Avant
By doctors for doctors

Issue 26 | June 2026

Connect

Dr Tony Lian and
Dr Al-Rahim Habib

Keeping members informed

When AI enters your practice

AI is coming into your practice whether you are ready or not. How to manage the medico-legal risks.

Don't let bill shock turn into a complaint

Unexpected bills are a leading trigger for complaints. Informed financial consent reduces your risk.

The impact of investigation

Professor Steve Robson on the emotional toll of Ahpra investigations and the push for reform.

Tom was looking for support professionally and personally. He found it all in one place.

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Keeping members informed

Doctors practise in a world where the pace of change shows no sign of slowing. The issues discussed in this edition of *Connect* reflect that reality, and Avant's ongoing commitment to helping members navigate it.

Artificial intelligence is reshaping how medicine is practised. The opportunities are genuine and significant, but so are the risks. AI chat tools are giving patients advice, meeting assistants are streamlining notes, practice staff are looking for tools to simplify their workload – there are endless applications. It's become very apparent to me that doctors need to be clear about what these tools promise and what liability they may quietly transfer.

Avant is continually working to ensure members are well informed as this technology evolves. Our two 'AI update' articles include practical advice on managing the risks.

Ahpra anticipates that increased use of AI and related technologies will drive "increased contestability of practitioner decisions." This will likely add to the thousands of Australian doctors who already receive complaints or notifications each year – with potentially dreadful consequences for their mental health. Professor Steve Robson writes candidly about this experience and Avant's sustained advocacy for regulatory system fairness that's mindful of doctors' wellbeing. Our message to any member facing a complaint or notification is simple: contact us straight away. You do not have to manage these situations alone.

With specialist fees in the media, financial transparency is another area where doctors are in the spotlight. Our article on informed financial consent offers practical, detailed guidance on what a robust process looks like across specialties. We also look at a recent dispute over fees, which is a timely reminder that best practice in this area is not optional.

Another case study involves a registrar who was taken to the tribunal after sharing clinical images with friends. This breach of professional standards prompted the reflection from the head of our Medical Advisory Services on three common things doctors often do that they shouldn't.

Avant's commitment to driving healthcare forward is demonstrated through our support of Dr Al-Rahim Habib and Dr Tony Lian, featured on the front cover. As part of a multidisciplinary team, their innovative use of an AI-powered tool is starting to make inroads in the detection of ear disease in Aboriginal and Torres Strait Islander children. This technology is a compelling example of how member-funded research is helping close health equity gaps.

In an environment where it's challenging to get research funding, I'm proud to be part of an organisation that invests in Australian healthcare in this way.

Many of us know that the business of medicine can be as demanding as its practice. This edition covers some of the matters that are a concern for practice owners. Top of mind are often financial considerations, such as optimising revenue, cash flow and financing growth. Avant Finance assesses the hurdles and options, and how specialist expertise can help practice owners achieve their goals.

These and other articles highlight how Avant is evolving to support members in more ways than ever. You can now draw upon expertise from many areas, with the common thread being an understanding of doctors. The insights in this issue of *Connect* draw from real situations our members have found themselves dealing with – just a small demonstration of how, as always, Avant is *by doctors, for doctors.*

Best regards,

Dr Steven Hambleton AM
Chair, Avant Mutual

> **Avant is working to ensure members are well informed as this technology evolves.**

In this edition

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Connect with us

We'd love to hear what you think of *Connect*, or what you'd like to see more of – email editor@avant.org.au.

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Acknowledgement of Country

In the spirit of reconciliation, Avant acknowledges the Traditional Custodians of Country throughout Australia, and their connections to land, sea and community. As a national organisation, we pay our respects to Elders past and present, of the lands on which we gather and work, and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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Putting AI to work in the community

As an intern in Darwin, Dr Al-Rahim Habib saw how increased connectivity and the introduction of telehealth programs were starting to change health outcomes in Aboriginal and Torres Strait Islander remote communities.

"I was always interested in data science," he says. "Then seeing how rewarding it was to get involved in kids' lives in these remote communities, and how much of a difference early intervention could make – that's what motivated me."

The clinical need was clear. Aboriginal and Torres Strait Islander children in rural and remote Australia experience some of the highest rates of otitis media in the world, yet access to specialist ear care is limited. And the chances of a missed diagnosis early are high. "If ear disease is not detected at a critical stage, poor hearing has downstream impacts on socialisation, behaviour and education," Dr Habib says.

He could see that frontline health workers had limited opportunity to gain experience interpreting otoscopic images at the point of care and that AI had the potential to help.

Developing the concept

The DrumBeat.ai project began in 2018 and quickly drew support from universities, tech companies and funding bodies. In 2021, a key grant from Avant to support his PhD gave Dr Habib the means to investigate whether AI's potential was real. "Funding from Avant was extremely important," Dr Habib says. "Their member grants support innovation that encourages early career doctors to follow their curiosity. They offer a path forward to get an idea off the ground."

The development of DrumBeat.ai's first AI-based otoscopy algorithm designed to detect ear disease, was the result. The system was trained on thousands of otoscopic images collected through telehealth screening programs involving Aboriginal and Torres Strait Islander children from across more than 100 communities over a ten-year period.

A second grant from Avant supported a comparative study, testing the algorithm directly against expert otolaryngologists. Initial results were promising, with the latest version demonstrating accuracy equal to, and even better than, an ENT specialist.

From theory to practice

By the time Dr Habib had completed his PhD, Dr Tony Lian had joined the DrumBeat.ai team as another PhD candidate. The project had a validated algorithm and published research behind it. The next challenge was to get the tool adopted in community settings.

Along with other research grants, a third grant from Avant is supporting Dr Lian through this clinical translation phase. Working with Aboriginal Community Controlled Health Organisations, the team will be evaluating how DrumBeat.ai integrates into remote primary care settings and existing clinical workflows.

The first clinic took place in early May 2026 in partnership with the Earbus Foundation of Western Australia and shaped how Dr Lian now thinks about the project.

"It's been critical to partner with communities who understand both cultural considerations and the lived experience of health workers, families and the kids themselves," he says.

"One of the exciting things during that first clinic was getting the patient's perspective. It was really fun to realise how interested and excited kids and their parents were to see what their ears looked like.

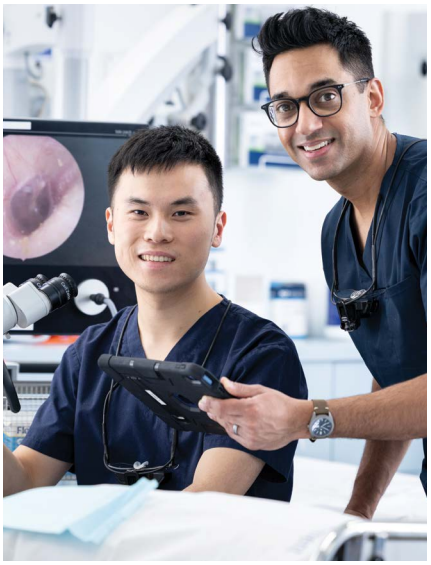
"Being able to show images and have them analysed straight away has been really important."

Faster results also mean referrals for secondary review can be set up promptly and are more likely to be followed through.

Looking ahead

The ongoing real-world implementation phase will recruit hundreds of Aboriginal and Torres Strait Islander children across rural, remote and urban clinics in Western Australia and Queensland.

For Dr Lian, Avant's support has shaped more than just the project. "The grant has had a major impact not just on DrumBeat.ai, but on how my career has developed – learning research skills, developing partnerships and presenting at conferences. It's allowed me to build from a model to something being implemented in real life."



Dr Tony Lian and Dr Al-Rahim Habib

> **It was really fun to realise how interested and excited kids and their parents were to see what their ears looked like.**
> Dr Tony Lian

Dr Habib, who drove the developmental phase, and Associate Professor Narinder Singh, who supervised both PhD researchers, are watching Dr Lian's progress with interest. "The DrumBeat.ai story has really evolved. It feels like we're at the start of a whole new chapter, with the tool moving into the field. Every year is more exciting as we see it being put to use and the partnerships grow."

The long-term ambition is to support national ear disease screening programs. And with international interest already following the project's results, the DrumBeat.ai team can see the model extending further still. ●

Find out more:
Avant Foundation grants

Advocacy in action: The impact of investigations

Professor Steve Robson
BMedSc, MBBS, MMed, MPH, MD, FRANZCOG, FRCOG, FACOG
Chief Medical Officer, Avant

All of us recognise that working as a doctor can be stressful. Our professional life is such that the risk of burnout, and even challenges to our physical and mental health, are ongoing.

We're not only juggling the demands of clinical practice, but also handling the administration required to comply with professional and regulatory standards. In many cases, we have additional roles such as being a practice owner, trainee supervisor or academic.

On top of this, thousands of Australian doctors receive complaints or notifications each year. In addition to Ahpra and the compliance branch of Medicare, lawyers' letters regarding civil matters and coronial investigations may put doctors in the spotlight. All are stressful to deal with and can affect us deeply.

There are times when it can be easy to get a sense that the health system is not oriented to caring for those who provide care.

I would like to remind you that Avant is here to help and support members during these stressful and challenging times.

A complaint strikes like a thunderbolt

Receiving an unexpected complaint or regulatory notification can strike like a thunderbolt, disorienting us and affecting our personal equilibrium. As a busy doctor working in the health system for almost four decades, I have had this experience. My sense of personal worth is closely tied to my work in medicine, so a notification or complaint can feel like an arrow through the heart. It's so hard not to take it personally.

Trying to maintain a clinical workload becomes difficult when having to respond to regulatory matters and fretting about what might happen. For some doctors, the effects of receiving and dealing with complaints and investigations can be so profound that they struggle to cope.

Avant has advocated over many years for the effective, fair and transparent management of complaints. For many members, the personal and emotional support we offer when dealing with such matters is every bit as important as our legal and professional help. Should you receive notice of a complaint or other regulatory matter, contact us immediately for help.

Improving the regulatory system

Ahpra's own data reveal that several doctors have taken their own lives or deliberately harmed themselves while subject to investigations. I find this utterly unacceptable.

I recently asked Ahpra CEO Justin Untersteiner what he planned to do about this. He told me that improving the system "to make sure it is safer for all practitioners" was one of his most pressing concerns. He added that Ahpra's role was "not only to protect the public, but also to minimise practitioner harm". While he admits there is work to be done to build confidence in the system, he was keen to convey that "if you're doing the right thing, you don't have to be worried."

Talk, don't catastrophise

My own experience is that a burden shared is a burden eased. It can be easy to become isolated, afraid to talk to colleagues or even family members. In the first instance, it's worth realising many of your colleagues will likely have had similar experiences. Talking to them can help a great deal in resolving the common feeling of isolation. And remember, the majority of notifications to Ahpra result in no further action.

It is also important for us to recognise when our colleagues and professional friends are facing challenges and need our support. Find a quiet time to ask somebody you're worried about, "Is everything OK? Anything you want to talk about?" Simple questions like these can seem like an incredible gift to people who are suffering in silence. ●

Health Directions podcast: Prof Steve Robson with Ahpra CEO Justin Untersteiner

Three things doctors do, but know they shouldn't

Dr Mark Woodrow
MBBS, MBA, GDipAppLaw, GCertArts, EMCert (ACEM), MACLM, AFRACMA
General Manager – Medical Advisory Services and
Deputy Chief Medical Officer, Avant

The behaviours I want to talk about are things we know many doctors do, despite being aware they probably shouldn't. They rarely end badly, but when they do, the consequences are serious and entirely avoidable. As someone who sees the outcomes of these situations up close, I can tell you the stress and potential damage to your reputation from an official reprimand or legal repercussions is not worth it.

1

Self-prescribing and treating family and friends

We've all been there. A family member needs a script refill. A neighbour stops you and asks you to 'just have a look'. It feels like a helpful thing to do and often seems awkward to decline. It's easy to justify: what's the harm?

But have you seriously reflected on what's happening? There's no proper consultation, no full history, and no documentation. You won't ask the questions you'd ask a stranger, and they won't tell you things they'd tell someone they don't know. The clinical risks of missed diagnoses, inappropriate prescribing and gaps in continuity of care are ones that can seriously compromise patient safety.

The Medical Board's Code of Conduct is clear. Wherever possible, avoid providing medical care to anyone you have a close personal relationship with. One area is non-negotiable: Schedule 8, psychotropic medication and/or drugs of dependence must never be prescribed to those close to you. Self-prescribing is treated the same way. The Board expects that you have your own GP and seek independent advice when you need care.

Disciplinary action for self-prescribing and treating family or friends may not be common, but it does happen. And the consequences can be severe: reprimands, suspension, deregistration. That's a heavy price for doing a favour.

2

Accessing medical records out of curiosity or concern

A colleague is admitted to your hospital. A friend has just had a procedure. A high-profile patient comes through the department and you're curious. You're not going to share the information. You just want to know.

The impulse is understandable, but health information is collected for one purpose only: the care of that patient. Accessing a record without a current clinical need, however well-intentioned, is a potential privacy breach. With electronic medical records (EMRs) everything you view is traceable, and health services are increasingly conducting routine audits, not just investigating high-profile cases. Sanctions that once meant you undertake some training now more often mean a formal reprimand, termination, or an Ahpra referral.

What's more, patients are now able to pursue a civil compensation claim against someone who accessed their records without justification.

The gap between how often it happens and how often people are caught is narrowing.

If you're concerned about someone, ask the treating team to keep you informed, with the patient's knowledge and consent. It's a small step that keeps you on the right side of the line.

3

Not seeking healthcare for themselves

This one is different. It's not a professional conduct issue in the same way, but it still matters to both you and your patients.

Doctors are, notoriously, not good at being patients. We minimise symptoms, delay presenting, avoid registering with a GP, and tell ourselves we'll deal with it later. There are understandable reasons for this. Time is genuinely scarce. There can be stigma, particularly around mental health, with legitimate concerns about professional consequences. For many doctors, being unwell feels incompatible with their role.

However, we know burnout is far more likely when doctors neglect their own health. This erodes empathy and impairs judgement, which significantly increases the risk of clinical error. The Code reflects this reality: it explicitly states that good medical practice means having a regular GP, seeking independent advice when you need care, and not self-diagnosing or self-treating.

Pushing through is a habit most of us formed early in our careers. But there's a point at which it stops serving you or your patients. The colleagues I've seen struggle most are often the ones who waited too long to seek support.

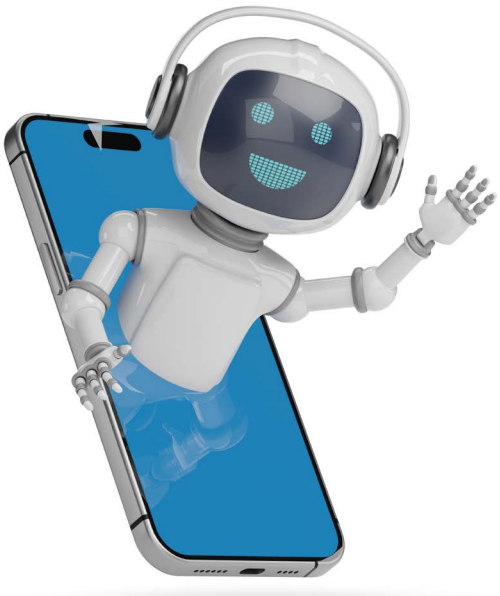
These behaviours make intuitive sense in the moment, which is exactly why they're so common. Our concern is that the risk is often higher than you appreciate, the cost when things go wrong is high, and in almost every case we see, it was entirely preventable. ●

When AI enters your practice

Dr Andrew Baird
MA, MBChB, DA, DRANZCOG, FRACGP, FACRRM
Claims Manager and Senior Medical Adviser, Avant

Artificial intelligence is rapidly reshaping how patients consult with doctors and how practices operate behind the scenes. In addition to medical scribes – which we've covered in previous articles – symptom checkers, AI chatbots and meeting transcription tools are becoming commonplace. This means doctors, healthcare workers and administration staff are all having to navigate new territory, with significant medico-legal implications.

Representing over half of all doctors in Australia, Avant probably has a better sense of the emerging issues than any other medical defence organisation. Our risk advisory experts are coming across increasing numbers of situations that may cause concern. Here are some recommendations on how to handle these and minimise the risk of falling foul of privacy regulations, or being held accountable for AI-based decisions you were not responsible for.



Scenario 1
The patient who already 'knows' what's wrong with them

Situation

Your patient arrives at their appointment having consulted an AI health tool: a symptom checker, a chatbot, or a consumer diagnostic app. They're confident of the diagnosis they've been given, and even how it needs to be treated.

Risks

- After listening to your patient describe their symptoms, you also examine them. You don't agree with the AI diagnosis and recommend a different treatment path. If the AI diagnosis later proves correct, you are at risk, both clinically and in terms of the patient relationship.
- Even where your diagnosis is sound, the patient may have unrealistic expectations about treatment. If you refer them for tests that confirm what the AI already told them, they may well express frustration, both at the expense they incurred and any delay in starting treatment.
- Patients anchored to an AI recommendation may be less receptive to your clinical reasoning. This could create friction and a risk that important advice is ignored.

Recommendation

Ask patients, early in the consultation, whether they've already used an AI tool or online resource to seek advice. This doesn't need to be adversarial; it's simply good history-taking in a world where patients increasingly arrive with information they have obtained online about their health.

Whether you agree or disagree with what the AI tool has suggested, explain your clinical reasoning clearly to the patient. If you have a different opinion, say why. If you think the AI diagnosis is valid, acknowledge that and explain the next steps.

Document everything in the patient record, including that the patient presented with an AI-generated opinion, what it said and how you responded. This protects you if the clinical picture changes later.

Scenario 2
The pre-screened patient

Situation

Some patients are now arriving at an appointment – particularly one using telehealth – having already completed a screening questionnaire or responded to prompts from a chatbot. These AI-powered 'triage tools' may be provided by your own practice or generated through a third party. The AI-generated notes that accompany the patient often summarise their responses.

Risks

- AI tools aren't good at picking up the nuances in a patient's answer or delving deeper if a response seems incomplete or inconsistent with the non-verbal information.
- AI-generated summaries may omit clinically relevant information the patient disclosed in the original interaction. If you rely on the summary rather than a thorough consultation, you may miss something important.
- It's unclear whether the doctor is responsible for reviewing all information the patient initially provided to the AI screening tool, or only the summary it generated. This distinction is important and is not yet clearly settled.

Recommendation

Treat any AI-generated summary as a starting point, not a substitute for clinical assessment. Review what has been provided, but conduct your own thorough history-taking and document your findings independently.

Any information provided by the patient, whether to you, an AI tool, or both, that is relevant to their care, should be captured in the medical record. If you identify errors or omissions in an AI-generated summary, correct the errors by documenting in your medical record, and note that you have done so.

Where practices are using AI triage tools, ensure there is a clear protocol for how AI-generated outputs feed into the clinical encounter. Be clear about who is responsible for reviewing AI generated information.

Scenario 3
AI tools recording meetings outside patient consultations

Situation

AI meeting tools, often bundled into platforms like Microsoft Teams or Google Meet, can automatically record, transcribe and summarise meetings. This output is often useful and saves time. But when the meeting involves a discussion of a patient case, referral, or outcome, there can be significant privacy implications.

Risks

- Patient information discussed in the meeting may be captured by the transcription tool and stored on overseas servers, outside Australian privacy frameworks.
- Participants in the meeting, including external consultants or specialists, may not have consented to being recorded by the AI tool, and may not even know that the meeting is being recorded.
- Many of these tools are enabled by default as part of standard software packages. Users often don't realise they have accepted terms that permit this data capture.

Recommendation

Consent to AI recording cannot be assumed, even among colleagues. If a meeting is being recorded by any AI tool, all participants must be informed, and consent before it begins.

Check your practice's standard software suite carefully. Microsoft 365 and Google Workspace, for example, now include AI features that may be active by default. Review what has been enabled and ensure it aligns with your privacy obligations. If you are unsure, seek advice before proceeding.

Any recording of patient information needs to abide by the Privacy Act and Australian Privacy Principles. This legislation governs how personal and health information is collected, stored, used and disclosed.

Scenario 4
Reception staff using non-clinical AI tools

Situation

Practice staff, who are often under pressure to keep up with all the required paperwork, use tools like ChatGPT to help draft patient correspondence. This might include appointment reminders, test result follow-ups and referral letters.

Risks

- Patients have almost certainly not consented to their health information being used in this way.
- When patient information is entered into a non-clinical AI tool as part of a prompt, that data may be captured and stored overseas. It may then potentially be used to train or improve the AI model. Most of these tools are not configured for healthcare use and do not meet the requirements of Australian privacy law.
- Even if no harm results, a privacy breach of this kind carries regulatory and reputational consequences for the practice.

Recommendation

Practices must have a clear, written policy on which AI tools can be used by staff, and the categories of information that can and can't be entered into them. Patient identifiable information and clinical details should never be entered into AI tools which are not approved for healthcare use.

This policy needs to be reinforced with staff regularly, including locums and temporary staff who may bring their own habits and assumptions to work at your practice. ●

Avant resource:
Artificial Intelligence for medical documentation

Build a practice-wide AI policy

These scenarios share a common thread: the need for governance. AI is arriving in practices through multiple doors – brought in by patients, embedded in software or adopted informally by staff. Without a clear framework, the risks multiply.

Every practice needs a written policy that addresses which AI tools are approved for use, what information may be entered into them, and what safeguards are in place. This policy should be part of onboarding for all new staff, whether temporary or permanent. It should also be regularly revisited as the technology evolves.

Practices should conduct regular audits of which AI tools are actually in use, not just which ones have been officially sanctioned. Tabling this as a standing item in practice meetings is a practical way to stay across it.

Patients should be informed about where their data is used and what protections apply.

The hidden risk of AI adoption

The cognitive and emotional load on doctors as they try to keep up with AI-assisted tools presents a growing concern.

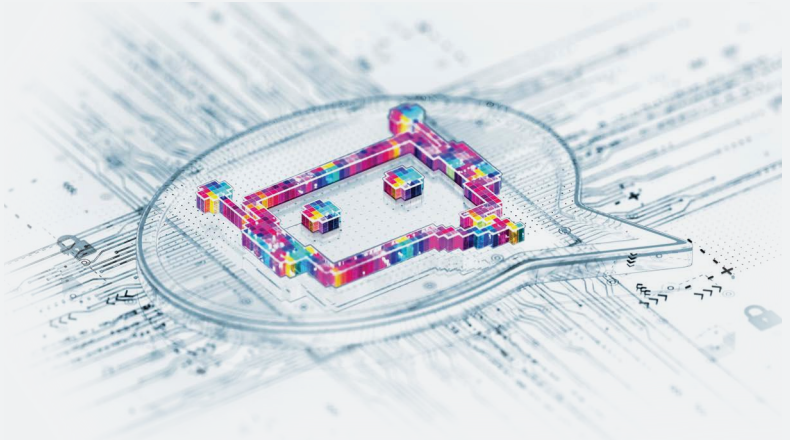
When a doctor acts on, or does not act on, an AI recommendation, they carry the medico-legal risk of that decision. The responsibility has not shifted, it has simply become more complex.

At the same time, there is an emerging expectation that AI tools will allow doctors to see more patients, respond faster and handle greater administrative loads. The efficiency gains are real in places, but so is the pressure. Doctors should be conscious of this dynamic, and practices should resist the assumption that AI simply expands capacity without limit.

The scenarios featured in this article are based on real situations. Certain information has been de-identified to preserve privacy and confidentiality.

But AI told me so ...

Dr Jack Marjot
MBBS, BSc, FACEM, Dip DHM, GAICD
Emergency medicine specialist,
Avant Mutual Board member



The past year has seen explosive growth in AI-assisted clinical evidence tools. These natural language platforms accept clinical questions and return synthesised, referenced answers drawn from scientific literature, guidelines and curated knowledge bases. Clinician uptake has been swift, and understandably so. Medical knowledge advances at a pace difficult for humans to assimilate, and the near-impossibility of staying current is one of medicine's lifelong pressures.

The promise of these tools is perhaps greatest for generalists, junior doctors, and those in under-resourced settings, where AI-assisted guidance could meaningfully offset the burden of limited specialist access.

This is almost certainly the first of many waves of AI that will redefine medical practice. The potential is genuine: greater healthcare equity, more timely evidence-based care, and a shift away from static knowledge resources toward advice that can be tailored to the patient at the bedside.

But what happens if AI gets it wrong?

The natural corollary of putting clinically relevant information at a doctor's fingertips is that they will act on it. That is, after all, the point. By design, these platforms push clinicians to the edges of their knowledge comfort zone and convert that extended reach into real-time clinical decisions.

The stated safety backstop is referencing, and with it the promise that the chain of epistemic accountability remains intact. Every AI recommendation is linked to a citable source that has passed through the traditional governance mechanisms of human peer review. Except it requires the clinician to audit it. The same clinician whose efficiency the tool is maximising and whose time is being saved from delving into primary sources. Routine verification is unlikely in the flow of busy point-of-care medicine, and the design of some tools does not necessarily invite it.

A doctor using an AI evidence tool is simultaneously being handed an answer and implicitly asked to verify it. That tension sits at the heart of the problem.

The gap between delivery and verification of the answer is where the risk exists. And it appears to belong to the clinician.

So who wears the clinical negligence liability when the tool gets it wrong?

The highest risk is advice that sits just beyond the clinician's knowledge base, couched among otherwise sensible recommendations, confident in tone, and wrong in a way that isn't ludicrous enough to trigger clinician suspicion. The kind of wrong that gets acted on.

Consider the junior ward doctor, managing an incidental mild hypokalaemia at 11pm, who asks an AI tool for guidance on intravenous potassium replacement. The answer is detailed, referenced, and confident. But the dose suggested is appropriate for critical replacement via a central line in intensive care, not an unmonitored ward patient. The doctor, at the edge of their knowledge and reassured by an answer that sounds authoritative, acts on it.

When patient harm results, the tool's defence is already written into its terms of service: the clinician could have, should have, followed the references back to the primary source and cross-referenced against others, identified the hallucination or the contextual inaccuracy, and disregarded it. But the trap is structural. The tool's entire value proposition is that you don't need to interrogate primary sources. Its liability disclaimer depends on the assumption that you will.

It is arguable that these failures will be rare with minor resulting harm, and that the net benefit to patient care (and clinician workload) is significantly positive. This is exciting technology and the clinicians using it are doing so in good faith, motivated by a desire to deliver better care to their patients.

But I think a medico-legal risk does exist for clinicians using these tools. A review of the publicly available terms of service across AI clinical evidence tools currently in widespread use reveals a common fundamental: absolute disclaimers of clinical liability. It is a sector-wide liability architecture, in which the tool is marketed as a trusted clinical co-pilot, and the risk is allocated to the clinician who uses it.

Many doctors will accept these terms at onboarding without reading them. As a profession we should be very mindful about this: embracing a new era of AI-enabled clinical care, while remaining alert to the ways these tools may quietly expose clinicians to unexamined risk, and recognise that the confidence these tools project is not matched by the liability that they accept. ●

Comment from Avant

AI is one tool of many in your toolbox.

Many AI tools, particularly those falling outside the Therapeutic Goods Administration's framework for software as a medical device, are unregulated so you will need to do your own due diligence to ensure the tool is fit-for-purpose.

When you use AI in a clinical context, once you accept AI's recommendations, the advice is yours. It will not be a defence to say, "AI told me so".

Issues around indemnity clauses and disclaimers are complex and they can have implications for insurance cover.

If the AI provider's terms and conditions include an indemnity clause or disclaimer, consider seeking advice before agreeing to it.

Why research funding matters

Dr Penny Browne OAM
Avant Mutual Board member and
Avant Foundation Committee member

Every diagnosis you make, every treatment plan you write, every surgical technique you've refined, none of it exists without decades of scientific research behind it. Medical research isn't peripheral to the practice of medicine. It is the foundation of medicine.

You may not be directly seeking research funding yourself, but the chances are you work alongside colleagues who are, or who have stepped back from a research ambition because the pathway became too uncertain. Doctor-researchers are a rare and valuable combination: practitioners who bring clinical insight and patient perspective to scientific inquiry in ways that laboratory researchers alone cannot. Ensuring opportunities to pursue a research project are economically viable matters for the future of Australian healthcare.

Australia's Medical Research Future Fund (MRFF) was established over 10 years ago to support health and medical research. Currently, around $650 million a year is being released, despite the original goal being to deliver $1 billion annually. Following a recent campaign supported by the key research peak bodies, Avant welcomes the Federal Government's commitment to increase MRFF spending over the next 4 years, reaching the $1 billion goal from 2030-31.

Supporting the research ecosystem's peak bodies

There are a number of peak organisations working across the research industry to advocate for Australian investment in world-class health and medical research. Avant Foundation endorses the critical role the Association of Australian Medical Research Institutes (AAMRI), the Australian Society of Medical Researchers (ASMR) and Research Australia (RA) play to support universities, institutes and individual researchers.

Beyond a clinical focus: driving system improvements

The need for research goes beyond disease-specific breakthroughs. Health systems research – the complex interplay of patient care, technology, workforce and economics that determines whether our healthcare system is safe, sustainable and high quality – is chronically underfunded. The evidence base for how we organise and deliver care affects every practitioner and every patient, yet it rarely attracts the attention or investment that clinical research does.

This is why in 2024, Avant set up a foundation to support research that promotes quality, safety, sustainability and professionalism in the practice of medicine.

Recently, the Avant Board made a landmark decision to commit $50 million of capital to create an enduring philanthropic legacy in support of medical research, education and health programs. The Avant Foundation awarded its inaugural $1 million Transformation Grant in 2025. This initiative aims to create meaningful, lasting change in how healthcare is delivered and experienced in Australia.

As Avant members, you are part of a mutual organisation that does more than protect doctors when things go wrong. Through our foundation, Avant is investing in programs that help things go right – for doctors, for patients, and for the healthcare system as a whole. That's something worth knowing, and worth being proud of. ●

Independent modelling consistently shows that every dollar invested into health and medical research generates strong returns through productivity gains, reduced health expenditure, commercialisation and workforce participation.

Professor Jason Kovacic, AAMRI president, Avant member

Transformative treatment for children with neurodevelopmental disorders

In the next decade, Professor Russell Dale and his scientific colleague Dr Shrujna Patel, envision a future where neurodevelopmental disorders in children, such as autism, ADHD and Tourette syndrome, are understood through biological markers. Their groundbreaking research has a goal of enabling personalised treatments tailored to each child's unique profile. As Professor Dale explains,

"It's about moving beyond symptom management to truly modifying disease pathways."

Thanks to winning the inaugural flagship $1million Transformation Grant from Avant Foundation, the project team, comprising neuroscientists, clinicians, dietitians and bioinformaticians from University of Sydney and Westmead Children's Hospital, are moving towards clinical trials. "The clinician-scientist partnership is crucial," Professor Dale emphasises. "We listen to families and bring cutting-edge science to the bedside."

Prof Russell Dale,
University of Sydney
Avant Foundation Transformation Grant 2025 winner

Find out more:
Avant Foundation

Avant Foundation is administered by Avant Services Co. Pty Limited (ACN 616 529 581).

Leasing vs buying your practice rooms

Jeremy Stagg
Head of Commercial Lending – SA, NT & WA,
Avant Finance

Many doctors assume that buying commercial premises requires deep pockets and creates cash flow pressure. The reality, in my experience working with medical professionals, is frequently the opposite.

Commercial lease payments and mortgage repayments on equivalent properties are often surprisingly comparable. The difference is that one builds an asset and the other doesn't. Over 10, 15, 20 or 30 years, that distinction can translate into a very significant difference to your financial future.

In recent years the lending landscape has changed. Previously, commercial property loans usually required a 30% deposit and came with repayment terms of around 15 years. Today, doctors can access loans for 100% of the property value – often with no additional security required – and terms of up to 30 years*. This has fundamentally shifted the equation between leasing and buying for medical professionals.

That said, ownership isn't the right answer for everyone. If you're early in your career, uncertain about your long-term location, or prioritising cash flow for staffing and equipment, leasing offers genuine flexibility and lower upfront exposure. Landlord incentives such as fitout contributions and rent-free periods can also make leasing attractive when setting up or expanding a practice.

The honest answer is that the right choice depends on your stage of career, your practice model and your long-term goals. I'd encourage every doctor to speak to their accountant or financial adviser about their unique financial circumstances – because they may find that owning is more accessible, and more financially compelling, than they expected.

Buying your consulting rooms is a decision worth examining carefully – and earlier in your career than most doctors think. The Avant Finance team works extensively with medical professionals and understands the financial and practical dynamics of running a practice. ●

The financial case for buying

Why buying often makes more sense than doctors expect:

- **Comparable cash flow:** Loan repayments on a commercial property are often in the same range as lease payments on an equivalent space – but you're building equity, not paying someone else's mortgage.
- **Tax advantages:** Depending on how you structure the purchase, you may be able to claim deductions on loan interest, building depreciation and certain outgoings. Talk to your tax adviser about what applies to your situation.
- **SMSF opportunity:** Many doctors hold their consulting rooms inside their self-managed super fund, where the maximum tax rate is usually 15% during the accumulation phase – well below their personal tax rate.
- **Passive income:** Subletting space to complementary service providers – such as a physiotherapist or psychiatrist – can offset costs and enhance your service offering from day one.
- **Retirement asset:** The option to keep ownership of the premises after selling a practice provides a source of ongoing rental income.

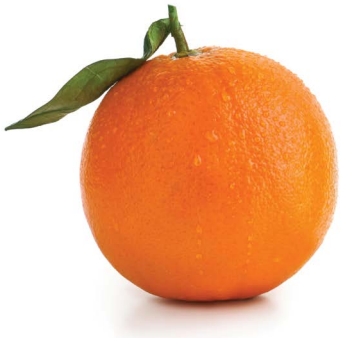
When leasing is the smarter move

Leasing may be the better fit for doctors who want to:

- **Preserve capital:** Staffing, equipment or marketing can require significant investment in the early stages of building your practice.
- **Co-locate with other practitioners:** Partnering with other health service providers allows you to share some of the infrastructure costs.
- **Maintain location flexibility:** Your patient catchment or personal circumstances may change and relocation is easier if you're leasing.
- **Negotiate landlord incentives:** Set-up costs can be significantly reduced through a contribution to fitout or rent-free period.

Find out more:
Avant Finance

“It really can be a case of own your rooms, own your future – but only if the numbers and your circumstances stack up.



Sorry for your loss … of revenue

Lena Wallish
Head of Practice Technology Services,
Avant Practice Solutions

You didn't go into medicine to manage billing workflows but, as a practice owner, revenue leakage is a business reality you can't afford to ignore. This issue rarely comes from undercharging; it happens in the gap between delivering patient care and actually receiving payment.

Even minor oversights in coding or documentation can add up quickly. The good news: most of these problems are preventable with the right systems in place.

Where the money gets lost

As the treating practitioner, you're responsible for selecting and authorising the Medicare Benefits Scheme item number – don't leave your practice manager to make assumptions about consultation length or complexity. When the handover between clinical and administrative processes is unclear, errors, missed charges and compliance issues follow.

This is especially true for inpatient and ward round work, where documentation is often unstructured. Without a clear system for recording and submitting billing details, you could be leaving money behind.

System maintenance creates its own risks. The Medicare Benefits Schedule is updated regularly, and private health funds won't process claims correctly if your fee schedules aren't current. Billing software misconfigured at set-up (e.g. missing referring doctor information or procedure specifics) triggers automatic rejections. By the time you notice, months of claims may need resubmission.

5 ways to *improve* your billing process

1. Standardise how billing information is captured

The less ambiguity in your documentation workflow, the fewer errors downstream. Digital forms, ward round templates and daily submission deadlines take the reliance off handwritten notes, and off your memory at the end of a long day.

2. Train your team properly

Most persistent billing problems trace back to inadequate training or poor set-up. New billing staff need structured onboarding and existing staff need regular refreshers as Medicare schedules change. Beyond knowing how to submit a claim, they need to know when something is wrong and how to fix it.

3. Keep your systems current

Ensure your billing team sets quarterly reminders to review and update Medicare fee schedules, private health fund billing codes and provider number registrations. Preventive maintenance is far less costly than chasing rejected claims.

4. Don't neglect follow-up

Many practices submit claims well, but under-resource the follow-up. Accounts age, months pass, and you're facing Medicare's two-year limitation period with revenue you may never recover. Effective debt recovery requires dedicated, systematic attention, which is hard to sustain when you're running a clinical practice.

5. Know when to bring in specialists

Resolving rejections, appealing fund decisions and navigating billing disputes require expertise that goes beyond most in-house teams. Bringing in this expertise and technologies to help can be a great investment.

The bottom line

The most cost-effective approach to billing isn't fixing problems; it's preventing them. When systems are properly configured, staff are well trained and documentation processes are clear, claims process smoothly, and you get paid for the work you've already done. ●

Find out more:
Avant's Billings & Revenue Recovery

Don't let bill shock turn into a complaint

Georgie Haysom
BSc, LLB (Hons), LLM (Bioethics), GAICD
General Manager – Advocacy, Education and Research, Avant

At a time when transparent communication about costs has never mattered more, Avant is supporting doctors to strengthen their processes around informed financial consent. This will help members reduce risk, prevent misunderstandings and protect patient relationships.

Most doctors understand informed financial consent (IFC) is more than just a courtesy or administrative task – it is a critical safeguard against medico-legal risk. At the heart of IFC is transparency. When patients clearly understand the financial aspects of their care, they are less likely to receive a bill they were not expecting. Conversely, if IFC is incomplete, delayed or inconsistent, they may feel misled when an account arrives. This can undermine trust and amplify a patient's emotional response if their expectations of care are not met.

A strong IFC process reduces medico-legal exposure in the same way as other fundamentals such as good documentation and a clear clinical consent process.

Why IFC and transparency matter for medico-legal protection

IFC is embedded in the Medical Board of Australia's *Good Medical Practice* code of conduct, and requires doctors to provide accurate, timely and comprehensible information about:

- consultation and procedure fees
- Medicare rebates
- likely out-of-pocket expenses
- other providers involved in the patient's care who may also charge fees.

Providing cost information proactively supports ethical, patient-centred care and helps mitigate medico-legal risk. Transparent discussions about fees demonstrate professionalism and fairness, helping to build trust and resolve issues early. Where trust exists, patients are often more understanding when something goes wrong. In contrast, confusion or dissatisfaction about cost may intensify distress and increase the likelihood of complaints.

What does strong IFC look like?

A robust IFC process is consistent, proactive and tailored to the complexity of the treatment. It also provides transparency at every step.

1. Start early to reduce risk

Ideally, IFC should occur before the appointment or procedure. Early, clear conversations reduce the likelihood of a patient experiencing 'bill shock', which is a recognised trigger for complaints. Reinforcing financial consent when making an appointment – including through online platforms, on arrival, during clinical discussions as well as when plans change, helps ensure that patients are appropriately informed.

2. Treat IFC as a process – not a form

Like clinical consent, financial consent is continuous, collaborative and patient centred. Providing verbal explanations supported by written materials helps promote transparency and strengthens your medico-legal position by demonstrating you have taken steps to ensure the patient understood the information. Having written information online or in printed materials also supports consistency across your practice team and is another important risk management measure.

3. Match the format to the complexity

Verbal IFC for simple, fixed-fee situations is appropriate when costs are predictable. This should still be supported by clear, accessible written information available elsewhere (e.g. website, brochures).

Written or electronic IFC is recommended for procedures with multiple components where costs may vary. Providing printed, emailed or app-based information helps ensure clarity and reduces medico-legal exposure.

Formal, tailored written quotes should be used for complex treatment or procedures. An itemised estimate is one of the most effective tools for preventing complaints. It demonstrates transparency and ensures the patient is aware of potential variations and additional costs.

The patient should review and accept the quote, with a copy retained in the clinical record.

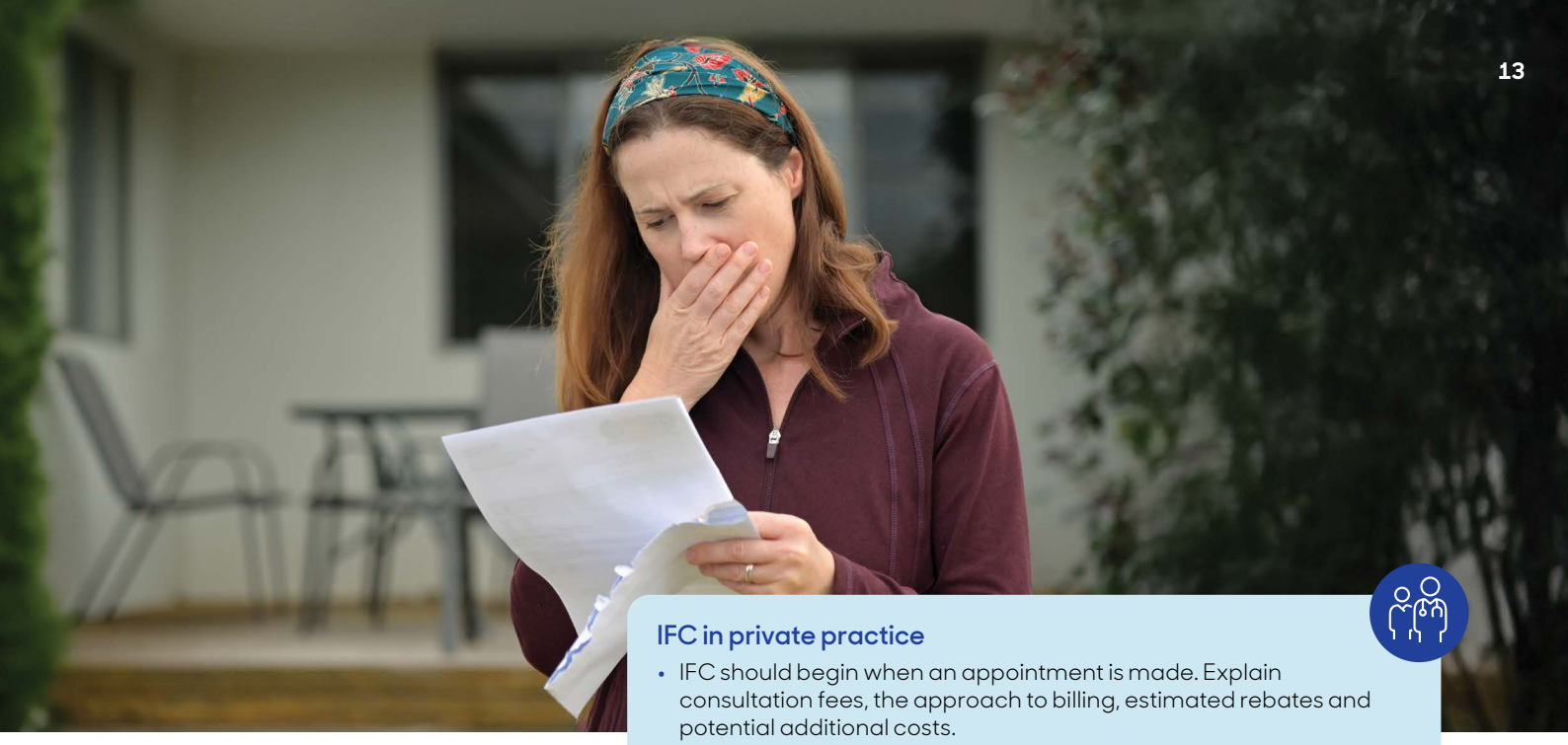
4. Clarify third party fees to prevent disputes

Misunderstandings about other providers' fees – such as anaesthesia, radiology, pathology, allied health or hospital charges – are a frequent source of complaints. Even when you are not responsible for these costs, medico-legal risk increases if the patient thinks you 'didn't tell them'. These should be raised with the patient as potential or related costs, with details on where to get more information.

5. Encourage patients to speak to their health fund

Directing patients to their private health insurer is an important part of a complete IFC process. Information you provide patients should include MBS item numbers for your services and the Medicare rebate. This will allow their health fund to confirm whether the full difference will be covered, or they should expect to pay an out-of-pocket gap cost.

Avant resource:
Informed Financial Consent



When outcomes are unexpected: how IFC protects you

If a patient experiences a complication, disappointment, or adverse event, emotions can run high. In such circumstances, surprise costs can increase the risk of a complaint.

A well documented IFC process:

- shows you genuinely attempted to support informed decision making
- demonstrates transparency and fairness
- builds trust, even in difficult circumstances
- provides strong evidence if a claim or complaint is lodged
- can prevent escalation altogether.

Reinforcing cost information at multiple touchpoints can also help prevent misunderstandings. As can documenting IFC in a way that reflects the complexity of the care being provided. Above all, adopting a practice-wide commitment to transparency helps build trust and supports a smoother, more positive experience for your patients.

Consistency and transparency remain your strongest assets in preventing complaints and maintaining patient confidence.

IFC in private practice

- IFC should begin when an appointment is made. Explain consultation fees, the approach to billing, estimated rebates and potential additional costs.
- If your practice uses an online booking system, costs can be explained on a click-through page, pop-up or a message directing patients to your website.
- Clinical and financial consent processes are often delivered by different team members, which means consistency is essential. A shared understanding within your practice reduces the likelihood of mixed messages.
- Regardless of the format used to provide information on costs (verbal, emailed standard information or a formal quote), document what you provided to the patient, and their agreement.

IFC for surgery and minor procedures

- For surgeons and other proceduralists, the complexity of the procedure usually dictates the level of detail a patient should be given.
- Where multiple procedures or services from other providers are required, written IFC is strongly recommended. This should explain your fees, outline what other providers will be involved, and direct the patient to where they can get information about these other charges and fees.
- Estimates, ranges and explanations of variables help manage expectations and reduce the risk of misunderstandings.
- For cosmetic surgery and non-surgical cosmetic procedures, there are some specific IFC requirements you need to address. These are set out in the Medical Board's *Guidelines for registered medical practitioners who perform cosmetic surgery and procedures.*

IFC for anaesthetists

- Proactive communication is key. Many anaesthetists find it helpful to have a brochure or digital information sheet outlining their role, billing structure and expected out-of-pocket costs.
- Ideally, this is provided when the patient sees the surgeon – or at least mentioned at that point – and is then sent directly to the patient by you or your practice staff.
- Ward-based or perioperative discussion can be appropriate in some circumstances, but should complement rather than replace earlier communication.
- If taking over a colleague's list, the best approach is generally to charge the same fee the patient was originally informed of. If you choose to charge a higher amount, this should only occur after full and timely disclosure to the patient.

Court dismisses specialist's claim for gap payment

Ruanne Brell
BA, LLB (Hons)
Senior Legal Adviser, Avant

Healthcare costs, fee transparency and out-of-pocket expenses are receiving increasing political and media attention. This is likely to lead to higher awareness from patients that they may have to cover a portion of costs themselves. And potentially more scrutiny of the informed financial consent process. This case highlights the importance of discussions about fees taking place before any costs are incurred.

Overview of the case

A privately insured patient was charged an anaesthetic fee above the Medicare scheduled fee, without prior discussion about the cost.

According to the court, where no fee is agreed and the patient is not informed about any gap payment, the Medicare scheduled fee was the reasonable fee and the maximum the practitioner was entitled to be paid.

No discussion about fees

The patient underwent a surgical procedure in a private hospital. The surgeon, who had arranged an anaesthetist to provide anaesthetic services, did not discuss the anaesthetic fees with the patient before the surgery. The anaesthetist did conduct a pre-operative consultation with the patient, where clinical matters were discussed, but there was no discussion about fees.

Following the surgery, the patient received a bill from the anaesthetist. Although the fee charged was lower than the AMA recommended fee, it was above the Medicare scheduled fee. As a result, his private health insurance did not cover the full amount and he was left with an out-of-pocket gap payment.

The patient disputed the additional amount and refused to pay. The anaesthetic services group the anaesthetist belonged to brought a claim to recover the outstanding balance.

Implied contract but no financial terms

The court found that a contract for anaesthetic services had been formed, but that no price had been expressly discussed or agreed. The court therefore found that no financial terms were agreed.

In those circumstances, the court decided that the law had to imply a reasonable fee into the contract. It determined that the Medicare scheduled fee was the reasonable implied fee.

The court found that even if it was common practice for anaesthetists to charge more than the Medicare scheduled fee, there had to be a discussion with the patient beforehand if a practitioner wanted to charge anything above that amount.

In this case, there had been no discussion of fees and no evidence that the patient understood he would have to pay a gap. The anaesthetist was therefore not entitled to charge the additional amount.

Claim for fee rejected

The claim for the amount above the Medicare scheduled fee was dismissed. As the scheduled fee had already been paid, the anaesthetist could not recover any further payment. ●

Avant resource:
Informed Financial Consent

In brief

When you intend to charge above the Medicare scheduled fee, the patient must be informed before treatment proceeds. Where no fee is agreed and the patient is not aware of any potential gap payment, a court will imply the Medicare scheduled fee as the reasonable fee payable. You would not be entitled to be paid any more than the scheduled fee, regardless of whether the fee charged was considered excessive or not.

Key messages

Doctors are entitled to set their own fees. However, you must clearly disclose fees and obtain the patient's consent before treatment. If you do not, a court may limit recovery to a reasonable fee.

Provide written confirmation of your fees, the item numbers and likely out-of-pocket costs in advance of the procedure. This reduces the likelihood of misunderstanding.

Financial arrangements should not be assumed or left unaddressed. Where a practitioner, such as a surgeon, is the main doctor dealing directly with the patient, they should provide details about other specialists who will be involved in a procedure. And advise the patient to contact them to get information about their fees.

Encourage patients to speak to their health fund to check whether the full difference between the Medicare fee and what you charge will be covered, or if they should expect to pay an out-of-pocket gap cost.

It is important to document the patient's agreement of your fees.

The case featured in this article is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

Tribunal's verdict on sharing clinical images with friends

Tracy Pickett
BA, LLB
Legal & Policy Adviser, Avant

When you're working in a high-stress environment, surrounded by colleagues who share your exposure to trauma, dark humour can be a typical coping mechanism. In this case, a 'rather juvenile' attempt to impress by sending graphic photos of patient injuries had serious consequences.

Inappropriate use of clinical images

A registrar working in orthopaedics at a major public hospital shared graphic photos, video and X-ray images of patients' injuries with friends via text or WhatsApp on several occasions.

The images often had unprofessional comments attached. In one case, part of a patient's name was visible in the image.

The images were discovered and a complaint was made to the regulator. An investigation by the hospital found that the images had not been accessed from patient files. Instead, they had been taken by the registrar. It was established the images had not been shared publicly on social media.

When the images were discovered, the registrar was suspended from their role and as a result lost the opportunity of a training position. By the time the tribunal hearing took place, 5 years later, they were working as a GP and part-time in a fracture clinic.

The tribunal found that the doctor's actions represented a substantial departure from the standards expected of a medical professional with their level of training and experience.

It commented that the conduct exhibited a 'flippant disregard' for the patients' pain and suffering, and sharing the images was inconsistent with a doctor's obligations to practise with integrity and compassion. The doctor accepted the regulator's position that this constituted professional misconduct.

Outcome

At the hearing, the tribunal noted that in the 5 years since the offending actions the doctor had no other disciplinary history. They had shown genuine insight into the inappropriateness of their actions and, since this time, their conduct had been exemplary.

The tribunal accepted the doctor had co-operated with the investigation and had not contributed to the delay in bringing the proceedings.

The tribunal concluded that while the conduct was serious there were mitigating considerations. These included that:

- no patient records were accessed
- despite part of a patient's name being visible, the patients were not identifiable
- the images were sent to individuals and not shared on social media or otherwise published
- there was no sexual or indecent intent, but rather juvenile efforts to impress during a period of personal and professional stress.

In the circumstances, the tribunal considered that issuing a reprimand – which would remain on the doctor's public record for a further 5 years – was not warranted. It was acknowledged that a reprimand may have been appropriate had the matter been heard more promptly. However, due to the time that had passed and the doctor's conduct since, no protective purpose would now be served by imposing a reprimand. The tribunal also agreed to an order that the doctor's name not be published.

Given the seriousness of the conduct, a fine was appropriate as a deterrent. The doctor was fined $5,000. Each party had to pay their own costs. ●

Key messages from the case

Clinical images must always be treated with sensitivity and respect – even if they are not obviously identifiable. Doctors who are tempted to share graphic images with friends to shock or impress may find themselves subject to significant professional penalties.

Key lessons

Only take clinical images where the image is necessary for patient care or, if for another reason such as research or education, make sure this is clear when obtaining patient consent.

When obtaining patient consent, explain how the image will be used, who will have access to it and how it will be stored. Where possible, take the image on a hospital camera or hospital phone. Save the image to the patient's file.

Always follow hospital or clinical guidelines in relation to taking clinical images.

Assume all images are identifiable, even if they appear de-identified and treat them as confidential.

Never share patient images with others or on social media without specific patient consent to do so.

Only access patient images for clinical purposes. And never access them without a valid clinical reason relevant to the particular patient.

Constant exposure to trauma can be desensitising. Take care to manage your own wellbeing and watch for signs of burnout.

The case featured in this article is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

When is a 'wait and see' approach reasonable in general practice?

Tessa Flynn
LLB, BA
Associate, Civil Claims, Avant Law

A patient later diagnosed with non-Hodgkin's lymphoma sued her GP for failing to diagnose the condition earlier. The court concluded that the GP's initial 'wait and see' approach was not negligent. What lessons does this case hold for doctors managing common symptoms that may later turn out to have serious causes?

The context

A patient in her early 50s saw her GP, complaining of worsening leg pain that interfered with her ability to walk.

During the consultation, the GP examined the patient and considered several possible explanations for the pain. Musculoskeletal causes appeared the most likely.

The GP arranged blood tests to investigate possible underlying causes, including iron deficiency, inflammation or muscle damage, and prescribed anti-inflammatory medication to manage the symptoms.

The blood test results arrived the following day and were within normal limits.

At that stage, no further investigations were arranged and there was no clearly documented plan for follow-up if symptoms persisted.

What happened next?

Over the following months, the patient visited the same medical practice on several more occasions and also consulted doctors at another clinic for unrelated health issues.

Clinical records from these consultations did not document complaints of leg pain.

Around 9 months later, the patient saw the original GP with worsening symptoms, including lower back and leg pain, as well as unexplained weight loss and lethargy.

The GP arranged further investigations, including imaging.

Tests revealed abnormalities in the bones of the pelvis and spine. Further scans and biopsies ultimately confirmed a diagnosis of non-Hodgkin's lymphoma with skeletal involvement.

The patient underwent chemotherapy and initially achieved remission. However, the cancer later returned and her condition became terminal.

The patient subsequently brought a medical negligence claim against the original GP.

The legal claim

The patient alleged that the GP had failed to adequately investigate her symptoms during the initial consultation.

Her case was that the GP should have taken further steps at that time, including:

- arranging imaging
- referring them to hospital or a specialist
- conducting further investigations
- ensuring appropriate follow-up.

The patient argued that if these steps had been taken, the lymphoma would likely have been diagnosed earlier and treatment could have commenced sooner.

The GP denied negligence and maintained that his management of the initial consultation was reasonable based on the information available at the time.

How the court approached the case

When courts assess medical negligence claims, they do not judge a doctor's actions with the benefit of hindsight. Instead, the key question is whether the doctor's conduct fell short of the standard of care expected of a reasonable practitioner in the same circumstances at the time the service was provided.

Although each state and territory has its own civil liability legislation, the legal principles applied by courts are broadly similar. In general, negligence will only be established if:

- the risk of harm was foreseeable
- the risk was not insignificant
- a reasonable practitioner would have taken additional precautions in the circumstances.

Courts will also consider factors such as the likelihood of the risk occurring and the burden involved in taking precautions to prevent it.

In this case, the risk of harm was that a delay in diagnosis would leave the lymphoma untreated and allow it to develop to a point where it was terminal.

Why the GP was not found negligent

The court accepted that the GP's consultation could have been managed better in some respects. For example, the judge noted that it may have been preferable to arrange a follow-up appointment or provide clearer advice about returning if pain persisted.

However, the legal standard is reasonable care, not perfect practice.

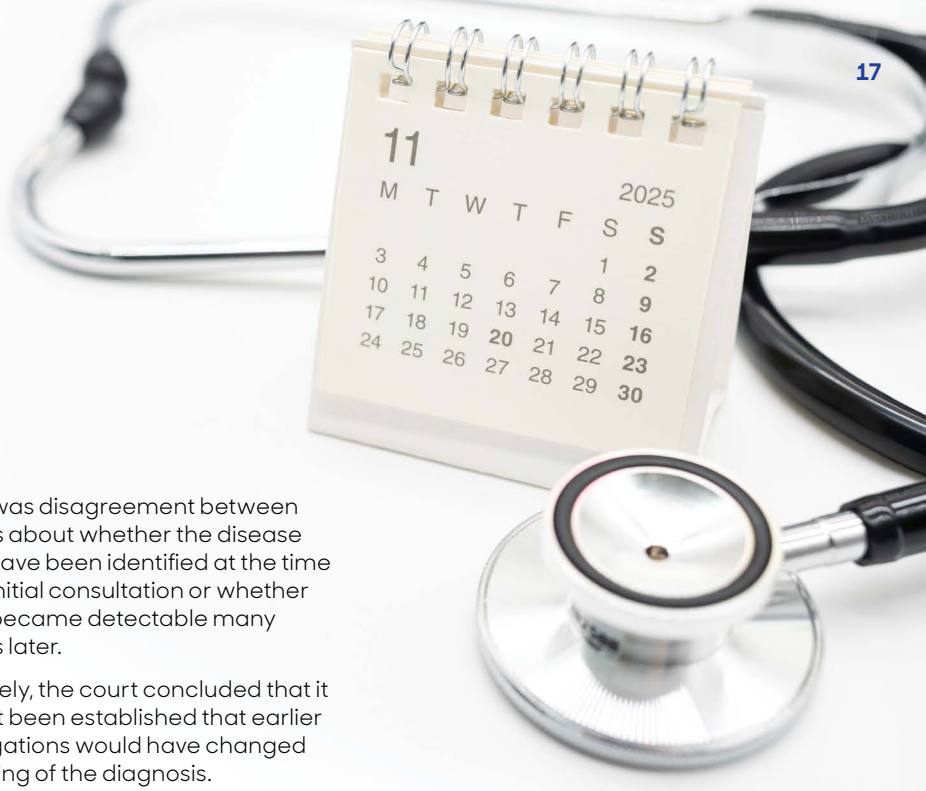
Several factors influenced the court's conclusion that the GP had not been negligent.

First, leg pain is a very common symptom and is usually caused by musculoskeletal problems that resolve on their own.

Second, the investigations that were arranged, including blood tests, were considered an appropriate first step in assessing the patient's symptoms.

Third, expert evidence suggested that most cases of musculoskeletal pain improve without further intervention. Because of this, it was reasonable for the GP to expect that a patient experiencing ongoing pain would return for further review.

The court therefore accepted that the GP's stepwise approach to investigation, sometimes described as a 'wait and see' strategy, was within the range of reasonable clinical practice.



The issue of follow-up

A key theme in the case was the absence of a clear follow-up strategy.

The trial judge noted that it would have been better practice for the GP to clearly explain the purpose of the blood tests and to advise the patient to return if the pain persisted despite normal results.

The judge described these types of measures as a form of 'safety net'.

However, the absence of such a safety net did not ultimately amount to negligence. The court accepted that a reasonable GP could assume that a patient experiencing ongoing significant pain would seek further medical attention if the symptoms continued.

Causation was also uncertain

Even if breach of duty had been established, the patient would still have needed to prove that earlier investigation would probably have resulted in an earlier diagnosis.

The court considered expert evidence about when the lymphoma would likely have become detectable.

There was disagreement between experts about whether the disease could have been identified at the time of the initial consultation or whether it only became detectable many months later.

Ultimately, the court concluded that it had not been established that earlier investigations would have changed the timing of the diagnosis.

Why this case matters

This decision highlights the realities of clinical practice, where doctors often need to make decisions in the face of diagnostic uncertainty.

Patients frequently present with symptoms that have multiple possible explanations, most of which are benign.

The law recognises that doctors are entitled to adopt a stepwise approach to investigation and that not every serious condition can be identified at its earliest stage.

At the same time, the case serves as a reminder of the importance of documenting clinical reasoning and clearly communicating follow-up advice to patients when symptoms remain unexplained. ●

Key lessons

Your actions and clinical decisions are assessed by courts based on what was known at the time of the consultation.

A stepwise approach to investigation can be reasonable when patients present with common symptoms that are usually caused by benign conditions. It is important to document why you consider a stepwise approach should be followed.

Failing to follow what may later appear to be best practice does not necessarily mean your care fell below the standard of reasonable clinical practice.

Providing clear safety-netting advice helps ensure patients understand when they should return for review if symptoms persist or worsen.

Careful documentation of your clinical reasoning, the advice you give to patients, and any plans for follow-up is important especially when the diagnosis remains uncertain.

The legal perspective

This case demonstrates the importance of considering the factual circumstances identified at the time of a consultation in assessing whether a practitioner has exercised reasonable care. Further, the Court of Appeal distinguished between reasonable care and best practice.

The Court of Appeal cautioned against venturing into hindsight reasoning when considering the probability of harm and found that the GP had not acted unreasonably in relying on the patient to re-present if her pain had not resolved (the 'wait and see' approach).

Tessa Flynn

The GP perspective

While the patient's later diagnosis and outcome evoke deep empathy, the case is a stark reminder of the realities of frontline medicine. The GP was faced with a common presentation of nonspecific pain. We always consider serious differentials, but we investigate step by step, and sometimes that means watchful waiting. We also rely on patients to return if symptoms persist or escalate, because not every case can realistically be followed up in an overstretched practice. Too often we're judged against a gold standard ideal, so it was reassuring to see the court recognise that reasonable care – not perfection – is the true standard.

Dr Ushma Narsai

Avant resource:
Missed or delayed diagnosis

The case featured in this article is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

Why getting property finance can be harder for doctors

Jacqui Lombard
General Manager - Residential Lending, Residential Broking, Avant Finance

Buying property is acknowledged to be one of life's most stressful events. As several members have told us, for doctors it's often particularly challenging.

Long shifts leave little time to check out the market. The pace of clinical life means that when the right property appears, there's rarely time to stop and organise finance. And irregular income structures often confuse lenders. These barriers can mean for many doctors it's all much harder than they expect.

A doctor's situation is different

Finding time to submit a mortgage application or restructure finances can genuinely be difficult. The experience when dealing with a regular bank can be dispiriting.

Dr Mark Loman, a musculoskeletal medicine practitioner in Port Macquarie, needed to refinance a bridging loan as his family moved from an acreage property back into town. He found the major banks were hard to deal with. "I was led around the garden path," Dr Loman says. "The big banks do not get it. If you're not there during office hours, tough."

What he needed was a lender who understood a procedural clinician's schedule; someone who would reply to emails after hours and turn things around without requiring him to take time off work.

It's a version of the same problem Dr Nitin Dhanani encountered when expanding his practice portfolio. During a period of rapid growth, his cash flow situation was misread by a lender focused on the wrong metrics. "The cash flow is where everyone struggles," he says. "Any profit is going in taxes and paying your principal at the beginning."

Complexity isn't unusual

For doctors with more complex property goals, such as ownership of practice premises, SMSF structures and investment properties, the challenge isn't just finding a lender willing to provide funds. They also need to work with people who have the depth of knowledge to structure finances suitably for their specific needs, and the flexibility to handle multiple property-related transactions over time.

Dr Loman's property journey spanned a home loan, a practice purchase, a fitout loan and an investment property, all requiring a different structure. Having an Avant Finance specialist to work with on these loans reduced the friction he experienced elsewhere. What struck him was not just their efficiency, but how well the team grasped his broader situation. "They didn't just deliver for my business dreams," he says. "They delivered for my family dreams."

Deposit dilemmas

The complexity of the property market doesn't only affect established practitioners. For doctors earlier in their careers, securing a first home comes with its own set of hurdles. Many don't know where to begin, what the process entails, or what documentation or insurance is needed. And the same mainstream lenders who struggle with complex portfolios often struggle with a training salary or a non-standard deposit.

Chelsea, a PGY3 critical care trainee, tried several mortgage brokers when looking for her first property. She found most weren't equipped to see the full picture. When she turned to Avant Finance, the difference was immediate. "They understood that I probably had a smaller deposit but I have a secure job with being a doctor," she says. That understanding translated to a 5% deposit loan — enough to get her foot in the door.

Paediatric registrar Dr Angelica Ronquillo had a similar experience buying her first home with her partner. "Buying a home for us was quite a daunting thought and process," Dr Ronquillo says. "Having the right team on our side made the entire process seamless and stress free."

When should you speak to a specialist?

Doctors have a financial profile that differs from most other professions, and a working life that makes it hard to find the time to invest. Avant Finance has helped thousands of doctors navigate property finance – from first homes on a training salary to complex SMSF and multi-property arrangements. Reach out to us:

- Before you start looking, to understand your borrowing power.
- When you're ready to buy a practice or fitout, before you make an offer.
- If your bank has said no, or you can't get to speak to them at a time that suits you.

Our specialists work around clinical schedules, making themselves available outside office hours, and are familiar with the income structures of salaried, VMO and practice-owning doctors. They are also experienced in navigating SMSF and complex multi-property arrangements. ●

Avant Finance:
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Pros and cons of holding life insurance inside or outside super

Michael Osbourne
Insurance Financial Adviser,
Life Insurance Personal Advice, Avant

A question we're often asked is whether to hold personal life insurance policies inside or outside superannuation. There are genuine advantages to each, and for doctors, the decision carries some profession-specific considerations worth understanding.

Before we get into these, here's a quick recap of the different policy types that can protect your quality of life and provide for yourself and your family:

- **Life (or death) cover:** provides a lump sum to your family if you die.
- **Income protection:** regular payments to replace your income, should you be unable to work due to illness or injury.
- **Total permanent disablement (TPD) cover:** a lump sum payment if you are no longer able to work due to permanent illness or injury.
- **Trauma or critical illness cover:** a lump sum payment if you are diagnosed with one of the specified medical conditions (usually covers 40-50 conditions, including stroke, heart attack and cancer).

A question many doctors face is whether to hold these policies inside or outside their superannuation. There are genuine advantages to each, and for doctors, the decision carries some profession-specific considerations worth understanding.

Holding cover inside superannuation

Income protection, TPD and life cover are available through most superannuation funds.

Automatic acceptance up to certain amounts often means no medical history check is required. If you already have these types of cover within your super it's essential to ensure the benefits will be sufficient for your needs and to consider the unique risks your vocation presents.

Many industry and employer super funds have group insurance policies available which can be cost effective. As premiums are deducted automatically from your super balance, it's easy to manage.

The trade-offs can be significant, however. Premiums paid from your super balance reduce what is available at retirement. Cover may not be portable if you change funds, which could mean reapplying and facing an updated assessment of your health. Death and TPD benefits may also be taxed depending on how and to whom they are paid.

Superannuation policies often carry more restrictive disability definitions, with some only paying a benefit if you are unable to work in any occupation, not just your own. A specialist who can no longer practise in their field but could theoretically work in another capacity may find themselves without a payout.

Trauma cover and practice expense cover are not available inside superannuation at all.

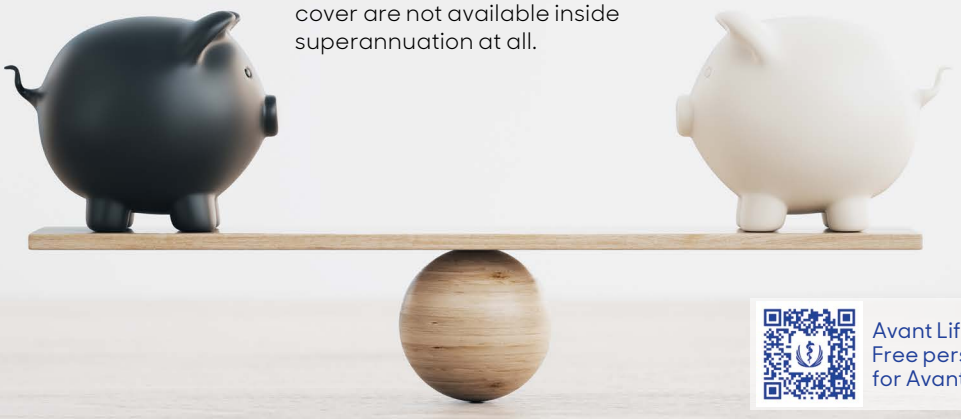
Holding cover outside superannuation

All personal life insurance types are available outside superannuation, including trauma and practice expense cover. Income protection premiums are tax deductible since any benefits paid are treated as taxable income. These benefits would be paid directly to you without passing through your superannuation fund, which can mean that payout of claims is less likely to be delayed. Importantly, you can hold cover that is specific to your specialty. Consequently, you are protected if you cannot work in your chosen field, regardless of what else you might be capable of doing.

For lump sums covers like death and TPD, the main differences are cost and tax treatment. There is no access to group discounts, and life and TPD premiums are paid from post-tax income. However, benefits for these covers are generally not taxed.

Finding the right balance

For most doctors, the answer is not clearly one or the other. A combination of holding policies inside and outside superannuation can balance tax effectiveness with the right level and type of cover. Given the complexity of medical careers, with highly specialised roles and sometimes multiple income streams, it is worth getting advice from someone who understands your profession. ●



Fostering trust and transparency

Dario Molina
BComm, ACA
Chief Executive Officer, Doctors' Health Fund

Over the past few months, we've seen growing media attention around informed financial consent, with an emphasis on improving medical cost transparency. This is an important conversation, and the private health insurance sector must be a part of it.

Private health fund members deserve a realistic picture of their healthcare costs, and greater cost transparency helps reduce potential bill shock and maintain trust between patients and doctors. Tools, such as the Government's Medical Costs Finder website, can be part of this.

Another aspect of improving transparency is providing clear information about what is and isn't covered in a health insurance policy. It also means keeping members informed about policy changes and being able to explain content that is often complex.

Standardised policy tiers clarify cover

In 2020, the Australian Government launched a standardised health insurance product tiering system to make it easier for members to compare policy options and find products that best suit their needs.

As a result, all hospital policies now fall into four tiers: Gold, Silver, Bronze and Basic. Each tier includes a defined minimum set of clinical category coverage, but this doesn't mean they are all the same.

The tiering system has helped policy holders to understand their cover. However, members still rely on their fund to provide clear and accurate information about what is and isn't covered under their policy.

In mid-2025, some people were impacted when a fund failed to comply with rules covering essential treatments required due to unexpected complications. Unfortunately, these members were misinformed about what was covered under their policy and charged an out-of-pocket expense.

Our approach to unexpected complications

At Doctors' Health Fund, we don't want our members to feel uncertain about whether essential treatments will be covered in such situations.

That's why we've made thoughtful inclusions that go above the minimum tier requirements. For example, while plastic and reconstructive surgery is not mandated in Bronze-tier cover, it is included in our Smart Starter Bronze Plus policy for members undergoing medically necessary procedures, such as skin cancer removals.

We also recognise that in some cases misinformation can be due to automated claims processing. While automation and streamlining of data claims can build efficiencies, we make sure that expert (human) oversight is available for tailored member support.

Promotion of no-gap agreements

Although the tiering system helps clarify coverage, it doesn't consider the quality of a health fund's medical gap schedule.

The medical gap agreements each of the health funds hold with hospitals can vary. This can make it hard for members to be confident they won't face out-of-pocket costs if their doctor charges above the Medicare schedule fee. Doctors' Health Fund is unique in offering a premium hospital cover, Top Cover Gold, that provides medical gap cover up to the AMA list of services and fees.

Paying up to AMA rates also recognises the value and expertise of medical practitioners and helps ensure they are fairly reimbursed for the services and care they provide.

It's in everyone's interest to support cost transparency across the healthcare system. As part of Avant, Doctors' Health Fund is involved in the discussions around making the Medical Costs Finder website workable and effective for doctors and their patients alike. This includes lobbying for amendments to the legislation currently before the parliament.

Uncertainty and misinformation can undermine trust. Both health funds and providers have a role to play in helping Australians make informed healthcare decisions and maintaining confidence in the system. ●

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