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12 steps to building powerful relationships

SMSF Health Check
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EDITOR’S MESSAGE

All Eyes On Healthcare Real Estate

Following the Healthscope IPO in 2014, there is increased interest from the institutional capital markets to invest in both healthcare operating platforms and healthcare real estate.

Further, there is an increasing trend for healthcare real estate sale and leaseback transactions in Australia to respond to the growing demand in Healthcare Services.

Demand across all health services is growing significantly, driven by Australia’s growing and ageing population, technology advancements and increasing private health insurance membership.

We believe there is an opportunity for existing practice groups and new doctors to participate in a new style of overall operating platform, one where the doctors remain the principals of, and in control of their practice, but take advantage of professional managerial expertise and operational economies of scale.

Secondly there is an opportunity to develop a healthcare real estate model to leverage this capital and the needs of doctors.

The Fintuition Institute, producers of The Private Practice program, are working with Healthcare Advisory firm Emerge Capital to design a strategic model that addresses the commercial, financial, operational and clinical aspects of healthcare property optimisation, acquisition identification, asset divestment and related due diligence.

We will be presenting this model at our upcoming Day Surgery Development Workshop in Sydney from Saturday 29 August – Sunday 30 August.

The content of our workshop has been designed in collaboration with the Australian Day Hospital Association – follow this link for course and registration details.

This two day workshop will guide delegates through the due diligence process as well as the project management and operational considerations for successful development and function of a day surgery/hospital. Topics for discussion include:

- Commercial Feasibility
- Operating Structures
- ‘Partnership’ Models
- Working with State Health Bodies
- Sourcing & Securing the Site
- Design and Construction
- Accreditation
- Dealing with Suppliers
- Dealing with Health Funds
- Staffing
- Leadership/Team Building
- Finance
- Facility Management
- Attracting Doctors
- Equity Participation Models

This edition of The Private Practice Magazine several articles of relevance to the topics above plus many more. We wish you happy reading and invite you to contact us via enquiries@theprivatepractice.com.au should you wish more information on any of our initiatives.

Steven Macarounas, Editor
editor@theprivatepractice.com.au
Amanda Low and Kenna Jefferson are uniting medical families across the country.

This is an extremely exciting time for the Australian Doctor’s Spouse Network (ADSN), as we have just concluded our very first meet the spouses picnics! These picnics are aimed at the spouses that have newly relocated to an area, and any that might want to meet other medical spouses and families. It gives the spouse an opportunity to get out and about with their families, and meet some others, and helps with the transition of moving to a new area.

ADSN held picnics in Sydney, Melbourne, Brisbane, Perth, Canberra, Wollongong and Newcastle.

Our very first picnics were small, causal and intimate, but the people who came were lovely, and gained lots from them. New friendships and networks were formed, and the promise of more meet ups between them to come. It was amazing to watch at the picnics, how small the medical community seemed to be and how although many people didn’t know each other, everyone had lots in common, purely because they were all medical families.

A huge thank you to all the people involved with the giveaways for the ADSN picnics – The Private Practice, Benchmark Financial Services, Beat Medical Recruitment, GSK insurance brokers, Brisbane?, and Dragonfly financial services.

The Australian Doctor’s Spouse Network will be holding more events through out the year to connect medical spouses and their families. We would love to hear suggestions on events, and locations that you would like to see ADSN facilitate. If you would like to be involved in the next ADSN spouse meet ups – please contact:

Amanda: adsn.amanda@gmail.com
Kenna: kenna.adsn@gmail.com

IT’S ALL ABOUT FAMILY
JOIN US!
Support the Australian Doctors Spouse Network by becoming a member, like us on Facebook, and checking out our web page, and remember to tell your spouse (and get them to join us).

www.australiandoctorsspousenetwork.com
facebook.com/AustralianDoctorsSpouseNetwork

twitter: AusDrSpouseNtwk

Amanda Low is a Registered Nurse and currently stay at home mother. Wife to a Plastic Surgical Trainee and is Co-Founder of Australian Doctor’s Spouse Network.
EVENTS

On the 12th and 13th of February our National network of medico specialist financial advisers gathered in Sydney to hear and ‘workshop’ the very latest techniques in adult learning.

Our objective; to continue to improve delegate engagement and the learning outcomes achieved at our courses and workshops.

Led by Christine Migliore, Director, Training and Education Medtronic Surgical Technologies, Asia Pacific, the two days of intensive training was enlightening, providing the tools and strategies for a more interactive, action-oriented education process.

We look forward to an exciting year ahead and invite you to review our program on page 17 and to follow this link for more information on our education partner network.
Financial Services

Advisers, Benchmark

David Silver and Bruno Dimasi

Time for an SMSF health check?

A case study from David Silver and Bruno Dimasi.

Recently, we’ve witnessed many media outlets refer to the ‘explosive’ growth in self-managed superannuation funds (SMSF) – a claim that the numbers appear to support. Between 2009 and 2014, the number of SMSFs increased by 29 per cent to 534,000. But something we’ve seen covered less in detail is how medical professionals in particular can harness the benefits of SMSFs.

While these may appear to be attractive benefits, we’d add a note of caution. In our experience, SMSFs are notoriously complex. In addition, as of March last year, the Australian Taxation Office (ATO) acquired new powers to deal with breaches by SMSF trustees, including administrative penalties and rectification directions. More than ever, trustees must make every effort to avoid potentially significant penalties.

But with control comes responsibility. By establishing an SMSF, you become the trustee. This means that you’ll need the time and desire to run your own fund, and that you are responsible if your SMSF does not comply with the governing rules. You should take this level of responsibility into account when considering whether an SMSF is appropriate for you.

As a rule of thumb, to justify the costs of establishing and running a SMSF, you’ll need to have a super balance of more than $250,000. Keep in mind that there might be additional costs, including accounting and auditing, as well as legal and actuarial services.

SHOULD YOU ESTABLISH AN SMSF?

Put simply, an SMSF is different to other super funds because it’s run by you. In this way, you’re not limited by the options offered by other funds; instead, you can invest, manage and build your retirement savings in a way that’s more tailored to your needs.

In terms of their structure, SMSFs are superannuation funds that are established for up to four members, backed by their own trust deed. In most cases, the trustees and members are the same. The trustees do the hard work of running the fund, including how to allocate assets. Such decisions are often made in consultation with experts, including accountants and financial advisers.

But with control comes responsibility. By establishing an SMSF, you become the trustee. This means that you’ll need the time and desire to run your own fund, and that you are responsible if your SMSF does not comply with the governing rules. You should take this level of responsibility into account when considering whether an SMSF is appropriate for you.

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THE ADVANTAGES OF SMSFS IN THE MEDICAL PROFESSION

Typically, an SMSF cannot acquire property from its members. However, an exception to this rule for property that is used ‘wholly and exclusively’ in a business may allow SMSFs to purchase a member’s practice rooms.

Under this exception, the SMSF may be able to purchase the medical practice from the member and lease the rooms back to the member’s business. This lease agreement must be drawn up on a commercial, arm’s length basis to avoid breaching superannuation law.

So, why would a doctor or medical professional seek to have their SMSF own their business premises? Essentially, there are two key benefits: tax concessions and asset protection.

First, superannuation funds pay a maximum tax rate on earnings of 15 per cent – which is half the current company tax rate. This means that the rent the SMSF receives from the business premises will be taxed at a much lower rate. In addition, because the rent is a business expense for the member (the doctor or medical practitioner), they can claim a tax deduction for rent.

In addition, a doctor or medical practitioner can access further tax advantages if their SMSF owns the property. When a doctor or medical practitioner retires, they may change the SMSF to an income stream and potentially sell the business premises without incurring capital gains tax (CGT). This is because, under current tax laws, income earned from assets that support a superannuation income stream are exempt from taxation.

Second, the SMSF structure can bolster asset protection. Under the Bankruptcy Act 1966, assets held inside a superannuation fund are given greater protection from creditors (subject to certain conditions). Given the potentially litigious environment of medicine, this extra level of security could be attractive to some doctors.

When thinking about using a SMSF to purchase their practice rooms, some medical professionals are concerned that they will not have enough super to cover the transaction. However, SMSFs may be able to borrow funds on a limited-recourse basis – provided they meet certain criteria. This means that you can boost your super balance by adding debt to cover part of the purchase price.

PUTTING THIS SMSF STRATEGY INTO PRACTICE

Let’s take a look at how a doctor could potentially use an SMSF to their advantage.

Carol is an ear, nose and throat specialist. She owns her practice rooms (in her own name), in which four other doctors work. With her husband, Tom, she has an existing SMSF. Carol’s friend, an ophthalmologist, suggests Carol should move the practice rooms into her SMSF to help lower her tax bill and further protect her assets.

To evaluate whether this strategy is suitable, Carol and Tom consult their financial adviser and accountant. One of their key concerns is CGT. After all, by selling her rooms to the SMSF, Carol will be disposing of the asset and may incur a CGT liability. Carol and Tom also need to check the trust deed of her SMSF. This is because, in some cases, trust deeds can be highly restrictive and prohibit the acquisition of certain assets, such as the medical practice.

SUPERANNUATION

The Private Practice Autumn 2015

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The purchase must also align with the scope of the SMSF’s investment strategy and the investment strategy should outline how trustees will manage the assets within the fund. Trustees must consider whether the practice investment meets the ‘diversification and liquidity requirements of their fund’. For example, trustees must ensure the SMSF will have sufficient cash to meet expenses into the future, including minimum pension payment requirements. It’s also important for Carol and Tom to be certain that owning the business property is strategically the appropriate thing to do, and does not for example, over expose them to property investments versus alternative investment options.

After consulting their financial experts, Carol and Tom decide to sell her practice rooms to their SMSF at market value. This is important to meet the arm’s length requirements of the ATO.

After this transaction, Carol must continue her business operation by entering into a lease agreement with the SMSF to rent the rooms.

YOUR NEXT STEPS
This article outlines the potential benefits of using an SMSF to purchase your medical practice. However, as you can see from the example above, it can be a complex transaction.

It’s important you take the time to devise the appropriate SMSF strategy. For one, you want to avoid falling foul of the ATO. More importantly, you want to implement suitable measures to enhance your benefits.

Given this situation, we recommend you seek expert advice on whether this is a suitable strategy for you. Financial advisers endorsed by The Private Practice can give you the guidance you need and work with your existing advisers, including accountants. These endorsed advisers have worked extensively with medical professionals and have a deep understanding of the individual issues you face and how to tailor solutions that are appropriate for your practice.

In our experience, high-quality advice in this field is critical. Maybe it’s time you booked yourself in for an SMSF-focused health check?

To discuss this article, or any other superannuation matter, please click on this link to our web site to find the financial adviser in your home state endorsed by The Private Practice.

Australian Taxation Office: ‘SMSFs investing in property: tips and traps’

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An integrated approach

BRISBANE SKIN and WESTSIDE DERMATOLOGY – a practice profile.

All through medical school, Dr Shobhan Manoharan had the ambition to become a plastic surgeon. When he graduated in 1999 from the University of Queensland, he negotiated a highly sought-after plastic surgical resident rotation at the Royal Brisbane Hospital that came with one caveat; it was twinned with a term in dermatology. Call it fate or opportunity, this signalled an interesting change in path. “I enjoyed the dermatology component even more than the plastic surgery. I loved the mix of ‘Medical, Surgical and Cosmetic’ in dermatology, and to this day that remains one of the mottos for my practices. The opportunity to work with lasers and devices also appealed to me greatly.”

Dr Manoharan completed his dermatology training in Brisbane and the United Kingdom, and in 2011 became co-director of the Westside Dermatology (WD) Group, Brisbane.

Is it a group practice – how does this work?

Over the following 4 years, Dr Manoharan and his co-director, Dr Davin Lim, have grown WD to become the largest private practice dermatology centre in Queensland, and one of the largest laser units in the country. Along the way, they have created offshoot dermatology sub-speciality clinics, such as Sweat Free Clinics, The Psoriasis Institute and Skin By Derms teledermatology service. WD is a team of 10 consultants, 2 nurse practitioners, 8 nurses, 15 support staff (including an administration manager and a full-time marketing manager).

Do you have employed doctors and paraprofessionals – how do you maintain quality control, and what kind of remuneration formula do you use?

The consultants pay a percentage of their billings as a service fee, and in return we provide them with the facilities, equipment and highly trained nursing and support staff. All our procedures are either performed by consultants or specialist dermatology registered nurses. We have rigorous selection criteria for staff. Staff selection is key, and careful consideration must be taken in regards to what individuals can bring to the team, and their interactions within.

We often select nurses who have extensive dermatology, plastic surgery or laser expertise, or employ young enthusiastic nurses who can be trained to become high-level specialist dermatology nurses by our consultants.

Ongoing professional development for all staff, nursing and support, are provided in-house, by external agencies and through courses and conferences. This has been a core philosophy since foundation and ensures that all staff is well-educated and up-to-date with advances in medical services and technology – this is particularly important in a rapidly evolving specialist cosmetic and laser practice.

We are particularly interested in your practice model and the integration of different forms of dermatology under the one roof – medical, surgical, cosmetic.

The theory behind Westside Dermatology is straightforward: build on the foundations of established medical dermatologists, add consultants with a varied range of medical and surgical skill-sets, then expand into laser and cosmetic practice. Another key component is the presence of nurse led clinics both medical (e.g. psoriasis, hyperhidrosis, acne) and cosmetic (e.g. laser hair removal, tattoo removal, basic cosmetic consultations).

The idea is to find niches in the market that can be serviced by your business, then putting in the appropriate, trained individuals to staff these at various price-points to suit the market.

For instance, a consultation with a psoriasis nurse practitioner is at a lower price-point than a dermatologist, but then patients may have access to specialist advice, initial assessment and treatment plans, and if necessary then have the opportunity to be triaged to higher level care either privately at the practice, or referred to the public hospitals (where many of our dermatologists also consult).

“When we started off, the wait-list to see a dermatologist varied from 6 weeks to 6 months. What we set about to do was change the traditional model of private practice dermatology, to have shorter wait-lists, and improve accessibility.”

Disruptive models in medicine
are often frowned upon, but Westside Dermatology embraced the concept, and set up rapid access services and invested in ethical marketing.

“We strive hard to maintain and expand our General Practice referral base, by providing an efficient, high-quality consulting service, and by being involved in GP education and interaction.

“However, we are well aware of the importance and the shift towards patient self-referrals also. Patients are more discerning, have done their research, and want to pick the provider of their choice. This is where marketing the practice is vital, and we do so enthusiastically in all forms of media, but within AHPRA guidelines.”

Following the 4 years of growth of WD and after overseeing the structural change of 2014, Dr Manoharan has decided to experiment with another project in the heart of Brisbane City, a boutique dermatology centre known simply as Brisbane Skin. Brisbane Skin is a novel concept in specialist dermatology dreamed up and created by Dr Manoharan and partner Dr Patricia Sutcliffe, Managing Director of the new practice.

The practice is a state-of-the-art facility offering medical, surgical and cosmetic dermatology in the heart of Brisbane in a brand new, luxurious environment. Natural elements have been generously incorporated into the design, to provide a welcoming environment aimed at making the entire patient experience relaxing and enjoyable. There is Spotted Gum timber throughout all areas of the practice, mixed with textured walls and feature lighting from the waiting room to the surgery.

This practice also differs from most other medical practices in that there is no traditional reception desk. Patients are greeted upon arrival and individually seated in the waiting room with iPads that are used for updating the patient’s medical records. All other reception duties, such as answering phones, making bookings and general paperwork are done in a completely separate area of the practice that is not visible to patients, to provide as much relaxation and tranquility to patient areas as possible.

All patient consultations aim to provide an extra level of service, whether for a consult with a dermatologist or to see a nurse. This is achieved through staff training in hospitality techniques, optimized patient transition between support staff and medical staff and all patient interactions – developing relationships between staff and each patient that comes to the practice is paramount.

With attention to patient experience as a base, Brisbane Skin offers the full range of dermatology services including medical consults, state-of-the-art laser facilities, and both dermatologist and nurse led cosmetic dermatology.

Have you considered planning for succession?

*With the WD entity our plan for succession would involve getting younger dermatologists on board with a view to transitioning interests over a number of years. However, with the Brisbane Skin model, we believe there may be an opportunity to franchise or provide a brand that may be attractive to a larger entity to acquire. Only time will tell...*
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A checklist and action plan for assessing your options with respect to buying in to or setting up your practice, and managing the process to fruition.

Practice Management and the Role of the Practice Manager:
A good practice manager is an invaluable asset, particularly during the period of practice set-up and establishment, but what exactly should this all-important role encompass, and how do you find and train the ideal candidate?

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The theory and tools for providing structure and systems for project and people management.

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Maximising practice and personal efficiency through smart adoption of technology and strategy.

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The use of family trusts and other mechanisms to help protect your personal assets from claim, plus proper planning to minimise adverse tax effects for beneficiaries.

Medical Practice Marketing:
Marketing communicates your promise – what differentiates yours from every other practice – but it also focuses on the way your practice delivers that promise: branding, generating referrals, the role of education, websites, internet, social media, patient experience and many more . . .

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Tips and strategy from commercial leasing and sales professionals.

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Understanding the importance of design on patient/customer attraction and satisfaction as well as efficient work-flow.

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“Thank you”

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Topics for discussion include:
• Commercial Feasibility
• Operating Structures
• ‘Partnership’ Models
• Working with State Health Bodies
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Further Information

Further details including confirmed presenters, course schedules, accommodation arrangements and social program will be forwarded upon registration.

In the meantime, should you have any queries please contact the Course Director.

Contact the Course Director to determine discounts available to you.

Steven Macarounas of Fintuition Institute on (02) 9362 5050 or via steven.macarounas@fintuition.com.au

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Chris Caton casts an economist’s eye on the financial state of the nation and at overseas indicators.

February was an outstandingly good month for the share market. The ASX200 rose by 6.1%, its strongest monthly gain since October 2011. This left it at its highest end-of-month close since December 2007. It was also the third positive month in succession, something that last happened in late 2013. The ASX200 is now above my end-of-year target of 5800, but for the moment I’m sticking with that guess. The share-market is, if not over-valued, then certainly fully valued right now. In accumulation terms, the market rose by 6.9% in the month, led by an 11.9% increase in the materials sector, the best since September 2007.

The US share market also rose strongly, by 5.5% as measured by the S&P500. It hit a record high on 24 February, finishing the month up by 2.2% year-to-date. The monthly gain in the S&P was also the strongest since October 2011. Of note, the Nasdaq is now less than 2% from its all-time high recorded as long ago as March 2000.

The US economy seems to be going through something of a soft patch (or perhaps just a cold patch). Its Q4 GDP growth was revised down from the first estimate of 2.6% to 2.2%, and the January production and spending numbers have been weak. That said, the labour market continues to do well. Employment has increased for a record number of months, and is growing at its fastest pace this century. Inflation remains low, with the CPI actually down by 0.1% in the year to January, due to lower oil prices, of course. The core CPI up by only 1.6%. The Fed remains convinced that it will begin to raise rates in mid-year, although at a pace not much faster than glacial.

The Greek situation could be characterised as “so far so good”. The Greek government has agreed to terms with the “troika” (the IMF, the European Union and the ECB) whereby the bailout agreement deadline has been extended to end-June (rather than end-February). If nothing else, this should contribute to lower market volatility.

Chinese economic data are always difficult to interpret in January/February because of the shifting timing of the Chinese New Year. Of most concern was a significant drop in imports of iron ore in January (after strong gains in 2014). Let’s hope this was a one-off! We also had a clear sign that it remains concerned about growth, the People’s Bank of China cut key short-term interest rates by 25 basis points on 1 March, for the second time in three months.

Also of global interest is the oil price. I suggested last month that the price may already have troughed. At the time, West Texas Intermediate was selling for $44 a barrel (although it doesn’t actually come in barrels!). That price is now around $50, so the forecast is certainly not wrong yet.

What I find most interesting is the fact that this oil price decline is treated in many ways as bad news. Last month I suggested that this is in part because it is treated as a “canary in a coal mine”—symptomatic of insufficient economic growth. And, of course, when the price falls, oil rigs are closed down and some people lose their jobs. But consumers eventually gain.

On this occasion, there is far more relative attention being paid to the losers than to the winners. When the Consensus Economics forecasts for February landed on my desk, I observed something that I’ve never seen before in close to two decades of following these data. Between January and February, the 2015 outlook for global GDP growth fell from 3% to 2.8%, quite a sizeable reduction in one month. And yet, the forecasts for the US and China were unchanged, and those for Japan and the Eurozone...
actually ticked up. So I investigated further and found major downward reductions in the forecasts for Canada, Nigeria, Russia, Saudi Arabia and Venezuela. What do those countries have in common?

MEANWHILE BACK IN OZ

The economic news was generally discouraging. This was particularly true of the labour-market report. After two months of strong employment gains and (small) declines in the unemployment rate, hopes that the corner had been turned were dashed when the unemployment rate rose to its highest level (6.4%) since August 2002. Later in the month, also, the news on plans for capital spending were not good, suggesting that business fixed investment was likely to fall significantly both this financial year and next. The weakness in mining capital spending is, of course, well-known, but these data suggested that non-mining capex will also remain moribund for a long time yet.

The national accounts for the December quarter of 2014 gave a good picture of the soft state of the economy. GDP, the nation’s output, increased by just 0.5% in the quarter and by 2.5% in the past year. Much of this growth came from exports—in volume terms—while residential construction and consumer spending also contributed. But the economy is being held back by the continued fall in mining capex and by little or no recovery in non-mining capex. In addition, falling commodity prices have stripped more than 2% from income growth in the past year.

The RBA made it clear in early March that it was prepared to proceed slowly with further interest-rate reductions. It is very doubtful that, when it eased in early-February, the RBA planned for that to be the only cut in this series. But the Bank does have the luxury of waiting to see if there are any signs of a slowdown in the housing market. So far, the answer appears to be no. In the year to February, capital-city house prices rose by 8.3%, up from the 8% recorded in the year to January. The early-March statement accompanying the decision made it clear that the Bank will ease further if necessary.

The currency did very little during the month, starting at 77.8 cents and finishing at 77.9 cents. It fell sharply after the early-month rate cut, but got that all back. My end of year forecast remains at 72 cents.

My end-of-year forecast of 5800 for the ASX200 (currently 5907) remains unchanged, although, as always, under review.
Bridging the Gap

In the tech sector, it’s common to hear that social media sites like Facebook, YouTube and Twitter are “connecting humans together”. Jason Borody says that there’s no doubt that such services have their uses, but we should be aware of their side effects.

Just as 24-hour news channels have found that negativity and fear spread faster than good news, social media has found this as well. The end result is a near-constant stream of negativity and fear, one click away, at all times. This has sweeping effects for virtually every industry, but the medical community has been hit harder than most.

Because trust is so important in medicine and healthcare, anything that would break that trust down can have devastating consequences.

The majority of the medical community comprises of doctors and nurses that genuinely care for their patients. However, like any industry, there are bad apples.

When a doctor or nurse performs in a way that is lacking in integrity, the consequences to the patient they treat can be severe. As a result, this patient may be driven to lash out at the healthcare practitioner or medical practice. This type of lashing out is just what the social media world thrives on, and is likely to spread incredibly quickly.

The end result is that we’ve all read articles about doctors making the wrong decisions. About nurses inaccurately dosing patients. About surgeons making significant, life-altering mistakes.

Although these situations happen very rarely, since the medical field covers so many people, they happen often enough to be commonly seen on the news, or social media. The end result is that even as medical practices and healthcare providers improve and get better, trust and faith in them is declining.

To say the least, this presents a massive problem to medical practices.

EARNING THE PATIENT’S TRUST

Although it’s not a good doctor’s fault that a bad doctor exists, sometimes on the other side of the world, good doctors must deal with the consequences. Don’t despair, there is a silver lining.

If a medical practice embraces this new patient paradigm, and takes a position of earning patient’s trust, they will be one of the very few practices that does so. As a result, even sceptical patients will come around, and eventually be the practices biggest fans.

Medical services are so vitally important to patients. When a patient finds a medical practice or doctor that “gets them”, they have found an invaluable asset they will never wish to replace.

Earning a patient’s trust starts the second they walk into the practice.

Everything in the practice should be designed to make them comfortable, and feel welcome. This goes from the furniture and décor of the place, to how they’re greeted when they check in.

Every member of the practice should deeply understand the importance of gaining the patient’s trust.

When a practice fully accepts their position as medical experts, and couple that with the growing distrust among patients, they can create an environment unlike anything the patient has seen.

Not only will this ensure patients come back as often as they need to, it also ensures that they will tell others about their phenomenal experience.

If you’d like to dramatically bridge the gap between you and your patients while still maintaining your reputation, Vividus can help. We develop strategies which help medical professionals grow their practice online and offline with targeted and strategic communication’s campaigns. Give us a call 07 3282 2233 or visit www.vividus.com.au and we’ll provide the marketing advice that best suits your needs.
Margaret Faux explains no payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance? In an article recently published in the Internal Medicine Journal, my co-authors and I have summarised a selection of available literature concerning medical practitioners’ understanding of Medicare claiming and compliance.

The seed of the paper originated in a systematic review of literature in this area which found that despite much commentary and opinion, little if any empirical research exists on this topic. We examined the complexity of day-to-day Medicare claiming, which has become labyrinthine to the point where it is beyond the comprehension of many, including medical practitioners who are largely dependent on Medicare for their livelihoods. The literature proffers that between $1-3 billion is leaked from Medicare each year as a result of inappropriate claiming (approximately 5-15% of total Medicare expenditure), yet no research has ever sought to critically analyse the potential causes of this phenomenon beyond suggestions of deliberate misuse of the system by rogue clinicians.

There exists an overarching assumption that doctors possess a high level of legal literacy in relation to Medicare claiming and compliance. However, the regulatory framework is complex such that a single medical service can be the subject of thirty different payment rates, numerous claiming methods and a plethora of rules, with severe penalties for incorrect claiming, including criminal sanctions. The evidence also suggests that despite Medicare claiming being a component of almost every interaction between a doctor and a patient in Australia, doctors receive little formal preparation in the proper use of Australia’s tax payer funded insurance scheme.

The administrative infrastructure required to support practitioners in relation to their claiming activities appears to have reduced over time, to the point where reliable advice and support is not readily available, and even senior members of the Australian judiciary have formed differing views concerning key elements of the operation of the scheme.

The majority of published manuscripts discussing inefficiencies in medical billing, particularly commentaries in peer reviewed journals, are quick to highlight medical practitioner rorting as a major factor (and sometimes the major factor) for Medicare billing inefficiencies. Our paper highlights that there may be other hypotheses to explain inefficiencies in medical billing beyond individual practitioner rorting. This approach acknowledges the complexity of the system and suggests that further rigorous, unbiased and critical exploration of this issue is needed.

In the spring of 2007 the then Minister for Human Services announced that $250 million in Medicare program savings had been achieved in the previous year through an education program for providers. This suggests a causal link between medical practitioner access to Medicare education and significant cost savings, and gives rise to an important question concerning why the current government has prioritised co-payments over alternative proven measures that do not impose burdens on consumers.

Other jurisdictions such as the U.S (where the 2012 Medicare services improper payments rate was reported as 8.5%) have recognised the need for the development of a national curriculum on the topic of claiming and compliance. Incorrect claiming is one of a number of reasons cited in the literature as contributing to Medicare’s current financial pressures. Others include an ageing population, the higher incidence of chronic disease and the increased use of expensive tests and treatments by doctors. However, these consumer changes in healthcare are a separate issue to inefficiencies associated with billing for those services, and both must be included in any discussion on system reform.

We conclude that research examining medical practitioner experiences and understanding regarding Medicare claiming and compliance is urgently required if we are to responsibly modernise Medicare, and that without further examination of this important topic, proposed Medicare reforms (including co-payments) may do nothing more than increase the incidence of both deliberate and unintentional non-compliance.

The new Health Minister Susan Ley has been charged with repairing the damage to the Medicare debate brought about by bullying ideologues. She will need to consult widely, it is true, but perhaps more importantly she will need to look within, because Medicare’s sustainability may depend more on internal efficiencies than artificially created price signals. As John Hewson said during the recent spill motion – ‘let’s hope politics gives way to policy’.

Margaret Faux is Managing Director of Synapse Medical Services.
Sonia Simms says you are never too young to leave your affairs in order. Think of it as a gift to your loved ones.

No matter what your age or life stage, you are never too young to start to put your financial affairs in order. You’re earning good money and work very hard for it so ensuring that it is protected and passed on according to your wishes is key. Our summary of estate and family planning gives you a checklist to have in place to protect your family and assets in the event that you pass away or get sick.

In your 30s completing your internship and earning a professional level of income. Married with a mortgage.

What you need
- Income protection insurance
- Wills
- Powers of attorney and guardianship
- Death benefit nominations in your superannuation
- Binding financial agreements

Why you need them
Income protection is important if you lose your job or cannot work because of accident or illness. Typically it meets your mortgage repayments and other debts, and ensures your house isn’t sold out from underneath you.

Wills allow you and your partner to leave your assets to one another and to protect your children’s inheritance if your surviving partner remarries.

A binding financial agreement (or a pre-nuptial agreement) can be put in place before, during or even after a relationship. It’s an agreement between two people about how their assets will be divided if their relationship breaks down. Such agreements are binding in Australia if they are correctly drafted and executed. They can be set aside by the Family Court, in some circumstances.

In your 40s – well into your career and may be in private practice. Married with children and increased mortgage.

What you need
- Income protection insurance
- Life insurance
- Trauma insurance
- Total and permanent disability insurance
- Wills
- Powers of attorney and guardianship
- Death benefit nominations
- Binding financial agreements

Why you need them
Income protection is important if you lose your job or cannot work because of accident or illness. Typically it meets your mortgage repayments and other debts, and ensures your house isn’t sold out from underneath you.

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In your 50s, at the peak of your career. No mortgage and your children are no longer living at home.

What you need
- Income protection insurance
- Life insurance
- Trauma insurance
- Total and permanent disability insurance
- Mutual wills
- Powers of attorney and guardianship
- Binding financial agreements
- Early inheritance for children

Why you need them
You may want to structure an early inheritance that you control and are around for to experience. Although nothing at law prevents you from making gifts to your children, there may be adverse tax and social security consequences for you and them. If you’re uncomfortable about the prospect of losing control of your assets, you can establish a trust to hold the assets you would like your children to benefit from, making yourself the trustee. This means the funds can be used to benefit your children, but you retain control.

An alternative structure of an early inheritance is to provide loans to your children, but this can also have adverse tax and social security consequences.
In your 60s, about to retire or transition to retirement

What you need
- Life insurance
- Trauma insurance
- Total and permanent disability insurance
- Wills
- Powers of attorney and guardianship
- Binding financial agreements
- Early inheritance for children/ grandchildren

Why you need them
You may want to structure an early inheritance that you control and are able to experience. Although nothing at law prevents you from making gifts to your children or grandchildren, be aware that there may be adverse tax and social security consequences for you and them. If you’re uncomfortable about the prospect of losing control of your assets, you can establish a trust to hold the assets you would like your family to benefit from, making yourself the trustee. This means the funds can be used to benefit your children and grandchildren, but you retain control. An alternative structure of an early inheritance is to provide loans to your family, but this can have adverse tax and social security consequences.

In your 70s – retired

What you need
- An up to date will
- Powers of attorney and guardianship / grandchildren
- Early inheritance for children
- Intergenerational wealth planning
- Aged care management
- Letter of wishes

Why you need them
Establishing a testamentary trust effectively allows you to rule from the grave. You can ensure that a trust over your assets is created on the day of your death, which means that rather than your assets being distributed directly to your beneficiaries, they are held for their benefit by a trusted individual or organisation. A testamentary trust protects your assets against third parties, and is especially effective if your intended recipients are likely to face a family law or commercial claim or bankruptcy.

Getting sound advice can make a difference to your financial position now and in the years to come. For more information on advice on estate planning, contact Michelle Gianferrari on 0421 446 513 or visit www.perpetual.com.au/medicalspecialists

Refer yourself to a specialist

A medico-specialist financial adviser

Medicos and other healthcare professionals are not like everyone else. When it comes to financial advice, you have particular needs, issues and concerns that need to be clearly understood from the outset. Which is why we’ve gone to considerable lengths to assemble a network of medico-specialist financial advisers – with extensive and successful medico experience. Like-minded professionals who will not only provide you with solutions but also educate you – so you can make fully-informed decisions. There’s a medico-specialist financial adviser in every state and territory of Australia.

Examine our network of medico-specialist financial advisers
DIVORCE AND SUPER

Self Managed Super Funds

and Divorce

Alexandra Cain explains the possible treatment of SMSF assets upon divorce and the tax ramifications.

According to the Australian Bureau of Statistics, the average age at which Australian couples are divorcing is increasing, with the median age for divorce for a male being 44.8 years. For women, this figure is 42.2 years. And these stats don’t include de facto relationship breakdowns.

The increasing age at which people are separating means they are more likely to have accrued enough assets to make it worthwhile for them to have established a self-managed super fund (SMSF). Indeed, the ATO’s figures show 39,514 SMSFs were set up in 2013, with the total number of SMSFs now numbering more than half a million funds. This makes it increasingly likely that an SMSF will be impacted by the asset split which generally evolves from a couple’s separation. So how are the assets in an SMSF treated in the event the members are separating and what are the tax implications?

Working out a property settlement upon separation is rarely easy. When it comes to deciding how the assets in a SMSF should be divided, there are special considerations, given that spouses who are separating may be members of the same SMSF and also trustees of the fund. Here we look at how the assets in the fund can be divided, what happens to the fund itself, and any tax implications as a result of transferring assets out of the fund or winding it up.

As a general principle, when a couple is separating, superannuation entitlements (including those in an SMSF) will be considered to be part of the group of assets that may be divided. As with other assets when a separating couple goes through a property settlement, the way assets are divided can be determined in two ways.

First a separating couple may agree how their superannuation interests are to be split. A ‘superannuation splitting agreement’ must follow strict legal formalities, including that both parties have received independent legal advice about the agreement. This is the path usually taken when the separation is relatively amicable.

The second approach is to have the Family Court decide how the property will be split following separation. If this is the case, then the court will generally need access to all the documents that relate to the fund, for instance the trust deed and any loan documents in the event the fund or its associated structures has borrowed money to invest in property.

OPTION 1

After it has been agreed that a party’s superannuation interest is to be split, either party may wish to exit the SMSF and transfer their superannuation interests (that is, both their pre-existing entitlements and those awarded (if any) as part of the property settlement) out of the fund. This could be to a new SMSF or another type of complying super fund. Capital gains tax may be incurred if the SMSF sells down its assets to generate cash for the transfer, but if assets are transferred in kind (that is, ‘in specie’) a capital gains tax concession may apply.

Alternatively, if the exiting party has reached an age at which he or she can access their superannuation interests, and has met other requirements (for example, they have retired), they may apply to receive payment of their benefits directly, rather than transferring to another super fund.

Under option 1, the exiting party would cease to be a member and trustee of the fund. The remaining member may retain his or her interest in the SMSF and continue to run the SMSF. It might also be possible to add other assets previously held outside the super environment to the fund.

However, unless the SMSF has a corporate trustee, the remaining member may need to appoint a corporate trustee or find another party who is willing to become an individual trustee, in which case the SMSF’s trust deed and other governing documentation may need to be amended to reflect the new situation.

OPTION 2

In the second option, the SMSF would be wound up after the existing members’ superannuation interests are adjusted according to the property settlement and all benefits are transferred to another SMSF, complying super fund or paid directly to the member. In this event, the trustees will have to go through the usual processes for winding up the fund, including filing a final tax return.

The tax implications of winding up the fund will vary according to the specific situation. However, capital gains tax liabilities may be deferred if the assets are transferred in specie to another SMSF or complying super fund. But it’s important to remember that even though the tax liabilities might be deferred when the assets are transferred out of the SMSF, they still exist. This is a consideration that should be made as part of the property settlement.

Whichever route is decided, it’s essential to seek advice from experts such as lawyers, accountants and financial planners who have had experience dealing with SMSFs that form part of a property settlement to ensure that both parties achieve an equitable resolution taking into account the potential tax liabilities.
Doctors, hospitals, insurance companies, and malpractice carriers have known for years that there is a direct correlation between patient satisfaction/patient complaints and lawsuits. Physicians have always prided themselves on being good communicators, but surveys show that they often overestimate their ability to communicate effectively with their patients. A well-publicized study reports that the average doctor interrupts a patient after 16 seconds during the interview process. So what can physicians do to improve their communication skills and lower their risk of lawsuits? Following are some ideas:

1. Prepare for your visit with the patient. Before entering the room, look at the chart or the electronic medical record, and know one or two facts about a new patient. This can be the patient’s referring physician or employment, or where the patient lives. The same applies to an existing patient. Don’t initiate the conversation talking about the patient’s medical problem. Regardless of your patient volume and how far behind in the schedule you are, start the conversation with some topic that is not associated with the patient’s health issues. This clearly sends a message that you care more about the patient than simply his or her blood pressure, shortness of breath, or dysuria.

2. Sit down – don’t stand – while speaking to a patient. Make every effort to be eyeball-to-eyeball with the patient. Never have a meaningful discussion when you are standing and the patient is sitting – or even worse, when the patient is lying down on the exam table.

3. If possible, don’t have any barriers – psychological or physical – between you and the patient. Be on the same side of the desk or exam table as your patient if you can.

4. Lean slightly forward when you speak to the patient. The patient will notice your body language before you even open your mouth. Leaning forward in your chair demonstrates a sincere interest in the patient.

5. Lock eyes with the patient. People normally make eye contact 70% to 80% of the time. If you fall below this average, you come across as shifty or lacking confidence. People who make less eye contact often aren’t aware of it, so ask a colleague to critique your eye contact.

6. Smile. Keeping a neutral face may feel natural, but the other person might perceive your expression as negative. People are looking for signs of approval, and the lack of a smile may even seem threatening and can make a patient defensive.

7. Don’t spend all of your time looking at the chart or the computer.

8. Don’t turn your back on the patient. This is disrespectful.

Ann Demarais and Neil Baum explain how to let your communication skills equal your clinical skills.
and a barrier to good communication. Avoid placing wall-mounted computers in the corner of the exam room in such a way that your back is toward the patient. This is certainly one advantage of mobile tablet PCs over fixed machines in the exam room.

9. Minimize interruptions. Nothing can derail your communication with your patient faster than being interrupted during the visit. It is very hard to get the train of thought moving in the right direction when you take a phone call, leave the room, or allow the staff to open the door to have you sign a prescription or an order.

Set guidelines for interruptions. Examples include the emergency department, the intensive care unit, or the operating room. If another physician calls, instruct your staff to say, "The doctor is with a patient; and if it is an emergency, I can interrupt him/her. If not, I can arrange for him/her to call you when he/she is between patients, which will be in 10 to 15 minutes." Most physicians calling another physician will respect this policy and allow you to call back.

10. Always ask the patient if his or her questions have been answered and if there is anything else that can be done to make his or her visit complete. This should be said while sitting down and not with your hand on the doorknob. The latter situation sends the message that you are finished with the visit and that you have mentally left the encounter with the patient. Asking the patient if there is anything left to discuss indicates that you are caring and you want to be sure that nothing unanswered is left on the patient's mind.

11. One technique is to use a 3 x 5 card given to the patients when they check in that asks, "What three questions would you like to have answered on your visit today?" When patients are in the reception area or the exam room, they can be filling out the card. This is a nice way to occupy time spent waiting to be seen by the nurse or the doctor, and ensures that a patient’s most pressing questions are answered during the visit. This also avoids the patient stopping the doctor in the hallway after the visit or calling back to have a question answered that the patient thought of after the doctor and patient have exited the exam room.

12. If possible, walk the patient yourself or have a nurse accompany the patient from the exam room to the checkout counter. Not only is this a nice courtesy and a sign of respect, but it also ensures that the patient will take care of the bill and make his or her next appointment. It is a fact that nearly every doctor will be involved in a lawsuit at some time during his or her career. It is estimated that only one in 100 doctors will make it through a career without facing a lawsuit. Although few lawsuits result in a damage award, the toll that a lawsuit takes on a doctor, his or her practice, and his or her family can be daunting. You can do damage control and stave off a lawsuit if you polish your communication skills and follow a few of the recommendations mentioned in this article.

BOTTOM LINE:
Improving communication with your patients means making the patient feel that he or she is the most important thing for that physician that day. Doing this will not only make you feel good and be a source of gratification, but will also reduce your liability and reduce your risk of lawsuits.
Ninh Van Bay & Danang

In part 1 of our Vietnamese family holiday story we featured the paradoxical Ho Chi Minh City, or as it’s still referred to by locals, Saigon, writes Steven Macarounas.

Frenetic, yet tranquil – there is a majesty and dignity to the rhythm and flow of HCMC that seems to marshal the chaos characteristic of many a south east asian city.

“It’s now time for deep relaxation. Our pre-dawn wake-up call stirs fuzzy heads in to consciousness, already packed (seasoned travellers after all), and following quick showers (almost redundant in this humidity) we make our way down to ‘the modern Asian art gallery’ that is the lobby of the Park Hyatt Saigon.

As it’s too early for the dining room, the ever-attentive and considerate staff have prepared a breakfast hamper for us which we attack in the maxi taxi on our way to the airport through streets already teeming with life.

Our brief Vietnam airlines flight delivers us to Nha Trang airport (once a US airforce base) at which a mini bus awaits to take us up the coast to a private jetty from which a speed boat whisks us across the idyllic, mountain surrounded waters of Ninh Van Bay to our final destination, the Six Senses resort.

As if arriving by speed boat is not dramatic enough, the eerily beautiful rock formations at each beach head, the glittering white coral sand, the lush tropical vegetation dotted with the thatched roofs of the villas discreetly peaking through the green, all make for the most grandest of entrances.

The Six Senses is an eco-resort, offering concentrated nature as its main feature; throw in stylishly rustic tropical island villas on the beachfront, the jungle or at the waters edge on the remarkably smooth rocks, and you have Gilligan’s Island with room service.

Speaking of service, it’s casual, relaxed and unobtrusive, in keeping with the promise of privacy, seclusion and space.

Our villa on the shore is an enormous two story beach house, understated yet sophisticated in its simple style and lay-out, made entirely of natural materials – as if designed by a world class architect marooned on a tropical island with only nature for tools.

Huge living areas, massive in and out-door bathroom, replete with deep wooden bath tub, day beds large enough for the whole family, our own salt-water pool, and only a few metres from the squeaky coral sand and refreshing sea.

The concept here is very cleverly executed, just enough facilities to provide a sense of resort life; great restaurants, a health spa, tennis courts, snorkelling, kayaking, cooking classes – but these are understated, casual, spread out and, in some cases, concealed by the surrounding vegetation and mountainous...
landscape; the overwhelming feeling is of a back-to-nature, back-to-basics beach holiday... ‘roughing it’ in comparison to your usual 5 Star resort, but certainly in style.

Before kids came into our lives 9 years ago, a resort based holiday was the furthest thing from our minds – now we are aficionados. We love a resort holiday at least once a year – as explained in earlier travel articles, to be effective at work and at home, I believe it’s crucial to re-charge your batteries as frequently as possible and to take the time to deeply connect with family, particularly young children if you have them – an exotic location with a bit of cultural adventure, gastronomic delights and the obligatory kids club certainly help.

Given limited time to achieve this, (certainly for most doctors who are loath to take more than 2 consecutive weeks holiday lest their practices crumble in their absence), the 5 star resort with impeccable hospitality and world class facilities at your fingertips certainly fits the bill perfectly. Our experience at Six Senses was definitely rejuvenating, and offered privacy and family ‘togetherness’ unlike any other resort we have experienced. Whilst not quite as luxurious as we are used to (we really have become embarrassing travel snobs), it is all the more memorable for it – the rustic, ship wrecked island feel was authentic and a real family pleaser and highly recommended for those wanting a unique holiday experience.
Back on a Vietnam airlines flight (really a most excellent carrier) making our way further up the Vietnamese coast to Danang, and our second of three resort experiences, Fusion Maia on the spectacular My Khe Beach.

Danang has been continuously inhabited since 192 AD, when it was first settled by Indonesians. Originally a part of the Champa Kingdom that ruled much of southern Vietnam until the 15th century, Danang has played an important part in Vietnamese history for many centuries.

Danang was colonised by the French in 1858 under orders from Napoleon III. Along with Hanoi, Saigon, Haiphong, and Hue, the French considered Danang one of Indochina’s five major cities. In 1936, French archaeologists established the Cham Museum, which today houses the finest collection of Champa Kingdom-era art.

In more recent history, Danang is best-known for its role in the American Vietnam War. The Danang Airbase was a major American airbase, used both by the Americans and the South Vietnamese. Nearby China Beach, named after its beautiful china-white sand, was home to the 510th Evacuation Hospital, where wounded American soldiers would come to recover. China Beach itself was an American in-country R&R spot, nicknamed the “Five and Dime”.

There is little to suggest the scars of war in modern Danang other than the ruins of the American airbase still resting along the beach, China Beach is nonetheless one of the top tourist destinations in all of Vietnam. A mile long, gorgeous white sand beach lies along the edge of clear blue waters, which is rapidly becoming a major attraction for tourists the world over.

The Fusion Maia, our home in Danang, is just what the doctor ordered, a spa resort focussed on ‘wellness’ and relaxation. I am a fervent and loud advocate of regular spa treatments as an important element of the ‘resuscitation holiday’ – their restorative qualities are undeniable and help you to dramatically accelerate the unwinding process.

Fusion Maia, ladies and gentlemen, offers two spa sessions per day per person for your nightly accommodation rate – for spa junkies like us this is heaven.

It becomes a competition for my wife and I to see who can tick off the most therapies on the menu – my favourites were the:

Mindful Energy Massage:
“Clear your energy and release stress with this mind-body therapy for emotional wellbeing. Feel our Reiki therapists balance you with their gentle warm energy touch that will open your heart and cells”, and Warm Pressure Sleep Therapy: “A calming full body massage, an Ayurveda-Swedish combo which uses warm coconut oil to ease your muscles into sweet surrender”.

With these and other variations of expert pampering morning and night you will feel as if you are walking on air and could almost forget all the other exceptional resort features.

Upon arrival guests are greeted by their personal Fusionista, a super organised valet committed to helping you get the most out of your stay by organising check-in, arranging reservations, booking tours, dealing with transfers, travel, villa entertainment, medical emergencies, in fact almost anything you may need.

It’s great to have one person with whom you establish a relationship to deal with everything – it takes any stress out of your stay and saves precious holiday time.

The villas at the Fusion Maia are more like self-contained holiday apartments boasting full kitchen, lounge room, private pool, garden and outdoor sun deck – super comfortable, spacious, two ensuite bedrooms (each with their own swivelling TV’s) on either side of the lounge designed
to separate relaxation starved parents from kids.

The pristine main pool is massive and points like a blue finger to the gorgeous beach bordering the eastern boundary of the resort.

An early rise and run along the beach, which stretches for kilometres, yields unexpected surprises – fishermen untangling nets pulled from their round woven reed dinghies, Vietnamese old and young greeting the new day with yoga, tai chi and other unknown martial arts, a beach soccer game played by young resort staff before starting work, crouching Grandmothers, conical hat clad, fanning coals over which pots of Pho simmer, producing mouth-watering aromas wafting down the shore – the experience is breathtakingly beautiful, the essence of a country captured in a stretch of sandy beach.

The dining at Fusion Maia is exceptional, several restaurants are scattered about the grounds serving Pan-Asian cuisine, simple, delectable seafood and poolside café fare.

The stand-out gastronomic experience here is breakfast – apart from it being served all day on the beach or at the spa area, the buffet breakfast in the main building is unbelievably good.

Quantity and variety don’t necessarily make for quality nor inventiveness, but the Fusion Maia buffet breakfast could quite possibly be the best I’ve ever had.

Classic Vietnamese dishes like Pho and Xoi (Sticky Rice) are available on the Asian bar alongside a station overflowing with health conscious options. The egg station and expert chefs produce the fluffiest of omelettes and creamiest of Benedicts.

The breakfast masterpiece for me was the soft boiled egg (deep fried) with caviar and wilted spinach – mmmm a food memory that will last forever.

It’s clear that Vietnam will become a regular travel destination for our family and a stay at this marvelous ‘wellness temple’ will be a must everytime.😊

The next leg of our Vietnamese voyage will take in the much anticipated Hoi An and the Rock Star resort that is the Nam Hai – the luxury levels are about to be turned up several notches as is the concentrated cultural experience of this UNESCO listed world heritage town.

Look out for our third instalment on Vietnam in our Winter edition.
The success of a day surgery can be judged by two criteria:
1) The quality of the services provided
2) Its financial sustainability

Both these criteria are inextricably linked to the design.

To ensure the objectives are met it is best to form a planning team consistent of stakeholders with the relevant experience in the operation and logistics of day surgery centres. This could include a surgeon, nurse, anaesthetist etc.

Licenses to construct and operate the facility will also be required along with the support of health care insurers to include day surgery rebates.

Most day surgeries provide services for a wide range of specialities although if demand is present, specialist centres for one discipline can be financially successful due to the efficiencies gained by continuous use of expensive specialised equipment.

Patient flow is the most important criteria to ensure optimum efficiency. Free standing facilities would be the most efficient as they are not constrained by other elements of a medical practice and usually provide the best access for admission and discharge.

Considering each of the 5 elements in the chart to the left;
Admission should be spacious and comfortable. Ideally the reception desk will have a separate section for payments. The ambience should be calming, this can be achieved with the help of colour, visual effects and even aromatherapy. A separate interview room may be considered for discussing payment confidentially.

The Pre Op area includes changing cubicles, toilets and generous storage for clothing and laundry.

The Operating Room provides an aseptic environment in which to carry out surgical procedures under local, regional or general anaesthetic. There are many regulations governing its design which cover:
- Cardiac protected body area
- Flooring
- Special air conditioning – HEPA filtration
- Scrub resistant paint
- Lighting
- Sterilisation requirements
- Etc etc

The recommended minimum size for the operating rooms in day surgeries is 42sqm although 36 sqm is deemed acceptable for certain disciplines. Whilst complying with a myriad of regulatory requirements. An anaesthetic area at the entrance is an option.

All corridors to and from the Operating Room should be 2 metres wide to allow for trolley access.

Recovery will consist of two areas:
Stage 1 where the patient will be transferred directly from the Operating Room on the trolley. Each trolley space requires 9sqm. The first stage recovery area will also house clean and dirty utility areas of 12sqm each. It should be fully equipped with emergency resuscitation equipment.

A nurses station should be located in the recovery area with good visibility to all patients. Patients amenities are required to be within easy access.

Stage 2 provides facilities for a mobile patient. Reclining beds. Comfortable chairs. Cubicles for changing back into the patients clothes.

Discharge areas are often overlooked in design. Adequate seating in these areas must be provided to avoid patient build up and lack of circulation. 3 comfortable chairs per Operating Room would be sufficient.

Throughout the whole design process, patient flow is essential to the success whilst complying with a myriad of regulatory requirements.

Only consider experienced design professionals for this task as they will be constantly updated with technology and regulatory changes.

Reference – Australian Academy of Medicine and Science

Come and hear Mike and our other panel of experts present at our Day Surgery Development workshop in Sydney from Saturday 29 - Sunday 30 August 2015. Follow this link for details.
Planning in the New Year

Adam Basheer explains the relationship between ‘measurement’ and ‘initiatives’ and their role in business planning.

So you have had a bit of a break, you have been refreshed and you are raring to go and make this year a big year. Then suddenly you realise a month has already gone, and now another two weeks and what have you actually accomplished?

One of the issues is that there seems to be so much you want to accomplish in a year. This tends to overwhelm us a little which in term makes us feel like we are not accomplishing anything. The excitement of the new year often brings a very positive view of our business, which is great, however this will lead to some disappointment, and in turn dishearten us as individuals if some reality is not put to the optimism.

The simplest means to put reality towards the optimism is to start contemplating what needs to happen in order to achieve the goals we might set ourselves. One way to start this process is to break the goals down into a set of measures that will enable us to know if the goal has been completed. As an example a goal might be to increase the bottom line by $500,000. This could be achieve in several measureable ways including increasing the top line (sales income) by say $1m or decreasing costs across the business by $500,000. A combination of the two is obviously possible. Perhaps the increased top line is likely to come from a new product of servicing being offered, in which case, when will the service start being offered? What is the reasonable early sales rate of this service? What will the sales rate increase to and how quickly will this happen? What will be needed to ensure that this sales increase occurs?

Out of this process will come two things:
1. What needs to be measured and when? E.g. sales per month of the new product.
2. What initiatives will need to task place to safeguard the success of the new product?

The financial measure become quite easy to establish as it is just a financial calculation to achieve your sales outcome. But measuring the implementation of the initiatives to make it happen become even more important. In order to measure each initiative you need to break them down into a series of tasks which become measureable activity. At the end of the process you have a series of measures, which are unlikely to be financial, in order to achieve the measurable financial goal.

As you start to understand all the outcomes you will need to achieve your measurable goal, you will start to build a list of initiatives needed to achieve this and then a set of measures of when tasks need to be completed. Starting to put all of these down onto a couple of pages and you are now starting to develop an actionable plan for the year.

It is only once you have all of the initiatives recorded and timings around them that you can start to get a feeling of how realistic they are. What needs to be achieved? Who is responsible for achieving it? What resources will they need to make it happen? Is it all realistic? If not, what will you drop or what further resources do you require to make it happen. Making this type of decision up front means that you can start to turn all those positive thoughts into something that can be realistically achieved. Measuring what you have done along the way will also give you that sense of achievement, well before the end goal has been achieved. This can help you avoid the disappointment and instead of becoming disheartened you become emboldened to make your business what you want it to be.
Finding the best cover

Do you know ‘your type’ of insurance cover? Katherine Ashby urges a closer look.

When purchasing life and disability insurance, three different types of policies are available for you to consider: Group, Retail and Direct. Each of these has both their advantages and disadvantages, which to the untrained eye, may not be immediately apparent. In this article we’ll look at how each policy type works and the implications for you as a policy holder.

DIRECT
A Direct policy is one that you purchase from the insurer without the assistance of a financial adviser. These are the types of policies you often see advertised on television, or receive in the mail. Direct policies are not available inside superannuation funds.

Direct policies are generally more basic than retail policies. The amount of cover that can be purchased is lower and policy documentation is shorter. Often these policies can be attained with less onerous underwriting and no medical requirements. As there is very little underwriting involved, the insurer doesn’t have the ability to assess and sort risk. This means premiums can often be higher than a policy distributed via a financial adviser.

Be wary of the fine print. Direct policies will often have more exclusions and more limited terms and conditions than Retail or Group policies. Terms and conditions look simpler, but this is achieved with tighter definitions and broader exclusions, such as excluding any pre-existing health conditions.

RETAIL
A Retail policy is one which is distributed by a financial adviser and is otherwise known as an individual policy. Retail policies offer the most comprehensive cover available in the market along with offering the highest possible sums insured. Retail policies may be owned directly by the life insured (yourself), by another person, company or trust. They can also be owned inside superannuation, including platform super funds, self-managed super funds (SMSFs), or through a separate super fund altogether.

Retail policies require a more extensive application process, as each applicant is assessed individually and priced based upon your personal risk profile (made up of age, gender, occupation, smoking status and health history). This means it may take longer to put the policy in place and some medical tests may also be required.

The upfront work of setting these types of policies up will benefit you as a policy holder in two ways. Firstly, you’re paying premiums which reflect your personal risk, rather than an averaged risk of all policy holders. Secondly, once your cover is in force, you have greater certainty of claim. This is because retail policies will generally cover all sicknesses and injuries, even those which you may have suffered in the past, once your health history has been assessed and the insurer agrees to your cover.

If the insurer is not willing to cover you for certain conditions, they will issue an exclusion upfront. For example, if a sickness or injury was serious, long-term, or recent, it may be enough for the insurer to deem the risk too high to cover you. This will be presented to you as proposed policy terms and you will need to agree to the exclusion before you can attain cover. Hence, if the insurer accepts your cover without exclusions, then you know you are covered for all sicknesses and injuries.

The one point you need to keep in mind is making sure you disclose all relevant information to the insurer on your application. This is referred to as your Duty of Disclosure and is governed by the Insurance Contracts Act (ICA). The ICA also sets out remedies available to insurers in the event that you leave something off your application (referred to commonly as non-disclosure). The insurer can have the right to alter your policy, avoid any claim and/or cancel your policy if you haven’t told them about an issue that would have affected their decision when you applied for cover. So it is important to make sure you answer the application carefully and honestly!

GROUP
Group cover is almost always owned inside superannuation funds. In the medical industry common super funds include First State Super, HESTA and formerly Health Super (since merged with First State). Group insurance is owned by the Trustee of the super fund and will usually provide default levels of automatic cover along with optional additional cover.

The default cover may exclude pre-existing conditions or may come with no exclusions. For additional cover, you will need to apply and be underwritten. Cover is generally set on a unit basis. This means each unit of insurance is worth a certain amount of cover and the cost stays the same over time. The downside is that for every year you get older, your insurance cover reduces.

As the cover is owned inside super, coverage is restricted to what can be offered under superannuation law. Any insurance owned inside super results in claim proceeds being paid into the super fund. The Trustee of the fund then needs to decide if the claim can be released to you under one of a number of conditions of release.

Terms and conditions are set by the insurer in conjunction with the policy owner, the super Trustee. The terms and conditions can change at any time if the Trustee and the insurer agree. If you have cover under a group scheme, you will be notified of any changes. However, you don’t have a say in whether or not you accept the changes, as they will automatically apply to you as a member of the scheme. This is one of the fundamental differences between Group policies and Retail policies.

Another thing worth noting is that the insurer of a group scheme can also change. Super funds will generally tender for insurers every few years to try to get a better deal for their members. If the insurer changes, then the terms and conditions, pricing, or even eligibility can also be effected.

In the past decade, Group insurance has been the most volatile. Premium has been eroded and this has resulted in some insurers making significant premium increases, along with changes to their terms and conditions. An example of this is Australian Super, the largest super fund (and group insurance plan) in Australia, with over two million members. In the past two years Australian Super has passed on premium increases to members twice (in some cases totalling up to 100%). In addition to the increases, in November last year, the fund then significantly restricted their definitions, particularly for total and permanent disability cover (TPD).

In the past, many people would combine group and retail cover by having their Life and TPD in a cheap Group scheme inside their super fund, and then add Trauma cover and Income Protection outside of super. If you do have any group insurance in place, it is worth speaking to your financial adviser to find out if any changes to your cover have happened in the last couple of years. It is important to understand what you are paying for when it comes to protection. While a Group policy was once a very cost-effective way to obtain cover, in many cases this price advantage you used to benefit from is no longer there.
The digital revolution is disrupting many industries. Alexandra Cain explains what’s driving it and who’s affected.

Right now, all over the world, bright entrepreneurs are working on start-ups they hope will one day rival the success of Facebook. Their work is part of a trend known as ‘digital disruption’. In essence, this is the ability of businesses to use new technologies such as mobile devices and the internet to challenge existing business models and the dominance of the major players across every industry sector. While this dynamic is extremely exciting, it’s also something investors need to remember when forming a view about asset allocation.

If someone with a crystal ball had said five years ago that the taxi and hotel industries – two sectors not traditionally associated with innovation – would be two of the industries most affected by ‘digital disruption’, most of us would have laughed in disbelief. Fast-forward to 2015 and we now live in a world where car ride app Uber now operates in more than 200 cities across the world, and their home – claims half a million people found a place to stay on New Year’s Eve 2014 through the site. So what’s driving this revolution and which industries are ripe for disruption?

What’s Driving It?

There are three factors that have led to digital disruption: mobile devices, social media and cloud computing. These factors on their own have the potential to transform our way of life. In combination, their ability to radically change the nature of our world cannot be underestimated and has only just begun.

The fact that people throughout the developed and developing world now use mobile devices is driving demand for apps and new technologies and changing the way we consume information. Social media means that news now spreads virally in a very short space of time. Cloud computing has essentially democratised access to software and hardware (more about this below).

Emerging and, increasingly, traditional businesses have recognised the centrality of these three factors in their business models and future revenue streams.

Who’s Affected?

Every single industry has the potential to be affected by digital disruption, but some industries will feel the brunt of this trend sooner than others. In its report Digital disruption: short fuse big bang, professional services firm Deloitte identifies financial services, IT and media as three sectors that have the most potential to be disrupted by new technologies in the near term.

Financial services: while this sector has already experienced disruption in many of its parts, it’s anticipated there will be further innovations that will impact the major banks in particular. Foreign exchange is an example of a sub-sector in this market that has already been disrupted.

Traditionally the province of the major banks, new entrants such as OzForex have challenged the existing business model. This business has always been online-only, which has allowed it to keep its costs down. In contrast, the big banks are grappling with legacy systems that make it more expensive for them to offer the same services as new market entrants.

However, it’s important to remember that customer loyalty, as well as the diversified nature of their businesses, will help the large banks to maintain their market share. These businesses are also cognisant of the potential for digital technologies to disrupt their offering and are working hard internally to combat this threat.

Technology information: this sector is one of the drivers of digital disruption but a game changer for this industry was the advent of ‘cloud computing’. This effectively allows all businesses and consumers to outsource their main hardware and software requirements to providers in this sector. This has produced a boom in the data centre sector and the flow-on effects from the cloud computing revolution have only just begun. For instance, we will increasingly buy consumer devices that are connected to the cloud – fridges that change the external temperature they receive from the cloud is just one example. In the not too distant future, televisions, appliances, cars and many other devices will be connected to the cloud.

Media: again, this sector has already experienced substantial disruption. Television stations have been affected by the existence of YouTube. Major publishing houses have seen advertising revenues decline thanks to emerging news sites such as BuzzFeed and Reddit and as a result of social media such as Facebook and Twitter. Expect further fragmentation in the media sector as a result of digital technologies.

Change in other industries such as manufacturing and education – as well as many others – might be slower, but it’s still coming. So how should retail investors factor digital disruption into their thinking about equities markets and other investments?

While it’s true change has been swift in sectors such as taxi cabs and hotels, overall, the impact of digital technologies and innovation won’t change business models in most industry sectors overnight.

However, it’s worth keeping an eye on the major players in the sectors in which you invest in terms of their plans in relation to the digital economy. Read annual reports and ASX announcements to get a feel for which ones are prepared and which ones are lagging this trend and factor your analysis into your investment decisions.

Alexandra Cain, journalist
Dr Starla Fitch advises to remember why you went into medicine and to infuse patient interaction with your passion.

It all started several years ago. A young female patient in her 20s was having surgery. It wasn’t clear if her tumor was going to be benign or malignant. She had a new husband and they were very much in love.

As I spoke to the couple before her surgery, I reviewed my plan. I could see they were scared but trying not to show it. I wanted them to feel positive. To try to focus on the possible good outcome.

So I looked at the young husband and said, “Now, are you familiar with my rule about stitches?” He looked at me quizzically and shook his head no. “Well,” I continued, “if your wife has five stitches, she will need flowers and candy to completely heal. If she has eight stitches, we’re talking jewelry. If she has twelve stitches or more, we’re talking matching jewelry.” Everybody chuckled. The air got a little lighter.

We proceeded to the O.R. and the case went well. Happily, her tumor proved to be benign. I went out to the waiting area. There was her husband. In his hand, he clutched a big box of chocolates. And, on the table in front of him was the biggest bouquet of flowers I had ever seen.

I asked, “What’s all this?” and he said matter-of-fact, “You said ‘flowers and candy.’” I gave him a super big hug but probably not as big as the one he received later from his wife.

Since that day, I often will tell the spouse about the need for special things to heal. Sometimes, when the husband is having surgery, I tease his wife and say that many husbands like a home cooked meal. Or I’ll suggest they get their husband a bell to ring so their wife can be at their beck and call during the recovery.

What has happened is nothing short of amazing.

One male patient reported to me on his first post op visit that his wife had bought him a red sports car. Thinking he meant a toy car, I asked to see proof. Sure enough, there was picture of his new convertible!

The next week, I was relating this fun story to another patient. I told the patient and her husband that I didn’t see how on earth anyone could top the sports car story. There was a big pause. The husband looked at his wife and said, “Do you really want that beach house?” I raised my eyebrows to the ceiling and said, “What?”

 Turns out, they had been looking at a beach house for their retirement and had recently found one in North Carolina. She nodded to her husband and said, “Oh, yes.”

When that patient came in for her post op visit, I quizzed her about the beach house. She said they were still going through negotiations with the seller and wasn’t sure it was going to work out. After a few weeks, she was all healed and I had to release her. But I asked her to let us know if they ever got the beach house.

Three months later, we received a post card at the office. All it said was, “Got the beach house!” I kid you not. There was so much dancing and jumping in our office that day, you’d have thought we got the beach house!

Recently, I asked a patient when he came in to get his sutures removed if his wife had given him a present. I asked it kind of in jest to take his mind off the suture removal. He got quiet for a minute. Then he said, “Yes, I did get a present. My wife said to me today I wish you didn’t have to go back to work. I’m going to miss you.”

I smiled.

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