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National Conference success

Prime Minister delivers keynote address

INSIDE

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AMA

AMA NATIONAL CONFERENCE SPECIAL EDITION

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In this issue

Cover pic: Prime Minister Malcolm Turnbull addressing AMA National Conference

National Conference photos by Lightbulb Studio

Doctors caring for doctors

BY AMA PRESIDENT DR MICHAEL GANNON

The health of doctors, especially our mental health, has been very topical in recent weeks.

It was a major focus at the AMA National Conference in late May, and it went viral on social media through the Crazy Socks for Docs awareness campaign, which was pioneered by Melbourne cardiologist, Dr Geoffrey Toogood.

Following National Conference, Minister Hunt announced a $47 million suicide prevention initiative, with $1 million set aside specifically to support mental health and reduce suicide in the health workforce. This was most welcome.

I have since written to the Minister about programs for mental health suicide prevention in the medical workforce.

I stressed to the Minister the importance of having the mandatory reporting requirements under the National Law amended, so as to not dissuade medical practitioners from seeking necessary medical treatment or assistance.

It is well known that doctors are at greater risk of suicidal ideation and death by suicide.

So far this year, we have lost several colleagues to suicide – and these are not isolated incidents.

While there is a wide range of factors involved in suicide, we know that early intervention could be critical to avoiding many of these tragic losses.

Unfortunately, the reality is that there are significant barriers, real and perceived, that prevent some doctors from seeking access to formal health care.

The AMA is working to change this situation, and is currently working with the Medical Board of Australia to establish accessible and robust doctors' health services across the country.

One of the key barriers that the AMA has identified to accessing care is mandatory reporting.

Mandatory reporting for doctors was introduced in NSW in 2008, and then into the National Law for all practitioners in 2010.

The intention of the legislation was to ensure the protection of the public by requiring doctors and other health practitioners to report colleagues under defined circumstances.

The legislation intentionally created a very significant bar for reporting by stating that only matters of grave significance should be reported to the regulator.

One of the requirements for mandatory reporting is to report on health and impairment. This obligation applies to both colleagues and treating doctors.

The AMA, medical colleges, and the medical defence organisations have been concerned for some time that this provision creates a barrier to health professionals in accessing health care, particularly in relation to mental illness.

The lived experience of doctors' health advisory services across the country confirms these fears.

An extensive study of over 12,000 doctors undertaken by beyondblue in 2013 revealed that one of the most common barriers to seeking treatment for a mental health condition were concerns about the impact of this on medical registration.

The Western Australian Government recognised this concern and after dogged, persistent, and forceful representation from AMA WA over many months, created a provision in their legislation to exempt treating practitioners from the requirements of the Act in WA.

While it has been difficult to collect clear evidence of the impact of the mandatory reporting provisions on doctors seeking treatment, the AMA, doctors' health services, medical colleges, and the medical defence organisations receive feedback from doctors regarding their fears about seeking medical treatment.

We know anecdotally of cases of doctors travelling to WA for treatment.

Of great concern, it is very clear that some doctors are actively avoiding medical care, where possible, out of fear of the mandatory reporting obligations.

The Western Australian exemption has not made a material difference to the rate of mandatory notifications in that jurisdiction.

The Independent Review of the National Registration and Accreditation Scheme for health professions commissioned by the COAG Health Council in 2014 listened to the concerns of the medical profession and other groups, recommending that the National Law to be amended to reflect the same mandatory notification exemptions for treating practitioners established in the Western Australian law.

As health practitioners, we know the dangers of delaying access to medical treatment or of only providing limited information.

This risk is particularly pronounced with mental illness, where delaying treatment can result in a person ending up with a far greater level of impairment.

As such, we believe the current legislative arrangements are not protecting health practitioners and, equally importantly, they are failing to protect the public.

In my letter to him, I told Minister Hunt it is time for Health Ministers in the seven jurisdictions (excepting WA) to act on the recommendation of the 2014 review report. I am hoping for his support on this most important matter.

Obesity Epidemic: Time for a rethink. Time for action. Time for leadership.

BY **AMA VICE PRESIDENT DR TONY BARTONE**

There is no shortage of axioms we associate with this topic. "Obesity is a life style disease." "It is a matter of choice." "It's a disease of modern society." "It's a matter of too much in and not enough out." Right? If only it was that simple. The only thing we can hand-on-heart truly say is that it is a multifactorial problem that requires a multi-pronged approach.

Recently at the AMA National Conference in Melbourne, I had the pleasure of being part of a panel (https://natcon.ama.com.au/session/tackling-obesity) discussing the multiple facets of what is the obesity epidemic and what needs to happen if we are to curb this rapidly progressing threat to our lifestyle and our health outcomes.

The panel facilitated by Professor Brad Frankum included Professor Stephen Duckett, Professor Steve Allender, Jane Fleming OAM; Mr Ahmad Aly, Dr Geoffrey Annison.

What was clear from the discussion was that the problem is immense. With two-thirds of Australians either overweight and or obese we are under no illusion. Recent Australian Institute of Health and Welfare data shows that it is even greater among men where there appears to be a social acceptance around their significant excess weight.

However, what is clear from the discussion is that we need to start looking at obesity as more than just an individual condition. We need to look at it at various levels, with many different strategic approaches focusing at individual, community and public health levels, as well as at government and regulatory perspectives, if we are going to achieve changes.

We need to seriously consider the evidence emerging that it is a biological disease; one that has its underlying components in genetic predisposition and one that has its expression in an obesogenic environment that is modern society.

Furthermore, this emerging body of opinion makes the point of the existence of a primitive response mechanism of our bodies to maintain and resist attempts at dieting, defending our weight through a raft of physiological and hormonal changes in response to the weight loss and defending the set predetermined weight. Hence, we can understand the resultant yo-yo weight loss/gain our patients report in response to many attempts at losing weight.

Clearly, prevention is extremely crucial but is not the sole solution. However its role cannot be diminished. It is cheaper to prevent a problem than to solve it. Being a GP, this is firmly underpinning all our efforts in lifestyle advice and behaviour modification that we discuss with our patients. GPs are ideally positioned to initiate the conversation with our patients and assists our patients with their journey in dealing with their situation. Furthermore, GPs, I believe, have a unique place in the communities they are part of and need to lead and be a part of the community solution.

The issue of a sugar tax came under the spotlight. Even though evidence was presented by Professors Allender and Duckett that a sugar tax directly led to modifying or a change in consumption behaviour and to a lesser extent to a reduction in weight (particularly in the Mexico example), such evidence was ignored by Dr Annison of the Food & Grocery Council who still, along with others, believes that moderation of intake and appropriate lifestyle choice is the sole solution to the problem.

Prof Duckett beautifully made the point that he felt a sugar tax was inevitable. Political overtones from the sugar production electorates would be a significant obstacle in the short term. He did make the point that if the politicians representing these electorates, which also have some of the highest levels of obesity, did not recognise the impacts on the health of their constituents, and did not make the hard decisions, why on earth are we paying them. The importance of top-line government/industry measures was further emphasised, as was more robust food labelling requirements.

Effort in this space must be proportional to the size of the problem. Prof Allender illustrated the comparison with a viral global epidemic that led to two-thirds infection rate with a resulting 20-year life expectancy outcome. The border response at our airports in the face of a possible virus would be absolutely enormous and immediate

Communities need to be empowered to develop solutions to lead the change. Studies are showing that a local community level reduction of 5 per cent in obesity in children, over a two-year timeframe, can lead to immediate health improvements and a reduction in the burden of mental health issues.

The appropriateness of bariatric surgery as an intervention in obesity needs to be well understood and supported by public health and government interventions, especially when it comes to public hospital funding. It is clear that bariatric surgery is not an isolated intervention but part of a suite a measures that is a lifelong contract by the patient.

AMA's forward direction examined at National Conference

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

Another AMA National Conference over with a stimulating and varied program, including appearances from the political leadership. It is rare to have a full hand of senior politicians – the Prime Minister, Health Minister, Minister for Ageing and Indigenous Health, Leader of the Opposition, Shadow Health Minister, and Leader of the Greens. It reinforces the fact that health is front and centre of national politics and will remain there as the next Federal election approaches.

Beyond national politics the Conference considered policy issues as diverse as obesity, organ and tissue donation, and the important topic of doctors' health. It was pleasing to hear the announcement by Health Minister Greg Hunt that the Government would commit funding to assist in addressing the issue of the mental health of doctors and medical students. This will form part of a larger piece of work that the AMA is embarking on to develop a framework for doctors' health and wellbeing.

In a year when there is no AMA election (as is the case in the odd-numbered years) delegates have more freedom to consider the policy topics, away from the politics of an election. Delegates have the opportunity to meet informally, as they did over breakfast on Sunday, when groups of members with interests in common came together to share a meal. As one psychiatry delegate commented, it provided a great opportunity to meet with other psychiatry members to realise shared interests and passions.

It was encouraging that members who had never before attended a National Conference were able to participate and see first-hand the work of the AMA. With the move in 2016 to representation from among practice groups, a more diverse representation of members is now supported to participate.

At the Annual General Meeting held during National Conference, the Chair of the Board, Dr Iain Dunlop, and I reflected on the year that was 2016. It was a strong year of medico-political advocacy and member engagement which can be seen in more detail in the Annual Report, available through the website.

I reported on the inaugural Future Leaders program, held in Canberra in early August. Calls for applications are currently open for doctors within the first five years of taking up a leadership position in a State, Territory or Federal AMA. The AMA Board is committed to investing in the development of the next generation of AMA leaders – I encourage you to apply if you qualify. Applications and selection criteria are available through the website.

At the Annual General Meeting the Chair announced to members the decision of the Board, taken after considerable research and reflection, to sell and lease back AMA House in Canberra. The Board took the view that more flexible investment of the capital tied up in the building would provide a better return on members' funds. The building is fully capitalised following an extensive upgrade to its infrastructure over the past four years. A sale is likely later in 2017 following a marketing campaign.

For those who were not able to attend National Conference, this edition of *Australian Medicine* provides a good overview.

Obesity Epidemic: Time for a rethink. Time for action. Time for leadership.

Physical activity is equally important but the role of gyms as being the sole solution is being beautifully challenged by the work of people like Jane Fleming. Participants aged between 18 and 87 frequenting her community-led physical activity programs, reveal the success of a program deserving closer attention and more support.

Fearless, strong leadership from the very top is required in this space. National governments and authorities can provide the coordination. But there needs to be leadership to facilitate a multi-pronged suite of policy and other interventions focusing at every level in the discussion – from Government right down to the individual choices and response. Our position statement outlines a suite of measures and initiatives at every level and no one, single measure is more important or acceptable in isolation. It does provide a pathway or a roadmap to guide advocacy and the basis for further engagement. Ultimately, every part of the medical profession has a role to play in leading their community and their profession in the future solution to this epidemic of the 21st century.

Service acknowledged at the highest levels

AMA President Dr Michael Gannon greets Prime Minister Malcolm Turnbull and leads him into National Conference to deliver the keynote address.

Prime Minister Malcolm Turnbull put it in a nutshell when he told doctors they were dedicated to service.

Addressing the AMA's National Conference in Melbourne on May 27, Mr Turnbull captured the theme of the three-day event when he put down his speaking notes to express appreciation for the medical profession.

"You've committed yourselves to a life of service – undiluted. A commitment. A compassion. We thank you for it," he said.

"Our health system is the envy of the world. Our skilled doctors, our nurses, all your allied professionals, work tirelessly to give the best possible care and your Government thanks you for that.

"Thank you for your dedication, thank you for your professionalism, thank you for your compassion.

"We will match you with a commitment to ensure that you have the resources at every level to continue to deliver the practical love that keeps Australians well."

The Prime Minister was the star attraction at the conference, which was bursting with high-profile and influential speakers who gathered to further the debate on the nation's healthcare policies.

Opposition Leader Bill Shorten addressed the conference and also thanked the medical profession for its commitment.

But he added his observation the Government was trying to silence doctors with its staggered thawing of the Medicare rebate freeze.

"If you like, it's the minimum they can get away with paying to keep people silent," Mr Shorten said.

"It's like cash for no comment.

"I believe the Government has got a calculus here. What is the minimum they can pay to make healthcare issues go away as an election point?"

The AMA has praised the Budget decision to lift the freeze, while also noting the announcement wasn't everything doctors had hoped for.

AMA President Dr Michael Gannon added that the Government – or any political party – should not be fooled into believing the AMA will be quiet about advocating for issues it believes in.

Health Minister Greg Hunt repeated his praise for doctors while again outlining his plan for the national health system.

Shadow Health Minister Catherine King expressed Labor's commitment to public hospital funding and to an immediate blanket lifting of the Medicare rebate freeze.

Greens Leader Richard Di Natale, a doctor himself, poured praise on the profession – noting the strong and positive stance the AMA has taken on marriage equality, while also delivering a caution over messaging around climate change policy.

Minister for Indigenous Health and Aged Care Ken Wyatt joined in on two policy sessions; Olympic and Commonwealth Games athlete Jane Flemming illuminated a panel on tackling obesity; news and media personalities Paul Bongiorno and Julie McCrossin moderated separate policy sessions; and actors presented an excerpt of a new play *Women Doctors in War.*

Beyond the valuable contributions the high-profile personalities made to the National Conference, the event was also well-served by a string of other guest speakers and panellists, as well as by the AMA leadership.

The conference addressed in detail many of the serious issues confronting the medical profession, including doctors' health and wellbeing; disease and threats beyond borders; organ donation; obesity; health care in violent situations; and tobacco control.

CHRIS JOHNSON

AMA a key player in federal politics

Dr Michael Gannon addresses National Conference.

AMA President Dr Michael Gannon opened the 2017 National Conference letting delegates know that while the past 12 months had been eventful, much had been achieved in the realm of health policy.

He continued with that theme throughout the three-day event in Melbourne, which brought together not only the elite of the medical profession but also the highest level of Australian political leaders.

"The AMA is a key player in federal politics in Canberra. The range of issues we deal with every day is extensive," Dr Gannon said.

"Our engagement with the Government, the bureaucracy, and with other health groups is constant and at the highest levels.

"Our policy work is across the health spectrum, and is highly regarded.

"The AMA's political influence is significant."

Describing the political environment over the past year as volatile – which included a federal election and two Health Ministers to deal with – Dr Gannon said the AMA had spent the year negotiating openly and positively with all sides of politics.

"Our standing is evidenced by the attendance at this conference of Prime Minister Malcolm Turnbull, Opposition Leader Bill Shorten, Greens Leader Senator Richard Di Natale, Health Minister Greg Hunt, Minister for Aged Care and Minister for Indigenous Health Ken Wyatt AM, and Shadow Health Minister Catherine King," he said.

"Health policy has been a priority for all of them, as it has been for the AMA."

While the Medicare rebate freeze was the issue to have dominated medical politics, there are still more policy areas to deal with in the coming year.

The freeze was bad policy that hurt doctors and patients.

"I was pleased just weeks ago on Budget night to welcome the Government's decision to end the freeze," Dr Gannon told the conference.

"The freeze will be wound back over three years. We would have preferred an immediate across the board lifting of the freeze, but at least now practices can plan ahead with confidence.

"Lifting the freeze has effectively allowed the Government to rid itself of the legacy of the disastrous 2014 Health Budget.

"We can now move on with our other priorities... We will maintain our role of speaking out on any matter that needs to be addressed in health."

Dr Gannon said while the Medicare freeze hit general practice hard, it was not the only factor making things tough for hardworking GPs.

General practice is under constant pressure, he said, yet it continues to deliver great outcomes for patients.

GPs are delivering high quality care and are the most cost effective part of the health system.

"One of the most divisive issues that the AMA has had to resolve in the past 12 months is the Government's ill-considered election deal with Pathology Australia to try and cap rents paid for co-located pathology collection centres," Dr Gannon said.

"We all know that our pathologist members play a critical role in helping us to make the right decisions about our patients' care. They are essential to what we do every day.

"It was disappointing to see the Government's deal pit pathologists against GPs.

"The recent Budget saw the rents deal dumped in favour of a more robust compliance framework, based on existing laws. This is a more balanced approach."

Other issues the President highlighted as areas the AMA is having significant influence included: Health Care Home Trial; the Practice Incentive Program; My Health Record; Indigenous Health; After-Hours GP Services; the MBS Review; public hospitals; private insurance; and the medical workforce.

CHRIS JOHNSON

AMA lends support to build the Indigenous health workforce

Dr Michael Gannon presents the 2017 AMA Indigenous Medical Scholarship to James Chapman

As a 13-year-old, James Chapman watched his father, a proud Indigenous man from Yuwlaaraay country, die after a short, seven-week battle with acute myeloid leukaemia. As a school leaver, he became his mother's carer for 12 months as she recovered from brain surgery.

Today, the 25-year-old, second-year medical student has won the 2017 AMA Indigenous Medical Scholarship – $10,000 a year for each year of study – to help him pursue his dream of becoming a medical professional.

AMA President Dr Michael Gannon who presented the Scholarship at the AMA National Conference in Melbourne, said that Mr Chapman's story was inspiring.

Dr Gannon believes the award is important because Indigenous people have improved health outcomes when they are treated by Indigenous doctors and health professionals. This is highlighted by the need to build the building the Indigenous health workforce where in 2017, there are just 281 medical practitioners employed in Australia as Aboriginal or Torres Strait Islander – representing 0.3 per cent of the workforce.

Mr Chapman said that while he did not realise it at the time, his father was a victim of the gap that exists between Indigenous and non-Indigenous Australians when he saw firsthand communities with access only to a visiting doctor and nurse.

He dreamed of one day becoming a doctor, but was discouraged by his teachers. As a young student at the University of Wollongong his study was derailed when his mother was diagnosed with a brain tumour, and he became her carer for a year while she recovered.

"Constantly in clinical environments, my dream of becoming a medical professional became more intense, and after my mother recovered, I began a Science degree with the intention of completing post graduate medicine," Mr Chapman said.

Now in his second year, Mr Chapman intends to study from Wagga Wagga from his third year onwards to experience rural health, and rural and remote Indigenous health care. He hopes to become a GP, working with Indigenous women and children in rural and remote Australia.

Dr Gannon said that, in 2017, a total of 286 Aboriginal and Torres Strait Islander medical students are enrolled across all year levels across Australia. However, four of the 15 colleges are yet to have an Indigenous trainee.

"The AMA Scholarship has assisted many Indigenous men and women, who may not have otherwise had the financial resources to study medicine, to graduate to work in Indigenous and mainstream health services," Dr Gannon said.

The AMA Indigenous Medical Scholarship was established in 1994 with a contribution from the Commonwealth Government. The AMA is looking for further sponsorships to continue this important contribution to Indigenous health.

Donations are tax-deductible. For more information, go to https://ama.com.au/advocacy/indigenous-peoples-medical-scholarship

MEREDITH HORNE

AMA Gold Medal presented for exceptional service to a 'one of a kind'

Dr William Glasson AO, the AMA President who steered a course through the medical indemnity crisis in the early 2000s, has been recognised with the highest honour the peak medical body can bestow – the AMA Gold Medal.

> "Bill was always a strong and passionate advocate for the AMA, the medical profession, the health system, and patients throughout his time as President, at both State and national level."

Dr Glasson, universally known as Bill, received the Medal in recognition of his exceptional service to the AMA over many years, and his long-term and ongoing commitment to the eye health of Indigenous people.

AMA President, Dr Michael Gannon, who nominated Dr Glasson for the Medal, said that the distinguished ophthalmologist is one of a kind – a truly deserving recipient of the AMA Gold Medal.

"Bill's generosity and altruism know no bounds. His work extends to outback Queensland, Indigenous communities, and East Timor," Dr Gannon said.

"Bill was always a strong and passionate advocate for the AMA, the medical profession, the health system, and patients throughout his time as President, at both State and national level."

Dr Gannon acknowledged when presenting the award that Dr Glasson's leadership produced a very positive outcome for the profession and the Australian people, following many years of hard work by his predecessors, the AMA Federal Council, and the State and Territory AMAs.

"His hours, days, and weeks of tense negotiations with the then Health Minister Tony Abbott paid off. Bill and Tony survived those tough days, and remain close friends to this day," Dr Gannon said.

"Bill always wears his heart on his sleeve. His style of advocacy is direct and to the point, tinged with a typical Queensland bush sense of humour, which reflects his origins in outback Winton, and characterised by his expert use of the Australian vernacular."

Dr Michael Gannon, Professor Claire Jackson, Dr William Glasson AO

Dr Glasson has been President of the Royal Australian and New Zealand College of Ophthalmologists.

He is a member of professional organisations such as the Royal Australasian College of Surgeons, the American Academy of Ophthalmology, the Australian Society of Cataract and Refractive Surgery, the American Society of Cataract and Refractive Surgery, and the Australian Optometry Association.

Dr Glasson is an Adjunct Associate Professor with the University of Queensland School of Medicine.

MEREDITH HORNE

AMA President's Award presented to a long-serving and dedicated GP

2017 President's Award – Dr Michael Gannon and Professor Bernard Pearn-Rowe

Professor Bernard Pearn-Rowe, who has been a constant advocate for general practice for almost three decades, has been recognised with one of the AMA's highest awards, the President's Award.

Professor Bernard Pearn-Rowe has juggled maintaining his solo GP practice in Perth with his active roles in AMA WA medical politics, including a term as AMA WA President, and his appointment as Foundation Professor of Clinical Studies at the University of Notre Dame.

Dr Gannon presented Professor Pearn-Rowe with his Award at the AMA National Conference 2017 Gala Dinner in Melbourne.

"During his time as Convenor of the federal AMA Council of General Practice (CGP), he has contributed to key policy areas including the role of general practice in primary care, e-health, medical education and training, GP workforce, red tape reduction, Health Care Homes, and the role of GPs in disaster situations," Dr Gannon said.

"Professor Pearn-Rowe has been part of an AMA CGP that has emphasised the importance of quality general practice and the need for Governments to support this as part of a high quality, sustainable health care system."

Amid his many commitments, Professor Pearn-Rowe has also found the time to pen a weekly medical column in *The West Australian* newspaper, making him an outstanding face of the AMA in WA.

Professor Pearn-Rowe was chair of the Royal Australian College of General Practice (RACGP) in Western Australia from 1989 to 1993, Chair of the AMA WA Council of General Practice (CGP) from 1998 to 2001, and Convenor of the Federal AMA CGP since 2004. He was appointed a Fellow of the federal AMA in 2004.

Professor Pearn-Rowe graduated in Medicine from the University of London in 1972 and joined the AMA in 1976. He has been active in AMA WA medical politics since that time, including a period as President of the AMA in Western Australia from 2002-2004. He was appointed a Fellow of the AMA in 2004.

He was appointed Foundation Professor of Clinical Studies at the University of Notre Dame in 2004 and was Foundation Professor and Head of Discipline of General Practice in the School of Medicine at the University of Notre Dame from 2006-2010. Since that time he has continued as an Adjunct Professor.

MEREDITH HORNE

Medical role models honoured at AMA National Conference

AMA Woman in Medicine

Dr Genevieve Goulding, an anaesthetist with a strong social conscience and a passion for doctors' mental health and welfare, has been named the AMA Woman in Medicine for 2017.

Described by her colleagues as a quiet achiever, ANZCA's fourth successive female President, Dr Goulding has used her term to focus on professionalism, workforce issues, advocacy, and strengthening ANZCA services for Fellows and trainees.

Dr Goulding is a founding member of the Welfare of Anaesthetists Group, which raises awareness of the many personal and professional issues that can affect the physical and emotional wellbeing of anaesthetists throughout their careers.

Dr Michael Gannon, who presented the award at the AMA National Conference, said that Dr Goulding was a role model for all in the medical profession.

"She has raised the profile and practice of safe and quality anaesthesia. She is committed to ensuring patients – no matter their background or position – can rely on and benefit from our health system," Dr Gannon said.

Dr Goulding continues to effect change with her work on the ANZCA Council and on the Queensland Medical Board, her numerous positions with the Australian Society of Anaesthetists, and her current work with the Anaesthesia Clinical Committee of the MBS Review.

Excellence in Healthcare Award

This year, AMA recognised a true medical leader Dr Denis Lennox, who has made an outstanding contribution to rural and remote health care in Queensland, and to the training of rural doctors.

Dr Lennox has had an extraordinary career since starting as a physician and medical administrator in his home town of Bundaberg in the 1970s.

Dr Gannon said that Dr Lennox had earned this award through his vision and revolutionary training of rural general practitioners and specialist generalists.

"Dr Lennox has been responsible for real workforce and healthcare improvements in all parts of Queensland, particularly through the Queensland Rural Generalist Program which has delivered more than 130 well-prepared Fellows and trainees into rural practice across Queensland since 2005 – an incredible achievement," Dr Gannon said when presenting the award.

An Adjunct Associate Professor at James Cook University and Executive Director of Rural and Remote Medical Support at Darling Downs Hospital Health Service, Dr Lennox prepares to retire from 40 years of public service.

AMA Women's Health Award

Dr Michael Gannon and Eleanor Crighton

A nurse and midwife in Darwin, Eleanor Crighton has been awarded the Women's Health Award – an award that goes to a person or group, not necessarily a doctor or female, who has made a major contribution to women's health.

Ms Crighton won the award for her outstanding commitment to Indigenous women's health.

Dr Gannon when presenting the award to Ms Crighton said that she had made a real difference to the lives of Aboriginal women in the greater Darwin region through them gaining access to affordable family planning.

"As an obstetrician, I know the importance of the work of women's health teams, particularly in Aboriginal community-controlled organisations like Danila Dilba," Dr Gannon said.

As the Women's Health Team leader at Danila Dilba Health Service, Ms Crighton has shown her commitment to Indigenous health by pursuing additional studies and gaining personal skills with the aim of filling gaps in health care services.

Ms Crighton has also worked tirelessly to raise awareness of Fetal Alcohol Spectrum Disorder, and has started training Danila Dilba's first home-grown trainee midwife, at the same time as pursuing her own Nurse Practitioner studies.

MEREDITH HORNE

AMA Roll of Fellows awarded for outstanding contribution

Professor Owler and Adjunct Professor Greenaway

Two new members were inducted into the AMA Roll of Fellows at the AMA National Conference 2017 in Melbourne.

Former AMA Tasmania President, Adjunct Professor Tim Greenaway, and immediate past Federal AMA President, Professor Brian Owler, were added to the Roll of Fellows in recognition of the outstanding contribution each has made to both the AMA and the medical profession.

AMA President Dr Michael Gannon said both of the new Fellows were distinguished representatives of the profession, and inspiring leaders who had fought hard for public health issues throughout their careers.

"Both Adjunct Professor Greenaway and Professor Owler have excelled in their medical careers, and in their roles as advocates for the profession, and both exemplify all that makes the AMA such a trusted and well-regarded contributor to national health policy and debates." Dr Gannon said.

Adjunct Professor Greenaway currently holds the role of Chief Medical Adviser with the Health Products Regulation Group in the Commonwealth Department of Health, whilst remaining an Adjunct Professor in the University of Tasmania's School of Medicine.

A leading Australian endocrinologists, Adjunct Professor Greenaway has been actively involved in undergraduate and postgraduate medical education for more than 30 years. An AMA member since 1994, he served as AMA Tasmania Vice President for two years before becoming President in 2014. During his Presidency, AMA Tasmania became debt-free and increased its membership.

On receiving the award Adjunct Professor Greenaway spoke about the important role the AMA plays in leading the health debate. "It is an extremely great honour…but as someone who now works within the Department of Health, I can assure you that the AMA is the most respected advocacy group within health," he said.

Adjunct Professor Greenaway presided over AMA Tasmania during the development of the statewide Tasmanian Health Service, worked closely with the Tasmanian Government through the Healthy Tasmania Committee to develop a raft of initiatives outlined in the Healthy Tasmania Five Year Strategic Plan, and implemented a new award for medical professionals.

Professor Brian Owler, throughout his career as a neurosurgeon, has combined clinical excellence with passionate advocacy for the welfare of his patients, colleagues, and the wider community.

Professor Owler said it was a very great honour to be included in the Roll of Fellows at the AMA.

"The AMA is not a bricks and mortar organisation, it is an organisation with people, staff, delegates, council members – both at Federal and State levels, and of course our members. People who are committed to looking after the welfare of their colleagues, to the betterment of their patients and to making the Australian community better also," Professor Owler said.

Professor Owler first became actively involved with the AMA as a medical student, becoming a Councillor, Student and Doctors in Training representative, and a member of the Residents' and Students' Committee. During this time, Professor Owler led AMA NSW's campaign on the provider number dispute.

Throughout his Presidencies and other leadership roles at the AMA, he has worked tirelessly for the benefit of doctors and patients, and made public health advocacy a priority.

He has led hard-hitting and effective campaigns on road safety, preventable deaths and injuries in children, Aboriginal and Torres Strait Islander health, fair health treatment for asylum seekers, climate change, and vaccination.

As head of the AMA, Professor Owler also campaigned for the Government to increase its efforts to fight the Ebola outbreak in Africa, not only because controlling the outbreak at its source was the best approach, but because it was the right thing to do.

MEREDITH HORNE

2017 AMA media and advocacy awards

At the 2017 AMA National Conference, six media and advocacy awards were presented.

A new award category was opened for this year's entries – the Best Public Health Initiative. State and Territory AMAs were invited to nominate an outstanding public health initiative or campaign – other than smoking and tobacco control – launched by their State or Territory Government in calendar year 2016.

Nominated by AMA NSW, The NSW Government, won this award for its campaign to combat childhood obesity. The NSW Health campaign is a comprehensive whole-of-government plan with the specific target of reducing overweight and obesity rates of children by 5 per cent over 10 years.

The judging panel, headed by Public Health Association of Australia CEO Michael Moore, noted that the campaign stood out for its clear strategic directions, and its strong focus on children and young people.

The Best Lobby Campaign 2017 was awarded to AMA Western Australia for their 'Three-year Employment Contracts for Interns' campaign.

The successful introduction of the three-year employment contracts for interns is a standout achievement. The reform eliminates the previous system of annual contracts, thereby eliminating both the cost and the stress of interns having to reapply for their jobs on an annual basis.

The judges commented that AMA WA's policy success should contribute to improved health outcomes across the WA system, with the hope that this initiative may spread nationally over time. In addition, the successful recombination of the Minister of Health and Mental Health is also a noteworthy success for the WA branch.

Best Public Health Campaign from a State or Territory 2017 was awarded to AMA Western Australia for highlighting 'Australia's Mental Health Crisis'.

AMA WA has developed a state-of-the-art best practice mental health program that is being recognised Australia-wide as the best of its kind using a dual approach to reach youth at school and adults in the workplace – two groups under severe mental health pressure.

Judges commended the branch on the clarity and quality of the campaign. They said the effectiveness in engaging and delivering its important message pointed to a significant public health intervention that deserved to be recognised.

AMA Victoria received Best State Publication 2017 for '*Vicdoc*', which covers the ethical, political, clinical, and work based issues facing the medical profession in great detail.

Judges commented that the publication was valuable and informative and a must-read for any Victorian doctor. The front covers were simple and with compelling use of images. The standard of writing in this publication was extremely high and very informative.

AMA Victoria was also awarded with the National Advocacy Award 2017 for their cooperation between federal AMA during the introduction of the Victorian Government's 'Assisted Dying' legislation.

AMA Victoria's actions and commentary on assisted dying have always referenced and reflected AMA Federal's policy position.

AMA Victoria called for improved funding for palliative care services, and legislative changes to the Doctrine of Double Effect through the enactment of legislation to provide legal certainty to medical practitioners in connection with the accepted clinical practices of double effect and non-provision of futile care.

Judges commended AMA Victoria on its clear and concise submission to the inquiry into a very sensitive and often divisive issue.

Most Innovative Use of Website or New Media 2017 was awarded to AMA Western Australia for their creation of WAhealthfirst.com.au.

This website utilised a new media approach that generates conversation from content advocating AMA WA's position on key political issues, most relevant to the recent State election earlier this year. An expected outcome of new media is to use technology available to provide clear and easy communication to the user. Judges commended AMA WA in the success of WAhealthfirst.com.au and said it was clear it simplified the voter education process of health policy while also providing the facts.

MEREDITH HORNE

Future leader receives AMA Award

Dr Linny Phuong and Doctors in Training Chair Dr John Zorbas

A junior doctor and researcher, whose experiences as the child of refugee parents inspired her to establish a health promotion charity for migrants, refugees, and asylum seekers, has won the AMA Doctor in Training 2017 Award.

Dr Linny Phuong, a Paediatric Infectious Disease Fellow at the Royal Children's Hospital Melbourne, was presented with the award by AMA President Dr Michael Gannon at the AMA National Conference 2017 in Melbourne.

Dr Phuong is the second winner of the Award, which was introduced in 2016 to recognise outstanding leadership, advocacy, and accomplishments of a doctor in training. The recipient is awarded a place at the AMA's Future Leaders Program.

Dr Gannon praised Dr Phuong, the founder and director of the Water Well Project, for her contributions to teaching, medical education, research, and doctors' wellbeing, as well as her professionalism and compassion towards children and their families.

"Dr Phuong exemplifies the characteristics of a caring doctor, an inspiring leader, and a tireless philanthropist and humanitarian," Dr Gannon said.

Dr Phuong is highly regarded by her peers at the Royal Children's Hospital where, as Deputy Chief Resident, she is in charge of the doctors' wellbeing portfolio. She is also a successful medical researcher, having published several papers.

Dr Gannon also paid tribute to Dr Phuong's awareness of the many challenges faced by refugee families in accessing health services, noting that five years ago, she founded the Water Well Project, a not-for-profit health promotion charity which improves the health and wellbeing of migrants, refugees, and asylum seekers by providing health literacy support and education.

MEREDITH HORNE

Towards tobacco free investment

The AMA Council of Doctors in Training (AMACDT) was delighted to have Dr Bronwyn King, Founder and Chief Executive Officer, Tobacco Free Portfolios, share her insights on leadership and advocacy at the AMA Leadership Development Dinner on 26 May 2017 at Eureka 89 in Melbourne.

Dr King was the keynote speaker at this event and spoke passionately about her experience working towards tobacco control that has led to a significant global shift towards tobacco-free investment.

A Radiation Oncologist, Dr King explained how she found out by accident that her Super Fund was investing her money in tobacco companies – the very companies that made the products which caused unimaginable harm to her patients!

Since then, Dr King has led the charge to persuade superannuation funds to exclude tobacco companies from their portfolios. 35 large Australian Super Funds are now tobacco-free, having divested approximately $2.5 billion worth of tobacco stocks.

There are many alarming statistics relating to tobacco:

- 15,000 Australians die early as a result of tobacco every year;
- In 2016, more Australian women died from lung cancer from breast cancer; and
- The World Health Organisation estimates that the world is on track for one billion tobacco-related deaths this century.

The problem is that most people don't know whether their money is being invested in tobacco or not.

Tobacco Free Portfolio's newest initiative, *Verified Tobacco-Free*, aims to solve this problem.

The team at Tobacco Free Portfolios have designed the *Verified Tobacco-Free* logo which will be available for adoption by Super Funds with tobacco-free investment policies, subject to an audit to confirm their tobacco-free status.

The *Verified Tobacco-Free* logo will help consumers to make easy, informed decisions in relation to their superannuation investment.

- Super Funds can proudly display the logo to clearly demonstrate their tobacco-free status;
- Fund members can be sure that their money is not being invested in tobacco; and
- *Verified Tobacco-Free* Super Funds can be 'named and famed', which will encourage other funds to follow suit.

A crowdfunding campaign is currently underway to support the initiative. Dr King aims to raise over $50,000 to make the *Verified Tobacco Free* initiative a reality. You can support Dr King's work by going to https://pozible.com/project/verified-tobacco-free.

Dr Bronwyn King

Dr John Zorbas, AMACDT Chair, praised Dr King's resolve and initiative and said her address had inspired all who attended to have the courage to lead and advocate for what they knew was morally and ethically right and in the best interests of patient care and the health of the wider community.

"In particular Dr King emphasised the value of having in place a strong network made up of family and friends to support you and help you to maintain a work life balance that's right for you. As a leader it's vitally important to recognise your own health needs and enlist support from those around you if you are to achieve your goals and continue to function effectively and efficiently."

The Leadership Development Dinner is held every year as part of AMA National Conference. This year over seventy doctors in training, medical students, consultants and international guests attended the event which is widely acknowledged as one of the most important events of its type, providing future healthcare leaders with an opportunity to gain new insights into effective leadership.

In 2018, the AMA Leadership Development Dinner will be held on May 25 at the National Portrait Gallery in Canberra.

BY SALLY CROSS
SENIOR POLICY ADVISER, AMA

Tobacco control in the spotlight at AMA National Conference

Dr Robert Parker, President AMA, NT collects the Dirty Ashtray Award from Dr Michael Gannon.

The AMA President Dr Michael Gannon announced the AMA/ACOSH *National Tobacco Control Scoreboard 2017* at the AMA National Conference.

Queensland topped the AMA/ACOSH National Tobacco Control Scoreboard 2017 as the Government making the most progress on combating smoking over the past 12 months.

Queensland narrowly pipped New South Wales for the Achievement Award, with serial offender the Northern Territory winning the *Dirty Ashtray Award* for putting in the least effort.

Judges from the Australian Council on Smoking and Health (ACOSH) allocate points to each State and Territory in various categories, including legislation, to track how effective government has been at combating smoking in the previous 12 months.

Dr Gannon described the results however as disappointing because no jurisdiction scored an A this year, suggesting that complacency has set in. He also said that it is disappointing that so little progress has been made in the Northern Territory over the past year.

"Research shows that smoking is likely to cause the death of two-thirds of current Australian smokers. This means that 1.8 million Australians now alive will die because they smoked," Dr Gannon said.

"It is imperative that governments avoid complacency, keep up with tobacco industry tactics, and continue to implement strong, evidence-based tobacco control measures."

The judges praised the Queensland Government for introducing smoke-free legislation in public areas, including public transport waiting areas, major sports and events facilities, and outdoor pedestrian malls, and for divesting from tobacco companies.

However, they called on all governments to run major media campaigns to tackle smoking, and to take further action to protect public health policy from tobacco industry interference.

The Northern Territory, a serial offender in failing to improve tobacco control, has been announced as the recipient of the AMA/ACOSH *Dirty Ashtray Award* for putting in the least effort to reduce smoking over the past 12 months.

It is the second year in a row that the Northern Territory Government has earned the dubious title, and its 11th "win" since the Award was first given in 1994. More than 22 per cent of Northern Territorians smoke daily, according to the latest National Drug Strategy Household Survey, well above the national average of 13.3 per cent.

"It seems that the Northern Territory Government still does not see reducing the death toll from smoking as a priority. Smoking is still permitted in pubs, clubs, dining areas, and – unbelievably – in schools," Dr Gannon said.

The Northern Territory Government has not allocated funding for effective public education, and is still investing superannuation funds in tobacco companies.

A full list of the State and Territory results can be found on the AMA website: https://ama.com.au/media/amaacosh-national-tobacco-control-scoreboard-2017-topped-qld

MEREDITH HORNE

acosh AMA

Dirty Ashtray Award

National Tobacco Control Scoreboard 2017

Results

Dirty Ashtray Award:
Northern Territory

Runners Up :
Victoria
Tasmania

Winner Award:
Queensland

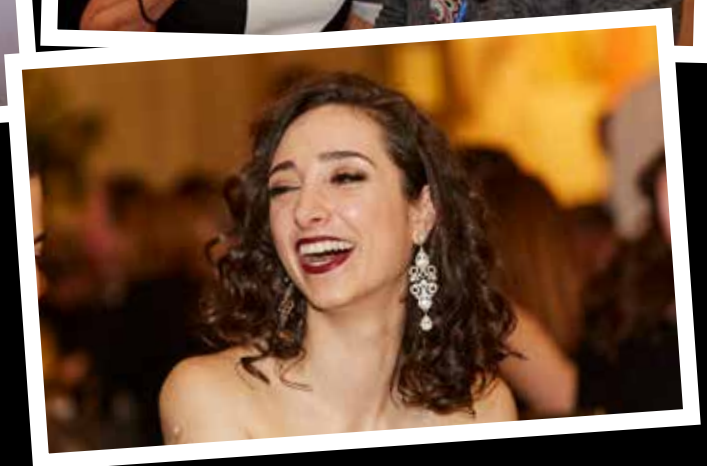
Governments across Australia need to step up, take action and avoid complacency.

AMA National Conference 2017 Photo Gallery

There was serious business and then there was some serious fun.

The mood of the weekend in Melbourne can be seen in the following photos.

Even more pics from National Conference will appear in upcoming editions of *Australian Medicine*.




AMA

My Health Record – lessons from the opt-out trial

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

The recent Federal Budget confirmed that the My Health Record will move to an opt-out model.

While the AMA has drawn attention to the shortcomings of the My Health Record over the past five years, we have always acknowledged the potential for a well-designed and constructed electronic health record to improve patient care.

The AMA originally proposed an opt out model and the Evaluation of the Participation Trials for the My Health Record has demonstrated this is the right approach, with the evaluation report saying opt-out is the only sustainable way forward. Ensuring universal coverage with cross-sector clinical input over time will enhance the value of the My Health Record for patients, their doctors and a patient's other healthcare providers.

One of the clear outcomes from the trial was that once patients understood the benefits of having a shared electronic health record and the measures in place to protect their information and its use, any concerns they had about privacy and the security of their information were allayed. In fact, the trial highlighted that patients already fully expected their doctors to be sharing their health information with one another.

This is a strong signal to the profession that, whatever reservations we have about the MyHealth record, our patients want us to use it.

Not surprisingly, the trial highlighted a number of critical improvements to the MyHealth record that are needed. These go to the heart of its ease of use, utility and accessibility.

Several of the Evaluation recommendations targeted these areas and reflect much of what the AMA has been saying for some time.

Certainly, more work needs to be done to convince GPs of the merits of the My Health Record and to address its shortcomings. One of the interesting findings in the evaluation was that while most health care providers made it clear that the MyHealth record required additional time with patients, practice managers and practice nurses reported that it made the practice more efficient with less need to chase information from patients and other health care providers. This represents an interesting tension, given that GPs are not funded for this effort. My view, along with the AMA, is GPs need to be properly funded for this work.

The evaluation report contains a number of recommendations on 'strategy' to increase uptake and use of the My Health Record. These particular recommendations, which touch on funding mechanisms, are vague and unclear but seem to suggest making use of the My Health Record a requirement for funding. This approach has delivered very mixed results in relation to the PIP e-health incentive and there is no way the AMA would support any change that linked the use of the MyHealth record to patient rebates.

I was pleased instead to see Health Minister Greg Hunt, at the AMA National Conference, say he intends to explore "real incentives to assist the medical workforce in their work". The profession is looking for support, not punitive approaches that can impact on doctors and their patients.

Over time, we can expect that utilisation of the My Health Record will be woven into standards for practice and accreditation across healthcare, from general practices to hospitals (public and private), to pharmacies and other allied health service providers, and to aged care facilities. Obviously, the AMA's role is to ensure that this does not happen until we have a clinically useful system.

Digital health will become a key part of future undergraduate and postgraduate training programs, meaning supervisors like me will need to ensure that we too are up to speed.

With more useful content being added to the record such as patient medications, pathology and diagnostic imaging reports, and discharge summaries, the more valuable the record will be for doctors and the patient's care. In my view, the value of the MyHR could be further enhanced by enabling the uploading of other documents where useful such as Care Plans, including Advance Care Plans and Advance Care Directives. This would help ensure the manner of a patient's care, particularly if away from home, aligns with their agreed goals and stated preferences.

Changes such as these, along with the reality that the vast majority of Australians will have a record created, should remove some barriers for engagement and facilitate greater interaction.

The AMA will continue working to ensure the My Health Record fulfils the promise that an effective shared health record can deliver.

The saga of trying to put Medicare on ice

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

Frozen indexation has meant effectively a cut in income for general practitioners who bulk bill their patients. Although small, it mounts up when multiplied by the number of patients they see.

If Medicare rebates on consultations lasting less than 20 minutes (the most common type of consultation) had not been frozen in 2014, instead of being $37 now they would have risen to about $40 this year if indexed to the consumer price index. That is according to a fact sheet produced by the Royal Australian College of General Practitioners.

Bulk-billing is hard to freeze

Although this may be thought to serve as a disincentive to bulk-billing, the Federal Health Minister Greg Hunt is quoted in the March 19th issue of The Australian as "highlighting the record increase in bulk billing rates, which have risen 3.5 per cent since the Coalition won Government". So it does not seem to have reduced bulk billing?

Mr Hunt went on to say: "In the last half-yearly figures that are just out, we've gone from 84.7 per cent, to 85.4 per cent, so in other words, Medicare funding is up and bulk billing rates are at their highest ever on a half-yearly basis."

Why freeze?

Associate Professor Helen Dickinson, a public service research academic at UNSW, explained the origin of the freeze a year ago in the Conversation and reported on ABC: "Although the Coalition is largely associated with this issue, Labor first introduced the Medicare rebate freeze in 2013 as a "temporary" measure, as part of a $664 million budget savings plan ... A continuation of the indexation freeze, initially for four years starting in July 2014, was further extended in the 2016 budget to 2020. It has been estimated this will save $2.6 billion from the health bill over six years."

The intention in the proposed 2014 Federal Budget was that the freeze would work alongside a co-payment and reduced reimbursement for short consultations. The continued freeze was the only measure that cleared the Senate. Although the justification for these proposed imposts on general practice included the absolute costs of primary care, these costs included a lot of activity other than general practice. According to the Australian Institute of Health and Welfare, health expenditure in Australia in 2014-2105 was $161.6 billion.

A freeze, or frost bite?

In 2013-2014 $58.8 billion was spent on hospitals and $54.7 billion on 'primary care' but as just said, this includes general practitioner services (about $9 billion), other health practitioners, community health care, dental services and medications. So with a total annual health budget of $161 billion, general practitioner services amounted to $9 billion or 17 per cent. The predicted savings from the freeze, each year, represent 0.25 per cent of total health expenditure. Has such a small saving been worth it?

If seeking to save money in health care, it is probably best to look first at the big expenditure items. This is why the review of the Medicare Benefits Schedule makes good sense and why, universally, there is an interest in demanding greater efficiency from our hospitals.

But as those who have had the responsibility for running a big and complex organisation know full well, it is wise to assess the likely flow-on from any cuts. Impositions on primary care are not likely to lead to the political pushback that cuts to high-powered specialty services will elicit. But if they demoralise this workforce, heaven help you in trying to integrate care for patients with complex chronic problems. And that will cost you far more in the long term than you will save by freezing general practice rebates.

Is a freeze on Medicare fair?

My final point concerns equity. How come private health insurance premiums rise each year whereas general practice fees do not? Private insurance premiums are heavily subsidised (30 per cent or $6.5 billion in the 2016 budget) by the federal government. So the Government does not worry about indexing its contribution to private health insurance but it does for Medicare. Work that one out if you can.

Rural Doctors Meet

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

> "So if you are feeling alone out there, out bush and distanced from urban life, you are not alone. Every country in the world has a rural region and rural health issues."

Far North Queensland – Cairns – was the meeting place of the 5th World Summit on rural Generalist Medicine and the 14th Rural WONCA conference last month. Nearly one thousand delegates from 38 countries. All there to discuss Rural Health. Rural doctors like you and me.

So if you are feeling alone out there, out bush and distanced from urban life, you are not alone. Every country in the world has a rural region and rural health issues.

And every country has us, the steadfast rural doctor. Even high density countries such as Japan has over 400 "outback" islands that are a Flying Doctor's distance away from a tertiary centre.

So we gathered to compare, learn, innovate, and extend a warm welcome to each other. For many, English was a second language. The themes throughout were resilience, rural courage, collegial connections and patient-centred care. Workforce distribution was also a big theme.

The Japanese were astounded by our numbers and the support we have garnered from fellow colleagues, colleges and the government. They are just starting to gain support and recognition for the Japanese Rural Generalist concept, just starting to enlist rural registrars. At this conference the opening of their Rural Generalist program was announced. One thing they do have that we don't is a weekly TV series of a heroic Japanese rural doctor who performs all sorts of medical miracles using only rural resources, very uplifting if you understand Japanese.

The Canadians said, "these Australian consider Rural Health so important they even have a MINISTER for Rural Health (Dr David Gillespie), wow." The Canadians seconded an Australian native (Dr Roger Strasser) to be the founding Dean of the Northern Ontario School of Medicine, a new Rural Medical school in their Outback.

African countries in their vivid headdress and clothing stood tall in their pride for the work they do with their limited resources and manpower. They are painfully aware that a number of their colleagues each year disappear from their workforce to work in developed countries. One African/Australian registrar really impressed me with her intention to say "no" to the lucrative rewards here in Australia to return after training to her native land to bring her Outback expertise to outback Africa.

Be proud of the fact Australia is a "go-to" country with the most progress with Rural programs and the main innovators of the Rural Generalist program.

We could learn from enthusiastic, new generation doctors such as the delegate from Brazil who is the brainstorm behind Rural Cafe. Go to this cafe from 3 different directions Facebook(@ ruralfamilymedicinecafe), Twitter (#RuralCafe) and YouTube (Rural Family Medicine Café). It is international and feels like having a cup of coffee in the safety of a collegial cafe. You cannot feel alone there. Bring your coffee.

For your sanity and to prevent the feeling of isolation, plan to be at any Rural Medicine conference in the future. The energy, the collegiality and sense of pride is well worth your precious downtime. Here are some suggestions:

1. Rural Medicine Australia (RMA) Melbourne, 19, 20, 21 October 2017. Theme Climate Change and Health;
2. 15th WONCA Rural Health Conference, South Asia Rural health conference (WRHC), New Delhi, 26, 27, 28, 29 April 2018; and
3. 26th Annual Rural and Remote Medicine Course of the Society of Rural Physicians of Canada (SRCP), St John's Newfoundland, 12,13,14 April 2018.

Hope to see you at one of these venues.

Time to shake the 'old boys club' tag

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

> "I'd argue the Association is looking to evolve and improve diversity in representation – in part driven by Doctors' in Training – with a growing self-awareness that lopsided gender representation in leadership roles is unhealthy."

Over the 25th to 28th of May, the AMA held its annual National Conference. We heard about the importance of AMA leadership from the Health Minister and Shadow Minister, Opposition Leader, Leader of the Greens and the Prime Minister. We had panel discussions on topics including tackling obesity, 'health care in danger' and doctors' health and wellbeing. All were engaging and thought-provoking, however it was a soapbox topic at the end of the conference that really sparked my interest. It came from a female Doctor in Training and was titled "The AMA is an old boys club. Does it really want to and if so, how can it be changed?"

Wow. Why did we wait to the end of the conference for this to be discussed? Looking around the room, the comment had merit. The conference was largely populated by males either rapidly heading for the wrong side of middle age or already there, with a smattering of female doctors and around 35 DiTs making up the numbers. At gatherings like this, it's easy to see how the AMA could be labelled an 'old boys club'.

Is this reflective of our membership? The answer is probably yes (for now) ... and no.

There's no doubt medicine was once a male-dominated workforce. We still see evidence of this in the significant gender imbalance in clinicians moving into the latter stages of their careers. For DiTs, this imbalance in the ranks of our seniors becomes starker when we review the relative parity in sexes within our own cohort. We also see the disproportionate abundance of males in leadership roles in our hospitals, health systems and representative bodies – including the AMA.

To the second part of the soapbox challenge: "Does it (the AMA) really want to and if so, how can it be changed?"

I'd argue the Association is looking to evolve and improve diversity in representation – in part driven by Doctors' in Training – with a growing self-awareness that lopsided gender representation in leadership roles is unhealthy. It is impossible for someone like me (a PGY6 white male in my 30's) to adequately represent the views and concerns of 2017 interns, let alone female trainees, by solely drawing on my own experiences. This is why we have councils and committees – so we can draw on a wide range of collective experience and speak as best able for the collective. Those groups are ineffective if there's more men named Richard at the table than there are women. In the last 12 months, we have seen improvements in female representation on AMA boards at both state/territory level and federally, however there is still some way to go.

So while the 'old boys club' tag might still be appropriate, it is only because we collectively let it be. We all have a collective responsibility to help the Association evolve and better represent us all. We shouldn't just hope the increased number of female medical students over the past decade or two will work their way through the ranks to leadership roles. We need to actively strive for change, remembering that we are what makes the AMA the AMA, so it must be pushed to evolve by those on councils and general members alike. We need to lead by example for the rest of the profession and find ways that allow female doctors to take leadership positions without unduly sacrificing work or family. We need to better represent female trainees in our advocacy work, especially at that critical time where training and starting a family intersect.

Raising the spectre of the 'old boys club' at the AMA's national conference was a bold move and step in the right direction. It's time now for us to work together and shake that tag forever.

Marriage Equality: A health issue?

BY ROB THOMAS, PRESIDENT AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

> "I can't imagine the stigma that must still exist around being gay in some parts of the country, and for me it explains the gap in mental and physical health outcomes for sexual minorities."

As a young gay man in the 21st century, I recognise the relative ease of my existence in expressing my sexual identity, compared to the previous generations. It's amazing to think how just a few short decades ago, open discrimination and jail terms were common for those in the LGBTIQ community in Australia just for their normal expression. Nevertheless, there are still steps to be taken when it comes to equality in this area, and marriage equality is just one of those necessary steps.

Recently, a lot of heat has been generated surrounding a prominent retired Australian tennis player's boycott of Qantas for supporting marriage equality. Her opinion, though she is entitled to expressing it, is potentially damaging to the LGBTIQ minority, as it reinforces harmful views that these people are "abnormal", or "morally wrong". Even in our more progressive existence nowadays, I have known people that have been bullied, shunned and even physically threatened for being gay. It's something that health professionals need to be aware of, and need to learn to combat.

My own experiences of LGBTIQ teaching in medical school have so far been somewhat lacking. I note that out of around 100 PBL (problem-based learning) cases in my preclinical years, only one centred around a gay relationship, and this was in the context of a cheating husband with an STI. While I don't deny that this sort of case is an important consideration, I don't see it as the norm in homosexual relationships. Little teaching was provided in terms of communicating with people of non-binary gender or diverse sexual orientations, and for some of my colleagues, I worry that their lack of exposure could lead to issues in communicating with patients.

In my rural term, it was amazing to see the community's reaction (or non-reaction) to all things LGBTIQ. When I asked the town's doctor if there were any LGBTIQ-identifying patients out of a pool of more than 1,000, I was surprised to hear there supposedly weren't any. I can't imagine the stigma that must still exist around being gay in some parts of the country, and for me it explains the gap in mental and physical health outcomes for sexual minorities.

Regardless of our personal opinion, as health professionals it is our duty to be accepting of our patients and provide a safe space for adequate history-taking and harm minimisation. The first step is learning the language – including the difference between sex, gender identity, and sexual attraction. Some moves to consider include incorporating non-binary gender identification on forms, and learning to be comfortable asking non-judgemental questions. Beyond that, it is our duty to speak up when significant social issues impact severely on our community's health.

I was incredibly inspired and proud when the AMA released its position on Marriage Equality. It recognises that this institutionalised discrimination has a serious effect on the mental health and health access of LGBTIQ people. While it is not just a health issue, the health impacts are undeniable, and I hope give rise to the Government taking action.

Thanks to decisive action, gone are the days where being gay is considered illegal, immoral or a mental health condition. With further action I believe we can achieve health equality for those in the LGBTIQ community, by addressing the larger social determinants of health.

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Improving Australia's organ donation rates

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

The 2017AMA National Conference, held on 26th-28th of May, featured a Q&A session on organ donation entitled *Improving Australia's Organ Donation Rates: Ethical and Practical Issues.*

The purpose of the 2017 AMA National Conference panel session on organ donation was to educate and inform delegates on:

- Australia's donor system and rates of organ donation;
- the ethical and practical issues associated with more controversial proposals to increase organ donor rates (eg, presumed consent, financial and non-financial incentives to donate);
- how individual doctors can promote organ donation within the community; and
- how the AMA can better raise awareness of organ donation within the medical profession and advocate for organ donation within the community.

The Hon Ken Wyatt AM, Minister for Aged Care and Minister for Indigenous Health, opened the session, highlighting the 2016 record donation rates (which has doubled since the national reform program started in 2008), saving 1713 lives.

Acknowledging that there are still 1400 Australians on the organ waiting list at any particular time, the Minister outlined several of the Government's reform program initiatives for increasing Australia's organ donation rates. These include:

- embedding a clinical governance framework for quality assurance and audit of clinical practice in DonateLife hospitals;
- ensuring the delivery of specialised education and training of health care professionals to get best practice support in discussing donation with potential donor families;
- a new system called Organ Match which will replace the current organ matching system to enable it to be more efficient;
- continued support of leave for living organ donor program; and
- conducting a new simplified, streamlined registration channel.

Following the Minister's opening address, the session turned to a Q&A format, moderated by Professor Geoff Dobb, Head of Intensive Care at Royal Perth Hospital, with panel members including:

- Mr Allan Turner, CEO of Zaidee's Rainbow Foundation;
- Dr Wendy Rogers, Professor of Clinical Ethics at Macquarie University;
- Mr Jason Ryan, Chairman of Transplant Australia; and
- Dr Helen Opdam, National Medical Director of the Organ and Tissue Authority.

Discussion and debate focussed on numerous issues including:

- consent in terms of 'opt in' and 'opt out' (Australia has an 'opt in' system of organ donation);
- cultural beliefs relevant to donation and transplantation;
- recognising tissue donation including eye tissue (which is very successful in Australia);
- seeking transplants overseas;
- including organ and tissue donation in end of life planning;
- the impact of donation after circulatory death (DCD);
- expanded criteria of older donors;
- the benefit of simplifying the registration process;
- that a large part of the community seems to support an opt out system;
- publicly acknowledging the generosity of those who are organ donors as a marketing strategy;
- inducements to become a donor (e.g. a grant towards funeral expenses for donors);
- integrating organ donor intentions on the MyHealth record;
- improving the engagement of GPs;
- whether patients are missing out on access to intensive care due to the occupation of these beds by potential donors;
- whether the focus on organ donation is taking away from a focus on preventive care?;
- the risks and benefits of donor families meeting recipients; and
- the challenge of supporting a person's wish to become an organ donor vs their wish of dying at home – what takes precedence?

The session will help inform the review of the AMA *Position Statement on Organ and Tissue Donation and Transplantation 2012* which will commence in the near future.

AMA members and others can view the session on the AMA's YouTube channel at https://www.youtube.com/watch?v=2-tu7IPxNr4

If you have any questions regarding the session or the upcoming review of the AMA's position statement, please contact ethics@ama.com.au.

Moving forward in aged care

BY PROFESSOR ROBYN LANGHAM, CHAIR, MEDICAL PRACTICE COMMITTEE

The AMA has long advocated for a stronger, more responsive and better funded aged care system. In light of the numerous reviews continuing in the sector, and the more recent and very worrying Oakden reports, aged care issues continue to gain greater prominence in the media spotlight.

The Medical Practice Committee (MPC), in conjunction with the Council of General Practice (CGP), have taken the lead in responding to these reviews. First, we developed a submission to the Department of Health on the *Aged Care Legislated Review* [https://ama.com.au/submission/ama-submission-department-aged-care-legislated-review-2016-17]. The submission argues that:

- The aged care system must evolve to accommodate Australia's increasing ageing population, address the lack of aged care staff, and fix the underutilisation of medical practitioners in these settings;
- Aged care staff and medical practitioners need access to highly skilled nurses, properly equipped clinical treatment rooms, and updated IT clinical software;
- There is immediate need for increased communication systems between the residential aged care facility staff, the residents' GP, the My Aged Care Gateway and Aged Care Assessment Teams (ACATs); and
- Governments must ensure the new consumer-driven system is flexible and efficient to meet the changing needs of the ageing population, and to ensure that rural areas are not left behind.

In addition, the AMA took part in a My Aged Care Gateway evaluation run by the Federal Department of Health. This highlighted that the system in its current form is having a negative impact on aged care. In particular, the AMA highlighted that:

- The Gateway is unnecessarily complicated, requiring all patients to undergo either a Regional Assessment Service (RAS) or assessment by an ACAT in order to access support services. Significant delays have resulted, with the AMA receiving worrying feedback that many elderly people go without the urgent care they need;
- The application process increases the administrative burden on doctors and practice staff, and creates confusion around the processes when a patient requires urgent care;
- The current website has had several malfunctions, causing significant waiting times on the My Aged Care hotline;
- Aged Care Gateway staff overlook information supplied on the application form about medical reasons why an older patient cannot answer the phone to organise services, resulting in further delays; and
- The application form does not integrate with practice software.

The strong message from the AMA is that for the My Aged Care system to work properly, it must be simple and efficient. Reports from members indicate this is not the case – and indeed the whole process is heading in the opposite direction.

It is clear there is much more advocacy needed, prompting MPC and CGP to also review the AMA's aged care position statements, specifically the Access to Medical Care for Older Australians, as a first step in driving the debate further.

The timing is appropriate; the government has contributed $1.9 million to develop an industry-led taskforce to improve the aged care workforce. This taskforce provides an opportunity for the AMA to push governments to ensure our future workforce is appropriately equipped to deal with the challenges ahead. For example, the government has predicted that the proportion of Australians 65 years of age and over will increase to 18 per cent by 2026.

The budget has provided an increase of $3.1 million for ICT support to the My Aged Care Gateway, with the stated aim of improving system performance and efficiency. This is a small amount of funding, but a nevertheless welcome addition and we hope to see some improvements in the future. I have no doubt that far more funding will be needed to address all the issues highlighted in our evaluation.

To that end, and in light of our advocacy agenda, I am interested in your views on the My Aged Care Gateway, so please feel free to send them to the AMA at ama@ama.com.au.

Public Hospital Doctors renewed by National Conference

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

AMA Council of Public Hospital Doctors had planned to meet at the end of April. Unfortunately, like so many circumstances, clinical demand conspired against us obtaining a quorum and we've had to postpone our meeting until after National Conference. That certainly did not curb the enthusiasm for the Council of Public Hospital Doctors, which saw a record number of delegates to this year's National Conference in Melbourne. Note that the Council relates to those who identify with public hospital issues, and it warmly welcomes trainees. Similarly, all medical practitioners are training throughout their careers, and I encourage all members to "identify" as Doctors in Training, as we are never not training. I encourage senior members with years of experience in the public hospital system, particularly full timers, to support this Council, lest it wither on the vine, and our organisation loses that perspective.

National Conference featured an impressive line-up of influential political and health leaders, including the Prime Minister and the Leader of the Opposition, and associated Health spokespersons, speakers and panellists. The high priority of health policy in the current National political debate was evident by the attendance of all the key players in the field.

It is now a great, and indeed important, opportunity to involve ourselves in the issues that matter to our profession and the health of the nation. National Conference is also a great opportunity for networking and finding out what matters to doctors on the ground. I had many helpful, interesting and informative conversations with public hospital doctors from across Australia who are raising a range of important issues. A major one that is about to explode on the medico-political scene is every perspective related to private health insurance, and its interplay with the public hospital sector across Australia.

A subset is the issue of private patients in public hospitals. This is on our agenda and is an issue which requires more discussion among other groups and at the State/Territory level so we can develop an appropriate response to it. It is of concern to a range of stakeholders and is a key area of discussion for the Private Health Ministerial Advisory Committee which was established in September 2016 to examine all aspects of private health insurance and provide the government with advice on reforms.

The macro- economics have altered radically in less than a decade, as have citizens' circumstances.

Similarly, the issue of public/private partnerships to build or operate new hospitals and re-develop existing hospitals is a topic of "interest" to many. There is no easy answer to this challenging phenomenon, which has many facets, but it's something we hope to discuss in more detail as the year progresses.

Specialist medical training positions remains an area of concern. We need to enhance the quality and number of training positions, particularly in rural and regional areas. Presently in Australia there are well over 3500 medical students graduating each year, while the number of advanced training positions in the various specialties is closer to 1000. To maintain the quality of the medical profession, a fundamental ambition, we need to look beyond universities and medical schools, and start looking at specialist training programs.

On the bright side, this year's Budget offered a potential of upside in the health area.

The Medicare rebate freeze will be slowly "thawed" stepwise across a range of services over the next couple of years. The AMA's advocacy for all medical practitioners, including those who don't directly contribute, has also resulted in other changes, such as reversing proposed cuts to bulk billing incentives for diagnostic imaging and pathology services and scrapping proposed changes to the Medicare Safety Net, which may have penalised vulnerable patients. Great news of course, but more work needs to be done on positive outcomes for overworked public hospitals, Indigenous health, mental health, aged care, rural health, and the medical workforce; plenty of room to improve. It is areas such as these that require strong policy and advocacy, driven by our committed Councils and committees within the AMA.

National Conference has been a great chance for the AMA CPHD to consider the input of new members who identify as public hospital doctors. I encourage you to maintain your enthusiasm for our unique, important group, so we can discuss issues important to us and help guide AMA policy in key areas.

TO THE EDITOR

Response from ACSQHC to General Practice Column

An article in the May 15 edition of *Australian Medicine* raised concerns regarding the Australian Commission on Safety and Quality in Health Care's (the Commission's) primary care program. The article speculated that this program would result in changes to the accreditation standards for general practices and the voluntary nature of the accreditation process.

These statements reflect neither the intent nor the reality of the Commission's work in this area. The Commission is not developing standards for general practices. Rather, the Commission is working on developing a set of safety and quality standards for all other primary health care services outside of general practice, such as dental practices, audiometry and podiatry clinics, where currently standards do not exist. The Royal Australian College of General Practitioners (RACGP) is responsible for developing and maintaining the standards for general practice accreditation. The 5th edition of the RACGP's standards is scheduled for release in October 2017.

The Commission's standards for primary health care services (which as noted, will exclude general practice) are being developed as part of a broader program to develop a package of nationally coordinated and consistent strategies, tools and resources to support patient safety and quality improvement in primary health care. This work was initiated by the Commission's Primary Care Committee and is being led by an expert steering committee, of which Dr Richard Kidd is a valued member.

The Commission has a role under its guiding legislation (National Health Reform Act 2011) to develop safety and quality standards and accreditation programs for Australian healthcare services. The Commission has already developed the National Safety and Quality Health Service (NSQHS) Standards in collaboration with hospitals and day procedure services.

Increasingly, the NSQHS Standards are also been implemented voluntarily by primary health care services, such as private dental practices, audiometry and podiatry clinics, and transport services. While the NSQHS Standards were developed for use by all Australian healthcare services, some primary care services have been challenged by the implementation process. A set of nationally consistent safety and quality standards, that harmonises with multiple existing sets of professional standards and is tailored specifically to the needs of primary health care services, therefore will have several benefits.

The Commission is not a regulatory body with the authority to mandate accreditation systems. Instead the Commission works in collaboration with the Australian Government, state and territory governments, health care services, clinicians and consumers to lead and coordinate national improvements in the safety and quality of health care. An example of this collaborative approach is the Commission's three-year joint project with the RACGP to develop the National General Practice Accreditation Scheme.

The National General Practice Accreditation Scheme was launched on 1 January 2017 and supports the consistent assessment of general practices against the RACGP's standards. Changes to accreditation arrangements under the new scheme are mostly administrative and do not impinge on the business of general practices. The scheme includes the establishment of an industry-based coordinating committee to provide governance and oversight (which includes representation from the RACGP and the Commission); a process for approving accrediting agencies to assess general practices; and a data collection and reporting framework that requires submission of de-identified, non-clinical data by accrediting agencies. The scheme helps meet the needs of general practice and consumer stakeholders who identified during a public consultation process in June 2014 that they wanted greater choice of accreditation providers, improved support programs for accreditation implementation and access to national accreditation data to support benchmarking and performance improvement.

The primary care standards currently being developed by the Commission will not duplicate systems already in place, but provide an important level of protection in areas where the relevant primary care professionals believe there to be a need. The aim of the standards will be the same as that of the Commission's NSQHS Standards: to protect the public from harm and to improve the quality of health service provision. It is important to remember that the Commission and Australia's clinicians share a common goal in improving patient care.

Dr Helena Williams

Dr Williams is a GP in Adelaide, South Australia, the Presiding Member of the Governing Council of the Southern Adelaide Local Health Network, and chair of the Australian Commission on Safety and Quality in Health Care's Primary Care Committee.

Response from Dr Richard Kidd

I appreciate Dr Helena Williams' response to my column, clarifying the Australian Commission on Safety and Quality in Health Care's intentions with respect to the accreditation of primary health services.

Nonetheless, I remain firmly of the view that the profession has every right to be wary. For example, the Commission's recent tinkering with general practice accreditation went well beyond what was required by earlier recommendations from the Australian National Audit Office.

I would like to see the Standards for Primary Health Services clearly exclude general practice, recognising that it has its own standards. This would provide some reassurance the standards for general practice will remain profession-led, although there is no doubt that the profession will need to remain vigilant.

Dr Richard Kidd, Chair AMA Council of General Practice

Research

Air pollution linked with heart damage

A new report presented by the European Society of Cardiology says that there is strong evidence that particulate matter (PM) emitted mainly from diesel road vehicles is associated with increased risk of heart attack, heart failure, and death.

The lead author Dr Nay Aung, a cardiologist and Wellcome Trust research fellow at the William Harvey Research Institute, Queen Mary University of London, UK, said the cause for the heart damage "appears to be driven by an inflammatory response – inhalation of fine particulate matter (PM2.5) causes localised inflammation of the lungs followed by a more systemic inflammation affecting the whole body."

Regarding how pollution might have these negative effects on the heart, Dr Aung said PM2.5 causes systemic inflammation, vasoconstriction and raised blood pressure. The combination of these factors can increase the pressure in the heart, which enlarges to cope with the overload. The heart chamber enlargement reduces the contractile efficiency leading to reduction in ejection fraction.

The researchers said they found evidence of harmful effects even when levels of pollution associated with diesel vehicles were less than half the safety limit set by the European Union.

Dr Aung said: "We found that the average exposure to PM2.5 in the UK is about 10 µg/m3 in our study. This is way below the European target of less than 25 µg/m3 and yet we are still seeing these harmful effects. This suggests that the current target level is not safe and should be lowered."

In the UK, where the study was conducted, the Government recently produced its third attempt at a plan to bring air pollution to within levels considered safe under European Union legislation after judges ruled the previous versions were not effective enough to comply with the law.

Dr Penny Woods, chief executive of the British Lung Foundation, said: "Air pollution (in the UK) is a public health crisis hitting our most vulnerable the hardest – our children, people with a lung condition and the elderly."

Dr Woods added that, while progress was being made in high-income countries to reduce deaths from cardiovascular disease and cancer, those caused by lung disease had "remained tragically constant".

The World Health Organisation (WHO) estimates that some 3 million deaths a year are linked to exposure to outdoor air pollution. WHO also believes that indoor air pollution can be just as deadly. In 2012, an estimated 6.5 million deaths (11.6 per cent of all global deaths) were associated with indoor and outdoor air pollution together.

Only one in ten people breathe safe air according to WHO guidelines and over 80 per cent of the world's cities have air pollution levels over what these guidelines deem safe.

The Australian Medical Association has developed a Position Statement on *Climate Change and Human Health* that acknowledges air pollution is the world's single largest environmental health risk.

MEREDITH HORNE

Study questions whether older doctors are wiser

An observational study published in the *BMJ* has investigated whether the outcomes of patients admitted to hospital differ between those treated by younger and older doctors.

The Harvard study was undertaken because the relation between a doctor's age and performance remains largely unknown, particularly with respect to patient outcomes. Clinical skills and knowledge accumulated by more experienced doctors can lead to improved quality of care. Doctors' skills, however, can

Research

also become outdated as scientific knowledge, technology, and clinical guidelines change.

The conclusion to the research suggests you're likely to live longer when treated by someone under 40.

The researchers are keen to stress that their findings should be regarded as exploratory. Nonetheless, they highlight the importance of patient outcomes as one component of an assessment of how a doctor's practices change over a career. The purpose of continuing medical education is to ensure that doctors provide high quality care over the course of their careers.

The study, performed at acute care hospitals in the U.S between 2011 and 2014, looked at patient readmissions, the costs of care, and deaths within 30 days of being admitted to the hospital.

The difference in patients' 30-day mortality rates were 10.8 per cent when they were treated by a doctors under the age of 40, compared to 12.1 per cent for doctors aged 60 and up.

There was an exception: for older doctors who were treating high volumes of patients, age did not translate to higher mortality in patients.

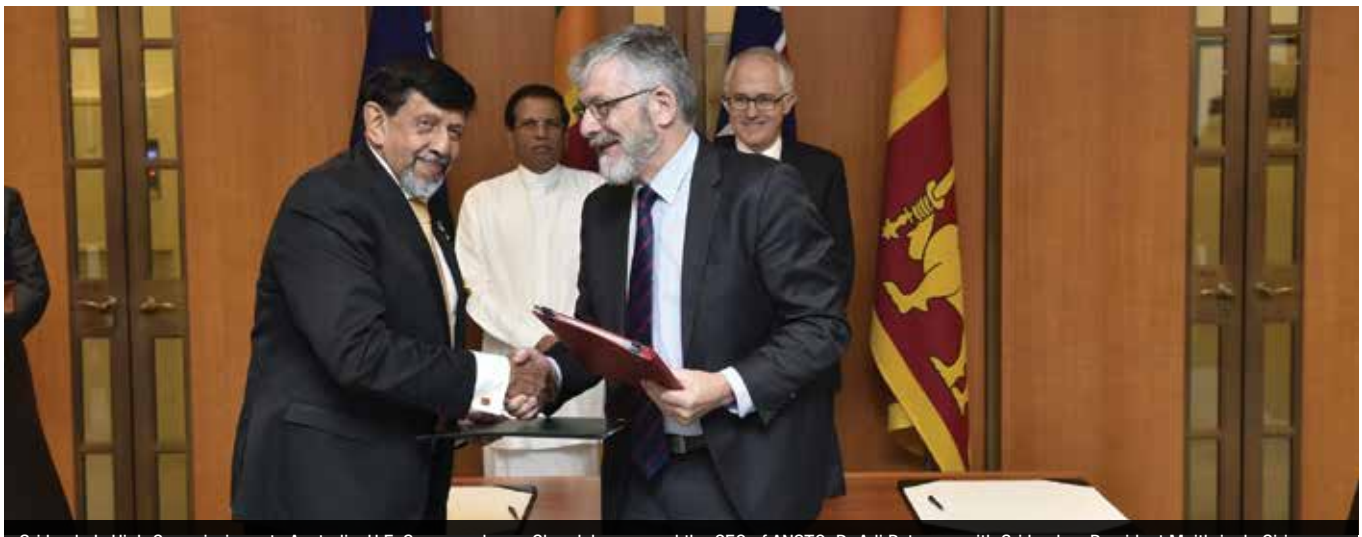
Dr Yusuke Tsugawa, the study's author said, older doctors bring experience because they've been practicing a longer time, but younger doctors have more current clinical knowledge.

"A lot of patients have a perception that older doctors give better quality of care. But previous studies, multiple studies, have shown that younger doctors have more aptitude. We found those treated by younger doctors had significantly lower mortality compared with those treated by older doctors," Dr Tsugawa said.

"Medical technologies are evolving all the time and it might be harder for older doctors to keep up with the evidence. And new guidelines are updated every five to 10 years. Newer doctors train based on the newest evidence and skills and technologies. Therefore, they may be more up-to-date when they start providing care."

MEREDITH HORNE

World leading Australian scientists developing nuclear medicine to save lives



Sri Lanka's High Commissioner to Australia, H.E. Somasundaram Skandakumar, and the CEO of ANSTO, Dr Adi Paterson with Sri Lankan President Maithripala Sirisena and Australian Prime Minister Malcolm Turnbull

The Australian Nuclear Science and Technology Organisation (ANSTO), has signed an MOU with the Sri Lankan Presidential Taskforce for Prevention of Chronic Kidney Disease to assist in the fight against Chronic Kidney Disease of Unknown Etiology (CKDu).

Sri Lanka's High Commissioner to Australia, H.E. Somasundaram Skandakumar, and the CEO of ANSTO, Dr Adi Paterson, signed an MOU that will see Australia provide new insights into the disease.

"ANSTO's expertise is in nuclear science, applied science and management of landmark infrastructure, and this new agreement is an opportunity to bring together all three, and to work on identifying the possible causes and treatments," said Dr Paterson.

CKDu is a major health problem in Sri Lanka affecting more than 15 per cent of the population aged 15-70 years in the North Central Province, mostly poor farmers living in remote areas. According to the World Health Organization (WHO), the disease is now also prevalent in the North western, Eastern, Southern and Central provinces.

The true number of CKDu cases and the cause of the disease remain unknown. CKDu is a progressive condition marked by the gradual loss of kidney function. There is an increasingly urgent need to identify the cause of CKDu in order to prevent and treat the disease and save vulnerable lives.

Priorities for addressing CKDu include earlier diagnosis and improved working conditions in such intense heat. Initial symptoms of the disease are nondistinct, such as tiredness and appetite loss, meaning people are usually diagnosed late, when damage to the kidney is extensive and irreversible. The only option at this stage is dialysis, which is not always available or accessible.

It is also a serious public health problem in other countries, particularly in Central America, and despite more than 20 years of study in Sri Lanka and globally, it is not well understood. While CKDu appears to disproportionally affect poor, rural, male farmers in hot climates, the reasons why are not yet clear.

The World Health Organisation has identified several potential contributing factors, including heavy metals in the groundwater, agrochemicals, heat stress, malnutrition and low birth weight, and leptospirosis.

ANSTO and Australia will bring together several types of science and science infrastructure, including the ANSTO operated Synchrotron, as part of the research effort to investigate the epidemiology of CKDu.

ANSTO has capabilities to investigate a number of the possible causes, routes of distribution and treatments, particularly in relation to studying any causal links with heavy metals in water, or agrochemicals.

MEREDITH HORNE

Germany set to introduce fines of up to €2,500 for failing to vaccinate

A new German law will be introduced obliging kindergartens to inform the authorities if parents fail to provide evidence that they have received advice from their doctor on vaccinating their children.

Parents refusing the advice risk fines of up to 2,500 euros under the law expected to come into force in June this year.

> "The children of parents who fail to seek vaccination advice could be expelled from their daycare centre."

Health Minister Hermann Gröhe said it was necessary to tighten the law because of a measles epidemic.

Germany has reported 410 measles cases so far this year, more than in the whole of 2016. A 37-year-old woman died of the disease this May, in the western city of Essen.

The German government wants kindergartens to report any parents who cannot prove they have had a medical consultation.

However, Germany is not yet making it an offence to refuse vaccinations. The children of parents who fail to seek vaccination advice could be expelled from their daycare centre.

Vaccination rules are being tightened across Europe, where a decline in immunisation, has caused a spike in diseases such as measles, chicken pox and mumps, according to the European Centre for Disease Prevention and Control (ECDC).

Italy made vaccination compulsory in May this year, after health officials warned that a fall-off in vaccination rates had triggered a measles epidemic, with more than 2,000 cases there this year, almost ten times the number in 2015.

In 10 European countries, cases of measles, which can cause blindness and encephalitis, had doubled in number in the first two months of 2017 compared to the previous year, the ECDC said last month.

Measles is a highly infectious vaccine-preventable disease, and globally still one of the leading causes of childhood mortality.

The World Health Organisation reports that the European Region includes highly effective and safe measles and rubella vaccines in their vaccination programs; however, due to persistent gaps in immunisation coverage outbreaks of measles and rubella continue to occur.

The Australian Medical Association endorses the overwhelming scientific evidence that vaccination saves lives. Important immunisation information is available in the Australian Academy of Science publication, The Science of Immunisation: Questions and Answers, which is available at www.science.org.au/immunisation.html .

MEREDITH HORNE

Hot Wheels!

BY **DR CLIVE FRASER**

Most car owners will not hesitate to option up their vehicle with fancy alloy wheels.

After all they are shiny and will lift the appearance of even the most ordinary sedan.

We used to call them “Mags” because that’s what they were originally made from.

“Mags” was a term that was simply short for magnesium, the 12th element in the Periodic Table.

In England in 1618 an Epsom farmer noticed that his cows wouldn’t drink from a well because of the water’s bitter taste.

The contamination was from hydrated magnesium sulphate which we now call Epsom Salts.

Doctors know that ingesting 300-400mg a day of magnesium from nuts, whole grains and leafy green vegetables will keep those essential enzyme systems running.

And whilst the average adult body contains 25 grams of magnesium, the average car contains much more.

With a melting point of 650°C it’s worth remembering that magnesium is also highly flammable with flame temperatures reaching 3,100°C.

Burning magnesium also reacts with nitrogen, carbon dioxide and water so don’t try to use these to put the fire out as they will only intensify the combustion.

Stronger and 75 per cent lighter than steel magnesium was perfectly suited to the manufacture of automobiles.

Because of its light weight from the 1930’s onwards magnesium was used in the fabrication of wheel rims.

But corrosion could let air leak through the rims and that flammability issue did cause problems when cars crashed.

A fire from a ruptured fuel tank could easily ignite the magnesium wheels and there really was no practical way of putting the fire out.

The most catastrophic example of this occurred at the 1955 Le Mans 24 hour endurance race.

A crash involving an Austin-Healey and a Mercedes 300SLR made mostly of Elektron (90 per cent magnesium) resulted in at least 84 fatalities.

The exact number of casualties is unknown, but may have been as high as 130 due to the catastrophic damage at the scene.

The body and wheels of the Mercedes burnt for hours and attempts by officials to douse the blaze with water only made the fire worse.

Having come from a family of firefighters I can remember my father’s stories of attending VW Beetle engine fires.

The air-cooled engine compartment was very prone to over-heating which damaged rubber fuel lines which in turn would leak and catch fire.

As the VW Beetle engine was made of magnesium alloys the resulting engine-bay fires were spectacular.

Fast forward to today and modern magnesium alloy wheels don’t have exactly the same flammability issues of their predecessors.

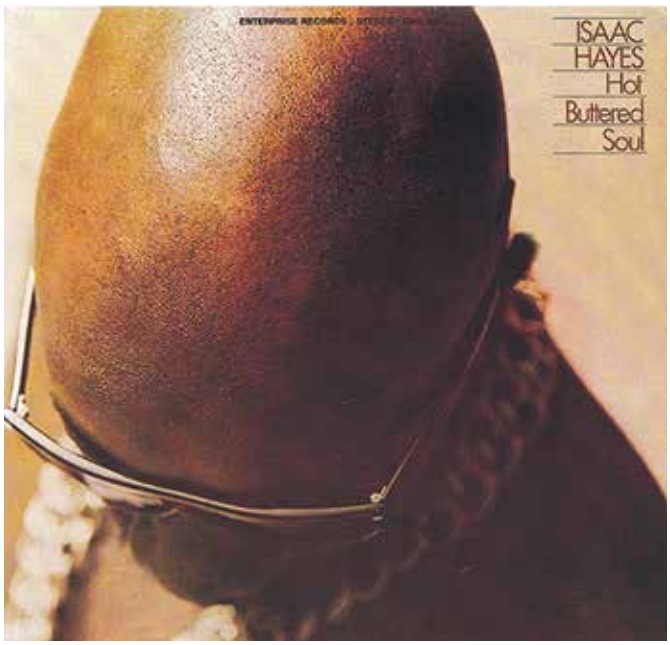
But the next time someone tells me that my wheels look “hot”, I’ll check their temperature before accepting the comment as a compliment.

BCF (bromochlorodifluoromethane) anyone?

Doctor Clive Fraser
doctorclivefraser@hotmail.com

Soul served hot and buttery

BY GUEST COLUMNIST PAUL SMITH, DEPUTY EDITOR OF *AUSTRALIAN DOCTOR*



There was a moment back in the late 80s when Whitney Huston's pitch perfect, vocal pyrotechnics in the final chorus of *I Will Always Love* You sent a shiver up my spine.

The shiver would end at the base of my brain in a twisted spasm of pain that gave me a facial twitch. It also produced a thought which today seems bizarre to me – that I didn't much care for music.

But then the late 80s was an era of mainstream aural horror. I

can still list the perpetrators: Wet Wet Wet, Bryan Adams, Whitney herself. And yes, Crowded House and REM.

And I harboured this dislike for music for some years until my life-changing conversion in a Bournemouth bedsit. The date: May 30th 1994.

At the time I was living in this English coastal town as a low paid hack on the local newspaper nurturing tobacco and drinking addictions. One of my colleagues – who we called Crabbers – was a reporter whose local patch was inhabited by people who had highest median age in England, somewhere above 72. The lack of news action in God's Waiting Room meant he spent a lot of time in the bookies testing to failure his foolproof betting system.

But he did have a big record collection. One night after running out of money at Edgecliff Arms we went back to his dingy flat. He put on one of his old vinyl records. "This is good," he said. The static crackled. I would have expressed contempt. It was *Walk On By* but instead of the Burt Bacharach, it was Isaac Hayes – whose version brought black soul to easy listening.

Twelve minutes later this song has been turned inside out into an epic, widescreen version of three minutes 60s pop, with fat incessant baselines and strings that pull your mind elsewhere, to bigger things. As proof of the revolution it has just performed, it ends with a final giant orchestral chord – it is saying "we are done". In my tiny life this was a biblical event,

Hayes had made his name as a songwriter with Stax Records. His first album was a flop. But then comes 1969, the midst of an artistic paradigm shift. In the freedoms this brings Hayes managed to knock out, with a group of Stax session musicians known as the Bar-Keys, *Hot Buttered Soul*. The final track on this album is *By the Time I Get to Phoenix* – a Jimmy Webb country favourite. Hayes makes it into a monster 18-minute track with his story of how a good man escapes the wrongs inflicted by a bad (a very bad) woman. It's ludicrous and brilliant.

To be honest if you want Whitney's technical perfection you have to look elsewhere. Hayes' singing isn't up to much. But to me all this opened up a new world. From Hayes it ran to Curtis Mayfield and then Terry Callier and the producer Charles Stepney and from that, the genius of black America.

Genius because you realised it was also forward to early 90s hip hop and back to jazz and forward to Dance and Breakbeat and Jungle and whatever is good now. *Hot Buttered Soul* just happened to be one of the million threads which stiches this glorious world together.

The consequence in my life was almost dramatic – after *Hot Buttered Soul* I spent weekends rummaging through boxes in second hand record shops hanging out with people denied regular sunlight.

I still dislike Whitney of course but only early Whitney. As the drugs destroyed her made *It's Not Right But It's OK*. That is a good record. And I feel such judgements prove that in my biblical moment I managed to escape becoming an evangelical music snob. Yes I still harbour prejudice. One of my undeclared ambitions is to get through life having never listened to an REM album. But then REM really do suck.

Prosecco – Italian Champagne?

BY DR MICHAEL RYAN

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Italy has always been a wine producing monster. The French lay claim to the most prestigious wines and senses of tradition but Italy makes more wine, has been doing it longer and can make great peasant wine to stellar wines that make you weep.

Whilst Dom Perignon lays claim to inventing Champagne in 1693, Prosecco was made in 1893 by Carpene Malvoti and now outsells Champagne on a worldwide market. Prosecco is a sparkling wine that can vary in style from spumante (sparkling), Frizzante (semi sparkling) and tranquillo (still).

The grape variety is now formally known as Glera. Other white grapes used may include Verdiso, Bianchetta Trevigianna, Perera, Glera Lunga, Chardonnay, Pinot Blanco , Pinot Grigio and Pinot Nero.

Prosecco is now descriptive of the region where this wine is made. It has been promoted from a DOC area with DOCG status, implying more prestige. Prosecco is located in Trieste in Northern Italy, north of Venice.

The term Prosecco is protected under European law and is not supposed to be used elsewhere. In Australia we still use the term Prosecco. It seems the law is on our side. The name has been in commercial use so has prior recognition as it refers to the grape variety, not a region. Otto Del Zotto from the King Valley in Victoria pioneered this wine.

So prosecco is much cheaper than Champagne. Generally stainless steel fermentation, with tank secondary fermentation to make the bubbles keeps the price down. Some producers are experimenting with the" metodo classic" akin to traditional methode as in Champagne.

The wine is served at 4-8 degrees. The usual aromas often include green apple, pear, honey dew, honeysuckle. Some more complex nutty creamy aromas develop with age. The bubbles are often softer as the pressure in the bottle is often only 2-4 atmospheres compared to 6-7 of Champagne. It is not known for its cellaring potential and usually drunk within 2-4 years of vintage.

It is mostly served as an aperitif. The Bellini cocktail is Prosecco and peach nectar mix. The most desirable cocktail that immediately transports you back to that Venetian bar is the Aperol Spritz. This is a mixture of Aperol, a light bitter liqueur from Campari, Soda water and Prosecco.

Wines tasted

1. **Carpene Malvoti Superior Prosecco DOCG – $25 bargain**

   Light yellow with delicate bubbles. The nose is classic green apples and tropical fruits. The mouth feel is smooth with balanced fruit and acidity. It sits well on the fore palate and I enjoyed with sashimi king fish with a dash of mirin and orange rind.

2. **Mianetto Cartzzi DOCG Dry Prosecco- Not cheap at $50**

   Golden hues on the eye. The bouquet is an alluring cornucopia of green apples, citrus notes, pears and almonds. The bead is fine and combined with a restrained delicate palate, makes this a sultry moreish wine. Beautiful with poached quenelles of chicken mousse.

3. **Dal Zotto Pucino Prosecco 2016**

   Light yellow with nice bead. Aromas of citrus, lemons, apples. Nice dry style with good fruit and zingy acidity. The balance overall is of a nice soft wine equally good as an aperitif or poached scallops.

4. **Santa & D'Sas King Valley Prosecco**

   Light green to yellow, good bead. Distinctive and fascinating aromas that show melon lemon notes. The mouth feel is subtle, effective with the apple and nutty tones in the palate.

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**

Jobs Board: Whether you're seeking a new position, looking to expand your professional career, or looking to recruit staff to your practice, doctorportal Jobs can help you. Discounts apply for AMA members. jobs.doctorportal.com.au

MJA Events: AMA members are entitled to discounts on the registration cost for MJA CPD Events!

UpToDate: 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.

doctorportal Learning: AMA members can access a state of the art CPD tracker that allows CPD documentation uploads, provides guidance CPD requirements for medical colleges, can track points against almost any specialty and provides access to 24/7 mobile-friendly, medical learning.

Learning.doctorportal.com.au

MJA Journal: The Medical Journal of Australia is Australia's leading peer-reviewed general medical journal and is a FREE benefit for AMA members.

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.

Career Advice Service and Resource Hub: This should be your "go-to" for expert advice, support and guidance to help you navigate through your medical career. Get professional tips on interview skills, CV building, reviews and more - all designed to give you the competitive edge to reach your career goals.

www.ama.com.au/careers

Amex: As an AMA member, receive no-fee and heavily discounted fee cards including free flights and travel insurance with range of Amex cards.*

Mentone Educational: AMA members receive a 10% discount on all Mentone Educational products, including high quality anatomical charts, models and training equipment.

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.

Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

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

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