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Highly ethical

AMA tops Ethics Index again, p3

INSIDE

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In this issue

Cover pic: The AMA Federal Council

AMA still the most ethical

The AMA Federal Council

When it comes to member associations, the AMA is the most ethical of them all.

That's what the Governance Institute's Ethics Index 2018 says, which is the same thing it said last year.

For two years in a row, the Ethics Index has rated the AMA as the most ethical membership association in Australia.

"Ethical behaviour in membership associations continues to be mixed," the Index's executive summary states.

"The respect seen for the medical sector transfers to the Australian Medical Association, and is seen as the most ethical."

The ethical score for the AMA is at 72 per cent (a slight increase from last year) and its net score is 62 (same as last year).

The Index is derived from Governance Institute research, which measures Australians' expectations and perceptions of ethics across a wide range of sectors and industries.

The AMA's net score placed it well ahead of the next highest ranking associations, Engineers Australia (54 per cent) and the National Farmers' Federation (49 per cent).

The lowest-ranked association, with a net score of -9, was the Construction, Forestry, Maritime, Mining and Energy Union (CFMMEU).

"It is worth noting that member associations are rated only by those aware of the respective associations," the Governance Institute report states.

In releasing its Ethics Index in August, the Institute said Australians have a good understanding of ethics and ethical behaviour, with 87 per cent rating it as important or very important to a well-functioning society.

"Ethics and ethical behaviour continue to be very important to society at large and Australia is no exception," it states.

"Over the last 12 months, media coverages of controversial and ethically charged events has abounded, and debate has continued at an individual or organisational level."

The Ethics Index is now in its third year, allowing for benchmarks to reveal whether ethical behaviour and expectations have improved or slipped in Australia.

AMA President Dr Tony Bartone, AMA Secretary General Michael Schaper, the AMA Federal Council, and the AMA Board of Directors have all welcomed the Ethics Index's findings and have praised the efforts of all at the AMA.

CHRIS JOHNSON

Coalition strikes back after own goal on health policy

Scott Morrison is the new Prime Minister, Peter Dutton's ambitions have been put on hold (for now), Malcolm Turnbull will leave politics, and Greg Hunt is lucky to be back as Health Minister (having run as Deputy to Peter Dutton).

The past days have seen a string of resignations, recriminations, a new front bench, and a new direction for the Coalition Government under Scott Morrison.

But through the murkiness of the Government's leadership crisis one thing is starkly clear – the Coalition had scored an own goal on health policy with a Federal election just months away. It has since done its best to undo the damage.

To continue the football analogy, the Government looked ready to go into a penalty shootout to decide the World Cup final without a goalkeeper.

Come election day, Labor could well have had free shots at goal on public hospital funding, private health insurance, the MBS review, primary care reform, and prevention – just for starters. And that is before Mediscare Mark 2 kicks in.

Yes, Labor is well prepared to repeat the tactics of 2016 to undermine the Coalition's credibility on health. And the polls provide further ammunition.

With Greg Hunt's resignation ahead of the leadership spill, the Government lost its third Health Minister since its election win in 2013.

After the co-payment disaster under Peter Dutton and the loss of Sussan Ley after her promising start in the key but complex health portfolio, things were looking pretty good for the Government and the sector with Greg Hunt at the helm.

Minister Hunt had won the trust and confidence of the profession, and had quickly developed a solid knowledge across the breadth and depth of health policy and the major players in the sector.

He was also a master at the PR side of health – lots of new drug announcements, photo ops with kids in hospitals, and a Ministerial office with an open door for advocates, lobbyists, and campaigners, including successive AMA Presidents.

He oversaw the gradual lifting of the Medicare freeze.

He was managing the MBS Review and the PHI Review with end dates in sight for reporting and implementing outcomes.

There was even talk of the Coalition matching Labor's promise on public hospital funding.

He was fixing the My Health Record legislation to give greater confidence on security and confidentiality – and pledging a big education campaign to convince the Australian people to stay opted-in.

And he was working with the AMA and others to develop a bold new vision for general practice and primary care.

Greg Hunt was across his brief and had strong and friendly working relationships with most of the major health sector players.

The failed Health Care Homes trial and the botched launch of the My Health Record opt-out phase are negatives, however.

Then he was gone, and with him a lot of the hope that genuine meaningful health reform was within reach.

With the Federal election due in the first half of 2019, it looked like the Coalition would have to go back to square one to rebuild its health policy credentials.

AMA President Dr Tony Bartone thought the new PM should put politics and payback to one side, and put Greg Hunt back in charge of Health. It takes months to train a new Health Minister, and there are only months left till the election.

Sure, the bureaucratic machinery will continue behind the scenes with the various reviews, but the portfolio needs a credible messenger.

The new PM Scott Morrison has listened to the AMA and has obviously tried to make peace with the warring factions by keeping Mr Hunt in the portfolio.

Good move.

In further promising signs of maintaining continuity in the all-important health policy arena, Mr Morrison has returned Ken Wyatt as Indigenous Health and Aged Care Minister and Bridget McKenzie to the rural health portfolio as the Regional Services Minister.

JOHN FLANNERY AND CHRIS JOHNSON

One in two patients left with out of pocket expenses

Figures showing that half of all Australians are routinely left with out of pocket expenses for Medicare services show the need for proper indexation of Medicare rebates, the AMA says.

The Australian Institute of Health and Welfare (AIHW) last month released its *Patients' out-of-pocket spending on Medicare services*, showing that in 2016-17, 10.9 million patients paid something from their own pockets toward their non-hospital services.

Health Minister Greg Hunt tried to counter the figures, pointing to a record bulk billing rate of 86.1 per cent.

But AMA President Dr Tony Bartone said that years of frozen Medicare rebates have taken their toll on the cost of providing health care.

"There is no doubt in our mind that obviously, the first and foremost thing the Government should do is actually have a Medicare rebate that reflects the cost of providing that care," Dr Bartone told reporters in Parliament House.

"The rebate, at the moment, bears no comparison to the cost of providing that care. It is woefully inadequate."

The bulk billing figures do not paint the full picture, he said, as only around two-thirds of patients have all their visits to a GP bulk billed.

The last Productivity Commission Report on Government Services 2018 showed that Australian Government total expenditure on GPs services per person grew by just 80 cents between 2015-16 and 2016-17 - from $370.60 to $371.40.

"The fact that the AIHW report shows the median out of pocket cost was $142 per person, despite the Medicare Benefits Schedule (MBS) being frozen for five years, shows that doctors – be they GPs, other specialists, pathologists, or radiologists – try to limit out of pocket costs," Dr Bartone said.

"When it comes to specialist treatment under private health insurance, Australian Prudential Regulatory Authority (APRA) figures show that more than 88 per cent of all procedures are performed with no out of pocket costs to patients, and a further 7 per cent are performed with an up-front gap of less than $500.

"While the current Government has commenced a slow thaw on indexation, it has not undone the damage of several years of freezing Medicare rebates that commenced in the 2013/14 Budget under Labor and was continued until recently by the Coalition.

"And we know that, for the most part, diagnostic imaging and pathology rebates will remain frozen, as they have for the past few decades."

Dr Bartone predicted that health would continue to be a major vote changer at the impending federal election, due by May 2019.

"The Federal AMA is already putting together its health policy manifesto, and expects to work constructively with the major parties on policies that will ensure a sustainable, properly funded, and affordable health system for all Australians," he said.

MARIA HAWTHORNE

Refugee family transferred from Nauru after AMA intervention

Strong lobbying from the AMA over the plight of a 12-year-old refugee on Nauru has resulted in him being flown with his whole family to Australia for urgent medical treatment.

The boy had refused food and medicine for more than 20 days due to his mental state after being detained for four years.

The Australian Border Force initially would not transfer the boy to Australia unless it was without his family. The boy refused to leave the camp unless his family, including his stepfather, accompanied him.

The family fled persecution in Iran and all have been acknowledged as refugees, meaning they are owed protection by Australia under international law.

But the Government's hard line led to a standoff between the boy and Border Force.

With the boy drifting close to death, the situation caused outrage in the Australian and international communities and also sparked the intervention of the AMA.

AMA President Dr Tony Bartone called on the Home Affairs Minister Peter Dutton to do the right thing by the boy and his family.

"My response to the Minister in this situation would be as simple as this: these people are in our care. They are owed a certain level of care by International Convention, and any person in the care of the Australian Government needs to be treated with that same access to the appropriate health care," Dr Bartone told ABC Radio.

"We're not saying that you need to have every possible service on the island, but if it does get to a situation where they need to … have that access, that ability to be transferred off the island; it's done expeditiously ahead of time, ahead of the critical nature.

"The reports that we saw … was a case where things were going too far too long and there are workarounds, there are options to take our people off the island when and so needed because of health care."

The AMA Federal Council unanimously passed three motions calling on the Government to act urgently to guarantee the health and wellbeing of asylum seeker children and their families on Nauru.

Dr Bartone said the medical staff employed by International Health and Medical Services on Nauru are doing their best in trying conditions, but the Australian public needs to be informed and shown that these asylum seekers are receiving appropriate care and support.

"The AMA repeats its call for a delegation of independent Australian health professionals to be allowed to visit and examine the asylum seekers – adults and children – and report on their condition to the Australian Parliament and the Australian people," he said.

"It is our responsibility to care for these people. It is all about human rights. It is the right thing to do."

Following the AMA intervention, the boy was medi-evacuated from Nauru to Australia by air ambulance, accompanied by his mother, stepfather and sister.

AMA Federal Council Motion 1:

Given multiple reports of a looming children's health crisis on Nauru, Federal Council calls for urgent action to prevent further harm to the health and welfare of child refugees and asylum seekers on Nauru.

We ask that these children and their families be removed from harm and have access to healthcare of an appropriate standard.

AMA Federal Council Motion 2:

Federal Council further demands that the Federal Government facilitates access to Nauru for a delegation of Australian medical professionals, to be appointed in consultation with the AMA, to assess the health and welfare of child refugees and asylum seekers. This includes access to the children and their families and/or carers, as well as the Nauruan officials administering to the children.

An appropriate delegation would potentially include a psychiatrist, a public health expert, a paediatrician and an infectious diseases physician.

Refugee family transferred from Nauru after AMA intervention

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This delegation would then make public the findings of its inspections and interviews to assure the Australian public that the Australian Government has done all that is possible to protect the health and wellbeing of asylum seekers and refugees.

AMA Federal Council Motion 3:

Federal Council further expects that the Australian Government satisfactorily provides comprehensive answers to the following two questions, which relate to the looming children's health crisis among refugees and asylum seekers on Nauru, who were placed there by the Australian Government:

1. *What are the healthcare arrangements, both physical and mental, in place for child refugee and asylum seekers on Nauru?*
2. *What are the transfer arrangements for the child refugee and asylum seekers on Nauru and their immediate family members or carers if they require transfer from Nauru to access healthcare treatments that are not available on Nauru?*

CHRIS JOHNSON

INFORMATION FOR MEMBERS

Specialty Training Pathways Guide – AMA Career Advice Service

With more than 64 different medical specialties to choose from in Australia, making the decision to specialise in one can seem daunting.

AMA members now have access to a new resource – one designed to assist in making decisions about which specialty pathway to follow. We know that concerns about length of training, cost of training and work-life balance are important factors in making these decisions, and information on the new site will help here too.

The absence of a comparative and definitive guide was raised by our doctors in training and medical students.

Responding to this need from our doctors in training and medical students, the AMA Career Advice Service has developed a comprehensive guide to the specialties and sub-specialties which can be trained for in Australia. The Guide will be updated annually to reflect changes made by the Colleges, and the 2017 update will be uploaded shortly.

The web-based Guide allows AMA members to compare up to five specialty training options at one time.

Information on the new website includes:

- the College responsible for the training;
- an overview of the specialty;
- entry application requirements and key dates for applications;
- cost and duration of training;
- number of positions nationally and the number of Fellows; and
- gender breakdown of trainees and Fellows.

The major specialties are there as well as some of the lesser known ones – in all, more than 64 specialties are available for comparison and contrasting.

For example, general practice, general surgery and all the surgical sub specialties, paediatrics, pathology and its sub specialties, medical administration, oncology, obstetrics and gynaecology, immunology and allergic medicine, addiction medicine, neurology, dermatology and many, many more.

To find out more, visit www.ama.com.au/careers/pathway

This new addition to the Career Advice Service enhances the services already available which include one-on-one career coaching, CV templates and guides, interview skills "tips" and, of course, a rich source of information available on the Career Advice Hub: www.ama.com.au/careers

For further information and/or assistance, feel free to call the AMA Career Advisers on 1300 133 665 or email: careers@ama.com.au

Please note current information within the guide relates to 2016 requirements. Information will be updated to reflect 2017 requirements soon.

Let the AMA's Specialty Training Pathways guide help inform your career decisions.

Rash decisions for health care workers

In a recent retrospective study of health care workers assessed in an Australian tertiary referral dermatology clinic, 49.7 per cent had experienced allergic contact dermatitis.

Allergic contact dermatitis is a reaction characterised by an itchy red skin rash that arises from a substance in contact with the skin.

Associate Professor Rosemary Nixon AM, who helps run the fortnightly Occupational Dermatology Clinic at the Skin & Cancer Foundation Inc., where workers suspected of occupational dermatitis are assessed with patch testing, says that Australian dermatologists have undertaken numerous studies to examine the frequency of allergic contact reactions.

“The major substances causing allergic contact dermatitis in health care workers are rubber glove chemicals, preservatives, excipients in hand cleansers, and antiseptics,” she says.

Patch testing is a form of skin allergy testing that is required to make a diagnosis of allergic contact dermatitis.

It requires considerable expertise and expensive allergens and materials. The Australian Baseline Series for patch-testing includes 60 of the most frequent and relevant contact allergens.

A/Prof Nixon says that dermatologists frequently treat patients who have experienced skin reactions to allergens.

“It is important to make a diagnosis of what is causing the problem, and patch testing is used to diagnose allergic contact dermatitis,” she says.

“This includes allergy to ingredients found in certain types of goods, such as skincare products, fragrances, plants, jewellery, hair dyes, liquid soaps, shampoos, baby wipes, and gloves.”

Several ingredients commonly found in goods include topical pharmaceuticals and methylisothiazolinone/ methylchloroisothiazolinone - a preservative used in a variety of skin care products - which has recently caused many reactions in Australia.

Other allergens include nickel, bufexamac, preservatives, and p-phenylenediamine (used in hair dyes).

Allergic reactions caused by diet differ to allergic contact reactions and are tested by prick testing or blood tests.

A/Prof Nixon says that medical professionals need to consider the likelihood of allergic reactions to substances touching the skin.

“Because the reactions are delayed, there may not be a clear-cut history relating exposure to an allergen and subsequent dermatitis,” she says.

JOHN FLANNERY

Disadvantage of Stolen Generations

A new Healing Foundation report, compiled by the Australian Institute of Health and Welfare (AIHW), has uncovered chronic health issues, disability, and alarming levels of economic and social disadvantage for the Stolen Generations and their decendants.

The report provides comprehensive data to illustrate the direct link between the forced removal of tens of thousands of children from their families and the real-life symptoms of Intergenerational Trauma within today's families and communities.

Prior to this report, it was not known how many Stolen Generation members were still alive, let alone where and how they live, which made it difficult to determine their needs and plan services to address them.

Key findings of the report include:

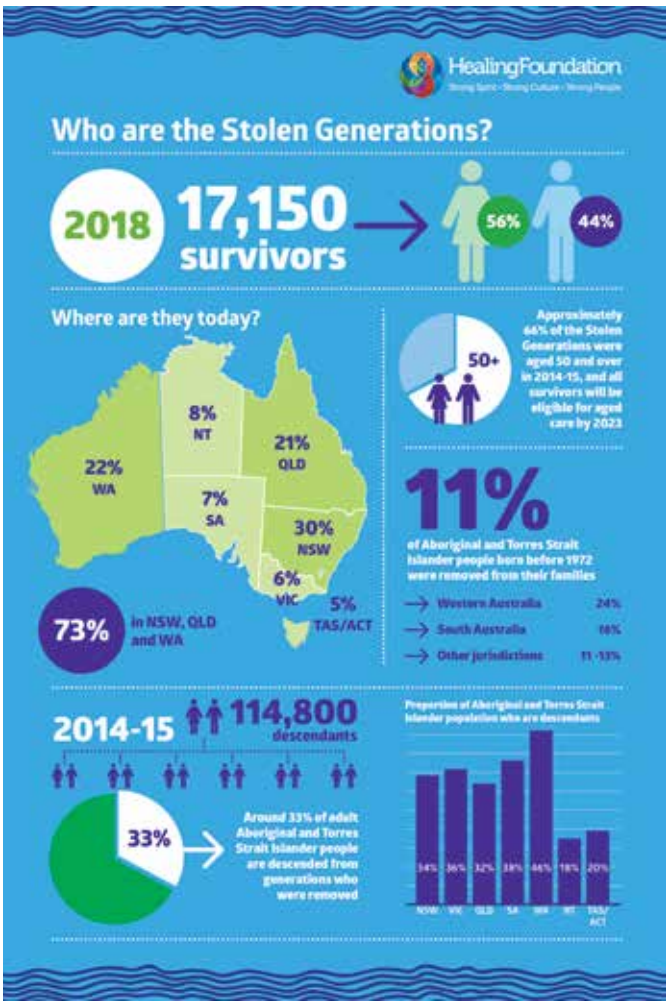
- In 2018, there are 17,150 survivors – 56 per cent female, 44 per cent male
- 67 per cent live with a disability or restrictive long-term condition
- 39 per cent (over the age of 50) report poor mental health
- 40 per cent have experienced homelessness in the past 10 years.

Even compared to Aboriginal and Torres Strait Islanders in the same age group, who are already at a disadvantage in Australia, Stolen Generation members are suffering more.

Compared to Aboriginal and Torres Strait Islanders in the same age group, they are:

- 3.3 times more likely to have been incarcerated in the last five years
- 1.6 times more likely to be in poor health
- 1.6 times as likely to have experienced homelessness in the last 10 years
- 1.5 times more likely to have mental health problems.

The Stolen Generations are more likely to report chronic health conditions like cancer (9.1 per cent compared to 7.1 per cent), diabetes (37.8 per cent compared to 28.8 per cent), and heart disease (44.2 per cent compared to 36.9 per cent).



The story of disadvantage extends to the descendants of the Stolen Generations.

The full report is at: http://healingfoundation.org.au/stolengenerationsreport/

JOHN FLANNERY

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY MARIA HAWTHORNE

Green light from Committee for Gold, Silver, Bronze, and Basic

The Federal Government's proposed private health insurance policy reforms look set to become law this year after a Senate Committee recommended passing the Bills.

The Committee investigating the new Gold, Silver, Bronze, and Basic policy proposals made just one recommendation when it reported in the first sitting week of the Spring session of Parliament - "that the Senate pass the Bills".

Committee Chair, Liberal Senator Slade Brockman, said that the Committee recognised that some people still had concerns about the policy categories, and the rules that will implement the product reforms.

"Some submitters disagreed with the inclusion of a Basic policy," Senator Brockman said.

"CHOICE, the Australian Medical Association, the Australian Private Hospitals Association, and Day Hospitals Australia objected to the category on the basis that these policies provide low value cover to consumers, and exist to take advantage of the financial incentives provided by Government.

"Submitters also expressed concerns that, if the draft rules were adopted, particular products or services may only be available in high product tiers. For example ... the AMA considered that, as 50 per cent of pregnancies are unplanned, pregnancy should be covered in Bronze rather than Gold."

Senator Brockman said that the Committee understands that private health insurance can be a complex product that is confusing to many people.

AMA President, Dr Tony Bartone, appeared before the Committee in August, and told it that even doctors were confused by the array of choices and policies on offer.

"It is for that reason that we support the concept of developing Gold, Silver, and Bronze insurance categories," Dr Bartone told the inquiry.

"Doctors are intelligent people. But I can tell you that we are all bewildered by the many different definitions, the carve-outs and exclusions from some 70,000 policy variations.

"That's not my figure – it's the Government's. It's unbelievable. No wonder we're always being caught out."

The Committee called for a public information campaign to help consumers understand the product design reforms, saying that would allow more consumers to be better informed about the different tiers and their inclusions.

Greens Senators Richard di Natale and Rachel Siewert lodged a dissenting report, arguing that the reforms would have little effect in improving the sustainability of the market.

"What we are instead seeing is an ideological commitment to throw good money after bad," they said.

"The private health system operates only through the generosity of vast public subsidies of more than $6.5 billion each year. There is no argument that, without these subsidies, the market would collapse."

Labor Senators Lisa Singh and Murray Watt also raised concerns that the reforms could have unintended consequences, including making it easier for insurers to cancel policies and harder for Australians to afford care when they need it.

"Labor Senators therefore support calls by the Australian Medical Association, Australian Healthcare and Hospitals Association, and others for the measures in this Bill to be reviewed after implementation," they said.

They endorsed the main report's recommendation to pass the Bills, ensuring their passage through the Senate.

The Government is expected to move to finalise the legislation in the Spring session.

The Committee report is available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/PrivateHealthInsur2018.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Allergy funding not to be sneezed at

The Federal Government has announced it will invest more than half a million dollars in projects to improve the lives of Australians who live with allergies.

It will fund projects identified as part a National Allergy Strategy, which was developed by the Australasian Society of Clinical Immunology and Allergy and Allergy and Anaphylaxis Australia.

Projects include development of standardised food allergy content to be included in all accredited food hygiene courses, and the development of online resources for teens and young adults with allergies to share their experiences.

Another project will determine how to improve access to care for people with allergic conditions, particularly those in rural and remote areas.

Allergies can have significant adverse effects on the quality of life and overall health of people, and affect about 20 per cent of the Australian population living with allergies.

About 4.5 million Australians are affected by hay fever and allergic rhinitis, while one in 20 Australian children and one in 50 adults has a food allergy.

Optimal Cancer Care for First Nations Australians

An Australian-first *Optimal Care Pathway for Aboriginal and Torres Strait Islander People with Cancer*, released in August by Cancer Australia, charts new approaches to cancer care for First Nations people, to boost their cancer treatment experience and results.

Indigenous Health Minister Ken Wyatt AM said this Optimal Care Pathway aims to tackle the growing gap in cancer outcomes between First Nations people and other Australians, by supporting the delivery of tailored, culturally safe and competent care.

"First Nations people are more likely to be diagnosed at a more advanced stage and are, on average, 40 per cent more likely to die from cancer than non-Indigenous Australians," Minister Wyatt said.

"Cancer is the second leading cause of death and one of the biggest challenges for Aboriginal and Torres Strait Islander people, not just for those diagnosed, but also for families, carers, Elders, and communities."

Minister Wyatt said that for services to be effective in improving Aboriginal and Torres Strait Islander health, they must operate with a fundamental understanding of, and respect for, First Nations culture.

"The new pathway provides health services and health professionals across Australia with principles and guidance to ensure that cancer care is culturally safe and responsive," the Minister said.

"Being aware of how a person's culture, values, and motivations can influence their decisions and preferences relating to the delivery of their care is an essential component in creating a culturally competent workforce. It is critical to better outcomes."

The *Optimal Care Pathway for Aboriginal and Torres Strait Islander People with Cancer* - endorsed by the Australian Health Ministers' Advisory Council - is accompanied by information and resources for Aboriginal and Torres Strait Islander people who may have or do have cancer, as well as for their carers, families, and communities.

Research

BY JOHN FLANNERY

Under pressure – new 'Triple Pill' for hypertension

A new low dose three-in-one pill to treat hypertension could transform the way high blood pressure is treated around the world.

A trial led by The George Institute for Global Health revealed that most patients – 70 per cent – reached blood pressure targets with the 'Triple Pill', compared to just over half receiving normal care.

With high blood pressure the leading cause of disease burden worldwide, it's expected the findings, published in *JAMA*, will change guidelines globally.

The George Institute's Dr Ruth Webster said this was a major advance by showing that the Triple Pill was not only more effective than standard care, it was also safe.

"It's estimated that more than a billion people globally suffer from high blood pressure, with the vast majority having poorly-controlled blood pressure.

"Our results could help millions of people globally reduce their blood pressure and reduce their risk of heart attack or stroke," Dr Webster said.

The researchers tested an entirely new way of treating hypertension by giving patients three drugs, each at half dose, in a single pill for early treatment of high blood pressure.

Traditionally, patients begin treatment with one drug at a very low dose, which is increased over time with additional drugs added and increased in dosage to try to reach target.

Dr Webster said that patients are brought back at frequent intervals to see if they are meeting their targets, with multiple visits required to tailor their treatments and dosage.

"This is not only time inefficient, it's costly," she said.

"We also know that many doctors and patients find it too complicated, and often don't stick to the process. This new approach is much simpler, and it works."

The trial, which was conducted in Sri Lanka, enrolled 700 patients with an average age of 56 and blood pressure of 154/90 mm Hg.

Patients were randomly assigned to receive either the combination pill or usual care – their doctor's choice of blood pressure lowering medication. The Triple Pill consisted of the blood pressure medications telmisartan (20 mg), amlodipine (2.5 mg), and chlorthalidone (12.5 mg).

Compared with patients receiving usual care, a significantly higher proportion of patients receiving the Triple Pill achieved their target blood pressure of 140/90 or less (with lower targets of 130/80 for patients with diabetes or chronic kidney disease).

At six months, 83 per cent of participants in the Triple Pill group were still receiving the combination pill compared to the majority of patients in the usual-care group still receiving only one, and only one third receiving two or more blood-pressure–lowering drugs.

Professor Anushka Patel, Principal Investigator of the trial and Chief Scientist at The George Institute, said this was big improvement.

"The World Heart Federation has set an ambitious goal that, by 2025, there will be a 25 per cent reduction in blood pressure levels globally, Prof Patel said.

Research

"The Triple Pill could be a low-cost way of helping countries around the world to meet this target.

"This study has global relevance. While the most pressing need, from the perspective of the global burden of disease, is low-and middle-income countries, it's equally relevant in a country like Australia where we're still achieving only 40-50 per cent control rates for high blood pressure."

The George Institute is now looking at strategies to maximise uptake of the study results. This includes examining the acceptability of the Triple Pill approach to patients and their doctors, as well as cost-effectiveness, which will be important for governments and other payers to consider.

The study was funded by the National Health and Medical Research Council of Australia as part of the Global Alliance for Chronic Disease.

Racial diversity of physicians in the USA

In the United States, racial and ethnic minorities have higher rates of chronic disease, obesity, and premature death than white people.

Black patients, in particular, have among the worst health outcomes, experiencing higher rates of hypertension and stroke. And black men have the lowest life expectancy of any demographic group, living on average 4.5 fewer years than white men.

The *Harvard Business Review* says that a number of factors contribute to these health disparities, but one problem has been a lack of diversity among physicians.

African Americans make up 13 per cent of the US population, but only four per cent of US doctors and less than seven per cent of US medical students. Of active US doctors in 2013, 48.9 per cent were white, 11.7 per cent were Asian, 4.4 per cent were Hispanic or Latino, and 0.4 per cent were Native American or Alaska Native.

Research has found that physicians of colour are more likely to treat minority patients and practise in underserved communities. And it has been argued that sharing a racial or cultural background with one's doctor helps promote communication and trust.

A new study from the National Bureau of Economic Research looked at how changing this ratio might improve health outcomes – and save lives.

Researchers set up an experiment that randomly assigned black male patients to black or non-black male doctors, to see whether having a doctor of their race affected patients' decisions about preventive care.

They found that black men seen by black doctors agreed to more, and more invasive, preventive services than those seen by non-black doctors. And this effect seemed to be driven by better communication and more trust.

Increasing demand for preventive care could go a long way toward improving health. A substantial part of the difference in life expectancy between white and black men is due to chronic diseases that are amenable to prevention.

By encouraging more preventive screenings, the researchers calculate, a workforce with more black doctors could help reduce cardiovascular mortality by 16 deaths per 100,000 per year – resulting in a 19 per cent reduction in the black-white male gap in cardiovascular mortality and an 8 per cent decline in the black-white male life expectancy gap.

Research

DNA to predict disease risk

Scientists have created a powerful new tool to calculate a person's inherited risks for heart disease, breast cancer, and three other serious conditions.

Reporting on research in the journal, *Nature Genetics*, the *New York Times* revealed that, by surveying changes in DNA at 6.6 million places in the human genome, investigators at the Broad Institute and Harvard University were able to identify many more people at risk than do the usual genetic tests, which take into account very few genes.

Of 100 heart attack patients, for example, the standard methods will identify two who have a single genetic mutation that place them at increased risk. But the new tool will find 20 of them.

The researchers are now building a website that will allow anyone to upload genetic data from a company like 23andMe or Ancestry.com. Users will receive risk scores for heart disease, breast cancer, Type 2 diabetes, chronic inflammatory bowel disease, and atrial fibrillation.

People will not be charged for their scores.

A risk score, including obtaining the genetic data, should cost less than $100, said Dr Daniel Rader, a professor of molecular medicine at the University of Pennsylvania.

Dr. Rader, who was not involved with the study, said the university will soon be offering such a test to patients to assess their risk for heart disease. For now, the university will not charge for it.

Dr Sekar Kathiresan, senior author of the new paper and director of the Center for Genomic Medicine at Massachusetts General Hospital, said his team had validated the heart risk calculation in multiple populations.

But DNA is not destiny, Dr Kathiresan stressed. A healthy lifestyle and cholesterol-lowering medications can substantially reduce risk of heart attack, even in those who have inherited a genetic predisposition.

The new tool also can find people at the low end of the risk range for the five diseases. This should prove useful to certain patients: for example, a woman who is trying to decide when she should start having regular mammograms, or a 40-year-old man with a slightly high cholesterol level who wants to know if he should take a statin.

BY JOHN FLANNERY

Dr Bawa-Garba wins appeal

Dr Hadiza Bawa-Garba, who was convicted of manslaughter by gross negligence over the death of a six-year-old boy in the UK in 2015, in August won her appeal to practise medicine again.

She was struck off in January this year over the death of Jack Adcock, who died of sepsis at Leicester Royal Infirmary in 2011.

BBC News reports that the doctor said she was 'pleased with the outcome' but wanted to 'pay tribute and remember Jack Adcock, a wonderful little boy'.

Jack's mother Nicola Adcock said she was 'disgusted' and 'devastated' by the judgement, and that it made a 'mockery of the justice system'.

Dr Bawa-Garba said that she wanted to let the parents know that she was sorry for her role in what happened to Jack.

"I also want to acknowledge and give gratitude to people around the world, from the public to the medical community, who have supported me," Dr Bawa-Garba said.

The doctor's appeal was funded by medics because they said the ruling would discourage practitioners from being open when reviewing mistakes.

Jack, who had Down's syndrome and a heart condition, had been admitted to the hospital in Leicester with vomiting and diarrhoea in 2011.

He died 11 hours later from a cardiac arrest caused by sepsis triggered by pneumonia.

The subsequent trial in 2015 heard the boy's death was caused by 'serious neglect' by staff who failed to recognise his body was 'shutting down' and close to death, the prosecution claimed.

At one point, Dr Bawa-Garba mistook Jack for another patient who had a 'do not resuscitate' order, the court was told.

The paediatric specialist only resumed treatment when a junior doctor pointed out the error, although the prosecution accepted Jack had already been 'past the point of no return'.

Dr Bawa-Garba said in her defence she had worked a 12-hour shift with no break and there was a lot of miscommunication in the ward.

Dr Bawa-Garba was suspended from the medical register for a year in June 2017.

However, the General Medical Council (GMC) appealed against the decision, claiming it was 'not sufficient to protect the public', and she was struck off in January 2018.

Thousands of doctors signed an open letter of support for Dr Bawa-Garba stating the case would 'lessen our chances of preventing a similar death'.

Earlier, three senior judges quashed the High Court's decision and restored the lesser sanction of a one-year suspension.

Announcing the ruling, Master of the Rolls, Sir Terence Etherton, said no concerns had ever been raised about the clinical competence of Dr Bawa-Garba, other than in relation to Jack's death.

"The evidence before the tribunal was that she was in the top third of her specialist trainee cohort," he said.

He added that the tribunal was satisfied her actions in relation to the boy were neither deliberate nor reckless, and did not present a continuing risk to patients.

Ebola in a war zone

Global health officials have warned that combating Ebola in the northeastern Congo outbreak is complicated by multiple armed groups in the mineral-rich region and a restless population that includes one million displaced people and scores of refugees leaving for nearby Uganda every week.

The Associated Press reports that insecurity means health workers might have to change a vaccination strategy that proved successful in Congo's previous Ebola outbreak.

The 'ring vaccination' approach of first vaccinating health workers, contacts of Ebola victims, and their contacts might have to give way to the approach of vaccinating everyone in a certain geographic area such as a village or neighbourhood. That would require a larger number of vaccine doses.

Vaccinations began in early August in the current outbreak, which was declared on August 1 and has killed 11 people in the densely populated region. The World Health Organisation (WHO) has said more than 3,000 Ebola vaccine doses are available in Congo.

While Congo's previous Ebola outbreak, declared over barely a week before the current one began, set off alarm by spreading to a city of more than one million people on the other side of the country, the current outbreak comes with the threat of armed attack.

An assault that killed seven people in Mayi-Moya, about 40 kilometres from Beni city, was likely carried out by rebels with the Allied Democratic Forces, the administrator of Beni territory, Donat Kibwana, told *The Associated Press*.

The rebels have killed more than 1500 people in and around Beni in less than two years.

The rebels sent the local population fleeing, Kibwana said.

Beni residents already had been shaken by the discovery last week of 14 bodies of civilians who had been seized by suspected ADF rebels.

The latest attack occurred as the WHO Director-General, Tedros Adhanom Ghebreyesus, was visiting the area to see the response to the Ebola outbreak, which is being carried out in some cases under armed escort.

"The active conflict in the area is a barrier to control Ebola," Tedros said.

"I call on all warring parties to provide secure access to all responders serving affected populations and saving lives."

United Nations peacekeepers, Congolese police, and, at times, Congolese troops have been travelling with convoys of health workers as they fan out to contain the outbreak. Hospitals are guarded by Congolese police and military police.

So far, Congo's health ministry has said 48 cases of hemorrhagic fever have been reported in this outbreak, 21 of them confirmed as Ebola.

Nearly 1000 people are being monitored. Screenings for the virus are being carried out at the heavily travelled border; officials have said travel restrictions are not necessary.

This is Congo's tenth outbreak of Ebola, which is spread via contact with bodily fluids of those infected, including the dead. There is no licensed treatment, and the virus can be fatal in up to 90 per cent of cases, depending on the strain.

Exams rigged against female applicants in Japan

One of Japan's leading medical schools has been automatically reducing the entrance exam scores of female applicants by 20 per cent for at least 12 years to graduate more male doctors, an independent inquiry has found.

The case has been examined in a report in the *British Medical Journal* (BMJ).

According to the BMJ, Tokyo Medical University's acting president, Keisuke Miyazawa, admitted to the exam rigging at a press conference on 7 August after the release of a damning report by external lawyers.

"For those people whom we have caused tremendous hardship, especially female candidates whom we have hurt, we will do everything we can," he said.

Miyazawa said that the school was considering options including financial compensation and retroactive admission of some women who would have passed without the automatic deduction. He said that he had not known of the score manipulation.

Tetsuo Yukioka, the school's executive regent and chair of its diversity promotion panel, stood beside him.

Both men spent much of the press conference with their heads bowed in an attitude of shame.

"Society is changing rapidly and we need to respond to that, and any organisation that fails to utilise women will grow weak," Yukioka said. "I guess that thinking had not been absorbed."

Kenji Nakai, a lawyer who led the inquiry, said that the rigging had been ordered by the former chair of the board of regents, Masahiko Usui, 77, with the approval of the former president, Mamoru Suzuki, 69.

Both men resigned last month amid allegations that they had inflated the exam score of the son of Futoshi Sato, a health ministry official, in return for increased research funding. Usui, Suzuki, and Sato have all since been charged with bribery.

As well as discriminating against women, the school secretly penalised men who had failed the entry test more than twice before. The school had far more applicants than places - only one in 11 men and one in 33 women who tried for a place succeeded in 2018 - so multiple attempts were common.

A computer algorithm automatically deducted 20 per cent from the score of everyone taking the first multiple choice segment of the entrance exam.

Men taking the test for the first or second time were then re-awarded 20 per cent, men taking it for the third time were given back 10 per cent, and men taking it for the fourth time - plus all women - were given back 0 per cent.

The investigators also found 18 instances of applicants' scores being inflated in return for donations to the school or bribes to its officials. In one case, a student's mark had been raised by 49 per cent in return for a donation to the school.

Investigators examined records dating back to only 2006 so that they could report their findings earlier, said Nakai.

The principal motive for the discrimination, he said, was the perception that female doctors are more likely to quit the profession young to have children, exacerbating a doctor shortage.

Because medical graduates in Japan typically work in hospitals affiliated to their medical school, this would be a problem for the institution itself, not just for society at large.

'Profound sexism' among the school's leadership also played a role, said Nakai.

The revelations have released a torrent of online criticism, much of it under the hashtag, "*It's okay to be angry about sexism*".

Female doctors in Japan have complained that staying in the profession is almost impossible after having children because childcare services are lacking and because women are expected to perform all household tasks while also working the extremely long hours demanded of male doctors.

The number of Japanese children waiting for kindergarten places this year rose to 55 000. The health ministry, which is also responsible for welfare programs, has announced plans to add 320,000 childcare places by 2021.

Suspicion is now widespread in Japan that exam rigging against women is not limited to one medical school. The education minister, Yoshimasa Hayashi, said yesterday that he plans to examine entrance procedures at schools around the country.

He will also decide what action to take against Tokyo Medical University after studying the report, he said.

Doctor Robot

The Guardian reports that robots could soon help hospital patients eat their meals, diagnose serious illnesses, and even help people recover from operations, in an artificial intelligence revolution in the NHS in the UK.

Machines could take over a wide range of tasks currently done by doctors, nurses, health care assistants, and administrative staff, according to a report prepared by the Institute for Public Policy Research (IPPR) and eminent surgeon and former Health Minister, Lord Darzi.

Widespread adoption of artificial intelligence (AI) and 'full automation' by the NHS could free up as much as £12.5 billion a year worth of staff time for them to spend interacting with patients, according to the report.

"Given the scale of productivity savings required in health and care – and the shortage of frontline staff – automation presents a significant opportunity to improve both the efficiency and the quality of care in the NHS," the report says.

"Bedside robots could help patients consume food and drink and move around their ward, and even help with exercises as part of their rehabilitation from surgery.

"In addition, someone arriving at hospital may begin by undergoing digital triage in an automated assessment suite.

"AI-based systems, include machine-learning algorithms, would be used to make more accurate diagnoses of diseases such as pneumonia, breast and skin cancers, eye diseases, and heart conditions.

"Digital technology could also take over the communication of patients' notes, booking of appointments, and processing of prescriptions."

The report sought to allay fears of significant job losses, signaling that machines would work alongside human beings, not replace them, so patients would benefit.

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

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.