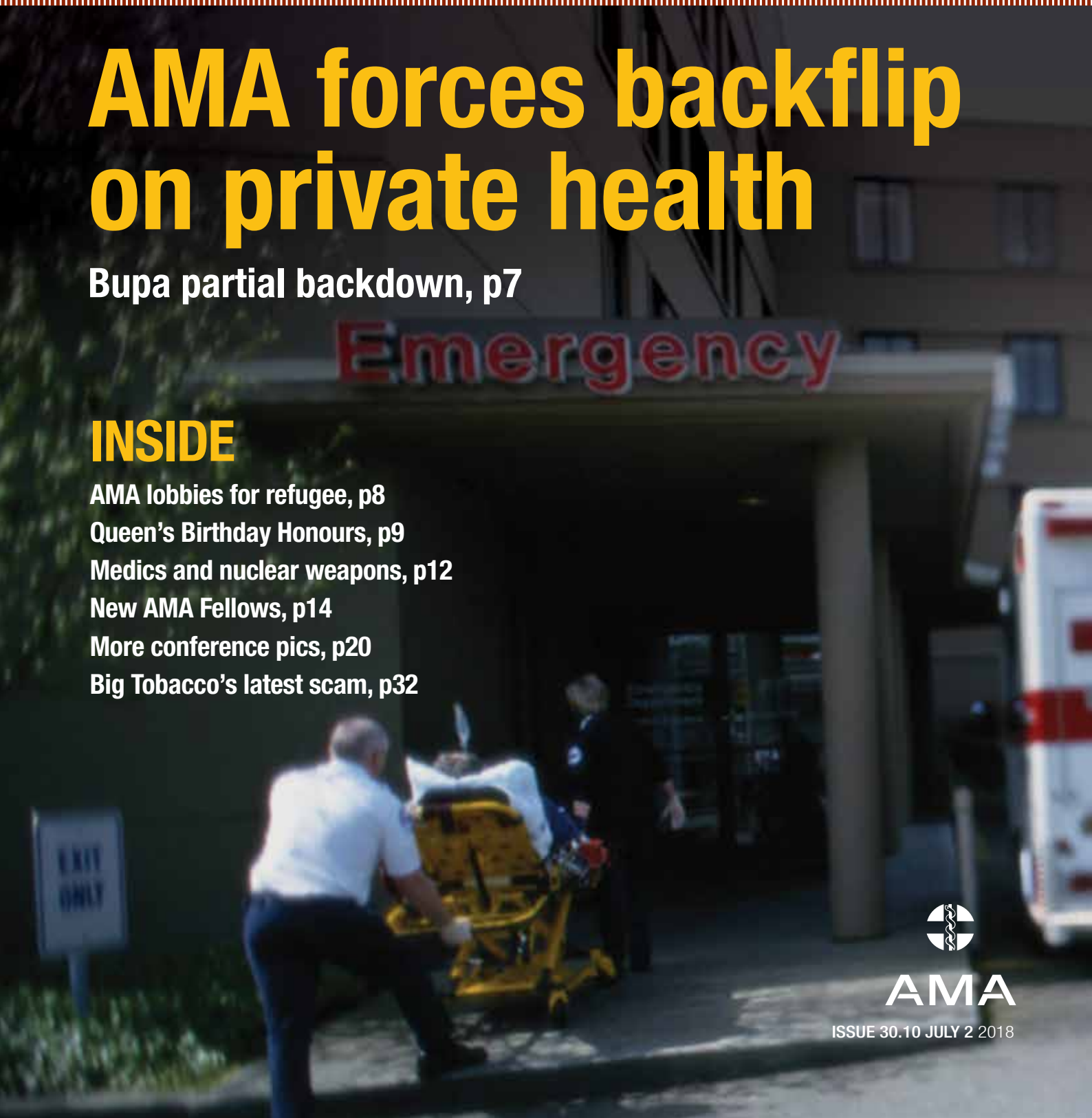
AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

AMA forces backflip on private health

Bupa partial backdown, p7



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AMA
ISSUE 30.10 JULY 2 2018

AUSTRALIAN
Medicine

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Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

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Vice President
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In this issue

National Conference photos by Lightbulb Studio

Primary care the primary objective

BY AMA PRESIDENT DR TONY BARTONE

On the day I was elected AMA President, I told journalists at my first media conference that general practice will be one of the central themes of my Presidency.

Primary care, led by GPs, is the thread that holds all the elements of the health system together.

Properly-funded and strategically-positioned and resourced general practice is the key to high quality, affordable continuity of care through all stages of life.

GPs are the entry point to health care for most Australians. GPs assist patients to navigate their way to the right care at the right time for their individual care needs.

I am a suburban GP in a very busy practice. I have extensive GP practice management and business experience. I am well placed to advise governments on GP policy.

For more than 30 years, I have seen and helped patients of all ages with their health. Over that time, there have been many changes, both in health policy and health care delivery.

People are living longer. There are more people living with complex and chronic conditions.

There have been amazing advances in technology and medicines. Lifestyle factors are having a greater impact on the health of individuals – just look at the rates of obesity, stress, depression, mental health.

Like all parts of the health system, general practice and GPs are under constant pressure. The demand for quality primary care and advice is huge and growing.

On the final morning of this year's National Conference, I emphatically told delegates that general practice has been systematically starved of funding, tearing at its heart; wearing it down, putting at risk its world-class outcomes in primary care .... threatening its very survival.

These comments have been quoted repeatedly over the last few weeks by many journalists in media.

General practice must be understood, supported, and respected by our politicians. This is the clear message I took to Health Minister Greg Hunt and Shadow Minister Catherine King in my first meetings. They listened and they agreed. They get the message.

The task ahead – and I mean in the short term, the here and now – is to work with the Government to produce a comprehensive plan for structural reform of primary care, built around the leadership of GPs, as part of a vision for our health system.

The time is right. There will be a Federal election sometime in the next 12 months. Some say as early as September, depending on the results of by-elections. Others remain confident the Government will go full term.

Whenever the election is, health will be at the top of the policy list – probably number one. Health policy won and lost votes last time around. It will be the same again.

It is the AMA's job to ensure that both the Government and the Opposition go to the voters with visionary health policies. It is our job to ensure that general practice is at the core of those policies.

Over the next few months, the AMA will be working to shape and inform these policies.

Building general practice is about more than funding, although there is no doubt significant additional investment is needed. We need more than a 55-cent increase in the Medicare patient rebate. The AMA advocates on this every day.

But we need to do more, much more.

We need to resource GPs and general practice to allow better access to quality GP care for patients in aged care facilities.

GPs must be central to the mental health care teams in our community, not sidelined.

GPs must be rewarded for all the work they do for patients that is not face-to-face time.

We need models of care that allow GPs to embrace the benefits of the My Health Record and telehealth.

We must cut the red tape burden on general practice, and free up time to allow doctors to be doctors.

... continued on p5

Not easy when it comes to e-cigarettes

BY **AMA VICE PRESIDENT DR CHRIS ZAPPALA**

The Canadian Government recently announced plans to adjust e-cigarette regulation. The Canadian aim is to de-regulate e-cigarettes for adults over 18 years old, but to still ban sale to adolescents, as well as advertising and flavours of e-cigarettes likely to appeal to young people. A tricky, if not impossible, balancing act. Clinicians need to be thoughtfully involved in this debate, drawing on the increasing evidence base.

The AMA has a thoughtful policy regarding e-cigarettes which underlines the potential harm of these products and notes that young people (largely from self-reported cohort analyses) do find e-cigarettes a gateway into habitual tobacco smoking. Conversely, the same self-report studies do suggest adults can use e-cigarettes as a successful quitting technique and to reduce cigarette consumption, such as a recent New Zealand self-report trial (six-month abstinence 7.3 per cent with e-cigarettes vs NRT patch 5.8 per cent vs placebo e-cigarette 4.1 per cent). Currently, Australian States and Territories ban e-cigarettes in a similar fashion to traditional cigarettes. Should we follow in the Canada's footsteps, however, or is the threat still too worrying?

Bear in mind e-cigarette use is increasing across all age groups. It is interesting to note that a large Canadian cohort study of grade 9-11 students was published last month showing 45 per cent of e-cigarette users tried a tobacco cigarette after two years, compared with only 13.5 per cent of non-current e-cigarette users. Moreover, e-cigarette advertising (taken together in all its forms, including online) contributed to expansion of the tobacco market by attracting low-risk adolescents who would otherwise be unlikely to initiate smoking. Ouch! It is completely unclear how the blunt instrument of legislation will be able to differentiate an opposite effect on young people who are not yet habitual smokers versus established smokers wanting to quit who have perhaps failed at other quit attempts and not just been seduced by the notion of 'safe nicotine'.

The e-cigarette market globally in 2016 was worth US$11.5 billion and double digit growth is anticipated to achieve a market size of up to US$90 billion in 2025. In 2016, Australian tobacco smoking rates have continued to decline to approximately 14 per cent (16 per cent male and 12 per cent female). In the same year, smoking prevalence in Canada was 15 per cent, France 24 per cent, Greece 40 per cent and Indonesia 57 per cent. In the age group 18-24 years in 2016 in Australia, smoking prevalence was also 14 per cent (but more in females) – down from 27 per cent in 2001. Australia has therefore done reasonably well without e-cigarettes.

We must remember vulnerable groups within our population, including Aboriginal and Torres Strait Islander people who represent 2.8 per cent of our total population. In 2014-15, 39 per cent of them over the age 15 years smoked daily. Prevalence is decreasing, but clearly this report card is not good. I suspect e-cigarettes help us no more here than they do in our mental health patients who continue to smoke at double the general population rates. Interestingly, 14 per cent of all Australian families are one-parent families and the single parent smokes at more than double the general population rate at 31 per cent. The other challenges and disadvantages faced by these people create a context that clearly requires more thought than e-cigarettes.

A NSW Government survey recently found approximately 70 per cent of all e-cigarettes contained nicotine. This compound remains addictive, damages and inflames airways, is ill-advised in pregnancy, can negatively impact higher cognitive function development in adolescents, and may be linked to cardiovascular morbidity/mortality and cancer risk. In a large UK cohort study published this month (which the Canadians seem to have missed), adolescents knew e-cigarettes were less harmful than tobacco cigarettes, but were unaware most products still contained nicotine, were unaware nicotine was addictive, and were unaware the addiction to e-cigarettes did increase their likelihood of later tobacco use. The Cochrane review in 2014 favourably comparing nicotine-containing e-cigarettes versus non-nicotine-containing e-cigarettes in terms of long-term abstinence doesn't compare with other quitting mechanisms and therefore shouldn't inspire confidence to invest in e-cigarettes as a safe and credible quitting tool.

The 2016 Australian National Drug Strategy Household Survey asked smokers about any cessation strategies they might have used (respondents were able to choose multiple responses). Among adult smokers who had tried to quit in the previous year (successfully or unsuccessfully), 3 per cent had contacted the Quitline, 14 per cent had asked their doctor for help, and 22 per cent had used nicotine gum, patches, or inhalers. Seven per cent reported using a smoking cessation tablet. Other responses included using some other type of product (9 per cent), reading cessation literature (11 per cent), using the internet (6 per cent), or using a mobile phone app (7 per cent). Going cold turkey was by far the most popular method, with about two in five quit attempters (39 per cent) adopting this strategy

In this light, we might be better served augmenting access to cognitive behaviour therapy or small group sessions to help with non-pharmacologic solutions. Abrupt versus gradual reduction with a quit date whether supported by pharmacotherapy, behavioural therapy or self-help therapy in either case had comparable quit rates at six months. We have combination

nicotine replacement therapy theoretically available (too often people do not use enough NRT and this is why they fail) and Champix (if you are old fashioned there might be a limited role for nortriptyline). Zyban is no longer available. Champix (Varenicline) costs many times more than the expected A$60M after the first five years. E-cigarettes are not cheap either. A month of vaping costs up to $40 per person depending on what one buys.

Three decades ago the World Health Organisation clearly established that a fundamental tenet of reducing tobacco consumption be not only via reducing overall smoking rates, but also encouraging non-smokers to remain non-smokers. The evidence does not suggest e-cigarettes should be viewed as safer or more successful than NRT. It is seductive for our addicted patients to think there might be a safe and clean way to ingest nicotine – but this misguided notion should be struck down immediately and with the full might of medical evidence available.

E-cigarettes may have the potential to assist some smokers to quit, but will increase harm from tobacco if they increase the number of children who become addicted to nicotine, reduce the likelihood smokers will quit completely in a mistaken belief they are safe with vaping, tragically entice former smokers back to smoking, or 're-glamorise' the act of smoking.

E-cigarette success rates in general do not exceed those in unassisted or low assistance NRT trials and current evidence remains insufficient, in my view, to demonstrate that e-cigarettes enhance quit attempts/success. Moreover, those attracted to e-cigarettes may be a different sub-group to those who have accessed conventional NRT (younger, non-white, higher income, lower dependence, shorter smoking history, higher lifetime quit attempts). It must be recognised, however, that the nicotine dose may be insufficient in e-cigarettes trialled to date (but patients can just use combination NRT anyway) and the level of counselling support has often been insufficient.

Perhaps nicotine used in e-cigarettes should be a scripted item no different than Champix when used as part of a supported quit attempt with cognitive behaviour therapy and GP/addiction physician input. Anything else is fraught and has no credible evidence basis. We would perhaps be better served expanding public and clinician education regarding quit aids and techniques and improving access to other more credible cessation aids e.g. let us fund combination NRT (patch and oral form together) for an appropriate period of time. We cannot sacrifice the vulnerable in the hope we achieve durable smoking cessation in a few. Let's stay our course for now and keep e-cigarettes in the shadows, thinking very carefully about any system that legitimises them as a quitting aid. Meanwhile, keep your eyes on Canada to see how they fare.

Primary care the primary objective ... from page 3

We need a comprehensive vision for positioning general practice as the solution to managing the growing burden of disease and assisting the strategic allocation of health care resources.

This vision will require additional infrastructure funding as well as clear resourcing to assist in managing the complex navigation of patients with chronic disease, leveraging our skills further with judicious and intelligent use of GP-led multidisciplinary care.

General practice can provide more focused leadership for community level public health, education, and preventive health activities. GPs are part of the community and they know their patients and their conditions.

We need the Government to put an end to any moves that fragment primary care. The health professions must concentrate on their scope of practice – stick to the practices for which they trained.

Policies that allow and encourage non-GPs to do the work of GPs are dangerous and will prove costly in the long run. Short-term cost savings can lead to health harms for patients and cost blowouts to the health budget.

And we must do more to encourage medical students and young doctors to pursue the noble profession and specialty of general practice – in the suburbs, the regions, and the country towns.

If we can build a strong, well-distributed GP workforce with significant and strategic investment in general practice, the pressure will come off the other stressed parts of the system.

In coming columns in the months ahead, I will talk about further about these pressures and the importance of a connected solution.

Many changes over the past five years

BY AMA SECRETARY GENERAL ANNE TRIMMER

As this is my last report as Secretary General, I would like to reflect on the changes that have taken place in the governance and operations of the AMA over the last five years. Five years ago, Federal Council was not only the policy-setting vehicle of the AMA but was also the corporate board with responsibility for finance, risk, corporate strategy, membership strategy and so on. With 35 members it could give neither of these responsibilities the investment of time or detailed examination required.

Five years on Federal Council operates as the focused, policy-driven heart of the AMA. Position Statements are debated robustly, differing views respected, and invited guests attend the policy sessions to inform Federal Council debate on a wide range of topics. Under Dr Beverley Rowbotham, Council proceedings have become more free-flowing which facilitates deeper engagement by the Council in complex policy development. A communiqué is provided to members after each meeting of the Council, published in *Australian Medicine*.

The Board, on the other hand, operates as a corporate board should, with detailed attention to finances, budget, risk, corporate strategy, membership strategy, investment, and corporate and legal compliance. The Board has taken difficult decisions, acting in the best interests of the company and its members. The Board uses its committees – Investment, Audit and Risk, and Nominations – to undertake the detailed analysis before bringing recommendations to the Board. The Board's governance is well-articulated through a Board Protocol and a Board Charter. These recognise the separation of responsibility between the Board and management, and the different roles played by the Chair and the President. The President's position as the public face and voice of the AMA is embedded.

The AMA continues to be a medico-political powerhouse. Negative commentary on the declining penetration of AMA membership among the total number of doctors has not diminished its significance or influence. This does not mean that Federal and State/Territory AMAs must not work closely and cooperatively together to address this issue and to ensure that the AMA remains relevant and integral to the next generation of doctors.

Over the past five years there have been changes made to the way Federal Council operates. Five practice groups are recognised as representing places or stages of practice – doctors in training, general practice, private specialist practice, rural practice, and public hospital practice. These inform the focus of much of AMA policy. They each have a seat at the table.

The practice groups are now represented by delegates at National Conference, enabling a spread of representation of the membership. The by-laws specify that any vacancies in delegate positions must be filled having regard to geography, gender and specialty.

Australia's Indigenous doctors now also have a seat on Federal Council as a result of an amendment to the Constitution approved at the Annual General Meeting in May which provided for a nominee of the Australian Indigenous Doctors' Association to be appointed.

More needs to be done to reform Federal Council to make it more representative of the membership, much as National Conference has been reformed. The AMA's five practice groups each have one seat on Federal Council. And yet each group represents a significant proportion of members. In my last report to Federal Council I put to the members that if Federal Council is to be truly representative then further reform must be undertaken in order to give adequate voice to the AMA's constituents.

In adopting such a change, I would also urge that regard be had to a balance of geography, gender and specialty. As the heart of AMA advocacy, Federal Council must evolve to reflect the membership and give voice to its diverse views.

I commenced my term as Secretary General with Dr Steve Hambleton as President, continued with Prof Brian Owler and Dr Michael Gannon, and completed it with newly-elected President Dr Tony Bartone. All are outstanding representatives of the AMA membership. I have served under two Chairs of Federal Council – Dr Iain Dunlop and Dr Beverley Rowbotham. Dr Rowbotham commenced her term with the change to Federal Council and has led the reforms to the way it operates. And I have served under two Chairs of the Board – Dr Elizabeth Feeney and Dr Iain Dunlop – who have led the transition of the association into the modern era.

When I came into the position of Secretary General, my aim was to develop a high performing culture within the AMA Group. I leave acknowledging the professionalism, talent, good humour, and outstanding commitment of the staff within the Secretariat and across the wider AMA Group. I am enormously proud of our achievements.

AMA outrage forces Bupa backdown

An AMA-led outcry over private health insurer Bupa's decision to fundamentally change its schedules has led to a partial backdown, forced on it by the Private Health Insurance Ombudsman (PHIO).

In March, Bupa – Australia's largest private health fund – announced changes to its no-gap and known-gap policies. Planned to start in August, no-gap and known-gap rates would only be paid to the practitioner if the facility in which the procedure takes place also has an agreement with Bupa. Medical benefit rates outside those facilities would only be paid at the minimum rate that the insurers are required to pay – that is, 25 per cent of the MBS.

The AMA described it at the time as a big leap towards US-style managed care; demanded a 'please explain' from Bupa; called on the Federal Government to launch an investigation into the move. Federal Health Minster Greg Hunt subsequently ordered the PHIO to do exactly that.

The AMA continued to oppose Bupa, leading a strong public and social media campaign against Bupa's proposed changes. In addition, the AMA has held ongoing discussions with Bupa to represent the concerns of AMA members.

The AMA Federal Council held lengthy discussions about Bupa's proposed changes and passed two motions formally rebuking Bupa's plans:

1. Federal Council expresses its concern at recent changes to health insurance products announced by Bupa. These changes threaten member choice and access to health care. Federal Council calls on Bupa to reconsider these changes and to act in the interests of its members and the broader Australian community.
2. That Federal Council recommends that the AMA advises Australian citizens how they can change their private health insurance.

Accordingly, the AMA has welcomed the Ombudsman's report, released in June, which outlines the detrimental impact of Bupa's changes on consumers and the lack of appropriate communications provided to policy holders.

In response to the Ombudsman's intervention, Bupa promised to restore future access to no-gap schedules for private patients in public hospital emergency departments. Additionally, Bupa has committed to contacting all customers regarding the previously announced changes to the removal of minimum benefits (restricted cover), and what customers can do if they are impacted.

AMA President Dr Tony Bartone said that both the PHIO report and Bupa's response to it were welcome. He said the move restores some level of transparency.

"The Ombudsman has acted strongly to ensure that there is improved communication and behaviour by health funds," Dr Bartone said.

"It sends a strong signal to all insurers to be open and honest with their customers. It is vital that credibility is restored to the value of private health insurance. If there is no value, people will not buy the product, and that will put pressure back on the public system."

Dr Bartone said visiting an emergency department was a stressful event and patients should not have to be worried about whether their public hospital has a contract with a specific insurer when they turn up for care.

He said Bupa made the right call by attempting to restore transparency to their cover.

"We also welcome their re-commitment to maintain both no-gap and known-gap schedules for pre-booked elective surgeries in public hospitals – again without requiring a contract," he said.

The AMA also noted that Bupa will be required to further communicate to its customers the changes to their policies before bringing in the change.

But the AMA remains critical that Bupa policy holders will not be able to use their no-gap or known-gap cover in non-contracted facilities.

"This remains a major concern for the AMA as it means that patients will still be required to ascertain whether their surgeon and their hospital have a contract with Bupa," Dr Bartone said.

The AMA has spoken strongly against this and will continue to do so, Dr Bartone said.

"It will continue to represent members views as it applies pressure on Bupa to try and resolve this critical issue."

CHRIS JOHNSON

AMA sought compassion for terminally ill Hazara refugee

AMA President Dr Tony Bartone intervened in the case of a dying Afghan refugee on Nauru, calling on the Federal Government to allow the man to receive palliative care in Australia.

Amid Australia's ongoing heightened debate over asylum seekers, the AMA called on the Government to put politics aside and provide the man the treatment he needed.

After learning that the required treatment for the 63-year-old with advanced lung cancer was unable to be provided on Nauru, Dr Bartone said he should be transported to Australia. The man had been officially recognised as a refugee.

The Government was insisting that the man, known simply as Ali, should be sent to Taiwan for treatment. But Dr Bartone said that was not a proper response from the Australian Government.

"Ali is a member of the persecuted Hazara minority in Afghanistan and has been formally recognised as a refugee," Dr Bartone said.

"He has advanced lung cancer. He needs significant palliative care services that he cannot receive on the island. This is not in dispute.

"The Australian Border Force has offered to transfer him to Taiwan. But this is not an appropriate management option. There is no Hazara community in Taiwan, he has no friends or family there, no-one to translate from his language, and no-one to perform the Shia Muslim rituals after his death.

"Amid Australia's ongoing heightened debate over asylum seekers, the AMA called on the Government to put politics aside and provide the man the treatment he needed."

"The AMA has always held that all people who are under the protection of the Australian Government have the right to receive appropriate medical care without discrimination, regardless of citizenship or visa status.

"They should be treated with compassion, respect and dignity. On any score – international obligations, conventions, respect, standards of clinical and ethical care – we must not fail to provide the requisite medical care on Australia's watch."

Dr Bartone repeated the AMA's call for the establishment of a transparent, national statutory body of clinical experts, independent of Government, with the power to investigate and report to the Parliament on the health and welfare of asylum seekers and refugees in Australian care.

He welcomed the appointment of Dr Parbodh Gogna as the Australian Border Force's new Chief Medical Officer and Surgeon General, but called on Immigration and Border Protection Minister Peter Dutton to ensure that Ali received the care he needed in a compassionate, timely, and respectful manner.

The AMA's *Position Statement on Health Care of Asylum Seekers and Refugees* (which can be found at https://ama.com.au/position-statement/health-care-asylum-seekers-and-refugees-2011-revised-2015) was released in 2011 and revised in 2015.

Its preamble states: "The Australian Medical Association affirms that those who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay. Like all people seeking health care, asylum seekers and refugees in Australia, or under the protection of the Australian Government, should be treated with compassion, respect, and dignity."

CHRIS JOHNSON

Former President among Queen's Birthday Honours


Professor Brian Owler.

Former AMA President Professor Brian Owler has been recognised in the Queen's Birthday Honours List for his service to medicine and education.

An adult and paediatric neurosurgeon in Sydney, Professor Owler was Federal AMA President from 2014-16 and AMA NSW President from 2012-14.

He was made a Member (AM) in the General Division.

Professor Owler was among a long list of medical professionals and AMA members who were honoured in the List for their significant contributions to the health of the community and their services to medicine.

Former Chair of the AMA Federal Council (1995-99), Dr Peter Arnold was awarded the Medal (OAM) in the General Division.

AMA President Dr Tony Bartone congratulated Professor Owler, Dr Arnold, and all doctors who received Honours for their dedication to their profession and their commitment to their patients and communities.

"The diversity and breadth of the accomplishments cited in the awards are testament to the significant contribution to the community made by doctors every day all across the nation," Dr Bartone said.

"The AMA is very proud of its members who have been honoured, and we congratulate all the doctors and other health professionals whose contributions and achievements have received due public recognition."

AMA members and former members who received Honours include:

OFFICER (AO) IN THE GENERAL DIVISION

Professor Rinaldo BELLOMO
Ivanhoe Vic 3079

For distinguished service to intensive care medicine as a biomedical scientist and researcher, through infrastructure and systems development to manage the critically ill, and as an author.

Professor Christopher Kincaid FAIRLEY
Hawthorn Vic 3122

For distinguished service to community health, particularly in the area of infectious and sexually transmitted diseases, as a clinician, researcher and administrator, and to medical education.

Emeritus Professor Vernon Charles MARSHALL
Ivanhoe Vic 3079

For distinguished service to medicine, particularly to renal transplant surgery and organ preservation, to accreditation and professional standards, as an academic, author and clinician.

Dr David Charles PESCOD
Beveridge Vic 3753

For distinguished service to medicine, and to Australia-Mongolia relations, particularly through the provision of surgical and anaesthetic care, and to health education and standards.

Professor Michael Francis QUINLAN
Nedlands WA 6009

For distinguished service to medicine, particularly through strategic leadership in the development of tertiary medical and social education in Western Australia as an academic and clinician.

MEMBER (AM) IN THE GENERAL DIVISION

Professor Rodney John BABER
Surry Hills NSW 2010

For significant service to medicine in the field of obstetrics and gynaecology as a clinician and researcher.

Professor Anthony Frank BROWN
New Farm Qld 4005

For significant service to emergency medicine as a clinician, author and educator, and to professional organisations.

Associate Professor Geoffrey David CHAMPION
Mosman NSW 2088

For significant service to medicine in the field of paediatric rheumatology, and to medical research and treatment of musculoskeletal pain.

Dr Michael Gerard COOPER
Castlecrag NSW 2068

For significant service to medicine in the field of anaesthesia as a clinician, teacher, mentor and historian.

Dr Paul Vincent DESMOND
Albert Park Vic 3206

For significant service to medicine in the field of gastroenterology as a senior clinician and researcher, and to professional associations.

Former President among Queen's Birthday Honours

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Dr Charles Roger GOUCKE
WA

For significant service to medicine in the field of pain management as a clinician, academic and mentor, and to professional societies.

Dr Timothy Roger HENDERSON
Alice Springs NT 0870

For significant service to medicine in the field of ophthalmology, and to Indigenous eye health in the Northern Territory.

Dr David Russell HILLMAN
Nedlands WA 6009

For significant service to medicine as an anaesthesiologist and physician, to medical research into sleep disorders, and to professional organisations.

Professor Lawrence William HIRST
Chelmer Qld 4068

For significant service to medicine in the field of ophthalmology through the development of clinical care techniques and eye disease management.

Dr Ian John KRONBORG
Footscray Vic 3011

For significant service to medicine, particularly gastroenterology, and through innovative substance abuse treatment programs.

Professor Christine Faye McDONALD
East Malvern Vic 3145

For significant service to respiratory and sleep medicine as a clinician-researcher, administrator, and mentor, and to professional medical organisations.

Dr Terence William O'CONNOR
Greenwich NSW 2065

For significant service to medicine, particularly as a colorectal surgeon, and as an educator, clinician and administrator of medical organisations.

Professor Brian Kenneth OWLER
Wahroonga NSW 2076

For significant service to medicine through the leadership and administration of professional medical organisations, and to education.

Adjunct Associate Professor Leslie Lewis RETI
Toorak Vic 3142

For significant service to medicine in the field of gynaecology and women's health as a clinician and educator, and to the community.

Adjunct Associate Professor Andrew Harris SINGER
Downer ACT 2602

For significant service to emergency medicine as a clinician, educator and administrator, and to professional medical organisations.

Dr Andrew Scott SKEELS
Bruce ACT 2617

For significant service to medicine, particularly in the field of palliative care, as a clinician and educator.

Professor Bernard Mark SMITHERS
Toowong Qld 4066

For significant service to medicine in the fields of gastrointestinal and melanoma surgery, to medical education, and to professional organisations.

Emeritus Professor David Harry SONNABEND
Rose Bay NSW 2029

For significant service to medicine in the field of orthopaedics, as a clinician and administrator, and to medical education.

Dr Domenico (Dominic) SPAGNOLO
Mount Lawley WA 6050

For significant service to medicine, particularly in the field of pathology, as a clinician, and to medical education as a researcher and author.

Dr John Douglas TAYLOR
City Beach WA 6015

For significant service to medicine as a urologist and urogynaecologist, to medical education, and to the community.

Dr Philip Geoffrey THOMPSON
Kenthurst NSW 2156

For significant service to medicine as a plastic and reconstructive surgeon, to health initiatives in South East Asia, and to professional organisations.

Professor David Allan WATTERS
Newtown Vic 3220

For significant service to medicine and medical education in endocrine and colorectal surgery, and through leadership roles with professional organisations.

Professor John William WILSON
Prahran Vic 3181

For significant service to medicine, and to medical research, in the field of respiratory disease, and to professional organisations.

MEDAL (OAM) IN THE GENERAL DIVISION

Dr Terence Francis AHERN
Brunswick Vic 3056

For service to medicine, particularly in the field of general practice.

Dr Peter Chester ARNOLD
Edgecliff NSW 2027

For service to medicine through a range of roles with professional organisations, and as a general practitioner.

The late Dr Keith Francis BECK
Late of Wauchope NSW 2446

For service to medicine through a range of roles.

Associate Professor Terry Dorcen BOLIN
Bellevue Hill NSW 2023

For service to medicine in the field of gastroenterology.

Dr Alan Edward BRAY
Woodville NSW 2321

For service to medicine, particularly to vascular surgery.

Mr Ian Alexander CAMPBELL
Horsham Vic 3400

For service to medicine as a surgeon.

Dr Kevin John CHAMBERS
Mildura Vic 3500

For service to medicine, and to the community of Mildura.

Clinical Associate Professor Michael James COOPER
Sydney NSW 2000

For service to medicine in the field of gynaecology.

Dr Jane Helen GREACEN
Bairnsdale Vic 3875

For service to medicine, and to community health.

Dr Stephen Bryce KINNEAR
Erindale SA 5066

For service to medicine, particularly to anaesthesiology.

Dr Jacqueline Kim MEIN
Cairns Qld 4870

For service to medicine, and to community health.

Mr Hugh Simpson MILLAR
Hawthorn Vic 3122

For service to medicine, particularly to otolaryngology.

Dr Michael MIROS
Loganholme Qld 4129

For service to medicine, particularly to gastroenterology.

Mr Donald Ivan MOSS
Ballarat Vic 3350

For service to medicine, particularly to urology.

Dr Roderic John PHILLIPS
Vic

For service to rogaining, and to paediatric dermatology.

Dr Jeremy RAFTOS
Kingston Park SA 5049

For service to medicine, particularly to paediatrics.

Adjunct Clinical Professor John Graham ROSENTHAL
South Perth WA 6951

For service to medicine, and to the community of Western Australia.

Dr Richard Frank WILSON
Summertown SA 5141

For service to the community through a range of roles, and to medicine.

CHRIS JOHNSON

Medics play key role against nuclear weapons


Associate Professor Tilman Ruff.

Nobel Peace Prize recipient Associate Professor Tilman Ruff delivered a sobering and powerful anti-nuclear weapons speech at the AMA Leadership Development Dinner on Friday, May 25 at the National Portrait Gallery in Canberra.

Professor Ruff is Co-President of International Physicians for the Prevention of Nuclear War (IPPNW, Nobel Peace Prize 1985); and founding international and Australian Chair of the International Campaign to Abolish Nuclear Weapons (ICAN), awarded the Nobel Peace Prize for 2017 *"for its work to draw attention to the catastrophic humanitarian consequences of any use of nuclear weapons and for its ground-breaking efforts to achieve a treaty-based prohibition of such weapons"*.

In his address to mostly young doctors, Professor Ruff said the fact he was invited to speak on such a topic at an AMA National Conference event was encouraging.

"In the 1980s, after producing detailed reports on the effects of nuclear war on health and health services, the World Health Organisation concluded that nuclear weapons constitute the greatest immediate threat to human health and welfare. They are the only weapons which loom as an acute existential threat to planetary health," he said.

"Every moment of every day that they exist, launch ready, they threaten everything we strive for and love, everything that matters, the species with which we share our Earth, and everything we are professionally obligated to protect and uphold. Everything that is made, built, lived and struggled for over generations, everything discussed at this conference, could become tragically irrelevant if we do not eradicate nuclear weapons before they are again used. In a recent article in the *New England Journal of Medicine* we asked the stark question: will it be the end of nuclear weapons or the end of us?

"We are the first humans in our long evolutionary history to face twin existential dangers of our own making – ecosystem disruption particularly through rampant global warming, and nuclear weapons. The first is evolving and partly reversible; the second acute and largely irreversible.

"The consequences of any use of nuclear weapons would be cataclysmic. If a war that began in the South China Sea or the Korean peninsula escalated, the warheads on Chinese ballistic missiles that would head for Australia would be up to five megatons, five million tons of TNT in explosive power. A single such warhead over a city would ignite hundreds of thousands of fires that would rapidly coalesce into a massive firestorm 45 kilometres across, releasing many times more energy than the explosion itself.

"In Canberra, spanning past Uriarra and Bywong, stretching to Royalla and Tidbinbilla, temperatures would exceed 800°Celsius and every living thing would die.

"In Melbourne, in this area would extend to Springvale, Wantirna, Warrandyte, past Greenvale and to Point Cook. Such a weapon over Sydney would burn all the area between Mona Vale, Parramatta, and Sutherland.

"It is the unequivocal conclusion of WHO and the Red Cross and Red Crescent movement, the world's largest humanitarian organisation, among others, that no effective health and humanitarian response is possible to even a single nuclear detonation on an urban centre. The only cure is prevention."

Professor Ruff went on to say that eradicating nuclear weapons has been urgent and unfinished business since the very first resolution of the United Nations General Assembly on 24 January 1946 called for the elimination of nuclear weapons. International law requires nuclear disarmament, to which all States are ostensibly committed.

"We have made substantial progress in controlling other kinds of indiscriminate and inhumane weapons," he said.

"Treaties which prohibit and provide for the elimination of

biological and chemical weapons, landmines and cluster munitions have dramatically reduced the production, stockpiling, financing and use of these weapons.

"In each case, the approach which has proven effective is to establish that these weapons can only have indiscriminate, unacceptable consequences; and codify their rejection in an international treaty that provides the same legal standard for all states. This then provides the basis and motivation for the weapons' progressive elimination. Stigmatise – prohibit – eliminate."

Professor Ruff told his audience that medical and scientific evidence, and effective evidence-based advocacy, was key to reaching agreement for the Treaty on the Prohibition of Nuclear Weapons and an international ban on nuclear proliferation.

But he said many nations, including our own, were not acting in ways that would advance elimination.

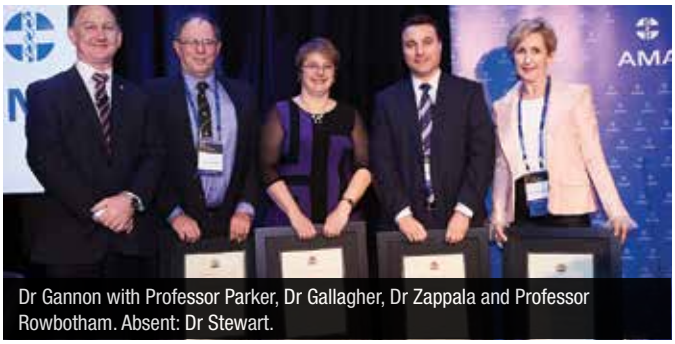
"We custodians of human health have a key role to play to now use the treaty as a tool to advance nuclear weapons elimination," Professor Ruff said.

"Albert Einstein said those who have the privilege to know have the duty to act. I feel that strongly, and that health evidence and health professionals have a key role to play.

"While this responsibility is heavy, it cannot be ignored. The problem will not go away through denial or inattention. While our predicament is unprecedented, so is the opportunity to do good. What better thing to do with one's life than, literally, labour to save the world."

CHRIS JOHNSON

Five new Fellows added to the Roll



Dr Gannon with Professor Parker, Dr Gallagher, Dr Zappala and Professor Rowbotham. Absent: Dr Stewart.

The AMA Roll of Fellows now has new names added, following the induction of five members deemed to be outstanding contributors to the medical profession and to the AMA.

The inductees include luminaries such as some past and present State and Territory AMA Presidents and Councillors, the current Chair of the Federal Council, and a past State President who two days after being inducted to the Roll, was elected Vice president of the Federal AMA.

The new inductees are: the Chair of the AMA Federal Council, Associate Professor Beverley Rowbotham; AMA Northern Territory President, Associate Professor Robert Parker; immediate past AMA Queensland President, Dr Chris Zappala; former AMA ACT President, Dr Elizabeth Gallagher; and long-time AMA South Australia State Councillor, Dr Nigel Stewart.

Announcing their addition to the Roll on the first day of the AMA National Conference on May, was one of the last formalities Dr Michael Gannon performed as President of the Federal AMA.

In doing so, he praised each of the new Fellows, saying they had all excelled in their respective medical specialties, and in their roles as advocates for the profession.

"They have contributed at both the State and Federal level to improve working conditions for doctors, and to making the Australian health system work more effectively for patients and communities," Dr Gannon said.

Associate Professor Beverley Rowbotham

Associate Professor Rowbotham was voted President of the Royal College of Pathologists of Australasia from 2007-2009, and AMA Federal Councillor for the Pathology Specialty Group in 2010. She has been elected four times to chair the AMA's Federal Council, a post she has held since 2014.

Professor Rowbotham is a Director of the largest specialised haematology diagnostics services in Australia, and is a Director of Australia's largest medical indemnity insurer. An advocate for good governance, she has established the Bev Rowbotham Doctors on Boards Australian Institute of Company Directors (AICD) scholarships awarded to medical students at the University of Queensland.

Associate Professor Robert Parker

Associate Professor Parker spent three years working on the Tiwi Islands before studying medicine to make a difference to the health and wellbeing of Indigenous people.

He was admitted as a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 1999 and has been an outstanding contributor to the AMA since joining in 1996. Professor Parker was elected AMA NT President in 2014 and has been an active member of the Federal AMA.

Dr Chris Zappala

Dr Chris Zappala is a Brisbane-based physician and the immediate past President of AMA Queensland. His relationship with the AMA extends 14 years.

His involvement with Federal AMA began in 2004 as a member of the AMA Doctors in Training Committee. He also served on the Medical Workforce Committee 2015-2017, AMA Council of Private Specialist Practice 2016-17, and Federal Council 2015-17.

Two days after being inducted to the AMA Roll of Fellows, Dr Zappala was elected Vice President of the Federal AMA.

Dr Elizabeth Gallagher

Dr Gallagher joined the AMA ACT in 2000, and was appointed to the AMA ACT Advisory Council as Obstetrics and Gynaecology representative in 2010. She was elected AMA ACT President in 2014.

In addition to representing AMA ACT at National Conference from 2013 to 2017, Dr Gallagher was an AMA Federal Councillor from 2015 to 2017, and was a member of the Medical Workforce Committee over the same period.

She has served as a Council member of the Australian Menopause Society and is a member of the International Menopause Society, the Australasian Gynaecological Endoscopy Society, the Urogynaecological Society of Australasia, and the Australian and New Zealand Vulvovaginal Society.

Dr Nigel Stewart

Dr Stewart has been an AMA member for 23 years, and has been a member of the AMA(SA) Council over a 15-year period.

Dr Stewart has a passionate commitment to rural and regional health services.

He has brought his considerable expertise and insight to AMA State and Federal advocacy. In 2006, he was awarded an AMA(SA) award for outstanding contribution to the medical profession, and in 2008 he won the Federal AMA Excellence in Healthcare Award.

CHRIS JOHNSON AND MARIA HAWTHORNE

Queensland Government awarded for investing in junior doctors

AMA Queensland President Dr Dilip Dhupelia collects the award for the Queensland Goverment.

A program aimed at increasing the health and resilience of doctors in training in Queensland public hospitals has won the AMA Best Public Health Initiative from a State or Territory Government Award.

Nominated by AMA Queensland, the *Resilience on the Run* program is the first consistent program offered to doctors in training in Australia to support their mental stress and emotional demands as they transition to a career in medicine.

"It is crucial to have healthy doctors – this leads to healthier patients," said outgoing AMA President Dr Michael Gannon when presenting the award at the AMA National Conference in Canberra.

"Doctors need to be well to deliver high-quality health care to their patients and the community, and to experience medicine as a rewarding and satisfying career.

"This was recognised by the World Medical Association last year when it updated the Oath of Geneva – the modern successor to the Hippocratic Oath – to reflect the importance of doctors attending to their own health.

"The Council of Australian Governments (COAG) has also recognised the need to reform laws that inhibit doctors from seeking help for mental health issues.

"With *Resilience on the Run*, the Queensland Government has acknowledged the unique stresses on doctors in training as they transition from medical school to the workforce."

AMA Queensland developed a pilot program aimed at equipping young doctors with the resilience and coping skills needed to survive and thrive in medicine, through a two-part workshop focused on developing resilience and mindfulness techniques, managing interpersonal relationships, and strategies for dealing with burnout and fatigue.

The program was piloted in 2016 with a cohort of interns at Rockhampton Base Hospital, Ipswich Hospital, and the Metro South health area.

In recognition of the strong results achieved for doctors in training in the pilot project, the Queensland Government provided funding in the 2017-18 Budget to deliver *Resilience on the Run* to all Queensland-based medical interns from 2017-2019.

"I note that AMA Queensland is now advocating for the State Government to extend funding for *Resilience on the Run* beyond the intern years to post-graduate years two to five, which would be a very worthy achievement," Dr Gannon said.

The judging panel, headed by Public Health Association of Australia (PHAA) CEO Michael Moore, noted that the campaign stood out for its quality and clarity of message, and its effectiveness.

State and Territory AMAs recognised for work in advocacy and communications

The AMA National Conference, held in Canberra in May, provided an opportunity to highlight the outstanding work of State and Territory AMAs over a range of categories. Presented at a cocktail event on the first night of the conference, this year's winners are:

Best Lobby Campaign 2018 – AMA

AMA Tasmania – State Election Campaign

The hard-fought Tasmanian election campaign has also led to a win for AMA Tasmania for the Best Lobby Campaign.

AMA Tasmania kept the public's attention firmly on health throughout the campaign with sensible, practical suggestions for the future structure of the State health system that were both appealing to voters and worthy of support from both major parties.

The judges, led by Canberra lobbyist Chris Fry, said the campaign led to significant increases in resources across all major areas – extra beds, an increased focus on waiting lists, a significant boost to mental health services, improved palliative care services, and extra infrastructure including a commitment to commence the Hobart Hospital redevelopment.

"But the really big achievement was for the Government to accept that the Tasmanian Health Service (THS) model needed fundamental reform," the judges said.

"The Government agreed to restructure the arrangements so that the over-centralisation of the model was reversed, and to introduce significantly stronger local decision-making into Tasmanian hospitals.

"Day-to-day autonomy is being introduced into local hospitals. A more regional focus is being established, catering for particular circumstances.

"The THS is being restructured, made more efficient, and the savings are being reinvested in better services. The THS now has to report through the Department."

Best Public Health Campaign from a State or Territory 2018 – AMA Western Australia

Starting the Conversation, Tackling Adolescence Suicide

AMA WA has tackled the difficult issue of talking to children and teenagers about mental health and self-harm, with its *Starting the Conversation, Tackling Adolescence Suicide* campaign.

The mental health module has been added to the successful Dr YES adolescent youth program, in which medical student volunteers go into schools to run small group discussions with high school students.

The module was significantly revised in 2017 following feedback from high school students, who indicated that they wanted to know more about self-harm and suicide, so that they can support their friends as well as seek help for themselves.

The judging panel, headed by Public Health Association CEO Michael Moore, said that mental health is one of the top issues in public health at the moment, and that the campaign is highly relevant to young people at school.

They commended the range and quality of the campaign material, describing it as a carefully constructed and effective program, with evaluation showing that more than 90 per cent of participants had achieved better coping strategies following the sessions.

"This program needs to be spread beyond Western Australia," the judges said.

Best State Publication 2018 – AMA Victoria

Vicdoc

For the second year in a row, AMA Victoria has won the Best State Publication for *Vicdoc*.

Judges described *Vicdoc* as a "beautifully-produced, good read, full of well-written and researched articles on clinical, industrial, and human interest topics - much more than a glorified newsletter or mouthpiece for a professional group".

Over the year, *Vicdoc* tackled key professional issues such as doctors' mental health, unrostered overtime, and how to use the new My Health Record. At the same time, it focused on breakthrough medical discoveries, including new strategies in breast cancer and interesting investigations into abuse of over-the-counter medications.

The coverage was rounded out with human interest stories, including how doctors with disability have made it in the profession, and the work of Australian doctors overseas.

Judges, led by News Corp national health reporter Sue Dunlevy, said that *Vicdoc's* glossy, clean layout made it a pleasure to read.

Most Innovative Use of Website or New Media 2018 – AMA

The most Innovative Use of Website or New Media Award recognises that State and Territory AMAs can use different media to get messages to members and the public.

AMA NSW has won this year's award for its Hospital Health Check website, which the judges commended for its simplicity and clarity.

"(The use of) large, colour-coded letter grade graphics, tabulated alongside hospital names in rows, is clear, concise, and communicates directly and comparatively the results of the survey," the judges, led by film producer, writer, and online content maker, Dan Sanguineti, said.

"Too often the delivery of key information becomes overwhelming in graphics, animations, and transitions, and a basic statement of results as displayed on the Hospital Health Check website is a welcome approach, that pitches perfectly to the desired successful outcome.

"Through media engagement, the survey results on the site allowed the policy debate discussions to shift and benefit the membership represented.

"This was shown by the NSW Government announcement on rule changes in line to address the information presented."

National Advocacy Award 2018 – AMA

AMA New South Wales – Marriage Equality – "This is a Health Issue"

The National Advocacy Award is given to the State or Territory AMA that has worked best with the Federal AMA on an advocacy campaign.

AMA New South Wales is the winner for its campaign in favour of marriage equality, which included the Federal AMA Position Statement on Marriage Equality, a video produced by Federal AMA and AMA NSW featuring past Federal AMA Presidents speaking in favour of marriage equality, and a doctors' rally at Martin Place in Sydney, organised by AMA NSW and supported by the Federal AMA.

The judges, led by Canberra lobbyist Simon Banks, said marriage equality was a significant issue for the profession, and one that divided views within the wider profession and community.

"NSW's submission involved public interest advocacy both directly, and through the prominent use of both traditional and social media, to highlight the health implications of the legal recognition of same sex marriage," the judges said.

"It also compelled members of the wider profession to step up and take a stance on this public health – not merely legal – issue.

"The campaign exhibited the selfless quality that any true profession can rightly take pride in. For these reasons, the NSW submission is this year's winner."

MARIA HAWTHORNE

Northern Territory gets another dirty ashtray

The Northern Territory Government, a serial offender, has again received the *Dirty Ashtray Award*, for putting in the least effort to reduce smoking over the past 12 months.

Releasing the AMA/ACOSH *National Tobacco Control Scoreboard 2018* on World No Tobacco Day, AMA President, Dr Tony Bartone, said it is the third year in a row that the NT has earned the dubious honour.

"The NT scored an E this year, and continues to fail miserably when it comes to protecting Territorians from the harms from smoking," Dr Bartone said.

"This completes a 'dirty dozen' for the Territory – its 12th 'win' since the Award was first presented in 1994.

"The Queensland Government has won the *Achievement Award* for the second year in a row, but it still only scored a C - a C for complacency."

Queensland was narrowly the best of the C-graders, scoring highest in the provision of smoke-free environments. It was just ahead of the Australian Government for its appropriate, evidence-based decisions about liquid nicotine and e-cigarettes.

Dr Bartone said that all Australian governments must urgently step up their efforts to combat smoking, including reintroducing education campaigns, and banning shop assistants and employees under the age of 18 from selling tobacco products.

"While Australia has made remarkable progress in tackling tobacco, we are in danger of losing momentum in the face of constant efforts by the tobacco industry to promote smoking," Dr Bartone said.

"Tobacco is unique among consumer products in that it causes disease and premature death when it is used exactly as intended. Two out of three smokers will die from their habit.

"Smoking kills. Smoking robs people, including young people, of their health.

"Governments must do more to help people to stop smoking, or to not take up the deadly habit in the first place.

"Strong government actions, including making packaging unappealing, keeping tobacco products out of view, and keeping tobacco prices high, have helped to encourage people to quit, or young people not to start.

"The Minister for Indigenous Health, Ken Wyatt, is to be commended for continuing funding of $183.7 million over four years for the *Tackling Indigenous Smoking* program.

"We know that public education and awareness campaigns can have a powerful effect on people's decisions, yet there has been no national media campaign on tobacco since 2012.

"It is especially disappointing that, yet again, the latest Federal Budget provides no new funding, despite expecting to raise more than $11 billion a year from tobacco taxes.

"It is important that we stay vigilant against any attempts to normalise smoking, or make it appealing to young people.

"This includes regulating e-cigarettes in exactly the same manner as tobacco cigarettes, and not allowing them to be marketed as quit smoking aids until such time as there is scientific evidence that they work as cessation aids, and do not cause further harm.

"But no one government is excelling.

"Tobacco control is still a public health priority, here and around the world.

"Australia has to reclaim its reputation as the world leader in tobacco control."

The AMA/ACOSH *National Tobacco Control Scoreboard* is compiled annually to mark World No Tobacco Day on May 31.

Judges from the Australian Council on Smoking and Health (ACOSH) allocate points to the State, Territory, and Commonwealth Governments in various categories, including legislation, to track how effective each has been at combating smoking in the previous 12 months.

The judges called on all jurisdictions to allocate consistent funding for strong media campaigns, and to ban all remaining forms of tobacco marketing and promotion.

They also called on all States and Territories to strengthen controls on the sale of tobacco by banning employees under 18 from selling tobacco products.

MARIA HAWTHORNE

Snippets

President at the Press Club

AMA President Dr Tony Bartone will deliver a televised address to the National Press Club of Australia in Canberra on Wednesday, July 25. The event coincides with AMA Family Doctor Week (July 22-28). Bookings can be made by visiting https://www.npc.org.au/speakers/dr-tony-bartone/ or calling the Press Club on 02 6121 2199.

New AMA bosses for some States

Dr Dilip Dhupelia has been elected the new AMA Queensland President. Dr Dhupelia is the Director of Medical and Clinical Services for Queensland Country Practice, Queensland Rural Medical Service for Darling Downs Hospital and Health Service, and works as a part time GP in Toowong in Brisbane's inner west. Dr Michael Cleary is AMA Queensland's new Vice President

Dr Kean-Seng Lim is the new AMA NSW President. Dr Lim is the 2015 RACGP General Practitioner of the Year and is a member of the AMA (NSW) Council. He is a GP Principal in a group practice in Mt Druitt and a GP Supervisor. He is currently the Secretary of the Mt Druitt Medical Practitioners Association. Dr Danielle McMullen is the AMA (NSW) Vice President.

Associate Professor Julian Rait is the new President of AMA Victoria. He is an eye specialist who joined the AMA as a young graduate from Melbourne Medical School in 1982. He most recently served the organisation as Chair of the Council of AMA Victoria and Chair of the Council of Private Specialist Practice for the Federal AMA. Dr Roderick McRae was elected new AMA Victoria Vice President.

Dr John Davis is AMA Tasmania's new President. A Hobart based general practitioner, Dr Davis returns to the President's chair after having previously held the position in 2014. Dr Davis is also a member of Tasmanian General Practice Forum. Dr John Burgess was elected Vice President of AMA Tasmania.

Dr Antonio Di Dio is the new AMA ACT President. Dr Di Dio is a Canberra GP. He has practised for the past ten years in Canberra. A key interest area for Dr Di Dio is pastoral care for colleagues, through roles with the Doctors Health Advisory Service in NSW and the ACT. He has also been prominent with the Medical Benevolent Society.

Advance Care Planning Australia wants applicants for ongoing ACD research

The National Advance Care Directive Prevalence Study is now open and ready for applications.

Advance Care Planning Australia (ACPA) is leading pioneering research to build a national picture of the prevalence of Advance Care Directives (ACDs) across all health and care services, and to evaluate how well an individual's clinical care plan aligns with their documented personal preferences.

It is inviting GP clinics, hospitals and residential aged care providers to take part. Following a successful pilot study last year, the research involves auditing the health records of people aged 65 and over to determine the prevalence of ACDs and other advance care planning documentation.

ACPA will send participating organisations a customised report presenting their results benchmarked against other de-identified participants. This will show how well advance care planning is being implemented within their service and help identify areas for improvement. Organisations that participate in future rounds of data collection will be able to track their progress over time.

More information can be found at: https://www.advancecareplanning.org.au/prevalence

Applications close July 26, 2018.

AMA National Conference 2018 Picture Gallery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AMA National Conference 2018 Picture Gallery


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DEAKIN UNIVERSITY

Deakin University, proud sponsor of the AMA Indigenous Medical Scholarship

Deakin University School of Medicine has come a long way in a short time, since its foundation in 2006. The School was established to produce work-ready medical graduates to address workforce shortages in Australia, especially in rural and remote areas. It is the first regional Medical School in Victoria, and has an annual intake of approximately 140 students into the four-year program. The School has rapidly become one of the most popular postgraduate medical courses in Australia, and has also been recognised in the 2016 ARWU rankings (Academic Ranking of World Universities), achieving a ranking of 100-150 in the world, in the field of Clinical Medicine and Pharmacy.

During the first two years of the program, students learn basic medical sciences and clinical skills in state-of-the-art facilities at Deakin University's Waurn Ponds campus. The final two years of the course are spent in the Clinical Schools: Geelong Clinical School, Greater Green Triangle Clinical School (Warrnambool), Grampians Clinical School (Ballarat), and Eastern Health Clinical School (Box Hill and other Eastern Health hospitals). During this time, students rotate through all major medical specialties. The fifth clinical school is the Rural Community Clinical School (RCCS) program, in which a cohort of students spend their Third year based in a rural General Practice, and then return to join their colleagues in one of the other four clinical schools in their fourth year.

One of the School's key visions is Social Accountability, and we aim to provide opportunities for students to join us from all walks of life, to learn how to become an excellent Deakin Doctors. This vision has resulted in the establishment of an Indigenous entry stream, and the appointment of two full time Indigenous academic staff members in medical and health education. We also are grateful for the support of AIDA (the Australian Indigenous Doctors' Association). We believe it is essential for all of our students to learn about the benefits of Indigenous health education, and the advantages that cultural training and education can bring. The School is a member of LIME (Leaders in Indigenous Medical education) and we are honoured to be participating in the AMA Indigenous medical scholarship scheme.

By Professor Jon Watson, Head of School, Deakin University School of Medicine

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

Family Doctor Week

BY DR RICHARD KIDD, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

"While GPs are happy to engage in discussions about potential funding reforms, these tend to put change off over the horizon. What general practice desperately needs is an injection of meaningful funding in the here and now while discussions about bigger reform takes place."

AMA Family Doctor Week
22-28 July 2018

YOUR FAMILY DOCTOR: HERE FOR YOU

In just a few weeks the AMA will again celebrate the vital role played by GPs in caring for community. Family Doctor Week highlights to the community, policy makers and politicians the importance of GPs in our health system and how patients benefit from the care we deliver.

This is an important time for general practice. The MBS Review Taskforce is expected to finalise its recommendations later this year, with the recommendations of its General Practice and Primary Care Clinical Committee likely to be of great interest to GPs. These recommendations may have significant implications for general practice.

The Minister for Health, at the AMA National Conference, having noted that Health Care Homes were not the end-point, talked about working in partnership with the medical profession to create a 'quality payment framework' that general practices could choose to be a part of.

While GPs are happy to engage in discussions about potential funding reforms, these tend to put change off over the horizon. What general practice desperately needs is an injection of meaningful funding in the here and now while discussions about bigger reform takes place. Improved rebates for residential aged care facilities care, a more realistic definition of after hours for in rooms consultations, red tape busting reforms to CDM items, CVC style payments for patients at risk of unplanned hospitalisations are AMA proposals that could be readily picked up and they would make a real difference for general practice.

The AMA is focussed on achieving significant, targeted investment in general practice, which will reward patient-centred care.

General practices are transforming to meet the challenges of the ageing population and the increasing incidence of chronic disease and multimorbity, and future funding arrangements will need to recognise this. The transformation of the Practice Nurse Incentive Program into the Workforce Incentive Program, supporting practices to employ non-dispensing pharmacists and other allied health professionals, is an example of successful AMA advocacy. In the long term, this will support practices to build their multidisciplinary health care team in order to provide patient-centred and comprehensive care.

The highlight of Family Doctor Week will be the AMA President's National Press Club, on Wednesday 25 July, where he will be talking about health reform and improving the patient journey. The speech will be broadcast live on ABC TV or for those who wish to attend in person tickets can be booked at https://www.npc.org.au/speakers/dr-tony-bartone/.

Download this year's Family Doctor Week at:

https://ama.com.au/sites/default/files/ama_fdw_poster_2018_FINAL_A3.pdf

and let your patients know you are there for them, as the AMA is there for you.

Good-bye to trans fats – well, not Down Under, it seems

BY **PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR,** PUBLIC HEALTH, UNIVERSITY OF SYDNEY

An American butter substitute that no longer contains trans fats.

Just about all the news from the US is dreadful at present, so the occasional good news story is to be treasured.

Here in Manhattan, I am tucking into a hot dog with mustard and pickles aboard a Circle Line Ferry circumnavigating the island. BUT! The hot dog contains no trans fats! So I worry only about everything else it contains. Nor does President Donald Trump's apocryphal diet of Big Macs contain trans fats. In the US, trans fats will no longer be legal in a few days. This ban does not, please note, stem from President Trump's Ministry for Magical Tweets but from advocacy based on science.

Trans fats are a big deal.

Making liquid vegetable oils solid is achieved by adding hydrogen – go back and check your chemistry lecture notes for details. This makes for 'pretend butter' that lasts longer on the shelf than the oils and tastes better. The problem is that the solid stuff, containing partially hydrogenated trans fatty acids, elevates LDL cholesterol and lowers HDL. Trans fats are said to cause about 500,000 deaths each year.

The US is not alone in banning them. About 20 countries have restricted their use. WHO Director-General, Ethiopian Dr Tedros Adhanom Ghebreyesus, is interested because while the US, Canada and parts of Europe are banning trans fats, low and middle income countries use a lot of them. But on the upside, companies such as Nestle, with global reach including infant formula production, have already removed trans fats from their products. Denmark was the first country to ban them, in 2003, and consumer pushback has been minimal.

The WHO now has a program called REPLACE (http://www.who.int/news-room/detail/14-05-2018-who-plan-to-eliminate-industrially-produced-trans-fatty-acids-from-global-food-supply) that offers a six-point plan for countries wanting to reduce trans fat consumption. Using each letter of the acronym REPLACE in turn, it begins with reviewing (RE) and mapping the sources of industrially-produced trans fats in the country and 'the landscape for policy change'.

The second step is to seek wherever possible to promote (P) the replacement of trans fats with healthier fats and oils. This includes communication with consumers and producers. The third step is the crunch – legislation (L) to eliminated trans fats. The last three letters of REPLACE – ACE – don't add much.

So while self-regulation in the food industry is better than nothing, the legislative stick is important. That trans fats can be removed without too much effort is surely a critical reason why the banning of trans fats is possible. It's rather similar to the relative ease of removing chlorofluorocarbons from aerosols and so diminishing damage to the ozone layer (https://www.acs.org/content/acs/en/education/whatischemistry/landmarks/cfcs-ozone.html). It has several – not many – similarities to tobacco as well.

However, Australia and New Zealand have adopted a very relaxed approach to trans fats – see (http://www.nutritionmyths.com/why-we-are-not-protected-in-australia-and-nz-against-trans-fats/#conclusion).

Trans fats will eventually be phased out thanks to technology and strong regulation. WHO support will help. Australia will be late to the table for no compelling reason, but I predict we will eventually get there. But not without cost in lives lost.

Embracing reform

BY DR SANDRA HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

I love the word reform. Form it again. Redo.

A simple concept. Kids do it. Their hunk of play dough gets smashed back together if they do not like the shape that came out. What forms at the second try may be a very different animal than the first start.

Potters at wheels who cannot quickly remould, will lump the clay back in a ball and re-form the vessel.

The process requires:

- insight to see a different view, what I call "putting on a different pair of glasses"; and
- the action of destruction as part of creation.

The adjectives 'courageous' and 'inspired' often describe ideas of reform.

Notice this is not tinkering at the corners, fussing with little wins and making small changes. This is thinking outside the box. Maybe even crushing the box with an elephant foot. It is the antithesis of expecting different results by doing things the old way.

Reforms and reformers are not popular. The status quo, no matter how dysfunctional, is known, comfortable, predictable. Change causes stress. I believe reforms occur when the pain of the old is greater than the discomforts of making the change.

So in our rural medical life, we need reform. You and I know it because it's just not working. Rural health has so many gaps. The statistics are there: insufficient manpower, longer hours, less downtime, more mental illness. I am talking about us.

We struggle to gain a sense of self-actualisation. There is the black cloud of uncertainty associated with working with limited resources such as diagnostic imaging and tests. One word of criticism from our non-collegial colleagues diminishes us. The frustrations of slow or non-existent internet, the cost of living, the distance to families, our loves. Our networks can be paper thin. The comfort of a nearby specialist is on our wish list.

No wonder the IMG who has completed their 19A/B moratorium heads straight for the comforts of urban life. Rural locum coverage are the norm, patients are weary, yet accepting, of yet another new (transient) doctor. We know there is inequity in health care delivery. And in our tired minds we know there is a better way.

So, some needed reforms include:

Medicare indexation. To quote the previous Chair of this Council, David Rivett: "I think it's time for a harder-nosed approach. In future, I'd love to see the AMA get a fighting fund established on behalf of GPs to try to get both (political) parties to index (rebates) fully." A fighting fund may mean altruistic dips into your pocket to fund a strong pre-election campaign to revamp the rebates to the patients. The picture is bigger than indexing our MBS payments, it is about how it affects patient life – in either dollars or access to care.

Medicare MBS and incentive restructuring to reward quality care. To quote a Federal Councillor: "Support quality care, get money back to the practices that are providing quality (and not high through-put corporate style clinics)." And another Councilor: "Focus on the attendance items which are quite separate from rooms based items" and "articulate a vision for the future of high quality, cost effective Primary Care that will save money in the long run. Our practices should become the 'hospitals of the future'. Community care should revolve around general practice. And: "Go big, or go home".

The Rural Generalist. The Collingrove agreement between Professor Paul Worley, the rural health commissioner, ACRRM and RACGP defines a generalist as "medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team".

Head up, Rural doctors. Reform is on your doorstep. You may not like it. There will be discomfort in the process of change, maybe loud voices, bewilderment and naysayers. Too much, too fast, too slow, too little, too late.

But kids can reform their clay. We can too.

Code Green

BY DR TESSA KENNEDY, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

When we talk about sustainability in health we are usually talking about spending and workforce. But what of the physical environment?

Existing AMA policy acknowledges that: "Human health is ultimately dependent on the health of the planet and its ecosystem. Climate policies can have public health benefits beyond their intended impact on the climate. These health benefits should be promoted as a public health opportunity, with significant potential to offset some costs associated with addressing climate change."

Yet the health sector itself contributes around seven per cent of all greenhouse gas emissions. Our own resource rich settings create an enormous amount of plastic and other waste which take a direct toll on patient health and our environment. The way we run our hospitals is also increasingly unsustainable from an environmental perspective.

Health facilities and workers should promote a holistic approach to health, including its social and environmental determinants. We are increasingly acknowledging this: hospitals are non-smoking areas, because tobacco is a significant risk to health. There have been efforts to improve food options and exclude sugar sweetened beverages from hospital canteens because obesity is a significant risk to health.

Yet every time I place a cannula, suture a chest drain, resuscitate a baby, I generate a large amount of disposable, non biodegradeable waste, including plastics and instruments that have barely touched a patient. When I wash my hands tens of times a day, paper towels are co-mingled with nonrecyclable rubbish. Many of us will drive to work because of lack of public transport options to suburban hospitals, especially when working shifts, and a lack of showering and changing facilities required to encourage active self-transport options like cycling or jogging.

Disposable coffee cups, choice of volatile anaesthetic gases, computers and lights left on overnight - there are many environment degrading and wasteful practices that would take little effort to change.

Nonetheless, I'm sure like me, many of you have felt like the threat of climate change is more of an existential one than of direct relevance to your every day. Even with good intentions it just feels too big, too far beyond our reach to change. Like any efforts we make are just a drop in a warming ocean.

But what if we could see the impact of our actions in the community we treat? To measure the impact of our efforts to change in terms of patient outcomes and cost savings that could be reinvested in our insatiable health budget? It would be a lot easier to stay motivated.

Luckily, we not only have a fantastic opportunity of many low hanging fruit to improve sustainability due to the current lack of priority it is afforded, but a proven model of how to go about achieving change from the UK NHS Sustainable Development Unit. This dedicated unit has coordinated research, policy and action to improve the sustainability of health care. They succeeded in cutting NHS greenhouse gas emissions by 11 per cent between 2007 and 2017, despite an 18 per cent increase in health service activity.

If we are sincere in acknowledging climate change and environmental degradation as one of the most significant threats to human health in our time, we must acknowledge our part in addressing it in how we work. As Associate Professor Forbes McGain of the University of Sydney and Doctors for the Environment Australia has said: "The [Australian] health-care system can't become low carbon and low waste without leadership, incentives and direction."

Being aware of the environmental impact of our work practices and changing our individual actions are a great way to bring the issue front of mind and help start a conversation with others. But to achieve sizeable change we need to issue a triage category upgrade for environmental sustainability, and we need the whole system to respond.

So, bring your Keep Cup. But also ask the coffee shop whether they would give discounts to everyone who brings one. Choose the instruments that go back to the sterilizer, not into the sharps bin. But also question whether the marginal cost saving of procuring single use plastic items offsets the clinical waste disposal and other environmental costs. Factor environmental impact into your choices and practices at work every day, and write to your chief executive to ask them to do the same. Improve patient outcomes locally, globally, and save money doing so – it's a no-brainer.

The science is clear – we've been issued a Code Green. And if we are serious about safeguarding human health, we must respond.

Is oral health the unspoken determinant?

BY **AMA PRESIDENT DR TONY BARTONE**

> "However, more recently, it is the modifiable risk factors like poor nutrition, smoking, substance use, stress, and poor oral hygiene that are considered to have the greatest impacts on periodontal diseases."

According to the Australian Institute of Health and Welfare's (AIHW) report *Australia's Health 2012*, most people will experience oral health issues at some point in their life. In fact, oral diseases are recurrently among the most frequently reported health problems by Australians.

Considered a disease of affluence up until the late 20th century, poor oral health outcomes have now become an indicator of disadvantage, highlighting a lack of access to preventative services. Insufficient access to, high cost of, or long waiting periods for dental services; and low oral care education, have all been associated with patients not seeking dental care when it is needed. Of course, non-fluoridised water supplies also has a role in explaining the prevalence.

However, more recently, it is the modifiable risk factors like poor nutrition, smoking, substance use, stress, and poor oral hygiene that are considered to have the greatest impacts on periodontal diseases.

Dental conditions frequently rank in the top 10 potentially preventable acute condition hospital admissions for Aboriginal and Torres Strait Islander people and were the third leading cause of all preventable hospitalisations in 2013-14, with 63,000 admissions.

Like most other health conditions, Aboriginal and Torres Strait Islander people have poorer oral health outcomes. While Indigenous people currently have most of the same oral health risk factors as non-Indigenous people, they are less likely to have the same access to preventative measures, leading to marked disparities in oral health between Indigenous people and other Australians.

While the majority of oral health concerns are often considered inconsequential, such as avoiding certain foods, or cosmetic with people embarrassed about their physical appearance, there is a significant body of evidence which suggests that oral health may be the undiscussed determinant of health.

More than two decades ago, population-based studies identified possible links between oral health status and chronic diseases such as cardiovascular disease (CVD), diabetes, respiratory diseases, stroke, and kidney diseases, as well as pre-term low birthweight. And the relationship appears to lie with inflammation.

It is clear more research is needed to determine the exact links (if any), between periodontal disease and chronic disease condition, however, the growing body of evidence links poor oral health to major chronic illnesses.

The Government has made numerous financial commitments to improving access to dental services, however, oral health data will continue to demonstrate that without equitable access to dental services, Australians, and particularly Aboriginal and Torres Strait Islander people, will continue to suffer poorer oral health outcomes, and potentially poorer health outcomes, as a result.

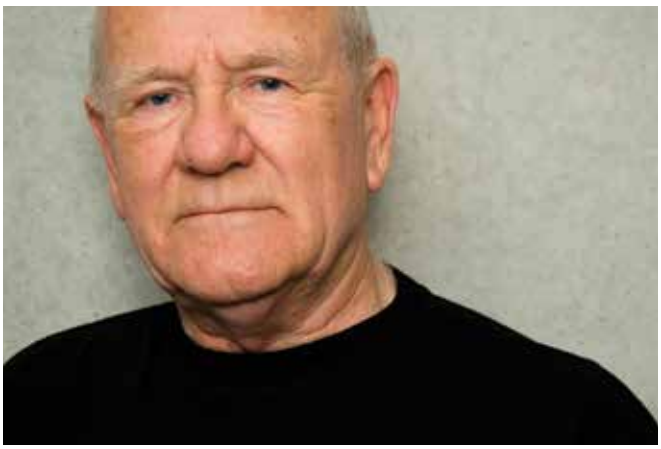
The AMA supports improved Doctor/Dentist collaborations if such partnerships could lead to increased early identification of both chronic disease and oral health conditions, particularly for Aboriginal and Torres Strait Islander peoples, for whom oral health services are less frequently accessed.

Dental Health Week is 6-12 August 2018.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Government recognises failing men's health



The Federal Government will establish a National Male Health Strategy.

To run from 2020 to 2030, the announced strategy is in response to the poorer health outcomes experienced by Australian males compared to females.

The Government hopes to identify what is needed to improve male health, and will develop the strategy in consultation with key experts and public feedback.

Health Minister Greg Hunt used the occasion of Men's Health Week in June to announce the plan, saying developing a good strategy was important because more males die at every stage of life.

"Males have more accidents, are more likely to take their own lives, and are more prone to lifestyle-related chronic health conditions than women and girls at the same age," Mr Hunt said.

In April, the Government also announced further funding for Men's Sheds to support the mental health and overall wellbeing of Australian men. The funding is a part of the total $5.1 million that the Government is providing to the Australian Men's Shed Association over the three years to June 2019.

AMA President Dr Tony Bartone said the AMA was pleased the Federal Government recognised that Australian males have poorer health outcomes, on average, than Australian females.

He welcomed the announcement of the strategy.

The AMA called for a National Men's Health Strategy in its *Position Statement on Men's Health 2018*, released in April.

"An appropriately-funded and implemented National Male Health Strategy is needed to deliver a cohesive platform for the improvement of male health service access and men's health outcomes," Dr Bartone said.

He said it was important medically because Australian men are less likely to seek treatment from a general practitioner or other health professional, and are less likely to have the supports and social connections needed when they experience physical and mental health problems.

Dr Bartone said Australian men should regularly take the opportunity to do something positive for their physical or mental health.

"Book in for a preventive health check with a trusted GP, get some exercise, have an extra alcohol-free day, or reach out to check on the wellbeing of a mate," Dr Bartone said.

The AMA Position Statement called for a major overhaul of men's health policy, including a new national strategy to address the different expectations, experiences, and situations facing Australian men.

Dr Bartone said that the AMA looked forward to engaging with the Federal Government to develop initiatives to address the reasons why men are reluctant to engage with GPs, and the consequence of that reluctance.

The AMA wants investment in innovative models of care to overcome such barriers.

In 2008, the Rudd Labor Government developed a National Male Health Policy, the first for Australia. Part of this program's funding enabled an Australian Longitudinal Study on Male Health to build a strong evidence base in male health. The study can be found here: https://tentomen.org.au/

The AMA *Position Statement on Men's Health 2018* is at https://ama.com.au/position-statement/mens-health-2018

MARIA HAWTHORNE and MEREDITH HORNE

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Aged care building as an election battleground

Opposition Leader Bill Shorten recently used an appearance on ABC's Q&A program to declare aged care is in a fundamental state of crisis and that he aims to make it a central national issue.

Mr Shorten said if the aged care system was not adequately funded at the national level, it was simply being set up to fail.

"It is a problem. It is a crisis," he said.

"We need to sit down as a nation. Forget the politics, take off your Liberal hat or your Labor hat when you walk in the door, and start talking about how we properly fund aged care."

The Government maintains that the latest Budget has seen a considerable boost in the overall spend for aged care, increasing from $18 billion a year to $23 billion over four years.

However, the Opposition believes that the Government has cut $2 billion from aged care by moving money from residential care and reallocating it to home care.

Speaking in Adelaide following the Q&A program, Mr Shorten said that there were many things to do to help improve aged care, and he has not ruled out a Royal Commission.

"We've got to make sure that aged care staff are valued, paid properly and properly trained. Two, we've got to make sure that the promises being made to vulnerable people in their care are being delivered on. Three, we've actually got to do a lot more to challenge the scourge of dementia," he said.

In April, the AMA launched its *Position Statement on Resourcing Aged Care 2018* to outline the workforce and funding measures that the AMA believes are required to achieve a high quality, efficient aged care system that enables equitable access to health care for older people.

AMA President Dr Tony Bartone said Australia's ageing population will require an increasing amount of medical support due to significant growth in the prevalence of chronic and complex medical disorders and associated increase in life expectancy.

The AMA has called for more Government funding and support to allow ongoing access to medical and health care at home, so people can remain in their home for as long as is appropriate.

The AMA also believes there needs to be improved access for older people in residential aged care facilities (RACFs) to doctors through enhanced Medical Benefits Schedule (MBS) funding, and research into improved models to facilitate medical care in RACFs. Currently, inadequate MBS funding is a barrier for GPs to attend residents of aged care facilities, as they do not compensate for the significant non-face-to-face time (travel, finding residents and staff, etc) that comes with caring for RACF residents.

The AMA also believes that more nurses are needed in full time employment in aged care, and a minimum nurse to resident ratio should be included in the Aged Care Quality Standards.

Dr Bartone said AMA members have reported cases where nurses are being replaced by junior personal care attendants, and some residential aged care facilities do not have any nurses on staff after hours.

"It is unacceptable that some residents, who have high care needs, cannot access nursing care after hours without being transferred to a hospital Emergency Department," he said.

The House of Representatives is currently conducting an *Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*. At the time of publication, more than 100 submissions had been received.

The AMA gave evidence at the inquiry in May and the submission can be read here: www.aph.gov.au/DocumentStore.ashx?id=00ae9808-57c3-476f-8533-385e701fa619&subId=563295

The AMA *Position Statement on Aged Care Resourcing* can be found here: www.ama.com.au/position-statement/aged-care-resourcing-2018

MEREDITH HORNE

Research

Big tobacco's latest scam revealed

A new study from the University of Bath's Tobacco Control Research Group has exposed evidence that big tobacco is still facilitating tobacco smuggling, while also trying to control a global system aimed at preventing it.

The research draws on leaked documents. It also investigates industry front groups and details elaborate lengths the industry has gone to control to undermine a major international agreement, the Illicit Trade Protocol.

The Protocol aims to protect public health by stopping the tobacco industry from smuggling tobacco, but the University of Bath research shows how tobacco companies are trying to get around it by employing elaborate scam techniques.

Released in June, the research paper was published in the journal *Tobacco Control* and it calls on governments and international bodies to crack down on the tactics of big tobacco companies.

It requires governments being much more vigilant in ensuring that the systems designed to control tobacco smuggling are free of industry influence.

The study argues that despite the tobacco industry claiming to have changed and to be themselves the victims of counterfeit tobacco (and have lobbied to work with governments to help tackle counterfeit tobacco), it is still facilitating tobacco smuggling.

Approximately two thirds of smuggled cigarettes may still derive from industry, the study states. It highlights how companies have developed their own track and trace system, known as Codentify, and lobbied around the world for it to adopted, while at the same time creating front groups and paying for misleading data and reports.

The University of Bath's research has revealed:

- Big Tobacco funding (through a front group) the World Customs Organisation's conference on illicit or smuggled tobacco;
- Philip Morris International (PMI) setting up a $100 million fund for research on illicit tobacco, which funds organisations whose previous reports on tobacco smuggling have already been widely criticised; and
- PMI funding INTERPOL to promote Codentify.

Leaked documents show the four major transnational tobacco companies hatched a joint plan to use front groups and third parties to promote Codentify to governments and have them believe it was independent of industry. It also reveals how these plans were put into action. For example, the study reveals how a supposedly independent company fronted for British American Tobacco (BAT) in a tender for a track and trace system in Kenya.

Professor Anna Gilmore, Director of the Tobacco Control Research Group, explains: "This has to be one of the tobacco industry's greatest scams. Not only are tobacco companies still involved in tobacco smuggling, but they are positioning themselves to control the very system governments around the world have designed to stop them from smuggling. Their elaborate and underhand effort, implemented over years, involves front groups, third parties, fake news and payments to the regulatory authorities meant to hold them to account.

"Governments, tax and customs authorities around the world appear to have been hoodwinked. It is vital that they wake up and realise how much is at stake. Our simple message is this: no government should implement a track and trace system linked in any shape or form to the tobacco manufacturers. Doing so could allow the tobacco industry's involvement in smuggling to continue with impunity."

The report's co-author Andy Rowell said: "By analysing new leaked documents from the tobacco industry and other contemporary evidence, it's clear that the masters of deception are up to their old tricks. The evidence suggests the industry is still facilitating tobacco smuggling, whilst trying to control the international system to stop smuggling. But authorities should not let the sly old tobacco fox look after the hen house."

To access the peer-reviewed paper see: http://tobaccocontrol.bmj.com/lookup/doi/10.1136/tobaccocontrol-2017-054191

CHRIS JOHNSON

Research

Active commuting might not be that hard

More than two in three Australians drive to work, according to the latest 2016 Census data. An active commute, where physical activity forms a significant part of the way people travel to and from work, is far easier than often thought – and it could even be a lifesaver.

One of the main hurdles for the uptake of active commuting could be based in an overestimation of the length of time people believe it would take to walk or ride to work, a recent study suggests.

Associate Professor Melissa Bopp, one of the study's co-authors from Pennsylvania State University, said: "Often people indicate that the reason they choose to drive is that it's much quicker than walking or biking when, in reality, that may not be the case."

When the study's participants were asked to estimate how long it would take them to bike or walk to a common location in town, they found that the majority of people estimated incorrectly. Ninety-one per cent of study participants incorrectly estimated how long it would take to commute with walking, and 93 per cent mis-estimated how long it would take to bike.

In Australia, rates of walking and cycling remain constant and low – even in smaller centres such as Hobart, Darwin and Canberra. Even in the most 'cycling-oriented' places (Darwin and Canberra), only about three per cent of commuters cycle.

The World Health Organisation (WHO) launched in June this year its first *Global Action Plan for Physical Activity 2018-2030*, to encourage an increased participation in physical activity by people of all ages and abilities across the world.

WHO recommends that adults aged between 18 and 65 should do at least 150 minutes of moderate-intensity physical activity throughout the week, or do at least 75 minutes of vigorous-intensity physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity. For additional health benefits, adults should increase their moderate-intensity physical activity to 300 minutes per week, or equivalent. Muscle-strengthening activities should be done involving major muscle groups on two or more days a week.

Active commuting offers an extremely effective health solution to modern sedantry lifestyles as supported by findings from the University of Glasgow published earlier this year in the *British Medical Journal*, a study that investigated the health benefits of cycling to work.

The Scottish-based researchers observed the incidences of heart disease, cancer, accidents and death, adjusting the study to consider other factors contributing to their health, such as sex, age, smoking, and time spent sitting down.

Cyclists had a 52 per cent lower risk of dying from heart disease, and a 40 per cent lower risk of dying from cancer. In terms of developing the disease at all, they had a 46 per cent lower risk of getting heart disease and a 45 per cent lower risk of getting cancer.

The commuters who walked to work also enjoyed some benefits, such as a 27 per cent lower risk of heart disease and a 36 per cent lower risk of dying from it. However, they did not have a lower risk of dying from any of the causes.

People who cycled combined with other modes of transport had 24 per cent lower risk of death from all causes, a 32 per cent lower risk of developing cancer and a 36 per cent lower risk of dying from cancer.

The Australian Heart Foundation estimates the cost of being inactive in Australia is $805 million each year, with much of the costs relating to healthcare spending ($640 million). The cost of physical inactivity to households is $124 million each year, due to diseases related to lack of exercise.

World leaders will meet later this year to take action on physical inactivity and other causes of NCDs, and mental disorders, when they take part in the Third United Nations General Assembly High-level Meeting on Non-Communicable Diseases (NCDs), being held on September 27 in New York.

The World Health Organisation's Global Action Plan for Physical Activity 2018-2030 can be found here: http://www.who.int/ncds/prevention/physical-activity/gappa/

MEREDITH HORNE

Europe's digital highway changing the future of health care

The European Commission continues to strategically progress digital changes to modernise its healthcare system, with significant funding announced in their June EU Budget.

The budget announcement proposes to create the first ever Digital Europe program and invest €9.2 billion to align the next long-term EU budget 2021-2027 with tackling increasing digital challenges.

Andrus Ansip, the European Commissioner's Vice-President for the Digital Single Market, said the announcement would ensure the EU budget was fit for the future.

"Digital transformation is taken into account across all proposals, from transport, energy and agriculture to health care and culture. We are proposing more investment in artificial intelligence, supercomputing, cybersecurity, skills and eGovernment – all identified by EU leaders as the key areas for the future competitiveness of the EU," Mr Ansip said.

The European Commission's legislative framework is based on new technologies enabling cross-border access of data to create more personalised, accurate and patient-oriented health care in a safe environment.

The framework is designed to overcome three challenges; ageing population and chronic diseases putting pressure on health budgets; unequal healthcare quality; and shortage of health professionals.

Currently EU citizens have the right to access health care in any EU country and to be reimbursed for care abroad by their home country.

The Commission's digital health goal is to reduce administrative costs, avoid human errors, optimise the use of medical data and increase quality of services by systematically aligning healthcare IT systems and implement systems that support open standards-based data exchange.

The Commission recently established a set of measures to increase the availability of data in the EU, building on previous initiatives to boost the free flow of non-personal data in the Digital Single Market.

Thirteen European countries signed a declaration in April for delivering cross-border access to their genomic information. This is a game changer for European health research and clinical practice: sharing more genomic data will improve understanding and prevention of disease, allowing for more personalised treatments (and targeted drug prescription), in particular for rare diseases, cancer and brain related diseases. The target of the EU is to make one million genomes accessible in the EU by 2022.

The European Commissioner for the Digital Economy and Society, Ms Mariya Gabriel, said the agreement was founded in the understanding modern health relies on digital innovation and cross-border interoperability.

"Secure access to genomic and other health data among Member States is essential for better health and care delivery to European citizens and to ensure that the EU will remain at the forefront of health research."

MEREDITH HORNE

American Medical Association reviews its position on assisted death

The American Medical Association is reviewing its opposition to medically assisted death, following a motion to maintain its position being rejected at the Association's annual meeting.

Delegates at the meeting, held in Chicago in June, voted instead for the organisation to continue reviewing its guidance on the issue.

A lengthy debate looked at whether the doctors' group should revise its Code of Ethics, resulting in what is known as the House Delegates voting 56 per cent to 44 per cent that its Council on Ethical and Judicial Affairs should further review its current position.

Delegates did not, however, vote that the Code of Medical Ethics be amended.

The decision was to send a report into the position back for further discussion, meaning the position remains the same for now.

The further review is set to take place at a future policy making meeting.

The current position is that physician-assisted suicide is "fundamentally incompatible with the physician's role as healer" and was adopted a quarter of a century ago.

Six States plus the District of Columbia (DC) have legalised medically assisted death. California's law, however, was recently overturned in the courts.

CHRIS JOHNSON

US doctors want to ban assault weapons

American doctors have called for a ban on the sale and ownership of all assault-type weapons.

The American Medical Association voted in June to amend its policy on firearms, resulting in the United States' biggest doctors group taking a stance against gun violence.

The AMA declared it to be a public health emergency.

The Association also raised the issue of bump stocks, which basically turn semi-automatic firearms into fully automatic ones, saying sale of them should be prohibited.

And it called for an end to the sale and ownership of high-capacity magazines and armour-piercing bullets.

The AMA also supports laws to require all firearms to be registered, to ban sales of guns to people under the age of 21, to make it illegal for anyone found of guilty of domestic violence to be in possession of a gun, and to keep schools gun-free zones.

Debate on all of the issues was reported to be contentious, with delegates who were gun owners wanting more time to review the language used in the resolution.

But the delegation voted overwhelmingly in favor of the ban on assault weapons resolution, 446 to 99.

In America this year alone, more than 6,300 people have died from gun violence.

CHRIS JOHNSON

AMA Member Benefits

AMA members can access a range of free and discounted products and services through their AMA membership. To access these benefits, log in at **www.ama.com.au/member-benefits**

AMA members requiring assistance can call AMA member services on
1300 133 655 or **memberservices@ama.com.au**

Jobs Board: Whether you're seeking a new position, looking to expand your professional career, or looking to recruit staff to your practice, doctorportal Jobs can help you. Discounts apply for AMA members. jobs.doctorportal.com.au

MJA Events: AMA members are entitled to discounts on the registration cost for MJA CPD Events!

UpToDate: UpToDate is the clinical decision support resource medical practitioners trust for reliable clinical answers. AMA members are entitled to discounts on the full and trainee subscription rates.

doctorportal Learning: AMA members can access a state of the art CPD tracker that allows CPD documentation uploads, provides guidance CPD requirements for medical colleges, can track points against almost any specialty and provides access to 24/7 mobile-friendly, medical learning.

Learning.doctorportal.com.au

MJA Journal: The Medical Journal of Australia is Australia's leading peer-reviewed general medical journal and is a FREE benefit for AMA members.

Fees & Services List: A free online resource for AMA members. The AMA list of Medical Services and Fees provides an important reference for those in medical practice to assist in determining their fees.

Career Advice Service and Resource Hub: This should be your "go-to" for expert advice, support and guidance to help you navigate through your medical career. Get professional tips on interview skills, CV building, reviews and more - all designed to give you the competitive edge to reach your career goals.

www.ama.com.au/careers

Amex: As an AMA member, receive no-fee and heavily discounted fee cards with a range of Amex cards.*

Mentone Educational: AMA members receive a 10% discount on all Mentone Educational products, including high quality anatomical charts, models and training equipment.

Volkswagen: AMA members are entitled to a discount off the retail price of new Volkswagen vehicles. Take advantage of this offer that could save you thousands of dollars.

AMP: AMA members are entitled to discounts on home loans with AMP.

Hertz: AMA members have access to discounted rates both in Australia and throughout international locations.

Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

Qantas Club: AMA members are entitled to significantly reduced joining and annual fees for the Qantas Club.

Virgin Lounge: AMA members are entitled to significantly reduced joining and annual fees for the Virgin Lounge.

MJA Bookshop: AMA members receive a 10% discount on all medical texts at the MJA Bookshop.