AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

# Back to business

New PM, same Health Minister, p3

## INSIDE



AMA

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# Medicine

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# In this issue



Cover: Health Minister Greg Hunt and AMA President Dr Tony Bartone

# New Health Minister the same


Dr Bartone on Sky News.

The AMA has welcomed the reappointment of Greg Hunt as Health Minister and has urged the Government to maintain a focus on delivering good health policy.

Mr Hunt resigned as Minister in the lead-up to the demise of Malcolm Turnbull as Prime Minister in August. With the ascension of Scott Morrison to the prime ministership, the AMA called for Mr Hunt to be reinstated.

Mr Morrison heeded the advice and Mr Hunt was renamed Health Minister in the new Cabinet.

AMA President Dr Tony Bartone said the events surrounding the Liberal Party leadership spill were a distraction to delivering good Government.

"We want to get on with the job. We want to get on with trying to advocate for the best policy for the best outcomes for patients of Australia," Dr Bartone said.

"We need to acknowledge that over the last decade or more there's been a significant disinvestment in general practice, in all facets of that care delivery. We've had a long-term freeze in the Medicare indexation, which is only just starting to thaw out now after decades of partial indexation. We've had virtually no attention to the issues of funding of aged care.

"My job, our Association's job, is to highlight the policies and the needs and the requirements of our patients, of Australians, and the expectations and the needs in the current situation."

Dr Bartone said the AMA was pleased Mr Hunt had been re-appointed Health Minister, particularly with a federal election expected within months.

There have been three Health Ministers over the past five years, from the same Government. The AMA hopes the Minister will now stay in office until the people of Australia decide who they want to govern them next.

"With an election due in the first half of 2019, new Prime Minister Scott Morrison has made the right call in leaving health in the safe hands of Greg Hunt," Dr Bartone said.

"A fourth Health Minister in five years would have undermined the priority that Australians place on good health policy.

"Greg Hunt has been a very consultative Minister who has displayed great knowledge and understanding of health policy and the core elements of the health system."

Dr Bartone said the health portfolio is broad and complex, and it takes time for Ministers to get fully across all the issues and get acquainted with all the stakeholders.

Only an election can now justify any change in Health Minister.

CHRIS JOHNSON

# Need for stability in health leadership

BY AMA PRESIDENT DR TONY BARTONE

Last month's leadership spills, which resulted in Australia having a new Prime Minister in Scott Morrison, almost delivered us the fourth Health Minister in five years. That would have been a disaster; especially with an election no more than nine months away (maybe even less).

Since the Coalition was elected in 2013, we have seen Peter Dutton and Sussan Ley come and go, and Greg Hunt resign as Health Minister amid the Government's leadership chaos.

Prime Minister Morrison could easily have left Greg Hunt out of his new Ministry, but he chose not to. He opted for consistency and stability. He made the right call.

In January 2017, Greg Hunt became Health Minister at a difficult time. His predecessor, Sussan Ley, left the portfolio in controversial circumstances. He inherited a lot of unfinished business.

To his credit, he worked hard from day one to get across his new portfolio, one of the toughest in politics, and he went out of his way to build personal relationships with the leaders of all the major stakeholders.

He worked closely with my predecessor, Dr Michael Gannon, and I am pleased that close relationship has extended to my Presidency, talking regularly on the phone and meeting often in person.

As Health Minister you need to understand the many issues and numerous policies and all the potholes and roadblocks in health to appreciate the vital need to have consistent leadership at the top of the Health Ministry.

It takes months to get across the detail and to get to know the key people.

Greg Hunt had to almost immediately deal with the fallout of the GP co-payment fiasco and the slow burn of the Medicare rebate freeze, which were undermining all efforts by the Government to be on the front foot on a range of policies – anything but the cursed co-payment and the feared freeze.

He fought hard within Cabinet to achieve the gradual lifting of the Medicare freeze.

He has had to gain thorough knowledge of the complex MBS Review process.

There was the ongoing review of Private Health Insurance and out of pocket expenses.

The rollout of the My Health Record.

The problems with the Health Care Homes trial.

Then there were the more tricky and delicate issues of mandatory reporting, medical workforce, climate change and health, the health of asylum seekers, Indigenous health, and mental health, to name but a few.

Add to this the complexities of the PBS, immunisation, and issues pertaining to scope of practice – the so-called 'turf wars'.

Then he had to consider contemporary major issues like aged care reform and the issue that we want him to concentrate on right now ahead of the election – general practice reform and investment.

It takes time to learn to be a Health Minister. And it takes even more time to become a good Health Minister. Greg Hunt has been easy to work with and always ready to listen.

That is why we went public with our calls for Greg Hunt to be re-appointed Health Minister in the new Ministry. Prime Minister Morrison obliged. A smart move I would say. If the Coalition had changed Ministers, their policy agenda would have drifted and left them extremely vulnerable on a sensitive policy front.

I met with Minister Hunt in the week of the election spills, when he was still the Minster, and we have spoken in the days that followed and since he was re-appointed.

Continuity of care is always important, even in politics. The AMA will build on this close relationship to improve health policy ahead of the next election.

Equally; I have also met with Opposition Leader, Bill Shorten, in recent weeks.

The AMA is in regular contact with Shadow Minister Catherine King, the Greens, and any party or Independent with an interest in good health policy.

It is important that all sides of the political divide understand and appreciate our health policies and why they are important to the Australian people. Our patients, their families and the community deserve no less.

Let me be very clear in assuring all that the AMA is in a very good position to influence health policy across the political spectrum in the months before the election, and even better placed to pass judgement on the health policies once the campaign itself is in full swing.

# The profession must help solve the egregious fees problem

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

This issue will not go away.

The shrill voices of opposition and those zealously defending their own turf (by blaming doctors) will only get more stentorian and insistent. The health funds, all hatching plans for managed care, are desperately trying to preserve their $1.8 billion profit. The politicians want to claim victory in increasing bulk billing rates without having to pay as much as they should either. The Government must be delighted with the emerging public expectation that bulk billing is a fair price for medical care – it is lamentable that we have not been more effective at changing this view. Our medico-political strategy perhaps needs to change here...

Dr Linda Swan, Chief Medical Officer for Medibank, recently made the point in *The Australian* that cost is not an indicator of quality (in health care). This is not true though, is it? While high fees might not always correlate with high quality (but absolutely can correlate), you can be fairly certain that low cost will always put quality in jeopardy. The saying 'cheap and nasty' has real meaning. If Government designs a budget, no frills, 'free' healthcare system it will necessarily produce a budget health outcome – as occurs in everything else in life. We have no problem generally accepting this truth and moreover, paying for quality when we perceive it elsewhere – the same should also apply for health care.

The extension of this observation is that we should not be ashamed to value ourselves properly. We work long hours, get woken in the middle of the night to come into work, accept significant responsibility and continuing education (which is costly), and so on... While in theory we can charge whatever we want – as can any other professional, business, sole proprietor etc – it does not mean we can obfuscate when it comes to explaining our fees. Patients should always have a choice not to proceed and an appropriate ability to ask questions. Regretfully, this does not always occur and I do not think anyone really regards this as appropriate.

There are three points that need to be underlined in this discussion and that we must find a way to have Government and our patients clearly understand.

1. If we keep wanting a bargain basement health service (i.e. bulk billing) we must expect quality cannot be achieved in all circumstances.
2. Bulk billing and health insurance rebates are not designed with the true costs of medicine – rather, funders wish to pay the least they can to preserve profits or for Government to spend money on something else (it really would be refreshing if Government and the health funds cracked open the AMA fees list and took heed).
3. You get what you pay (or don't pay) for.

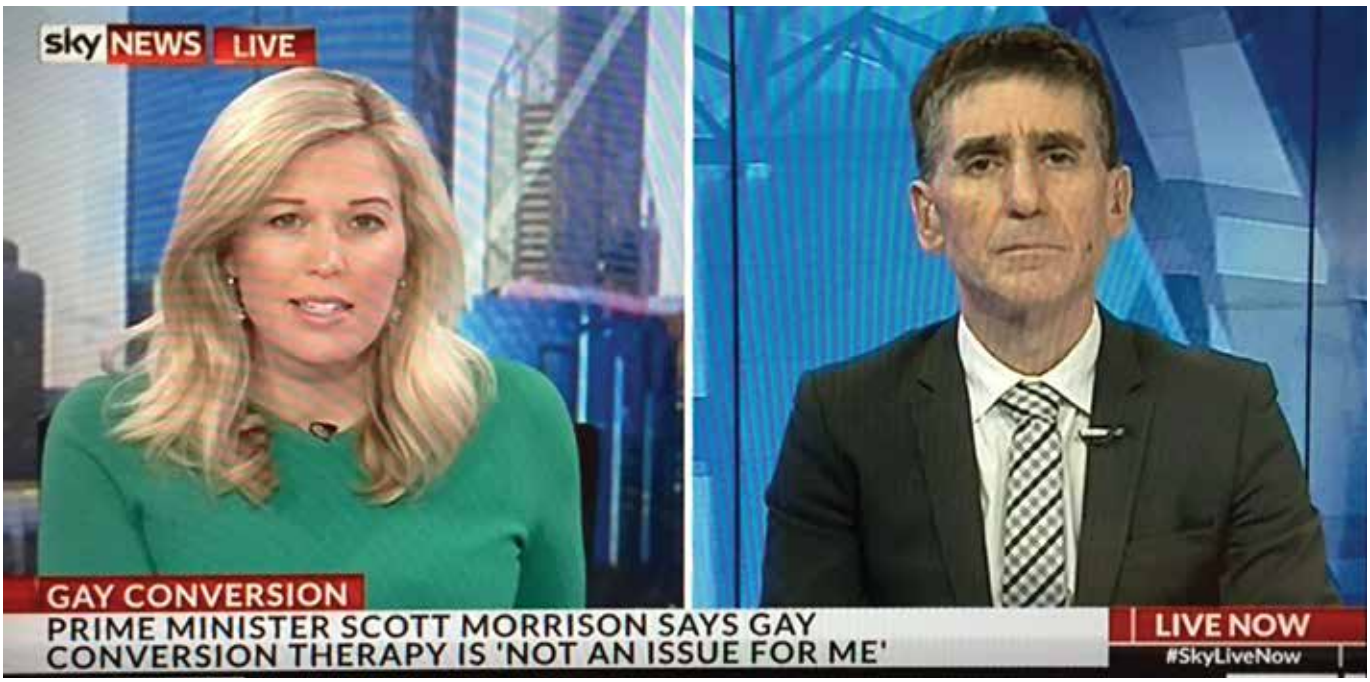
Having said all of this, there are some doctors' fees that do seem excessive, i.e. many times above the AMA fees (which have kept pace with inflation over time and better represent fair value and the cost of practice). Quite clearly, we need to be honest with patients about the full costs of their care before it happens when they still have time to opt out and ask questions. The huge majority of the profession agree that booking/administrative fees are not appropriate. Even if we were wavering on this issue, we must realise that patients (plus Government and funders) are going to be increasingly derisive of this practice. Let's please deal with all of this now in our own way rather than have to endure an imposed solution from one of the funders who remain conflicted by their desire to pay as little as possible.

There are four initial solutions that we, the profession, should consider implementing immediately.

1. Administrative/booking fees must go. Bill honestly and up front.
2. Obtain informed and signed financial consent from all patients (if you cannot give an exact price give a reasonable range and stick to it).
3. Allow an appropriate 'cooling off' period for the patient to consider options and opt out if they desire.
4. Let's develop a definition of what is unequivocally 'egregious' billing and develop a credible strategy of how we deal with this.

Health funds and Government are going to define their own version of what is appropriate or not, so the profession should take the lead. We must preserve a system that rewards increased effort or superior skill, otherwise everyone just regresses to the mean where there is no incentive to do anything other than the bare minimum. We cannot strike this happy medium that preserves 'fee for service' medicine if the few outliers do not realise the harm they are doing to us all.

# No place for conversion therapy




The AMA has fully condemned the notion of conversion therapy aimed at "curing" homosexuality, saying there is no place for it in this day and age.

Prime Minister Scott Morrison has failed to condemn the discredited practice, which was originally promoted by fundamental churches in the United States but has long been described by psychiatrists and the medical fraternity as bogus and even harmful.

Yet some fundamentalists have begun talking about the "merits" of the practice again.

When asked about it on Melbourne Radio 3AW, Mr Morrison said it was not an issue for him and he had no intention in getting involved in the debate.

"I respect people of all sexualities, I respect people of all religions, all faiths. I love all Australians," the Prime Minister said

"I've never been involved in anything like that, I've never supported anything like that. It's just not an issue for me and I'm not planning to get engaged in the issue."

AMA President Dr Tony Bartone would have liked the Prime Minister to have gone further with his remarks.

"It did seem to be a missed opportunity to put for once and for all that there is no place for conversion therapy in our society in the 21st century," Dr Bartone told Sky News.

"We know that it's associated with negative outcomes, it's not based on any research, it's archaic, and it's only associated with long-term harm to the patients involved."

Dr Bartone went on to talk about the Building Respectful Relationships school program, saying it was healthy to educate children about the risks of sexual assault and sexuality more broadly.

"The opportunity to have a broad-based education across the whole spectrum is obviously got to be in the long-term best interest of a broader understanding, a broader education, a broader appeal," he said.

"And so anything that increases that understanding and that awareness we would think is a good thing."

The AMA has also used social media to state its position regarding conversion therapy.

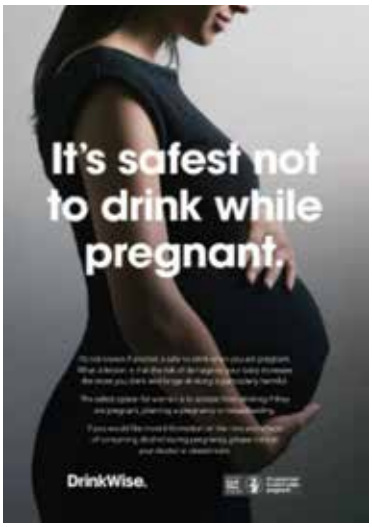
"The AMA unequivocally condemns conversion therapy, as does the World Medical Association," it Tweeted.

The associated graphic in the Tweet states: "Conversion therapy is harmful to both the individuals who are subjected to it, and society more broadly, as it perpetuates the erroneous belief that homosexuality is a disorder which requires a cure."

CHRIS JOHNSON

BY CHRIS JOHNSON AND MARIA HAWTHORNE

# AMA wise to DrinkWise poster




A lobby group funded almost entirely by alcohol companies has recalled thousands of posters advising women that it is "not known if alcohol is safe to drink when you are pregnant" after a complaint from the AMA.

DrinkWise had enlisted Tonic Media to distribute 2400 posters to hospitals and GP clinics around the country. The posters have now been replaced with ones with amended wording.

AMA President Dr Tony Bartone, who raised concerns with DrinkWise, said the small print was "fundamentally incorrect" because the science was clear that alcohol had devastating effects on unborn babies.

"Alcohol is a teratogen, it can cause birth defects, so we couldn't understand why that messaging was there," he told Fairfax Media.

"I told them about the misleading information and potential outcomes and they responded in a quick and timely manner."

The backdown even made the pages of *The New York Times* and the *Washington Post*.

# Future leaders gather in Canberra

A dozen of the AMA's best and brightest merged on Canberra over the first weekend in September for the Federal AMA Future Leaders Program.

Young doctors from each State and Territory took part in an intensive schedule aimed at exposing them to the world of political advocacy, particularly in the health policy realm.

The group toured Parliament House and met with senior political advisers from both sides of politics, committee clerks, health advocates, and AMA advisers.

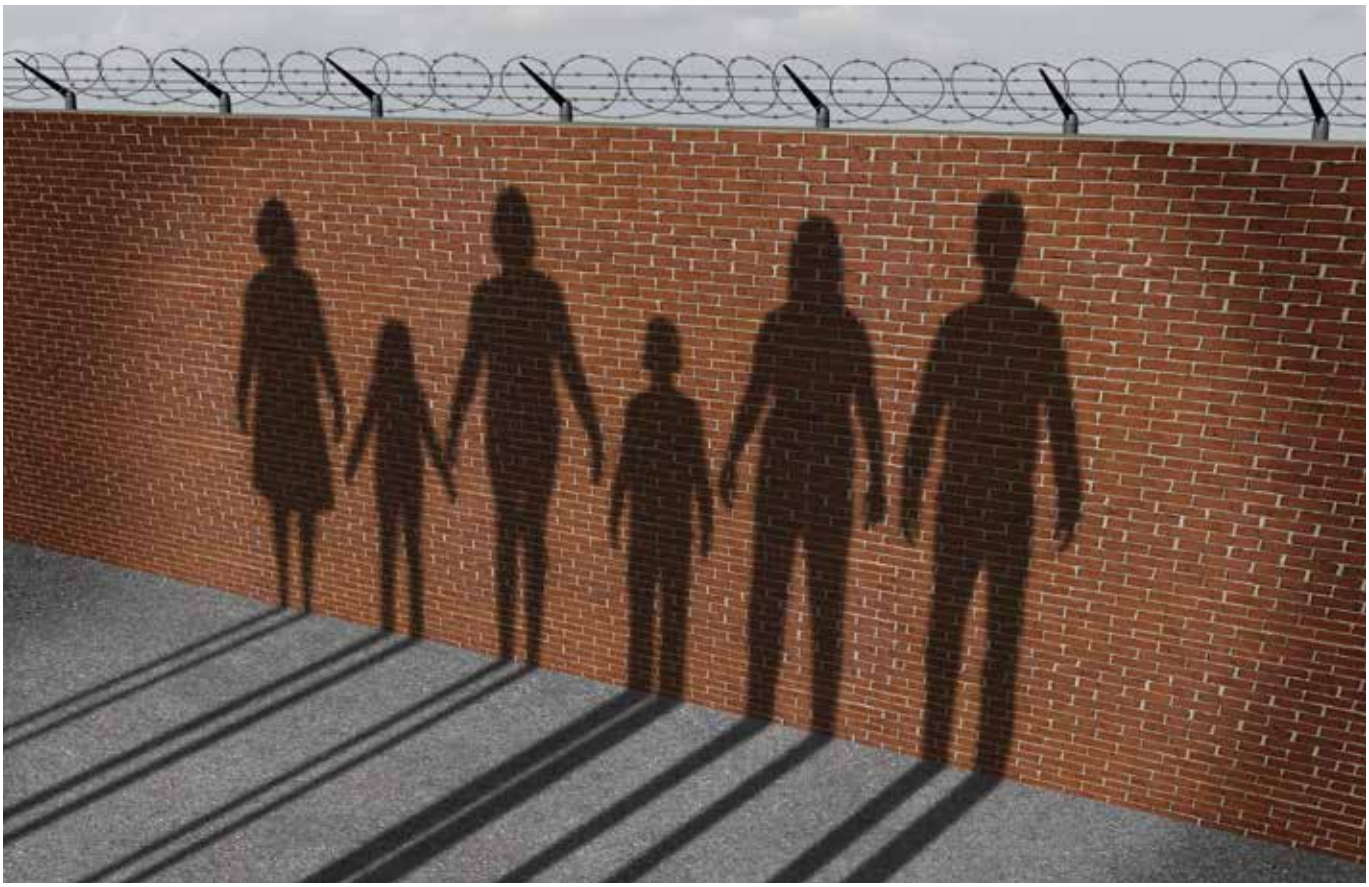
The particpants were (as pictured here on the steps of the Parliament House foyer):

Back row - Dr Michael Wu (Tas), Dr Brian Fernandes (NSW), Dr Malcolm Forbes (Vic),

Middle row - Dr Benjamin Wakefield (Qld), Dr Rebeka Stepto (ACT), Dr Mikaela Seymour (Qld), Dr Georgina Taylor (NT), Dr Alison Sorensen (WA),

Front row - Dr Sanjay Hettige (NSW), Dr Hannah Szewczyk (SA), Dr Chantelle Berenger (NSW), Dr Laura Raiti (VIC).

# Pacific Island Forum shouldn't ignore refugees on Nauru



While regional leaders gathered together on Nauru for the Pacific Islands Forum early in September, the AMA used the occasion to repeat its call for better treatment of asylum seekers.

The meeting also coincided with fresh reports about children threatening suicide due to their detained status on Nauru.

AMA President Dr Tony Bartone said such children and their families should be removed from Nauru immediately.

"We need to be perfectly clear, we've put out a resolution, a call, that all children on Nauru and their families be taken off the island as a matter of urgency because we know for a fact they've come from very difficult situations, from damaged backgrounds, a lot of trauma, a lot of stress, in that previous past," Dr Bartone told Sky News.

"They've been in a situation of continual uncertainty, unfamiliarity with the detention, even albeit in a community setting. We need to ensure that the mental health and wellbeing of these people are what we would expect is first order of priority for anyone in the care of the Australian Government.

"And we've called for children and their families be taken off Nauru as a matter of urgency, whether it's to Australia, whether it's to another destination that has the agreement of the Australian Minister. That's for them to decide. But we can't see any reason why they should remain on Nauru any longer."

New Zealand's Prime Minister Jacinda Ardern used the gathering to repeat her offer to resettle the refugees in New Zealand. Australian Prime Minister Scott Morrison has so far refused the offer, repeating the stance of his predecessor Malcolm Turnbull.

World Vision boss Tim Costello recently described the treatment of asylum seekers on Nauru as torture.

"There's no question that the psychological torture of not being

able to actually resettle, and you can't go back home, is torture," Mr Costello has said.

Dr Bartone did not use that terminology, but he stressed that there was great harm being done to the detained asylum seekers.

"We've received some alarming reports, both through social media and through other indirect channels, about the consequences in the long-term harm that some of these children are experiencing," Dr Bartone said.

"And the effects that they're having on their mind and effects that they're taking out on their body, the way they even live day to day. We've just been very categorical. They cannot remain, they should not be allowed to remain in situations which are putting them at harm, continued harm, and risk their ongoing mental health and wellbeing.

"Obviously, it certainly is within the realms of significant mental harm and mental stress. We can argue about the terminology, we can argue about whether it reaches that, but from any point or any shape or form, it's unacceptable that they continue to have the ongoing effects on their mental health and wellbeing."

The AMA Federal Council unanimously passed three motions in August calling on the Government to act urgently to guarantee the health and wellbeing of asylum seeker children and their families on Nauru – including that they be removed from the island; that a delegation of Australian medical professionals be given access to assess those on the island; and that the Government answer specific questions about the health and transfer arrangements of the refugees.

CHRIS JOHNSON

# Pacific islands unified on climate change and health

As clearly outlined by Nauruan President Baron Divavesi Waqa in his welcome to the Pacific Island Forum, the meeting was a time for action on climate change.

"There has never been a greater need for our ocean of islands to strengthen their resolve to work together for the benefit of our people and our environment," he told the gathered Pacific Island Forum leaders.

The Pacific community was looking for action from Australia not to abandon the emissions reduction commitments made under the Paris Agreement.

Dame Meg Taylor, Secretary General of the Pacific Islands Forum said: "Climate change is one of the biggest challenges threatening our Leaders' vision for the region, and it can only be addressed collectively.

"We must bolster our efforts to work together as the Blue Pacific – driving the resilient development of our region, while advocating for strong and sustained international action to keep temperature rise below 1.5 degrees."

Australia's new Foreign Minister Marise Payne acknowledged Pacific island countries are particularly vulnerable to the effects of climate change and to the impacts of natural disasters.

The Pacific Islands Forum also listened to calls for action from the region's leadership to address childhood obesity, following recent statistics from the World Health Organisation showing at least 20 per cent of children and adolescents aged 5 to 19 years were obese in 10 of the Forum's 18 members.

"Building a Strong Pacific is the theme for this year's Leaders Forum but that will be very difficult to do without dedicated regional action to fight childhood obesity," Dame Meg said.

"Non-communicable diseases are devastating to the Pacific in many ways, but childhood obesity is one of the most formidable challenges our region faces," said Dr Colin Tukuitonga, Director General of the Pacific Community, the principal scientific and technical organisation in the Pacific region.

"This call for action reflects our common commitment towards improving the health of Pacific youth and ensuring they are able fulfill their full potential."

MEREDITH HORNE

# Health care fertile ground for mergers and acquisitions

> "Signals show that healthcare's deal boom is set to continue, with cashed up buyers chasing an increasingly narrow pool of assets that combine quality businesses with growth potential."

Australia is becoming increasingly attractive to healthcare business investors, with mergers and acquisitions (M&A) rising sharply over the past decade.

The recently released MinterEllison's *M&A Outlook: Healthcare 2018* report reveals that nearly $A48 billion worth of M&A transactions took place in Australia in the past ten years.

Australia also represents 27 per cent of all Asia-Pacific healthcare M&A since January 2017.

The report identifies a number of global healthcare M&A drivers and challenges – including meeting the demand of an ageing population; increasing regulation and compliance costs; and spin-offs by larger conglomerate companies to get 'back to basics'.

"We expect that the next 18 months should see robust M&A activity in global healthcare," said Shane Evans, MinterEllison Partner and national Health Industry group leader.

"Signals show that healthcare's deal boom is set to continue, with cashed up buyers chasing an increasingly narrow pool of assets that combine quality businesses with growth potential."

Formed through extensive analysis of healthcare global deal data, the report highlights that a record $US306 billion of deals (averaging 81 per cent premiums paid) have been announced through the first half of calendar 2018.

Technology giants are also identified as viewing healthcare as a fertile ground. These players will impact existing business models, supply chains and valuations of incumbent players, as was highlighted with Amazon's influential acquisition of US online pharmacy group PillPack for $US1 billion.

The report is available via the MinterEllison website: https://www.minterellison.com/articles/healthcares-deal-boom.

AUSTRALIAN COMMUNITIES FOUNDATION

**The AMA would like to acknowledge the generous contribution from the sub-fund: B B & A Miller Fund towards the AMA Indigenous Medical Scholarship.**

# Updated guidelines for management of OA

The Royal Australian College of General Practitioners (RACGP) has updated its Guidelines for the management of hip and knee osteoarthritis (OA), recommending sufferers adopt a combination of lifestyle changes, regular exercise and cognitive behavioural therapy to help manage symptoms of the condition.

The updated guidelines have also meant changes to the classification for the efficacy of medication for hip and knee osteoarthritis sufferers looking for further pain relief.

According to the guidelines: "While paracetamol has long been considered first-line therapy for OA, current evidence from a systematic review of randomised controlled trials (RCTs) suggests that, on average, the reduction in OA pain achieved with paracetamol is too small to be of clinical relevance."

The guidelines' technical document suggests that the use of nonsteroidal anti-inflammatory drugs (NSAIDs) including Ibuprofen (such as Nurofen), result in small but clinically relevant improvements in pain and function in individuals with knee and/or hip OA, and are likely to be more effective than paracetamol for most people.

With more than two million Australians affected by the degenerative joint condition, the updated guidelines provide important information to GPs looking to help their clients impacted by the painful and frustrating symptoms of osteoarthritis.

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 Twitter news

**Dr Nikki Stamp FRACS** @drnikkistamp · Aug 15
Yes!!! Doctor in training or junior doctor pays absolutely no credit to the huge amount of work and care they do. #medtwitter #ILookLikeASurgeon ping @ama_media

**The BMJ** @bmj_latest
What should we call doctors in training? @Abi_Rimmer talks to @scarlettmcnally about her work to find a new term to replace "junior doctor" bmj.com/content/362/bm...

**AMA Media** @ama_media
The man who wrote the book on general practice has been recognised with the AMA's highest honour, the AMA Gold Medal. John Murtagh's contribution to medicine as both a doctor and an educator is incomparable ...

4 · 22 · 99

**Richard Harris** @drharry64 — Following

Replying to @julestullberg @ama_media @MonashUni

Congratulations Dr Murtagh! I have a very old copy of his book on
my shelf from my initial foray into general practice.

7:37 AM - 19 Aug 2018

**Hannah Gadsby** @Hannahgadsby — Following

My doctor called me nanette today

11:20 AM - 20 Aug 2018

1,377 Retweets 32,584 Likes

248 · 1.4K · 33K

**FatherBob** @FatherBob — Following

Good and conscientious call.

**AMA Media** @ama_media
The AMA calls on the Government to allow a delegation of independent Australian doctors to examine asylum seekers on Nauru - adults and children - and to report their condition to Parliament and the Australian people ama.com.au/media/ama-call... #auspol #Nauru

12:16 AM - 20 Aug 2018

**Geir O'Rourke** @geirorourke — Following

This summer...


**Lleyton.** @LleytonBW1 — Follow

Its great to see the The AMA Federal Council calling on the government to act urgently to guarantee the health and wellbeing of asylum seeker children and their families on Nauru. #OENV18

**AMA Media** @ama_media
The AMA Federal Council of doctors has unanimously passed a resolution calling on the Government to guarantee the health and wellbeing of child asylum seekers on #Nauru and their families ama.com.au/media/ama-call... #auspol

11:07 AM - 20 Aug 2018

**Ming The Merciless** @MGliksmanMDPhD — Following

AMA ramps up pressure on #LNP Government to stop denying proper, timely medical treatment to #refugee children on Nauru medicalrepublic.com.au/ama-ramps-pres ... @Medicalrepublic Makes me proud to be an AMA member. @amapresident @ama_media

**AMA ramps up pressure over Nauru • The Medical Republic**
AMA calls for Canberra to "exhaust all avenues" to ensure refugee children be taken off Nauru so they can access appropriate medical care
medicalrepublic.com.au

4:18 PM - 22 Aug 2018

INFORMATION FOR MEMBERS

# How dangerous is sport-related concussion?

Just 25 minutes into the 2015 Rugby World Cup Final, pitting the Wallabies against the All Blacks, Aussie veteran Matt Giteau attempted a tackle on Kiwi lock Brodie Retallick that went wrong, crashing him to the ground where he lay in a daze. After stumbling about on all fours for a few seconds, Giteau slowly got to his feet and staggered sideways as he tried to walk, a classic sign of concussion. Although he seemed to recover quickly, a medical officer pulled him from the pitch and he was out for the rest of the game.

"They wouldn't have done that a decade ago," says Dr David Hughes, Chief Medical Officer at the Australian Institute of Sport (AIS) and co-author of a new CPD learning module on concussion in sport. "That they pulled a key player off the ground in such an important match shows just how seriously the football codes are taking the issue of concussion."

Dr Hughes says there's been an enormous cultural shift in how sport-related concussion is approached over the past few years.

"There was a time, particularly in contact and collision sports, when getting up and playing on after a concussion or even after being completely knocked out was seen as being tough or a sign of your commitment to the game. That has shifted, and a lot of the heavy lifting has been done by the sports codes themselves."

Nowadays, he says, you'll rarely see a professional player returning to the field until six days or so after concussion, let alone in the same game. And for many top athletes who are concussed, it may be weeks before they're competing again.

"There is far more focus on the welfare of the athlete. We understand that there's no such thing as a good concussion."

Dr Hughes says the new awareness around the issue of consciousness is happening at the grassroots as well, and not just at the professional level.

"There's parental concern, and there's an understanding that concussion is not just about professional contact and collision sports, but it's actually a public health matter. In the professional sports, you've got access to medical professionals and video, which makes identifying and dealing with concussion that much easier, but at the school or amateur level it's a lot more difficult."

To address this need, the AIS and AMA put out a joint statement on concussion, and the two bodies have also set up a website with information for parents and teachers as well as coaches and medical practitioners.

Dr Hughes says there's still a lot of confusion over the issue in the general community.

"You have the situation where a child suffers a concussion and the parent immediately thinks their child will have long term brain issues, and there's just no evidence that this is the case. But we do know there's a need to differentiate between children and adults. Children take longer for symptoms to resolve, and the recommendation is to wait 14 days following symptom resolution before the child resumes competitive sport."

Then there's the question that has been all over the media in the past couple of years of whether repeated concussion can lead to degenerative brain disease. Dr Hughes says he thinks the jury is still out.

"There was a paper published in JAMA by a group in Boston which has maintained a brain bank of professional athletes. Out of 220 people who had donated their brains, 210 had signs of degenerative brain disease. So you get all these headlines saying 90% of football players have degenerative brain disease. The problem is you can't extrapolate from this study because it's such a skewed sample. Everyone who donated their brains already had symptoms, and that's why they donated."

He says the fact is that the vast majority of people who suffer sport-related concussion will go on to lead perfectly normal lives.

"The AIS and AMA are not saying there are no long-term effects. All we're saying is the studies have not been done. There is no research to date that clearly demonstrates cause and effect between sport-related concussion and later degenerative brain disease. There's a lot of passion and emotion around the subject. You can hold up a slice of someone's brain and then show a video of that same person being concussed many years ago, and it's a very powerful image. But it's not good scientific research."

**Are you interested in learning about concussion in sport? Access doctorportal's free learning module to gain CPD points.**

# Women encouraged to put their health first

The Jean Hailes fourth annual Women's Health Survey of 15,000 women across Australia reveals mental health and wellbeing is a rising concern.

Almost half of women surveyed had been diagnosed with depression or anxiety by a doctor or psychologist. And two-thirds of women reported feeling nervous, anxious or on edge nearly every day or on more than seven days in the last four weeks. Most women (53 per cent) also were not able to stop or control worrying.

Chris Enright, Head of Education and Knowledge Exchange at Jean Hailes for Women's Health, believes the pressures women face juggling their busy work load with their numerous family constraints of caring for children and aging parents are having a negative effect on health and wellbeing.

"Our survey reflects that women worry about their health, particularly their weight, and getting enough time to themselves just to unwind, and 9.5 per cent of women drink alcohol every day," Ms Enright says.

The survey plays an important role in looking at the big picture because very little research exists on what information women like, trust, and need in relation to their health.

"These findings help us to understand the behaviours of women in relation to their health, and importantly, how we can help them to lead healthy lifestyles," Ms Enright says.

"What we also found interesting is that half of survey respondents describe themselves as overweight or obese yet 70 per cent of women say they do at least two hours of moderate physical activity every week."

The good news in the survey is that smoking rates were found to be low.

"Hardly any of the 15,000 women that we surveyed are regular smokers," says Ms Enright.

"Ninety per cent hadn't smoked in the past year. And half of women describe their health as very good or excellent."

The survey was launched as a part of celebrating Women's Health Week 2018 and can be found on their website: https://jeanhailes.org.au/womens-health-survey-2018

MEREDITH HORNE

# Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTHS:

| Name | Position on council | Committee meeting name | Date |
|---|---|---|---|
| Dr Andrew Miller | Federal Coucillor - Specialty Member (Dermatology)/ MPC Member | Ministerial Advisory Committee on Out of Pocket Costs and Fee Transparency | 28/02/2018 |
| Dr Andrew Miller | Federal Coucillor - Specialty Member (Dermatology)/ MPC Member | Ministerial Advisory Committee on Out of Pocket Costs and Fee Transparency | 23/03/2018 |
| Dr Liz Gallagher | AMA ACT past president | Department of Health Stakeholder Advisory Group on National Maternity Services Strategy | 24/08/2018 |
| Dr Amir Rahimi | AMA Victoria general practitioner representative | Nursing and Midwifery Board stakeholder forum on nurse prescribing | 15/08/2018 |
| Dr Tony Bartone | AMA President | National Medical Training Advisory Network | 13/07/2018 |
| Dr John Zorbas | Proxy - AMA Council of Doctors in Training | National Medical Training Advisory Network | 13/07/2018 |
| Dr Tony Bartone | AMA President | DVA/Defence Meeting | 21/8/2018 |
| Dr Richard Kidd | Chair - Council of General Practice | PIP Advisory Group | 10/8/2018 |
| Dr Richard Kidd | Chair - Council of General Practice | DVA Health Providers Partnership Forum | 1/8/2018 |

# 2018 Snapshot
# Women's Health Survey

Jean Hailes FOR WOMEN'S HEALTH

Our fourth annual Women's Health Survey reveals the health needs and behaviours of women across the country. This year, 15,262 women aged 18 years or older and living in Australia responded to the survey. Here are some highlights:

## Physical health

**50.8%** of women described themselves as **overweight or obese**

**9.5%** of women reported **drinking daily**

**50.4%** of women described their overall health as **very good or excellent**

**70.3%** reported doing at least **two hours of moderate physical activity** per week

## Mental and emotional health

**Two thirds of women (66.9%)** reported **feeling nervous, anxious or on edge** nearly every day or on more than seven days in the last four weeks

More than **a third of women (34.3%)** reported **not getting time to themselves** on a weekly basis

Almost **half of women (46.1%)** who responded to the survey had been **diagnosed with depression or anxiety** by a doctor or psychologist

## Health needs

More than **one in four women (25.5%)** have discussed or need to discuss with their doctor a **lack of interest in sex** in the last 12 months

Almost **one in four (23.9%)** could **not afford to see a health professional** when they need one

## Health information

Top 5 health topics **women want to know about**

1. **Weight management (34.9%)**
2. **Healthy eating /nutrition (31.7%)**
3. **Mental and emotional health (29.3%)**
4. **Anxiety (28.3%)**
5. **Menopause (24.9%)**

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For any media enquiries, please contact Janelle Carrigan on 0409 939 920 or janelle.carrigan@jeanhailes.org.au

# 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

# 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

# Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON

## Government response to AHPRA inquiry not good enough

The AMA welcomes the long overdue Australian Government response to the Senate Community Affairs References Committee Report Complaints mechanism administered under the Health Practitioner Regulation National Law which was released in May 2017.

Considering the length of time it took to prepare this report it is reasonable to expect that the Government's response would be fulsome and had addressed the issues raised – this is not the case.

The report is disappointing – for 7 out of the 13 recommendations the Australian Government's answer is that it will recommend that the COAG Health Council write to Australian Health Practitioner Regulatory Agency (AHPRA) requesting advice on how AHPRA is addressing these recommendations.

The national scheme is often criticised by the profession. The AMA was upset by the decision to publicly link tribunal decisions, where there was no finding against the doctor. It is why we fought to have this changed. The AMA has also raised concerns about the National Registration Scheme, particularly about the detrimental impact a caution can have on a medical practitioner.

More work here is needed, and the AMA is constantly engaging with AHPRA and the MBA on this. As a result, there have been some significant improvements in the notifications process, the communication and education as a result – which the AMA has warmly welcomed.

The Senate report also makes clear that there is a raft of new changes being contemplated now. Some of these the AMA has previously rebutted.

"We remain disappointed that we have to make the same arguments over and over again," an AMA policy spokesman said.

"For example, it is why we are so disappointed that the issue of a non-medical practitioner heading up the MBA has again been raised in the recently released consultation paper on proposed legislative updates to national registration."

The AMA has always stated (and will do so again in its submission on these proposed updates) that the Chair of the Medical Board is a very influential position, requiring a strong understanding of medical practice and a move to appoint a non-medical practitioner would be unsettling for the profession and is likely to lead to a loss in confidence in the scheme.

The inquiry was initiated following concerns expressed by both practitioners and complainants in the Committee's earlier inquiry into the 'Medical complaints process in Australia'.

## Expert Panel for Life Saving Drugs Program

The Government has appointed Australia's former Deputy Chief Medical Officer Dr Tony Hobbs as chairman of the Life Saving Drugs Program Expert Panel.

In announcing the appointment, Health Minister Greg Hunt said the panel was being established to help improve access to lifesaving medicines for rare diseases.

The Life Saving Drugs Program (LSDP) provides free medicines to treat patients with rare and life-threatening diseases.

Medicines funded through on the LSDP include some high cost medicines that do not meet the criteria to be funded on the Pharmaceutical Benefits Scheme.

Currently, the Government funds 13 different medicines for nine very rare diseases through the LSDP, providing physical, emotional and financial relief for people and families in need.

The LSDP supported 393 patients in 2016-17 at a cost of $116 million and over the past six years the number of patients accessing these medicines through the program has grown over 65 per cent.

"The new expert panel will support the evaluation of medicines for funding and provide advice to the Chief Medical Officer," Mr Hunt said.

"The diverse experience of the appointees will ensure that the program is supported by some of the very best minds in evidence evaluation and health technology assessment."

Other members of the six-member panel will include clinical experts Professor Jonathan Craig and Professor Elizabeth Elliott, health economist Adjunct Professor Jim Butler, consumer nominee Nicole Millis and industry nominee Liliana Bulfone.

Dr Hobbs' appointment is for four years, with the new expert panel members' terms varying from two to four years.

"Highly respected in their fields, this group will make a major contribution in considering the suitability of new medicines for inclusion on the LSDP through advice to the Commonwealth Chief Medical Officer," Mr Hunt said.

Other recent changes to the LSDP include clearer eligibility criteria for inclusion on the LSDP, a more transparent and timely assessment process, new pricing policies similar to those that

# Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

apply to PBS medicines, and the review all of the currently funded LSDP medicines.

The changes follow the Government response to a review of the LSDP chaired by Professor Andrew Wilson.

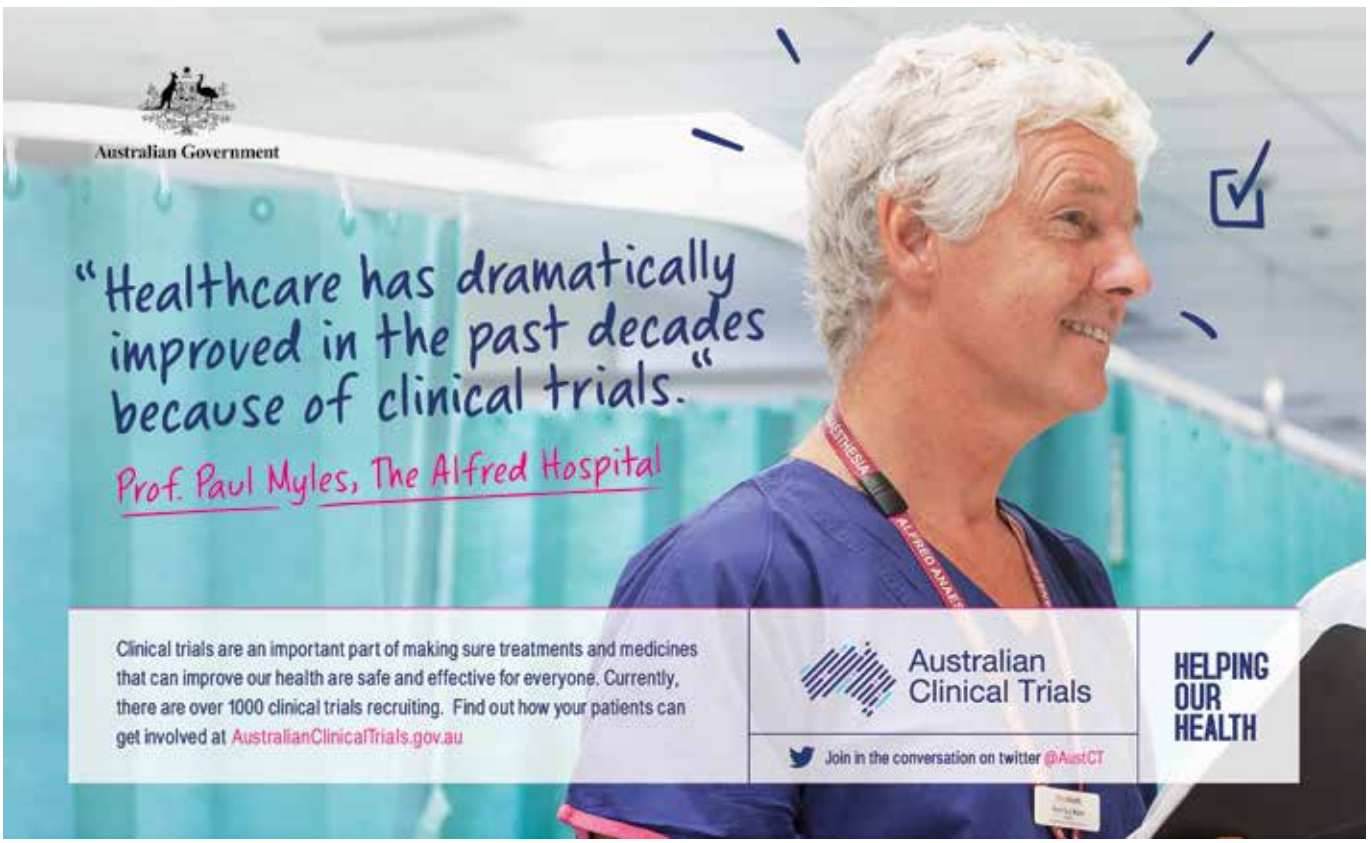
## President meets Opposition Leader while PM changes

Opposition Leader Bill Shorten recently met with AMA President Dr Tony Bartone in what Dr Bartone described as a "very productive" meeting.

The pair met immediately following the change of Prime Ministership, giving them more than enough to talk about.

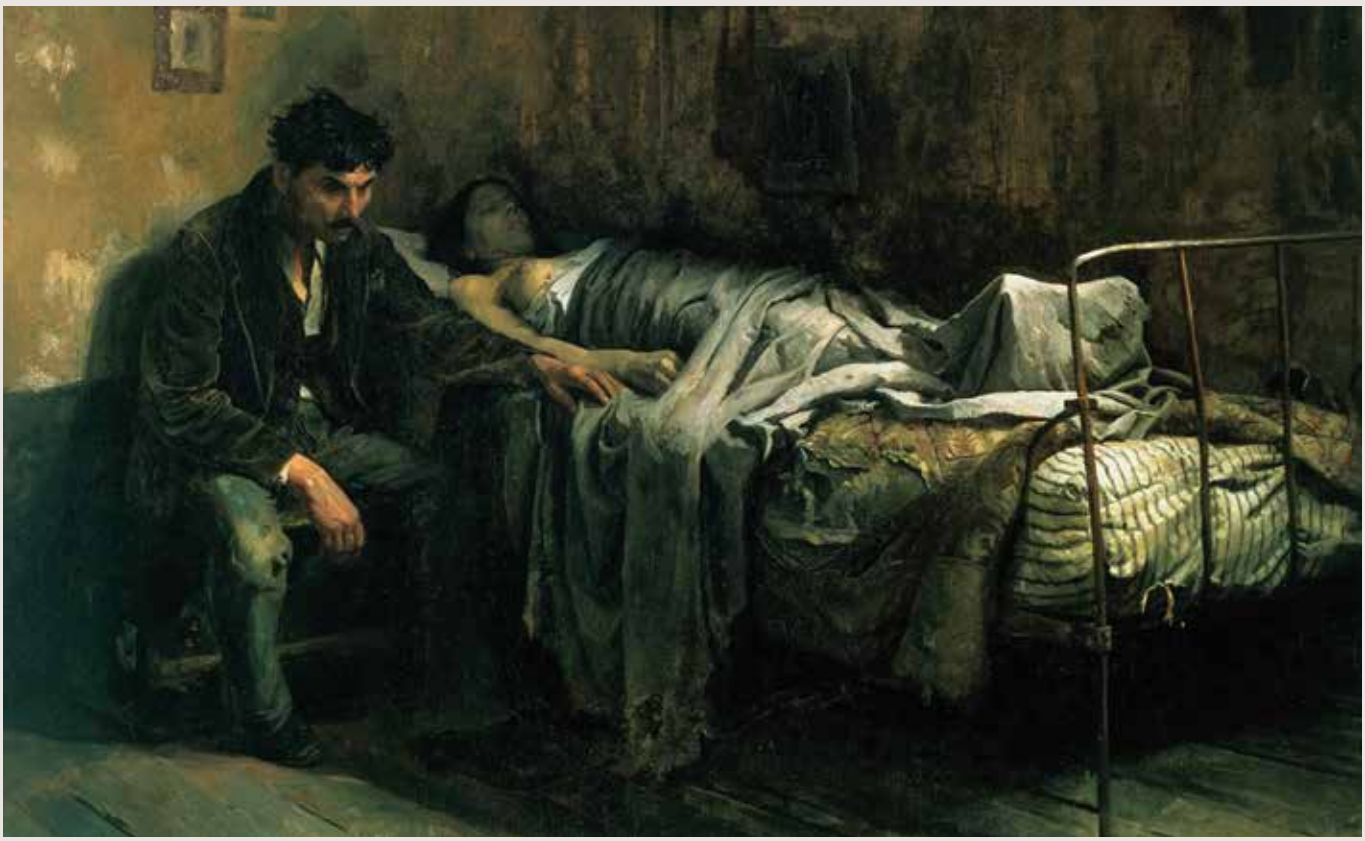
But Dr Bartone focussed on health policy, discussing issues surrounding general practice, mental health, aged care, and dementia.

Although talking about health with the AMA President was enough to make the Labor leader happy, a buoyant Mr Shorten had an additional reason. The meeting was held on the same day that Newspoll reported him as Australia's preferred Prime Minister.



# TB and HIV – still miles to go

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



In 1966, we junior interns at Sydney's Royal North Shore Hospital were accommodated at Lanceley Cottage. It lay just beyond the thoracic unit, where patients with active TB were treated on the top floor. Their medication included PAS (para-aminosalicylic acid) – not liked because of its volume or its aspirin-like taste. Walking to the main hospital each morning, we had to dodge the PAS 'rain' from disgruntled patients as they tipped their daily dose over the balcony. Compliance with treatment, even in hospital, has been a problem for as long as effective chemotherapy has been available.

Human tuberculosis has been around for at least 5,000 and perhaps 9,000 years. The mycobacterium shows great resilience. If it had been listed on the stock exchange, it would have yielded a high dividend with few interruptions. Most recently, it has settled into the communities where HIV/AIDS is prevalent, adding to the burden of misery.

Nor is it limited to humans. As Wikipedia points out: "Seals and sea lions that bred on African beaches are believed to have acquired the disease and carried it across the Atlantic to South America."

Like HIV, TB's victims are often young, triggering art and poetry to lament the loss (see the photo above of a painting by Cristobal Rojas, himself suffering from TB at the time of this painting).

On September 26 this year, a high-level meeting of the UN will convene in New York with the theme "United to end tuberculosis: an urgent global response to a global epidemic". High-level meetings attract heads of state and are rare events for health.

Previous meetings have considered HIV (2011) and non-communicable disease (2014). So this is big ticket.

As with most top-drawer international diplomatic events, the UN meeting has been preceded by much hammering out of the agenda. For example, In November last year, the Moscow Declaration to End Tuberculosis was agreed to by 75 ministers of health. Strong on rhetoric, but also substantial, it aimed to promote multi-sectoral action (never forget that TB thrives in impoverished societies), "track progress, and build accountability – signalling a long overdue global commitment to stop the death and suffering caused by this ancient killer".

The WHO provides the following facts about TB:

1. In 2016, 10.4 million people became ill, and 1.7 million died from it (including 400,000 among people with HIV). More than 95 per cent of deaths occur in low- and middle-income countries;
2. Seven countries account for 64 per cent of the total cases, with India leading the count, followed by Indonesia, China, Philippines, Pakistan, Nigeria and South Africa;
3. In 2016, an estimated 1 million children became ill and 250,000 children died (including children with HIV-associated TB); and
4. It's a leading killer of HIV-positive people: in 2016, 40 per cent of HIV deaths were due to TB. HIV increases the risk of TB 20-30 fold.

In some places, TB has become resistant to isoniazid and rifampicin, two major treatments, and to other drugs as well. Fortunately, new diagnostic methods can rapidly detect multi-drug resistant (MDR) TB, enabling shorter and probably more efficacious treatment regimens. The magnitude of MDR-TB is seen in the claim that only a quarter of infected people are currently detected and fewer are adequately treated.

Earlier this month, the WHO announced changes to drug-resistant treatment regimens.

Using available high-quality evidence, a new priority ranking of the medications has been proposed, such that treatment is based on a careful balance between expected benefits and harms.

The second important change is a fully oral regimen as one of the preferred treatments for MDR-TB, with injectable agents to be replaced by more potent alternatives such as bedaquiline (the first-ever medicine to be developed specifically for MDR-TB).

"The treatment landscape for patients with MDR-TB will be dramatically transformed for the better," said Dr Soumya Swaminathan, WHO Deputy Director-General for Programmes.

"WHO has moved forward in rapidly reviewing the evidence and communicating the changes needed to improve the chances of survival of MDR-TB patients world-wide. Political momentum now needs to urgently accelerate, if the global crisis of MDR-TB is to be contained."

While TB is yielding to effective new treatments such that it is possible to envision a day when it has been eliminated, no such confidence can be applied to HIV.

The August 2018 report from UNAIDS, Miles to Go, http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf draws attention to stalling in the program to reduce the incidence and prevalence of HIV and AIDS. It speaks critically of 'complacency': in 2017, 180,000 children became infected. One million people die of HIV/AIDS related illnesses each year. But we must balance these disturbing figures against a remarkable achievement with treatment: 22 million people are on anti-HIV drugs.

It is at the intersection of HIV and TB that urgent action is needed. As Michel Sidibé, who comes from Mali and serves as Executive Director of UNAIDS, the Joint United Nations Programme on HIV/AIDS, and as Under-Secretary-General of the United Nations, writes in the Foreword to the UNAIDS report,

"The upcoming United Nations High-Level Meeting on Tuberculosis is a huge opportunity to bring AIDS out of isolation and push for the integration of HIV and tuberculosis services. There have been major gains in treating and diagnosing HIV among people with tuberculosis, but still, decades into the HIV epidemic, three in five people starting HIV treatment are not screened, tested or treated for tuberculosis, the biggest killer of people living with HIV." (Mr Sidibe's attention has recently been rather distracted by sexual harassment concerns.)

So, with TB and HIV we have achieved much – not only in Australia, where we are blessed with the necessary prosperity to detect and treat, but also globally and in poorer countries.

To bridge the remaining gaps, we require money, committed people, political enthusiasm and broad vision. Several Australian doctors and nurses are making major contributions to the control of TB and HIV throughout Asia and elsewhere. Let's salute them while realising there is space for more to join them.

Further background: *BMJ*, Revisiting the timetable of tuberculosis https://www.bmj.com/content/362/bmj.k2738

# Collaboration, not competition

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

Team work in providing comprehensive and quality patient care is not a new concept. Within the medical profession, we recognise our professional limitations and operate only within our scope of practice. When needed, we seek the opinion, or skills and expertise of other colleagues.

> "With an aging population and the rising incidence of chronic disease adding to the complexity of patient care, there is an enhanced focus on the role and importance of well-coordinated multidisciplinary health care teams."

With an aging population and the rising incidence of chronic disease adding to the complexity of patient care, there is an enhanced focus on the role and importance of well-coordinated multidisciplinary health care teams. However, it is critical that these teams work effectively. Mutual respect for the skills and expertise of team members is fundamental, with each making their contribution within their scope of practice to meet the health care needs of the patient.

We all know the dangers to our patients of poorly coordinated, fragmented care. We also know that best practice care starts with the right assessment and diagnosis by a medical practitioner and, in the case of general practice, a longitudinal relationship with the patient. Despite this, we see ceaseless ambition of some pharmacist groups for prescribing rights and a greater role in the provision of health services, such as preventative health, disease screening and detection and chronic disease management.

For a GP, the community pharmacist, who is responsible for the dispensing and supply of medications, provides an important and complementary role in the delivery of quality patient care. Pharmacists are vital to the safe provision and use of medicines. They provide assurance that correct dosages are dispensed and that patients understand when and how to take their medications.

The AMA places a high value on the professional role of pharmacists working with medical practitioners and patients to: ensure medication adherence; improve medication management; and provide education about patient safety.

The AMA fully supports pharmacists undertaking roles within their scope of practices to support patient health care. But the community needs a clear understanding of how the core education and training differentiates medical practitioner and pharmacist scopes of practice.

Taking comprehensive histories, undertaking examinations, determining appropriate diagnostic investigations, making a diagnosis, and managing and treating a patient are the domain of the medical profession because that is what we, not pharmacists, are trained to do.

Certainly, the AMA recognises the benefits of integrating non-dispensing pharmacists into general practice to provide enhanced patient care. That is why we worked with the Pharmaceutical Society of Australia in developing such a plan that now, through the incoming Workforce Incentive Program, will see GPs and pharmacists supported to work even more collaboratively in the best interest of patients. With medical oversight, the current role of pharmacists may well expand to support a greater role in the provision of more holistic patient care. Patient wellbeing, after all, is a fundamental tenet of both our professions' codes of ethics.

What we don't want to see is patient care further fragmented, services duplicated, and access to the right care delayed. This simply causes undue costs to the health system and poor health outcomes for patients. What GPs and pharmacists should do is continue to work together respectfully, acknowledging the different skills and expertise we bring to the team for the patient. Our patients deserve collaboration, not competition, and policy makers must continue to avoid simplistic ideas that are driven by commercial needs and not good patient care.

# RUOK?

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


September 13 – R U OK? Day. R U OK? Day is a national day that encourages all of us to take the time to talk and to listen to each other to prevent suicide. It is held mid-September each year. This Day stems from one suicide, one grieving son, Gavin Larkin*, who felt there ought to be something that can be done to prevent suicide. He championed a movement to encourage people Australia-wide to ask one question: are you okay? This is a national movement, 80 per cent of Australians are aware of this day of action and one in four have participated in an R U OK? Day activity.

It is more than a question, it is an act of taking away stigma – to make it OK to ask. Simply asking the question opens a door for both of you to talk about your mental health. It makes you talk about the steps to make sure you are both okay.

We doctors ask this question to our patients every day. It is now time to take this question out of therapeutic relationships and just ask someone different, reach out where you do not usually go. Ask a Rural Doctor.

We all know a doctor who has suicided. There was another one in Far North Queensland a few months ago. Internationally, one doctor dies by suicide per day. In the United States, Dr Pamela Wible, (author of *Physician Suicide Letters – Answered*) says that is roughly equivalent to one medical school per year.

Doctors in training lists some of the causes: "...brutal expectations ...the work eats you alive ... hours expected to work, the conditions we work under, family sees less and less of us. How difficult this job is, the expectations..." There is an element of bullying and a culture that discourages getting help.

Dr Michael Myers, a New York University psychiatrist who studies doctor suicides, states there are obvious occupational factors: access to lethal drugs, the knowledge to use them, learned fearlessness, exposure to vicarious trauma. Then there is the practice of medicine itself: an epidemic of burnout fueled by everything from long shifts and huge, complex caseloads to what many doctors say is a punitive and unsupportive regulatory culture.

Rural doctors, RU OK?

Most of you are okay. You have chosen a fulfilling profession in a challenging location, you have empowered yourself with generalist skills, you have a work-life balance. You love rural.

Some of you are not OK.

You are the "us" we worry about.

RU OK?

** Full story at http://www.abc.net.au/news/2017-09-04/r-u-ok-day-the-true-story-behind-the-creation/8865546*

# Prevention of HTLV-1 is the only cure

BY AMA PRESIDENT DR TONY BARTONE

The Federal Government recently announced the formation of a new taskforce consisting of relevant health care providers, researchers, clinicians, and all levels of government to combat HTLV-1 in remote Indigenous communities.

Human T-cell lymphotropic virus (HTLV) - an oncogenic virus first discovered in 1979, and the first retrovirus to be discovered - predominantly affects CD4+T cells, which play an important role in the body's immune system.

HTLV-1 infects up to 20 million people globally, with the virus prevalent in south-western Japan and the developing countries of the Caribbean basin, South America, and sub-Saharan Africa.

HTLV-1 was first detected in 1988 in Central Australia in the Indigenous population, and recent studies indicate that 45 per cent of Indigenous adults who reside in remote communities in Central Australia have been infected with HTLV-1.

Commonly transmitted through contaminated blood, unprotected sex, and breast milk, the virus is associated with a fatal haematological malignancy - Adult T cell Leukemia/Lymphoma (ATLL) - and inflammatory diseases involving organs including the spinal cord, eyes, and lungs.

In Indigenous Australians, the most typical clinical manifestation of HTLV-1 is bronchiectasis (a condition in which the airways of the lungs become damaged).

The extent and seriousness of the disease is dependent on the viral load in the blood stream.

Uveitis (inflammation of the middle layer of tissue in the eye) is another serious complication of HTLV-1, which was found through a case study done in Central Australia.

It can result in blindness, so it is important for treating professionals to be well informed about HTLV-1.

Unfortunately, there are no treatments currently available for HTLV-1 infection, but the following prevention strategies could result in the reduction of transmission and, ultimately, the eradication of the virus:

- Encourage the use of condoms among the sexually active population, and routine testing for HTLV-1 in areas where the virus is prevalent.
- Organ donors and blood transfusion products should be tested, and transfusions and transplantations avoided where testing shows a positive result. Monitoring and follow-up are vital in these instances.
- Mothers who test positive to HTLV-1 should be advised to avoid breastfeeding or reduce it to three to six months, and alternative methods of infant feeding should be advised.
- Injecting drug users should be educated and advised to use sterile needles, and regular testing for HTLV-1 should be available.
- Evidence-based and up-to-date information regarding HTLV-1 should be available to health care providers so they can educate their clients on how to protect themselves.

The AMA supports an enhanced focus on Aboriginal and Torres Strait Islander people at risk of blood-borne viruses, including specific resourcing of management and research to address HTLV-1.

This is consistent with the AMA's active participation in the Close the Gap strategy, and our series of Indigenous Health Report Cards, which have highlighted diseases such as rheumatic heart disease and otitis media, and which later this year will provide an audit of success or failure in Indigenous health policy over the past decade.

On top of this, the AMA supports other policies and initiatives that aim to reduce preventable diseases, many of which have an unacceptably high prevalence in remote Indigenous communities.

The AMA remains committed to working in partnership with Aboriginal and Torres Strait Islander groups to advocate for Government investment and cohesive and coordinated strategies to improve health outcomes for Indigenous people.

# Increasing the length of internship – what will we actually achieve?

BY DR CHRIS WILSON, CO-CHAIR AMA COUNCIL OF DOCTORS IN TRAINING

> "Changing the role title to 'intern' does not automatically reduce the service requirements and increase the educational value of rotations – someone still has to write the discharge summaries."

In 2015, a COAG review of Australian Medical Intern Training was completed. The intent of the review was to look at the internship model and assess if internship was producing "fit for purpose" clinicians. As part of the review, four models for change were proposed. Model A, the least revolutionary with no significant change to the structure but increased access to non-traditional settings including general practice, was the most preferred by doctors in training. Model B proposed shifting from a time-based internship to one focussed on specific mandatory skills and exposure to the "patient journey" and "different care contexts". Models C and D were more revolutionary, with a proposed two year program either starting in the final university year or covering the first two postgraduate years.

As mentioned, the opinion of the AMA CDT and DiTs across the country at the time of the review was that, while there is always room for improvement, internship is not broken. Despite this, after the release of a COAG Health Council response to the review in July this year, we look to be pressing towards the two year model.

In a postgraduate world, internship commencing during university would be unworkable for obvious reasons, so the current preferred model is an internship covering PGY1 and 2.

While on the surface this looks like significant change, what does the second year actually achieve? There is agreement that general registration should be granted after successfully completing the first year, as it is now, so no change on the registration front. If it comes with increased opportunities for exposure to patients across the health spectrum and more structured learning, this will be to the advantage of doctors in training, the healthcare system and in the long run, our patients.

It's not clear though how this would be distinguishable from the current roles undertaken by PGY2 doctors. Changing the role title to 'intern' does not automatically reduce the service requirements and increase the educational value of rotations – someone still has to write the discharge summaries.

One potential benefit would be an expectation that all rotations are accredited as suitable training environments by a Medical Board delegate (like the Post Graduate Medical Councils). Thankfully, this already happens in most jurisdictions, however, there is a danger that without additional resources, regions where it is not standard to accredit beyond PGY1 could see their accreditation processes watered down to meet demand. Currently, the federal body responsible for the coordination of State/Territory-based accreditation bodies, the Confederation of Postgraduate Medical Education Councils, remains unfunded. It seems absurd for the Government to push for change in the makeup of internship yet not fund the body responsible for enacting it.

Should we move to a two year model, we would also expect doctors in training be able to obtain job surety over the period of internship in the form of a minimum two year contract. This would be a sign of good faith from employing health services that they intend to train and support their doctors in training during this transition period.

AMA CDT's position in 2015 was that internship is not broken and that position remains unchanged. Without tackling the creep of increasing service need forcing education and training to become ancillary components of internship, it's hard to see a second year bringing with it much improvement.

# Summit emphasises need for national medical workforce strategy

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

The Medical Workforce and Training Summit convened by the AMA in March, the first since 2010, is notable. The Summit drove home the importance of ending the expansion of medical schools, finding strategies to address workforce maldistribution and ending the poor coordination between the Commonwealth and State governments when it comes to workforce planning and training. If we are to preserve the public-private balance in medicine with a focus on quality, then we need to help Government solve this problem. It's vital that the Summit's call for a national medical workforce strategy overseen by the nation's health ministers will be heeded.

Australia is now becoming saturated with doctors, as emphasised by recent workforce data. AIHW projects that there will be an oversupply of at least 5,000 doctors in 2020 (I suspect this is under-estimated). The prospect of organising vocational training for all these graduates is daunting and as we are currently finding, not really feasible. Some Colleges are training record numbers of trainees with, it appears, no real sense of what all of these specialists are going to do.

Everyone must make a living somehow, so this is when we see fringe medical practices emerge and the enervating effects of bulk billing become prominent. The obstetricians provide a worsening example of this problem. Ultimately high quality, 'fee-for-service' medicine is in jeopardy and we set the stage for an indentured medical workforce trapped in managed care practices without independent decision-making, public practice (which will always be underfunded) or doing something else.

A 2015 OECD study showed that Australia has the highest medical graduate rate per capita with 3.4 per 1000, compared to New Zealand and the United Kingdom (2.8 per 1000) and the United States and Canada (2.6 per 1000), with Australian medical graduate numbers more than doubling in the past decade. We will graduate just under 4,000 new doctors in 2018 and this number will increase as Curtin and Macquarie Universities come online with increased Commonwealth places over the next couple of years. Unemployment looms.....

It is estimated there will be 118,803 doctors registered in Australia in 2019. This compares to 79,653 employed in medicine in 2012. Health Workforce Australia estimated our doctor to patient ratio has increased to 3.6/1,000 which is well above the OECD average of 3.2/1,000 and well above the UK (2.8/1,000) and USA (2.5/1,000).

The universities like the thought of their graduates getting jobs but this is unashamedly not their primary concern. They are not concerned at the prospect of their graduates obtaining vocational training. They are not concerned about the profession's ability to mentor and train the extra junior doctors as residents. All the university wants to do is fill seats. They're not worried about doctors or the profession – this is our concern. I accept this is how universities operate – they are a business selling education. Therefore, we definitely should not let them (or Government) dictate workforce outcomes for the profession.

The high graduating workforce numbers adds to the pressure on the growing cohort of vulnerable doctors in training. They should be assured of transparent and fair selection and examination processes with open knowledge of workforce trends. The AMA has a clear need to strengthen relationships with the Colleges and move us collectively in this direction.

Post-graduate training opportunities have grown by 2.5 times in the last 15 years or so, but there remain real challenges in resourcing vocational training opportunities for registrars such that this will remain a bottleneck that will only become more problematic as graduating numbers increase. In this environment it is clearly imperative that medical student and vocational training numbers should reflect credible workforce data and not be driven by political/institutional desires or parochial interests.

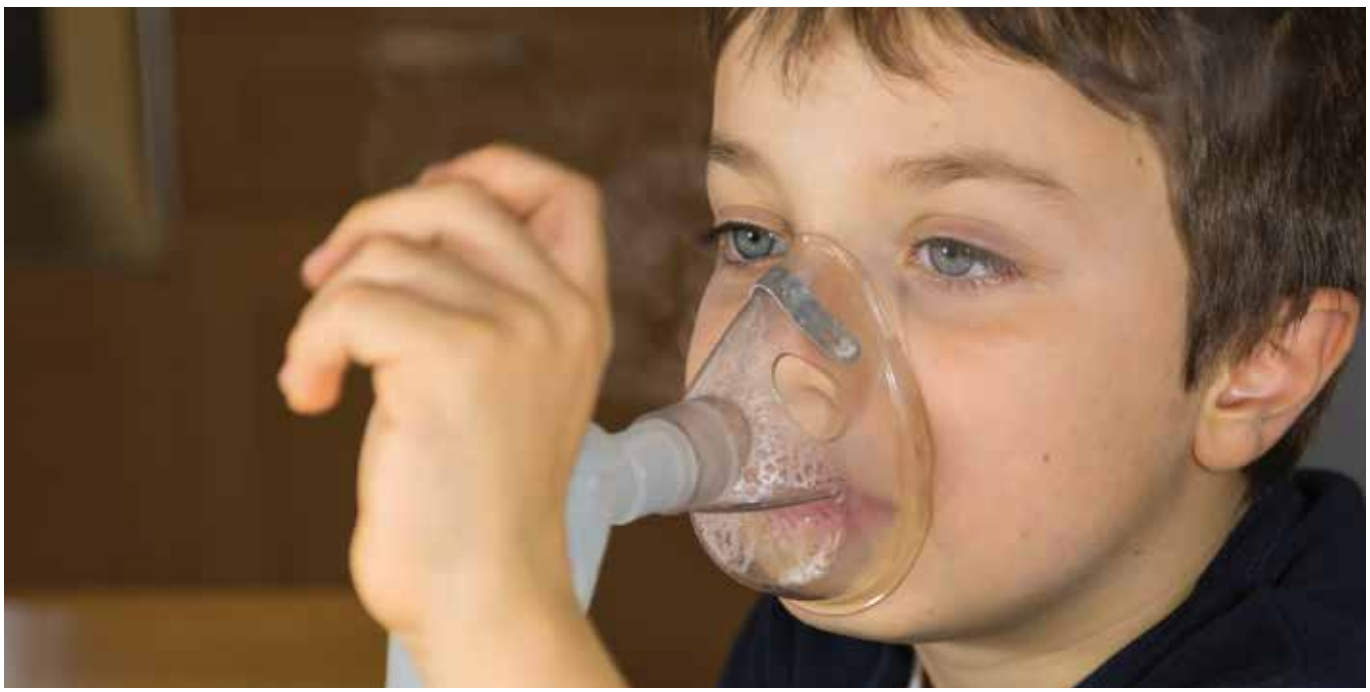
It is important to acknowledge the strides being made to meet the health needs of our rural communities with the design of the National Rural Generalist Pathway now underway; nevertheless, as a physician who practises in both metropolitan and regional Queensland, I am keenly aware of the shortages of specialists and sub-specialists in the regions and outer-metropolitan areas. It's perhaps forgotten sometimes that regional centres servicing large geographical areas also need specialists and sub-specialists. Innovative solutions that will not cost much are part of the solution e.g. combined public-private jobs that capture the principles of easy entry-gracious exit as espoused by the AMA, with industrial recognition of the difficulties faced by regional/rural doctors.

As well as moderating the size of the workforce which requires urgent attention, an important area of work for the MWC will therefore be advocating for the colleges and jurisdictions to increase specialty training positions in areas of unmet community need, based on the advice of the National Medical Training Advisory Network.

# Research

BY CHRIS JOHNSON

## New report into asthma facts



Asthma prevalence in Australia is one of the highest in the world, with 2.5 million Australians reporting to have asthma. Asthma costs Australia $28 billion per year.

Despite this, a surprising number of people are not aware that it is a long-term illness. Neither do many people realise that asthma can lead to death, and that preventive treatment is the gold standard.

Asthma Australia used Asthma Week in September to try to clarify the facts around asthma and strive to make more Australians aware of the role they can play in improving the lives of people they care about.

Asthma Australia commissioned a report through the YouGov Omnibus platform and received responses from 1,012 Australians from a range of demographic and geographic profiles.

Called *Busting Asthma Myths*, the report aims to generate greater attention from across the community to the needs of people with asthma.

The five facts presented in *Busting Asthma Myths* are that in one way or another, asthma impacts most Australians; that it is a long-term disease; that it is life-threatening; that its triggers are varied; and that using a preventer every day is the best way to reduce symptoms and flare ups.

The full report can be found by following the links on Asthma Australia's website https://www.asthmaaustralia.org.au/act/home

## Avocado, 'ave a go

Researchers in four US universities are paying people to eat avocados every day for six months.

Calling the study the Habitual Diet and Avocado Trial, the scientists from the University of California Los Angeles, Penn State, Tufts University and Loma Linda University are aiming for 1,000 participants to join the trial.

Each of the four universities will take 250 people, with some participants to eat one avocado every day while others only eat two per month.

The study will look at the health benefits or otherwise of regular avocado eating and will pay particular attention to whether avocados can help with weight loss.

# Research

While it is generally agreed that avocados provide a reliable source of the "good fats" that can help control cholesterol levels, concerns have been raised in recent times about just how healthy the fruit actually is.

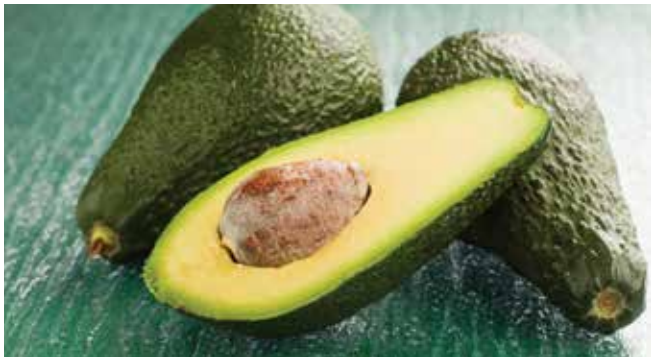
LLU has already reported that it seems illogical that avocados might help with belly fat loss, because they contain the highest fat content of any fruit.

The study will try to determine if eating one avocado a day will help reduce fat in the abdomen.

The Penn State researchers will specifically examine a study published in the *Journal of the American Heart Association* that found that replacing saturated fats with one avocado every day could lower blood pressure.

Participants will receive $300 each and two dozen avocados to eat (after the study) at their own leisure.

They will need to visit clinics at the university campuses, attend monthly dietary meetings, and undergo two abdominal MRI scans.



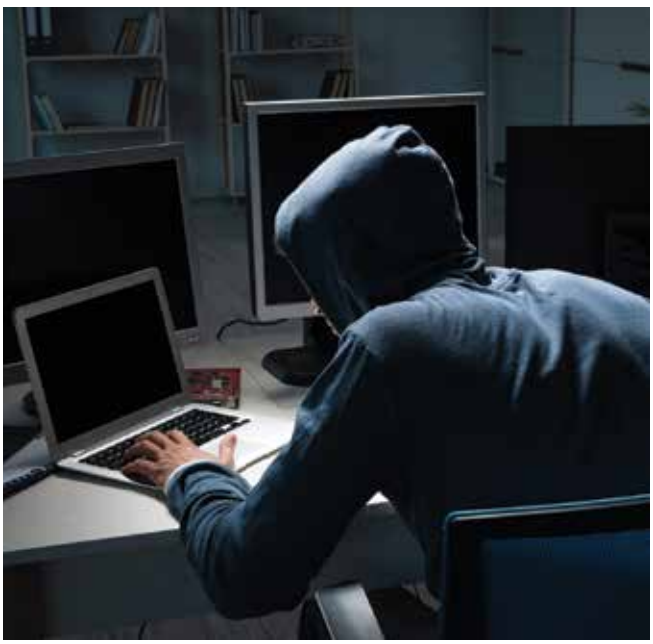
And they must be 25 years of age or older and be at least 90cm or 100cm around the waist, depending on gender.

Once the trial is complete, a fifth school – Wake Forest University – will analyse and deliver the final results.

The study is being funded by industry group the Hass Avocado Board.

BY JOHN FLANNERY AND CHRIS JOHNSON

# Russians who meddled in US election also messing with American vax debate



The same Russians trolls who interfered with the US election are also spreading misinformation about vaccines, according to research from Washington DC.

Scientists at George Washington University have recently released a study in which they found Russian trolls and bots flooding Twitter and other social media outlets as part of the immunisation debate.

The discovery was made while the scientists were researching ways to improve communication methods for American health workers.

They were amazed to find extensive deliberate misleading content being spewed online in attempts to skew the debate and dissuade consensus over vaccinations.

Further digging uncovered that several false online accounts belong to the same Russian trolls who meddled with the 2016 US election. Malware bots were also being used.

But, in further evidence of deliberate efforts to confuse the situation, the trolls tweeted both pro- and anti-vaccine content, according to the researchers.

“The vast majority of Americans believe vaccines are safe and effective, but looking at Twitter gives the impression that there is a lot of debate,” said Assistant Professor David Broniatowski of GWU.

“It turns out that many anti-vaccine tweets come from accounts whose provenance is unclear. These might be bots, human users or cyborgs – hacked accounts that are sometimes taken over by bots. Although it’s impossible to know exactly how many tweets were generated by bots and trolls, our findings suggest that a significant portion of the online discourse about vaccines may be generated by malicious actors with a range of hidden agendas.

“We started looking at the Russian trolls, because that data set became available in January. One of the first things that came out was they tweet about vaccines way more often than the average Twitter user.”

The research states that trolls tweeted on vaccines about 22 times more often than regular Twitter users.

A random sample of 1.7million tweets was collected between July 2014 and September 2017 was examined. Non-vaccination rates of children in the US is climbing.

Some of the misinformation – and deliberate lies – that are being tweeted talk of “vaccine damaged children” and a “secret government database”. Other tweets link the debate to God, race, and even animal welfare.

Click baits were also used, encouraging social media users to click on advertisements and other content, only to be diverted to malicious messaging about immunisation.

Earlier this year, Twitter deleted 3,800 accounts linked to the Russian government-backed Internet Research Agency, which is the same group researchers at GWU examined.

The researchers didn’t examine Facebook, but in the face of damming criticisms this year of the social media giant’s operations, it removed 135 accounts in April linked to the Internet Research Agency.

More recently, Facebook removed another 650 fake accounts linked to Russia and Iran that appear to have be set up purely to spread misinformation.

The study is published in the *American Journal of Public Health.*

# Health records in the USA

It seems that the challenge of achieving broad acceptance of an electronic health record – for privacy, clinical, security, or technical reasons – is not confined to Australia.

CNBC reports that one of the biggest and most overlooked problems in the US health system is that patients still find it too hard to share their medical information between doctors, especially those working in different hospitals.

It's a huge problem for many reasons. It makes it harder for consumers to access the highest-quality care, and new patients who walk into a hospital are like strangers - caregivers won't know if they have an allergy or a chronic disease.

But some of the largest technology companies in the world announced in August that they are undertaking a new effort to fix that. And they have a good reason to do it, as the lack of open standards around health data is a huge barrier for them to get into the $3 trillion health system.

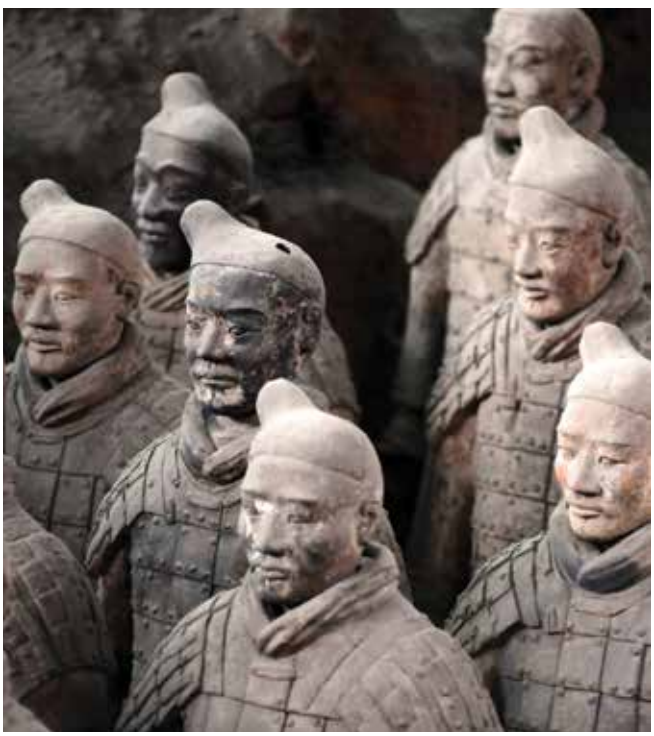
Tech giants – Alphabet, Amazon, IBM, Microsoft, and Salesforce – released a joint statement, saying that:

> *We are jointly committed to removing barriers for the adoption of technologies for healthcare interoperability, particularly those that are enabled through the cloud and AI. We share the common quest to unlock the potential in healthcare data, to deliver better outcomes at lower costs.*

These companies are rivals in some important ways, so it's a strong signal that they came together on this issue.

To address the problem, these tech companies are proposing to build tools for the health community around a set of common standards for exchanging health information electronically.

# Smoke free warriors in China



Xi'an, capital of Northwest China's Shaanxi province – and home to the famous Terracotta Warriors - has unveiled a regulation that bans smoking in all indoor public venues.

The regulation, released in August, also prohibits smoking in some outdoor public places, such as schools, stadiums, and health institutions for pregnant women and children.

Smokers who do not adhere to the regulation will be fined 10 yuan (US$1.5 dollars), and venue owners may be fined up to 1,000 yuan.

The regulation will take effect on November 1.

Xi'anis the latest major Chinese city to ban smoking in all indoor public venues, following Beijing and Shanghai.

There are over 300 million smokers and 740 million people exposed to second-hand smoke in China.

The country has set a target to reduce the smoking rate among people aged 15 and above to 20 per cent by 2030 from the current 27.7 per cent, according to the Healthy China 2030 blueprint, which was issued in 2016.

# England to stop selling energy drinks to kids, no bull

The UK Government is banning the sale of high-sugar, high-caffeine energy drinks to children in England.

Concerns have flared across Britain in recent years over the damage energy drinks are doing to children and teenagers; and a consultation process was implemented to determine the best way to prevent sales to minors.

Prime Minister Theresa May said the consultation formed part of the government's strategy to tackle childhood obesity.

Energy drinks such as Red Bull and Monster Energy are often sold at cheaper prices than soft drinks in the UK, placing consumption of them by children in that country about 50 per cent higher than that of those in other European nations.

Some large retailers in Britain have already banned sales of energy drinks to young people.

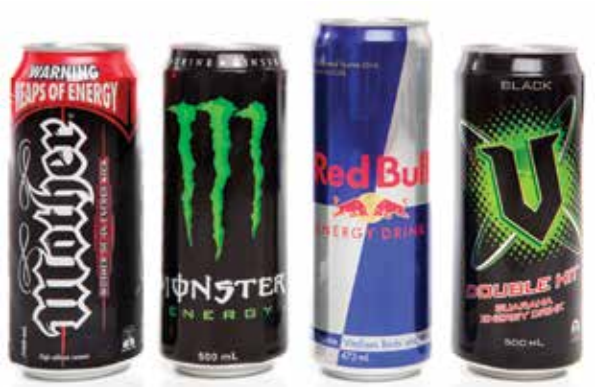
But according to government figures, two-thirds of children aged 10 to 17 and a quarter of those aged six to nine currently drink them.

Government figures also state that sugared energy drinks have 60 per cent more calories and 65 per cent more sugar than regular soft drinks.

However, it is the high level of caffeine in energy drinks that is being used as the major justification for the ban.

Hyperactivity, sleeping problems, headaches and stomach aches in children are often linked to the consumption of energy drinks.

According to reported statistics, a 250ml can of Red Bull contains about 80mg of caffeine, which is about three times that found in a 500ml can of Coca-Cola.




The ban will apply to drinks containing more than 150mg of caffeine per litre.

The Conservatives in the UK have taken numerous productive steps in relation to childhood obesity, having already introduced a tax on sugary drinks.

In Australia, no such action has been taken or appears to even be considered.

Instead, the Coalition Government in Canberra has backed a much criticised pledge from the soft drink industry to reduce sugar content in its drinks by 20 per cent by 2025.

The AMA wants the Government to introduce a tax on sugary drinks in Australia.

The AMA has a policy of price differentiation making a difference to people's behavior.

# WMA backs Turkish medical leaders

The World Medical Association (WMA) has called for the reinstatement of the leaders of the Turkish Medical Association (TMA) following their dismissal by the Turkish Government.

The dismissal comes on top of the removal of the TMA Secretary General, Dr Bülent Nazim Yilmaz, from his duty as a public servant, and the termination of family medicine contracts of TMA Council members.

WMA Secretary General, Dr Otmar Kloiber, urged the President of Turkey to intervene to stop these unwarranted attacks on leading members of the medical profession.

Earlier this year, the TMA issued a press statement declaring that 'War is a Public Health Problem', a self-evident fact that war causes major health problems.

Dr Kloiber said the TMA statement is in line with WMA policy and the widely-held belief that war should be avoided wherever possible because of its impact on health.

"We are appalled at the way leading members of the TMA have been treated over the past few months," Dr Klober said.

The TMA has a proud record of upholding human rights and denouncing all violence.

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

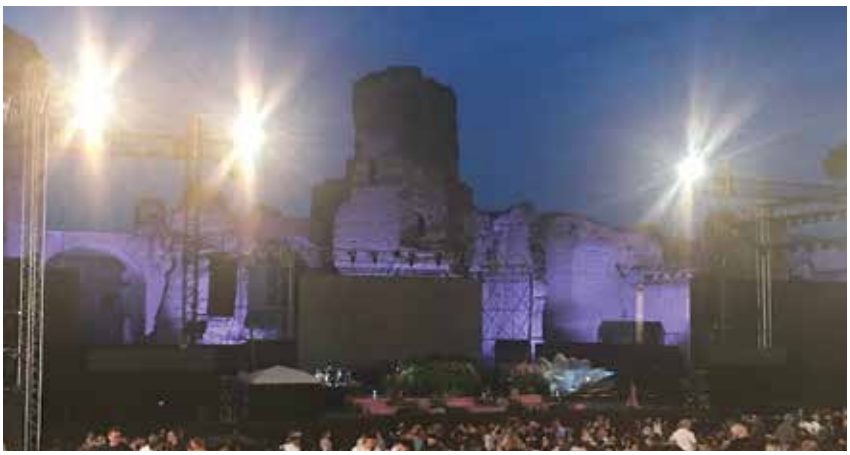
For further information and/or assistance, feel free to call the AMA Career Advisers on 1300 133 665 or email: careers@ama.com.au

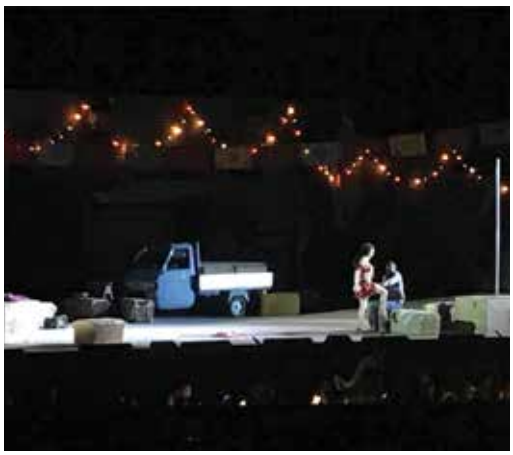
Please note current information within the guide relates to 2016 requirements. Information will be updated to reflect 2017 requirements soon.

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

# Soaking in the Baths of Caracalla

BY CHRIS JOHNSON





When in Rome....

Surely a visit to Italy has to include a night out at the opera?

After all, the Italians invented the opera. They know how to put one on.

At the end of the 16th century, the first opera *Dafne* was performed in Florence and the artform soon swept across the rest of Europe. Since then, however, opera has been "owned" by all of Italy.

So, in Rome for a couple of nights before venturing further across Italy, the opera seems like a "must-do" event.

Fortunately, the Italian Opera in Rome (Teatro dell'Opera di Roma) moves outdoors during the summer months to the spectacular Terme di Caracalla.

Terme di Caracalla, or (in English) the Baths of Caracalla, is a popular tourist attraction in Rome. During the day thousands flock to wander around what was once the second largest public bath house in the ancient city.

We are talking AD 212 to AD 530 – ish.

These spectacular ruins dominate the landscape where they are located and are worth exploring during daylight hours.

But at night, when the opera is on, it is a different world.

Famously in 1990, it was the venue for the very first Three Tenors concert.

The northern hemisphere summer this year featured an impressive list of operas and concerts.

I got to see Georges Bizet's *Carmen* and what a treat.

A beautiful summer's night in the most tranquil of outdoor settings made this a highly memorable occasion.

With the imposing ruins as the backdrop, and used effectively for projections and props throughout the show, it was simply stunning.

The story of *Carmen*, the sensuous Spanish gypsy girl, is quite captivating and the opera's singing and music outstanding.

I soon found that I was barely looking at the English words scrolling down an offstage screen.

I was absorbed in the theatre of it all and, even without reading the words, understood the whole narrative.

Venue information states that it holds 20,000 people. There was nowhere near that many people in attendance and it didn't even look like it had that capacity. It seemed very intimate.

I couldn't have chosen a better thing to do on my first night in Rome.

It was so good that I returned to the Baths of Caracalla the very next evening to see Icelandic singer Björk in concert.

The venue hosts selected pop shows too and the elfish Björk knows how to entertain.

It was a visually stunning concert and her voice is other-worldly.

Two nights enjoying the very best of music in the Baths of Caracalla can make you feel very clean.

# Talking about airbags

BY DR CLIVE FRASER

In 1953 an American engineer (John Hetrick) patented a "safety cushion assembly for automotive vehicles".

Hetrick remarked that: "In the spring of '52, my wife, my seven-year-old daughter, Joan, and I were out for a Sunday drive in our 1948 Chrysler Windsor. About three miles outside Newport, we were watching for deer bounding across the road. Suddenly, there was a large rock in our path, just past the crest of a hill. I remember hitting the brakes and veering the car to the right. We went into the ditch, but avoided hitting both a tree and a wooden fence.

"As I applied the brakes, both my wife and I threw our hands up to keep our daughter from hitting the dashboard. During the ride home, I couldn't stop thinking about the accident. I asked myself, 'Why couldn't some object come out to stop you from striking the inside of the car?'"

Having been an engineer in the US Navy, he was familiar with compressed air being used to drive torpedoes. And it would be compressed air that he thought would inflate his safety cushion.

About three months later a German engineer (Walter Linderer) also took out a patent on a remarkably similar device.

Seatbelts were being offered as an option in US cars around that time, but their fitment wouldn't become mandatory until 1968.

America's obsession with Constitutional rights meant that US States were reluctant to legislate for their citizens to be forced to wear a seat belt.

So it would be the introduction of airbags in the mid-1970s that would be relied upon to protect vehicle occupants in the event of a crash.

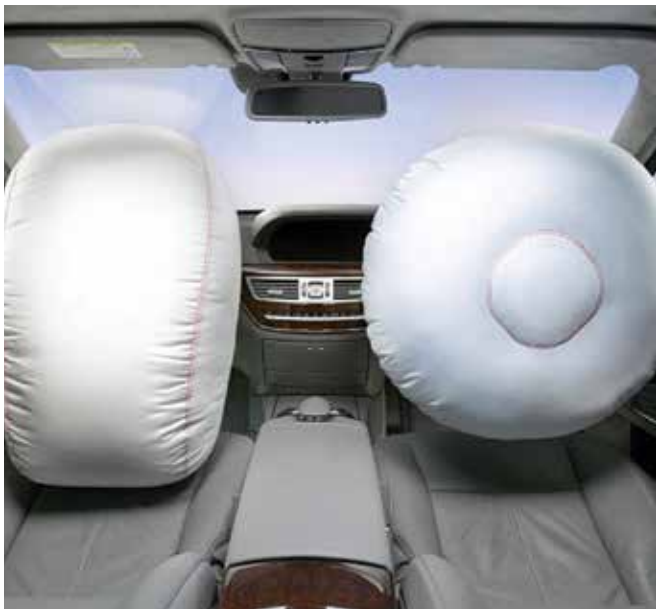
Across the Pacific a Japanese seat belt manufacturer (Takata) started making airbags in 1988 and by 2014 it held 20 per cent of the world market.

But in 2013 recalls of Takata airbags began due to injuries and fatalties associated with airbag deployment.

In 2014 there was the case of a pregnant woman who was killed in a collision involving her 2003 Honda Civic which contained a defective airbag.

The 42-year-old woman died when a metal fragment from a ruptured driver's airbag sliced into her neck in the crash.

The deployment of the airbag occurred when she was travelling



at 30 km/h in what should have been a survivable collision.

Her daughter, delivered after the mother's death, died three days later.

It seemed likely that affected airbags had been in cars for more than 10 years.

So the very device designed to protect an occupant in a crash could actually kill you and 53 million vehicles worldwide have been recalled.

In many US States the fine for not wearing a seatbelt can still be as low as $10.

The good folk of New Hampshire are still not required at all to wear a seatbelt (children must be restrained).

With the State's motto being "Live Free or Die" I can't see much possibility of legislative change in New Hampshire any time soon.

And for residents hoping that an airbag is all they need in a crash, they may need to be reminded that airbags for safety also rely on properly worn seat belts.

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.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