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On message over My Health Record

AMA advocacy gets results, p3

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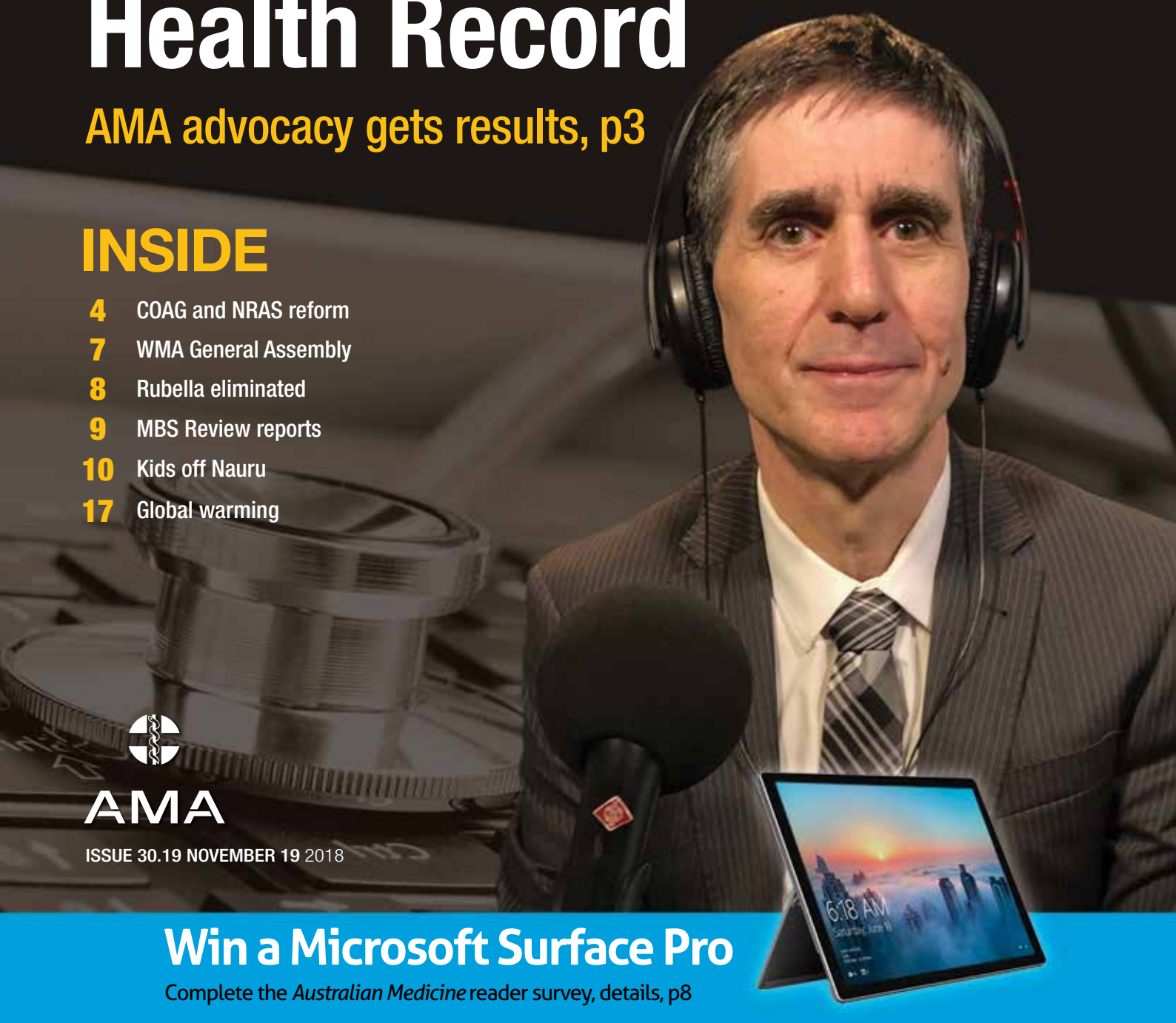

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In this issue

AMA success on My Health Record

AMA lobbying regarding the My Health Record system has paid off, with the Senate Committee conducting an inquiry into it accepting many of the AMA's suggestions and the Government moving to legislate some of them.

Health Minister Greg Hunt has announced measures to strengthen safety and privacy measures, and to protect against domestic violence and misuse of the system.

"We have examined the recommendations from the Senate Inquiry, we have listened to concerns raised by a range of groups and My Health Record users," he said.

The Government is moving amendments to Labor's original legislation to further strengthen the My Health Record Act.

These include:

- Increasing penalties for improper use of a My Health Record.
- Strengthening provisions to safeguard against domestic violence. The proposed provisions will ensure that a person cannot be the authorised representative of a minor if they have restricted access to the child, or may pose a risk to the child, or a person associated with the child.
- Prohibiting an employer from requesting and using health information in an individual's My Health Record and protecting employees and potential employees from discriminatory use of their My Health Record. Importantly, employers or insurers cannot simply avoid the prohibition by asking the individuals to share their My Health Record information with them.
- No health information or de-identified data to be released to private health insurers, and other types of insurers for research or public health purposes.
- The proposed amendments also reinforce that the My Health Record system is a critical piece of national health infrastructure operating for the benefit of all Australians, by removing the ability of the System Operator to delegate functions to organisations other than the Department of Health and the Chief Executive of Medicare.

"Furthermore, the Government will conduct a review looking into whether it is appropriate that parents have default access to the records of 14-17 year-olds," the Minister said.

The proposed amendments are in addition to those announced in July, which have already passed the Lower House. They include that law enforcement agencies can only access a person's My Health Record with a warrant or court order and anyone who chooses to cancel a record at any time will have that record permanently deleted.

AMA President Dr Tony Bartone supported the Government's proposed amendments.

"We initially worked with the Government on a first draft of the Bill to fix the concerns about warrant access, and to allow people to delete their record, which gives them the practical ability to opt-out at any time should they choose," Dr Bartone said.

"These amendments are now in the Bill.

"We also called for a significant national communications effort to ensure that people know more about the My Health Record.

"In a positive move, the Senate Committee agrees that the legislation should now be passed.

"The AMA also supports the Labor amendments to the Bill. We consulted Labor about their suggestions and agree that they further improve the Bill, and provide stronger protections for our patients.

"We have had successful Committee review of the legislation, improvements made with the input of the Opposition, and consultation to hear and respond to major stakeholder concerns.

"We also welcome the commitment to review the issue of parental access to the records of 14-17 year-olds.

"This and other concerns that arise can be addressed through policy change once the My Health Record Act is passed."

Shadow Health Minister Catherine King said more needed to be done.

"The Liberals are finally moving to clean up their My Health Record mess – by adopting Labor's proposed changes – but they still need to act and extend the opt-out period," she said.

In its final report, the Senate Standing Committee on Community Affairs has acknowledged the AMA's input to the inquiry and the AMA agrees with many of the Committee recommendations.

Senior executives and doctors from the AMA appeared before Senate hearings on the matter, as well as submitting written recommendations for the way forward with My Health Record.

Of particular concern for the AMA were privacy issues and the sharing of information to third parties from a patient's My Health Record.

The AMA called for warrant-only access to My Health Record data for law enforcement and other Government purposes; permanent deletion of all data in a patient's My Health Record if the patient opts out; and stronger provisions to prohibit health insurer and employer access to My Health Record data – this includes a prohibition on health insurers access under the secondary use framework.

The AMA has called for greater investment in the public education campaign to ensure all Australians understand the My Health Record and are well placed to make an informed choice to participate or opt out.

CHRIS JOHNSON

COAG blows chance for genuine NRAS reform

BY AMA PRESIDENT DR TONY BARTONE

The AMA recently lodged its submission to the COAG Health Council on the ***Regulation of Australia's health professions: Keeping the National Law up to date and fit for purpose***.

The Council is considering potential reforms to the Health Practitioner Regulation National Law (the National Law), which provides the legislative base for the National Registration and Accreditation Scheme (NRAS) for doctors.

Our submission spells out how the AMA considers the COAG Health Council has blown a genuine opportunity to properly evaluate the effectiveness of the National Law.

The COAG consultation document provided to stakeholders did not allow proper analysis of the effectiveness of the scheme.

In the absence of data or any analysis, the consultation paper simply offered a grab-bag of poorly thought-out ideas and thoughts. It lacked intellectual rigour.

The AMA's major concerns include:

Chairing of National Boards

- The Chair of the Medical Board is a very influential and challenging position, and a non medical Chair is simply not equipped or appropriate in this position.
- In the AMA submission to the implementation project for the National Scheme, the AMA first requested that this proposal not proceed. It is frustrating that we have been providing the same advice on this issue, yet it keeps coming back.

Improving the notification and assessment process

- The AMA has supported increased transparency and efficiency throughout the notifications processes since the NRAS was established. Responding to demands for documentation is time consuming and can be stressful when the practitioner is not confident that they are appropriately satisfying the demand.
- There are a number of proposals in the consultation document that would make the current system more efficient and workable. The AMA supports these changes.

Right of appeal of a caution

- The AMA has previously called on the Australian Health Practitioner Regulation Agency (AHPRA) to add a provision for a practitioner to seek independent review of a decision by the Medical Board to issue a caution, and supports this proposal.
- A caution can have a significant negative detrimental effect on a practitioner's career; and the civil, criminal, and administrative legal systems in Australia generally provide avenues for appeal for decisions that have serious economic or personal consequences on individuals.

Reporting of professional negligence settlements and judgements

- The AMA strongly opposes this proposal and supports the status quo. The AMA believes that the proposed amendments are fraught and have the potential to make significant detrimental changes to the medical insurance landscape.

Production of documents and the privilege against self-incrimination

- The AMA cannot find reasons that AHPRA and the National Boards want to remove this basic common law right and/or create an alternative regime for admissibility of evidence. The AMA does not support this proposal and will strongly contest its development and implementation.

Public statements and warnings

- The AMA does not support the Medical Board or AHPRA being able to issue a public warning even before a tribunal has completed its actions. To do so would imply guilt, and is likely to ruin a practitioner's reputation.
- A public warning is a severe and non-retractable step and should never be considered before a health practitioner has been shown to have breached a code of conduct or been convicted of a relevant offence.

The AMA submission is at https://ama.com.au/submission/ama-submission-second-stage-reforms-national-registration-and-accreditation-scheme

Government, health funds, private hospitals or usurper groups – who is the true opponent?

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

As all doctors know, we have discussions with various groups in order to protect the interest of doctors and our patients. We should not be ashamed of the component of self-interest in this – let's own that whole heartedly and do it well. When doctors are well-trained, have good working conditions, are rewarded for their efforts, and valued and compensated for working long hours or becoming expert in a field, the quality of health care that results is good. There is of course a large component of public health and patient advocacy that the AMA does as well. So, where does our biggest threat come from?

Look for example at the perplexing suggestion for surgical assistant fees to be bundled with the surgeon and/or reduced. This is unequivocally a dumb idea and one we hope we can dissuade Government from enacting and are working hard to do so. This is indeed a threat, but one I think we can push back and/or divert with ongoing representation. Like a great deal of advocacy, it takes finesse, contacts, access, understanding and persistence. I do think we achieve real improvement.

I've said many times before that the threats we face from usurper groups aspiring to back-door role substitution result, in part, from our failure to assist in a true solution of the geographic maldistribution of doctors in this country. We will continue to endure blunt, often misguided Government tools or ideas attempting to solve this problem. This is one area where the AMA and Colleges need to get together – but the threat from usurper groups can be quelled if we do this quickly and effectively.

Private hospitals are at least partially and vicariously responsible for us when working in their institutions and we usually work well together. Indeed, our interests of high-quality health care, stable businesses and good working conditions coincide. Occasionally there will be a hospital that fails to act when it should, or acts too precipitously when it shouldn't, but these instances are rare. One of the profession's defences against this is strong, empowered medical leadership in all institutions. More on this another time.

So that leaves the health funds. Insurers are facing more difficult market conditions and desperately want to preserve their nearly $2 billion profit. Selling less valuable insurance products that leave patients bereft and create hardship for doctors/private hospitals is part of their game, along with an unrelenting desire to pay as little as possible at every opportunity and make this decision someone else's fault. For example – "The doctor is using the wrong prosthesis" or "the hospital has charged too much" or "we want to reduce unnecessary care". Whatever that means?

I was taking part in a panel discussion recently at the Ramsey Health Managers national conference. Among the panel members was Mr Marc Miller, Chief Strategy Officer, Medibank. Setting aside that he volunteered he had opted out of the My Health Record, he made some other very interesting comments. We were asked about the imminent Gold, Silver, Bronze and Basic categorisation change to private health insurance (PHI). Rather than accepting that having many thousands of policies is not appropriate and there is undeniable need to make private health insurance more transparent, affordable and useable (i.e. less exclusions), he lamented about the time allowed for Medibank to prepare for the changes and indicated they were probably not going to make a huge amount of difference.

I agree that the categorisation of policies is a passably reasonable idea that will likely miss the mark. It is, nonetheless, curious to me that there is not greater fund recognition of the current problems with PHI products and a want to reverse current membership decline. One cannot make up for the increasingly inappropriate burden of exclusions by offering a Westfield gift voucher for $100. The portion of total PHI funds paid to doctors is small – we are not the problem, but there is a predictable and relentless desire to unfairly blame doctors for the poor affordability of PHI. The health funds clearly need to forget the vouchers, and supporting non-evidence based care and substitutes for quality medicine; and offer a limited range of understandable, credible products with minimal to no exclusions that people can actually depend on at any stage of the life cycle.

The real clanger Mr Miller dropped was the suggestion that the system would be improved if all doctors were contracted, including at private hospitals. We should never forget many of the funds want to control everyone and everything, including the choices doctors can make in treating their patients – not necessarily in the best interests of patient outcome, but in minimising their costs (remember they already make close to $2 billion). Managed care and/or any inappropriate control of treatment decision-making or options by health funds must be aggressively avoided. Measures that frustrate the referral process under the guise of fee transparency are equally fraught for the same reason. The independent doctor-patient relationship is sacrosanct, and in this, private hospitals are our firm ally. The public health departments are also allies because Government realises the total funding pool for health care requires PHI and the public system could never efficiently

COAG review document poorly thought out

The AMA is deeply disappointed that the COAG Health Council has squandered the opportunity to properly evaluate the effectiveness of the Health Practitioner Regulation National Law, AMA President Dr Tony Bartone has said.

The COAG Health Council is considering potential reforms to the National Law, which provides the legislative base for the National Registration and Accreditation Scheme for doctors.

"The consultation document provided to stakeholders does not allow proper analysis of the effectiveness of the scheme," Dr Bartone said.

"In the absence of data or any analysis, the consultation paper simply offers a grab-bag of poorly thought-out ideas and thoughts. It lacks intellectual rigour."

Dr Bartone said health practitioners need to be able to operate in a system that provides clarity and which supports the health and wellbeing of patients and practitioners alike.

"The counter-productive impacts of the existing mandatory reporting legislation are front of mind for the medical profession," he said.

"We have seen with mandatory reporting how getting the system wrong prevents health practitioners accessing the medical care and treatment they need in a timely way.

"We need to ensure that we do not make similar mistakes with the National Law scheme."

The AMA has lodged its submission to the COAG Health Council on the *Regulation of Australia's health professions: Keeping the National Law up to date and fit for purpose*.

"We have called for the scrapping of the concept of a non-medical Chair of the Medical Board of Australia yet again – this position is simply too important and challenging to have someone who does not understand medical practice," Dr Bartone said.

"We support improving the notification and assessment process, as this will increase transparency for doctors and patients.

"We welcome Health Ministers backing the AMA position to allow for a right of appeal for a caution. A caution can have a significant detrimental effect on a doctor's career, and it is time this was formally recognised."

CHRIS JOHNSON

The AMA submission is at https://ama.com.au/submission/ama-submission-second-stage-reforms-national-registration-and-accreditation-scheme

Vice President's message

...continued from page 5

manage significantly increased workloads, e.g. beyond current overstretched built capacity.

Ponder also that Medibank is responsible for nearly half of all complaints to the PHI ombudsman. Their payments to patients are far from the highest and frequently inferior to the not-for-profit insurers. Refer to the AMA Private Health Insurance Report Card:

https://ama.com.au/system/tdf/documents/AMA%20Private%20Health%20Insurance%20Report%20Card%202018.pdf?file=1&type=node&id=48140

In general, my patients tell me they have greater issues claiming with the for-profit funds. It also appears that hospitals have greater difficulty negotiating contracts with for-profit funds – recall the terrible limitations Medibank attempted to write into hospital contracts a couple of years ago that started their public relations decline. We should also all be wary of the BUPA-led charge to restrict gap payments to contracted hospitals only. Funds now have to use a large portion of premium income to advertise products with more and more exclusions that represent declining value for money.

For-profit health funds, including Medibank, want doctor fee transparency and control of our behaviour – but seem unwilling to create transparency and value for money in regard to their own product. They could embrace the spirit of Gold, Silver, Bronze and Basic categorisation to improve the transparency and value of health insurance products to improve membership – but seem to rail against the change or side-step it. Rather than tightening their grip on healthcare decision-making and restricting costs to preserve profit, they should invest in good quality health care with independent doctor decision-making which we know produces good outcomes – which is what people will pay for. The true antagonist is revealing itself.

President attends WMA General Assembly

AMA President Dr Tony Bartone recently attended the World Medical Association's annual General Assembly, joining the leaders of peak medical groups from more than 50 other nations.

The General Assembly was held in Reykjavik, Iceland in October.

Dr Bartone represented Australia while participating in high level discussions pertaining to the medical profession.

Among the issues discussed were:

Clinical independence

In a revision to the Declaration of Seoul, the Assembly warned that unreasonable restraints on physicians' clinical independence imposed by governments and administrators were not in the best interests of patients, because they might not be evidence based and they risked undermining trust between patients and their doctors. The meeting said physicians must retain clinical independence and professional autonomy if they are to provide quality health care to their patients.

Capital punishment

Physicians around the world should be advised that any participation in capital punishment is unethical, the meeting agreed. Delegates reaffirmed WMA policy that physicians must not participate in executions 'because such participation is incompatible with the physicians' role as healer'

Licensing of physicians fleeing prosecution for serious criminal offences

Physicians who have been convicted of genocide, war crimes or crimes against humanity, should be denied a license to practice medicine anywhere in the world, the meeting agreed. In an updated policy statement, the WMA says that such physicians should also be denied membership of national medical associations.

Telemedicine

In revised ethical guidelines for physicians, the meeting said that telemedicine should not be regarded as a way of cutting costs or of increasing physicians' earnings. Nor should it be viewed as equal to face to face health care. Telemedicine should be employed primarily in situations in which a physician cannot be physically present within a safe and acceptable time period.

Biosimilar medicinal products

The Assembly revised WMA policy on biosimilar medicinal products, warning of the risk that insurers and health care providers may prefer these products to the original products because they are cheaper. This could occur even when the biosimilar product might not be appropriate for an individual patient or in situations when adequate clinical equivalence to an original product had not been demonstrated. Revised guidance was agreed saying that there should be no substitution between biosimilars and other drugs without the attending physician's permission.

Dr Bartone with Dr Kate Baddock from the New Zealand Medical Association.

WMA General Assembly session in progress.

The assembly also installed a new President for the next 12 months, Dr Leonid Eidelman, Past President of the Israel Medical Association, and the current head of the anesthesiology department at the Rabin Medical Center in Petah Tikva

And election also took place for a subsequent President (2019-20). Dr Miguel Roberto Jorge was elected President-elect. He will take office in a year's time. Dr Jorge is the Director of International Affairs of the Brazilian Medical Association, and an Associate Professor of Psychiatry and Academic Director of the Federal University of São Paulo Medical School.

CHRIS JOHNSON

No more rubella in Australia

Rubella is officially eliminated from Australia.

The World Health Organisation (WHO) has verified that Australia has wiped out the contagious viral illness.

Also known as German measles, rubella causes a fever, rash and swollen lymph glands and if contracted by pregnant women during the first 10 weeks of pregnancy, can result in miscarriage or stillbirth or cause life-long problems for their babies.

Health Minister Greg Hunt hailed the WHO announcement about rubella as a "great day for public health in Australia" and said the achievement sends a powerful message that vaccinations work.

"I commend the efforts of Australia's health professionals over the decades and the millions of parents who ensure their children are always vaccinated," Mr Hunt said.

"Our National Immunisation Program played an essential role this huge achievement by ensuring high levels of vaccination coverage for rubella.

"The science is in and the medical experts' advice is absolute – vaccinations save lives and protect lives and they are an essential part of a healthy society."

Australia has high-performing surveillance systems to rapidly detect and respond to rubella cases.

Confirmation this disease has been eliminated is testimony to the success of the country's immunisation program, the Minister said.

Australia has had rolling epidemics of rubella with the largest number of cases reported in 1958 with more than 5,000 notified cases, 1963-64 with more than 3,000 notified cases and in the early 1990s with more than 4,000 notified cases.

The current National Immunisation Program provides free vaccination for protection against rubella for children aged 12 months with a booster at 18 months.

The WHO has confirmed Australia has also maintained its measles elimination status, after being verified in 2014.

CHRIS JOHNSON

Concerns expressed over MBS Review reports

AMA President Dr Tony Bartone has this month written to the Chair of the MBS Review Taskforce, Professor Bruce Robinson, to provide feedback on the MBS Review Clinical Committee Report on Anaesthesia.

In his letter to Prof Robinson, Dr Bartone also raised concerns regarding the proposed maximum three-item rule for surgical (MBS Group T8) items in the MBS Review Clinical Committee Report on Urology.

Furthermore, Dr Bartone called on the MBS Review Taskforce to make the Clinical Committee reports publicly available on the internet and urged the Taskforce to consider extended consultation timelines to ensure proposed changes are based on robust clinical and profession feedback.

"I note that whilst the MBS Taskforce has deliberated on recommendations over the last several years, the profession has been given only weeks or months to respond. The AMA has heard of significant dissatisfaction amongst the craft groups regarding the unreasonable timeframes," Dr Bartone wrote.

"The AMA therefore, urges the Taskforce to be flexible on the consultation timelines, as is reasonably practical, to ensure proposed changes are based on robust clinical and profession feedback.

"Separately to this, we call on the MBS Review Taskforce to make all the clinical committee reports publicly available on the internet as they are released. This will ensure transparency of the review process, that relevant craft groups are not unintentionally missed, and that multiple clinical committees with overlapping issues and specialties can be cross referenced for accuracy and consistency."

On the MBS Group T8, Dr Bartone raised a significant concern regarding the three-item rule for surgical items.

"The AMA has received compelling feedback from a large section of the profession across multiple specialties, that the three-item rule itself is not currently accepted as a fair or workable option," he said.

"Furthermore, I have received information that some professions have received advice that the three-item rule across all specialties is being put to committees as a fait accompli and that it is non-negotiable.

"I seek your strongest assurances that the three-item rule is open for further discussions and that the MBS Taskforce will coordinate with the affected Colleges, Associations and Societies to come to mutually agreeable changes; that is consistent, as much as is reasonable, across the specialties; that align with contemporary clinical evidence and practice and improve health outcomes for patients."

Dr Bartone also said any recommendation made by the MBS Review Taskforce Principles and Rules Committee to introduce limitations that would jeopardise patient safety or access to care, undermine overall clinical opinion or have restrictions that run counter to evidence-based best practice, should be opposed.

CHRIS JOHNSON

Secretary General departs AMA

The Board of the Federal AMA has accepted the resignation of Dr Michael Schaper from his role as AMA Secretary-General, which he began in August this year.

AMA President Dr Tony Bartone and Chairman of the Board Dr Iain Dunlop issued a statement on October 30, saying Dr Schaper wished to pursue other opportunities.

"Dr Schaper has held the role of AMA Secretary General during a period of change within the organisation," the statement read.

"The Board thanks Dr Schaper for his time over recent months and wishes him every success in his future endeavours."

The AMA's Director of General Practice and Workplace Policy, Warwick Hough, has been appointed Acting Secretary General in the interim.

CHRIS JOHNSON

AMA won't back off over Nauru

Continued lobbying from the AMA has seen a high level of support maintained for the urgent removal of refugee families from Nauru.

While the Government avoids talking publicly about the issue as much as it can, pressure is being kept up to have all asylum seeker children removed from the island.

Reports of plans to relocate the children by the end of the year have been welcomed, but the AMA wants confirmation and more details.

"We need to know if the families will be accompanying the children," AMA President Dr Tony Bartone said.

"And we need to see a legislated long-term policy to ensure that the health and wellbeing crises that occurred on Nauru never happen again – on Nauru or at any other centres run by the Australian Government."

The Government has grappled with an onslaught of criticism over its handling of the worsening asylum seeker issue.

But Dr Bartone continues to pressure the highest levels of power.

Following his recent letter to Prime Minister Scott Morrison, demanding a policy rethink and the urgent transfer of children and their families from Nauru, Dr Bartone has maintained the call through numerous media appearances as well as closed-door meetings.

"We need a solution in this area. We need a solution which brings to a head this ongoing crisis," he said.

"We're talking about the lives of children, in particular, many in very, very serious states of urgent medical care requirement, and we really do need to know that every day that goes by is another day of suffering for these children in particular," he said.

"What we're saying is the Government and the appropriate department there is remaining steadfast with the lack of transparency in the approaches, in the information sharing. The information flow is very, very slow, very, very guarded, and very, very piecemeal when it does come our way. This is unacceptable obviously."

The AMA President has met with Shadow Immigration Minister Shayne Neumann and has said Labor's proposal is pragmatic – in the absence of anything meaningful coming from the Government – and the AMA was backing it.

"This approach, this legislation, will seek to both reduce the bureaucratic process in this transfer, increase the transparency, increase the medical decision-making powers, and increase the independent medical oversight of the whole medical treatment process on the facilities... and ensure that vulnerable children, in particular, but anyone who requires urgent medical attention is afforded that care, appropriate care, before they get too far down the track," Dr Bartone said.

A host of other medical and health groups, as well as the Law Council of Australia, have backed the AMA's call for the immediate removal of asylum seeker children and their families off Nauru.

CHRIS JOHNSON

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 Innes Rio	AMA Member	Health Expert Advisory Group	18/09/18
Dr Tony Bartone, Dr Richard Kidd	AMA President, AMACGP Chair	Senate Inquiry into Aged Care Quality and Safety Commission Bill 2018 and related Bills	10/10/2018
Dr Simon Torvaldsen, Dr Kean-Seng Lim	Chair, AMA WA Council of General Practice, AMA NSW President	House of Representatives Inquiry into Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018	26/10/2018
Professor Mark Khangure	Federal Councillor - specialty member - radiologist	Australian Digital Health Agency - diagnostic imaging sector interoperability workshop	8/10/2018
Dr Danielle McMullen	AMACGP member/NSW AMA Vice-President	TGA stakeholder meeting on opioid regulation	29/10/2018

Catching up with the Councillors

In our second installment of short, light and friendly profiles of members of the AMA Federal Council, *Australian Medicine* talks to AMA Vice President Dr Chris Zappala.

AM: What are you reading right now?

CZ: I love well written fantasy books. Currently I'm stuck on Robin Hobb reading the *Liveship Traders Trilogy*, but also have a real soft spot for Raymond Feist, Trudi Canavan and Steven Erikson, who are all piled up on my bedside table. I'm still transitioning to iPad books.

AM: What music do you like?

CZ: Lots. George Ezra is a favourite at present (does anyone else think his voice in no way matches what he looks like?) with old favourites of Evanescence, Michael Jackson, Madonna (I'm a child of the 80s and cannot help it). In my wayward days I perplexingly liked Def Leppard. The only live concert I've ever been to is Crowded House! Classical taste is more unchanging – the classical and romantics are favourites and I really love the slightly older Beethoven. Chopin and Mozart were magicians. The only 'modern classical' music I like are some of the theme songs or musical items – Hanz Zimmer is amazing, plus also Sibelius before he stopped working after he got his life pension from the Finnish Government.

AM: Your favourite holiday destination?

CZ: Tricky, how can there be just one? I love Europe but prefer getting off the beaten track. My favourite 'all round' destination though is probably Ireland – everything about it is great including the people. A real holiday though is at a relatively deserted beach resort or wilderness place where your phone doesn't work and your partner has confiscated your laptop. It's absolutely perfect if I get to take the dogs.

AM: Your favourite meal?

CZ: Easy. Mum's Scallopini Milanese (remember my heritage is Italian) – seasoned, lightly crumbed veal (not too thick) with mashed spud (without being stingy with the butter), roasted pumpkin and the green of your choice so long as it is not broccolini.

AM: Favourite drink?

CZ: I drink little alcohol and only really learnt to when I worked for two years in London and the local pubs (close to work and close to home) became regular haunts with friends. Having invested years ago in one of those Zip taps that give you sparkling water I'm a devoted convertee, combining the sparkling water with a generous squeeze of fresh lime. I know an amazing dessert wine - Vinedo de los Vientos (Alcyone Reserve) Tannat Uruguay. Try it.

AM: What teams do you follow?

CZ: I'm a long-suffering Brisbane Roar fan. My fellow season ticket holders say I bring the team bad juju, but I think we're just going through a discovery/re-building phase that is not my fault. This year looks a bit better so far.....

AM: Why medicine?

CZ: I remember when in Grade 12, I gave my university application form to the school student counsellor who gently admonished that it was the most confused set of choices he had ever seen. I wanted a profession that would challenge me cerebrally and that I could get absorbed in; that had reasonable people contact and I felt produced a net positive/gain. Why I did respiratory and sleep medicine is trickier – the work looked interesting (now sub-specialise in interstitial lung disease and pulmonary hypertension which is a whole other story). My future colleagues all seemed really easy going and affable and the current clinical unit director where I have my public appointment who also taught me as a student asked me to consider the discipline.

AM: Why the AMA?

CZ: Without the AMA doctors would be doomed, plus I mostly enjoy the time I spend doing AMA activities. My plea though – doctors need to realise that everyone else is aggressively pushing partisan, or self-centred agendas – which is absolutely fine as this is how the 'game' is played. But we need to do the same. Doctors, however, are the only ones feeling vulnerable or ashamed when they stick up for themselves or seek false refuge in the persuasive effects of good evidence, 'the high moral ground' or collaborative models of that have as an intended consequence to diminish and humble them. We need to get out of a crouch and start to stand up for ourselves and only the AMA can do this for all doctors. If we let the AMA be our collective medicopolitical tool with cohesive support, I hope this makes everyone's job (including mine) a little easier and allows us to care for our patients more effectively and efficiently.

This is my story, so let's talk about it

BY PROFESSOR STEVE ROBSON

This article first appeared in the *Medical Journal of Australia*

I dicovered CrazySocks4Docs Day – held annually on June 1 – only this year. The day aims to "encourage conversations about mental health and help reduce the stigma for doctors experiencing mental illness". When I discovered the day thanks to my burgeoning Twitter obsession, I experienced an incredible and overwhelming reaction.

Almost exactly 30 years before, as an intern in the central Queensland city of Rockhampton, I had tried to kill myself. Three decades later, I am now President of a specialist college, but I had kept the entire episode to myself and tried to forget it. I am deeply ashamed of not learning from my own experience and using it to help others.

I hope it isn't too late.

Perhaps by fate I was introduced to cardiologist Dr Geoff Toogood, the incredible and inspiring founder of CrazySocks4Docs, at a College meeting a couple of weeks ago. The meeting was so unexpected and so overwhelming I choked and could barely speak, but it made me determined to take something positive from my own experience all those years ago. Hence this article.

I have a strong feeling that my own experience mirrors that of many doctors around the country, but it is worth explaining. I hope it will help others understand why I have been silent and have not taken the actions I should have. When I heard that Rockhampton junior doctor Frith Footitt had taken his own life on New Year's Day this year, I could not bring myself to read any of the details. The tragic outcome could easily have befallen me.

My internship was a very bad year. I had found medical school difficult – I was not a natural academic like so many others in my year – but hoped that my intern year might prove better. I was wrong.

Halfway through 1988, it seemed clear to me that I was making even more of a hash of internship than I had of many subjects back at university. To make matters worse, Rockhampton was a long way from my family and my junior doctor colleagues all seemed to be more capable and were thriving.

As I reached the halfway point in my internship, I felt overwhelmed with inadequacy. I had a patient die and felt responsible. My ward work was just barely adequate. My consultants and registrars were not exactly glowing in their feedback. I had an all-pervasive sense of failure, that so many years of struggle at medical school had been a complete waste and that I was little short of dangerous. I could see no way out.

So, one night, I made careful plans to kill myself. I won't go into detail but suffice to say that I wanted the end to be painless and clean. I stole some supplies from the wards – standards of drug security were much slacker 30 years ago – and set about writing letters. Luckily, I had few personal affairs to put in order.

Incredibly, a work colleague arrived unexpectedly and began knocking on the door of my small hospital unit. That person – I won't reveal the gender – knew I was in because my car was parked just outside. There were knocks and calls, "I know you're in there …"

It was completely distracting. I had inserted a cannula in my left hand, so took it back out and threw the tubing and bag of intravenous fluid in the bedroom. When I answered the door, I must have looked very flustered and suspicious.

I will never know what made this person visit me unexpectedly. Perhaps my emotional state wasn't as well disguised as I thought. Perhaps it was just plain good luck. Perhaps it was something else.

I spent quite a while talking to the person, though not about my plans for the night. Enough, however, to make me take a step back from the brink. To reconsider. To think about other options. Looking back, that person probably had an inkling that I was about to do something dramatic. That impromptu visit saved my life.

I won't pretend that I had an epiphany or that I suddenly was better. I did seek help, although I didn't completely disclose just how close I was to suicide.

Rather than put my career, for what it was worth then, further in jeopardy by talking to one of my hospital colleagues, I made an appointment with a GP in town. I started in a roundabout way, and ultimately confessed that I had made elaborate plans for kill myself.

To this day, I can remember the GP's advice. Under no circumstances tell anybody or see a psychiatrist (I only knew of one in Rockhampton at the time, and was about to become his intern for a three-month term!). If I had a record of suicidality or mental illness, I would never be able to buy income protection or life insurance, and I would probably never get a good job. Indeed, don't tell anyone …

I was bonded to the Royal Australian Navy, with the hope of spending time as a seagoing medical officer. The advice I had received was startling – what if I was rejected from serving and had to pay back my return-of-service instead? I couldn't afford it. There was no way I was going to risk my Navy job – what if they were so worried about me jumping overboard that I was banned from the fleet?

I elected to try antidepressant treatment, but I remember it being very unpleasant. The options were more limited 30 years ago. The GP warned me that if anyone found out about prescriptions for antidepressants, I might be in trouble with the Queensland Medical Board, perhaps struck off until I could prove myself.

The episode left me with two key messages, both of them very wrong. The first was that not thriving as an intern (or being "a-copic", as one of my registrars disparagingly put it) meant I would never be appointed to a training program. The second was that seeking help was a sign of weakness, something to be ashamed of and hidden.

Today, I am President of my College. I have had a good career and, on balance, have done more good than harm to the patients I care for. In the end, there was some light at the end of the long, dark tunnel. I just couldn't see it at the time.

Why shine a light on my own past, 30 years later? Why speak about this so publicly? I have had a good career and achieved most of the things I had hoped to. Why rake up the past? Why not stay silent as I have for three decades?

If a person who has reached the highest point in their specialty still feels ashamed of events 30 years ago, and is reluctant to admit it, how must those who are going through things and feeling disempowered now feel? I am determined to use my own example to point out that mental health problems are nothing to be ashamed of.

Today, I am not ashamed of how I felt or what I did 30 years ago. I am ashamed and disappointed in myself that I have not used my position to advocate more strongly for colleagues in difficult emotional circumstances. I am ashamed that I was embarrassed and ashamed.

Doctors commonly are under pressure, are more prone to mental health problems, and often have access to the means of killing themselves. These are occupational hazards. In the same way that pilots are exposed to simulated decompression and hypoxia so they recognise the warning signs, we should recognise the warning signs and the debilitating and potentially lethal effects of psychological decompression.

When trainees of the College of which I am President took their own lives, I stayed silent.

When a junior doctor took his life while working at the same hospital that I did when I tried the same thing, I stayed silent. When I met Geoff Toogood, I stayed silent. Even after the shock realisation that CrazySocks4Docs day was almost exactly 30 years after I tried to kill myself as an intern, I stayed silent.

Enough silence.

It is absolutely vital that each and every one of us is honest and acknowledges the pressures and strains of our profession; that we see mental health issues not as sources of shame, but as potential occupational hazards that put not only ourselves at risk, but the patients we care for. I should have spoken up sooner.

For every doctor, especially our juniors, it is important to understand that mental health and emotional issues are nothing to be embarrassed about or ashamed of. They are important and need acknowledgement and treatment. We need to support each other and make this message abundantly clear.

If I had not been interrupted, I would have died 30 years ago. Luckily for me, that didn't happen. Now I find myself a College President. If you feel now the way I did 30 years ago, seek help and support as soon as you can. Speak out. Who knows where you might end up.

Professor Steve Robson is President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and is a member of the Australian Medical Association Federal Council.

If this article has raised issues for you, help is available at:

Doctors' Health Advisory Service (www.dhas.org.au):

NSW and ACT ... 02 9437 6552
NT and SA ... 08 8366 0250
Queensland ... 07 3833 4352
Tasmania and Victoria ... 03 9495 6011
WA ... 08 9321 3098
New Zealand ... 0800 471 2654

Medical Benevolent Society (www.mbansw.org.au/)

AMA lists of GPs willing to see junior doctors (www.doctorportal.com.au/doctorshealth/)

Lifeline on 13 11 14

beyondblue on 1300 224 636

beyondblue Doctors' health website: www.beyondblue.org.au/about-us/our-work-in-improving-workplace-mental-health/health-services-program

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Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON

New mental health program tells kids to just be you

Former Prime Minister Julia Gillard has launched a new school-based mental health initiative that aims to give teachers the tools to help students manage their mental health.

The Federal Government has invested $98.6 million.

The program Be You will be delivered by Beyond Blue – of which Ms Gillard is the chairwoman – in partnership with Headspace and Early Childhood Australia.

The program will be rolled-out by Beyond Blue in 6,000 schools and 2,000 early learning services in 2019.

Teachers and educators, including those still in training, will have access to free online courses and materials on mental health and suicide prevention.

The program will also be supported by more than 70 frontline staff from Early Childhood Australia and Headspace who will help schools and early learning services around the country implement the program, through online, telephone, and face to face consultations.

"Half of all lifelong mental health issues emerge before the age of 14," Ms Gillard said.

"We have the opportunity to grow Australia's most mentally healthy generation. It's a big ambition and to achieve it we are asking everybody to get involved."

Health Minister Greg Hunt said the program will provide Australian teachers with the skills and resources to be able to teach students how to manage their mental health and wellbeing, build resilience, and support the mental wellbeing of other students.

"It will ensure that students have all the support required for healthy social and emotional development," Mr Hunt said.

"Be You will teach educators to identify any students who may be experiencing mental health difficulties, and to work with the families and local services to get the right help early on. It will also help educators look after their own mental health."

Education Minister Dan Tehan added that Be You builds on the strengths of current school-based mental health programs, and complements the recently launched Australian Student Wellbeing Framework.

"I encourage all Australian schools and early learning providers to engage with beyondblue and Be You to support the mental health and wellbeing of our students," Mr Tehan said.

"As half of all mental health disorders in Australia emerge before the age of 14, schools and early learning services in Australia represent one of the best opportunities for mental health issues to be detected early and managed.

"Schools also play a vital role in prevention by helping our children and young people learn the skills they need to look after their own mental health and wellbeing."

The Government is also providing $2.36 million over four years to the University of Queensland to evaluate the program. This will assess the effectiveness and cost-effectiveness of the program, and identify opportunities to strengthen or improve it.

Medicine made free for extremely rare disease

The Government has made a new medicine available for free for an extremely rare and life-threatening disease, potentially saving patients hundreds of thousands of dollars a year.

The new medicine Galafold® (migalastat) for the treatment of Fabry disease is now listed on the Life Saving Drugs Program, which provides free access to highly specialised medicines to

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

treat patients with rare and life-threatening diseases.

Patients with Fabry disease have a rare enzyme deficiency, which means their bodies have trouble breaking down a fatty substance called globotriaosylceramide.

The condition usually presents in childhood with episodes of severe pain. Other symptoms include skins rashes, headaches, fatigue, vertigo, fever and vomiting and diarrhea.

It can result in potentially life-threatening complications including kidney failure, heart attack and stroke. It can have a major impact on patients and their families.

Currently, there are about 100 Fabry patients receiving enzyme replacement therapy through the LSDP.

Galafold® is a new oral medicine alternative for the treatment of Fabry disease patients aged 16 years and older.

It provides greater treatment choice for Fabry patients, reduces disease symptoms and dramatically improves quality of life, whilst also allowing patients to manage their own treatment at home without the need to have painful injections or infusions.

Without subsidy, Australian Fabry patients would pay hundreds of thousands of dollars for this treatment, putting them beyond the reach of most families who have to fight this extremely rare condition.

Health Minister Greg Hunt said it is the first medicine included on the Life Saving Drugs Program following the implementation of reforms to make the process more timely, transparent and improve patient access through the program.

"Our Government currently funds 14 different life-saving medicines for nine very rare diseases through the program, providing physical, emotional and financial relief for 400 Australian patients," he said.

"These medicines are very expensive and would be too high of a financial burden on patients."

Medicines funded through this program include high cost medicines that do not meet the criteria to be funded on the Pharmaceutical Benefits Scheme (PBS).

The new the Life Saving Drugs Program medical expert panel was announced in August. The panel, chaired by Australia's former Deputy Chief Medical Officer Dr Tony Hobbs, supports the evaluation of medicines for funding on the program and provides advice to the Chief Medical Officer.

AMA

AMA Fees List – 1 November 2018

The 1 November 2018 AMA Fees List data is now live on the Fees List website! feeslist.ama.com.au.

CSV and full PDF files can be accessed from the 'Download' section on the dashboard.

The Summary of Changes can be found under the 'Updates' section on the dashboard.

Financial AMA Members will continue to have unlimited, free access to the Fees List and all its handy features.

Login to the new Fees List website using your same login details for ama.com.au

Need Login Assistance?

Contact Member Services on 1300 133 655 or by email memberservices@ama.com.au.

New to the Fees List online?

Check out this demo video on all the new features: https://youtu.be/o97dkpyeh1E

The Fees List website works best with our supported browsers. See our Web Browser Support Policy for more information.

For more information, contact feeslist@ama.com.au

Keeping cool in the global warming debate

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

I have a dear friend and colleague who injects good humour into intense discussions by observing, "So many storms; so few teacups!"

When our Editor asked me to write about climate change I took fright: teacups were scarce but storms abounded.

Our addiction to Growth

Climate change and global warming are terms that strike fear. They have apocalyptic features that make us worry about future generations.

Miles Little, an eminent Sydney surgeon and ethicist, has thought and written extensively on the topic. In a recent email he wrote:

> *We live with what we condone. Western liberal societies condone almost any practices that produce "growth", and many of those practices have consequences that destroy or degrade the environment in the interests of material and short-term benefit. The destructive forces of climate change and pollution are enhanced by the laissez faire attitude our political leadership takes to the negative consequences of land resumption, land clearance and the polluting effects of industry and mining. We seem to be caught in a series of vicious vortices, in which we can no longer even acknowledge our present or future losses.*

The latest from the IPCC

An October report from the Intergovernmental Panel on Climate Change (IPCC) (http://report.ipcc.ch/sr15/pdf/sr15_headline_statements.pdf) claims that we are already 1°C above pre-industrial levels. Without further reduction in greenhouse gas emissions over the next 12 years, warming will increase beyond 1.5°C.

In brief, the estimates of damage due to an increase of 1.5°C are somewhat lower than for an increase of 2°C but not all that much. It's rather like asking how much less damage would occur if you dropped one nuclear device rather than two.

Discussions about climate change carry heavy baggage. There is the science, the imputed causes, the doomsday anxiety and prophetic proclamations about the end of the world, the confusion that occurs when advocates mix science and politics (explosive) like a salad.

Blaming a single cause

We tend to seek a single entity – coal, for example – that we can blame. Unlike tobacco and lung cancer, there is no one cause of climate change. The underlying systems are super-complex, not one-germ-one-disease type arrangements. Little argues that we need a different style of thinking to handle the complexities of climate change. The risk in overlooking the complexity and multiple determinants of climate is accompanied by a second risk, that of minimising in our minds the immensity and complexity of social and economic changes required to reduce our dependence on fossil fuel.

Banning nuclear weapons looks pretty tame fare in comparison with halting and reducing man-made global warming. Take a look at any major construction project and note how utterly dependent the project is on fossil fuel. In passing, note that the production of one tonne of ready-mix produces one tonne of CO2.

An unhealthy debate

The debate about climate change has not been healthy. Climate change sceptics are labelled – pejoratively – climate change deniers and suffer opprobrium otherwise reserved for Holocaust deniers. This leads to predictable reaction – political pushback and paralysing polarisation.

We need to go back to basics. Science, as philosopher Karl Popper and biological scientist Peter Medawar wrote years ago, proceeds by creative guess work, by conjecture that becomes the hypothesis which is then tested. Scepticism and humility are keys to the success of scientific progress.

In science, formulating the hypothesis is followed by efforts to knock it down. Even if the hypothesis survives it is only ever a provisional statement. The door of science is always left ajar for new information that may lead in new directions. Uncertainty is ineradicable. This is often forgotten in the fast and furious debate over climate.

What we can do

First, as with all social factors that determine the health of our communities and set the agenda for our patients' health problems, we can do things individually in managing our patients. This will be critical with near-inevitable global warming.

As clinicians we use often incomplete information to achieve practical diagnosis and treatment. We can discuss with our

... continued on p19

Issues to be aware of when responding to compliance audits

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

The Department of Health regularly conducts compliance audits of practitioners to ensure that the amounts claimed under the Medicare Benefits Schedule (MBS) are correct. I thought it might be beneficial to provide you with some information about the Department's processes, your obligations and options when responding to an audit. The AMA's Legal Counsel has assisted me in this to ensure you understand the process and are equipped to respond to any compliance concerns that may arise while still protecting patient privacy.

When conducting an audit, the Department's general approach is to:

(1) identify the practitioners to be targeted in the audit. This could be through tip offs or data analysis;

(2) send the identified practitioners a letter asking them to verify their compliance; and

(3) depending on the audit target's response, issue a Notice to Produce under section 129AAD of the *Health Insurance Act* 1973.

The following looks at the privacy and other issues that GPs and general practice managers need to be aware of at each stage of the process.

Initial letter

The initial letter will usually advise the practitioner of the concern that has given rise to the compliance action; and ask them to provide evidence that they have met the requirements of the items being audited. This evidence is usually in the form of some documentation.

Practitioners should note that this letter is asking practitioners to **voluntarily**:

- provide documentation to support their claims; or
- acknowledge where they have not fully met the requirement of the item claimed and thus have been overpaid.

Practitioners need to be mindful of protecting patient privacy when voluntarily providing documentation to support their claims. The sections below have more information on why and how.

Practitioners who think they may have claimed inappropriately may avoid an administrative penalty if they voluntarily acknowledge their error and the overpayment of benefits. Where the Department has already sent an initial letter, the maximum reduction of the administrative penalty is 50 per cent. Any overpayments plus any applicable penalty will then be raised as debt owing for repayment.

Notice to Produce

Depending on the outcome of the initial letter, the Department may issue a Notice to Produce.

A practitioner can still receive a reduction in the administrative penalty after a **Notice to Produce** is issued, if they voluntarily acknowledge the overpayment before the time to respond to the **Notice to Produce** expires. However, the maximum reduction is lower (25 per cent) than if the practitioner had acknowledged the error prior to receiving the **Notice to Produce**.

Practitioners will have at least 21 days to respond before the **Notice to Produce** expires and a debt for the claims in question is raised.

Privacy issues

Australian Privacy Principle 6 prohibits practitioners from disclosing their patient's records unless an exception applies. A key exception is where disclosure is 'required or authorised by law' (APP 6.2).

A practitioner is legally required to comply with a Notice to Produce. This means that a practitioner will not be breaching the Privacy Act if they provide patient information in response to a Notice to Produce. However:

- practitioners should only provide patient information to the extent necessary to comply with the Notice to Produce; and
- the AMA recommends that practitioners exercise their statutory right to only provide documentation containing 'clinical details relating to an individual' to a departmental medical adviser.

By contrast, a practitioner may breach the *Privacy Act* if they provide any documentation containing health information **prior** to the Department issuing a **Notice to Produce**. This is because practitioners are not legally required to respond to the initial letter. This means that practitioners:

- should not volunteer any patient information at the initial letter stage; and
- if they do choose to respond, must redact enough personal information to protect the privacy of the patient.

So why does the Department send initial letters?

Part of the reason why the Department sends initial letters is that voluntary compliance avoids more expensive and difficult compliance processes.

The other reason is that section 129AAD of the *Health Insurance Act* provides that the CEO Medicare must give practitioners an opportunity to respond to a request for documents before they issue a **Notice to Produce**. In other words, they must ask you to provide supporting documentation even though it is not mandatory for you to do so, and if you do and that documentation contains patient information you will be breaching the *Privacy Act*, before they can issue a binding Notice to Produce, which then protects you under the Privacy Act for providing the information.

Other consequences of voluntary repayments

The AMA appreciates that practitioners may choose to voluntarily acknowledge an overpayment to avoid the administrative costs of locating records to prove their claims were legitimate. However, practitioners should be aware that if they voluntarily acknowledge an overpayment, any associated incentive payments claimed in conjunction with the payments for services that have been voluntarily acknowledged will also be recoverable.

The Department of Health also discourages practitioners from voluntarily acknowledging "no service" when a service was provided because of the flow on impacts on the patient's My Health Record and MBS claim history.

Accordingly, it is recommended that practitioners consult with their medical defence organisation before responding or submitting any documentation to the Department to ensure they are aware and understand the financial and legal consequences.

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patients the prognosis for climate change, always ending with the rather unsatisfying statement that we can't be sure. But we can start thinking now about measures to assist vulnerable people – in the design of future nursing homes for example – to cope with higher temperatures.

Second, as a profession we can provide health-related comment for public debate and policy based on our limited understanding of the science of climate change but with more certainty about its current and future impact on human health. We can also comment on how we might cope with higher temperatures that will affect the health of vulnerable people.

Under pressure from the apparent urgency of the problem, our view of science may be distorted so it turns into a political process, where consensus rules – 10,000 scientists cannot be wrong (oh, but the history of science shows that they can) – and uncertainty is excluded. This arrogates to science a degree of certainty that it does not claim for itself and makes a mess of the debate.

When we engage as a profession in public discourse about climate change, we may support alternative sources of energy most notably hydro, wind and solar on the basis of prudence. In so doing we assume nothing. The business case for the development of these technologies must be sound, allowing the market to operate in favour of less dependence on fossil fuels.

We might support a price placed on carbon, as has been done in other countries. Revenue so generated could then subsidise renewable energy production.

The need for civic action

The medical profession – as a profession – has an important part to play, nationally and internationally. In a recent editorial The *BMJ* (BMJ 2018;363:k4410 doi: 10.1136/bmj.k4410) examines the IPCC report and concludes:

Although Government action is crucial, so is civic action. In particular, doctors and other health professionals have a strong record of steering society to make difficult, unpopular, and at times expensive choices for the sake of public health and safety. This has historically included improved sanitation, housing, water treatment, and air quality and, in the 1980s, reducing the risks of nuclear war.

Such an approach accepts the science – with its uncertainties and no claim on ultimate truth – and commits to do what is within our ability and remit to do but without going beyond that ability as happens when we engage in strident polemic that demands certain actions from Government ('Government must…'). This does not solve the problem. Instead it tears its own fabric and reduce the likelihood of political change necessary for success.

Reflections on a rural medicine conference

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

Rural Medicine Australia is the biggest Australian conference focusing on rural medical issues. There aren't many of you rural doctors, too few of you as a matter of fact, but still we meet every October. This meeting is getting bigger and bigger, in fact there were over 750 delegates at RMA18 in Darwin this year – that's big.

Representatives from both State and Federal politics attend this conference. I heard that this year Federal Department of Health representative quietly went to multiple sessions to listen and absorb what us rural doctors were troubled by and advocating for. Shadow Health Minister Catherine King came to us in person to address the crowd, Rural Health Minister Bridget McKenzie relayed a taped message.

The Keynote addresses were each inspiring:

- Dr Jillann Farmer, the Medical Director of the United Nations' Medical Services Division, and a former rural Australian GP who stated she was an expert of nothing, but her generalism was her strength.
- Orange Sky Laundry, networking and peer support disguised by a free laundry service.
- Donna Ah Chee, the CEO or the Central Australian Aboriginal Congress of NT, an inspiring powerful Aboriginal woman.
- The Rural Health Commissioner, Emeritus Professor Paul Worley, discussing something other than the National Rural Generalist Pathway, talked about the backbone behind all rural doctors – our families.
- Dr. Glenn Singleman, an extreme sport enthusiast and a rural doctor, taught us that whether it's base jumping or remote resuscitations, it is all about perception and fear

There were plenty of skill enhancing sessions, such as ENT emergencies, ophthalmological emergencies, Rural emergency workshops, and, most memorably, trauma management done outside in the stinking humidity – a real life Australian simulation.

However, many of the workshops and break-out groups were focused on the business end of life in rural Australia. For students there were lessons for preparing for exams from those who have sat them and help with career planning. There were rural women workshops focusing on the subtleties of bullying. And then there were discussion on how to survive, with stories from as far as Japan and from each State and Territory and across the medical specialties.

Rural doctors also know how to party. Every night of the conference there were events happening. Even after the conference finished I noticed there were harbour cruises, surfing in the wave pool and visits to the RFDS museum.

I have been to many conferences over the years, but this one is unique. The networking among rural doctors is so much more important for rural doctors because it becomes our safety net when we go back to the isolated areas where we live and work. We learn names and see faces – new and old – and we begin to learn who we can turn to. We also learn who we need to provide support to and foster a career in this challenging but rewarding part of medicine.

We leave the conference inspired – with good memories and a to-do list of projects for the year that follows.

RMA19 will be at the Gold Coast in October next year. Mark it on your calendar and I will see you there.

Rabbiting on about bush medics

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

You'd be forgiven for thinking that our current issues with recruitment and retention for bush medics were a recent development. The formation of the Rural Generalist Taskforce has brought with it a renewed focus on the challenges of rural and remote medical workforce staffing. If you've been following Professor Paul Worley on twitter (@PaulWorleySA), you'd be well aware of how busy he's been talking to stakeholders and interested parties across the country, gaining consensus on need if not direction.

> "On the more successful side, the Rural Clinical School has given early career exposure to people interested in rural medicine, with an associated increase in the number of people working rurally down the track."

But this isn't a new issue. In the late 1990s, workforce figures released by the federal Department of Health identified a growing disparity in the number of GPs per head of population in rural and remote Australia compared to metropolitan centres. The response at the time was about as nuanced as a sledgehammer – a rapid up-titration of medical school positions without much thought for downstream training or how people would actually move from a city start point to a country end point. Surely they would just migrate out to where they were needed, right?

Since then we've seen a number of further initiatives trying to tackle the same problem, all with varying and at best limited success. On the more successful side, the Rural Clinical School has given early career exposure to people interested in rural medicine, with an associated increase in the number of people working rurally down the track. This approach has been shown to increase the likelihood of working rurally for both students from regional and urban backgrounds.

We've also upped the number of students with a rural background we select for medical school to around 25 per cent, which instinctively you'd think would increase the number of rural doctors, however clearly 25 per cent of graduates are not returning to the bush.

Other programs aimed at getting doctors out of the city and into the regions have been far from a success. The Bonded Medical Placement and Medical Rural Bonded Scholarship schemes have not driven a generation of docs to practice in the bush. Conversely, the schemes have created resentment at the way naïve teenagers were tied to draconian contracts without full knowledge of what they were signing. The AMA is currently in the process of working with the Department of Health to unpick the mess and find a model that works for both the participants and the communities they were intended to serve.

So has anything changed since the ill-fated policies of the early 2000s? The answer is subtly, yes. There's growing recognition that a medical student does not equal a qualified doctor, and that the (often forgotten) bit in-between, those years as a doctor in training, are key to where you end up working.

It's something that the Council of Doctors in Training has been rabbiting on about for years. You can't expect someone to spend their formative years in a metropolitan centre and then just pick up stumps and move to the bush once they've got a fellowship because there are lots of doctors in the city.

Just like trickle-down economics that approach hasn't worked.

Training years are also spent doing things other than training, like finding partners, having children, growing support networks and creating financial stability. If we want people to end up working in regional areas, we need to support more people to train in regional areas.

And that's the difference in the current approach. Professor Worley and the Rural Generalist Taskforce are joining the dots between students and independent, competent rural generalists, offering suggestions on how that path might be travelled. This is by no means a straight-forward task, but at least we are now acknowledging the need to look beyond graduating more students and the trickle-down approach to solve workforce distribution issues.

Divestment – medical students say no to fossil fuels

BY ALEX FARRELL, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

In August, the Australian Medical Students' Association (AMSA) put our money where our mouth is, and announced our intention to divest from fossil fuels. It was a significant moment, as Australian medical students joined the growing movement in the medical sector, including the American Medical Association, the British Medical Association and the Canadian Medical Associations.

> "Climate change is the biggest global health threat of this century. That was the conclusion of the Lancet Climate Change Commission, and a message that must be taken up with urgency by the medical profession."

Climate change is the biggest global health threat of this century. That was the conclusion of the Lancet Climate Change Commission, and a message that must be taken up with urgency by the medical profession. The impacts on health are clear; the increase in severe weather including drought and heat-waves, worsening air pollution and worsening of infectious and respiratory diseases.

Australian medical students have always been passionate about taking tangible steps to reduce their impact on the environment, and the AMSA project Code Green has previously run campaigns such as #MoveMindfully and worked to improve the sustainability of AMSA events.

However, this was our biggest step yet, driven by Code Green, and one I am exceptionally proud of our organisation for taking. For those who are unfamiliar, divesting from fossil fuels is moving investments to a bank or portfolio that doesn't directly or indirectly fund the fossil fuel industry. It is an advocacy tool that redirects money away from problematic industries and towards ethical alternatives. It is also a statement – a public statement of where we stand as medical students on the fossil fuel industry and its impact on human health.

The announcement was made in an address to medical students from across the country at the 2018 AMSA Global Health Conference in Melbourne, and was supported unanimously by student representatives from all the Australian medical schools. It is a signal that young doctors are conscious consumers who will make decisions about their choices to shop and invest with social and environmental impacts in mind.

As future doctors of Australia, we want to invest in a healthy future. We know that there is more to medicine than just curing illness once our patients are already sick. We need to take into account the upstream factors that are making them sick, and the way our society and our environment affects our health.

Australia's healthcare system is responsible for more than seven per cent of the nation's total carbon footprint. Earlier this year, AMSA held a forum with a sustainability expert Dr David Pencheon, who founded the Sustainable Development Unit in the UK's National Health Service. This unit successfully led the NHS to cut its carbon emissions by 11 per cent between 2007 and 2015. Whilst addressing the RACP Congress, Dr Pencheon said: "Doctors have nothing to lose, but the future." As the ones who will see the impact of climate change play out in the lives and health of our patients, the current situation is no longer a status-quo we can accept. Many changes are necessary and possible, but for now, let's keep it simple.

Divesting doesn't require an overhaul of our health system. It doesn't need a change in Government policy. It is simply a change of bank. Something that everyone, from the smallest student group, to the largest medical representative organisations and colleges, to clinics and hospitals, has the capacity to do.

Internationally, medical associations are leading the way on divesting from fossil fuels. We have already seen doctors use divestment as a tool for public health in Australia, like the work of Dr Bronwyn King from 'Tobacco Free Portfolios'.

It is time that we join together to focus that energy and drive on climate change, following the example of Doctors for the Environment. Together, the investments that the medical industry make have a large impact. Let's use that impact to join other global leaders to stand together for health, and against fossil fuels.

Let's be clear eyed while moving forward on private health insurance

BY ASSOCIATE PROFESSOR JULIAN RAIT OAM, CHAIR, AMA COUNCIL FOR PRIVATE SPECIALIST PRACTICE

On October 11, Health Minister Greg Hunt announced the final rules that support the new private health insurance clinical categories and the Gold, Silver, Bronze and Basic classification system.

CPSP and the AMA have called on these reforms to deliver simplified, better value private health insurance products for consumers. A system that offers more comprehensive coverage, with clear definitions, and less caveats and carve outs. Will the new system deliver total clarity and transparency? Not quite, but it is going to be a lot simpler for consumers than trying to navigate through the current 70,000 policy offerings.

The AMA has always supported, two key aspects of these reforms:

1. Clarity about what medical conditions are covered in each tier of benefits; and
2. The use of standard clinical categories across all private health policies.

The new classification system categorises existing policies into easier to understand tiers. These tiers, in combination with new Private Health Information Statement (which includes mandatory information about what each policy covers), should make it easier for people to compare policies, to shop around and actually see what they are covered for.

This should enable consumers to know that when they book in for a procedure they are covered now and not have to wait an additional 12 months or try the public system.

The tiers outline minimum requirements, but they still allow insurers to add additional cover. The legislation clarifies that insurers can move people onto new products, closing old products, but introduces new protections about warning and information for consumers. Additionally, the Minister is on the record stating that "importantly consumers will not be forced to change their policy cover if they are happy with it".

There are also some more hidden benefits that will come in with the new system.

1. That the system provides full mandatory cover for the medical conditions in each tier; partial cover is not permitted (except in Basic cover and for Psychiatry, Rehabilitation, and Palliative Care – except in Gold cover where there are no exclusions allowed at all);
2. The inclusion of gynaecology, breast surgery, cancer treatment, and breast reconstruction in bronze tier products;
3. That a clinical category covers the entire episode of hospital care for the investigation or treatment;
4. That an episode of hospital treatment covers the miscellaneous services allied to the primary service; and
5. Patients with limited cover for psychiatric care can upgrade their cover (once) to access higher benefits for in-hospital treatment without serving a waiting period.

While these look obvious, they haven't always been included in policies. From next year they will be.

The Minister has called for an April 1, 2019 commencement to coincide with the annual announcement of new premiums. However, as with most major changes, not all groups can adapt as quickly as others. So, while the reforms start next year, insurers have a further 12 months to ensure that each of their products is compliant and to move people onto new products if required. This is not ideal, but the transition for the smaller insurers is likely to be very resource intensive. The Minister has stated that his expectation is that the great majority of policies will be ready to go by April 1 next year. He has also stated that these reforms will have an overall neutral to -0.3 per cent impact on premiums compared with current policy settings.

But we also need to be clear eyed here. This will not solve the wider issue of how to bridge the ongoing premium increases in the 4-5 per cent range, and wages growth at 2 per cent range. That fundamental paradox to a long-term, sustainable private health insurance system remains. These reforms will not address the concerns around private health insurer behavior, nor will they address the variation in rebates. These reforms are about making life a little easier for our patients, and our practices. But the AMA will need the support of all our members going forward – for clearly, the bigger problem is yet to be addressed.

MBS Review – Chance for your say

BY ASSOCIATE PROFESSOR ANDREW C MILLER, CHAIR, AMA MEDICAL PRACTICE COMMITTEE

The AMA support for a review of the MBS has always been contingent on it being clinician-led, with a strong focus on supporting quality patient care. This includes having the right mix of practising clinicians on each committee, with genuine input into a process of transparent decision making.

The AMA, of course, would like to see a review process that delivers a schedule that reflects modern medical practice, by identifying outdated items and replacing them with new items that describe the medical services that are provided today. In doing so, it is crucial that any savings from the MBS review be reinvested into the MBS, and that the review is not simply a savings exercise.

The MBS Review is by no means a small feat, undertaking to review 5,700 items, some which have not been reviewed in 30 years. Obviously, the outcomes of this herculean review not only impact on Government operations and budgets, but significantly affect the entire health system—the always difficult balancing act between the public and private health sectors, the vast number and range of medical practitioners, specialties and medical services, and of course the public.

It was noted by the AMA that the Senate estimates transcripts (30 May 2018) indicated about $600 million in Government savings from the MBS reviews over the 2017 and 2018 budgets, with only $36 million reinvested into new items.

With so much at stake the AMA, specialty colleges, associations and societies must all work individually, and together to hold the MBS Review clinical committees, Taskforce and Government to account on their considerations and recommendations. They cannot be based on anecdotal evidence and narrow perspectives, rather than on data, scientific or robust evidence, or extensive and lived perspectives.

In that vein, I thought it timely to provide a sample of some of the AMA work in this space.

MBS Review clinical committee reports – consultation timeframes

Within the last two months, the Department of Health has requested feedback from AMA on 25 MBS Review clinical committee reports. The reports included around 2,000 MBS items and more than 2,000 pages. The number of items reviewed in these reports are almost 40 per cent of the total number of items in the entire Medicare schedule.

The MBS Review Taskforce has provided the AMA, colleges, associations and societies with only a few months to respond, whilst the Taskforce has deliberated on the review over the last three years. Furthermore, the reports are not publicly available – rather they are sent in a targeted fashion to certain stakeholders. The AMA has pushed back on this and called for them to be posted publicly online.

Obviously, this expediated consultation timeframe presents risks for having the ability to interrogate the clinical appropriateness of proposed changes for the profession, and increases potential for unintended consequences to go unremarked. The AMA has raised these issues with the Minister's office and the Department to call for timeframes to be pushed out, as is reasonably practical, to ensure the profession are appropriately and adequately consulted on the recommendations.

Surgical assistants

In September, the AMA worked extensively behind the scenes with the Medical Surgical Assistants Society of Australia (MSASA), the Royal Australasian College Of Surgeons (RACS), individual surgical assistants (AMA members and non-members) and AMA Council members to tease out the key issues and lodge a submission strongly opposing the MBS Review Taskforce's proposed changes to remuneration arrangements for surgical assistants. The AMA was also responsible for ensuring other groups were aware of the submission process.

A number of AMA communications and medical media was generated around the proposed changes and AMA's response. This included AMA 'Rounds' and GP Network News, and in the medical press and social media.

The following key issues formed the basis of the AMA submission:

- that surgical assistants are independent practitioners and they should remain so;
- negative impact on surgical training;

- risk of de-skilling GPs in rural and remote areas;
- proposed derived fee – baseless assumptions;
- Private Health Insurance and Out of Pockets Reforms already underway;
- there are alternative mechanisms to address Taskforce's concerns; and
- no data provided on the problem.

MBS Review Clinical Committee reports - Gynaecology, Breast Imaging, Nuclear Medicine

The AMA has also lodged a submission to the Department of Health on the MBS Reviews on gynaecology, breast imaging and nuclear medicine.

The main issues raised in the submission related to the gynaecology review and the following were discussed:

- Inadequate profession engagement;
- Time based item descriptors – perverse incentive and unintended consequences;
- Additional auditing provisions – onerous and unnecessary;
- Item restructure – simplification and streamlining are required; and
- Recommendation 19, Item Number 35750 – disagree with recommendations.

In this submission, the AMA also provided broad observations on the MBS Review including concerns regarding operation of committees, as well as inadequate communication and consultation and the removal of the reports from the public website.

MBS Review Clinical Committee reports – Anaesthesia and maximum 3 item rule for surgical items

The AMA recently wrote to the Chair of the MBS Review Taskforce (Prof Bruce Robinson) supporting the Australian Society of Anaesthetists (ASA) opposition to the majority of the MBS Review anaesthesia clinical committee (ACC) recommendations. In the same letter the AMA also raised concerns regarding the maximum three item rule for Group T8 surgical items.

The AMA urged the MBS Taskforce and Government to work with the ASA to come to mutually agreeable changes to the anaesthesia items in the MBS that align with contemporary clinical evidence and practice and improve health outcomes for patients.

The AMA also communicated to Prof Robinson that it is deeply concerned that whilst on the one hand the PRC deferred its decision regarding the three-item rule, due to consultation feedback, but on the other hand this recommendation is taken forward and applied in a specialty clinical committee report (eg urology) without reference to any previous profession feedback on the recommendation.

The AMA sought Prof Robinson's assurances that the three-item rule is open for further discussions and that the MBS Taskforce will coordinate with the affected Colleges, Associations, and Societies to come to mutually agreeable changes; that is consistent, as much as is reasonable, across the specialties; that align with contemporary clinical evidence and practice and improve health outcomes for patients.

AMA MBS Review Webpage

Finally, the AMA 's own MBS Review webpage is now live and provides AMA members (and the public) with a one-stop bulletin board on AMA's engagement and advocacy with the MBS Reviews. I encourage you to visit the website for further information and future updates on AMA's advocacy work on MBS Reviews. There you will also find all of the AMA's submissions to date to the MBS Reviews, and advice on what we are currently working on. Furthermore, it provides the contact details so that those members who are interested in helping the AMA formulate its response to reviews can have their voices heard.

Only by members being engaged can the AMA hope to have a positive influence the direction, and outcomes, of the MBS Reviews.

Willingness grows to end RHD

BY AMA PRESIDENT DR TONY BARTONE

The Brown family who recently travelled from Maningrida to Canberra, to share their story. All three children have the potentially fatal rheumatic heart disease.

Rheumatic heart disease (RHD) is a preventable illness affecting about 6,000 Australians, with Indigenous children 55 times more likely to die from the disease than their non-Indigenous peers.

The AMA recognises the role RHD contributes to the widening of the life expectancy gap between Indigenous and non-Indigenous Australians. In 2016, we launched a Report Card on Indigenous Health, ***A call to action to prevent new cases of RHD in Indigenous Australia by 2031*** (target year for 'closing the gap' in Indigenous life expectancy).

Our Report Card made a strong statement on the devastating impact of RHD and the importance of new, collaborative strategies to control the disease. Its recommendations included calling for Australian Governments to commit to a target to prevent RHD. It also recommended that governments work in partnership with the Indigenous community to fund and implement a strategy to end RHD.

The Report Card also provided an opportunity for a group of leading health, community, and research organisations to form a coalition END RHD. The purpose of the coalition is to advocate for urgent, comprehensive action on this preventable disease of inequality, and to support those living with the disease and prevent new cases arising.

> "Our Report Card made a strong statement on the devastating impact of RHD and the importance of new, collaborative strategies to control the disease."

The founding members of END RHD are the AMA, Heart Foundation, RHD Australia (based at the Menzies School of Health Research), the END RHD Centre of Research Excellence (based at Telethon Kids Institute), the National Aboriginal Community Controlled Health Organisation (NACCHO), the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the Aboriginal Health Council of Western Australia (AHCWA), the Aboriginal Health Council of South Australia (AHCSA), the Queensland Aboriginal and Islander Health Council (QAIHC), and the Aboriginal Health and Medical Research Council of NSW (AH&MRC).

To eliminate rheumatic heart disease in Australia, the coalition calls on the Federal Government to:

- guarantee that the Aboriginal and Torres Strait Islander leadership drives the development and implementation of RHD prevention strategies;
- set targets to end RHD in Australia;
- fund a roadmap to end RHD by 2031;
- commit to immediate action in communities at high risk of rheumatic heart disease; and
- invest in strategic research and technology to prevent and treat acute rheumatic fever and rheumatic heart disease.

In the two years since the Alliance was formed, END RHD has been working with the communities at risk, securing funding and political will to translate research into action and educating Australians to play a role in ending RHD.

I believe the momentum is growing. RHD was discussed at the COAG meetings in August and October 2018. This has been further helped by the recent commitment from Indigenous Health Minister Ken Wyatt, to a Roadmap to end RHD in Australia, which is due to be completed by early 2019.

There is no doubt that funding is a crucial part of the equation to ending RHD. Recent developments include $3.7m being allocated to five Aboriginal medical services for local community-led pilot Acute Rheumatic Fever (ARF) and RHD prevention programs.

A further $950,000 has been granted to the Telethon Kids Institute to work with the Kimberley Aboriginal Medical Services to establish an innovative END RHD community program focussed on environmental health and local workforce development.

On 23rd October 2018 an advocacy event at Parliament House, co-hosted by END RHD and the Snow Foundation, where the Government was asked for non-partisan commitment to eliminate RHD in Australia. Minister Wyatt and Shadow Assistant Minister for Indigenous Health Warren Snowden both made commitments in public to tackle RHD as a non-partisan issue. It is an important step for political leaders to acknowledge the seriousness of the problem.

Now, with community-driven change and funding to enable the change, we can hopefully start to bring about the end for RHD in Australia.

Research

BY CHRIS JOHNSON

Quality of life study for young children with heart disease

Young children with heart disease and their families may have poorer quality of life than the general population, leading to calls for routine screening to enable early intervention and better outcomes.

A study by medical researchers from UNSW Sydney and the Sydney Children's Hospitals Network has identified a number of potentially modifiable factors that contributed significantly to child quality of life.

The paper – the largest Australian study on the quality of life in young children with complex congenital heart disease (CHD) – was recently published in the *Journal of Pediatrics*.

"The findings are striking and highlight the significant challenges children with heart disease and their families face," said study author Associate Professor Nadine Kasparian from UNSW Medicine.

The study included young children aged one to five years, all of whom had undergone at least one heart operation.

"We examined their and their mums' physical, emotional, social and cognitive health, using a well-established quality of life measure," said Dominique Denniss, a UNSW Medicine Honours student and author on the study.

"We looked at quality of life from a multi-dimensional perspective, taking into account a whole range of factors that can influence a child's sense of wellbeing."

Overall, the study found that many children with complex CHD have meaningful impairments in quality of life, compared to their healthy peers, especially when it comes to their emotional health.

"Our youngest children in the study, aged between one and two years, showed functioning that was below what we might expect in the general population for almost every domain," Professor Kasparian said.

"For our two to five year-olds, we found one very striking result – emotional functioning was, on average, more than 10 points below what we might expect to see for healthy children the same age. That's an important difference."

The study found that feeding difficulties and mothers' levels of psychological stress played an important role for children's quality of life.

Additional factors were having the most complex form of congenital heart disease (functional single ventricle CHD) or having another health condition in addition to heart disease.

The results were similar for mums, with key factors for lower health-related quality of life being difficulties in their family, psychological distress, whether their child had any additional physical conditions, and perceiving their child as having a difficult temperament.

While the study highlights profound difficulties for young children with heart disease and their families, it is also important because these factors can potentially be addressed.

"We now have a roadmap showing us what we can do to make a difference for these children and their families. We now know what avenues there are for better care and support," Professor Kasparian said.

"For example, if maternal psychological stress is playing a role in influencing quality of life, there are evidence-based interventions and supports we can offer that can make a difference.

"Similarly, with feeding difficulties, there are things that we can do in hospital and in the community to help our babies with feeding difficulties.

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"There are also ways we can nurture the developing relationship between sick babies and their parents to improve overall quality of life."

Based on their results, the researchers call for routine screening of health-related quality of life for all children with complex CHD, so they don't continue to fall through the cracks. They also make a series of recommendations for improving clinical practice and health policy.

Congenital heart disease is any structural abnormality of the heart that babies are born with – some are diagnosed *in utero*, and some soon after birth. CHD affects about 1 in 100 newborns, or about 1.35 million babies each year around the world.

Australia's first National Childhood Heart Disease Action Plan was announced in February this year, and is currently in public consultation phase.

Food environment impacts consumption and health

Doubling your portion sizes could be the key to a healthier diet, according to the results of a new Deakin University study.

Deakin Business School's Professor of Marketing Chris Dubelaar worked with researchers in France and Australia to test if doubling the portion size of healthy foods increased consumption as it does with unhealthy foods, and if the amount of food eaten differed according to the eating environment.

The findings from Professor Dubelaar's study showed the influence food environments have on consumption – with factors such as portion size and even what we watch while eating having an impact on health-related behaviours.

The first part of the study involved 153 French university students who were given small or large servings of a healthy (apple chips) or unhealthy (potato chips) snack in a laboratory setting to eliminate potential social influences.

For the second study, 77 high school students attending a film festival were given a small or large serve of baby carrots as a snack. The students watched either a film about a restaurant that included many eating scenes or a romantic comedy with no food-focused content.

The researchers found that doubling the portions increased consumption of both healthy and unhealthy snacks, meaning people could potentially increase their portion sizes to fill up on healthy food and avoid junk food.

In the second study, however, the portion size effect with the healthy snacks was influenced by the movie being watched, with the food-related film viewers eating less than those watching the other film – showing those participants who watched people eating on film felt less inclined to indulge themselves.

Professor Dubelaar said the study findings presented interesting insights into the potential for manipulating portion size as a way to increase healthy eating.

"Previous studies have found that people will eat more unhealthy food when presented with a large portion size," he said.

"The results of our current study tell us that this portion size effect also holds true with healthy foods, which opens up the potential for adjusting portion size when trying to encourage healthier eating habits.

"For example, parents trying to get their children to eat more veggies could serve up larger portions. This would also work for healthy snacks such as fruit or any food you want someone to eat more of."

Professor Dubelaar said it was particularly interesting to find

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that during the food-oriented film, all participants ate the same amount of food from both the large and the small portions.

"This tells us that our food environment has an even larger impact on our consumption than we thought. This also provides an opportunity for those seeking to control intake to consider their environment when they're eating to help reduce the effects of portion size," he said.

Professor Dubelaar's full study *Might bigger portions of healthier snack food help?* has now been published online ahead of print publication in the Food Quality and Preference journal.

The study was conducted by researchers at Deakin University, the Grenoble Ecole de Management, University of Technology Sydney and Macquarie Graduate School of Management.

Medical research building the economy

Australia's investment in medical research has significantly boosted the country's welfare, economy and future potential, according to a new study launched at Parliament House, Canberra.

The Association of Australian Medical Research Institutes (AAMRI) President Professor Tony Cunningham AO released a report of the study in October and said for every dollar invested in medical research, Australia gains a $3.90 return to the economy.

"A near $4-to-$1 is an extraordinary return on investment. This return is far higher than the level needed to secure government funding for just about any other investment in infrastructure," Professor Cunningham said.

The new study, by KPMG Economics, has identified that the medical research sector – including the downstream medical technology and pharmaceutical sector – employs more than 110,000 people.

It also found that the health gains that flow from medical research result in a larger and more productive national workforce.

"Investing in medical research must remain a top priority for Australia – not only for the health and wellbeing of all Australians, but also to help build a strong economy through employment, knowledge creation and through our burgeoning medical technology and pharmaceutical export industry," Professor Cunningham said.

The findings demonstrate the national workforce is estimated to be significantly larger than it would have been in the absence of medical research – 23,000 full-time employees more.

The report also shows today's economy, as measured by GDP, is $2.6 billion larger as a result of historical medical research. Significantly, welfare, a measure of how well off we are as a population, is $1.5 billion higher that it would have been in the absence of medical research.

Professor Cunningham said the in-depth study of the impact of medical research in Australia was a timely reminder that we can only expect the positive health and economic outcomes if we are willing to put in the investment.

"I'd like to thank the Australian community and our politicians for making that investment," he said.

To view the full report, visit https://aamri.org.au/KPMGReport.

WMA backs WHO in call for more doctor involvement in fighting air pollution

The first World Health Organisation conference on air pollution was held in October-November in Geneva, Switzerland.

In its report on air pollution and child health, the WHO said health professionals should help shape public health policy on reducing the exposure of pregnant women, children and adolescents to air pollution.

The report adds that health professionals are trusted sources of information and guidance and play an important role not only in treating ill health caused by air pollution but also in educating families and patients about risks and solutions and communicating with the broader public and decision-makers.

This role must be amplified, and the broader health sector must become more engaged in preparing a comprehensive approach to addressing this crisis, the Who report states.

"Polluted air is poisoning millions of children and ruining their lives," said WHO Director-General Dr Tedros Adhanom Ghebreyesus.

"This is inexcusable. Every child should be able to breathe clean air so they can grow and fulfil their full potential."

The World Medical Association has echoed the call.

Speaking at the WHO conference, Dr Lujain Alqodmani from the WMA welcomed the call and said health professionals must be well informed about air pollution health risks and what measures can be taken to combat the crisis.

One suggestion would be to follow the example of Kuwait University, which has included air pollution as a main environmental health determinant in its medical curriculum.

She said at the WHO conference that the whole health workforce needed to be equipped with the right skills to address air pollution health risks as part of the initial clinical patient evaluation.

Medical education institutions should produce advocacy teaching materials about air pollution and health and be accessible through online tools to health workers and implemented by health care institutions.

"Physicians around the world are aware of air pollution. It impacts the quality of life for hundreds of millions of people worldwide, causing both, a large burden of disease as well as economic losses and increased health care costs," Dr Alqodmani said.

CHRIS JOHNSON

Medical practices going green all over the planet

The World Medical Association is urging physicians around the world to 'go green'.

The WMA is offering physicians and their national medical associations a free online service, My Green Doctor, to add environmental measures and climate change awareness to their medical practices.

Dr Todd Sack, managing director of the service, said that most physicians and other health professionals who use My Green Doctor will save money by lowering office expenses.

My Green Doctor explains how the clinic starts its own Green Team that meets for a few minutes each week to make gradual changes.

Each step is described, so no environmental knowledge is needed. One American practice has been saving more than $2000 per physician year.

The benefits of going green will be seen almost immediately, with savings to electricity and water bills.

The program goes on to help the practice to adopt wise choices in chemicals usage, recycling, food choices, and transportation decisions.

Tools for teaching patients and families good environmental choices and climate change preparedness are also a big part of what My Green Doctor offers.

"Patients look to their health providers for role models," Dr Sack said.

"When we recycle, keep organic gardens, bicycle to work or drive energy-efficient cars, our patients and neighbours pay attention.

"Now used by physicians in 35 countries, the WMA's My Green Doctor program could be valuable for all members of national medical associations."

My Green Doctor is a free service for WMA members who register at www.mygreendoctor.org. Members receive a free waiting room certificate – available in any language – just for registering.

CHRIS JOHNSON

A self-guide to guided tours

BY CHRIS JOHNSON

The only way to see Siena ... discover it yourself.

To guide or not to guide... that is the question.

I'm not a fan of the guided tour (see the Travel section of *Australian Medicine* October 15, 2018 edition for more on that).

I would much rather wander around significant sites at my own leisure, read the information boards, marvel at what's to be seen – and go have a coffee.

Some travellers love the guided tour and gain immense satisfaction from being instructed by an expert.

And there is a lot to be said for that, if that's your thing.

For some, two hours following a guide is the perfect tourism experience.

A couple of recent outings have convinced me that when all is said and done, the type of guided tour experience you have as a tourist pretty much comes down to the tour guide.

Both of these tours occurred in Italy in this year's northern hemisphere summer. A friend had paid for a day trip in Tuscany, leaving from Florence and venturing into the Chianti wine region, and beautiful small towns of San Gimignano, Monteriggioni, and Siena.

The tour was a gift and I was very grateful for it. And I loved it. The locations were wonderful and there was plenty of free time to explore for ourselves.

And then there was Raul.

Our guide, Raul, was a nice enough fellow and he certainly knew his facts and figures.

Intense might be an apt way to describe Raul.

On the bus ride he sat at the front, faced the passengers and spieled off names, dates and numbers by rote. No emotion. All very clinical.

Raul even told people off for talking in the bus while he was speaking.

So... when it came to Siena, our last stop of the day, and a two-hour guided walking tour with Raul, I absconded and discovered tall towers, darkened alleyways, old colleges and churches, and more than one enticing bar/café all by myself.

I had the best time in Siena and I have Raul to thank for that.

A few days earlier, I was in Rome. It was my last day there and I just had to see Michelangelo's work on the ceiling of the Sistine Chapel.

I didn't care about anything else in the Vatican, but I had to see the Sistine Chapel.

Long lines into the Vatican meant I could have been there a few hours before even getting to the ticket booth.

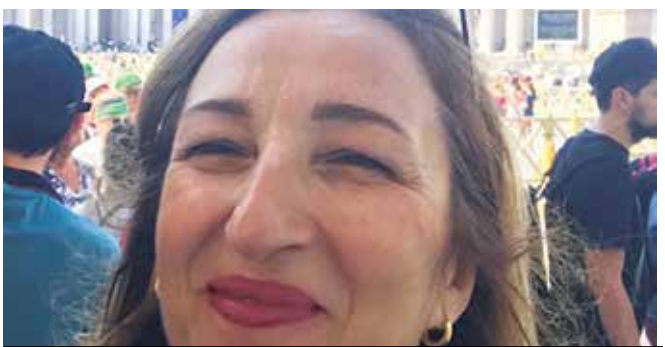
I allowed a touter to talk me into a 'jump the queue' guided tour that cost me five times as much as the price of entry.

It was worth it.

Not only did it slash my waiting time, it enhanced my whole experience.

And that had everything to do with Ruza.

Ruza was my guide, and our group was about 20 people.



Ruza, the perfect tour guide.

She was Croatian and gave tours in English, Spanish, Italian and maybe even Swahili (maybe not).

Ruza was fun and funny, and she kept the whole group engaged.

She cracked jokes, she had really interesting facts, and she made the whole tour – not just the Sistine Chapel part – an enjoyable experience. I found myself hanging off her every word.

The Vatican tour was incredible, and it had everything to do with Ruza.

And I'm sure some of the people I saw lined up waiting for tickets on the way in were still there when I came out a couple of hours later.

Book Review

REVIEWED BY **CHRIS JOHNSON**

Booming: A Life Changing Philosophy for Ageing Well

By Marcus Riley

Marcus Riley is the Chief Executive Officer of BallyCara, a charitable organisation and public benevolent institution providing health, accommodation and care services for older people. He is also a Director and the Immediate Past Chair of the Global Alliance for the Rights of Older People. A United Nations agency – the Stakeholder Group on Ageing – has also appointed him its Asia-Pacific Region Focal Point.

So, it would seem that Riley is well qualified to write a book about ageing well. That assumption would be correct. Riley's 20 years' experience as a positive ageing advocate are evident throughout this highly readable book.

With some excellent tips for successful ageing, *Booming* easily serves as an engaging read for older people, but also as a tool for medical professionals to recommend to their patients. It is all about being positive and meeting head-on the challenges and delights of growing old.

"People can accept the negativity that abounds about getting older, concede that they will decline and wither on the vine – or we choose to seize the opportunity to revel in our extended later years with joy, passion and wisdom," the author writes.

Promoted as a blueprint for successful ageing, *Booming* is very much an inspiring guide.

AMA Indigenous Medical Scholarship 2019

Applications are now being sought for the 2019 Australian Medical Association (AMA) Indigenous Medical Scholarship. Applicants must be of Aboriginal and/or Torres Strait Islander background.

Applicants must be currently enrolled full-time at an Australian medical school and at least in their first year of medicine. Preference will be given to applicants who do not already hold any other scholarship or bursary.

The Scholarship will be awarded on the recommendation of a selection panel appointed by the AMA. The value of the Scholarship for 2019 will be $10,000 per annum. This amount will be paid in a lump sum for each year of study.

The duration of the Scholarship will be for the full course of a medical degree, however this is subject to review.

Applications close 31 January 2019.

To receive further information on how to apply, please contact Sandra Riley, Administration Officer, AMA on (02) 6270 5400 or email indigenousscholarship@ama.com.au. An application package can be also downloaded from the AMA website www.ama.com.au/indigenous-medical-scholarship-2019.

The Indigenous Peoples' Medical Scholarship Trust Fund was established in 1994 with a contribution from the Australian Government. In 2016, the Trust Fund became The AMA Indigenous Medical Scholarship Foundation. The Foundation is administered by AMA Pty Ltd.

If you are interested in making a donation towards the Scholarship, please go to www.ama.com.au/donate-indigenous-medical-scholarship.

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"Oh What a Feeling!"

BY DR CLIVE FRASER

Australia's best-selling vehicle in 2018

For the past 32 years the top-selling motor vehicle in the United States has been the Ford F-Series truck.

While the current thirteenth-generation F-Series is 340kg lighter than the previous model the Ford F-Series is anything up to 6.4 metres long and won't fit in my garage, or even in the average parking space.

Unfortunately, Americans just seem to love big, heavy, gas-guzzling commercial vehicles for personal transportation.

In Australia we have always been less ostentatious in our choices.

There are plenty of Hyundai Getz's and Toyota Yaris' out there and we're all doing our best to reduce greenhouse emissions and save the Barrier Reef from extinction.

Or are we?

It wasn't that long ago that the top selling car in Australia was the economical Toyota Corolla.

Back in 2015 it was the model that enticed the most buyers, and was closely followed in sales by the Mazda 3.

These cars made sense on increasingly congested roads.

They were affordable (aka cheap to buy) and more importantly economical (aka cheap to run).

And with the price of a litre of fuel in 2015 being $1.22 they were also easy on the wallet.

Fast forward to 2018 and fuel has peaked at $1.70 per litre.

Inland Australia is experiencing one of the worst droughts on record, the Great Barrier Reef is bleaching and unseasonal hail storms are wiping out crops.

But Australian politicians are some of the world's most vocal climate change deniers.

And our top-selling car for the past three years has been the Toyota Hi-Lux, followed closely by the equally porky Ford Ranger.

Both are hardly compact or economical.

I can understand why station wagons gave way to SUVs as drivers appreciated the higher seating position, roominess and the flexibility of a third row of seating in many models.

But this has given way again to gigantic twin cab utes.

They have no more than five seats, but there is bucket loads of

space in the tray for tools and camping gear.

The residual value of these work-horses has traditionally been very good.

In the second-hand market they are in demand with young tradies who are starting their careers and have limited funds.

But I just can't see the sense of using one of these 'cars' for family transportation.

Without a canopy anything in the back is ripe for the picking.

Squeezing into a parking space is challenging and the economy of the non-diesel variants is pitiful.

Is driving such a big vehicle an Aussie macho-thing?

Probably not, if the number of female drivers is any indication.

Light trucks have become more car-like, but I think the decision to purchase one is similar to buying up-sized fast food.

Do they represent better value?

Expanding waist lines and bigger vehicles are meaning that more people can't fit through doorways and more cars won't squeeze into garages.

Do we really need all of this?

I think not.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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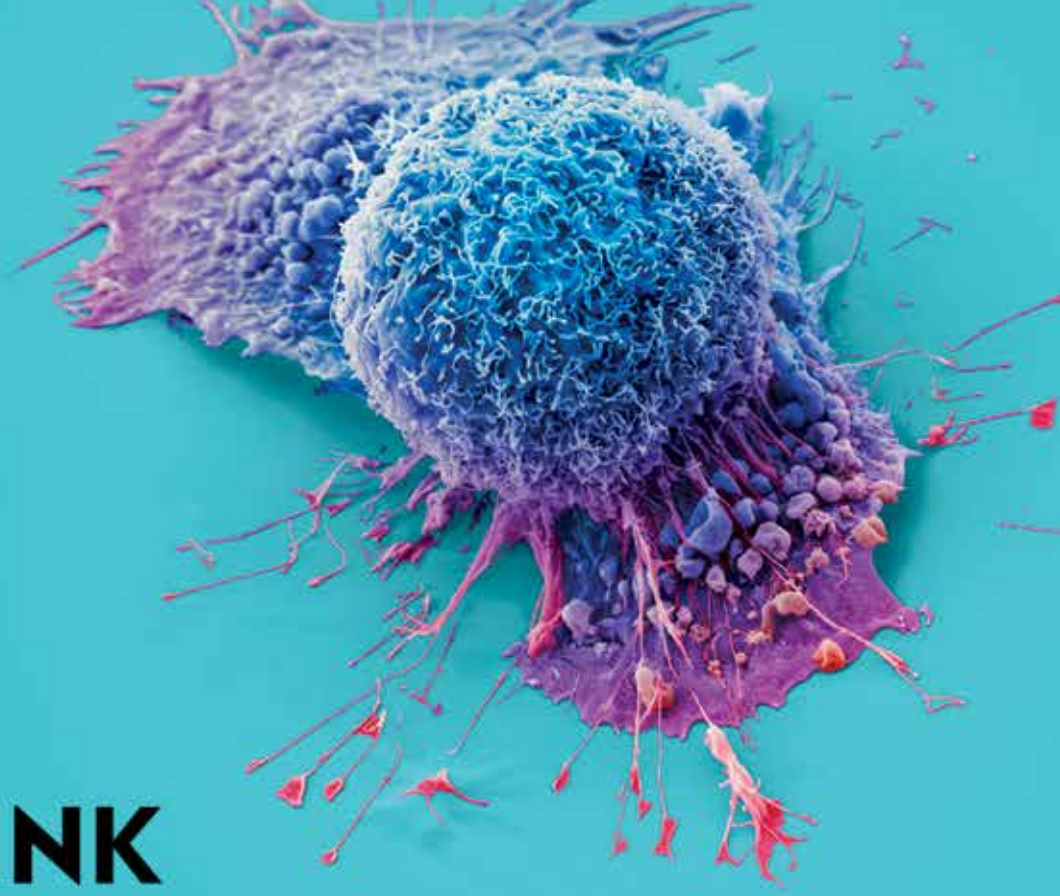

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