Hunt and his magic sorting hat, which will help categorise the almost 70,000 policies into four groups. Each tier has a set of minimum standards which hospital cover policies must meet before it can be included in that category.

Under the new categories, Gold, Silver and Bronze policies will not have restrictions for included clinical treatments, with the exception of hospital psychiatric care, rehabilitation and palliative care. And only the new Basic category can have restrictions (outside hospital psychiatric care, rehabilitation and palliative care), which must be clearly indicated.

AMA lost its bid to rid the system of junk policies, which in recent years have flooded the market. These low cost policies cover a very small range of procedures, or allow patients to choose their own doctor in a public hospital, or cover accident and ambulance only. Often the restrictions and low levels of cover are not immediately clear to patients, and many take out limited policies only to discover they are are not covered for the treatments they need.

The AMA has recommended that if a basic policy is to be allowed, that these policies very clearly outline to patients what they are covered for.

The organisation was also disappointed by the Federal Government's decision to have pregnancy cover in the higher level of insurance only, given that many pregnancies are unplanned which

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AMA NEW SOUTH WALES

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heightens the possibility that people will be caught underinsured in this area. Pregnancy is one of the major reasons young Australians consider private health insurance, but they are less likely to be able to afford higher level policies.

Similarly, doctors from various specialties expressed concerns that the new categorised tier system may push patients onto public hospital waiting lists, as certain treatments for spinal, cataract, bariatric, some orthopaedic surgery and sleep studies will only be insured in the Gold category, despite some policies currently covering these treatments in lower tiers.

Orthopaedic and neurosurgeons stated that the categorisations will leave patients with a Cornelian dilemma, forced to choose between the spine surgery they need and the one they can afford. The current categorisation splits spine surgery between Gold and Silver bands, with spine stabilisation and fusion restricted to the top level of cover. The specialists argue that evidence overwhelmingly suggests spinal fusion is the most effective treatment for a number of elective and emergency spinal conditions.

"Splitting funding for spinal conditions between Silver and Gold will result in a patient's level of private health cover influencing clinical decision making," said Associate Professor Matthew Scott-Young, an orthopaedic surgeon.

Dr Bill Sears, Immediate Past President of the Spine Society of Australia and a Sydney-based neurosurgeon, argued that health fund coverage for spinal surgery should be across all policies.

"Australians who choose to take out cover for private spinal surgery are entitled to feel confident that they will receive the procedure that is best suited to their problem," he said.

The group also raised concerns that practitioners would be forced to opt for less effective procedures that could lead to poorer outcomes for patients, who could face a lifetime of chronic pain.

A number of professional medical associations lodged submissions to the Federal Government during its consultation process, highlighting risks with the proposed categorisations. Chief among these concerns was the potential unintended consequences that could arise from splitting the treatment of a single condition across different levels of cover.

Doctors warned that new framework would lead to treatment driven by item numbers, not by the best available evidence for the best possible patient outcomes.

The Australian Society of Ophthalmologists also expressed their disappointment that cataracts would be restricted to the Gold tier. Cataracts are among the most common elective surgeries, with 80,000 cataract extractions done in NSW public and private hospitals in 2016/17. According to the Australian Institute of Health and Welfare, 28% were performed for public patients.

The Australian Society of Orthopaedic Surgeons has suggested that Bronze policies should cover any accident or emergency treatment at a private hospital, while Silver should cover all elective procedures but with a higher excess payment, and Gold should cover all elective procedures but with no or low excess payments.

This recommendation is closely aligned with the AMA's suggestion that the Silver category cover everything, but with excesses.

Meanwhile, bariatric surgeons indicate restricting weight loss surgery to Gold cover will impact patients' ability to access the surgery, which is already limited in the public hospital system by a shortage of services. And ear surgeons are calling cochlear implantation surgery to be extended to the Silver and Bronze tiers. The Australasian Sleep Association has also argued restricting access to sleep studies could lead to significant health problems for patients.

At the time of writing, another round of consultation was underway with submissions due in early August.

The AMA is now in the process of working with the Colleges, Associations and Societies to give Government advice on the proposed rules, including clinical definitions and MBS item coverage under these definitions. dr.

CLEAR AS MUD

Distilling the wide variety of private health insurance policies into four different categories will make private health insurance a lot easier to compare, right?

Well, maybe not exactly. Because within each Gold, Silver, Bronze and Basic category, private health insurers can label products that meet the minimum requirements within that band, plus a few extras, as a 'plus product'. For example, you could have a Silver Plus product, which gives you the benefits outlined within the stated category, and few other things as well.

The addition of plus products, however, might be the best possible solution to an unintended consequence of the new system, which is that it disincentivises insurers from putting additional hospital services in a lower level product.

And yet another potential source of confusion for consumers is around quality of coverage. Lower benefits paid by the insurer mean higher out-of-pocket costs for patients. Patients may have a Gold policy and receive pregnancy cover, but what the fund pays the doctor varies. So, when doctors charge above the medical schedule, patients – even those on Gold cover – could face a gap, which may come as a surprise to some.

Patients often assume that the doctor's fee is the reason for an out-of-pocket cost. Yet, as the doctors know there can be a significant difference in the amount an insurer will pay towards a medical service, and it varies insurer to insurer and procedure to procedure.

All of this can can be confusing for patients, especially if not communicated early.

SESSIONAL VMOs DEMYSTIFYING REMUNERATION

There are three remuneration options for sessional VMOs to choose from, but each comes with its own advantages and disadvantages.

Andrew Campbell
MANAGER
INDUSTRIAL RELATIONS

ALL VMOs would be aware of the difference between a Sessional contract and a Fee-for-Service contract. Sessional VMOs charge for public patient treatment at an hourly rate, whereas Fee-for-Service VMOs charge a prescribed fee per procedure or consultation (currently 107.7% of the MBS). What many VMOs are not aware of is that under the VMO Sessional Determination there are three different options for remuneration. This article will explain each option, as well as some of the advantages and potential pitfalls of each.

It's important to note that there is no overall financial advantage of one option over the other as all three options will provide the same remuneration in the long run. For Options 2 and 3, a reconciliation must take place at the end of a specified period, being 12 months or less. Any over payments or under payments must be addressed at this time. All three options require the VMO to keep the same accurate and complete records of the time spent providing services to patients and the hospital.

OPTION 1

Budgeted actual hours remuneration

Option 1 is used by the majority of our VMO members. It is the typical model used in a principal and contractor relationship for professional services, with the additional requirement to estimate the number of ordinary rostered hours that will be completed in specified period, being 12 months or less. The VMO will record the number of hours spent each month providing services to public patients, as well as time spent teaching, training, participating in committees, and attending meetings at the request of the LHD. The VMO will submit a claim through VMoney and receive payment shortly after.

The key risk with this option is failure to address any underestimation of budgeted hours. The VMO should keep an eye on the number of budgeted hours left for the specified period and request any necessary increase as early as possible to avoid having to seek any retrospective adjustments. Note that on-call allowances and call-back payments are not included in the estimated budgeted hours.

If the VMoney checkers have any concerns with the claims, these concerns should be raised with the VMO prior to processing the claim. Please be in contact with AMA (NSW) if you have chosen this option and are facing difficulties with rejected claims, e.g. incomplete claim, hours worked in excess of budgeted hours, non-payment for call-back travel time, etc.

OPTION 2

Specified procedures remuneration

Option 2 is designed to accommodate VMOs who prefer to work under a fee-for-service type model. An assessment is made over the specified time period of:

i. The types of procedures to be performed;
ii. The number of procedures expected to be completed during ordinary hours; and
iii. The average time that the procedures are expected to take.

VMOs are then remunerated each month for the number of procedures performed in that month. Time spent completing non-clinical work and call backs, as well as payment for on-call allowances, are to be estimated separately and paid in equal monthly instalments. A reconciliation is conducted at the end of the specific period and adjustments are made as necessary.

OPTION 3

Agreed hours remuneration

Option 3 builds on the budgeted hours estimated in Option 1. The budgeted hours are divided into 12 equal instalments, providing a smooth monthly income stream for the VMO. In a similar fashion to Option 2, time spent completing non-clinical work and call backs, as well as on-call allowances, are estimated separately and paid in equal monthly instalments. A similar reconciliation is conducted at the end of the specified period.

Advantages and risks

Both Option 2 and Option 3 have the advantage of providing a smooth monthly income stream for the VMO. The three key risks to watch out for are:

a. Underestimating the number of patients who elect to have their procedure completed as private patients in the public hospital;
b. Overestimating on-call hours and the number of emergency procedures performed; and
c. Neglecting to keep accurate and complete records of each attendance.

Failure to accommodate for (a) and (b) can come back to haunt the VMO at reconciliation time, as any overpayment must be returned to the LHD. The administrative burden in challenging an alleged overpayment can be onerous. Without accurate and complete records it is difficult for a VMO to defend any overpayment claim.

Risk (a) provides further cause for concern for a VMO with respect to what is colloquially known as 'double dipping'. Federal and State healthcare agreements do not permit a VMO to receive payment from the NSW Government (i.e. the LHD) and the Commonwealth Government (i.e. Medicare) for the same professional service. Consequences for the VMO may include having to return the Medicare payment. Please call AMA (NSW) if you have concerns regarding this risk.

SUMMARY

While the majority of VMOs operate under Option 1, it is important to be aware of the advantages and disadvantages of the different models. Regardless of which option you choose, be sure to maintain meticulous records and keep an eye on your estimated hours and procedures as the year progresses. A copy of the Sessional Determination is available at http://www.health.nsw.gov.au/careers/conditions/Pages/v.aspx.

Should you have any further questions please contact Andrew Campbell at 02 9902 8125 or andrew.campbell@amansw.com.au.

ARE YOU **COVERED?**

PICTURE THIS SCENARIO: You're a consultant providing paid services in a public hospital and you sustain a workplace injury. Perhaps you slip and injure your ankle on a wet floor or damage your hand during a procedure. Would it be reasonable to believe that expenses associated with the injury are covered by a workers' compensation insurance scheme?

If you're a VMO you may be surprised to learn that the answer is likely 'No'.

VMO engagements have a number of characteristics that are similar to an employment model. However, since VMOs are deemed to be independent contractors under the Health Services Act, they aren't automatically covered by workers' compensation insurance. This is in contrast to Staff Specialists who are provided with coverage as employees of NSW Health, and have access to compensation for medical expenses, as well as paid leave provisions while recovering from injury. Should a VMO be unable to immediately return to work following an injury then the VMO will be unpaid for time away from the hospital.

As a VMO, it may be wise to consider personal accident and illness insurance to ensure that you are financially secure should any accident or illness prevent you from working. Insurance can provide cover for medical costs associated with the injury as well as income protection for the recovery period.

In addition, many VMOs may not realise that they wouldn't be covered by the Local Health District's public liability insurance policy. It is a requirement of many LHDs that public liability insurance is obtained by the VMO prior to accepting the engagement. Public liability insurance is distinct from the professional indemnity insurance you hold with an MDO. It's designed to provide cover in situations where you are found to be liable for the personal injury of another person, or liable for damage to property.

AMA (NSW)'s commercial partner, Specialist Wealth Group, can provide information regarding the types of insurance available to cover accidents and injuries in the workplace.

Please contact Robyn Bulless in Membership Services on 02 9439 8822 to arrange a no-obligation telephone consultation with Specialist Wealth Group to discuss your insurance needs.

SUPERANNUATION & VMOS

VMOs in NSW are deemed to be independent contractors by law, which many doctors mistakenly believe denies them access to superannuation. This is not always correct. While Fee-for-Service VMOs are not entitled to superannuation*, Sessional VMOs are entitled to superannuation if the following criteria are met:

- The VMO engages with the Local Health District using a Sessional Contract made under the Public Hospitals (VMO Sessional Contracts) Determination; and
- The VMO engages with the Local Health District as an individual or sole trader.

Sessional VMOs engaged using a sole-director practice company are not entitled to superannuation**. VMOs using practice companies would do well to seek independent professional advice regarding their engagement structure, as any perceived taxation advantages of the company structure should be weighed up against the loss of the 9.5% p.a. superannuation benefit. AMA (NSW) members may contact our commercial partners Cutcher & Neale and Specialist Wealth Group for a no-cost consultation regarding the financial advantages of different VMO engagement structures at 1800 988 522. dr.

*Fee-for-Service VMOs cannot claim superannuation because the relevant ATO ruling applies only to individuals who, amongst other factors, are not paid to achieve a 'result'.

**VMOs engaging in a manner other than as individuals or sole traders cannot claim superannuation because the legislation requires the recipient to be a natural person.

REJECTION OF VMONEY CLAIMS

AMA (NSW) has noted concerns from a number of VMOs regarding the rejection of lines in their VMoney claim without adequate explanation. As the concerns have been raised across a number of Local Health Districts, we've engaged with the Ministry of Health to consult regarding what we believe should be best practices for the checkers when processing a VMoney claim.

AMA (NSW) will assist the Ministry in creating an education and training package to better outline the information required by the checkers. A review of the existing VMO Claims Auditing Information Bulletin will commence shortly, and we welcome input from all members following any issues that you're facing with the current process.

Please contact Andrew Campbell at 02 9902 8125 or andrew.campbell@amansw.com.au if you wish to contribute to the consultation. dr.

MEMBER FEEDBACK

Are you affected by the below? Let us know.

- **NSW HEALTH has rescinded its policy on office accommodation for staff specialists, and have indicated a desire to move toward an 'open plan' or 'agile' workspace model. This will clearly affect Staff Specialists and may also impact VMOs, in particular VMO Heads of Department.**
- **Some PHI providers are publishing information regarding the average out-of-pocket fees charged by an individual specialist for episodes of care covered by that insurer.**

Contact enquiries@amansw.com.au if you want to comment on these issues. dr.

LOADINGS FOR FFS VMOS IN REGIONAL HOSPITALS

NOT ALL Fee-for-Service VMOs may be aware, but under the Determination there are additional loadings available beyond the 10% loading for after-hours call backs.

Where the medical service is provided in a hospital which has no Resident Medical Officer, Registrar or Career Medical Officer available as medical practitioner of first contact on a 24 hour a day, seven days a week basis, a fee-for-service VMO should be paid a 10% loading on top of the ordinary fee-for-service payment (currently 107.69% of the scheduled MBS rebate). This is regardless of the time of day and whether the service is pre-booked.

If a VMO ordinarily resides within a 50-kilometre radius of the regional hospital where an emergency after-hours service is provided, the VMO is entitled to a 20% loading on top of the ordinary fee-for-service payment. The loading drops to 10% if the VMO moves outside the 50km radius.

Should you have concerns that you're not being remunerated correctly and are unable to resolve the matter with hospital administration, please contact Andrew Campbell at 02 9902 8125 or andrew.campbell@amansw.com.au to discuss this further. dr.

RADIOLOGISTS: ARE YOU GETTING UNDERPAID?

RADIOLOGISTS may be getting paid much less for performing MRIs in CTP cases.

Under the current scheme (which is for people injured in a motor vehicle accident from 1 December 2017), the Motor Accidents Injuries Act 2017 indicates insurers are required to pay the AMA Fees list's maximum fee for MRIs in CTP cases.

The AMA rate for CTP MRIs is $1635. Although it is referred to as a 'maximum amount', Section 3.30 of the Injuries Act indicates that this is a set amount, not a cap.

However, some radiologists have flagged that they are only receiving $700, which is the discounted AMA Fees list rate for MRIs in Workers Compensation cases – not CTP cases.

SIRA states that it is common for insurers and service providers to negotiate fees where appropriate, and some insurers and service providers agree to use fees other than the AMA fees, which is allowable.

However, if you have not come to such an agreement with an insurer and you are receiving below the AMA Fees list rate for CTP MRIs, you are encouraged to raise the issue within the complaints process of the relevant insurer. SIRA will review the complaint if a resolution is not struck between the service provider and the insurer.

AMA (NSW) is currently seeking clarification on this issue with SIRA. dr.

The Motor Accident Compensation Act 1999 continues to apply for people injured in a motor vehicle accident up to and including 30 November 2017. Under this scheme, there is no limit set to the fees that are charged.

BAD DEAL: USE OF BROKERS

AMA (NSW) received complaints from a number of radiologists that insurers are increasingly using a broker to arrange bulk patient deals.

The broker offers radiologists a bulk number of referrals in exchange for a discounted fee for radiology investigations.

Some doctors expressed concern that this practice interferes with the treating doctor's ability to make a referral to the radiologist whom they deem best suited to meet the patient's needs. While this practice may benefit insurers' profit margins, it is not in the best interests of patients.

AMA (NSW) is seeking further clarification on this issue.

If you have any further information regarding this practice, or would like to raise any other issue with AMA (NSW), please contact our offices on (02) 9939 8822 or enquiries@amansw.com.au. dr.

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AMA NEW SOUTH WALES

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Can our **tax system** help your child buy their first home?

Home ownership is still the Great Australian Dream, and with these tax strategies, Cutcher & Neale can help you make it a reality for your loved ones.

Jarrod Bramble - Partner

With housing prices at an all-time high, entering the market can be a daunting process for many first-time buyers, especially when it comes to the initial and often hardest hurdle: saving for a deposit.

So what mechanisms are available within our current taxation legislation that can be used to assist you or your child into their first home?

Appropriate Practice Structure

Correct structuring can help you to accumulate wealth through tax efficient strategies (i.e. minimising your tax liability).

Whilst there are many models to choose from, under an appropriately structured service trust model, the final profit from operating the Practice can be distributed in a tax effective manner to Beneficiaries as directed by the Trustee.

This means rather than paying the top marginal rate (47% inc Medicare) you could distribute to your child at a lower marginal rate. On a $20,000 distribution, this could amount to a tax saving of $9,400 if your adult child earns no other income.

As always, there is specific legislation that governs the implementation of this strategy, so please seek professional advice before you make your move.

Efficiently Structured Investment Portfolio

The structuring debate can also stretch to your family investments and it is vital to understand the options available to you.

For example, a company has its profits taxed at 30%. A dividend could be paid to a family trust (which own the shares), with the distribution (and franking credits) then distributed to various Beneficiaries.

First Home Super Saver Scheme (FHSSS)

The FHSSS was introduced in the 2017 Federal Budget, as a means to get first home buyers into their first home sooner through voluntary superannuation contributions.

If the criteria for accessing the scheme are satisfied, the amount that can be accessed is based on voluntary contributions made after 1 July 2017. This is capped at $15,000 per annum and a $30,000 lifetime limit. The amount released will be equal to the contributions made less applicable 15% tax plus notional earnings as calculated by the ATO.

The benefit changes along with your income level, and it is generally more advantageous the higher your income is.

For those who are starting to save towards their first home, or for parents who want to assist their children in purchasing their first home, the FHSSS could be a valuable strategy to keep in mind.

Stamp Duty Concessions

For those residing in NSW, the Government's 2017 reforms in relation to Stamp Duty were massive developments for those looking to enter the market, and could save you (or your child) thousands of dollars when purchasing a first home.

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

Cutcher & Neale
ACCOUNTING AND FINANCIAL SERVICES

ADVERSE ACTION CLAIMS

Costly and easy to make, adverse action claims pose a significant risk to employers, but there are practical steps you can take to safeguard your business.

WE'VE ALL heard of unfair dismissal, anti-discrimination and anti-bullying laws. Yet many business owners still don't seem to know about the "adverse action" rules that have been part of the Fair Work Act since 2009. Adverse action claims can be far costlier for businesses than other types of claims, and much easier for workers to make. They also extend well beyond dismissal situations, potentially limiting how businesses make decisions, implement change, or exercise management discretion affecting their employees and contractors.

Adverse action claims are increasingly being made by people who are unhappy with management decisions or seeking an outlet for their disgruntlement. It's not uncommon for staff members who have been the subject of performance management or recently been terminated to make these claims. Employees may also use this type of claim to prevent an employer from going ahead with a restructure or change process they don't like.

Given that a single breach of adverse action rules can carry a penalty of up to $63,000 (on top of any compensation payable and other orders), we encourage members be aware of the risk and start learning what adverse action rules mean for them.

What is adverse action?

Adverse action is an extremely broad concept. Anything that "injures" a person in their employment or that prejudices their position could fall into the definition. It also extends to independent contractors (e.g. refusing to use a contractor's services) and to prospective employees (e.g. failing to hire them).

In practical terms, adverse action could potentially include investigating or suspending an employee, issuing them with a warning, reducing their hours, failing to offer them their preferred shift pattern, or limiting their access to training and promotion. It might also include something less obvious, like requiring them to change the way they perform their duties. For contractors, it might include ceasing to use or renew their services, or including unreasonable terms in their contracts. Threatening to do any of those things could also be adverse action and, unlike discrimination laws, there's no comparator test for adverse action, so it's not relevant to argue, "I treated them the same way I'd treat anyone else".

Is all adverse action unlawful?

No. Although adverse action includes many things, not all adverse action is unlawful. It is, however, unlawful to take adverse action against a worker because of a workplace right, or another prohibited reason. You can't take adverse action against an employee:

- because they have a workplace right (e.g. they are entitled to be paid a particular award rate)
- because they exercise a workplace right (e.g. they make an enquiry about their employment conditions, or complain about something at work)
- because they fail to exercise a workplace right (e.g. they don't elect to take overtime as time in lieu but want it paid at overtime rates instead)
- because they have a disability or temporary illness (e.g. they take time off work because they're sick)
- because they have some other protected feature (e.g. family responsibilities, pregnancy)
- because of industrial activities or relationships (e.g. because they're a member of a union or engage in union activities)

As well as workplace rights, other protected attributes include all the usual anti-discrimination attributes, including race, colour, gender, sexual orientation, age, physical or mental disability, marital status, family or carer's responsibilities, pregnancy, religion, political opinion, national extraction or social origin.

But that's not why I did it!

When faced with an adverse action allegation, many managers will acknowledge they did take adverse action. However, they'll deny they took that action for a prohibited reason.

Firstly, to be unlawful, only one of your reasons needs to be prohibited. So, even if you have a list of legitimate reasons why a warning is warranted, if you include even one unlawful point (e.g. the employee's history of taking sick leave), then the warning will be tainted.

Secondly, there's a reverse onus of proof. That means there's a presumption that adverse action was taken for an unlawful reason unless you can prove otherwise. If an employer or manager can't provide sufficient evidence to convince the court that their reason was not unlawful, the claim will succeed. Think about that for a moment – how would you prove that you didn't consider the employee's history of taking sick leave?

What about during probation?

Unlike unfair dismissal laws, there's no protection for employers during an employee's probation period. Even if an employee has been with an employer for less than six months (or less than 12

months in a business with less than 15 employees), the employee is still eligible to bring an adverse action claim against an employer.

What's the risk?

There's no cap on the compensation that can be awarded in adverse action cases. In unfair dismissal cases, the maximum compensation is six months' pay at the high-income threshold rate (currently $72,700), but compensation in adverse action cases could be much higher, depending on the circumstances. The court can also make other orders, including injunctions or reinstatement orders.

In addition, adverse action laws are penalty provisions, so there are fines for breaching them that apply on top of compensation or other orders. For a company, the maximum penalty per breach is currently $63,000. For an individual, the maximum penalty is currently $12,600. Even if the maximum penalties aren't awarded, prosecutions for adverse action usually include a number of different alleged breaches and a number of different respondents, so when you add up a few different penalties each for a few different managers, directors, and the employing entity, the fines can be really expensive.

What can you do?

Adverse action laws aren't supposed to prevent employers from making reasonable and necessary business decisions. They do, however, hold employers and managers accountable for their decision-making processes. The critical issue is to make sure you can clearly explain your valid reasons, and provide evidence demonstrating that your decision-making processes were robust and appropriate. You must ensure affected workers also understand and accept those legitimate reasons.

Here are some practical tips for minimising the risk of an adverse action claim:

✔ Slow down and think about what you're doing. Emotional decisions usually blur the real reasons for your actions and they're often based on untested assumptions rather than real facts. They also make it harder for you to say you considered all the relevant circumstances rationally (and disregarded the irrelevant, unlawful issues) before landing on your final resolution.

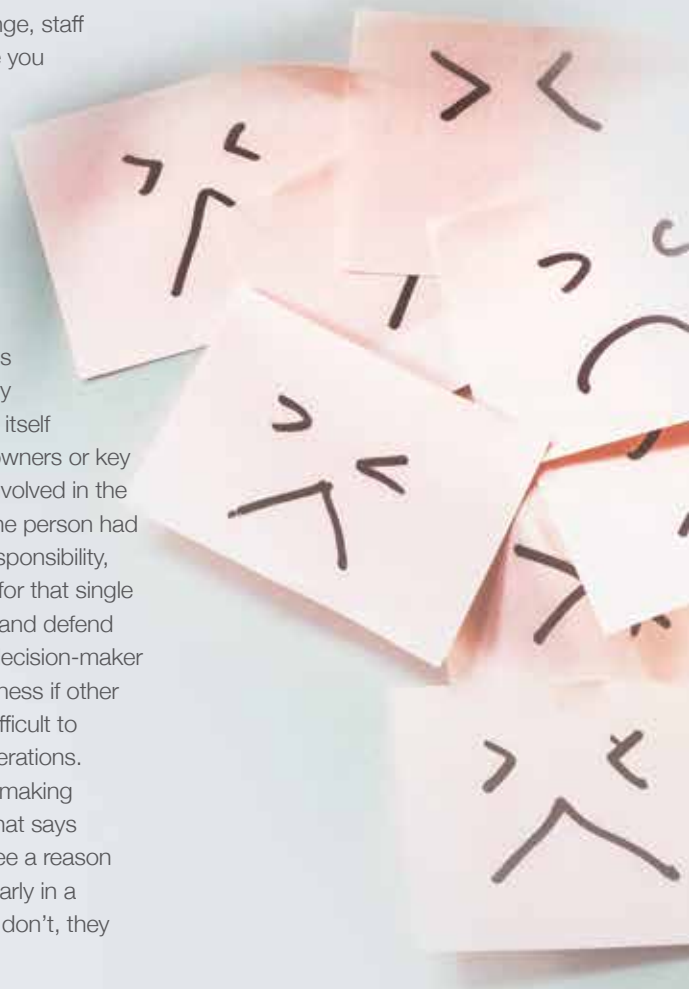
✔ Ensure you can explain why you're doing something before you do it. If you can't explain your actual reasons from the outset, then how will you be able to convince a court later that you didn't do it for a different, unlawful reason? Likewise, if you are relying on some form of complex analysis, then you need to be able to distil that into a simple, clear message that you can roll off like an elevator pitch, but back up with further detail if you need to.

✔ Consider the impact of your choices before you make final decisions. Even if you believe something is good for your business, the employees and workers affected by your actions may have a different perspective. Modern Awards include consultation provisions that require employers to consult with employees about major changes. However, consultation can also be really useful even when it isn't required. Even if you proceed with the change, staff members usually appreciate you listened to their views.

✔ Know who's responsible for particular decisions in your business and set up appropriate delegations where appropriate. For example, if you run a group practice and a worker makes an adverse action claim, they will usually sue the business itself as well as all the directors, owners or key managers they think were involved in the decision. However, if only one person had ultimate decision-making responsibility, then it will be much simpler for that single person to stand up in court and defend their reasons. Isolating the decision-maker can also help protect a business if other stakeholders would find it difficult to disregard illegitimate considerations.

✔ Document your decision-making processes. There's no law that says you have to give an employee a reason for dismissing them (particularly in a probation period), but if you don't, they may jump to conclusions that it had something to do with the sick leave they took last week. Likewise, if you're making a business decision, such as rolling out a new procedure, then it's helpful to be able to point to Board minutes or a business case document that shows what you took into account and why. dr.

The views and information provided in this article are of a general nature only and do not constitute legal advice. It is not tailored for your particular circumstances. If you would like specific assistance with issues raised in the article, please contact our professional services team on professionalservices@amansw.com.au. If we are unable to provide specific advice or legal services to you directly (or to do so within your desired timeframes), we would be happy to refer you to appropriate external providers. In that regard, AMA (NSW) has relationships with preferred providers who will generally provide a free initial consultation to our members.



There's no arguing that the rise in energy prices have had a huge impact on businesses across Australia, with business owners being forced to tighten their belts in order to stay afloat.

A recent enquiry by the *Australian Competition and Consumer Commission (ACCC)* found that electricity prices have nearly doubled on top of inflation in most parts of Australia over the last decade.

The reason for the price hikes can be attributed to a number of factors including high gas prices and limited gas availability on the East Coast, a lack of national energy policy, and the closure of large old generation coal-fired power stations without adequate replacement.

"Historically, energy markets have increased upon the closure of base load generation. The next major closure will be the Liddell power station in NSW. It has around the same capacity as Hazelwood in VIC did, but the difference between Liddell and Hazelwood is the fact that Hazelwood advised the market six months before the shutdown, which caused the market to enter into panic mode," said Doug Payne, Sales Director at Make it Cheaper.

Australian Small Business and Family Enterprise Ombudsman, Kate Carnell said, that while households are experiencing increases of approximately 15-18 per cent, for most SMEs it's above 20 per cent; and regardless of your political persuasion, "the energy system is broken and needs to be fixed, and we can't afford to see businesses close and jobs lost while governments and energy companies get their act together."

Over the past year, a number of reforms to the retail energy market have been put in place to help consumers survive this difficult period. However, the ACCC enquiry found that much more needs to be done in order to get the market back on track, and how long this will take is anyone's guess.

In the meantime, business owners are being urged to take advantage of the increased competition in the energy sector and switch to an energy plan that better suits their needs.

But with consumer confidence at an all-time low, it appears that many customers have given up trying to navigate complex pricing structures and complicated policies filled with technical jargon and discount claims that are hard to compare and conditional. But this is not the solution and will only result in more financial strain being placed on business owners.

To combat rising energy costs, business owners are being encouraged to employ energy management specialists to manage their energy contract and identify competitive market rates that are suited to the operational requirements of the business. Energy brokers take the time to understand their customers' needs to ensure that the energy contract they sign up to delivers cost savings, as well saving the business owner time now and well into the future.

Throughout 2017, energy specialists Make it Cheaper found that **85% of New South Wales businesses** were overpaying on their energy bills, and in that year alone identified savings to the value of **$5,456,452** - an average saving of **$1,100 p.a.** for each participating business.**

To find out whether you could be reducing the costs of your practice's energy bills, go to **bit.ly/AMA_NSW** or contact **(02) 8077-0196**.

**Analysis undertaken across 4,960 individual NSW business meters.

AMA NEW SOUTH WALES

make it cheaper the saving experts

PRESIDENT'S CUP 2018

Clear blue skies on an early winter's morning greeted 40 players at St Michael's Golf Course to contest the 2018 President's Cup.

President's Cup Winner

WAYNE MAYBURY WITH DR GEORGE THOMSON

President's Cup Runner Up

DR GEORGE THOMSON WITH DR ROBYN NAPIER

THE PRE-MATCH breakfast was excellent and worthy of mention as the players gathered in the clubhouse. This idyllic scene was made even more welcoming by the sight of migrating whales just off the coast. It was then time to face the challenges of the course. St Michael's was at its pristine best. Fairways wide and welcoming and pin placements that demanded the very best of approach shots. A golfer's dream.

It didn't take long before the dreams of our golfers were shattered. The course threw down the challenge and, regrettably, very few of our team met it. As a measure of the level of broken dreams, the average stableford score for the group was 25 points. For the information of non-golfers, that is appalling, particularly when considering the quality of our group, made up as it is of players on low handicaps from some of the leading courses in the State.

The winner of the individual event was Mr Wayne Maybury with 40 stableford points. Runner-up with 33 points was the President of the AMA (NSW) Golf Society, Dr George Thomson. Winners of the 2BBB were Dr William Benz and Mr Wayne Maybury with 44 points. Runners-up on 41 points were Dr Alan Home and Dr Malcolm Patch.

Both nearest-the-pins were won by Mr Wayne Maybury – a clear indication that Wayne was certainly in the zone for St Michael's on the day.

For our many members who fervently follow Dr Alec Harris I can only say that, as always, he acquitted himself well, but on the day was just desperately unlucky. On the other hand, his brother Don – who is a great supporter of the Golf Society – played well, but sensational is not a word that would describe his day out.

A very special thanks must go to the staff at St Michael's and, in particular, the Secretary Manager, Mr Geoff Wagner, who oversees proceedings to ensure all visitors have a memorable and enjoyable day.

The next AMA (NSW) Golf Society event is the Spring Cup to be held at one of our very popular courses, Stonecutters Ridge on Friday 14 September with an early morning start.

In the meantime – good golfing to all. dr.

AMA (NSW) Golf Society Calendar of Events 2018

Spring Cup – Friday 14th Sept
Stonecutters Ridge Golf Club

BMA Cup – Tuesday 11th Dec
(revised date)
Terrey Hills Golf Club

AMA (NSW) Golf Society
Claudia Gillis
Phone: 9439 8822
Email:
amagolf@amansw.com.au

A warm welcome to all of our NEW MEMBERS

AMA (NSW) provides services tailored for doctors' needs, to help you concentrate on your clinical work. AMA (NSW) and its partners can help you with workplace issues, finance, insurance and more. To find out more, phone our membership team on 02 9439 8822.

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Dr Victoria Bray
Dr Vinay Kulkarni
Dr Yew-Chin Lau
Dr Yulia Bedretdinova

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

Dr Alice Palmer
Dr Basil Ireland
Dr Dudley Jacobs
Dr Gerald Viset
Dr John Tonkin
Dr Keith Sharrock
Dr Robyn Young
Dr Ronald Rivett

CALL FOR **VOLUNTEER** DOCTORS

Take part in a rewarding opportunity to join a new medical, nursing and dental team going to provide health care to communities in Leyte in the Philippines, which was devastated by hurricane Yolanda in 2013, leaving 1.4 million people homeless. Trip organisers Trips+ have partnered with a local NGO (Operation Blessing) to visit three communities around Leyte to provide basic medical care. Guided local tours, accommodation, transfers and a short island resort holiday included in the cost of the trip.

DATES: 19 TO 28 JANUARY, 2019

For more information go to the Trips+ website, or contact Justin Pagotto from Trips+ on 0428 389 392.

AMA NEW SOUTH WALES

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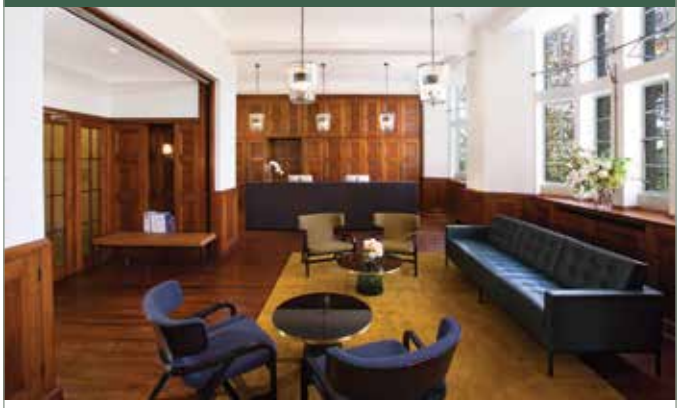

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PREFERRED PARTNERS

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

Specialist Wealth Group | Specialising in financial advice exclusively to medical, dental and veterinary professionals, Specialist Wealth Group customises holistic solutions across financial planning, insurance, estate planning and finance advice on superannuations. Specialist Wealth Group understands your profession, and can help you accelerate your financial future, from interns to specialists.

Commonwealth Bank | Whether you're looking to purchase a property, your first practice, improve your business operations or expand the range of services you offer, our Premier Banking and CommBank Health teams can help get you where you want to be. Our Relationship Managers can take you beyond day-to-day banking as you continue to build your health business and help secure your financial future.

Prestige Direct | Our philosophy is to keep it simple, keep our overheads down and provide quality cars at competitive prices. So if you're looking for a great deal on your next prestige car enquire about Prestige Direct.

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

MEMBER SERVICES

American Express | Corporate affinity programs and discounts on Gold, Platinum Edge and Platinum credit cards. You'll enjoy the special benefits and extra value we've negotiated for you.

Qantas Club | Discounted rates saves you hundreds of dollars on membership. Joining fee $247.38, save $151.62; one year membership $415.80, save $124.20; two year membership $754.60, save $225.40.

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.

Virgin Australia – The Lounge | Significantly reduced rates to the Virgin Australia Lounge for AMA members and their partners. Joining fee is $160 (save $170) and annual fee is $325 (save $95).

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

Make It Cheaper | Make it Cheaper can run a free energy bill comparison for you and help you find a competitive deal and save. Call 02 8077 0196 or email amansw@makeitcheaper.com.au for a free quote.

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

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

Audi Corporate Programme | AMA members are now eligible for the Audi Corporate Program, which gives members a range of privileges, including AudiCare A+ for the duration of the new car warranty, complimentary scheduled servicing for three years or 45,000km, and much more.

Mercedes-Benz Corporate Programme | Members can enjoy the benefits of this Programme which includes complimentary scheduled servicing for up to 3 years/75,000 km, preferential pricing on selected vehicles and reduced dealer delivery charges. Also included is access to complimentary pick-up and drop-off, access to a loan vehicle during car servicing and up to 4 years of Mercedes-Benz Road Care nationwide.

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

Alfa Romeo | Alfa Romeo's® Preferred Partner Program gives members significant discounts across the Alfa Romeo® range. Go to www.alfaromeo.com.au/fleet and use your Preferred Partner Login.

Persian Rug Co. | Persian Rug Co. stocks Australia's largest selection of over 10,000 handwoven rugs, including complete collections of authentic traditional, village, tribal, kilim & designer pieces. Our team has excellent experience working alongside clients to provide beautiful handwoven rugs to meet their unique residential and commercial requirements. Members receive a 20% discount on online and in-store purchases.

Call AMA (NSW) member services on 02 9439 8822 or email services@amansw.com.au. Visit our websites www.amansw.com.au or www.ama.com.au

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We're dedicated to delivering you outstanding choice, value and service.

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Value: We keep out-of-pockets and rate rises to a minimum. In 2018 Doctors' Health Fund announced the lowest published rate increase of all the health funds, and in fact it's our sixth consecutive year of below industry average increases*.

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Thomas - NSW Doctors' Health Fund member^

Call **1800 226 126** and speak to one of our experts today or visit **doctorshealthfund.com.au** to get a quick quote.

* Averages published by the Department of Health http://health.gov.au/internet/main/publishing.nsf/content/privatehealth-average-premium-round. Individual premium increases may vary from the average due to impact of the PHI rebate and product claims experience.
^ Doctors' Health Fund Member Survey 2018.
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