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The AMA's election plan: health first

With the Federal election campaign underway, the AMA has been quick out of the blocks to promote its election priorities. Key health priorities include ending the Medicare rebate freeze, supporting general practice, a better deal for public hospitals, indigenous health and recognition for the value of preventative care.

The recent change of AMA President, with Western Australian obstetrician, Dr Michael Gannon, taking over from Prof Brian Owler, has not seen any change in the issues being pursued.

Dr Michael Gannon, new AMA President

Indeed, Dr Gannon's first media conference saw him immediately state his support for general practice, oppose the patient rebate freeze, support additional public hospital funding and call for a greater emphasis on mental health. He also stressed his ongoing commitment – and that of the AMA – to addressing indigenous health.

"We want to improve general practice. We want Governments to recognise the value in primary care, the value in preventative health. We need to have more constructive criticisms about how we're going to fund the cost of public hospitals."

"I've committed myself to continuing the AMA's long history in trying to close the gap between Indigenous and non-Indigenous Australians. I want to do more on mental health. I want to do more on speaking up for people who can't speak for themselves."

At the same time, Dr Gannon emphasised his willingness to work constructively with whoever was the Federal Health Minister, "I think we can do better in our relationship with the Government, but of course we find ourselves in the middle of an election campaign, and we need to be talking to all parties now during the campaign, and then we need to see who's

Leader of the Opposition, Bill Shorten

elected in a few weeks' time."

Rebate Freeze and Primary Care

With the ALP's commitment to lift the Patient Rebate Freeze, a clear difference has now emerged between the two major parties in health policy. The AMA has been pursuing the issue of the rebate freeze for some time, with Dr Gannon recently saying, "The freeze is unfair, and it's wrong. It reflects

Prime Minister Turnbull meets with the AMA Federal Council

a continued under-investment in general practice; the best value for money part of our health system in so many ways."

"High quality primary care reduces the need for more expensive hospital admissions. For too long we've under-invested in general practice."

Continued page 6...

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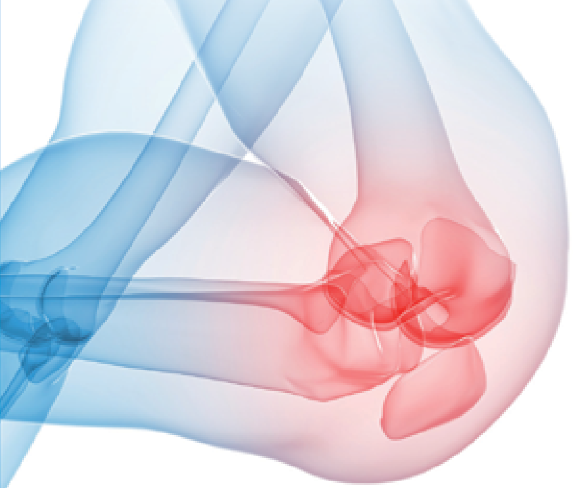

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Capital Conversations

WITH PRESIDENT, **DR ELIZABETH GALLAGHER**

It seems to have come around quickly, but my two-year tenure as President has come to an end. Thus, here is my last Capital Conversations, and the opportunity to reflect on my term. It has been an honour to hold this position and represent our ACT members at local and Federal level. I have certainly grown in confidence and experience, and hope to be able to use these new found skills to serve the ACT Medical Community into the future.

If one word can describe the past 2 years, it's "change". I have seen the end of an era with the retirement of Christine Brill after 32 years as CEO, and welcomed Peter Somerville into the role. We have a new Director General of ACT Health, Nicole Feeley, following the resignation of Dr Peggy Brown. I have seen the appointment of a new ACT Health Minister, Simon Corbell that followed Katy Gallagher's move into the Senate.

The ACT Medicare Local won the tender and became the Capital Health Network with Dr Martin Leidvogel appointed as chair. This coincided with Dr Rashmi Sharma standing down as chair and, fortunately for us, joining the AMA (ACT) Board.

My Personal Experience

With my direct involvement, I have also seen first-hand what sort of organisation the AMA (ACT) is, and also clarified what I would like it to be. As AMA (ACT) President, I've been proud to be one of the first people the media talks to on a broad range of local health related topics. ACT Health's performance of course, but also public health issues, which are probably my strongest interest. I believe that by looking after our profession, we are able to improve the provision of medical care and health outcomes in our community.

I came to recognise that, as the representatives of the medical profession, it's important we don't lose sight of our ability to lead by example and influence policy and thereby improve the health of our community.

I have well and truly been taken out of my O&G silo and given the opportunity to look at many other areas of medicine. In particular, my appreciation of how important quality general practice is as the key to the co-ordination and maintenance of good health has grown enormously. I am in awe of the skill and dedication required to be a GP, especially considering the bureaucracy and regulations GPs face every day, not to mention the continual uncertainty over funding and the unfair patient rebate freeze.

My Thanks to You All

So I will end these few philosophical ramblings to say a few thanks. I could not have done this job without the support of my Board, and the CEO(s). In particular I would like to thank two of my predecessors as president – Dr Iain Dunlop and Dr Andrew Miller – from whose example and guidance I have learned so much. I thank Prof Steve Robson for stepping up as my President Elect just at a time I thought I may not have a successor! Dr Susanne Davey has taught me so much about quality General Practice and Dr Jo Benson has provided the experience and vital corporate knowledge. Given her recent resignation, Jo will be sadly missed.

We've been fortunate to gain Dr Rashmi Sharma as Chair of the Advisory Council and a board member together with Prof Jeff Looi and Dr Antonio Di Dio; all-in-all a good mix of experience and "new blood".

With one vacancy left after the elections, I have decided to take up the Board's invitation and become the final member of the Board thus maintaining my involvement, at least at a local level, which I am honoured to do.

Elections Aplenty

I now hand over to Steve Robson at a time that has challenges on several fronts. While all the health leadership roles in the ACT are reasonably settled, Steve takes over in the midst of a fiercely contested Federal election and a looming ACT election. Who knows whether this will mean a change – or changes – of government?

The launch of the AMA's Federal election campaign focussed on the Medicare rebate freeze. One thing that particularly irks me is when politicians refer to the Medicare rebate being a rebate for doctors. As we know, it is a rebate to patients for services provided by doctors, at a rate the government is willing to pay – not what the service is worth.

While Labor has announced it will lift this freeze, it is important to maintain pressure and make sure any promises are carried through into actions.

Locally, things will pick up as the October local election draws nearer, and it is important we stay strong on local policy as well. I look forward to supporting Steve Robson in his endeavours to engage local politicians directly. I feel confident you are in good hands with Steve and his team.

AMA (ACT) is now on Facebook!

AMA (ACT) has jumped into the wide world of Facebook so please get online and like us. It's a great way to find out what's going on quickly and keep up to date with events. Recent posts have featured the decision by Fair Work Australia to retain one agreement for ACT hospital doctors and the meeting with ACT Health Minister, Simon Corbell. It's easy – just search for AMA ACT.

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Prof Steve Robson takes over as AMA (ACT) President

Canberra Obstetrician and Gynaecologist, Prof Steve Robson has taken over from Dr Liz Gallagher as AMA (ACT) President. The official handover was made at the AMA (ACT)'s annual general meeting at the Hotel Realm held earlier in May.

Prof Robson has already indicated that he wants to pursue an expanded role for AMA (ACT) in public health issues including advocating for an evidence based approach to dealing with the problem of alcohol-fuelled violence in Canberra. With the ACT Government wrestling with the issue in a white paper process that proposes longer opening hours and higher licensing fees, Prof Robson has called on the ACT Government to look at the experience in NSW and the recent changes to "last drinks" laws being implemented in Queensland before adopting a local policy.

In taking office Prof Robson paid tribute to Dr Liz Gallagher and the work she'd undertaken over the last two years, a period that started with the 2014 Federal Budget and has ended amidst a federal election and in the lead up to the ACT election. Dr Gallagher's service as president was recognised at the AMA (ACT) AGM and acknowledged by all present.

In addition to Prof Robson, the new AMA (ACT) Board is now in place with a mix of new and continuing board members – Dr Suzanne Davey, Secretary, Dr Andrew Miller, Treasurer, Dr Iain Dunlop, Dr Rashmi Sharma, Prof Jeff Looi, Dr Elizabeth Gallagher and, taking over from Prof Robson as President Elect, Dr Antonio Di Dio.

Dr Antonio Di Dio – President Elect

Dr Di Dio is a well-known Canberra GP and practice principal at the Yarralumla Surgery. Born in rural Sicily, Antonio moved as a child with his family to country NSW. He went on to graduate from the University of Sydney in 1990 and then achieved a Dip Obs and awarded his RACGP fellowship in 1996.

Having practised for the past ten years in Canberra, first in outer metro Erindale and since then at the Yarralumla Surgery, Antonio says his passion is in quality care and looking after his medical colleagues.

Dr Di Dio is similarly passionate about participating in medical life as a whole – from teaching and examining medical students, first with Sydney University and then with the ANU, postgrads with RACGP and assisting overseas trained doctors.

Another key interest area for Antonio has been pastoral care for colleagues through the Doctors Health Advisory Service in NSW and the ACT. He's also been prominent with the Medical Benevolent Society and through his work as Deputy Director of the Professional Services Review.

Antonio paid tribute to his supportive family, four of whom are teenagers and the wonderful opportunities to get involved in their lives whether through formal activities with school boards or the joy of coaching sporting teams.

VALE

The president, Prof Stephen Robson, Board members and staff of AMA ACT extend their sincere condolences to the family, friends and colleagues of **Dr Kim Frumar** and **Air Vice Marshal (Ret.) Dr Michael Douglas Miller AO**.

AMA (ACT) AGM and Presidential Inauguration

The AMA (ACT) Annual General Meeting was held at the Hotel Realm on Wednesday 11 May with the highlight of the night being the inauguration of Prof Steve Robson, as the new AMA (ACT) President, by outgoing president Dr Elizabeth Gallagher. The AGM and preceding dinner was an opportunity for AMA (ACT) members to get together, renew some old friendships and acknowledge the work of office bearers, board members and staff in a successful year.

It was also an opportunity to recognise Dr John Donovan and Dr Tony Griffin in achieving their 50 year memberships of the AMA.

Mercedes Benz now a Corporate Partner

AMA (ACT) is also pleased to welcome Mercedes Benz as a corporate partner and Mercedes Benz Canberra not only provided a display vehicle for the evening but donated the use of Mercedes Benz vehicle and a night's accommodation at Peppers Craigieburn at Bowral as prize on the night. Dr Catherine Lubbe was the lucky winner of the Mercedes Benz prize and we thank Mercedes Benz Canberra for contributing to a successful night.

AMA (ACT) members are now entitled to access the Mercedes Benz Corporate Programme on production of a letter verifying their membership.

Annual General Meeting

This year, we thought it would be a good idea to hold a dinner as part of the Annual General Meeting and combine the formal meeting with an opportunity for colleagues to catch up and hear what's been going on. The Hotel Realm proved an ideal venue for a relaxed evening and an AGM that was both quorate and started on time.

Members inspect the Mercedes Benz display car prior to the AGM

Dr Catherine Lubbe with Alex Turbin from Canberra Mercedes Benz

We were fortunate to have Dr David Blythe, representing the ACT Health Director General, Nicole Feeley, give the meeting a run-down on his newly created role to act as liaison between medical staff and the Director General. Dr Blythe, an intensive care physician and medical administrator from Western Australia, stressed the importance of having good lines of communication between the medical staff of ACT Health and the Director General. David encouraged those present to contact him and tell him about their issues and concerns, or brickbats and bouquets that go into working for or with ACT Health.

After Dr Blythe's address, the formal part of the meeting proceeded quickly with Dr Gallagher presenting her final report as AMA (ACT) President emphasising the change that has occurred over the last two years and thanking board members and staff for their efforts. Dr Gallagher, in particular, paid tribute to long-serving Secretary Dr Jo Benson who has recently stepped down.

Dr Andrew Miller then presented the 2015 financial report. The Annual Report can be accessed at https://ama.com.au/act/annual-report-2015.

President's Award to Dr Peggy Brown

Dr Gallagher announced that the 2015 AMA (ACT)'s President's Award was awarded to Dr Peggy Brown, former Director General of ACT Health and ACT Director of Mental Health Services. The extended citation for Dr Brown's award reads:

"For outstanding service to the health of the ACT community and the medical profession in the areas of psychiatry and health administration. Dr Brown has shown outstanding leadership and professionalism from her first appointment as ACT Chief Psychiatrist in 2004 then ACT Director of Mental Health Services in 2005 and for her term as Director General of ACT Health from 2010 until 2015.

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50 Year Members – Dr John Donovan and Dr Tony Griffin

Dr John Donovan

John joined the AMA in 1965 and is a former president of AMA (ACT). His long-term commitment to the AMA (ACT) has been outstanding and even now is a key member of the Canberra Doctor Editorial Committee. Thank you John.

Dr Tony Griffin

Tony joined the AMA in 1965 after first qualifying as a pharmacist and then undertaking medicine. He received his RANZCR fellowship and soon after moved to Canberra. Tony played a key role as AMA (ACT) Treasurer in purchasing our first premises. Thank you Tony.

Dr John Donovan with Dr Elizabeth Gallagher, AMA (ACT) President

Dr Tony Griffin with Dr Elizabeth Gallagher, AMA (ACT) President

Dr Brown is much admired for her work in leading ACT Health through a period of growth and change including the opening of the Centenary Hospital for Women and the Canberra Region Cancer Centre.

Dr Brown's longstanding commitment to mental health policy development and implementation has given her a national and international reputation acknowledged by her peers. She has held numerous positions on professional bodies and, while Director General of ACT Health, chaired the Australian Health Ministers Advisory Committee."

Dr Karen Flegg, Dr Tony Griffin and Dr Colin Andrews

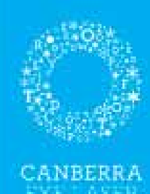
Presentation to Dr Elizabeth Gallagher

At the conclusion of the AGM, incoming AMA (ACT) President, Prof Steve Robson, presented Dr Gallagher with a memento to recognise her service.

AMA (ACT) Presidential Inauguration

The AGM ended with Prof Robson being inaugurated as AMA (ACT) President by Dr Gallagher.

Prof Steve Robson with Dr Elizabeth Gallagher



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Pathology deal?

Pathology services will be quarantined from the Federal Government's overhaul of Medicare in a major concession secured by the profession in exchange for dropping its campaign against the axing of bulk billing incentives.

Under the deal, the Government said it would "not change the Pathology Services Table, excluding those from the MBS Review, for the next three years, without consultation and agreement with the sector".

Royal College of Pathologists of Australasia President, Dr Michael Harrison, said the arrangement meant "there will be a moratorium for the next three years on any further changes to [the] Pathology Services Table without agreement from the profession".

As part of the deal, the Government has also promised to hold off on axing pathology bulk billing incentives until measures are in place to clamp down on the rents pathologists pay.

But the AMA said the deal "doesn't guarantee anything".

"The cut to bulk billing incentives for pathology has merely been deferred. The cuts are still there, they're still taking $650 million out of health over the next four years," AMA President Brian Owler said.

Professor Owler said he had been in contact with Pathology Australia about the deal, and they had admitted there was no guarantee the pathologists would continue to bulk bill.

"They don't have the ability to make that guarantee, and it will be up to the individual pathology companies to actually make that decision over time," he said.

Under the deal struck with Pathology Australia, the Government has committed that, if it is re-elected, it will introduce provisions to the Health Insurance Act to clarify what is meant by 'market value' and link it with local commercial market rents.

This will be backed by "appropriate compliance mechanisms", and those seeking to register collection centres will need to provide more information.

There are around 4000 collection centres across the country, and the Government will need to consult closely with general practice to ensure that the new regulations are not simply a form of price control that puts many existing leases into jeopardy.

The Government has declared there will be a moratorium on any new collection centre approvals until the new regulations are in place, and "the measure to remove bulk billing incentives will commence at the date that the changes to the regulatory framework take effect".

The AMA's election plan...continued

...from page 1

The AMA's push to lift the rebate freeze has seen campaign materials and information released and members urged to join in the conversation. The onus is on the Turnbull Government to step up and show that they're willing to support hard working general practitioners.

More information on the campaign can be found at ama.com.au

Public Hospital Funding

With the Turnbull Government having announced a further $2.9bn in extra public hospital funding over the forward estimates, it's now up to the ALP to announce its plan for our hard-pressed public hospitals. While it's likely the ALP will make a major announcement prior to the election, one thing's for certain – whoever is in government after 2 July will face major challenges in ensuring that public hospitals can keep up with the growing demands being placed upon them.

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The AMA's 2016 Federal Election Positions in a Nutshell

Issue	The AMA calls on the major parties to commit to:
Medicare Benefits Schedule Indexation Freeze	• immediately reverse the indexation freeze upon taking office • lift future indexation of patient rebates to levels that cover the true cost of providing high quality health services
Public Hospitals	• provide certainty to Commonwealth funding for public hospitals with a long-term plan that provides sufficient funding for at least a decade • ensure public hospital funding is quarantined from opportunistic policy making in the short term political cycle • at a minimum, include adequate provision for population growth and demographic change, and provision for annual indexation at a rate that is relevant and appropriate to the health goods and services costs incurred by hospitals.
Removal of Pathology and Diagnostic Imaging Bulk Billing Incentives	• a genuine interest in health policy, not just fiscal policy • maintain the current subsidies – the bulk billing incentives must not be removed
Medical Workforce and Training	• ensure that the medical workforce meets future community need by: • requiring the National Medical Training and Advisory Network to complete workforce modelling across all medical specialties by the end of 2018; • establishing a Community Residency Program to provide prevocational doctors with access to three month general practice placements, particularly in rural areas • increasing the GP training program intake to 1700 places a year by 2018 • further expanding the Specialist Training Program to provide 1400 places a year by 2018, with priority given to training places in rural settings, specialties that are under-supplied, and generalist roles
Tackling Chronic Disease	• appropriate funding for the planned Health Care Homes trial • use the DVA CVC program as the basis to calculate how much extra money is required. This is essential if we are to improve care for patients and ease pressure on the hospital system as a result
Indigenous Health	• correct the under-funding of Aboriginal and Torres Strait Islander health services • establish new and strengthen existing programs to address preventable health conditions that are known to have a significant impact on the health of Aboriginal and Torres Strait Islander people such as cardiovascular diseases (including rheumatic fever and rheumatic heart disease), diabetes, kidney disease, and blindness • increase investment in Aboriginal and Torres Strait Islander community controlled health organisations. Such investment must support services to build their capacity and be sustainable over the long term • develop systemic linkages between Aboriginal and Torres Strait Islander community controlled health organisations and mainstream health services to ensure high quality and culturally safe continuity of care • identify areas of poor health and inadequate services for Aboriginal and Torres Strait Islander people and direct funding according to need • institute funded national training programs to support more Aboriginal and Torres Strait Islander people to become health professionals to address the shortfall of Indigenous people in the health workforce • implement measures to increase Aboriginal and Torres Strait Islander people's access to primary health care and medical specialist services • adopt a justice reinvestment approach to health by funding services to divert Aboriginal and Torres Strait Islander people from prison, given the strong link between health and incarceration • appropriately resource the National Aboriginal and Torres Strait Islander Health Plan to ensure that actions are met within specified timeframes; and • support for a Central Australia Academic Health Science Centre. Central Australia faces many unique and complex health issues that require specific research, training and clinical practice to properly manage and treat, and this type of collaborative medical and academic research, along with project delivery and working in remote communities, is desperately needed
Rural GP Infrastructure Grants	• address the problems that led to the poor take up of GP infrastructure grants in the last funding round • an increase of a further 425 grants in the next term of Government; and • scrap the requirement for practices to match funding on a dollar for dollar basis
Prevention	• fund prevention and early intervention as a sound and fiscally responsible investment in Australia's health system • increase investment to properly resource evidence-based approaches to preventive health • deliver sustainable funding for non-government organisations (NGOs) that advocate, educate and provide services to those affected by chronic diseases and health problems, including alcohol and substance abuse, domestic violence, blood-borne viruses, aged care, mental health and public health awareness
Tobacco	• ban the sale of e-cigarettes to anyone aged under 18 years; • ban the marketing of e-cigarettes as smoking cessation aids, as there is currently no evidence to support this • apply the same marketing and advertising restrictions to e-cigarettes that apply to tobacco products • provide funding to support the various jurisdictions to pursue more smoke-free environments, recognising that nationally consistent legislation around smoke-free environments is in everyone's best interest. All Australians deserve an opportunity to dine, socialise and work in completely smoke-free situations • appropriate funding for doctors who take the time to support their patients through the process of smoking cessation. Such funding recognises that patients require tailored advice, and may require ongoing support to reinforce their decision to quit smoking • continued funding for international litigation to fight efforts to undermine Australia's world leading tobacco control measures, including Plain Tobacco Packaging
Physical Activity	• a National Physical Activity Strategy that clearly defines practical, prioritised and evaluated measures and national indicators of physical activity participation • bring together stakeholders and all tiers of government to help boost participation rates in physical activity, especially among those groups known to have low participation rates • work with State and Territory governments to provide structured opportunities for young people to be physically active • champion low and no-cost opportunities and providing information about easily accessible participation in physical activity • make active transport measures a priority in all transport and infrastructure policies. Many countries have developed innovative ways to provide and promote active transport, and in turn reap the benefits. The Government should be examining these, and applying them to the Australian context

The importance of good relationships with your colleagues

BY **KAREN STEPHEN, RISK ADVISER, MDA NATIONAL**

A Surgeon had set up practice in an outer metropolitan suburb eighteen months previously. He had steadily built up his number of patients and had been working hard on the administrative side of the practice. Out of the blue, he received a letter from AHPRA saying a patient had made a complaint about his post-operative care. It had been a complex case but the Surgeon had thought the patient was satisfied with the outcome of surgery. The letter of complaint indicated that the patient had seen another local Surgeon for a second opinion. Shortly afterwards the Surgeon received a letter from the hospital about an audit of his cases, prompted by a complaint from the same local Surgeon.

Rivalry between doctors has been around since 400BC with the rivalry between Hippocratic and Western Greek doctors. One doctor criticising another doctor's care has been labelled "jousting"[1] and has caused complaints and negligence claims. Conversely, a supportive relationship between colleagues has been found to reduce the chance of being sued after an unexpected event.[2]

Courteous communication with colleagues is expected by the Medical Board:[3]

Good medical practice involves:

4.2.1 Communicating clearly, effectively, respectfully and promptly with other doctors and healthcare professionals caring for the patient.

4.2.2 Acknowledging and respecting the contribution of all healthcare professionals involved in the care of the patient.

4.2.3 Behaving professionally and courteously to colleagues and other practitioners including when using social media.

Maintaining good professional relationships

- "Network" – talk to colleagues at conferences about patients.
- In letters to referrers explain your treatment rationale. Clarify responsibilities where several colleagues are involved in patient care.
- Be approachable to junior and other staff – a call directly to you may allow you to intervene before a situation gets out of hand.[4]
- Deal with any dispute with a colleague quickly, professionally and without involving patients.
- Refrain from engaging in arguments or inflammatory commentary with colleagues.
- Refrain from airing grievances on social media or by email. One Surgeon who exchanged angry emails over a "turf war" five years ago still has these emails appear on the first page of a google search of his name.
- If you have difficult relationships with colleagues, consider doing a course such as one of the colleague interactions series run by the Cognitive Institute.[5]
- If asked for a second opinion, avoid making disparaging comments about other doctors.

A dispute between two Surgeons involved one Surgeon sending a series of letters to hospital administrators, patients on a waiting list, medical insurers, the AMA and a hospital medical staff representative. The letters included concerns about the other Surgeon's post-operative care. The other Surgeon sought damages for defamation. A lengthy case, appeal and cross-appeal ensued, with the original claim successful in part.[6]

If you see a colleague's error:

- Obtain the facts first – do not communicate or act on speculative information.
- Avoid insinuating to a patient that another doctor's treatment was inadequate. The patient may misquote you and you may not get the chance to explain what you really said.[7] You may also get named in a claim made by the patient.
- Consider what is best for the patient.
- Ask yourself if this is an error or a legitimate difference in medical opinion.
- Consider any hospital/ institutional requirements.
- Think about whether this falls within mandatory reporting requirements.[8]
- Ask yourself how you would want to be made aware if you were the involved clinician.
- Seek advice from MDA National.

Medical records

Raising concerns in the medical records may appeal because it avoids a direct conversation, but it doesn't allow the colleague to address misunderstandings, and it creates evidence which may be used in a negligence claim. Document objectively, without criticising others' care. Ensure your notes adequately reflect your treatment plan and rationale

Contact MDA National on 1800 011 255 or peaceofmind@mdanational.com.au with your medico-legal enquiries. We're here to support our Members.

This article is provided by MDA National. They recommend that you contact your indemnity provider if you need specific advice in relation to your insurance policy.

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Dr Yeong Joe Lau is an Australian trained orthopaedic surgeon with an interest in disorders of the lower limb. He has now returned to Canberra to start practice after completing local and international fellowships in foot, ankle, knee and hip surgery.

Joe operates at The Canberra Hospital, Canberra Private Hospital and National Capital Private Hospital. He consults from The Specialist Consulting Suites at Canberra Private Hospital.

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Legal risks in sham contracting

Is the cleaner you hire to tidy your practice once a week a contractor? What about the receptionist who works on a casual basis? We thought it might be time for a reminder of the risks in hiring contractors that may in fact be regarded at law as employees.

The recent unanimous High Court decision in *Fair Work Ombudsman v Quest South Perth Holdings Pty Ltd* [2015] HCA 45 highlights the heightened focus regulators have taken on sham contracting arrangements, and the dangers of non-compliance when upheld in Court. Here's what you need to know about sham contracting – whether you're an employer or an employee.

What is Sham Contracting?

Sham contracting occurs when an employer treats a worker as an independent contractor when they're not. Section 357 of the *Fair Work Act 2009* (Cth) prohibits an employer from representing to an employee that a contract of employment is, in fact, a contract for services under which the employee would work as an independent contractor.

With an increasing number of Australian businesses relying on a flexible workforce, some employers try to engage workers as independent contractors to avoid legal obligations towards employees such as payment of payroll tax, workers compensation premiums and superannuation contributions.

In addition, sham contracting contraventions are invariably coupled with failures to comply with employee minimum entitlements, such as the National Employment Standards and applicable award provisions. It's not always deliberate, but regardless of how the arrangement comes to be, it is illegal and viewed seriously by the regulators.

The ATO and other regulatory agencies have the power to investigate employers where sham contracting arrangements are suspected. Prosecutions may result for unpaid superannuation, underpaid workers compensation insurance premiums and recovery of unpaid wages and entitlements. Businesses found to have engaged in sham contracting will also be liable for significant pecuniary penalties under the *Fair Work Act 2009* (Cth) sham contracting provisions. Once an employer has had one finding made against it to the effect that a "contractor" is in reality an "employee" other authorities will almost certainly be interested. This makes getting your contracting relationships wrong an expensive experience.

What's the Difference?

Since both independent contractors and employees trade their labour for money, how is an employee to be distinguished from an independent contractor?

Unfortunately, making the distinction is not straightforward.

The distinction between employees and independent contractors is reflected in the *Fair Work Act 2009* (Cth) and other employment legislation by restricting benefits and entitlements like annual leave and unfair dismissal rights to employees as distinct from independent contractors. However, there is a perennial problem in the employee/contractor distinction because there is no simple and clear definition in the legislation which distinguishes the two.

The authorities will look at the totality of the relationship between the parties when determining whether an individual is an independent contractor or an employee.

A court will look beyond contractual descriptions to the real substance of the relationship and the nature of the interactions which constitute their relations using a range of factors, none of which will be determinative. Ultimately, it will be a question of fact determined by all the surrounding circumstances. Case law suggests that the following are key assessment criteria:

- Who has effective control over the way the work is performed, the place of work and hours of work?
- Can the worker perform work for others and do they have the genuine right to do so?
- Does the worker have their own place of work or are they available to work in other locations?
- Does the worker use their own tools and equipment?
- Is the worker able to delegate or sub-contract the work to others?
- Can the worker be suspended or dismissed?
- Does the worker present to the world at large as an employee?
- How is the worker paid? (for example a weekly wage as opposed to invoice on completion of tasks)
- Is the worker paid a gross amount or is tax withheld before payment?
- Does the worker receive paid holiday and sick leave?

In essence, a true contracting arrangement is one between a person or entity in business for themselves who, as a contractor, is engaged to provide services to another as their principal whereas an employee is in a "master-servant" relationship with their employer – that is, a relationship of personal service.

So the Jim's Cleaning person you hire to clean your practice once a week is a contractor, while the person you hire as your receptionist working business hours in your practice five days per week is an employee (whether full time, part time or casual).

This article appears courtesy of AMA NSW and "The NSW Doctor".

Key points:

1. Determining whether an independent contractor is really an employee can be difficult and will ultimately be determined by a Court or the ATO.
2. Employers need to rely on accepted guidelines from case law where there is uncertainty. This involves careful consideration in each situation and includes weighing up how the parties work together.
3. There are serious implications if you get it wrong – including liability for underpayments (particularly annual and long service leave), unpaid superannuation and tax and penalties for sham contracting.
4. Increasingly, the Courts are focusing on the independent contractor's business and its client base. If the company is the only client, it can significantly increase the risk of the contractor being found to be an employee.
5. If you engage independent contractors directly (not through a company), particularly on a full-time basis, you should review your practices and test whether – in actual fact – the independent contractors should instead be treated as employees.
6. Even where a person is a "real" independent contractor, in some cases a company may need to make superannuation contributions on the contractor's behalf (increasing the associated costs by 9.5%).

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Thyroid nodules

BY **DR ROHIT TAMHANE,** MBBS FRANZCR

Palpable thyroid nodules are estimated to occur in approximately 1% of males and 5% of females living in non iodine deficient locations. Ultrasound evaluation of thyroid reveals nodules in 50% of adults, women more commonly than men.

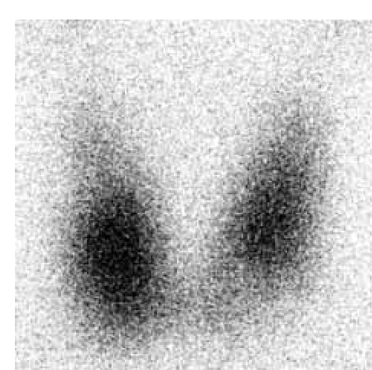
The incidence of thyroid cancer is increasing with differentiated (papillary and follicular) cancers comprising up to 90% of all thyroid cancers. The chance of a thyroid cancer being malignant depends on the age and sex of the patient; rapid nodule growth; palpable fixation of the nodule; presence of enlarged cervical lymph nodes and other syndromes including multiple endocrine neoplasia type II.

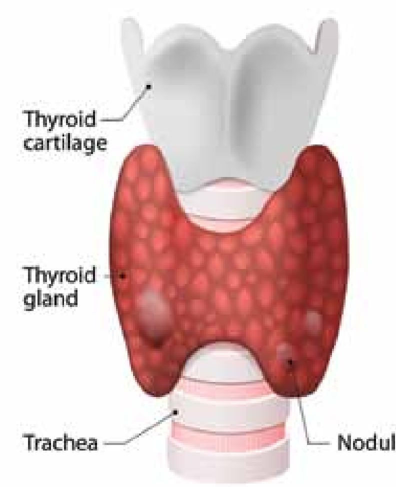
TSH is often performed initially in the assessment of thyroid nodules. Most guidelines suggest patients with a low TSH should be further assessed with a thyroid nuclear study and patients with either a normal of high TSH should be assessed with a diagnostic ultrasound.

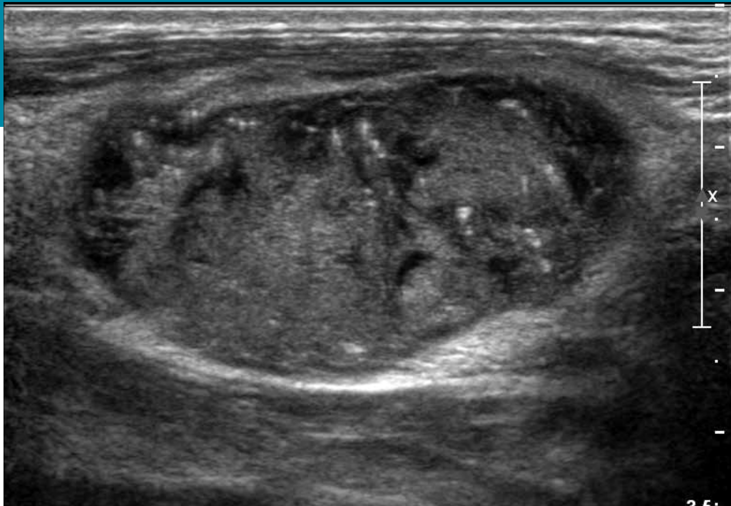
On thyroid scintigraphy, hyperfunctioning or "hot" nodules are most common. The risk of malignancy in "hot" nodules is less than 1% and therefore these nodules do not need biopsy. The reported rate of malignancy in non functioning or "cold" nodules is approximately 5% and therefore should be further assessed with ultrasound +/- biopsy. Scintigraphy is also useful in the further assessment of indeterminate nodules on ultrasound.

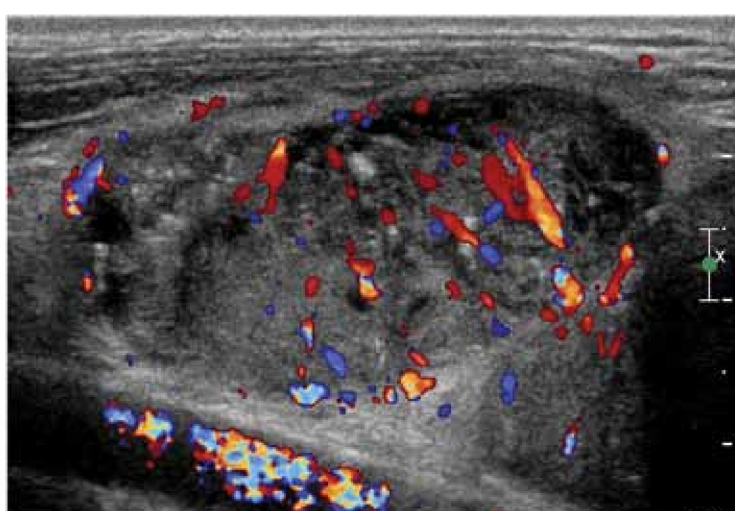
Ultrasound assessment of the thyroid gland allows excellent assessment of the thyroid nodule, the rest of the gland and assessment of cervical lymph nodes. Ultrasound features that suggest an increased likelihood of malignancy in a nodule include: microcalcifications (macrocalcifications are common in benign nodules), taller than wide appearance, internal vascularity and enlarged cervical lymph nodes on the same side of the neck.

Ultrasound guided fine needle aspiration (FNA) biopsy of thyroid nodules is a commonly performed procedure. The most common adverse effect of thyroid FNA is bleeding. This is most common in deep lesions or lesions with greater than 50% cystic component and indeterminate specimens, and this can depend on the experience of the doctor performing the biopsy. Rarer complications include: delayed diffuse thyroid swelling; recurrent laryngeal nerve palsy; cervical radiculopathy and post aspiration thyrotoxicosis.









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General practice: patient privacy checkup

The Office of the Australian Information Commissioner (OAIC) has recently released their privacy assessment report examining the privacy policies of 40 general practices across Australia.

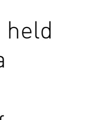
Chair of the AMA Council of General Practice (AMACGP), Dr Brian Morton, who runs a busy suburban general practice in Sydney, has reiterated the AMA's position that patient privacy is a priority for every GP and every general practice.

Dr Morton said that the OAIC report showed that some general practices needed to do more to ensure that they had a privacy policy that was *fully* compliant with the Australian Privacy Principles (APP). The report does not suggest that patient privacy had been in any way compromised by any of the practices.

"Privacy law is a very complex area and this report, which looked at a small sample of practices, is an important reminder that general practices should review and update their privacy policies on a regular basis," Dr Morton said.

The OAIC report provides some useful guidance for GPs, highlighting how practices could improve their privacy policies, including:

- how easily policies could be read and comprehended;
- the provision of appropriate contact information, and provisions in the event an individual wanted to access or correct information held about them, or make a complaint;
- identifying the kinds of personal information collected and held, as well as why and how it is collected and held;
- describing the reasonable steps the practice took to protect patient information, and how a privacy complaint is dealt with; and
- how health information (including Individual Health Identifiers and prescribed medicines) is collected, used, or disclosed through the MyHealth Record system and the Electronic Transfer of Prescriptions (eTP) service.



Dr Morton said that patient privacy is fundamental to the trust relationship between doctors and patients, and practices go to great lengths to ensure the privacy of their patients' records.

"General practices are serious about protecting patient privacy, but the report sends a clear signal that we can do better, including with getting all the paperwork right," Dr Morton said.

"The AMA has already acted upon the concerns of the OAIC, updating our own Privacy and Health Record Resource Handbook to include an updated privacy policy template to guide practices when writing or updating their privacy policy.

"This resource is available on the AMA website at https://ama.com.au/article/privacy-and-health-record-resource-handbook-medical-practitioners-private-sector

"The AMA will continue to work with practices to help them to navigate privacy laws, and have in place the right policies and processes to satisfy their legal and ethical obligations," Dr Morton said.

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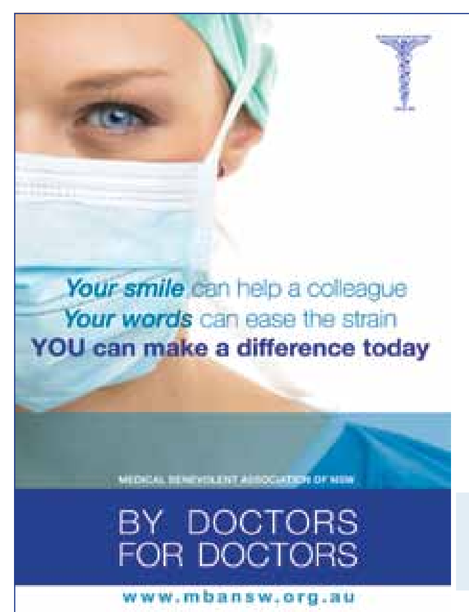

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The MBANSW is funded by your donations; please allow us to continue to provide support and assistance to your colleagues in need by making a donation to the Medical Benevolent Association Annual Appeal. Donations can be made visiting our website www.mbansw.org.au

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What do you know about leave?

How well do you know the leave provisions in ACT Medical Practitioners Enterprise Agreement? Do you know how many different types of leave you have an entitlement to? Would it surprise you to know that there are *forty three* types of leave available to you?

The most common forms of leave you're probably aware of are annual leave, personal leave, maternity leave, study leave and conference leave.

Annual and Personal Leave

A full time forty hour per week employee is entitled to 160 hours annual leave per year. If you are regularly rostered to work Sundays, for each Sunday worked you accrue an extra 0.1 weeks leave up to a maximum of five days. Annual leave accrues on a daily basis from the commencement of employment. Unused annual leave is paid out on separation from the ACTPS. As a general rule, leave applications should be lodged as soon as possible, but there is no guarantee that they will be approved.

Personal Leave (including what used to be called Sick Leave) is available to you if you are unfit to work because of personal illness or injury. It is also available if you are required to provide care to a member of your immediate family or household who is ill or injured. There is provision to take personal leave in extraordinary or unforeseen circumstances. If you have prior service with another hospital or health service recognised under the Public Sector Management Act for personal leave purposes you will be credited with any personal leave balance accrued with your previous employer.

If your employment contract is for twelve months or longer you are credited with 3.6 weeks personal leave on commencement of employment and an additional 3.6 weeks annually. Short term temporary employees (employment contract less than twelve months) receive a one week credit after four weeks and an additional 0.2 weeks credit every four weeks up to a maximum of two weeks.

Maternity Leave

An employee who is pregnant is eligible for 52 weeks maternity leave.

An employee who is eligible for maternity leave and who has completed twelve months of continuous service, including recognised prior service, is eligible for paid maternity leave of eighteen weeks in addition to payment under the Federal paid maternity leave scheme.

Study leave

Study leave may be granted to JMOs other than Interns, subject to the provisions of Clause 106 of the Enterprise Agreement.

For face to face courses half hour study time for every hour of compulsory lecture and/or tutorial attendance, up to a maximum of four hours study time per week may be granted.

Where no face-to-face course is provided a maximum of four hours study time per week for a maximum of 27 weeks per year may be granted.

Approved study leave may be accrued to a maximum seven working days to enable study prior to a written, oral or clinical exam.

Employees who have given continuous service of more than one year shall be allowed to accrue study up to a maximum of 14 working days.

Study leave accruals are not paid out on termination of employment.

Conference Leave

The Agreement is silent on the amount of Conference Leave available to Junior Medical Officers to attend conferences and workshops associated with their field of study. One limiting factor would be the amount of expenses associated with attending that are able to be claimed for reimbursement.

These expenses, limited to a maximum of $3,062 per annum for Resident Medical Officers, Registrars, Junior Registrars and Senior Registrars and $2,041 per annum for Interns, are to be reimbursed (upon presentation of appropriate documentation) by the employer, provided that no expenses or allowances shall be payable in respect of travel or accommodation outside Australia, except where that travel is approved in advance.

The 38 Other Forms of Leave

Hidden away in the Communication and Consultation section of the Agreement is a sub-clause titled "Attendance at Industrial Relations Courses and Seminars". The little publicised clause provides for employees to attend recognised short courses and seminars for the purpose of gaining a better understanding of industrial relations issues relating to the Agreement. Leave with full pay for a maximum of fifteen days or shifts in any calendar year may be granted.

Annex E to the Agreement contains details of some of the more unusual leave types.

These include unpaid leave to accompany your domestic partner for the period, or part of the period, of a posting.

You may be thinking of standing for election to the Commonwealth Parliament, or maybe the ACT legislative Assembly. To assist with campaigning you can access three months unpaid leave.

If you were to volunteer as an organ donor you would be entitled to three months paid leave in any year. As a blood donor you are also entitled to paid leave to cover time necessary to attend including travel time and time to recover.

If you are in the Australian Defence Force Reserve you are entitled to up to four weeks paid leave in order to fulfil training and operational duty requirements.

If your residence or its contents is significantly damaged in a disaster you can access three days paid leave in any twelve month period.

Ten days unpaid leave in a two year period is available to attend a ceremony integral to the practice of your religious faith.

Have you been selected by an official sporting body to attend a national or international sporting event as an accredited competitor or official? Leave with pay is available to attend training and the event.

If all else fails you could apply to "Take leave where leave cannot be granted under any other provision". This is available for up to twelve months, usually unpaid, but in special circumstances may be granted on full or half pay.

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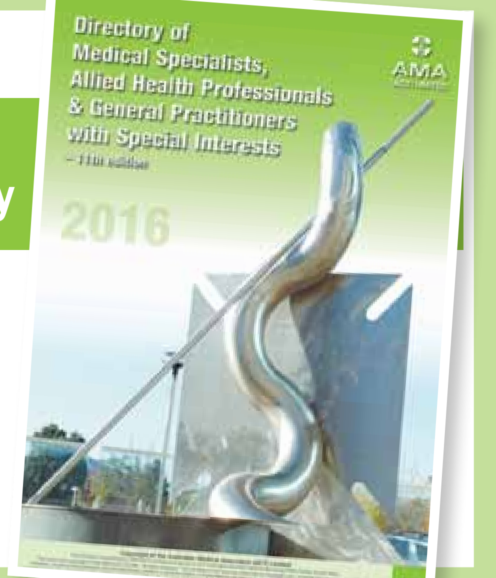

Would you like to help AMA (ACT)?

The work of AMA (ACT) thrives on the contribution we get from our volunteers and helpers. Whether that be as an officer bearer or board member, member of our Advisory Council, Council of Doctors in Training, *Canberra Doctor* Editorial Committee or contributor to *Canberra Doctor*.

With Prof Steve Robson taking over as President of AMA (ACT) and a new Board in place, opportunities have arisen for you to assist us on the AMA (ACT) Advisory Council and the editorial committee of the *Canberra Doctor*.

AMA (ACT) Advisory Council

The Advisory Council, chaired by Dr Rashmi Sharma, is established by the AMA (ACT) Constitution to provide a forum for policy development and policy review and to provide advice to the AMA (ACT) Board on policy matters.

The format of the meetings usually sees a brief verbal report from the craft and special interest group representatives and then a discussion on a particular policy issue or issues. With this being an election year in the ACT, the Advisory Council has been considering the issues relevant for AMA (ACT) to be pursuing in the lead up to and during the election period.

The Advisory Council is made up of representatives of the various craft groups, together with salaried doctors, medical students and doctors in training. In addition, the AMA (ACT) President is a member as are the AMA (ACT) representatives to the AMA Council of General Practice, Council of Salaried Doctors and Council of Doctors in Training.

The AMA (ACT) Advisory Council usually meets three times a year on a Wednesday evening starting at 6.30pm at the AMA (ACT) offices in Barton. Dinner and refreshments are provided.

For more information or to join the Advisory Council please contact Peter Somerville on 6270 5410 or execofficer@ama-act.com.au

Canberra Doctor Editorial Committee

The *Canberra Doctor* is produced in ten editions each year and is the primary means by which the AMA (ACT) communicates with the medical profession in Canberra and the surrounding region. With the recent resignation of the chair of the Editorial Committee, AMA (ACT) Board has called for expressions of interest both as chair of the committee and for positions on the committee. Committee meetings are usually held on the second Thursday of each month from February to November with the meeting commencing at 6.30pm for about an hour.

Any assistance members feel able to contribute, either as a members of the committee or as a contributor to the *Canberra Doctor* would be most welcome.

For more information or to join the *Canberra Doctor* Editorial Committee or to contribute to the *Canberra Doctor*, please contact Peter Somerville on 6270 5410 or execofficer@ama-act.com.au

Dr Rashmi Sharma, Chair of the AMA (ACT) Advisory Council

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WASHINGTON POST: WONKBLOG

The sobering thing doctors do when they die

BY CAROLYN Y JOHNSON

In "How Doctors Die", a powerful essay that went viral in 2011, a physician described how his colleagues meet the end: They go gently. At the end of life, they avoid the mistakes — the intensive, invasive, last-ditch, expensive and ultimately futile procedures that many Americans endure until their very last breath.

"Of course, doctors don't want to die; they want to live. But they know enough about modern medicine to know its limits," Ken Murray wrote.

A new study reveals a sobering truth: Doctors die just like the rest of us.

"We went into this with the hypothesis we were going to see very large differences," said Stacy Fischer, a physician who specializes in geriatrics at the University of Colorado School of Medicine. "What we found was very little difference to no difference."

The study in the Journal of the American Geriatrics Society examined 200,000 Medicare beneficiaries to bring some hard data to the question. They found that the majority of physicians and non-physicians were hospitalized in the last six months of life and that the small difference between the two groups was not statistically significant after adjusting for other variables. The groups also had the same likelihood of having at least one stay in the ICU during that period: 34.6 percent for doctors vs. 34.4 percent for non-doctors. In fact, doctors spent slightly more time in the ICU than non-doctors, the study found — not enough time to signify a clinical difference, but suggesting that, if anything, doctors may be using medicine more intensively.

In one regard, doctors seemed to die slightly better than non-doctors: 46.4 percent of doctors used hospice during their last six months compared with 43.2 percent of non-doctors. Doctors also spent nearly 2½ more days in hospice than non-doctors.

But these differences are small, and overall, they are far from the powerful mythology that doctors are dying better than the rest of the populace.

"Doctors are human too"

"Doctors are human, too, and when you start facing these things, it can be scary, and you can be subject to these cognitive biases," said Daniel Matlock of the University of Colorado School of Medicine.

This is striking because it is the opposite of what doctors say they'd prefer. One survey asked doctors and their patients what treatment course they would choose if they were faced with a terminal illness. Doctors said they would choose less medicine than their patients in almost all cases.

Many people have witnessed a death that seemed to be exacerbated by modern medicine: a drug that came with side effects but never seemed to halt the disease's progress, the surgery that was totally unnecessary and might even have sped up someone's death. Doctors have seen that happen even more often.

"Patients generally are not experts in oncology, and yet they have to make decisions without knowing what the whole course of their illness will be," Craig C. Earle wrote in the Journal of Clinical Oncology. "We, on the other hand, have shepherded many patients through this journey toward death."

That's why powerful anecdotes about doctors who die better, whose last moments are spent peacefully and with family, give us hope: There is a better way.

But Matlock and Fischer think their data may reveal the odds against the patient, even when the patient is a doctor. The health-care system may simply be set on a course to intervene aggressively.

Stopping the Train

"These things that encourage low-value care at the end of life are big systems issues," Matlock said. "And a strong, informed patient who knows the risks and benefits — maybe even they have a hard time stopping the train."

There are definite limits to the study: It could not control for differences in education or income among people in the sample. Most of the doctors who died were white men.

But the findings may reveal a deep bias that lies at the root of medicine. Fischer pointed out that the entire health-care system is aimed at fixing problems, not giving comfort. For example, a hip replacement the day before someone dies is something the medical system is equipped to handle: Surgeons can schedule it, and health insurance will pay for it. But, Fischer pointed out, if a patient needs less-skilled home care — such as help with feeding and bathing — it's much harder to write a prescription.

This article first appeared in The Washington Post on 6 June 2016.

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CANBERRA Doctor

A News Magazine for all Doctors in the Canberra Region

ISSN 13118X25

Published by the Australian Medical Association (ACT) Limited
42 Macquarie St Barton
(PO Box 560, Curtin ACT 2605)

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Advertising:
Ph 6270 5410, Fax 6273 0455
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Articles:
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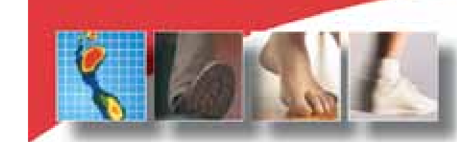

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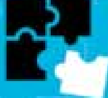

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