AUSTRALIAN
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# Unhealthy climate

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**Managing Editor:** John Flannery
**Editor:** Adrian Rollins
**Production Coordinator:** Kirsty Waterford
**Contributors:** Sanja Novakovic
Odette Visser
**Graphic Design:** Streamline Creative, Canberra



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42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au



## AMA LEADERSHIP TEAM

**President**
Professor Brian Owler

**Vice President**
Dr Stephen Parnis

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# Commonwealth retreat on health?

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

A year ago, the Federal Government changed Health Ministers.

Amid the chaos of the bungled co-payment proposals, the-then Prime Minister Tony Abbott sought to defuse the health policy crisis undermining his agenda by replacing the underperforming Peter Dutton with the untested but up-and-coming Sussan Ley.

It was new Health Minister Ley's job to take the heat out of the co-payment debate – to consult and to keep things calm. It worked. A month later, on 15 January this year, the co-payment was gone – dead, buried, cremated.

At the time, the AMA called on the Government to shift its health priorities to chronic disease management, public hospital funding, Commonwealth/State relations, prevention, and medical training.

We stressed to the Government and the community that there was no health funding crisis facing Australia, as claimed by the Government and some commentators.

The foundations of the health system were sound. Health spending was not out of control. Our health system was, and is, the envy of the world.

It is not perfect, but the foundations – the balance between public and private, the defined roles for the Commonwealth and the States, high life expectancy, and good health outcomes – continue to underpin a healthy nation.

The problem for the Government was that the damage from the 2014 Budget would not go away. The quest for significant savings in the health budget had come to a sudden halt with the demise of the co-payment.

A change of strategy came in the 2015 Budget with the announcement of the Review of the Medicare Benefits Schedule (MBS) and the Primary Health Care Review.

While welcoming the reviews and offering willing AMA participation, we let it be known from the beginning that the AMA would not support a process that was primarily about cost cutting and Budget savings.

Despite assurances from the Minister, all the rhetoric around the reviews was about removing items, not introducing new items as well, as had been agreed at the outset. There was unanimity around building a modern MBS that reflects modern medical practice. That unanimity is frayed as we near the end of the year. We await preliminary reports from both reviews.

In October, the Minister announced a review of the private health insurance sector. This came after months of inappropriate behaviour by some funds in their negotiations with private hospitals, and questions being raised about the value of many private health policies. The emergence of 'junk policies', where patients discovered they were not covered for care in a private hospital, added further impetus for the review.

Meanwhile, the private health funds continued pushing for a greater role in primary care, moves not rebuffed by the Minister. In fact, the former Health Minister, Peter Dutton, actively campaigned for a greater role for PHIs.

Then, in November, the Government released its-long delayed response to the mental health review. This virtually amounted to the Government allocating funding packages to Primary Health Networks to be distributed to various care providers and services at the local level. There is still scant detail, and only a small number of PHNs operating at an efficient level, so question marks remain over this strategy, especially given the lack of commitment to a key role for GPs.

The worry is that the mental health approach may be a signal for what is to come with the Primary Health Care Review.

So, at the end of the year, what is 2016 in health looking like?

We have seen active demonising of doctors in the MBS review process, and a clear plan to cut costs. We have seen a willingness for PHIs to play a more active role in all areas of the health system – despite inappropriate behaviour and lower value products for patients. We have seen strong indicators of a Government pursuing a US-style managed care system. And we have seen signs of the Commonwealth retreating from its core responsibilities in funding and delivering health services.

These are worrying signs. Things are no longer calm.

Next year is an election year. The AMA will be watching things very closely, and we will be standing up for what is best for doctors, their patients, and the community.

# Much to be proud of in year of hard fights and painful revelations

BY **AMA VICE PRESIDENT DR STEPHEN PARNIS**

As 2015 draws to a close, I thought it timely to consider the year as a whole, rather than focus on a single issue. Understanding where we have been is usually the best indicator of where we are going.

In health funding, 2015 has been an incredibly busy year. Our health system continues to be dissected on the premise that it is unsustainable, with various interventions by governments and other major players (such as private insurers).

Announcements and major policy changes in health funding seem to occur on a weekly basis. In no particular order, we have confronted issues relating to general practice co-payments, the Medicare Benefits Schedule, public hospital funding, the evidentiary basis for diagnostic tests and therapeutic procedures, the cost of pharmaceuticals, variation in medical practice across the nation, and activity based funding.

Are there any common threads to be drawn here?

It seems to me that, for the money we spend and the outcomes we achieve, Australia has a health system to be proud of.

But it is an extremely complex system, and any proposed change always risks undermining access and outcomes in unanticipated ways.

We have sought to acknowledge and welcome change for the better, whenever it promised improved access to care, more efficient practice, or better health outcomes. At the same time, however, we have needed to ring the warning bell when things have gotten out of hand. Remember the assertion that 30 per cent of all health care provided in Australia was unnecessary? How about the attempt to characterise major medical complications as mistakes, with the inference that there was always someone to blame?

Aside from funding concerns, workforce remains a huge issue for us all – teaching, training and research have been fundamental aspects of being a doctor for generations, and yet the future for all of these endeavours is uncertain.

New medical schools have been established without due consideration of Australia's need to expand postgraduate training and, for the first time in my life, junior doctors fear being unable to complete their training through no fault of their own.

Some painful revelations this year have led to hopeful signs within medicine. There is a greater understanding now than ever before of the stressors and risks we take on when we become medical students and doctors. I am encouraged by the great work being done across the country to comprehend and contend with doctors' health, and the establishment of nationwide services for doctors' health is becoming a reality.

We have all struggled with a greater understanding that bullying and harassment have afflicted the medical profession and its institutions for far too long. What was regarded by some as a rite of passage can no longer be tolerated. It is time for systemic changes to ensure that professional standards are taught, supported and enforced. This will take some years to achieve, but we will get there.

I'm proud of the work we have done on behalf of our patients. We have advocated for fairness in access to medical care, whether it be to improve services and doctor numbers in regional areas, or to maintain community rating in private insurance policies. We have spoken on many public health initiatives – physical activity, road safety, and concussion, to name a few. We have called for Australia to do its fair share to mitigate the health impacts of climate change.

But I'm probably proudest of our work for the most vulnerable – our indigenous Australians whose health outcomes and incarceration rates remain atrocious, those caught in the Ebola epidemic in West Africa, and the victims of family violence.

For those Australians nearing the end of their life, we have sought to ensure that palliative care is better understood, resourced and practised, and we won't shy away from the contentious aspects of end of life care in 2016.

I encourage you all to find some time over the Christmas-New Year period for rest and reflection, and time with loved ones. I pay tribute to our colleagues who have to work at this time, and acknowledge the sacrifices they and their families make.

My best wishes to you for a successful and healthy 2016.

# Constitutional changes give members greater say

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "The year is finishing with a range of reviews across the spectrum of health care, from the Medicare Benefit Schedule to private health insurance to primary care. What is missing is a clearly-articulated vision for the health system of the future"

The year started with a battle to overcome the Government's planned changes to general practice with a mandatory copayment, changes to the reimbursement for level A/level B consultations, and a freeze on Medicare rebates.

While the AMA and other groups were successful in overcoming the first two proposed changes, the third remains in place, notwithstanding ongoing advocacy and promises from Health Minister Sussan Ley to lift the freeze.

The year is finishing with a range of reviews across the spectrum of health care, from the Medicare Benefit Schedule to private health insurance to primary care. What is missing is a clearly-articulated vision for the health system of the future - one that is capable of meeting the changing needs of the Australian population while also being sustainable.

The MBS review threatens to become bogged down in detail, with separate working groups investigating areas of clinical practice. The first six reviews are underway, and initial reports are due in early 2016.

The AMA has created a platform for clinicians to share views on the clinical content being considered by the review groups. It can be accessed at www.doctorportal.com.au/discussions/. The site is open to doctors, who need to be authenticated to make use of it. If you are having trouble logging in to doctorportal, visit www.doctorportal.com.au/user-register/.

Federal Council met over the last weekend of November with a full agenda of policy items for discussion and resolution.

We are sometimes asked by members how the AMA reaches a particular policy position, and how policy evolves within the AMA.

The process is well developed and has been consistent for many years. Draft Position Statements are prepared from consideration and debate within the relevant councils and committees of Federal Council or, from time to time, through the plenary sessions at National Conference. They are then taken to Federal Council for adoption. These then inform the public positions taken by the President and Vice President, who are the primary spokespeople for the AMA.

Since the adoption of the new constitution in 2014, which focuses the work of Federal Council on medico-political issues, working groups have been used more frequently, with contributions from both members of the Council and other members of the AMA. This has supported broader engagement of the membership in AMA policy development.

In a similar vein, at its most recent meeting Federal Council discussed the format and frequency of the National Conference.

Federal Council approved revised member representation through delegates drawn from the primary practice groups that are reflected in AMA advocacy – general practice, hospital practice, specialist private practice, rural practice, and doctors in training.

The delegates will be drawn from the members of Federal Council, with the practice groups and the State AMAs each represented by half of the remaining delegates at National Conference.

Amendments will be required to the Constitution at the 2016 Annual General Meeting to introduce the revised structure which, if approved, will be in place for 2017.

# Health neglected in climate talks

**"There are already significant health and social effects of climate change and extreme weather events, and these effects will worsen over time if we do not take action now" – *Professor Brian Owler***

More than half of governments around the world are yet to develop national plans to protect their citizens from the health effects of climate change despite increasing warnings it will cause more extreme weather, spread disease and put pressure on food and water supplies.

As leaders from around the world attending the United Nations Climate Change Conference in Paris reaffirmed their commitment to provide $139 billion a year by 2020 to the UN's Green Climate Fund and other climate initiatives, an international survey of 35 countries, including Australia, has found a general lack of focus and urgency around the looming threat of climate change to health, with most governments doing little work on likely effects and how to mitigate them.

The survey results underline calls from the AMA, the World Medical Association and other national medical organisations for the health effects of climate change to be made a priority.

AMA President Professor Brian Owler said that while much of the Paris talks were about carbon emission targets, there should be equal emphasis on equipping health systems to cope with the extra burden of problems created by climate change.

"Climate change will dramatically alter the patterns and rate of spread of diseases, rainfall distribution, availability of drinking water and drought," Professor Owler said. "The incidence of conditions such as malaria, diarrhoea and cardio-respiratory problems is likely to rise."

The AMA President's comments came as a survey coordinated by the World Federation of Public Health Associations (WFPHA) found almost 80 per cent of governments are yet to comprehensively assess the threat climate change poses to the health of their citizens, two-thirds had done little to identify vulnerable populations and infrastructure or examine their capacity to cope, and less than half had developed a national plan.

The result underlines the importance of repeated AMA calls for the Federal Government to do much more to prepare for the effects of climate change, which Professor Owler said were "inevitable".

Earlier this year the AMA released an updated Position Statement on Climate Change and Human Health that warned of multiple risks including increasingly frequent and severe extreme weather events, deleterious effects on food production, increased pressure on scarce water resources, the displacement of people and an increase in health threats such as vector-borne diseases and climate-related illnesses.

"There are already significant health and social effects of climate change and extreme weather events, and these effects will worsen over time if we do not take action now," Professor Owler said.

"Nations must start now to plan and prepare. If we do not get policies in place now, we will be doing the next generation a great disservice.

"It would be intergenerational theft of the worst kind — we would be robbing our kids of their future."

In May, the AMA and the Australian Academy of Science jointly launched the *Climate change challenges to health: Risks and opportunities* report that detailed the likely health effects of climate change and called for the establishment of a National Centre of Disease Control to provide a national and coordinated approach to threat.

The WFPHA said the results of its survey should serve as a wake-up call for governments to do much more.

"The specifics of these responses provide insight into the lack of focus of national governments around the world on climate and health," the Federation said.

Disturbingly, the survey found that Australia was one of the laggards in addressing the health effects of climate change, having done little to assess vulnerabilities and long-term impacts, develop an early warning system or adaptation responses, and yet to establish a health surveillance plan.

On many of these measures, the nation was lagging behind countries like the United States, Sweden, Taiwan, New Zealand and even Russia and China.

Climate and Health Alliance Executive Director Fiona Armstrong, who helped coordinate the survey, said the results showed the Federal Government needed to place far greater emphasis on human health in its approach to climate change.

"As a wealthy country…whose population is particularly vulnerable to the health impacts of climate change, it is very disappointing to see this lack of leadership from policymakers in Australia," Ms Armstrong said.

Public Health Association of Australia Chief Executive Officer Mike Moore said the increasing number and ferocity of bushfires and storms underlined the urgent need for action.

"It is time to ensure that health-related climate issues are part of our national planning and budgeting if we are to pre-empt many avoidable illnesses and injuries," Mr Moore said.

The AMA's *Position Statement on Climate Change and Human Health* can be viewed at: https://ama.com.au/position-statement/ama-position-statement-climate-change-and-human-health-2004-revised-2015

ADRIAN ROLLINS

# Gatekeeper role of GPs under scrutiny in MBS review

The crucial gatekeeper role played by GPs is coming under scrutiny as the Federal Government explores a possible overhaul of the operation of Medicare as part of its review of the MBS.

While around 35 Clinical Committees will be set up to conduct an item-by-item review of the MBS, a memorandum by Review Taskforce Chair Professor Bruce Robinson shows "high-level" issues affecting the overall functioning of the Medicare system are also under active consideration.

The Review Chair was at pains to insist that there was no set savings target for the MBS Review, but added there was "a need to look at the full breadth of the $19.1 billion MBS spend, not just general practitioner services".

His comments came as it was revealed the final results of the MBS Review would not be submitted to the Government until December 2016, almost certainly putting them beyond the next Federal election, which is due by late next year.

Much of the attention so far has been on the Review's appraisal of more than 5700 items on the MBS, but the fact that it also encompasses an examination of the over-arching rules governing the operation of Medicare is less well known.

But the far-reaching possibilities this entails started to become clearer at a series of stakeholder forums organised by the Taskforce, including fundamental changes in professional roles and responsibilities, models of remuneration, and the use of the MBS to "actively guide" clinical decision-making.

In his report on consultations, Professor Robinson said some had complained that the gatekeeper role played by GPs was limiting the effectiveness of team-based care, such as by requiring all referrals to be made through the GP.

The Taskforce Chair said that though some participants reaffirmed the importance of GPs as gatekeepers, there were suggestions that specialists be able to make direct referrals in selected cases, such as a physiotherapist requesting a knee x-ray.

Suggestions of any dilution in the central role played by GPs in coordinating care fly in the face of the latest advice from health experts here and abroad, who have argued that, far from diminishing the position of the family doctor, governments should enhance it.

In its latest review of the Australian health system, the Organisation for Economic Cooperation and Development argued strongly against any further fragmentation of the health system, and urged that primary health care be strengthened.

And University of Sydney researchers last month reported that GPs were holding health costs down by coordinating the care provided by hospitals, specialists, allied health professionals and community and aged care services.

"If general practice wasn't at the core of our health care system, it is likely the overall cost of health care would be far higher," the researchers said.

The MBS Review process has also included discussion about a shift away from the fee-for-service remuneration model to pay for performance – an issue being explored in detail by the Primary Health Care Advisory Group being led by former AMA President Dr Steve Hambleton.

"While many participants felt the MBS could improve quality of care by paying for performance, concerns were voiced that clinicians may be averse to taking on high-risk patients who are unlikely to achieve target outcomes," Professor Robinson reported. "Furthermore, some rebates may need to reflect the additional risk that providers would be taking on – potentially a complex analysis."

In addition to exploring so-called 'macro' issues, Professor Robinson provided more detail on how the review of individual Medicare items would proceed.

He said each of the Clinical Committees would conduct an initial "triage" of usage patterns, evidence and descriptors to identify items in need of more detailed investigation.

It would then conduct a rapid evidence review and make recommendations to the Taskforce based on its appraisal.

Given the scale of the task, Professor Robinson said the Committees, which would be peer-nominated and clinically-led, would be likely to appoint subsidiary working groups.

Already, six pilot Clinical Committees have been established, including in obstetrics.

The Taskforce Chair said items suggested for review fell into one of six categories: they were obsolete, misused, applied inappropriately, under-utilised, placed undue restrictions on providers or did not reflect modern practice.

He said participants stressed the importance of Taskforce plans to share the evidence used to support recommendations about items, to improve clinical practice and inform the future direction of research.

The Review Taskforce is due to provide an interim report to the Government by the end of the year.

Professor Robinson's Memorandum of the MBS Review Taskforce November 2015 Stakeholder Forums can be viewed at: https://ama.com.au/sites/default/files/Summary%20Memorandum%20MBS%20Review%20Stakeholder%20Forums%20November%202015%20%282%29.pdf

ADRIAN ROLLINS

## MBS Review – tell us what you think

The Federal Government's MBS Review could have far-reaching implications for clinical practice.

To facilitate conversations about the clinical aspects of the Review and identify the common clinical opinions, the AMA has created an online discussion forum in doctorportal for medical practitioners.

To start or contribute to a discussion, click here: http://www.doctorportal.com.au/discussions/

Information on how to register for doctorportal is available at www.doctorportal.com.au/user-register/

# Women stopped from getting to the top

Women are struggling to make it into the upper echelons of the medical profession despite comprising an increasing majority of those embarking on a medical career.

Australian Institute of Health and Welfare figures show that last year women made up 40 per cent of the medical workforce and 53 per cent of early-career practitioners, including just over half of all specialists in training.

But, despite this, researchers have found that they are failing to progress through to senior positions in representative numbers, comprising less than a third of specialist college board members and medical school deans, 33 per cent of state Chief Medical Officers and just 12.5 per cent of large hospital CEOs.

A study of medical leadership in Australia, published in BMJ Open, has found that women are under-represented in medical leadership roles due to a combination of ill-informed attitudes and inflexible work and career demands.

Through detailed interviews with a sample of 30 medical leaders (22 of whom were men), a team of researchers from Melbourne University, Monash Health and Deakin University found although some thought the representation of women at senior levels would increase because of the pipeline of females entering the profession, the majority – both men and women – identified a series of barriers that prevented women from advancing.

"Most interviewees believed that gender-related barriers were impeding women's ability to achieve and thrive in medical leadership roles," the researchers said, and identified three broad impediments – perceptions of capacity, organisational arrangements and professional culture.

The most commonly-cited barrier was parenthood, with several medical leaders referring to an inherent incompatibility between high-level leadership and motherhood.

But several remarked on the tendency of managers, and women themselves, to underestimate their capabilities.

A number of leaders interviewed for the study, *Reasons and remedies for under-representation of women in medical leadership roles*, reported that women were often "not taken really seriously", and were consider to be "too feminine" to be an effective leader.

In their findings, the researchers said that, as in other professions, the lack of women in senior leadership positions was justified by a range of explanations including it was "too soon" to see women in these roles, they were too busy with their families, or were not natural leaders.

The researchers said the basis for these explanations was thin, pointing out that women have made up a sizeable proportion of the medical workforce for decades and are still not moving into leadership roles in numbers consistent with their representation in the workforce.

On the career-limiting impact of parenting, they said that "cultural assumptions that childrearing and household responsibilities impede women from entering leadership roles is, at least in part, based on discriminatory social norms".

They pointed out that inflexible work arrangements made this a structural, rather than inherently biological, barrier. Some of those interviewed for the study suggested that, rather than following a standard linear path, medical careers could be structured to follow a more M-shaped trajectory that would support women to enter, or re-enter, leadership roles at an older age "if that suited their life-course".

The researchers cited cultural norms and unconscious biases in the medical profession about what a leader should look like, and how they should behave, as another impediment faced by women.

They also identified other institutional impediments. For example, because the responsibilities for childrearing and maintain a household continue to fall disproportionately on women, they tend to gravitate towards specialties that give them the time and flexibility to fulfil these roles, such as general practice and public health medicine.

But these specialties, the report said, tended to have a less influential presence in large health services compared with traditional male-dominated specialities, such as surgery.

"Achieving meaningful change will require us to move beyond 'fixing the women' to a systemic, institutional approach that acknowledges and addresses the impact of unconscious, gender-linked biases," the researchers said. "Revisiting rigid career structures, providing flexible working hours, offering peer support, and ensuring appropriate development opportunities, may all assist women to enter leadership roles."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

## Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

# FBT tax cap: we are not entertained

Patients could face a blow-out in waiting times for elective surgery if the Federal Government pushes ahead with controversial plans to cap tax concessions on entertainment benefits for hospital employees, the AMA has warned.

The nation's peak medical group had told Treasury its proposal to impose a $5000 cap on salary sacrificed meal and entertainment expenses that are eligible for fringe benefit tax exemptions would harm the ability of public hospitals and other not-for-profit health groups to attract and retain skilled medical staff, undermining the services they are able to provide.

In its May Budget, the Federal Government claimed the tax concession – currently worth around $17,000 a year - was being exploited and abused, and estimated its crackdown on the perk would raise $295 million over four years.

But AMA Vice President Dr Stephen Parnis said the Government had not provided any substantive evidence to back its claim FBT concessions were being used unfairly, and urged it to proceed with great caution in making any changes.

"The AMA is deeply concerned that the reforms canvassed in the exposure draft could significantly affect the ability of institutions, including public hospitals, to recruit and retain staff," Dr Parnis said, warning this could cause treatment waiting times to blow out.

"If the current supply of medical specialists decreases, we believe it is reasonable to predict a lengthening of waiting lists for elective surgery and outpatient clinics."

Public hospitals and not-for-profits have relied on the FBT concession to help them compete with the private sector for the services of doctors and other health workers.

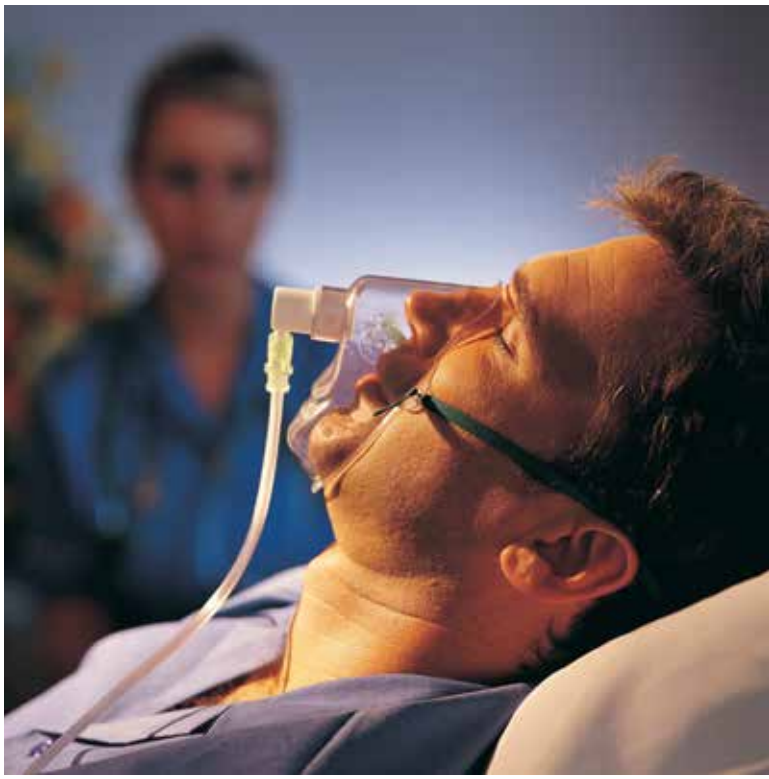
Dr Parnis said that many practitioners chose to forego higher wages on offer in the private sector to work in public hospitals because of the chance to practice advanced acute care, undertake research and provide teaching and training.

But he said they still deserved to be fairly remunerated for their skills and experience, and the FBT tax concession helped to make the salaries hospitals could offer competitive.

The AMA has warned that putting a cap on the concession would have a number of serious unintended consequences for the health care system, particularly the supply of medical specialists.

In the short-term, any drift of medical specialists away from the public system will likely cause waiting lists for surgery to blow out.

In the longer term, because the health system relies on senior and experienced hospital medical staff to help train the next generation of practitioners, Dr Parnis said the loss of even some



of these workers to the private sector because of reduced tax breaks would undermine teaching capacity.

He said this was particularly worrying because it was coming at a time when the pressure on hospital teaching capacity had never been greater as a result of rapid growth in the number of medical graduates.

Several organisations have written to Treasury urging that the $5000 cap on entertainment expenses that are eligible for FBT exemptions be raised.

St John's Ambulance said it relied on the FBT exemption to help attract and retain skilled staff, and suggest the cap be increased to $20,000, while the Fred Hollows Foundation recommended it be set at $30,000.

The Salvation Army, meanwhile, warned a $5000 cap would hit the salaries of half its staff.

The Tax Institute recommended the cap be set at $15,000.

The tax change is due to come into effect from 1 April 2016.

ADRIAN ROLLINS

# Govts ponder internship overhaul

Medical students in the final year of their degrees may be required to undertake prevocational training as part of two-year transition to practice arrangements under contentious changes to internships proposed by a Council of Australian Governments review.

The review, commissioned by the Australian Health Ministers' Advisory Council, found that although the current internship model was not broken, changes in health care and the way hospitals operate meant it "no longer fits the purpose of meeting the long-term health needs of the community".

In particular, the inquiry reported that many medical graduates were leaving university highly qualified but with limited experience in providing actual patient care and "no baseline of work-ready capabilities they are expected to meet".

Hinting at the possibility that medical graduates could face an entrance exam for internships, the review suggested graduates be required to satisfy "entry requirements that reflect... expectations of work-readiness" before commencing.

It said the current internship model in most cases provided for little experience outside of public hospitals, and was increasingly falling short of what was required because it gave graduates only "limited exposure to the full patient journey and range of patient care needs which are important in developing well-rounded doctors".

Instead, it has recommended that the current one-year internship be replaced with a two-year 'transition to practice' model in which the first year would continue to serve as a prerequisite for general registration, while the second could include entry into vocational training.

"We believe a two-year timeframe is more realistic to provide diverse experience, build a strong general foundation and more adequately prepare graduates for vocational training," the review said, noting that the "vast majority" of doctors currently complete a second general year that is unstructured and poorly aligned with the next stage of training.

More radically, it suggested that the two-year model include the final year of medical school and the first year of postgraduate training, though it acknowledged that this was a profound change that should initially be piloted across a range of medical programs and health service settings before being embraced.

Less controversially, the review said there was a need to improve the supervision of interns, to shift the basis of assessment to a demonstration of specific capabilities and performance, and to ensure that clinical experience is gained in a wide range of settings.

AMA President Professor Brian Owler said he was "delighted" the review had taken up the peak medical group's suggestions for improved supervision and assessment, as well as expanded prevocational experience in community, private and other non-traditional settings.

The push to expose interns to a wider range of experiences has come as figures reveal an increasing proportion of final-year medical students come from the nation's capital cities – a trend at odds with hopes to address the rural doctor shortage by increasing the number of aspiring doctors coming from country and regional areas.

> "... although the current internship model was not broken, changes in health care and the way hospitals operate meant it 'no longer fits the purpose'" - *Internship Review*

A survey by the Medical Deans of Australia and New Zealand found 76 per cent of final year students last year came from capital cities, up from 67 per cent in 2010.

There has been a growing effort to recruit more students from the country in the expectation that a higher proportion are likely to go on to practise in rural areas.

While approving plans to increase the breadth of intern experience, Professor Owler said there were "question marks" over the suggestion that the two-year transition to practice be split between university and the workplace.

"The AMA is yet to be convinced that there is any evidence or need to support such a radical change," he said.

The AMA President said the fundamentals of the current intern system were sound - a view backed by the review's conclusion that the existing milestones for medical registration should remain unchanged.

He said it was pleasing that the review had heeded the AMA's call that changes be made incrementally and based on evidence, including its adoption of the AMA's suggestion for an annual National Training Survey.

The review's findings and recommendations have been referred to a working group comprising representatives from the Medical Board of Australia, the Australian Medical Council, and all State and Territory Postgraduate Medical Councils.

Professor Owler said the working group should also include doctor in training representatives, and involve extensive stakeholder consultation.

ADRIAN ROLLINS

# Medicare safety net back down

Health Minister Sussan Ley has been forced to back down on proposed changes to the Medicare Safety Net after failing to convince the Greens and crossbench Senators to back the savings measure.

In a decision that blows a $267 million hole in the Turnbull Government's Budget, Ms Ley has pulled legislation that would have made it harder for patients to get financial assistance with medical expenses.

> "Cutting and dicing good policies might result in short-term political fixes, but is not the way governments should manage a $65 billion health care system" – *Sussan Ley*

The changes, announced in the ill-fated 2014 Federal Budget and introduced to Parliament in October this year, were to have come into effect from 1 January 2016. But the Minister's decision means that the reforms will be held over until at least next year – raising the risk that they become an issue in the lead-up to the next Federal election, due by late 2016.

Ms Ley tried to put a positive spin on the reversal by arguing she was unwilling to compromise on key aspects of the proposal in order to secure the support she needed to get it passed.

"This is a good measure that aims to address significant inequities in a system failing to help the very people it's designed to protect – our most vulnerable patients with complex and costly medical needs," she said.

Despite what she described as "constructive" discussions with the Greens and crossbench Senators, Ms Ley said she was "unwilling to compromise over the fundamental integrity of the policy's intention and design in favour of a quick political solution".

"Cutting and dicing good policies might result in short-term political fixes, but is not the way governments should manage a $65 billion health care system," the Minister said.

The Federal Government wanted to replace the Original Medicare Safety Net, the extended Medicare Safety Net and Greatest Permissible Gap with a single Medicare Safety Net, increase the out-of-pocket costs patients pay before being eligible for assistance, and impose a universal cap on safety net benefits.

AMA President Professor Brian Owler said the proposed changes would have hurt the sickest and most disadvantaged the hardest, and called on the Government to scrap them altogether.

"The Government's changes would have created a financial and emotional burden for Australian families with considerable and unavoidable health needs," Professor Owler said. "We recommend that the Government scrap the proposed changes altogether."

While the Minister's decision will add to the pressure on the Budget, the AMA President urged her not to seek to fill the savings gap by turning the multiple reviews she has commissioned into the MBS, primary care and private health insurance into cost-cutting exercises.

"The Government must not be tempted to use the reviews to recoup the almost $267 million in Budget savings it was pursuing with the Safety Net changes," Professor Owler said.

The safety net changes were expected to hit patients in need of complex and ongoing treatment, including cancer sufferers and those with mental illness, particularly hard, increasing Australia's already high level of out of pocket costs.

Shadow Health Minister Catherine King said the Government's back down was a vindication of Labor's opposition to the changes.

Ms King said that although the Opposition was prepared to discuss what it considered to be sensible reforms, "we could not support this unfair and flawed legislation in its original form".

But Ms Ley hit back, saying that changes made by Labor while in government had not worked.

"Labor's own failed safety net reforms taught us that tinkering around the edges by placing inconsistent caps on the claiming of some Medicare items, such as IVF, but not others, will not solve the problem," the Minister said, and indicated that the Government had not given up on the reform proposal altogether.

The Minister said the Government would look to revisit the changes as part of its broader overhaul of Medicare and primary health care.

"The current measure will remain on the table while we continue to work...on an agreeable solution as part of our broader discussions on Medicare and primary care reform," she said.

ADRIAN ROLLINS

# Big questions hang over mental health reforms

Primary health care networks will be paid by the Commonwealth to provide tailored "integrated care packages" for patients with mental health problems in a major overhaul of the mental health system unveiled by the Federal Government.

In its long-awaited response to the National Mental Health Commission's review of the system, the Government announced a fundamental shift away from direct funding and program delivery. Instead, it will set up a pool of funds which can be used to pay the nation's 31 Primary Health Networks (PHN) to plan and commission local services for mental health patients.

"Just like any other chronic disease, mental illness is often complex and requires access to multiple health professionals and support services to address it properly," Health Minister Sussan Ley said. "Experts recognise many patients with severe or complex mental health needs would benefit from an integrated health care package tailored to their individual needs, and that's what we're delivering."

While patients can still choose to have Medicare-subsidised psychology sessions through GP-designed mental health plans, the Government expects a large proportion will opt instead for care packages provided by PHNs in partnership with Local Hospital Networks.

AMA President Professor Brian Owler said that although the changes were well-intentioned, much hinged on funding and the capacity of the PHNs.

Professor Owler said the focus on tailoring care to individual need and local service planning and delivery was welcome, but a lack of detail on funding and service delivery left big questions hanging.

"The success of this new direction in mental health service delivery will depend very much on the capacity and capability of PHNs," the AMA President said.

Professor Owler said the new framework needed to deliver genuine patient-centred care, rather than simply giving PHNs the power to determine what package of care patients can have, based on the services it has chosen to organise.

"It is particularly important that the system neither reduces nor compromises the patient's choice of health care provider, and their ability to plan and manage their care with their GP," he said. "It is equally important that the system does not lock people into a package of care provided or commissioned by the PHN with predetermined providers, with limited or no ability to change providers once the package has commenced."

In addition to questions about the capacity of PHNs to develop and organise tailored care packages, concerns have been raised that the arrangements will add to administrative costs by essentially funnelling funding through an additional layer of bureaucracy.

In addition to commissioning PHNs to deliver tailored care packages, the Government will establish a phone and internet service to act as a single gateway for patients to access the full range of mental health services, and will redesign primary mental health care program to a "stepped care" model to better target services.

National Mental Health Commission Chair Professor Alan Fels said the Government's plans were a "ringing endorsement" of the *Commission's Contributing Lives, Thriving Communities* review, which condemned current arrangements as fragmented and inefficient.

"These reforms have far-reaching potential to improve the lives of millions of Australians," Professor Fels said. "The focus must now be on effective and efficient implementation."

But a key recommendation from the Commission that $1 billion be redirected from hospital mental health care services to bolster primary care has been rejected by the Government, underlining concerns about the adequacy of resources to be provided to GPs under the new arrangements.

The overhaul has also raised questions about the general approach the Federal Government is taking to reforms in health care.

Professor Owler said the fact that the new framework entailed Commonwealth withdrawal from funding and program delivery to instead assume a "strategic leadership" role was of concern.

He said the AMA would be watching closely to see whether the Turnbull Government adopted a similar approach in primary care and private health insurance policy, and tried to unload greater responsibilities onto the states and territories and the private sector.

Ms Ley said there would be a trial of the new arrangements this financial year, and they would be phased in over three years from early 2016-17.

ADRIAN ROLLINS

# Large profits, inefficiencies driving health premiums up

Private health insurers are hitting consumers with unjustified premium increases and overly complex insurance products in their pursuit of big profits, according to a leading industry analyst.

> "Health funds are coming under increased scrutiny over their strategy of pursuing relentless above-inflation premium increases while downgrading the quality of the cover they offer"

As the Federal Government undertakes a review of the sector amid mounting complaints about the value of health insurance, Credit Suisse analyst Andrew Adams has released a scathing critique of the industry in which he argues funds are not operating efficiently, have deviated away from their core principles, and have set profit and capital targets that are unjustifiably high.

Health funds are coming under increased scrutiny over their strategy of pursuing relentless above-inflation premium increases while downgrading the quality of the cover they offer.

Health Minister Sussan Ley has launched a review of the sector after it was revealed policies covering 500,000 people had been downgraded last financial year despite surging industry profits and premium revenue.

Ms Ley said the confluence of factors suggested there was "something wrong" with the way the industry was regulated.

But AMA President Professor Brian Owler said insurers, driven by the pursuit of profit, were downgrading the cover of policyholders – often without their knowledge or full understanding – leaving many without the insurance they thought they had paid for.

At the same time the funds, led by Medibank Private, are looking to force private hospitals to accept responsibility for a greater share of treatments arising from medical complications.

Medibank has just struck a deal with large hospital operator Healthscope which, it claims, is aimed at reducing hospital-acquired complications and avoidable readmissions.

Professor Owler said that although every effort needed to be made to reduce complications and avoidable readmissions, insurers should not be using the pursuit of quality improvements as an excuse for cutting costs and pumping up profits.

"What we don't want is punitive measures that punish patients and interfere in what would otherwise be routine clinical cases in order to save money," he said.

There are also concerns the industry is seeking to undermine community rating, the principle under which all policyholders pay the same premium for a given policy, regardless of age, health or claims history.

It has been suggested that insurers be allowed to offer discounts for those with healthier lifestyles, such as non-smokers and the physically active, though Medibank chief George Savvides told *The Australian* such an approach was not financially feasible.

Instead, he suggested no-claim bonuses for those who stayed healthy and a reward for long-term members.

But such measures would discriminate against those who, through no fault of their own, became sick, and would increase the deterrent for people to seek care – potentially leading to more serious and costly ailments later on.

Like Professor Owler, Mr Adams is concerned that patients are being made to pay for the pursuit of profits by insurers.

Official figures show the industry recorded a $1.1 billion after-tax profit in 2014-15, and premium revenue surged by 7.3 per cent.

In his analysis, reported in *The Australian*, Mr Adams pointed out that the industry delivered a 17.5 per cent return on equity – by comparison, for the major banks it is around 9.5 per cent – and held double the capital considered to be adequate.

He calculated that reducing the return on equity to 12.5 per cent could enable the industry to reduce its premium increases to just 2.5 per cent over the next three years, compared with the 7 per cent it is seeking next year alone.

Mr Adams questioned why such a heavily regulated and subsidised industry was being allowed to generate such high profits, and said the case for premium increases needed to be re-examined : "In our view, regulated price increases need to also take into account prior year performance and capital position, which could justify a period of below-inflation premium increases".

In addition to these concerns, Mr Adams said the recent proliferation of health policies – more than 20,000 different types are on offer – had increased costs and inefficiencies in the industry, and suggested there would be some "quick and easy gains to be made by going back to basics".

"Restricting the level of policy selection to a small number of simplified and homogenous products and reducing the excess returns being generated by the insurers themselves, will significantly assist the affordability and simplicity of private health insurance in the market," he said

ADRIAN ROLLINS

# The urge to serve – Australian doctors abroad

Every day, somewhere in the world, Australian doctors and nurses are putting their skills – and themselves – on the line, treating everything from shrapnel and gunshot wounds to glaucoma, malaria and cervical cancer.

Like their counterparts from many other countries, they travel to some of the most difficult and dangerous places to do what they can to save lives and alleviate suffering.

Tragically, as with the recent devastating attack on the Medecins Sans Frontieres hospital in Kunduz, some pay the ultimate price for their commitment.

There are fears that combatants are increasingly targeting health workers and facilities. According to the International Committee of the Red Cross, there were almost 2400 attacks on health workers, facilities and ambulances in just 11 countries between January 2012 and the end of last year.

Through its Health Care in Danger project, the ICRC is working with governments, armed groups, NGOs and others to try arresting this trend.

In the meantime, Australian doctors and nurses continue to front up to provide care, regardless of the hazard.

In this Special Report, *Australian Medicine* presents the experiences of two medicos - a Brisbane-based anaesthetist and a Canberra obstetrician – who have undertaken humanitarian work overseas, and draws on the expertise of a Sydney urological surgeon who has worked extensively with those who have volunteered to work with the Australian Army Medical Corps in some of the most dangerous conflict zones.

Their accounts show that such service can be gruelling, harrowing and, occasionally, terrifying. But it can also be deeply rewarding – as attested to by the fact that they keep on going.

ADRIAN ROLLINS

# Flight into danger

It was not getting in to Ebola-struck Sierra Leone that most worried Red Cross medico Jenny Stedmon – it was getting out again.

“I flew in on an Air France flight, and the day after I arrived they stopped flying. All borders were shut,” she recalls. “It was a very volatile situation.”

Dr Stedmon, an emergency physician and anaesthetist, was a member of one of the first medical teams deployed by the Red Cross to Sierra Leone as the scale of the west African outbreak – which would eventually claim more than 11,000 lives – started to become clear in mid-2014.

The Brisbane-based anaesthetist, who has worked as a volunteer for the Red Cross for more than 20 years, was among the first medical specialists the humanitarian organisation contacted as it organised its initial response to the unfolding crisis.

A week after getting the call Dr Stedmon, leaving behind a worried husband, found herself immersed in a medical emergency the like of which she had not encountered before through deployments as far afield as Thailand, Yemen, Sudan, East Timor, Nepal and the Philippines.

Before each deployment, the Red Cross sends their volunteers oodles of information, and ensures they have the supplies and equipment they will need when they arrive.

But because nothing like the Ebola outbreak had been encountered before, Dr Stedmon admits all were going in “a little blind”.

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Dr Jenny Stedmon on deployment with the Red Cross in the Philippines following Typhoon Haiyan

The mission was to set up an Ebola treatment centre on the grounds of one of Sierra Leone's main hospitals to help cope with the flood of cases arriving on a daily basis.

"Everyone was on a learning curve," Dr Stedmon remembers. "I had never put on personal protective equipment in my life. There was a lot of fear."

The Red Cross team learned what they could from World Health Organisation workers who had already been in-country for some time, and did what they could.

As an anaesthetist, Dr Stedmon usually works as part of the surgical team. But in emergency situations such as this, people just pitched in where they could provide the greatest help.

In battling Ebola, she found most of her time spent delivering medicines, water and food to the sick: "This was really basic health care delivery".

After a month working in such a physically and emotionally demanding environment, Dr Stedmon and her colleagues were due to be rotated out.

But getting out of a country isolated by the international community was always going to be a challenge, and so it proved.

Eventually, she was driven across Sierra Leone to the border with Guinea where a waiting canoe carried her and her suitcase across the river. It was a white-knuckle ride, with the humanitarian worker more than a little alarmed by the strong possibility she might drown.

Once across, she was taken to an airfield at "a little place in the middle of nowhere". Her fellow travellers included a health worker who was the sole survivor of a team massacred by frightened villagers who believed they were spreading Ebola rather than trying to fight it.

The experience caused Dr Stedmon to reflect that, "You never know where the danger is going to come from."

Though danger is an inescapable part of working in areas afflicted by war or disaster, Dr Stedmon has never been directly attacked.

"I have been lucky so far," she said. "I have never actively been involved in a violent act [and] I have never been impeded in my work."

But she has had some good friends who have not been so lucky.

One of her best friends, New Zealand nurse Sheryl Thayer, was among six Red Cross workers assassinated by gunmen in a brutal attack on a field hospital near Grozny in Chechnya in 1996.

Another friend was seriously injured when a land mine blew up the Red Cross vehicle she was riding in near Fallujah in Iraq.

The Red Cross itself takes the safety and security of its staff and volunteers very seriously, Dr Stedmon said.

During her deployment in 2004 to the Yemen civil war, for example, the organisation took care to make sure the field hospital she worked at was away from the front lines, and even though there was "a lot of shooting going on, none [was] near us".

Similarly, during the Sudan civil war, Dr Stedmon worked at a field hospital set up right on the border with Kenya, and patients were flown in by plane for care for everything from snake and hyena bites to landmine injuries and gunshot wounds.

Through all these deployments, Dr Stedmon has generally found local people and combatants, from whatever side, have respected the Red Cross's neutrality.

But she is worried that a shift in attitude seems to be underway that could render Red Cross work ever more hazardous.

"I would never say it's not dangerous...but I get the feeling there is erosion of respect and knowledge of the symbol [going on]," Dr Stedmon said. "Most people are reasonable, but there appears an increasing number of situations where there is no respect.

"It's probably getting more dangerous to work for the Red Cross than when I started. That is my gut feeling."

It is why Dr Stedmon is so passionate in her support for the ICRC's Health care in Danger project, which aims to highlight attacks on health workers and educate combatants about the need to respect Red Cross neutrality.

"The time has come for the medical profession to stand up and say it's not acceptable. We should be able to treat people in safety."

ADRIAN ROLLINS

## WHAT IT IS LIKE TO VOLUNTEER FOR THE RED CROSS

### TRAINING:

Three-day basic training course;

Week-long medical course drawing on expertise in areas like war surgery and emergency medicine.

### PRE-DEPLOYMENT:

Detailed briefing notes; vaccinations; medical kits

### DEPLOYMENT:

**Duration** – typically three months, though in intense disaster response situations one month.

**Equipment and supplies** - apart from personal belongings, everything else supplied.

**Support** – extensive network of experienced in-country staff look after travel, accommodation, logistics

**Costs** – Red Cross covers air fares, food and shelter, and provides a per diem

**Work absence** – Dr Stedman has the support of her employer, Redlands Hospital, and takes unpaid leave for duration of deployment (gives them some scope to employ a locum if needed).

### POST-DEPLOYMENT:

Extensive debriefing

# The drive to care, regardless


Professor Mohamed Khadra

A hysterical woman is dumped at perimeter of an Australian Defence Force camp. Her abdomen has been crudely sliced open and then stitched up. Wary soldiers suspect she has been implanted with a live bomb.

A team of volunteer Australian Army Medical Corps doctors, accompanied by a bomb disposal expert, carefully operate on the woman, successfully extracting a land mine that had been inserted behind her rib cage and designed to go off as it was being pulled out.

It is a harrowing but true scene from Mohamed Khadra's latest book, Honour, Duty, Courage, in which he seeks to answer why doctors and nurses with well-paid jobs and comfortable lives in Australia put it all on hold to go to poor and violent places to help complete strangers.

So who are these men and women, and why do they do it?

After picking at the puzzle for years Professor Khadra, a urological surgeon as well as an author, thinks he has a pretty fair idea.

"These are people driven to put their own needs and wants last," Professor Khadra, who is head of surgery at Sydney Medical School, says. "They have an innate sense for protecting and nurturing others, and for fairness."

For the book, Professor Khadra talked extensively to many men and women who have volunteered to serve the Australian Army Medical Corps in deployments that have plunged them into the heart of brutal armed conflicts.

What he found were people with an overriding sense of duty that drove them to serve, both at home and abroad.

"These are the people who are on multiple committees for the hospital, the college and the department. They are the ones who at high school organised charity days," he says.

Professor Khadra himself shares many of these characteristics – in addition to his clinical work he serves on medical boards and committees, is a senior examiner, a head of department and is an active researcher.

But he says he is "completely humbled" by the selflessness and humanity of those who have served, and continue to volunteer for, army deployments.

"Some people ask what medicine can do for them. These people feel a duty to give back to medicine."

But Professor Khadra's account shows that they pay a high personal price for their devotion.

The relentless mental and physical demands of working in a forward medical post, faced daily with the threat of death and

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evidence of unspeakable depravity, mean anyone who serves in these roles does not leave unchanged.

"I don't think you can see the atrocities to the depth that they have seen and not come back altered," he says, though in recent years there has been improvements in support for those returning from service.

Not only do they bear emotional scars, but there is often a financial cost.

Professor Khadra says the payments the volunteers receive can be enough to keep the doors of their private practice open and pay their staff, but little more.

He says that most have only modest financial resources, and when they return after three months' absence they often have to re-build their practice from scratch because patients have moved on to other practitioners.

To add indignity to the situation, often they face resentment from colleagues who have had to carry a bigger workload during their absence or, in at least one case Professor Khadra knows of, be accused of using their military service to try and drum up business from GPs.

Balanced against these disincentives is the powerful pull of duty.

But will that continue to be enough to ensure the Medical Corps will continue to play the role it has?

Professor Khadra is not sure.

He says there is a perception that those who have entered medicine in the last decade do not have the same sense of duty to give back as those who have come before them – a view fuelled by the difficulty encountered in finding younger colleagues willing to take on teaching duties.

But Professor Khadra is hopeful that, when the time comes, people will continue to step up as have the generations before them.

ADRIAN ROLLINS

# 'Everything presents at extremes...' – a Solomon Island's experience

BY DR ELIZABETH GALLAGHER, SPECIALIST OBSTETRICIAN AND GYNAECOLOGIST, AMA ACT PRESIDENT

Dr Elizabeth Gallagher (second from left) with other staff and volunteers at the National Referral Hospital in Honiara

The mother lost consciousness just as her baby was born.

The woman was having her child by elective Caesarean when she suffered a massive amniotic fluid embolism and very quickly went into cardiac arrest.

We rapidly swung into resuscitation and, through CPR, defibrillation and large doses of adrenaline, we were able to restore her to unsupported sinus rhythm and spontaneous breathing.

But, with no equipment to support ventilation, treat disseminated intravascular coagulation, renal failure or any of the problems that arise from this catastrophic event, it was always going to be difficult, and she died two-and-a-half hours later.

Sadly, at the National Referral Hospital in Honiara, the capital of the Solomon Islands, this was not an uncommon outcome. Maternal deaths (both direct and indirect) average about one a month, and this was the second amniotic fluid embolism seen at the hospital since the start of the year.

I was in Solomon Islands as part of a team of four Australian practitioners – fellow obstetrician and gynaecologist Dr Tween Low, anaesthetist Dr Nicola Meares, and perioperative nurse and midwife Lesley Stewart – volunteering to help out at the hospital for a couple of weeks in October.

It was the first time I had worked in a developing country, and it was one of the most challenging, and yet satisfying, things I have ever done.

Everything from the acuteness of the health problems to the basic facilities and shortages of equipment and medicines that we take for granted made working there a revelation.

The hospital delivers 5000 babies a year and can get very busy. As many as 48 babies can be born in a single 24-hour period.

The maternity ward at Honiara's National Referral Hospital

The hospital has a first stage lounge and a single postnatal ward, but just one shower and toilet to serve more than 20 patients. The gynaecology ward is open plan and, because the hospital doesn't provide a full meal service or much linen, relatives stay there round-the-clock to do the washing and provide meals.

From the beginning of our stay, it was very clear that providing training and education had to be a priority. I was conscious of the importance of being able to teach skills that were sustainable once we left.

The nature of the emergency gynaecological work, which includes referrals from the outer provinces, is that everything presents at the extremes...and late. Massive fibroids, huge ovarian cysts and, most tragically because there is no screening program, advanced cervical cancers in very young women.

When I first got in touch with doctors at the hospital to arrange my visit, I had visions of helping them run the labour ward and give permanent staff a much-needed break. But what they wanted, and needed, us to do was surgery and teaching.

To say they saved the difficult cases up for us is an understatement. I was challenged at every turn, and even when the surgery was not difficult, the co-morbidities and anaesthetic risks kept Dr Meares on her toes.

In my first two days, the hospital had booked two women - one aged 50 years, the other, 30 - to have radical hysterectomies for late stage one or early stage two cervical cancer. I was told that if I did not operate they would just be sent to palliation, so I did my best, having not seen one since I finished my training more than 12 years ago.

I also reviewed two other woman, a 29-year-old and a 35-year-old, both of whom had at least a clinical stage three cervical cancer and would be for palliation only. This consisted of sending them home and telling them to come back when the pain got too bad.

It really brought home how effective our screening program is in Australia, and how dangerous it would be if we got complacent about it.

We found the post-operative pain relief and care challenged. This was because staffing could be limited overnight and the nurses on duty did not ask the patients whether they felt pain - and the patients would definitely not say anything without being asked.

Doing our rounds in our first two days, we found that none of the post-operative patients had been given any pain relief, even a paracetamol, after leaving theatre.

We conducted some educational sessions with the nursing staff, mindful that the local team would need to continue to implement and use the skills and knowledge we had brought once we left. By the third day, we were pleased to see that our patients were being regularly observed and being offered pain relief - a legacy I hope will continue.

The supply of equipment and medicines was haphazard, and depended on what and when things were delivered. There was apparently a whole container of supplies waiting for weeks for clearance at the dock.

Many items we in Australia would discard after a single use, like surgical drains and suction, were being reused, and many of the disposables that were available were out-of-date – though they were still used without hesitation.

Some things seemed to be in oversupply, while others had simply run out.

The hospital itself needs replacing. Parts date back to World War Two. There were rats in the tea room, a cat in the theatre roof, and mosquitos in the theatre.

The hospital grounds are festooned with drying clothes, alongside discarded and broken equipment – including a load of plastic portacots, in perfect condition, but just not needed on the postnatal ward as the babies shared the bed with their mother.

It brought home how important it is to be careful in considering what equipment to donate.

The ultrasound machine and trolley we were able to donate, thanks to the John James Memorial Foundation Board, proved invaluable, as did the instruction by Dr Low in its use.

The most important question is, were we of help, and was our visit worthwhile?

I think the surgical skills we brought (such as vaginal hysterectomy), and those we were able to pass on, were extremely useful. Teaching local staff how to do a bedside ultrasound will hopefully be a long-lasting legacy. Simple things like being able to check for undiagnosed twins, dating, diagnosing intrauterine deaths, growth-restricted babies and preoperative assessments will be invaluable.

The experience was certainly outside our comfort zone, and it made me really appreciate what a great health system we have in Australia, and what high expectations we have. I want to send a big thank you to the John James Memorial Foundation for making it all possible.

# Deadly attacks raise fears of breakdown in rules of war

Governments and armed groups are being pressured to ensure the safety of patients and health workers in conflict zones amid a spate of high-profile attacks that have left dozens dead and injured.

The World Medical Association, the International Committee of the Red Cross, the World Health Organisation and several other peak health groups have jointly called on national governments and non-state combatants to adhere to international laws regarding the neutrality of medical staff and health facilities, and ensuring this commitment is reflected in armed forces training and rules of engagement.

The call follows an admission by the US military that a deadly attack on a Medecins Sans Frontieres (MSF) hospital in Kunduz in which 30 people were killed – including 13 staff and 10 patients – was a tragic mistake.

"This was a tragic and avoidable accident caused primarily by human error," the US's top commander in Afghanistan, General John Campbell, said, adding that the error was "compounded by systems and procedural failures".

Though the location of the MSF hospital was widely known, a series of technical and operational errors led the crew of the US gunship that launched the devastating attack to mistake the hospital for the headquarters of the Afghan security service, which had been briefly seized by the Taliban.

The strike co-ordinates for the security building took the aircraft to an open field, so the aircrew decided to launch the attack on the nearest building that matched the description they had been given, which turned out to be the MSF hospital. The aircrew, and the operational command in Kabul, did not check the co-ordinates of the planned target against a "no-strikes" list.

MSF International President Dr Joanne Liu said the incident showed the deadly consequences of any ambiguity about how international humanitarian law applied to medical work in war.

"We need a clear commitment that the act of providing medical care will never make us a target. We need to know whether the rules of law still apply," Dr Liu said.

The Kunduz attack has added to the urgency for action to be taken to ensure the safety of medical staff and hospitals in combat zones.

The International Committee of the Red Cross (ICRC), through its Health Care in Danger project, recorded 2398 attacks on health workers, facilities and ambulances in just 11 countries between January 2012 and the end of last year.

Policy and Political Affairs Officer for the ICRC's Australian mission, Natalya Wells, said such attacks were not new, and were virtually a daily occurrence.

Ms Wells often health workers were caught in the cross-fire, particularly as a result of indiscriminate attacks in urban areas.

But she said that on occasion they were also being deliberately targeted, underlining the need for all combatants to respect the Geneva Conventions.

Ms Wells said that through the Health Care in Danger project, the ICRC was working with governments, armed forces and non-state combatants to improve awareness of, and respect for, laws and conventions around the protection of patients, health workers and medical facilities, particularly in conflict zones.

As part of the effort, governments attending the 32nd International Conference of the Red Cross and Red Crescent between 8 and 10 December were expected to back a resolution reaffirming their commitment to international humanitarian law and a prohibition on attacks on the wounded and sick as well as health care workers, hospitals and ambulances.

In addition, Ms Wells said the ICRC had held meetings with 30 non-state combatant groups from four continents about international humanitarian law and the rules of armed conflict.

The discussions have included incorporating knowledge of these conventions into their training, backed by sanctions for any breaches.

Promisingly, Ms Wells said that so far "one or two" non-state armed groups, though not signatories to the Geneva Conventions, have discussed creating a similar code of conduct for their forces.

ADRIAN ROLLINS

# Taking a risk on insurance

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

I saw a survey 30 or more years ago from Massachusetts regarding the attitudes of people with health insurance about paying for health care.

There were two interesting contradictions.

Respondents were asked whether they felt money should go to paying for heroic neurosurgery with little chance of success, or whether the cash should instead pay for prevention programs, such as immunisation. A large majority voted for prevention. Later in the same questionnaire, they were asked whether there should be limits on expenditure if they needed extensive neurosurgery. This time most voted for unlimited expenditure.

> "In the US, more attention is given to adjusting health insurance premiums for risk than we give it in Australia, although we do rate our private insurance premiums in favour of those who have lower risk because they are younger"

The second contradiction concerned whether people who smoked should pay extra for their health insurance. A small minority said yes. Later in the questionnaire, respondents were asked if people who did not smoke should get a discount. A larger proportion said yes!

In the US, more attention is given to adjusting health insurance premiums for risk than we give it in Australia, although we do rate our private insurance premiums in favour of those who have lower risk because they are younger. Remember, age is the most important risk factor for just about every disorder.

But in Australia we have largely stuck to the principle of spreading risk across the whole population, as with Medicare and also most private insurance. True, we are used to risk-rating when it comes to paying for life assurance, where pre-existing illnesses or high risks bump up the premium. One of the fears about genetic profiling is that it may hold prognostic information that a risk-rated health insurance scheme may use to increase premiums, or even entirely exclude high-risk individuals.

The economics of risk-rating are far from simple. One of the appealing features of one-size-fits-all community rating is the smaller administrative load compared with acquiring risk data from all subscribers then doing all the individual calculations. True, progress in information technology makes this an easier task compared with even a decade ago, but it remains a big deal.

A case can be made for private health insurance companies to be given the freedom to determine what they cover and what they charge - providing they receive no government subsidy. In such a world, they would be free to risk-rate the premiums. They could then compete with one another for customers based on what they offer and what they charge.

The limitation on such an arrangement is that private health insurance is not entirely private.

In so far as government pays several billion dollars a year subsidising the cost of premiums, it has a justifiable say in how private insurance does its business.

Also, much surgery and other procedures have moved progressively to the private sector and are no longer accessible in a timely fashion by people in need who do not have private insurance.

This is policy creep, and it has landed us in a megamess.

The contradictions of the surveyed American subscribers I just described are trivial by comparison.

Discussions about premiums are like discussions about the garnish you would like with your meal while your meal is not discussed with you.

Health Ministers routinely forget the origins of Medicare as a universal scheme, and the current Federal Minister is no exception.

... from p23

Sussan Ley recently walked into this bog by describing Medicare as a safety net variant for citizens who cannot afford private insurance. This is untrue. It never was proposed as a safety net.

It was and remains universal, and the premiums are universal as well. A big topic for another day.

That pathetic economic policies have caused Medicare great damage does not entitle governments responsible to rewrite history. But enough on this.

Smokers make a fair point that through taxes on tobacco they pay for any excess health costs they incur, and they have the convenient habit (convenient to those who pay for health care) of dying younger than non-smokers. Apocryphal stories hold that Margaret Thatcher censored anti-smoking campaigns when in office for this reason. She took a position on the board of a tobacco giant in her retirement.

So health insurers would need to tread carefully before encouraging their members to quit smoking by offering a lower premium. Would such a move push privately insured smokers into the public system? My guess is it would not. But if it did, neither the public nor the private health care systems would be likely to notice more than a ripple. With smoking rates down to 17 per cent in general, and smokers now concentrated in socioeconomic groups such as Aboriginal communities which have low rates of private insurance anyway, smokers are not a big client group for the private insurers.

Would providing discounts to non-smokers, as an alternative to penalty rates applied to smokers, do much for discouraging smoking? Probably not - for the reasons already stated in relation to penalties.

If premiums were calculated according to behaviour, money would have to be spent on enforcement and checking to see that people who claim they do not misbehave are acting accordingly.

Remember the case of a blonde spin bowler who was paid by a nicotine company to forsake the filthy weed, only to be photographed misbehaving. You have been Warned!

# Another year of hits for GP advocacy

BY DR BRIAN MORTON, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

As another year comes to an end it is time to reflect on what the AMA, with advice from the AMA Council of General Practice, has achieved on behalf of GPs during the year.

> "The AMA has had to try and educate politicians about the value of general practice, highlighting that it is the most cost effective part of the health system"

This year has certainly had its challenges, not the least of which was the lack of understanding or recognition within Government of the key role of general practice. The AMA has had to try and educate politicians about the value of general practice, highlighting that it is the most cost effective part of the health system.

Our GP Registrars and Supervisors have had to face a year of uncertainty regarding new GP training arrangements, with the AMA pushing hard for the retention of the apprenticeship model and strong professional control. The future remains unclear. The implementation of changes is being rushed, and is focused on cost control rather than quality considerations.

On a more positive note, the AMA developed and released its Community Residency Program to ensure that pre-vocational doctors have the opportunity to gain valuable experience in, and of, general practice. With input from the AMACGP and Council of Doctors in Training, the AMA has also finalised a Vision Statement for General Practice Training which, at the time of writing, was close to being released.

In collaboration with the Pharmaceutical Society of Australia, we finalised and released our plan for supporting the integration of non-dispensing pharmacists into general practice. The plan was backed by independent economic analysis and the Government is taking a serious look at it, given the benefits to the health system and patients alike.

AMA advocacy saw after hours funding return to the Practice Incentives Program (PIP) this year, with a new funding model structured to encourage and reward practices providing their own after hours coverage. Our representations to the PIP Advisory Group were successful in securing an additional funding level introduced at Level 4 for complete after hours coverage by a cooperative. The incentive and this tier have, seemingly, been well received.

The AMA has developed and revised a number of Position Statements this year covering issues including the Medical Home, Primary Health Networks, the General Practice Nurse, Fundholding, and 10 Minimum Standards for Medical Forms.

The AMA made a number of submissions, the most important probably being that to the Primary Health Care Review. It called for the Government to increase investment in general practice, and proposed sensible reforms that build on general practice's proven track record. The AMA also made a number of other submissions on the PIP eHealth Incentive, General Practice Accreditation, the Strategic Framework of the National Diabetes Strategy, the GP Rural Incentives Program, and the RACGP's alternate pathways to Fellowship.

My time as Chair of the AMACGP is now heading into its last six months. You will see in the 15 February 2016 edition of Australian Medicine a notice calling for nominations for a General Practice craft group representative to Federal Council.

The next few years are likely to bring increasing changes for general practice as we make greater use of technology in our practices to provide care for our patients and seek to enhance the benefits of coordinated, integrated and multidisciplinary care.

If you feel strongly about the future of general practice I encourage you to put your hat in the ring.

Merry Christmas, season's greetings, and a happy and safe New Year to you all.

# Why I am an AMA Member

BY DR DANIKA THIEMT, CHAIR, DOCTORS IN TRAINING COMMITTEE

I have been an AMA member for five years now, and the question most commonly put to me by my peers is "why are you a member of the AMA, and what does it do for me?"

As the representative body for all doctors in Australia, the AMA certainly has a responsibility to its members.

It plays a key role in ensuring our training and working environment is world-class, and that doctors are able to practice medicine safely.

But the AMA also has a responsibility to the Australian public.

While the core business of the AMA is its members, it is not simply an organisation designed for doctors.

The AMA prides itself on the role that it plays in the Australian public health arena and the voice it provides on health issues of national and international significance.

With my few words this month, I aim to explain to you why I am a member of the AMA, and why I plan to remain one.

## The AMA plays a key role in the Australian public health arena.

For years, the AMA has been very active in trying to improve public health in areas as diverse as tobacco control, alcohol, road safety, physical activity, food labelling, vaccination and concussion.

In October last year, the AMA convened the National Alcohol Summit, bringing together local, State and Federal Government representatives, community leaders, health experts, law enforcement officials and members of the public to discuss the health effects of excessive alcohol consumption, including alcohol-related violence, and the part culture, advertising and sport play in encouraging drinking.

On smoking, the AMA has long exerted pressure on governments to tighten tobacco controls, and this year worked to ensure legislation keeps pace with emerging trends by developing a Position Statement on e-cigarettes and their potential adverse health effects.

The AMA has also been vocal regarding domestic violence.

This year, it partnered with the Law Council of Australia to produce and launch *Supporting Patients Experiencing Family Violence: A Resource for Medical Practitioners*, to help doctors to better provide support and referrals for patients affected by domestic violence.

## The AMA protects public health funding.

As well as striving to improve public health, the AMA plays a vital role in safeguarding the health system.

Each year it draws on Commonwealth data and the experiences of public hospital doctors to produce an annual Report Card on performance of our hospitals. The AMA's ongoing advocacy has ensured that public hospital funding is a high-profile issue for Federal, State and Territory leaders.

## The AMA protects the health rights of those in need.

The AMA is vocal about Australia's human rights obligations regarding asylum seekers and refugees, particularly ensuring they have access to health care. The AMA has called for an independent panel of doctors to inspect and report on detention centres, and protested strongly about the Border Force Act and its draconian anti-whistleblower measures.

## The AMA understands the importance of climate change and its implications for global health.

The AMA was one of the first professional bodies to draw attention to the significant health effects that climate change will have. It surveyed its members on the issue and incorporated their views in the revised *Climate Change and Human Health Position Statement*, which was released in the lead-up to the United Nations Climate Change Conference in Paris.

The daily grind of the AMA is not about 'protecting our turf', but about protecting the health of Australians and their health system.

The AMA may not always be acting directly for you, but it is always acting in the best interest of the Australian public and the Australian health system. That is why I am a member.

This makes my answer to my peers simple. I am not a member of the AMA for what it does for me, I am a member for what it does for Australia.

# Bullying and sexual harassment: a problem finally in the open

BY **JAMES LAWLER**

> "Bullying, discrimination and sexual harassment wasn't an issue identified by students this time last year, but it featured heavily in the responses for our survey for 2016. The issue won't die and won't go away until we admit it exists and work collaboratively at solutions to bring about change"

At the beginning of this year, AMSA surveyed medical students regarding what its advocacy priorities should be for 2015. Internships and medical training issues came top, as well as mental health, looming higher education reforms and Indigenous health.

Bullying, discrimination and sexual harassment never came into the reckoning, not in our survey, nor in our policy plans for the year. When I look back on 2015, and the steps the medical profession has taken, I wonder why.

Clearly, for many students, and indeed doctors, this type of behaviour is sometimes so ingrained in our culture that it is taken for granted. Indeed, despite evidence to the contrary, about half of Australia's medical students believe that teaching by humiliation makes them better doctors, according to research published in the MJA this year.

Despite well-meaning assertions from senior colleagues that 'my generation' can lead the cultural change needed in our hospitals, many young doctors tell me that some of the worst bullying occurs between senior registrars and junior registrars, registrars and interns, or between registrars in different departments. It confirms one of the things I've learnt this year – you can't lead culture change only from the bottom up.

Senior leadership needs to be the starting point for any culture change to occur. When General David Morrison spoke out about sexual harassment in the Australia Defence Force, it was delivered from the top down. Hierarchy still certainly exists from medicine, but who would be the equivalent in our hospitals – the AMA President, College Presidents, Health Ministers, the heads of health departments and ministries hospital CEO's? In reality, we need collaborative statements and endeavours to show leadership from "the top" if we are to get real leadership.

Importantly, culture change needs to be framed positively. This issue has created a negative perception of the medical profession, and so it should in cases where bullying occurs.

But in order to move forward, we need to champion the heroes rather than demonise the villains. We need to encourage those who are happy to admit past poor behaviour to reform. We need to promote the great teachers in our hospitals and share their methods. We should congratulate the Royal Australasian College of Surgeons for their work, and insist other colleges look to do the same.

We need to deal with the "small" incidents – the inadvertent sexist jokes, the racist stereotypes and the inappropriate comments, and have ways to respond proportionately, since those small incidents build to major incidents when left unchecked. Most importantly, we need to look out for each other – teaching, supervising and supporting each other in positive environments, so that we can better patient care.

Bullying, discrimination and sexual harassment wasn't an issue identified by students this time last year, but it featured heavily in the responses for our survey for 2016. The issue won't die and won't go away until we admit it exists and work collaboratively at solutions to bring about change.

# Freezing and madcap MBS Reviews

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

I, like many rural GPs, have two main sources of income: the local hospital and my practice. My patient demographic is largely low-income retirees and families with above-average mortality and morbidity, as is common throughout rural Australia.

While my hospital income continues to stay afloat through honest indexation, my practice income is being savaged by the freeze on MBS rebates, and threatened further by the madcap MBS reviews currently underway.

> "Why any sane government would wish to cut funding to general practice further is beyond me. We are dirt cheap already"

These can only be seen as a cost-cutting exercise by the Federal Government.

Why any sane government would wish to cut funding to general practice further is beyond me. We are dirt cheap already. And the poisonous and negatively skewed indexation formula, Wage Cost Index 5 (WCI5), present since Medicare's inception, ensures Treasury of around a 1 per cent decrease in costs per service annually.

Not satisfied with this, we now have a raft of disjointed and speedy non-consultative MBS reviews overseen by Professor Bruce Robinson, who should have long ago declared a conflict of interest and disqualified himself from any participation.

One cannot, and must not, be in the position of heading a review of such import to our patients and their rebates with a declared predetermined attitude that huge waste exists, and massive savings are there to be taken back and given to swell Treasury's coffers.

Has his review looked at the concrete cancer which undermines the very foundations of Medicare, namely WCI5? No, and it will not.

The current MBS reviews can only be seen as a sham and farce exercise in stupidity, focussed on cost-cutting rather than bettering patient outcomes.

To date, figures show GPs are shouldering the Medicare freeze - that is, wearing decreased rebates and still bulk billing. Primary Healthcare, which has 71 medical centres, has announced it expects net profit to be 5 per cent lower this financial year. I would expect most bulk billing GPs to be undergoing similar losses of income.

If the Medicare rebate freeze remains in place to 2018, either GPs cut costs and quality or reject bulk billing.

Co-payments are not dead. They are being enforced stealthily by Government. The trouble is that GPs have no idea who should receive their charity and be bulk billed, and who should not. We do not have access to a patient's financial status, and nor should we.

But there are more positive developments to report.

The Federal AMA is about to enhance rural representation at National Conference, if the proposed changes to the Constitution accepted by Federal Council at its November meeting are ratified at the next General Meeting of our Association.

It means that rural and regional health care provision has never been higher on the AMA agenda.

And, on 13 November, the first roundtable meeting of rural and remote stakeholders was held at Parliament House, chaired by the recently-appointed Minister for Rural Health, Senator Fiona Nash.

Although too brief a meeting to achieve any outcomes, it does show promise for the future.

# Recognising the contribution of our IMGs

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

> "Australia's medical workforce situation is now at a critical point, particularly regarding access to training places and workforce distribution. The AMA is leaving no stone unturned in seeking solutions to the many problems we are encountering"

In August, I promised readers of this column that I would let you know when the AMA's Position Statement on international medical graduates (IMGs) was ready.

At the time, I compared the challenges IMGs faced in 2004 (when the AMA published it first Position Statement) with contemporary circumstances. Australia's medical workforce situation is now at a critical point, particularly regarding access to training places and workforce distribution. The AMA is leaving no stone unturned in seeking solutions to the many problems we are encountering.

Our 2004 position statement on IMGs, or overseas-trained doctors as we knew them then, was appropriate for the time, but Australia's medical workforce situation has changed since then. IMGs working in Australia now face a different set of challenges, and the burgeoning number of Australian graduates require an accessible training pipeline.

IMGs – doctors who did their primary medical training outside Australia – remain an important part of the workforce. After all, they represent more than 25 per cent of Australia's medical workforce, and a much higher proportion in rural and remote areas of the country.

The AMA Federal Council approved a new Position Statement in late November. International Medical Graduates 2015 acknowledges the enormous contribution IMGs are making to the delivery of health care in Australia, particularly in providing patients with access to care in under-serviced communities.

The document outlines the AMA's priorities for assessing, recruiting, training and supporting IMGs. We recommend that:

- Australia follows ethical recruitment guidelines (not taking doctors from countries that have an even greater need for them);
- IMGs have the information they need to make fully informed choices about working in Australia;
- nationally consistent standards are used for assessing, training, and supervising IMGs;
- flexible assessment pathways are available for IMGs, including workplace-based assessment;
- medical colleges use transparent standards when assessing overseas qualifications;
- IMGs have strong English language skills, but that the benefits of multilingual skills when caring for patients from non-English speaking backgrounds is also recognised;
- there is mandatory orientation (including cultural sensitivity) for IMGs;
- there is appropriate educational and community support for IMGs and their families;
- employers should make all reasonable efforts to recruit locally before employing IMGs;
- IMGs receive the same pay and conditions as their locally trained colleagues; and
- the 10-year moratorium on Medicare provider numbers be removed.

The AMA is adamant that better workforce planning is an urgent priority. There is no doubt that, in the years to come, our reliance on IMGs will change.

In 2015, we still lack the data and the institutional will of governments to ensure adequate training and a fair distribution of doctors across the nation.

I believe the IMG Position Statement demonstrates the AMA's ongoing commitment to IMGs, and our determination to address the medical workforce predicament that we face.

You can read the full statement at https://ama.com.au/position-statement/international-medical-graduates-2015

# Queensland first to adopt national code for shonky health workers

BY **DR ROBYN LANGHAM**

Health care workers in Queensland who are not registered under the National Registration and Accreditation Scheme for health practitioners will be the first in Australia to be regulated under the new *National Code of Conduct for Health Workers* (National Code).

The new National Code sets national standards of conduct and practice for all health care workers, against which disciplinary action can be taken such as the issuing of a prohibition order (see below for more detail on code requirements). The Code applies to many occupations, such as dieticians, naturopaths, paramedics, speech pathologists, counsellors and anaesthetic assistants.

The National Code will allow State governments to effectively and consistently deal with health care workers who are incompetent or engage in exploitative, predatory or illegal conduct.

The AMA has lobbied for some years for the introduction of just such a national framework to protect the public from incompetent and unethical health care workers.

Although New South Wales, Queensland and South Australia already have some form of legislative control, the approaches are inconsistent, and a health worker prohibited from practising in one of those states could still set up practise in another State.

After a long consultative process, in April 2015 all State and Territory governments agreed to adopt the National Code, and to introduce a supporting code-regulation regime, including mutual recognition of prohibition orders across Australia.

Queensland is the first state to give the agreement effect, starting from 1 October 2015.

It should be noted that the Code can also apply to registered health practitioners in situations where a practitioner is practising outside their scope of practice - for example, a registered medical practitioner providing naturopath services.

In its 2014 submission, the AMA argued against the Code applying to any registered health practitioner.

We considered that the relevant national registration board should deal with any concerns or complaints about its registrants practicing outside their scope of practice, regardless of whether the practitioner has ventured into a scope of practice that requires more or less qualifications than their registration.

It will be difficult for a consumer to separate a registered health practitioner's scope of practice from other services they may provide, and therefore know which avenue to pursue if they have concerns about the practitioner.

The AMA's submission is at https://ama.com.au/submission/ama-submission-code-conduct-april-2014

Information on the new Queensland National Code of Conduct for Health Care Workers is at:

https://www.health.qld.gov.au/system-governance/policies-standards/national-code-of-conduct/default.asp

Breaches of the Code within Queensland can be reported to the independent Queensland Health Ombudsman at http://www.oho.qld.gov.au/make-a-complaint/

The National Code includes clauses requiring health care workers to:

- provide services in a safe and ethical manner;
- obtain consent;
- engage in appropriate conduct in relation to treatment advice;
- report concerns about treatment or care provided by other health care workers;
- take appropriate action in response to adverse events;
- adopt standard precautions for infection control;
- take appropriate action if diagnosed with infectious medical conditions;
- not make claims to cure certain serious illnesses;
- not misinform their clients;
- not practice under the influence of alcohol or drugs;
- not financially exploit clients;
- not engage in sexual misconduct;
- comply with relevant privacy laws;
- keep appropriate records;
- be covered by appropriate insurance; and
- display code and other information.

# Independent medical assessments

BY DR MICHAEL GANNON

A major source of confusion for, and complaints from, patients relates to independent medical assessments, particularly regarding the role of the doctor and the nature of the relationship between the doctor and the person being assessed (the examinee).

When conducting an independent medical assessment, a therapeutic relationship does not exist. The doctor's role is to provide an impartial medical opinion to a third party (such as an insurer), not to treat the person or to advocate on their behalf. The assessment results in a report to the third party and not to the examinee or their treating doctor.

> "When serving as a medical assessor, the doctor's primary duty is to the third party. It is this dichotomy between the doctor-patient relationship and the assessor-examinee relationship that lends itself to confusion"

Most people attend a doctor for therapeutic purposes, where the doctor's role is to care for you, to protect the confidentiality of your personal information, and to advocate on your behalf if required. In a therapeutic relationship, the doctor's primary duty is to the individual patient.

When serving as a medical assessor, the doctor's primary duty is to the third party. It is this dichotomy between the doctor-patient relationship and the assessor-examinee relationship that lends itself to confusion. To make matters worse, many people who present for an independent medical assessment will already be nervous or anxious because compensation, insurance cover and even employment, may depend on the outcome. Confusion over the nature of the assessment may only add to the anxiety.

Because examinees must consent to participate in an assessment, and for a report to be provided to the requesting party, it is essential to ensure that they fully understand the role of the doctor and the nature of the assessment. Effective communication is key.

To assist members in discussing assessments with examinees, the AMA has updated the *Ethical Guidelines on Independent Medical Assessments 2010. Revised 2015*, which provide guidance on:

- the role of the doctor and the nature and purpose of an independent medical assessment;
- obtaining consent from the examinee;
- using chaperones, support persons and interpreters;
- what to do if the examinee refuses or withdraws consent;
- use of audio or video recordings;
- managing incidental clinical findings;
- preparing the report; and
- attending court and giving evidence in relation to the assessment.

The Guidelines have been updated with advice from several medical defence organisations, and are can be downloaded from the AMA website - along with a range of other AMA medico-legal guidelines addressing sickness certificates, disclosing medical records to third parties, maintaining professional boundaries, acting as an expert witness and conducting patient examinations.

The *AMA Ethical Guidelines on Independent Medical Assessments 2010. Revised 2015* supersede the *AMA Ethical Guidelines for Conducting Independent Medical Assessments 2010* and *AMA Guidelines for Report Preparation and Court Attendance in Relation to Independent Medical Assessments 2010.*

These and other guidelines are not just for members, and can be used to help inform patients and their families, as well as third parties such as employers, about the ethical and legal obligations of doctors in a range of medico-legal focussed issues.

All guidelines are publicly accessible on the AMA's website at https://ama.com.au/advocacy/ethics-professionalism (under Reports, Guides and Publications).

# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

## Govt under pressure as hospitals stumble

Mounting evidence that public hospitals are struggling to make headway in meeting key performance benchmarks is increasing the pressure on the Federal Government to agree on a permanent boost to funding as part of any overhaul of Commonwealth-State health arrangements.

Australian Institute of Health and Welfare figures show that the performance of public hospitals is slipping back as massive funding cuts announced in the 2014-15 Federal Budget begin to bite.

The proportion of urgent emergency department patients receiving treatment within the recommended time fell back in 2014-15 from 70 per cent to 68 per cent – brining to an end six years of continuous improvement and leaving performance well short of the target of 80 per cent, which was due to be reached two years ago.

The goal for all emergency department visits to be completed within four hours, which was meant to be achieved this year, has also been missed.

The results bear out warnings made by the AMA earlier this year that the Commonwealth's funding cuts for hospitals would undermine the delivery of care.

Launching the AMA's annual Public Hospital Report Card in April, President Professor Brian Owler said the Federal Government's cuts – amounting to $57 billion in the next 10 years – were creating "a huge black hole in public hospital funding".

"It's the perfect storm for our public hospital system," he said. "There's no way that states and territories can even maintain their current frontline clinical services under that sort of funding regime, let alone build any capacity we actually need to address the shortfalls now."

Health Minister Sussan Ley rejected the warnings at the time, but the latest evidence of declining performance are likely to make it increasingly difficult for the Government to win State backing for an overhaul of funding arrangements without more money on the table.

In their last meeting for the year, the nation's leaders were due to discuss a proposal by South Australian Premier Jay Weatherill to increase the goods and services tax to 15 per cent, with the proceeds to go to the Commonwealth. In exchange, the states would be given a guaranteed slice of income tax revenue.

Weak growth in consumer spending has undermined the flow of revenue to the states from the GST, making it increasingly difficult for them to fund fast-growing demand for public hospital services.

Mr Weatherill said giving states a slice of the faster-growing income tax take would enable them to keep funding health.

The states have been ramping up the pressure on the Commonwealth over the impact of its spending cuts.

Queensland Health Minister Cameron Dick told a meeting of the nation's health ministers last month that the Coalition Government's cuts would slash $11.8 billion from the State's hospital system. The Victorian Government has calculated it stands to lose $17.7, while New South Wales has figured a $16.5 billion loss, South Australia $4.6 billion, Western Australia $4.8 billion and Tasmania $1.1 billion.

The big cuts form a challenging backdrop for discussions of reform to Federal-State relations that include proposals for Commonwealth public hospital funding to be replaced by a "hospital benefit payment" that would follow individuals, similar to Medicare.

Government discussions of changes to the private health insurance industry have included reference to option two in the Reform of the Federation Discussion Paper, which proposes a Medicare-style payment for hospital services, regardless of whether they are provided in the public or private system.

Under the arrangement, the price of hospital procedures would be set by an independent body and the Commonwealth would pay a proportion. For patients in the public system, the states would be expected to make up the difference, while in private hospitals the gap would be covered either by insurers or the patients themselves.

States would retain responsibility and operational control of public hospitals, and would be able to commission services from the private sector, while the Commonwealth would discontinue the private health insurance rebate.

ADRIAN ROLLINS

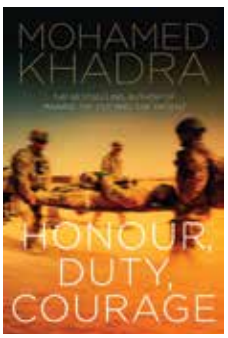
# Summer reads

***Australian Medicine* presents a selection of books to stimulate and entertain this summer.**

## Honour, Duty, Courage

**By Mohamed Khadra**

*Penguin Random House; 249 pages; $34.99*

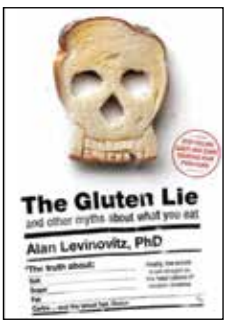



What drives doctors with good jobs and loving families to risk life and limb by volunteering to work in some of the most hazardous places in the world? In his latest book, Sydney-based surgeon Mohamed Khadra sets out to answer that question, interviewing dozens of health professionals about their experiences working as volunteers for the Australian Army Medical Corps. He creates two fictionalised characters to recount their stories, and what emerges is a portrait of people imbued with a strong sense of duty (and a penchant for adventure) who are severely tested, physically, mentally and emotionally. Deployed to a forward surgical unit in a war-torn country that could be Rwanda, Afghanistan or Iraq, the book's two protagonists – emergency surgeon Dr Jack Foster and anaesthetist Dr Thomas McNeal – are confronted with extremes of human depravity and deep ethical dilemma as they cope with a relentless flow of casualties from all sides of the conflict. Khadra gives a sympathetic account of the often harrowing situations such volunteers confront, and how these experiences stay with them long after the deployment ends.

## The Gluten Lie: And other myths about what you eat

**By Alan Levinovitz**

*Black Inc; 272 pages; $22.99*




For his day job, Alan Levinovitz researches religious myths to find out what they mean and why they are persuasive. With this background and expertise, it is no wonder he has turned his attention to the world of food. Few areas are as prone to fads, half-digested ideas and quackery than what we eat. Flick through any newspaper or magazine, or surf the web, and you will be quickly hit with advice about the latest 'super-food', fad diet or poisons lurking in what you eat. In his brightly written and tightly-argued book, Levinovitz seeks to chart how some of the big myths about food of our times have emerged and taken hold, causing many into dietary contortions as they seek to confine themselves to 'safe' foods. He examines the science and shows how mass beliefs, in some cases verging on hysteria, about MSG, salt, sugar, grains, meat and gluten have arisen, mostly based on very thin evidence. Unlike diet books, Levinovitz doesn't dispense advice about what you should eat, but instead asks some hard questions of those who do.

## Happiness by design: change what you do, not how you think

**By Paul Dolan**

*Penguin Random House; 235 pages; $16*


For many years, the overriding advice for those seeking to improve their happiness has been to change their mindset. Bookshelves abound with tomes advising people to think their way to a good mood. But Paul Dolan takes a refreshingly different approach. Drawing on the latest research in behavioural economics and brain science, he draws some general conclusions. Climate, for instance, does not exert a major influence on satisfaction. Wherever people live, they acclimate to the weather and get on with other aspects of their lives. He repeats the well-founded observation that volunteering tends to be correlated with a great sense of purpose, while television is associated with a sense of pleasure. So, how do individuals improve their happiness? Following the dictum that attention shapes experience, Dolan advocates identifying the things in life from which you derive joy or contentment, and seeking to make room for more of these experiences. Hardly earth-shattering advice, but powerful in its own way. As a *Scientific American* reviewer observes, Dolan touches on an important idea: happiness need not be pursued, simply rediscovered. In other words, sources of pleasure and purpose are all around us, if only one knows where to look.

# Beware the hidden extras

BY **DR CLIVE FRASER**

Christmas is that time of year when most of us are thinking of taking a well-earned break.

And with flying now cheaper than ever, why not go even further afield for a getaway?

It's always tempting to snap up one of those fly-drive packages.

But the Australian Competition and Consumer Commission have recently been warning us about the airlines using "drip-feed pricing" to lure us into a deal that ultimately costs us (much) more.

Just as well, then, that the car hire part of the package doesn't contain any hidden extras, or does it?

In nearly 60 years, I have yet to hire a car without the uneasy feeling that something unexpected might suddenly catch me out and cost me more than I had budgeted for.

I guess it all started on my honeymoon with my partner when the brakes on our Peugeot 306 failed at the top of the Alps.

I diagnosed the problem by taking a front wheel off, only to notice that the almost red-hot wheel nuts had melted into the bitumen.

My dearly beloved made her best efforts, speaking in a non-native tongue to the French call centre, to explain that the car was "les dangereux".

We were told to keep driving to Chur, which I thought was just a place that sounded like my teeth grinding together.

I resolved that we weren't going any further on our honeymoon in a car with no brake pads.

Eventually, a replacement car (with an empty fuel tank) arrived, and a French dare-devil drove our hire car back to the depot via a series of mountain passes, still with no brake pads.

I reasoned that they thought we were Americans because we spoke English and that they were trying to kill us.

Either way, the experience left us traumatised. And yes, it still Hurtz!

But the worst part of all was finding, on my return to Australia, that my credit card had been raided by the car hire company to fill the defective returned vehicle with fuel, even though I was given a replacement car with an almost empty fuel tank.

Fast forward to New Zealand's beautiful South Island, where my travel voucher said that the CDW (collision damage waiver) was included in my fly-drive package when their computer said it wasn't.

Once again it seemed to Hurtz a lot, particularly when their Ford

Territory had a chip as big as a bullet-hole in the windscreen and the vehicle report showed no pre-hire damage.

I am not intending to single out any particular car hire company, but I do think one needs to be extra careful about the fine print when a credit card has been swiped.

My best hiring experience so far has been with, of all things, a trailer.

I had some furniture to move and I thought a large enclosed trailer would do the job.

The small hire company was really helpful and said that, for only a few dollars more than the cost of hiring a trailer, I could hire a whole truck with a tail-lift loader.

No hitching up, and 37 cubic metres of space with no lifting at all.

What a bargain, I thought.

But what I was most impressed about was the effort that the attendant made to document all of the pre-existing damage to the truck's cab by photographing every bit on his iPad.

He found dents and scratches that I hadn't noticed, and on the return of the undamaged truck I knew there would be no surprises on my credit card statement.

I wonder if that firm hires out motorhomes for a second honeymoon?

Safe motoring,

**Doctor Clive Fraser**
doctorclivefraser@hotmail.com

# Does Christmas and moderation mix?

BY DR MICHAEL RYAN

The big man will be stumbling from house to house as he consumes endless beers left outside Australian houses on Christmas night. There is not much call for milk and cookies anymore.

It used to be simple - a XXXX, a Tooheys or a Carlton Draught would do it.

Now there is a plethora of hipster micro-brewed beers to choose from for Santa's repast. Perhaps a cool, aromatic, Belgian hopped mid-strength beer served in a broad-based balloon glass with a slice of lime. And, of course, with a macrobiotic quinoa juju berry cookie?

I love variety and the fact the range of choices has evolved.

But sometimes you just zip in for a can of Bundy and coke and end up spending 10 minutes passing your eyes over the mid-strength, zero sugar, O.P. or lime-infused options.

I must fully applaud the lower alcohol versions that now share shelf space with their heavier cousins.

Lower alcohol wines can be produced a number of ways - purposely picked early so there is less sugar to ferment, which means less alcohol. Another method is to stop the fermentation process by chilling the wine down, deactivating the yeast. Alcohol can be also reduced through reverse osmosis. Brewed beverages reduce alcohol by using less sugar in fermentation.

My substance abuse colleagues often wonder whether I should book in for a rehab spell, as I tell them I only drink wine for the taste.

Being inebriated is a real pain at Christmas. Putting the kids' swing set together with 10 screws left over, you end with something resembling a work of Gaudi architecture. Always let the cousins go first.

Then there's the slicing of the ham. Don't let on there is a bit of fingertip somewhere in the mix.

Xmas used to be predictable for me. Smoked salmon and scrambled eggs with **Veuve Cliquot Rose** for breakfast. A bone dry aromatic **Clare Riesling** with oysters. A sparkling Red, usually **Seppelts Show Reserve**, with the ham and assorted meats. Maybe some **Bass Phillip Pinot Noir** with duck. A few German beers and a lie down.

Now we are more aware of our promoting responsible drinking, I am enthusiastically flying the flag for the low alcohol options.

Recently, I convinced the wife to do a mock Christmas lunch run, all in the name of research.

The oysters were paired with the **2014 Matua Lighter 9 per cent alcohol Marlborough Sauvignon Blanc**. Very light color, with classic, yet subdued, gooseberry and lychee notes. The flavor is crisp with some diminished fruit and mouth feel.

Next we had an old fashioned prawn cocktail with the **Lindeman's early picked 8.5 per cent alcohol Semillon Sauvignon Blanc**. Some attractive citrus grassy notes and white peach aromas were apparent. The nature of the wine is a rounded, medium fruit-driven wine with a crisp finish. Overall, it did its job.

The next challenge was roast duck with a mandarin and star anise-infused glaze. **The Lindeman's early picked Shiraz** 8.5 per cent alcohol, with its reserved style, complemented it well. Restrained red currant aromas with mild vanillin oak influences were noticeable. Served slightly chilled, it had enough flavor to pair the meal.

Whilst not a classic plum pudding, my wife conjured up some form of sticky date pudding with brandy custard. Out of left field, I grabbed a **Matso's 3.5 per cent alcohol ginger beer from Broome**. Spicy ginger notes and a nice balance of sweetness and herbal notes really matched well.

Using the practice Breathalyzer, I found I was under 0.05 and the other guests didn't have to put up with suggestions that we turn on the Karaoke machine. Also, I could have easily erected the kids' cubby house without it looking like the Ettamogah Pub.

Low alcohol beverages can run the risk of appearing to lack flavor - alcohol adds sweetness as well as providing a more complete tasting experience.

But overall, our low-alcohol mock Christmas lunch was a success.

Now to bring on the real thing!

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