AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

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Doctor, your own health is important

Doctors' health panel: Dr Toogood, Dr Dean, Dr Schultz, Dr Myers, Dr Haikerwal, Dr Browne

Doctors' health was a major theme of the AMA National Conference 2019, with a number of speeches, sessions and motions dedicated to keeping the issue at the forefront of the collective mind of the medical profession.

AMA President Dr Tony Bartone, in his opening address, told conference delegates that the health and wellbeing of doctors was a high priority for the Association.

"We have led some innovations recently... but despite these welcome initiatives, addressing the individual and organisational issues that can harm doctors' physical and mental health remains a challenge for our profession," he said.

"The rate of suicide among medical professionals continues to be a blight on our profession. Most doctors have been touched by the loss of a colleague during their careers."

Dr Bartone also led the resolution of a conference motion to reaffirm the AMA's support for the updated World Medical Association Physician's Pledge – the Declaration of Geneva – that now includes: "I will attend to my own health, wellbeing and abilities in order to provide care of the highest standard."

The AMA motion affirms that doctors must also value the health of their colleagues.

The conference opened with delegates citing the pledge.

Keynote speaker, Dr Michael Myers, Professor of Clinical Psychiatry at SUNY Downstate Medical Centre in Brooklyn, New York, said the updated pledge was a "watershed moment" that brought tears to his eyes when he first heard it.

"To see it finally embedded in the charter, the recognition of the importance of our own health, was extremely important and gratifying," Dr Myers said.

He said it was vital to keep talking about doctors' own health to ensure it remains a high priority on the profession's agenda.

"In so many respects, we're still a vocal minority, but I just see that getting louder and louder," he said.

"... So many doctors feel, when they fall ill, a sense of inner marginalisation."

Dr Myers said keeping the "three Rs" of Recognition, Representation, and Rights at the centre of discussion about doctors' health would drive the momentum for action and progress.

"We give so much to others that we really don't take care of ourselves," he lamented.

Former AMA President Dr Mukesh Haikerwal chaired a conference session on doctors' health, with Dr Myers as a panel member.

Others on the panel were Avant chief medical officer Dr Penny Browne, psychiatrist Dr Helen Schultz, Beyond Blue board member Dr Jessica Dean, and crazysocks4docs founder Dr Geoff Toogood.

As already reported *Australian Medicine,* Dr Toogood was awarded the AMA President's Award for his ground-breaking work in building awareness of doctors' mental health.

Dr Bartone joined another panel during the conference to discuss reforming Australia's mental health system.

CHRIS JOHNSON

Coverage of some National Conference events and proceedings appear in this edition of *Australian Medicine*, as well as the previous edition of June 3. conference stories will also appear on the *Australian Medicine* web page https://ama.com.au/ausmed

New Government, new challenges, new goals

BY AMA PRESIDENT DR TONY BARTONE

The AMA has just come through a very busy and productive period.

After being both an interested observer and at times an active participant in the federal election campaign, we moved seamlessly on to our annual showpiece – our National Conference in Brisbane in late May.

The timing could not have been better.

National Conference gave us the opportunity to conduct a public audit of the re-elected Coalition Government's policies and how we will work on them – and hopefully some new ones – with Health Minister Greg Hunt over the next three years.

The Conference also allowed us to put the spotlight on some of the big issues facing the AMA, the profession, the health sector, and the Australian community. These included mental health, aged care, doctors' health, gender equity, artificial intelligence, and the future medical workforce.

These issues are core business for the AMA and – along with the continuing work on general practice and private health – will be at the centre of our ongoing policy and advocacy activity.

Importantly, the Conference also gave me the chance to reflect on my first year as President and spell out what I hope to achieve in my second year.

I am immensely proud that the AMA over the last year delivered big time for general practice.

Over one billion dollars in funding for general practice was announced in the 2019-20 Budget and MYEFO – one billion dollars of funding that both sides of Parliament agreed to fund.

This was no accident or lucky occurrence. We put this on the agenda.

The AMA has for years pushed for genuine reform to the way that general practice is funded.

We have advocated for a model that will allow for coordinated, patient-centred care, which maintains GP stewardship of the system.

We have now finally seen real funding for this with the $450 million announced in the Budget for GPs to assist the coordinated care for people over 70.

This is a good first step, but this policy approach must be expanded. We will be pushing the Government to introduce funding for coordinated care for all Australians with a chronic illness.

Our advocacy for more support for GPs to visit Residential Aged Care Facilities was successful. The Government increased funding for GPs visiting Residential Aged Care Facilities and retained the Aged Care Access Incentive.

But we are also concerned about the future of general practice, not just for we GPs who have seen practice costs continue to rise while our rebates have stalled, but for the next generations of GPs.

GP training places have remained undersubscribed for two years running.

This is extremely worrying and an ominous sign. It is further evidence of the declining appeal of a General Practice career for an ever-increasing number of graduates.

On another front, we also had successes with rural health.

There was a very welcome additional $60 million in funding to fast track the National Rural Generalist Pathway in the Budget.

The National Medical Workforce Strategy was also announced.

Both of these measures will help deliver much-needed doctors to rural and remote communities, but they won't be able to deliver for years.

Our Public Hospital Report Card had quite an impact during the election campaign. It showed clearly that the public hospital sector is not in good shape.

Doctors and nurses are doing more than their fair share – they are having to do more with the funding they have.

When governments underfund, they are making a choice to constrain the supply of public hospital services.

Our advocacy for greater funding will continue.

The other side of the equation – private health and private health insurance – is also unfinished business.

We backed the intent of the Government's reforms, including the concept of developing the Gold, Silver, and Bronze insurance products.

But the Government reforms do not address affordability in an enduring way – this problem is starkly obvious, even with the slightly smaller 2019 round of premium increases.

It is very difficult to see how private health insurance can stay affordable with increases in premiums averaging 4 to 5 per cent a year, when wages growth is firmly stuck around 2 per cent.

There is increasing corporatisation of private health and the market power is shifting in favour of private health insurers. Insurers should not determine the provision of treatment in Australia.

They should not interfere with the clinical judgement of qualified and experienced doctors.

We will help shape the Government's private health reforms.

Similarly, we must revive the government focus on preventive health – from all levels of government.

Prevention receives a paltry amount of the total health budget. This completely misses the point of preventive health care.

This time last year, I set out some objectives for the AMA.

Strong advocacy on patient access to primary care, to mental health and aged care, to in-hospital care and for our Indigenous people, as well as those in rural and regional areas. We delivered on many fronts.

Work on improving the collaborative relationships between the Federal and State and Territory AMAs. This is in progress and ongoing.

Ensure steadiness, security, and confidence in the Federal AMA Secretariat amid a period of external and personnel changes.

Our systems and processes are working, and a new Secretary-General will be in place soon.

I believe that, overall, we have made significant progress but there is more to do.

In the year ahead, the AMA will be extremely vigilant on private health care. I will ensure the AMA resists any threats to the sustainability of private health care and patient access. It is this access that fundamentally helps underpin access to our universal health system.

We will also raise our focus on doctors' health and wellbeing. This will include the formation of a coordinated leadership group to implement a national framework to improve and enhance the health and wellbeing of the medical profession.

This will require considerable coordinated action and cooperation between the Federal and State AMAs.

We have a lot to do. The good news is we won't be distracted by a federal election.

Beyond gold

BY **AMA VICE PRESIDENT DR CHRIS ZAPPALA**

As the dust is settling after the election (I will leave the President to give a summary of his reflections in this regard) I thought it useful to examine in some detail what we need to do to rescue private medicine from the slow decay it is currently experiencing.

The quarterly health insurance statistics have just been released – they provide for sobering reading. Private health Insurance (PHI) coverage rates continue to whittle away, now down to 44.5 per cent. We are feeling the effect of this decline in the private sector – it is not just a number. The Government (or the Opposition) does not have an overarching strategy of how to deal with this – a notable omission in the election campaign.

The AMA is seeking pointed and meaningful discussions with Government (and I think State/Territory AMAs should be active in this space with their Governments as well). Perhaps we should also include consumer groups, private hospitals and even the funds themselves (they often dance to a different tune though). The State/Territory angle should not be under-estimated as the COAG forum is clearly very important for driving essential policy reform. Moreover, each State/Territory Minister knows their public health system cannot handle extra patients all withdrawing from private health.

It is worth noting that health funds (bear in mind for-profit funds currently comprise nearly 70 per cent of all funds compared to only 16 per cent in 2005) have done very well improving and preserving their profit which currently stands at a robust $1.8 billion. In 2014 the PHI sector profit was around $1.4 billion – so a nice increase for them. During this same period the average medical gap has remained static at $60-61 during which time we have endured a frozen MBS rebate.

This is one indicator that gaps are not driven solely (or predominantly) by doctors. We are all familiar with the five-year freeze of the MBS rebates (which was inadequate to begin with). From 2010 to 2018, PHI premiums increased by a cumulative 49 per cent – compared with the health CPI cumulative increase of 40 per cent. By contrast, doctors were faced with a paltry 5.7 per cent increase in the MBS rebate. It is clear who is winning.

Nationally, Australians spent $29.4 billion on out-of-pocket health-related expenses in 2016-17. Most of this was on prescription and non-prescription medications ($10.8 billion or 37 per cent), dental services ($5.7 billion or 19 per cent), and other health care such as aids and allied health services outside Medicare ($6.7 billion or 23 per cent). Medical costs make up only 21 per cent of out-of-pocket expenditure for individuals.

In terms of outlays by funds for private specialists, again, the amount spent on doctors is only a small percentage. Of the $3,965 million in the December 2018 quarter paid by insurers for hospital treatment benefits, only $613 million was for medical services or around 15 per cent. The answer to the affordability problem is not doctor bashing. The statistics aren't there to support it and this malicious diversionary tactic will backfire on the entire industry.

Perplexingly the benefit schedules can inexplicably vary significantly. Not just between insurer, but between state and territory. The resultant gaps are not borne from doctor fees being too high, but due to insurance companies paying hugely variable amounts which do not reflect the cost of providing the service. For example, if a doctor does not have an arrangement with a fund, then only 25 per cent of the Medicare rebate is paid which drastically increases the gap for a service which might be completely covered without a gap in another hospital with another doctor.

Critically, **if legislation forced funds to pay the same amount (e.g. the AMA fee), appropriately indexed and defined, for each item regardless of whether the doctor has an agreement with a fund or where the service is occurring, gaps would significantly reduce overnight.**

In the PHI report card last year the AMA highlighted total hip replacement and how the fund rebate can range from $329 to $1,120. The ALP election policy supporting cancer care shows that reform to ensure appropriate, indexed rebates for care can be entertained. Reducing gaps requires reform of the PHI industry and rebates, not forcing doctors to reduce fees. We must however always ensure our fees are reasonable and be derisive of over-charging and over-servicing.

Widely differing rebates are incredibly confusing for patients. It isn't addressed by the reforms to date, and it isn't addressed by the Government's new fee transparency website proposal. Doctors' fees without information on insurers and MBS rebates will not inform patients about their out of pocket costs. Surely if we are going to do transparency of fees to help patients, let's also demand transparency of rebates. This is not negotiable.

Our next approach around this thorny problem should include active collusion with consumer groups to strengthen our case. A carefully devised national campaign with succinct outcomes is required that encompasses effort from the entire AMA family as well as other stakeholder groups such as Colleges/Associations. The conversation needs to change and to this end we must be seen to be actively trying to manage egregious billing and extinguish administrative/booking fees. Primarily however, we need to promote high-quality medicine as our goal and not always be dragged into a defence of the cost of medicine. We do things well and have good outcomes – this is a good starting point for our renewed campaign.

Inspiring international guest at National Conference

A standout guest at this year's AMA National Conference was the highly impressive Dr Barbara McAneny, President of the American Medical Association (the "other" AMA).

A leading and high-profile oncologist from Albuquerque, New Mexico, Dr McAneny delivered an inspiring keynote address at the Leadership Development Dinner on the first night of the conference in Brisbane.

Her topic was leadership, but she also detailed the legal fights the American association is having against the introduction in some US States of draconian and punitive anti-abortion laws. She told of similar fights to try and stop the unravelling of many elements of former US President Barack Obama's universal healthcare laws.

Dr McAneny spoke with *Australian Medicine*.

"I think leadership stems from having taken the time and effort to step back and look at the big picture issues that affect day-to-day life, and then being able to communicate that vision of how things could be, as opposed to how things are, to other people," she said.

"So that you can then convince them that the goal you see, the vision that you have, is worth working towards.

"I have no idea how it is in Australia, but in the United States in general we are not doing as well as we should be on equity in the medical workforce. In the lower levels of medical schools now we finally have about 50 per cent women.

"We do not have good representation of other minorities; we do not have good representation of the LBGTQ community. For us it is also Native Americans where we lack representation. We have a scarcity particularly of black men applying for medical school, but also of black women, of Asians, Hispanics.

"The United States is a melting pot, but we do not have a medical workforce that really reflects that diversity. We would have a stronger, better system if we did.

"I think we would have more wins if we did, because when you have a physician who relates to and is deeply embedded in the community they serve, they are going to see the issue of equity.

"They're going to see the needs of various people. They're going to see someone not as a concept, but as a human being who is trying to decide what to do about the tough decisions of life.

"They will see a woman who is deciding 'can I carry a pregnancy to term? Is this the right time for me? Can I do this well?', as opposed to just a statistic. Those are heart wrenching decisions

Dr Barbara McAneny

for every woman and those decisions need to be made between the woman, any advisers she so chooses – from her family to God – and her physician.

"We think that it is our ethical duty to provide patients with full and complete information as to what their options are, to the best of our ability. That's what physicians are as trusted advisers – to interpret healthcare literature and help a person make their own decision that fits them best. That's medically reasonable, that's our job, and any policies that punish physicians for doing that, are bad policies. Anything that criminalises healthcare provision is bad policy.

"I'm fascinated to see the similarities in the processes of our two countries. You are in the process more of developing your private health insurance. I hope that you can avoid some of the errors the United States has made in having private health companies become so very profitable.

"I hope that you can maintain the focus that you have on general practice – which we would call primary care. That seems to be, from what I've heard, at the heart of that physician-patient relationship, that trusted adviser, coach, teacher role that we don't want to lose.

"So I would hope that Australia could learn perhaps from some of the lessons of what the United States has done badly and see if you can't do it right. And then maybe we can turn around and learn from you."

CHRIS JOHNSON

The end of an era for Federal Council

Professor Beverley Rowbotham AO

This year's National Conference was the last to have Associate Professor Beverley Rowbotham AO as its Chair.

Dr Rowbotham is stepping down as Chair of the AMA Federal Council after a five-year stint at the helm.

At the Federal Council meeting held in Brisbane immediately before National Conference, and throughout the conference itself, praise and thanks poured out in abundance.

Everybody – everybody – speaks incredibly highly of Dr Rowbotham and the manner in which she has professionally and personably led the AMA's policy governing body.

AMA President Dr Tony Bartone thanked Dr Rowbotham for her "intelligence, her wit, and her sheer unflappability" in chairing the Federal Council.

Dr Rowbotham spoke to *Australian Medicine* at the National Conference venue.

"There is some sense of relief because I did a lot or work chairing Federal Council, but mainly I feel affection and sadness that that part of my career is over," she said.

"I've loved it. It's a great job. The Federal Council is great people and I really believe in the power of the group over any one person and what they can do for Australia's doctors and health care.

"I guess the real challenge was that the Federal Council changed after the constitutional changes five years ago. So this was a new beast where Federal Council was responsible for policy only, instead of all the other responsibilities it once had – and just making the most of that opportunity.

"I will stay on Federal Council a while longer yet because I have another year of my term as a pathology representative.

"The AMA has never been in better shape. It's a remarkable organisation. We are well supported. The policy people are outstanding. The can-do attitude that is part of any modern organisation – the AMA has it in bucketloads.

"What I wanted to bring to Federal Council was the whole concept of consensus decision making.

"We do represent our entire membership. And beyond that, whether they like it or not, Australia's doctors are represented by the AMA – all 110,000 of them."

CHRIS JOHNSON

Embracing artificial intelligence

Artificial Intelligence (AI) in health care made an interesting topic for a panel discussion during one session of National Conference.

Increasingly transforming the way medicine is practised, AI impacts all areas of care – from interaction with patients, to management and administration, clinical assessments and therapeutic procedures.

Delegates were told that AI was here to stay and that the ethics of dealing with it must be thoroughly canvassed.

Chaired by AMA (WA) President Dr Omar Khorshid, the discussion provided one of the most interesting sessions of the conference.

Director of the Centre for Health Informatics, Professor Enrico Coiera, said "Our fate is to change" and it was a matter of embracing AI professionally and ethically.

"Humans have a willingness to trust technology if it seems to be doing a good job," he said.

RANZCR President Dr Lance Lawler stressed the importance of ethics and AI, and detailed the development of the first formal ethical principles for the use of AI in health care.

Other excellent contributions to the panel discussion were made by Health Informatics Society Australia CEO Dr Louise Schaper and Torrens University Vice-Chancellor Professor Justin Beilby.

CHRIS JOHNSON

Seven new Fellows inducted

The AMA has inducted seven new members into the AMA Roll of Fellows, in recognition of their outstanding contributions to both the medical profession and the AMA.

The new inductees are (pictured above left to right with Dr Bartone):

- immunologist and past AMA NSW President, Professor Brad Frankum OAM;
- distinguished neuroradiologist and past Royal Australian and New Zealand College of Radiologists (RANZCR) President, Professor Mark Khangure AM;
- orthopaedic surgeon and AMA WA President, Dr Omar Khorshid;
- anaesthetist and past AMA SA President, Dr Andrew Lavender;
- dermatologist and past AMA NSW President, Clinical Associate Professor Dr Saxon Smith;
- past AMA ACT President and dermatologist, Associate Professor Andrew Miller AM; and
- consultant surgeon and ex-Army officer, Associate Professor Susan Neuhaus (pictured separately)

AMA President Dr Tony Bartone announced their addition to the Roll at the AMA National Conference in Brisbane.

“These seven outstanding doctors have excelled not just in their medical specialties, but in their roles as advocates for the profession,” Dr Bartone said.

“They have made real contributions at the State and Federal level to improve working conditions for doctors, to improve safety for patients, to train the next generations of medical practitioners, and to make the Australian health system work more effectively for patients and communities.

“I commend them for their service.”

CHRIS JOHNSON

Good to be back in the fold

National Conference provides a forum for delegates to raise issues, ask questions, make points, and have a say.

It allows an opportunity for some to tell their story.

Such was the case with Dr Daniel Byrne from South Australia, who expressed his delight at having re-joined the AMA after many years away. He also spoke with *Australian Medicine*.

"I was an AMA member in the 90s and I never felt like general practice was much of a focus for it then. I was a young doctor," Dr Byrne said.

"I had kept across things and have been the Chair of the RACGP South Australia and Northern Territory.

"Recently, I have really enjoyed seeing what the AMA has been doing. And I've become quite involved with many people inside the AMA, particularly from South Australia and the last four presidents, and I have found them all very supportive, engaging and collegiate.

"So I re-joined just a few years back after many years away. I left in 1996. But in addition to working with the good people inside the AMA, I have also been very aware that at the same time the AMA has been coming out on some important issues like climate change and refugees and doctors' health.

Dr Bartone with Dr Byrne

"To me it's almost like 180 degrees from the AMA I remember in the 90s. I'm now on the South Australian council and feeling very much like I belong to an organisation that represents me and that stands up for health care and how it impacts so many areas."

INFORMATION FOR MEMBERS

Voluntary assisted dying laws begin

On November 29, 2017, the Victorian Parliament passed the *Voluntary Assisted Dying Act* 2017.

From June 19, 2019, Victorians at the end of life who are suffering and who meet strict eligibility criteria will be able to request access to voluntary assisted dying.

The law allows for an 18-month implementation period to give health services time to plan and prepare for voluntary assisted dying.

Health Victoria provides an extensive range of information for 'consumer and community information' as well as 'health practitioners and services information'. These are available at: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioners.

These resources include explicit information for doctors who wish to participate in VAD as well as those who do not wish to participate including those with a conscientious objection to VAD. Guidance is also provided for doctors and other healthcare practitioners on how to respond to a patient's request for information on VAD (A health practitioner who is providing health or professional care services to a patient cannot initiate a discussion about voluntary assisted dying or suggest voluntary assisted dying to the patient. They can, however, respond to a patient's request for information).

Through the AMA Victoria Peer Support or VDHP, AMA Victoria will continue to support all Victorian members and listen to their views during the VAD process. Please refer to the AMA Victoria website at https://amavic.com.au/policy-and-advocacy/voluntary-assisted-dying

AMA Doctor in Training of the Year

An obstetrics registrar who developed her own training program for gynaecological surgery after returning to work from maternity leave has been named the AMA Doctor in Training of the Year for 2019.

Dr Rebecca Ryder, a senior registrar at Sunshine Coast University Hospital, was presented with her award at the AMA National Conference in Brisbane.

"Dr Ryder has all the attributes of a great clinician and a great leader, with her commitment to learning, training, mentoring, and safe practice," said AMA President Dr Bartone said.

"Her colleagues, who nominated her for this award, describe her as a natural leader, as approachable, compassionate, sensible, and decisive.

"She is passionate about the wellbeing of doctors in training, and is currently completing a research project on trainee resilience. In the first study of its kind, she has surveyed every obstetrics and gynaecology trainee in Australia and New Zealand.

"She aims to use her study as another platform to advocate for the fair treatment of trainees, and for workplace reforms to reduce bullying.

"She has also put her own experiences to practical use in training and teaching. When she returned to work in 2017 from maternity leave, she recognised that her prior gynaecological surgical experience was limited, and developed her own upskilling program.

"Her template is now used to teach laparoscopic surgical skills to other junior trainees.

"She has also, in her own time, assisted in surgery with a private gynaecologist, giving her experience in procedures she would not see in a public gynaecology setting.

"She has been actively involved with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), as a trainee representative and a hospital re-accreditation team member.

"She has run the RANZCOG basic obstetrics skills workshop for junior registrars for the past two years, leads a monthly education meeting with the group practice midwives, and is a strong advocate for collaborative maternity care practices.

"Dr Ryder has been an effective mentor to junior registrars, and meets monthly with her fellow registrars to check on their wellbeing.

"She also put her impressive organisational and negotiation skills to excellent use in 2018, organising a ball for Queensland Trainees and Fellows in aid of White Ribbon, the domestic violence awareness charity.

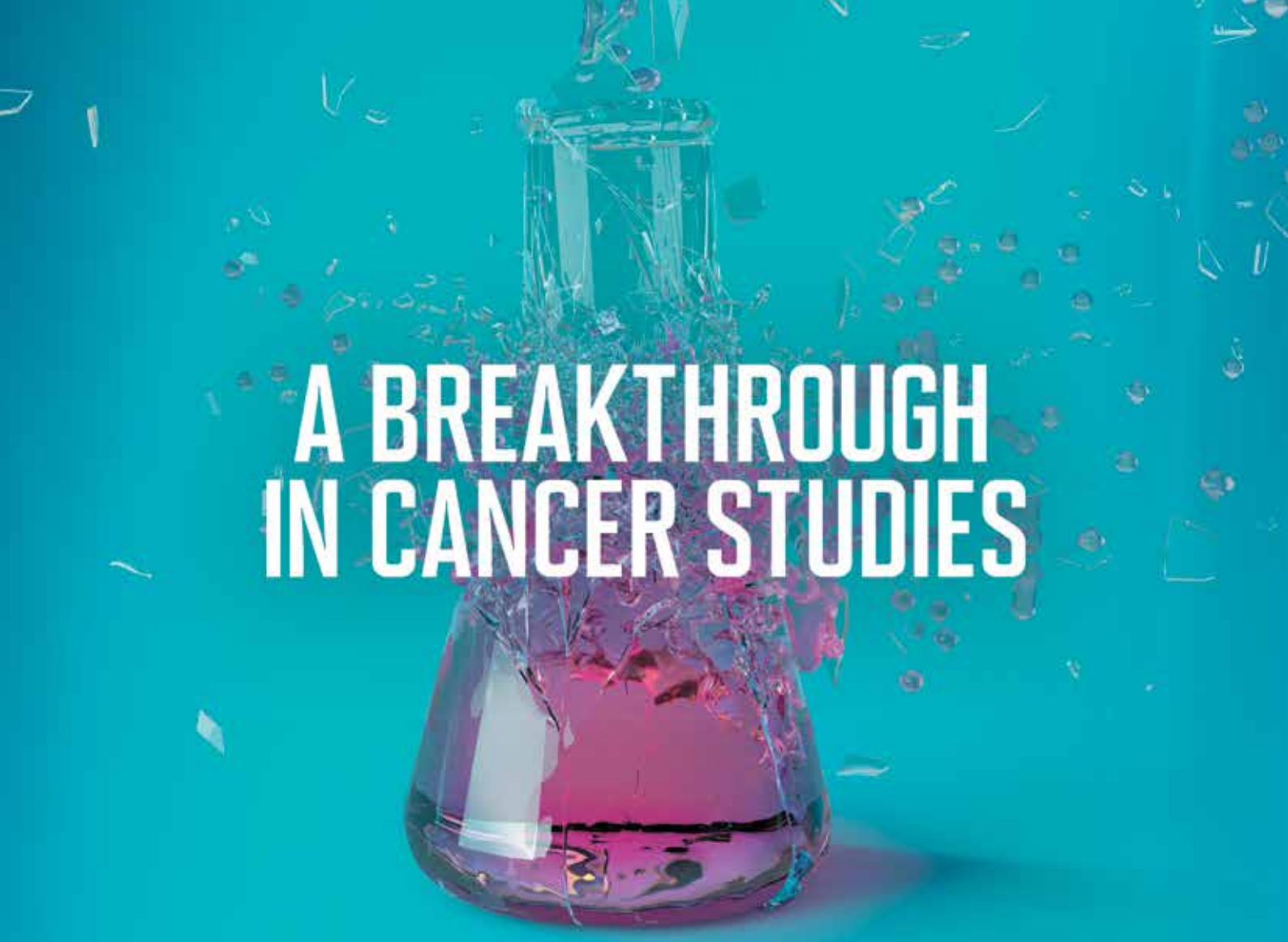
"The event was sold out, and raised more than $9,000 for White Ribbon. RANZCOG Queensland has undertaken to run a similar fundraiser every two years, and Dr Ryder has agreed to coordinate the organising committee for the next one.

"Somehow, she manages to balance her responsibilities as the mother of two young children with her high workload as a senior registrar, and her mentoring and charitable work.

"While she is an outstanding clinician and leader, she remains humble, friendly, and responsive to feedback.

"With her outstanding skills, work ethic, achievement to date, and her potential, she is a very worthy winner of the AMA Doctor in Training of the Year Award."

MARIA HAWTHORNE



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More awards from the AMA National Conference

The Queensland Government's ground-breaking introduction of the State's first health promotion agency, Health and Wellbeing Queensland, has won the prestigious 2019 AMA Best Public Health Initiative from a State or Territory Government.

AMA President Dr Tony Bartone announced the award at the AMA National Conference in Brisbane. It is the second year in a row that the Queensland Government has taken out the Award.

Nominated by AMA Queensland, the Health and Wellbeing Queensland initiative is a coordinated, whole-of-government public health plan to minimise illness, to protect and promote health, and to combat the State's biggest public health issues, starting with obesity.

"AMA Queensland has long been calling for such a body, as doctors at the front line of health care in Queensland are experiencing first-hand the impact of growing numbers of patients needing treatment for chronic diseases caused by obesity and lifestyle factors," Dr Bartone said.

****

State and Territory AMAs have once again been recognised for their exceptional work in advocacy and communications over the past year.

This year's winners are:

Best Public Health Campaign 2019 – AMA Victoria

The Medically Supervised Injecting Centre at North Richmond

Best State Publication 2019 – AMA Victoria

Vicdoc

Most Innovative Use of Website or New Media 2019 – AMA Tasmania

TASTalk_Media Review

Best Lobby Campaign 2019 – AMA New South Wales

Bupa Campaign – The Fight for Choice

National Advocacy Award 2019 – Federal AMA

2019 AMA Public Hospital Report Card

Highly commended – AMA Western Australia

GP Registrar New Fee Category

AMA National Conference 2019 Picture Gallery

PHOTOS BY NAOMI COLLEY – LIGHTBULB STUDIO

AMA National Conference 2019 Picture Gallery

PHOTOS BY NAOMI COLLEY – LIGHTBULB STUDIO


National
Conference
Brisbane


DEFENCE JOBS AUSTRALIA

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

WITH CHRIS JOHNSON

Chris Bowen takes on health portfolio

Former Treasurer Chris Bowen is the new Shadow Health Minister, having been appointed by Labor's new leader Anthony Albanese.

Mr Bowen was Treasurer in 2013 under Prime Minister Kevin Rudd. He mostly recently served as Shadow Treasurer under the Labor leadership of Bill Shorten for the past six years.

Catherine King, who held the health portfolio for Labor for six years, has been appointed Shadow Minister for Infrastructure, Transport and Regional Development.

Ms King congratulated Mr Bowen on his appointment and said she greatly enjoyed her time in the health portfolio.

"It was a great honour to serve as Labor's Shadow Health Minister for six years and I'll always be proud of the ambitious health agenda we took to last month's election," Ms King said.

Mr Bowen praised Ms King's efforts in the area and said he was keen to embrace the portfolio.

"I'm delighted to have been appointed as the Shadow Minister for Health by the Leader of the Opposition Anthony Albanese. As the longest serving Shadow Treasurer in Australian history, it's time to hand over the portfolio," Mr Bowen said.

"I would also like to acknowledge my predecessor as Shadow Minister for Health, Catherine King. Catherine has spent the last six years advocating for a better healthcare system for all Australians.

"As Shadow Minister for Health I will hold the Morrison Government to account for their appalling record and cuts to the health system in Australia...

"I'll be keen to tackle the scourge of diabetes, obesity and the other health challenges in areas of low income and poor health outcomes. Closing the Gap of Indigenous disadvantage in health will also be one of my key areas of priority.

"I have long had a passionate interest in mental health and suicide prevention. This will now be a focus in my portfolio. Medicare is one of Labor's greatest achievements. It must be protected and grown. To be a successor of the likes of Bill Hayden and Neal Blewett as Labor's Health spokesman is a great honour.

"I look forward to becoming Minister for Health in the Albanese Labor Government."

Julie Collins has kept her portfolio as Shadow Minister for Ageing and Seniors.

Mr Shorten will remain in the Shadow Cabinet as Shadow Minister for the National Disability Insurance Scheme.

Submission to Government's proposed aged care funding

The AMA has submitted its formal comment to the Health Department on the new residential aged care funding model – the Australian National – Aged Care Classification (AN-ACC).

The AMA supports in principle the new funding model and the rigorous research that lies behind it. In particular, the AMA is pleased that a fixed plus variable funding model, adjusted for geographic location is recommended. If designed correctly, this will hopefully address the difficulties imposed by pure activity-based funding for smaller aged care providers in different geographic locations.

The new transparency associated with a case-mix classification and funding model is also a very positive development for aged care providers, Government and consumers. The AMA agrees, this type of model creates the potential at some point in the future, to define staffing requirements by AN-ACC class, and develop best practice models of care for each case-mix/class. This type of transparency is very welcome and is somewhat overdue in the Australian aged care sector.

While activity-based funding has many positives, the success of shifting to an activity-based funding model will depend on the price generated by the funding formula. The AMA notes price is out of scope in this consultation. No matter how robust a funding formula is, if the price paid per activity is too low, or not adjusted to staff wages growth or insufficiently indexed, the funding model cannot generate high quality care and positive resident outcomes.

The full submission can be viewed at: https://ama.com.au/submission/ama-submission-department-health-%E2%80%93-proposal-new-residential-aged-care-funding-model

The evolution continues

BY DR BEVERLEY ROWBOTHAM AO, CHAIR, AMA FEDERAL COUNCIL

This will be my last column as Chair of AMA Federal Council, having decided not to re-nominate for the role after having had the privilege of serving as Chair since 2014.

> "Fortunately, the AMA is well positioned to deal with the returned Government and the list of issues for discussion is extensive."

Federal Council is a unique and wonderful forum that brings together so many different parts of medicine in our efforts to advance the interests of the profession and fight for the needs of our patients. In my experience, Federal Council has proven to be a cohesive group, working to these common goals and striving to achieve decisions by consensus.

Meeting just one week after the election result, the most recent Federal Council focused on what this result meant for the health system and the AMA's ongoing advocacy efforts. The AMA featured strongly in the media throughout the election period and released a very balanced assessment of the health policies of the major parties in the last week of the campaign.

Fortunately, the AMA is well positioned to deal with the returned Government and the list of issues for discussion is extensive. Primary care reform, private health insurance, prevention, mental health, aged care, hospital funding are all issues that will need to be prosecuted. It was certainly good to see the Health Minister give a commitment at AMA National Conference to working with the AMA in developing a national preventive health strategy as well as a ten-year plan for primary health care reform.

Now that the election is over, one of the first tasks that the Health Minister will have to deal with is the MBS Review, with Federal Council extraordinarily disappointed at comments attributed to the Chair of the MBS Review in the medical media. The AMA supported the concept of the MBS Review on the basis that it would be focused on modernising the Medicare schedule and the reported suggestion that the Review was, in part, inspired by allegations of rorting have tarnished its processes and recommendations.

The breadth of Federal Council papers never fails to impress me. Aside from reports from multiple groups, our papers provide a snapshot of the significant amount of work that the AMA deals with daily. Prevention, Indigenous health, Medicare, public hospitals, medical workforce, general practice, out of pocket costs, task substitution, mental health, portability of leave entitlements and doctors' health are just some of the issues headlined in updates provided by the Secretariat.

Importantly, Federal Council is also changing. It has recognised the need for it to better reflect the diversity of the profession. While there has been longstanding representation from States/Territories, craft groups and specific areas like doctors in training and public hospital doctors, in more recent times the membership of Federal Council has expanded to cover Indigenous doctors and our rural members.

This evolution is continuing, with this meeting of Federal Council deciding to adopt specific gender targets. We agreed to a target of 40 per cent women, 40 per cent men, 20 per cent flexible for all AMA Councils and Committees, with the aim being for women to hold 50 per cent of Federal AMA representative positions overall by 2021. When I first joined the Federal Council many years ago, I was one of very few female faces around the table and it is great to see the AMA take this step forward.

While I am not re-nominating for the role of Chair, I will remain on Council for the remainder of my term as the representative of the pathology craft group. I look forward to being able to have more freedom to raise issues of concern to my specialty and wish the new Chair, once elected, all the very best for what is an exciting and very important role in the AMA's policy making process.

The value of general practice

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

Last month, there was a lot of online discussion about GPs not bulk billing for an entire day. Unsurprisingly, the idea received a lot of support from the GP community. I fully understand the sentiment behind this idea and why it was so popular. For too long general practice has been undervalued.

> "Despite the Minister for Health stating at this year's AMA National Conference that GPs are fundamental to the Australian health system, we have not seen new genuine investment to support this role."

We know that a robust primary healthcare system not only improves patient outcomes but lowers overall health costs. If you regularly visit your GP you will live longer and live better. Despite this, general practice has received minimal significant investment.

The AMA has advocated for increased funding to general practice through increased (or unfrozen) Medicare rebates and also through additional funding such as incentive payments and more recently coordinated care payments.

We were encouraged by the inclusion of over $1 billion of funding announced by the Morrison Government as part of the 2019-20 Federal Budget. We were pleased to see Labor endorse this spending. This was largely due to consistent AMA advocacy.

Of the $1 billion, over $200 million was allocated to the Quality Incentive Payments for general practices. The Budget also announced the retention of the Aged Care Access Incentive (ACAI). Both major funding issues I have outlined in earlier articles.

Another key funding announcement was $448.5 million to improve continuity of care for patients over 70 with chronic conditions. This would provide additional funding for GPs who coordinate the care of their patients. While it is a positive step, it is funding that can and should be available to all patients with chronic health conditions.

And this is the issue. This is all we have seen for years. Despite the Minister for Health stating at this year's AMA National Conference that GPs are fundamental to the Australian health system, we have not seen new genuine investment to support this role. The failure of the healthcare homes is a perfect example of this – it was a good idea that was doomed to fail by a lack of investment.

At the National Conference I proposed on behalf of the Council of General Practice that the AMA lobby the Federal Government to increase funding for general practice so that it represents at least 16 per cent of the health budget, and that this figure should be mandated. This was overwhelmingly supported by delegates from all States and Territories and across the medical profession.

We proposed this because general practice has been undervalued for years. The only way we can guarantee the real and continued investment is by mandating it.

Sixteen per cent of the Federal health budget is in increase of around $2.5 billion and would allow not just real investment in the general practice, but deliver funding for the reforms that will allow GPs to continue providing the world leading care we currently do for our aging population.

It will also show us that the Government does value us and the role we play. Years ago, I chose to travel to Papua New Guinea and volunteer as a doctor. That was a fantastic experience, but it was my choice. Now, I feel like I am being asked to do the same in my own community despite having to support my family. As GPs, we regularly bulk bill our elderly patients or those who cannot afford out of pocket costs because we want to provide the best care to them that we can despite the fact it means we take a pay cut. These patients should not have to pay, but we should not be the ones who bear the cost.

It comes down to how the Government values general practice and what role it sees for general practice in the health system.

We have known for years that a robust primary healthcare system improves population health outcomes while lowering costs, and that general practice is the cornerstone of this system. It's time for real funding and for the Government to show us that it really values general practice.

The morning after the night before

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

Whatever your expectation of the outcome of the recent federal election, we can all celebrate another peaceful transition of government. We should not take democracy and peaceful elections for granted. Their safety and freedom were secured through powerful traditions and in part in two world wars in which Australians participated – lest we forget.

But the celebrations are over and we are back in the kitchen – and even with the help of a dishwasher there is a lot of cleaning up. One virtue – at least so it appears to those of us who live in a world of constant restructuring – is that continuity will likely prevail in federal health policy for three more years.

Yet there is plenty for the new Morrison Government to do – and plenty promised – much of it contained in the recent federal budget, to create a productive agenda.

Stephen Duckett, at the Grattan Institute, a Melbourne think tank, and a group of expert policy critics, published in The Conversation of April 3 an analysis of that budget. A huge array of items was slated to receive increased funding, including $0.5 billion to pay for patients with diabetes to receive long-term care through general practice clinics, using "a new annual payment for each person with diabetes who signs up with a specific GP. Funding is [to be] provided for about 100,000 people to sign up – about 10% of all people with diabetes in Australia." In addition, Duckett et al wrote:

> *"The indexation freeze on all GP services on the Medicare Benefits Schedule (MBS) will lift from July 1, 2019, at a cost of $187.2 million. The freeze will be lifted on various X-ray and ultrasound MBS rebates from July 1, 2020.*
>
> *"The budget announces[d] $461 million for youth mental health, including 30 new headspace centres, some of which will be in regional areas."*

MRI scans are to be more readily obtained and cheaper. More medications are to be paid for through the Pharmaceutical Benefits Scheme.

Aged care services, the object of a Royal Commission, received increased funding. As Hal Swerrisen, a senior health service manager and policy guru and associate at the Grattan Institute, said:

> "*There is more funding for aged care. Currently, 130,000 older people are waiting for home care packages – often for a year or more. Nearly half of residential care services are losing money and there are major concerns about quality of care.*
>
> *"The short-term fix is to give residential care $320 million to try to prevent services going under. The budget includes 10,000 previously announced home care packages, at a cost of $282 million, but that still leaves more than 100,000 people waiting."*

Lesley Russell, an adjunct associate professor at the Menzies Centre for Health Policy in Sydney and long-time observer of health policy, expressed disappointment about prevention in the budget. The election promises, which came a few weeks later, provided little additional encouragement.

> *"Preventable diseases and conditions are a key factor in health inequalities and rising health-care costs. The two issues looming large are obesity and its consequences, and the health impacts of climate change.*
>
> *"There is $5.5 million for 2018-19 and 2019-20 for mental health services in areas affected by natural disasters, and $1.1 million over two years for the Health Star rating system – otherwise nothing for primary prevention."*

Funding for public hospital services elicited a proposal in the Coalition's election manifesto.

> *"Our new five-year public hospital agreement with the states and territories delivers $31 billion more funding for hospitals (between 2020-21 and 2024-25).*
>
> *"Annual hospital funding will more than double from $13.3 billion in 2012-13 to $29.1 billion in 2024-25.*
>
> *"In addition, a new $1.25 billion Community Health and Hospitals Program will improve health care specialist services including cancer treatment; drug and alcohol treatment; preventive, primary and chronic disease management; and mental health."*

All these announcements, welcome as they are, are set within the context of the prevailing health care system. For example, in a recent post-election statement, the Prime Minister nominated the prevention of youth suicide as an claiming his immediate attention. As noted, with the expansion of headspace he may see this an early win.

But large-scale reforms, especially ones in anticipation of changes in the care of patients that will follow from the genetics and 'omics' revolution, the massive developments occurring in the electronic management of information, and the shift to integrated hospital and community care for people with serious chronic illnesses, are barely mentioned either in the recent budget or the election promises. Indeed, coordinated care for patients with serious and continuing illnesses so common in old

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Rural Medicine: a rewarding career

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

What is rural medicine really like?

That's a question I wish I could answer, but I can't. I can't speak for all rural doctors because our experiences and our work are so unique.

Let me give you an example. In January this year I was working in the Arctic. Every day I had to spend an hour just getting dressed to go outside before I could head out on a snow covered, icy vehicle to visit my patients. At the same time back here in Australia, many of my colleagues were supporting their communities through brutal heatwaves and drought.

These are the extremes. But there are people who live in these extremes and, as you can imagine, they have unique medical challenges. I doubt that my colleagues back in Australia were as wary of frost bite as I was.

I can tell you that despite the cold, despite the hours I was required to work for being one of two doctors in town, despite the lack of fresh food, I loved it.

Earlier this year we held an AMA Council of Rural Doctors meeting and one of our conclusions was that we need to emphasise the positives of rural medicine. Too often we hear the doom and gloom. We know that rural doctors work longer hours and that there is chronic underfunding. We know that there are towns with no doctors. It's a catch 22: we keep telling everyone how hard it is to be a rural doctor to try and get more resources and then complain that we can't attract enough doctors.

Well I'm here to tell you that despite the challenges, rural medicine is fantastic. I am never going to give it up. Despite the concerning picture that the 2019 AMA Rural Health Issues Survey painted of rural medicine, we were so thrilled to read the heart-warming comments from rural doctors about the satisfaction and joy they get from working and living rurally.

Let me share a few of my favourites:

> *"I love living [here] – the people, the diversity of practice, the location. It has everything a family needs. I know every day I make a big difference to the health of our town."*

> *"It is hard but rewarding. Less access to specialists, psychologists and even big State hospitals, but it's a joy to grow the relationships with my patients both professionally and as me being just a next-door neighbour in a small country town."*

> *"It is expected and rewarding to provide 'womb to tomb' obstetric, anaesthetic, ED, general medicine and palliative care to my patients. I appreciate greatly the opportunity to use all my skills on a continuing basis. I cannot imagine the hell of urban practice…"*

> *"My family lives on 100acres 10min from their school and my admitting hospitals."*

> *"Patients are more appreciative and less demanding."*

> *"[The] Community spirit, opportunity to provide extended level of care that I would not get to provide in capital city."*

> *"[The] lack of driving, clean air."*

> *"Rural GPs are very respected in their communities. They live in the most astonishing places. Safe places away from the rat race. Rural Australia is a great place to raise kids."*

> *"No traffic lights."*

It is still hard, but there are so many benefits to rural medicine. We use a broader range of skills, we develop meaningful relationships with our patients and communities as we provide womb to tomb care, and we don't have to deal with traffic.

Are you curious about rural medicine? Reach out to one of us. Ask us what it is really like. Give that friend of yours from med school who works rurally a call and ask them what it's like. Better yet, go visit them. Go fishing.

We want you to come and work with us. We want you to see what rural medicine is really like. Who knows? You might find that you love it and want to become one of us.

Medical training survey needs your input

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

From internship through to fellowship, every doctor in training can think of jobs they'd go back to in a heart beat and in equal numbers, roles they'd run a mile from. The quality of supervision, workplace culture and education opportunities are all critical in shaping the experience of DiTs.

Anecdotally, the advent of activity-based funding, the drive for efficiencies in health and the influx of new graduates have combined to increase the stress and erode the quality of our prevocational and vocational training programs. At least that's how it feels.

The problem is that word – 'anecdotally'. We don't have any high-level data to say how medical training is faring. As trainees we're totally reliant on the word of our colleagues when it comes to assessing the educational quality of a job before we work it. When outrageous and unsafe roles with zero education value reach the public consciousness, too often they're easily dismissed as one-offs or outliers. But how do we know? The truth is we don't because we've never asked. This is especially so in the black hole of unaccredited service registrar positions.

The AMA Council of Doctors in Training, in conjunction with the Confederation of Postgraduate Medical Councils, has spent years pushing for the creation of a national training survey as a way to track and compare training across the prevocational and vocational spectrum; in hospitals, primary care and anywhere else doctors in training work. We made the point that there was no robust data around training to the 2015 Internship review (https://ama.com.au/submission/medical-intern-review) and thankfully, the reviewers and COAG agreed with us.

Now coined the Medical Training Survey, AMA CDT has been there since its inception. We were part of the robust discussions on questions, we argued and gained agreement that you can't divorce training from other components of work like supervision and workplace culture.

There is safety and power in numbers. In the last 12 months we've seen the bravery of individuals stepping forward to call out unhealthy, unsupported and unsafe roles. Behind the few that make their concerns public, we know there are many more trying to keep their heads down and survive. The Medical Board has been tasked with delivering the MTS, meaning the survey will be independent of our employers and the Colleges, and we have agreement not to release data that could identify individuals.

It's a crowded survey space for DiTs, including our own AMA Hospital Health Checks. However, we believe the Medical Training Survey will provide the training data and comparisons we've been seeking. It will shine a light onto service roles with no educational value. It will highlight employers who prioritise the training of their doctors for the good of their staff and their patients. But it won't achieve all this without your input.

The strength of the MTS will be in the volume of responses. It is beholden on all of us to spend the 10 minutes to complete the survey, not just those who feel their job could be improved. The data from roles we love will give us the standard against which to assess those we don't. The MTS will expose those outlier roles and give us robust data to argue for accreditation of the lost tribe of service registrars.

The MTS will open August 1 and close in line with the AHPRA registration period.

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age is hardly addressed at all.

One might expect that a government priding itself on its economic management and concerned with achieving greater productivity (or efficiency) would propose changes that would enhance the productivity of health services that it supports. These would require big thinking.

McKinsey and Company, a consultancy, in a recent newsletter, considered ways in which greater productivity could be achieved in health services, which have been notoriously slow to improve on this measure.

The neat thing about these proposed changes is that are likely to have strong appeal to those who use them. All of the strategies depend upon the judicious use of currently available technologies to extract more from patient records, decentralise care wherever possible, link patients to doctors speedily and effectively, real-time patient monitoring, improved supply chains for medical provisions and more.

Besides providing small amounts of money for incremental changes to existing services we should be thinking bold and thinking ahead.

Rural practice and general practice are not silver medals

BY MADELEINE GOSS, PUBLIC RELATIONS OFFICER, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Recently, I was at the AMA National Convention, where there is an opportunity for attendees to express opinions, ideas or concerns related to the medical profession. The session was aptly named *Soapbox*.

One doctor stood up and said that senior doctors should be telling medical students to be realistic in their career aspirations. We ought to be directed to areas of workforce shortage and not lured by fancy equipment and procedures offered by specialties. This was in the context of rural workforce shortages and is particularly pertinent considering the decreasing numbers of GP registrars.

We know that medical workforce distribution is a multifactorial issue, with inter-professional support, career development opportunities and financial recompense being significant bones of contention. For instance, the AMA passed a motion which encouraged a more flexible and portable training and employment model for GP registrars, as the remuneration is less compared to non-GP registrars and standard workplace entitlements are not protected. The medical culture must also be addressed as part of the puzzle to meet future workforce demand. There is an unspoken stigma surrounding rural practice and general practice which compels capable and passionate doctors and medical students to justify their career choices.

I completed a longitudinal program in regional Western Victoria, with fantastic GPs who also staffed the local hospital and nursing homes. Nineteen other students in my cohort were placed in similar sites across the state. We came together every six weeks for formalised teaching and exposure to specialties we may not see in our towns. The most common opening line of a specialist who would come to teach was "oh, you're just going to be GPs; I'll change what I was going to do."

This was frustrating to us, because, as medical students, we should be receiving standardised teaching. However, it was much more insulting to GPs. It is true that the minutiae of some topics are not relevant to general practice, but this detail is not taught at the medical student level, so why were our teachers changing their lessons? These types of interactions insinuated to my peers and me that doctors choose general practice because they "couldn't make it" elsewhere and because we were going to follow that path, we needed to know less. That is not to say there aren't specialists who appreciate the unique skill set of general practitioners, but it only takes one bad apple to spoil the barrel; one throw-away comment or action that one medical student will not forget. As we know, those in the medical profession are often perfectionists and enjoy challenging themselves, so once this idea of "settling" for general practice has been planted, it is difficult to uproot.

Rural medicine has a similar undercurrent. While completing my job applications, I heard many students say site X was their "rural backup". This may not be as much of an issue outside of Victoria due to the ballot system used to allocate interns, but the current Victorian z-score system reinforces the idea that the "best" interns are in the metropolitan hospitals and the rural hospitals get whatever is left over.

I am pleased to say that this attitude seems to be changing, in that, at least among my cohort, many students aspire to practise rurally. However, we are often required to justify this choice. The doctors who came to teach my rural cohort would often express their condolences that we had to practice rurally. A friend of mine is based at a regional Victorian hospital and got an excellent intern-z score; she was one of the top five students in our cohort. She wants to stay where she is because she loves the hospital and has settled in the area with her partner. She tells me she often gets looks of sympathy when people hear she is placing this rural hospital as her first preference in job applications because there is an assumption only people who performed poorly would preference rural hospitals. She must justify that she did not do poorly; she has a genuine interest in rural practice. Meanwhile, our classmates who want to work in city hospitals are accepted as the status quo.

This brings me to my point. Perhaps we would not have such a degree of rural workforce shortage and loss of interest in general practice if these career choices were not looked upon as consolation prizes. Like AMSA President, Jessica Yang said in her AMA National Conference address; we need to lift each other up. We need to encourage all doctors in their endeavours and back this with our actions. We must foster equality within medicine, providing fair pay, access to support, education and respect so that we can put it into practice for the betterment of Australian healthcare.

Caring for the vessel through which patient care is delivered

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

In this column, I offer an overview of where AMA's influence is being brought to bear in alignment with a small but important October 2017 amendment of the Declaration of Geneva of the World Medical Association that was discussed at the 2019 AMA National Conference (and even by me in the Workforce Issues debate); "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard."

> "The AMA continues to consolidate the national health program for doctors and medical students with funding support from the Medical Board of Australia."

Self-care is a critical virtue, but I also insist that there is an associated obligation that we all care for our colleagues, enquire about their wellbeing by regularly 'checking in', and encourage them to seek support at the earliest indication of something being not quite right. Don't forget the President awarded his President's Medal to Dr Geoffrey Toogood of Crazy Socks 4 Docs fame. Of course, employing public hospitals must show the same level of concern and care by providing a safe workplace and having good, empathetic management systems.

The AMA is participating in the development of a Federal Government funded national framework for tackling mental ill health in doctors and medical students. The framework will assist design of safe, supportive environments (in universities, Learned Colleges and hospitals) and provide strategic direction on improving mental health and reducing suicidal behaviour.

The AMA continues to consolidate the national health program for doctors and medical students with funding support from the Medical Board of Australia. The AMA's subsidiary, Doctors' Health Services Pty Ltd (DrHS), is coordinating the delivery of services by doctors' health advisory services in every State and Territory. Under that umbrella there are some funded support and training packages in late development stage anticipated to have real positive practical effect.

Particularly from your CPHD's perspective, we should never overlook the positive duty our employing public hospitals have to care for all of their staff. This goes to doctors' mental health and general wellbeing but also, now that I think of it, goes to issues I have recently tackled in my *Australian Medicine* columns, like NSW trying to implement open-plan office space and the lack of a nationally consistent rules to transfer parental leave entitlements between jurisdictions. Additionally, I'm aware of several health services who are bloody-mindedly interfering in a workplace entitlement related to clinical support time for over-worked and over-stretched employed doctors. These perverse examples demonstrate workplace rights and entitlements go to the very heart of professional respect which have an obvious nexus to doctor wellness.

The OECD has noted that macro-economic statistics such as national GDP don't offer a picture about peoples' lived experience. The measurement of well-being (and 'real' progress), says the OECD should include health status; work life balance, social connection, involvement and governance.

So, wondering out loud, should we have public hospitals investigating the effect their workplace is having on health and wellbeing in conjunction with traditional clinical and financial indicators?

At a minimum, perhaps hospitals need to start asking doctors what the impact is on them when there is (poor) hospital clinical engagement and variously dysfunctional organisational decisions, fatigue reduction strategies and managerial styles. The measured results are unlikely to be good but what if these became annually reported public hospital KPIs? We do tend to be motivated to achieve positive change in the areas we transparently publish and are held against. A public hospital 'wellness index' may well be a well-judged (puns intended) treatment plan. Perhaps a new AMA report card is on its way....

Reviewing genetic and genomic testing policy

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

As we review the AMA's *Position Statement on Genetic Testing 2012*, it is evident that every doctor, regardless of area of practice, must now have a practical knowledge of human genetics and relevant testing in a variety of clinical settings. With the rapidly expanding integration of genetic and genomic services into mainstream health care, we will continue to advocate for a sufficient workforce to meet the demands and expectations of the community. This requires appropriate education and training, workforce planning, investment and infrastructure to ensure that everyone has equitable and efficient access to safe, evidence-based genetic and genomic testing, relevant health care professionals, pathology services, specialist genetic services and counselling services throughout the country.

> "While genetic and genomic testing is a relatively new technology, it is imperative that we remove these sorts of barriers and disincentives that undermine community confidence in the system in order to realise the benefits such testing provides."

Our policy must also be responsive to the ongoing ethical, legal and social challenges associated with genetic and genomic testing such as the exponential rise and influence of direct-to-consumer genetic testing and the right to protection of genetic information.

A significant issue recently discussed by the AMA's Ethics and Medico-Legal Committee (EMLC), the relevant committee coordinating the policy review, is genetic discrimination. Genetic discrimination is where an individual is treated unjustly or unfairly because of their actual or perceived genetic status. The fear of genetic discrimination can be a deterrent for many people who would otherwise benefit from genetic or genomic testing. A common example of this relates to the life insurance industry.

Until recently, a person applying for life insurance in Australia had to reveal any known genetic test results which could then be used to assess their insurance eligibility. While some may argue that insurers using genetic or genomic test results is no different to using family history, the fear that a positive genetic test would be used by the life insurance industry to deny an individual insurance (or subject them to higher premiums) is a known deterrent for many who would otherwise benefit from testing.[1]

While genetic and genomic testing is a relatively new technology, it is imperative that we remove these sorts of barriers and disincentives that undermine community confidence in the system in order to realise the benefits such testing provides. In response to community concern, the Financial Services Council recently enacted a moratorium on life insurance genetic tests. As of July 1, Australians will be able to obtain up to $500,000 worth of life insurance without having to disclose an adverse genetic test result. While some may argue this does not go far enough, it is a step in the right direction. The moratorium is due for review in 2022 and will be in place until at least 30 June 2024.[2,3]

But as genetic and genomic testing becomes more mainstream, we need to consider whether there will come a point where genetic information should be treated the same as other medical information or should it always be afforded a degree of 'special protection'? This will be an ongoing discussion and, as with many social issues, community and professional attitudes to the protection of genetic information will likely shift over time and it will be essential that the relevant ethical, legal and regulatory frameworks reflect and support this.

These and other issues relevant to genetic and genomic testing will be considered by the EMLC as we undertake the review of the policy. The current *Position Statement on Genetic Testing 2012* is available on the AMA website at https://ama.com.au/position-statement/genetic-testing-2012. If members would like to provide their views on revising the statement, please send them to ethics@ama.com.au

1 Louise A Keogh and Margaret F A Otlowski. Life insurance and genetic test results: a mutation carrier's fight to achieve full cover. Med J Aust 2013; 199 (5): 363-366.

2 Financial Services Council. Media Release. FSC Announces Moratorium on Genetic Tests for Life Insurance to Start in July 2019. 30 October 2018.

3 Financial Services Council. Media Release. Update on Genetic Testing Moratorium and Life Code Review. 15 March 2019.

MBS Review implementation – a watchful eye on unintended consequences

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

Co-claiming attendance items with T8 surgical operation items

AMA surgical colleagues will be acutely aware that from November 1, 2017, subsequent attendance items (eg 105,116, 119 etc) have had a block put on them so they can no longer be claimed with Group T8 surgical operation items that has a schedule fee of $300 or more. The AMA has no issue with the principles behind this change as it is premised on the complete medical service rule, whereby the attendance component of the service is inherent in the surgical operation MBS item.

However, recognising that there may be instances where it is necessary for a subsequent consultation and an unrelated procedure to be claimed for the same patient on the same day, the November 2017 changes provided new items for attendances for such situations – that is, they are not inherently related to the surgical operation. Three new subsequent attendance items (111, 117 and 120) were introduced and can be claimed if during the attendance, the specialist or consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled, and the schedule fee for the operation is $300 or more. The new structure does not preclude claiming an initial attendance in association with a procedure; in recognition of occasions when treatment is urgent.

It was through the AMA's engagement with its members that we determined that there was a gap in this new structure. It was clear that there were unforeseen consequences such as disadvantage to rural and remote patients; and where access block and workforce shortages applied – there was no consultation item that allowed for a planned procedure AND an attendance for another clinical purpose. Accordingly, the AMA worked closely with the Australian Department of Health (the Department), over the last 18 months, which resulted in the successful introduction of a new item (115) on April 1, 2019, that mirrors the intent of items 111, 117 and 120.

Item 115 can be claimed where there is a scheduled operation and a subsequent attendance item for an unrelated matter. It is important that the clinical purpose of the attendance is unrelated to the conduct of the procedure and that delay of the consultation represents a clinical risk to the patient. In all situations, the specialist or consultant physician must be satisfied that there is a clinical risk to defer the consultation for the patient to another time, and patient records clearly identify why the consultation is considered necessary for the patient, including the clinical risk to defer the consultation.

The Department has advised that item 115 would not be appropriate to be claimed where there is a routine review attendance and an unscheduled procedure such as a capsulotomy is performed as a result of the review. Similarly, 115 should not be claimed for routine extended consultations with procedures.

Thoracic Medicine - Respiratory and Sleep study items

On November 1, 2018, the MBS implemented changes to respiratory function test and sleep study items. The Department is planning a review of initial claiming data for the new and amended thoracic items. As part of this review process, the Department will consider any clinical or implementation concerns raised following November 1, 2018, through formal submissions from relevant organisations. The Department has advised that as some issues about implementation have already been raised, organisations such as the AMA should commence discussions around a possible submission ahead of the formal review.

If members wish to raise any significant issues (eg reduced patient access to services) with the new thoracic medicine items please report these to the AMA via Ms Tham Vo, Senior Policy Adviser at tvo@ama.com.au

Research

WITH CHRIS JOHNSON

Aussie diet research discussed at Prague

Dietetics researchers at Flinders University are exploring solutions to help turn around the situation where more than a third of what Australian children and adults eat and drink each day are unhealthy foods.

This is up to three times higher than public health recommendations.

Strategies for parents to provide fewer unhealthy foods to young children were being presented by PhD candidate Brittany Johnson at an international conference in Prague.

"We've found that intervention strategies are needed to focus on parents' physical resources and social supports, including reducing the availability of unhealthy foods at home, overcoming child resistance and having more support from co-parents," says Ms Johnson.

"We also found that parents' motivation can be enhanced by confidence, planning and their intention to reduce unhealthy foods. To boost their confidence, parents can use positive self-talk, which is reminding yourself that you can reduce how much unhealthy foods children eat, or to provide healthier alternatives that their child likes."

She says planning tips include establishing clear plans before entering a supermarket, such as avoiding the snack isle to help reduce how often unhealthy foods are purchased.

This is part of an extensive array of research projects into improving diet quality that Flinders University Nutrition and Dietetics researchers presented at the International Society of Behavioural Nutrition and Physical Activity Annual Meeting in Prague, between June 4 and 7. The meeting attracted more than 1000 researchers, practitioners and policy makers aiming to promote innovative research and policy about behavioural nutrition and physical activity.

Poor diet is a key risk factor for many chronic conditions, with unhealthy foods being a key contributor to our food-related environmental impact, considering the production, processing, packaging and huge current consumption of these foods.

Flinders University's Dr Kacie Dickinson presented work describing Nutri-Score, a labelling system developed in France, and its impact in evaluating the healthfulness of packaged food and beverages. This was part of a project she conducted at the University of Toronto in 2018, funded by an Endeavour Research Fellowship.

"This work helps shed light on which types of products nutrition policies should target to improve the healthfulness of packaged foods," said Dr Dickinson.

In other research presented at the conference, PhD candidate Chelsea Mauch showed that a family's resources of time and money have an influence on unhealthy food intake in Australian toddlers. With a rise in the number of dual-parent working families, time-poor parents can turn to technology for support.

"Meal planning apps with synced shopping lists can help parents to work together in reducing the time burden of food-related tasks and make healthier choices," Ms Mauch said.

Dr Dorota Zarnowiecki presented work describing the development of a rapid assessment tool measuring diet risk factors for obesity in young children, conducted in collaboration with researchers from across Australia within the Early Prevention of Obesity in Childhood Centre for Research Excellence (www.earlychildhoodobesity.com) and with memory expert Associate Professor Glen Bodner from Flinders University. This work has used insights from psychology to develop a measurement tool that is accurate, quick and easy for parents

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to use, and cost-effective in measuring risk factors for early childhood obesity within large-scale surveys, community programs and clinical settings.

Eating disorder research project gets huge support

Deakin University has secured $1.34 million in funding to lead ground-breaking research into prevention and early intervention for eating disorders, under the Medical Research Future Fund Millions Minds Mission grant program recently announced.

The four-year project will be spearheaded by experts working across multiple disciplines and research institutions to deliver tailored therapy programs for those most vulnerable to eating disorders, direct to their smartphones.

Web and app Integrated Resource for Eating Disorders (WIRED) will flip the typically negative role social media networks and apps play in proliferation of eating disorders to become a key avenue for prevention.

Chief Investigator and Associate Professor in Deakin's School of Psychology Matthew Fuller-Tyszkiewicz said anorexia was the most fatal of psychiatric disorders, yet the vast majority of those affected did not seek help.

"One in 10 Australians will experience disordered eating at some point in their lives, and the burden of disease is similar to depression and anxiety, costing the economy about $70 billion per year," Associate Professor Fuller-Tyszkiewicz said.

"But people experience eating disorders very differently, they can be triggered by wide-ranging things like trauma, low body image, or traits of perfectionism, so if we want to address these issues it's crucial we target people in a way that is relevant to them."

The first two parts of the project will look at developing web and app based interventions targeted at two vulnerable groups: young adults and gay men. The first led by Victoria University's Dr Sian Mclean and the second by University of Melbourne researcher Dr Scott Griffiths.

"The clichéd way to look at it is that women want to be thin and men want to be muscular, but what we will be creating is an even more personalised intervention approach that can be delivered online," Associate Professor Fuller-Tyszkiewicz said.

"It will look at the specific symptoms of individuals to identify their most pressing needs and then adapt the content delivery to that, so they get the intervention modules that will be most effective for them straight away.

"Those first few sessions, when people are really vulnerable and need to be heard, they are critical to keep people engaged. By collecting enough data, and setting up an intervention to respond, we can adapt that program in the same way a therapist can adapt in face-to-face therapy."

Associate Professor Fuller-Tyszkiewicz said of all the people who experienced eating disorders, only a quarter sought help.

"We want to overcome some of those barriers by meeting people where they are," he said.

"The barriers to treatment can be cost-related, lack of access in rural areas, the time commitment, or lack of anonymity. People often feel ashamed to seek help. We believe an app can overcome a lot of those barriers, and hopefully do just a good a job as face-to-face therapy."

The apps will be informed by a third piece of work, led by Dr Suku Sukunesan, a social media analyst at Swinburne University.

"There is a lot of chatter on social media about eating disorders, and a significant and concerning part of that content is about promoting these disorders and trying to help people maintain their symptoms," Associate Professor Fuller-Tyszkiewicz said.

Research

"We want to create algorithms that take information from social media platforms to better understand this conversation. We can then try to disrupt those negative discussions to offer more positive messages about what works to combat disordered eating and what's healthy."

Work officially begins on the project in July, and it's hoped the first versions of the apps will be rolled out from early next year.

Associate Professor Fuller-Tyszkiewicz said there would be end-user engagement at all stages of the project to ensure the best chance of uptake, and a cost evaluation of the intervention would be carried out by Deakin Health Economics

"We believe this can be a cost-effective way to deal with what is a really worrying and expensive mental health issue," he said.

"Young people are using social media and apps so we want to meet them where they're at, and help them engage with these tools differently so these platforms are not perpetuating problems, but providing solutions."

WIRED will be a collaboration between Deakin and Latrobe University, the University of Melbourne, Swinburne University, Victoria University, the Butterfly Foundation, the Australia and New Zealand Academy for Eating Disorders, and the Victorian Centre of Excellence in Eating Disorders.

New technology breakthrough could revolutionise devices

Monash University materials scientists have helped uncover an important breakthrough in fundamental physics that further paves the way for the development of next-generation flexible, wearable devices powered by 'spintronics'.

An alternative to electronics, 'spintronics' relies on an electron's spin, rather than its charge. In traditional electronics, devices are powered by the positive and negative flow of an electric charge through silicon semi-conductors, whereas spintronics relies on the magnetic field generated as an electron 'spins' on its axis, much like the movement of a spinning top. With quantum-mechanical properties allowing for lower energy use and faster data transfer, spintronic devices have the potential to revolutionise technology design and use into the future.

In collaboration with an international research group led by Cavendish Laboratory at Cambridge University, Monash University's Department of Materials Science and Engineering Professor Chris McNeill led a breakthrough in the understanding of spin properties in semiconducting materials other than traditionally-used silicon, in particular, semiconducting polymers.

Since silicon is hard and brittle, it cannot be used to conduct electricity through flexible, bendable devices, such as wearable technologies or foldable screens. Semiconducting polymers, in the form of thin bendable plastic, can be used instead, although their semiconducting properties are not as well understood.

In the study, published by international science journal *Nature Physics*, Professor McNeill and his team revealed the underlying fundamental physics of electron spin in semiconducting polymers. Using the Small Angle X-Ray Scattering/Wide Angle X-Ray Scattering (SAX/WAX) beamline at the Australian Synchrotron, Professor McNeill helped to show that the microstructure of semiconducting polymer thin films strongly influences how long electrons in the material maintain their spin state, an important property for device exploitation.

"It was also important to determine spin behaviour at room-temperature, as spintronic devices will need to function normally in everyday settings, exactly like your smartphone and laptop does," said Professor McNeill.

"Our findings provide fundamental direction on how to engineer semiconducting polymers to get the best spin performance, and therefore further progress the development of next-generation devices that move beyond the current boundaries of traditional electronics."

"Since spintronics requires less energy, and allows for faster data transfer, we've now laid the groundwork for some exciting new possibilities for researchers to explore at the intersection of technology and physics," said Professor McNeill.

Study suggests doctors should not fear litigation for end-of-life care

Clinical practice that seeks to alleviate the suffering of patients at the end of their lives will not be punished under the law, according to the authors of a perspective published in the *Medical Journal of Australia.*

Research

Led by Professor Geoffrey Mitchell, professor of General Practice and Palliative Care at the University of Queensland, the authors wrote that the convergence of two separate conversations – the overuse of opioids, and the passing of assisted suicide legislation in Victoria, and shortly, in WA – had created a "perfect storm" of fear for clinicians involved in end-of-life care.

"An unintended but predictable consequence appears to have arisen: anecdotal reports of some practitioners choosing to abandon end-of-life care altogether rather than risk professional ruin should they persist in the use of any opioid therapy," wrote Professor Mitchell and colleagues of the opioid overuse debate.

In terms of assisted suicide, the fear is that "the use of medicines to minimise suffering and distress at the very end of life may hasten death and be construed by critics as euthanasia by stealth".

Professor Mitchell and colleagues recently published a systematic review in the *Journal of Law and Medicine* (2018; 26: 214-245) which tested "the extent to which there have been legal sanctions against health practitioners on the basis of overmedication possibly hastening death, in the setting of life-limiting illnesses".

"We identified 12 cases in total across all jurisdictions in publicly available electronic databases, and of those, only two had adverse findings recorded," they wrote.

"Database searches revealed that neither led to criminal proceedings. This indicates that regulatory bodies are not seeking to blame practitioners when death occurs in the presence of opioid administration, and that the intention to alleviate suffering and adhere to good clinical practice is respected.

"[Practitioners] should use both treatments and doses that are clinically indicated to alleviate the person's suffering. Opioids should not be avoided, and the minimum dose that achieves pain relief or reduction of chronic breathlessness should be prescribed.

"Clinical practice that seeks to alleviate suffering will be respected by the law and not punished. Practitioners can be assured that the law does not constitute a hazard to safe practice, but an ally to be valued."

Erectile dysfunction a predictor of heart disease

Erectile dysfunction is a predictor of overall cardiovascular health and silent myocardial ischaemia. Treatment with medication and psychotherapy remains the gold standard, according to the author of a narrative review published in the *Medical Journal of Australia*.

Dr Christopher McMahon, a sexual health physician at the Australian Centre for Sexual Health wrote that the prevalence of complete erectile dysfunction is about 5 per cent among 40-year-old men, 10 per cent among men in their 60s, 15 per cent among men in their 70s and 30 to 40 per cent among men in their 80s.

"Erectile dysfunction is associated with increasing age, depression, obesity, lack of exercise, diabetes mellitus, hypertension, dyslipidaemia, cardiovascular disease, lower urinary tract symptoms (LUTS) and benign prostatic hyperplasia," Dr McMahon said.

"However, only half of the men who self-report ED are concerned about it."

A thorough medical, personal and culturally sensitive sexual history and clinical examination is essential to diagnosis of erectile dysfunction. Treatment requires lifestyle modification to reduce the impact of comorbid vascular risk factors and treatment of organic or psychosexual dysfunction with either pharmacotherapy alone or in combination with psychosexual therapy.

"The treatment options for men with ED are effective, safe and well tolerated," wrote Dr McMahon.

"Treatment with ED pharmacotherapy alone or in combination with graded psychosexual therapy is effective in improving and/or restoring sexual function in most men. Overall, there is a high level of consensus on the management of ED in the selected guidelines with few inconsistencies."

Treatments include psychosexual therapy, oral pharmacotherapy, patient-administered intracorporal injection therapy, vacuum constriction devices, and surgery which is usually limited to patients with major penile arterial or venous disease, corporal fibrosis or Peyronie disease, who are either unresponsive to or are not candidates for ED pharmacotherapy.

World News

WITH CHRIS JOHNSON

The ills of tobacco

The World Health Organisation has used World No Tobacco Day to highlight the rate of tobacco-related lung diseases around the globe.

More than 40 per cent of all tobacco-related deaths are from lung diseases like cancer, chronic respiratory diseases and tuberculosis.

WHO is calling on countries and partners to increase action to protect people from exposure to tobacco.

World No Tobacco Day was on May 31 and the AMA issued a strong statement in support of the day and action needed to reduce tobacco harm.

"For many years, Australia has been considered a world leader in tobacco control, with plain packaging, graphic warnings, restrictions on advertising and continued increases in excise," AMA President Dr Bartone said.

"As a result, smoking rates in Australia halved between 1991 and 2016, from 24 per cent to 12 percent.

"Despite these declines, smoking continues to be the leading preventable cause of death and disease in Australia, and it is a leading risk factor for many chronic health conditions.

"Tobacco is unique among consumer products in that it causes disease and premature death when used exactly as intended.

"Two in three smokers will die as a result of smoking. Smoking increases the risk for coronary heart disease, stroke, peripheral vascular disease, respiratory disease and many cancers.

"World No Tobacco Day provides an important opportunity to discuss quitting strategies with current smokers. Hopefully it also encourages many smokers to engage in a quit attempt."

The WHO issued its own strong statement highlighting the damage tobacco causes to lung health.

"Every year, tobacco kills at least 8 million people. Millions more live with lung cancer, tuberculosis, asthma or chronic lung disease caused by tobacco," said WHO Director-General Dr Tedros Adhanom Ghebreyesus.

"Healthy lungs are essential to living a healthy life. Today – and everyday – you can protect your lungs and those of your friends and family by saying no to tobacco."

In 2017, tobacco killed 3.3 million users and people exposed to second-hand smoke from lung-related conditions, including:

- 1.5 million people dying from chronic respiratory diseases
- 1.2 million deaths from cancer (tracheal, bronchus and lung)
- 600 000 deaths from respiratory infections and tuberculosis

More than 60,000 children aged under five die of lower respiratory infections caused by second-hand smoke. Those who live on into adulthood are more likely to develop chronic obstructive pulmonary disease (COPD) later in life.

The WHO is urging countries to fight the tobacco epidemic through full implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) and enforcing effective tobacco control actions, including WHO's recommended "MPOWER" policy measures, for example by reducing demand for tobacco through taxation, creating smoke-free places and cessation support.

It is also encouraging parents and community leaders to take steps to safeguard the health of their families and communities by informing them of and protecting them from the harms caused by tobacco.

Tobacco smoking is the primary cause for lung cancer, responsible for more than two thirds of lung cancer deaths globally. Second-hand smoke exposure at home or in the workplace also increases risk of lung cancer. Quitting smoking can reduce the risk of lung cancer: after 10 years of quitting smoking, risk of lung cancer falls to about half that of a smoker.

Tobacco smoking is the leading cause of chronic obstructive

World News

pulmonary disease (COPD), a condition where the build-up of pus-filled mucus in the lungs results in a painful cough and agonizing breathing difficulties. The risk of developing COPD is particularly high among individuals who start smoking at a young age, and those exposed to second-hand smoke, as tobacco smoke significantly slows lung development. Tobacco also exacerbates asthma, which restricts activity and contributes to disability. Early smoking cessation is the most effective treatment for slowing the progression of COPD and improving asthma symptoms.

Infants exposed in-utero to tobacco smoke toxins, through maternal smoking or maternal exposure to second-hand smoke, frequently experience reduced lung growth and function. Young children exposed to second-hand smoke are at risk of the onset and exacerbation of asthma, pneumonia and bronchitis, and frequent lower respiratory infections.

Tuberculosis (TB) damages the lungs and reduces lung function, which is further exacerbated by tobacco smoking. About one quarter of the world's population has latent TB, placing them at risk of developing the active disease. People who smoke are twice as likely to fall ill with TB. Active TB, compounded by the damaging lung health effects of tobacco smoking, substantially increases risk of disability and death from respiratory failure.

Tobacco smoke is a dangerous form of indoor air pollution: it contains more than 7,000 chemicals, 69 of which are known to cause cancer. Though smoke may be invisible and odourless, it can linger in the air for up to five hours.

In order to achieve the Sustainable Development Goal (SDG) target of a one-third reduction in NCD premature mortality by 2030, tobacco control must be a priority for governments and communities worldwide. The world is not on track to meet this target.

A pedestrian holiday that isn't for everyone

BY **ANDREW LEWIS**

"Now that's a strange looking dog." I did not think those words would pop into my head when embarking on a four-State, 17-destination, 7,060-kilometre, high summer annual leave motorcycle journey, living outdoors, by myself, camping all the while. But I did think that this would be a little pedestrian when compared to my past journeys, which have traversed much of the continent.

All of my stuff has to fit on the motorbike. My fondness for organisation, the amount of gear and order that has to go into packing my bike once prompted a colleague to utter "that behaviour is the most OCD thing I have ever seen". And, before you ask, "don't you get hot in those leathers?", it's no problem when riding but, when you stop, it's like wearing a wet suit in the sauna.

On previous trips my *modus operandi* has been to maximise escape from the usual, seek extreme heat and travel huge distances away from people. But, having relocated to Canberra in October 2016 to serve Federal AMA, I took the opportunity to travel the backroads and visit some key features of my home State of Victoria (with some Queensland and South Australia thrown in).

Back in 2012, when half of Queensland was literally under water with floods, I camped right on the water's edge under a tree at Copeton Dam. This north central NSW dam was only at 12 per cent capacity rather than it being filled to its usual 1.5 times the size of Sydney Harbour, and there was a major bushfire. It was very, very smoky camping.

The ride out, heading north at my preferred dawn departure time having decamped as usual under an uninterrupted star canopy, was reminiscent of what I imagine a battlefield to feel like just after the combatants have departed. This was the residual effect of the fire having ravaged around the dam, closing the roads and causing evacuations. I didn't see burnt bush as I sped by but there was an eerie light, a low-pressure atmosphere and it felt oddly lonely. Once before I have had that feeling when on one of these past journeys. Back then, just after sun-up somewhere near the West Australia north-east border with the Northern Territory, I came across a crashed road train with a collapsed cabin (driver clearly had not survived). This crash had obviously occurred overnight and had just been cleaned up. I'm still not sure whether imagination creates sensations or whether there are experiences not fully explainable.

Anyway, on this trip, I had a great time for a few days camping on my best mate's property on Mt Tamborine in Queensland. Then it was time to head south.

Apart from a murderous ride on a 25-kilometre track into a mid-NSW national park after 600km in the saddle, this holiday was fairly cruisy riding. Oh, hang on, I forgot about the 900 kilometres in one day from the desert of Wyperfeld National Park (north Western Victoria) back to Canberra. What a killer! Note to self, feet swell in the heat, motorcycle boots do not move, the pain causes screaming inside your helmet.

The only irritant at Buchan Caves (Victoria south east) was that my underground camera skills were found wanting to the point not one stalactite deserves re-publishing here. The caves don't beat Jenolan for variety or beauty but for sheer volume; fantastic. I had not been to Wilson's Promontory (most southern tip of mainland Australia) since 1989, despite its closeness to Melbourne, but I can report it is an absolute jewel. Really oddly, the water is warm, much warmer than just experienced mid NSW coast. The 15-kilometre hike beginning before sunup took in three bays to the West with an occasional black wallaby sighted hoping on the beach.

In Halls Gap, the Grampians, Western Victoria, the four-hour or so hike up to the lookout was lactic acid inducing and despite heading off before sunrise, my tee shirt was as wet from perspiration as if I had jumped into a bathtub. Rewarded with fantastic views from a great height and after a one-hour rest of

we go back down the single track. An exhausting number of hours later I find myself back at the top; what a total idiot! I had lost the track three quarters of the way down and clearly chose the wrong direction having re-found the track. Be aware, hiking ridge lines means up and down are not as obvious as you might think; that is my excuse anyway.

Beach relaxation in Port Elliot on the Fleur Peninsula and Robe, both in South Australia, along with camping on a stream in Mt Beauty (the Victorina high country), was just like a 'normal' holiday. Goannas roam free and the beach is uninterrupted north and south from my bush camp. So, there I was, on my birthday, by myself on the beach, in the near dark, about to watch the sun rise, and was later to watch a dolphin pod surf waves. I notice a strange dog in my peripheral vision. It was staring and then I noticed the moving pack... of dingos. Harassment without contact began and they didn't wander off into the dunes until I showed my 6'4" frame and made confusing ridged arm movements. Happy holidays and if I learnt anything, it seems to me, Lindy Chamberlain was right!

Andrew Lewis is an AMA senior industrial adviser

Good theatre = good health

BY CHRIS JOHNSON

Are the dramatic arts good for mental health? Of course. Physical health? Absolutely.

Switched on theatre groups know this and build programs with the aim of enriching the minds and lives of both audiences and performers.

The Street Theatre in the nation's capital is one such organisation that creates seasons of good theatre that equate to good health.

Maura Pierlot, an award-winning author and playwright, who hails from New York and has called Canberra home for the past 25 years, is a former medical news reporter and editor of *Australian Medicine*. Her new work *Fragments*, a series of eight interrelated, dramatic monologues that explore mental health issues facing young people, will be performed at The Street Theatre later in the year.

Pierlot says: "The arts are transformative. Theatre projects can increase self-esteem and enhance well-being. Theatre enables people to tell stories, whether their own or imagined stories.

Theatre can be inspirational, educational, hopeful, empowering, engaging, transformative. It can lead to personal growth, improved self-esteem and increased well-being.

"Theatre creates dialogue, provides a forum for exercising one's voice, space to explore new identities, create awareness about social issues, combat stigma etc. Theatre has performative aspects, but can also play therapeutic, pedagogical and activist roles."

Watching a live show can be so exhilarating that it has cardiac benefits. Researchers who monitored a small sample of theatregoers during a performance of *Dreamgirls* found their heartbeat was at an elevated range of 50 to 70 per cent for nearly a half-hour, tripling from its resting state by the second act.

In 2017 the Australian Theatre for Young People (ATYP) commissioned research on the mental health impact of its program on young people over the last 20 or so years. They wanted to determine whether participating in drama offered benefits other than more acting and performing skills.

Almost 90 per cent of the more than 1,200 who participated in the ATYP survey indicated that drama participation had a positive effect on their self-esteem, with 94 per cent reporting a positive impact on their general wellbeing.

The Street Theatre welcomes Western Australia-based Spare Parts Puppet Theatre back to its stage bringing their adaptation of Roald Dahl's *The Twits* from July 10 to July 13.

Arriving just in time for the July school holidays, this very irreverent classic will take Canberra audiences into the world of grumpy old couple, Mrs and Mrs Twit. Blending comedy and puppetry and perfect for kids 4+ The Twits is bound to put a grin on faces of all ages. As Dahl says in The Twits, "a person who has good thoughts cannot ever be ugly."

Spare Parts Puppet Theatre's director, Michael Barlow said that *The Twits* is a classic Dahl comedy of a pair of horrible bullies getting their just desserts in the end. "Roald Dahl has a special gift for making fun of adults who treat children unfairly and our heroes can only win by breaking the rules and playing a few tricks of their own. As laugh-out-loud entertaining as *The Twits* is, it is a great show for encouraging us all to think about how we treat each other."

First Seen: new works-in-progress, is The Street's storied program for theatre-makers. Now in its eighth year, *First Seen* promotes the creation of high quality, original performance work, encouraging debate on issues and relationships. In 2019, the works selected are immersed in personal stories and journeys, and life-changing illness and all written from the heart.

In July, Hanna Cormick will undertake a creative development process for *Zebracorn*, a title for her new work drawing on how in medical training, doctors are taught "when you hear hoofbeats, think horses not zebras", to prevent overdiagnosis of rare conditions when a common one is more likely, but rare disease patients are falling through the cracks.

Zebracorn explores how in her late-20s, living in Paris, Cormick became profoundly ill with a series of mysterious and rare medical conditions. A physical-theatre video-art fantasia will take audiences on kaleidoscopic journeys into the underbelly of chronic illness and rare disease.

Powerful play takes message overseas … and regional Victoria

Hallowed Ground – Women Doctors in War, the stunning play based on the book co-written by the AMA's own Associate Professor Dr Susan Neuhaus, is going overseas. The play has been invited to the Edinburgh Fringe Festival in August.

Performances of the play received standing ovations at the Adelaide Fringe Festival in February. It will be a feature of the Australasian Military Medicine Meeting in that city in October.

Meanwhile, it is touring regional Victoria throughout June. Details, venues and dates can be viewed at https://theshifttheatre.com from the Shift Theatre.

Holden Equinox

BY **DR CLIVE FRASER**

At exactly 1.54am on June 22, 2019 the earth's South Pole will be maximally tilted away from the sun and consequently the Southern Hemisphere experiences its shortest day of the year.

This celestial event is called the winter solstice, a Latin word meaning 'stationary sun'.

There are many superstitions about the winter solstice though it's undoubtedly not a myth for those who suffer Seasonal Affective Disorder.

While in some cultures this day marks the depths of winter, in others it's celebrated as the birth of the sun because after this day two more minutes of daylight are added every day.

Halfway between the solstices lies the equinox derived from the Latin for 'equal night'.

That's the date twice a year when sunrise and sunset are exactly 12 hours apart and a line through the Equator would pass straight through the sun.

Automotive manufacturers have always been keen on naming their cars after celestial objects and events with names like Galaxy, Meteor, Astra, Telstar, Nova, Apollo, Gemini and Saturn coming to mind.

Funny that no one has ever produced a vehicle named the Uranus.

In 2017 the Holden Equinox replaced the Captiva.

The previous model apparently sold well on Manus Island and Nauru.

The Equinox is another mid-sized SUV in what is a very competitive field.

Made in Mexico they sell very well in the United States as a Chevy.

But they are being discounted very heavily in Australia with some dealers offering $13,500 off the list price to clear un-sold inventory.

I had my test vehicle for seven days and clocked up 1500 kilometres around Cairns and up to Cape Tribulation.

I must say that the Equinox LT left nothing wanting in terms of performance.

With a two-litre turbo it produces 188kW of power and 353Nm of torque driven through a nine-speed automatic.

By way of comparison that's more power than a Ford XR V8 GT.

It does prefer PULP though.

For $5,000 less there is a 1.5 litre petrol LS with only 127kW and only six speeds.

There is also a very economical 1.6 litre diesel variant which the salesman told me to steer away from.

My Equinox was front wheel drive which meant that Emmagen Creek was as far north as I would be going on the Daintree track.

GPS with an 8-inch touchscreen came standard on my model and there were only a few spots where it wanted me to go bush.

Safety features included Blind Spot and Rear Traffic Alerts.

The warnings are switchable between a beeping sound or a vibrator placed in the driver's seat to stimulate the perineum.

I must admit that this made me wonder whether the 7th planet name might have got the moniker after all.

There's also Lane Keep Assist and Lane Departure Warning to keep you on the straight and narrow and Forward Collision Alert and Autonomous Emergency Braking just in case.

Active Cruise Control would have been nice, but isn't offered.

An Equinox with all the bells and whistles and all wheel drive will set you back $47,290 drive away.

But don't forget to look for deals as all the vehicles are 2018 build.

My test vehicle was built in January 2018 and was first registered in April 2019.

So just like the name says it had already travelled 1,175 million kilometres in orbiting the sun before I sat in it.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

Louis' boy a conference hit

BY CHRIS JOHNSON

Hands up who went to National Conference. Keep them up if you went to the Saturday night Gala Dinner at the Brisbane Town Hall. Hold them up high if you realised that the musical entertainment for the night was the grandson of the late great, one and only, jazz royalty Louis Armstrong.

That's right Satchmo's grandson is Herb Armstrong and young Herb now calls Australia home – Brisbane in fact.

Herb shared with everyone at the dinner his flamboyant, larger than life style. He was in fine voice as he belted out a string of jazz, soul, funk and rock classics.

It was all great fun, but did I mention he is Louis Armstrong's grandson?

Louis Armstrong (nicknamed Satchmo) was one of the most influential figures in American music and, for that matter, pop culture. Which means he had an enormous impact on the rest of the world.

He changed the direction of music and movies and he helped shaped jazz into what we know today.

A master trumpeter with a beautiful gravelly singing voice, Satchmo indeed was and is a true legend.

Born and raised in New Orleans, the great jazzman died in 1971.

Grandson Herb is also from New Orleans and he has some mighty big shoes to fill.

But hello Dolly, what a wonderful world.

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