AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

The Bartone Ultimatum

Twilight summit sets up My Health Record win for the AMA, p3

INSIDE

AMA

ISSUE 30.13 AUGUST 20 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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In this issue

Cover photo by Kym Smith, News Corp Australia

The Bartone Ultimatum:
"Fix the My Health Record"

During a private twilight meeting in Melbourne three weeks ago, AMA President, Dr Tony Bartone, put a strong demand directly to Health Minister Greg Hunt – fix the privacy provisions of the legislation or the My Health Record (MyHR) will remain in limbo for years to come.

Dr Bartone had made public his intentions a week earlier at the National Press Club in Canberra when he declared to journalists that he would do 'whatever it takes' to force the Government to take action to make the privacy protections of health information as watertight as possible in the digital health age.

The new AMA President stayed true to his word.

With the blessing and support of the AMA Federal Council, Dr Bartone, a Melbourne GP, took a four-point shopping list to the Minister – amend the Act to ensure health data is not disclosed without a warrant or court order; ensure that people who opt-out do not end up with a permanent MyHR; run a public information campaign; and extend the opt-out period.

The Minister, wanting the controversy to end, and ultimately wanting the MyHR to succeed, agreed to all the items and, after obtaining a sign-off from the Prime Minister, he issued a media release to publicly confirm the actions to be taken.

Minister Hunt said the Government will strengthen privacy provisions under the My Health Record Act, and the legislation will be strengthened to match the existing Australian Digital Health Agency (ADHA) policy.

"This policy requires a court order to release any My Health Record information without consent," Minister Hunt said.

"The amendment will ensure no record can be released to police or government agencies, for any purpose, without a court order."

Dr Bartone told ABC Radio *AM* that "we can now move forward and have certainty around the protections to the privacy of those medical records that our patients expect when they confide their information with us".

"The assurance that people who opt-out will have their records deleted will hopefully appease concerns in that area," Dr Bartone said.

"The privacy protection of our records and the security protection of our records is of considerable and paramount importance to us.

"We have protocols and procedures in place. We work with our IT providers to ensure that everything is in compliance and in the utmost preparedness for any cyber attack that we can envisage," Dr Bartone said.

The AMA will examine the amended legislation carefully to ensure that patient, community, and professional concerns are addressed satisfactorily.

Dr Bartone said that the AMA remains committed to the potential clinical benefits of an electronic health record, but the future of the record depends on getting the security and privacy settings right.

Dr Bartone and Minister Hunt at the Melbourne meeting.

"It would be a tragedy if, after more than a decade of development, we have to go back to square one in building a secure and workable electronic health record."

Despite Minister Hunt's announcement, the Labor Opposition is calling for the My Health Record system to be suspended until privacy concerns can be allayed.

Shadow Health Minister, Catherine King, raised concerns that non-custodial parents could create records for their children and use them to locate their children and estranged partners.

"The Government needs to deal with this issue," Ms King said.

JOHN FLANNERY

Advocating for the best possible My Health Record

BY AMA PRESIDENT DR TONY BARTONE

I recently had a private meeting with Health Minister Greg Hunt in Melbourne to raise with him growing concerns being raised by AMA members, other doctors, security experts, politicians, patients, and the media about privacy and the My Health Record.

The AMA has a long history of supporting and promoting an efficient and secure electronic health record, but we have also emphasised that it must be the right electronic health record – one that meets clinical expectations, one that respects and protects patient privacy, and one that is acceptable and useful to doctors and patients.

Our priority has always been on ensuring that the clinical expectations of the My Health Record were achieved. However, the public and political debate around privacy and security of the My Health Record is extremely worrying, and must be resolved satisfactorily, or it could undermine the clinical objectives and benefits for doctors and patients, derailing the whole project for many years to come.

The AMA had to act, and we did.

At the National Press Club in July, I declared that I would do 'whatever it takes' to force the Government to act to ensure the privacy and confidentiality of the My Health Record and preserve the sanctity of the doctor-patient relationship. Only moments after the Press Club, I spoke to the Minister and arranged the now widely-reported meeting.

One of the major concerns, among others, is the provisions in the *My Health Record Act 2012* that permit the My Health Record System Operator to use or disclose patient data to an enforcement body without a court/tribunal order.

So, backed by the AMA Federal Council, I took the following demands to Minister Hunt at our meeting:

1. Amend the *My Health Record Act 2012* to ensure sensitive health data is not disclosed without a warrant or court order.
2. Introduce amendments so that if people choose to cancel their record, even after they opt-out, they will not end up with a permanent My Health Record.
3. Develop and rollout a fully resourced, public information campaign to ensure all Australians are aware of the My Health Record and have access to all the information they need to make an informed choice.
4. Extend the opt-out period to give people more time to consider that choice.

The Minister and the Prime Minister agreed to all these demands. Minister Hunt immediately issued a media release to that effect following our meeting.

This is a significant victory for AMA advocacy, but clearly there is still a long way to go.

The My Health Record is not new. It was formerly called the Personally Controlled Electronic Health Record and has been available and used since 2012. It is a patient's own record - a summary of dis-aggregated information from many silos in the health system in the one place under their control.

It promises greater efficiencies in recording, storing, and sharing vital health information. It alone is not the solution, but it will be an enabler to wider platform improvement, allowing more innovation in electronic health records, communication, and information sharing. God knows, it might even spell the end of the fax machine in our health system.

We must solve all the problems and address all the concerns. Then we must push on to make a workable and safe electronic health record a reality, which is enthusiastically embraced. Of course, the time and effort placed on the nominated doctors, especially during the implementation, will be significant and must be recognised by the Government. This will be the focus of significant AMA advocacy going forward. Without this, the implementation will struggle significantly

There is no doubt that more issues and concerns will arise. Some will be about the legislation and privacy. Some will be about the clinical benefits, or less than perfect interoperability. Some will be a matter for consumers as they decide whether to opt-out. Others will be for other peak bodies in the social services, security, privacy sectors, or other fields to consider.

The AMA stands ready to continue to work constructively to deliver a strong and effective electronic health record that works to improve the quality of patient care and coordination in the Australian health system.

What use the high moral ground when you are being eaten alive?

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

GPs' livelihood and ability to practise are being attacked on many fronts. Dubious role substitution creep from usurper health care practitioners must stop. Does the fight need to come to their doorstep instead of doctors always being in defence?

The Acting President of the Pharmacy Guild recently likened the AMA to a "salivating and barking dog," following a perceived "onslaught of abuse and derision," in a response to broader scope of practice for pharmacists. The hyperbole was rousing!

> "The benefits of an enduring, familiar family doctor who knows you well and can provide wide-ranging advice and treatment is well evidenced and the appropriate cornerstone of our health care system."

It was suggested that prescribing medications, being able to capably understand and diagnose a patient's medical problems without appropriate training or ability to garner a full history and examine, and to provide health prevention advice is within the scope of pharmacy training? Clearly not true. The aircraft engineer doesn't pilot the plane, serve the drinks, or unload the luggage. Being able to work a sphygmomanometer and having a basic understanding of physiology does not make you a doctor or capable of giving medical advice while standing in the middle of a retail pharmacy. The benefits of an enduring, familiar family doctor who knows you well and can provide wide-ranging advice and treatment is well evidenced and the appropriate cornerstone of our health care system. Pharmacists are not required to do any part of this job.

It was also asserted that self-defined broader scope of practice for pharmacists will also save money and time for patients. Not really if outcomes are inferior. Where is the evidence that pharmacists behaving as quasi-doctors achieves anything? Regular interactions with general practitioners is crucially important in developing an enduring bond, discussing risk factor modification, and so on. Government cannot 'de-fund' general practice, then attempt to remove the more simple work, and expect the system will still work given growing patient complexity and potential risk.

If you want to be a doctor – go to medical school. Australia is graduating just under 4000 doctors this year – there's no lack of space! Please, do not abandon doing the job you are actually trained to do. Patients need direction in how to use their inhalers every few months (or their technique degrades), explain the purpose of medications (both prescribed and over the counter), clarify dosing regimens for patients, make sure warfarin interactions with diet are understood by patients, sort out pill boxes or Webster packs to reduce medication errors, and so on. This unequivocal in-scope pharmacy activity is performed far less than it should. If it was done frequently and properly, it would be far more useful to patients and contribute more robustly to the safety and quality of the system, compared to the constant attempts to do a doctor's job in a rudimentary and inferior way.

The AMA has always decided it is morally and ethically more appropriate for doctors to not dispense medications as a system-wide policy (bearing in mind it has usefully occurred in rural areas for a long time). It would actually be very convenient to patients if doctors did dispense medications (to use one of the Guild's main arguments for role substitution), and we could make it cheaper to the system as a whole if the costs reflected the dispensing fees only, without profit being generated, and/or any profit being retained within the practice for other patients' services. If doctor dispensing of medications became a reality, individuals would not have to do it, if they didn't want to. If patient convenience and cost are paramount in the system, whereas training, evidence, and professionalism do not matter as much to decision-makers, then we perhaps need to recognise this.

Offence might serve us better than defence. Is the AMA position due for a re-think?

BY JOHN FLANNERY AND MARIA HAWTHORNE

Medical Board backs down on naming doctors

The Medical Board of Australia (MBA) has backed down on its plan to publicly name doctors who had been under investigation, regardless of whether any adverse finding had been made against them.

AMA President, Dr Tony Bartone, recently wrote to the Board Chair, Dr Joanna Flynn AM, and Chief Executive Officer, Martin Fletcher, to express concerns over the plan.

Dr Bartone said the AMA had "significant concerns" about the recommendation to publicly link disciplinary and court decisions to the registration details of doctors - regardless of whether the doctor has been found guilty of any transgression.

"The AMA is very concerned about the potential for medical practitioners to suffer discrimination as a result of being named in a previous tribunal proceeding, particularly where there was no finding against the practitioner," Dr Bartone wrote.

The AMA was also concerned about cases where the issue was relatively minor or had occurred some years ago, where the doctor or their practice complied with the tribunal's recommendations, and where other safeguards have been introduced to protect patients.

"In many cases, the public will not read the linked information but will assume that, because it has been linked by a reputable regulatory body, it is serious and of ongoing relevance," Dr Bartone said.

"The AMA finds it difficult to comprehend that medical practitioners who are named in a tribunal procedure are offered less protection from discrimination than a person who has served a prison term.

"For example, the Commonwealth legislation would prohibit the Australian Health Practitioner Regulation Agency (AHPRA) from republishing information about persons who have been convicted of up to 30 months imprisonment.

"And yet, medical practitioners who have committed a minor transgression (even when they have taken steps to ensure the issue can never occur again), or where the practitioner is not found guilty, will have links to the disciplinary process listed against them in perpetuity. This seems palpably unfair."

In late July, the Board announced that it would now only publish links to serious disciplinary decisions on the public register in the event of an adverse finding against the doctor.

"The Board has changed its position after listening to advice from many doctors and other stakeholders that this was not fair when no adverse finding had been made about the doctor," it said in a statement.

IMGs leaving rural practice after failing exams

ABC News has reported that international doctors are leaving practice in rural areas after failing exams set by the Medical Board of Australia (MBA).

According to the report, four out of five overseas doctors, some of whom have worked in small towns for as many as 10 years, are failing the MBA clinical exam, which is designed to prove they meet national standards.

Historically, overseas doctors were not required to sit any local exams before they were placed in 'areas of need' across rural Australia, where more than 3000 foreign doctors are currently practising.

MBA Chair, Dr Joanna Flynn AM, told ABC reporter Danielle Grindley that, ideally, all doctors who worked in Australia would have the full qualifications before they started work, but some years ago there was a period of workforce need, especially in rural areas.

"But today the expectation that those doctors will meet the Australian standard has become clearer," Dr Flynn said.

"If their performance in the exam is at a very low level, it raises questions about whether they are actually safe to practise."

In 2013, all international doctors were told they had three years to pass the clinical exam or face deregistration.

Dr Flynn said there was a period of leniency, where many doctors were given extensions, but that time had come to an end.

"The Board has a set of standards that are now being very deliberately implemented," she said.

"For some people, that raises the bar that they have to cross to be able to either get into the workplace in the first place, or remain in the workplace."

In a statement, a Health Department spokeswoman said the Medical Board of Australia was 'independent of Government and neither the Minister nor the Department could intervene on individual registration matters'.

Aged Care Survey reveals trends in practitioner visits and patient contact

The latest AMA Aged Care Survey Report has been released, with results providing insight into the perceptions and priorities of members in providing medical care in the aged care sector.

Conducted in late 2017, the survey sought feedback from AMA members, and was released in July this year.

Because older Australians living in Residential Aged Care Facilities (RACFs) require a high level of medical care, many of the questions focused on medical access in RACFs.

In 2017, there was significant aged care system review by the Federal Government and consultation with stakeholders regarding the quality of care older Australians receive – therefore, quality of care questions were included, in order for the AMA to accurately understand members' current views.

This survey revealed that, since the last survey in 2015, medical practitioner visits have increased by 1.2 visits (from 7.4 to 8.6 visits per month) while the average number of patients seen per visit has remained relatively similar, with only a slight increase of 0.1 patients per visit (from 6.5 to 6.6 patients per visit).

However, the average reported non-contact time on each patient seen (13 minutes 35 seconds) has decreased since 2015 (17 minutes 30 seconds), although is similar to the 2012 average (13 minutes 54 seconds).

Although non-contact time has decreased, several members remain concerned about non-contact time demands, commenting on the considerable amount of paperwork involved, responding to faxes and phone calls, and discussing issues with RACF staff or relatives of residents.

This has been a common concern for respondents of all the surveys and was listed as a major influence to decrease visits to, or never visit, RACFs.

All surveys indicate an increased demand for RACF-visiting medical practitioners. The average reported time spent on each patient has increased since previous years.

"The 2017 survey saw an average of 17 minutes 7 seconds spent on each patient, while in 2012 and 2015 the average was 16 minutes 6 seconds and 16 minutes 12 seconds, respectively," the report states.

"This indicates that, although the number of patients seen per visit remains the same, medical practitioners are making more visits to RACFs and spending slightly more time with each patient."

Respondents aged 41-60 remain the largest age group reporting they visit RACFs (46.94 per cent) and contributing to the highest proportion of monthly visits (49.32 per cent).

Respondents aged 61 and over contribute to 47.11 per cent of monthly RACF visits, and those aged 40 or under contribute to only 3.57 per cent.

"This raises concerns that as the older age groups move into retirement, there could be a shortage of medical practitioners willing to visit patients in RACFs," the report states.

"Respondents were asked of their intentions to visit RACFs over the next two years. Over one third (35.67 per cent) of respondents who currently undertake RACF visits intend to either visit current patients but not visit new patients, decrease the number of visits, or stop visiting RACFs altogether."

The full survey can be found at: https://ama.com.au/article/2017-ama-aged-care-survey

BY JOHN FLANNERY AND MARIA HAWTHORNE

Asylum seeker death was preventable

The Queensland Coroner has found that the death of Iranian asylum seeker, Hamid Khazei, was preventable.

In a ruling released on 30 July, the Coroner, Terry Ryan, said: "Consistent with the evidence of the expert witnesses who assisted the court in this matter, I am satisfied that if Mr Khazaei's clinical deterioration was recognised and responded to in a timely way at the MIRPC clinic, and he was evacuated to Australia within 24 hours of developing severe sepsis, he would have survived."

Coroner Ryan said it would be possible to characterise the circumstances that led to Mr Khazaei's death simply as a series of clinical errors, compounded by failures in communication that led to poor handovers and significant delays in his retrieval from Manus Island.

"However, attributing responsibility for those events solely on failures by individual clinicians tasked with his care and others responsible for arranging his transfer from Manus Island is not helpful when looking for ways to prevent similar deaths from happening in future," the coroner said.

"It is important to consider the broader context in which Mr Khazaei's death occurred in order to find ways to prevent similar incidents."

AMA (NSW) President, Dr Kean-Seng Lim, said the Federal Government should accept and implement the recommendations of the Queensland Coroner as soon as possible.

"The first recommendation in the Queensland Coroner's report is that the health and wellbeing of asylum seekers who need a medical transfer be made the overriding consideration," Dr Lim said.

"This should have been standard practice before, but it is imperative that the Department for Home Affairs develop and implement this policy now.

"The report also recommends the clinics providing medical services to asylum seekers in regional processing countries be properly accredited.

"Once again, this is something that should have always been the case and needs to be acted on with all haste.

"This is especially important given the description of the initial treating facility Mr Khazaei encountered.

"It has been longstanding AMA policy that asylum seekers should be afforded the same level of care that can be expected in Australia," Dr Lim said.

Code of Conduct revision

The AMA has lodged a submission with the Medical Board of Australia on the draft revised document, *Good Medical Practice: A Code of Conduct for Doctors in Australia (2018)*.

Dr Bartone said that the document is very important for the medical profession and for patients, and that all doctors must have the opportunity and ample time to consider any changes, even minor changes, to the Code.

"It is of the utmost importance and necessity that the Board ensures all doctors are aware of these public consultations, and have sufficient time to respond, as they are the ones legally subject to the provisions of the Board's codes and guidelines," Dr Bartone said.

"We note the Board has now extended the public consultation until 17 August 2018.

"The format of the Code - both the current Code and the draft revised Code - contains a combination of clear, explicit statements intermingled with vague, ambiguous 'motherhood' statements.

"The clear, explicit statements provide doctors with sufficient guidance to meet the expected standards of ethical and professional conduct, but the more ambiguous statements do not, making it extremely difficult and distressing for doctors who are then unsure how to fulfil their obligations under the Code.

"It is vital that the Board gets this process right.

"A strong agreed Code will provide greater information and clarity for patients and the wider public as to what constitutes appropriate professional conduct or practice that they can accept from the medical profession," Dr Bartone said.

The AMA submission, outlining the concerns of the AMA and suggested changes, is at https://ama.com.au/submission/ama-submission-medical-board-australias-public-consultation-draft-revised-good-medical

AMA members honoured in Mongolia

Left to Right: Dr Samantha Hargreaves, Dr Philip Popham, Dr Emma Readman, Dr Kym Jansen, Mongolian President, Khaltmaagiin Buttulga.

Dr Elizabeth Farrell.

Last month, in a private audience with the Mongolian President, four Australian doctors were awarded the Mongolian Silver Friendship Medal (Nairamdal).

Medical specialists, and AMA members - Dr Kym Jansen, Dr Emma Readman, Dr Samantha Hargreaves, and Dr Philip Popham - were honoured for their contribution to health care in Mongolia.

The Medal is the highest honour bestowed upon a foreign citizen by the Mongolian Government, and is solely given to foreigners who have contributed to strengthening the collaboration between their country and Mongolia through their work.

These four doctors are the first Australians to be awarded the Friendship Medal. Dr Elizabeth Farrell AM, a member of the same group, was awarded a visiting Professorship from the Mongolian National University of Medical Sciences.

These amazing doctors have been visiting Mongolia annually for the past 10 years.

The group initially concentrated on promoting minimally invasive gynaecological surgery, but recently expanded their role to encompass all aspects of women's health, including anaesthetic care. The affiliation has seen rapid advances in surgical, anaesthetic, and obstetric care.

Over the last two years, the Epworth Foundation has expanded this project by funding three-month scholarships for two doctors from Mongolia to visit Australia annually.

The group has recently formed the Mongolian Australian Medical Affiliation (MAMA) - Women's Health, and plan to continue their collaboration.

Doctor recognised for service to performing arts

Dr Alastair Robert Jackson, an AMA member from Victoria, was in June awarded a Member in the General Division of The Order Of Australia (AM) for service to the performing arts, particularly to opera, through a range of governance roles, and as a patron and benefactor.

Dr Jackson is a patron of many arts organisations such as Orchestra Victoria, Opera Melbourne, and the Australian Brandenburg Orchestra. He also serves as a member of The Music Board of the Australian International Opera Awards, which nurtures young Australians seeking an international operatic career.

AMA Twitter news

Aboriginal Health @NACCHOAustralia — Following

Thank you @amapresident for your ongoing support #MyHealthRecord utilised by @AMSANTaus for 6 years @MyHealthRec @AuDigitalHealth @ama_media

The Today Show @TheTodayShow
The Australian Medical Association has vowed to do "whatever it takes" to protect patient privacy amid growing concerns over the security of the Federal Government's "My Health Record" site. #9Today

7:31 AM - 26 Jul 2018

5 Retweets 4 Likes

Paul Worley @PaulWorleySA · Jul 28
Meeting in Sydney with **the AMA** Council of Doctors in Training. Great practical insights into how to make the National Rural Generalist Pathway successful for rural communities and attractive for junior doctors. Great to have this support from our next generation!

1 5 29

Dana McCauley @Dana_Adele · 15h
Health Minister Greg Hunt has agreed to redraft the My Health Record Act to protect patient privacy, after meeting with AMA President Tony Bartone
smh.com.au/politics/feder... @amapresident #auspol #MyHealthRecord

Health Minister backs down on My Health Record
Federal Health Minister Greg Hunt has bowed to pressure and agreed to tear up the controversial legislation behind the My Health Record to prote...
smh.com.au

AMA Media @ama_media · 27m
"It does not make sense to have pregnancy cover in the highest levels of insurance only. Pregnancy is a major reason that young people consider taking up private health insurance. They are less likely to be able to afford the Gold policies" @amapresident #auspol

3 3 11

Kate McDonald @KateMcDawdle — Following

Very impressive speech from @ama_media president Tony Bartone. #npc @PressClubAust

1:02 PM - 25 Jul 2018

2 Retweets 2 Likes

Gino Pecoraro @PecoraroGino — Following

Replying to @ama_media @amapresident

More than 50% pregnancies unplanned. Should be covered like other "accidents" in ALL insurance policies

1:37 PM - 7 Aug 2018

Aboriginal Health @NACCHOAustralia · Jul 25

Thank you @amapresident Dr Tony Bartone speaking at @PressClubAust #NPC for the AMA endorsement of the #UluruStatement from the Heart " expressing the aspirations of Aboriginal and Torres Strait Islander people with regard to self-determination and status in their own country."

Indigenous health

I am very pleased that one of my first announcements as AMA President was the AMA endorsement of the *Uluru Statement from the Heart*.

The Uluru Statement expresses the aspirations of Aboriginal and Torres Strait Islander people with regard to self-determination and status in their own country.

The AMA has for many years supported Indigenous recognition in the Australian Constitution.

The Uluru Statement is another significant step in making that recognition a reality.

The AMA is committed to improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

It is simply unacceptable that Australia, one of the wealthiest nations in the world, cannot solve a health crisis affecting fewer than three per cent of its citizens.

1 20 31

You Retweeted

Sky News Australia @SkyNewsAust · Jul 25

.@amapresident: The AMA calls on major parties to boost funding for public hospitals beyond the outline in the next agreement. There must be a plan to lift public hospitals out of their current funding crisis.

MORE: bit.ly/2BuFqi1 #newsday

#newsday
@SkyNewsAust

5 18 16

TEN Eyewitness News @channeltennews · Jul 25

Doctors across Australia are warning the aged-care sector is headed for crisis with more specialist GPs refusing to visit nursing homes. The **Australian Medical Association** today called for an overhaul of the elderly care sector. @PhoebeBowden reports. #TenNews

Doctors Call For Aged Care Reform

The Today Show @TheTodayShow · Jul 26

The **Australian Medical Association** has vowed to do "whatever it takes" to protect patient privacy amid growing concerns over the security of the Federal Government's "My Health Record" site. #9Today

Security Concerns
#9Today

Paul Karp @Paul_Karp — Following

AMA's Tony Bartone says Labor has pledged $2.8bn more for public hospitals and predicts Coalition will match it because they "don't want another Mediscare style campaign" #auspol #npc

12:48 PM - 25 Jul 2018

7 Retweets 1 Like

Henry Belot @Henry_Belot — Following

Greg Hunt called the head of the Australian Medical Association after his speech today, pledging to clear up "any perceived ambiguity" re My Health Record roll out, according to AMA.

4:10 PM - 25 Jul 2018

8 Retweets 5 Likes

AMA Family Doctor Week 2018

Meet the 2018 Family Doctor Week Ambassadors

As a key feature of AMA Family Doctor Week 2018, we shared the stories of GPs from around Australia to highlight how family doctors are crucial and much-loved members of their communities.

Their individual stories can be read here: https://ama.com.au/ausmed/features

Dr Chris Clohesy – NT

Dr Chris Clohesy is the only doctor on hand to treat patients in the Maningrida Health Clinic in the Northern Territory, right on the edge of Kakadu. While Dr Clohesy admits "it is a ridiculously busy clinic", he also believes it is important that he lives in the community. "I have been really welcomed by this community. That makes me feel great."

Dr Amanda Bethell – SA

Dr Amanda Bethell loves spending her days with a wide range of people from all ages and stages and walks of life in Port Augusta, on South Australia's beautiful Eyre Peninsula. "We share their challenges and learn from each other."

Dr Jim Glaspole – Victoria

Recruited by his father in 2002, into the busy family practice in eastern Melbourne, Dr Glaspole loves the continuity of care with patients. "This practice has been part of the community for more than 50 years...Even though they move away from the area, many still choose to come to this clinic."

Dr Rashmi Sharma OAM – ACT

Twenty years ago, Dr Rashmi Sharma opened a medical practice in the southern suburbs of Canberra with her sister Divya. Now, caring for second and third generation patients, Dr Sharma says she feels "very proud of what we have been able to do for this community. Of the all the caps I wear, general practice is the one thing I enjoy the most."

Dr Simon Torvaldsen – WA

Practising at his Mt Lawley Surgery, a few kilometres north-east of Perth's city centre, Dr Simon Torvaldsen believes "we sometimes forget the degree of trust they put in us. And for me, the sheer variety keeps the day interesting and the brain nimble."

Dr Jane Gorman – Tasmania

Variety is the spice of life for Tasmanian, Dr Jane Gorman, who works two days as a GP and two days as a private assistant and doing orthopaedic work. Dr Gorman says working as a GP is very rewarding: "you get to see how your patients develop and you're with them two years down the track."

Dr Danielle McMullen – NSW

Primary care is a passion for Dr Danielle McMullen that came from wonderful mentors and supervisors. Because of that, she wants to give back and has ensured she remains an advocate for the profession and for excellence in training of young doctors.

AMA Family Doctor Week 2018

Dr Colin Owen – Queensland

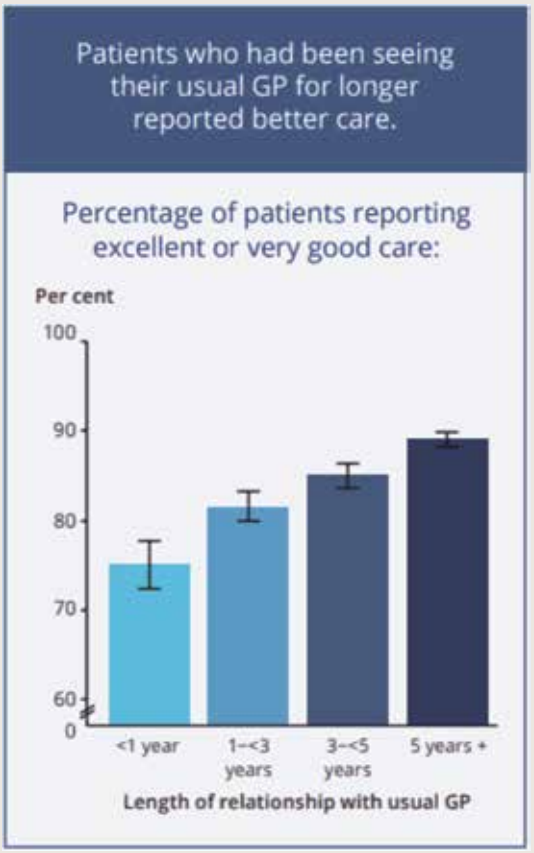
Described by those who know him as a hero of the bush, Dr Col Owen has been practising medicine in Inglewood, in south-west Queensland for half a century. On a busy day, Dr Owen could see up to 60 patients. Joking, he says that he is "getting the hang of it". But it is the continuity of care that he finds really special: "I have been involved in treating five generations of patients. That's really amazing."

Landmark Australian survey reveals GP–patient relationships matter

Key findings

- Almost nine in 10 (87 per cent) patients with both a usual GP or usual place of care felt that they received excellent or very good care in the previous year.
- The least positive patient experiences were reported by those with a usual place of care only, and not a regular GP.
- Patient-reported experiences of care were similar across different care settings, including GP clinics, community health centres, and Aboriginal Medical Services.
- Better experiences of care were reported among patients who had been seeing their usual GP for longer periods of time. Around nine in 10 patients (89 per cent) who had been seeing their usual GP for five years or more.

AIHW's Report can be found here: www.aihw.gov.au/reports/primary-health-care/mhc-coordination-of-health-care-experiences-2016



Source: Australian Institute of Health and Welfare

Queensland hospitals to ban sugary drinks and junk food

Queensland has heeded the AMA's call to ban sugar-sweetened drinks and unhealthy snacks from its public hospitals and health care facilities.

Vending machines and cafes will go junk-free by the end of this year, after the new guidelines are drawn up.

State Health Minister Steven Miles said junk food advertising around children in schools, sports grounds, and public transport hubs will also be phased out under the State-wide ban.

Minister Miles said Queensland's nutritional standards guidelines are expected to eventually be adopted by other States.

"It's staggering that one-quarter of Queensland kids are either overweight or obese," he told the ABC.

"Our public health facilities can lead by example.

"By the end of the year, we'll have a set of nationally agreed standards for healthier food and drink choices in public health care facilities.

"I want to see these standards phase out sugary drinks and junk food."

The exact threshold of what will be deemed "unhealthy" is yet to be determined.

The AMA called for health care facilities to provide access to healthy foods, and to remove or replace vending machines containing sugary drinks and other unhealthy foods, in its *Position Statement on Nutrition 2018*.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY JOHN FLANNERY AND MARIA HAWTHORNE

Super Saturday for health

The big message from the Super Saturday by-elections is that health remains one of the biggest, if not the biggest, issue on the minds of voters, and will once again be a critical factor in the next Federal election, expected in the first half of 2019.

Labor, which retained the seats of Perth, Fremantle, Longman, and Braddon – with Mayo being retained by the Centre Alliance's Rebekah Sharkie – campaigned hard with a local focus on public hospital funding and access to health services.

There is a strong theory in Canberra circles that the controversy around the My Health Record further undermined the Coalition's health policy credentials.

Writing in *The New Daily*, political commentator, Paula Matthewson, a former adviser to PM John Howard, said that "*... the lesson is that health is more important to more voters than almost any other issue, including the economy. Get health policy wrong and you risk throwing away the election"*.

Matthewson said that Labor's '*Hospitals, not Banks*' slogan ranked in effectiveness with Labor's 2016 *Mediscare* campaign to focus voters' minds on health policy.

The Federal AMA is already putting together its health policy manifesto for the next election. General practice reform, public hospital funding, private health insurance, the MBS Review, the My Health Record, and medical workforce will feature prominently.

Funding boost for Indigenous health research programs

The Federal Government has announced $23.2 million in funding for new research projects that tackle Indigenous health challenges, including kidney health and mental wellbeing.

Health Minister Greg Hunt said the National Health and Medical Research Council (NHMRC) funding was aimed at improving Aboriginal and Torres Strait Islander health outcomes.

"Investigation and investment where it is needed is critical to delivering better health outcomes for First Nations Peoples, to protect lives and save lives," Minister Hunt said.

Monash University will receive more than $320,000 to develop a point-of-care test to diagnose and manage chronic kidney disease, which affects almost one in five Indigenous adults.

A further five projects across five different States will examine social and emotional wellbeing issues affecting Indigenous infants, children, adolescents, and young people.

The direction of future First Nations research will be informed by the NHMRC's Road Map 3, which will include a yearly report card and a commitment to spend at least 5 per cent of annual NHMRC funding on Aboriginal and Torres Strait Islander health and medical research.

Minister for Indigenous Affairs, Ken Wyatt, said the Road Map 3 had been developed in consultation with communities, First Nation researchers, and the broader health and medical research sector.

Endometriosis plan released

Australia has its first National Action Plan for Endometriosis, the painful condition that affects one in 10 Australian women.

Health Minister Greg Hunt said that the plan is designed to improve the quality of life of patients through better treatment and faster diagnosis, with the ultimate aim of finding a cure.

The Government is investing $1.2 million to help implement the Plan's recommendations, taking the investment in the Plan to $4.7 million.

"Endometriosis is a chronic menstrual health disorder that affects around 700,000 Australian women and girls," Minister Hunt said.

"It often causes debilitating pain and organ damage, and can lead to mental health complications, social and economic stress, and infertility.

"Many have suffered in silence for far too long, enduring diagnostic delays of between seven and 12 years on average.

The National Endometriosis Steering Group will oversee the implementation of the National Action Plan over the next five years.

Steering Group members include Dr Susan Evans, Janet Michelmore AO, Sylvia Freedman, Nola Marino MP, Jessica Taylor, Professor Peter Rogers, Professor Jason Abbott, and immediate past AMA ACT President, Professor Stephen Robson.

More information is available at http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt095.htm

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Let's get physical

Physical activity is one of the core elements of the Federal Government's new national sport plan, Sport 2030, which was launched at the National Press Club by Sports Minister, Senator Bridget McKenzie.

Sport 2030 is being promoted as a comprehensive plan to reshape the face of Australian sport and build a healthier, more physically active nation.

The objective is to get more Australians more active, more often, drive sporting excellence and success, safeguard the integrity of sport, and strengthen the sports industry.

It will position sport and physical activity through the next decade and beyond for all Australians and reflects the Government's strong commitment to link sport, physical activity, and preventive health.

Under Sport 2030, the Government will reframe sport policy to include physical activity, as well as organised and high-performance sport, and commit to reducing inactivity among Australians by 15 per cent by 2030.

This will mean that participation in sport and physical activity will be ramped up across the country, so every Australian can be either playing sport, be part of it, or engaged in healthy, active living.

Online form to report dodgy medical ads

Seen a medical ad that doesn't look quite right? You can now report dodgy ads for medicines and medical devices through a single online form.

The Therapeutic Goods Administration (TGA) has launched a web hub bringing together news and information about the regulation of therapeutic goods advertising, including fact sheets, e-learning modules, and forms for reporting unfair or misleading advertising, and submitting enquiries.

The TGA is now the sole body for handling complaints about medicine and medical device advertisements aimed at the public, with new sanctions and penalties for advertisers who do not comply with regulations.

The revised Therapeutic Goods Advertising Code has also been published.

The hub is available at https://www.tga.gov.au/advertising-hub and the Code is available at https://www.tga.gov.au/publication/therapeutic-goods-advertising-code.

Mandatory reporting

In response to an AMA recommendation, the COAG Health Council has approved a targeted consultation process for amendments to mandatory reporting requirements by treating practitioners.

The targeted consultation process will seek feedback on proposed legislation that strikes a balance between ensuring health practitioners can seek help when needed, while also protecting the public from harm.

The COAG Communique states that the consultation process will involve professional bodies representing each registered health profession, consumer groups, National Boards, and professional indemnity insurers.

The results of the consultation process will inform a Bill, which will be presented to the Queensland Parliament as soon as possible.

Western Australia is not included in this process. Its current arrangements will continue.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

More consultation needed on Gold, Silver, Bronze, and Basic policies, AMA tells Senate Committee

The AMA has called for more consultation on proposed private health insurance reforms, arguing that the changes will need to work with the Medicare Benefits Schedule (MBS) Review, which is still underway.

AMA President, Dr Tony Bartone, told a Senate inquiry into the Gold, Silver, Bronze, and Basic system that the AMA supports standard clinical definitions, as coverage for a condition should not vary between insurers and policies.

"Standard clinical definitions are one policy lever to stop this," Dr Bartone said.

"But to make them work, we need to engage with each specialty within the medical profession.

"Right now, the Government has released the private health insurance rules for comment. They have done this before the Senate has finished its deliberations, before this legislation is finalised.

"These rules outline what the Medicare Benefits Schedule (MBS) items are that 'sit behind' the definitions.

"More time is needed on this critical work. It would be wise for there to be more consultation and a better outline of how these reforms will work in tandem with the MBS Review, which is of course updating all these items and their descriptors."

Dr Bartone said the AMA welcomed the decision not to allow restrictions in the Gold, Silver, and Bronze policies, and acknowledged the effort the Government is going to, in order to make private health insurance more affordable for younger Australians.

But he urged the Government to be careful.

"We don't support dismantling community rating. This must be protected to maintain equity of access to private health treatment," Dr Bartone said.

The AMA is disappointed that pregnancy cover has been limited to Gold policies, he said.

"It does not make sense to us, as clinicians, to have pregnancy cover in a higher level of insurance only," he said.

"Many pregnancies are unplanned, meaning people are caught out underinsured when pregnancy is restricted to high-end policies.

"Pregnancy is a major reason that the younger population considers taking up private health insurance.

"They are less likely to be able to afford the higher-level policies. We need to make sure it is within reach."

The Senate Committee was due to report on 13 August.

The CARs that ate hospitals

The Australian Commission on Safety and Quality in Health Care has released its latest six-monthly report for the National Alert System for Critical Antimicrobial Resistance (CARAlert) system, which shows the continuing threat of antimicrobial resistance by dangerous bacteria.

The two key findings in the report highlight the prevalence of *Carbapenemase-producing Enterobacteriaceae* or CPE (in the hospital setting) and *Neisseria gonorrhoeae* (in the community).

The report found that:

- Continued volume of CPE reports (255 in 6 months to 31 March) highlight the importance of effective infection prevention and control to help combat the threat of antimicrobial resistance.
- For the first time, two extensively drug-resistant *N. gonorrhoeae* infections have been reported in Australia, following a report in the United Kingdom of a similar strain.
- 653 CARs were reported by 58 participating laboratories between October 2017 and 31 March 2018 – a similar number to same period in previous year.
- 48 per cent of CARs were detected from patients attending hospitals.

The report is at www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/what-is-aura/national-alert-system-for-critical-antimicrobial-resistances-caralert/

Shared Responsibility

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

> "If the Department hopes to increase compliance through education, it needs to have on staff medical advisers who understand the legislative requirements and have experience in their application."

New amendments to the Health Insurance Act 1973, strengthening the Government's debt recovery powers and seeking to tackle the role of corporate entities in billing under Medicare, have recently been passed by Parliament.

Practitioners may have a debt to the Commonwealth raised against them due to receipt of incorrectly, inappropriately, or fraudulently claimed Medicare benefits. However, according to the Government, a large proportion of these debts has proven difficult to collect. New powers will allow the Department of Human Services to off set a portion of future bulk billed claims against debts. If the practitioner doesn't bulk bill, the new arrangements will allow garnisheeing of other funds owed to them.

So, more than ever, it is in practitioners' interests to get their claiming right from the outset.

The problem, as many of you have no doubt found, is trying to get clarity when you are unsure of how to interpret an item or an applicable rule. The Department of Human Services 'ask MBS' email for billing enquiries was supposed to provide this. However, the answers are often very unclear or non-committal.

What you are likely to get today, at best, is the regurgitation of either the item descriptor, rules, or legislation back in response to a query. At worst, you will get a misinterpretation and advice that is contrary to the rules. The incorrect advice recently provided to a GP Registrar that GPs could not claim a consultation when providing a vaccination, where the vaccine is funded under the National Immunisation Program, is a prime example.

This is not good enough and must be addressed! The AMA Council of General Practice recently made this point to the head of compliance at the Department of Health. If the Department hopes to increase compliance through education, it needs to have on staff medical advisers who understand the legislative requirements and have experience in their application. The Department of Health should also consider bringing 'ask MBS' within its realm of responsibility.

The other legislative change, which will take effect on 1 July 2019, is provision for a Shared Debt Recovery Scheme. To date, all the liability for a Medicare debt has been with the individual practitioner, except in cases where another party has engaged in fraud. The new change provides that, where contractual or other arrangements exist between a practitioner and an employer or corporate entity, both may be held responsible for the repayment of the debt.

What the percentage split of the liability between the employing/contracting organisation and the individual practitioner is, is still to be finalised. Although it is likely it will be similar to the average of current billing splits. Both sides will have the opportunity, where a shared debt determination is made, to make a case for a review of assigned liability.

The objective of this measure is for a fairer assignment of liability and to facilitate greater billing assurance from a practice level as well as from the practitioner level. This is a proposal that the AMA strongly supported as part of improving debt recovery arrangements.

We are still to see how these new compliance arrangements will play out in practice. Most GPs seek to do the right thing, and the AMA be watching the implementation of these measures with interest to ensure its fairness and appropriate application.

Providing primary care for refugees

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

Imagine. You have been asked to organise health care for a population of 70 million people. They are not well off – in fact, most are poor. Many different nationalities and ages are represented and they are to be found in well over 20 countries scattered across the face of the earth. Where would you begin?

The population I have in mind for you to care for comprises all the displaced persons in the world at present. So, at first blush, my request to you is ridiculous.

There are many demands. The Rohingya mother with a child with diarrhoea in the Kutupalong refugee settlement in Bangladesh will require entirely different care to the 55 year old man with pneumonia in one of the boats smuggling refugees from Somalia to Yemen. But the provision of basic medical care remains a possibility for more of these displaced people than we think.

The 70 million displaced persons in the world comprise such a vast geopolitical problem I find it easy to think – in my despair – that there is nothing that can be done. But the Rohingya refugee, Nur Jahan, I referred to was able to take three year-old-daughter Amina to a primary health clinic (pictured) in the refugee settlement in southeast Bangladesh for immediate treatment. The facility is operated by the UNHCR and is open 24 hours a day. And it is one among hundreds serving refugees.

Well over 90 per cent of consultations are for acute infections. The range of services offered through primary care in dozens of countries are comprehensive, ranging in focus from HIV through child survival to food security.

The power of primary care to manage potentially lethal illness, especially in children, should reinforce our view of the importance of primary care in Australia. Immunisations and basic public health measures can be provided through primary care with great benefit in even the most difficult circumstances.

The 2017 progress report and public health overview from UNHCR – the office of the United Nations High Commissioner for Refugees http://www.unhcr.org/news/stories/2018/7/5b5050344/despite-record-displacement-2017-unhcr-notes-public-health-gains.html – states that primary care-based efforts have been successfully directed to the treatment and immunisation against diphtheria.

> *"...in the densely populated refugee settlements in south-eastern Bangladesh where refugees live in tightly packed bamboo-framed shacks — as well as typhoid in Rwanda and monkey pox in the Democratic Republic of the Congo."*

It is not commonly known that great progress has been made since 2000 in child survival. This is worldwide and immunisation has been a central plank in this achievement. UNHCR has been making a contribution. The mortality rate for under-fives has been steadily declining worldwide at 0.4 deaths per 1,000. (The fourth Millennium Development Goal – reduce child mortality – was met. The web site reports that:

- Between 1990 and 2015, the global *under-five mortality rate* has declined by more than half, dropping from 90 to 43 deaths per 1000 live births.
- Between 1990 and 2015, the *number of deaths* in children under five worldwide declined from 12.7 million in 1990 to almost 6 million in 2015.)

Mental health care for refugees remains rudimentary and is directed principally to the major psychoses and epilepsy, despite the potential for preventive work among those traumatised by their experience of disruption and displacement.

All of which is definitely a feather in the cap of primary care.

There is a growing appreciation worldwide of the value of effective primary health care whether through supplicated, principally medically staffed services in economically advanced communities, or the use of health workers with elementary skills in less economically privileged nations or in regions where doctors and nurses are unavailable. It is a great tribute to agencies such as UNHCR and similar organisations, many dependent on volunteers and donor support, that the misfortune of 70 million displaced people can be so often relieved through primary care.

Membership is a two-way street

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

Doctors understandably ask, "What is the AMA doing for me?" They look to find value in a service they purchase for a monthly fee of $123. Non-members do not join if they do not see worth in the money they would spend.

In my view, the question is ass backwards. Rather, every member or non-member ought to ask, "What can I do for the AMA?"

> "Our mental health, our rates of depression, alcoholism and suicides is higher than our city medical cohort. Eventually, many of you leave the rural regions because it is unsustainable for you."

Because us paying AMA members are not spending a monthly fee to gain a service. No. We are joining a professional network, the most recognisable medical brand in Australia. The fee gives us the privileges and the duties to be an AMA member.

Rural doctors are sadly not seeing this. AMA membership is lower in rural areas.

Yet, it is we, the rural cohort, that needs the AMA the most. We are challenged with isolation, being a lone wolf in a community, not having professional networks to support us in times of need. And, we are a sponge of needs. We want a medical community, we need advocacy in issues not understood by the urban administrators, and we seek Continuing Medical Education to feel good about our clinical acumen. We need a voice to be heard, and someone who can see our vision.

Where are those needs being met? The AMA is not the only professional networking organisation. Rural Doctors Association of Australia, RACGP - Rural, ACRRM are other choices. The organisations need not have "Rural" in their name, but they ought to be medical.

Sometimes the needs are unaddressed. Our mental health, our rates of depression, alcoholism, and suicides is higher than our city medical cohort. Eventually, many of you leave the rural regions because it is unsustainable for you.

So, what are some of the duties that can engage AMA rural members, so you can receive while you are gaining?

Well, you can come to the party. You can sign up, join a teleconference, a webinar, send in an email opinion on some rural issue. Yes, it is work. No kidding, you read papers as thick as telephone books, you sweat when you are asked questions that have NO ANSWER, your heart aches when you give examples of the rural health gap.

Have you received support from your State AMA office? Yes? Then, give it back. Volunteer to be a support for another. No? Then, get involved in AMA State functions. Tell them you needed support and it was missing. Until you are part of the solution, you are part of the problem.

Sometimes, you go to a conference in some big city, like Darwin. To get there you travel a dirt unsealed road or catch a prop plane that comes to your community a few times a week. The financial sacrifice you make is more than just the cost of the conference. You lose at least a day of income getting to the venue and another day of lost income as you get yourself back. There, at the Rural Conference, you will talk to others with red dust on their four-wheel drive. You meet your family.

How do I know you are not coming to the party? At the most recent election for the position I sit in, the Chair of the Council of Rural Doctors, all of you who identify as rural, received a ballot. Can you guess how many of you came to the party to just cast a vote? Fewer than 10 per cent. The election was a reflection of engagement. Those of you who did not vote, please feel guilty RIGHT NOW.

To quote JFK, "Ask not what your country can do for you, ask what you can do for your country".

My gratitude to Dr Chris Clohesy, NT representative to the AMA Council of Rural Doctors, for the seed of the idea of this article, especially the JFK quote.

Great Expectations (A tale of two systems): a saga of mental health care access

BY DR BERNADETTE WILKS, DEPUTY CO-CHAIR, AMA COUNCIL OF DOCTORS-IN-TRAINING

They say it takes a village to raise a child. I say it takes seven doctors, four friends with a spare room, and over $20,000 in under two weeks for a junior doctor to access appropriate mental health care. At least that was my experience over a five- month period when I assisted a friend and colleague to navigate the Victorian mental health care system.

I naively anticipated that my friend, as a doctor, would have streamlined access to the best mental healthcare. But the experience was nothing of the sort. Instead, I have been left in shock over the complete lack of affordable services, the scarcity of acute services, and the disenfranchisement felt by patients and their loved ones when engaging with mental health care services.

This shock is not a response to the work of health care workers. On the contrary, it is their herculean hard work that compensates for scarce resources. Instead, it is a disbelief that despite increased societal focus on improving the mental health of all Australians, the required infrastructure is crumbling.

The process to assist my friend started with a call to the CATT team, a 24-hour psychiatric crisis assessment service linked with public hospitals, who triage the need for inpatient or outpatient care. The wait time was three hours and, as compassionate and informative as the CATT team was, they could provide no guarantee they would be available if my friend needed an acute admission to a public psychiatric hospital. Unfortunately, one night, when there were concerns she was a danger to herself, the CATT team were called but were already busy with another mental health crisis. So, we had to resort to calling the police. As can be anticipated, having the police turn up to my friend's house and force her into a car bound for a hospital at which she had previously worked only added to the trauma.

The next challenge faced by patients admitted to hospital after an acute mental health crisis is the step-down to outpatient care. Only patients at risk of imminent harm to themselves, or others, access acute public hospital beds, of which there are too few, and consequently patients are often discharged prematurely. My friend applied for admission to a private psychiatric hospital but there were no beds immediately available and there was no time frame for when the bed would be available. In the interim, she needed a place to stay. She was not well enough to be on her own so, rotated between friends and family with enough space, time, and dollars to assist until a private inpatient bed became available.

The total cost for my friend's one-and-a-half-week admission was over $20,000. To add insult to this bank injury was the poor care provided. My friend saw her psychiatrist for around 10 minutes a day, except for one day when the consultation lasted 20 minutes, but ended with a throwaway line that my friend may have a borderline personality disorder and should look up for herself what such a diagnosis means.

Clearly, this experience deterred her from wishing to seek further care, confused her parents as to why so much money had led to such poor care, and exasperated me as to what I could actually do to help her get better. Even being in a position to access additional advice from psychiatrist friends was not sufficient to bridge the gap between need and service provision.

At the most recent CDT meeting, the Council were updated on the progress of *Caring for Those Who Care: Preventing anxiety, depression and suicidal behaviour among Australia's medical workforce* project, overseen by the AMA in conjunction with BDI, Orygen, United Synergies, and Everymind, and funded by the Government and the Black Dog Institute as part of a broader $47 million suicide prevention initiative. Updates were also provided by a Director of the AMA's subsidiary, Doctors' Health Service, on innovative proposals to utilise the further funds promised by the Health Minister at the 2018 AMA National Conference. CDT discussed the promising avenues of telehealth, incentives such as CPD points for GP visits to promote self-care, and the continued issue of poor DiT awareness of free services such as State-based doctors' health advisory services.

And yet, I left the discussion with an inescapable sense of futility that we are directing doctors to seek help from a broken system. My heart breaks to think how much harder it must be for the rest of society to access mental health care.

The system is broken.

The Medicare rebates for clinical psychology sessions are capped at six to 10, and yet evidence clearly demonstrates that at least 16 sessions are needed to evoke change in conditions such as eating disorders and obsessive-compulsive disorder. Patients who attend ED with suicidal ideation attempts may be coerced into falsely denying their intent to make it easier for hospitals to manage the mismatch between service demand and beds. Australia needs more psychiatric care workers and yet, at present, the Royal Australian and New Zealand College of Psychiatrists struggles to fill its training places.

While efforts to address the unique aspects of doctors' mental health abound, tailored approaches do nothing to fill the void where quality, broadly available, adequately resourced mental health services should be. Urgent, bipartisan support is needed to raise the bar of mental health care provision to meet community demand. Doctors aren't always that different, after all.

2018 AMSA National Convention: Welcome to Perth-fect engagement

BY ALEX FARRELL, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

In early July this year, the Australian Medical Students' Association held our 59th National Convention in Perth. As the world's largest student-run conference, it hosted more than 1000 medical student delegates from across Australia and New Zealand. It was a week of innovative academic and social programs, enhanced by intervarsity competitions, field trips, and workshops. A team of over 100 student volunteers from universities in Western Australia worked for two years to make this huge undertaking possible.

As always, the National Convention was an opportunity for students to showcase their talents, ranging from research with poster presentations and 3 Minute Thesis, Sports Day competitions, debating (won by Monash University), and the Emergency Medical Challenge (won by University of Western Australia).

The academic program was full of motivational Australian and international plenary speakers showcasing contemporary health issues.

The program opened with Burns Specialist, Prof Fiona Wood, speaking to students about harnessing the power of science and technology to strive towards excellence in health care. We were fortunate to be joined by former AMA Presidents, A/Prof Rosanna Capolingua, who spoke on navigating leadership in the medical community, and Dr Michael Gannon, who reflected on his experiences within both AMSA and the AMA, and the advocacy that both groups drive forward. Dr Nikki Stamp spoke on paying attention to detail while not becoming overwhelmed by the minutiae.

There was the opportunity to hear from doctors about working in every context imaginable, from Dr Jeff Ayton's experiences in Antarctica, Dr Nick Coatsworth travelling from Congo to Darwin with Medecins Sans Frontieres, and A/Prof Gordon Cable's work in aerospace medicine.

There was also an array of fantastic speakers bringing their expertise from outside the medical world. Steven Bradbury's recollections of his remarkable Olympic victory included messages that are applicable to all of our daily lives; memory athlete, Daniel Kilov, shared the techniques that make his work possible; and social advocate, Yasmin Abdel-Magied, spoke on challenging stereotypes through personal interactions and navigating a hyper politicised world.

Students left with increased clinical understanding, having battled it out against the hosts of the 'IM Reasoning' podcast run by Dr Nic Szecket and Dr Art Nahill in an interactive case reasoning session; heard from Prof Nick Talley on negotiating OSCEs and clinical examination; and participated in workshops on everything from reading ECGs to performing rhomboid skin flaps.

From doctors' mental health to social issues and innovative medical practice, students learnt about the prominent issues of today's medical landscape, as well as seeing the endless pathways and opportunities medicine can lead to. Perth Convention 2018 aspired for delegates to discover parts of life and medicine they never knew about before, engage in important issues, meet incredible, like-minded people, and be inspired to leave a lasting positive impression on the field of medicine in Australia.

So, Discrimination is still OK if you are a Public Hospital Doctor?

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF PUBLIC HOSPITAL DOCTORS

When the doctor failed in law to have her interstate service recognised for the purposes of accessing a paid parental leave entitlement (the details of the case are below), it was said by an (accurate) wag, *"the law said she wasn't discriminated against because she was female or because she was pregnant; she was discriminated against because she is a doctor and it turns out that's not illegal"*. This is a problem your AMACPHD, in concert with ASMOF, has resolved to fix.

> "Without this protection, the technical meaning of service continuity can be easily broken, causing zero entitlement."

I have worked to ensure AMA Victoria/ASMOF Victoria's Enterprise Agreements have for some time now counted any employed doctor's interstate public hospital work (and actually also any time worked in accredited private sector positions) as part of the minimum 12-month continuous service required to enliven a paid parental leave entitlement. Despite the merits being obvious, this negotiated outcome has, so far, not been achievable in other jurisdictions. Without this protection, the technical meaning of service continuity can be easily broken, causing zero entitlement. This may occur even when the [typically] pregnant or any-gendered primary carer doctor has not stopped working in Australian public hospitals since their graduation. The continuously-employed person has crossed a jurisdictional boundary.

Medical practitioners are a necessarily mobile workforce. For those in accredited training, choice of work location can be limited, so the absence of parental leave portability penalises the doctor simply for pursuing their Fellowship requirements. For specialists and career medical officers, keeping this antiquated barrier disincentivises their interstate mobility. Easy access to different clinical settings and experiences which enhance patient care is reduced; not to mention that potentially underserviced communities miss out on a doctor!

So, without a change to the way in which parental leave entitlement is managed, where does the modern law stand? If you wish to research it, the case to which I have alluded is cited as *2009 NSWADT 148*, from the NSW Administrative Decisions Tribunal. The case concerned a NSW public hospital doctor's parental leave being refused for lack of service continuity even though all of her training career had been in NSW, but for a College-directed one year training move to Victoria before returning. The case decision did state that, while it was not a discriminatory outcome, it was an "inequitable" result given the doctor had, for over 10 years, worked continuously for Australian public hospitals. The case decision made favourable obiter dictum to the existing availability of Long Service Leave portability suggesting the same rule could be expanded to parental leave because, that would *"not only be fair but consistent with the underlying objective of the Anti-Discrimination (NSW) Act"*.

With these views in mind, the immediate past AMA President recently wrote to the Australian Health Ministers' Advisory Council (AHMAC, a sub-committee of the Council of Australian Governments) arguing for what would be a pretty straightforward amendment to public service recognition rules. The President squarely pointed out to AHMAC that the existing entitlement framework was now entirely out of step with the fact that 40.7 per cent of the (2016) medical workforce are female, and that there is an additional perceivable trend for males to take on primary carer responsibilities.

If the opportunity arises, of course your AMACPHD will be involved in consultation to ensure no perverse outcomes arise from rule drafting or change implementation. For now, our focus is to remove this silly barrier to career paths and to show our support for further moves towards a positive modern culture. Also in the mix for AMACPHD is that female practitioners are undesirably underrepresented in leadership roles, and we think this change would assist the promotion of equality of opportunity. It's good public policy and it's confirmed to be consistent with the intended thrust of anti-discrimination law. Nothing should stop Health Ministers from delivering this much-needed and overdue, sensible change.

Pharmacist prescribing – what the AMA thinks

BY A/PROF ANDREW C MILLER, CHAIR, AMA MEDICAL PRACTICE COMMITTEE

When the AMA cautions against independent prescribing of schedule 4 and 8 medicines by nurses, optometrists, pharmacists, and other non-medical health practitioners, we are usually accused of trying to 'protect our turf'.

In fact, the AMA supports many models of non-medical practitioner prescribing.

The critical factors for the AMA in considering non-medical practitioner prescribing are that it: is within the scope of practice, training and expertise of the health practitioner; occurs within a medically-led and collaborative health care team; and, above all, does not compromise patient safety. It is for these reasons that we fully support dentists independently prescribing. Dentists are trained to prescribe medicines for dental conditions and prescribe within their scope of practice.

The Pharmacy Board of Australia recently hosted a stakeholder forum to discuss pharmacist prescribing, which was attended by the AMA. The Board is keen to explore the potential for pharmacists to prescribe, initially within a hospital or general practice setting.

Pharmacist prescribing is an excellent example to illustrate the AMA's position on non-medical prescribing and why we urge a conservative and sceptical approach to expansions of scope of practice into prescribing.

Firstly, the Pharmacy Board argues that pharmacist prescribing is necessary to meet an unmet demand. This argument is nearly always used by non-medical practitioner organisations when seeking to prescribe medicines. However, the AMA is yet to see good quality, consistent evidence that demonstrates superior effectiveness - and cost-effectiveness - of non-medical health practitioner prescribing compared to medical practitioner prescribing.

Without evidence of improved outcomes for patients and the health care system as a whole, the AMA does not support expanding prescribing for the sake of a health practitioner's career satisfaction. Indeed, Health Ministers have agreed that expansion of non-medical prescribing should not occur without this evidence.

Secondly, the AMA strongly believes in a strict separation between prescribing and dispensing. We have applied this long-standing policy to our own profession. In fact, at the AMA's annual National Conference in May this year, we reaffirmed this strong position. Medical practitioners should only ever dispense medicines in situations where pharmaceutical services are unavailable. For example, in remote areas of Australia. This removes any potential conflict of interest in deciding the most appropriate treatment for patients, which medicine to prescribe, or not to prescribe at all.

There is an inherent conflict of interest with any pharmacist associated with a community pharmacy being involved in prescribing that should not be overlooked. Even if a community pharmacist were simply 'continuing' an existing prescription initiated by a medical practitioner, the commercial benefit of recommending additional 'complementary' medicines is undeniable.

Thirdly, the AMA opposes independent prescribing of Schedule 4 and 8 medicines by non-medical practitioners because of the risks to patient safety.

Only medical practitioners are trained to take a comprehensive history, examine, and put together the whole person when making a diagnosis, initiating investigation, management, and treatment. Only medical practitioners are trained to know the full range of clinically appropriate treatments for a given condition, including when not to prescribe; and to understand the potential impact of treatments on other unrelated conditions that may co-exist.

We do support, and value, non-medical health practitioners prescribing under the following medically-led and/or supervised models:

- prescribing by protocol or limited formulary;
- initiating therapy according to protocol and symptoms; and
- continuing, discontinuing, and maintaining therapy according to a pre-approved protocol.

Most non-medical prescribing occurs in public hospital or primary health care settings where these collaborative care models work well. For example, in a public hospital, care by a nurse practitioner, which includes prescribing, occurs under a protocol that covers the care provided by a clinical unit. The protocols clearly set out: the medications a nurse practitioner can prescribe; in what circumstances they can prescribe; and when the nurse practitioner will refer the patient to a medical practitioner.

If pharmacists wish to prescribe, they will need to provide compelling evidence and detailed examples of models and settings where an ability to prescribe medicines, rather than provide advice about medication management as they do now, will improve outcomes for patients compared to the care provided by currently endorsed prescribers.

Conscientious Objection: the AMA is Listening

BY DR CHRIS MOY, CHAIR, AMA ETHICS AND MEDICO-LEGAL COMMITTEE

The AMA's Ethics and Medico-Legal Committee is undertaking a routine, five-year review of the AMA's *Position Statement on Conscientious Objection 2013*. While the definition of a conscientious objection is itself being reviewed, the current Position Statement states that it occurs when a doctor refuses to provide, or participate in, a legal, legitimate treatment or procedure because it conflicts with his or her own personal beliefs and values. A conscientious objection is based on sincerely held beliefs and moral concerns, not self-interest or discrimination.

> "But does this go far enough to ensure that those patients seeking a legal treatment are not impeded in accessing the care they seek by a doctor with a conscientious objection?"

The issue of conscientious objection is increasingly relevant for the medical profession, particularly in terms of legislation related to abortion, as well as the emerging area of voluntary assisted dying. Relevant legislation generally recognises that doctors have a right not to provide a treatment or procedure to which they conscientiously object; however, the area of contention largely lies in whether or not a doctor invoking a conscientious objection must refer the patient to another practitioner.

In relation to abortion, some States mandate such a referral (such as Victoria), while others do not. Interestingly, while the state of Victoria mandates referral in terms of abortion, it does not do so in terms of the new voluntary assisted dying legislation.

The Federal AMA's current policy does not specifically address the issue of referral. Instead, it says that:

> *A doctor who makes a conscientious objection to providing, or participating, in certain treatments or procedures should make every effort in a timely manner to minimise the disruption in the delivery of health care and ensuing burden on colleagues. If you hold a conscientious objection, you should inform your patient of your objection, preferably in advance or as soon as practicable and inform your patient that they have the right to see another doctor. You must be satisfied the patient has sufficient information to enable them to exercise that right. You need to take whatever steps are necessary to ensure your patient's access to care is not impeded.*

But does this go far enough to ensure that those patients seeking a legal treatment are not impeded in accessing the care they seek by a doctor with a conscientious objection?

This is a discussion that our Federal Council will have at their meeting in August. Council will consider whether the AMA should support the concept of 'effective referral'. While the definition of "effective referral" is itself under review, it is sometimes defined as the requirement of a doctor with a conscientious objection to refer a patient in a timely manner to another doctor who the practitioner reasonably believes does not have a conscientious objection to the treatment being sought. Council will also consider issues such as:

- in what situations is mandating effective referral appropriate, if any? (eg, abortion, contraception, IVF, voluntary assisted dying); and
- how can doctors working in facilities with institutional conscientious objections assist patients in receiving the care they seek?

Following this initial discussion by Federal Council, the Ethics and Medico-Legal Committee will consult with State and Territory AMA offices to ensure members have the opportunity to provide their views on this very important issue. We will keep members informed of the progress of the review, consultation opportunities, and the policy decision-making process.

In the meantime, if you have any questions regarding the review of AMA policy on conscientious objection or would like to express your views on this topic, please email ethics@ama.com.au.

Research

BY JOHN FLANNERY AND MARIA HAWTHORNE

Higher rates of chronic disease as Australians live longer

Australians are generally healthy and living longer lives but, as a result, rates of chronic disease and age-related conditions are rising, the latest snapshot of the nation's health shows.

Australia's Health 2018, released by the Australian Institute of Health and Welfare, shows that Australia is in the top third of OECD countries when it comes to life expectancy, but one in two Australians has a chronic health condition.

Fewer Australians are smoking or putting themselves at risk from long-term alcohol use than in the past, and more children have been immunised.

"But with a population that is living longer, we are now experiencing higher rates of chronic and age-related conditions," AIHW CEO Barry Sandison said.

"Half of Australians have a common chronic health condition, such as diabetes, heart disease, a mental illness, or cancer. Importantly, almost a quarter of us have two or more of these conditions, often making our experiences of health and health care particularly complex."

Mr Sandison said that about one-third of Australia's disease burden is due to preventable risk factors, such as smoking, excessive alcohol consumption, and not getting enough exercise.

"Our expanding waistlines are a notable example," he said.

"About six in 10 adults - or 63 per cent - are either overweight or obese, while carrying too much weight is responsible for seven per cent of our total disease burden."

The two-yearly report shows a clear connection between socioeconomic position and health. Compared with people living in Australia's highest socioeconomic areas, those in the lowest group are almost three times as likely to smoke or have diabetes, and twice as likely to die of potentially avoidable causes.

Life expectancy for Indigenous Australians has improved over time. However, the estimated life expectancy for an Indigenous boy born between 2010 and 2012 was 10.6 years lower than for a non-Indigenous boy, and for girls the difference was 9.5 years.

The report can be read in full at https://www.aihw.gov.au/reports/australias-health/australias-health-2018

On an average day in Australia

850
babies are born

440
people die

380
people are diagnosed with cancer

170
people have a heart attack

100
people have a stroke

14
people are newly diagnosed with end-stage kidney disease

1,300
people are hospitalised due to an injury

8 women & 2 men
are hospitalised due to assault by a spouse or domestic partner

Source: Australian Institute of Health and Welfare – Australia's Health 2018

Research

CSIRO whacks Aussie mozzies

CSIRO reports that one of the world's most widespread disease-spreading mosquitoes, the *Aedes aegypti*, has been suppressed by more than 80 per cent in a landmark Australian trial.

In an international partnership between CSIRO, Verily, and James Cook University, scientists used specialised technology to release millions of sterilised male *Aedes aegypti* mosquitoes across the Cassowary Coast in Queensland in a bid to combat the global pest.

CSIRO Director of Health and Biosecurity, Dr Rob Grenfell, said the results were a major win in the fight against disease-spreading mosquitoes.

"The invasive *Aedes aegypti* mosquito is one of the world's most dangerous pests, capable of spreading devastating diseases like dengue, Zika, and chikungunya, and responsible for infecting millions of people with disease around the world each year," Dr Grenfell said.

"Increased urbanisation and warming temperatures mean that more people are at risk, as these mosquitoes, which were once relegated to areas near the equator, forge past previous climatic boundaries.

"Although the majority of mosquitoes don't spread diseases, the three mostly deadly types - the *Aedes, Anopheles* and *Culex* - are found almost all over the world and are responsible for around 17 per cent of infectious disease transmissions globally."

From November 2017 to June this year, non-biting male *Aedes aegypti* mosquitoes sterilised with the natural bacteria *Wolbachia* were released in trial zones along the Cassowary Coast in North Queensland.

They mated with local female mosquitoes, resulting in eggs that did not hatch and a significant reduction of their population.

Climate change and health

According to experts interviewed by *ABC News*, Australia is missing out on billions in short-term health savings that could come with tougher greenhouse emission targets.

Tony Capon, Professor of Planetary Health at the University of Sydney, says that air pollution can lead to premature deaths and problems such as heart attacks and asthma.

He and others point to ballpark figures suggesting the energy and transport sectors alone cost Australia at least $6 billion a year in health problems.

"They're conservative figures and we're not taking account of this information in our public policy," Professor Capon said.

"We consider these costs external and we don't look at the full ledger."

Experts like Professor Capon argue that a move towards less-polluting forms of energy and transport would deliver much-needed savings to Australia's budget bottom line.

Research suggests cutting emissions can pay for itself through savings on health costs, not only in China but in developed countries too.

Burning fossil fuels produces CO2, which is bad for the climate, but it also tends to produce air pollutants such as sulphur dioxide, nitrogen dioxide and very fine particles that can play havoc with our respiratory and cardiovascular systems, even in countries with good pollution laws.

While air pollution levels in Australia may be low when compared to countries such as China, there is evidence that even low levels can be damaging to health.

Drug use the source of one in four new hepatitis C infections

Two in five people who have injected illicit drugs in the past year are living with hepatitis C, highlighting the urgent need for prevention and treatment, new Australian research shows.

Researchers from the Kirby Institute at the University of New South Wales and the National Drug and Alcohol Research Centre (NDARC) estimate that 6.1 million people who inject drugs are living with hepatitis C globally, with one-quarter of new infections occurring in people who inject drugs.

It is the first time that researchers have estimated the global, regional, and national numbers of people who inject drugs who are living with hepatitis C.

Lead author, Associate Professor Jason Grebely, said that, in Australia, almost 40,000 people who have recently injected drugs are living with HIV. However, Australia is one of only four countries worldwide with high coverage of both needle and syringe programs and opioid substitution therapies.

Research

"Australia has been an international leader in its response to hepatitis C," Associate Professor Grebely said.

"The fact that hepatitis C treatments are available for all individuals, without restrictions based on current or previous drug use, means that we are likely to achieve the World Health Organization goal to eliminate hepatitis as a major public health threat by 2030, including among people who inject drugs."

However, the outlook is not so bright globally, with only one per cent of people who inject drugs living in countries where needle and syringe programs and opioid substitution programs are widely available.

The greatest number of people with hepatitis C who have recently injected drugs live in eastern Europe, east and south-east Asia, and North America, and more than half of them live in just four countries – Russia, the United States, China, and Brazil.

"It is concerning that more than half of all hepatitis C infections among people who have recently injected drugs occur in countries with inadequate coverage of harm reduction services," Judy Chang, from the International Network of People Who Use Drugs, said.

"The global elimination of hepatitis C as a public health threat will not be achievable unless we improve access to harm reduction services, de-stigmatise drug use and drug users, and improve the overall health of people who use drugs."

The researchers estimate that about 71 million people world-wide are living with hepatitis C.

The research was published in *Addiction* on 24 July.

Studies spell double trouble for women

There's been a double whammy of bad health news for women, with one study finding that women with diabetes are more likely to develop cancer, and a second finding that women are twice as likely as men to be under-treated for heart attack.

In the first study, researchers from The George Institute for Global Health reviewed the health outcomes of almost 20 million people involved in 47 studies.

They discovered that having diabetes – type 1 or type 2 - significantly raises the risk of developing cancer, with a significantly higher risk for women.

Women with diabetes were 27 per cent more likely to develop cancer than women without diabetes. For men, the risk was 19 per cent higher.

Overall, women with diabetes were six per cent more likely to develop any form of cancer than men with diabetes.

"The link between diabetes and the risk of developing cancer is now strongly established," lead author, Dr Toshiaki Ohkuma, said.

"We have also demonstrated, for the first time, that women with diabetes are more likely to develop any form of cancer, and have a significantly higher chance of developing kidney, oral, and stomach cancers, and leukaemia.

"The number of people with diabetes has doubled globally in the past 30 years, but we still have much to learn about the condition.

"It's vital that we undertake more research into discovering what is driving this, and for both people with diabetes and the medical community to be aware of the heightened cancer risk for women and men with diabetes."

The George Institute research was published in *Diabetologia*, the journal of the European Association for the Study of Diabetes.

In the second study, published in the *Medical Journal of Australia*, University of Sydney researchers found that women admitted to 41 Australian hospitals with ST-Elevation Myocardial Infarction (STEMI) in the past decade were half as likely as men to receive appropriate diagnostic tests and treatment.

They were also less likely to be referred for cardiac rehabilitation, and prescribed preventive medications, at discharge.

Death rates and serious adverse cardiovascular events among these women were more than double the rates seen in men six months after discharge.

"The reasons for the under-treatment and management of women compared to men in Australian hospitals aren't clear," lead author and cardiologist, Professor Clara Chow, said.

"It might be due to poor awareness that women with STEMI are generally at higher risk, or by a preference for subjectively assessing risk rather than applying more reliable, objective risk prediction tools.

"Whatever the cause, these differences aren't justified. We need to do more research to discover why women suffering serious heart attacks are being under-investigated by health services, and urgently identify ways to redress the disparity in treatment and health outcomes."

BY JOHN FLANNERY AND MARIA HAWTHORNE

Paris bans smoking in parks

France 24 International News reports that Paris city officials have introduced a new measure to ban smoking in six public parks across the city.

The measure is part of a four-month experiment by the city to reduce smoking in public spaces.

Instead of issuing a ticket or fine, park staff will be tasked with informing tobacco users that smoking is no longer allowed on the premises.

A 2013 study of similar bans in selected parks and beaches in Canada found that, although tobacco use significantly decreased after a 12-month observation period, no venue remained 100 per cent smoke-free.

Another study published the same year by researchers at Columbia University concluded that smoking bans in parks serve to 'denormalise' the act of smoking.

E-cigs in the USA

An *Open Access* article published in the *British Medical Journal* reports that, despite an apparent overall decrease in e-cigarette use in the USA, there are indications that JUUL, a sleekly designed e-cigarette that looks like a USB drive, is increasingly being used by youth and young adults.

However, the extent of JUUL's growth and its marketing strategy have not been systematically examined.

A variety of data sources were used to examine JUUL retail sales in the USA and its marketing and promotion. Retail store scanner data were used to capture the retail sales of JUUL and other major e-cigarette brands for the period 2011–2017.

A list of JUUL-related keywords was used to identify JUUL-related tweets on Twitter; to identify JUUL-related posts, hashtags, and accounts on Instagram, and to identify JUUL-related videos on YouTube.

In the short three-year period 2015–2017, JUUL has transformed from a little-known brand with minimum sales into the largest retail e-cigarette brand in the USA, lifting sales of the entire e-cigarette category.

Its US$150 million retail sales in the last quarter of 2017 accounted for about 40 per cent of e-cigarette retail market share.

While marketing expenditures for JUUL were moderate, the sales growth of JUUL was accompanied by a variety of innovative, engaging, and wide-reaching campaigns on Twitter, Instagram, and YouTube, conducted by JUUL and its affiliated marketers.

The discrepancies between e-cigarette sales data and the prevalence of e-cigarette use from surveys highlight the challenges in tracking and understanding the use of new and emerging tobacco products.

In a rapidly changing media environment, where successful and influential marketing campaigns can be conducted on social media at little cost, marketing expenditures alone may not fully capture the influence, reach, and engagement of tobacco marketing.

Plain packs in legal win

Australia has won a landmark ruling on tobacco plain packaging laws, with a panel of judges at the World Trade Organization (WTO) rejecting arguments brought by Cuba, Indonesia, Honduras, and the Dominican Republic against the legislation.

ABC News reported last month that Honduras says it will appeal the decision, claiming that there are errors in the ruling.

The WTO panel said Australia's plain packaging laws contributed to improving public health by reducing use of and exposure to tobacco products, and rejected claims that alternative measures would be equally effective.

The win for Australia effectively gives a green light for other countries to roll out similar laws. It could also have implications for alcohol and junk food packaging.

Australia's law goes much further than the advertising bans and graphic health warnings seen in other countries.

Introduced in December 2012 by the Gillard Government, the law bans logos and distinctive-coloured cigarette packaging in favour of drab olive packets that look more like military or prison issue, with brand names printed in small standardised fonts.

Studies have shown that the law is an effective measure in stopping people from smoking.

E-cigs in China

A study by the Society for Research on Nicotine and Tobacco, and published in *Oxford Academic*, has found that awareness of e-cigarettes is high among Chinese middle school students, but use remains very low.

The study examined data from the Global Youth Tobacco Survey, which was completed by 155,117 middle school students (51.8 per cent boys, and 48.2 per cent girls) in China.

About 45 per cent of the middle school students had heard of e-cigarettes, but only 1.2 per cent reported using e-cigarettes in the last 30 days. Among those who had never smoked, e-cigarette users were more likely to intend to use a tobacco product in the next 12 months than non-users, and more likely to say that they would enjoy smoking a cigarette.

E-cigarette use was associated with previous experimentation with cigarette smoking, having noticed tobacco advertising in the past 30 days, having close friends who smoke, and thinking tobacco helps people feel more comfortable in social situations and makes young people look more attractive.

The study concluded that e-cigarette use among youth in China remains low, but awareness is high; e-cigarette use was associated with increased intentions to use tobacco; and enhanced prevention efforts are needed to target e-cigarette use among youth.

Chinese youths use e-cigarettes as a tobacco product rather than an aid to quitting. Among never-smokers, e-cigarette users were more likely to have intentions to use a tobacco product in the next 12 months, more likely to use a tobacco product offered by their best friends, and more likely to enjoy smoking a cigarette than non-users.

Medicinal cannabis in the UK

BBC News reports that specialist doctors in the UK will soon be able to legally prescribe cannabis-derived medicinal products.

Home Secretary Sajid Javid said that products that meet safety and quality standards are to be made legal for patients with an 'exceptional clinical need'.

The legalisation follows high-profile cases involving severely epileptic children. Many had previously been denied access to cannabis oil. Other forms of cannabis will remain illegal.

Mr Javid's decision was made after the Chief Medical Officer for England, Prof Dame Sally Davies, and the Advisory Council on the Misuse of Drugs said patients with certain medical conditions should be given access to the treatments.

Their advice was part of a review into medicinal cannabis launched by the Home Secretary following an outcry over Billy Caldwell and Alfie Dingley, who have rare forms of epilepsy, being denied access to cannabis oil.

The parents of the boys say the medicinal cannabis controls their seizures.

The Home Office recently granted them licences to access the treatments.

Obesity in the USA

In an interesting and worrying trend in the USA, a major survey suggests that some people who are declaring they are exercising more may be also reporting that they are becoming more obese.

According to a *Bloomberg* report, about 24 per cent of US adults surveyed last year said they exercise enough each week to meet government recommendations for both muscle strengthening and aerobic exercise, according to a large annual health survey. That was up from 21 per cent in 2015.

But the same survey says 31 per cent of adults indicated they were obese last year, up slightly.

Another, more rigorous government study has also found adult obesity is inching up.

So, if more Americans are exercising, how can more also be getting fatter?

Some experts think the findings may reflect two sets of people — the haves and have-nots of physical fitness, so to speak.

Experts say it's possible the people becoming more active are already normal weight.

The numbers come from an in-person annual national survey that for more than 60 years has been an important gauge of US health trends. Roughly 35,000 adults answer the survey every year, including questions about how often, how long, and how vigorously they exercise in their leisure time.

Polio in PNG

In a recent article in the Lowy Institute's *The Interpreter*, Kaveri Devi Mishra explained how the news of pulse polio resurfacing in Papua New Guinea has created new challenges for a public health care system already confronting many related health problems.

Polio virus is a potentially deadly disease that can spread through communities, causing paralysis and disability, mostly among vulnerable young children.

The World Health Organization (WHO) has confirmed the outbreak, almost 18 years since PNG was declared a polio-free nation.

Papua New Guinea is already ranked by the WHO as having the worst health status in the Pacific region.

The polio outbreak comes at a time when the country is also facing huge challenges from diseases such as malaria, tuberculosis (TB), cancer, diarrhoeal diseases, pneumonia, and HIV/AIDS.

By landmass, population and economy, PNG is the largest nation among Pacific island countries, yet the country's health indicators have either stalled or gone backwards over the past 30 years.

There is only one doctor per 17,068 people in PNG, which is exceedingly insignificant.

PNG has 0.58 health workers per 1000, whereas the WHO recommends 2.5 health professionals per 1000 people for maintaining primary health care.

Ms Mishra says that India might offer a model for eradication. While it was once a hotbed for the polio virus, a massive, nationwide campaign of eradication in India saw it eventually declared polio-free in 2011.

But precautionary measures are still in place. Given India's population is 1.2 billion and PNG's is only 8 million, surely PNG can likewise apply stringent measures against polio.

Medical student killed in Nicaragua

The killing of a medical student in Nicaragua has been condemned by the World Medical Association (WMA).

Brazilian student, Rayneia Lima, was shot while driving home from her hospital shift in Managua, Nicaragua's capital city.

WMA President, Dr Yoshitake Yokokura, said this was a tragic death and illustrated the high risks that doctors in Nicaragua are taking every day in coping with the breakdown of the country's public health care system.

"We repeat our warning about the rapidly deteriorating situation in the country. Attacks on health workers, medical vehicles, and hospitals are unacceptable.

"The Nicaraguan Government must immediately end this state of affairs.

"The breakdown of law and order has undermined basic health care in the country and is endangering all those medical staff who are striving to deliver health care in the midst of this crisis.

"It is the duty of all of us to do what we can to bring this appalling situation to an end."

Wynns Coonawarra – have a cigar

BY DR MICHAEL RYAN

I was swanning around the local bottle shop looking for some inspiration. An old stalwart caught my eye; Wynn's Black Label 2015 Coonawarra Cabernet Sauvignon. There have been some great vintages at modest prices. So, I plucked a few bottles and delivered them home. What I found transported me back to an era when Cabernet and Coonawarra were kings.

The Coonawarra region is quite restricted; a mere 5000 hectares. The 2x20km strip of the classic terra rossa soil is one of the country's most precious wine growing assets. The red soil over limestone originates from a time when the area was an ancient seabed.

The other miracle is the millions-of-years-old subterranean flow of water that provides the very deep-rooted grape vine a source of water. The predictable rain, and a cooler climate that is only 80km from the Southern Ocean, allows for a slow ripening effect, resulting in intense flavour.

A canny Scotsman, William Wilson, recognised in the 1850s the potential to grow excellent fruit in this area and persuaded John Riddoch to do the same in 1861. John Riddoch would go on to become known as the Coonawarra's founding wine father. The name, Coonawarra, is derived from the Aboriginal word for Honey Suckle. Financial depression, the tyranny of distance, and his death in 1901 saw the Coonawarra Fruit Colony severely cropped.

The modern-day Wynn's winery is on the site of John Riddoch's original plantings. The stone, three-gable winery is iconic, and adorns the Wynn's wine labels. Patriarch, Samuel Wynn, a wine merchant from Melbourne, and son, David, became the innovators of the region when they purchased the property in 1951.

Wynn's is no stranger to corporate ownership, having been syndicated since the 1970s. Treasury Estate own the winery now. Testament to sensible ownership is the fact that winemakers, Sue Hodder and Sarah Pigeon, and viticulturist, Allen Jenkins, have a collective of many decades with Wynn's and remain.

The Wynn's team has worked exceptionally hard over the years with improved clonal selection, trellising, and pruning resulting in stellar wines with bang for your buck. Challenges include climate warming and climate fluctuation over the past 15 years.

The 2015 release of the Wynn's Black Label Cabernet Sauvignon is held in high esteem, being the 60th vintage release of this wine. No other Australian vineyard can lay claim to 60 concurrent vintages of Cabernet Sauvignon. The team has nurtured this wine well, as they have the Single Vineyard and V&A series. Not to mention 'Wynnsday' every 1st August. But that's a story for another day.

WINES TASTED

1. Wynn's "The Siding" Cabernet Sauvignon 2016 Coonawarra

Rich vibrant purple colour. The nose is uplifted by bright red fruits with typical cassis notes. The anterior palate is soft with restrained fruit, blueberries, and raspberries, with a notable pause until prominent tannins and acidity balance the wine and give its robust nature. Drink now with Duck Terrine. Cellar 5 years plus.

2. Wynn's Black Label Cabernet Sauvignon 2015

Dark purple, a layered cassis nose with plums, spice, brambly notes. Generous supple palate supported by long integrated tannins. This 60 year anniversary wine is outstanding value. Drink with a chargrilled sirloin. Cellar 10 years.

3. Wynn's The Messenger Single Vineyard Cabernet Sauvignon 2010

Deep purple with brown hues on the rim. A complex nose reflecting its age, with ripe cassis notes enveloped in spicy cigar box aromas with a subdued Coonawarra mintiness. A full flavoured anterior palate, melding in to supportive tannins. The wine is plush with a savoury feel. A venison ragout would match. Cellar another 10 years.

4. Wynn's John Riddoch Cabernet Sauvignon 2009

Deep lively purple colour. The complex ever evolving bouquet impresses with dark plums, cassis, spicy notes, with a trail of mintiness. Over an hour the nose morphs into brooding complex dark fruits with secondary nuances of violets. A generous gorgeous palate that dances into seamless forceful tannins. A wine that will live for 30 years. Have with high-grade, charred, medium wagyu rib fillet.

Timing is everything

BY DR CLIVE FRASER

In my last column, I gleefully mused about what an enjoyable evening I had watching the understated spectacle of the Royal Wedding on Saturday 19th May 2018.

What I didn't mention was the unexpected interruption to my Saturday evening at 9.55 PM precisely with an email in my Inbox from AHPRA.

My immediate reaction should have been one of relief that the good souls at AHPRA were burning the midnight oil catching up with the back-log of complaints so that they can all be dealt with in a timely fashion.

But no, the Royal Wedding was still on the 'telly' and I thought that history in-the-making just wouldn't be the same if I paused and watched the Royal Wedding in catch-up mode.

My paranoia then set in. Could this email from AHPRA be about another vexatious complaint?

Had I failed to delete another favourable post on Facebook, I wondered?

I knew, though, that it must have been a very important message to disrupt myself and countless other doctors on a weekend.

Taking a closer look, though, the message had actually been sent by AHPRA on behalf of the Australian Digital Health Agency advising that, "This year, every Australian will get a My Health Record unless they tell us they don't want one".

I was aware that the esteemed organisation and publisher of this column, the AMA, was supportive of the MHR, but I still wasn't sure why I was being told about all of this on a Saturday evening, and during the Royal Wedding.

Then I realised that the opportunity to opt-out of My Health Record ends on 15th October 2018. Well, the Australian Digital Health Agency better get onto telling us about it, hadn't they?

And no worries at all that most of my patients have no knowledge at all about their digital data going online, and myself and my colleagues are still unsure about what will be shared.

After hearing that the largest online appointment booking app (HealthEngine) was sharing data with law firms, marketers, and other entities, I can understand the general public's reservations about who has access to their health data.

Curiously, HealthEngine still has a data-sharing arrangement with the Federal Government's My Health Record.

And, going forward, who knows who will want access with one major health fund (NIB) already stating, "We desperately need this data!"

Could all of this just be another example of how inevitable digital disruption is in our lives?

Instead of pushbikes, would Uber be delivering midwives to those home-birthing mothers?

Would Google reviews eventually replace my CPD?

But, in a digital world that operates around the clock, I've learnt to avoid sending emails, texts, tweets etc after close of business.

I may be awake at 3 AM and have finally found inspiration, but there is no way that I would share my thoughts after midnight lest I find myself compared with a certain US President.

So, as I delved into the fine print associated with My Health Record, I have discovered that I can be registered under a pseudonym.

I noted that *DisappointedVoter* and *AngryTaxpayer* were almost certainly taken by now.

But I was sure that *DoctorCamShaft* would be mine for the taking as I had the forethought to grab this moniker when Hotmail first launched in 1996.

The automotive world also targets consumers by using big data for marketing opportunities.

Setting up a bridal registry, searching on Google for a pram, or posting on social media that someone just passed their driving test all suggest life events which may trigger the purchase of a vehicle.

Trawling through this sort of data is said to be 10 times more effective than a traditional marketing campaign.

In my humble opinion, the Federal Government's decision to make the My Health Record mandatory unless an individual advises that "they … don't want one" should be coming with a lot more explanation.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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.

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