AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Family Doctor Week

July 21-27 highlighting GP-led health care, p3

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AMA
ISSUE 31.13 JULY 15 2019

AUSTRALIAN
Medicine

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

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Cover photo by Odette Visser

Focusing on the family doctor

From July 21, the AMA will embark on a week of accelerated activities to highlight the importance of the family doctor and the great work of general practitioners.

This year's Family Doctor Week runs between July 21 and 27, with the theme of *Your family doctor and you: partnering for health.*

AMA President Dr Tony Bartone will use his televised address to the National Press Club on Wednesday, July 24 to outline what is needed from the Government and policymakers to ensure general practice is strengthened and that Australia has an affordable and accessible health system for all into the decades ahead.

His address is titled: *Enough talking – time for action on long-term health policy vision*.

At the AMA National Conference in May, Health Minister Greg Hunt committed to working with the AMA on a 10-year plan for primary health care and general practice. This was in direct response to pressure from the AMA, and Dr Bartone is pushing for the plan to develop a sustainable long-term funding model for general practice.

"One that will better support us to provide targeted pro-active preventive care, make better use of technology and our healthcare teams to ensure patients can access the care they need when they need it," he said.

"One that will deliver patients a better experience on their healthcare journey, where they are engaged in their care, where their care is integrated and well-coordinated, and their risks for poor health and preventable hospitalisations are minimised."

Dr Bartone said that as a GP for more than 30 years, he knows both the satisfaction of providing comprehensive patient care, and the frustration of the value of that service being undermined by a fragmented system.

"As President of the AMA I have undertaken to ensure the GP voice is heard, to secure a significant investment in general practice, to improve access to health care across the board and to enhance the value of general practice as a career of choice," he said.

Over the past year, the AMA has secured more than $1 billion in extra government funding to be rolled out over the coming years to support general practice – including for the new Practice Incentive Program Quality Incentive, retention of the Aged Care Access Incentive, more flexible access to GP care for patients over 70, and bringing forward the lifting of the Medicare freeze on remaining GP MBS items.

"There is much more to do to ensure general practice is supported to provide quality outcomes-based care, now and in the years ahead, regardless of their location," Dr Bartone said.

"The AMA wants to see GPs supported when they need to spend more time with their patients, to provide telehealth services to their usual patients and to provide affordable effective care for hard to heal wounds."

In this edition of *Australian Medicine* there are short interviews with family doctors from around Australia, highlighting the variety of their work and the joy they receive from providing quality primary health care.

CHRIS JOHNSON

Q&A with the President

BY AMA PRESIDENT DR TONY BARTONE

For the President's column this month, AMA President Dr Tony Bartone sat down with *Australian Medicine*, as the 46th Federal Parliament opened, to discuss the AMA's priorities following the recent federal election.

***AM:* How is the AMA positioned post-election?**

TB: I think the outcome of the election, and our presence and our activity during the campaign, highlighted our importance and our position in the whole health debate. We got an enormous amount of cut-through in a very congested and crowded space.

In the days leading up to the election we were the go-to voice for impartial, non-partisan assessment of the various parties' policies. We had a very detailed brief of the criteria against which to assess them and we gave them a very unbiased assessment in the whole process.

***AM:* Is the election result and outcome one we can work with?**

TB: Clearly, I've got as relationship already with the Minister (Health Minister Greg Hunt). Yesterday for example, I saw him at the coffee shop in Parliament House. He stopped, came over and had a chat. In that process we covered three or four key issues that were on the agenda right that very minute. So, that's the immediacy and the importance of that ongoing relationship, which wouldn't have been as possible if we were still building with someone new – be it of either party. He knows what our issues are and he knows that when I say something, it's representing the wider membership. However, I will stick to the key principles. I won't be dissuaded from any important piece of advocacy that we need to do.

People say, 'what's your agenda now?' Guess what? It hasn't really changed. There has been an enormous number of issues that we prosecuted. If we look at our pre-election document, we covered 21 items, 40 pages, a detailed list of asks – and they remain as relevant now as they did a week before the election campaign.

There is an increased desire by the Prime Minister and the Minister on mental health. That remained one of the areas which we called out both sides on before the election. We highlighted the lack of clarity and the lack of detail in the approach across the whole mental health spectrum.

The Minister called a roundtable in the second week he was back in the chair, for all the stakeholders in that space. We were at that roundtable and we made our views known quite clearly. In doing so, we will work to help set a clear framework and an agenda in the months ahead.

And I think our National Conference was very clear on mental health. NatCon said they want the AMA to take a leadership role in trying to solve this issue.

***AM:* What about the crossbench? How important will the minor parties and independents be to the AMA?**

TB: Obviously the Government has a majority in the Lower House, but in the Upper House there's no clear ascendancy. But we will work with all sides of the House, all parties, all people, about good health policy. We have an informative role. If we can inform and educate the various Members of Parliament, that's two-thirds of the job done.

***AM:* Is the AMA entering a new era?**

TB: I don't want to overplay the hand, but clearly there are the optics as well as the synergy of a number of announcements and situations – we have new Secretary General; we have a new Board make-up with two new Board Members; there are new faces around the Federal Council; there's going to be new impetus and activity to achieve outcomes.

We've had a number of challenges over the last 12 months that we have overcome; and there was the uncertainty of an election cycle. I've had the privilege of leading the AMA into an election season. It was important to advocate. Now we've got an outcome, we've got three years of a Government that needs to develop a conversation and a policy platform with the Australian people at a time of increasing pressure and scarce health resources. At a time when the value proposition for private health is being questioned. At a time when waiting lists are getting longer and longer and longer. At time when more and more people are suffering from the effects of poor collaboration in mental health policy reforms. At a time when aged care is in focus every day for all the wrong reasons.

The wider macro economics of the health portfolio, the wider media space, the optics of a new Sec-Gen, the challenges ahead for the Association family, make it a very, very critical time in terms of setting us up for the future. Not just for my next 12 months, but with a view to the life of this Government and beyond.

Q&A with the President ... continued

AM: **Was your recent meeting with Home Affairs Minister Peter Dutton productive?**

TB: We had a very respectful conversation. We are very clear about each other's issues and concerns and we will continue to have constructive dialogue in the weeks ahead. The Government has a particular course of action – a particular way ahead – and we will remain engaged to ensure that at the end of the day we can hand-on-heart be clear about our commitment to the ongoing, independent medical assessment and access to appropriate medical care of the refugees.

We had a very, very open and informative conversation. I think at this early juncture, there was an acknowledgement of the intent to continue to have that conversation.

AM: **What is at the top of the list of current AMA priorities?**

TB: The Minister has announced a 10-year plan for general practice. Clearly, that remains very, very important in the piece. But so does the impending crisis – current and worsening crisis – that is private insurance and private health care. The system that we leave for the doctors of tomorrow and our patients is very much in the balance, depending on the outcome of that conversation.

Mental health, aged care – I've spoken about them both already, but they are right up there at the top of our priorities. There is also clearly a focus during the remaining part of my term on the health and wellness of our doctor colleagues around the county.

Indigenous health is always on the agenda. Obviously, it continues to remain a high priority for the AMA.

AM: **Ken Wyatt is the Minister for Indigenous Australians and the first Indigenous Minister with the portfolio. He is no longer the Indigenous Health Minister – that appears to be part of his new portfolio and is also obviously part of the wider Health portfolio. Do you think this new arrangement will be good for Indigenous Health policy, or is there a risk that it could get somewhat lost a little in the new mix?**

TB: I'll reserve judgement. It remains early days and obviously that is one of the key areas we need to work with. There has been a month of enormous activity up on the Hill sorting out who's who and their relative staff. It's still too early. This week has been as much ceremonial and administrative as anything.

AM: **Why is being part of the AMA important today?**

TB: This is a really crucial time for the AMA. We have a new Government, with a focus on some clear areas where it wants to take health policy. But clearly, we have to ensure that we have a whole-of-health, a holistic, approach to health policy. And clearly, we need to ensure the survival of the symbiotic nature that is the private and public health system that underpins our access to universal health care. If private health collapses, universal health care will be a thing of the past – and with that so will be the access, especially for the underprivileged and socially disadvantaged.

That's one reason why doctors should embrace the AMA.

It's an exciting time to be part of it – to have the opportunity to influence policy and influence outcomes. Be part of the collective voice – whether it's at National Conference; whether it's through the various committees and councils through the States and Territories; whether it's at a national perspective for Federal Council. There are many opportunities and avenues to influence and be part of that vision. Get on board, because it's a fast-moving train and there's plenty happening.

What will the end look like?

BY **AMA VICE PRESIDENT DR CHRIS ZAPPALA**

Recently, a colleague, friend and mentor passed away and I was left bereft. It is difficult when any close colleague passes away, but strangely easier when they've already retired rather than succumbed 'while in the saddle'. As always, this prompted some reflection and how this colleague managed the latter stages of their career and how we as colleagues supported them. Critical in end-of-career planning being positive and productive is the insight and willingness of the senior doctor to participate in this process and to recognise its importance. There is a growing body of literature which examines how doctors approach the end of their career and their views about this. In short, there is room for improvement.

As a physician I am aware, as suggested in the literature, that it is harder to recognise marginal loss of cognitive capacity compared to a loss of dexterity for a surgeon. Any surgeon would find abhorrent (I imagine) the prospect of doing harm and avoidable mistakes while operating within the full view of an operating team. I have witnessed heartless and even hostile ends to careers when gormless administration disrespects senior colleagues and abruptly ends a career based on perceived risk. The failure here is in the discussion with and preparation of that doctor to an end of their career.

I am concerned that institutions and practices do not prepare well enough for the end of doctors' careers. Some of us are very happy to hang up the shingle and ride off into the sunset. Some of us will prefer to transition to a different role – but these roles need to be developed and appropriately recognised and resourced. It is crucially important that this discussion and active transition of senior clinicians to statesman/woman roles occur more often so we continue to have the benefit of the senior clinician's wisdom and experience, but there is respectful recognition of declining capacity in some respects. I would much prefer for the profession to manage this process rather than administrators whose motivations and sensitivities will be different.

The other aspect to this discussion is helping doctors decide what they themselves might want to do if they cease seeing patients. Several doctors have spoken to me expressing their discontent after finishing clinical work, wanting to continue some useful undertaking related to medicine. They'd felt poorly prepared for the transition and unclear on the options available. The Medical Board of Australia has a very wide definition of 'practice' which can include administration, teaching or consultancy-type work. I recall a surgeon who had retired from clinical practice who was one of my anatomy tutors at university. Most students saved their questions for him because he always gave such an articulate, helpful answer with clinically applicability threaded through. We loved him! I'm quite certain my experience and learning of anatomy would have been poorer without this surgeon. Hopefully he enjoyed teaching us. Thank goodness he was happy to do this and was provided the opportunity.

I've occasionally witnessed senior doctors also take on research leadership roles, or policy/administration roles as they progress out of clinical practice. Unfortunately though, many doctors are not aware of these options and they would benefit from guidance. Advocacy needs to be undertaken to expand these opportunities for senior clinicians and the profession clearly needs to be strong in supporting our colleagues throughout their career.

Hopefully no one would argue against the notion of respecting our senior colleagues with a role that preserves their stature and relevance/contribution to medicine. We definitely can do better as a profession in managing this evolution of practice and assisting our colleagues with what can be a difficult transition for some. End-of-career planning is something the AMA could help with to a greater extent. I've witnessed this evolution from a distance and now much more closely and I'm convinced our professional association can have a very positive influence in the life of doctors in doing this. There is also a nice synergy in helping doctors as they start their career as a medical student and doctor-in-training – throughout their practicing life – but also being present towards the end of their career with a helping hand.

Bupa-Terry White deal devaluing and dangerous

The AMA has slammed a so-called 'health benefit package' deal between insurance giant Bupa and Terry White chemists as an insult to GPs and a threat to patients.

AMA President Dr Tony Bartone said the deal being promoted by TerryWhite Chemmart pharmacies in partnership with Bupa, is an attack on general practice and a devaluing of quality primary health care in Australia.

The package is asking pharmacy customers to pay an annual subscription to receive health checks (BMI, blood pressure, blood glucose, and total cholesterol), flu vaccinations, pharmacist health consultations, and REWARDS points.

"It is a misguided marketing exercise that is an insult to GPs, a threat to the health of patients, a blight on the health system, and the Government should outlaw it immediately," Dr Bartone told the media.

In a wider statement, Dr Bartone described the arrangement as crass commercialisation of primary health care, and a sneaky move to introduce US-style managed care to the Australian health system by stealth.

"The AMA and other responsible medical groups used the recent election campaign to increase government and community focus on the importance of investing in high quality general practice," Dr Bartone said.

"Properly funded and resourced primary health care, led by general practitioners who are skilled and experienced in holistic health care, is the future of health care in this country.

"The best and safest place for people to access quality primary health care and advice is the local community general practice from highly trained and experienced GPs.

"General practice provides confidentiality, privacy, and the value of the doctor-patient relationship throughout all stages of life.

"It is not appropriate to conduct sensitive, sometimes life-saving, health checks in busy retail environments, many of which promote dangerous, unproven alternative medicines and therapies.

"General practice is the foundation of quality primary health care in Australia, and any threats to undermine it or replace it with inferior models of care must be rejected.

"It is outrageous that a large health insurer like Bupa would endeavour to undermine general practice, especially after a thorough Government review of private health insurance to ensure that policyholders received high quality and value for money for their significant investment in insurance.

"This partnership will fragment quality primary health care and put further question marks over the value of private health insurance – just as radical new reforms are being implemented."

The AMA is asking Health Minister Greg Hunt to investigate the role of Bupa in this partnership.

"There has been no attempt at meaningful consultation by Bupa – a major player in the private health insurance and aged care sectors – with the AMA and the medical profession about this potentially dangerous initiative," Dr Bartone said.

"Bupa is sailing into uncharted waters with this arrangement. It should be focused on its activities in private health, aged care, and its recent foray into Defence health services, rather than pursue a partnership that seeks to sabotage general practice and put patient care at risk."

Dr Bartone said pharmacists and GPs work well at the local community level in long-established partnerships that are built on mutual trust and respect for each other's specialised scopes of practice.

"Pharmacies marketing unnecessary and expensive pathology tests and other 'health screening' services to their customers – and charging an annual subscription – is a push to increase profits at the expense of evidence-based, cost-effective health care," he said.

"These activities are not within the scope of practice of a pharmacist."

"Pharmacies in the community play an important role in providing medicines information to the public, and ensuring that all Australians have access to medicines in a timely and safe manner.

"But doctors are the only health professionals trained to fully assess a person, initiate further investigations, make a diagnosis, and understand and recommend the full range of clinically appropriate treatments for a given condition."

JOHN FLANNERY

AMA Family Doctor Week

21-27 July 2019

Your family doctor and you: Partnering for Health

Family Doctor Week is an opportunity to highlight the great work of general practitioners and primary care providers. Here, *Australian Medicine* profiles doctors from around the nation – letting them tell their stories and explain why they enjoy being family doctors.

You can actually change the course of someone's life

Dr Alison Soerensen – Western Australia

The Murray Medical Centre is a GP-owned centre in Mandurah, a seaside location south of Perth.

Dr Alison Soerensen did her first year of GP training at the centre and returned to work there after gaining Fellowship of the Royal Australian College of General Practitioners. It is a large practice and provides the full spectrum of primary care. It has 12 full-time equivalent doctors.

"I was doing seven to eight sessions a week, four patients an hour, one hundred patients a week," Dr Soerensen says.

"Young babies and mums mostly. I have a Diploma in Breastfeeding Management. Being able to be involved, often as the first GP who is a constant in a woman's life, is very rewarding.

"Up until that point, it can be transient for them. They might see a GP sporadically. Then they realise the importance of having a regular GP.

"I was barely 17 when I finished high school. I thought medicine was interesting but very maths and science based. I applied to UWA and in order to be considered for medicine it had to be your first preference. So I put it as my first preference and thought I'd let the uni decide.

"My mother found something I had written as a five-year-old. It was my life's goals. They were: have three children, get married, be a doctor."

Dr Sorensen was instrumental in implementing a national policy for breast-feeding mothers sitting exams, and last year was named WA's top junior doctor.

"I practise across the spectrum of general practice – from the cradle to the grave," she says.

"I also am connected to the local hospital. Being able to be a part of somebody's life for more than just a moment ... you can actually change the course of someone's life. Sometimes you're the only constant."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

Comprehensive general practice is exactly that

Dr Ines Rio – Victoria

Dr Ines Rio is no stranger to the AMA membership, being highly and enthusiastically involved in numerous Committees and Councils at the State and Federal levels – as well as other medical networks and boards – some as chair.

She is also a well-known and friendly face at North Richmond Community Health and at the Royal Women's Hospital Victoria.

Dr Rio is a GP at the community health centre and does obstetric work at the women's hospital.

"I'm a GP two days a week and see outpatients at the hospital half a day a week. Then I run the GP liaison unit at the Royal Women's Hospital," Dr Rio says.

She describes the North Richmond Community Health clinic as a fascinating place.

"It is incorporated within a big public housing complex," she says.

"It is a completely bulk-billed clinic with 11 GPs. It is multi-disciplined, even with a dental service.

"We get a real range of people here. There is massive socio-economic deprivation. There have also been these wonderful waves of refugees, from the East Timorese and Lebanese in the 70s, through to Africans and refugees from the Middle East today. We have on-site interpreters.

"We also cater for the very middle class as Richmond becomes more gentrified. It's an interesting waiting room, with varied people.

"Comprehensive general practice is exactly that. We can be dealing with trauma, with grief, domestic violence, drug abuse.

"General practice is relationship-based performance. You form these enduring, longitudinal relationships with patients and their families.

"You are more effective over time. You learn more about them and you learn how to negotiate the healthcare system better for each particular patient.

"Over time, they trust you. They disclose information. They realise that it is actually about you being on their side.

"I am locally trained. Went to Monash, then went into hospitals dipping in and out of lots of different specialties. I was interested in them all and didn't want to give any up. And that's what general practice gives you.

"When you're a GP, you build an enormous amount of knowledge and skills, and you learn so much from your patients.

"I have a very strong interest in maternity care, particularly women under 19. Anti-natal care. I run a shared maternity care program."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

It just gets better and better as you get older

Dr John Saul – Tasmania

Dr John Saul is part of Eastern Shore Doctors, a practice that has four clinics and 35 doctors located between the Hobart suburbs of Lauderdale and Bellerive.

"You need 35 doctors for 20 FTEs these days," Dr Saul says.

"We get the opportunity to practise semi-rural medicine down here too because of some of the locations. We all try and encourage doctors to work at out of area locations.

"It's great being a family doctor. You really don't know what you'll get – acute emergency, mental health.

"At the moment I am treating a woman and also her great grandson. There's 80 years difference between them.

"You just get involved in so much of what they do.

"As a family doctor, it just gets better and better as you get older. Nine out of ten problems that present to GPs, we can usually handle ourselves."

Dr Saul does some work in rural areas, particularly in Bridport on Tasmania's north-east coast.

Sometimes on holiday, he even does some locum work in Queensland.

"I was born in Bernie and grew up in Tassie. I have three grown kids. I wanted to go to university in Hobart for rowing and sailing, and I got in.

"Once I started to get involved in medicine, I realised how enriching it was. It can be a grind, but the patient contact is so fulfilling.

"One of my patients was an elderly lady who had an intellectually disabled son. A few years ago, about 18 months before she died, she said to me 'when I'm gone, he'll be your responsibility'.

"To have someone express that much faith in you is pretty touching and very strong.

"He has family around who look after him, but I do oversee it. I have known him and the family for 30 years and I will probably be looking after him for another ten years at least. Our two families keep an eye on each other these days. We often see each other in the moorings.

"We have some really good doctors here. Registrars are trained well. We do a lot of palliative care here too."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

The appeal of being deeply involved in people's lives

Dr Melinda Choy – Australian Capital Territory

Dr Melinda Choy is a GP at the Gordon Family Practice in Canberra's southern suburbs. She shares her work life between that practice and the Australian National University's medical clinic at the Canberra Public Hospital where she tutors.

"A typical Thursday (the day she spoke to *Australian Medicine*) would be I start seeing patients at 9am until midday. I have a variety of patients and a mix of regular patients, some are family members, some new patients," she says.

"I have lunch then I quickly get out the door and off to the ANU medical clinic at the Canberra Public Hospital. My first focus there is that I've got to get a park.

"I teach first year medical students and give medical skills tutorials. I teach them how to take a good patient history. That initial history is so important.

"I have 8 to 10 students and I teach between 1.30 and 5pm. Sometimes after that, I go to a desk and tidy up something from research.

"I've been at Gordon a year in August. I was a registrar there and am now a very new Fellow.

"One of the privileges of general practice is you get to see people get better, which is nice.

"Even if you don't – people face enormous struggles – you get to see the resilience.

"As you face it with them and help, the side privilege is seeing how people rise up to the meet their challenges. You see their strength.

"I like seeing different members of the same family. We have five doctors spread across different hours.

"That idea of helping people and extending your ability to help – general practice allows that. Teaching allows that a bit too.

"What got me into medicine was an attraction to the science of it all, but also the appeal of being deeply involved in people's lives."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

It's still about what walks through the door

Dr Michael Bonning – New South Wales

Since February, Dr Michael Bonning has been part of Balmain Village Health, in Sydney's inner west.

He loves being a GP. But his career trajectory has been less than typical.

He joined the Royal Australian Navy while at medical school and two weeks after the earthquake and tsunami in Indonesia, he was there and saw what medicine can do.

"I wanted to be a part of that," he says.

"The most interesting thing for me is having the opportunity to do things with my medical training.

"I've done some time in border protection; I have done medical work on behalf of NATO in the Middle East; an ANZAC ceremony in Greece; I've had all sorts of multicultural experiences in South-East Asia. I got to work with some very interesting people.

"I'm currently also the chief medical officer of an adventure travel company and it raises money for charities. So I've been to places like Kilimanjaro, Machu Picchu, the Great Wall of China, the New York Marathon, Argentina's Peak of Aconcagua."

Yet, Dr Bonning says his work in Balmain Village is also extremely enjoyable and rewarding.

"I really like seeing patients. I see about 25 patients a day between 11am and 6.30pm," he says.

"The challenge in general practice is still about what walks through the door. You don't know what you're getting.

"I like medicine because you can work on looking after patients from a preventive point of view – 'pre-hab'. That's especially the case for older patients.

"We really understand them. We know their families.

"I had a great relationship with our family GP. He saw I was somewhat interested and really engaged me. For a 12 to 14-year-old kid, that was pretty exciting.

"A really close family friend had a brain tumour and died. But the care he received was incredible. It made an impression on me to see how much we could do for people."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

The relationship you have with patients over time

Dr Penny Need – South Australia

Dr Penny Need is a practice partner at Pioneer Medical Centre, located at Tea Tree Gully in the outer north-eastern suburbs of Adelaide.

She initially went there as a registrar and Dr Peter Ford was her supervisor.

“Four of us ex-registrars bought the practice from Peter. I love it. It’s a good practice. It is across the board primary care,” she says.

“I see a lot of women and children and I like that focus. I also treat a lot of mental health.

“I enjoy medicine because of the relationship you have with patients over time. That is very powerful. It’s also challenging. A lot of people are struggling out there.

“Dad was a doctor and Mum was a nurse and they met at the children’s medical facility.

“I am the youngest of four children, but the only one who became a doctor. I thought it would be exciting. I love talking to people. I loved (TV serial) *A Country Practice* and Terence Elliot (played by Shane Porteous) was my idol.

“I’m the mother of three boys as well. This work is very accommodating of family and provides flexibility.”

Dr Need’s career has also seen her very much involved in medical education – at the University of Adelaide, and Southern Adelaide Local Health Network.

Currently, she is a Senior Medical Trainer at GPex, the South Australian training organisation specialising in training GPs in excellence.

“A big part of my role is in teaching. I spend .3 of my time in the practice and .7 in teaching,” she says.

“I am training the next generation of GPs and what I see is promising. There is good evidence that we will get some very good GPs.”

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

It's 27 years later and I'm still loving it

Dr Fiona MacDonald – Northern Territory

In Darwin, Dr Fiona MacDonald is somewhat of a legend. A bit of a local hero. She won't admit to that, but after 27 years at the Danila Dilba Health Service she is known to many as a dedicated doctor with a big heart.

Danila Dilba is an Aboriginal community-controlled Indigenous health service for the greater Darwin area.

"We have a different structure to most centres, but we still aim to be a comprehensive health service," Dr MacDonald says.

"I've been here 27 years and have a long-standing relationship with many of my patients. I really appreciate that and so do they.

"We have half-hour appointments. We are very focussed on getting people to trust the medical service.

"Recently, there was one young woman who was in hospital and when asked if she had a GP, she said 'my doctor is Dr Fiona'. That is a big deal for an Indigenous person to recognise you as their doctor and express that kind of trust in you. It meant a lot to me when I heard that."

There are five clinics across the service, and they are all located so local people can access them easily. Dr MacDonald spends her time between clinics in Darwin and nearby Palmerston.

"We work slightly differently from most GPs. We are part of a team yes, but most patients see Aboriginal health professionals before seeing us," she says.

"It is about cultural brokerage. Even with me, some patients still feel more comfortable and tell their stories differently with Indigenous people in the room. We have Indigenous staff.

"I was good at school and I went on a school trip to New Guinea. I loved it. I recognised the good work people were doing there. It made me want to help Indigenous people wherever I could. This is how I have been able to do that, through medicine.

"I am a Melbourne girl. I thought I would come up here for a while then I'd go back to inner city living in Melbourne. I met my partner here. I have three teenage children. It's 27 years later and I'm still loving it."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

It's a great thing to help look after someone's health

Dr Nick Yim – Queensland

Transitioning from pharmacy to medicine isn't common, but for Dr Nick Yim it was a turning point in his education that built the career he has today.

Torquay Doctors (Torquay Family Practice) in beautiful Hervey Bay has just got a new owner.

"I'm actually about to take ownership. It is a doctor-owned practice and I will be one of three GPs who own it," Dr Yim says.

"The clinic has four FTE GPs and three FTE nurses.

"I'm from Brisbane. I did my undergraduate at the University of Queensland in pharmacy.

"I was in third year pharmacy and I had a friend who chose medicine. I thought I'd regret it if I didn't choose medicine too. I made the transition.

"I went to the Gold Coast for my residency in medicine. The traffic was too much for me and I moved up here about six years ago. I'm going to be in Hervey Bay permanently now. It's a great thing. I leave home in the daylight and I get home in the daylight. It is only 800 metres to get to my practice from home. For me here, it's lifestyle, liveability, location.

"I see about 30 patients a day and there is a lot of variability. I see quite a lot of chronic disease – diabetes, heart disease, cancer. I have a lot of older patients. It's a great thing to help look after someone's health. It's longitudinal care – from kids being born, to end of life.

"My partner used to see doctors here when she was a kid. Her parents still see them. This clinic has a country feel about it.

"Hervey Bay has about 58,000 residents in the area, but with the holiday influx that shoots up to about 100,000 in peak times.

"The biggest reason I'm doing medicine is the longitudinal care. We know the people. I love it. It's great to be part of the work."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

The importance of good policy design for family doctors

Professor Jeanette Ward, of Notre Dame University's Nulungu Research Institute in Broome, WA, has a career focus on formulating public health policy – to help make better GPs. Here, Dr Ward explains her role in delivering good outcomes for family doctors and primary health.

"Perhaps I am not quite the typical example for Family Doctor Week. I am a medical specialist in systems, structures and population health.

"What is my role in promoting high-quality general practice? First, I am accountable to many hundreds of thousands of patients, all of whom deserve an equitable, effective and responsive health system based on solid evidence and great policy.

"Second, their health and wellbeing is critically dependent on the design of the overall health system, especially the quality of the primary health care they receive. Yet some people live where general practitioners are in short supply.

"When the foundation of primary health care in any given region is weak, the resources required to create, coordinate and perfect multidisciplinary cost-effective teamwork focussed on patient need is also in short supply.

"These regions are easily identifiable by their population-based age-standardised rate of potentially preventable hospitalisations (PPHs). High PPH rates reveal a local system under stress. Tinkering with minor inputs is not going to work to change these rates.

"Third, when health policy is developed by an inattentive affluent and isolated political class afforded – by its very social circumstances – a paradoxical protection from the consequences of any poor policy decision inflicted on others, the economists call this a moral hazard. Ill-informed policy buries GPs in a quagmire of red tape, short-term thinking and marginal reforms.

"Once I realised the influence of policy and system design on health outcomes, I knew that public health medicine was the career direction for me. Just as my colleagues hold themselves professionally accountable for the advice they give and the decisions they make in collaborative patient management for individuals, I also aim to work as a public health physician (FAFPHM) to the high standards required by large populations."

AMA Family Doctor Week 2019

Your family doctor and you: Partnering for Health

Why I want to be a family doctor

Clare Vincent of Ballarat, Victoria is 25 and is a medical student in her final year. She is the current Vice President (External) of the Australian Medical Students' Association.

Originally from West Gippsland, Ms Vincent wants to build a medical career in rural Australia.

"I have loved my general practice rotation this year. I thought it was such a good variety and very interesting medicine," she says.

"I enjoyed the combination of procedural skills and then the continuity of care with the patient. I was lucky enough to see quite a few of them for second appointments. It was a five-week rotation, but I am doing my elective within a general practice as well. I have learned so many procedural skills.

"Rural generalism is where I see myself. I want to provide a service to a rural area.

"I did my Honours in a hospital and I loved the environment of being in a hospital. I didn't really enjoy the cell-based research that I was doing, so I decided to give medicine a go … and I have loved every minute of it.

"The best subjects are ethics, legal and professionalism. I'd love to come back and do some teaching with junior doctors one day. Pay it forward.

"It's a privilege to walk through any moment with a patient. As a student it's even more of a privilege because they are letting you be a part of something quite emotional to them and let you learn from it.

"I'm thankful to patients who have let me in the room and let me a part of their care. It has really helped my education and I remember them for that."

Zero suicide goal and suicide prevention adviser announced

The current CEO of the National Mental Health Commission has been appointed as the Federal Government's National Suicide Prevention Adviser.

Christine Morgan will work with Health Minister Greg Hunt and the Department of Prime Minister and Cabinet on a whole-of-government approach towards preventing suicide.

In making the announcement, Prime Minister Scott Morrison said he was committed to taking all necessary action to tackle the suicide rate, and ensure Australian families, communities and those facing challenges get the support they need.

"I am particularly focused on continuing our strong support for those most at risk, including our veterans, Indigenous Australians and young people," the Prime Minister said.

"Suicide is the leading cause of death for young Australians, accounting for over one-third of deaths among younger people aged 15-24 years. The prevalence of suicide among Aboriginal and Torres Strait Islander people is around twice that of non-Indigenous Australians.

"Providing greater support for all Australians needing mental health and suicide prevention services is a key priority of my Government.

"Suicide takes far too many Australians, devastating families and local communities. One life lost to suicide is one too many, which is why my Government is working towards a zero suicide goal."

Lifeline – 13 11 14

Beyond Blue – 1300 22 4636

Let's face it, Facebook isn't your doctor

The AMA has spoken out against people seeking medical advice online from sources found on Facebook and YouTube, following the news of one cancer patient publicly declaring that dodgy advice from such sources had almost killed him.

While it seems obvious that people should not turn to questionable online sources for medical advice, growing numbers of Australians appear to be doing exactly that – at least as a first step.

Chair of the AMA Ethics and Medico-Legal Committee Dr Chris Moy warned against seeking diagnoses and treatment through Facebook and YouTube.

"It is extremely seductive sometimes because sometimes you'll be given sort of easier options or what appears to be sort of simple options than your doctor is prescribing," he told Radio 3AW.

"But the bottom line is that people need to open their eyes. We're talking about the Wild West there. There are no checks and balances, no accountability and even worse, even though sometimes people are giving sort of well-meaning advice, it's likely people are getting something out of it – either popularity or they're actually getting some monetary advantage out of it.

"It is actually pretty scary what can happen, and so we're just asking people to open their eyes and go to see their doctor where they're protected."

The issue was highlighted recently with a news report of a young man inflicted with leukaemia taking something described as 'super vitamins' after being advised to do so by a Facebook posting. The man said the pills almost killed him.

"Quite often the options that are presented may seem just easier or natural or, you know, common sense. But the problem is that sometimes these natural therapies can actually have side effects," Dr Moy said.

"The other thing is that it's often the delay in treatment. For example, you might have a symptom and go 'oh well, this seems simple, I'll take the advice of Facebook', and it turns out that this treatment actually delays you seeing a doctor, which actually means there's a delay in treatment and it could be something as bad as picking up the cancer. And that may make the difference."

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

WITH CHRIS JOHNSON

President talks Medevac Bill with Home Affairs Minister

During the first week of the 46th Parliament, AMA President Dr Tony Bartone held a number of meetings at Parliament House, Canberra.

One high-level appointment was with Home Affairs Minister Peter Dutton in what Dr Bartone described as a very respectful conversation about the health of asylum seekers.

Mr Dutton repeated the Government's intention to repeal the Medevac Bill, and Dr Bartone stressed the AMA's view that all asylum seekers and refugees in the care of the Australian Government should have access to quality health care.

The Government has subsequently introduced repeal legislation to the House of Representatives, but it will not pass the Parliament before late October because it has been referred to a Senate inquiry first.

"We are very clear about each other's issues and concerns and we will continue to have constructive dialogue in the weeks ahead," Dr Bartone said.

"The Government has a particular course of action – a particular way ahead – and we will remain engaged to ensure that at the end of the day we can hand-on-heart be clear about our commitment to the ongoing, independent medical assessment and access to appropriate medical care of the refugees."

Dr Bartone insisted there must be a robust process for the independent medical assessment of the health of asylum seekers and refugees in the care of the Australian Government.

The AMA is represented on the Independent Health Advice Panel by AMA ACT President Dr Antonio Di Dio.

Mr Dutton assured Dr Bartone he would remain engaged with the AMA in all matters dealing with the health of asylum seekers and refugees.

Dr Bartone said the AMA will have regular ongoing discussions with Mr Dutton and other relevant Ministers as the process continues.

"We had a very, very open and informative conversation," Dr Bartone said.

"I think at this early juncture, there was an acknowledgement of the intent to continue to have that conversation."

Government focus on healthy ageing for Indigenous Australians

To coincide with NAIDOC Week in July, the Federal Government announced an investment of more than $5.6 million towards medical research focusing on healthy ageing for Aboriginal and Torres Strait Islander peoples.

The aim of the targeted research is to address the need for rigorous, culturally-informed research that ultimately improves the health and experiences of ageing in older Aboriginal and Torres Strait Islander peoples.

The National Health and Medical Research Council (NHMRC) will provide the funding to support six research projects.

Aboriginal and Torres Strait Islander peoples currently have poorer health outcomes and higher rates of disability than non-Indigenous Australians of the same age.

They are also more likely to live with chronic and complex conditions that lead to a poorer quality of life and to die at a younger age.

"This funding will support practical and innovative research into the best approaches to prevention, early intervention, and treatment of health conditions of greatest concern to ageing Indigenous communities," said Health Minister Greg Hunt and Minister for Indigenous Australians Ken Wyatt in a joint statement.

"Ultimately, parity in health outcomes is the only acceptable goal, and this funding will help to achieve it."

NAIDOC Week also saw the release of two key Australian Institute of Health and Welfare (AIHW) reports.

Data released by the AIHW for the 2017–18 period showed

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

198 organisations provided primary health services to about 483,000 clients, with 81 per cent of them being Aboriginal and Torres Strait Islander.

Organisations providing Indigenous primary health services employed nearly 8,000 FTE staff, and more than half of these (54 per cent) were Aboriginal or Torres Strait Islander people.

Improvements in health were seen and included:

- First antenatal visit before 13 weeks (up 3.2 percentage points to 42.4 per cent);
- Influenza immunisation for clients with chronic obstructive pulmonary disease (up 5.3 percentage points to 37.2 per cent);
- Influenza immunisation for clients with Type 2 diabetes (up 3.2 percentage points to 33.8 per cent);
- Absolute cardiovascular risk (down 3.5 percentage points to 29.8 per cent); and
- HbA1c (refers to glucose and haemoglobin joined together) result recorded for clients with Type 2 diabetes (up 3.1 percentage points to 52 per cent).

However, the reports also highlighted an increase in:

- Low birthweight (up 1.8 percentage points to 13.2 per cent);
- Smoking status of women who gave birth in the previous 12 months (current smoker) (up 0.5 percentage points to 49.5 per cent);
- Smoking status result (current smoker) (up 0.2 percentage points to 51.7 per cent);
- Recording kidney function test results for clients with Type 2 diabetes (down 0.6 percentage points to 62.0 per cent); and
- Reported service gaps in mental health and youth services.

The AIHW reports are:

Aboriginal and Torres Strait Islander health organisations: Online Services Report — key results 2017–18; and

National Key Performance Indicators for Aboriginal and Torres Strait Islander Primary Health Care: Results to June 2018.

New medicines listed under the PBS

The Federal Government has allowed affordable access to four new medicines through the Pharmaceutical Benefits Scheme.

Under the PBS, treatment for diabetes, severe cystic acne, depression and lung cancer are now available to patients for $40.30 per script, or $6.50 with a concession card.

The new PBS listings from are:

- **Pemetrexed®**, a medicine for the treatment of metastatic non-small cell lung cancer, and mesothelioma will also have its authority level reduced to make it easier for doctors to prescribe. In 2018, more than 950 patients accessed this medicine and could benefit from this change to the listing which will make it easier to prescribe. Without PBS subsidy, patients would pay up to $200 for each course of treatment.
- **Oratane® (isotretinoin)**, will be listed to the PBS to help treat the 21,000 people per year with severe cystic acne, providing doctors with an alternative for patients who require a lower therapeutic dose. Without PBS subsidy, this medicine would cost patients $43 for each course of treatment.
- **Phenelzine®**, will be made available through the PBS for the treatment of patients with depression, when all other anti-depressant therapy has failed. In 2018, more than 900 patients accessed alternative brands and are expected to benefit from this listing. Without PBS subsidy the medicine would cost patients around $800 a year.
- **Fiasp® (insulin aspart)**, a fast acting mealtime insulin that improves blood sugar control in adult patients with diabetes Without PBS subsidy, patients would pay either $124.24 or $206.59 per script depending on the form prescribed. In 2018, 126,000 patients accessed another form of insulin as part on the PBS and could benefit from this listing.

Every medicine was recommended to be added to the PBS by the independent expert Pharmaceutical Benefits Advisory Committee. By law the Federal Government cannot list a new medicine without a positive recommendation from the PBAC.

Health Minister Greg Hunt said the Government was committed to ensuring Australians can access affordable medicines, when they need them.

"Since 2013, the Morrison Government has listed over 2,000 new or amended items on the PBS," he said.

"This represents an average of around 31 listings per month – or one each day – at an overall cost of around $10.6 billion."

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Government agency working with industry on specialist software

A Federal Government agency is partnering with Australian software organisations to design world leading software for medical specialists.

The Australian Digital Health Agency has provided nine specialist software vendors with $40,000 to complete designs that seamlessly and securely integrate the My Health Record into their current systems to bring benefits to specialists, such as cardiologists or anaesthetists.

In addition to the funding, the Agency will provide design expertise to work with each vendor's design teams to co-produce improvements in design with their users.

Following an open approach to market, the Agency is partnering with:

- Best Practice Software;
- Clinic to Cloud;
- Clinical Computers;
- Genie Solutions;
- Intrahealth;
- Medical-Objects;
- Medical Wizard;
- Software for Specialists; and
- Zedmed.

The software organisations will work with the Agency and specialists to develop these designs over the coming months.

Many specialists already use My Health Record through software systems they use in public and private hospitals. Having easy access to the My Health Record system in their private clinics as well will ensure a more complete picture of a patient is available during specialist consultations and improve continuity across care settings.

The Agency ran an expression of interest process in May 2019, where software developers with a clinical information system being used in at least 10 private specialist practices in Australia at May 1, 2019 were invited to apply.

Your family doctor and you: Partnering for Health

AMA Family Doctor Week 2019

21-27 July 2019

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For more information: **ama.com.au/family_doctor_week_2019 #amafdw19**

Partnering for Health

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

This month, the AMA will be celebrating our nation's GPs and the central role of general practice in the Australian health system. Each year AMA Family Doctor Week takes the opportunity to recognise the dedication and hard work of GPs right across the country in caring for their patients and delivering quality health care to communities.

The theme for this year's Family Doctor Week is *Your family doctor and you: partnering for health*. This theme recognises the partnership between practitioner and patient, between members of a patient's healthcare team, between GP supervisor and GP registrar, and the one that most needs to be enhanced, between Government and general practice.

The trusted relationship between GPs and their patients underpins patient-centred care and is fundamental to the provision of quality care. Partnering with our patients to ensure the care we provide is respectful of, and responsive to their preferences, needs and values is core to our approach and our ability to provide comprehensive and holistic care. It is one of the reasons most GPs get real satisfaction from their work and the impact they can have on patient outcomes.

This partnership with patients drives us also to partner with other specialists and health professionals to ensure our patients continuity of care on the occasions where services outside our scope of practice are required. Sometimes, these partnerships are within our own practice, where we might bring in psychologists, diabetic educators or pharmacists to support our patients in managing their conditions and medications. At other times they are external to practice, involving other private practising or salaried specialists, aged care facilities, community pharmacies, community services and hospitals. Good two-way communication and access to relevant information to inform patient management and treatment is vital.

For too long though, general practice has not been appropriately funded to deliver all that it could to improve patients' health, their healthcare experience and their outcomes. There is no doubt in my mind that the GPs of Australia go above and beyond for their patients. We would not be one of the best health systems in world if that were not the case. I don't need to tell you about the number of hours we spend outside of a face-to-face consultation ensuring our patients are supported and their care coordinated.

It is time that work was funded. It is time we are supported when we need to spend longer with a patient, when we provide services outside of the consultation for our established patients – such as repeat scripts and telehealth services, and to make better use of our healthcare team to triage, monitor patient progress, enhance patient health literacy and support them with self-management.

It is time we had a long-term funding plan to support general practice to evolve and provide more proactive, preventive care, coordinated integrated care and improved patient outcomes. We need Government to partner with us, by investing in us to deliver our patients the best care in the best way.

Another partnership that should not be forgotten is the one between GP Supervisor and GP Registrar. Together, you are the future of our profession. The AMA is working to ensure fair and equitable employment conditions that meet the needs of registrars and supervisors alike. We need to ensure that the attractiveness of GP training is not undermined by inequitable employment conditions.

The AMA is committed to advocating for and promoting general practice. It's hardwired into our DNA. Since last Family Doctor Week, AMA advocacy has helped secure a Federal Budget announcement of $448.5 million to improve continuity of care for patients over 70 with chronic conditions, $201.5 million to better fund the Quality Improvement Incentive and retain the Aged Care Access Initiative, $62.2 million for rural generalist training and $187.2 million through the lifting of the freeze on over 100 Medicare items for general practice.

The Minister for Health told AMA National Conference he wants to work with the AMA on a 10 Year Plan for Primary Health Care. As part of that, the AMA wants to see support for general practices to better utilise their multidisciplinary healthcare team in supporting patient care, funding for the work done on behalf of patient outside of the consultation and support for innovative ways of delivering care that improve patient access, health literacy and health outcomes.

We also want to see the introduction of specific MBS telehealth items, the introduction of an extended Level B item, funding to support continuity of care, a re-alignment of the after-hours in-room items, funded dressing to support better wound care and the lifting of caps on the incoming Workforce Incentive to enhance the multidisciplinary breadth within the practice team.

That is our vision for general practice. I invite you to celebrate that vision for general practice with us during Family Doctor Week.

Reducing the burden of death and disability in Australia

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

Good news is rare enough – so let's celebrate. Here's a report showing that the health of Australians is improving!

Between 2003 and 2015, the all-up impact of illness decreased by 11 per cent and premature deaths by 20 per cent. Big gains were observed in rates that combined death and disability from heart disease and from stroke. Here's how we know.

The Australian Institute of Health and Welfare (AIHW) is charged with the responsibility of collecting and analysing health-relevant information from surveys and statistics across the country. It has recently published a report on what it calls the 'burden of illness' – a composite measure of the effect of early death and (generally) later suffering. They write:

> *Burden of disease analysis combines living with poor health (the non-fatal burden of disease) with dying prematurely (fatal burden). Fatal and non-fatal burden combined is referred to as total burden. Burden of disease is recognised as the best method to measure the impact of different diseases or injuries in a population.*

And the burden is, for most Australians, getting lighter.

Because studies of the burden of disease depend so heavily upon data and analytics, it takes time to collect all the essential information from multiple sources and then to analyse and package it. The report refers to how things were in 2015. Listing all the doctors and public health experts and others who contributed their wisdom to the interpretation of the data takes six pages.

But this four-year lag is compensated for because the report provides information about trends between 2003 and 2011 and between 2011 and 2015: what's happening to life expectancy and how long men and women might expect to live their lives free of disability. For men, the 'adjusted' life expectancy (without the burden of illness) is 71.5 years, and for women 74.4 years – for people born in 2015. The report states that while:

> *the life expectancy of those in the highest and lowest socioeconomic groups increased (or stayed the same) in 2015 compared to 2011, the disability-free life expectancy increased in the highest group but decreased in the lowest group.*

The report also states: "The five top disease groups causing the most burden in 2015 were cancer, cardiovascular diseases, musculoskeletal conditions, mental and substance use disorders, and injuries; together, these accounted for around two-thirds (65 per cent) of the total burden."

The total burden was split evenly between premature deaths and disability.

The report draws another encouraging fact to our attention – there is room for improvement. Although prevention is extremely difficult for most non-infectious diseases, there is evidence that, by using a comprehensive, all-weapons-blazing approach to tobacco, we have done ourselves a heap of good. What we have learned and developed there should guide the planning of our response to other preventive challenges.

At present, obesity is the hardest condition to prevent. Perhaps a magical medication will come to our rescue as has happened with hypertension and with HIV. Note, in passing, that transmission of the virus can be almost completely halted when HIV-positive people are treated optimally.

In the meantime, if the political and individual will were there, action could be taken to alter our food and fitness environment. But that is a big ask.

At a recent Melbourne conference on prevention, Federal Health Minister Greg Hunt, via a video message, encouraged those present to think creatively and widely about prevention. He used the example of new medications for conditions such as cystic fibrosis to demonstrate the power of innovative thinking. This is part of an appropriate response.

It needs the support of political commitment – as we saw with tobacco – to tackle vested interests in food manufacture and retailing – to re-set community opportunities to choose food wisely and easily. We should overcome the shocking social class differences in obesity rates which reflect variations in purchasing opportunity and responses to advertising and packaging.

The report gives encouragement to all of us who wonder occasionally whether or not we doctors are actually making a difference. Prevention rarely provides the short-term rewards we receive from clinical care. But take heart from the gains achieved in the long term; for example, in treating hypertension and the slow but steady decline in stroke deaths and disability. Of course, improved acute stroke treatment is also making a big contribution.

Let's hope that, when the next burden of illness study is published, we can celebrate even further achievements.

Much to be gained from conferences

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

In April this year, I was back in my native Canada for R&R – not rest and relaxation – Rural and Remote, a major rural health conference organised by the Society of Rural Physicians of Canada/La Société de la Médicine Rurale du Canada. R&R 2019 was held in Halifax this year in the Spring. It was an occasion to bring frozen Canadian Outback doctors together in a big city during a warm month. Unfortunately, the weather did not cooperate, even the Haligonians (the demonym for someone from Halifax) were shocked with the below-zero temperatures and snow on the streets.

> "There is a lot we can learn from listening to our colleagues. There is also a lot we can learn from international experiences."

Like our Australian rural health conferences, this gathering was family friendly with lots of fun activities for children and special educational lectures for partners. The Canadians lived up to their friendly stereotype and there was a lot of back-slapping and "how you going, eh?" I overheard more than a few discussions in French.

I was also pleased to see that rural Australia was well represented with a presentation from Aussie Doc Olga Ward on Australian Skin cancers and Dennis Pashen active on Twitter. It was also great to see Dr Roger Strasser speaking about drivers of generalism, as the Dean of the Northern Ontario School of Medicine, he is the grandfather of medical training of rural generalists internationally.

I write about conferences in my articles because they are important for rural doctors. As I have said in the past, they allow us to form those crucial connections which help us to survive in our remote workplaces. But they are also important for our continuing education and development as doctors. There is a lot we can learn from listening to our colleagues. There is also a lot we can learn from international experiences.

I was not surprised to see many of the same topics on the R&R program that I regularly see on the programs at Australian conferences: challenges to providing maternity care, the need for more rural health political advocacy, addressing cultural safety, the lack of rural specialists, the need for more support for families and trainees, and the lack of rural research. Rural generalism was also on the program. It is important for us to know that the issues we face in Australia are not always unique and that we can look to the experiences and expertise of our international colleagues for solutions.

Of course, it is not all the same – I don't remember ever seeing a presentation on how to ensure your patients do not freeze between the hospital and the retrieval aircraft at an Australian conference, or axe-throwing for entertainment.

Still, there are lessons we can and should learn. There are also lessons we can share with Canada.

Another conference I recently attended was the 2019 AMA National Conference. The content of this year's NatCon was fantastic, but my highlight was meeting up with old and new rural doctors from around Australia. We met up whenever we could between the sessions, running out of room at breakfast on Sunday to network and share our experiences and thoughts on important and emerging issues.

There were also important debates on the AMA's rural health policies. The policy debate on the lack of medical research directed to regional Australia was well presented by Dr Shehnarz Salindera, and I look forward to the AMA advocating for a dedicated rural health research stream.

The Great Debate about the Australia's medical education and training model no longer being fit for purpose provided many unique perspectives on an issue we feel so acutely as rural doctors – the maldistribution of the medical workforce. This debate provided me with insights I would not have had otherwise.

There is a lot we gain from attending conferences. We learn, we share, and we connect. I encourage all of you to attend a conference, like RMA in the Gold Coast, 23-26th October this year. Or why not consider a trip to Ottawa for next year's R&R 2020, 23-25 April 2020? It's a bit later in April, so you might get lucky and miss the snow.

We're not afraid of a bit of blood: enacting grassroots change

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Australia needs more blood donors; one in three Australians will need blood during their lifetime, but only one in 30 donate.

At the close of May, the Australian Medical Students' Association (AMSA) wrapped up its annual national blood donation drive: Vampire Cup. Vampire Cup pits 22 medical schools around Australia (with representation from New Zealand as well) against each other to see which university can roll up its sleeves and donate the most blood. It is run in the lead up to winter, and particularly flu season, in order to boost blood stocks in this critical period.

Vampire Cup was first incepted in 2008, where it garnered 400 donations Australia-wide. This year, we had our largest number of donations ever, with a total of 3,461 blood donations – more than 10,000 lives saved.

This initiative is a prime example of how passionate young students can tangibly make change at a grassroots level, utilising inter-university rivalry for a good cause. These individual-led, but large-scale movements, rely on sheer numbers of people like you and me in order to enact widespread action.

Rallies, marathons, charity drives, boycotts: these all require individual acts of change with varying degrees of entry to get involved. If a grassroots movement has too many barriers in getting involved, then it will never engage a critical mass of participants. Vampire Cup, and blood donation in general, has its own barriers to participation. Some hurdles can be overcome; local Vampire Cup representatives organised group bookings around students' lecture times and placement hours, taking away the uncertainty of individually booking appointments. Some hurdles cannot be overcome. Personally, I have never been able to donate blood due to health reasons, along with many other iron-deficient individuals, people underneath the weight threshold, and men who have had sex with men within the preceding 12 months.

If an individual cannot personally contribute, what can they do? Widen your scope for involvement.

Vampire Cup counted donations made by friends and family of medical students towards their cohort's numbers, encouraging those like me to recruit those who otherwise would not have engaged with the initiative at all. James Cook University rallied record numbers of Townsville residents, collaborating with a local celebrity to advertise on radio with a Game of Thrones-inspired call to action. They ended up completely booking out their local blood donation centre for the remainder of the competition.

Conversely, a low bar of entry to a social movement can sometimes be seen as tokenistic. We have all seen a trending hashtag or a changed Facebook profile photo and rolled our eyes, asking ourselves how that will at all contribute positively to whatever issue they are highlighting. Particularly topical is the recent movement against single-use consumables. While it is easy to scoff at your colleague who pulls out their folding metal straw, it impossible not to notice the consecutive moves of using keep cups, banning plastic bags and avoiding plastic straws, along with positive changes from large industry players.

This is what fundamentally underlies a successful grassroots initiative: identifying your problem, then stepping up your game as you identify a new facet to the problem. "Raising awareness" should only ever be your first step and action, while incremental, must be targeted. Vampire Cup started from the idea that medical students could contribute directly to public health before even graduating. Now, it is AMSA's most recognised initiative and has expanded to contribute to organ donation and bone marrow donation.

Congratulations to Australian National University who holds a four-year streak of having the largest percentage of their cohort donating, and James Cook University who had the largest number of donations from any cohort this year, and in Vampire Cup history. Congratulations also to Corinne Antonoff, the AMSA Vampire Cup National coordinator.

Post exam Stockholm syndrome

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

I recently passed my Fellowship exams after many years of arduous constant study, a journey many reading this will remember with mixed emotions. My success was greeted by many words of congratulations from family, friends and colleagues. But one response was not one of celebration but of warning. Warning that often, once the pressure of years of exams is removed, anxiety and or depression could follow. In fact, the friend who made me heed this warning did so from personal experience. For nearly six months after the completion of the very same training program's fellowship examination, my friend's life was dominated by low grade depression and anxiety. Not the sort that prevents high functioning at work; not the sort that prevents one from going about the usual business of life; but a depression that left them apathetic, unmotivated, tired, uninterested in socialising and constantly bored.

After pondering this warning, I recalled a number of situations where colleagues failed to thrive after the completion of their exams. The primary exam left a number of my friends depressed; a depression compounded by guilt that they felt depressed when they had passed an exam many had failed. Another friend struggled to socialise. Any social event left this friend either paralysed at the thought of meeting friends, or bored when they were in the company of others. I have witnessed many relationships end after the completion College exam. Another colleague experienced complete inertia. They were unable to complete small tasks such as journal club presentations or a low acuity audit. They struggled to complete simple everyday activities such as shopping, cleaning or paying bills.

A literature and Google search uncovered very little literature of substance on post-exam depression or anxiety and most were opinion pieces. The term 'post-exam depression' along with the acronym PED appeared intermittently. But this was in the context of university students leaving the social, educational and cultural network of university life and transitioning to the less exhilarating, more constrictive life of a working adult. PED shared some characteristics with stories shared by colleagues after their College exams but there was more to the mental health changes witnessed in my colleagues than adjusting to adult life.

An opinion piece published in the Australian and New Zealand College of Psychiatrist's Australasian Psychiatry in 2010 titled Post-exam blues described the exact predicament my friend warned me about. The article bemoaned the lack of formalised criteria for the problem whose symptoms are subacute and unable to fulfil the criteria for conditions such as adjustment disorder, PTSD or demoralisation. Could the sudden withdrawal of stress hormones such as adrenalin and cortisol be the drivers behind the emotional changes post College exams? Or do some doctors suffer an existential crisis once the purpose, precision and predictability of day-to-day life are removed by passing an exam?

When speaking to friends and colleagues about their post-College exam experience, many alluded to a type of Stockholm syndrome where life was easier with the exam as the exam provided a daily purpose, schedule and goal. In other words, trainees developed dependency upon the captive states of exam lock down and negative feelings towards anything that distracted them from their study goals. The exam offered a valid excuse for not cleaning, paying bills, replying to messages or not attending a dinner. With the exam removed and time no longer an obsessive concern, it became unclear why answering an email, going out to dinner or making plans for a Sunday was distressing or challenging. Is our need to progress through and survive medical training stronger than our impulse to dislike the progress to the point that we leave? Or does our 'ego under stress' spin the endless ardours of training into sentimental feelings towards the medical profession, creating a bond with the very process that causes distress, anxiety and isolation?

Prevention of post-College exam depression and anxiety is limited by the lack of discourse around the prevalence, causation and definition of the phenomena. As a profession we need to expand our understanding of the impact of training beyond the immediacy of exam failure to the wholescale impact throughout College speciality training.

Clinicians should remain in charge of governance parameters

BY DR OMAR KHORSHID, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

As I wrote in my *Australian Medicine* column in May, Australia enjoys what is internationally recognised as close to the best health care in the world. In terms of outcomes, it is the best. Our overall life expectancy is 4th in the world, a remarkable feat considering our diverse population. Notwithstanding our world renown performance on patient outcomes, it appears Government Ministers want more. More system-wide efficiencies and even better patient outcomes.

The Department of Health is currently leading a consultation on behalf of COAG Health Ministers, to introduce a Clinical Quality Registry (CQR) National Framework to achieve four priorities:

i. Improve [healthcare] efficiency and ensure financial sustainability;
ii. Deliver safe, high quality care in the right place at the right time;
iii. Prioritise prevention and help people manage their health across their lifetime;
iv. Drive best practice and performance using data and research

The idea of implementing a CQR National Framework has been around since 2010, and much of the ground work was done at this time but it was never implemented. There are at least 60 different CQR in Australia and it could be beneficial if there was a system to broaden the range of clinical quality registries and participation in them. Certainly, CQRs are widely recognised as a powerful tool to improve the quality and effectiveness of patient care within a clinical domain.

There could also be substantial benefits if all CQR in Australia were of a consistent high standard, with similar architecture, operating systems, data structure and governance to permit comprehensive national reporting. But there are some details in the draft consultation paper that clinicians should be aware of.

The role of clinicians is uncertain. In one part of the consultation paper there is recognition that clinician leadership is critical to CQR success . However, responsibility for determining important CQR parameters , such as the design of the clinical indicator instruments that determine which patient outcomes are measured, and the management of outliers and the granularity of benchmarked data reporting, is allocated to the government agencies. It is critical that clinicians, though their Colleges, Associations and Societies, remain in charge of designing the accreditation standards and governance parameters relevant to measuring quality of patient care. They have the specialty and sub-specialty expertise, know best practice standards and best placed to nominate the most relevant clinical indicators.

Another design feature of the CQR Framework is 'consistent outlier management' and reporting. This needs to be well managed to encourage, rather than deter, clinician engagement. The interpretation of benchmarked outlier data points is not straight-forward. The measurement is a point in time and the cause will be relevant to the particular clinical indicator, the clinical domain and patient characteristics. Possible reasons for clinical variation might be inaccurate data, insufficient case-mix adjustment or some underlying problem with administrative practices, resource constraints (i.e. delayed access to diagnostic equipment/treatment), clinical knowledge or technique.

The Australian Orthopaedic Association's National Joint Replacement Registry (AOA NJRR) has been highlighted as a world-leading registry that has changed the practice of orthopaedics in Australia and around the world and saved government and the public hundreds of millions of dollars as a result. The AOA NJRR has recently commenced providing feedback to individual surgeons on their joint replacement revision rates compared with their peers as a professional way to reduce consistent outliers. This is an instructive example of a profession and clinician led CQR that is improving patient outcomes without naming and shaming alleged outliers and while maintaining the profession's control of the sensitive data.

Rushing to publish and 'expose' individual clinicians on the basis of benchmarked data will not improve patient care in a complex, team-based healthcare system. Instead, it will engender a culture of blame, fear, and reluctance to openly report or treat high risk/high complexity patients for fear of reputational damage. Furthermore, it will deter clinicians and public hospitals for taking on difficult patient cases because this will diminish their performance in league tables.

It would be a poor outcome indeed, if the approach to reporting identified outcome data perpetuates a reduced supply of clinicians with the skill and experience of treating complex patients. This outcome does not make any sense with a population that continues to get older and sicker.

All clinicians should be sceptical about the meaning of 'low value care' and how this term is used in the draft CQR National Strategy. I have no objection to moving away from health care procedures that are no longer endorsed by clinical colleges, associations or societies as current best practice. Clinical

New Government must take a new approach to Aboriginal and Torres Strait Islander health

BY AMA PRESIDENT DR TONY BARTONE, CHAIR OF AMA INDIGENOUS TASKFORCE

The re-elected Morrison Government is in a unique position to make meaningful policy changes to deliver enhanced health and life outcomes for Aboriginal and Torres Strait Islander people. With the appointment of the Hon Ken Wyatt MP as the first Aboriginal Minister for Indigenous Australians and the existing agreement with the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, the Government has the opportunity to draw on a wealth of Indigenous knowledge, experience and expertise to design and implement policies and programs that actually work for Aboriginal and Torres Strait Islander Australians.

To create real change in Aboriginal and Torres Strait Islander health, we know we need to look beyond a person's physical health – we need to look at and address the broader social determinants – the conditions in which people are born, grow, live, work and age. This requires cooperation and unity of purpose from all relevant ministers and portfolios, as well as all levels of Australian governments – something that has continually proven to be a challenge. The AMA urges the Government to take a holistic approach to Aboriginal and Torres Strait Islander health and ensure that relevant ministerial portfolios work together to give it the attention and investment that it truly deserves.

One particular issue that requires immediate action is the increasingly serious suicide crisis among young Aboriginal people, particularly in Western Australia. We know that suicide is a major contributor to the overall health and life expectancy gap between Aboriginal and Torres Strait Islander people and their non-Indigenous peers. The AMA welcomes the Government's recent commitments to addressing suicide among Aboriginal and Torres Strait Islander people, including the roundtable recently held by Health Minister Greg Hunt, but much more needs to be done. A good start would be to implement the recommendations of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project which looked at the effectiveness of existing suicide prevention services and programs.

The Government should also consider adopting the Uluru Statement from the Heart, which is supported by the AMA. The Uluru Statement expresses the aspirations of Aboriginal and Torres Strait Islander people to exercise self-determination – a key factor that positively affects all parts of life and a known protective factor against suicide. The concept of Aboriginal and Torres Strait Islander self-determination is not new to the Australian parliament, having been on the national agenda since at least the 1970s, yet Aboriginal and Torres Strait Islander communities are still waiting for their voices to be heard. Adopting the Uluru Statement of the Heart would allow a healing process to begin for many Aboriginal and Torres Strait Islander people, through recognition of past and current injustices, and has the potential to underpin all government endeavors to improve the physical and mental health of Aboriginal and Torres Strait Islander Australians.

The AMA is hopeful that, with this Government having the first Aboriginal person leading the Indigenous affairs portfolio and having a formal partnership in place with peak Aboriginal and Torres Strait Islander organisations, positive health and life outcomes can be delivered for Aboriginal and Torres Strait Islander people. We no longer want to see Aboriginal and Torres Trait Islander people, who represent just three per cent of the total population, suffer from the poorest health in Australia – one of the wealthiest countries in the world.

The AMA has a strong history of advocating for long-term funding and commitments to Aboriginal and Torres Strait Islander health to close the health and life expectancy gap between Indigenous and non-Indigenous Australians. We will continue to call on the Government and other key stakeholders to commit to addressing the social determinants that impact on health outcomes and ensure that appropriate action is taken to produce genuine and sustainable change.

Finance and economics ... continued

evidence is constantly evolving. However, the last thing we need in this country is the erosion of clinician led healthcare, replaced by recipe book medicine – where the 'recipe' is written by governments, or government agencies.

As a head of department in a public hospital, I have spent years implementing our own patient reported outcome measurement project. In my experience, doctors are interested in the best outcomes for patients and in a system that delivers high quality care in an efficient manner. However, clinicians will and should resist change for change sake or government-led change that erodes clinician decision making.

The Great Workforce Debate revisited

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA, CHAIR OF THE AMA MEDICAL WORKFORCE COMMITTEE

The annual AMA National Conference is always one of the highlights for the year. This year, I was fortunate to be the Chair of the Great Workforce Debate. The novel idea of two teams arguing why a statement is accurate (or inaccurate) was an intriguing way to discuss a very serious issue that profoundly affects us all. The topic of the debate was: Australia has an oversupply of doctors and the current model of medical school and vocational training is no longer fit for purpose in this context.

I would like to again thank our fantastic speakers: Associate Professor Susan Neuhaus, Ms Jacoba van Wees and Clinical Associate Professor Saxon Smith for the affirmative and Dr Chris Wilson, Dr Ines Rio and Dr Roderick McRae for the negative. From various stages of their careers and with unique perspectives on the specific issues around the model of education and training, the speakers were engaging and entertaining while debating the topic. While the affirmative won a slim majority of the audience at the end, they did lose support throughout the debate as a great credit to the negative team. Initial score was 74 per cent agree and 26 per cent disagree with the topic statement – but after the debate this had shifted to 58 per cent agree and 42 per cent disagree. Interesting isn't it?

The debate itself is worth watching. You can view it at: <https://www.youtube.com/watch?v=-0rRIMUX0F4&list=PLRZ9-Pjsi3pv4vIZ2IkuOqC2N8yKTSdu7&index=8>

It covered many important issues such as the large number of early postgraduate doctors waiting for vocational training positions, and the current reliance on overseas trained doctors to fill specific workforce shortages and how the maldistribution of the workforce is creating numerous stresses. Interestingly, both sides tried to argue for a degree of system evolution and not revolution/upheaval – which suggests there is a reasonable degree of happiness with much in our system. This is always worth bearing in mind.

One of the most interesting outcomes of the debate for me was seeing the personal views of the debaters change during their preparation (they got very competitive as well). I spend a significant amount of time thinking about the issues of maldistribution, the increasing number of graduates and the structural challenges of vocational training and over-supply, but I sometimes have to take a step back and consider how I view these issues – there are so many different experiences and perceptions throughout our profession that it is clear we have a large task in gaining a consensus on the optimal plan to improve workforce disposition, training and diversity.

This is now our great challenge: we need to stop looking at the threats to our own specialties or our own regions and step back to consider the whole workforce and the effects change has on others in the profession. We need to know what the Government's goals are and how we can help them solve these problems in a fashion we are happy with. My rural and remote colleagues might say that this is easy for me to say – I don't have to deal with the closure of the local maternity service or deal with the stress of not having someone to take over for me when I retire as the last doctor in town. But we need to view these issues not as individual problems to be solved simply by pumping more cash into the service; we need to view this as an issue which has emerged out of years of neglect and poor planning and a dire need to modernise the practice of medicine around what patients want/need. We need to look at who we are training, where this is taking place and what they are training in and ask if this is the best use of our resources.

The Commonwealth is currently scoping a national medical workforce strategy and already there are early signs that the outcomes are being dominated by jurisdictions, Government and Universities and not sufficiently the medical profession. For example, I am concerned about the suggestion that vocational change has in some way failed (or is failing) and the acceptance that over-supply is the price we pay for crippling maldistribution, despite the AMA being clear for many years on how this might be fixed.

The Minister for Health sent a video to National Conference thanking the AMA for the hard work we have done over the past few years and stating he looks forward to continuing that work. In his speech, he noted the recent Commonwealth Fund report which showed Australia is ranked first in the world for clinical outcomes, and that we have the second best health system in the world (maybe they had trouble jotting up the scores). Perhaps this is part of the problem – we don't want to change a system which is delivering robust outcomes.

But it is not destined to stay this way. Convenience and cheapness are trump cards these days so our vision for medicine, for example, in regard to the 10 year primary care plan the Minister has announced, needs to avoid scratching about for small amounts of money and instead be truly aspirational and lock in medical-led care as the cornerstone of our system, that is nimbly and efficiently meeting patients' needs and expectations.

We have not always had great success in coalescing the combined efforts and intents of all AMAs towards a single focus or campaign. Perhaps evolution of the medical workforce should represent a goal for us in this regard given the intricate

Private Health Insurance – what next?

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

With the recently concluded federal election and the return of a Coalition Government, the AMA believes it is time to concentrate on the agenda ahead. This was the focus of a recent combined meeting of the Council of Private Specialist Practice and the Health Financing and Economics Committee held on June 29 in Brisbane.

Following two years of deliberation by the Private Health Ministerial Advisory Committee, the Government recently implemented reforms to private health insurance. Reforms that: developed clearer consumer communication; introduced standardised clinical definitions; and brought in the Gold, Silver, Bronze and Basic tiers of insurance.

The Government has also made a start at reforming the system in other ways as well – bolstering the power of the Private Health Insurance Ombudsman, allowing upgrades for mental health cover, and finding savings through cuts to the amount paid by insurers for prostheses.

But the Government reforms did not address affordability in the longer term – this problem is starkly obvious with the last round of premium increases. The rate of increase in premiums has slowed, but still outstrips inflation and, more importantly, outstrips wages growth.

Private health insurance appears to be facing a crisis, with more than a dozen successive quarters of decreasing coverage. If affordability is not addressed, membership rates will continue to fall, threatening the viability of the entire health system. The combined meeting agreed that further reforms are required – and required soon.

The meeting explored the reality facing private health insurance today. The population is ageing. We have ever increasing numbers of high cost patients in the insurance pool, while younger people are voting with their feet, choosing not to join and even walking away from PHI in growing numbers.

A recent speech from the Australian Prudential Regulation Authority recognised this issue as well, talking about what insurers will need to do in order to remain stable. It's a difficult task, Australia's health system is complex – but this is one aspect that we cannot get wrong.

The meeting explored options for the future but recognised that if we go too far down the path of restricting outlays, cutting costs and reducing rebates, people will see little value in their private health insurance product, and therefore, the private health system.

The meeting explored future reforms of the private health sector – and all were in absolute agreement that any reforms need to protect independent clinical decision-making by clinicians, who are chosen freely by the patient. The meeting also agreed that medical consultations should be conducted in an appropriate facility free from financial interference by insurers. The meeting also supported the abolition of poorly indexed, differential insurance rebates.

Furthermore, as medical professionals we acknowledged that we will have to contribute to increasing the stability of the sector and find ways to cut costs to the system. We will have to engage on more effective ways to treat patients in lower cost environments (such as day hospitals) where it is clinically appropriate to do so. We will also need to have a conversation with Government about greater investment in the private system.

The meeting explored what we need to do for the next three years of a Coalition Government. We agreed that the AMA needs to be engaging in constructive reform with stakeholders to address the underlying concerns. We need to look at how to put value back into private health insurance in the eyes of policy holders, while also delivering affordability in the eyes of consumers.

We need to look at reducing unnecessary cost through innovation, while guarding against clinical decision-making being driven by health funds. And we need to look at reducing premiums through looking at what other levers might need to be pulled by government – including additional investment – to shore up the private system.

The meeting generated many new ideas – but it was only the start of the next tranche of work for the AMA.

Medical workforce ... continued

involvement of all Governments in managing the medical workforce. We will hopefully do better if the messages and requests for change are heard simultaneously and loudly in the office of every Health Minister in the country. There is much work to do in this space that has ramifications across medicine and daily practice – so a united approach and effort is critical.

Research

WITH CHRIS JOHNSON

Verification of depression screening tool for Indigenous Australians

A culturally-specific screening tool for depression in Aboriginal and Torres Strait Islanders has been successfully verified and should be rolled out nationwide, according to the authors of research published by the *Medical Journal of Australia*.

Researchers set out to determine the validity, sensitivity, specificity and acceptability of the culturally adapted nine-item Patient Health Questionnaire (aPHQ-9) as a screening tool for depression in Indigenous Australians.

The research was led by Professor Maree Hackett, Program Head of the Mental Health Division of the George Institute for Global Health, in Sydney.

"Screening tools for depression have not been formally validated for Aboriginal and Torres Strait Island people across multiple States and Territories in Australia," Professor Hackett said.

"Detection of depression in Aboriginal and Torres Strait Islander people in primary care has been little investigated. A recent systematic review of diagnostic psychiatric instruments found that none had been formally validated for Indigenous Australians."

The study involved 500 adults (18 years or older) who identified as Aboriginal or Torres Strait Islander people and attended one of 10 primary health care services or service events in urban, rural and remote Australia that predominantly serve Indigenous Australians.

Of those 500 participants, 108 (22 per cent) had a current episode of major depression according to the Mini-International Neuropsychiatric Interview (MINI) criterion. The sensitivity of the aPHQ-9 algorithm for diagnosing a current major depressive episode was 54 per cent, its specificity was 91 per cent, with a positive predictive value of 64 per cent.

For screening for a current major depressive episode, the area under the receiver operator characteristic curve was 0.88; with a cut-point of 10 points, its sensitivity was 84 per cent and its specificity was 77 per cent.

The aPHQ-9 was deemed acceptable by more than 80 per cent of participants.

"The aPHQ-9 cannot replace careful assessment and diagnosis, nor should it be used to determine the need for treatment," Professor Hackett and her colleagues wrote.

"Even at the highest positive predictive value in our study, one-third of people identified with the aPHQ-9 as having a major depressive episode would not have major depression according to assessment with the MINI, and, conversely, we would still miss some people with major depression.

"Determining the consistency (test–retest reliability) and inter-rater reliability of the aPHQ-9 are the next steps for ensuring that the aPHQ-9 provides consistent results, regardless of who administers the test.

"Apart from screening and diagnosis, assessments for depression may be used in epidemiology studies, treatment monitoring, and outcome assessment. We do not yet know the responsiveness of the aPHQ-9 scores to treatment of patients.

"As the evidence base for screening for depression increases, we must develop culturally appropriate, cost-effective interventions for preventing, treating and managing depression in Indigenous Australians."

Sleep apnoea treatment can help with depression

Researchers at Flinders University have found that continuous positive airway pressure (CPAP) treatment of obstructive sleep apnoea (OSA) can improve depression symptoms in patients suffering from cardiovascular diseases.

Using data from the Sleep Apnoea Cardiovascular Endpoints (SAVE) trial led by the university, the new study has found a significant decrease in cases of depression after patients received CPAP treatment for their sleep apnoea.

From detailed analysis of the SAVE data, university researchers and collaborators at the George Institute have found that CPAP for moderate-severe OSA in patients with cardiovascular disease has broader benefits in terms of preventing depression, independent of improved sleepiness.

Prior studies investigating the effect of CPAP on mood with various experimental designs and length of follow-up periods have yielded heterogenous results.

Professor Doug McEvoy from Flinders University said the trial was largest trial of its type and one of very few studies reporting such an effect.

"Patients who have had a stroke or heart attack are prone to suffer from low mood and are two to three times more likely to develop clinical depression, which then further elevates their risk

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of future heart attacks and strokes," Professor McEvoy said.

SAVE trial participants were recruited from more than 80 clinical centres in China, Australia, New Zealand, India, the USA, Spain and Brazil and were predominantly overweight and older males, habitual snorers and had moderately severe OSA.

The latest study showed a significant fall in depression symptoms in OSA patients after CPAP treatment, independent of improvements in daytime sleepiness.

The positive effect of CPAP treatment on depression symptoms was manifest within six months and persisted during the 3.7 years of follow-up.

The positive effect of CPAP treatment on depression symptoms was more pronounced in patients with lower mood scores prior to treatment.

The research paper has been published by *The Lancet* in *EClinicalMedicine*.

Ignoring cues for some types of unhealthy behavior might be out of our control

A University of New South Wales psychology experiment has shown why it can be so hard to direct attention away from cues that might lead to excessive alcohol drinking and eating of unhealthy food.

When someone is stressed, tired or otherwise straining their brain power, ubiquitous neon lights and advertisements can be harder to ignore, especially when they might be signalling something rewarding.

Psychologists at UNSW Sydney conducted an experiment that found exactly that. The research has been published in *Psychological Science*.

The experiment showed for the first time that ignoring such cues becomes harder as soon as a task has to be performed while also holding other information in one's memory.

"We knew already that participants find it hard to ignore cues that signal a large reward," said study lead Dr Poppy Watson.

"We have a set of control resources that are guiding us and helping us suppress these unwanted signals of reward. But when those resources are taxed, these become more and more difficult to ignore."

Researchers did not know before whether a general inability to ignore reward cues was something people have no control over or whether executive control processes are used to constantly work against distractions.

It has now become clear that the latter is the case, but executive is a limited resource.

Executive control is a term for all cognitive processes that allow us to pay attention, organise, focus, and regulate our emotions.

"Now that we have evidence that executive control processes are playing an important role in suppressing attention towards unwanted signals of reward, we can begin to look at the possibility of strengthening executive control as a possible treatment avenue for situations like addiction," Dr Watson said.

In the experiment, participants looked at a screen that contained various shapes including a colourful circle. They were told they could earn money if they successfully located and looked at the diamond shape, but that if they looked at the coloured circle – the distractor – they would not receive the money.

They were also told that the presence of a blue circle meant

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they would gain a higher amount of money (if they completed the diamond task) than the presence of an orange circle. The scientists then used eye tracking to measure where on the screen participants were looking.

To manipulate the ability of participants to control their attention resources, they had to do the task under conditions of both high memory load and low memory load.

In the high-memory load version of the experiment, participants were asked to memorise a sequence of numbers in addition to locating the diamond, meaning they had fewer attention resources available to focus on the diamond task.

"Study participants found it really difficult to stop themselves from looking at cues that represented the level of reward – the coloured circles – even though they were paid to try and ignore them," Dr Watson said.

"Crucially, the circles became harder to ignore when people were asked to also memorise numbers. Under high memory load, participants looked at the coloured circle associated with the high reward around 50 per cent of the time, even though this was entirely counterproductive."

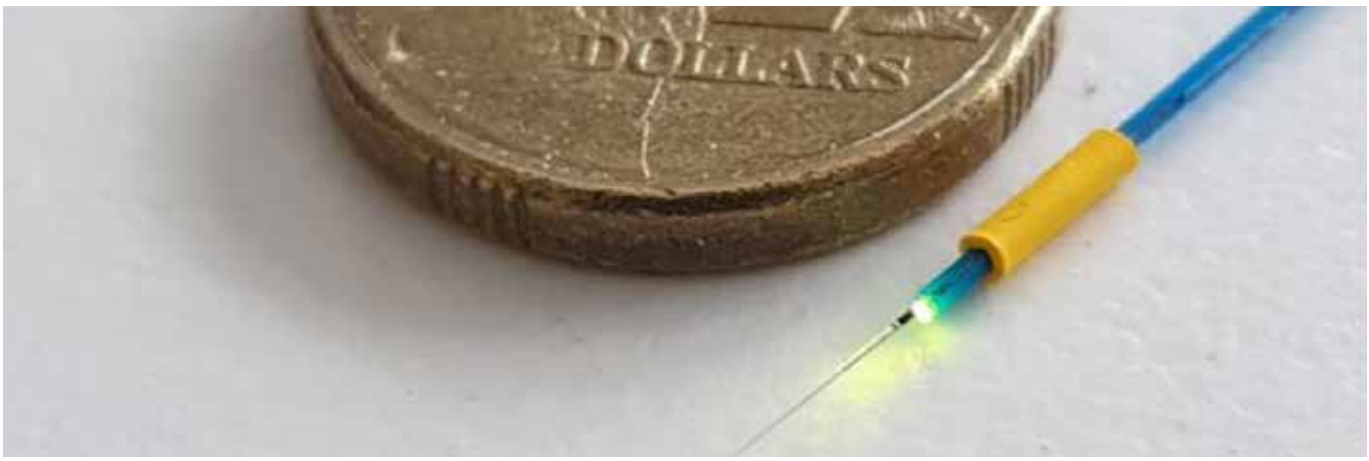
The findings demonstrate that people need full access to cognitive control processes to try and suppress unwanted signals of reward in the environment.

This is especially relevant for circumstances where people are trying to ignore cues and improve their behaviour, for example consuming less alcohol or fast food.

The researchers now want to look at how executive control can be strengthened – and if that presents an opportunity for situations like drug rehab.

Research

Small blood flow monitor being developed



A tiny fibre-optic sensor with the potential to save lives in open heart surgery, and even be used during surgery on pre-term babies, is under development at Flinders University.

The new micro-medical device has the potential to surpass traditional methods used to monitor blood flow through the aorta during prolonged and often dangerous intensive care and surgical procedures – even in the tiniest of patients.

The continuous cardiac flow monitoring probe is being described as a safe way to give a real-time measurement of blood flow.

"The minimally invasive device is suitable for neonates right through to adults," said research leader Strategic Professor John Arkwright, an expert in using fibre-optic technologies in medical diagnostics.

Professor Arkwright said the device had the potential to be a game-changer, particularly for very young babies, which are particularly susceptible to sudden drops in blood pressure and oxygen delivery to their vital organs.

"It's a far more responsive measurement compared to traditional blood flow monitoring, and without life-threatening delays in the period 'snapshot' provided by current blood flow practices using ultrasound or thermo-dilution," he said.

Neonatal expert and co-investigator Dr Scott Morris from the university said the new sensor-catheter device promises to deliver accurate blood flow information in critically ill patients, from pre-term babies to cardiac bypass patients.

"This tiny device, which could even be used in pre-term infants, has the potential to be far superior to the intermittent measure of averaged blood flow delivered by traditional methods which generally only show time averaged flow every 30 minutes or so," Dr Morris said.

A provision patent has been filed for the device, which is seeking industry partners for further development.

Chief investigator Albert Ruiz-Vargas hopes the device will be picked up for further development, and introduction into regular intensive care and surgical procedures.

"The proof-of-concept prototype is potentially a low-cost device which has passed initial testing in a heart-lung machine," Mr Ruiz-Vargas said.

"It can be inserted through a small keyhole aperture in the skin into the femoral artery in individuals where heart function is compromised and is so small it can even measure small changes in flow in the tiny blood vessels of infants.

"It's a simple design, which can give readouts similar to a pulsating heartbeat response on a laptop or nearby screen."

For the first time, the Flinders researchers have found an effective model to continuously measure intra-pulse blood flow using a fibre-optic sensor which has the potential to advance monitoring in a medical setting.

They say more research is now required to determine how the sensor will behave under more physiological conditions and to examine different encapsulations to comply with human safety.

The research to-date has been published in the *Journal of Biophotonics (Wiley)*.

World News

WITH CHRIS JOHNSON

Huge IVF mix-up goes big time legal

A lawsuit filed in the Eastern District of New York has accused a California fertility clinic of giving the wrong children to a couple who tried to conceive through IVF.

According to US media reports, the lawsuit states that the couple, who are Asian ethnicity, was shocked to give birth to two boys who were not of Asian descent.

The couple are now suing CHA Fertility and two men who are named as the clinic's co-owners and directors, for medical malpractice and intentional infliction of emotional distress.

The lawsuit says DNA tests confirmed the children were not related to the couple and that they have relinquished custody.

It notes that after giving birth on March 30, the couple "was shocked to see that the babies they were told were formed using both of their genetic material did not appear to be".

The event has made headlines around the world. The BBC reports there were earlier signs things were not going to plan when a scan revealed the couple was expecting boys, despite doctors having told them they did not use male embryos during the treatment. The doctors reportedly told the couple that the scan was inaccurate.

Compounding the situation, the newborns are not only unrelated to the couple, they are not even related to each other.

Lawyers for the couple told the BBC their clients suffered from "the grossly negligent and reckless conduct of CHA fertility" and that "our goal in filing this lawsuit is to obtain compensation for our clients' losses, as well as to ensure that this tragedy never happens again".

The couple say they had tried for years to conceive before spending more than US$100,000 on the IVF process.

The fertility clinic has reportedly so far not commented.

World News

Massive cholera vaccination in the Congo

Phase 2 of the biggest ever oral vaccination campaign against cholera has just taken place in 15 health districts in the four central provinces of the Democratic Republic of the Congo (DRC) - Kasaï, Kasaï Oriental, Lomami et Sankuru, the World Health Organisation reports.

The second dose of vaccine confers lasting immunity against cholera, and was targeted at 1,235,972 people over one year of age. The five-day, door-to-door campaign involved 2,632 vaccinators recruited mainly from local communities, whose job it was to administer the oral cholera vaccine, fill in vaccination cards and tally sheets, and compile a daily summary of the teams' progress.

In parallel, 583 community mobilisers had been selected – one mobiliser for every three teams in urban areas and one mobiliser for every two teams in rural districts. Their job was to alert local people that vaccinators will visit their homes. They used loudspeakers to spread the message, particularly in the early evening.

The campaign was organised by the country's Ministry of Health with technical, logistic and financial support from WHO, Gavi, the Vaccine Alliance and the Global Task Force on Cholera Control (GTFCC). It is the second such campaign in this central region of the DRC. A total of 1,224,331 people over one year of age were vaccinated during the first round in late December 2018. The purpose of the vaccination campaign is to contain the serious epidemic that resulted in 9,154 presumed cases and 458 deaths in the five affected provinces in Kasaï region between January and December 2018.

"This cholera vaccination campaign marks the intensification of our response in the DRC," said Dr Matshidiso Moeti, WHO Regional Director for Africa.

"WHO and our partners are working with national authorities to rollout the vaccine, which comes in addition to multiple interventions introduced since the beginning of the cholera epidemic, including sanitation and water quality control in the affected areas, many of which have little access to a safe water supply."

The oral vaccines were provided from global cholera vaccine stocks managed by Gavi, the Vaccine Alliance.

"This vaccination campaign will play a key role in bringing this cholera outbreak under control," said Dr Seth Berkley, CEO of Gavi.

"The DRC is currently going through an unprecedented combination of deadly epidemics, with Ebola and measles outbreaks also causing untold misery across the country. It is vital that the global effort to control these outbreaks continues to receive support. We cannot allow this needless suffering to continue."

INFORMATION FOR MEMBERS

Genomic medicine here to stay? Have your say.

The Australian Genomics Health Alliance needs non-genetic medical specialists who work clinically in Australia to tell them about genomics in healthcare, present and future. It doesn't matter if you do or don't know much about this, or don't currently incorporate genomics into your practice; your opinions, views and experiences are valuable to us.

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Your input will help shape future workforce practices and continuing education and training programs.

For queries, contact amy.nisselle@mcri.edu.au – Dr Amy Nisselle. This is a National Health and Medical Research Council-funded Australian Genomics activity (University of Melbourne HREC 1646785.8).

World News

WHO reports good progress in eliminating trachoma

The number of people at risk of trachoma globally has fallen from 1.5 billion in 2002 to just over 142 million in 2019, a reduction of 91 per cent, according to a recent report from the World Health Organisation.

Trachoma is the world's leading infectious cause of blindness.

New data presented at the 22nd meeting of the WHO Alliance for the Global Elimination of Trachoma by 2020 (GET2020), held at Mozambique in June, also showed that the number of people requiring surgery for trachomatous trichiasis – the late, blinding stage of trachoma – has dropped from 7.6 million in 2002 to 2.5 million in 2019, a reduction of 68 per cent.

Trachoma remains endemic in 44 countries and has blinded or visually impaired about 1.9 million people worldwide. Mapping of trachoma has been completed to identify its distribution and target control measures through the SAFE strategy.

SAFE is an acronym for **S**urgery for trachomatous trichiasis; **A**ntibiotics to clear ocular C. trachomatis infection; **F**acial cleanliness to reduce transmission of ocular C. trachomatis; and **E**nvironmental improvement, particularly improved access to water and sanitation.

"Eliminating trachoma contributes to the ocular health and quality of life of the poorest, most disadvantaged people worldwide and thereby moves us a step closer to achieving universal health coverage," said Dr Mwelecele Ntuli Malecela, Director of WHO Department of Control of Neglected Tropical Diseases.

"Ridding the world of this painful, debilitating disease is being made possible through generous donations of the antibiotic azithromycin, sustained contributions from a network of dedicated funding agencies and partners, and the efforts of hundreds of thousands of front-line workers who work tirelessly to engage communities and deliver interventions."

Scott McPherson, Chair of the International Coalition for Trachoma Control said: "Eliminating trachoma has immediate benefit in preserving vision for people at risk. But work against trachoma has required the creation of innovative partnerships, which will help ensure that the most remote and marginalised people are not left behind as more comprehensive health services are strengthened."

In 2018 alone, 146,112 cases of trichiasis were managed and almost 90 million people were treated with antibiotics for trachoma in 782 districts worldwide.

Since 2011, eight countries have been validated by WHO as having eliminated trachoma as a public health problem. At least one country in every trachoma-endemic WHO Region has now achieved this milestone, demonstrating the effectiveness of the SAFE strategy in different settings.

The significant reduction in the global prevalence of trachoma has resulted from increased political will in endemic countries, expansion of control measures and generation of high-quality data. The global program has been supported by the world's largest infectious disease mapping effort – the Global Trachoma Mapping Project (2012–2016) – and, since 2016, by Tropical Data, which has assisted health ministries to complete more than 1500 internationally-standardised, quality-assured and quality-controlled prevalence surveys.

In 1996, WHO launched GET2020, and with other partners in the Alliance, supports country implementation of the SAFE strategy and strengthening of national capacity for epidemiological assessment, monitoring, surveillance, project evaluation and resource mobilisation. Elimination of trachoma is inexpensive, simple and highly cost–effective, yielding a high rate of net economic return.

Trachoma is a disease of the eye caused by infection with the bacterium Chlamydia trachomatis. Transmission occurs through contact with infective discharges from the eyes and nose, particularly in young children who harbour the main reservoir of infection. It is also spread by flies which have been in contact with the eyes and noses of infected people.

The immune system can clear a single episode of infection, but in endemic communities the organism is frequently reacquired. After years of repeated infection, the inside of the eyelid can become so severely scarred (trachomatous conjunctival scarring) that it turns inwards and causes the eyelashes to rub against the eyeball (trachomatous trichiasis), resulting in constant pain and light intolerance. This and other alterations of the eye can lead to scarring of the cornea. Left untreated, this condition leads to the formation of irreversible opacities, with resulting visual impairment or blindness.

World News

World update recognises emotional key to healthy workplaces

In its recent 11th Revision of the International Classification of Diseases (ICD-11), The World Health Organisation recognised the serious effects of burnout, defining it as a syndrome resulting from chronic workplace stress that has not been successfully managed.

The condition is characterised by feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job and reduced professional efficacy.

Recent findings reveal that workers who describe themselves as mentally distant, or disengaged had 37 per cent more absenteeism, 49 per cent more workplace accidents, and 60 per cent more issues with accuracy and defects.

In Australia, AccessEAP is a leading Employee Assistance Program (EAP) provider. It says businesses need emotionally intelligent leaders who know how to respond to a situation in a way that facilitates positive behaviours.

Its Clinical Director Marcela Slepica said: "Emotions and vulnerability are part of who we are and that doesn't just go away when we enter the workplace. Opening up to colleagues and letting them know when I was feeling vulnerable, allowed me to make real connections, gain support and feel better sooner. Leaders should show compassion and support workers to do the same, simply put, leaders need to lead by example."

Insight and awareness around the feelings of others is a skill that can be learned and developed. Upskilling managers to both identify and manage their own emotions, as well as those of employees, is vital for a harmonious workplace. With five generations working side by side, leaders need to adapt their style to respect the needs of different generations.

AccessEAP says it is risky for an organisation to ignore the feelings of their team. Engagement is fundamentally an emotional phenomenon, so when employees have a strong reaction, it can impact on many areas including, working relationships, concentration, productivity and decision making. Understanding the impact that feelings can have on a worker's ability to function and knowing how to manage them are essential skills for leaders.

Someone who is unhappy or burnt out will impact on others. It is estimated that to replace a full-time employee it costs a business around six to nine months of that person's salary, recruitment and training costs. For someone who is earning $50,000, it could cost $25,000 to $37,500 to replace them. To avoid this costly result, AccessEAP says, it is imperative to focus on engagement and wellbeing initiatives, which essentially means recognising the importance of emotions.

Just in time!

BY **DR CLIVE FRASER**

100,000 kilometres is a reasonable distance for any car to travel.

Most of my colleagues have off-loaded their cars long before the odometer goes around the clock.

But my car is going fine and I'm still weighing up the energy options for whenever I finally trade it in (petrol, ethanol, diesel, LPG, hybrid, electric, hydrogen, nuclear etc).

After 10 years, my car is ready for some maintenance, particularly replacing parts that are made of rubber.

Fortunately my car has a timing chain rather than a rubber timing belt.

The chain should last the life of the engine.

But the air conditioning, alternator and sundry other peripherals on my car are all driven by a single serpentine belt which snakes around seven pulleys.

That belt is made from a synthetic compound called ethylene propylene diene monomer rubber (EPDM).

The same compound is used to make O-rings and seals.

Over time the belt wears and becomes shiny, cracked and prone to failure.

Far better to replace it now and throw the old belt in the boot as a spare.

Trying to find the right replacement belt was an interesting exercise in checking and cross-checking to make sure that I ordered exactly the right one.

My vehicle has electric power steering which saved one pulley and reduced the belt length by 15 centimetres.

So it was a 6DPK1698 belt that I needed.

6DPK referred to the six ribs on both sides of the belt and 1698 was the exact length in millimetres.

The multiple ribs reduce slippage and the fact that they are on both sides of the belt provides flexible stress relief so that the belt can be bent around pulleys in both directions.

New belts also have an additional stamp for the date of manufacture.

After all there is no point replacing an old belt, with an old belt.

My next challenge was how to get the used belt off?

I can honestly state that out of the 525 million hours of video on Youtube no one has posted a clip on my engine which shows exactly how to do it.

So it was with a lack of skill and experience I released the

tensioner and delivered the old belt.

I then noticed that it was also a 6DPK1698.

The new belt should fit, I thought.

But there was another mark that really caught my eye.

It said that the old belt was made on the 14th of November 2009 in Germany by Continental.

Funny about that, because my car was assembled by BMW just six days later in Southern Bavaria.

And somewhere along the line the belt was fitted in the engine plant before the engine was fitted to my car.

These dates confirm that in the automotive world everything is made 'Just in time'.

Pioneered by Toyota parts usually arrive at the factory on the same day that they are fitted on the assembly line.

No one keeps a large inventory which is costly to store and may not be used.

It's all good until natural disasters, industrial action or some other unexpected event occurs.

That can see cars leaving the factory without a spare wheel etc.

I was very proud that I'd replaced the serpentine belt myself on my car.

So what did I do with the old belt?

I put it in the boot ... 'Just in case!'

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

The beasts who boogie

REVIEW: King Gizzard and the Lizard Wizard at the Roundhouse in Sydney

BY NICHOLAS ELMITT

There is always a buzz in the crowd leading up to a King Gizzard and the Lizard Wizard show. Fans are always keen to chat, speculating on what the set list will be. With 14 albums under their belt since 2012, and a 15th due for release in August, they have plenty of material to choose from.

Despite their eclectic back catalogue, I was pleased they opened with a new track off their forthcoming album *Infest the Rats' Nest*. That pleasure quickly became tinged with nervousness as a death pit formed in front of me. I was able to avoid it for the most part, but it was clear that I was in for a wild show.

King Gizzard and the Lizard Wizard (as the fans call them) are a hard band to pin down. The genre-spanning seven piece from Melbourne includes two drummers, but every member is a multi-instrumentalist. Famous for releasing five albums in 2017, fans were naturally excited when their first album since then was released in March this year. *Fishing for Fishies* was a 'blues-boogie-shuffle-kinda-thing' – a catchy album with an environmental message about the risks of overfishing and plastic in the ocean. Despite the playful songs, few were surprised when the Gizz decided to follow this up with thrash metal. That's just what they do.

Another of their many talents is weaving their many musical styles into one coherent 90 minute concert. At the second of their two student shows, they did not disappoint.

After playing three tracks of thrash metal, including their most recent single *Organ Farmer*, the Gizz played a couple of classics, including the ever popular slow jam *Work This Time*. I was grateful for the change in pace, but I knew it would be temporary.

The beats picked up and they launched into *Cyboogie*, a funky synth-fueled banger. They weaved in a few of my personal favourites including parts of *Altered Beast* from the *Murder of the Universe* concept album, and the driving microtonal beats of *Rattlesnake*.

The Gizz then turned back to their upcoming album to close the set. The audience were panting almost as hard as the band at the end of *Self Immolate*.

The show was one of my musical highlights of the year. Fantastic all round musical performances matched by the psychedelic light show and lead singer Stu McKenzie's trademark stage gymnastics. The Roundhouse at UNSW was an excellent venue, with great acoustics, for such a dynamic show.

Gizz Fans know not to hope for their favourite tracks because each show is unique, taking bits and pieces from their expansive catalogue. Some find the breadth of work intimidating and give the Gizz a pass (some are also put off by the name), but in my experience there are always a few Gizz songs that will fit your taste, no matter what.

The Gizz are constantly touring, so don't worry if you miss them this time because they will be hitting the road again within the next 12 months. I highly recommend you check them out.

Nicholas Elmitt is an AMA Policy Adviser.

Australian Medicine welcomes concert and album reviews, and other music observations, from members. Please send to ausmed@ama.com.au for consideration.

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