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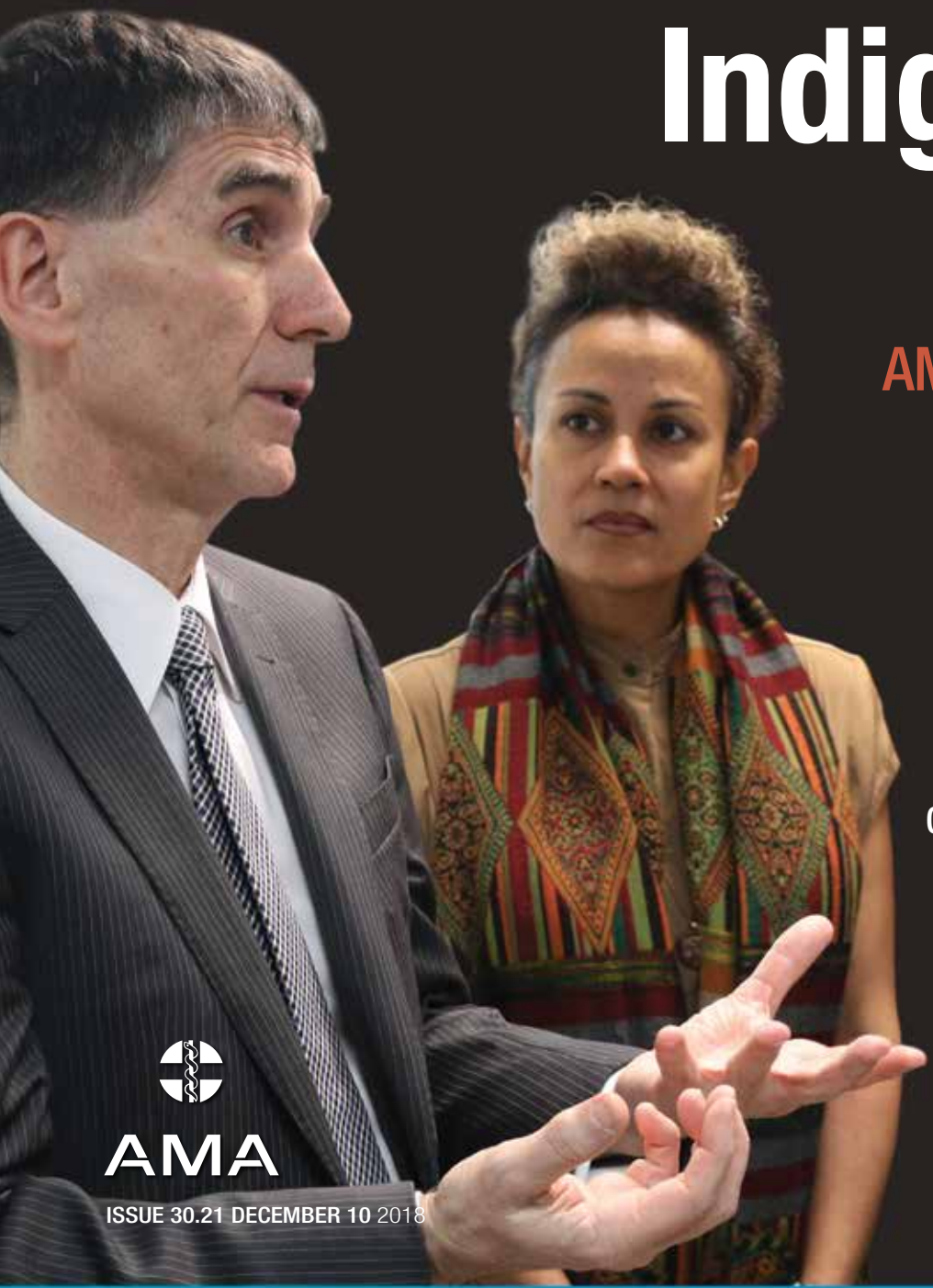

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In this issue

This is the last edition of *Australian Medicine* for 2018.

Thank you to all of our columnists, contributors and readers over the past year.

We wish you all a Merry Christmas, Happy New Year and safe holidays.

Stay informed by checking our website, which will be updated with regular news.

And please take a moment to complete the *Australian Medicine* Reader Survey online, details on page 11.

Cover pic: AMA President Dr Tony Bartone and NACCHO's Donnella Mills at the AMA Indigenous Health Report Card 2018 launch.

The gap isn't closing

> "The strategy has all but unravelled, and efforts underway now to refresh the strategy run the risk of simply perpetuating the current implementation failures."

The nation is failing in its efforts to close the health and life expectancy gap between Indigenous and non-Indigenous Australians.

The AMA *Indigenous Health Report Card 2018*, launched in Brisbane on November 22, scrutinises the 10-year-old Closing the Gap Strategy and concludes that it is unravelling.

The strategy must now be rebuilt, not refreshed, said AMA President Dr Tony Bartone.

One of the strategy's main targets was to close the life expectancy gap by 2031, but Dr Bartone said it was obvious Australia is not on track to meet that goal.

"Ten years on, progress is limited, mixed, and disappointing," he said.

"If anything, the gap is widening as Aboriginal and Torres Strait Islander health gains are outpaced by improvement in non-Indigenous health outcomes.

"The strategy has all but unravelled, and efforts underway now to refresh the strategy run the risk of simply perpetuating the current implementation failures.

"The strategy needs to be rebuilt from the ground up, not simply refreshed without adequate funding and commitment from all governments to a national approach."

Political leadership and increased funding are lacking on the issue, Dr Bartone said.

A refocussing of effort and priorities is needed.

"It is time to address the myth that it is some form of special treatment to provide additional health funding to address additional health needs in the Aboriginal and Torres Strait Islander population," he said.

"Government spends proportionally more on the health of older Australians when compared to young Australians, simply because elderly people's health needs are proportionally greater.

"The same principle should be applied when assessing what equitable Indigenous health spending is, relative to non-Indigenous health expenditure."

The Australian Institute of Health and Welfare estimates that the Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden, meaning that the Indigenous population has 2.3 times the health needs of the non-Indigenous population.

This means that for every $1 spent on health care for a non-Indigenous person, $2.30 should be spent on care for an Indigenous person.

But this is not the case, Dr Bartone said. For every $1 spent by the Commonwealth on primary health care, including Medicare, for a non-Indigenous person, only 90 cents is spent on an Indigenous person – a 61 per cent shortfall.

For the Pharmaceutical Benefits Scheme, the gap is even greater – 63 cents for every dollar, or a 73 per cent shortfall from the equitable spend.

"Spending less per capita on those with worse health, and particularly on their primary health care services, is dysfunctional national policy," he said.

"It leads to us spending six times more on hospital care for Indigenous Australians than we do on prevention-oriented care from GPs and other doctors."

The Report Card outlines six areas where the Closing the Gap Strategy can be rebuilt.

... continued on p6

Deadline looms for election health policy

BY AMA PRESIDENT DR TONY BARTONE

As Christmas draws nearer with the promise of, hopefully, a quieter time for most Australians, the pressure is growing on the major parties to finalise the health policies they will take to the next election, expected in May.

The Government has been sent a very clear message by the results of the Victorian election and the Wentworth by-election, with health featuring prominently in both those elections.

Former AMA President, Professor Kerryn Phelps, the new Independent Member for Wentworth, ran hard on health issues in her winning campaign.

The Victorian Labor Government went to the voters with promises of significant investment in hospitals, a mental health royal commission, and free dental care for state school children.

Health must and will be one of the priorities for voters in the Federal election.

The Government still has many balls in the air, which need urgent resolution.

The biggest, of course, is the MBS Review – and it is starting to cause significant alarm in the profession as new items are being rushed out to clear the decks ahead of the election.

Haste makes waste, and this is becoming clear as the MBS Review rollout continues at pace. It is almost impossible to keep up. Doctors, health insurers, government agencies, hospitals, and other authorities are having problems absorbing the new information and reflecting the changes in fees and business practices.

It seriously is bordering on a crisis. The AMA has and continues to advise the Government and the Minister to consult more closely in this process. This could end badly.

The AMA position on the Government's My Health Record is quite clear. Following very robust representations from the AMA, the Government has legislated changes to make the Record more secure by tightening controls on privacy, confidentiality, and third-party access.

It is our view that the My Health Record needs to succeed. There will be teething issues, but the Record will make a difference. It will be part of that innovative next step in the process of transformation in the way we handle and manage health information for the benefit of our patients - and with the stewardship of scarce health resources critically important in the mix.

It will reduce duplication and wastage. It will reduce complications and readmissions through medication mismanagement. It will have the potential to save lives - our patients' lives.

On private health, we have called on the Government to undertake a public education campaign to explain the new Gold, Silver, Bronze, and Basic categories of private health insurance policies. These changes are far from perfect.

However, private health insurance is perilously facing possibly becoming an irrelevant commodity. Patients need to know clearly what they will get for their significant investment. Otherwise they will shun the product, and the system will suffer.

On a positive note, the AMA exerted significant influence over the passing of the Aged Care Quality and Safety Commission Bill 2018 with an amendment that stipulates a Chief Clinical Advisor, who must be a medical practitioner, will be appointed to assist the Aged Care Commissioner.

Aged care has re-emerged as a significant health policy issue.

Meanwhile, the AMA remains in tight, detailed, and lengthy negotiations with the Government over one of the 'make or break' policies at the next election – a significant new investment in general practice.

We have made it abundantly clear to both Minister Greg Hunt and Shadow Minister Catherine King that general practice is the mainstay of primary care in Australia – but it is at breaking point.

We continue to press strongly for a significant package of GP reforms – backed by appropriate funding and resources to refresh and upscale infrastructure.

Our hardworking and dedicated general practices and GPs need support. Their integral position needs to be understood and appreciated by our political leaders as a valuable piece of the health care system. It is local. It is efficient. It is cost effective. And, if properly resourced, it can enhance the linkages in our health pathways and truly deliver better outcomes for our community.

What about Labor, I hear you say? The Labor Opposition cannot be complacent on health policy either. They have already announced a funding policy for public hospitals, but remain vague on My Health Record, private health, mental health, and aged care.

Labor cannot depend on going into the election with another Mediscare campaign. Voters want positives, not negatives - another clear message from the recent Victorian election. They must engage deeply with the electorate.

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Promoting high-quality health care – stick, carrot or neither?

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

There is no doubt all doctors want to offer high quality care to all their patients. Of course we make occasional mistakes and no one should under-estimate how much we berate ourselves for those. And occasionally they weigh very heavily. We all struggle to a variable degree in managing these internal musings; dealing with ambiguity and facing up to errors and unintended deficiencies wrought by our hand that cause regretful harm. This aspect of professionalism and learning from these internal musings is a critical part of our training and continuing development, and is a defining dimension of being a doctor.

> "In 78 per cent of cases the tribunal made no mention of physical or mental harm to patients as a result of the misconduct. By contrast, penalties were severe with 43 per cent of cases resulting in removal from practice and 37 per cent in restriction of practice."

What then is the best way to promote high quality care? Regulation is becoming onerous in the (political) pursuit of quality care. I think the parenthesis is important here. An interesting article by Elkin in the *Medical Journal of Australia* in 2011, examining doctor discipline between 2000 and 2009 under the (new) Australian Health Practitioner Regulation Agency (AHPRA) regime showed the discipline rate to be reducing. The discipline rate was 6 per 10,000 doctors. In 78 per cent of cases the tribunal made no mention of physical or mental harm to patients as a result of the misconduct. By contrast, penalties were severe with 43 per cent of cases resulting in removal from practice and 37 per cent in restriction of practice.

Ponder then the very significant increase in complaint rates in the last decade in all jurisdictions. In my home State of Queensland, under the yoke of the relatively new Office of the Health Ombudsman, in their 2016-2017 report they note a nine per cent increase in complaints (compared to the previous year) to 10,262. But only 13 cases in the same time period were referred to the tribunal and only 10 serious investigations requested from AHPRA. The point here is – regulation loving Governments are pouring money into more expensive medical regulation systems to promote patient safety (and by extension ensure quality), with no real sense or data that there is a problem of declining quality or increasing patient harm at the outset. It could be construed that this is a very expensive political outcome for no real gain in promoting quality or safer health care.

So what about another Government invention to promote safety and quality – the HAC! Hospital Acquired Complications are now punishable by reduced funding – the Independent Hospital Pricing Authority (IHPA) pricing system is truly mind boggling and quite impressive.

I was asked recently to review the respiratory failure section of the weighty and solemn tome detailing hospital acquired complications. I started hopeful and optimistic that this document would live up to the effort and hype. Disappointment was swift. There did not appear to be a clear definition of what constituted respiratory failure (in this context) and there was a fatiguing, unenlightening but painfully earnest discourse on the basics of respiratory care that would not have surprised any doctor, nurse, physiotherapist etc. In fact, the commentary definitely strayed towards condescending and it occurred to me to wonder what audience the authors had in mind given I imagined anyone who worked in a hospital would likely find the chapter I read unhelpful and a tad insulting. The talk about penalising avoidable re-admission is similar – something we know has no evidence basis when tried overseas e.g. in regard to chronic obstructive pulmonary disease (COPD) re-admissions. Negative. Misguided. Probably unhelpful.

This all made me ponder a case I heard about recently where a penalty was applied for a HAC – in this case a pressure area. This cachectic but mobile patient with metastatic cancer had fractured their foot and needed a Moon boot. He was in hospital receiving palliative care and a chest tune-up. There was family and community supports being brought to bear and so on. The boot unfortunately led to a hidden pressure area under the boot on the leg which was dealt with when discovered. The hospital was penalised for allowing a pressure area to develop.

Vice President's message

...continued from page 5

Regrettable – without a doubt. Unintentional – certainly. Avoidable – hmmmm, I guess, but easier said than done. Such a vulnerable patient receiving various treatments (including chemoradiotherapy) – has this penalty hit the mark? Was there a particular system failure? Are patients safer in future and has the application of the HAC penalty driven a pursuit of higher-quality care? I do not think so on all counts. What did the penalty achieve then?

The problem with these penalties devised with political intent in mind and a 'thin' evidence-basis is that you foment discontent and erode confidence in regulation and system management. Moreover, and perhaps more worrying, it drives gaming behaviour among institutions to avoid penalties and preserve operating viability. One potentially begins to practice a more risk-averse style of medicine that is often more expensive, subjects the patient to more tests/interventions and consumes greater resources. All this when there was not really a problem with patient safety and the quality of health care to begin with! There are too many sticks!

We should ask the architects and promoters of greater medical regulation and/or the Hospital Avoidable Complication list what carrots there are for beleaguered doctors to offer good quality care? System architects need to be very careful that they are not leading us into an adversarial system where avoidance of risk and penalty become paramount with no compensation or recognition of extra effort or superlative service and care. Let's please also have some carrots!

Closing the Gap

...continued from page 3

These include: equitable, needs-based expenditure; implementing health and mental health plans; filling primary health care service gaps; environmental health and housing; addressing social determinants; and placing Aboriginal health in Aboriginal hands.

"We need those leaders, those health leaders in those various communities, to come together with the peak bodies, with the Aboriginal controlled community health organisations, and all the other people as stakeholders in this space to come together to work collaboratively and with common purpose," Dr Bartone said.

"We will not close the gap until we provide equitable levels of health funding. We need our political leaders and commentators to tackle the irresponsible equating of equitable expenditure with 'special treatment' that has hindered efforts to secure the level of funding needed to close the health and life expectancy gap."

The peak body for Aboriginal controlled health services welcomed the release of the AMA's 2018 Report Card on Indigenous Health and joined its call for rebuilding the Closing the Gap from the ground up.

National Aboriginal Community Controlled Health Organisation (NACCHO) joined the AMA in calling for the Closing the Gap Strategy to be rebuilt from the ground up.

NACCHO Chairwoman Donnella Mills called for the immediate adoption of the Report Card's recommendations.

"We congratulate the AMA on their work to support closing the gap and endorse the recommendations in the Report," she said.

"The Report highlights research which indicates the mortality gaps between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians are widening, not narrowing.

"Urgent and systematic action is needed to reverse these failures and to have any prospect of meeting the Council of Australian Governments' goal to Close the Gap in life expectancy by 2031."

CHRIS JOHNSON

The AMA 2018 Indigenous Health Report Card is at https://ama.com.au/article/2018-ama-report-card-indigenous-health-rebuilding-closing-gap-health-strategy-and-review

Shadow Minister commits to Indigenous health policy

Dr Bartone with Shadow Assistant Minister for Indigenous Health, Warren Snowdon.

Shadow Assistant Minister for Indigenous Health, Warren Snowdon, used his speech at the Report Card launch to outline some of Federal Labor's election policy commitments, including moving Indigenous health funding back to the Department of Health, expanding the Deadly Choices program, and restoring advisory committees.

"When you're sitting in an office in Canberra, it's okay to listen to people who might know more than you," Mr Snowdon said.

"If you want to provide a service to an Aboriginal or Torres Strait Islander person, well, get an Aboriginal or Torres Strait Islander person to provide the service.

"In talking about the Aboriginal and Torres Strait Islander Health Plan, we're halfway through the 10 years – 2013 and 2023 – and we still don't have a fully costed implementation plan.

"I can tell you that if we are successful at the election, we will be reviewing and costing that plan as a matter of some urgency, and we'll do it within the first 12 months."

Indigenous Health Minister, Ken Wyatt, could not attend in person but sent a video message, in which he outlined positive achievements in childhood mortality and other areas, and the Government's engagement with Indigenous communities.

MARIA HAWTHORNE

President's message

...continued from page 4

Both sides need to tell us what they will be doing on public health, prevention, Indigenous health, asylum seeker health, aged care, and mental health – along with the major structural, access, and affordability reforms.

They need to articulate a vision, a blueprint for change, which is both transformational and recognises that we need to get ahead of the curve in management, presentation, and, more importantly, prevention.

The AMA will release its election policy manifesto early in 2019.

So, strap yourselves in. The next six months will be quite a ride all the way to election day.

I wish all AMA members and your families a safe, relaxing, and rewarding holiday season.

A new model of Indigenous health care

AMA President Dr Tony Bartone with Brisbane North PHN CEO Abbe Anderson and IUIH CEO Adrian Carson at the IUIH head office in Windsor, Brisbane.

Adrian Carson laughs ruefully when he tells the story of the first Indigenous health service in Brisbane.

"The first Aboriginal medical service opened in an old shopfront in Red Hill in 1973. It didn't last a week before it was firebombed," Mr Carson, the CEO of the Institute for Urban Indigenous Health (IUIH) says.

Forty-five years on, it is a different story, with IUIH's network of 20 community-controlled clinics across south-east Queensland making real improvements to health outcomes for the growing Aboriginal and Torres Strait Islander population.

IUIH was formed in the wake of the launch of the Closing the Gap Strategy. Five separate Community Controlled Health Services (CCHS) agreed to join forces and work together to improve the health of the growing Aboriginal and Torres Strait Islander population in the region.

"Before, we used to work against each other. ATSICHS (the Aboriginal and Torres Strait Islander Community Health Service Brisbane) would hire a doctor, and six months later Yulu-Burri-Ba (Aboriginal Corporation for Community Health) would offer him more money and he'd leave," Mr Carson said.

"It was good for the doctor, but not good for the sector overall to be competing against each other.

"The way that IUIH has pulled the community-controlled sector together doesn't exist everywhere. In other areas, there's infighting, and then the risk of negative media coverage if some groups miss out on funding.

"Our model provides good care and good outcomes. We've been able to provide services that they said we would never be able to provide."

With about 65,000 Aboriginal and Torres Strait Islander people in south-east Queensland, the region is home to more than one-third of the State's total Indigenous population. And that figure is projected to grow to more than 130,000 by 2031.

IUIH brings together the founder of that first, firebombed clinic – ATSICHS - with Kalwun Development Corporation, Kambu Aboriginal and Torres Strait Islander Corporation for Health, Yulu-burri-Ba Aboriginal Corporation for Community Health, and Moreton Aboriginal and Torres Strait Islander Community Health Service.

The clinics have a total of 35,000 clients, and provide 120,000 episodes of care a year.

They use a "one-stop shop" approach to delivering primary health care, with general practice, social work, psychiatry, dental, physiotherapy, podiatry, immunisation, and other health care services provided in one location, with Indigenous staff and a welcoming and familiar environment.

IUIH is also a major employer of Indigenous people, with 660 staff, and was a finalist in this year's BHP-Billiton/Reconciliation Australia Indigenous Governance Awards.

One of its maternal health programs has halved the pre-term birth rate in four years to 6 per cent, and is the subject of a paper currently being reviewed by *The Lancet*.

"If this program was in Cape York, we'd have a Nobel Peace Prize," Mr Carson said.

MARIA HAWTHORNE

Updated statement on complementary medicines

The AMA has updated its Position Statement on complementary and alternative medicines and therapies, to reflect recent changes to healthcare regulations and medicine monitoring systems.

Healthcare regulations to protect the public from unethical and unsafe alternative health practitioners, and monitoring systems to provide the public with better information about alternative medicines, has caught up with AMA policy positions.

The AMA has long advocated for better regulation of non-registered health practitioners, such as naturopaths, herbalists and Ayurveda practitioners. New sections of the AMA's Position Statement acknowledge the adoption of regulations in each State and Territory that require these kinds of health practitioners to comply with a code of conduct, and enable sanctions to be applied if the code is breached.

The Position Statement continues to call for a national public register of non-registered health practitioners who are subject to a banning order in their State, to help inform employers and the public. All Australian governments agreed to this register in 2015 but it has still not been established.

The update also reflects the Therapeutic Goods Administration public database of adverse reactions to medicines, which helps inform the public as well as health practitioners about medicine risks – especially important with complementary medicines that can adversely interact with conventional medicines.

A new warning to patients has been added to the Position Statement following substantial and increasing expenditure by individuals on unproven medicines and therapies. The Australian complementary medicine industry revenue has doubled in recent years to $4.7 billion in 2017 (source – *Complementary Medicine Australia 2017 – sales of Australian complementary medicine has doubled from $2.3 billion to $4.7 billion in three years*). Spending on unproven alternative medicines and therapies may leave individuals unable to cover out-of-pocket costs for evidence-based, conventional health care.

The AMA last reviewed the *Complementary Medicine Position Statement* in 2011-2012. It was substantially rewritten at that time.

CHRIS JOHNSON

The full update statement can be found at: https://ama.com.au/position-statement/ama-position-statement-complementary-medicine-2018

From AMA House to the House on the Hill

Former AMA President Dr Kerryn Phelps AM now adds MP to her name, having won the federal seat of Wentworth in the recent byelection caused by the resignation from the electorate of former Prime Minister Malcolm Turnbull.

Dr Phelps ran as an independent in the formerly safe Liberal seat in Sydney Harbour's southern shore.

In an upset win, she became the first non-Liberal Party member for Wentworth since 1944, and has pushed the Coalition into minority Government.

She is also the fist woman of the Jewish faith elected to the House of Representatives.

In her first speech to Parliament on November 26, Dr Phelps called for a "compassionate compromise" for refugee children and their families on Nauru.

"Australia's treatment of asylum-seekers is a source of shame and sorrow for me and for many thousands of my medical colleagues and other Australians," she said.

"This cruel treatment of asylum-seekers asking Australia for help... ignores the human experience at the heart of the policy of offshore processing and indefinite confinement on Manus Island and Nauru.

"No longer can we tolerate our Government holding the lives of these children and their families to ransom to make a point about maritime arrivals. Yes, we need strong border protection. But it is not — and must not be — a choice between deaths at sea and indefinite offshore confinement.

"There is a mismatch between what the Australian Government has been doing and what the majority of the people of Australia want, and this must be resolved. We must find a compassionate compromise."

Dr Phelps also used her first speech to call for urgent action on climate change.

"We have to think about the human experience that will result from failure to take action," she said.

"The imminent disappearance of island nations like Kiribati or Tuvalu, altered food supply, drought, floods, increases in water-borne and insect-borne diseases.

"The people most vulnerable to the effects of climate change will be children, the poor, the sick, the elderly."

Dr Phelps is a high-profile activist for marriage equality and human rights.

Prime Minister Scott Morrison, and most of his front bench Ministers, left the chamber before Dr Phelps delivered her speech.

The AMA has congratulated Dr Phelps on her election win.

CHRIS JOHNSON

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.

The AMA would like to acknowledge the contributions of the following donors: Reuben Pelerman Benevolent Foundation; the late Beryl Jamieson's wishes for donations towards the Indigenous Medical Scholarship; Deakin University; The Anna Wearne Fund and B B & A Miller Fund, sub-funds of the Australian Communities Foundation.

Catching up with the Councillors

In our continuing series of light and friendly profiles of members of the AMA Federal Council, *Australian Medicine* talks to Council Chair Dr Beverley Rowbotham.

AM: What are you reading right now?

BR: I have just finished *The Lost Man* by Jane Harper. She writes terrific thrillers set in the Australian outback. This is the best yet. Before that I had read *Outline* by Rachel Cusk. This is an interesting style of storytelling where the narrator is invisible and the story unfolds from conversations she has with others. I am interested enough to read the rest of the trilogy.

AM: What music do you like?

BR Indie rock – my son is an indie rock musician.

AM: Your favourite holiday destination?

BR Noosa, Queensland. Perfect any time of the year.

AM: Your favourite meal?

BR Asian Australian fusion – with chips.

AM: Favourite drink?

BR Our friends make wine at Ballandean in Queensland. The label is Bent Road. It is terrific – at last we have the right vines planted for Queensland conditions. And coffee – Neighbourhood Coffee Roasters at Albion in Brisbane.

AM: What team/s do you follow?

BR Australian Men's test cricket – we can rebuild! Queensland League teams, and any team Wayne Bennett is coaching.

AM: Why medicine?

BR: It is the sweet spot – interesting and useful, the meeting place of science and the humanities.

AM: Why the AMA?

BR To be a doctor is to be a member of a tribe. It is a specific calling and way of life. And the AMA is the natural home of the tribe. I have met terrific people at the AMA – doctor colleagues and the fantastic people who manage our policy – who are passionate about good medicine and good careers for doctors. That is worth defending.

Win one of two Microsoft Surface Pros

Australian Medicine Reader Survey 2018

Grab a chance to win one of two Microsoft Surface Pro tablets, simply by completing the *Australian Medicine* readership survey.

At *Australian Medicine*, we value the views of our readers.

Please take a few moments of your time to answer some simple questions about what you like and don't like about the magazine, and how we can better meet your needs and interests.

Please go to the following link:

https://www.surveymonkey.com/r/25KG2PW

for your chance to win a Microsoft Surface Pro.

Thank you for your feedback and ideas.... And good luck in the draw.

When the doctor becomes the patient

Former Federal AMA President, Dr Steve Hambleton, fell ill suddenly and unexpectedly last week in Canberra.

He flew in to Canberra early on Wednesday 7 November for a meeting of an MBS Review Committee. He made it to the meeting, but not for long. By midday, he was in the ED at Canberra Hospital.

After tests and care and an overnight stay in Canberra Hospital, he was on a 6.00am Thursday flight home to Brisbane and straight back in to hospital in his home town.

He underwent surgery later that day, and remains in hospital recovering.

In a brief window of opportunity during his transition from robust doctor to vulnerable patient, Steve found time to write a 'Thank You' note to all his carers, which is also an emotive account of his patient journey.

Thank you all …

Dr Steve Hambleton

Thank you to all the people who made my stay in the Canberra Hospital a little more bearable.

Thank you to Dr Eleanor who, when I asked for help, was decisive and supported my need to seek help. Thank you to Dr Andrew for making that call to the hospital to smooth the way for me.

Thank you to the staff at the triage desk, to whom I was just another person. I was treated with care and compassion. I was not that well, and not at my best, but very grateful. I wasn't the only one there. Around me were people from all walks of life, with a bandage here or there, and their own personal stories to tell. Some were impatient. But if it bothered them, they did not show it.

Thank you to the cleaners. Your work behind the scenes makes a huge difference. My body told me it was time to vomit, which is always a bit awkward when wearing a suit and tie. On one knee on the floor in a clean toilet rather than a soiled one made all the difference to me. I am sorry if I made your next run a little bit harder.

Thank you to the triage nurse who kept me informed while I was in the waiting area, and for showing me to my bed.

Thank you to the emergency nursing staff. You don't know how much comfort the sight of you in your uniform brings to those of us feeling helpless.

Getting changed out of my suit (which makes me feel important) into that gown confirmed that I was truly the patient on this occasion, totally dependent on the kindness and skills of others.

Thanks to the Emergency Physician who took a history from me. You asked me to describe my pain and I could not. It was pain, bad pain. It was waxing and waning every few minutes, and I was struggling to find an adjective that would help you. You smiled and were patient as you gently probed and questioned.

I was not a very good historian. In that moment there was a lot of my history I could not remember. Certainly not dates and times, and what happened in what order, and I don't really have any chronic diseases. It made me think about how much harder it must be for those that do.

Thank you for putting in that intravenous line, which sort of validated for me that I was not a fraud and did need to be there.

Thank you to the student nurse, who recorded my observations and administered the first of the medications. I was not well, and probably did not express my thanks all that well.

Thank you to your Senior, who was quietly guiding you as you administered the analgesia. The pain did not go away immediately, but the warm feeling on my skin was reassuring that something was being done.

I wondered how the meeting that I left was going, and what my colleagues were thinking about my sudden departure.

Thank you to the wardsmen who transported me to the radiology department on two occasions. For your light-hearted banter as we weaved our way along the corridors in my bed, which seemed to have lost its steering. We need to get that trolley fixed – it just wouldn't go straight. Sorry about the rubbish bin. It was a welcome distraction to take my mind off the way I was feeling.

Thank you to the ultrasound operator who was gently efficient – his job was to be in that darkened room, applying his knowledge of anatomy to help answer the clinical questions.

Thank you to the CT scan nurse and the radiographer for your part of the diagnostic journey.

I spent a long time in your emergency department. I love the reference to the flight deck, which is your central point. I was there long enough to hear shift changes and the handovers.

I heard you gently managing the patient with the mental illness, whose understanding and connection with our reality was tenuous at best.

I heard you keeping the patients' relatives informed about the next steps on their journey.

I heard you manage the man with dementia who was someone's brother/husband/father. He was loud, and he was angry as he fought his demons. Despite that, he was treated with the same kindness as all your other patients. Do you remember telling me that by the time he left the Department that he was "the nicest old man". I hoped that you would be around if ever I was that man in the future.

I wanted to go home but needed to stay. I needed help and you gave it to me willingly and I am so grateful. When I leaned on the call button accidentally or when I needed extra help, you were there quickly.

Did you know that if you hold your breath you can watch your oxygen "sats" go down and make the alarm go off? The machines beep to tell you when things are going well, and when they are not.

Thank you for letting me use the phone to keep my family informed. It seemed every time you came into my room, I was talking to someone else.

Thank you for letting me go home when you knew that I was still not quite right. I know you worried about whether it was the right decision. Thank you for tolerating that uncertainty.

Nothing in medicine is absolute – it's all about trade-offs.

As I walked through the Department on the way out, I could not believe the patient load you were facing.

Thank you to the night registrar who, even at the end of his shift, had a smile for me.

Dr Steve Hambleton is a former President of the Federal AMA and AMA Queensland.

AMA Twitter news

The AMA shared some of the Tweets from doctors in America responding to gun violence and the NRA.

The AMA also joined many doctors across the world in the Twitter debate, to condemn the NRA's stance.

AMA Media @ama_media · Nov 11
Doctors across the world are using the hashtag #ThisisOurLane in response to this loaded tweet from the NRA

> **NRA** @NRA
> Someone should tell self-important anti-gun doctors to stay in their lane. Half of the articles in Annals of Internal Medicine are pushing for gun control. Most upsetting, however, the medical community seems to have consulted NO ONE but themselves. nraila.org/articles/20181...

Stephanie Bonne @scrubbedin · Nov 10
Hey @NRA ! Wanna see my lane? Here's **the chair** I sit in when I tell parents their kids are dead. How dare you tell me I can't research evidence based solutions. #ThisISMyLane **#ThisIsOurLane** #thequietroom

Westley Ohman
@westleyohman
Following

I fix blood vessels for a living. When you work at a major trauma center, that means fixing blood vessels shredded by bullets. My lane is paved by the broken bodies left behind by your products. #ThisisMyLane

Steve Robson @DrSteveRobson · Nov 13
Gun violence? Doctors are right in the middle of that lane. Thank God this is rare in Australia.
#ThisISMyLane
#GunControlNow
#NRABloodMoney

abc.net.au/news/2018-11-1... via @abcnews

Doctors post blood-soaked photos after NRA tells t...
Their haunting images from hospitals depict the graphic aftermath of gun violence.
abc.net.au

Judy Melinek M.D.
@drjudymelinek
Following

Do you have any idea how many bullets I pull out of corpses weekly? This isn't just my lane. It's my @#*!%$# highway.

> **Judy Melinek M.D.** @drjudymelinek
> 'Stay in your lane,' NRA tells doctors who want to reduce gun deaths nbcnews.com/health/health- ... via @nbcnews

7:12 AM - 9 Nov 2018

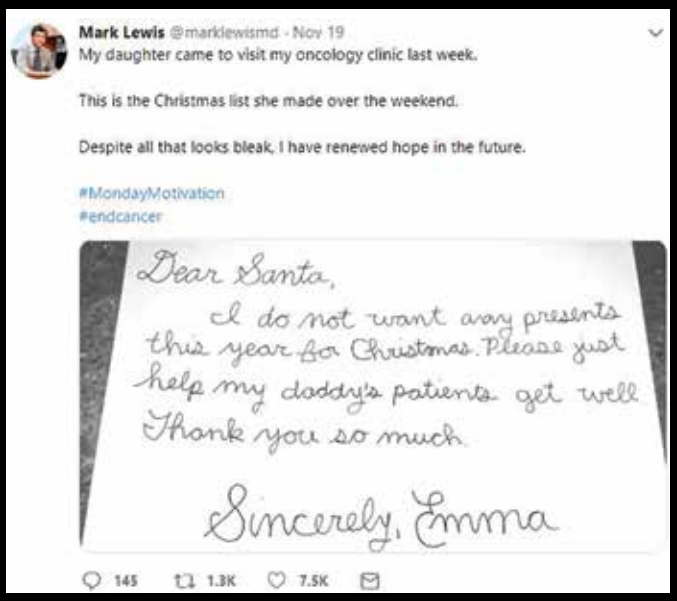
161,421 Retweets **539,804** Likes

Nakari Thorpe @nakarithorpe · Nov 22
The Closing the Gap strategy has "all but unravelled" and needs a complete rebuild to meet its health targets by 2031, according to the **Australian Medical Association** (AMA) Indigenous Health Report Card 2018 | @EllaMareeAB #auspol

Insiders ABC
@InsidersABC
Following

The Australian Medical Association says the Closing the Gap strategy has "all but unravelled" and that the policy needs to be rebuilt, writes #Insiders panellist @murpharoo #InsidersReading #auspol

Jessica van Vonderen @jessvanvonderen · Nov 23
ICYMI: The AMA calls for a "complete restructure" of the Closing the Gap strategy @abcnews @ama_qld



Owler running for Labor

Another Former AMA President, Professor Brian Owler, has put his hand up for federal politics.

The high-profile neurosurgeon has been preselected for the Labor Party to contest the Sydney electorate of Bennelong.

Bennelong is currently held by Liberal Party MP John Alexander and is the seat former Prime Minister John Howard held for 33 years.

The electorate has fallen into Labor hands before, however, when Maxine McKew ousted Mr Howard in the 2007 election. She held the seat for one term.

In announcing his candidacy while standing next to Opposition Leader Bill Shorten, Professor Owler said he had thought about it "long and hard" before deciding to enter the contest.

Professor Owler is a well-know advocate for refugees and voluntary assisted dying.

CHRIS JOHNSON

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Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON AND HANNAH WIGLEY

AMA appears before House of Reps Committee

The AMA was represented by Dr Kean-Seng Lim and Dr Simon Torvaldsen at the House of Representatives Standing Committee on Health, Aged Care and Sport to discuss the AMA's submission on the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018.

The Bill aims to obligate residential aged care providers to publicly publish their staffing ratios to improve transparency and consumer choice.

The pair appeared as witnesses to the inquiry, with their evidence being considered by the Committee.

Dr Torvaldsen pointed out that while said it was a necessary requirement to have adequate staff at residential aged care facilities (RACF), it was not sufficient alone.

"In other words, if you don't have adequate staff, it is impossible to deliver good quality care, but having adequate staff alone—particularly if they're not well trained or the corporate culture's not good or they're staff who just don't want to be there—doesnt guarantee good quality care," he said.

"So, it's only the first step in the journey. But, to illustrate the point, I've been talking to the nurses and the staff who work in the facilities that I visit. Earlier in the week, when I spoke to one of the nurses and said that I was going to have to change my normal time of visiting on a Friday morning because I was giving evidence to this Committee and we were looking at what could be done to improve staffing ratios, she burst into tears and she thanked me for standing up for what was so desperately needed. And this comes from the people who are working there. They want to give good care."

On palliative care, Dr Torvaldsen said it should be regarded as an integral function of aged-care facilities.

"It's a fundamental part of what we do and what we should be doing," he said.

"I think that that is most properly addressed by looking at the training and the skills mix, and just emphasises the fact that we were talking about earlier: that ratios alone without proper skills and adequate training don't give the whole picture. I guess the difficulty is that we have to use some kind of instrument to adjust for case mix and needs and so forth. If someone has a better suggestion than ACFI (Aged Care Funding Instrument) [or ACAT – Aged Care Assessment Team], then we would be only too happy to hear it and to discuss it."

Dr Lim said the AMA recognised that measuring the staff numbers in RACFs was just one element of achieving and maintaining high standards of care.

"It comes under this question about what the purpose of measurement is," Dr Lim said.

"If the purpose of measurement in this case is the combination of accountability and transparency, which are important from a consumer perspective, we do also need to consider the element of improvement.

"The measure which has been suggested here is the staffing ratio. If we follow the Donabedian model of quality improvement, it's actually a structure measurement. There are three elements to measuring: structure, process and outcomes. If you choose just one of three only, the problem is that we are always going to end up having, well, perverse outcomes.

"It's useful to consider this as a foundational element but also useful to consider that this is probably not going to be the final thing, and it's not the complete measurement but just part of it. For there to be informed accountability and transparency from a consumer perspective, this needs to feed into process and outcomes measurements as well."

The Donabedian model is a conceptual model that provides a framework for examining health services and evaluating quality of health care.

The AMA's submission to the Inquiry says that while residents living in RACFs typically have high care needs, the level of care, and therefore staff to resident ratios, vary between RACFs.

For example, a RACF that has a lower staff to resident ratio and few nursing staff may still provide high quality care if most of the residents have low care needs.

Conversely, a facility may offer a relatively higher resident to staff ratio with few nursing staff, but the quality of care is poor because the needs mix of the residents is consistently high. The most widely understood expression of level of care per resident is the ACAT assessment.

Similarly, contextual data could include the level of need of residents in peak periods of the day. For example, mornings are particularly busy as staff must get residents out of bed, bathe or shower them, feed them, and assist in toileting. Conversely, residents require less assistance while asleep and staffing levels may reduce at this time.

"The Government should also provide information on the roles of the different staff categories," the submission states.

"This includes information on what the different types and levels of nurses entails. This would ensure consumers are able to make

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an informed choice. The AMA is presuming that the staffing ratios and subsequent information will be published on My Aged Care, as this is where consumers will look to compare RACFs.

"There should be more information on the roles and mix of allied health professionals. Many RACFs do not employ allied health professionals but instead engage with them externally, and this should be reflected in the reporting mechanisms. Allied health professionals are an essential part of the aged care workforce and their availability is crucial to resident care. The different types of allied health professionals should also be categorised, as older people may seek certain types of allied health support when choosing their RACF.

"The AMA is concerned that publishing staffing ratios alone may potentially result in setting a 'poor standard' of staffing as the commonly accepted 'minimum'. Whereas, a regulated minimum staff ratio, developed in consultation with the medical profession and other key stakeholders, would prevent this. Staffing ratios need not stifle innovation, but rather can lay the foundation on which better quality care standards can be built. A regulated minimum will, in our strong opinion, still allow RACFs to find innovative ways to care for their residents, through a different mix of staff, above the minimum 'safety net' of staff required."

The AMA's full submission to the inquiry can be found at:

https://ama.com.au/submission/ama-submission-standing-committee-health-aged-care-and-sport-%E2%80%93-inquiry-aged-care

My Health Record opt-out extended

The My Health Record opt-out period has been extended until January 31, 2019.

The Government had to back down and delay the cut-off date for people wanting to delete their digital health records in the new system.

The Senate forced the Government into its embarrassing position by voting in mid-November – just before the opt-out was supposed to end – to extend the period.

Despite this, Health Minister Greg Hunt described the vote as win for the Government because Labor had tried to extend the opt-out period by 12 months.

"Labor's plan to delay and derail the rollout of the My Health Record was blocked today," Mr Hunt said after the Senate vote.

"We thank the crossbench for not delaying this important policy change as Labor tried so desperately to do."

But Shadow Health Minister Catherine King said the Government was "dragged kicking and screaming" into accepting the extension.

"For months, Labor has been calling for an extension in order to get this important reform right. For months, the Liberals have been insisting there was no need for an extension," Ms King said.

"But in the Senate on Wednesday the Government quietly capitulated and accepted a two-and-a-half month extension.

"It's extraordinary that Labor had to force the Government's hand by introducing legislation to make this happen.

"Minister Hunt could have implemented an extension with the stroke of a pen weeks ago."

More than one million Australians have already chosen to opt out of My Health Record system. The extension gives another 17 million Australians the opportunity to do the same.

AMA President Dr Tony Bartone said the time had come now to get on with the process of implementing the online system, which he described as an important and valuable tool in the delivery and communication of health records.

"At the end of the day, it's called My Health Record because patients will be able to control and ensure who can or can't see," Dr Bartone said.

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"Now, if a patient doesn't feel comfortable with the security or privacy provisions that have been enhanced significantly... they can opt-out.

"Now there'll be a degree of people that will fall into that category, but what we've been missing now... we don't have the critical mass of records created with the critical information and data.

"We still don't have most hospital data on that My Health Record for the ones that have been created. We're only now getting the ability to have the pathology and diagnostic imaging results communicated. And the list goes on."

Government expands football partnership aimed at young Indigenous health

The health, wellbeing and future prospects for children in remote communities will be winners, through a major extension of the successful John Moriarty Football program to 12 centres across New South Wales and Queensland.

The Federal Government is committing up to $4.5 million for the expansion, to be driven through a partnership between the Football Federation of Australia (FFA) and John Moriarty Football (JMF).

JMF and FFA will work together to provide senior coaching staff, mentoring, training and education for children involved in the program. FFA will also identify and support pathways to national football programs.

"This is a game-changing move for Aboriginal and Torres Strait Islander communities, designed to help children between two and 16 to reach their full potential in football, in education and in life," Indigenous Health Minister Ken Wyatt said.

"We have seen the success in the remote Northern Territory centres of Borroloola and Robinson River, which have been involved in the program since it was established in 2012, with more than 90 per cent of children in Borroloola now participating.

"Two hundred children have enrolled each year, including Shay Evans who is now playing with the Westfield Young Matildas.

"I congratulate Shay and her fellow JMF scholarship winners, but scores of other participants are also continuing to kick personal and life goals, both on and off the field."

The JMF program is community driven, with children supported to attend school and make healthier lifestyle choices.

The expanded program will focus on primary health through:

- Nutrition programs, with meal plans developed by a sports dietitian;
- Mental wellbeing, through emotional self-regulation training, with coaches focussing on building resilience;
- Community cohesion, through gatherings to support tournaments and holiday clinics encouraging community interest and participation; and
- Parental involvement to enable families to improve health through physical activity.

JMF Managing Director Ros Moriarty said the Foundation was "extremely grateful" for this "very significant" funding commitment.

"We look forward to replicating our model of football as a powerful tool for wellbeing, supporting resilient, healthier outcomes for young players, their families and communities," Ms Moriarty said.

NSW and Queensland communities to participate will be selected on the basis of evidence of strong local interest and intention to embrace the program.

"Our game has a deep history of Indigenous participation, and this step will allow us to do so much more to improve health outcomes for Indigenous children," said Moriarty Foundation Board Member and FFA Board nominee Craig Foster.

"Football has the power to unite the whole community to support opportunity for all young Australians."

FFA Chief Executive David Gallop said FFA had been a keen supporter of John Moriarty Football for several years.

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"Matildas Head Coach Alen Stajcic has visited Borroloola on a number of occasions and scouted Shay Evans back in 2014," he said.

"This announcement will help achieve our vision of involving more Indigenous Australians in football, as players, coaches, referees and administrators.

"We look forward to working closely with John Moriarty Football to generate significant health and community benefits while offering a pathway for Indigenous footballers to emulate the success of Young Matilda Shay."

Mr Wyatt said regular sport and physical activity, particularly for young children, has documented and far reaching health benefits.

"It reduces the risk of obesity, increases cardiovascular fitness, promotes healthy growth of bones and muscles, improves coordination and balance, and gives children a greater self-confidence and belief in their abilities, on and off the sporting field," the Minister said.

"The JMF program has the potential to contribute to Closing the Gap in health equality, education and employment, and positively impact on the high chronic disease prevalence rates among First Nations people."

The three-year funding will be provided through the Indigenous Australians' Health Program over 2018–19 and 2020.

Government releases new national plan for FASD

The Government has unveiled a new national plan to ramp up the fight against fetal alcohol spectrum disorder (FASD), and has allocated more than $7 million to the initiative.

FASD is often an outcome of parents either not being aware of the dangers of alcohol use when pregnant or planning a pregnancy, or not being supported to stay healthy and strong during pregnancy.

The disorder can inflict lifelong physical and neurodevelopmental impairments that can result from fetal alcohol exposure.

Health Minister Greg Hunt said the aim of the new national plan was to significantly help reduce the impact of FASD on individuals, families and communities.

"This plan will show us the way forward to tackle the tragic problem of FASD – guiding future actions for governments, service providers and communities in the priority areas of prevention,

screening and diagnosis, support and management, and tailoring needs to communities," he said.

"Alongside the plan's release, I am pleased to announce a new investment of $7.2 million to support activities that align with these priority areas.

"This funding will enable work to start immediately and help protect future generations and give children the best start possible."

Funding includes $1.47 million for prevention; $1.2 million for screening and diagnosis; $1.2 million to inform schools and workplaces and support the justice system; $1.2 million to tailor solutions to local communities; and $1.55 million to continue developing a one-stop digital hub for information and support.

Indigenous Health Minister Ken Wyatt said the Government's approach to FASD was to invest in activities which have been shown to be effective.

"Success is underpinned by a team effort, with collaboration between families, communities, service providers and governments," Mr Wyatt said.

"FASD requires a national approach, linking in closely with local solutions. We are acknowledging the scale of the issue in Australia and intensifying efforts to address it."

Steadfast support

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

> "GP services are in high demand as the population ages, complex and chronic disease become more prevalent, and poor lifestyle choices add to the risk for and burden of disease."

As 2018 rushes to a close I want to reflect on some of the AMA's activities this year in supporting GPs in their role as the primary provider of medical care. The primacy of the role that the usual GP and their general practice plays in a patient's health care is something that the AMA steadfastly defends. Throughout this year we have strongly advocated for an improvement to GP funding to sustain and nourish general practice in effectively delivering patient-centred quality care and in meeting the health care needs of the community.

GP services are in high demand as the population ages, complex and chronic disease become more prevalent, and poor lifestyle choices add to the risk for and burden of disease. Yet, general practice is the most efficient and cost-effective part of Australia's health system. Given the increasing cost pressures general practices have experienced over the years, this is a true testament to the general practice profession.

While the Federal Budget this year made some down-payments towards improving GP funding, much more is required to support our vision for general practice into the future. A vision that involves general practice being supported as its patients' medical home and that strengthens and supports team-based care. A vision that involves GPs being rewarded for the non-face-to-face work involved in caring for patients, that enables better access to quality GP care to patients in aged care facilities and at home, that supports greater use of technology to enhance access to care and its continuity and delivery. A vision that ensures quality improvement is supported and rewarded.

The Government must invest, and invest significantly, to make this vision a reality.

This is a message that AMA leadership and advocacy has continually impressed upon key politicians and around Commonwealth departmental meeting tables throughout the year.

Our proposal and advocacy for the integration of non-dispensing pharmacists into general practice to enhance medication management resulted in incentive reforms that will see practices further supported to build their practice-based health care teams. From July 1 2019, the Workforce Incentive Program will see the provisions of the Practice Nurse Incentive Program expanded to include non-dispensing pharmacists and allied health providers for all eligible general practices regardless of location.

While the MBS Review process has had its issues, when it comes to general practice and primary care the AMA is optimistic that our message around improved rebates, the centrality of the GP to the health system and to patient care has resonated. The AMA is keen to see the recommendations of the MBS Review Taskforce in this space support longitudinal care, patient centred and multi-disciplinary care, and provide for enhanced access via telehealth services.

Finally, the AMA, through a number of submissions, in our discussions and representations, has worked hard to convey the risks to patient care and health system expenditure of moves that would fragment primary care. Proposals for inappropriate expansions of scopes of practice, prescribing rights, and models of care that would see skilled GPs excluded from elements of the cradle to grave care they provide have been and will continue to be stridently argued against.

The coming year, I'm sure, will provide many more opportunities for the AMA to advocate for and support general practice.

In the meantime I wish you all safe and happy holidays.

Preventing heart disease – a continuing story

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

Public Health England (PHE) is the organisation responsible for the oversight of all preventive activity in England. This ranges from vigilance for infectious disease outbreaks and epidemics, through immunisation programs, to advice and support for prevention in general practice – including that relating to non-communicable diseases, especially circulatory disorders.

With the increased prevalence of cardiovascular disease in an ageing population, PHE has been reviewing investment in its prevention strategy. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749866/CVD_ROI_tool_final_report.pdf)

> "This is attributable, almost equally as best we can tell, to improvements due to primary prevention, most notably dramatic downturns in smoking, and to improved treatment."

As in Australia, since the mid-1960s, deaths in middle age from heart attack have decreased in England by well over 50 per cent. This is attributable, almost equally as best we can tell, to improvements due to primary prevention, most notably dramatic downturns in smoking, and to improved treatment.

Falls in the rate of 'sudden death', which are substantial, are an obvious place where primary prevention is working. But the evidence is difficult to collect and assess. As Earl Ford, an American epidemiologist, and Simon Capewell, a clinical epidemiologist from Liverpool University in the UK, wrote in 2011 (www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031210-101211), "Changes in risk factors may explain approximately from 44 per cent to 76 per cent of declining CHD mortality and treatments may explain approximately from 23 per cent to 47 per cent. Thus, both prevention and treatments have contributed immensely to the decline in CHD mortality."

Nevertheless, despite these advances, cardiovascular disease remains a major problem. This year, according to calculations from the Australian Heart Foundation, based on data from the Bureau of Statistics, about 8,000 Australians will die from a heart attack.

Heart attack death was previously restricted to economically advanced societies, but it now spread widely through economically developing, and even the poorest, nations. Here, death from heart disease follows the pattern we saw in Australia before the decline in mortality began in the 1960s, namely, middle-aged men and women, rather than the elderly, being at serious risk. Our effectiveness in managing infectious disease in those less affluent countries means that those people are now more prone to the degenerative diseases familiar to us.

What is the scope for prevention in clinical practice? A survey this year by the Heart Foundation found: "One in two Australians who have had a heart attack [and there are about 40,000 of them under 55] continue to smoke. Of these, close to 40 per cent did not even attempt to quit ... almost one in four have failed to regularly monitor their blood pressure levels. More than a quarter are not having regular cholesterol checks. Around one in three tried to increase their physical activity levels or lose weight, however failed to maintain the changes."

In clinical practice, prevention of death – and disability – from cardiovascular disease is a deep concern –a frequent reason for consultation and prescription and a major consumer of time in general practice.

Despite the lack of information about outcomes, Public Health England, with help from the University of Sheffield, examined the available evidence for what works and how much it costs (including general practitioners' time). PHE settled on five interventions – detection and treatment which had merit both in terms of medical outcome and cost for:

1. Hypertension
2. Atrial fibrillation (anticoagulation)
3. Hypercholesterolaemia
4. Diabetes
5. Non-diabetic hyperglycaemia ('pre-diabetes')
6. Chronic kidney disease.

Based on a 2014 health survey in England, the prevalence of individuals aged 16+ with one or more of these high risk conditions was 49 per cent.

The best evidence concerning effective interventions for each condition was then assembled, along with data on the cost of the most effective interventions and the duration of likely effect following the interventions. This information was combined into a package which allows individual practitioners to calculate the local costs and benefits of these interventions in their practice.

"The single intervention with the highest net total savings in the short term (years 2-5) is to optimise the proportion of people taking statins... a saving of £700 million in England [total population: 45 million] by year five. However, in the long term (20 years), optimising antihypertensive treatment is the single intervention predicted to save the most money (over £2 billion)... but most of the lifestyle interventions are not cost-saving over 20 years."

What may we conclude for Australia? Among the preventive interventions for managing cardiovascular disease in general, and heart disease in particular, we are committed to long-term care for optimal effect. This may not become obvious for 20 years, but this is not to gainsay it.

Preventive treatment requires a philosophy of long-term care and support to be effective.

The Wet

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

It's just water. H20. It is a molecule that creates life, births memories, emotions, causes disease and death.

For many rural doctors, the season of 'The Wet' has begun.

There is a sense of de ja vu - the smells, the sounds, the fears, the wonders of this season, the sense of rebirth. Sweet green tree frogs, horrid cane toads, the galahs leave, and meliodosis returns.

Meliodosis is a result of Burkholderia pseudomallei, a bacterium particular to the tropical wet zones. Transmitted through dirt either on the skin or inhaled, thankfully unlike ebola, person to person transmission is not suspected. Serology studies reveal that 80 per cent of children in an endemic region have antibodies against B psedomallei. For most then, it is obviously not fatal, subclinical. However, of those infected with clinical manifestations, the numbers are horrifying. Without antibiotic treatment the mortality rate is 90 per cent. Even with antibiotic treatment the mortality rate is 10 per cent for uncomplicated cases, but for those unlucky to be diagnosed with fulminant disease, death rates are as high as 80.

Meliodosis can be a great deceiver. It often acts like tuberculosis. Serology tests are deceiving, with false negatives and positives. Culture is the mainstay of diagnosis. The time to disease onset is not known but there have been cases where it has been many years after exposure. It can cause osteomyelitis, cellulitis, and only in Australia, it can cause encephalomyelitis. Strangely, also only in Australia, infected men may get a melioid prostatic abscess, not seen elsewhere in the world.

Here is my Wet season mnemonic: Mud, meliodosis, meropenum, multiple presentations, murderous, mangoes, Merry Christmas. Make it a gut reaction. You need to think of it in sick patients in the wet season.

Medicine is a seasonal profession. Whether it's the flu in Winter for city doctors or Meliodosis in the Wet for Top End doctors, we have to be prepared.

The Wet causes a shift of perspective in the Top End. Aboriginal Elders have a spark in their eyes, there is a gearing up of tools, getting the water crafts ready, a careful teaching of the young'uns about reading clouds and listening to the berries on the trees. Us White fella Kartiyas are stocking up supplies so we can survive the potential flood – diesel, bread, batteries, candles and water.

When the rain finally comes it fills the ears, soaks the skin, and transforms our communities. Overnight roads can flood, horses can swim over their fences, brown becomes green, flowers begin to sprout, crocs have a bigger territory to roam. The next morning, we find holes in the roof that we didn't know existed. But we are prepared. And we are prepared for Meiodosis cases when they inevitably arrive.

Out in the community, spirits change, I hear more laughter, there is a ubiquitous feeling of relief. Smells change. Eucalypts smell more gummy. The earth smells musky. Colours change, with the rainbows comes a whole spectrum of colours not seen in the Winter.

And then we all wait. Because 'The Dry" is about to happen, sometime after Australia Day. We look forward to the cooler winter months. The cycle continues.

A letter of thanks: the bright side of medicine

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

Much has been written about negative experiences of doctors in training (DiT). This reflects a harsh and true reality. But there are still many doctors whose treatment of DiTs is inspiring and ought to be celebrated as evidence that all is not bullying and harassment in medicine.

These are my stories, many of which are small and seem too insignificant to write. But I still feel a wave of gratitude towards these colleagues. Stories that illustrate how very simple support structures and actions by others can work as safe guards against bullying and harassment and improve well-being. I hope these stories empower other doctors in their ability to make dramatic changes in the lives of their colleagues with just small acts and not to be discouraged by the frequently and well publicised stories about the dark side of medicine.

Internship Bullying

During a general medical rotation I worked to my full capacity but it was to no avail. I was still belittled by my registrar; scolded not taught. I was on the verge of tears most days and my heart raced in my chest, unable to eat. Medical registrars from other teams asked if I was okay, having noticed a change in my demeanour. These questions of concern were crucial as they validated how I was feeling.

Day three of the rotation and I was at a loss as to how I would survive another three months. It was then that I remembered my hospital had a Royal Australasian College of Medical Administrators (RACMA) Consultant in charge of intern welfare, Rob*, along with two medical workforce personal tasked with the same duty. Rob had provided us with his mobile number during orientation. I did not have the courage to call so I texted Rob instead. Within an hour Rob had actioned a plan that saw me moved to another medical team, who were informed about my vulnerable state. The medical work force unit called me throughout the remainder of the term to ensure I was okay and my new registrar spent the next three months rebuilding my confidence.

Pre-Vocational Nurturing

During an anaesthetic rotation, I was rostered to a list that was cancelled. Instead of my consultant going back to his office to complete his mountain of non-clinical work, he spent the remaining three hours going through the basics of anaesthetics, setting up anaesthetic drills with mock patients and had me problem solve anaesthetic machine faults. I was made to feel like I was of value, even if not in training, and he applauded my progress in the coming weeks after I continued to practise his lessons.

My smooth transition onto a training program was the result of supportive colleagues, without whom I may have taken many years to gain College entry. This support started at the medical workforce level, where the staff did their best to allocate HMO2 rotations to meet my career aspirations. This was followed by anaesthetic consultants and registrars who read (and re-read and re-read) cover letters and resumes, facilitated access to courses, championed research opportunities and dedicated hours to interview practice.

Vocational Training Humanisation

My non-science background has proven a challenge to my educators as my method of learning and reasoning are not standard. But during training, belittlement turned into nurturing and a recognition of different versus wrong ways of learning and reasoning. This requires extra effort and time as my consultants navigated how my brain works to best form their explanations. There are increasing numbers of graduate-entry doctors with diverse backgrounds and the challenge for the system is to work with and not against these differences.

Life does not stop because you have an exam, job application or Masters essay. And our humanity is not immune to the impact of failures. The acknowledgment of this human reality is crucial to balance work and life. Each time a consultant anticipated the impact of life events, humbly shared their stories of struggles, sent a text message to check in, took time out to have a chat over coffee, altered a roster to ease work pressures, stayed back hours unpaid to help me pass exams, offered me time off, or showed an interest in me outside medicine; untenable situations become moments of gratitude.

*(*name changed)*

#GoodDoctorsTeach Australian Medical Students' National Teaching Awards

BY ALEX FARRELL, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Winner of the AMSA National Award for Excellence in Teaching Dr Zafar Smith and students from James Cook University.

Every day, great doctors around Australia go above and beyond to teach students, and role model what medicine is all about. This year the Australian Medical Students' Association (AMSA) celebrated those teachers in medical schools and hospitals with the National Awards for Teaching Excellence.

The AMSA National Awards are the highest honour bestowed on a teacher by medical students across the country. They are based on nominations from around the country, and represent students' appreciation and recognition of teachers who have made an especially positive impact on their studies. There are a number of award categories including excellence in teaching, in rural education, teaching by a junior doctor, and as well as teaching by a member of an allied health profession.

Although it is such an important part of the doctor's role, the teaching culture across different hospitals varies widely. Despite the recent focus and positive steps in the last few years, bullying, harassment, and teaching by humiliation are still too common an experience. These awards are part of AMSA's #GoodDoctorsTeach campaign, acknowledging those who tackle this by actively creating a positive teaching culture within medicine.

AMSA received close to 100 nominations for the awards. Reading those nominations was heart-warming, as student after student

shared stories of the teachers who have inspired, motivated and challenged them. It was a reminder of just how significant the impact of teaching is on the lives of students, and of how many exceptional teachers there are.

On behalf of Australian medical students, I'd like to thank all the doctors and allied health professionals who make it part of their daily work to make medicine a welcoming and exciting place for students and junior doctors, and nurturing their passion. Consultant or intern; metropolitan or remote; doctor, midwife or echocardiographer: the way you treat your students is making for better future doctors, and a better medical culture in Australia.

Excellence in Teaching winner: Dr Zafar Smith (James Cook University)

Quote from students:

"Dr Smith has gone above and beyond teaching us Emergency Medicine in our 3rd year. He completely re-vamped the course making it much easier to learn and more enjoyable. Every single person I know has enjoyed his lectures, tutorial and approachability. He uses interactive methods of teaching which engage the class, such as gosoapbox and kahoot quizzes to test us, and has even created a deck of cards with Emergency medicine case studies that we were all able to get our hands on and use for our exams. As this is his first year of coordinating and lecturing this course, he has outdone himself and on behalf of Med 3 at James Cook University, we would like to recognise his efforts and generosity, and the fun spirit he has brought to sometimes difficult topics."

Excellence in rural education winner: Dr Elizabeth Kennedy (University of Melbourne, Goulburn Valley Region)

Quote from student:

"Dr Kennedy has provided me with outstanding mentorship over 2018, cementing my passion for rural medicine ... She is consistently motivated to include students in the extracurriculars of the medical profession, including education events in the Goulburn Valley Region, attending Youth Forums regarding young women's health, and promoting student engagement in the community. She constantly provides me with the mentorship and support to strive for more, and to be the kind of person and doctor that is needed in a rural area. She constantly gives her medical knowledge, emotional support and more to her patients and I learn from her each and every day."

Excellence in teaching by a junior doctor winner: Dr Kenneth Cho (University of Sydney and University of Western Sydney, Nepean Hospital)

Quote from selection panel:

"Kenneth's work developing a JMO-led bedside tutorial program and a JMO-led Friday lecture series, run by Junior Medical Officers for medical students is an example of the way anyone, despite age or experience, can lead by example to create a culture of teaching where they work."

Excellence in teaching by a member of an allied health profession winner: Mr David Law (Echocardiographer, University of New South Wales, Coffs Harbour Hospital)

Quote from student:

"David- Coffs Harbour's most prized sonographer- is probably the only teacher I've had who has been able to explain ECGs in a way that makes sense. But more important than that is how he has made the hospital such an inclusive place for medical students to be, welcoming us to catheterisation lab, and always taking the time to explain things to us."

AMA advocacy on medicine shortages

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

AMA members increasingly report that shortages of PBS medicines are impacting on the care of their patients.

We are all familiar with the scenario; patients turn up at their local pharmacy to be told that their current prescription for a long-standing condition cannot be filled. Usually alternative medicines can be prescribed, but these may not be subsidised under the PBS, or easily accessible themselves.

> "It challenges the concept of stable chronic disease management, increases the risk of patient confusion resulting in medication errors and wastes the valuable time of patients and doctors."

This situation is stressful, and sometimes expensive, for patients. It challenges the concept of stable chronic disease management, increases the risk of patient confusion resulting in medication errors and wastes the valuable time of patients and doctors.

Medicine supply shortage is not a new phenomenon, but it is becoming more frequent. Shortages are attributable to several factors, including the consolidation of suppliers in the US following changes in regulations; emerging markets in China and India that have also reduced the number of suppliers due to greater competition; and requirements to upgrade plants and processes following stricter quality controls and standards. With fewer suppliers worldwide, this means that a problem in production from one source may result in magnified impact across the globe, often impacting several brands.

For Australia, the impact is exacerbated: as the TGA points out, Australia has only two per cent of the world's medicine usage and more than 90 per cent of prescription medicines are imported. Australia enjoys a relatively lowly place in 'the queue' for medicines in short supply. In addition our long supply lines complicate delivery of medicines requiring critical transport conditions, increasing the risk of in-transit spoilage, and reduce the capability of rapid resupply in any circumstance.

While medicine shortages are outside the direct control of governments, there is still considerable scope for regulatory bodies to take action to minimise the impact of shortages.

The AMA first started advocating for more proactive government interventions and regulatory solutions in 2012. The then AMA Vice-President, Professor Geoff Dobb, led the charge, meeting with and writing to Health Ministers, pharmaceutical industry representatives and the TGA. Subsequently, the TGA began working with industry stakeholders, the AMA and others to work out better ways of anticipating and managing shortages.

This ultimately led to the development in 2014 of a Medicine Shortages Protocol, an agreement signed by the TGA, Medicines Australia and the Generic and Biosimilar Medicines Association. The protocol established a voluntary regime for suppliers to notify the TGA of shortages in a timely manner as well as a public database of shortages activity.

Unfortunately, industry compliance has been patchy and as a consequence the TGA often becomes aware of shortages after they are impacting patients; and so before remedial action can be taken. This has rendered the shortages database next to useless.

COAG intervention led to a TGA review early last year. The AMA again contributed to the search for more effective solutions by participating in a stakeholder committee and providing feedback based on Medical Practice Committee advice.

It has become clear that, despite pharmaceutical industry opposition, a mandatory rather than voluntary reporting scheme is needed. The AMA fully supported the proposal that pharmaceutical companies must report all medicine shortages to the TGA within specific timeframes and that the TGA must also publish information about all shortages that have a critical patient impact.

The 'mandatory notifications' law was passed in Parliament last month and will come into effect on January 1 2019. Drafting of a new guide for pharmaceutical companies on their responsibilities is underway.

Will this fix the problem? It will certainly improve the ability of the TGA, health organisations and health practitioners to proactively

manage shortages and to source alternatives.

However, a critical player in the continuum of medicine supply is not covered in the new legislation nor mentioned in the accompanying guide. In subsidising the supply of nearly all medicines prescribed in Australia, the PBS has a significant role to play in minimising the financial impact on patients of medicine shortages.

Where an alternative medicine may be available to patients, but not subsidised under the PBS, or subsidised but with restrictions which do not encompass the specific patient use a simple, a temporary change to the PBS authority restriction may provide needed relief. For example when there was a shortage earlier this year of norfloxacin, subsidised under the PBS to treat complicated urinary tract infection, ciprofloxacin – a good alternative – could not be prescribed under the PBS because its use does not extend to any form of UTI not due to pseudomonas (prostatitis only).

The voluntary notifications scheme may not have allowed the Department of Health to act in a timely way to effect temporary amendments, but there should be no excuse from next year.

The AMA has now raised this concern with the Department several times and been assured that timely shortages information would lead to a timely PBS response. The AMA will be watching closely.

You can find out more about accessing alternative medicines during a shortage on the TGA's website.

Research

BY CHRIS JOHNSON

Smoking fathers, low sperm sons

A new study has linked low sperm count in some men to the fact that their fathers smoked while their mothers were pregnant.

Research has long shown the link between maternal smoking during pregnancy and reduced sperm count in male offspring, but Sweden's Lund University has now made a link to smoking fathers.

The research team has found that men whose fathers smoked at the time of pregnancy had half as many sperm as those with non-smoking fathers.

This is independent of nicotine exposure from the mother.

News Medical reports that the study was conducted on 104 Swedish men aged between 17 and 20.

"Once the researchers had adjusted for the mother's own exposure to nicotine, socioeconomic factors, and the sons' own smoking, men with fathers who smoked had a 41 per cent lower sperm concentration and 51 per cent fewer sperm than men with non-smoking fathers," the report states.

The research team at Lund University claim discovery of this point and is the first to publish.

Researcher Jonatan Axelsson, specialist physician in occupational and environmental medicine, said he was "very surprised" that, regardless of the mother's level of exposure to nicotine, the sperm count of the men whose fathers smoked was so much lower.

"Unlike the maternal ovum, the father's gametes divide continuously throughout life and mutations often occur at the precise moment of cell division," he said.

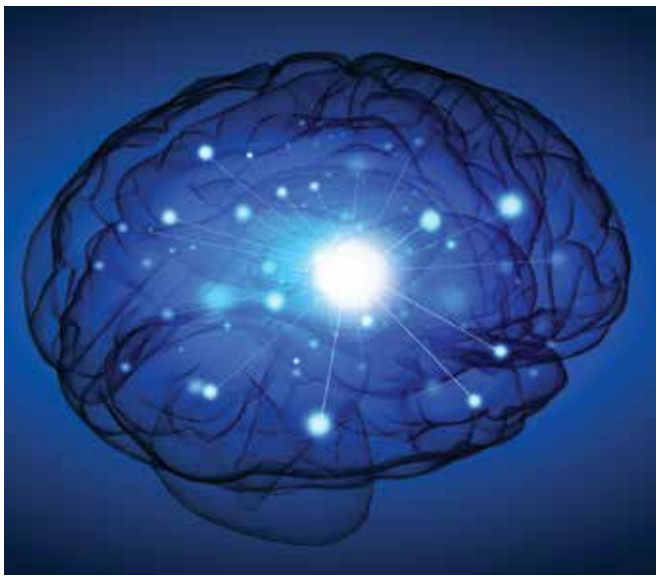
"We know that tobacco smoke contains many substances that cause mutations so one can imagine that, at the time of conception, the gametes have undergone mutations and thereby pass on genes that result in reduced sperm quality in the male offspring.

"We know there is a link between sperm count and chances of pregnancy, so that could affect the possibility for these men to have children in future. The father's smoking is also linked to a shorter reproductive lifespan in daughters, so the notion that everything depends on whether the mother smokes or not doesn't seem convincing. Future research could perhaps move us closer to a causal link."

News Medical states: The biomarker cotinine is a metabolite from nicotine which can be measured in the blood. By measuring the level of cotinine, researchers can see whether the parents themselves smoke or whether they have been exposed to passive smoking. Many previous studies have shown that it is harmful to the fetus if the mother smokes but, in this study, the link between the father's smoking habit and the son's sperm count is even clearer.

Most newly occurring mutations (known as *de novo* mutations) come via the father and there are also links between the father's age and a number of complex diseases. In addition, researchers have observed that smoking is linked to DNA damage in sperm and that smokers have more breaks in the DNA strand. Children of fathers who smoke have been reported to have up to four times as many mutations in a certain repetitive part of the DNA as children of non-smoking fathers.

Brain mapper finds hidden region



World-renowned cartographer of the brain, Scientia Professor George Paxinos AO from Neuroscience Research Australia (NeuRA), has discovered a hidden region of the human brain. The region is found near the brain-spinal cord junction and Professor Paxinos has named it the Endorestiform Nucleus.

Professor Paxinos suspected the existence of the *Endorestiform Nucleus* 30 years ago but has only now been able to see it with better staining and imaging techniques. Commenting on this discovery, Professor Paxinos said it's like finding a new star.

"There is nothing more pleasant for a neuroscientist than

Research

identifying a hitherto unknown area of the human brain. In this case, there is also the intrigue that this area is absent in monkeys and other animals," said Professor Paxinos, adding, "there have to be some things that are unique about the human brain besides its larger size, and this may be one of them."

The discovery of new brain regions helps researchers to explore cures for diseases including Alzheimer's, Parkinson's disease and motor neuron disease.

The *Endorestiform Nucleus* was noticed when Professor Paxinos introduced the use of chemical stains, combined with imaging techniques, in the production of his latest atlas.

The *Endorestiform Nucleus* is located within the inferior cerebellar peduncle, an area that integrates sensory and motor information to refine our posture, balance and fine movements.

"I can only guess as to its function, but given the part of the brain where it has been found, it might be involved in fine motor control," said Professor Paxinos.

Many neuroscientists researching neurological or psychiatric diseases, in humans or animal models, use Professor Paxinos' maps as guides for their work.

An increasingly detailed understanding of the architecture and connectivity of the nervous system has been central to most major discoveries in neuroscience in the past 100 years.

"Professor Paxinos' atlases, showing detailed morphology and connections of the human brain and spinal cord, provide a critical framework for researchers to test hypotheses from synaptic function to treatments for diseases of the brain," said Professor Peter Schofield, CEO at NeuRA.

"It is truly an honour for *Elsevier* to be continuing Professor Paxinos' legacy of publishing with us," said Natalie Farra, Senior Editor at *Elsevier*. "His books are world-renowned for their expertise and utility for brain mapping, and for their contributions to our understanding of the structure, function and development of the brain."

Professor Paxinos is the author of the most cited publication in neuroscience and another 52 books of highly detailed maps of the brain. The maps chart the course for neurosurgery and neuroscience research, enabling exploration, discovery and the development of treatments for diseases and disorders of the brain.

The discovery of the *Endorestiform Nucleus*, is detailed in Professor Paxinos latest book titled *Human Brainstem: Cytoarchitecture, Chemoarchitecture, Myeloarchitecture*.

Call for global bipolar research volunteers

Australian researchers are seeking 5,000 adults who have been treated for bipolar disorder to volunteer for the world's largest genetic investigation into the chronic illness that can prove devastating.

The Australian Genetics of Bipolar Disorder Study aims to identify the genes that predispose people to bipolar disorder in order to develop more effective, personalised treatments, and ultimately, find a cure for the illness.

QIMR Berghofer Medical Research Institute (QIMR Berghofer) is the base for the Australian arm of the international study, with collaborating centres throughout North America and Europe.

The study aims to recruit 100,000 participants, with Australian researchers hoping to contribute five per cent of the overall study population.

Approximately one in 50 Australians (1.8 per cent) will experience bipolar disorder during their lifetime.

The complex disorder, which occurs commonly in families, typically results from a combination of genetic and environmental influences. Those living with bipolar disorder may be at higher risk of developing other health issues, including alcohol and drug abuse, anxiety, cardiovascular disease, diabetes and obesity. They also carry a 15 times greater risk of suicide than the general population, accounting for up to 25 per cent of all suicides.

Researchers are seeking 5,000 male and female Australian volunteers aged 18 and older, who are currently being, or have been, treated in the past for bipolar disorder. Their involvement will allow researchers to shed light on the genes that predispose people to the illness to ultimately develop more personalised treatments.

Globally, about one in 50 of the population experiences bipolar disorder during their lifetime. In Australia, it is estimated that 1.8 per cent of males and 1.7 per cent of females have experienced bipolar disorder in the previous 12 months.

Participation in the study is free and simple. Volunteers complete a 20-minute online survey, and those who qualify will be asked to donate a saliva sample. Study researchers will analyse DNA from saliva samples to identify specific genes associated with bipolar disorder. The knowledge will be used to improve current, and develop new treatments for bipolar disorder.

Anyone wishing to volunteer for the Australian Genetics of Bipolar Disorder Study should head to www.geneticsofbipolar.org.au, email gbp@qimrberghofer.edu.au or call 1800 257 179.

Massive malnutrition deaths among children in Yemen

Eighty-five thousand children under the age of five are estimated to have died from acute malnutrition in Yemen during the course of the three-year war there.

The United Nations has declared that up to 14 million Yemenis are suffering from famine, with the war causing the world's worst humanitarian crisis.

The Save the Children charity has calculated that 84,700 children died between April 2015 and October 2018 from untreated cases of severe malnutrition.

The aid workers in Yemen say many cases go unreported because only half of the country's health facilities are operational and many people are too poor to access those that are open.

Food, medicines and other humanitarian aid and supplies are also not reaching the country.

"For every child killed by bombs and bullets, dozens are starving to death and it's entirely preventable," said Save the Children's Yemen director Tamer Kirolos.

"Children who die in this way suffer immensely as their vital organ functions slow down and eventually stop. Their immune systems are so weak they are more prone to infections with some too frail to even cry.

"Parents are having to witness their children wasting away, unable to do anything about it."

If acute malnutrition is left untreated, up to 30 per cent of children in the conflicted are will die each year, the charity stated.

Fighting in Yemen worsened in 2015 when a Saudi-led coalition launched an air attack against the Houthi rebel movement that had forced President Abdrabbuh Mansour Hadi to flee the country.

CHRIS JOHNSON

Vax exemption sees chickenpox outbreak in North Carolina school

A school in North Carolina with a high vaccination religious exemption rate has experienced that State's worst outbreak of chickenpox in more than 20 years.

By the end of November, 36 students at Asheville Waldorf School had contracted the varicella virus, most commonly known as chickenpox.

It is the largest outbreak there since the disease's vaccine became available more than two decades ago.

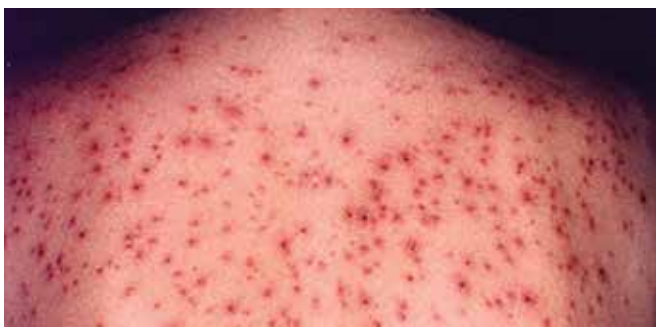
The school has one of the highest vaccination exemption rates in the North Carolina.

Dr Jennifer Mullendore of Buncombe County Department of Health and Human Services said the outbreak was concerning, even though chickenpox is not usually life-threatening.

Two to three out of every 1,000 children infected with chickenpox required care in a hospital, she said.

"People don't think it's a serious disease, and for the majority of people it's not. But it's not that way for everybody," Dr Mullendore said.

"To me, that's not a mild disease, and if you're the parent of one



of those children, you probably don't think so either."

Asheville Waldorf School has 152 students and 110 of them have not received the chickenpox vaccine, which was made available in the United States in 1995.

During the 2017-2018 school year, the school had a higher rate of religious exemptions for vaccination than all but two other schools in all of North Carolina.

CHRIS JOHNSON

US moves on e-cigs and flavours

The Food and Drug Administration in the United States of America has launched a huge effort to counter underage use of tobacco products, including e-cigarettes.

In a multifaceted attack, the FDA has limited sales of many flavoured e-cigarettes to outlets that have either age-restricted entry or age-restricted areas inside stores.

Online sales will also require more stringent verification.

FDA Commissioner Scott Gottlieb said the organisation's aim was to make sure no child could access a fruity flavour product in a convenience store.

He said shops wanting to sell fruit-flavoured e-cigarette products needed to age-restrict completely or have a separate room that is age-verified.

"A curtain or a partition won't cut it," he said.

"The bottom line is this – I will not allow a generation of children to become addicted to nicotine through e-cigarettes."

He said he didn't believe that vaping and tobacco shops would have trouble complying.

The restrictions reflect concerns that vaping could lead to nicotine addiction early in life and affect the developing adolescent brain.

Concerns are too that young vapers will eventually start smoking more harmful tobacco products such as regular cigarettes.

The FDA plans also to ban menthol and other flavours in cigarettes and cigars, but that will require new regulations that could take years to kick in.

CHRIS JOHNSON

Quarter of young English women struggling with mental health

Official National Health Service figures recently released revel that one in four young women in England are suffering some form of mental illness.

Depression and anxiety are the biggest problems, but the NHS reports found young women aged 17 to 19 were twice as likely to be struggling with mental health issues as young men of the same age.

A total of 23.9 per cent of young women in that age group admitted to a mental health disorder.

The results come form a survey of 9,000 young people across the country. Statisticians from NHS Digital analysed the findings and ensured only diagnosable conditions were included in the final results.

Mental health issues in younger children and teenagers were not as prevalent, but were slowly on the rise, the study found.

Pressure over body image, social media, school exams, and sexual harassment are all reported as significant factors contributing the mental health disorders of many of the young women.

CHRIS JOHNSON

Taking a gamble on TheLott

BY DR CLIVE FRASER

After protesting recently about MHR (My Health Record) and all of the possibilities of my privacy being breached, I thought that I would let my colleagues know that I have just celebrated a sentinel birthday which for the purposes of this column I'll call my 40th.

There was a week-long celebration with all manner of food and beverages, culminating in the ritual of gift giving.

After a lifetime of consumerism I think that I can reliably claim to have at least one of everything, so what birthday gift would you buy a man who has it all?

With $100 million dollars on offer in a mid-week Gold Lotto draw I'd say that you'd probably buy a ticket in that, just for fun.

After all, if I won I could help myself to another LCD screen or gadget of my choosing to fill a house that is already bulging with 'stuff'.

But with only a one in seven million chance of winning I regret to say that I usually never check my numbers with any of these gifts.

After an anxious phone call from the generous donor I thought that I had better check to see whether I had won the grand prize.

Too inconvenienced to go to a shrinking number of news agencies I thought that I'd check my numbers on-line.

I downloaded TheLott app and as per the instructions I took a photo of the ticket.

But the response was: "Sorry, your request cannot be serviced at present #1008."

No luck there.

My next step was to create a log-in at www.thelott.com.

The site required my full name, title, date of birth, phone number and full residential address.

Greedily, I willingly provided all of this information.

After all I had a one in seven million chance of taking out the jackpot, retiring, philanthropy and all that stuff.

But then I was hit with the startling reality that at those odds I was more likely to be killed by my Takata airbag and that I had just given all of my identifying information to the Tatts Group.

There weren't even any frequent flyer points on offer for handing over my personal data.

Tatts Group is after all a benevolent company which has a monopoly on lotteries and a big stake in wagering and gaming solutions (aka pokies) in Australia.

Surely they didn't employ any stalkers or terrorists and I'd be safe in my abode.

In terms of data security I thought that Tatts Group would have to be safer than giving my personal information to a Commonwealth Government whose Ministers regularly guarantee that they support their leader.

So what does this story have to do with motoring?

I'd say nothing at all.

That is, apart from when you are driving in your car I'd recommend keeping your windows wound up and your doors locked while abstaining from handing out your personal identifying data.

Oh, and don't forget to get your faulty Takata airbag replaced.

After all. Life is a gamble.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

Get your Christmas music cheer on

BY CHRIS JOHNSON

It's time to pull out those old Christmas albums – on CD, vinyl or cassette – or rush into any department store and find a few Christmas CDs in the sale bins.

Or maybe download a few festive tunes ready to blast through the living room on Christmas Eve and *ad nauseam* all Christmas Day.

But let's face it, Christmas songs can get a tad irritating – especially when they are played over and over again in supermarkets, department stores and shopping malls.

So, to counter all the dross being served up in the name of festive cheer, *Australian Medicine* is recommending a few Christmas albums that have been released over the years and that are well worth listening to.

Of course, don't go past *Bing Crosby's White Christmas* (1986), *A Jolly Christmas* from Frank Sinatra (1957) or *Elvis' Christmas Album* (1957). They are classics for a reason. But there is so much more out there.

Some Christmas albums are somewhat challenging, like Bob Dylan's *Christmas in the Heart* (2009). This is actually an exceptionally good album and a genuinely sincere Christmas offering from His Bobness. But for those who can't stand his ageing croaky singing voice, it might not be uplifting Christmas fodder. For those who can appreciate a master at work, however, this album is gold.

Add some twang to your party tunes with *The Ventures' Christmas Album* (1965). This album throws up the very coolest of surfy, instrumental versions of the Christmas classics.

Christmas on Death Row (1996) sounds a little depressing, but it's not. A compilation released by Death Row Records, it features Snoop Dogg, Isaac Hayes, Smokey Robinson and many others offering funny, peaceful and light gansta renditions of original and reworked Christmas tunes.

Ella Fitzgerald's *Ella Wishes You a Swinging Christmas* (1960), needs no explanation. It's Ella. It's fantastic!

Get down with *James Brown's Funky Christmas* (1995), get solemn playing *Christmas with Johnny Cash* (2003), cool with *The Beach Boys' Christmas Album* (1964), and get very laid back with Willie Nelson's *Pretty Paper* (1979).

And if you want some beautiful Christmas ballads performed to perfection, *Sufjan Steven Presents Songs for Christmas* (2006) is a cracker.

There are heaps of Christmas albums out there. Many, like some on this list, have been long forgotten. Some are so very worth looking for.

And if you want to download just one Christmas love song, search for Dan Folgelberg's *Same Old Lang Syne*, released as a single in 1980 and subsequently included in his 1981 album *The Innocent Age*.

AMA Member Benefits

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

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

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

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

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

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

Learning.doctorportal.com.au

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

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

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

www.ama.com.au/careers

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

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

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

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

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

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

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

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

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