IN DUE COURSE
Changes to self-education deductions

OPTIMUM RESULTS
How SEO can benefit your practice

IN PROFILE
The Cosmetic Medicine Centre

TRADING PLACES
A medico-legal perspective on practice succession planning
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Too many questions and not enough answers?

**We're here for you.**

You have devoted many years to looking after others and have not been able to find the time to obtain the answers to all the questions you have about financial matters; your business; you and your family’s future.

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The world demands more and more of us every day.

Despite all the advantages of living in a modern, technologically advanced society, it seems we have to work harder than ever before to achieve the same degree of professional, financial and lifestyle success experienced by previous generations of professionals.

Sure, much of this dilemma is of our own making – we want more, spend more and therefore need to earn more, which generally means working more, harder and longer.

Paradoxically, many of you will be of a generation that strongly values family time, recreation and work/life balance – a favourite theme of ours.

As we meet many younger doctors around the country, completing their training and contemplating their next move and career/lifestyle path, we see firsthand this dilemma playing out in their minds. The solution for many – and, in our opinion, a worrying trend – is not to ‘go into’ practice but to either stay in the public system or become permanent locums/employees.

This reaction may come from an informed perspective and be a true choice for some, but for most it’s a result of poor understanding of business principles and their role in achieving success in all aspects of life. It doesn’t help that, since Hippocrates, the healthcare ‘industry’ has practiced a self-imposed moratorium on doing business, and doctors have not been encouraged to address the business side of the delivery of their oath.

The truth is, you can have your cake and eat it too.

Running a medical business doesn’t have to mean poor clinical outcomes and ‘customer’ service. In fact, the opposite is true if your goal is to own and run a profitable and growing practice. But to achieve this you will have to adopt new methodologies and embrace a new way of thinking.

The rewards are significant and many, the most valuable to my mind being TIME – time to be ‘present’ in the lives of your loved ones and to be able to provide them with the widest possible range of options for their future and success.

We all have it in us to be powerful performers in our chosen professions – the key is understanding and embracing the ingredients required for success.

My daily meditation mantra helps me stay on track; perhaps it will also help you:

‘Today I am filled with clarity, focus, commitment, confidence, motivation, enthusiasm energy, productivity and success.’

In this, our 10th edition of The Private Practice eZine, we offer you a mix of articles from our education partners that reinforce this message. We hope you enjoy them.

Happy reading!

Steven Macarounas, Editor
editor@theprivatepractice.com.au
Courses & Workshops

Our courses and workshops are designed to help lift your level of knowledge of business, financial and lifestyle management to improve efficiencies and help you run successful practice and personal lives.

Since our first event in 2009, we have presented to over 2000 delegates and run tailored events for:

- Dermatologists
- Obstetricians & Gynaecologists
- Ophthalmologists
- Cancer Physicians
- Rheumatologists
- Plastic Surgeons
- Cosmetic Practitioners
- Geriatric Physicians
- General Practitioners
- Practice Managers

We continue to work with many colleges, societies and associations, and are pleased to announce our recent engagement by both the Australian Orthopaedic Association and the Thoracic Society of Australia and New Zealand – we look forward to staging events on their behalf later in the year and into 2014.

We are extremely proud of the difference we are making in the lives of our delegates and subscribers, and invite you to join our growing community of ‘medico entrepreneurs’ by attending upcoming events – follow the link below for our current course and workshop schedule.

The Private Practice Courses and Workshops
https://theprivatepractice.worldsecsuresystems.com/programs
“Fantastic, a real eye-opener.”

“Excellent workshop. Saved me time, educated me and inspired me to start my private practice.”

“Comprehensive, encouraging and provided availability of future contacts/resources when needed.”

“Realisation of the many unknown factors involved in ‘strategising’ my future, achieving direction and focus on my own personal goals.’

“Excellent and very useful education exercise. I personally feel the topics covered in The Private Practice courses should be included as part of the training modules for RANZCOG Trainees.”
EVENTS

Practice Succession Planning Workshop
Sydney 27-28 April

GPCE Sydney
17-19 May
EVENTS

RANZCOG Private Practice ‘Comprehensive’
Melbourne 24-26 May

RANZCOG Private Practice Symposium
Sydney 15 June
Exiting your practice requires a strategic approach. As Linda Sirol writes, participating in one of the Private Practice workshops is a great starting point.

What comes to mind when you think of succession planning? For many, it’s mainly about getting the ducks all in a row – just in case something happens. Personal risk, practice risk and estate planning are all important, but there’s more to practice succession planning if you want to create a valuable and sellable practice.

Achieving your lifestyle, professional and financial goals is about more than the ‘just in case’. It calls for a strategic and coordinated approach to exiting your practice, ensuring that changes in ownership, management and delivery of clinical work in your practice are all planned, on purpose and proactive.

A true appreciation of the full scope of practice succession planning – this is just one of the key learnings gained by attendees of a national series of Succession Planning workshops for medical practitioners. In the two-day workshops, which were delivered over the past year, presenters shared strategies, tactics and tools to help practice owners and managers formulate their own practice succession plans.

Interestingly, feedback from attendees revealed two widely experienced ‘a-ha’ moments. Firstly, that regardless of practice size, it’s possible to create a practice that is valuable and sellable. Secondly, that there are more exit options available than an outright sale to a third party – and for many practice owners, the alternatives are far more attractive and viable than the usual approaches.

**GAINING INSIGHT**

Through the workshops, presenters also gained valuable insights into the specific issues and challenges faced by medical practitioners in relation to planning their exit from practice. In the months to come, the Private Practice education partners will be delivering a revised and updated version of the workshop.

The workshop is ideal for medical practitioners who would like to find out how to:
- Maximise practice value
- Create a sellable practice
- Attract a buyer/successor
- Safeguard the estate
- Safeguard practice value
- Maximise the 'take home' value – i.e. what’s left of the sale price after paying taxes

The workshop is also suitable for those seeking to:
- Maximise return on the proceeds of sale of their practice.
- Ensure continuity of care for patients.
- Ensure continuity for other practice stakeholders, such as employees.
- Achieve a transitional exit.
- Explore alternatives to ‘closing the doors’.

The course is delivered over two days and is facilitated by a select group of high-quality presenters who are experts in their field.
Is your equipment finance as complex as a triple bypass?

It’s time for a second opinion

As you well know, running a practice involves balancing a myriad of priorities. Purchasing equipment is high on the list, but it’s often devilishly complicated – it takes specialist expertise to put together a simple and cost-effective solution.

This is where Investec comes in. We specialise in providing financial solutions for medical and dental professionals, so our team thoroughly understands the pros and cons of different methods of funding your equipment. Whether it’s buying outright or leasing, you can rest assured that we’ll work out the optimal structure for you; even better, you can finance the equipment on an Investec credit card and earn Qantas Frequent Flyer miles on your eligible purchase.

Take a look at investec.com.au/medical or call one of our financial specialists on 1300 131 141 to find out how we can help.
With the legislation around work-related self-education expenses set to change next year, Anna Carrabs suggests seeking advice on how you will be affected.

On 13 April 2013, former Federal Treasurer Wayne Swan announced that work-related self-education expenses would be subject to an annual deduction limit of $2000 per person, as of 1 July 2014. This proposal was again outlined as part of the handing down of the Budget on 14 May 2013.

This issue will be particularly pertinent to medical professionals who need to maintain their Continuing Professional Development (CPD) Hours.

Currently, taxpayers are not restricted in the amount of self-education deductions they are allowed to claim, apart from the $250 threshold that reduces most self-education deduction claims.

### What are self-education expenses?

Under current legislation, self-education deductions relate to costs necessarily incurred in connection with a ‘prescribed course of education’ – i.e. ‘a course of education by a school, college, university or other place of education, and undertaken by the taxpayer for the purpose of gaining qualifications for use in the carrying on of a profession, business or trade or in the course of any employment’.

Typically, self-education costs are considered to be the costs associated with undertaking a university degree or some other course of education. However, note that Tax Ruling TR 98/9 considers that the term ‘qualifications’ is defined widely so as to include not only degrees and certificates, but also the attainment of new skills or accomplishments.

It is not clear from Mr Swan’s announcement if the current legislation dealing with self-education will continue with a deductibility limit overlayed, or if the whole section will be repealed and replaced, which may include the introduction of new definitions and concepts.

Conceivably, if the Government chose to rewrite the self-education legislation, the definition of what comprises self-education could be broadened to include not only the attainment of new skills (as per current legislation), but also the maintenance of existing skills (i.e. continuing professional development).

Under current legislation, costs associated with continuing professional development are not considered to meet the definition of self-education and, accordingly, are wholly deductible. However, the proposed legislation may put this treatment in jeopardy.

For more information on how this may affect your personal circumstances, speak to a William Buck advisor. Visit [www.williambuck.com](http://www.williambuck.com) to locate your nearest office.
Avant, a more rewarding relationship

For 120 years, Avant has been providing doctors with comprehensive advice, support and defence outcomes.

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Volatility in the share market, mortgage rate rises and the falling Australian dollar don’t necessarily mean we’re headed for a recession, writes Chris Caton.

Share market volatility continued in June. At the close on 20 June, the Australian market had fallen by 3.4% from its 31 May level, while the US market was down by 2.6%. This brings the year-to gains to 2.4% and 11.4% respectively.

At the low point for this correction, during the day on 13 June, the Australian market was down by more than 10% from its 14 May close of 5221.

There is no doubt what the major international force driving markets is: the continued concern that the Federal Reserve (Fed) may end its programme of quantitative easing (QE). QE expands the Fed’s balance sheet, and the chart below shows the apparent effect this has had on the US share market in recent years.

![FED BALANCE SHEET AND S&P500](chart.png)

SOURCE: Deutsche Bank, Bloomberg Financial, L.P.

Chris Caton is Chief Economist of BT Financial Group.
GROWING PAINS

In a June press conference after a Federal Open Market Committee meeting, Fed Chair Ben Bernanke indicated that the Fed is likely to begin to ‘taper’ QE – that is, to buy fewer long-term securities than the current $85 billion per month – before the end of 2013, with an eventual aim of ceasing such purchases altogether by mid 2014.

Note that this wasn’t a statement of what the Fed will do so much as a statement of what it plans to do, provided that the economy still shows consistent signs of growth.

Note also that ‘tapered’ purchase would still result in further expansion of the Fed’s balance sheet, so if the above chart has any meaning that should still be consistent with a rising share market.

The share market fell significantly that afternoon, and again on the following day. Meanwhile, long-term interest rates have risen sharply, with the 10-year bond rate now at 2.44%, from 1.64% as recently as 1 May. This, in turn, causes mortgage rates to rise and thus calls into question the ongoing housing recovery.

I continue to think market analysts are jumping at shadows, and that a world in which the Fed is comfortable ending its programme is a world that should be conducive to further share-market gains. It is, however, just as well that these issues are being discussed long before we get to the end of the process; the more market volatility this causes now, the less there may be later.

In addition to the US effect, the Australian market has been held back by concern about the state of the Australian economy, along with continued soft Chinese data.

The national accounts for the first quarter, released in early June, depicted an economy growing at just 2.5% in the past year, down from 4.4% as recently as a year ago. They also suggested that the mining investment boom has already peaked, which removes from the economy a major source of growth in recent years.

We knew the end of this boom was coming; it just arrived a little earlier than anticipated.

This slowdown led to calls of recession, and to assessments that the Australian economy would already be in recession, were it not for exports. The latter statement is meaningless: as a general rule, if one excludes all the stuff that is growing strongly, the average growth rate always falls.

DOUBTING THE DOUBTERS

A couple of well-regarded private-sector economists have gained some publicity with their estimates that there is a 20-25% chance of a recession within a year. Think about that. What they are saying is that it may happen but it probably won’t. Who can disagree with that?

The issue is that it’s not clear that the rest of the economy will pick up the pace quickly enough to offset the loss of growth from mining capital spending.

I am frequently asked just where the replacement growth is going to come from, and the answer does not always convince doubters. The response must be that it won’t come from any one sector, but from everywhere that is helped by lower interest rates and a lower exchange rate (along with an improvement in business sentiment that seems likely to occur after 14 September).
While I acknowledge that the current circumstances are challenging, there is simply no inevitability that economic growth in Australia will slow further. Prior to the GFC, year-to-growth dipped to 2.5% or less in 2006, 2003, 2000 and 1997 (see chart).

So, a slowdown of the magnitude of the current one seems to happen about every three years or so. In none of these four cases did the economy finish in recession and it remains an unlikely outcome in this current case.

OUR FALLING DOLLAR

The exchange rate has continued its plunge towards fair value. At time of writing, it stands around 92 cents (still well above my estimate of 80 cents for its ‘fair value’). The RBA is standing on the sidelines cheering the dollar on.

As a rule of thumb, a 5-cent drop in the currency has a stimulative effect on the economy about equal to a quarter-point rate cut. It makes our exports easier to sell, and makes domestically produced goods more competitive with those from offshore (fresh-baked bread at Coles, for example). Thus the decline in the currency to date should do the work of two rate cuts.

The fall in the currency has added to the perils of the Australian market for overseas investors. Since the recent peak in our market, the $A has fallen by 8%, so a US investor in our market is down by about 16% in the past five weeks.

Financial markets continue to think that the cash rate has further to fall, and they may be right. My view is that, given that the cash rate is at a record low, the RBA will be extremely parsimonious in cutting further. It is probably hoping the rate cuts already in place will get more traction, and that the lower exchange rate will help enough to obviate the need for further cuts.

MEA CULPA

Last month I stood by my then forecast of 5300 for the ASX200 at the end of the year. The ongoing weakness so far this month has persuaded me to revert to my original forecast, published in early January, of 5100.

Last year, the reverse happened; I cut my forecast by 200 points in mid 2012 and my original forecast finished up being too high by just 51 points. The lesson: never change a forecast until you are absolutely sure that it’s wrong. ☹️
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SA: Andy Murdock, Ora Financial Strategies (08) 8211 6611.
WA: Wayne Leggett, Paramount Wealth Management (08) 9474 3522.
ONE STEP AHEAD

Having the right practice-management tool at hand means practice managers can create their own unique manual to overcome the challenges presented by constant policy and system updates. By Anna-Maria Gibb.

A recent review of the ‘position description’ for practice managers reminded me of the many areas in which they, and often the practice principal, must have expertise – from planning, human-resources management, systems and finances to equipment and software, compliance and marketing, to name a few.

Following on from that thought was the challenge faced by practice managers in keeping up to date with ever-changing requirements and knowing where to access the most relevant resources and information.

CHANGING TIMES

Over the past 12 to 18 months, a number of industry changes have occurred. Practice managers have had to maintain awareness and implement each change relevant to their practice. For instance:

• Practice software and systems have had to be updated where applicable so the Personally Controlled Electronic Health Record (PCEHR) could be implemented.

• This increased use of technology means practices must have sound data security systems in place. If a practice is thinking about moving to cloud-based computing, it is important to consider the privacy implications of data-storage locations and access.

• Many practices are jumping on the social-media bandwagon, and with this comes a range of policies and procedures that need to be developed.

• For general practice, the introduction of the 10 National Safety and Quality Health Service (NSQHS) standards will impact on their practice accreditation in the future.

In addition, six of these standards are being incorporated into the amended editions of the Royal Australian College of General Practitioners (RACGP) standards for General Practice. These standards need to be converted into policies and procedures, with staff trained to understand and implement them.
• Human-resource management incorporates recruitment, induction, selection, training and performance management. Practice principals and managers need to ensure they are complying with a range of legislative requirements here, including:
  – Compliance with Equal Employment Opportunity and Anti-Discrimination legislation, with the provision for staff to access the Fair Work Act and relevant awards.
  – Implementation and understanding of changes to parental-leave rights.
  – Compliance with the new national Work Health and Safety Act, where the key areas of management commitment include consultation, safe work practices, training and supervision, reporting safety and workers compensation and return to work.

KEEPING UP
Part of the answer to this challenge is the recognition that practices run more effectively with a current, reliable, practical ‘Policies and Procedures Manual’. While policies and procedures are part of the solution, the next question is whether practice principals and managers have the time, resources and knowledge to continuously update their manual, communicate the changes to personnel and keep track of the changes.

Practices can access information about the medical and business environment from a range of sources, including the Private Practice, the Australian Association of Practice Managers, relevant colleges and business associations.

Another option is to enhance the use of technology, selective outsourcing of this task and, most importantly, partnering with an organisation that understands the medical industry and can support the needs of practices in the development and implementation of relevant policies and procedures.

PUTTING POLICY INTO PRACTICE
At MyPracticeManual we have provided our clients with a range of policies and procedures, resources and advice on these relevant issues as the changes have been introduced. For instance:
• Practices using MyPracticeManual have had policies and procedures relating to amendments in the 4th edition of the RACGP standards for General Practice included in their manuals, while manuals designed specifically for specialist practices have policies and procedures linked to the NSQHS standards.
• Practices have also been able to access a range of position descriptions, induction checklists and training plans, all of which can be customised to reflect practice requirements and form a critical part of the performance-management process.
• When the Nurses Award and Health Service Professional Award were both updated on the 1 July 2012, practices could access the most current details immediately. In accordance with legislative requirements, practice staff can access their awards easily.
• The New Doctor Checklist reflects the changing documentation required by Medicare and other organisations. Practices in regional, rural and remote areas with a large number of locums and international medical graduates find these resources simplify the process of setting up and inducting new practitioners to the practice.
• The development of the Practice Familiarisation checklist also means new doctors feel quickly informed and welcomed to the practice, as well as part of the team.
REDUCING RISK

Over the past few months, changes to policies and procedures relating to secure messaging, clinical coding and PCEHR Rule 25 (pertaining to healthcare provider organisation policies) mean practices must comply in order to receive Practice Incentive Program payments.

Practices keen to embrace the paperless office are enthusiastic adopters of new technology. The increased use of offsite, cloud-based technology has created a need for practice principals to be aware of the relevant privacy legislation affecting data storage, and the National Privacy Principle No. 9, which relates to trans-border data flow. Policies and procedures defining a practice’s management and handling of data and privacy are key to ensuring staff understand the importance of complying and minimising risk.

The increased use of the Internet and social media has created a need for usage policies that clearly define acceptable and unacceptable activity, and the consequences of the unacceptable activity. Practices taking a proactive approach by being clear and transparent about expectations are less likely to have unacceptable activity.

Policies and procedures relating to staff involvement in new online activities, such as the maintenance of a practice Facebook page, can be easily incorporated into the manual.

More practices are employing nurse practitioners and medical assistants who are required to have an understanding of the legal limitations of their roles, the potential risks and the liability of the practitioner. Clear position descriptions and clinical management policies assist in creating role clarity and minimising risk.

There is also an increased move to have qualified practice staff, such as practice managers, who hold AAPM certification. Clear selection and recruitment guidelines enable the practice to consider the skills, education and experience requirements for the role to be filled, and to assess applicants objectively.

A future challenge for practices will be the increased outsourcing of practice-management services, such as medical typing and bookkeeping. Similar to the use of cloud technology for data storage, practices will need to ensure the supplier/outsourcing organisation they choose complies with Australian laws and requirements.

PROVIDING ACCESSIBILITY

As an effective, integral and dynamic part of a practice, a procedures manual must be accessible, relevant and current. Accessibility is best achieved through the use of secure methods that allow all practice personnel access from their main computer terminal. In this era of search engines and widespread Internet access, staff expect to be able to search for and access information online.

MyPracticeManual facilitates this by incorporating a communication function, allowing users to easily communicate their feedback and suggestions via direct links to the relevant section. The communication loop is completed with a function that enables the manual administrator – usually the practice manager – to highlight new or changed policies and procedures to practice personnel when they access the manual.

The ability to access previous versions of the practice’s policies and procedures at any given point is critical for medico-legal risk management, as well as providing excellent backup. In addition, procedures have been written in plain English so users can quickly determine relevance.

With the exponential increase of external information necessary to the running of a practice, incorporating hyperlinks to appropriate organisations allows a practice to easily access the current information necessary to support practice policymaking. Practice personnel can easily access information such as accreditation standards, which assist in their understanding of the background behind the practice’s policies and procedures.

Maintaining currency involves constantly scanning the medical-practice environment and being able to filter and distil the overload of information into practical content that keeps practice personnel informed.

Meeting the extreme challenge of keeping a practice’s policies and procedures is an essential task for the practice-management team. Optimising the use of technology, including web-based resources, as well as outsourcing part of the task, are options for practices to consider.

Being able to partner with organisations that understand the medical environment and business operations that can support your practice makes the challenge less daunting, and will provide a manual that will serve as an important tool in the management of a successful business.
Most healthcare practices have an online presence designed to provide valuable information to the community and attract patients and clients. However, a professional site is of no value if potential patients can’t find it. A website needs Search Engine Optimisation (SEO) to be effective.

So, what is SEO? It’s the process of improving and promoting a website in order to increase the ranking of the site in search engines. And why is this important? The higher a website appears on the list of search results, the more people view the site itself. In short, SEO equals visibility.
SEO is affected by the keywords and phrases used on a website. It is also influenced by the way other sites link to the site and the structure of the website itself. User-generated content, fresh content and social-media links play a role as well.

While it may seem otherwise, SEO is not all about the search engines – effective SEO always considers the user of the site. The content of the site itself should be friendly, useful and engaging, and the site itself should be easy to understand and navigate. It’s not enough to just attract attention through enhanced visibility. Good SEO practice makes visitors want to stay on the site once they arrive.

WHY SEO IS IMPORTANT
Every day, people search for medical information online. They go to major search engines such as Google and type in words and phrases related to their health. They research conditions and symptoms and look for information on procedures and treatments. Most importantly for your practice, they search for healthcare providers that meet their needs. If your website isn’t listed on the first page of search-engine results, you might as well be invisible.

Healthcare is moving from a provider-driven system, where patients are referred to a medical practice, to an increasingly patient-driven system. Patients are making decisions about which providers or facilities to visit and are more actively involved in the healthcare decisions that impact their lives, and they are studying websites to obtain the information they need to make those decisions.

If your practice is dependent on professional and word-of-mouth referrals, you may be missing a large pool of potential patients. When combined with a professional and engaging website, SEO increases your visibility to potential patients in your community. Traffic to your website equals patients to your door – it’s as simple as that.

Let’s look at some key components of SEO and discuss how you can use them effectively.

KEYWORDS & PHRASES
SEO begins with keywords. Search engines use a process called indexing to categorise the written and visual content on web pages, and rank them according to relevance. When an individual enters a word or phrase into the search line of Google, for example, the search engine looks through the websites it has indexed and returns results based on the site’s relevance to the subject of the search. Those search subjects are known as keywords.

It is important that you understand the keywords and phrases that most closely fit your practice. This involves knowing the demographics of your target market and the language they use when referring to your specialty or services. In short, you must know the language people use most often when looking for your practice.

Consider your specialty. What language do people most often associate with your practice? Patients are more likely to search for ‘cancer treatment’, for example, than they are ‘oncology’. An oncologist will want to use both of these terms on a practice website to increase visibility to professional people and patients.

As you develop your list of keywords, think about your average patient. What is important to this person, what common concerns are expressed in your office and which questions are asked most frequently? These are clues to the type of keywords your patients use.

DOMAIN NAMES
A domain name is the online address of a website. If you are unfamiliar with SEO you may overlook the importance of a domain name when your website is being designed. Many doctors simply use their own name or the name of their practice as a domain. A domain name such as www.yourbusinessname.com is convenient and certainly identifies your practice, however it’s not the most powerful choice.

Studies have determined that people are more likely to click your link out of a list of search engine results if they see a keyword in your domain name. Potential patients are encouraged to visit your site when they see the exact word or phrase they typed into Google or Bing. Your domain name should include a keyword if possible but still clearly point to your practice.

CONSIDER YOUR CONTENT
What kind of content does your website provide? Do you have a blog or FAQ section that provides general health information related to your practice and specialty? If so, how often is this content updated and refreshed?

Search engines look for more than just keywords when they index your website – they also look at how those words are used and the number of times they appear. Packing a lot of keywords into a few paragraphs
is actually harmful to your visibility. Using keywords naturally within multiple paragraphs or blog posts is preferred.

Content should be updated regularly with new articles, blog posts or tips posted relatively frequently. Not only does this indicate to search engines that your site is active and well maintained, it increases the appeal of your site to visitors.

Well-written information presented in a professional way is attractive to potential patients. It establishes you as an expert in your field and builds trust between you and the community. Most importantly, it gives website visitors a reason to return to your site and consider visiting your practice.

People talk about and share information they find valuable. They will share articles or blog posts from your site on social-media sites such as Facebook. Your blog posts may even be referenced or listed as links on other sites. This type of link building and social-media activity is amazingly valuable for SEO purposes. The more your content is shared, the more search engines view it as valuable to their users.

STAY LOCAL

Local SEO is crucial to your success in attracting new patients. Your goal is to draw visitors from the local area rather than across the greater region or the world. For this reason, healthcare SEO focuses on targeting local communities and service regions.

Feature your physical contact information prominently on your website – ideally your practice location and address should be easily seen on your main webpage within five seconds. You may want to include information about your service area and even include towns or regions in your keywords so potential patients understand the communities you serve.

People will often search based on a city or location. Even if they don’t do this, the search engines are designed to use location as part of their response algorithm. It’s important that your location is included in the behind-the-scenes framework of your site, as well as the content. Make sure search engines can clearly determine your location and use it as a factor in your ranking.

Help visitors cross the bridge from visiting your website to visiting your practice. Consider listing your physical address and service areas in the header and footer of every page on your website. Include office hours and contact information so they know how and when to call for an appointment or consultation. Make it as easy as possible for website visitors to convert to patients and clients.

Also take the time to list your website in online professional directories. Online healthcare directories such as www.healthengine.com.au or www.healthshare.com.au provide detailed and industry specific listings indexed by area. Potential patients often look for providers in their area using these sites.

Local SEO is a bit complex, but it’s very important to your overall strategy. It can often give you a competitive advantage in the online marketplace over your nearest competitor. Making sure your website is submitted to local search engines and online directories can make all the difference in your results.

SEO is a crucial tool in marketing your healthcare practice. Used properly, it is critical to increasing your website’s visibility in the community and attracting new patients and clients to your practice.

Outsourcing SEO can help to ensure that your website is reaching your target audience, upholding the reputation of your practice and helping to bring new patients through the door. The team at Vividus can work with you to develop an SEO strategy designed to reach the communities you serve. For more information, call 07 3283 2233 or visit www.vividus.com.au
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The Cosmetic Medicine Centre
Having worked in cosmetic medicine for 26 years, **Dr Mary Dingley** knows what it takes to run a successful business. Here we go behind the scenes and discuss the systems, policies and procedures that make her Brisbane practice stand out in a highly competitive field.

After receiving her Bachelor of Medicine and Bachelor of Surgery degree from the University of Queensland back in 1984, Dr Mary Dingley worked in the public-hospital system for three years before being presented with a unique opportunity.

“I was asked by an organisation to consider entering the emerging field of cosmetic medicine, with a view to both treating patients and doing some research and development,” recalls Dr Dingley, who has worked exclusively in private cosmetic medicine ever since.

“In those days there weren’t many cosmetic procedures available – we had collagen injections, some chemical peels, leg-vein injections and hair-restoration surgery, and that was about it,” she adds. Working between Sydney and Brisbane, Dr Dingley says it was often a struggle but she persisted. “At the time medical advertising was not permitted and the only people in Australia that knew anything about cosmetic medicine had read about it in overseas journals, so attracting clients was all about word of mouth,” she explains. “As more procedures became available, things started to evolve and I decided to set up on my own.”

Initially working out of sessional practice rooms in Brisbane, Dr Dingley soon realised that she would need her own space and her own staff.

“For cosmetic medicine you need very specific facilities as you do a lot of things onsite,” she says. “You also need staff who have the ability to interact with clients, which requires training.”

As well as calling in architects to design a space to fit the needs of her growing clientele base, Dr Dingley relied on the expertise and advice of her husband, Roman Krumins, who specialises in corporate solutions and management consultancy.

“Roman got involved in the business when our present premises were set up and we’ve been working together ever since,” says Dr Dingley. “He has been crucial to helping me with advice on everything from purchasing major equipment and management issues to putting training regimens in place.” (See page 28,)

In the 12 years since establishing The Cosmetic Medicine Centre in the Brisbane suburb of Toowong, Dr Dingley’s reputation has been consolidated by her willingness to continue learning and embracing new technology.

“I’ve been involved in cosmetic medicine since its birth in Australia and it’s an area that continues to excite me,” she says. “The technologies available are constantly evolving, and I enjoy the learning and the fact that we can offer a wide range of treatments to our clients.”
How many people work in your practice?

In addition to myself we currently have two other doctors who work in the practice on a sessional basis, plus three nursing staff, three reception staff and a practice manager. There is also another doctor who uses our large theatre for hair-restoration surgery which is performed under local anaesthetic.

We also have trainees pass through at various times – some dermatologists who wish to get some practical knowledge of laser therapy, as well as registrars.

Which treatments does your practice offer?

We perform cosmetic injections (botulinum therapy and fillers) and we have about 15 different laser and light sources – focused ultrasound and radiofrequency devices, as well as cryopilolysis [also known as CoolSculpting].

What does your role in the practice involve?

I used to do everything, but now that the practice has grown I concentrate more on the clinical side of things. I also decide on what clinical equipment we need to buy, as the field of cosmetic medicine is always changing, with new procedures being developed and equipment being constantly updated.

How do your patients hear about you?

Generally through word of mouth, and we receive referrals from dermatologists, plastic surgeons and other practitioners. We have a website and are listed in the Yellow Pages – both the printed and online versions. The only ads we place are done
periodically in conjunction with equipment suppliers.

**Which systems, policies and procedures have you implemented?**


For staff, we have Induction Training Procedures, Hand Hygiene, CPR, Fire Safety, Product Training, email advice and discussions around process improvement.

**What, in your opinion, does it take for a practice to succeed in the highly competitive cosmetic medicine arena?**

Firstly, you have to have an ethical practice and be good at what you do. Many look at cosmetic medicine as an easy offshoot of another part of medicine, but it’s not something that just anyone can do well – one needs to have an aptitude for cosmetic medicine to get good results and have people return.

A practice based on advertising and discounting will generate patients who are impulsive and price-driven, and may not return. Such practices tend to come and go – it’s like ‘supermarket’ medicine.

To succeed long-term, there must be an ethical base with a focus on the patient and giving them results.

Many of these patients will be extremely loyal and become long-term ‘friends’. The most loyal are actually those who tried somewhere else and regretted the change, and returned never to leave again!

**How important is a good practice manager to your business?**

Absolutely essential! As the practice started to grow we realised that we needed much more in the way of management. Our practice manager, Christine Malone, was very willing to learn all she could, so we sent her to do a Diploma in Practice Management at New England University. Although she has always been extremely competent and a great asset to our business, Christine says the course made her aware of the things she wasn’t doing and it has given her greater confidence.

**What most inspires you about your work?**

With any job, it’s the people you meet every day, and for me it’s the evolution of those people that you see over time, the honing of techniques to individuals and the feedback I get. I’m constantly inspired by the changes one can make in people’s lives by changing something in their appearance that may be holding them back. It’s nice when you’ve seen people for 25-plus years and they are looking and feeling fantastic, and you know you’ve had a part in that.

**Do you do any ongoing training?**

Yes. In cosmetic medicine there are constantly new techniques and new pieces of equipment coming out, so it’s necessary to remain up to date. I go to two or three conferences a year, in Australia and overseas, and I’m constantly attending workshops, some of which I present.

**You recently attended The Private Practice Succession Planning Workshop – did you learn anything that could be applied to your practice?**

It was good to get an idea of how other doctors (provided they are suitable), could be brought in, with a view to ultimately taking over the practice. It would be hard for anyone to set this sort of practice up from scratch – it takes so much organisation and so much equipment. We have a ready-to-go, extremely functional organisation but it would be very expensive for someone to just buy straight out. The workshop showed how it would be feasible for someone to ease in.
Describe your role within the practice.
I’ve been working on the business with Mary for the past decade. On a daily basis I offer general advice regarding the procurement of major equipment for the practice, and I’m a sounding board for Mary when she has issues around management and conflict resolution. On a broader level, I put all of the practice manuals in place, coached the practice manager during her studies and set up training regimens for staff.

Why does The Cosmetic Medicine Centre stand out?
With any successful practice it’s primarily about the proficiency of the practitioner. Mary is one of the longest-practising cosmetic medicine practitioners in the country and it’s a testament to her proficiency that most of her work comes via referral. In addition, Mary has an enormous selection of machines so can provide a full range of services, and her expertise across the range is outstanding. Client confidence also comes down to the practice itself and the management of the ‘journey’ a person goes on when opting for a procedure. The Cosmetic Medicine Centre is very appealing – there is ample parking, the environment has been beautifully designed and is always well maintained, the reception staff are trained to be welcoming and put clients at ease from the second they walk in the door, and the procedures are performed in an absolutely professional manner to the highest possible standard.

How are the practice’s high standards maintained?
The Cosmetic Medicine Centre is independently certified by Global-Mark and is the only certified cosmetic medicine practice in Australia. We undergo a regular audit, and I am involved in that process. The audit shows that the practice has all of its business and operation manuals in place, and that everything taking place in the rooms on a day-to-day basis reflects what is in the manuals.

Having certification definitely gives the practice an advantage – it is a confidence-booster for everyone working here and, most importantly, for clients.
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TRADING PLACES

If you are thinking of selling your practice but want to stagger the transition period and retain your good name, Georgie Haysom recommends doing your research well in advance.

Having devoted a significant amount of time and effort to build up your own medical practice, not to mention the financial investment, there’s a lot at stake when you decide the time has come for you to sell. In addition to satisfactory financial compensation, as a doctor you value continuity of care for your patients and want to feel reassured that the practice will be in good hands.

As an example, let’s say XYZ Pty Limited, a company that runs medical practices, has offered to buy your practice (by purchasing the shares in your practice company) for an attractive sum, to be paid in three equal installments over the next two years. In return, XYZ wants you to work a certain number of days per week, for a percentage of your gross earnings.

The proposed arrangement is that you will transfer the shares in your practice company to XYZ upon payment of the first installment. Payment of the second and third installments of the purchase price is dependent on you meeting a set target of treating a certain number of patients per week, which seems achievable based on your previous workload.

The purchase price will set you up for retirement and you can wind down your own practice over the next few years. In addition, you won’t have to worry about running the administrative side as all reception and support services and equipment will be provided by XYZ, leaving you to focus on what you love to do – treating patients.

After all the hard work you have put in over the years, it sounds like an attractive offer. But is it really?
FOR YOUR CONSIDERATION

Before agreeing to sell your practice, there are a few things you need to consider:

1. Can you meet any patient or billing targets contained in the contract? What might prevent you from meeting these service obligations, and what will happen if you don’t meet them? In the scenario above, failing to meet the billing targets means you will not be paid the second and third installments of the purchase price.

2. If you are selling shares in your practice company and payment of the purchase price is to be by installments, don’t agree to transfer the shares or hand over the share certificates until after the last payment. Keep security over the shares until the total purchase price is paid.

3. Find out about the corporate group seeking to buy your practice. What happens if the company goes bankrupt or becomes insolvent before the entire purchase price is paid? If you’ve already transferred the shares in your practice company, how will you get them back?

4. Be careful about the use of your name. If you sell a practice company that uses your name, that name will become the property of the corporate practice. Consider changing the name of your practice company before you sell to avoid potential difficulties trading under your name in the future.

5. Beware of what you are agreeing to by signing the contract. The courts will generally not look behind the terms of the written contract. Standard contracts are often used, and you need to consider whether this is appropriate for your circumstances. The courts will assume you are a sophisticated contracting party and that there was equality of bargaining power when the terms of the sale were being negotiated.

6. Consider what the contract says about medical records. Usually the clinical records will be part of the property that is sold with the business. Ensure the contract contains a clause allowing you the right to access and copy relevant medical records in the case of a claim or complaint against you in the future.

7. Be clear about the services and equipment the company is to provide, and the ongoing financial arrangements. Many practitioners assign their Medicare billings to the practice and are then paid a percentage by the practice. In the case of a dispute with Medicare where repayment of benefits is required, because your provider number was used, you will be obliged to repay Medicare the full amount, even if you only received a percentage. Include a clause in the contract allowing you to recoup the balance from the company if this situation occurs.

8. Include a workable dispute resolution clause in the contract and, if there is a dispute, call in a mediator early. Early alternative dispute resolution with an accredited and experienced mediator may save you significant legal costs in the case of a dispute.

9. At Avant, our Practitioner Indemnity Insurance Policy does not provide cover for commercial disputes arising from the sale of your practice or business. If there is a dispute over the contract, Avant’s Practitioner Indemnity Insurance Policy will not respond, and you need to be aware that legal costs associated with a commercial dispute of this nature can be significant. Be sure of your obligations under any agreement before you sign it.
It’s important that you obtain your own legal advice from a lawyer with experience in commercial transactions, preferably in mergers and acquisitions. Asking a family member who is a lawyer to have a look at the contract for you or believing that you can deal with it yourself is unlikely to be sufficient – formal, independent legal advice should be sought on all aspects of the transaction.

Finally, remember that when you sell your practice, it is no longer yours. The company that bought your practice will be in charge of the staff and how the practice is run, including the name under which it operates.

NOTE: This article was previously published in Avant Member Update – February 2012. It is not comprehensive and does not constitute legal advice. You should seek legal or other professional advice before relying on any content, and practice proper clinical decision-making with regard to the individual circumstances. Avant is not responsible to you or anyone else for any loss suffered in connection with the use of this information. Information is only current at the date initially published.

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The rules on referrals

Worried about whether your referrals would stand up to scrutiny in a Medicare audit? In the interest of clearing up your concerns, Margaret Faux undertakes the forensics on this complex subject.

We always seem to get stuck at the referral slide. Typically, about 15 minutes into our presentations for The Private Practice, Steven Macarounas is forced to politely interject to end the barrage of questions from the specialists in the room. The questions tend to run along the same lines:

- If the GP doesn’t stipulate to whom in our practice the referral is for, can we simply circle the name of the doctor or ‘fill in the blank’?
- I have a colleague who is booked up for four months. Sometimes he sends patients who have been referred to him by their GP to me, as they can get in to see me quicker. Is it okay for me to ‘take over’ the referral?
- If I am seeing a person with problem X and am then asked to see the same person at 4am for a new problem (Y), can I bill an initial assessment 110 (though technically there is no referring doctor for the Y problem) because the patient is already under my care?
- If the patient goes to acute care for a period then comes back, does that start another ‘period’ with a 110, new referring doctor, or just continue with the 116 because one is basically continuing care for the same problem?

A sound business model builds the practice as a saleable asset, as opposed to the individual doctors within it. How can we achieve this when Medicare requires that referrals name the individual doctor?

Although referrals should be one of the simplest components of Medicare, this is not the case. Indeed, it’s a topic that is neither well understood nor easily or briefly explained, yet referrals are an important and deeply embedded component of our national health scheme. So, let me answer those questions.

The legal requirements

All legal requirements relating to referrals can be found in section 20BA of the Health Insurance Act 1973, and regulations 29, 30 and 31 of the Health Insurance Regulations 1975 – neither of which provide absolute clarity as to whether a referral must be to a named specialist or not, and this is the cause of much of the confusion. But it’s not so much what the legislation says, it’s what it doesn’t say that provides some answers.

The language of both the Act and Regulations clearly refers to individuals rather than practices, and uses the singular rather than plural. This is seen in the use of phrases such as:

- ‘referral to a consultant physician or specialist’
- ‘a patient is to be referred by a referring practitioner to another practitioner’
- ‘in the practice of his or her specialty’
REFERRALS ESSENTIALS

- Must be in writing.
- Must be signed by the referring practitioner.
- Must be dated.
- Must be retained for 18 months.
- Must specify a service to be rendered by the specialist.
- Must give the specialist necessary information about the patient’s condition.
- The referral must be received before the service is provided.
- Referrals do not need to be in writing in a medical emergency.
If you give the words their plain-English meaning, which is a key principal of statutory interpretation, one would conclude the intention is that patients are referred to a person not a practice. But what the legislation doesn’t say is also relevant.

Both the Act and Regulations are silent as to whether the referral must specifically name the specialist to whom the patient is being referred and, in the absence of such direction, it must be assumed that this is not a Medicare requirement.

The legislative requirement is that the patient is referred ‘to another practitioner’, but nowhere is there a further requirement to address the other practitioner by name. What is required is that the patient is referred to ‘a single’ specialist as opposed to everyone in the specialist practice – all of whom could theoretically charge an initial consultation for that patient, which is clearly not the policy’s intention.

It is therefore accepted medical practice, as opposed to a legislative requirement, that referrals address a specialist by name where possible. But the reality is that sometimes, for very good reasons, referrals arrive addressed to ‘Dear Cardiology Practice’. Interestingly, this is something GP software facilitates but most specialist software does not. That notwithstanding, what should you do in these circumstances?

Many practice managers will call the referrer and request a revised referral naming the specialist. If a referral pad has been used, some will circle the name of the specialist who sees the patient on the day, while others will simply insert a name or ‘fill in the blank’. For those whose personalities border on the edge of OCD, the most sensible preference is option one, which offers indisputable certainty.

But the correct response is that as long as all other requirements concerning the need for the referral and the content of the referral have been satisfied, and the referral is taken up by one specialist only, then the legal requirements have been met and the referral is valid. Put simply, there is no Medicare requirement whereby a referral must address a specialist by name.

Can you ‘take over’ a referral?
An often-asked question is what to do in circumstances where an otherwise valid referral does name a particular specialist but that specialist is not available to see the patient.

Firstly, always keep in mind the GP who made the initial referral and the reasons for that referral. Sometimes a GP will refer to a specific specialist because the GP is of the view that a particular practitioner will best meet the medical needs of the patient. But it’s also true that sometimes the GP simply wants their patient seen ASAP, and any specialist will do.

There is nothing in the legislation to prevent another specialist from ‘taking over’ a referral on a permanent basis and claiming the relevant specialist-referred MBS items. Though, of course, it would be prudent for someone to communicate the change of specialist and the reasons for the change to the referrer.

In circumstances where the named specialist – the principal – is not available and a locum is covering, the locum tenens provisions of the MBS provide the solution. The patient does not have to be seen by the principal and can be seen under that referral, by a locum. A new referral is not required as it is accepted medical practice that the original referral applies to the locum.

In these circumstances Medicare benefits are determined based on the qualifications of the locum, not the principal. And it should be noted that an initial consultation can only be claimed once, by either the locum or the principal – whoever first saw the patient under that referral.

Emergencies and new conditions
In circumstances where one is seeing a person with problem X and is then asked to see them at 4am for a new problem when there’s clearly no ability to obtain a new
referral, there are a few options. A second initial consultation can be claimed under the original referral when the patient presents with a new condition, unrelated to the first condition. In my work we see this very often and it will usually be necessary to add the words ‘not duplicate service’ and ‘new condition’ to the claim to ensure it is paid.

The Medicare website provides a useful example of a patient who is regularly reviewed for glaucoma who then develops a pterygium. This would commence a new episode of care and a new initial consultation item would be payable. And as long as the original referral was worded broadly enough, there is no requirement contained anywhere in the legislation specifically indicating that a new referral must be issued in these circumstances – and sometimes it’s just not possible.

However, if the original referral specifically requested only the treatment and management of glaucoma, then you’ll need a new referral for the pterygium.

Alternatively, if the treatment is an emergency situation or occurs in a hospital and it is not possible to obtain a referral, you can obviously proceed and treat the patient without a referral. The detailed records you will include in the hospital file will be all that’s required should the claim ever need to be substantiated.

What is a course of treatment?

Often questions about referrals come down to the definition of a single course of treatment and determining when one course of treatment ends and another begins. This is not always easy. Medicare describes a single course of treatment by a specialist as including an initial consultation and the continuing management and treatment of the patient up to the point where the patient is referred back to the care of the GP, as well as any subsequent follow-ups of the same condition.

Often patients will spend a period of time in acute care during the course of an admission, and this doesn’t always occur at the start of that admission. An episode in acute care does not necessarily commence a new course of treatment, for which a new initial consultation would be payable. The patient can go to intensive care or theatre, or even be discharged home and return, and still be receiving care for the same problem under the same referral.

Of course, sometimes a referral will expire during the course of treatment and a new referral will be required – and this does not automatically commence a new course of treatment. If you are managing the same condition then an initial consultation should not be claimed again. The new referral simply ensures claims are paid at the specialist rate.

What is the referral asking you to do?

Implementing the precise request contained in the referral should not be overlooked. This Professional Standards Review case is a cautionary tale:

**PSR annual reports – 2004-2005**  
Dr D, Consultant Physician in Gastroenterology

The reasons the Commission gave for making this request were the overall number of rendered services and daily servicing by Dr D (13,602 services at a Medicare benefit of $1,507,595 and 60 or more services a day on 33 occasions) and the level of consultations in association with procedural items on the same day.

After conducting his review, which included obtaining advice from a senior consultant physician in gastroenterology, the Director formed the view that Dr D did not receive a proper referral to a consultant physician to justify a claim for an MBS item 110 (initial consultation), nor did Dr D document that he had rendered a service that justified an item 110 consultation.

The Director was of the view that the request Dr D received was for a procedural item (endoscopy etc.) rather than a referral to a consultant physician for management of a patient’s problem. Dr D’s medical records focused on a history of the gastrointestinal problem but there was no evidence of any history taken of other problems or of the general health of the patient.

It was apparent from the request documentation that some patients had significant medical problems. Also, there was no evidence that a physical examination was made prior to the procedure. On advice provided by Dr D, he allows five minutes for the consultation and 10 minutes for the procedure.

Following much discussion, Dr D agreed that his conduct constituted inappropriate practice, that the ‘request’ to perform a procedural item was not a valid referral (as required by the legislation), and agreed to be reprimanded and to repay $70,000 in Medicare benefits.
Aspects of this case are difficult to reconcile with the fundamental nature of specialist physician practice, as the PSR found that the request received by the gastroenterologist was valid for the procedure only and not for any consultation. If that was the case, it seems to have reduced the gastroenterologist to being little more than a technician.

Nonetheless, the example provides a clear message to medical practitioners to exercise caution in rendering services not specifically articulated in the referral document, and to keep a thorough record of services provided.

**Period of validity**

GP referrals are usually valid for 12 months and specialist referrals three months, although GPs can state the length of the referral to be something other than 12 months if they so choose. The start date is the date of the first consultation covered by that referral, not the date of the referral itself.

When an admitted patient is referred to a specialist, the referral is valid for three months or the duration of the admission, whichever is longer. The referral in this instance does not need to be a separate letter or document. Regulation 30 provides that a signed referral contained in and forming part of the patient’s hospital file is sufficient.

Indefinite referrals are intended to be just that – indefinite – but most of you will know this is simply not the case.

Medicare even provides written material on its website advising specialists not to request a new referral and advising GPs not to issue a new referral unless a new condition arises. Yet, anecdotally, doctors and practice managers will tell you that indefinite referrals seem to ‘expire’ in an arbitrary fashion.

Usually, practices become aware of this when their claims suddenly start rejecting. Then, having called Medicare, they are informed that the referral has expired, despite protests that it was indefinite.

Only one option remains – get a new referral. If you don’t you cannot claim the specialist-referred items. This remains a peculiarity of the system.

Backdating referrals is illegal and serious penalties apply for breaches. But how do you manage the situation where you thought you had a valid referral prior to your first consultation with the patient but it turns out you didn’t?

The first indication is usually when your claim is rejected with one of the ‘something’s up with the referral’ rejection codes. In a medical-billing company where we submit thousands of claims daily, problems with the referral is one of the most common causes of rejected claims. Often, once the data has been carefully checked to ensure name and provider number were correctly entered and phone calls have been made, it turns out that an intern or resident – whose provider number does not yet allow them to refer – has written the original referral.

Interns, residents and some registrars working in public hospitals do not have a provider number that allows them to refer to private clinicians outside of the hospital. They are able to write a referral on behalf of their supervising consultant, as long as the consultant signs the referral. The privilege of referring comes with their qualifications, a little later in their careers.

The original referral in this scenario therefore contained an error, in that it named the wrong referring doctor and provider number, and until this is fixed, the claim will not be paid. But the question here is whether you should revert to claiming the non-referred items until such time as you have a valid referral, or whether a genuine error can be corrected.

It’s one of those grey areas on which the legislation is silent. It’s not a lost, stolen or destroyed referral and so those provisions cannot apply. It’s simply an honest mistake usually made by a well-meaning junior doctor.
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Sue Ayres, Practice Manager

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Indefinite referrals are intended to be just that – indefinite – but most of you will know this is simply not the case.

As a reader of The Private Practice eZine, you’ll already be switched on to the concept of building your practice as a business asset. And now you have been assured that there is no Medicare requirement to specifically name the specialist to whom the patient is being referred, this no longer needs to be viewed as an impediment to building your practice for sale.

While referrals are a complex but largely comprehensible aspect of the Medicare scheme, their role in state-run, public-hospital clinics is unimaginably labyrinthine in comparison. As many of us struggle to reconcile the federal legislation and the National Healthcare agreement – in the context of regularly changing national-partnership agreements, contentious Council of Australian Governments conferences held by health ministers and the potential impact of the National Disability Insurance Scheme – perhaps we should be thankful private-sector referrals are fairly straightforward!

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Do you hear the whisper?

Just when you thought the best was out of your reach, now you can have it!

COMING SOON...

Register your interest: info@seeforth.com.au
Dealing with difficult patients

In the medical profession it is essential to know how to handle patients who find themselves outside of their comfort zone. Here Dr Neil Baum provides some insights and strategies.

All of us in the healthcare profession have had the experience of interacting with a difficult patient. It doesn’t matter if you are a pathologist, pediatrician or primary care physician, you will have had the experience of dealing with the difficult patient.

Fortunately, difficult patients make up only a small percentage of the patients that we care for. Doctors report that about one in six patients are ‘difficult’. That translates into three or four unpleasant visits with patients each day.

Unfortunately, few of us have had any formal training on managing a difficult patient. It is something we have learned, or maybe not learned, by trial and error. Oftentimes, the errors associated with managing a difficult patient can lead to undesirable consequences.

In this article, I will discuss how to identify the difficult patient and provide a three-step technique for managing a difficult patient.

WHY DO PATIENTS BECOME DIFFICULT?

First, most patients in the healthcare situation, such as in our offices or in the hospital, are out of their comfort zone. Even the most self-confident individual when placed in a situation of uncertainty may become uncomfortable, anxious, and even hostile when not knowing what to expect.

This is an important reason to always explain what you plan to do to a patient. This relieves the patient’s anxiety and can make the patient much more mentally comfortable when confronted with a medical test, procedure or diagnosis with an unfavorable prognosis.

Second, patients are often in a stressful situation. Remember, what is commonplace to each of us is probably a first-time experience for our patients. Take, for example, the history and physical examination. Patients will be required to reveal personal secrets and issues that they wouldn’t share with their partners, best friends or clergyman or woman. Then they will commonly get undressed and wear a gown that seldom covers the entire body, and then be probed in areas of the body that have never been touched or explored before.

If we just imagine what our patients are experiencing, it is not difficult to understand why they are stressed when they come to the doctor’s office. We even have a name for it, ‘white coat hypertension’, as frequently these visits are associated with a mild elevation of the patient’s blood pressure.

Finally, health issues and fear of the unknown lower a person’s threshold for anger, potentially precipitating a conflict. When patients are placed in a stressful situation and when they are out of their comfort zone, their threshold for anger is lowered, and they will often say and do things that would not normally occur outside of the healthcare environment.

Therefore, it is imperative that all of us in the healthcare profession, which includes receptionists, office managers, file clerks...
If we just imagine what our patients are experiencing, it is not difficult to understand why they are stressed when they come to the doctor’s office.
and insurance and billing agents, be just as cognisant as the doctors, nurses and physician assistants who spend more time eyeball to eyeball with the patients, to the potential for patients to become anxious, uncomfortable and psychologically disoriented in the medical environment.

WHY IS IT IMPORTANT TO SUCCESSFULLY MANAGE THE DIFFICULT PATIENT?

Studies have shown that happy customers/clients/patients may tell one to three others about their positive experience with you and your practice. This is exactly the positive word-of-mouth reaction that you desire to create for all of your patients. You want them to have a favorable experience from the time they make the phone call to make an appointment until they pay their bill and leave the practice.

On the other hand, a dissatisfied patient will tell 10 to 20 family members, friends, existing patients and potential new patients about their negative experience with your practice. This is a situation that must be avoided. It is important to make sure that even the most difficult patient ends up with a positive experience, and that whatever the patient perceived that was unfavorable does not happen again.

In addition, you must express that you are sorry that the patient had an untoward experience. It isn’t hard to calculate or envision that patients with a bad result and a big mouth can impact hundreds of others with their negative experience. I am reminded of a lady that had a problem paying for durable medical goods and was upset that we asked her to pay for the goods since her insurance would not cover their cost. She probably told several hundred people about how mercenary and avaricious Dr Baum is. I would have gladly given her catheters for a long time to avoid the damage and embarrassment that she caused!

A dissatisfied patient is more likely to have a poor outcome and make greater use of the healthcare system. These patients are not likely to be compliant and follow directions, and thus their outcomes are less than optimal. Also, the dissatisfied patient is more likely to litigate against the physician for the unhappy experience or the patient’s less-than-optimal outcome from a procedure or test.

If those aren’t reasons enough to resolve the complaints of the difficult patient, it has been shown that those doctors who reported having more difficult patient encounters were 12 times more likely to report burnout than those reporting fewer difficult encounters.

CLUES THAT YOU MAY BE CONFRONTED WITH A DIFFICULT PATIENT

What are the clues that you might be dealing with a difficult patient?

Just as there are signs and symptoms associated with various diseases and conditions, there are signs that you may have or may create a dissatisfied patient.

First, listen carefully to the tone of voice. If the patient is speaking louder than expected or more rapidly than usual, then you must modulate and soften your voice and speak slower. Watch the body language. Look for signs for agitation, such as wringing of the hands or tapping of the feet, which is a sign of impatience.

Look for fear or frustration. Clenched fists and clenched teeth are other signs that you are dealing with a dissatisfied patient. A furrowed brow or distended jugular vein indicates anxiety and tension. A patient who is in a defensive position, such as with crossed arms, will often provide clues about the intense conversation that is about to take place. Pay attention to the breathing pattern. A restricted breathing pattern or sighing is an indication that the patient is upset.

Another warning sign is the doctor shopper. If a patient has seen multiple
A dissatisfied patient will tell 10 to 20 family members, friends, existing patients and potential new patients about their negative experience with your practice.

physicians for the same complaint, it is unlikely that all of the physicians were problematic. It is more likely that the patient is the source of the problem, and it is unlikely that you will be the knight in shining armour that diagnoses a difficult condition or cures the patient of his or her malady.

It is those patients that you want to set reasonable expectations very early in the doctor-patient relationship. Patients with chronic medical problems lend themselves to having difficulty with physicians and their staff. Patients who make frequent office visits (more than would be expected for their medical condition) may be difficult to manage.

You can also expect to be challenging any patient who is taking multiple medications, especially analgesics. Studies have pointed out that patients who insist on being prescribed an unnecessary drug are likely to present a challenge and be a management problem.

Finally, be wary of the patient who arrives with a briefcase full of articles and citations gleaned from the Internet. I suggest that you do not dismiss the patient’s efforts as it only demonstrates the patient’s interest in his or her medical condition. I recommend that you direct the patient to credible websites or refer the patient to your own website if you have information on the medical condition.

I usually do not read all of the patient’s articles but instead suggest that the patient review sites that I deem authoritative and credible. I then offer to discuss the information or the articles on the next visit. This way I don’t discount the patient’s efforts but rather lead him or her to information that will be useful and not confusing or misleading.

Also, I suggest that patients with chronic medical conditions be discouraged from entering blogs with other patients. It is has been my experience that blogging lends itself to confusion. Well-meaning patients who have the same diagnosis will give your patients advice that may not apply to their disease or condition. For that reason, I suggest that they avoid Internet blogging.

THE THREE-STEP RESPONSE TO MANAGING THE DIFFICULT PATIENT


Step 1: Don’t Interrupt
Allow the patient to complete his or her discussion without any interruption on the part of the physician. During the average patient encounter, the physician will often interrupt the patient after only 16 seconds7. A patient will have spent a lot of emotional energy to speak to the physician about his or her negative experience. Make every effort to remain focused, listen to the patient, and do not interrupt until the patient is finished with his or her dialogue.

After the patient has had an opportunity to vent his or her concern, validate the frustration with empathy. Rather than becoming defensive, consider saying: “I understand that you are upset at having to wait, and I apologise for the delay.”

Step 2: Involve the patient in the solution
Ask how to provide a solution. You will be amazed at how many times the patient will give you the answer or provide suggestions for resolving the problem. Ways to involve the patient include asking the patient, “What do you think I should have done?” or “Do you have any suggestions of how to solve this problem?”

By involving the patient you have clearly demonstrated that you are listening to the patient’s concern and that you are committed to making the situation better. Involving the patient also demonstrates that you are interested in his or her goodwill and that you care about the patient’s experience with you and your practice.

Step 3: Provide the patient with an opportunity to discuss concerns
We are not mind readers, and we don’t know what additional concerns patients may have. For example, patients may be concerned that the situation not be repeated with either themselves or with other patients. This is of particular importance when there has been a complication or with errors of commission or omission.

There are patients who are altruistic and have a concern about their fellow patients, and want reassurance that the situation will not be repeated.

Another common concern is the cost of additional care when a mistake has been made. For example, if a lab test was omitted or the wrong test was done and the test has to be repeated, patients want to know that they or their insurance company won’t be charged if the error occurred in your office or at the laboratory.

I am reminded of a story of a patient who had a mammogram but the radiologist didn’t check the film’s quality after the study. The radiologist had to bring the patient back for an additional mammogram, and she was charged for the additional study.
The radiology department did not manage this properly, and the patient left the primary care doctor who ordered the study and the hospital and referred herself to Mayo Clinic.

Again, asking about patients’ concerns demonstrates your caring and compassion. After all, patients don’t really care how much you know compared with knowing how much you care!

A FEW SUGGESTIONS

I believe it is important to have a discussion with a difficult patient in a private location where the discussion cannot be overheard by others in the office. I suggest that you escort the difficult patient from the exam room to another secure location in the office to have your discussion in private and without interruption.

I recommend that you sit next to the patient, not across the desk from the patient. The reason is that you want to avoid any barriers, including physical ones, separating you and your patient. You also want to maintain good eye contact with the patient. This is not the time to be looking at the chart or a computer screen. Inform your staff that you will be talking to a patient and that you are not to be interrupted during this conversation. After you have listened to the patient, it is helpful to ask the patient additional questions. This sends the message you are interested in finding a solution and that you are actively listening.

At the end of your discussion, thank the patient for bringing the issue to your attention. You may even consider sending the patient a note acknowledging your discussion and your plan of action. If you have to get back to the patient, specify a day and time that you will be calling.

If you don’t have a response or answer at that time, call the patient and let him or her know the status of your follow-up and when you might be in contact again.

Follow-up is vital to the success of managing the difficult patient.

SUMMARY

Managing the difficult patient is part and parcel of the practice of medicine. You are likely to have satisfied patients who have a positive experience with your practice. However, there are going to be a few that will try your communication and interpersonal skills.

Resolving the issues of the difficult patient can be gratifying and as rewarding as solving a difficult diagnostic problem or successfully resolving a medical problem using your surgical skills.

Finally, if you can handle the difficult patient, the others are so much easier to manage!

IN BRIEF

Dr Neil Baum is Associate Clinical Professor of Urology at Tulane Medical School and Louisiana State University Medical School, both in New Orleans, LA. He is also on the medical staff at Touro Infirmary in New Orleans, and East Jefferson General Hospital in Metairie, LA. Visit http://neilbaum.com/meet-dr-baum or follow Dr Baum’s blog at http://neilbaum.wordpress.com/

REFERENCES

3. Saxton, See article in PPM by James Saxton on the I’m Sorry Principal.
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FULLY EQUIPPED

Andre Karney is Head of Medical Finance at Investec.
Looking to upgrade your equipment? **Andre Karney** provides some insight into the finance options available to medical professionals.

To run a successful practice there are a number of important considerations. Aside from looking after your patients, it’s also important to have the right equipment and facilities. Equipment costs can vary dramatically depending on your specialisation, however equipment is an asset rather than a liability as it gives you the ability to improve the quality of treatment you give to your patients. Understanding there are options available for you to fund this purchase is of the utmost importance.

**IT’S YOUR CHOICE**

You can either buy your equipment outright with cash, or you can save your cash and gain commercial benefits sooner by financing your equipment purchases using one of a few different finance options. While financing arrangements are common, they can be complex and, depending on the commercial benefits of the purchase and various tax structures, it’s important to get advice from finance experts on the best solution for you.

By choosing the appropriate financing method to suit your circumstances, you could realise the following five advantages:

1. Keep your cash to invest in other channels or purchase growth assets.
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5. Make monthly repayments for select Investec finance and loan contracts on the Investec card, and earn Qantas Points on the repayments.

There are a number of finance options available to medical professionals for practice equipment. A financial specialist at Investec can go through the options available, which will help you to think about all the possibilities and to assist you in finding the right solution for your particular needs.

The reason Investec can help you make the right decision is because we have over 20-odd years experience in working with medical practitioners, so we know this market in a deeper way than anyone else.

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INSURANCE

WELL PREPARED

In the first of a three-part story, Katherine Ashby looks at trauma insurance and how to calculate the right level of cover.

While the first life-insurance policies can be traced back hundreds of years, trauma insurance is a comparatively new entrant to the market. Trauma insurance was first released in 1983, thanks to a South African surgeon named Dr Marius Barnard. The first policies were issued in Australia around 10 years later.

Dr Barnard saw a need for financial assistance for patients who suffered a significant illness or accident. As he has explained: “When I went into private practice I could not help but notice that while many patients eventually fully recovered medically, they suffered severe financial problems. This was not because of the cost of the operation but because of the disruption to their lives and their loss of income.”

Trauma insurance can fill this gap. Where total and permanent disability requires you to be unlikely to work again, and income protection pays if you are unable to work either temporarily or permanently, trauma payments require you to meet the definition of one of a list of specified diseases and injuries. It is not about the level or length of the disability but is based on the diagnosis.

You may have heard trauma insurance referred to by another name, such as 'living insurance', 'critical illness insurance' or 'crisis recovery insurance'. Trauma insurance can be complicated, with different policies covering different conditions, each with specific definitions.

Initially, just a handful of conditions were covered: cancer, heart attack, stroke and coronary artery surgery. This list has since expanded and some policies cover up to 40 conditions, including degenerative diseases such as multiple sclerosis and Parkinson’s disease, paralysis, comas, loss of speech, deafness, chronic organ failure, major organ transplants, occupationally acquired HIV and even severe rheumatoid arthritis.

Because trauma insurance provides a payment based on diagnosis rather than the level of impairment, working out the right sum to be insured for is complicated. For cancer, consider the fact that a claim may be for a T2N0M0 melanoma or may be for stage-three lung cancer. Trauma insurance provides you with a one-off lump sum, which means income and capital requirements need to be considered. Deciding on the right amount of cover for you will involve a detailed discussion with your adviser around two key areas – what you will need at the time of your illness/injury; and what you want your life to look like afterwards.

INCOME NEEDS

Firstly, your adviser may consider your income needs. As income protection only covers you for 75% of your income, many advisers will recommend that you top this up to 100% with trauma. While the period you allow for is up to you, a general rule of thumb is to ensure you are covered for at least two years.

You may also consider the other income in your household. If you were undergoing

Editor’s note:
In my previous life as a financial adviser I assisted a significant number of doctors in designing and implementing their insurance portfolio – sadly I have also facilitated too many claims on their behalf. I urge you to read this article carefully and ensure you are adequately protected – see page 59 for a list of endorsed specialist advisers who can help with your insurance review.

Katherine Ashby is the Senior Product Technical Manager, Life Insurance at BT Financial.
For more information about how BT can help protect you financially, please speak to your nearest Private Practice endorsed Financial Adviser:

- **New South Wales**: Warren Skinner, Fintuition (02) 9362 5050
- **Victoria**: Denis Durand, Durand Financial Services (03) 9909 7553
- **Queensland**: Scott Moses, Lane Moses Private Wealth (07) 3720 1299
- **South Australia**: Andy Murdock, Ora Financial Services (08) 8211 6611
- **Western Australia**: Wayne Leggett, Paramount Wealth Management (08) 9474 3522
CASE STUDY
Eleanor is a 44-year-old anaesthetist. She is married to Matt, an engineer, and they have two children, aged eight and six. In the initial meeting with her insurance adviser, Eleanor discussed how difficult it was to consider what she would do if diagnosed with a serious disease or injury, but there were a number of scenarios she was sure of. Eleanor knew that if she had to go through treatment for cancer, she wanted Matt to be able to care for her and the children. She also said if she was diagnosed with a degenerative disease such as multiple sclerosis, she would want to change her priorities, step away from work and focus on her wellbeing.

Eleanor and her advisor put together a sum insured that would cover 25% of her income for two years (her income protection policy would provide the other 75% if she had to take time off work). They also calculated a lump sum for medical care and enough to pay off Eleanor and Matt’s mortgage. While paying off the mortgage was not a specified need, the ability to do this would allow either Eleanor or Matt to cease working.

While the future is uncertain, talking through and understanding their protection plan has given Eleanor and Matt confidence that they are prepared for the unexpected.

Note: Part 2 of this feature will look at policy features and structural issues to be aware of when considering trauma cover.

MEDICAL COSTS
Secondly, you and your adviser may consider the cost of having access to the best medical care available. You should consider the cost of treatment, potential travel and accommodation, along with ongoing therapy. It can be difficult to quantify how much could be required. In a report commissioned by the Cancer Council of NSW and produced by Access Economics, the cost of treatment and loss of productivity from cancer was estimated at hundreds of thousands of dollars (Cost of Cancer in NSW – http://www.cancercouncil.com.au/wp-content/uploads/2010/11/costofcancer_summary.pdf).

When looking at medical costs, it isn’t just about treatment costs. Having access to quality rehabilitation services will assist your recovery. Whether this means physiotherapy, wellness services, counseling or alternative medicine, your plan needs to include an amount to fund your recovery.

MOVING FORWARD
Finally, it’s important to contemplate what changes you may like to make to your life. Will you still have the same drive to return to work? Your priorities could change, and planning for this can give you the ability to reduce your hours or cease work entirely. If you’re working towards retirement, you may wish to bring this date forward. Your adviser can discuss how these objectives can be achieved, such as through replacing income or reducing debt, so less income is required.

While trauma insurance is not well known, you are more likely to claim on this cover than life or permanent-disability insurance. Spending time with your adviser to talk through your personal situation and plan for your individual needs is an important step in making sure you have the right level of cover in place.
Websites That Attract Patients

8 out of 10 Australians search for healthcare information online.
Without an effective website you are missing out.

Most medical websites are dead on arrival when it comes to getting enquiries or new patients. They are either poorly designed, hard to find, or lack the best practices necessary to motivate people to call you.

Vividus custom medical websites will build your reputation and business:
- Professional medical web design
- Freedom to manage your own web content
- Online referral forms
- Streamline patient information resources
- Patient appointment request forms
- Detailed weekly reports on user statistics
- Search Engine friendly (SEO)
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Testamentary Trusts

The way you set up your will could bring unexpected benefits to family members in a range of situations, writes Donal Griffin.

In recent years, the term ‘Testamentary Trust’ has been used to describe what is usually known as a Discretionary Family Trust, established under a will. The popularity of testamentary trusts arises from the considerable benefits that can flow from their establishment.

A number of these benefits arise from the fact that, although assets of the trust may be controlled by the intended beneficiary, they do not form part of that beneficiary’s estate. This feature means a beneficiary’s inheritance through a testamentary trust can be advantageous in a number of circumstances.

BANKRUPTCY
Unfortunately, the incidence of bankruptcy in our society has increased significantly. Often a wife will guarantee her husband’s business venture and vice versa. To some extent we can all be at risk, whether in high-risk occupations, such as medicine, or not. However, if someone is forced into bankruptcy but their inheritance has been provided through a Testamentary Trust, it will be protected from creditors.

DIVORCE
As with creditors, an inheritance held within a Testamentary Trust is unlikely to be the subject of a Family Court order in the case of a marriage break-up. It may be regarded as a financial resource and have some effect on the terms of a property settlement, but this outcome is usually preferable to the property being at the disposal of a Family Court order.

SPENDTHRIFTS AND PEOPLE WITH DISABILITIES
It is common for people suffering from a variety of disabilities to be unable to properly manage their financial affairs. At the same time, families may wish to ensure that an adequate fund is set up to meet their beneficiaries’ reasonable needs without affecting any pension rights they may have.

The flexibility of a Testamentary Trust, especially if combined with a memorandum of wishes as to how the trust should be administered, can be an appropriate arrangement.

Donal Griffin is Director of de Groots Lawyers.
TAXATION ADVANTAGES
Although the above features are in themselves good reasons to consider a Testamentary Trust in your will, the basis of their popularity is the considerable tax savings that can arise under Section 102AG of the Income Tax Assessment Act 1936 (ITAA).

The effect of this section is that children under the age of 18 years who receive income from a Testamentary Trust are taxed on that income as an adult, and therefore enjoy the normal tax-free threshold of $18,200 (2013/14) – or $20,542 if the low-income tax offset applies – and marginal tax rates that apply to adults.

Without this special provision of the ITAA, trust distributions to minors may only access a tax-free threshold of $416 and thereafter the effective tax rate applied to the minor’s income is 66% of income up to $1307 and 45% after $1308, on the entire amount of income (excluding the Medicare levy).

With the tax-free threshold of $18,200 in 2013/14, this makes Testamentary Trusts even better vehicles for clients.

DRAWING COMPARISONS
The following example illustrates the advantages of establishing a Testamentary Trust compared with a traditional will provision.

Assume a husband dies leaving a dependant wife and three infant children. His estate is valued at $1,000,000. If this were invested at, for instance, 8%, it would generate an income of $80,000.

Example 1: The husband’s will leaves everything to his wife or he has no will. Her tax position is therefore:

<table>
<thead>
<tr>
<th>Beneficiary</th>
<th>Income</th>
<th>Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife</td>
<td>$80,000</td>
<td>$17,547</td>
</tr>
</tbody>
</table>

Example 2: The husband’s will establishes a Testamentary Trust controlled by his wife and providing for his wife and three children to be beneficiaries. The family’s tax position might be:

<table>
<thead>
<tr>
<th>Beneficiary</th>
<th>Income</th>
<th>Tax</th>
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</thead>
<tbody>
<tr>
<td>Wife</td>
<td>$20,000</td>
<td>$ nil</td>
</tr>
<tr>
<td>Child 1</td>
<td>$20,000</td>
<td>$ nil</td>
</tr>
<tr>
<td>Child 2</td>
<td>$20,000</td>
<td>$ nil</td>
</tr>
<tr>
<td>Child 3</td>
<td>$20,000</td>
<td>$ nil</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$ nil</strong></td>
</tr>
</tbody>
</table>

In example 2, there is a tax saving of $17,547 when compared to example 1, which shows what happens if no trusts are used. It is important to remember that this level of saving is annual and may be possible for many years.

Note: Tax calculations based on rates effective as at 1 July 2013. Medicare levy is not considered for these purposes. Although the income amounts in example 2 are above the tax-free threshold of $18,200, no tax would apply as a result of the low-income tax offset.

A WORD OF WARNING
Even though a testamentary trust may be considered by a will-maker to be a prudent provision for family members, like all provisions of a will it may be attacked by certain ‘eligible applicants’ under a Family Provision application.

The surviving spouse, children and certain dependants have the right to challenge a will in this way. While there are strategies that may be used to frustrate or restrict Family Provision claims, they are unlikely to result in the same benefits provided by a Testamentary Trust.

NEW TRENDS
Increasingly, the traditional husband and wife will – i.e. each to each other and then to the children – is being replaced by a Testamentary Trust controlled by the surviving spouse, under which the spouse and children are potential beneficiaries. If the funds in the trust justify it, wills along these lines can provide that, upon death of the spouse, sub-trusts come into existence for the benefit of each child and that child’s family, and would be controlled by the child concerned at a particular age.

Another trend increasing in popularity is where grandparents are providing education trusts for their grandchildren, which have the added advantage of maximising the tax-free income that can be applied for the grandchild’s benefit.

While largely promoted as a tax-saving mechanism, Testamentary Trusts have many other advantages and their inherent flexibility makes them worthy for consideration in your overall estate-planning strategies.

If you would like to review your asset-protection strategies, please contact Donal Griffin on 02 9101 7018 or dgriffin@degroots.com.au
There’s a technological revolution under way for healthcare practices across Australia. It’s been slow to start but, ever so gradually, the winds of change are blowing through waiting rooms nationwide.

The change is patient-centric technology. The way patients now interact with healthcare services is causing practices to adopt technology faster than ever. Healthcare information is now at the fingertips of every patient and clinicians are competing to keep up.

In a world where mobile applications are being created every day, health information can be obtained in real time and the personal health records of children can be accessed and updated by parents, how should healthcare practices be responding?

By understanding and embracing new healthcare technologies, Tania Taylor says you can drive efficiency, lessen the burden on staff and provide your patients with the level of service and connectivity they now expect.

TOP 10 HEALTH APPS

In November 2012, American technology news website onlineitallmatters.blogspot.com ranked the following as the world’s 10 most popular health apps:

1. WebMD
2. ZocDoc
3. LoseIT
4. Medscape
5. Epocrates
6. Fooducate
7. Glucosebuddy
8. iTriage
9. Sleepcycle
10. Lifecraze

Tania Taylor is Director of Partner Business at 1stAvailable.com.au

ONLINE ACCESS

The healthcare industry has traditionally been slow to adopt new technologies into its services, especially non-medical technologies – even though there is significant evidence these shifts have simplified and completely reshaped other industries, such as travel, banking and retail.

It’s no surprise that a credible and longstanding favourite such as WebMD would sit firmly in the number-one spot as most popular health app, but the real eyeopener came with ZocDoc – a US-based online appointment booking portal, which came in at number two.

Online appointments are a relatively modern concept when it comes to healthcare
bookings, so why is this technology resonating so strongly with both practices and patients?

Online appointment booking allows patients to enjoy a no-fuss, no-waiting-on-hold experience. Booking takes the click of a mouse or a tap on a smart phone. The patient has certainty in booking with the relief of knowing they have a convenient appointment when they need one. It also offers some anonymity and privacy – appointments can be made discreetly, anytime and anywhere.

Consumers have become accustomed to the convenience of online access to services and products, shaped by sites such as wotif.com, seek.com, realestate.com.au, etc. They appreciate being able to access everything they need in one place, which is what these major portals have in common, along with the fact that they have forever changed their industries and the way consumers utilise their services and products.

But the benefits are not only reaped by consumers. Online-appointment booking has the power to reduce your practice’s front-desk load – it eliminates the ‘negotiation process’ with the patient and it’s fast, easy and automatically transferred into your Practice Management Software. This provides both parties with convenience, control and empowerment.

In 2010, the Thomson Reuters PULSE Healthcare Survey indicated that more than 8% of Americans now book healthcare appointments online. While the latest figures are not yet available, the rapid growth of online appointments in the US by leading companies such ZocDoc would suggest that the percentage is likely to have achieved critical mass.

It’s no longer a question of will it happen but when it will become mainstream.

SMARTENING UP
Canada serves as a good example of how technology is changing healthcare booking practices. According to Ed Percy, a Quebec-based vendor of eHealth software and services, patients will increasingly use digital technologies to compare, assess and choose their healthcare providers.

“You’re working in the last of the great supply-driven industries and the arrival of consumerism is going to stress healthcare in ways we can hardly envisage,” Percy recently told delegates at healthcare conference in Montreal.

At the same conference, Mary Russell, Project Director of Personal Health Records for the Nova Scotia Department of Health and Wellness, said online access to healthcare will be crucial to reforming primary healthcare. She is testing the introduction of online personal health records to patients in that province.

“Consumers are doing everything else online these days,” she said. “They expect the same connectivity with healthcare. We are way behind. It’s not a matter of if we do this, but when and how.”

Dave Sellers is Director of Operations for the West Carleton Family Health Team in Ontario, which currently has 3700 patients using personal health records connected to clinicians via the clinic’s electronic health-records systems. He said: “Patients would rather text or email than pick up the phone, and it’s more efficient for staff to handle electronic messages than phone calls.”

Joe Cafazzo, head of the Centre for Global eHealth Innovation at the University of Toronto, says online access to clinicians and health records is just one way in which digital technologies is driving healthcare consumerism. He agreed with the general consensus, adding: “A flood of new sensoring and monitoring technologies that consumers can download onto their smartphones is on its way.”

Making Appointments
In addition to using the Internet as a research or communication tool, about 8% of Americans are going online to schedule healthcare appointments.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;35</td>
<td>9.6%</td>
</tr>
<tr>
<td>35-64</td>
<td>8.9%</td>
</tr>
<tr>
<td>65+</td>
<td>3.9%</td>
</tr>
<tr>
<td>Total</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

CASE STUDY: MEDICROSS

A recent study by 1stAvailable.com.au revealed that 60% of Australians feel frustrated by the process of finding and booking a healthcare appointment, while 51% postponed treatment simply because they could not find an available appointment that suited them.

When Australians could not access a convenient healthcare appointment, the study found three in five patients (59%) experienced increased pain, almost half (46%) had their condition worsen and more than one in three (35%) had their general health deteriorate.

Medicross is a shining example of how practices are evolving to meet patient needs. As one of the fastest-growing healthcare practice groups in Australia, Medicross comprises over 17 practices located across Queensland and has adopted new technologies to facilitate its growth.

Seeing a GP or dentist with Medicross is now a technology-driven experience that begins from booking your appointment online or through a mobile app to having a Skype consultation with your specialist. Each Medicross practice offers online appointment booking, free Wi-Fi, Telehealth consultations and Electronic Medicare claiming options, and is constantly staying abreast of technology changes that can be implemented to enhance the patient experience and make its practices run more efficiently.

According to Charles Jewaskiewitz, Managing Director of Medicross, the latest innovations in healthcare-practice technology enable patients to experience increased convenience and accessibility.

“We have implemented the latest technology to ensure that we are minimising any barriers to accessing convenient healthcare treatment,” he explains, adding that the tech-driven experience begins when the patient books an appointment with a Medicross GP or dentist.

“They can virtually peer into the appointment book of their preferred Medicross practitioner – in real time – to find an appointment that best suits them,” he adds.

“The appointment can be booked either online at 1stAvailable.com.au, through the Medicross.com.au website or through the Medicross 1stAvailable mobile app – all without waiting to call and speak to the receptionist during opening hours.”

As Charles points out, one important aspect of its practice-management strategy is making sure that, as Medicross practices grow, the burden on administration staff doesn’t increase.

“Online-appointment booking ensures both new and existing patients have the convenience and flexibility of booking an appointment with their preferred practitioner without relying on already burdened practice-management staff. Information is automatically transferred into our practice-management system, Genie,” he says.

In addition, Medicross has introduced free Wi-Fi access across the waiting rooms in its practices in order to make the waiting-room experience more enjoyable and help patients to pass the time.

“Let’s face it – GPs rarely run on time. So instead of patients reading outdated gossip magazines, they can now surf the net, reply to emails or access their social-media accounts using any web-connected portable device,” says Charles.

The practice also offers patients access to specialists via Telehealth video consultations, which fall under the Medicare scheme. Patients who need to see a specialist can have their consultation together with their GP on Skype.

“The advantages are that it’s convenient for the patient who doesn’t need to travel, and because the GP sits in on the appointment, they get the information straight away,” Charles explains. “Patients are voting to manage their healthcare needs online. They all want to access their provider online and the leading providers are the ones that have made that move first.”
EMBRACING EHEALTH

As healthcare systems evolve, so does the technology that supports it. Practices are currently under pressure to adopt these technologies to help the Federal Government achieve its national eHealth goal of ensuring every Australian has access to healthcare, thus reducing the cost of healthcare in Australia. The strategy includes the Personally Controlled Electronic Health Record (PCEHR), medication management tools, online claiming mechanisms, call centre triage, the National Broadband Network, decision support and much more.

Another innovation in technology targeted toward the patient-centric eHealth vision is the recently launched Federal Government initiative, My Child’s eHealth Record app. It allows parents to view information in and add information to the new health, growth and development part of their child’s Personally Controlled eHealth Record.

During the launch, Federal Minister for Health Tanya Plibersek highlighted the benefits of the app, which allows parents to add and monitor information such as immunisations, height, weight and development milestones.

“The app connects parents to their child’s eHealth record, which is a new function added recently as part of the ongoing rollout of the Government’s national eHealth record system,” said Plibersek.

This is further evidence that while technological change and innovation has been slow, it is definitely gaining momentum.

BEING BUSINESS WISE

It’s important to remember that business efficiency is also a cornerstone of the Australian healthcare industry, and practitioners are cautioned not to lose sight of those efficiency driven systems when contemplating technology upgrades and business-improvement processes. It would be easy to put your own business aspirations aside while this tide of change is being forced upon you.

The shift in consumer behaviour towards technology driven empowerment is not something to be afraid of – we should welcome it with open arms and capitalise on the enormous business benefits it can bring. In many instances, having the right technology in place can make it quicker, cheaper and easier to manage a patient, which can ultimately make your practice more profitable.

Understanding how consumers want to access these services helps you make the right technology choices. Essentially, patients want an easy-to-use, one-stop shop with one password and login and the ability to find all the services they need. For instance, with an online appointment service they don’t want have to visit a number of websites to find the various medical services they may require when they can conveniently locate these services via a single online portal. This is what differentiates good and great services.

Embrace technology – it’s here to stay! ☺

WHAT PATIENTS WANT

A 2011 survey from Intuit Health, reported in Healthcare IT News, found that 73% of those surveyed would use a secure online communication solution to make it easier to get lab results, request appointments, pay medical bills and communicate with their doctors’ offices.

The study indicated that the driving factors were:

- Patients want more efficient visits with their providers – 81% of the survey’s respondents would schedule their own appointments, filling out forms prior to the appointment.
- Patients want easy and secure access to information – 78% of respondents would use a secure online method to communicate with their doctor and access medical histories.
- Young patients prefer online access – 59% of generation Y respondents and 29% of Baby Boomers said they would switch providers for one with better online access.

These staggering statistics demonstrate that consumers across all age demographics now expect online convenience and will migrate to services that offer them.

1stavailable.com.au is a 24/7 online channel that allows you to find and book healthcare appointments instantly, using any web-connected device. Consumers can now track down available appointments, including last-minute cancellations, with registered dentists, GPs, physiotherapists, chiropractors and other allied health services, at times and locations that best suit them.
Bearing in mind that first impressions only take 90 seconds to form and over 85% of buyers cite colour as the key factor in determining their purchasing decisions, the importance of paying attention to the effects of colour within your business should not be underestimated.

Chromatherapy – the use of colours to influence emotions – has its roots in ancient Egyptian and Chinese cultures. Around 1000 AD, the Persian philosopher Avicenna wrote that colour was an “observable symptom of disease”. His view was that red moved the blood, blue or white cooled it and yellow reduced muscular pain and inflammation.

Using colours in interior design to influence emotions has particular relevance to the healthcare field. Ask yourself if there are any hues that could be used in your recovery rooms to help the healing process? Or what about the calming effect of colours chosen in your waiting rooms, which may help to de-stress your patient before their appointment?

We all recognise that certain colours bring out different emotions in us. You would never see a spa’s relaxing massage room painted red for instance, or a child-care centre in neutral greys, so how do we use it for the best effect in the healthcare industry?

If you want to have a positive effect on your patients from the second they walk into your practice, Mike Watson suggests exploring the colour spectrum.

Mike Watson is Director of Innova Design.
EMOTIONAL BONDS
The chart above refers to the emotions research has shown can be activated by certain colours.

Taking these results into consideration, it’s logical that most corporate clients prefer to include white and blue in their reception areas, therefore making a first impression of professionalism with sincerity. Take a look at the New South Wales State Government website – http://www.nsw.gov.au – and you’ll see that blue and white feature heavily.

While not wishing to influence your corporate identity, the high usage of black, purple or red would not be recommended in these areas. However, in trying to produce a calming influence be careful the space doesn’t lack any features of interest. The cheapest way to add visual interest is with the addition of feature walls or coloured chairs.

Your eyes are drawn to the features, so try to direct the traffic in the direction you want – to the reception desk. While patients are waiting, though, try to ensure the image is reinforced by the activities going on around them. Some well-chosen coffee-table books or travel publications would work better than the oft-used trash magazines or ancient copies of Reader’s Digest.

Treatment rooms and surgeries are naturally white, pure and clean. Consulting rooms are really where you can use colour to have a positive influence. It’s here that you have the full attention of your patients, which presents the ideal opportunity to positively influence each person so they are more likely to come back. We certainly don’t want patients consistently leaving your room with a sense of grief, so positive and affirming colours would be wise, with no dramatic features that will distract attention.

LASTING IMPRESSIONS
Though I’ve been specific about some of the colours to avoid, I’ve been less clear about which ones to use. This will depend largely on the demographic of your client base. If you have a city-based practice and your clients are coming from corporate offices, their opinion of the services you provide and the fee you charge would be positively influenced by a corporate look and feel – i.e. crisp and professional blues, whites and greys.

If you run a suburban family practice with lots of children as patients, these colours would likely be a turnoff. A random mix of primary colours would attract the kids, while the use of ‘homey’ beiges will appeal to adults.

This effect was highlighted to me recently when visiting a CBD-based dentist who had recently bought the long-established practice and was looking to refurbish. The interior had not been touched for over 20 years. The dentist was very professional, presentable and extremely friendly, and on getting to know him I would have recommended him wholeheartedly to my friends and booked myself in for any treatment.

His problem was getting people in. He said he had several instances where potential clients had come in from the offices surrounding him, looked around the reception and walked out again without even taking a card. He could only attract new customers on price as the impression given from reception detracted from the value of his service.

His solution was to refurbish using colours that would specifically attract the corporate clientele in the local area.
WALK THIS WAY

The chart below shows that particular colours will attract particular shoppers and how large retailers use this knowledge.

Attention to flooring is particularly important. When you enter a sizeable space, the floor constitutes the largest visual area. As well as improving general maintenance, the use of colours on the floor can encourage patients to move in a certain direction – a path to the front door, for instance, will always be followed.

The best news is that the right colours cost no more than the wrong colours! 😊
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According to Wayne Leggett, Self Managed Super Funds are complex, laden with mythologies and should not be tackled by amateurs.

You don’t need to be a medical practitioner to understand the dangers of self-diagnosis of a medical condition or, worse still, deciding on how best to treat the condition.

While this knowledge doesn’t stop some people (especially men) from indulging in this foolishness, most of us know the most sensible and safe approach is to place our health and wellbeing in the hands of those qualified for the task.

Why is it, then, that when it comes to the task of managing financial affairs – particularly retirement plans – so many people see no problem in attempting to devise and manage their own strategies themselves?

The Australian Taxation Office did the financial services industry a disservice in electing to refer to private superannuation funds of four or less members administered by them as Self Managed Superannuation Funds (SMSFs). While there may be some people capable of doing so, the vast majority of SMSF trustees have neither the necessary knowledge nor the capacity to manage a super fund.

Fortunately, most people recognise this reality and engage the services of professional financial advisers who possess the requisite expertise in superannuation planning and management, especially for SMSFs.

While this has probably been the case since the genesis of Self Managed Super Funds, the raft of recent legislative changes affecting superannuation has taken the complexity of managing SMSFs to a whole new level. And, given the potential penalties for not complying with superannuation regulations, there is little question this is now something best left to the experts.

This is not to suggest that having a SMSF is not an appropriate solution. In fact, when it comes to the differences between a SMSF and a public-offer fund, it is these differences that determine whether a SMSF is the right choice.
FIVE FALSEHOODS

Before we get into when a SMSF is appropriate, let’s first dispel a few myths about when a SMSF is needed.

• One common misconception is that you need a SMSF if you want to invest in direct shares. While this may have been true at one stage, most of the better public-offer funds, and even some of the industry funds, provide the opportunity to include direct equities in your superannuation asset mix.

• Another belief is that you need to have your own fund in order to have tailored insurance solutions through your super. Again, these days most of the better super funds allow members to apply for their own chosen levels of death, total and permanent disablement, and income-protection cover.

• The ability to enhance your estate-planning requirements is another reason often quoted. As a great many super funds now allow non-lapsing binding death benefit nominations, while this may have been an advantage of SMSFs in the past, it is no longer the case.

• Cost-cutting is often proffered as a benefit of having a SMSF. With the costs associated with the bulk of superannuation vehicles being driven down, largely through competition, and the compliance costs associated with SMSFs (such as annual financial statements and tax returns, an annual audit certificate and annual supervisory levy), quite often a SMSF is actually more expensive than a good public-offer fund.

• Perhaps the greatest falsehood proposed is superior investment returns. Unless you intend to limit the investment universe of your super to direct property, cash and direct Australian shares, you are almost forced to utilise the products of professional investment managers. This being so, any thoughts pertaining to outperforming the professionals would be seen as foolhardy.

ALL THE RIGHT REASONS

If there are so many reasons not to have a SMSF, who would want to establish one? The answer is relatively simple – you need a SMSF if you wish to do any or all of the following:

1. Combine the purchasing power of your superannuation balance with someone else, such as your spouse or children (up to four members).

2. Sell assets to, or buy assets from, your own superannuation fund. Note that acquisition of assets from fund members is limited to ‘listed securities’ or ‘business real property’.

3. Borrow money for investment purposes through your superannuation. Note that strict rules apply to how and for what purpose such borrowings may be made.

In the current regulatory and investment climate for superannuation, any other reason for the creation of a Self Managed Super Fund is, quite simply, not a reason.
If the time has come to find a new medical indemnity insurer, Chris Mariani suggests undertaking some comparisons to ensure you have all of your needs covered.

Doctors often cite their major concern when switching medical indemnity insurers as being whether their ‘tail’ will be covered – i.e. “I’ve practised for 10 years and been insured with the one insurer. If I move to a new insurer, will they cover a claim that develops tomorrow from a patient I treated 10 years ago?”

The good news is your ‘tail’ will be covered, as long as you avoid the traps. But the decision to switch should be based on a number of other equally important factors, as summarised in the table opposite.

From my observations, doctors tend to consider switching after experiencing poor service, when their colleagues suggest they switch or when they discover another insurer is cheaper. So, if the time has come for you to switch, it’s essential to do it safely. The first step is to seek expert advice based on your particular circumstances – medical indemnity and the legislation surrounding it is complex.

CHANGING TIMES

Recently, MIGA acquired the commercially owned Invivo, which is backed by QBE Insurance. Doctors previously insured with Invivo have – or will be – offered renewal into MIGA upon expiry of their Invivo policy. This may lead to changes in cover and premium.

The Invivo sale effectively means doctors now have four Medical Defence Organisations (MDOs) to choose from when selecting a medical indemnity provider – Avant, MDA National, MIGA and MIPS.

Most doctors tend to choose a MDO based on the recommendations of their peers or mentors, and often they do so as a medical student or young doctor – at a time when most policies are either free or a few hundred dollars. Over time, premiums can rise to tens of thousands of dollars for higher-risk specialities, and the policy originally chosen may not suit their particular circumstances.
WHAT TO CONSIDER
If the time has come to consider switching, what should you review in making your decision? While each practitioner’s circumstances will be different, the following provides a general overview of the items you should query.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims reporting</td>
<td>Ensure your tail is covered with the new insurer. This means selecting the appropriate ‘retroactive date’ with the new insurer. Secondly, ensure you report all claims and circumstances to your current insurer before you switch. If in doubt, report it!</td>
</tr>
<tr>
<td>Continuous cover</td>
<td>Some of the MDO policies provide ‘continuous cover’, which means as long as you stay continuously insured with that MDO, you can ‘late notify’ a claim that you should have notified in an earlier policy with that MDO. You lose this benefit when switching insurers.</td>
</tr>
<tr>
<td>Policy coverage</td>
<td>Compare the actual policy coverage of your current policy to the new policy. Does the new policy cover suit you and your practice structure and risks. Some policies do not provide cover for employment and hospital disputes, tax audits or Medicare audits. Some policies include cover for the doctor’s practice entity and employed staff, but the extent of cover varies widely and you need to read the fine print closely. Also read the insurer’s category guide to check you are covered for all of the procedures and aspects of healthcare you provide.</td>
</tr>
<tr>
<td>Membership benefits</td>
<td>Weigh up what membership benefits will you lose when leaving your current MDO, if any, against those you may gain from the new MDO. For example, one MDO may provide a loyalty payment that increases based on tenure, therefore reducing premiums over time.</td>
</tr>
<tr>
<td>Future premiums</td>
<td>Don’t just look at the premium quoted. Ask what the premiums will be in future years, especially where you are starting out in private practice or changing specialities or billings – all of which can significantly change.</td>
</tr>
</tbody>
</table>

COVERING UP
The Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 Cth requires an insurer to make a compulsory offer covering all ‘otherwise uncovered prior incidents’. This means a medical indemnity insurer has to provide you with ‘retroactive cover’. There are two important items you need to address when switching insurers:

1. You must provide the new insurer with the correct ‘retroactive date’. This date should be stated on your current policy schedule – it will depend on your circumstances and may be:
   - The date you first commenced practice or first registered in Australia.
   - The date your insurance cover moved from an ‘occurrence’ policy to a ‘claims made’ policy (the MDOs moved to ‘claims made’ policies between 1997 and 2004).
   - If you have purchased a run-off policy with a previous insurer and continue that cover, your new policy may provide a retroactive date starting at the end of the run-off policy.

2. Before you cancel your current policy or allow it to lapse, you must report to your existing insurer all claims and all circumstances in which a reasonable person would expect may result in a claim being made against you in the future.
   - Even if you are not switching insurers, it’s wise to check that the retroactive date noted on your policy covers you correctly. Your MDO will rely on the retroactive date you declare – if it’s wrong, you risk a gap in your cover.

   If you discover the date is not correct, simply put in a call to your MDO.

WORTH NOTING
Medical indemnity insurance in Australia is generally provided under a ‘claims made and notified’ policy. This means the ‘trigger’ is the date you first become aware of a claim (or a circumstance that a reasonable person would expect may result in a claim) and first report it to your insurer.

Generally, claims-made policies require you to report the claim to the insurer during the policy period. Some policies provide ‘continuous cover’, which we recommend as a key policy feature when advising clients at Medical and General Risk Solutions. Our general rule is: ‘If in doubt – report it!’ This is particularly relevant when you are switching insurers.
Taking Control

If you want to establish a sound financial portfolio that fits your individual circumstances and meets your future needs, you need to engage an adviser that doesn’t take a ‘one size fits all’ approach. By Scott Moses.

The value proposition for financial advice is not stock picking or managed-fund picking. It’s about getting a client’s structure and financial life in order, and keeping it that way forever. This means moving clients towards their goals and objectives in a professionally managed way.

So, if we start with the specific risks a client should take on and those they can’t afford to, portfolios should be dynamically managed to focus on and control these risks. The current industry process simply does not do this, even though it claims to.

Most investors have, as their investment objective, the desire to achieve a real return – i.e. a return over and above inflation – outcome over a defined time period. The industry approach to meeting the investment objective has been to set a broadly fixed ‘strategic asset allocation’ (SAA) of 60/40, for instance, and implement this along single asset-class lines (typically in a multi-manager structure for each asset class).

Here’s a brief synopsis on what accounts for the vast majority of portfolio construction in Australia, and in fact, the world.

In 1952, Harry Markowitz developed the idea that combining assets that moved differently at different times meant you could get a better outcome with less risk when you combined these assets together in a portfolio (the concept of correlation). In other words, don’t put all your eggs in one basket. His work resulted in an optimal portfolio that was about 60% US equities and 40% US Government bonds. This thought process and concept was revolutionary, unfortunately what followed wasn’t.

Practitioners globally took this, and essentially invested according to the 60/40 principle, instead of the principle of risk reduction – even though this 60/40 result was very specific for the particular time period and data-set for which it was tested. Furthermore, Harry Markowitz himself said that more robust models should be used to forecast future expected returns, risks and correlation to come up with a more robust model. They weren’t. It spread globally and now we, in Australia, essentially do the same thing – though our SAA is closer to 70/30.

Next came a wave of new diversification, where we still invested in 60/40 portfolios, but instead of 60% being in US equities and 40% in US Government Bonds, it was now 60% in ‘growth’ assets and 40% in ‘defensive’ assets.

We started investing in different ‘asset classes’ – property, infrastructure, high-yield bonds, hedge funds, sector funds, distressed debt, private equity, etcera. These asset classes became identified as ‘diversification’, and were classified as either ‘growth’ or ‘defensive’.

However, while all of these ‘asset classes’ have different names, they often share the same risk factors – the components of risk that contribute to the overall behaviour of the ‘asset class’.

All ‘asset classes’ are just a basket of risk factors, and if different ‘asset classes’ have the same risk factors, then they largely carry the same risks and so aren’t diversifiers at all. The year 2008 confirmed this, with catastrophic results.
The Private Practice Autumn 2013

RISKY BUSINESS
The basis upon which portfolio construction and risk control is determined is sound, but the assumptions and application of the theory are not. The original basis of portfolio construction was about reducing risk – but since risk means different things to different people and everyone has a different timeframe in which to measure outcomes, we can’t keep using the same simplistic framework.

With computing power we can now focus on risk at an individual client level, but we need to think about portfolio construction differently if we’re going to be client-specific.

There’s another spanner in the works here, though. Markets move, risks change and correlations are not static. Since market prices and circumstances change every day, risks and the potential returns associated with those risks change every day.

That being the case, how can one have static allocations to any asset over time if you are managing to a risk target? Why do clients have fairly fixed allocations to ‘growth’ or ‘defensive’ assets, when the risks associated with them are constantly changing?

The new process should be to recognise that with any forecast return, there comes a level of uncertainty and distribution of potential outcomes. To be able to model this involves a detailed assessment of all the risk drivers of each asset class across the investment spectrum, and the inter-relationships across these asset classes.

If this is completed with fundamental and mathematical rigour, the investment manager can get a true understanding of the risks present in a client’s portfolio and how they interrelate to each other, and thereby manage according to this.

HAVING FAITH
With a robust understanding of a client’s requirements and the risk drivers within every investment, good financial advisers can build portfolios from a blank canvas. We can ignore the flawed assumptions and peer risk focus of the past and instead build portfolios with the sole intention of getting the client the best result given the trade-offs and risks they can, should or are prepared to take.

Financial Advisers should play a critical role in the lives of all Australians. By their own admission, members of the general public are by and large financially illiterate. This is a significant failing of education, government, society and the industry – everyone should play a part in the financial literacy of the population.

The faith in the process will return when clients feel they can go to an adviser who is always acting in their best interests and who has access to resources and systems that allow her/him to build the best possible outcome for them. I implore you to engage in your own financial literacy and engage such an adviser.

As a member of The Private Practice Education Partner Network Scott Moses is a regular presenter at our courses and workshops. For more information on wealth management matters contact enquiries@theprivatepractice.com.au
If you want to gain a greater understanding of how the property market works, **John McGrath** recommends observing several key economic indicators.

People often ask me what’s going to happen in the property market next. I’m happy to share my thoughts and observations, but another way is to simply take a look at the key indicators of the economy.

Of course, the economy isn’t the only thing affecting the market – it’s also affected by social trends, such as the aging population and more people living alone, creating higher demand for apartments. Government incentives such as the First Home Owners Grant can also have a big impact, but the fundamental driver of the property market is the economy.

Why is this the case? Because property is an expensive item and people are not about to make major financial commitments when they’re worried about the economy. Here are six economic indicators to keep an eye on.
1. **Gross domestic product (GDP):**
   This indicates our economic production as a nation and, on a per-capita basis, it’s a useful indicator of our standard of living. A growing GDP creates a flow-on effect to property because people will generally look to improve their standard of living as their incomes grow.

2. **Confidence:**
   Demand for property always drops when people are lacking confidence. Check out the monthly Westpac-Melbourne Institute Consumer Index to get a snapshot of market mood (the equilibrium is 100). Business confidence is equally important. When businesses are suffering, they stop hiring, reduce costs and even reduce prices, thereby resulting in lesser profits. They focus on the bottom line rather than further investment or expansion. When business contracts so does the broader economy, affecting job stability and incomes.

3. **Cost of living:**
   Inflation or consumer price index (CPI) gives us an idea of demand and cost of living. The Reserve Bank has a target of 2–3% and factors any movements either side of this into its monthly decision on interest rates. When inflation and cost-of-living pressures are high, people batten down the hatches and put off all kinds of spending decisions, choosing to save instead. Real estate takes a direct hit – without buyers, properties don’t sell!

4. **Employment:**
   Jobs are crucial to a stable property market. Nothing will disturb the market more than high or rising unemployment. Without jobs, people can’t pay their rents or mortgages, and this can result in increased mortgagee sales and falling prices.

5. **Interest rates:**
   Nothing will stimulate a property market more than falling interest rates. This is because mortgages tend to be the biggest expense of a household, so when rates go down, households can save significant dollars or buy more property with cheaper finance.

6. **Household wealth:**
   Strong or increasing household wealth usually makes people want to upgrade their lifestyles with a bigger house or a move to a better location. There are three main ways to increase wealth – get a pay rise, save or invest. Following the global financial crisis, saving was the preferred avenue to wealth and debt reduction was the primary aim of most households. By the end of 2012, we were saving about 10% of our incomes and our average loan-to-value ratio was just 50%. Now people are starting to invest again, with almost one in two new loans in New South Wales going to investors at the start of 2013.

This is by no means an exhaustive list. But if you want to do a health check on the Australian property market, at any given time, then these are the economic indicators to watch.
Ever dreamed of making Bali your second home? Thanks to an outstanding residential development in the island’s south, it’s possible to turn that dream into a reality.

It’s little wonder Australians love Bali – it’s not only quick and easy to get to but is abundant with natural beauty, populated by wonderfully warm people, replete with world-class restaurants and spas, and offers the chance to really get away from it all with family and friends.

Although many of us dream of making this glorious Indonesian island home, doing so is not necessarily realistic. There is, however, an achievable alternative – investing in AYANA Residences.

Set over 6.5 hectares of mature landscaped gardens, AYANA Residences are adjacent to the award-winning AYANA Resort and Spa, in the beach-resort area of Jimbaran – known as the ‘Golden Mile’ due to the five-star resorts that line the coast. The property sits on the last remaining piece of prime cliff-top real estate in South Bali and basks in the beauty of the Indian Ocean.
WHY BUY IN BALI?

So, why would you invest in one of the property’s 115 apartments or eight villas? Here Mariusz Mierzejewski, Director of Sales and Marketing at AYANA Residences answers our questions.

What are the most outstanding features of AYANA Residences?

As a true residential/lifestyle development, AYANA Residences are really a first in Bali. The apartments and villas are located on 6.5 hectares of mature landscaped gardens adjacent to the award-winning AYANA Resort and Spa. As part of a 77-hectare integrated estate, the Residences comprise 1.3 kilometres of private coastline and offer majestic views across the Indian Ocean.

AYANA Residences offer great value for money as they are very low density. There’s no other project in Bali that has only 115 apartments and 8 villa units spread across 6.5 hectares of land. The property is also based in one of the fastest growing areas in Bali.

In addition, Bali’s real-estate market has been bullish for several years, boosted mostly by demand from foreign investors and record tourism arrivals. The outlook of future capital growth is spectacular.

Buyers have absolute freedom to use their unit without any restrictions. There are no limits on how often or for how long they visit.

They can come and go as they please and either leave their unit vacant at other times or rent it out all-year-round. There is 24-hour Personal Concierge Service to take care of buyers’ travel and arrangements around Bali – even before they move in to their units.

The sustainable, low-density design – created by Yasuhiro Koichi, the same architect, landscape architect and interior designer as AYANA Resort and Spa – offers the largest living space of any luxury residences in Bali.

The property is also adjacent to AYANA Resort and Spa, so it offers convenient access to the dining, spa and recreational benefits of one of the world’s most lauded resorts – it houses seven restaurants, an outstanding spa, Rock Bar, a golf-putting course, tennis courts, five pools, Kids Club and more.

AYANA Residences’ tenants can enjoy exclusive use of their own expansive Club House, Ashoka, which means ‘painless or without sorrow’ in Sanskrit. Facilities here include swimming pools, a fitness center and mini-cinema, jogging trails and a lounge.

What are the key benefits to AYANA Residences owners?

Owners benefit from the amazing location, size and design of the units, along with convenient access to the facilities of AYANA Resort and Spa, plus unlimited usage – there are no restrictions on how often or when they can occupy their unit.

What makes Jimbaran Bay such a unique location?

Jimbaran is known as Bali’s ‘Golden Mile’. Traditionally a fishing village, this tranquil coastal community features Bali’s most exclusive resorts and private residences. The location of AYANA Residences is as strategic as it is breathtaking, and it’s only 10 kilometres from Bali’s international airport.

Please describe the general response to the Residences since the May 2013 launch.

We’re pleased to report that more than half of the first phase of the development had already been sold as of the launch date in May. This really shows the investor confidence in the developer, management team and quality of the design. Our buyer demographic is varied – we have investors from Indonesia, China, Japan, USA and Australia – and the feedback to date has been fantastic!
AT A GLANCE

• Low-density development adjacent to AYANA Resort and Spa in Jimbaran.

• Just 10 kilometres from Denpasar International Airport.

• Five hectares of botanical gardens.

• Convenient access to AYANA Resort and Spa’s restaurants, bars and Thermes Marins Bali Spa (named #1 Spa in the World by Condé Nast Traveler in 2010).

• Complete privacy plus 24-hour security within each residential unit, and in common areas.

• A dedicated concierge service.

• A designated car park and storage facility.

• A dedicated Club House with a mini movie theatre, state-of-the-art fitness centre, yoga area, swimming pools, library, lounge, juice bar and barbeque area.

• Walking, cycling and jogging trails.

• Pet-grooming facilities.

• A short drive to some of the island’s iconic attractions, including Jimbaran Fish Markets and Uluwatu Temple.

• 15 kilometres to Bali International Medical Center and SOS emergency health services.

For more information, visit www.ayanaresidences.com or email info@ayanaresidences.com
According to Dr Dike Drummond, learning how to install and activate your own personal off switch can mean the difference between finding true work/life balance and remaining eternally stressed.

One of the reasons work/life balance is so difficult for doctors is the missing ‘Off’ switch in our programming. Over a long period of time we are so thoroughly trained to be ‘On’ as a doctor that this programming can dominate our entire lives by running continuously, both at work and at home.

**When did this last happen to you?**

You had a stressful day in the office and couldn’t wait to finish up with your last patient and get out of the office. You thank your lucky stars you aren’t on call tonight but on the way home the hassles of the day keep repeating themselves in an endless loop in your mind.

You walk through your front door to be welcomed by your family – even the dog is wagging its tail. You flop down at the dinner table and eat for the first time today, and that tape in your head just keeps on running. Your eyes are open, you are looking right at your family as they talk and you realise you are simply not there.

The little voice in your head is wondering if you prescribed the right dose for Mrs Kowalski and if you told your partner on call about Mr Yee’s delirium the last time he was in the hospital.

Does any of this sound familiar? If so, it’s because you were trained up on how to practice clinical medicine. Along the way you were conditioned to be a workaholic, emotion-free, superhero-like Lone Ranger. These skills and programming work very well to produce an effective and efficient doctor but they were never intended to be used outside of the clinic or hospital.
INSTALLING YOUR ‘OFF’ SWITCH

The first step is known as a ‘boundary ritual’ – it’s a specific action you take at the boundary between work and home, and it’s designed to send an ‘Off’ signal to your conscious and subconscious mind.

This ritual is something you design and practice with the mindful intention that it will switch off the parts of your doctor programming that don’t serve you when you are away from work and stow away the stresses of this day until you return.

Here are some examples of simple boundary rituals:

• Before you sit down and talk with your family, take a shower and/or change your work clothes for home clothes.

• Take a deep and cleansing breath, sink into your seat or give yourself a whole body stretch with an audible sigh as you release the cares of your work day.

• When you arrive home, go for a walk around the block before going inside. While walking, practice using your steps to release work and come into the present.

Flicking your doctor switch ‘Off’ is the first step to creating work/life balance and it will allow you to be completely present with your family and friends.

LASTING EFFECTS

There are three keys to building an effective ‘Off’ switch:

1. Utilise all of your senses:
   Your boundary ritual ideally contains as many sensory modalities as possible. The four big ones are movement, sound, feeling and intention.

2. Use a ‘trigger’:
   A trigger is an existing habit – something you always do each time you leave the office or enter your home. You use this as a trigger to remember to perform your boundary ritual. Common triggers include:
   • Turning off your office lights.
   • Putting the keys in your car ignition.
   • Turning the car off when you arrive home.
   • Grasping the doorknob of your home.

3. Proceed with mindfulness and intention: Practice your ritual with mindfulness and a clear intention to release, relax, let go and turn the doctor programming ‘Off’. You can even say a short phrase to yourself, such as: “I release the doctor until the next time he/she is needed”.

Remember, building your own ‘Off’ switch and creating true work/life balance is a process. You have been conditioned to be constantly switched ‘On’, so it will take some practice and tweaking to refine your boundary ritual and turn off the mind chatter once you walk out of your practice door.

BUILD YOUR OWN ‘OFF’ SWITCH

Start by answering these three questions:

• What would you like to use as your first pass at a boundary ritual?
• What will you use as your trigger to help you remember your ritual?
• When will you try it out?

When you arrive home, go for a walk around the block before going inside.