AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Home Affairs

Exclusive interview with the Chief Medical Officer, p3

INSIDE

AMA

ISSUE 31.03 FEBRUARY 18 2019

AUSTRALIAN
Medicine

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Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

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In this issue

Cover pic: Dr Parbodh Gogna, Department of Home Affairs Chief Medical Officer and Surgeon General, with AMA President Dr Tony Bartone.

Home Affairs top doc in rare and candid interview

Dr Parbodh Gogna doesn't give media interviews – and he has been asked numerous times since taking up the post of Chief Medical Officer with the Department of Home Affairs.

It was a job he started in July 2018 and a role that also makes him the Surgeon General for the Australian Border Force (ABF). He was previously the Director of Medical Services at a Central Queensland hospital. The jobs could hardly contrast more.

"This is very much different to what I've done before," he tells *Australian Medicine* in an exclusive interview inside his Canberra office.

"Before, I was involved in clinical governance, clinical reviews, and was doing clinical work as well... Obviously this is a more strategic role.

"I provide advice on everything from the stuff that is political and in the media from immigration detention, through to countering violent extremism.

"And there's so much more. We're involved in policy sprints on fentanyl for example, as part of work addressing the opioid issue.

"Obviously, the key focus for the department is the free movement of people, goods and chattel to make Australia a very prosperous environment.

"I'm involved with immigration in a health setting. So, it's about what people require to have undertaken so they can come into our country."

While he insists it is no way the largest part of his job, Dr Gogna acknowledges that the asylum seeker issue is the most talked about. And he is determined that the issue will be attended to respectfully and thoroughly on his watch.

"I can assure you that people are not cruel," he says in relation to offshore detention.

"It's certainly complex. Obviously if a bill passes into law, we follow the law of the land and we will look at all elements of it because we will be required to operationalise it.

"But we're agnostic. We will follow the law that's given down to us.

"It is a policy by Government that underpins offshore processing, and the Minister is clear on the pillars that support the non-arrivals of boats."

Referring to the legislation that was before Parliament and which has only recently passed, Dr Gogna talks of an "oversight element" which he says will translate into an "oversight function" for his department.

"The human factor is to make sure people are well cared for. And, obviously, I'm always fully in support of that," he says.

"We've got large contracts with professional organisations to provide services. There is clinical scrutiny, in the same way that all doctors should have their work scrutinised and told what a great job they're doing or have any complaints raised.

"It is a high premise of medicine. We don't deny care. There are lots of emotive parts to this and we rely on the people who we contract to, to provide services.

"And with offshore detention where we are involved with another country, the sovereign country has direction for that too."

On a day-to-day basis, Dr Gogna's work involves him in much more than the refugee issue. On one front, he deals with the movement of people in and out of Australia, overseeing a system that conducts about 920,000 medical checks a year from a horde of 9 million temporary visitors.

Protecting Australia from diseases and pandemics is a high priority. So too are potential terrorist attacks, violent extremists, or violently fixated individuals and how to best protect the Australian public from them.

As Surgeon General of the ABF, he oversees the health screening of those who seek to be employed with it.

"At entry, how do we asses on a psychometric level?" he says.

"What we review and look at is whether a person with a particular condition is able to perform this role on a patrol boat, for example.

"There are health requirements, there are physical requirements, and if they are to be in a role where they will need to be in possession of guns, there are use of force requirements.

"Our people working at sea on vessels could be dealing with pirates, with foreign fishers, and with drug seizures."

As a central department, the Home Affairs portfolio encompasses the ABF, Australian Federal Police, ASIO, Australian Transaction Reports and Analysis Centre, and the Australian Criminal Intelligence Commission.

Dr Gogna is a long-standing member of the Australian Medical Association, and once sat on the AMA WA Council as its Rural GPs representative.

CHRIS JOHNSON

Doctors win on refugee vote lost by the PM

The AMA was in favour of the legislation and has led the campaign to have sick asylum seekers brought to Australia for treatment and to get children and their families off of detention in Nauru.

Australian doctors will have more say over decisions whether asylum seekers in offshore detention should come to Australia for medical treatment.

The Government of Prime Minister Scott Morrison has suffered a historic defeat, losing a vote in the House of Representatives on the medivac evacuation bill when Labor was joined by the Greens and independents to back giving doctors more power over the fates of refugees.

A day after the vote in the Lower House, the Government lost again on the same bill in the Senate.

The legislation will become law after it receives royal ascent by the Governor-General.

The AMA was in favour of the legislation and has led the campaign to have sick asylum seekers brought to Australia for treatment and to get children and their families off of detention in Nauru.

It has long called for doctors to be allowed on the island to assess and monitor the health of the asylum seekers.

The series of votes the Government lost in the House 74 to 75 amounted to allowing doctors to visit Manus Island and Nauru to conduct health checks on the asylum seekers already there and to recommend medical evacuations as they see necessary.

Two doctors must assess each person for medical or psychiatric condition. These assessments can be done remotely if required.

If the doctors recommend transferring an asylum seeker for treatment, the Home Affairs Minister must approve or refuse the transfer within 72 hours. A medical panel to be known as the Independent Health Advice Panel will reassess the situation if the Minister refuses, which can only be on grounds of an adverse security assessment or a substantial criminal record.

A defeat on such a substantive bill has not been recorded on the floor of the House of Representatives since 1929.

Compounding the embarrassment was that the original bill came from the Government, which was aiming to shore up its own power over the health and fate of asylum seekers.

But Labor amended the bill, which became similar to that which was put forward by independent MP Kerryn Phelps, to hand much more control to doctors.

The voting result was immediately described by many as a de facto vote of no confidence in the Government because it has lost control of the House.

But Mr Morrison was not about to fall on his sword and call an immediate election – which is exactly what the Prime Minister in 1929 Stanley Bruce did after losing control.

Instead, Mr Morrison announced he would reopen detention facilities on Christmas Island in anticipation of a renewed push by people smugglers to bring asylum seekers to Australia.

The newly passed legislation specifically applies only to Nauru and Manus.

“We have approved putting in place the reopening of the Christmas Island detention facilities, both to deal with the prospect of arrivals as well as dealing with the prospect of transfers,” the Prime Minister said.

“My job now is to do everything within my power, and the power of the Government, to ensure that what the Parliament has done to weaken our borders does not result in boats coming to Australia.”

A Federal election is expected in May.

CHRIS JOHNSON

Will Budget deliver policy vision?

BY AMA PRESIDENT DR TONY BARTONE

The April Federal Budget provides the Government with the ideal opportunity to unveil the details of its long-term vision for the Australian health system.

But will it happen? The Government will need to produce some health policy magic if it wants to cancel the Opposition's traditional perceived advantage in this area.

With the Federal election expected in May, there is plenty of time for the Government to roll out a series of fully-funded policies designed to meet the increasing health care demands of a growing and ageing population.

> "The AMA and the medical profession will watch closely to see which MBS Review recommendations become Government policy."

The conditions are ripe for a new round of significant and meaningful health reforms, underpinned by secure, stable, and adequate long-term funding, to ensure the best possible health outcomes for the Australian population.

The 2019 Budget and the election come as the Government finalises significant reviews, most notably the Medicare Benefits Schedule (MBS) Review and the implementation of the review of the private health insurance (PHI) sector.

The AMA and the medical profession will watch closely to see which MBS Review recommendations become Government policy. It has been our view from the start that the MBS Review must not be a cost saving exercise – it needs to be a credible clinical process to produce a strong contemporary MBS.

The PHI reforms – the Gold, Silver, Bronze, and Basic policies – are already being introduced. We are yet to see how they will be accepted by the public and the health professions.

At the same time, the Government will be navigating the implementation of vital public hospital funding negotiations with the States and Territories via the Council of Australian Governments (COAG) processes. The AMA is adamant that more funding is needed to ensure hospital capacity to meet rapidly growing patient demand. We also believe that all governments – Commonwealth, State, and Territory – need to commit their fair share, and work cooperatively to build efficiencies in the system.

The Government, led by Health Minister Greg Hunt, has shown strong commitment to the Pharmaceutical Benefits Scheme (PBS), and we expect this ongoing commitment to be reflected in the Budget.

The Aged Care Royal Commission will have impacts across the health system, which the next Government will have to manage.

The key to successful health reform is keeping all the important and disparate sections of the health system linked – and the key to keeping everything working to a common goal is general practice and the local GP.

The AMA stresses that this Budget and the imminent election policies from all parties must contain a significant, long-term funding commitment to primary health care, led by general practice. This will be one of the key factors by which we will judge the Budget and the election policies.

The Government acknowledged the importance of general practice in the Mid-Year Economic and Fiscal Outlook (MYEFO) statement in December, but the funding commitment was inadequate. More is needed.

In our Pre-Budget Submission, the AMA set out a range of policies and recommendations that are practical, achievable, and affordable. They will make a difference. We urge the Government to adopt them in the Budget process.

We stuck mainly to the major pillars of the health system – public hospitals, the private health sector, the PBS, and primary care – in this Submission.

We also highlighted emerging policy priority areas such as aged care, mental health, and medical research.

The AMA will release a broader policy agenda – encompassing Indigenous health, public health, prevention, and other issues – ahead of the election.

Health should never be considered an expensive line item in the Budget. It is an investment in the welfare, wellbeing, and productivity of the Australian people.

Health is the best investment that governments can make.

The case for medical leadership – part one

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

As I look around me in the healthcare landscape I notice a progressive, enervating loss of good quality medical leaders – both in the public and private sectors as well as in community practices. Even more worrying is the perplexing trend for institutions/hospitals to marginalise medical administration and often hand duties over to non-medical professionals who have less formal training e.g. a FRACMA. Medical input is becoming more 'advisory' rather than the doctors having true responsibility and decision-making authority and strategic influence. This is a big problem for the profession – but also for institutions, practices and our patients.

Is this worrying diminution and marginalisation of medical leadership because of our own torpor and misguided lack of desire to fill these posts (to our peril)? Perhaps we are fairly beaten in an open and transparent selection process? Does the wider medical profession wholeheartedly support doctors in leadership positions appropriately? Whatever the reason, I regard the loss of medical leadership as one of the most substantial threats currently facing the medical profession. Even when people agree, there seems perplexingly insufficient action from all doctors to improve our leadership prospects. I therefore want to spell out the strong case for medical leadership to be nurtured and reclaimed and point a pathway forward.

Where we started to go wrong

Clinical governance is the framework through which organisations achieve and safeguard a high quality service. It is necessary to acknowledge that doctors provide a valuable contribution to the quality of patient care through diagnosis and treatment. By taking crucial decisions regarding clinical care and therefore resource utilisation, clinicians need to be at the heart of clinical governance[1]. While doctors view clinical governance as essential, they are increasingly disillusioned and some are sceptical of the benefits. Not surprisingly, the knowledge and application, as well as perceived utility by medical professionals of clinical governance tools (e.g. risk management), are associated with the mortality rate of their units and with some efficiency indicators. However, the medical frontline staff seem to not consider homogeneously useful the clinical governance tools application on its own clinical practice[1]. We are vexingly dubious therefore of an integral component of enlightened medical leadership.

The NHS has served as a microcosm of change since the Griffiths report in 1983. Doctors were challenged, threatened and removed by non-clinical or at least non-medical managers asserting commercial/business management and rules (there is much more to the post-Griffith reforms in which he also argued for medical leadership to become a much higher priority). It was perceived that doctors subsequently disengaged from the management and leadership of the NHS with the consequent alienation of the medical profession. Unfortunately, doctors then abrogated their responsibility and 'retreated' to clinical work alone[2]. We see this self-destructive attitude in Australia too.

The ripple effects of this were felt everywhere. Nonetheless, a quiet body of work was building which showed that clinicians delivering high-quality health leadership, particularly in the USA, pointed the way towards improved patient outcomes. It is now recognised that a lack of clinician involvement hinders the achievement of progressive, high-quality care[2]. A younger generation of doctors demand a higher level of emotional intelligence and a corporate outlook, coupled with a patient-focused leadership style borne from a deep and wide understanding of the political, financial and business skills required to operate organisation successfully[2]. This can be difficult to find.

The Francis report which followed the Stafford Hospital scandal in the late 2000s highlighted that one of the factors behind patients dying unnecessarily or being harmed was the disengagement of doctors[3]. Several studies show a clear and positive relationship between medical engagement and organisational performance, reinforcing the view that involving doctors in leadership roles is not an optional extra, but central to raising standards of patient care[3]. In this we must be active participants and not over-emphasise the travail of medical leadership training and participation.

Clearly, to be a good clinician alone does not imply someone will be a good leader or medical administrator. In Scandinavia it was found that doctor-managers significantly based decision-making on personal professional experience, i.e. they still act as clinicians[4]. This effect was irrespective of their level within the structure or gender. Doctor leaders cannot therefore be chosen based on clinical prowess or the 'last person standing'.

The profession can however break free from its insouciance and enervating scepticism of management to become superlative, progressive participants that shape organisational culture and healthcare reform.

Opposition promises health reform commission

Labor has promised to establish a permanent health reform commission if elected to government this year.

Delivering her address to the National Press Club in Canberra, Shadow Health Minister Catherine King said Australia was a long way off from achieving the universal healthcare system that was truly accessible and affordable for all.

"We can and must do better to deliver on the vision of Medicare," she said, before outlining her plan for long-term health system reform.

Ms King said a Labor government would set up a health reform commission to be an independent, legislated body – comparable to the Productivity Commission – and charged with developing and overseeing a long-term health reform agenda that transcends election cycles.

"Where the Productivity Commission has an economic and financial focus, the Australian Health Reform Commission will focus on finding ways to improve our healthcare system and health outcomes for all Australians," she said.

"It will be a body explicitly charged with reducing health inequality and improving the universality of our health system. And it won't just develop long-term reforms – it will hold Governments accountable for delivering on them.

"Commissioners will be appointed for at least five years, giving them the time to develop rigorous and durable solutions that cannot easily be unpicked by one side of politics or another.

"And it will report not just to the Federal Health Minister but to all Governments through COAG – meaning a Federal Government will not be able to simply conceal or ignore inconvenient recommendations."

Ms King said the commission's recommendations would be public and governments would "ignore them at their own peril".

It would have a broad mandate, with its priorities directed by COAG.

"I'm doing something unusual for a politician," she said.

"I am acknowledging that no one Minister in one jurisdiction can solve the problems facing us alone. They're simply too big. We have to work together."

CHRIS JOHNSON

Vice President's message ... from p6

Can we do better with doctors in charge?

In daily practice, doctors have a significant impact on resource utilisation; deliver and influence the quality of medical care and; affect the speed and extent to which changes occur in medical practice[5]. Successful healthcare organisations must be able to leverage the unique perspective of medical leaders as these institutions strive to innovate and adapt in a competitive environment where their main business is providing clinical services to patients. Thus, developing medical leaders in medicine is essential, especially given the dynamic demands of the current health system. Critically, doctors develop greater organisational awareness through leadership courses e.g. financial, planning, human resources and marketing[5]. More on this later. Parts two and three of this discussion will appear in my subsequent columns.

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Aged Care Royal Commission starts

The Royal Commission into Aged Care Quality and Safety is underway, with victims of abuse and neglect, and their families, being asked to come forward with their stories.

The hearings began, however, with numerous families of elder abuse victims being denied entry into the main courtroom in Adelaide where the inquiry has begun.

Most had to settle for a live steam of the proceedings into an overflow courtroom.

In her opening statement, Commissioner Lynelle Briggs described a "rising torrent of concern" that the aged care sector was not functioning as it should.

"We will look at the expectations of Australians," she said.

"A key feature of our task is a focus on the future and what the aged care system in Australia should be – a world-class caring system in which those receiving aged care and their loved ones can have confidence.

"A system which has services that are compassionate, fit for purpose, customised to individual needs, and of the highest standards in terms of quality and safety."

In his remarks, Commissioner Richard Tracey QC warned nursing home bosses not to instruct their staff against giving evidence to the Royal Commission.

"It would be unlawful for an employer to take punitive action against an employee or former employee who has assisted us," he said.

"The hallmark of a civilised society is how it treats its most vulnerable people — and our elderly are often among the most physically, emotionally and financially vulnerable.

"Frail and elderly members of our community deserve to, and should be, looked after in the best possible way."

Witnesses will begin giving evidence next month in Adelaide before the Commission moves around Australia for further hearings.

The inquiry was established by the Federal Government in response to numerous cases of appalling neglect and abuse at some aged care facilities coming to light – the most disturbing being at the Oakden facility in Adelaide, which was exposed in 2017.

The Commission was announced in September 2018, with Commissioners required to deliver an interim report to the Government by October 31 this year and a final report by April 30 next year.

There is speculation, however, that the inquiry could be extended.

CHRIS JOHNSON

Strawberry tampering investigation report released

Food Standards Australia New Zealand (FSANZ) has released its report on the strawberry tampering incident, with key recommendations focusing on the need for improved communication during incidents, particularly those involving criminal matters.

"The Government has already acted in response to this incident by strengthening penalties for intentional contamination of food, and helping FSANZ progress their review into high-risk horticulture sectors," Mark Booth, CEO of FSANZ said.

"The report's recommendations, once implemented, will help ensure an improved response to any future incidents. These improvements will support our growers and ensure Australians can continue to trust in our effective and responsive food safety system."

Mr Booth said several recommendations focused on improved communication in incidents involving criminal investigations, as well as a review of existing food incident protocols.

"I'd like to thank all of the stakeholders who contributed to the development of this report," he said.

The report can be found at:

http://www.foodstandards.gov.au/publications/Pages/Strawberry-tampering-incident.aspx

Submission delivered to workplace sexual harassment inquiry

The Australian Human Rights Commission (AHRC) is holding a national inquiry into sexual harassment in Australian workplaces and has called for broad community submission to inform its report.

The AMA has made a 30-page submission to this inquiry. A copy of the AMA's submission can be found on the AMA website (link below).

The inquiry followed the AHRC's 2018 national survey involving 10,000 respondents investigating the prevalence, nature and reporting of sexual harassment in Australian workplaces and the community more broadly. The survey report stated that close to half of sexual harassment events in past five years occurred in four key industries; one of which was the health industry.

The AMA accepts evidence that workplace sexual harassment is widespread in the health sector and supports initiatives to stop its destructive effects. Where this behaviour continues, the rights and wellbeing of individuals and the efficiency of organisations is undermined which can lead to less than optimum health care. We made known to the inquiry that these views are underpinned by AMA's Position Statements which act as the leading voice for change to prevailing medical culture norms and community expectations.

The underlying thesis of AMA's submission is that there is chronic under-reporting of what is a serious problem. We provided the inquiry with across jurisdiction doctor-in-training survey results (often called: Hospital Health Checks) showing the prevalence of sexual harassment and their lack of confidence in complaints being handled appropriately.

The AMA submission addressed the cultural drivers behind this wrong behaviour and the behaviour's negative impact on the promotion of optimal patient care and worker well-being. We reflected on good existing practice, effective cultural change models operating in Australian public health and provided analysis of a broad suite of responses to the problem including:

- establishing measurable objectives and goals for improvement;
- increasing professionalism in managing systems dealing with complaints;
- enhancing knowledge and improving training;
- promoting useful employment regulation and entitlements; and
- improving leadership competencies and promoting diversity as these encourage people to accept legitimacy of difference which in turn norms respect in the workplace.

The AMA submission suggested a four-step approach:

1. **REGULATION and LEADERSHIP** – Applying good enforceable rules consistently and fairly combined with leaders acting as good symbols to copy / who set the right standard.
2. **VISIBILITY** – Regular reporting of 'where change is at' and marketing of definitions, complaint processes, organisational steps to combat.
3. **LEGITIMACY** – Differences arising from the diversity of style, background and/or gender become accepted; not tolerated nor resisted. Women in leadership positions are encouraged through fair recruitment. Fairness and equity are the basis for agreed rights obligations and entitlements.
4. **RESPECT** – The standard is set and properly reinforced, difference is embraced and valued. Necessarily unacceptable workplace behaviours are marginalised as the culture, instead of breeding contempt, breeds respect.

The AMA Submission acknowledged the good work being done by many stakeholders within the profession and the desire of the profession to facilitate change towards best workplace practice. Transformation to stop sexual harassment is the way to ensure the wellbeing of everyone; including patients.

BY ANDREW LEWIS
AMA SENIOR INDUSTRIAL ADVISOR

The AMA submission to the National Inquiry into Sexual Harassment in Australian Workplaces can be found at:

https://ama.com.au/submission/ama-national-inquiry-sexual-harassment-australian-workplaces-submission-2019

Qld mandatory reporting recommendations not good enough

The AMA is disappointed with the majority recommendation of a Queensland State Parliamentary Committee over mandatory reporting laws.

The Committee recommended the Queensland Government pass, without any further changes, proposed mandatory reporting laws for doctors treating other medical professionals for mental health issues.

The Queensland Parliament Health, Communities, Disability Services, and Domestic and Family Violence Prevention Committee recommended early in February passing the *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018.*

The Committee said the Bill would effectively soften laws introduced in 2010, which had been interpreted as effectively barring doctors from accessing the same level of health services their patients enjoyed, for fear of potential repercussions.

It rejected the calls to amend laws to mirror the proven Western Australian model, which exempts treating doctors from reporting their doctor patients.

Under Council of Australian Governments (COAG) arrangements, if passed, the Queensland law will apply in all States and Territories except Western Australia, where doctors will remain exempted from mandatory reporting provisions.

AMA President Dr Tony Bartone said while the Committee believes the changes go in the right direction, it is frustrating that lawmakers continue to ignore the overwhelming advice of doctors and medical bodies about this issue.

"We have already lost too many talented, brilliant, and dedicated colleagues who felt they could not seek help because they would be reported," Dr Tony Bartone said.

"The Committee has sought to reassure stakeholders that the proposed law before the Queensland Parliament is an improvement on the status quo, and we hope that the law will be applied according to the findings and spirit of the Committee's report, making it easier for doctors to seek the help they need.

The AMA has gone to great lengths – appearing at consultations, writing submissions, talking to governments – over many years to highlight how this policy works, and why it needs to change.

"We had recommended the WA model because we know it has worked, and will continue to work, and because introducing it in the other jurisdictions would have brought much needed national consistency," Dr Bartone said.

"In 2014, 74 per cent of respondents to the Independent Review of the National Registration and Accreditation Scheme called for a national exemption for treating doctors. That review recommended national adoption of the Western Australian law.

"In 2017, 75 per cent of submissions to the COAG Health Council called for the adoption of the WA model, but lawmakers again chose to ignore the advice.

"The AMA notes that the dissenting report of the Committee calls for the adoption of a WA-style model to protect Queensland doctors and their patients.

"So while the report has chosen a different legislative model to the WA option, one significant positive of the report is that it again reaffirms that all Ministers do not want to see the law act as a barrier. It further reaffirms that Ministers believe the new model will remove that barrier.

"It will now be up to the Australian Health Practitioner Regulation Agency (AHPRA) and COAG Health Ministers to convince all practitioners who are unwell that the new provisions provide the necessary protections to seek treatment, and we will hold them to this.

"The AMA supports the Committee in its call for the development of a comprehensive education program to raise awareness of the proposed new mandatory reporting regime – to tell doctors that it is okay to seek help.

"The AMA calls on all governments supporting the national scheme to ensure that this guidance is delivered as soon as possible, not months or years from now, so doctors no longer need to suffer in silence."

CHRIS JOHNSON AND MARIA HAWTHORNE

The AMA submission to the Parliamentary Inquiry is at:

https://ama.com.au/submission/ama-mandatory-reporting-submission-2018

If in doubt, sit them out

The AMA has joined with other leading sports medicine experts to launch a Position Statement on concussion in sport.

Under the message 'if in doubt, sit them out', the statement urges athletes, coaches and parents across all levels of sport to be more conscious of concussion injuries and not rush to return someone to play after they have been concussed.

The document and accompanying website give those involved in sport access to the most up-to-date, trustworthy recommendations on how to diagnose and treat concussion.

The *Concussion in Sport Australia Position Statement* was launched at the Australian Institute of Sport (AIS) in Canberra in mid-February.

The AMA partnered the AIS, the Australasian College of Sport and Exercise Physicians (ACSEP), and Sports Medicine Australia to establish awareness group Concussion in Sport Australia to help promote more discussions about the signs and dangers of concussion.

"Sports-related concussion can affect athletes at all levels, all ages, and across a wide range of sports," AMA President Dr Tony Bartone said.

"Concussion can be hard to recognise. It is not always a result of a direct hit to the head – any hit to the body that transmits a force to the head can result in concussion – and symptoms may take hours or even days to develop.

"We don't want to stop people participating in sport. Physical activity is crucial for all of us, not just for our health, but for social engagement.

"However, it is important that athletes, coaches, parents, teachers, and doctors understand some fundamental information about identifying and managing sport-related concussion.

"We can't negate all the potential complications that may arise from a concussion, but with prompt identification, medical assessment, and management, we can minimise the risk of those complications.

"This is even more critical when we are dealing with the developing brain in children and adolescents.

"Our message to anyone who suspects a child or teenager has been concussed in sport is clear – if in doubt, sit them out."

Dr Bartone (far right) at the launch. Pic: Odette Visser

AIS Chief Medical Officer Dr David Hughes said there was growing concern in Australia and internationally about the incidence of sport-related concussion and the potential health ramifications for athletes at all levels of sport.

"The website provides a valuable and trusted resource for the management of sports-related concussion for all Australians, regardless of the sport, location or level of participation," Dr Hughes said.

ACT Brumbies and Australian Rugby 7s player Tom Cusack said everyone involved in sport should ensure that a participant's health is the number one priority.

"As a professional athlete, I know the importance of a player's health – it should be the focus of all sporting organisations," he said.

CHRIS JOHNSON AND MARIA HAWTHORNE

The Concussion in Sport Australia Position Statement is at: https://ama.com.au/position-statement/concussion-in-sport-2019

A range of videos, fact sheets, online training, and other practical resources relating to concussion in sport can be found at: https://www.concussioninsport.gov.au

New guidelines for venous thromboembolism

The first Australasian guidelines for the diagnosis and management of venous thromboembolism (VTE) have been produced, with a summary published online by the *Medical Journal of Australia.*

Led by Associate Professor Huyen Tran, Head of the Haemostasis and Thrombosis Unit at Alfred Health and Monash University in Melbourne, a working group from the Thrombosis and Haemostasis Society of Australia and New Zealand developed the guidelines, which are available in full at https://www.thanz.org.au/resources/thanz-guidelines.

VTE, which includes deep vein thrombosis (DVT) and pulmonary embolism (PE), is the third most common cardiovascular disease globally, with an annual incidence of over 10 million people.

"In Australia, at least 17,000 people develop VTE each year (annual incidence, 0.83 per 1000 population)," Professor Tran and colleagues wrote.

"The lifetime risk of VTE is eight per cent, with one per cent of people aged over 80 years experiencing their first VTE.

"This disease is a major cause of health-related economic loss for the patient and the community (estimated to be $1.7 billion for Australia in 2008). It is a chronic and frequently recurrent disease."

Coauthor Associate Professor Harry Gibbs, Deputy Director of General Medicine at Alfred Health, said three important new recommendations were for oral factor Xa inhibitors (rivaroxaban or apixaban) 'upfront' rather than injections of low molecular weight heparin; every VTE patient receives three months (six weeks for those with distal DVT) of anticoagulation with a decision then to be made about whether to continue long-term; and, that 'low-intensity anticoagulation over the long term is both safe and effective and is suitable for many patients'.

The major change to guidelines was a recommendation to use a factor Xa inhibitor, such as rivaroxaban or apixaban, rather than warfarin for the treatment of acute VTE.

Other recommendations from the guidelines:

- the diagnosis of VTE should be established with imaging; it may be excluded by the use of clinical prediction rules combined with D-dimer testing;
- proximal DVT or PE caused by a major surgery or trauma that is no longer present should be treated with anticoagulant therapy for three months;
- proximal DVT or PE that is unprovoked or associated with a transient risk factor (non-surgical) should be treated with anticoagulant therapy for three to six months;
- proximal DVT or PE that is recurrent (two or more) and provoked by active cancer or antiphospholipid syndrome should receive extended anticoagulation;
- distal DVT caused by a major provoking factor that is no longer present should be treated with anticoagulant therapy for six weeks;
- for patients continuing with extended anticoagulant therapy, either therapeutic or low dose direct oral anticoagulants can be prescribed and is preferred over warfarin in the absence of contraindications;
- routine thrombophilia testing is not indicated; and,
- thrombolysis or a suitable alternative is indicated for massive (haemodynamically unstable) PE.

CHRIS JOHNSON

Rural health conference is better together

The 15th National Rural Health Conference is a biennial event being held in Hobart from 24 to 27 March 2019. With a theme of 'Better Together!' the conference program highlights how we can work better together to improve the health and wellbeing for everyone living in country areas.

The four-day event provides learning and networking opportunities to public and private healthcare professionals, health consumer advocates and carers, students and researchers, and interested people from sectors such as education, transport and housing.

The conference will feature a number of prominent Keynote speakers presenting on a range of topics, including:

- **Isabelle Skinner**, CEO of the International Council of Nurses, on how addressing the United Nation's Sustainable Development Gals will lead to healthy people in a healthy world;
- **James Buchan**, World Health Organization Collaborating Centre, will provide a global view of the rural health workforce;
- **Sir Harry Burns**, Professor of Global Public Health at the University of Strathclyde, Scotland, on early childhood trauma, social determinants of health and an anticipatory care approach;
- **Bo Remenyi**, Paediatric Cardiologist and NT 2018 Australian of the Year talking about her work tackling Rheumatic Hear Disease in the NT;
- **Kelvin Kong**, an otolaryngology head and neck surgeon and Fellow of the Royal Australasian College of Surgeons on hearing loss and poor educational outcomes for rural children;
- **Saul Eslake**, economist and Vice Chancellor's Fellow, University of Tasmania, on a Tasmania case study for education, employment participation and health outcomes;
- **Sandro Demaio** from ABC's Ask the Doctor, Chief Executive Officer of EAT; and founder of the Sandro Demaio Foundation;
- **Cassandra Goldie**, Chief Executive Officer of the Australian Council of Social Services will join **Richard Di Natalie**, Leader of the Australian Greens, and **Kalinda Griffiths** from the Centre for Big Data Research, University of NSW to discuss managing health into the future; and
- **James Ward**, Head Aboriginal and Aboriginal Health Infectious Disease, South Australian Health and Medical Research Institute will be addressing sexually transmitted infections in remote Australia.

The full list of keynote presenters and the conference program can be found on the Rural Health Alliances conference website at www.ruralhealth.org.au/15nrhc where online registration is also available.

Strengthening general practice

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

The year ahead is set to see a number of changes come into effect that will impact general practice. There is real opportunity and imperative for Government to deliver on some beneficial and successful health reform to truly support GPs in delivering patients the right care at the right time.

The Quality Improvement Incentive is set to be introduced on May 1 and will see the cessation of the Quality Prescribing, Diabetes, Asthma, Cervical Screening and Aged Care Access incentives. This new incentive has the potential to play a fundamental role in the building of high performing primary care, through continuous and data driven quality improvement. But only if it is adequately funded.

The AMA's pre-Budget submission calls for a significant, long-term funding commitment to primary health care, led by general practice. This includes the retention of the Aged Care Access incentive to ensure that those GPs who leave their practices to visit aged care facilities continue to be supported to do so.

Still on the subject of providing care to residents of aged care facilities (RACFs), last year's Mid-Year Economic and Fiscal Outlook provided for the removal of derived fees with the introduction of a new $55 single callout fee. This will be reflected in MBS items come March 1.

With the finalisation of Medicare Benefit Schedule Taskforce Review the AMA wants to see sensible changes that will underpin and reward continuity of care, strengthen the capacity of general practice to provide targeted and improved access to comprehensive care. The AMA will be watching to see which recommendations from the Review are taken up and will be providing advice on their implementation. Long overdue is a funding mechanism that will supplement existing MBS fee for service items and support pro-active, coordinated, team-based care.

General practices from July 1, via the Workforce Incentive Program (WIP), from metro to remote, will be supported to expand their in-practice health team by engaging the services of a non-dispensing pharmacist or allied health provider to enhance the range of care provided. To ensure that practices can grow their capacity to meet patient health care needs and deliver quality and comprehensive health care the AMA wants this support extended to lifting the caps on the subsidies available under the WIP.

Soon the vast majority of Australians, unless they opt out, will have a My Health Record created for them. Having an electronic health record that treating practitioners can access when providing care to a patient in an acute situation will aid in improved clinical outcomes, through informed, timely treatment, the prevention of unnecessary medication errors, and unnecessary hospital re-admissions. If it is appropriately contributed to and utilised, it will be a vital tool in enhancing the transfer of information and connectivity across the health system.

Hopefully, the changes implemented this year will lay the foundation for a sustainable health system that supports the value of care provided more than the volume. As a profession we must push for and embrace those changes that will improve patient outcomes, while rejecting or seeking appropriate modifications to those that will undermine the delivery of quality health care.

The upcoming Budget is the Government's opportunity to define and fund a vision for general practice for the long-term. With a federal election pending the AMA will be working hard to ensure that the key political parties understand what is required to deliver Australians a strong health system now and into the future.

Drug testing – the decision is political

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

How can we help to prevent drug-related deaths of young people attending music festivals? One suggestion receiving media attention and polarising the debate is drug testing at the venues.

Three facts from medicine and public health should help the decision-makers. But many facts from chemistry, biochemistry and pharmacology also need consideration. That is not my domain.

Hope and the silver bullet

First, let's accept that hope springs eternal: when confronted with a complicated problem we wish for a simple solution – a magic bullet. We forget that there are seldom simple solutions to complex social problems.

We see the occasional successes of 'precision medicine' where a single new medication dramatically alters the course of a disease; for example, the tyrosine kinase inhibitors in the management of patients carrying the phi chromosome who develop chronic myeloid leukaemia. In general, we pursue the one thing that will make a big difference – usually without finding it. Pill testing might be mistaken for such a silver bullet.

The messiness of reality

Second, we health professionals should accept that we usually manage complex medical and surgical problems incrementally – often muddling through. This can be quite effective, but it's messier. A bit like evolution, which makes many mistakes – as any obstetrician would verify.

But we still pursue the silver bullets! Consider the energy and money supporting the search for risk factors for cardiovascular disease. Google 'coronary heart disease risk factors' and hundreds of scientific papers will full your screen. Beside the six principal 'planet-sized' factors, such as smoking, where political action has decreased the incidence of atheromatous heart disease, there are many other factors – 'asteroids' – where tiny associations have been demonstrated but nothing therapeutic has eventuated. Useless.

Living with ambiguity

Third, it is unlikely that one intervention alone will reduce or eliminate drug use in the socially, psychologically and chemically complex context of a young person's musical festival. In public health, as in clinical practice, it is uncommon to find one therapeutic effort which kills a problem stone dead. You could argue that immunisation comes close; while the successes of immunisation programs are clear, it would be a mistake to reduce these programs to doctors turning up with needles or to oral vaccines. These programs are sophisticated organisational efforts, costing millions; but reflect, for a moment of humility, on how few diseases we have eradicated this way.

In 1993, my public health colleague, Simon Chapman, wrote a superb paper showing the dramatic decline in smoking rates over the past 20 or 30 years and asking if it could be due to one particular intervention.

One can readily do a randomised trial of a new medication for blood pressure, but not to show the effect of plain packaging of cigarettes on smoking rates. Chapman showed that smoking fell at a steady rate against a background of lots of actions – banning advertising, health promotion, taxing tobacco, changing community knowledge and attitudes, and more.

But none of these individual interventions changed the gradient of the downward-sloping line. Taken together, though, they were clearly associated. To determine the effect of any one of these interventions was, Chapman suggested, akin to trying to unravel gossamer with boxing gloves https://www.ncbi.nlm.nih.gov/pubmed/8374457

If pill testing were introduced, it would be impossible to attribute to it any reduction in deaths – from, say, one or two to none, or, for that matter, an increase of the same order – any more than we could measure the effectiveness of sniffer dogs and uniformed police. The numbers are too small and the evaluative methods do not extend to the microscopic level.

Living rurally

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

At an AMA Council of General Practice meeting last year, we discussed the skill of knowing how to live rurally. One of the challenges many young doctors face when they first move to a new rural or remote town is socialising. How do you relax at 'the local' when everyone is a patient? How do you date? How do you negotiate these boundaries?

Rural doctors work longer hours on average than their urban counterparts. This leaves less time for sleep, for leisure, for friends and family.

But there are also challenges that we share with all doctors. One challenge that the AMA spent a lot of time fighting in 2018 was getting Australia's mandatory reporting laws right. This is an issue that affects all doctors (except in Western Australia where the laws make more sense), but an issue which affects rural docs more acutely.

When you are one of a few local doctors and one of your colleagues comes to you, what do you do? Do you break the law risking your own career? Or do you report your colleague, removing one more doctor from a town desperately short of doctors already? This would ensure that no other doctor in town would seek help.

Last year there was a lot of discussion about Professor Steve Robson's heartfelt personal account of his time as an intern in rural Queensland. After an attempt to take his own life was interrupted by a colleague checking up on him, he set about dealing with his mental health. He saw his GP. Their advice: don't tell anyone.

Progress has been made, but the stigma still exists and there are other challenges, particularly for rural doctors. If Steve had wanted to talk to someone despite the advice he received, the only psychiatrist he knew in town was about to become his supervisor. As it was later revealed, his colleagues had to hide the help they provided even from him.

Know who you can turn to when you need help. In one of my articles last year I wrote:

"find someone to help you, someone you can trust. Let this someone not be yourself."

As rural doctors we are used to the challenges of living rurally and we love it. We want more doctors to come and join us. In 2018, the AMA had major successes with the progress made on the National Rural Generalist Pathway and the Stronger Rural Health Strategy announced in the budget. These initiatives were heavily influenced by AMA advocacy over many years.

But just when it seems progress is being made, the positive developments are undermined by laws like mandatory reporting that will punish doctors for seeking help. If mandatory reporting laws are not fixed in Australia, this issue continues to be a serious one for all doctors. The AMA will continue to advocate for laws which protect all doctors in 2019.

It's not always easy out bush, but we build networks to support each other. We need to be able to trust these networks. This is just one of our skills, but it is an important one.

Public Health Opinion ... from p15

It might be argued that pill testing should be assessed in terms of adverse events, other than death, related to drug use. This would increase the sample size and make assessment of effect easier, but who defines an adverse event? To what extent does the enumeration of an adverse event depend upon available professionals able to make the diagnosis, and what would be the relevant post-event time-span? And remember, it is deaths we are seeking to prevent, not simply improving efficiency.

Politics please

The decision to provide pill testing, is, therefore, political, not medical, nor scientific. It cannot be ducked by saying that there is, or is not, evidence on which to base a decision.

Prima facie, it sounds like a good idea. Those knowledgeable of the sociology and psychology of youth music festivals, and young people themselves, should offer their opinions. Assuming that they favour testing, that pill testing is technically accurate, and that the cost is reasonable, it should be tried. We should observe carefully for the inevitably unintended side-effects.

This is how we usually, and slowly, make progress in promoting and protecting the health of the public.

Wasting time

BY DR TESSA KENNEDY, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

In medicine a 'typical' career path is neatly defined. A smooth arc from student to intern to undertaking specialty training to becoming a consultant, whereupon you find your 'forever job' and settle in. Done. Right?

Tell that to every trainee working in an unaccredited registrar job. To every trainee who has changed or is considering changing specialty training. To every new consultant who finds themselves scraping around for fractional appointments on opposite ends of a major city.

It's easy to get stressed out by a winding road when the expectation is constant progress towards a specific destination, and to be afraid of a protracted training time when its demands on you are unsustainable.

When I graduated medical school it was just ahead of the 'intern tsunami'. A surge of graduates thundering towards vocational training, the only certainty being that gaining entry to your chosen program would become less certain. So many of us with a goal in mind put our heads down and sprinted, did a Masters, a Diploma, and got 'on the escalator' of specialty training, buckled down, held our breath and tried to sprint to the finish.

We were so afraid of being left behind, of training taking longer than the minimum expected, of doing anything that can't be 'accredited' – but what about not being the best doctors we can be? Relative lack of job security aside, it's not all bad.

Some of the most interesting and inspiring careers start can without clear direction or veer dramatically off course, often take unexpected direction at uneven pace, meandering then leaping forward, gathering skills either deliberately or by chance. My partner studied ecology and biodiversity at university, before working in finance, intelligence, corporate affairs and now public policy and government relations. He has no streamlined career path ahead of him, but a unique skillset that creates diverse possibility.

A good friend of mine spent a number of years in unaccredited jobs chasing a dream of plastic surgery, and ultimately found his place in dermatology – on first application – where his procedural skills separated him from the rest. Many post graduate students bring with them a wealth of experience from other fields, in law, visual arts, computer science and more. I know others who have taken a year out to repeat an exam, travel, go on electives, volunteer, climb Everest or start a family. How can any of these things be a waste of time?

All these scenarios result in a longer absolute period between graduation from medical school and specialty fellowship, but I suspect this only increases the likelihood of distilling job satisfaction, gradually carving out a niche for yourself that resonates most clearly with your values. It may also mean that you have more of an opportunity to enjoy the view along the way.

A better work life balance is not a millennial luxury but a necessity to rediscover equilibrium in an altered social context to that of the generations of doctors who came before us. With many more dual professional couples, a distinct wife drought – especially for female professionals – and no sign of the hours in the day expanding beyond 24, there needs to be space and time for family, for life outside the hospital and rooms.

I try to live by the principle that there is no wasted experience. To believe that every job, every failure, every misdirection can provide some kind of learning, some new skills, even if they mightn't seem that relevant or useful at the time.

There is probably an exception that proves the rule – such as trainees who commit significant time and expense on a training program before exhausting attempts to pass fellowship exams and being removed from training. Or more commonly, trainees caught by the ubiquitous tension between service and training, performing secretarial and other tasks that are predominantly a function of system inefficiency.

Medical training is too often accepted as something life will be put on hold for, something to 'get through'. No wonder we are all so keen not to extend it. We can't hold our breath indefinitely. But rather than trying to race through, I think we're better off making the process more sustainable.

We shouldn't have to be afraid of taking a circuitous route to a final specialist qualification, but rather celebrate the diversity it brings.

This will require not only change in mindset, but change in structure of vocational training pathways. We need to redefine specialty training across Colleges in a more interchangeable, modular fashion, accrediting an individual's skills and competencies rather than just time spent in a certain kind of job. We should expand global health training opportunities, and perhaps follow New Zealand, where taking parental leave can actually count towards several months of general practice training, a fantastic approach to recognising the skills it will develop.

These moves would discourage trainees to remain on a certain 'escalator' despite changing ambitions due to the sunk costs fallacy and allow greater lateral movement, encourage diversity of skillmix among similar professionals, and perhaps help break down barriers between specialty silos.

There is no wasted time – there is only unrecognised experience.

A difficult pill to swallow

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Festival season comes and goes each summer and, along with it, the debate on mitigating harm from recreational drug use rears its head. Following a spate of tragic overdoses at music festivals across the country, it is clear that Australia needs a new approach. Harsh legal penalties and media storms are clearly not changing the behaviour of Australia's young people, so perhaps reframing recreational drug use as a health issue could make addressing this crisis easier.

> "Harm from illicit drug use poses unique public health and social issues. In 2016, there were 1808 drug-induced deaths in Australia, the highest in 20 years."

The main debate of 'harm minimisation' versus 'zero tolerance' seems confusing when considering that Australia's National Drug Strategy is actually built upon three pillars of harm minimisation: demand reduction, supply reduction and harm reduction. Demand reduction involves a cultural shift among young people that may be beyond the grasp of one lifetime. Supply reduction is in full-force with Australia's world-class border security, with So, the most achievable pillar modification is harm reduction. However, current resource allocation amongst these three pillars is greatly skewed against this course. Of the $1.7 billion spent on illicit drug interventions in 2009-10, 66 per cent was spent on law enforcement, 21.3 per cent on medical treatment, 9.2 per cent on prevention and a mere 2.1 per cent on harm reduction. Despite this funding, lifetime use of illicit drugs has been gradually increasing since 2001; suggesting the current distribution of resources, and subsequently, our focus, is on the wrong pillar.

Harm from illicit drug use poses unique public health and social issues. In 2016, there were 1808 drug-induced deaths in Australia, the highest in 20 years. The burden of drug-associated harm is distributed disproportionately across Australian society, tending to affect Indigenous communities, rural and remote Australians, LGBTQIA+ individuals and especially young people.

Pill testing trials have been supported by many major medical organisations, including AMA and AMSA, as an alternative which seeks to change the behaviour of Australia's youth, while recognising that the presence of recreational drugs in youth culture is not going to disappear overnight. This is where the zero-tolerance policy is failing. Illicit drug use has its roots as a youth health issue, with people in their 20s most likely to use recreational drugs. Pill testing services at music festivals and the like may be the first time young Australians come into contact with relevant health services that can help them make informed decisions about their drug use. Australia's first pill testing trial at Canberra's Groovin' the Moo Festival 2018 had 130 patrons using the service, with 42 per cent changing their behaviour as a result of undesired substances detected with or instead of the desired intoxicant, and two novel substances detected among festival-goers' party favours

Of course, pill testing is not the antidote to the burden of drug-associated harm. There needs to be ongoing, meaningful support for national drug prevention programs and relevant education, which could, for instance, start at the grassroots level with pill testing facilities. Young people who are using drugs recreationally are not choosing to overdose, but with less than 10 per cent of drug intervention funding focused on prevention, and the nature of recreational substances, it is impossible to make informed decisions. Making pill testing available empowersour young people to make more responsible decisions, which ultimately bring about less harm, if we give them the tools to do so.

"None of these deaths at music festivals have been intentional. Young people would support pill testing, but no one is talking about alternatives in a meaningful way. There is no information available about how it would work. In this age of information technology, young people will always support quick and easy access to information, for instance, finding out what is in their pills when they plan to take them," remarked a medical student I spoke to recently.

Use of illicit substances and the associated consequences is an issue every health professional encounters. As part of Australia's youth demographic we are privy to the culture and motivations of substance use, while as future doctors, we also see the potential consequences of such choices. This puts us in a unique position to advocate for meaningful, appropriate change to Australia's approach to substance use. We can only hope that with greater research and reframing of recreational drug use as a health issue, rather than a criminal one, that we can see happier, healthier, more well-informed patients when the responsibility of their care falls on our shoulders.

A refresher on the who, what and where of recent Government initiatives

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

A person once said: "I only became paranoid when everyone started plotting against me." For those of us with public hospital Private Practice Agreements (PPAs), it is important to be wary, as the environment changes. A patient might have every appearance of a similar public patient in the next bed, but once the public hospital case presentation elects to be managed privately, you are the treating practitioner with all the resultant liabilities and risks.

In the public hospital system, both salaried specialists and the system are increasingly relying on CMBS funding to support clinical activity and patently inadequate hospital budgets. Australia's hospital funding arrangements have always assumed there will be some private patients being treated in public hospitals. Agreements between the Commonwealth and the States have typically included specific provisions as to how some patients in public hospitals will choose to be admitted and receive treatment as private patients.

Within each hospital there is always a degree of unique evolved behaviour and standards of record keeping (the local 'culture'), and a salaried specialist can accept a 'sign here' approach to their PPA. Consequentially, there is scope, albeit unintended, for incorrect information to be supplied to Medicare for which the specialist personally could be said to have claimed a Medicare rebate for a medical service they did not provide (thus breaching s128A of the *Health Insurance Act (Cth) 1973)*. Simple examples where mistakes might arise include:

- incorrect billing of Medicare, erroneously using the specialist's provider number, for patients seen by a different specialist (this might occur purely for the sake of administrative convenience where all private patients in a Unit are billed using the one provider number);
- billing of Medicare, using the specialist's provider number, for patients on the booking list, but who did not attend on the day (an administration procedural problem);
- in out-patient settings, registrars performing the ordering of investigations and/or conducting consultations for procedures; or
- reliance on midwives to order and follow-up investigations (fundamental to managing obstetrics clinical workloads).

Each of these is not necessarily a compliant medical service eligible for Medicare billing. (Note that when all indirect, downstream, hospital procedures/activity is considered, compliance is likely demonstrated).

In light of such risks, I am aware of a late 2018 well-sourced rumour that the Medicare Benefits Practitioner Review Unit was about to embark on a retrospective (to 2009!) audit of public hospital specialists. I am also aware of a recent, significant, but remarkably unheralded, change to the *Health Insurance Regulations (Cth) 2018* (HIR) relevant to PPAs. So, feeling paranoid is appearing to be a rational response.

Happily, I can assure you that the rumour of a broad scope specialist audit is just that because of the intervention of our President, Dr Tony Bartone. The Department of Health has given Dr Bartone solid assurance that there is to be no audit and there is no intention to target specialists as rumoured. But what about the implications of this new HIR?

With respect to a patient being treated under your PPA, the new HIR 100, makes mandatory that the hospital record include the approval of the referral by the referring practitioner, and the said referral must be signed by the referring practitioner. The AMA is now contemplating the implications of these new HIR requirements, a few of which your AMACPHD thinks have:

- the potential to slow admissions and reduce the number of patients being seen in order to meet administrative compliance;
- an impact on Unit funding through such a slowdown of admissions;
- the potential to test whether there is actual capability (hospital governance systems) to ensure compliance occurs; and
- the potential to cause a new liability exposure arising for salaried specialists with existing PPAs, and if so, how that should be best managed (including whether PPA terms account for the HIR and/or ensure appropriate indemnity exists).

Public Hospital Doctors ... from p19

With of this in mind, you would think the protection of specialists from liability and supporting the existing efficient arrangements without impractical 'tweaks' would be the sensible approach. Given 'sensible' is not a highly pursued operative word in the context, specialists need to be constantly alert to the changes in the environment, and constantly vigilant. A useful start to being informed is the *AMA & ASMOF National Guide on Rights of Private Practice in Public Hospitals 2016*. It relevantly advises:

- specialists themselves should retain oversight of billing of patients in relation to PPAs;
- specialists should know by way of written agreement before the arrangement begins exactly what its terms and conditions are;
- health services should clarify the legal position to participating specialists and indemnify them, clearly and in writing, for any risk incurred;
- appropriate administrative support should be provided to participating doctors;
- issues of indemnity, legal and professional risk must constantly be identified and addressed in a professional and timely manner by hospital administrators; and
- health service should ensure the PPAs they offer are compliant.

A copy of the AMA & ASMOF Guide can be found at the following link:

https://ama.com.au/system/files/article_attachments/Final_AMA_ASMOF_Guide_to_RoPP.pdf?file=1&type=node&id=45054

Your AMACPHD look forward to ensuring the voice of public hospital doctors is heard in this 2019 federal election year. As you read this journal, you will be alerted to the Pre-Budget Submission 2019-20 and look-out for AMA announcing its federal election policy priorities.

AMA

Information from the Department of Human Services

Health professionals: would you like to learn more about our programs?

We have a range of health professional education resources on our website to help you better understand our health programs.

We offer a range of education guides, eLearning guides and infographics about:

- Australian Immunisation Register education for vaccination providers (www.humanservices.gov.au/organisations/health-professionals/subjects/air-education-vaccination-providers)
- Child Dental Benefits Schedule education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/cdbs-education-health-professionals)
- Compliance education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/compliance-education-health-professionals)
- Department of Veterans' Affairs education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/dva-education-health-professionals)
- Health Professional Online Services (HPOS) education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/hpos-education-resources)
- Incentive Programs education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/incentive-programs-education-health-professionals)
- Indigenous health education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/indigenous-health-education-health-professionals)
- Medicare Benefits Schedule education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/mbs-education-health-professionals)
- Medicare digital claiming education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/medicare-electronic-claiming-education-health-professionals)
- Pharmaceutical Benefits Scheme education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/pbs-education-health-professionals)
- Provider Digital Access (PRODA) education for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/proda-education-health-professionals)

Head over to our education services for health professionals (https://www.humanservices.gov.au/organisations/health-professionals/subjects/education-services-health-professionals) today and select the topics you would like to know more about.

Ethical obligations should guide relationships with industry

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

Following a 12-month review, the AMA recently released the updated *Guidelines on Doctors' Relationships with Industry 2018*.

The guidelines have undergone a major revision with significant changes highlighted below.

> "...urging doctors to recognise the influence of industry marketing on their own behaviour and to take appropriate steps to minimise it."

While industry and doctors often work together for the benefit of health care, both may be in a position to profit financially (or otherwise) from collaboration, potentially undermining public trust and confidence in the medical profession if doctors do not manage actual and perceived conflicts of interest appropriately.

The updated guidelines greatly expand on doctors' ethical obligations to be guided by the primacy of patient care and ensure relationships with industry:

- reflect core professional values such as transparency, accountability, trust and fairness;
- do not compromise, or be perceived to compromise, doctors' professional judgment and professional integrity;
- are open and transparent, able to withstand public and professional scrutiny, meet public and professional standards and expectations and adhere to relevant legislative and regulatory requirements;
- promote effective stewardship and responsible use of health care resources; and
- uphold professional autonomy and clinical independence.

The guidelines also include a new section on industry marketing and promotion, urging doctors to recognise the influence of industry marketing on their own behaviour and to take appropriate steps to minimise it. In addition, doctors should be aware of the influence of industry marketing and promotion on patients' expectations and be prepared to discuss patient requests for inappropriate medications and treatments. A particularly problematic example is the increasing 'medicalisation' of normal human processes (for example, wrinkles or male pattern baldness), where a non-medical condition is portrayed by industry as a medical issue that can be 'treated' with certain medications or treatments resulting in increased demand for, and sales of, products or services which do not actually benefit health care.

The guidelines continue to highlight the importance of integrating formal training in medical curricula to recognise the influence of industry marketing and promotion on prescribing behaviour and in managing ethical relationships with industry. The guidelines advocate that medical schools and other educational bodies should be open and transparent about industry-sponsored sessions and support the AMSA position that it should not be compulsory for medical students to attend any educational sessions or extra-curricular activities organised by industry and those who choose not to attend should not be penalised.

The guidelines have also made some amendments to the section on dispensing and related issues. The current industry guidelines advise that should a doctor choose to dispense therapeutic products, they should be mindful of actual or perceived conflicts of interest and only dispense products that are evidence-based. The previous (now superseded) policy statement advised that doctors should not dispense therapeutic products unless there is no reasonable alternative. This particular policy position will now be considered within the review of the AMA guidelines on doctors owning pharmacies which is due to start shortly.

In addition to the sections outlined above, topic areas such as professional education and training, industry sponsored research, industry sponsored meetings and activities, training organised by industry, key opinion leaders, remuneration for services, product samples, industry representatives and relationships with other medical service and health service providers are also addressed in the guidelines.

If you have any questions in relation to the *Guidelines on Doctors' Relationships with Industry 2018*, please send them through to ethics@ama.com.au. The guidelines are accessible on the AMA website at https://ama.com.au/position-statement/doctors-relationships-industry-2018.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON

More than half a billion dollars for aged care

The Federal Government has committed an extra $662 million in aged care funding, describing it as a significant investment in senior Australians.

Prime Minister Scott Morrison announced the funding on the eve of the Royal Commission into aged care holding its first hearing.

Of the money, $320 million equates to every person living in residential aged care having an extra $1800 spent on their care by June.

More than $280 million will go towards an extra 10,000 home care packages, with additional funding also earmarked for dementia care and for veterans with mental health conditions.

"Older Australians have worked hard all their life, paid taxes and done their fair share, and they deserve our support," Mr Morrison said.

"Looking after older Australians is the Government's top priority. It's why as Prime Minister and Treasurer I have delivered thousands of additional home care places.

"These places give older Australians a choice about how and where they want to live."

But Labor has described the funding as "too little, too late" and said the Government has cut more in aged care funding than it is now committing to give back.

"This announcement isn't even half of Scott Morrison's aged care cuts as Treasurer," said Shadow Ageing Minister Julie Collins.

"The waiting list for home care has grown to 127,000, with many waiting more than a year to receive the care they have been approved for."

And while the Council on the Ageing Australia has welcomed the extra money, it said some of it should be allocated for extra staff in aged care facilities.

"It is disappointing there are no conditions attached to require providers to use the additional funding to increase staff numbers and/or support workforce training and development programs that will lift the standard of care in nursing homes," Chief Executive Ian Yates said

Boost for ice treatment

The Minister for Regional Services, Bridget McKenzie, has announced funding of $61 million so Primary Health Networks across Australia can continue to commission drug treatment services for those addicted to ice.

The money hopes to ensure those who need help the most have access to treatment.

"To date, the National Ice Action Strategy has successfully delivered more than 400 treatment services across Australia – based on the needs of local communities," Senator McKenzie said.

"Individuals, families and communities can be hit hard by someone's substance misuse – its effects are felt deeply and can continue for years.

"We are committed to making sure people are able to access appropriate treatment support when and where they need it.

"The Primary Health Networks commission targeted treatment services based on local needs and priorities in their community and this $61 million boost means the networks can continue their great work."

The funding forms part of the broader treatment funding under the National Ice Action Strategy providing $241.5 million for Primary Health Networks to commission additional drug and alcohol treatment services to meet local need.

For free and confidential advice about alcohol and other drugs treatment services, people can call the National Alcohol and Other Drug Hotline on 1800 250 015.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Labor commits to new hospital on NSW south coast

The NSW South Coast

Labor has promised to build a new Eurobodalla Hospital if it wins government in this year's federal election.

Opposition Leader Bill Shorten and Shadow Health Minister Catherine King made the announcement at the beginning of February.

They said a Labor government would invest $25 million to ensure the new hospital in the Eurobodalla Shire on the NSW south coast became a reality.

"Our $25 million commitment is part of Labor's Fair Go Action Plan to protect Medicare and fix our hospitals, and is on top of a $175 million commitment by the NSW Labor Opposition," Ms King said.

"People in the Eurobodalla Shire – from South Durras to Tilba – deserve the same access to vital hospital care as people in Sydney and larger regions."

The $25 million investment will go towards:

- A state-of-the-art emergency department
- Operating theatres
- Maternity and paediatric services
- Pathology services
- Radiology services, including x-ray, ultrasound and CT scanning
- Palliative care
- A helipad
- Up to 20 mental health beds
- Community drug and alcohol services
- A rehabilitation unit.

Precision medicines research gets Government grant

The Federal Government has allocated $10 million to Murdoch University to invest in research that will help use a person's DNA and their environment to create personalised medicine for numerous medical conditions including obesity, autism, and type 2 diabetes.

The funding will go to the Perth-based Australian National Phenome Centre (ANPC) at Murdoch University, which is set to revolutionise the diagnosis, prevention and precision treatment of numerous medical conditions.

Health Minister Greg Hunt said precision and personalised medicine promises to transform the way we practice medicine.

"This will bring the best and the brightest to save lives, to protect lives. This will help to harness the power of technology and the brilliance of people like Professor Jeremy Nicholson and Professor Elaine Holmes (the leaders of the ANPC)," the Minister said.

"A person's phenome is a snapshot of their unique biology that results from complex interactions between their DNA and their environment, which includes factors relating to diet, lifestyle and exposure to pollutants.

"Analysing these biological 'fingerprints' helps researchers better understand the underlying causes of disease and ultimately to develop personalised therapies and treatments.

"Using the ANCP's sophisticated range of cutting-edge technologies, researchers plan to map the phenomes of large sections of the population, giving them a window into environmental and social factors influencing health trends and providing generations with a 'crystal ball' to look into their future health risks."

Researchers will have a particular focus on the detection, treatment and prevention of obesity, autism, and type 2 diabetes among children and the Australian Indigenous population.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

The ANPC is Australia's first dedicated metabolic phenotyping laboratory and a hub within an international network of compatible centres.

In addition, Western Australia provides a unique, contained population to collect such information from and has a history of successful population studies.

"The Centre brings together all five Western Australian universities and leading health and medical research institutes: the University of Western Australia, Curtin University, Murdoch University, University of Notre Dame Australia and Edith Cowan University," Mr Hunt said.

The funding comes from the Government's Medical Research Future Fund, which is an endowment fund that will mature at $20 billion, providing a sustainable source of funding for vital medical research.

Murdoch University welcomed $10 million in Federal Government support, saying it will place Western Australia at the forefront of international precision medicine research.

Vice Chancellor Eeva Leinonen acknowledged the Government support for the major WA-collaborative project, saying it was a significant investment into the future health of people in WA, Australia, and millions more around the world.

"This ground-breaking research will revolutionise the way in which many challenging diseases and health conditions are diagnosed, treated and prevented," Professor Leinonen said.

"The ANPC will put WA and the nation on the global stage, pioneering research that will translate into transformational benefits across human health, animal health, agriculture and food."

Research

BY CHRIS JOHNSON

Study exposes failings over transplant organs from executed Chinese prisoners

A landmark study, led by researchers at Macquarie University and published in *BMJ Open*, has uncovered mass failings in complying with international ethical standards concerning the publication of peer-reviewed research on transplant organs sourced from Chinese executed prisoners.

The world first study found that research published in peer-reviewed English language journals between January 2000 and April 2017 regarding transplantation of organs, did not meet the ethical standards of international medical bodies such as the World Health Organisation (WHO), The Transplantation Society, and the World Medical Association.

The study exposed mass failings and very poor compliance with ethical standards in the reporting of organ donors and found:

- 99 per cent of studies failed to report if organ donors had given consent for transplantation;
- 92 per cent of studies failed to report whether organs were sourced from executed prisoners; and
- 19 studies, involving 2688 transplants, claimed that no organs from executed prisoners were used.

However, these studies took place prior to 2010, when there was no volunteer donor program in China.

Lead researcher, Professor of Clinical Ethics Wendy Rogers from Macquarie University, believes the studies need to be retracted and investigated and that agreed standards for reporting transplant research for peer-reviewed papers would help stop publication of unethical research.

"The world's silence on this barbaric issue must stop. Researchers and clinicians who use the research risk complicity by accepting Chinese methods of organ procurement," Professor Rogers said.

"Research which has used unethically obtained materials has no place in peer-reviewed journals. As an academic community we need to come together to say enough is enough."

Professor Rogers and her co-authors propose an international summit to develop and implement standards for reporting organ procurement.

Research

"It is extremely concerning to us as academics, as it should be to the medical research community at large, that there is now a large body of unethical research that transplant researchers in Australia and internationally may have used and benefited from. To maintain ethical standards, this research should be retracted pending investigation into each of the individual papers," she said.

The use of organs from executed prisoners is widely condemned around the world because of the potentially coercive situation of being on death-row, which can undermine the possibility of ethically-valid consent. In some cases, consent may not be being sought at all.

China has long received condemnation for harvesting organs from executed prisoners from organisations like Amnesty International who have led campaigns calling for an end to the practice. However, as late as 2014, 90 per cent of transplant organs in China were sourced from executed prisoners, according to Dr Huang Jiefu of the Chinese Organ Donation Committee.

Members of an independent people's tribunal recently gave a draft judgement which concluded that forced organ harvesting from prisoners of conscience has taken place in China and on a substantial scale, adding to concerns about the source of the organs used in the transplants reported in this research.

In 2006, the Transplantation Society explicitly stated that it would not accept conference papers based on research involving organs sourced from executed prisoners, setting the standard for medical journals across the world. However, this new research has found major breaches of this ethical standard.

Most recently, the Transplantation Society has reissued a requirement for all journals to reject papers that do not abide by ethical principles to ensure compliance among the research community.

This is the first time that a study has been conducted to track the progress of the transplant community in blocking publication of research that uses organs from executed Chinese prisoners.

A recent Australian parliamentary inquiry has recommended that the Australian Government do more to combat organ trafficking and transplant tourism which accounts for nearly $2.3 billion a year. China claims to have banned the practice of organ harvesting from executed prisoners from January 2015 and implemented a zero-tolerance policy, however several charities and pressure groups suggest that the practice is still continuing.

Encouraging signs from early intervention for cerebral palsy

Early identification of cerebral palsy in children is the key to early interventions that may improve the quality of life and natural history of the condition, according to the authors of a narrative review published by the *Medical Journal of Australia*.

Cerebral palsy is a movement disorder encompassing a wide range of non-progressive neurological disabilities, and is the most common cause of physical disability in childhood.

Although the incidence of cerebral palsy is declining in Australia, it affects about 2.1 per 1000 live births. Improved neuroprotective strategies, such as the use of maternal magnesium sulphate during labour, the use of maternal antenatal steroids, and better ventilation protocols in pre-term babies, may be responsible for the decline incidence, according to the review authors.

Dr David Graham (Concord Centre for Mental Health and the Kids Research Institute, Sydney), Dr Simon Paget (Children's Hospital, Westmead) and Dr Neil Wimalasundera (Royal Children's Hospital, Melbourne), found evidence for the benefit of early intervention in cerebral palsy is weak but shows potential.

"There are currently two multicentre national trials that are evaluating the effect of early intervention in infants identified to be at high risk of developing cerebral palsy," the authors wrote.

Research

"GAME (goals, activity, motor enrichment) is a goal-oriented, activity-based, environmental enrichment therapy program that is designed for children under six months of age who are at high risk of developing cerebral palsy; and REACH (Rehabilitation Early for Congenital Hemiplegia) is a trial for children aged between three and nine months who have been identified as having congenital hemiplegia; the study is designed to compare the efficacy of modified constraint-induced movement therapy with infant bimanual therapy."

The authors also identified a framework to help clinicians and families work towards improving the quality of life of children with cerebral palsy, called the six Fs framework:

- **Function**: how a child performs an activity is not important, the goal is to allow them to try;
- **Family**: the family is the essential environment of the child and they know the child best; supports and resources for the whole family are vital to the child's health;
- **Fitness**: all children need to be physically active, regardless of the disability status; health promotion is more than a focus on remediating disability;
- **Fun**: childhood is about fun, and it is incumbent upon caregivers to find out what the child wants to do;
- **Friends**: social development is an important aspect of child development, regardless of ability; it is the quality of relationships that matters; and
- **Future**: child development is all about becoming, and this encompasses the other five Fs; the goals and expectations need to be considered in light of the present realities.

"Early interventions with targeted therapies are showing promising results in altering the natural history of cerebral palsy as well as enhancing patient activities," the authors concluded.

"There remain many challenges in the management of a child with cerebral palsy, but there exist a number of interventions with a good evidence base."

Study shows more Indigenous health workers needed

Indigenous health worker numbers are not growing, according to a joint study by the Australian National University (ANU) and the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA).

The study, based on Census data, shows a 13 per cent decline in the proportion of Indigenous health workers aged 15 to 24, 25 to 34 and 34 to 44.

While there an increase of 338 Indigenous health workers nationally, the number did not commensurate with population growth, said research lead Alyson Wright, from the National Centre for Epidemiology and Population Health at ANU.

"We found a considerable decline in numbers of younger Indigenous health workers," she said.

"There are many reasons why this could be case – we know that workforce is aging, but there are also fewer opportunities to gain the health worker qualifications."

The study found increases in health workers in Queensland and New South Wales, but large declines of workers in the Northern Territory.

"We need to find out more about what is working in Queensland and New South Wales," Ms Wright said.

"The 11.2 per cent decrease in overall proportion of health workers located in the Northern Territory is concerning, given the need to improve health outcomes in this jurisdiction."

Karl Briscoe, CEO of NATSIHWA, said the role is unique.

"Aboriginal and Torres Strait Islander health workers are the conduit between the community and the health services," Mr Briscoe said.

"There is nothing else like being an Aboriginal and Torres Strait Islander health worker.

"It is the world's first ethnic based health profession that has national training curriculum as well as national regulation sitting behind it."

Research

Researchers say there is growing evidence that the inclusion of Aboriginal and Torres Straight health workers helps facilitate culturally appropriate care.

"We know that Aboriginal and Torres Strait Islander health workers are extremely important for improving the health outcomes in Aboriginal and Torres Strait Islander communities," Mr Briscoe said.

"We need research to identify the ratio to increase to ensure cultural safety and to respect cultural sensitivities around men's health.

"Aboriginal and Torres Strait Islander health workers are critical to delivering culturally appropriate care. They can reduce communication gaps, improve follow-up practices, help with medical advice and provide cultural education."

Researchers in the study analysed data from the Australian Bureau of Statistics' Census in 2006, 2011 and 2016.

The findings were published in *Australian New Zealand Journal of Public Health*.

Debilitating skin conditions high in Australia

The first prevalence study of Hidradenitis Suppurativa (HS) in Australia estimates a large number of adults are currently undiagnosed with the debilitating skin condition.

HS is a chronic skin condition characterised by inflamed areas and boils typically located in the inverse body areas, most commonly the axillae, groin, buttocks and inframammary areas.

HS can occur at any age, but the condition commonly develops in young adults. Also known as acne inversa, HS can take on a variety of forms that differ from person to person, making diagnosis and treatment difficult.

Based on a large representative sample of the Australian adult population (N = 11,433) using a previously validated HS screening questionnaire, the peer-reviewed, PLOS ONE published study estimates the prevalence of HS to be 0.67 per cent, or approximately 165,000 Australians.

Dr Miriam Calao, study author and Medical Manager at AbbVie Australia, said the extensive study was an Australian first and estimates the prevalence and diagnosis rates of HS.

Dr Calao said: "HS is a debilitating condition that can leave people in persistent pain. It can significantly impact an individual's quality of life by interfering with work, social and leisure activities. By estimating prevalence, diagnosis rates, demographics and management pathways in Australia, this study will hopefully support the medical community in tackling HS and the associated negative effects of the condition.

"Among those surveyed, 88 individuals were identified as potentially having HS, but only six (6.8 per cent) had received a medical diagnosis. Many, both diagnosed and undiagnosed individuals, had seen several clinicians or specialists regarding their condition. A quarter of undiagnosed individuals had not seen any clinician at all.

"The low diagnosis rate may be the result of a combination of factors, including decentralisation of care, lack of familiarity of some clinicians with the disease, and many patients not seeking medical help."

Dr Diana Rubel, Dermatologist at Canberra Hospital and an author of the paper, said clinicians have a responsibility to give patients accurate and timely diagnoses.

"It's a sad fact that HS often impacts every aspect of the patient's life, including their education prospects, career and relationships. This study will hopefully create dialogue between healthcare professionals on how best to identify and refer patients suspected of having HS," Dr Rubel said.

"The study highlights young women as particularly susceptible, with multiple appointments over many years needed before they receive an accurate diagnosis. It's clear more must be done by the medical community to help these patients."

PLOS ONE (Public Library of Science) is a peer reviewed, multidisciplinary Open Access journal. It features reports of original research from the natural sciences, medical research, engineering, as well as the related social sciences and humanities.

AbbVie Pty Ltd funded this study and participated in the design, research, analysis and interpretation of data, as well as writing, reviewing and approval. AbbVie is a global, research and development-based biopharmaceutical company.

BY CHRIS JOHNSON

Have a smoke at 99 and risk prosecution

Hawaiians have come up with a creative way to curb smoking – they want to raise the legal age to 100.

The "Aloha State" is already a leader in the campaign against smoking; it was the first American State to raise the age for smoking cigarettes to 21.

But now, legislation aims to go much further by making it illegal for anyone under the age of 100 to smoke.

The plan is to phase out smoking in the State all together within five years.

The bipartisan bill states that cigarettes cause more preventable disease, death, and disability than any other health issue and that they are considered the "deadliest artifact in human history".

If successful, the bill will introduce new laws that will raise the minimum smoking age dramatically, and by 2024 make it illegal for all but centenarians to puff on the cancer sticks.

Republican co-sponsor of the bill, Cynthia Thielen, said the aim was to "keep people healthy and alive in the Aloha State," and is reported in the *Washington Post* acknowledging that getting the bill passed would be a challenge.

"(It is an) initial push to say 'this is important. We need to act on it.'," she said.

Democrat co-sponsor, Richard Creagan, told the *Hawaii Tribune-Herald* he thought the bill had a good chance of being passed because legislators were obliged to protect people's health.

"In my view, you are taking people who are enslaved from a horrific addiction, and freeing people from horrific enslavement. We, as legislators, have a duty to do things to save people's lives. If we don't ban cigarettes, we are killing people," he said.

"Basically, we essentially have a group who are heavily addicted – in my view, enslaved by a ridiculously bad industry – which has enslaved them by designing a cigarette that is highly addictive, knowing that it highly lethal. And, it is.

"This is more lethal, more dangerous than any prescription drug, and it is more addicting."

According to the Centres for Disease Control and Prevention, cigarettes are the leading preventable cause of death in the United States.

They lead to the deaths of more than 480,000 people across the America each year.

The CDCP states that cigarette smoking has been linked to 90 per cent of all lung cancer deaths and 80 per cent of all deaths from chronic obstructive pulmonary disease.

Most adult smokers began smoking as teenagers, but research shows that smokers who quit between ages 35 and 44 improve their health and potential lifespan significantly.

US goes on the record in its bid to help Taiwan at the WHO

Taipei has welcomed a move from Washington aimed at helping Taiwan regain observer status in the World Health Organisation.

Taiwan did not receive an invitation to the World Health Assembly (the decision-making body of the WHO) the past two years. It had been a regular observer between 2009 and 2016.

Pressure from Beijing, following the 2016 election of independence-leaning Democratic Progressive Party in Taiwan, has resulted in the WHO denying Taiwan the observer status it had previously enjoyed.

But the United States House of Representatives recently passed a bill to include America's efforts to get Taiwan invited again to the WHA included in an annual report by the US Secretary of State.

This is a significant move and shows the US to be not only serious about helping Taiwan in its WHO campaign, but also happy to be public about it.

While the move might also have a lot to do with the trade war and tensions currently simmering between the US and China, it is a boost for Taiwan.

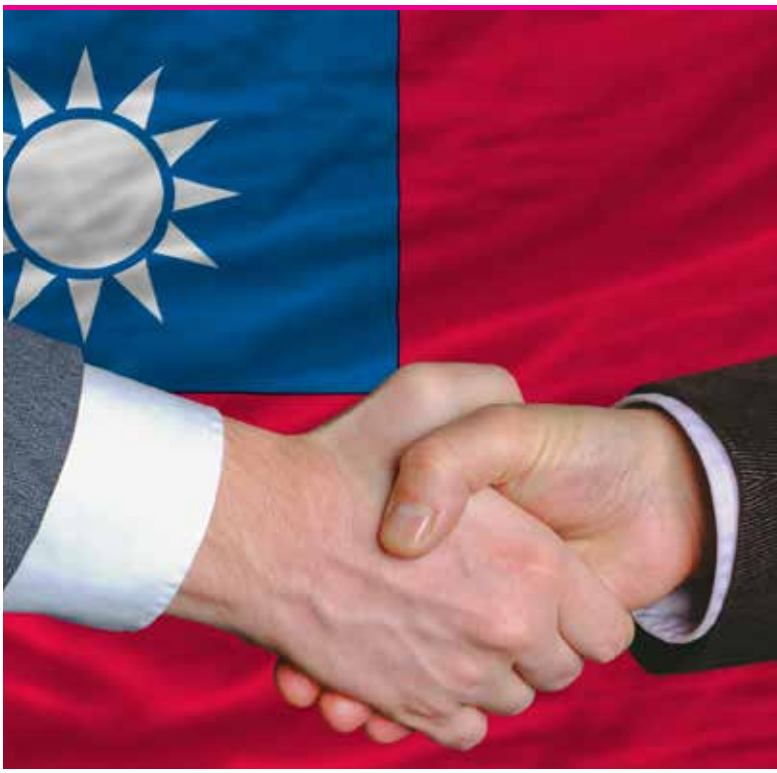
Taiwan is an enthusiastic and responsible contributor to global health issues, having invested about $6 billion in medical and humanitarian aid in more than 80 countries since 1996.

Its international successes in both medical breakthroughs and global assistance is also considerable. It has established many disease prevention systems. Taiwan insists it needs the WHO to protect the health of its own people, but that it can also contribute greatly to global health protection.

"For many years... it has participated in the WHA and WHO technical meetings, mechanisms and activities; steadily contributed to enhancing regional and global disease prevention networks; and dedicated its utmost to assisting other countries in overcoming healthcare challenges in order to jointly realise WHO's vision that health is a fundamental right," Taipei has said in a statement.

"Therefore, there is widespread support that Taiwan should be invited to attend the WHA.

"Located at a key position in East Asia, Taiwan shares environmental similarities for communicable disease outbreaks



with neighbouring countries and is frequently visited by international travellers.

"This makes Taiwan vulnerable to cross-border transmission and cross-transmission of communicable disease pathogens, which could lead to their genetic recombination or mutation, and give rise to new infectious agents.

"However, because Taiwan is unable to attend the WHA and is excluded from full participation in related WHO technical meetings, mechanisms, and activities, it is only after much delay that Taiwan can acquire diseases and medical information, which is mostly incomplete. This creates serious gaps in the global health security system and threatens people's right to health."

The WHO's own constitution states:

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

Doctors Without Borders providing tele-mental health service for refugees

Médecins Sans Frontières (Doctors Without Borders) has launched a free tele-mental health service, providing psychological support to former patients including Nauruan nationals, asylum seeker and refugee patients. The remote service is a medical commitment by MSF to provide continuity of care to former patients who remain highly vulnerable on Nauru.

"Since our forced departure in October, we continue to hear from patients who are experiencing severe levels of mental health distress and who struggle to access quality psychological care," Dr Christine Rufener, clinical psychologist and MSF mental health activity manager, said.

"This telehealth service is MSF's only remaining option to continue to act on our medical and ethical commitment to former patients."

MSF will provide psychological consultations from Australia to all former patients currently on Nauru, based on the same one-door-for-all principle. MSF has informed authorities on Nauru and welcomes collaboration and coordination with other medical providers in the interest of providing the best possible care to patients.

MSF has reiterated its call for the immediate evacuation of all refugee and asylum seekers from Nauru as the risk of developing dangerously severe mental health problems remains high for all those trapped on the island. Refugees and asylum seekers must have fast access to permanent resettlement, alongside their families, so that they can begin rebuilding their lives.

"While mental health care can help to temporarily relieve some symptoms, there is unfortunately no therapeutic solution for asylum seekers and refugees who remain held indefinitely on Nauru. Until then, we will do everything possible to continue to deliver the independent mental healthcare they desperately need," Dr Rufener said.

Second worst Ebola outbreak taking its toll

Almost 100 children have died in the world's second largest outbreak of the Ebola virus, with 65 being younger than five years old.

According to the charity Save the Children, 97 children had died in the eastern Democratic Republic of Congo since August last year when the outbreak of the virus was declared there.

There are more than 800 cases reported in the country.

It is the tenth outbreak of Ebola – and the second most severe – in the Democratic Republic of Congo since 1976 when the virus was first identified near the Ebola River.

The worst outbreak was from to 2014 to 2016 in a number of West and Central African nations, infecting 28,652 people and killing 11,325 of them.

In this outbreak to date, 811 people had reported symptoms of hemorrhagic fever by early February, with 750 having been tested positive for Ebola.

There have so far been more than 500 deaths from this outbreak.

January was high period when fatalities jumped from 20 a week to more than 40 a week.

"We are at a crossroads. If we don't take urgent steps to contain this, the outbreak might last another six months, if not the whole year," said Heather Kerr, Save the Children's country director.

"It is paramount to convince communities that Ebola is an urgent and real concern.

"People have disrupted funerals because they didn't believe the deceased had succumbed to the virus. Aid workers were threatened because it was believed they spread Ebola.

"We have to scale up our efforts to reach out to the vocal youth and community leaders to build trust and to help us turn this tide. Treating the people who are sick is essential, but stopping Ebola from spreading further is just as important."

Children account for about 30 per cent of all cases and are at greater risk of dying from the virus than are adults.

The World Health Organisation has stated that while the global risk of Ebola transmission remains low, it is very high for the Democratic Republic of Congo and the Central African region.

This is the first Ebola outbreak in an active war zone.

Surge in measles cases in Europe

Measles cases in Europe last year were at their highest number this decade, having tripled to 82,596 between 2017 and 2018.

There were 72 deaths from the virus in 2018, jumping from 42 in 2017.

World Health Organisation data shows the Ukraine to have had the highest number of cases last year, which was more than ten times greater than the next highest country, Serbia.

But France, Italy, Greece and Israel have also reported high numbers of measles cases.

More than 90 per cent of the cases reported are in ten countries only.

The WHO says vaccinations rates, while improving, are not high enough to prevent the virus from spreading.

WHO regional director for Europe, Dr Zsuzsanna Jakab said: "The picture for 2018 makes it clear that the current pace of progress in raising immunisation rates will be insufficient to stop measles circulation.

"While data indicate exceptionally high immunisation coverage at regional level, they also reflect a record number affected and killed by the disease.

"This means that gaps at local level still offer an open door to the virus."

In 2018, the Ukraine's cases shot to 10 times that of the previous year – to 1,209 per one million population – and is thought to be because vaccination rates for measles, mumps and rubella there fell sharply during its conflict years with Russia.

In 2016, the Ukraine only had a 31 per cent vaccination rate. But vaccination rates have dramatically improved since 2018 and are now reaching the 90 per cent mark.

The Ukraine figures go a long way towards inflating the total number of measles cases in Europe, which jumped from 25,863 in 2017 to more than 82,000 in 2018.

But the rise in measles in some of the other countries is also worrying.

The top ten measles countries in Europe between January and December 2018 were:

- Ukraine (53,218)
- Serbia (5,076)
- Israel (2,919)
- France (2,913)
- Italy (2,517)
- Russian Federation (2,256)
- Georgia (2,203)
- Greece (2,193)
- Albania (1,466)
- Romania (1,087)

Meanwhile, the United Kingdom recorded 953 measles cases in 2018.

Indian medics fighting increased UK impost

Indian doctors and other healthcare professionals working in Britain are currently campaigning against what they say is as an unfair doubling of a surcharge imposed on them because they are from outside the European Union but living and working in Britain.

The UK's Immigration Health Surcharge was introduced in April 2015, but from December 2018 it was raised from 200 British pounds to 400 pounds per year.

It is imposed on anyone in the UK on a work, study or family visa for longer than six months. The money is meant to help funds for the National Health Service (NHS).

The British Association of Physicians of Indian Origin (BAPIO) argues that the hike in the surcharge will severely affect attempts to recruit more healthcare professionals from India to meet staff shortages in the NHS.

It also says there are already stringent regulatory and financial hurdles for Indian doctors working in Britain.

The BAPIO is on the case and lobbying the UK Home Office directly, asking for the increase to be dropped.

But so far, the Government has not warmed to the request.

Confusion over contaminated blood products in China

Blood plasma products sold by a Chinese state-owned pharmaceutical company are reported to have been contaminated with HIV.

According to state media and provincial government reports, more than 12,000 units of plasma were recalled after products in the same batch tested positive for the virus.

The intravenous immunoglobulin was produced by Shanghai Xinxing Pharmaceutical Co. Ltd.

In addition to the news reports, the contamination was further confirmed in an online announcement by the company's parent company China Meheco Group.

Confusingly, however, China's National Medical Products Administration denied there was any HIV positive results in the batch.

The day after the company's statement, the official Administration issued its own statement saying additional tests conducted for HIV, hepatitis B and hepatitis C "turned negative".

That statement was subsequently published by the state-owned *National Business Daily* but appears to have censored soon after.

Canadian diplomats sick of Cuba

Canada has pulled half of its diplomatic staff from its Cuban embassy amid ongoing concerns over mysterious health symptoms inflicting North American diplomats there since 2017.

With the latest Canadian diplomat in Havana recently falling ill, it brings that nation's total cases to 14.

Canadian and United States diplomats in Havana have been suffering dizziness, headaches and nausea from an unknown source – thought to be linked to a mysterious high pitched sound emanating through the diplomatic precincts.

Suggestions that the sound is caused by endemic crickets has been dismissed by the sufferers and those acting legally on their behalf.

The US has already reduced embassy staff in Cuba to 18, from more than 50, as dozens of its diplomats fell ill.

The withdrawal has not helped the US-Cuba relations, which have been severely struggling under the presidency of Donald Trump.

Cuba appears to be cooperating with Canada, however, despite describing the move to withdraw staff as "incomprehensible".

Canada's diplomatic staff in Cuba has dropped from 16 to 8.

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I need a boost!

BY **DR CLIVE FRASER**

Medical students are taught to take a good history before laying a hand on a patient.

We're told that if you listen to your patient, they will tell you the diagnosis.

For example, chest pain on exertion is likely to have a very different cause to chest pain after over-indulging at meal times.

With so much technology and so many special investigations available it is still vital to listen to our patients before ordering a battery of tests.

The best mechanics adopt the same approach.

A squeaking sound from the front end when turning right should tell you to check the left front wheel bearing and vice versa.

But just like in medicine, mechanics are more reliant than ever on scanning devices to diagnose cars that have become impossibly complex.

So the first symptom of my car's malaise was a hissing sound from the motor when going up a steep hill.

There were no more noises until 500 kilometres later when on the same steep hill my car lost power, the check engine light illuminated, and it went into 'limp-home mode'.

While my car still technically 'went' it had no power, stayed in lower gears for longer and was locked out of its 6th and 7th speeds.

In the examination room (my garage) it dis-robed and a visual inspection and palpation provided no further clues.

So the next step was to connect an OBD scanning tool to see whether there were any fault codes in the ECU (Engine Control Unit).

My dealer charges $220 to hook up their factory tool, but I have an assortment of OBD scanners that I have purchased from eBay and Aldi over the years.

The cheapest of these cost me only $4 from eBay including postage.

It's a useful tool that connects to a free App on my Smartphone via Bluetooth.

All of my scanners detected two codes on my car:

P227962 – A leak was detected in the intake air system. The Signal Comparison Is Faulty – Current, Stored.

P246309 – The soot content of the diesel particulate filter is not OK. There is a component fault – Current, Pending.

At this point I consulted with a pulmonology colleague who just

happens to own an identical car with the same symptoms, and the same fault codes.

He generously forwarded to me his repair bill from the dealer which did remind me that my $4 OBD scanner was worth investing in.

His leak in the intake air system turned out to be due to a split rubber hose between the turbo-charger and the inter-cooler.

For those of us without mechanical knowledge I would suggest reading no further.

But I was intent on fixing my low-mileage car from Sindelfingen, or else.

I scoured my car for a leaking hose before calling in another colleague for assistance.

That colleague could hear the faintest hissing sound as I drove my car onto his hoist.

A turbo-charger boosts at six to eight psi which is equivalent to the pressure caused by the weight of a column of water about five metres high.

It was the sound of that pressure squeezing air through a tiny hole that we could both hear.

And that was the sound that started off the whole problem in the first place.

I was more confident than ever that I would be able to fix my car.

My colleague was also the owner of a smoke machine which would be needed to find the leak.

To be continued...

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

So many contenders for Queen of Rock

BY CHRIS JOHNSON

Joan Jett on stage in Brisbane

Is it even worth trying to name the definitive Queen of Rock?

So many amazing female rockers have stood the test of time and could quite comfortable lay claim to the title.

If Elvis was the King ... then who is the Queen?

Is it Madonna? Aretha? Janis? Lady Gaga? Beyonce?

Any of those women could own the throne ... as could a long list of others.

Just to make the task even more difficult, there are myriad sub-genres. For example, Aretha Franklin is known as the Queen of Soul ... but she could also be the Queen of Rock as she exquisitely belted out numerous rock hits over her lifelong career.

Tina Turner is often referred to as the Queen of Rock n Roll (Wanda Jackson claimed that title too back in the day). But then, Tina is sometimes referred to as the Queen of Soul also. Isn't that Aretha's moniker?

It's all too confusing.

So ... let's narrow the search to what's going on right now in our own back yard.

There are two women who have been touring Australia – one has just finished and one is just beginning – who have both earned the title Queen of Rock.

The Red Hot Summer Tour this year has been staged throughout Australia in two phases. The first brought us Joan Jett and the Blackhearts.

If there ever was a Queen of Rock, it is Joan Jett.

Her firebrand style of the music is nothing short of brilliant. And her live performances are as an energetic now as they were when she fronted her first band way back in the seventies – the all-girl outfit The Runaways. She is now 60 years old and she is still rocking hard.

Jett's recent shows in Australia had crowds roaring along to *I Love Rock N Roll* (especially the line *put another dime in the jukebox baby*), *Cherry Bomb, Do You Wanna Touch*, and *Crimson and Clover.*

Jett is a deserved Rock and Roll Hall of Famer and a very worthy choice for Queen of Rock.

And then there is Suzi Q. The second phase of the Red Hot Summer Tour is underway and headlined by the always incredible Suzi Quatro.

Australia has a special relationship with Suzi, who frequents our shores regularly.

Like Joan, Suzi is never anything less than outstanding. She is so good live in concert and her lengthy string of hits – again dating as far back as the seventies – is etched in our psyche.

Devil Gate Drive, The Wild One, 48 Crash, Can the Can, If You Can't Give Me Love ... the list goes on.

Suzi loves Australia and we love Suzi... and she is definitely Queen of Rock material.

Suzi Quatro, 68, is actually referred to in many official lists (and plenty of not so official ones) as the Queen of Rock.

And what about our homegrown contenders?

Deborah Conway of Do-Re-Mi fame, as well as an impressive solo career, is currently touring and probably should be known as Australia's Queen of Rock.

Then there's Renée Geyer – our Queen of Soul perhaps? And Kylie – Queen of Pop?

Whether from Australia, Britain, the US or anywhere else, it seems pretty clear that naming the one and only, definitive, ultimate Queen of Rock is not such an easy task.

But then again, Elton John has just released Australian dates for his farewell tour.

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