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THE NSW doctor

AMA NEW SOUTH WALES

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TRANSPARENCY IN MEDICINE

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The Australian Medical Association (NSW) Limited
ACN 000 001 614
Street address
69 Christie Street
ST LEONARDS NSW 2065
Mailing address
PO Box 121, ST LEONARDS NSW 1590
Telephone **(02) 9439 8822**
Outside Sydney Telephone **1800 813 423**
Facsimile **(02) 9438 3760**
Outside Sydney Facsimile **1300 889 017**
Email **enquiries@amansw.com.au**
Website **www.amansw.com.au**
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Editor
Andrea Cornish
andrea.cornish@amansw.com.au

Designer
Gilly Bibb
gilly.bibb@amansw.com.au

Advertising enquiries
Andrea Cornish
andrea.cornish@amansw.com.au

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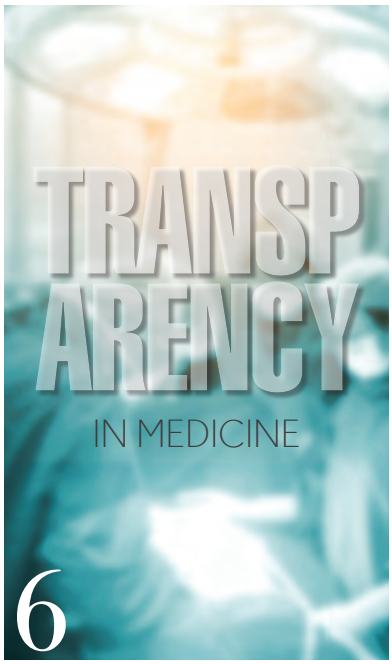

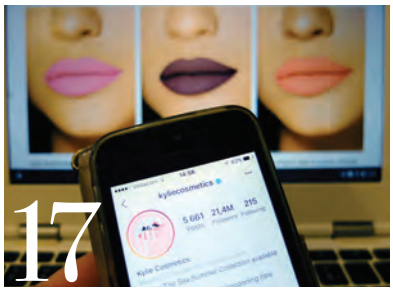

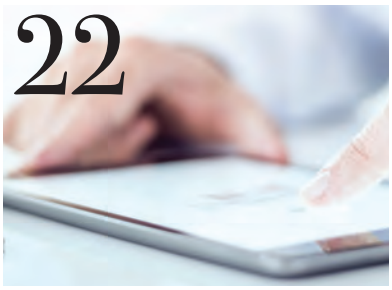

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DATA AND MEDICINE

Big data is changing almost every aspect of our lives, including healthcare. How we, as a profession, respond to this challenge will shape how that information is shared publicly.

Dr Kean-Seng Lim
PRESIDENT
AMA (NSW)

MEDICINE IS OFTEN accused of being slow to respond to changes in society and technology. While this is not universally true, it is probably fair to say that models of care have not evolved substantially over the last 100 years. Regardless, the environment in which we practice continues to evolve, driven by increasing access to information and data, and changing consumer and payer expectations and behaviour.

The easy accessibility of information and reviews has changed the way we, as consumers, make choices regarding our purchases and how we shop. We can research potential acquisitions prior to purchase, rating them on a multitude of criteria we select based on available information ranging from technical specifications to user reviews and price. We can then choose where to purchase a product ranging from traditional bricks and mortar shops to online outlets.

So how does this look in the world of healthcare?

Patients are able to review medical practitioners on doctor ratings websites, such as Whitecoat and Healthshare, as well as through the review mechanism on Google. The Commonwealth has also proposed the development of a website on medical fees to help patients gauge potential out-of-pocket costs for common services. The move has been followed by Medibank, which recently announced it would be providing specific information about potential out-of-pocket costs doctors charge for common procedures. Its 'Find a Provider' website already provides information on how often a specialist charges and out-of-pocket costs by percentage of claims.

We know private health insurers have extensive data available to them. As a general practitioner, my clinical software allows me to not only view the contact details of a referred specialist, but also details such as the number and percentage of patients who have been billed under a no or known gap arrangement with a specific private health insurer. I have patients who have refused to see a particular specialist after looking up his/her review online.

While there can be debate on the validity of available data, it is clear that it is out there, and it is being used. It is also clear that what is currently available may not provide the best basis on which to make decisions. Google reviews are based on anecdotal patient experience. While they may help consumers learn whether the practice has good parking, or the doctor is a good listener – they do little to provide objective evidence about the quality of care being provided by the practitioner.

This is our challenge.

Alongside consumer reviews and demand for transparency around fees, we are increasingly seeing a push for transparency around outcomes.

In general practice, the Quality Improvement payment of the Practice Incentive Program will now require the uploading of deidentified clinical data on a range of measures such as completeness of data, recorded rates of influenza immunisation and patients with diabetes who have had their HbA1c recorded.

The data is out there. But how will it get used and who will control how the information is contextualised and presented to the public?

Data and digital disruption is part of the world we live in. Our challenge as professionals, and as an association, is how we manage this.

If we don't, other organisations – such as private health insurers – will step in to fill that void. We need to take ownership of this space, with a mature and balanced approach to data and transparency. dr.

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REPORTING OUTCOMES: ON WHOSE TERMS?

Whilst there is a recognition that reporting clinical outcomes is hugely challenging, it is diffiicult to ignore the growing consumer appetite for quality data.

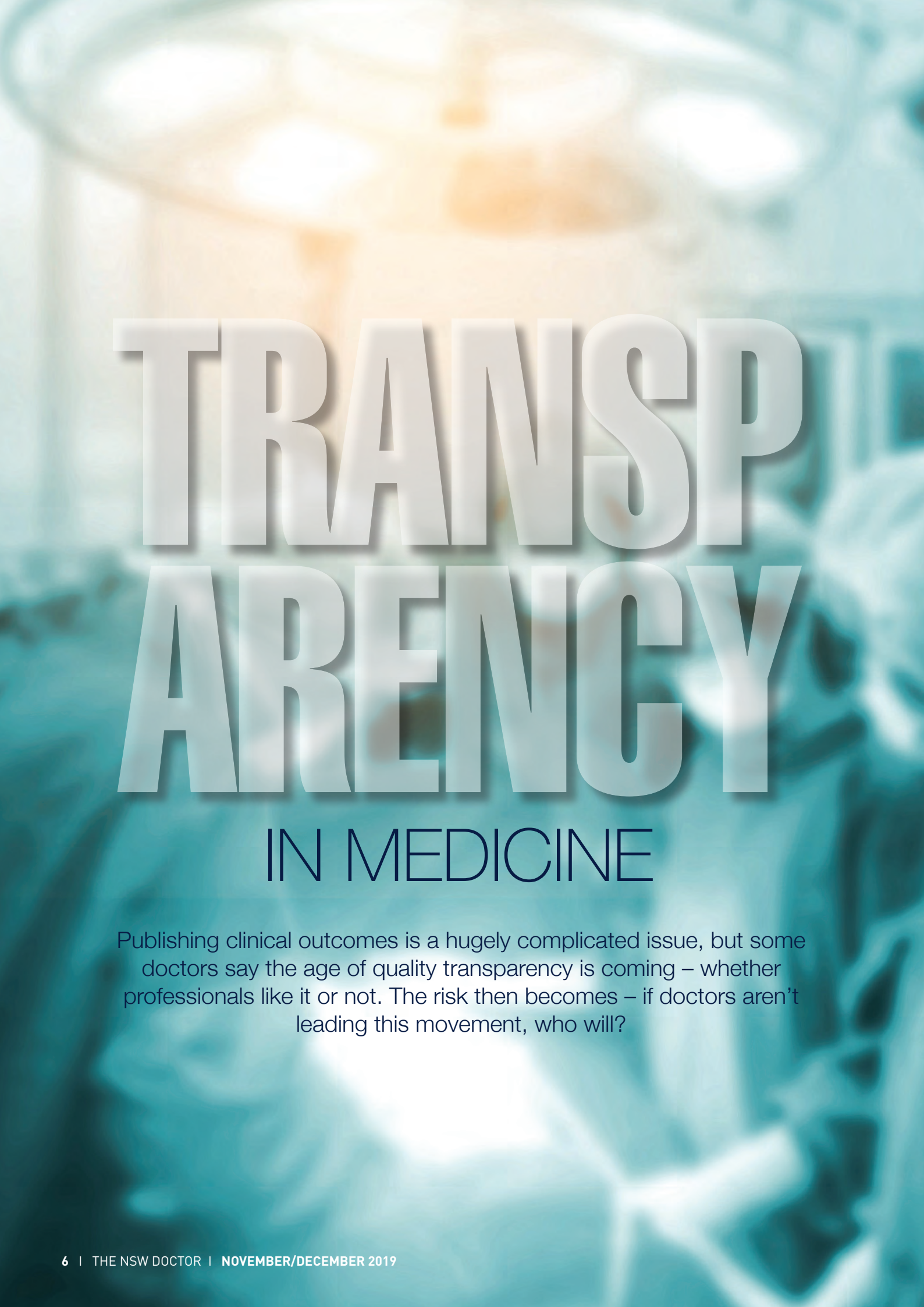
Fiona Davies
CEO
AMA (NSW)

IN THIS EDITION, we delve into the incredibly challenging issue of data and transparency in healthcare. For a profession with as many different opinions as there are doctors, nothing is more certain to spark fierce debate than the topic of data and reporting. We have felt considerable trepidation in even deciding to cover this issue, such is the strength of the views. In doing so, we are not seeking to take a position but instead recognise that this is an important issue facing the profession. If there is one simple truth from this topic of discussion, it is this: as doctors, you will all be reported on or reviewed, the only question is 'on whose terms'? At the moment, it appears that it is going to be entirely on someone else's terms – be it private health insurers, governments or patients who don't understand the key elements to the provision of quality care. That seems to be the worst of all outcomes.

We are genuinely interested in the views of members about the best way forward in this space and we want to actively encourage feedback and debate. This is a challenge which requires the collective wisdom of all members and we look forward to that input.

Speaking of challenges, we note with significant concern the intervention of SIRA to review fees for patients injured at work. We meet with SIRA regularly and remain constantly vigilant about attacks on the profession regarding independence and appropriate payments. I was personally involved in the first negotiations to establish the AMA List of Fees as the basis of the schedule for injured workers. It is an essential right for employees injured at work to be able to access specialist GPs or other specialists and we will be fighting for that right. dr.

fiona.davies@amansw.com.au



TRANSPARENCY IN MEDICINE

Publishing clinical outcomes is a hugely complicated issue, but some doctors say the age of quality transparency is coming – whether professionals like it or not. The risk then becomes – if doctors aren't leading this movement, who will?

BEFORE INSTANT REPLAY, 3D rendering, and hot spot technology, sports officials were Gods.

Their decisions were final. Coaches, players, and fans could shake their fists and throw their hats to the floor in disgust, but at the end of the day they had to suck it up. A call – even a bad call – was ineradicable.

But as technology evolved, multiple camera angles combined with frame-by-frame reviews gave sports fans a vantage point that was sometimes superior to that of the umpire or referee.

Almost overnight, the mist on the mountaintops where sport officials were revered completely dissipated, and transparency became the new buzzword.

A good case study on transparency is the US National Basketball Association. NBA referees are arguably one of the most analysed professionals in the world.

In 2015, the NBA started publishing the 'Last Two Minutes' – officiating reports that contain reviews of every call (or non-call) made by referees in the final two minutes of close games. The reports include the call type, committing and disadvantaged players, comments, the review decision, and a link to the video of the play. For the first time in print, referees' mistakes were laid bare for all to see.

While referees may have been nervous about it initially, it has allowed them to dissect their performances and, ultimately, improve.

Data not only reveals mistakes; it can reveal bias. Even prior to publishing the Two Minute Reports, the NBA has been using data to reveal whether referees' calls were biased on certain factors. Did they favour the losing team? Were they more likely to benefit the home team – thus the long-held theory of 'home court advantage'? Did they have an implicit or unconscious racial bias? A study published in the *Quarterly Journal of Economics* in 2010 found they did. Specifically, their research found white referees tended to call more fouls on black players, while black referees tended to call more fouls on white players. However, after being made aware of their implicit bias, referees changed their behaviour. Later studies revealed a significant reduction in this type of implicit bias.

In 2017, the NBA expanded its focus on data-driven game review with the intention of creating objective referee measurement standards and track the progress of call accuracy and errors per game over multiple seasons.

Has data made NBA refs perfect? No. But they now have about a 95% accuracy rate on all calls and non-calls, which they've been able to maintain for the last few years.

Moving beyond basketball – AMA (NSW) President, Dr Kean-Seng Lim argues we should be applying the same principles of data-driven performance to medicine.

"If we are looking at a world where there is increasing transparency and accountability, then we as individuals and we, as an organisation, probably need to be thinking about that," he says.

**If you're really keen to hear more about NBA officials, instant replay and call accuracy, listen to Michael Lewis' podcast* Against the Rules *– a fascinating seven-part series that unpicks Americans' relationship to authority and rules.*

AMA POSITION STATEMENTS: INDICATORS AND OUTCOMES

The health system has been looking at clinical and performance indicators since the 1980s. In the last four decades, clinical indicators have been developed for specific diseases and services, as well as patient safety and clinical governance areas.

Quality improvement is supported through several mechanisms, including the Australian Commission on Safety and Quality in Health Care (ACSQHC), Federal Government funded practice incentives, audit and peer review processes, accreditation, and continuing professional development.

The AMA's Position Statement on Clinical Indicators, developed in 2012 and revised in 2016, states, "Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritisation, and when assessed over time, provide a method of assessing the quality and safety of care at a system level."

In 2016, the AMA also released its Position Statement on Measuring Clinical Outcomes in General Practice.

In this statement, the AMA echoed the ability for clinical outcomes to be used to improve quality in healthcare.

"Medical practitioners use outcome measures intrinsically to assess when treatment should be changed, referred to another, or discontinued. While outcomes may not be the only measure of quality, they by and large provide the ultimate validation of the effectiveness and quality of medical care."

Measuring outcomes involves using clinical indicators across several areas. This includes patient reported outcome measures (PROMS) and patient reported experience measures (PREMS). AMA's position statement on clinical outcomes notes, "Medical practitioners have generally been more comfortable with the use of clinical indicators which measure practice processes and clinical activities, as these are components of care that can be reliably measured and that clinicians have more direct control over."

TRANSPARENCY IN HOSPITALS

While patient groups are increasingly demanding greater insight into safety and quality measures in hospitals, the drive for transparency at the individual clinician-level has raised concerns within the profession. What does the push to report surgical outcomes mean for proceduralists?

Public reporting on outcomes in medicine is a difficult topic, and while there are benefits to patients – and potentially to doctors – it is not without some significant risks to medical professionals. It also impacts doctors differently depending on their area of specialty, their stage of career, and their patient demographics. While there are many facets to this discussion, for simplicity we've divided this article into two: transparency at the secondary/tertiary level and transparency at the primary care level, which we will cover in a later issue. This article will look at reporting at both the hospital and individual clinician level.

WHEN MEDIA reported on obstetrician and gynaecologist Professor Stephen Robson's decision to publish surgical outcomes data, the reaction from the medical community was mixed.

Australia's Chief Medical Officer, Professor Brendan Murphy, applauded the move toward transparency.

"Any doctor claiming superiority has an obligation to provide the data to back that up," Professor Murphy told the *SMH*. "The overall standard of surgeons in Australia is very good, but there are some surgeons at the top of their specialties that are probably worth paying more for, and they are certainly not necessarily the people currently charging very high fees."

Professor Robson said his decision to publish the data was not made lightly. After a period of deliberation, he published a five-year audit of his surgical practice on his website, detailing the number of surgeries he had performed and benchmarking his complication rates against clinical indicators published by the Australian Council on Health Standards.

He told the *SMH,* "I just thought 'oh, bugger it'. It's time for me to help patients make an informed decision about the quality of care they get and maybe I can inspire my colleagues to do the same," he said.

"Surgery is like sex: everyone talks up their performance," Professor Robson added. "But getting the objective data to verify their claims is much harder to come by. When something is veiled in secrecy it can feed mistrust and anxiety."

However, the Royal Australasian College of Surgeons (RACS) did not support the move. The College warned that the data could be misinterpreted by patients and there was a risk that this type of reporting could lead to comparisons between doctors that would unfairly rank those who took on more complicated patients, or doctors at the beginning of their careers would be unfairly judged. It also warned there could be a temptation to "cherry pick" less complicated cases.

PUBLISHING OUTCOMES

Dr Fred Betros strongly supports collection of clinical data on patient outcomes, but suggests his concern (and that of others) is, how would it be used?

"The collection of data on patient outcomes is nothing new – it is what we are doing with it that is the main issue here," he says.

"There is a real fear within our profession, that this type of reporting can be seen as having a 'witch-hunt' mentality. I believe that identifying a problem on its own is worthless. If you look for problems actively, you also need to be part of the solution and have a means to help rectify the situation."

WHAT ARE THE BENEFITS?

Public health experts and health consumer groups argue there are a number of benefits to publishing clinical outcomes, including increased transparency for consumers which heightens a patient's ability to make an informed decision about their healthcare, as well as opportunities for clinical improvement.

The Australian Commission on Safety and Quality in Health Care published a study "*Public reporting of safety and quality in public and private hospitals,"*

in March 2019 which examined findings from expert groups, as well as consumer and clinician focus groups to inform options for national reporting standards of safety and quality in health care across public and private hospitals in Australia.

The report's findings speak to a consumer appetite for greater transparency around safety and quality information.

In looking at reasons why safety and quality information should be reported publicly, consumer focus groups believed it would allow patients to make more informed choices.

At the moment, there is little objective and transparent information available. In the absence of such information, many rely on information given by the healthcare system and healthcare providers, as well as the opinions of friends and family who have had similar experiences.

Consumers also indicated the reporting of safety and quality information would compel hospitals and providers to improve coordination of care, as well as processes and communication.

In addition, the consumer groups felt public reporting would arm patients with information about potential or actual areas of safety concerns within hospitals.

Lastly, consumer groups in the report suggested hospital-level information was a good first step, with a view toward clinician-level reporting.

Clinician focus groups, however, did not agree with clinician-level reporting, with one interviewee noting this "elevates the importance of one person above the clinical team".

Clinician focus groups in the report did stress that public reporting of safety and quality information at the hospital-level would provide several benefits, including driving improvements in clinical quality and promoting transparency which would support patients in decision-making.

Clinicians also noted that in the absence of good public reporting, too often the gap is filled by overwhelmingly negative media stories. Public reporting was also cited as a means of enabling GPs to provide an objective assessment of performance between hospital providers and refer their patients accordingly.

The found data collection and reporting arms patients with information to make better decisions about their own healthcare. This includes the role GPs have in providing advice to consumers.

According to Dr Betros, "First and foremost, ensuring best outcomes for our patients should always be the leading benefit of this type of data collection / reporting. A patient should be reassured that when they see a practitioner, that doctor can benchmark themselves against their peers in an objective and data driven way. Additionally, in the long run this also protects the practitioners. It indicates to the purchaser of that care (whether it be the patient, Medicare, private insurers or the public hospital system), that there is real value in the service provided."

WHAT ARE THE CHALLENGES?

Publishing clinical outcomes is not without its challenges.

While the AMA supports mechanisms for quality improvement, it cautions against the misuse of clinical indicators in its AMA's Position Statement.

"There is an inherent danger that a focus on achieving clinical indicators and performance against them diverts attention from patient care. This danger is particularly present if outcomes measured against clinical indicators are used to; dictate or impose levels of safety or quality or for pay for performance purposes."

Other dangers, as highlighted by the RACS, are that some practitioners could be unfairly judged for taking on more complicated patients, or doctors at the beginning of their careers might be deemed less competent. There are also concerns some doctors might avoid high-risk cases. In addition, there could also be a tendency to over-treat patients and ignore whether that's in the patient's best interest.

Dr Betros stresses that if public reporting of outcomes was to become more commonplace, we would need to find a way to use this data to improve the care provided by practitioners who sit outside of the data norms.

One other potential challenge, which was cited by several clinicians in the ACSQHC's "Public reporting of safety and quality in public and private hospital report" was that decision-making processes could be hindered by fears of negative consequences.

The report noted, "Several clinicians across all clinician focus group forums commented that a significant potential barrier to public reporting was the lack of political will to publish information. The potential for negative consequences from poor performance was viewed as impacting the decision-making process and hindering more transparent sharing of information."

It is also noted by clinicians, that in team-based care scenarios, it is difficult to separate performance of one clinician. If there is a bad outcome, who's fault is it?

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One potential alternative would be to report outcomes at a hospital ward level, or another option would be to report outcomes by grouping clinicians by speciality within a hospital, but there is no consensus within the medical profession to wholly support those options.

AMA's Statement on Clinical Indicators is clear that performance data should not be used for promotion or disparagement.

It also states that the selection of clinical indicators to be used for quality improvement "should be entirely voluntary" and driven by the local level as this improves the scope "for 'buy-in' from the practice workforce." It also stresses that there should be no cost to use the clinical indicators and so practices' administrative burden isn't increased as a result.

WHO SHOULD BE RESPONSIBLE?

The question remains, if greater transparency and publication of clinical outcomes were to become commonplace, who should be leading this process?

The AMA's Position Statement on Clinical Indicators, states, "For high standards of quality and safety to be assured it is essential that there is a strong clinical involvement in and ownership of the development of clinical indicators and the processes set up to measure and to assure safety and quality. Clinical indicators should therefore, independently of government, be developed and ratified by the relevant medical specialty."

The focus groups – both consumers and clinicians – in the ACSQHC's "Public reporting of safety and quality in public and private hospital report" did not have a consensus on where responsibility should lie for public reporting. However, there was a common view that ideally, a single, national body should be empowered to release information.

WHAT SHOULD BE REPORTED?

Clinicians in the ACSQHC's "Public reporting of safety and quality in public and private hospital report" took a general view that no information should be off limits, but there was concern that too much information without context would not be helpful.

Consumers identified indicators such as infection-rates, surgical mishaps, post-intervention and procedure outcomes, medication errors, readmission rates, length of stay and waiting times, as well as reporting outside of the hospital environment, as being most relevant.

Clinician groups in the report expressed a desire for increased transparency around relative risks and benefits of procedures such as caesarean sections.

HOW SHOULD IT BE REPORTED?

There is a clear consensus that any data that is reported needs to be done in a way which is meaningful to both patients and doctors, that both helps in decision-making (in a patient's point of view) and improvement (in a clinician's point of view).

CASE STUDIES

HAND HYGIENE

In terms of using data to drive change, Australia's handwashing campaign has been cited as a major success story. Since it was implemented in 2009, the National Australian Hand Hygiene Initiative (NHHI) has driven significant improvements in handwashing compliance and reduced the transfer of potentially harmful bacteria.

"One of the most transformational things we've done in healthcare, the thing that has really made a difference in people's lives, is simply focusing on better hand hygiene," says Dr Jaspreet Saini, general practitioner. "That was really a big 'A Ha!' moment for me."

Research presented at the 2019 European Congress of Clinical Microbiology & Infectious Diseases found that for every 10% increase in hand hygiene compliance, there was a corresponding 15% decline in the incidence of *Staphylococcus aureus* infection in 132 public hospitals in 2016-17.

In the study, researchers analysed outcomes of the NHHI from Jan 2009 to June 2017. Hand hygiene compliance auditing is done three times a year by trained auditors who collect data using direct observation of their colleagues when in clinical encounters. In NSW, more than 220 facilities regularly submit data as part of the NHHI. The clinical impact of the scheme was analysed by linking data on hospital-level incidence of *Staphylococcus aureus* infection with hospital-level hand washing compliance.

In NSW, facilities use data to compile reports that can identify areas of high compliance or low compliance with hand hygiene. These areas include departments, professional groups, as well as compliance with specific 'moments'.

Interestingly, a study released in 2018 by the University of NSW found handwashing compliance among doctors and nurses dropped from 94% to 30% when human auditors stopped monitoring their behaviour and researchers used automated surveillance.

This suggests data collection and the reporting of data collection has an influence on behaviour.

SURGICAL VARIANCE REPORTS

Medibank teamed up with the Royal Australasian College of Surgeons (RACS) to create a series of Surgical Variance Reports reports which analyse clinical and other indicators for common procedures within surgical specialties, including general surgery, urology, ear, nose and throat surgery, vascular surgery and orthopaedic surgery.

The first of the reports were published in 2016, based on de-identified Medibank claims data from 2014. In 2017, a second series of reports were created on surgical variance within surgical specialties, as well as a review of same-day surgery for hernia repair.

Additional reports published in 2018 and 2019 respectively look at

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rehabilitation pathways following hip and knee arthroplasty and volume-outcome relationships in pancreatic-oduodenectomy.

"The Medibank Private initiative with the Royal Australasian College of Surgeons has some merits, but I am cautious with respect to some areas of their reporting," says Dr Betros.

In Dr Betros' area of practice, Medibank offered individual surgeons the ability to look at the data regarding that individual's personal performance against their peers who perform similar services.

"I participated in this exercise as I was certainly interested to see how I performed personally, and I wanted to see the type of data Medibank was using in its reporting."

The report analysed KPIs such as length of stay, unplanned readmission, unplanned ICU admissions, which Dr Betros says are "good markers of quality". However, it also looked at measurements such as the average cost of an episode of care and the average cost of the prosthesis used.

"These are obviously important considerations for us as clinicians and whilst this may prompt some of our colleagues to look at their practice for areas where responsible, improved financial efficiency can occur, I am concerned it could have other unwanted effects."

Dr Betros argues that to solely look at the cost of an admission, without ensuring quality outcomes are maintained is a concern.

"If we are to report on data that is driven by cost savings, there also needs to be a mechanism that ensures all drivers of change keep the outcome of the patient treatment as the highest priority," he says.

"At the moment, I see no safeguards in place to protect our patients and our clinicians from having treatment options potentially influenced by some of these financial drivers if an organisation chooses to do so – especially when the organisation is the payer of these services."


Dr Fred Betros

Whilst he acknowledges financial viability is important to organisations such as Medibank and they should have some input into how their funds can be spent in the most efficient way, we need to carefully consider how much input they have on treatment options.

"If we are going to report on outcomes and performance, it has to be in a way that ensures we provide the best possible care for our patients, by clinicians who can demonstrate an appropriate level of performance – standardised and accepted by their peers, using our limited resources in a clinically responsible way."

COLONOSCOPY CERTIFICATION AND RECERTIFICATION PROGRAM

An example of how service provision can be standardised, is to look at the current nationwide Colonoscopy Certification and Recertification Program. The Australian Commission on Safety and Quality in Health Care has provided for the Gastroenterological Society of Australia (GESA) to oversee a triennial program aimed at ensuring colonoscopic services provided in Australia meet a minimum standard set. It was initially a voluntary program, but now participation is mandatory, with clinicians being required to provide de-identified outcomes for three blocks of 50 colonoscopies performed by that clinician over a three-year period.

"The collection of data on patient outcomes is nothing new – it is what we are doing with it that is the main issue here."

Dr Fred Betros

According to Dr Betros, "There are very clear standards that are required to meet ongoing certification, such as the rate of reaching the caecum / terminal ileum plus adenoma and sessile serrated adenoma detection rates. These standards have been proven to represent good quality colonoscopy and it is reasonable to expect practitioners providing this service to meet those standards." dr.

GOOGLE REVIEWS

All negative online reviews can be confronting, but none more so than those tied directly to your business page listing.

IT CAN TAKE A minimum 12 years of education and training to become a plastic surgeon, but seconds to ruin a doctor's online reputation.

Reputational damage and the legal responsibility of review platforms to monitor and respond swiftly to complaints of allegedly defamatory material are the broader issues being examined by the NSW Supreme Court.

In a landmark case, a Sydney plastic surgeon is suing Google for defamation over business reviews which, according to his statement of claim, indicated he had "butchered" patients, was "incompetent", a "fraud", an "illicit drug user" and had "no morals".

The surgeon, whose name is suppressed, claims negative reviews appeared on his Google listing for more than a year and reduced the number of people clicking on his website.

In early July 2019, he secured an injunction against Google and a judge ordered a contempt charge be considered after a series of negative reviews remained online. However, a second judge did not rule for the charge to proceed in light of evidence about when removal requests were made.

Justice Desmond Fagan commented on the "mental gymnastics' required to figure out how to make a removal request, given that Google operates in different countries. While requests to remove comments were made to its subsidiary Google Australia, the removals are handled by Google LLC in the US.

At the time of writing, the case was scheduled to return to court in October, and the outcome was too late to be reported by print deadline.

AMA (NSW) TAKES MEMBERS COMPLAINTS TO GOOGLE

AMA (NSW) has received similar complaints from members regarding negative Google reviews. As business reviews are linked to a medical practitioner's business listing they can have a more direct impact on the doctor's reputation than those hosted on third-party doctor ratings websites.

Members cite the professional damage and distress negative reviews can cause and the lack of consequence for those who are responsible for such comments.

In both May and July, AMA (NSW) wrote to Google to outline our significant concerns with the platform's mandatory business review function.

We highlighted that doctors are limited in their ability to respond to negative reviews. They cannot 'balance' negative reviews with positive testimonials from patients, as this is strictly prohibited by advertising rules under the Health Practitioner National Law.

While we acknowledged that medical professionals have the option of asking Google to remove a review if they believe the comment breaches Google's reviewing policy, this does not alleviate the reputational damage and distress caused in the interim.

Consequently, AMA (NSW) suggested there be a mechanism for medical practices to disable Google reviews from their listing, as the potential for professional harm outweighs any benefit the public might derive from the business review.

The response from Google was disappointing and their suggestions did not resolve the problem of false negative reviews being posted and the time and effort it takes to bring them down.

AMA (NSW) will continue to advocate on this issue on behalf of its members. dr.

AHPRA advertising rules and Google reviews

AS THE CASE currently before the NSW Supreme Court illustrates, the only way for a doctor to remove reviews from their Google listing is to flag the defamatory comment with Google, at which point it is up to Google to determine whether they will remove the review.

But not all reviews are bad. In fact, evidence suggests the vast majority of online doctor reviews are positive. A look at 33 doctor rating websites found 88% of comments were positive, 6% were negative and another 6% neutral.

But given Google reviews are linked to your business page listing, is there any potential these reviews could be considered testimonials and therefore put your business in breach of AHPRA's advertising rules? The short answer is no.

Practitioners need to ensure that their advertising complies with the National Law and advertising. It is important to note that compliance is linked to whether the doctor controls the review.

In general terms, if a practitioner can edit reviews or disable the review functionality (such as how Facebook currently functions) then they are in control of the reviews. If a practitioner has no control over the review functionality (such as with Google or Whitecoat reviews) then those reviews would not be considered to form part of the practitioner's advertising.

Practitioners are not required to attempt to remove reviews – whether they are positive or negative – that are not within their control.

However, if a doctor responds to a review on a third-party site or reproduces the review on another platform or site that they use for advertising, this may be considered a contravention of the National Law.

While it is not necessarily a contravention of the National Law to respond to a review left on a third-party platform (such as a practitioner's Google listing), doctors should proceed with caution.

A response to a review may contain information that causes the review (and/or response) to be considered a testimonial.

Practitioners are not required to attempt to remove reviews – whether they are positive or negative – that are not within their control.

By responding to a review, the practitioner is then considered to be using that review in their advertising, and therefore the prohibitions around testimonials become relevant.

Under the National Law, a testimonial includes recommendations, or statements about the clinical aspects of a regulated health service. Accordingly, a response to a review could be considered a testimonial or advertising a regulated health service if, for example:

- the review being responded to is a positive statement or recommendation about the clinical aspects of care,
- the response itself includes information about the clinical aspects of care, or
- the response changes the context of the review into a positive statement or recommendation (whether considered by itself or in addition to the review).

If you're unsure whether responding to a review would mean that the review becomes a testimonial and subsequently contravenes the National Law, you should refrain from responding to the review until you've sought independent advice.

If a third-party site contains testimonials in breach of the National Law, where these testimonials are outside the control of the individual practitioner, AHPRA may decide to raise these concerns with the third-party platform owners themselves.

Since 2017, under the Advertising Compliance and Enforcement Strategy, AHPRA has dealt with over 2500 practitioners across all professions who have had low and moderate risk advertising breaches. According to AHPRA, all of these registrants have acted to make their advertising compliant when the matter was raised with them, either immediately or in response to proposed regulatory action.

Further information about testimonials and the National Law can be found at **www.ahpra.gov.au/Publications/Advertising-resources** and Guidelines for advertising regulated health services. dr

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#PLASTIC SURGERY

If advertising from medical professionals is so tightly controlled by AHPRA, why is Instagram full of before and after photos and hashtags with doctors' names?

THE AUSTRALIAN Society of Plastic Surgeons (ASPS) has been taking a hard a look in the mirror.

In June this year, the Chair of ASPS Ethics Committee, Dr Richard Theile wrote an editorial published in the *Australasian Journal of Plastic Surgery*, describing a "worrying deterioration of standards".

The editorial targeted the growing use of social media self-promotion and the rise of the plastic surgeon entrepreneur.

"At best unethical behaviour can be inadvertent … at worst it is driven by greed and ego where the patient becomes a commodity to be exploited," Dr Theile wrote.

The response follows earlier accusations from Professor Emerita Nichola Rumsey, a leading international expert on appearance psychology, that some plastic surgeons are using "soft-porn" images on Instagram that give patients unrealistic expectations of outcomes and contribute to consumers' negative perceptions of body image.

The ASPS released an Ethical Framework document that will form the basis of a new Code of Conduct to address concerns with unethical social media behaviour.

ASPS has also pledged to hold members personally responsible for their social media content, even outsourced or originally posted by patients.

BUT WHAT ARE THE RULES?

The aim of regulating advertising of healthcare services is to protect the public from false or misleading claims and to help ensure people can make informed decisions about their healthcare.

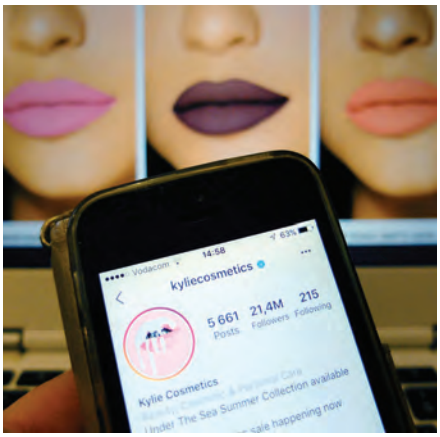
According to AHPRA, before and after photos, in general, would not be considered testimonials under the National Law as they are not usually a recommendation or statement about treatment left by a patient. However, AHPRA stipulates that if photos used in advertising are accompanied by a review of the service by the patient (or purportedly by the patient), and the review contains information about the clinical aspects of a regulated health service, then this may be considered a testimonial.

So, although before and after photos are not generally testimonials, they still have the potential to breach the National Law and advertising guidelines if they are deemed to be misleading or deceptive, or to convey to a member of the public inappropriately high expectations of a successful outcome and to encourage the unnecessary use of services.

Before and after photos have the potential to be considered a breach of the advertising provisions of the National Law, in that they can create an unreasonable expectation of beneficial treatment.

Appendix 6 of the guidelines for advertising regulated health services contains information on using before and after photos in advertising. In summary, before and after photographs are less likely to be misleading if:

- the images are as similar as possible in content, camera angle, background, framing and exposure
- there is consistency in posture, clothing and makeup
- there is consistency in lighting and contrast
- there is an explanation if photographs have been altered in any way, and
- the referenced procedure is the only visible change that has occurred for the person being photographed

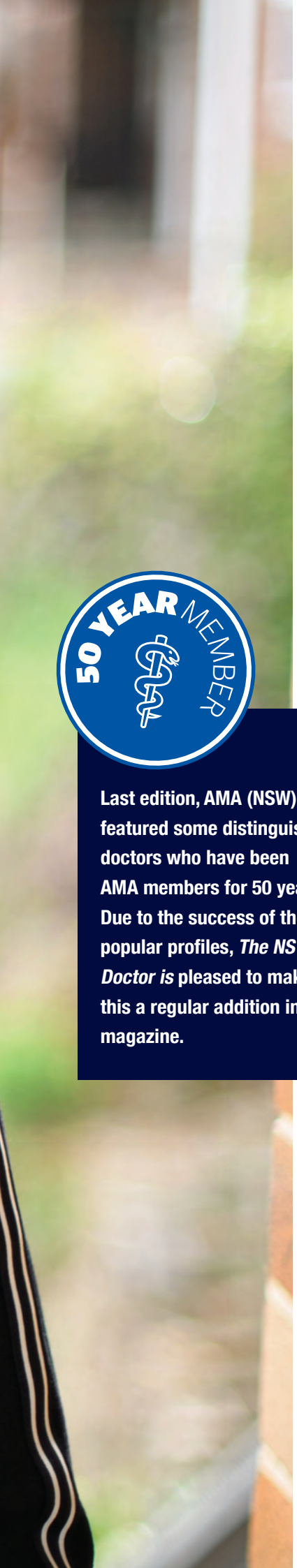


SUPPORT FOR #PLASTIC SURGERY

Some plastic surgeons have defended their use of social media, saying it provides a platform to exhibit their work and an opportunity for honest discussion, information and education.

"I personally use my own work to showcase on social media real patients of all sizes, shapes, and backgrounds and share their stories to provide honest insight into what is real and possible," said Dr Anh Nguyen in an open letter to *The NSW Doctor*.

"To assume patients are swayed by advertisements and generic or stock images is an oversight of how discerning our potential patients are. They look for experience and qualifications such as a FRACS and to see if they are a member of ASPS." dr.



50 YEAR MEMBER

Last edition, AMA (NSW) featured some distinguished doctors who have been AMA members for 50 years. Due to the success of these popular profiles, *The NSW Doctor is* pleased to make this a regular addition in the magazine.

Insight

BEYOND INDIVIDUAL PATIENT CARE

50-year member and former Chief Health Officer for NSW, **Dr Sue Morey AM** has been an important figure in the maturation of public health medicine in Australia.

WHEN DR SUE MOREY graduated medical school from Sydney University in 1967, her understanding of public health medicine was limited.

"As a medical student, 50 years ago, I remember little of what we were taught in Public Health lectures. I think we learned how to dig a deep pit latrine, but that was certainly not an inspiration for a future career for a young medical student. At that time, I would never have imagined the directions in which my medical career would take me," Dr Sue Morey stated in her 2016 oration for the RACP Congress, titled "What Would Redfern Think?"

Upon graduation from med school, Dr Morey became a medical registrar at Royal Prince Alfred Hospital. This marked the beginning of her association with the hospital that would span more than two decades.

In 1969, as a medical registrar on rotation from RPA, Dr Morey worked in Papua New Guinea. It was during this time that, "I learned that the country's health problems were not going to be solved solely by doctors caring for individuals, and I learned to think about the economics of health, practising in an area where the health budget of the entire country was less than that of the hospital in which I worked in Sydney."

COMMUNITY HEALTH

After her rotation in PNG, Dr Morey passed the membership of the College of Physicians and went overseas to work in England. She returned after a couple years and became involved with what was then a new concept – community health services. The area around RPA was very under-privileged and, at the time, there was concern that more should be done for residents in the local area.

This led to development of community health services in Glebe and Newtown, and Dr Morey was there from the beginning. She was introduced to the concept of public health as a concern for a defined population – defining the characteristics and health problems of

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that community, identifying gaps in the services and then developing services to fill those gaps. As they were connected to a major tertiary hospital, they had access to specialists and integrated care. Not only did they offer community-based allied health and mental health services, but also a diabetic clinic, an antenatal clinic for pregnant teens, and services for alcohol and drugs, health promotion, palliative care and geriatrics.

Dr Morey worked as a Co-ordinator of Services in the Community Care Teaching Unit at RPA from 1972 to 1976. They gave students projects that linked the clinical care provided by GPs and specialists with the epidemiology and preventative aspects of specific diseases.

In 1976, Dr Morey was promoted to Head of the Department of Community Medicine at RPA. Three years later, in 1979, Dr Morey did a Masters of Public Health at Harvard – an experience she describes as one of the "great highlights of my career."

It was during this time that she learned the academic discipline that underpinned the work she was doing in Australia.

In 1981, Dr Morey was also made RPA's Head of the Division of Community and Allied Sciences. This coincided with her involvement with a small group of doctors working in Community Medicine who met to discuss the need to develop registrar positions that would assist students in public health to move from theory into practice.

According to Dr Morey, Australia was one of the last English-speaking countries to formalise training in public health medicine.

Dr Morey helped form the Australian Association of Community Physicians in 1985 and served as President from 1986 to 1988. The RACP Council accepted a proposal to form a Faculty in 1988 but preferred the term Public Health Medicine to Community Medicine. Dr Morey was chosen to be the Foundation President of the Australasian (initially Australian) Faculty of Public Health Medicine of the Royal Australasian College of Physicians (1990-1993).

The Faculty established the term "public health physician", which is now recognised, and created an accredited training program.

She served as Chief Health Officer for NSW from 1988 to 1994, and describes this as "a very difficult and privileged position" as it allowed her to be involved with all of the key policy-making bodies – medical boards, the National Health and Medical Research Council, the Health Minister's Advisory Council, and more.

RURAL HEALTH

She turned her attention to the link between health inequalities for people living in regional and rural Australia, and access to doctors and clinical care. With Jack Best, she became involved in the feasibility studies and establishment of most of the University Departments of Rural Health and many Rural Clinical Schools.

Underpinning this work was the idea that students trained in a rural location would want to remain there. Now more than a third of medical students each year are doing a minimum of one year's clinical training in rural and regional Australia.

In 1999, Dr Morey was made a Member of the Order of Australia for her service to the development and promotion of improved public health services.

She continues to work as a Health Services Consultant and serves on the Council of the Medical Benevolent Association of NSW. dr.

DIGITAL RECALL AND REMOTE CLINICAL APPRAISALS

AMA (NSW) is looking for feedback from VMOs to find the best approach to addressing the non-payment for Digital Recall and Remote Clinical Appraisals.

Andrew Campbell
MANAGER
INDUSTRIAL RELATIONS

TO BEST INFORM AMA (NSW)'s approach to addressing the non-payment for Digital Recall and Remote Clinical Appraisals for VMOs, we welcome feedback from VMOs.

In a modern technology-driven environment, doctors must embrace and adapt to changes in service delivery in the same manner as other professionals. The replacement of pagers with mobile phones in the 1990s allowed for significant time improvements for on-call clinician responses. Not long after, broadband internet connectivity and remote logins allowed doctors to review images and scans from the comfort of their own home. At first this was restricted to personal computers and laptops, but now this is possible on tablets, mobile phones and even smart televisions. You may be surprised to hear that the smartphone in your reach has a million times more computing power than all of NASA when the Apollo 11 landed on the moon exactly 50 years ago.

When the provisions of the current VMO Determinations were drafted, it was not envisaged that such technology would be available to allow for what we may now call Digital Recall, ie. the remote review of medical images and scans while on call (or even when not rostered on call). However, we believe the definition of Services under the Determinations is broad enough to encompass digital recall.

Up until 1985, VMOs were not paid for the time spent attending to public patients in public hospitals. Looking back now, it does seem quite unfathomable that doctors would agree to such arrangements. Will we look back in another 35 years' time and say the same thing about payment for Digital Recall?

This year, AMA Queensland and ASMOFQ negotiated a Digital Recall

clause for Junior and Senior Medical Officers, which sees consultants paid at a minimum of 30 minutes work for each time they provide a service using digital resources. Digital Recall is defined in the Award as follows:

"… digital recall includes, but is not limited to, work that requires access, review and/or creation of a record containing a patient's medical information, care or treatments received, test results, diagnoses, and/or medications taken and includes clinical decision documentation."

The clause does, however, note that review of information that would reasonably be conveyed effectively verbally by phone is not considered to be Digital Recall. In contrast, the NSW JMO award does allow for payment to junior doctors for remote clinical appraisals. Unfortunately, the claiming process is burdensome, with doctors required to jump through nine different hoops before being paid (PD2014_002). AMA (NSW) was not involved in the negotiations, but is looking to improve the payment process.

We welcome feedback from VMOs working in a variety of specialties and geographic areas as to the remote duties that they currently undertake. What we are particularly interested in hearing from you is:

- What is the nature of the calls (and emails, texts etc.) you receive while on call?
- How often would the call necessitate you to return to the hospital as opposed to providing an appraisal remotely?
- What are the specific advances in technology that would have previously required you to attend the hospital?

Please contact me via email at andrew.campbell@amansw.com.au or 02 9439 8822, should you wish to provide input. It's important that we hear from as many of VMOs as possible. dr.

PROFESSIONAL INDEMNITY **INSURANCE FOR VMOS**

With the advent of new quinquenniums for several Local Health Districts in 2019 we have received questions from VMOs regarding Contracts for Liability Coverage, otherwise known as Treasury Managed Fund (TMF) cover. While we cannot provide insurance advice, we can provide general information regarding TMF coverage. VMOs have two or more options for TMF coverage depending on where they are based:

- **Coverage for public patients only**
- **Coverage for public patients and private paediatric patients**
- **Coverage for public and private patients**

Options 1 and 2 are available to all VMOs, but option 3 is generally only available to VMOs working outside of metropolitan areas.

Should you wish to utilise TMF cover for private paediatric or private adult patients, it is a requirement that the patient not be charged an out-of-pocket fee. Should you wish to charge an out-of-pocket fee, you will need to rely upon professional indemnity insurance cover from your MDO.

All VMOs must have professional indemnity insurance as a condition of engagement with their LHD.

It is not correct to say that by accepting option 2 or 3 you are waiving your right to charge a gap to your private patients.

VMOs engaging through a practice company must also note that their contract requires the company to have public liability insurance*.

Please contact your Medical Defence Organisation or AMA (NSW) with any further questions. dr.

Such insurance may also be useful for sole traders. You may wish to contact our preferred partners Specialist Wealth Group to discuss your public liability insurance needs.

VALE JUSTICE JAMES MACKEN AM

THE HON. JAMES MACKEN AM was a Justice of the Industrial Court of NSW. He presided over proceedings between AMA (NSW) and NSW Health which ultimately led to the modern VMO Determinations.

Before his appointment to the NSW Industrial Commission, he had a successful career as a barrister and was a forceful advocate for the organisations whose brief he accepted. He was well known to the maritime industry through numerous industrial proceedings in NSW.

Justice Macken presided over a number of VMO arbitrations with his determinations often referenced in the NSW Court of Appeal and by the full bench of the Industrial Commission.

AMA's former Medico-Legal and Strategic Policy Division Director, Mr Allen Thomas had a long history with Justice Macken and recalls attending his lectures on industrial and employment law for the Law Society of NSW.

"He was a fearless advocate before he went to the bench," Mr Thomas says.

"One of the best there was."

Justice Macken is remembered for a lifetime of achievements across a broad range of areas, including the formation of the Bush University in the Kimberley region. In addition, he became a volunteer ranger of the Ku-ring-gai Chase National Park and founded the Coasters Retreat Fire Service after the 1994 bushfires.

He passed on September 19 surrounded by family. He is survived by 11 children. dr.

WORKPLACE BULLYING

Bullying in the workplace should always be taken seriously. Here's your guide to preventing and responding to bullying claims from employees.

Felicity Buckley
HR ADVISOR
PROFESSIONAL SERVICES

BULLYING AT work occurs when a person, or group of people, repeatedly behave unreasonably towards another worker or a group of workers at work and that behaviour creates a risk to health and safety.

Unreasonable behaviour includes victimising, humiliating, intimidating or threatening and the test is whether a reasonable person might see the behaviour as unreasonable in the circumstances. It could be between workers, from a supervisor or manager to a worker, or even from a worker to a supervisor or manager.

Bullying does not include reasonable management action carried out in a reasonable manner. An employer or manager can still make decisions about poor performance, take disciplinary action, and direct and control the way work is carried out. However, management action that isn't carried out in a reasonable way may be considered bullying.

Examples of bullying

- Persistent use of abusive, insulting, or offensive language or aggressive yelling or shouting;
- Unnecessarily interrupting or disrupting an employee's work or inappropriately interfering with an employee's personal property or work equipment;
- Repeatedly denying access to information, consultation or resources;
- Continually giving feedback in an insincere or disrespectful manner.

ANTI-BULLYING APPLICATIONS

To make an application with the Fair Work Commission for a stop bullying order, a person must be a worker. This includes an employee, a contractor, a subcontractor, an outworker, an apprentice, a trainee, a student gaining work experience or a volunteer. If you have already dismissed an employee, they can't make an anti-bullying application.

Remedies can include any order considered appropriate to prevent further bullying, including an order that you stop specified behaviour, that your behaviour be monitored regularly, that you provide training and support to your workers, or that you review your bullying policy. The Commission cannot issue fines or penalties and cannot award any compensation (but if orders are made and not complied with, penalties may be imposed for non-compliance).

HANDLING A BULLYING CLAIM

Employers and businesses have a duty to ensure the health and safety of their workers and this includes providing a workplace free from bullying. From time to time, you may receive complaints of bullying at work. Here are some points you may want to consider.

We recommend that you deal with all bullying complaints as soon as possible, and by managing the situation appropriately, you can hopefully avoid an employee making an anti-bullying application to the Commission.

In the first instance, speak to the employee who is making the complaint and confirm whether they want you to take this further. The employee should be encouraged to put their complaint in writing. If a complaint is not detailed in writing, or specific details regarding the allegation are not provided, it can be more difficult to address or investigate.

At this point you may want to consider whether it would be safe and appropriate to resolve the issues between the parties. If this is not appropriate or the employee would like you to move forward with their complaint, the next step is to investigate their claims. The most appropriate way to do this is usually to meet with the accused employee to discuss. It is a good idea to provide them with notice of this meeting and invite them to bring a support person along, if they wish. The meeting will be an opportunity for you to discuss the allegations of their behaviour and your concerns, and provide them with the opportunity to respond. You may also need to meet with other employees

who may have witnessed the alleged bullying behaviour. Once you've had the meetings, you'll then be able to consider any information they have provided before deciding whether you believe the behaviour is bullying or not. We recommend you keep accurate records throughout the process, including claims made, dates and times of meetings, minutes of all discussions, as well as your response to the investigation and any actions you end up taking.

Essentially, the process followed should be the same regardless of who is involved. Your procedure for dealing with a bullying complaint must always be objective, fair and transparent and you will need to be extra mindful of this if you, as the employer, are the one accused of bullying. The person appointed to conduct the investigation should be as neutral as possible and it's best to address any conflicts of interest before you start.

POSSIBLE OUTCOMES OF A BULLYING CLAIM

It is important to take a claim of bullying seriously, but we would caution you against going into an investigation with a preconceived idea of what the outcome will be. We generally recommend that you take your time to consider all parties' responses before making your decision.

If the results of your investigation conclude that bullying has occurred, a possible outcome or combination of outcomes may include:

- Dismissal
- A warning
- Workplace training on the expected standard of behaviour
- Structural changes to minimise or eliminate the risk of further bullying
- Review practice policies and procedures
- Access to an employee assistance program
- Ongoing monitoring of behaviour

If the outcome of your investigation is that bullying did not occur, there may still be issues that need resolving. There may be a clash of personalities and it's important to work through this to restore a conflict-free workplace. If you find that the allegations were made vindictively it may be appropriate to take further disciplinary action, in accordance with your practice's policies and procedures.

Handy tips to prevent bullying in the workplace:

- Create an anti-bullying policy and culture and lead by example
- Train managers to identify bullying behaviour and have difficult conversations
- Communicate with your employees regularly and provide timely and constructive feedback
- Promote productive and respectful working relationships
- Identify and call out bullying behaviours early
- Proactively manage workplace stressors and risks

More information

The Fair Work Ombudsman and SafeWork NSW websites contain further information on workplace bullying as well as some helpful resources including guides for preventing and responding to bullying in the workplace.

If you have any questions or concerns, please contact our Professional Services team on (02) 9439 8822 or professionalservices@amansw.com.au dr.

Disclaimer: *The views and information provided in these articles 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.*

PS.

>>>>>>>>>>>>>>>>>>>>>>>>>>

NEW WEBINAR

We understand that our members are stretched for time so we have listened to your feedback and have created a webinar that will allow you to learn more about workplace relations matters from the comfort of your own home or office at a time that suits you.

Our new webinar covers what you need to know about casual employment. It was prepared in response to significant interest from employers for further information about casual employment following recent regulatory and case developments. It is part of our Employer Essentials seminar series and stems from our popular Contracts and Fair Work Act Compliance seminar.

If you employ casual employees at your practice, we encourage you to view this webinar. You may learn a thing or two about casual employment and how the Professional Services team can assist.

Where can I access it?

To view the webinar and download the accompanying handout, visit the AMA (NSW) website and go to the Employer Quick Links page or search for webinar.

What's it about?

Participants will learn about:

- **Casual employees under the Fair Work Act;**
- **Casual employment under Modern Awards, including casual conversion;**
- **The risks of employing long term casuals, including the decision in Workpac v Skene;**
- **The AMA (NSW) casual contract and how to access it.**

Who should watch it?

Any doctors (or their practice managers) who:

- **employ casual employees;**
- **intend to employ casual employees;**
- **want to learn more about casual employment under the Fair Work Act, Modern Awards and/or common law;**
- **want to know about how the AMA (NSW) can assist with casual employment.**

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To access the Lexus Corporate Programme please contact **Mark Nikolaevsky** from Sydney City Lexus.

Mark Nikolaevsky | Lexus Corporate Sales Manager
PH 0418 465 963 | E MarkNikolaevsky@sydneycitylexus.com.au

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1. Conditions apply. See Sydney City Lexus for further details.
2. Complimentary servicing expires at 3 years or 60,000kms from the date of first registration, whichever occurs first.

* Eligible models for the Corporate Programme are subject to change and may vary from time to time. Please contact Sydney City Lexus for more information.

TIPS ON TERMINATION OF EMPLOYMENT

It's not all farewell cards and goodbye lunches when a permanent employee moves on. Final pay should include several key entitlements...

Lyndall Humphries
SENIOR ADVISOR (EMPLOYMENT LAW) PROFESSIONAL SERVICES

Q. I have a permanent employee whose employment is coming to an end. What entitlements do I need to pay on termination of employment and when is the final pay due?

A: In terms of the entitlements that need to be paid on termination, a permanent employee's final pay will generally include:

- outstanding wages
- accrued and untaken annual leave and annual leave loading
- long service leave (if applicable)
- redundancy pay (if applicable)

It will not include accrued and untaken personal (sick/carer's) leave as this is not paid out on termination.

In terms of timing, most Modern Awards specify that you must pay an employee their final pay no later than seven days after the day on which their employment terminates (which may be different to their last day of work). An exception may apply to payments in lieu of notice in the event you terminate an employee without notice. This is because under the *Fair Work Act 2009* you must not terminate an employee without notice unless you have paid the employee the relevant payment in lieu of notice. This does not apply in cases of serious misconduct. In practical terms, this means that any payment in lieu of notice must be paid at the time of termination.

If you do not pay an employee their termination entitlements on time, you may be in breach of the *Fair Work Act* or Modern Award and if so, penalties may apply. You should also consider any relevant terms in the employee's contract of employment.

Q: The employee has asked for a reference once they leave. Should I give one?

A: Before deciding whether to give a reference, you should first consider whether you are required to give one, for example by law or under a contract, policy or other agreement. If there is no requirement to give a reference, you are under no obligation to provide one, but you may choose to give one at your discretion.

A reference may help a former employee to move on and secure a position elsewhere. This may be important to you if the employment relationship did not end particularly well and you want the employee to focus their attention elsewhere or if the relationship ended amicably and you want to support the employee transition to a new role.

You should note that there may be legal risks associated with providing references. These risks could potentially include negligence, defamation or discrimination claims, but this does not necessarily mean that these claims are likely. It would obviously depend on the circumstances.

If you do give a reference, whether in writing or verbally, the reference should be honest, accurate and fair. It should not include misleading, false or irrelevant personal information.

Often the best option for employers is to provide a statement of service instead of a reference. A statement of service typically sets out the employee's start date, end date, position and a summary of their duties, and does not comment further. As the information in a statement of service is generally a matter of fact and not opinion, it is more likely to minimise your exposure to risk.

If you have any questions about final pay on references or termination of employment, please contact the Professional Services team. dr.

CONTACT US
EMAIL
professionalservices@amansw.com.au
PHONE
02 9439 8822
VISIT
www.amansw.com.au

SPRING CUP

Competition was particularly tight during the Spring Cup, as this was Golf Society members' last opportunity to improve their chances to win the Shepherd Trophy.

WHAT BETTER way to contest the AMA Golf Society Spring Cup than on a perfect Spring day at the beautiful St Michael's Golf Course.

A solid field of players teed off with an early shotgun start and enjoyed a relatively calm day. As always, the course presented us with a great test of our golf. Accuracy was rewarded and, typical of St Michael's, stray shots were punished.

As this was the last event in 2019 that could count towards the points scored for the Shepherd Trophy, a number of the regulars were on deck in an endeavour to improve their scores.

It was also pleasing to see so many guests with many of them joining the Golf Society as full members. There was also a strong team from Concord Golf Club, and they were warmly welcomed by our Society Medical Secretary, Dr Robyn Napier.

The winner of the AMA Spring Cup was Dr Michael Burke with 38 Stableford points. The whisper is that with such a strong score his odds for the Shepherd Trophy have now shortened considerably. The words 'Winx Odds' were mentioned in hushed tones, but as Dr Napier cautioned us, there is always a dark horse quietly running in the field not far behind the perceived leaders.

Runner up with 35 s/ford points was Dr Robert Drummond.

Winners of the 2BBB with 48 s/ford points were Dr Bob Drummond and Dr Bill Lynch. Now there's a name to keep in mind for the Shepherd Trophy/BMA Cup in December.

2BBB runners up were Dr Michael Burke and Dr Stuart Ludowici with 43 s/ford points.

Nearest the Pins went to Dr Stuart Ludowici and Carly Harkin. Congratulations to all our prize winners and well done.

During the luncheon, Dr Napier presented an apology from our Golf Society President, Dr George Thomson who was preparing for his left hip replacement the following day. The group sent their regards to George, wished him well, and collectively expressed the hope that he would be back on deck for the BMA Cup in December.

As always, we were made to feel most welcome by all the management and staff at St Michael's, and in particular the General Manager, Jeff Wagner – a very able golf pro in his early days on the tour. To all AMA golfers who have not played St Michael's, we can only say don't pass up the opportunity.

Our next event is the all-important BMA Cup which will once again be held at Terrey Hills Country Club on Thursday 5 December 2019 with an early morning shotgun start.

For any details concerning the AMA Golf Society please contact Claudia Gillis at AMA. Phone 9439 8822 or Email: amagolf@amansw.com.au.

In the meantime, good golfing and we look forward to welcoming you to Terrey Hills in December. dr.

Spring Cup Winner

DR MICHAEL BURKE WITH
DR ROBYN NAPIER

Spring Cup Runner Up

DR ROBERT DRUMMOND WITH
DR ROBYN NAPIER

AMA (NSW) Golf Society

BMA Cup – Thurs 5th Dec
Terrey Hills Golf Club

- *7:00am - breakfast*
- *8:00am - shotgun start*
- *Competition prizes including*
  - *NTPs & longest drive*
  - *BBQ gourmet lunch*
- *Trophy & prize presentations*
- *Start organising your teams now!*

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

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- View by appointment.
- Flexible terms and lease negotiation.

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- Possibility for future full or part-time work.

Please contact: Andrea
0425 201 474

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Please contact: Liezeil
9554 7788 or 0499 098 461

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- Consulting rooms with spectacular views.
- One room suits O & G.
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Please contact: Sarah
0414 838 968 sea.reach7@live.com

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- Excellent staff consisting of one full time secretary and one casual.
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Please contact: Chris Babich
Australian Babich Medicos- Leaders in Practices Sales and Valuations
0416 132 366 chris@babichmedicos.com.au

AMA (NSW) Preferred Partner Benefits

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

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.

April Invest

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

Accountants/Tax Advisers

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

Tyro

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

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

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.

Preferred Partner Spotlight

Specialist Wealth Group specialises in financial advice to medical, dental and veterinary professionals. With a wealth of industry experience, the expert team of Specialist Wealth Group understands your profession, and can help you accelerate your financial future. It doesn't matter what stage of your career or life you are at, Specialist Wealth Group can help anyone from interns to fully-trained doctors to people contemplating retirement. Specialist Wealth Group customises holistic solutions across:

- Financial planning
- Insurance
- Superannuation
- Estate planning
- And investment

AMA (NSW) members can receive:

- A free initial consultation
- A 20% rebate on insurance
- A 50% discount on establishing a self-managed super fund
- Discounted brokerage rates on investment management
- And other great benefits

To access the benefits provided by Specialist Wealth Group, please contact our member services team on 02 9439 8822.

Member Services

AMA Training Services

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

Accor Plus

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

Alfa Romeo

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

Audi

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.

BMW

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.

Emirates

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

Hertz

Receive exclusive rates and benefits when you rent with Hertz in Australia (terms and conditions apply). Weekdays – 10% off the best rate of the day; Weekends – 15% off the best rate of the day; 5+ Days – 15% off the best rate of the day; Prestige Collection – 15% off the best rate of the day.

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.

Sydney City Lexus

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

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.

Mainly Mobile/Optus

Mainly Mobiles Communications has teamed up with Optus to provide AMA (NSW) members with a great offer: new Optus mobile customers will receive a 10% discount on their new 24-month mobile handset plan; existing Optus mobile customers will receive a 5% discount on their new 24-month mobile handset plan.

Medical Staff

Medical Staff specialises in the recruitment and placement of Nursing Staff, Locum Doctors and Allied Health Professionals in Private and Public Hospitals, Aged Care Facilities, Retirement Villages, Private Clinics, Universities, Schools, Medical Surgeries and Home care services including personal care and domestic help.

Mercedes-Benz

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. Included is access to complimentary pick-up and drop-off, loan vehicles during servicing and up to 4 years of Mercedes-Benz Road Care nationwide.

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Receive 10% off Nespresso Professional Zenius Machine, cost $674.10 (Save $74.90), and a complimentary bundle of accessories worth $251, including a Aeroccino4 milk frother, Nespresso Coffee&Co Coffee Dispenser, and a dozen Cappuccino cups and saucers. Valid ABN and business name required to redeem offer.

Nungar Trading Company

Members will receive free Australia-wide shipping or a free tin of Stockman's polish when you purchase a pair of R. M. Williams Comfort Craftsman, Dynamic Flex, Adelaide or Sydney Boots at $430 (RRP $595).Standard sizing. Option of leather sole POA. International Postage POA. Order on www.nungar.com.au and mention this offer in the comments box.

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Persian Rug Co. stocks Australia's largest selection of over 10,000 handwoven rugs, including authentic traditional, village, tribal, kilim, and designer pieces. Our team works with clients to meet their unique residential and commercial requirements. Members receive a 20% discount on online and in-store purchases.

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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).

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

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To refer a member go to www.amansw.com.au

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members@amansw.com.au

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- Full upgrade of all services, plus façade rectification and two new glass lifts to ensure headache free ownership
- Resulting rental increase from c. $550psm to $1,050psm average
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