AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Together we stand

AMA backs Indigenous constitutional recognition, p7

INSIDE

AMA

ISSUE 27.08 AUGUST 17 2015

Feel to Believe

INADA

The World's Best Massage Chair

1962

The history of the massage chair is the history of Inada Japan

Japanese Ingenuity,
Elegance & Luxury...
When only the Best will do!

2015
Dreamwave

made in Japan **ONLY Japanese Made Massage Chairs in Australia**

INADA MASSAGE CHAIRS AUSTRALIA HEAD OFFICE
114 Roberts Avenue, Peakhurst NSW 2210 (by appointment only) Ph: 02 8307 0878

INADA MASSAGE CHAIRS LOCATIONS
Top Ryde City Shopping Centre - Level 1, Next to Freedom Cnr Devlin St & Blaxland Rd, Ryde. OPEN 7 DAYS
319 Swan Street, Richmond VIC 3121. OPEN 7 DAYS 10am-6pm
SYDNEY / MELBOURNE / PERTH / QLD Australia Wide Delivery **WWW.INADA.COM.AU**

50th ANNIVERSARY · 3 YEAR WARRANTY IN HOME · Interest Free Finance Available

The ORIGINAL Japanese Massage Chair
Manufacturer, since 1962, world's first & still #1
The history of the massage chair is the history of Inada

AUSTRALIAN
Medicine

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

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

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
Associate Professor
Brian Owler

Vice President
Dr Stephen Parnis

In this issue

Cover: AMA President Associate Professor Brian Owler with Reconcilliation Australia Chief Executive Officer Justin Mohamed (L) and Indigenous leader Pat Dodson.

Indigenous constitutional recognition – more than symbolism

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The AMA takes its commitment to closing the gap in Indigenous health outcomes seriously, and this involves engaging regularly with Indigenous leaders and communities, and with others committed to addressing social disadvantage.

The Garma Festival, which is held in Arnhem Land each year, brings together a diverse group of people to discuss Indigenous rights and culture, including health, education, and other social issues. I was fortunate to attend this year.

Garma is an opportunity to engage with Australia's Indigenous leaders and to hear from Indigenous peoples, in their own words, what is needed to improve the health and lives of Australia's First people.

One of the most important features of the program is the key forum. Sitting in the traditional meeting place of the Yolngu clan, high on an escarpment looking out to the Arafura Sea, it seems a long way from Canberra or the SCG. However, topics of constitutional recognition and racism towards Indigenous people in our society, including footballers, were among those most discussed.

The Aboriginal concept of 'health' centres on social and emotion wellbeing - a concept that applies to anyone. Indigenous people face racism on a daily basis. The treatment of Adam Goodes raises an important questions for the nation, for non-Indigenous people, and our commitment to issues such as raising the standards of health, education, and economic outcomes of Indigenous people.

There was clearly anger, which was well articulated by Noel Pearson's speech on the topic, in which he asked "how well do we know our fellow Australians"? He called on the better parts of ourselves and this nation to triumph over racism.

The AMA is a supporter of *Recognise* - the campaign for constitutional recognition of Australia's First Peoples. This is more than about symbolism. It is an important part of reconciliation and about the value that this nation places on Indigenous members of the Australian community. While there is bipartisan support for this process, the next step is for Indigenous people to agree on what form the change should take, and subsequently the specific wording of the question that should be taken to any referendum.

There was palpable disappointment at Garma at the response from the Prime Minister in rejecting a proposal for a series of Indigenous meetings to come to an agreement before wider discussion. It was pointed out that Indigenous people are often asked to take responsibility. There was a significant consensus around the need for Indigenous people to take this role.

Perhaps there is concern about the results of that process, and the model that is offered. Whatever the reason, unless there is unity behind the proposal, the referendum risks failing - and that would be a grim day for all Australians.

Many of the most important legal battles for Aboriginal land rights involve Arnhem Land and the While at Garma, there was also time to discuss some of the more concrete health issues. I sat with Professor Alan Cass, Dr Paul Laughton, and Senator Nova Peris discussing the high rates of renal failure in the Northern Territory, the role of prevention in addressing chronic kidney disease, the impacts of dialysis on patients and their families, along with the need to increase the rate of kidney transplantation.

As most chronic kidney disease is preventable, our discussion again highlighted the need for good primary care, particularly in Indigenous health. The Aboriginal community controlled health system is so important, particularly in the Northern Territory. It is one of the reasons why the AMA campaigned so strongly on the Government proposals that threatened funding for primary health care, such as the co-payment proposals and the freeze on Medicare indexation. These proposals all effectively defund primary health care.

While there was time for discussing health, in line with the Government's Indigenous Advancement Strategy, there was a lot of discussion around education and employment. There is good work being done but, as was highlighted in some of the conversations on the sidelines with people working in schools and communities, health has to underpin these strategies. There cannot be any relaxing of our commitment to Close the Gap.

Bullying Medicare puts profits above patients

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Australia has an excellent private health care system, of which we can be very proud.

Patients cannot be denied coverage, and those with pre-existing conditions can join a health fund and receive insurance coverage following a reasonable waiting period. There is a range of health insurers in a viable industry.

The system respects patient autonomy by allowing members to choose their doctor.

Private health insurance – which funds the majority of elective surgery in Australia – significantly reduces a burden that would otherwise be imposed on our overworked public hospital system.

However, the benefits of our private health insurance system are now at serious risk.

With the float of Medibank Private in 2014, the largest single health insurer (29.1 per cent market share and 3.8 million members) now has the primary goal of maximising returns for shareholders – apparently at the expense of patients who are their members.

The current dispute between Medibank Private and the Calvary Health Group underlines the problem.

As things stand, Medibank Private members will no longer be fully covered for treatment in a Calvary Hospital. This is particularly concerning for patients in the ACT, Tasmania, and South Australia, where Calvary Hospitals are most prominent.

Medibank Private has asserted that they will not pay for treatment in the instances of a number of so-called 'preventable complications'.

The AMA has no problem with insurers refusing to cover sentinel events that are entirely avoidable. Identification issues such as operating on the wrong limb, providing the wrong blood type in a transfusion and providing medication prescribed to the wrong patient should not happen with the right checks and balances.

However, the Medibank Private list of 165 different 'preventable' clinical conditions or events includes complications that occur despite full preventative measures. Their list is unilateral, based on spurious evidence, and flies in the face of work being done by authoritative bodies such as the Australian Council for Quality and Safety in Healthcare.

As a clear example, despite every risk reduction measure undertaken by clinicians and hospitals, deep venous thrombosis and subsequent pulmonary emboli will still occur as a consequence of conditions such as cancer.

Unbelievably, the rare but tragic incidence of maternal death associated with childbirth from conditions such as amniotic fluid embolism is considered a 'preventable' clinical event by Medibank Private. They say this absolves them of the responsibility to provide insurance coverage for the care provided.

These examples should alarm the entire medical profession. It indicates a fundamental lack of understanding of, or respect for, the medical culture that puts patient care first. It also demonstrates an intent to ignore clinical expertise and evidence, and an attempt by an insurer to dictate terms to those providing care.

So what does all of this mean?

It means patients get less value for their money.

It means hospitals are punished inappropriately despite delivering the best possible systems of care.

It means more patients will be compelled to seek care in the public system.

And it means that a major health insurer thinks it knows better than the medical profession when it comes to medical care.

We need transparency on health insurance practices and policies. Many patients remain confused about fundamental aspects of their health insurance policies, and practices such as encouraging minimal private insurance – so called "junk" health policies – need to go. Informed consent is an obligation doctors take seriously. So it should be when it comes to health insurance.

We don't want to follow the American path, where insurers dictate the terms. Under that system, costs blow out, care is compromised, and patients suffer. The AMA will do all it can to avoid this appalling scenario coming to Australia.

AMA ensures doctors heard on Medicare review, asylum seeker care

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "Family Doctor Week, held in mid-July, was well received, with the centrepoint being the President's address to the National Press Club"

As the AMA passes the midway point of 2015 there is a noticeable change of gear following the winter recess of Federal Parliament. While it appears unlikely that there will be an early Federal election, the AMA is preparing for all eventualities.

With two major reviews underway – into primary health care and into items listed on the MBS - the AMA secretariat is gearing up for the demands of responding to the reviews.

The primary care review has a more defined scope and is chaired by immediate-past AMA President, Dr Steve Hambleton. The MBS review, chaired by Professor Bruce Robinson, is more complex and will take a commitment of resources. With indications that there will be between 80 and 100 groups looking at specialist items, the task is considerable.

The AMA has convened a meeting of the specialist Colleges and medical societies to discuss the parameters of the Robinson review and a co-ordinated approach. From the start, Health Minister Sussan Ley has proposed that the MBS review be clinician-led, and the AMA will play a key role in co-ordinating that clinician input.

Family Doctor Week, held in mid-July, was well received, with the centrepoint being the President's address to the National Press Club.

The event underlines the central role of the AMA in the health debate. This was further emphasized by the media debate generated by the President's observations on the actions of some in the private health insurance industry, and on funding for public hospitals.

The National Press Club address fell in the middle of the national leaders' summit held by the Prime Minister with State and Territory leaders. The summit focused attention on fundamental reforms to the Australian taxation system. While the AMA has not expressed a view on the type of reform needed, the outcome of the debate will significantly affect the future health care funding, as has been alluded to by New South Wales Premier Mike Baird.

On the subject of Family Doctor Week, I urge you to watch and download the videos that were produced as part of the event. They can be accessed via the AMA website, and present a positive reflection on the central role that the GP plays in our health system.

On other recent matters, the secretariat is scoping the review of the AMA position statement on health care of asylum seekers and refugees in the context of the offshore detention, and the introduction of the Border Force Act with its secrecy provisions. The latter issue has generated a reasonable level of correspondence and calls to the secretariat.

The AMA will be convening a small forum in coming weeks to focus on the health needs of those in detention. For some time the AMA has been concerned at the loss of independent oversight of the health care of detainees, particularly children. This clearly remains an ongoing concern for many members.

AMA takes stand against racism, backs Indigenous constitutional recognition

The AMA has thrown its support behind constitutional recognition for Indigenous Australians and combating racism, condemning its insidious effects on social and emotional wellbeing.

As the on-field treatment of Indigenous AFL star Adam Goodes intensifies the focus on racism in the community, AMA President Professor Brian Owler said racist attacks were not only immoral but had all-too-real detrimental effects on the health of those who were its targets.

Professor Owler, who attended the Garma Festival at the Northern Territory town of Nhulunbuy in early this month, said the experience of Adam Goodes, who was badly shaken by the incessant booing directed at him by AFL crowds in recent weeks, showed that racism could have real consequences for individual mental health, as well as overall social and emotional wellbeing.

He said this was why the AMA viewed racism as a health issue and was committed to Indigenous constitutional recognition.

"The Aboriginal concept of 'health' centres on social and emotion wellbeing - a concept that applies to anyone," the AMA President said. "Indigenous people face racism on a daily basis. The treatment of Adam Goodes raises an important questions for the nation, for non-Indigenous people, and our commitment to issues such as raising the standards of health, education, and economic outcomes of Indigenous people."

"It comes back to social and emotional wellbeing. It is about respect for Indigenous culture and their place in the community being recognised and valued."

In light of this, he questioned Prime Minister Tony Abbott's decision not to support the development of a consensus Indigenous position on constitutional recognition to help inform a proposed referendum on the issue – a decision that deeply disappointed Indigenous leaders.

Professor Owler warned the Federal Government that its risks derailing its headline Indigenous Advancement Strategy and undermining recent progress in closing the gap by neglecting health issues and sidelining Indigenous leaders and communities.

The AMA President said that although Government efforts to improve school attendance, encourage young people to get a job and to make communities safer, were laudable, by themselves they would not bridge the big gap in wellbeing between Indigenous Australians and the rest of the community.

Ceramonial bunggul performance to open the Garma Festival at Nhulunbuy early this month

"Health is essential to learning, to going to school, for training and employment," he said. "Health must underpin these strategies. The lack of focus on health is one of the reasons why I struggle to understand the Government's Indigenous Advancement Strategy."

Professor Owler said there had been real progress in addressing Indigenous disadvantage, including reducing infant mortality, but cautioned the disruption and uncertainty created by last year's decision to slash $500 million from Indigenous services and programs put recent gains at risk.

"There is clearly a lot of good things that are being done, but we still have an enormous problem, and Indigenous health is one of those areas where you cannot take the foot off the pedal, because the moment you stop you can lose all the gains you have won," he said.

Last year's Budget cuts are continuing to resonate. An analysis of the 2015-16 Federal Budget by Menzies Centre for Public Policy Adjunct Associate Professor Dr Lesley Russell found that the share of total health funds being directed to Indigenous health programs will fall to 1.07 per cent this financial year before a minor improvement to 1.13 per cent in 2016-17.

Dr Russell said Commonwealth funding for Indigenous policies as a percentage of total outlays and of GDP was in decline, and that Indigenous organisations were losing out in the competition for funds to deliver Indigenous programs.

ADRIAN ROLLINS

GP pay up for grabs in primary system overhaul

"If the Government is genuine about improving how we care for patients with chronic and complex disease in primary care, greater investment and genuine commitment to positive reform is needed" - Brian Owler

Set fees and performance payments are among changes to GP remuneration being considered as part of efforts to remodel the primary health system to improve the care of patients with chronic and complex conditions.

The Federal Government's Primary Health Care Advisory Group, led by immediate-past AMA President Dr Steve Hambleton, has canvassed a number of GP payment options in a discussion paper outlining potential reforms to address the rising chronic care challenge.

While the current fee-for-service model worked well in the majority of instances, the *Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care* Discussion Paper said it did not provide incentives for the efficient management of patients who required ongoing care.

It suggested alternatives including capitated payments, where GPs, health teams, practices or a Primary Health Network receive a set amount to provide specified services over a given period of time; or pay-for-performance, where remuneration is tied to the achievement of particular care outcomes; or a combination of all three.

The discussion paper also suggested ideas regarding how care was organised and managed, including the creation of medical homes, GP-led team-based care, improved use of technology and upgrading techniques to monitor and evaluate care.

AMA President Professor Brian Owler welcomed the release of the discussion paper, but warned the Government that reform would not succeed without significant investment in general practice.

Professor Owler said several of the options for reform canvassed by Dr Hambleton's Group had long been supported by the AMA, including GP-led team-based care, the improved use of technology, care coordinators, and an expanded role for private health insurers.

He said the new payment models outlined were a challenge for the medical profession, and would need ongoing discussion.

But he warned that the Government needed to support general practice if it was genuine in seeking to improve care.

"What is missing from the discussion paper is an explicit statement that we need to better fund and resource general practice if we are to meet the health challenges of the future," Professor Owler said. "The final outcome from this Review must be more than simply re-allocating existing funding."

Dr Hambleton emphasised that the paper had been developed to encourage discussion, but warned that things needed to change.

He said increasing life expectancy meant more patients were presenting with multiple chronic and complex health complaints, and current arrangements were increasingly struggling to meet their care needs.

More than a third of Australians have a chronic health condition and the discussion paper said that because the system was not set up to effectively manage long-term complaints, many were turning up unnecessarily in hospital and emergency departments, adding millions of dollars to the nation's health bill.

... from p6

Health Minister Sussan Ley said it was "essential" to review the provision of chronic care, because Medicare benefits for chronic care were soaring – up almost 17 per cent to $587 million in 2013-14 alone.

"We are committed to finding better ways to care for people with chronic and complex conditions and ensure they receive the right care, in the right place, at the right time," Ms Ley said. "This discussion is a real opportunity to cater for the increase in chronic and complex conditions, and this approach ensures that health professionals and patients continue to be central to this process."

But Professor Owler said the reality was that primary health review was being undertaken at a time when general practice was under sustained attack from the Government, and a "more positive" attitude was urgently needed.

"General practice has been the target of regular Budget cuts that undermine the viability of practices, and threaten the long term sustainability and quality of GP services," he said. "The freeze on Medicare patient rebates is the prize example. It is causing great harm to GPs, their practices, and their patients.

"If the Government is genuine about improving how we care for patients with chronic and complex disease in primary care, greater investment and genuine commitment to positive reform is needed," Professor Owler said.

As part of its consultation process, the Primary Health Care Advisory Group is conducting an online survey that will be open until 3 September. To access the survey and discussion paper, visit www.health.gov.au

In addition, the Group is holding a series of public meetings in major cities and regional centres around the country, and will host a nationwide webcast on 21 August.

It is due to present its final report to the Government by the end of the year.

ADRIAN ROLLINS

Medibank putting profits before patients, says AMA

The nation's largest health insurer has been accused of putting profits before patients amid revelations that it has refused to cover the medical expenses of a mother who dies in childbirth.

AMA President Professor Brian Owler told the National Press Club that maternal death in childbirth was one of the more than 150 'preventable' clinical conditions Medibank Private was refusing to cover in hard-ball negotiations with private hospitals.

The AMA President said maternal death during childbirth, while rare, did happen, and Medibank's position was "offensive" and betrayed a lack of understanding of medicine and the motivations of doctors and other health workers.

"I find it offensive that a private insurer would refuse to cover the costs of that patient and hospital in such a tragic event," he said. "If someone thinks that a financial incentive will motivate doctors, nurses or anyone else in a hospital to prevent maternal death any more than they desire to do so now, then they have no understanding of medicine or the people in it."

"They are putting shareholders before patients."

The issue blew up last month after Medibank abandoned negotiations with the Calvary Health group on health cover.

Calvary was resisting Medibank demands that it pick up the tab for treating 165 medical conditions the insurer claimed would be caused by incompetence or neglect in the care patients received.

Medibank has argued that by insisting on a long list of exclusions, it is encouraging private hospitals to lift their standards of care. And it has received the backing of rival insurers Bupa and NIB, which argue it is time to hold hospitals to account for poor or inappropriate care.

Senior Bupa executive Dwayne Crombie told The Australian that insurers would take an increasingly hard line with private hospitals over costs: "I think you are going to see much blunter discussions. I totally support Medibank's approach, and we would think similarly".

NIB Chief Executive Mark Fitzgibbon told the same newspaper that "the trick here is to transfer the risk of poor quality to the

... from p10

person best placed to manage that risk, which is clearly the hospital. It's right that the hospitals take that risk".

But while the AMA accepted that hospitals should be held accountable for avoidable errors such as operations on the wrong limb or using the wrong blood type in a transfusion, Professor Owler said trying to avoid responsibility for complications like deep vein thrombosis that can and do arise despite the use of extensive preventive measures, was wrong.

> "What we should be doing is waiting for the evidence to come forward and then make recommendations. That is not what Medibank are doing" - Brian Owler

The AMA President said the Australian Commission on Safety and Quality in Health Care already regulated the safety and quality of health care, and there was no evidence to support the items on Medibank's list.

"What we should be doing is waiting for the evidence to come forward and then make recommendations. That is not what Medibank are doing," he said.

A Medibank spokesman told News Corp the insurer rejected the criticism and said it would be rare for a hospital not to cover the cost when a mother died in childbirth, and if this did occur the insurer would "vigorously contest" the decision on behalf of its members.

"We understand it is a common industry practice not to pay for this event, because it is rarely charged," the spokesman said.

The AMA President said the insurer's decision to walk away from its talks with Calvary Group, which meant Medibank Private members would no longer be covered for treatment at the group's hospitals, was in keeping with a shift in the health fund's focus since being privatised from patient care to shareholder returns.

He said it was clear Medibank's intention was to simply to shove costs off its books and instead dump them onto private hospitals, and would have the effect of forcing the most complex clinical cases onto the public hospital system.

Already, there is a well-established trend for private patients to be treated in public hospitals.

Figures released by the soon-to-be- abolished Private Health Insurance Administration Council show that public hospital admissions of privately insured patients surged from 20.9 per cent in 2003 to 28.8 per cent last year, and patient volume growth in public hospitals outstrips that in the private sector.

Professor Owler warned the Calvary hospital stoush was part of an aggressive and unwelcome push by Medibank to have a much greater say in the provision of care.

He said the nation had been well served by a private health insurance system which was open to all, regardless of health status. Under industry rules, patients can join the health fund of their choice even if they have a pre-existing condition, and they cannot be denied coverage (the principle known as community rating).

But the AMA President expressed concern that Medibank was trying to drag the system down a path toward US-style managed care, in which insurers were able to dictate what doctor a patient saw, and what sort of treatment they received.

"A US-managed care system is a system that places an enormous administrative burden on the patients and on the practices," he said. "It actually increases costs and, at the end of the day, the only one that wins is the insurer. We don't want to go down that system."

"[But] I am concerned that as Medibank Private, given its float and new direction, that we are slowly heading towards that direction."

While the private health insurance sector was not uniform, and mutual funds operated to benefit members, Professor Owler said Medibank's relentless cost-cutting could create competitive pressures that would undermine the ability of other insurers to maintain their level of coverage and services.

Mr Crombie said that although Bupa did not have shareholders, it was facing cost pressures similar to those driving Medibank.

ADRIAN ROLLINS

Worrying trends in MBS review

There are mounting concerns about the direction of the Federal Government's far-reaching overhaul of the Medicare Benefits Schedule amid indications up to 100 review groups will be established to examine specialist items.

The AMA has cautiously welcomed the MBS review, led by Sydney University Medical School Dean Professor Bruce Robinson, and has undertaken to help organise and coordinate the input of clinicians.

But AMA President Brian Owler has convened a meeting of medical profession leaders for the later this month to discuss worrying aspects of the Government's approach to the review, including excluding specialist colleges and societies from direct involvement, opaque processes for the selection of review members that raised the risk of influence by individual vested interests, and a lack of transparency regarding the work of review groups and their decision-making.

Professor Owler warned the Government that it risks jeopardising the medical profession's support for the process if it turns out to be just a cost-cutting exercise that lacks transparency and excludes clinical input.

"Doctors are not afraid of change and reform. We will willingly participate in reform where it is in the best interests of our patients," he told the National Press Club last month.

He said the MBS, which list treatments and procedures for which the Government will provide a Medicare rebate, was due for an update because of improvements in medical technology and innovations by doctors to provide better and more effective treatments.

"However, our support is predicated on this review not being aimed at cutting the funding to health," Professor Owler said. "We agree with not paying for procedures that don't work for certain indications, but we also need to ensure that we don't deprive people of important services."

He voiced concern that the Government might use the review mostly to remove items from the MBS, rather than ensuring the schedule was up-to-date and reflected advances in care and medical practice.

"The MBS review cannot be a cost-cutting exercise," he said. "If there are clearly savings that are identified and the evidence is there that supports those savings, then fine. But we also need to make sure that we have the ability to introduce new items onto the MBS. This cannot be about just taking items off."

The AMA President said there were a lot of procedures and services currently not covered by the MBS that should be included, and lamented that currently the process for getting new items on the schedule was lengthy and costly.

He said an important aspect of the review was the opportunity to add new items and make the MBS "modern".

> "The AMA is convening a meeting of medical colleges, associations and societies later this month to discuss to MBS review, including concerns over its structure and direction"

"What we need to do as part of this review is ensure that we can actually add new things on and make sure that we do actually come up with a modern MBS," the AMA President said. "If we get the sense that this is a cost-cutting exercise, then AMA support and, I suspect, the support of the whole medical profession, will be jeopardised."

The MBS review meeting being convened by the AMA later this month will be addressed by Professor Robinson.

In his letter to college and society leaders inviting them to the meeting, Professor Owler detailed a number of issues regarding the Government's approach to the review, including that:

- it had not articulated a strategic vision for the health system to guide the review's outcomes;
- that it had not been given specific and quantifiable aims;
- that specialist colleges and societies were excluded from direct involvement;
- that the criteria to be used to select review members was unclear; and
- there was a lack of transparency around individual reviews as they progress, and the decisions that will come from them.

"Any review of this nature must bring the profession along with it," the AMA President wrote in his letter. "In the absence of a Government process that facilitates that, it is very important for the medical profession to be collaborative and coordinated."

ADRIAN ROLLINS

National action on bullying, harassment

The AMA has commenced work with the peak advisor to the nation's health ministers to ensure doctors and interns nationwide have access to effective procedures for complaints regarding bullying and harassment.

AMA President Professor Brian Owler has held talks with the Chair of the Australian Health Ministers' Advisory Council, David Swan, about establishing or improving policies and processes regarding workplace bullying and harassment in each State and Territory.

Professor Owler said rules and procedures varied greatly across the country, and it was vital to ensure that all medical staff – no matter where or for whom they worked – felt confident and comfortable in reporting instances of bullying and harassment.

"We need to make sure that it is safe for people to actually come forward without fear of reprisal, without fear for their careers," the AMA President told the National Press Club last month.

He said that for many junior doctors, their employer was the relevant Health Department, rather than a medical college or senior practitioner.

"What we need to do is make sure that the policies and procedures [regulating acceptable workplace behaviour and handling complaints] are in place. [At the moment] they vary right across the country," he said. "[We] need to make sure that those procedures are set up right across the country, and we're working through AHMAC to make that happen."

A number of states are examining the work done by the NSW Ministry of Health on workplace bullying and sexual harassment, and Mr Swan said AHMAC was keen to collaborate with the medical profession on the issue.

Professor Owler applauded the work being undertaken by the Royal Australian College of Surgeons on the issue, and said a complaints process being developed by the College should be replicated across the profession.

Mr Swan said AHMAC was keen to see the outcomes of the RACS work, which he said could provide a good basis for future collaboration between states and the medical profession.

Professor Owler said that, vital though it was to ensure there were effective bullying and harassment policies and complaint procedures in place, the real issue was to stop such behaviour in the first place.

"The most important thing is that we do need to change the culture," he said. "The vast majority of senior doctors are very supportive of junior doctors but we know that that is not always the case. So where we do see a problem...we need to speak out and make sure that we don't allow that to happen. And as leaders, as senior doctors within the profession, the responsibility is on us to make that happen."

ADRIAN ROLLINS

Intern system needs upgrade, not overhaul

Calls to dump the current medical intern training system and replace it with a two-year prevocational program or absorb it in the final year of medical school are ill-considered and unnecessary, the AMA has told a Government inquiry.

In a submission to the Council of Australian Governments' Health Council National Review of Medical Intern Training, the AMA argued that although aspects of the current intern system could be improved, any changes should be incremental and underpinned by evidence.

AMA President Professor Brian Owler and AMA Council of Doctors in Training Chair Dr Danika Thiemt told the review there was nothing to show that a wholesale overhaul of existing arrangements was warranted.

"It is hard for us to agree that the current internship model is flawed when there is so much variety and flexibility across Australia, and when the calibre of doctors in training emerging are world-class and are regarded as such," they said. "That is not to say there is no room for improvement, but we do not believe this has to take the shape of frame-breaking change, and any change should be informed by a strong evidence base."

The COAG review is being conducted amid expectations a growing number of medical graduates will miss out on an internship place this year as Federal and State governments squabble over funding and responsibility.

A national audit found that there was a shortfall of 366 intern places this year, and Australian Medical Students' Association President James Lawler said anecdotal reports indicated there would not be enough places in 2016.

"This is a bittersweet time for medical students around the country, with excitement at their internship offers conflicting with the fact that they are now competing for training places in a system that is already overwhelmed," Mr Lawler said.

The review has been asked to examine four options, ranging from leaving the system as-is, to increasing intern term periods, establishing a two-year UK-style prevocational training program or drawing internship-like duties back into the final year of medical school.

In their submission, Professor Owler and Dr Thiemt argued strongly against the latter two options.

"The AMA believes there is no evidence to support radical changes to the structure of the internship along the lines suggested in [these] options," they wrote. "These options are unrealistic, would require a significant investment of resources, including cost and additional supervisor input, and may result in unintended negative consequences. In any case, it is unlikely that cash-strapped jurisdictions would be in any position to fund them."

The AMA leaders said the UK-style model might be superficially attractive, but there was no evidence that it would deliver any improvement on current arrangements, while the type of learning gained through university education was "very different" from that provided in a workplace, where interns are required to make decisions about care, albeit under supervision.

"There is no evidence to show that the current model of internship in Australia is 'broken', or that radical changes to its structure are required," Professor Owler said. "The current model of intern training in Australia has served the community well. Instead of sweeping changes, we need to build on what works."

But he said the review had highlighted a lack of data surrounding the quality and effectiveness of the intern year in preparing junior doctors for independent practice, and the AMA has proposed that remedying this be a priority.

"The AMA believes the review must propose new systems to provide better information on the quality of medical intern training, the transition from medical school to intern training, and in the remaining prevocational and vocational training years," the AMA President said.

The AMA has recommended there be a national survey of medical training, similar to the survey that the General Medical Council undertakes in the United Kingdom.

ADRIAN ROLLINS

Doctors 'obliged' to speak out on asylum seeker health

AMA President Professor Brian Owler has accused the Federal Government of trying to intimidate doctors and other health workers from speaking out about the treatment of asylum seekers being held in immigration detention centres.

The AMA President has mounted a strongly-worded attack on controversial provisions in the Government's Border Force Act aimed at gagging whistleblowers amid mounting claims that many detainees – including children – have been sexually and physically abused while in custody.

> "As doctors, we have an ethical and moral obligation to speak out if we have concerns about the welfare of our patients, whether it be the treatment of an individual or whether it be at a system level" - Brian Owler

Professor Owler said doctors were ethical and morally obliged to advocate for the welfare of their patients, and the new laws - which threaten up to two years imprisonment for unauthorised disclosures – placed them in an invidious position.

"As doctors, we have an ethical and moral obligation to speak out if we have concerns about the welfare of our patients, whether it be the treatment of an individual or whether it be at a system level," he said.

Asked if the AMA was advising doctors to refuse to work in detention centres under these conditions, the President said that it "wouldn't matter what I said, I suspect. I think doctors would vote with their feet and they would go and provide health care to asylum seekers, because that's what they do".

"Doctors will always go and look after the patient, and they will put their own interests second."

The apparent attempt to gag critics has come against the background of ongoing reports of abuse and assault at detention centres.

The independent Moss review of allegations of abuse at the Nauru detention centre, released in March, found evidence of rape, the sexual assault of minors, and guards trading marijuana for sexual favours from female detainees.

Despite this, a separate Senate committee inquiry heard last month that no detention centre staff accused of abusing children have been charged.

Transfield, which has a $1.2 billion contract to operate the Nauru and Manus Island detention centres, said that of 67 allegations, just 12 had been referred to police.

In other testimony, a former senior doctor with Immigration Department contractor International Health and Medical Services, Dr Peter Young, told the Senate committee that medical staff were directed not to report mental health problems.

Dr Young, who was director of mental health for IHMS, said he was told several times not to report that asylum seeker mental health had been harmed by being detained at the Nauru detention centre.

Separately, the Government-appointed Council on Asylum Seekers and Detention has been told that detainees begin to suffer serious mental health problems within three months of incarceration.

Immigration Minister Peter Dutton has sought to provide assurances that health workers who spoke out would not be prosecuted under the Act, but Professor Owler said much more was needed.

"The AMA has been concerned about the provision of health care to asylum seekers, particularly those in the offshore processing centres of Nauru and Manus Island," he said. "Legal advisers have confirmed that the Act provides penalties, including potential imprisonment for doctors, nurses and other health workers who speak out about abuse or the wellbeing of asylum seekers."

Professor Owler said that if medical whistleblowers were not liable for prosecution, then "it should be clearly and directly spelt out in the legislation".

"We call for this exemption because, for a doctor, an asylum seeker is no less a patient than any other patient. If we are willing to compromise the rights of doctors and patients for one group, how can we ensure that other groups will not be compromised in the future?" he said.

ADRIAN ROLLINS

OBITUARY

Emeritus Professor Pricilla Kincaid-Smith

When world-renowned medical expert and pioneering doctor Pricilla Kincaid-Smith died last month, it brought to an end a remarkable career marked by numerous firsts.

But it almost might never have happened.

Among the numerous obstacles Emeritus Professor Kincaid-Smith had to overcome were the arcane social mores of post-war Australia. When she moved here in 1958 after marrying her husband Ken Fairley, the laws of the time dictated that she would not be allowed to work.

It won't surprise anyone who knew her that she was not about to let that stop her.

Within a year of arriving in the country (and having already established her credentials in the UK as a dual-qualified physician and pathologist), she had joined the AMA and managed to secure research positions at the Baker Institute and in the University Department of Medicine, as well as being an Honorary Physician at the Queen Victoria Hospital. Within a decade she was appointed Director of Nephrology at the Royal Melbourne Hospital in 1967.

Equipped with such ability and determination, it is not surprising Professor Kincaid-Smith went on to achieve world-wide renown, taking on breakthrough roles with the University of Melbourne, the Australian Medical Association (AMA) and World Medical Association, and discovering the link between headache powders and kidney disease.

Just as she became a leader in her chosen specialty nephrology, so she also blazed a trail for Australian women to hold leadership positions in Australia's medical community.

It all began in Johannesburg, South Africa where Professor Kincaid-Smith was born in 1926, one of four children.

She was a talented hockey player and swimmer and reports indicate that she was more interested in sport than attending classes, but despite this, she started university at just 16.

Originally wanting to study physical education, she was deemed too young and ended up in medical science, where she topped most of her classes and discovered her passion for medicine.

After two years working in South Africa, Professor Kincaid-Smith moved to London where she spent six years training in pathology and cardiology - nephrology, her major specialty, did not exist as a speciality at the time.

It was following this that she moved to Australia with her husband.

Professor Kincaid-Smith achieved many firsts in her life. She was the first female Professor at the University of Melbourne in 1975, first female President of the Royal Australasian College of Physicians in 1986, first female chair of the AMA in 1990 and the first female, and first Australian, chair of the World Medical Association in 1994.

While she joined the AMA soon after arriving in Australia, it was not until the 1980s that she became more directly involved, driven by a strong sense that doctors should actively engage with Government in the delivery of health services.

During her time on AMA Federal Council, she served on numerous committees, including making major contributions to the workforce committees. Dr Kincaid-Smith was, appropriately, the first recipient of the AMA's Woman in Medicine Award.

In addition to all these amazing achievements, as part of a team with her husband, Professor Kincaid-Smith discovered the link between the overuse of headache powders Bex and Vincents and kidney disease in the early 1960s.

She then actively lobbied for restrictions on the availability of the analgesics, and was heavily involved in setting up the renal transplant unit at the Royal Melbourne Hospital.

Dr Kincaid-Smith published more than 480 original papers in refereed scientific journals, 103 chapters in books, wrote three herself and edited a further 10.

Dr Kincaid-Smith made remarkable contributions to medicine, both in Australia and internationally. She worked long and hard for the profession and will be remembered for her passion and dedication.

KIRSTY WATERFORD

Cannabis meds? Follow the evidence, says AMA

AMA President Brian Owler has called for a considered, evidence-based approach to the use of cannabis for medicinal purposes as the clamour for its legalisation as a treatment for conditions such as cancer, epilepsy and multiple sclerosis grows.

Professor Owler told the National Press Club that marijuana's use as a recreational drug should not be allowed to cloud the assessment of its potential medical applications.

But likewise, he warned against a wholesale embrace of cannabis as a treatment without proper scientific evaluation of its effectiveness for a wide variety on maladies.

"It's not about the fact that it's cannabis. It's actually about the fact of how effective it is," he said. "There are some conditions where it clearly may be beneficial, and perhaps we don't need to have an in-depth trial on those sorts of indications. But there are clearly others where the evidence is actually not there."

His comments came as Federal Labor intensified the pressure on the Federal Government over the issue after the ALP National Conference passed a motion calling for reform of existing regulations governing the use of cannabis.

Already, several states are taking significant steps toward the use of cannabis for medicinal purposes. New South Wales has initiated a series of clinical trials, and Victoria and Queensland have reached an agreement to let their citizens who are suffering terminal or life-threatening conditions to take part.

But Labor's Shadow Assistant Health Minister Stephen Jones said the participation of the Commonwealth was vital to allowing its medicinal use.

"The truth is, neither State nor Commonwealth governments can go it alone," Mr Jones said. "We need Commonwealth leadership to deal with the complex overlay of State and Federal laws that deal with registration of medicines [and the] cultivation, supply and use of prohibited drugs."

He said Labor believed in a national approach based on medical science.

"Cannabis should be treated like any other medicinal product," Mr Jones said. "There is evidence to show that medicinal cannabis can reduce the pain and nausea associated with cancer treatment. It may also help with controlling epileptic fits [and] multiple sclerosis.

"But right now cannabis medicines can't be prescribed by doctors. We need scientific verification and approval by the Therapeutic Goods Administration."

Prime Minister Tony Abbott last year said that he had "no problem with the medical use of cannabis, just as I have no problem with the medical use of opiates".

"If a drug is needed for a valid medicinal purpose...and is being administered safely, there should be no question of its legality. And if a drug that is proven to be safe abroad is needed here it should be available," the Prime Minister said.

While there is growing clamour to legalise medicinal cannabis, Professor Owler said it was nonetheless important to take a cautious and well-informed approach.

"We need to have proper trials and regulate it as a medication just like any other medication," he said. "It's not about trying to deny access to the drug, but we also want to make sure that we don't do any harm. We want to make sure that people are actually getting the drug for the right reasons, and that it's actually going to benefit them in the future."

ADRIAN ROLLINS

Medicines Australia's new Code of Conduct – what it means for medical practitioners

From 1 October 2015, pharmaceutical companies who are members of Medicines Australia will begin collecting information about payments they make to individual health practitioners so that they can start publishing it on their websites next year.

The Medicines Australia Code of Conduct now requires its members to publicly report details of certain categories of payments made to practitioners.

Medical practitioners who receive payments or benefits from pharmaceutical companies should ensure they fully understand the new requirements and any implications for them. For example, practitioners should be aware that the public reports will be published in a format to allow data to be downloaded and analysed.

Reporting will commence in two stages.

From 1 October 2015, pharmaceutical companies will collect data on the relevant categories of payments so that they can publicly report on the payments made to individual health practitioners.

In line with Australian privacy legislation, companies will need to seek consent from individuals before this can be published. Individual practitioners will be able to withhold consent.

From 1 October 2016, pharmaceutical companies will only be able to enter into relationships with practitioners who consent to this information being published as a condition of accepting the payment.

The AMA supports transparency of pharmaceutical company relationships with practitioners.

The AMA lobbied hard – starting in 2012 – to make sure a US-style transparency system was not imposed in Australia. This would have required the collection of information about every industry-practitioner 'transaction' equal to or more than $10 in value, such as providing tea and biscuits at a meeting.

The Medicines Australia Code increases the transparency of industry-practitioner relationships for the public without creating an unnecessary red tape burden.

The final model is similar to codes of conduct adopted in Europe by focusing on significant transactions most likely to provide meaningful information to patients about their practitioners' relationships.

The AMA also made strong representations to the Australian Competition and Consumer Commission which resulted in the public reporting requirements being phased in over 12 months, so that all parties will have the opportunity to understand, plan for, and fully comply with the new requirements.

Unfortunately, although the AMA strongly opposed the ACCC's reporting requirement, all information will be reported in a form that can be downloaded and analysed.

The AMA argued that the public should only be able to search for one practitioner name at a time, consistent with its use by patients seeking information about their health practitioner.

A full list of the categories of payments that will be publicly reported, and the detail of the information included in the reports, is available on the AMA website at: https://ama.com.au/medicines-australia-new-code-conduct-what-it-means-medical-practitioners.

Further information is also available on the Medicines Australia website at: https://medicinesaustralia.com.au/code-of-conduct/.

GEORGIA MORRIS

Trying to grab hold of vapour

New South Wales has enacted new laws to ban the sale of e-cigarettes to children in the latest move to tighten the legal noose around the supply, use and marketing of the controversial product.

The nation's most populous state has amended its Public Health (Tobacco) Act to bring restrictions on the sale, display and promotion of e-cigarettes to young people broadly into line with those applying to other tobacco products after NSW Health Minister Jillian Skinner expressed concerns the devices might act as a "gateway" to tobacco smoking for children.

"This is a comprehensive piece of legislation which will guard against the re-normalisation of smoking among the young, as it has the potential to undermine decades of successful anti-smoking efforts in New South Wales," Ms Skinner said.

The NSW legislation follows calls made by the AMA early this year for the marketing and advertising of e-cigarettes to be subject to the same restrictions as those that apply to tobacco products.

An AMA Working Group on the issue found that, because e-cigarettes essentially mimic the act of smoking, there were realistic concerns that they would encourage users to move on to tobacco products.

These concerns were heightened after an investigation in NSW found a large number of e-cigarette solutions marketed as nicotine-free actually contained the drug, creating the risk is that non-smokers using them would develop an addiction to nicotine.

The new NSW laws make in an offence to sell or supply e-cigarettes to minors (including through a vending machine) or to smoke them in a car in the presence of a child. In addition, tighter restrictions have been placed on their advertising and display.

Already, it is illegal to sell or supply e-cigarettes containing nicotine anywhere in Australia, and the Therapeutic Goods Administration has not recognised them as a therapeutic aid for quitting smoking.

But regulation of the sale and supply of e-cigarettes that do not contain nicotine is much less clear-cut.

Several states, including Western Australia, Queensland and South Australia, specifically prohibit the sale of devices designed to resemble tobacco products, and the WA Health Department recently won a Supreme Court case arguing that the rule applied to e-cigarettes.

To reduce ambiguity, the Queensland Government last year specified that smoking products included personal vaporisers.

But in several states and territories – including Victoria and Tasmania - the sale and use of e-cigarettes that do not contain nicotine remains essentially unregulated, as long as there is no therapeutic claim made, and it is not marketed as a toy or food to children.

But the AMA Working Group found that much of the marketing for e-cigarettes occurred online, and was clearly designed to appeal to young consumers.

"Many e-cigarettes have a very sleek appearance, are brightly coloured, and use sweet, fruit and chocolate flavoured solutions – all features intended to appeal to younger users," the Working Group's report said.

Its concerns have been echoed by the Cancer Council of Victoria, which said the almost total absence of regulation regarding e-cigarettes in some states was extremely concerning, given that they were "designed to mimic the act of smoking, have not been properly evaluated for safety and are clearly promoted to young people, with their fruit, confectionary and energy drink flavours".

The AMA has called for national action to curb the marketing and sale of e-cigarettes, arguing that, "it would be an enormous backward step for public health if all the gains in tobacco control made in recent decades were to be undermined by increases in nicotine addiction through the use of e-cigarettes".

ADRIAN ROLLINS

Dreaming of how things might be

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

Five years ago I enjoyed a sedate six-day cycling tour of the west coast of Ireland.

The signs on the rural roads and lanes and friendly directions from locals were every bit as entertainingly useless as apocryphal stories suggest, as in, "Oh, if I wanted to get there I wouldn't start from here!"

The Australian health care system is as complicated as the Irish rural by-ways.

Given the immediacy of our need for health care - not much health care is truly elective - bringing the system to a complete halt while we undertake a total demolition and rebuild is not possible. Not even the transformative might of information technology has been able to achieve a radical change like that in health care.

Nevertheless, it makes fair sense to engage in imaginative reflection about how the system might, in fancy, be seriously different. Three pressure points should attract our attention in such an exercise.

First, we are like the lost cyclist in Ireland when it comes to managing chronic illness.

No one would start with fee-for-service as the way to pay for care for people whose needs span years and who need continuity. Evaluation of experimental programs of joined-up care for people with chronic physical and mental illnesses, as documented by McKinsey and Co, a consultancy, demonstrate the importance of aligning the way care is paid for with the goals of care.

In an ideal health system, we would document what we achieve, and we would pay more for better care and less for poorer care.

Of course, patient variability makes this difficult, but others have shown how it can be done.

It is perfectly acceptable to try out several approaches, and trials are underway in Australia to assess their merits. Regrettably, few, if any, of these trials of care include testing of new ways of paying for it.

Second, we need to radically reconsider the health workforce.

At present the situation is chaotic, devoid of plans that seriously consider what health professionals - numbers, skills and rewards - will be fit-for-purpose in 10 or more years.

In planning for the redevelopment of Westmead Hospital in Sydney, I ask my colleagues what changes in design are mandated by patients increasingly being vertical rather than horizontal? Where will we locate the Centre for Information Science (IS), given the centrality of IS in clinical care, research and health service management? We do not yet easily accommodate the thought that IS professionals are foundational for the health workforce of the future. They dominate the biosciences in research already. We should debate and decide what we expect the doctors of the future to do.

The steam has gone out of medical education reform in the past 10 years. The fires need stoking.

Third, a new vision is needed for public health.

The words 'public health' have lost their flavour, and are now taken to mean publicly-funded health services, especially via Medicare.

Yet this is the era in which we face the enormous challenge of climate change - both the management of its consequences, and efforts to mitigate, if not halt, it. The health effects are not considered newsworthy, yet it is a global public health disaster in the making.

We cannot go on forever holding the hand of the tooth fairy as we ignore growing economic inequalities and their consequences for health, in Australia and elsewhere.

Who, among our thousands of health professionals, will take the lead in relation to these highly political public health problems?

So, we may not be able to take apart our health system as though made of Lego, but there are heaps of challenges to which we can apply our imagination as we dream of things that never were, and ask, 'Why not?' And we can start here.

Govt needs to relieve strain on health system's heart

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

> "If private insurers can recognise that general practice is where they need to be investing, then it is time the Federal Government did so as well"

The benefits of co-ordinated care are widely recognised, and worldwide work is progressing to develop and implement systems and models of care that facilitate and support it.

In Australia, improving the continuity of patient care through better co-ordination has been on the agenda for almost two decades. As a GP, it is frustrating when the role of GPs in the co-ordination of patient care is so often undervalued by Governments in their ongoing quest for cost savings.

Despite the Government's rhetoric acknowledging general practice as being central to the health system and its desire to rebuild it, the indexation freeze and other attempts to cut rebates stand in stark contrast to this intent.

Every time general practice is undermined with a rebate cut, the loss of an incentive, or an indexation freeze, our capacity to provide a higher level of care is compromised.

We have care planning and team care arrangements that recognise the GP's central role in co-ordinating services to support patients to better manage their chronic and complex conditions. However, these arrangements are limited, inconsistent with established referral practices, and encased in red tape. This impacts on their effective use.

More than $1 billion has been "invested" by the Federal Government in a shared electronic health record to help ensure continuity of care. Unfortunately, most of that investment could have been saved if greater stock had been put in the advice of clinicians and the medical profession. In particular, that it must be an opt-out system and that information uploaded to the shared health recorded needed to be clinically relevant.

In the past decade there have been multiple trials around co-ordinated and collaborative care. We've had the Co-ordinated Care Trials in Queensland, HealthPlus in South Australia, the recent Diabetes Care Project trial, and Victoria is currently running the Care Point trial.

To varying extents, these trials recognise the role of general practice. We must build on the lessons learned from them, bearing in mind the recent findings of a report on nurse-led, hospital-based co-ordinated care interventions that found no demonstrated effect. What this shows, I believe, is that the best place for care co-ordination is at the central point of health care, which is general practice.

Private health insurers appear to be slowly coming around to the view that if they want to stem the rise in hospital-based claims (and their resultant payouts), then they need to start looking at supporting primary health care. They need to recognise that general practice holds the key for them, and that the challenge is to develop a funding model that will enable them to support GPs in keeping their patients out of hospital.

As AMA President Professor Brian Owler said in his address to the National Press Club during this year's Family Doctor Week, there needs to be urgent recognition of the costs of providing high quality care.

If private insurers can recognise that general practice is where they need to be investing, then it is time the Federal Government did so as well.

The current review into primary health care, led by former AMA President Dr Steve Hambleton, provides a vital chance to shift the focus of our health system back to its heart.

Junior doctor wellbeing - whose job is it anyway?

BY DR CHRIS WILSON, PHYSICIAN TRAINEE AND CO-CHAIR, DIT COMMITTEE, AMAWA

As doctors, caring for people is what we do. It's 'core' business. Simple, right? There's my article sorted...

Unfortunately it's not that simple. There's one group that we're not so good at caring for - a group routinely and systematically neglected. That group is us.

Doctors in Training work in high stress environments, face daily pressures few understand and work hours that can only be described as unsociable. Recent tragic events across the country have reminded us just how important it is for the medical profession to look after its young.

We all know of studies highlighting the increased incidence of mental health issues in doctors and medical students and our general reluctance to seek help. Now, with a renewed focus on harassment and bullying in the medical profession, the time has come to ask - who cares for us?

The pastoral care of DiTs is a fragmented network of cobbled-together services just waiting for someone to slip through the cracks.

Yes, there are some fantastic resources available to doctors in crisis, but why do we need to hit rock bottom before someone will step in? If I haven't hit crisis (and am trying desperately to avoid ending up in one), who do I ask for help? What debriefing is offered when a MET call ends badly, or a patient has an adverse outcome? Who do I approach if I'm being bullied or harassed by a senior colleague? Where do we turn when we see cracks appearing in the wall but the dam is yet to burst? The honest answer is I'm not sure, and if I - a PGY4 registrar with a good insight into how my hospital works - can't answer those questions, what hope does an acutely stressed intern have?

There is no clear, consistent approach. Interns and RMOs are sometimes 'looked after' by hospital Post Graduate Medical Education units, despite this not being strictly their remit. Therefore, this happens with varying success.

Registrars in training programmes may receive some support from their college and/or hospital departments, but again it is highly variable. Service registrars are generally plain out of luck.

> "Ultimately, the responsibility falls to our employers. The hospitals and health services we work for have a duty of care to provide a safe and supported environment"

Who should be responsible for the wellbeing of Doctors in Training?

Ultimately, the responsibility falls to our employers. The hospitals and health services we work for have a duty of care to provide a safe and supported environment. Yes, we have a significant role to play in maintaining our own wellbeing and that of our colleagues. However, there should also be clear, consistent and easily accessible services available to DiTs (and all other staff) while at work. We should have a proactive approach that identifies doctors in need early and puts in place strategies to prevent a crisis developing.

The Medical Board of Australia (MBA) and the AMA have recently entered into an agreement for the national delivery of health services to medical practitioners and medical students. The newly formed Doctors Health Advisory Service, guided by an expert advisory council, will work to establish a consistent, national approach to health services for doctors across the country. This will be a welcome step forward in ensuring that all doctors have access to suitable health services, no matter what city, region or state they may live in.

The need for an easily accessible, consistent suite of services across the nation has long been called for, and the intention of the MBA and AMA is to ensure doctors and medical students, no matter where they live, have access to the highest possible standard of care.

The AMA are taking a lead on doctors health, but this is not enough – at local, state and national levels we must all take an active role in caring for those we work with.

Foreign aid cuts a health disaster for many

BY **NICKY BETTS**

As a final-year medical student, I am the first person to admit that I've been very fortunate so far in life.

Most of these blessings are facets of our rich, first-world society - free, high-quality health care and cheap tertiary education, not to mention the basics that I take for granted every day like somewhere to live, food and clean water.

> "These cuts fly in the face of the 0.7 per cent of GNI commitment Australia agreed to at the UN in 1970, and which has been repeatedly reaffirmed ever since"

Sometimes, though, it can become easy to forget two things. Firstly, I did nothing to deserve these blessings. Secondly, billions of people around the world are less privileged than I am. For these reasons, I am thoroughly disappointed in the $1 billion cuts to foreign aid announced in the recent Federal Budget.

Under the previous Labor government, Australia had a bipartisan commitment to contribute 0.5 per cent of its Gross National Income (GNI) to foreign aid, though this was delayed several times.

Little did we know at the time that the 0.38 per cent of GNI level reached at the time Labor left office would be the peak.

Since then, a succession of major Budget cuts by the Coalition Government have driven our foreign aid contribution down to the point where we are now only giving 0.22 per cent of our GNI.

These cuts fly in the face of the 0.7 per cent of GNI commitment Australia agreed to at the UN in 1970, and which has been repeatedly reaffirmed ever since.

Meanwhile, our counterparts in the UK have recently passed a Bill legally ensuring that they will continue to give at least 0.7 per cent of GNI as aid.

As this happens, Australia quietly retreats into the shadows cast by brighter shores, staring at our feet and mumbling something incoherent about a budget deficit.

Doctors and medical students alike should be outraged.

Our profession is one in which we are privileged to have the opportunity to help people each and every day.

In medical school, we are taught that it is essential to be an advocate for our patients, especially those who have no voice. We must apply this principle to the people of the developing world and fight for effective altruism.

The recipients of Australia's development assistance have no real means by which to communicate their needs with our government, but doctors can take up this mantle. Of course, various advocacy groups are already doing this. However, it is clear that current efforts are inadequate.

We need to face facts - these aid cuts will cost lives. Real people with families will die. Australia's foreign aid provides vital health services in developing countries, as well as emergency assistance to other countries when disasters strike, such as the recent earthquakes in Nepal.

If Australia, one of the most economically developed countries in the world, refuses to provide these funds to countries in our region, who will?

We tend to forget it, but giving aid also benefits us.

For instance, Australia should leverage its expertise as a leader in tropical diseases to fight the epidemic of tuberculosis in Papua New Guinea, or else the consequences might spread to our shores. Instead of diverting our aid money to offshore detention programmes for refugees, we should invest in developing countries to alleviate poverty and assist displaced people whose lives have been torn apart.

It is the responsibility of doctors to advocate for not only the health outcomes of Australian citizens, but those individuals without the good fortune to be born within our sunny borders. Foreign aid is an essential component of Australia's contribution to global health and wellbeing, and must be consolidated rather than compromised.

Nicky Betts is a final year medical student at the University of Western Sydney, and Vice-Chair External of AMSA Global Health.

Just tripping

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

> "The Charlestown shooting was barely over, but this did not faze the free press in California, with both AK47s and automatic Glock pistols being advertised as Father's Day gifts"

Some of life's greatest mysteries have such simple answers.

For instance, have you ever wondered why, when air hostesses take back those hot towels they hand out, they use such a long-handled pair of tongs? Well, I got the answer recently when the gentleman seated alongside me in cattle class used his to address first his neck, then both axillae, and finally his crutch - the latter very thoroughly, I must add.

I am just back from a road trip around western USA, which was heaps of fun and something to put on your bucket list. Yosemite, Zion, the Grand Canyon and the West Coast - with its awe inspiring Redwood forests - are sights you should not miss. I was hard pressed to think of grander scenery in Australia until I recalled my last dive on the Great Barrier Reef.

However, we should be very thankful that in Australia we do not have direct-to-patient marketing of pharmaceuticals as they do in the US.

Cialis, Xarelto, and Humira all flood free-to-air television advertising spots, with Cialis even trumpeting free 30-day samples of its daily pill, surely enough to get any red blooded male over 40 highly excited.

The Charlestown shooting was barely over, but this did not faze the free press in California, with both AK47s and automatic Glock pistols being advertised as Father's Day gifts.

Again, Aussies should be glad we have very restricted access to such military hardware - and I speak as a gun owning cattle farmer as well as a rural GP.

On a positive note, the Americans are much more considerate and polite drivers than most of us, and much more gregarious and most forthcoming in offering advice on local must-do activities.

'Obamacare' was ratified by the Supreme Court while I was in New York and the press praised it - in words that echo the basic mantra of our AMA - as being a step towards accessible, affordable and quality health care for all Americans.

The press in USA, I must say, is more enlightened than many of our Aussie throwback, frequently extolling both the cost, and the health outcome benefits, of proactive preventive primary health care.

Same-gender marriage was backed by the Supreme Court the next day, causing much surprised and joyous celebration among the rainbow coalition. At long last, it ensured them equal rights in all states. I trust our Parliament can now be as enlightened and recognise that sexual preferences are hard-wired into DNA, and must not be legally discriminated against.

On a more worrisome note, the financial pages of the *New York Times* noted the strong support of US pharmaceutical giants for the Trans Pacific Partnership trade agreement, on the grounds that it would be a tool to maintain prices and ensure the longevity of patents.

If you have yet to visit New York, put it on your bucket list too. If a simple country bumpkin like me loves it on his third visit, so will you.

IMGs: then and now

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

In nearly 25 years as a practising doctor, I've been fortunate to have worked with hundreds of overseas-trained doctors or, to be precise, doctors who did their primary medical training outside Australia. They have enriched my professional and personal life, and I have learned much from them. Indeed, many have become life-long friends and colleagues.

These doctors, or international medical graduates (IMGs) as we know them, have made an enormous contribution to the health system over the last couple of decades, especially in rural and regional Australia.

The AMA last published a position statement on IMGs in 2004. Let's consider what was happening over a decade ago. For a start, it was apparent that Australia was experiencing a serious shortage of doctors, and there was a growing need to tackle medical workforce shortages in rural areas in particular. In response, the Government moved to relax the arrangements for recruiting IMGs, and we saw them enter the Australian workforce in large numbers. This situation, perhaps more than anything else, illustrated the shortcomings of medical workforce planning in this country.

There were also problems with assessment processes for IMGs working in Australia.

Many IMGs wanting to start or continue working in Australia faced unnecessary delays in their registration and renewal.

The AMA was also aware that some IMGs were being exploited by employers, sometimes using them in preference to locally trained graduates. Of particular concern was the poor access to supervision and oversight for many IMG doctors working in more isolated clinical settings.

Fast forward to 2015. Twenty five per cent of doctors in Australia are IMGs.

So what else has changed over the last 11 years?

A positive development has been the introduction of nationally consistent standards for assessing and supervising IMGs, and medical colleges now have a clear and mandated role in assessing applicants for specialist positions.

Also, the Australian Medical Council has far better processes in place. Its capacity to conduct examinations has been boosted, and there is now a competent authority assessment pathway.

There have been other beneficial changes, as well.

But one thing that has not changed are the flaws in workforce planning.

Unlike in the 1990s, the issue is not one of too few doctors.

Instead, we now face burgeoning numbers of junior doctors who deserve – but cannot obtain – the training jobs they need to enable them to complete their training. In many respects, we now have a flooded training pipeline.

Publicly available statistics show that large numbers of doctors are employed by health departments around Australia using 457 visas.

At the same time, there are insufficient training positions for the increasing number of Australian medical graduates.

This is an imbalance that has to change.

Recent modelling by Health Workforce Australia indicates that while Australia is likely to suffer from an oversupply of medical practitioners in the next 10 to 15 years, IMGs will continue to be a significant and important part of the medical workforce.

Many continue to work in very challenging environments and need our ongoing support.

In light of the changes since 2004, the AMA Medical Workforce Committee is revising the AMA Position Statement on International Medical Graduates. It will focus on the problems that continue with assessing, recruiting, training and supporting IMGs. I will write about our new document in a future column.

In conclusion, it's essential to remember that in the global profession of medicine, many Australian-trained doctors have benefitted enormously from training and working overseas. I am one of those beneficiaries, and I hope the international cross-pollination of our profession may long continue.

Biosimilar drugs – should doctors be concerned?

BY ASSOCIATE PROFESSOR ROBYN LANGHAM, CHAIR, MEDICAL PRACTICE COMMITTEE

In June, the Australian Parliament passed legislation allowing prescribed biological medicines to be substituted with biosimilar drugs when they are dispensed by pharmacists.

Under the change, the Pharmaceutical Benefits Advisory Committee (PBAC) will assess on a case-by-case basis whether a specific biological medicine can be safely switched for a biosimilar by a pharmacist. As for all prescribed medicines, doctors can still control what medicine is dispensed to their patients by marking 'do not substitute' on the prescription.

Is pharmacist substitution of biologicals a good thing? Or will this pose risks to patient health? And what are biological and biosimilar medicines anyway?

The AMA is satisfied with the regulatory arrangements introduced for biosimilars, but it is important that doctors are aware of the potential implications for their patients. Here's a summary of the key facts.

What are biologicals?

A biological medicine is made from a living organism, typically extracted from a human cell or tissue-based system. Biologicals include:

- hormones used to treat hormone deficiencies, e.g. insulin for diabetes;
- monoclonal antibodies for the treatment of autoimmune diseases and cancers;
- blood products, e.g. for the treatment of haemophilia;
- immunomodulators, e.g. beta-interferon for multiple sclerosis;
- enzymes, e.g. to remove blood clots; and
- vaccines to prevent a number of diseases.

The manufacturing process for biologicals is complex and sensitive to variations because of the nature of the biological substances used and modified. Subtle variations of a biological substance exist between batch preparations from the same manufacturer.

What is a biosimilar?

A biosimilar is not a generic biological medicine.

A biosimilar medicine is highly similar to a biological medicine that has already been approved but for which the patent has expired. Unlike a generic medicine, which is made from the same chemical compounds and has the same chemical structure as the original brand medicine, a biosimilar is not a generic copy of the reference biological medicine.

While a biosimilar's manufacture is based on the same active ingredient as the original biological, by their nature they cannot be identical.

Before a biosimilar can be approved for sale in Australia, any differences between the biosimilar and its reference medicine must have been shown not to affect quality, safety or efficacy through a robust clinical trial process.

Biosimilars, like generic medicines, will be significantly cheaper than the original biological medicine, although not to the same extent given the higher costs needed to invest in clinical trials, manufacturing and post-approval monitoring programs.

There are already biosimilar versions of medicines listed on the Pharmaceutical Benefits Scheme (PBS) being prescribed to patients.

What are the issues?

Biologicals are more likely to cause an immune reaction than chemical medicines.

In turn, small changes in the manufacturing process or composition of a biological may result in the emergence of

> "Is pharmacist substitution of biologicals a good thing? Or will this pose risks to patient health? And what are biological and biosimilar medicines anyway?"

... from p26

immune reactions, even if the agent had previously been well tolerated. For example, in one instance a minor alteration in the manufacturing process of erythropoietin alpha triggered acquired pure red blood cell aplasia in a small cohort of patients.

It is therefore important that effective adverse event reporting mechanisms are in place to ensure that any patterns of adverse events are quickly identified and tracked to the specific biological brand.

Because of the documented variability between biologicals and biosimilars, it is conceivable that adverse reactions may increase with substitution.

Some consumer groups and pharmaceutical companies have argued that allowing biologicals to be switched at the dispensing point will make it more difficult to identify the specific brand if an adverse event occurs.

Government regulation

The Therapeutic Goods Administration (TGA) will remain the regulatory body responsible for assessing and approving a biosimilar as a safe and equally effective treatment compared to another medicine before it can be sold in Australia. The TGA is currently reviewing its assessment guidelines.

Once the biosimilar has been approved by the TGA, the PBAC will also consider if the biosimilar medicine should be listed to allow substitution by a pharmacist under the PBS.

The PBAC has stated that it will not recommend a biosimilar as suitable for substitution unless it is sure of its equal safety and effectiveness.

The PBAC's assessment will include consideration of whether there is available data to support safe switching between the original product and the biosimilar product, and whether it can be safely substituted by a pharmacist at the point of dispensing.

Examples of biosimilar brands available in Australia include:

- Aczicrit, Grandicrit and Novicrit with the active substance epoetin lambda – all have been approved by the TGA but only Novicrit is listed on the PBS; and
- Nivestim, Tevagrastim and Zarzio with the active substance filgrastim – all have been approved by the TGA and all are listed on the PBS.

No biosimilar has yet been approved for substitution by a pharmacist.

What should doctors do?

- When prescribing biological medicines, doctors should ensure they mark the prescription as 'do not substitute' if they have any concerns about the impact on their patients of switching to another brand;
- doctors should discuss this decision with their patients so that patients are also aware they must not allow their pharmacist to substitute the medicine;
- doctors who find out that a pharmacist has substituted a medicine ignoring the 'do not substitute' mark on the prescription should report the behaviour. Under PBS related legislation, this can attract a $2000 fine or 12 months in gaol. Report breaches to the Department of Human Services by phoning 132 290 or emailing pbs@humanservices.gov.au;
- any suspected adverse event should be reported to the TGA:
  - by phone on 1800 044 114;
  - by email at adr.reports@tga.gov.au;
  - online at https://www.ebs.tga.gov.au/ebs/ADRS/ADRSRepo.nsf?OpenDatabase

The AMA welcomes members' views on this issue to president@ama.com.au. Member comments help inform AMA advice and activities.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Not nanny state, just good sense

AMA President Professor Brian Owler has rejected criticism of smoking bans, pub lock-outs, bicycle helmets and other public health measures that are the target of a Senate inquiry into so-called 'nanny state' laws.

Cross-bench Senator David Leyonhjelm, who advocates strongly libertarian views, has taken aim at Commonwealth laws, policies and guidelines he claims restrict personal choice, including restrictions on the sale and use of tobacco, alcohol, marijuana and pornography, as well as bicycle helmet laws, and other measures he considers to be paternalistic.

The Liberal Democrat has won Senate backing to chair a broad-ranging one-year inquiry into what he says is a burgeoning 'nanny state'.

"[What you do is] not the Government's business, unless you are likely to harm another person," the Senator said. "Harming yourself is your business, but it's not the Government's business."

But Professor Owler said such an exceedingly narrow view failed to take account of the effect a person's actions had on others.

"I agree that the Government should not be interfering with choices and behaviours of individuals without reason," the AMA President said. "But, as individuals, we live in a society. As such, the choices and behaviours that we make as individuals affect those around us."

For example, he said, laws against using a mobile phone while driving were considered by some as an intrusion on their individual rights.

But he said people who drove while on their mobile were four times more likely to be involved in an accident, possibly killing or maiming someone else. He said, even if only they were injured, the rest of society still picked up the tab for their hospitalisation, treatment and rehabilitation.

Among Senator Leyonhjelm's targets are pub lock-out laws introduced in King's Cross and the Sydney CBD following an escalation of deadly alcohol-fuelled attacks in the city's major entertainment districts.

"There's no question it's a sort of collective punishment for the guilt of individuals," he told Fairfax Media. "It was a classic moral panic."

But Ralph Kelly, whose son Thomas was killed after being punched in the head in a random attack in King's Cross in 2012, said Senator Leyonhjelm's claim was "absolute rubbish".

Mr Kelly, who with his wife addressed the AMA National Conference last year about their work raising awareness of alcohol-related violence, said the lock-out laws were working to make Sydney safer for revellers.

Professor Owler, who was at the forefront a calls for Government action following to spate of violent street attacks earlier this decade, said doctors saw first-hand every day the tragic effects on people of their behaviour and the actions of others, which was why they were "unashamed champions" for public health.

"Government does have a role to play in making this country a safer and healthier society," Professor Owler said. "It does have a role in regulating and modifying the behaviour of individuals so that the rest of us can be confident that we won't be run over by someone distracted by talking on their mobile phone, or run off the road by a drink driver."

The AMA President said the attack on sensible laws and regulations was dismaying, and added that it was "very concerning" sufficient Federal MPs shared Senator Leyonhjelm's extreme views to enable him to launch his inquiry.

"The existence of this Committee is a distraction from the real discussion of preventive health care and injury prevention that we should be having," he said.

"There should be a clearly articulated approach to prevention.

Health on the hill

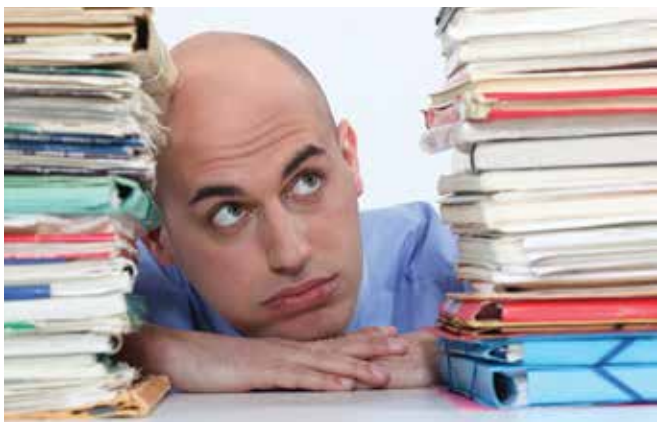
POLITICAL NEWS FROM THE NATION'S CAPITAL

... from 28

"More importantly, we need all those who have a responsibility for prevention, governments at all levels, to live up to their responsibilities for prevention."

ADRIAN ROLLINS

Doubt cast on Govt commitment to cut red tape



The Federal Government has been put on notice to significantly increase its engagement with the medical profession if it is genuine in its ambition to cut medical red tape.

In a scathing assessment of current Government initiatives, AMA Secretary General Anne Trimmer said deregulation work being undertaken by the Health Department and the Health Ministerial Advisory Committee was not informed by the practical experience of doctors and appeared to be of little relevance or value.

The Australian National Audit Office (ANAO) is conducting a review of the Government's implementation of its deregulation program, and has sought the AMA's input.

Surveys of GPs conducted by the AMA have shown that red tape is a major burden on medical practice, with estimates that general practitioners spend, on average, 4.6 hours a week on compliance activities. Across the profession, that was the equivalent of 15 million standard consultations a year.

Ms Trimmer said the AMA had identified and promoted four simple measures that could achieve real reductions in red tape without compromising care, including:

- scrapping PBS authority prescription requirements;
- assigning doctors a single Medicare provider number;
- streamlining Centrelink and Department of Veterans Affairs forms; and
- putting third party forms into electronic format.

Despite this, the Department of Health in its *Health Portfolio Annual Deregulation Report 2014* had nominated a set of initiatives the AMA Secretary General said would have "very little meaningful relevance to our membership, or are of limited value".

She said many initiatives did not appear to be genuinely linked to the deregulation program, such as the replacement of Medicare Locals with Primary Health Networks, and none of the numerous ongoing consultations between the Department and the AMA specifically related to deregulation.

"To the extent that advice may have been sought on some of the initiatives, this was not sought on the basis of tackling red tape," Ms Trimmer said. "The AMA has not been asked by the [Department] to put forward ideas on red tape reduction, and it would appear that the deregulation program is being managed by the [Department] with very minimal stakeholder involvement or input."

She said similar concerns applied to the deregulation work being undertaken by the Health Ministerial Advisory Committee (MAC).

The AMA official told the Audit Office there was "a very low level of awareness of the MAC, and no apparent mechanism through which it interacts with stakeholders or seeks their views".

In particular, she said the committee did not include representatives of small to medium-sized medical practices, which bore much of the red tape burden.

"This, and the absence of organisational representation, makes it difficult to understand how the MAC can be expected to provide the type of robust policy advice the Government needs on red tape reduction," Ms Trimmer said, adding that clinical input was "critical" for the development of effective deregulation policies.

The ANAO is due to table its report in the first half of 2016.

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Future Fund controversy shadows top research body appointments

The man charged with heading the Federal Government's review of the Medicare Benefits Schedule has been appointed to a three-year term on the National Health and Medical Research Council.

Sydney University Medical School Dean Professor Bruce Robinson is among 13 people appointed to the NHMRC by Health Minister Sussan Ley to provide expert advice on health, research ethics and funding.

"The new Council provides an impressive cross-section of high-level skills and experience which will be extremely valuable for this key organisation," Ms Ley said.

The appointments come soon after a change of leadership at the NHMRC helm following the replacement of long-serving chief executive Professor Warwick Anderson with Professor Anne Kelso.

Changes at the top of the NHMRC have come at a sensative time, with accusations the Government has sidelined the research body from a central role in helping set the direction for the controversial Medical Research Future Fund.

The Federal Government was accused of setting the $20 billion MRFF up as a slush fund after it was revealed that, instead of having the central role in deciding how MRFF funds would be allocated, the NHMRC will now be just part of a Government-appointed expert advisory committee.

AMA President Professor Brian Owler said the arrangement was concerning.

"We don't want to see this money being used at the whim of the Finance Minister," Professor Owler said.

Shadow Health Minister Catherine King said that, "as it stands, the Bill is creating what could very likely become another Government slush fund: $20 billion in funding with no independent oversight of how the earnings from that money is to be spent," she told Parliament.

But Ms Ley said the strategy for the MRFF would be developed with reference to the NHMRC's strategy for medical and public health research, and the priorities it set.

"The Medical Research Future Fund is being set up to deliver national projects and priorities, and it will naturally work hand-in-hand with the NHMRC and other areas of Government to deliver that," the Minister said.

Among those appointed, or re-appointed, to the NHMRC are Professor Sandra Eades, Adjunct Professor Graeme Samuel, Professor Ian Olver, Professor Brendan Crabb, Professor Sharon Lewin, Professor Kathryn North, Professor Michasel Kidd and Professor Sharon Lewin.

ADRIAN ROLLINS

Call to sideline NHMRC on wind farm health effects

The Federal Government has been urged to sideline the nation's peak medical research body and set up a stand-alone scientific committee to investigate the health effects of wind farm noise.

The Senate Select Committee on Wind Turbines, chaired by Democratic Labor Party Senator John Madigan, has recommended the establishment of an Independent Expert Scientific Committee (IESC) on Industrial Sound to research the health effects of wind turbines "and any other industrial projects which emit sound and vibration energy" and develop a national noise standard for wind farms.

The IESC, which along with a National Wind Farm Ombudsman, would be paid for through a levy on wind farm operators, would provide advice to State governments on the health effects of any proposed or existing wind farm, and the Senate committee called for states that did not accept expert advice or adopt the national noise standard to be overruled by the Commonwealth.

The recommendations are in keeping with Government hostility to the wind power industry.

Senior Government leaders including Prime Minister Tony Abbott and Treasurer Joe Hockey have made no secret of their distaste for wind farms, and the Government recently insisted on a major cut in the national Renewable Energy Target, as well as directing the Clean Energy Finance Corporation to stop investing in wind energy projects.

The Senate Committee report will add to political tensions around renewable energy policy, which is shaping as a key battleground for the next Federal election after Labor declared it should provide 50 per cent of electricity by 2030.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from 30

Across the world countries are ramping up their investment in wind power. China has trebled its capacity since 2010 and wind now supplies enough energy to power 100 million homes. In the United States, more than 100 projects are underway and the US Department of Energy estimates it will provide 20 per cent of electricity by 2030.

The importance of renewable energy technologies was underlined by President Barack Obama who, in a speech overnight, declared power plant operators must cut slash carbon dioxide emissions by 32 per cent from 2005 levels by 2030.

"No challenge poses a greater threat to our future and future generations than a change in climate," President Obama said.

"This is one of those rare issues, because of its magnitude, because of its scope, that if we don't get it right, we may not be able to reverse. There is such a thing as being too late."

The Senate Select Committee, which included cross bench senators David Lleyonhjelm and Bob Day, expressed disappointment at the AMA's stance on the health effects of wind power. In its Postion Statement on the issue, the AMA has said there is a lack of evidence to back claims that the sound generated by wind farms affects human health.

"This is regrettable given the influence that the Association's views have on the Australian medical community," the Committee said. "It is hardly surprising if general practitioners turn a blind eye to, or downplay, the complaints of those who claim to be suffering the effects of wind turbines when the peak body's assessment of the authenticity of these impacts is so dismissive."

The Committee also cast doubt on the reliability of National Health and Medical Research Council investigations of the issue, after the nation's peak research body reported a lack of evidence to support claims of the harmful effects of wind turbines.

It proposed the IESC take the lead on conducting research on the issue, dismissing the NHMRC's efforts in the area as "manifestly inadequate".

But in a dissenting report, Labor Senator Anne Urquhart shredded the credibility of Sarah Laurie, who the majority senators relied heavily upon for evidence of the adverse health effects of wind farms, as an authority on the issue.

Senator Urquhart pointed out that Ms Laurie had voluntarily given up using the title Doctor following a complaint to the Australian Health Practitioner Regulation Agency in 2013, and that numerous judges and tribunals before which she had appeared had rejected her capacity to provide expert or authoritative evidence.

In a hearing on the Stony Gap Wind Farm last year, Ms Laurie called for investigation of the theory that some people were so exquisitely sensitive to certain frequencies that from Australia they could detect an earthquake in Chile.

The judge hearing the case found that Ms Laurie's testimony did not "contain evidence of a causal link between contemporary operating wind turbines and the kind of health problems reported by deponents".

The judge said that Ms Laurie "rejects all studies...which are not consistent with her theories".

A Canadian Environmental Review Tribunal hearing a case regarding the Dufferin Wind Power Project considered that the evidence presented to it by Ms Laurie "does not indicate that she has conducted a comprehensive review of all literature, nor that she has the expertise to assess the sufficiency of the research methodology in individual research studies".

Senator Urquhart said that, in contrast to the lack of scientific evidence linking wind farms to adverse health effects, the evidence on the health effects of other forms of power generation were well-established.

While not dismissing the concerns of those who believed their health had been harmed by wind farms, the Labor Senator said many of the symptoms complained about were very common in the general population.

ADRIAN ROLLINS

Emergency: real stories from Australia's emergency department doctors

Edited by Dr Simon Judkins

2015, Penguin Random House, RRP $32.99, 260 pages

REVIEWED BY **ADRIAN ROLLINS, EDITOR, AUSTRALIAN MEDICINE**

It's not surprising so many television dramas are set in hospital emergency departments, where life is portrayed at being lived at an intensity well beyond the norm.

In this celluloid world, every day is filled with raw human emotions, adrenaline-pumping action, wrenching life-and-death decisions, and a heady mix of tragedy and triumph against the odds.

This may be one of the rare instances where reality matches – and in some cases, exceeds - the imagination of the dramatists.

In *Emergency*, 26 physicians give outsiders an intriguing glimpse into what it really means to be on the medical frontline.

In well-crafted and frequently moving accounts, they relay both the what of the job – retrieving everyone from toddlers to octogenarians from the brink of death – and its consequences: the lasting emotional effects of these experiences, which are often pushed to one side in the heat of the moment, but resonate loudly in the all-too rare moments for quiet reflection.

Take the story of the emergency doctor dangling over the edge of a conveyor belt to comfort a trapped worker whose legs have been crushed and amputated in a garbage compactor.

Or the physician who finds himself wading through puddles of blood to treat a stream of bullet-riddled gang members brought to hospital from the badlands of Cape Town.

Or the gut-wrenching realisation for a resuscitation team that, despite their herculean efforts, they have been unable to revive a two-year-old who strangled herself playing with a cord dangling from the blinds above her bed.

The stories in the collection traverse the breadth and depth of emergency medicine practice.

Readers are transported from major Australian city hospitals to the PNG highlands, to Uluru, Sydney Harbour and bleak industrial estates.

They witness the exhilaration that comes from saving a life, and the trauma that can accompany losing one.

They also get a glimpse into the challenges of practising this exacting craft – the marathon hours, the high levels of stress, the frustrations caused by inadequate resources, the seemingly endless demand for help, and the lack of time and space to reflect.

But what shines through, and what television scriptwriters tend to overlook, is the commitment to patients that overwhelms all else.

It is what drove Dr Mark Little to try just one more time after 75 minutes of failed attempts to revive a 60-year-old builder who had suffered a cardiac arrest – this time to succeed.

It is apparent in the tortured reaction of staff to the death of a toddler, despite their valiant attempts.

"This is fucked," Dr Judkins recalls one nurse saying. "Why does this happen? This is not right."

"This is why we do the job," he responds, articulating his philosophy that, while they were unable to save this particular life, they had the skill to save others, "and that's incredible".

AMA Vice President Dr Stephen Parnis, an emergency physician in Melbourne, says it is not just about saving lives.

Relating the experience of advising and supporting a favourite uncle during a four-year battle with bile duct cancer, Parnis reflects that some of the most rewarding aspects of the job come from caring for the dying: "To ease their anxiety and pain, to calm their fears, to share that time with them, is a privilege".

Practising emergency medicine is not for everyone, and the risk of burnout can be high.

The hours are long and often unsociable – after all, medical emergencies can happen any time – and the demands can be relentless.

But it is clear that for those who shared their experiences in *Emergency*, the connection with patients, the chance to save lives - or, on occasion, to ease death - and the satisfaction that comes from working as part of a well-drilled team, more than make up for these inconveniences.

Higher drug price fears in trade deal fall-out

Health groups remain concerned the massive Trans-Pacific Partnership trade deal will push up the cost of medicine and hamper public health initiatives despite indications United States negotiators are prepared to give ground on controversial intellectual property protections.

While the future of the controversial trade pact is clouded following the failure of officials from 12 nations to seal an agreement in Hawaii last month, reports have emerged that the US is willing to back down on demands that data used to produce biologic medicines be subject to a 12-year exclusivity clause.

The clause would delay the competition pharmaceutical companies would face from cheaper generics, adding billions of dollars to their bottom line.

On the eve of the Hawaii talks, Trade Minister Andrew Robb told Fairfax Media he was pushing for the data exclusivity period to be slashed to five years, and it is understood the United States' chief negotiator, US Trade Representative Michael Froman, was considering a counter-proposal for a base period of five years, followed by a three-year extension contingent on "certain circumstances".

The secretive nature of the talks has meant that most observers have had to rely on information gained by websites like Wikileaks for information about the direction of negotiations on the deal which, if concluded, will encompass about 40 per cent of the global economy.

Mr Robb said that although the deal was not concluded at Hawaii, "we are definitely on the cusp".

"While nothing is agreed until everything is agreed, I would say we have taken provisional decisions on more than 90 per cent of issues," the Minister said.

But he admitted data protection for biologic medicines was among a number of "big outstanding issues" to be resolved: "You've got to set a balance somewhere between people getting a return on innovation on investment, and enabling competition to bring prices down for the rest of the community."

Biologic medicines are derived from biological sources, and though they comprise only a fraction of drugs listed on the PBS, many are extraordinarily expensive, with a course of treatment often costing hundreds of thousands of dollars. In 2013-14, they accounted for a quarter ($2.3 billion) of PBS spending in 2013-14.

While the US may have given ground on access to biologic data, the AMA and other health groups remain concerned that other clauses in the proposed trade deal, including provisions allowing pharmaceutical companies to "evergreen" drug patents and giving investors scope to block governments taking public health measures, could undermine health care.

The AMA Federal Council has called on the Federal Government to reject "any provisions in trade agreements that could reduce Australia's right to develop health policy and programs according to need".

The Association said it was concerned that aspects of the proposed TPP could be used to attack key health policies and measures including the PBS and the cost of medicine, food labelling and tobacco control laws, restrictions on alcohol marketing, the operation of public hospitals and the regulation of environmental hazards.

Among the most controversial provisions are investor-state dispute settlement (ISDS) procedures that would enable corporations to mount legal action against government policies and laws they felt harmed the value of their investment or future profits.

Tobacco giant Philip Morris Asia used just such provisions in a 1993 investment agreement between Australia and Hong Kong to challenge Australia's world-first tobacco plain packaging legislation in the courts and seek compensation, arguing that the policy undermined the value of its investment by 'expropriating' its trademarks and branding.

It is understood that Australia is arguing that health and environment policies, as well as the Pharmaceutical Benefits Scheme, be made exempt from ISDS provisions.

In addition, the TPP includes proposals demanding the removal of technical barriers to trade – provisions which companies have used to challenge regulations such as alcohol warning labels, alcohol excise, and front-of-packet food labelling.

There are also concerns market access rules in the TPP may be used to restrict government support for public hospitals and other health services by requiring that there be competitive neutrality between such entities and private health providers.

Medical charity Medecin Sans Frontieres is also apprehensive about the deal.

It said that without major changes in the Hawaii talks, the deal would have a "devastating impact" on global health.

MSF was particularly concerned about provisions it warned would "strengthen, lengthen and create new patent and regulatory monopolies for pharmaceutical products that will raise the price of medicines and reduce the availability of price-lowering generic competition".

It said some of the most concerning provisions centred on patent evergreening, which would force governments to grant drug companies additional patents for changes they made to their medicines, even if these were of no therapeutic benefit.

ADRIAN ROLLINS

Extended warranties – don't bother!

BY DR CLIVE FRASER

In 2007, the United States' housing bubble burst and precipitated an economic phenomenon that became known as the Global Financial Crisis.

Fearing a recession, the Australian government embarked on a program of economic stimulus in February 2009.

There was the ill-fated Home Insulation Program which caused the death of four installers and many more house fires.

There was also a very generous Small Business Tax Break which gave businesses a 50 per cent tax deduction for assets in addition to normal depreciation allowances.

Environmentally, I know I should have gone with the home insulation, but I didn't like the thought of cowboys climbing around in my roof and messing up my wiring.

So I did my bit for the Australian economy and bought a new car.

It was not made in Korea, so it didn't come with a five- or seven-year warranty.

I would be covered for three years, which curiously coincides with the parliamentary electoral cycle.

I've never been a fan of extended warranties, which are very lucrative for retailers and often are sold with a 100 per cent mark-up.

But that 50 per cent Australian Taxation Office tax deduction persuaded me to spend another $1500, and I extended my manufacturer warranty by another three years, matching the Koreans.

It's now 2015 and that extended warranty is about to end.

I've had my car closely inspected for oil leaks and broken bushes and have found nothing to repair, other than the radio, which has developed a gremlin.

After 40 minutes the sound starts breaking up and the broadcast becomes inaudible.

The station most affected by this has no ads and full coverage of the cricket, so this is a problem which just has to be fixed.

At this point I called the insurance company who under-wrote the policy and they reassured me that my radio was covered by their warranty, and all that I would need to do is take my car to a local dealer.

I would have no problems getting my car repaired, or so I thought.

Trouble began when the dealership service advisor told me that their dealership only honoured their own extended warranty, and that all of the services would have to be done at their dealership.

True about their policy, not true about mine.

Next problem was that he wanted me to sign a form charging myself $130 for them to take a look at my car.

I protested that it was a warranty issue and that I was covered.

There was no retreat on their part.

As a psychiatrist I'm well accustomed to dealing with individuals lacking insight, so I remained calm.

Besides, the problem with the radio was intermittent, and it wasn't even misbehaving at the dealership.

I had the presence of mind to collect some tangible evidence by recording the distorted sound on my phone, which led to an immediate retreat by the dealership who now, without even sitting in my car, was offering to replace my radio ($1300 for parts plus fitting).

They would need to sight my service book (again for the second time) and, oh, I would need to show them every receipt for every service since 2009.

I did remind them that my problem was with the radio and not with the motor or gearbox, but they were insistent. As they rightly pointed out, that was a condition of my policy which I had not read.

Undaunted, I retrieved every skerrick of information they requested with just the right amount of cockroach poo on each page to prove that they were all originals.

So was the extended warranty exercise worth it?

No way!

PS My car radio sells for $50 on eBay.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

O'Leary Walker – the future is Clare

BY DR MICHAEL RYAN

You just know that the wine made by two passionate good mates with a pedigree and longevity in the wine game is going to be good.

David O'Leary and Nick Walker had both worked in the service of large multinational wine teams for many years, and in 2000 they heeded the call of a change back to hand crafted boutique styles of winemaking. From this, O'Leary Walker Wines was born.

Both are graduates of the University of Adelaide's Roseworthy Agricultural College, and have shone since. David has worked for some of the big companies in Australia such as Thomas Hardy and Sons and Chateau Reynella, as well as in France and California. In 1988 he won the Jimmy Watson Trophy (for the best one-year dry red wine), and won recognition as the International Red Winemaker of the Year in 1992 and 1994. While he has won accolades for his reds, Clare Valley Riesling has been an abiding passion for him.

Nick has developed great affinity with sparkling wine through his work at Wolf Blass and Yellowglen. He is third generation winemaker and has deep affection for Eden Valley Riesling.

It is a testament to their skills that, together, they have received more than 300 gold medals and 60-odd trophies for their wines. It is an amazing tally in just 14 vintages.

They work tirelessly in the vineyard, nursing their fruit like expectant mothers.

It always begins in the vineyard. Eighteen thousand cases of wine divided between nine different product lines are made using fruit from 70 per cent of the vineyards owned by David and Nick. The remaining 30 per cent is made using fruit from high quality growers from the Adelaide Hills (Sisters Vineyards), McLaren Vale, The Barossa and Coonawarra.

Their wines have always been value for money. They cannot compete with the corporates, but then again, they don't really want to. Their philosophy of "let's make great wine, give it some character and have some fun" echoes through to the end product.

Unfortunately, though, they – like many a boutique winemaker – face a constant threat from taxes and rising transport costs.

WINES TASTED

1. Hurtle Sparkling Pinot Noir

70 per cent Chardonnay, 30 per cent Adelaide Hills. Light golden yellow in color. The nose delicately unfurls its strawberries and cream nuances and hints of yeasty biscuits. The palate is flavoursome, with a subtle acid and tannin effect. A very cleansing aperitif/dry style. Will cellar for five years and be awesome.

2. 2015 Watervale Riesling Clare Valley

Light yellow, with hints of green tinges. Lemon-lime notes with mild oiliness fill the bouquet. A lush Riesling with great acid backbone; but not sweet. Awesome with raw Haloumi cheese.

3. 2015 Adelaide Hills Sauvignon Blanc

Very pale yellow-green. Hints of white peach with grassy floral notes. Good upfront palate with a very dry finish. Flathead or Jewfish fillets would suit.

4. 2013 Cabernet Sauvignon Malbec Clare Valley

This is a new wine. Nice alluring purple-red colors. Cassis fruits with violets and Cabernet dust. The nose evolves into the darker fruit spectrum. The fruit is generous with good tannin structure. The Malbec is a great addition, filling in some anterior palate and adding floral notes. Organic pork on the rib with celeriac mash went well. Cellar some five years

5. 2012 Clare /McLaren Vale Shiraz

Garnet red, with some ageing brown colors evident. The nose wafts dark stewed prunes, black olives and hints of tobacco. Great fruit in the anterior palate that lingers and marries with subtle silky tannins. Venison and blackberry/juniper jus and mash.

AMA Member Benefits

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

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

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

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

Careers Advisory Service: Your one-stop shop for information and resources to help you navigate through your medical career.

CPD Tracker: Record your continuing professional development (CPD) online with the AMA's CPD Tracker, a free service for members.

Amex: American Express is a major partner of the AMA and offers members special discounts and extra rewards on a range of credit cards, merchant services and offers for existing AMA cardholders.

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

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

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

OnePath: OnePath offers a range of exclusive insurance products for AMA members.

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

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

Not a member?

Join now to discover the representation, services, resources and benefits available to members:

www.join.ama.com.au/join