

A U S T R A L I A N

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**Medicine**

**Managing Editor:** John Flannery  
**Editor:** Chris Johnson  
**Contributors:** Maria Hawthorne  
Meredith Horne  
Simon Tatz  
Alyce Merritt  
**Graphic Design:** Streamline Creative, Canberra

### Advertising enquiries

Streamline Creative  
Tel: (02) 6260 5100

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

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Dr Michael Gannon



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Dr Tony Bartone

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# The world view of health

BY AMA PRESIDENT DR MICHAEL GANNON

It was a great privilege to attend the 206th Council Session of the World Medical Association (WMA) in Zambia last month. It was held in the spectacular setting of a hotel on the banks of the Zambezi River, which constitutes the border between Zambia and Zimbabwe before and after its waters thunder over the spectacular Victoria Falls.

The WMA is the peak body representing 111 National Medical Associations (NMAs). As you might imagine, the NMAs are completely disparate in terms of the populations they serve, and no time is devoted to discussing minor industrial matters.

However, the professional matters that influence medical practice and the ethical principles that unite doctors from the six WMA regions are profound.

Substantially, WMA policy is in keeping with AMA policy. The AMA's strong policy book means we are able to contribute substantially and effectively to the WMA's determinations.

Policy documents are worked up through three separate sub-committees before being voted on by the broader Council sessions. They do not become formal WMA policy until endorsed by the General Assembly, which is held once a year. This year's meeting will be held in Chicago in October.

We discussed at length a whole variety of issues, including:

- organ and tissue donation;
- boxing;
- climate change;
- medicinal cannabis;
- HIV/AIDS;
- hunger strikers;
- tuberculosis; and
- smallpox destruction.

Some of the WMA's work remains particularly contentious, including the statement on medical tourism. It is largely accepted that patients should ideally not travel overseas for medical treatment where they might displace local patients, and with follow up mechanisms that are likely to be less than optimal. However, there are numerous examples where it is desirable for patients to travel overseas for health care. In some countries, organ transplantation is not possible.

Issues like these vary across the planet with culture, history, and geography. I live over 2,000 km from the closest city of 100,000 people. Yet my friend and colleague, Dr Andreas Rudkjøbing, President of the Danish Medical Association, travels across the Oresund Bridge from near Malmo, Sweden, to Copenhagen to work every day.

One recurring theme at both WMA and AMA meetings, and last year's meeting of the Confederation of Medical Associations of Asia and Oceania (CMAAO), is the continuing threats to the independence of doctors. I found my conversations with the President of the Turkish Medical Association particularly distressing.

The WMA passed a resolution in support of Dr Serdar Küni, the Human Rights Foundation of Turkey's representative in Cizre and former President of the Şırnak Medical Chamber, who remains imprisoned after six months of detention on charges that he provided medical treatment to alleged members of Kurdish armed groups.

The case of Dr Küni is one example among many of ongoing arrests, detentions, and dismissals of physicians and other health professionals in Turkey since July 2015, when unrest broke out in the country's south-east.

The WMA condemns practices that gravely threaten the safety of physicians and the provision of health care services. The protection of health professionals is fundamental, so that they can fulfil their duties to provide care for those in need, without regard to any element of identity, affiliation, or political opinion.

Across the world, doctors face increasing control of their practices by governments, by other regulators, and by their paymasters. In Australia, both government and private health insurers increasingly interfere in the independent practice of medicine.

The WMA's Declaration of Seoul contends that *'the central element of professional autonomy and clinical independence is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals'*.

I spoke against an editorial revision of this and the Declaration of Madrid, both of which enshrine the independence of doctors as being essential to the inviolability of the doctor-patient relationship, and the need to put the needs of the patient first.

I look forward to my continuing engagement with the WMA. The Declaration of Geneva is currently being subjected to editorial review. I encourage all of you to consider its wise words and let them influence your practice day on day. There are principles and policies on show at the WMA that invoke 2,500 years of medical ethics.

It is worthwhile taking a step or two back from the latest progressive idea, folly, trend, or gimmick and reflect on the Hippocratic traditions of medicine, which of course predate the majority of the world's great religions and its many forms of government.



# My Health Record

BY AMA VICE PRESIDENT DR TONY BARTONE

Just the mention of anything relating to a digital health record is enough to make most health bureaucrats' eyes glaze over and a politician may even experience a heart flutter! The corridors are littered with the projects and goodwill of many people who have passionately sought to lead the innovation the change the digital transformation in health. Yet in 2017 we are still grappling with the challenge of delivering one of the largest transformational undertakings in health. Ask anyone in leadership where things are at at the current time and you are likely to get many different answers.

Since the National Electronic Health Transition Authority (NEHTA) and the evolution of Australian Digital Health Agency (ADHA) there has been much anticipation about essentially the next round of engagement and subsequent transformation.

With the announcement of the new National Digital Health strategy later this year it is timely to revisit this topic. The My Health Record was never designed to replace an organisation's patient health record. It could be said that it was to facilitate the communication and sharing of medical information on behalf of patients. It is clearly going to be of most benefit to Australians with chronic and complex illnesses, to ATSI and to mentally ill and older Australians and to rural and regional Australians.

The capability exists now for sharing of simple but important clinical information. Electronic referrals Allergies, Shared Health Summaries (SHS), Medication, Immunisations and very soon Path and DI all could be shared and recorded in a central location for each patient. However, up to now the number of registered users remained very small and as such the utility minimal. This is starting to change following a reversal from an "opt in" to an "opt out" strategy following the recent trials of Nepean Blue Mountains and Northern Queensland were undertaken.

Massive communication campaigns enlisted and essentially people in these regions were advised that they all had a digital health record unless they opted out. This success of these trials largely underpinned the announcement made by the COAG Health council Communiqué of March 2017 where the ministers agreed to a national opt out model for long term participation arrangements in the My Health Record system.

The agency (ADHA) rightly points to the figures that some 4.7 Million consumers are registered individuals on My Health Record.

(almost 20 per cent of the Australian population), 1.7 million plus clinical documents (including some 700,000 shared health summaries with 7 million prescription documents for dispensed medications and 1 million immunisation documents from Medicare's ACIR programme.

However despite 6000 General Practices registered being incentivised to upload SHS to the My Health Record as many as 20 per cent of these practices have not submitted the minimal govt required SHS uploads which has placed all or some of their electronic health incentive (PIP) payments at risk. There are still ongoing discussions with the Path and DI sectors regarding the path for uploading results to the record (let's be clear, however, the capability exists right now). Pleasingly but only just recently NSW Health Pathology announced that it will upload results to the Record.

There is clearly a lot to do still. The utility and the number of records will be significantly improved by more usage and further incentivised buy-in and adoption. The long-term benefits and improvements are worth the challenge but there is a lot of work and effort and disruption required and this needs to be recognised and assisted by significantly rewarding change and facilitating the process and provision of resources.

Organisational transformation requires energy, drive, time and learnings. Infrastructure for many State hospital systems needs to be significantly up-scaled. Utility will be also driven by novel applications. The task of data cleansing equally daunting in magnitude will further drive outcomes.

There are other potential stumbling blocks now still. Recent Privacy issue regarding setting the privacy settings on an individual file demonstrates that there still is confusion both in the sector and lack of understanding amongst patients. We need additional resources training all in the sector and informing patients and educating the community as increasingly more healthcare organisations look to upload various elements to the record.

Perhaps, even more pressingly, the negotiations regarding the uploading of pathology and DI results needs to be fast tracked and facilitated.

It is still going to be a while before GPs can start to render their fax machines obsolete.



## The busy month of May

BY AMA SECRETARY GENERAL ANNE TRIMMER

“It is indicative of the high level of political interest in health policy that this year both the Prime Minister and the Leader of the Opposition are participating, in addition to the Minister for Health and Shadow Minister for Health.”

May is the busiest month in the AMA calendar with the Federal Budget, the AGM, and National Conference all taking place.

This year there is no election of office-bearers as part of National Conference, nor is there an election for positions on Federal Council. These are held every second year, in the even-numbered years. The President and the Vice President have a two-year term through to May 2018.

The National Conference program is now final. If you are not attending as a delegate but are interested in participating, general registrations remain open and can be accessed via the National Conference website. It is indicative of the high level of political interest in health policy that this year both the Prime Minister and the Leader of the Opposition are participating, in addition to the Minister for Health and Shadow Minister for Health.

As many members will be aware, the AMA has invested significantly in recent years in improving the digital delivery of information. The doctorportal platform is one example. In coming months the platform will be used to deliver online learning which will also provide CPD points. Online delivery of learning content will grow over time, with the AMA recognising that members want to learn in their own time, and often in a location where face-to-face learning is not readily accessible.

Another member benefit that will transition to a digital version during 2017 is the AMA Fees List. The new web-based Fees

List will provide greater flexibility and security with members and their practices accessing the content via an online portal. An additional benefit is that changes in the MBS can be more readily accommodated as they are released, and incorporated into the Fees List. More information on the project will be made available over coming months.

In my last column I reported on the discussions at the March meeting of Federal Council about transparency of data on medical practitioner clinical quality performance, and transparency of fees charged by medical practitioners. As I noted at the time, both are areas of interest to the private health insurance sector which is making forays into the area of disclosure through websites such as Whitecoat.

At the instigation of the Nick Xenophon Team the Senate has agreed to refer to the Community Affairs References Committee, an inquiry into medical and private health insurance costs in what it argues is a bid to address medical fee structures and lack of transparency that is reducing access to private health care. The inquiry will look into the affordability of private health insurance and out-of-pocket medical costs, and other price issues affecting consumer access. These will include the role and function of medical pricing schedules such as the MBS and the AMA Fees List.

The AMA will be making a strong submission to the inquiry, with the committee to report by 27 November 2017.

# Assurances given on generic prescribing

Amid pre-Budget speculation in Parliament House and around the health sector in Canberra that the Government was considering making generic prescribing mandatory, the AMA went public with its concerns and sought clarity and certainty from the Government that its proposed Pharmaceutical Benefits Scheme changes would not interfere with the independence of doctor prescribing.

“Doctors need to keep the control over prescribing medicines for their patients, despite any push for them to prescribe generic drugs.”

The AMA wanted confirmation that prescribing independence would be respected and preserved, that doctors could prescribe brand medications where they were the most appropriate for individual patients, and that the changes would not impose a new bureaucratic burden on busy doctors. These assurances were given by Health Minister Greg Hunt’s office. The AMA will support the changes on the basis that all savings are ploughed back into health.

Doctors need to keep the control over prescribing medicines for their patients, despite any push for them to prescribe generic drugs.

The AMA says generic drugs can be a satisfactory alternative to brand name medicines, but doctors know what is best for their patients and should not be forced into prescribing anything.

Assurances have been given to the AMA that any Budget changes aimed at saving the PBS a reported \$1.8 billion over five years will not mean doctors will be forced into prescribing generics.

AMA Vice President Tony Bartone explained these assurances when discussing reports of the changes on ABC Radio.

“There are occasions where the generic option isn’t a universally good option for some parts of our patient population,” Dr Bartone said.

He said the fact that generics and brand name medicines are chemically the same can cause a level of confusion that could result in some patients either not taking or delaying their medication.

“There are little nuances in this area and that’s where I’m saying

that it’s not universally the best option,” Dr Bartone said.

“But as long as everyone’s on the same page and aware of what is being alternatively supplied and understanding the nuances of that, it’s a perfectly legitimate option to be offered.

“What we’re talking about is health literacy and being fully engaged and aware of the whole conversation around the issue.

“And yes, ultimately, anything that allows a more efficient system, a more efficient PBS, and allows those savings to be ploughed back in to offer newer, more novel medications which are being developed all the time... well that’s a good thing.”

Dr Bartone said the AMA’s concern was initially raised following reports suggesting the changes would be forced on doctors.

The Government would change the prescribing software used by doctors so that generic medicines were given by default.

GPs would have to opt out of the system each time they wanted to prescribe a particular brand name drug.

But Dr Bartone said the Minister had assured that changes to the system would not be mandatory.

“There was talk about this generic option being a mandatory or compulsory option. And what we responded to was that for some of our patient population, that’s not a good thing,” he said.

“And now we’ve received assurances that this is not going to be mandatory. There won’t be an arduous workaround, and it will allow us to maintain our clinical independence.

“That is making sure that the medication that we choose is in our patient’s best interest and we know that our patient will be aware of it and will take it, because they’re used to taking it and there won’t be the possibility of confusion.”

Before the Budget, Mr Hunt told the ABC’s 7.30 that any savings from the changes would go back into the PBS by listing new medicines.

“Our commitment is that there will always be 100 per cent doctor control over the prescriptions that they give,” he said.

“That’s what it has been, that’s what it is and that’s what will be and that’s what it will always be under a Coalition Government.”

Dr Bartone told the same program that: “Independent clinical decision making and prescribing is something that the AMA holds very dear and very true to our hearts.”

CHRIS JOHNSON

# Meeting over labelling of oils in food

On April 28, ten members from the Australia and New Zealand Ministerial Forum of Food Regulation (the Forum) met to consider the future of transparent labelling of all oils on food products.

Ministers agreed to extend the scope of this project to cover all parts of the food label, including the identification of all fats and oils and to proceed with the development of regulatory and non regulatory options. The residual issues, such as additional consumer research will also be undertaken as part of this next stage with a progress report to be provided at the next Forum meeting.

This is an issue the Australian Medical Association has previously raised with the Federal Government. In November 2016, AMA President Michael Gannon wrote to then Minister Sussan Ley about the AMA's concerns regarding palm oil.

The background to this story is that back in 2011, the Government's Review of Food Labelling Law and Policy (known as 'The Blewett Review') made a specific recommendation regarding the labelling of fats and vegetable oils:

**Recommendation 12:** That where sugars, fats or vegetable oils are added as separate ingredients in a food, the terms 'added sugars' and 'added fats' and/or 'added vegetable oils' be used in the ingredient list as the generic term, followed by a bracketed list (e.g., added sugars (fructose, glucose syrup, honey), added fats (palm oil, milk fat) or added vegetable oils (sunflower oil, palm oil)).

Following this recommendation, the Government announced that Food Safety Australia and New Zealand (FSANZ) would undertake a technical evaluation to provide advice on the proposed changes.

The AMA supports the implementation of Recommendation 12. Australian consumers have the right to know the type of added sugars, fats and vegetable oils are in their food. In particular, because of the health and environmental issues associated with palm oil, consumers should be informed of whether food products contain palm oil.

The AMA recognises the evidence that certain fats pose a risk to cardiovascular health, even when consumed at low levels. The AMA's position statement, *Obesity – 2016*, stated:

Labelling of packaged food items must facilitate healthy food choices by enabling consumers, from all socio-economic and cultural backgrounds, to easily recognise and compare food items in terms of their effects on weight and health. Research shows that consumers make choices on the basis of nutritional information, and prefer 'at a glance' information.

The complexity of nutritional information, especially on food labels, may seem confusing to the public. However, the goal of such labels is to better inform consumers as to the content of the food. Energy and fat content is the most common reference point on food labels. Food labelling needs to be constantly reviewed in very practical terms and should consider what people need to know about the foods they consume and how to know if they are eating the right quantity for their needs.

Doctors are very aware of how difficult it is for families to find the appropriate information they need to make healthier food choices, especially in the busy routines of daily life. The nutrition information on packaged food labels should be a good source of this information.

Food labelling which is simple and informative is key to making it easier for people to make healthy choices about the types and amounts of food and beverages they consume. There is a need for more effective, and user friendly, food labelling to be implemented in Australia.

At the Forum's last meeting, in November 2016, they identified that labelling of sugars and fats/vegetable oils is a very complex issue and agreed that consideration of the recommendation should continue as two separate pieces of work – one looking at naming sources of fats and oils and the other to further investigate labelling approaches for providing information on sugars.

Victoria had been the only State or Territory publicly committed to supporting the mandatory labelling of oils on food products. This decision has been delayed for many years, and environment and health groups agree that it is time for our region to follow the lead of the EU, USA and Canada and introduce the mandatory labelling of all oils.

Australian environmental groups have been speaking up on this issue for years, particularly in relation to the rampant unsustainable production of palm oil. Without clear labels consumers have no ability to know where the palm oil is sourced from, or how, and therefore cannot demand sustainably produced oil, or even make an informed choice based on clearly disclosed facts.

In Galaxy Research polling conducted in March 2017, 90 per cent of Australians and 93 per cent of New Zealanders currently support mandatory labelling of all oils so they can make informed choices, while 88 per cent indicated that mandatory labelling of all oils would help them make decisions relating to their health.

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SIMON TATZ, DIRECTOR, PUBLIC HEALTH



# Not happy with draft National Maternity Services Framework

*The following is largely taken from the AMA's submission to the draft National Maternity Services Framework. The full submission can be viewed at: <https://ama.com.au/submission/ama-submission-national-maternity-services-framework>*

The AMA is appalled that an opportunity for Australian governments to articulate a national vision to guide the future of public sector maternity services is being wasted.

The Queensland Government is leading a project to develop a national public maternity services policy, but the AMA has deep concerns about the conduct of the project and its outcome.

The draft National Maternity Services Framework is so lacking in substance, so general and generic, that it ends up providing no 'framework' at all. State and Territory health services could provide any kind of maternity services of any standard and still meet the Framework 'requirements'.

Australia should be striving to have the best maternity services in the world – we are certainly capable of achieving this. Instead it appears that governments are ignoring the elephant in the room – the increase in recent years of infant mortality in some areas of Australia.

It is clear that the views of medical practitioners – the leaders of the provision of high quality maternity services in Australia – have been ignored. The AMA has already complained to the Queensland and Federal Health Ministers about the inadequate

process for ensuring that the development of the Framework was informed by the full range of health care professionals involved in the provision of maternity services.

Medical practitioners involved in 21st century best practice maternity care include specialist Obstetricians, General Practitioners, Anaesthetists, Psychiatrists, Obstetric Physicians, Pathologists and Haematologists. Not even the two key medical practitioners, obstetricians and general practitioners, were genuinely consulted.

The draft Framework does not explain how we will measure the success, or indeed failure, of maternity services in Australia. No quantifiable benchmarks have been provided for what constitutes success – no goals or standards are set. The key and obvious quantifiable measures – maternal and perinatal illness and death – are ignored in the proposed list of National Core Maternity Indicators.

The health of mothers and babies should be paramount, and yet this seems to be a secondary consideration in this Framework. Of course it is important that services are women-centred, recognise cultural differences and are equally accessible by all women. However, we should also recognise and be guided by the evidence and a much greater requirement to focus on the safety and needs of the other half of the equation in this care – the baby.





“The draft National Maternity Services Framework is so lacking in substance, so general and generic, that it ends up providing no ‘framework’ at all.”

The fact is that obstetrician-led maternity services provide the best outcomes for mothers and babies. The practice of obstetrician-led care ensures risk is managed appropriately and any co-morbidity or extra precautions to improve patient safety are properly considered.

It is devastating for our obstetrician members to see mothers and babies suffer needlessly. All too often an obstetrician is only made aware of a labour problem once it has become acute or serious, sometimes many hours after it began to develop. The obstetrician is then expected to assume all responsibility for the care and outcome of the mother and baby.

The popular public hospital maternity services model tends to be midwife-led with obstetrician rescue. But sometimes it is too late for rescue.

An obstetrician has broad medical education in addition to their speciality training spanning 15 years, giving them the clinical and surgical skills to assist mothers and babies in all scenarios. Midwifery training is narrower in scope and much shorter, however midwives are often put in the position of managing a patient’s entire pregnancy and labour.

The Framework does not discuss appropriate models of care, let alone the available evidence supporting (or not supporting) different models of care. It does not provide any guidance to governments about the appropriate mix of health practitioners making up a high quality maternity service. It is not acceptable to dodge this issue by saying that Australian environments and conditions are too diverse for this to be prescribed. Access to maternity services cannot be ‘equitable’ if some women – particularly those in rural and remote areas – are only offered substandard models of care.

Related to this is the lack of acknowledgement or discussion about the workforce issues which exist in several states and territories, and are especially in crisis in rural and remote areas. There is little point in proclaiming a ‘vision, values and principles’ if there are insufficient positions for health practitioners, a lack of training opportunities, and adequate infrastructure, to support maternity services in rural and remote Australia.

Women put their trust in the health practitioner managing their care. Not only must this health practitioner be able to fully assess, monitor and address problems as they arise, but

they should fully inform women of the risks to themselves and their babies of the choices they make regarding their maternity care plan, whether this concerns the risks of smoking through pregnancy or the risks associated with home births. The AMA fully supports women making their own decisions based on their values and preferences – as long as they are fully informed of the risks and benefits.

Finally, in relation to the *Phase 1 Consultation Report for the National Maternity Services Framework* that was released at the same time as the consultation draft Framework, the AMA notes that stakeholders were not provided with the opportunity to verify its accuracy.

The AMA understood that this report would be published in order to increase transparency about the consultation process undertaken to inform the draft Framework.

Instead, the report makes no mention of the late one-on-one meeting that was required with the AMA after it had not been included in the stakeholders identified for consultation. The AMA is listed as one of the stakeholder groups attending stakeholder workshops – which is not true. The AMA was not invited to participate in any workshops until it was too late to attend, and nor did it receive an on-line survey to complete. The views of the AMA provided at its one meeting with consultants are not reported.

The report also does not list which stakeholders were contacted, why they were chosen, or what lead time was provided to those stakeholders who were contacted to attend workshops. This is hardly an accurate report of the ‘consultation’ undertaken.

The AMA cannot support the draft National Maternity Services Framework in its current form. Our primary concerns are articulated above, and some specific comments on the draft Framework text are provided in an attachment.

The AMA instead supports the alternative framework being developed by the Royal Australian College of Obstetricians and Gynaecologists – *Maternity Care in Australia*. This document is evidence-based and provides considered, realistic, meaningful and systematic guidance for public sector maternity services aimed at improving outcomes for mothers and babies.

CHRIS JOHNSON

# No Jab No Pay gets tougher

Parents who refuse to vaccinate their children will have their fortnightly family benefits docked under a new Federal Government immunisation push.

The AMA sees no problem with the new measure, saying vaccinating children is a public health priority and that the No Jab, No Pay policy – introduced in January last year – works.

“Beginning next year, families who have not had their children vaccinated will lose \$28 per child every fortnight in family tax benefits...”

Beginning next year, families who have not had their children vaccinated will lose \$28 per child every fortnight in family tax benefits, after the Government closed a loophole allowing families earning more than \$80,000 to escape penalty.

The current scheme fines families a one-off \$726 supplement, but welfare reforms cancelled that payment to 400,000 high-income families – meaning they could avoid being penalised if they didn’t immunise their children.

So from July 1 next year, each fortnightly Family Tax Benefit Part A payment will be reduced by \$28 for every child that hasn’t been properly immunised, meaning there will be one policy in place for all.

“This isn’t about punishing people,” said Social Services Minister Christian Porter.

“If you do the right thing and get your kids immunised, absolutely no problems whatsoever. But if you are one of the small group of people who don’t do that and cause safety ill-effects for other children in environments like child care, then you can and will face a penalty.

“And I just think that’s completely and utterly fair, and it produces a result which is better health for more kids.”

AMA President Dr Michael Gannon agrees.

“No Jab, No Pay is a success,” Dr Gannon said.

“There’s another 200,000 kids that are protected as individuals, and that, in an exponential way, increases the protection afforded to other children in playgroups and schools from

serious infectious disease.

“I think how much better we can do is difficult to know. We know that there is something like one to two per cent of Australian families that you will never reach.

“They live in a fantastic world of thinking that there’s some broad conspiracy with vaccination. But what we always strive to do is to reach that three, four, five, six per cent of vaccine-hesitant parents.

“That involves individual doctors and nurses being respectful and careful in delivering the information. There’s no doubt about the science, but it’s a case of taking people with us, not purely punitive measures.”

Mr Porter said that without a valid medical reason, there was no excuse for parents not to immunise their children.

“These parents are not only putting their own children’s health at risk, but the health of every other person’s children at risk, too,” he said.

“Reducing fortnightly payments rather than withholding the supplement at the end of the year as occurs at present, will serve as yet another constant reminder for parents to have their children’s immunisation requirements up to date.

“It’s certainly been designed based on the best behavioural economics science to try and make sure that we are giving disincentives, structured into the system, to ensure that people behave in a way that’s in the best interests for their kids.

“And ultimately the principle here is that, where the taxpayer allows for a very generous system of Family Tax Benefits, that money shouldn’t be applied to families who are either making conscious decisions, or simply failing to act, and do so in a way that endangers the health of other children whose families are doing the right thing.”

The No Jab, No Pay rule applies to 1.5 million families. About 134,000 of them are currently missing out on the supplementary payment because they do not immunise their children.

Immunisation rates have, however, risen for one-year olds by 1.35 per cent to 93.63 per cent nationwide. For two-year olds the rate rose 1.75 per cent to 90.06 per cent.

CHRIS JOHNSON

# Protection of patients and practitioners

The Medical Board of Australia (MBA) and Australian Health Practitioner Regulation Agency (AHPRA) recently released the report *Independent review of the use of chaperones to protect patients in Australia* and have accepted all its recommendations.

This review into the chaperone provisions was established to consider whether, and if so in what circumstances, it is appropriate to impose a chaperone condition on the registration of a health practitioner to protect patients while allegations of sexual misconduct are investigated.

Allegations of sexual misconduct can arise from a number of reasons including a misunderstanding or miscommunication, and poor physical examination technique, through to more serious boundary violations or sexual assault. If a practitioner is concerned about a potential misunderstanding or malicious allegation, they should consider using a chaperone as it affords the doctor some protection. The AMA patient examination guidelines provide more information about chaperones for practitioners and patients here <https://ama.com.au/position-statement/patient-examination-guidelines-1996-revised-2012>

The AMA lodged a submission to the review stating that there is a place for the sensible use of a chaperone when there are questions of misconduct and called for a balanced approach to managing situations where an allegation of sexual misconduct is made against a practitioner. The submission agreed that the previous system was flawed, and offered options to strengthen the system rather than removing the option of using a chaperone as a restriction altogether (as occurred in the United Kingdom). Of course, the AMA argued that any solution must ensure that patients are protected.

The AMA contended that removing the ability for boards to impose chaperone condition would have the following consequences:

- a) Practitioners with allegations against them will be removed from their practice for a substantial period of time potentially losing their referral base, their professional reputation their standing in practice, or ultimately their business.
- b) Practitioners who are concerned that they may be subject to false claims will need to employ a chaperone to be present at all times to ensure they have a witness as a preventative measure. Patients may bear the cost of this additional resource.

Professor Paterson's report recommended that chaperone conditions be discontinued as an interim restriction in response to allegations of sexual misconduct with a view to making greater use of gender-based restrictions, prohibitions on patient



contact and suspensions. The Board and AHPRA have agreed with this recommendation and the AMA intends to monitor the implementation of these changes closely with a view to reviewing whether they are effective or cause unintentional and irreparable harm to practitioners.

APHRA and the Board have committed to establishing a new specialist committee to deal with notifications involving allegations of sexual boundary breaches that will be supported by a new specialist team within AHPRA to increase the timeliness of investigations. The AMA will work with the regulators to ensure that the implementation of the new measures lead to a quick resolution of cases and afford practitioners due procedural fairness – particularly given the potential consequences for the practitioner under review.

Most importantly, the AMA was glad to see that the Board and AHPRA have also agreed to provide for the use of chaperones as a condition in exceptional cases.

The AMA has raised its concerns about the potential for these new restrictions to prevent a doctor from conducting any practice subsequent to an allegation of sexual misconduct with the Minister for Health and Sport. The AMA also stated this concern in its submission to the Standing Committee on Community Affairs Inquiry into the complaints mechanism administered under the Health Practitioner Regulation National Law.

Further developments in this space will be monitored closely by the AMA, as the principle of procedural fairness has been challenged by this report. Procedural fairness is an important part of the National Registration and Accreditation Scheme and the AMA intends to defend it rigorously.

CHRIS JOHNSON

# Interim cervical screening MBS rebates and other arrangements

Doctors are being urged to encourage women to continue with their scheduled cervical cancer screening under the current National Cervical Screening Program regardless of the delay of the new program.

There are also important interim arrangements in place from 1 May to 30 November to ensure MBS items for cervical screening continue until the new program begins on 1 December 2017.

1. A Medicare rebate is now available for the Liquid Based Cytology (LBC) test, set at \$36 per test, as well as for the conventional cytology test. However a Medicare rebate is only payable for one cervical screening test for cytology for each patient, either the LBC test or the conventional cytology test.

If you choose to do both tests, you will need to inform your patient that she will incur an out-of-pocket cost.

2. Until 1 December 2017, turnaround times for cervical screening test results may be longer than usual as the pathology workforce adjusts to the change but the delays should not pose risks for women.
3. You may need to liaise with your pathology provider about the scope of cervical screening technologies they offer and for advice about preparing conventional slides or LBC samples.
4. State and Territory registers will continue to send cervical screening reminders and follow up communication to eligible women and their providers until 30 November 2017. You should continue to issue recalls and reminders to patients according to your current procedures.

CHRIS JOHNSON


INFORMATION FOR MEMBERS

## AMA List of Medical Services and Fees

### 1 MAY 2017 Summary of Changes

The 1 November 2016 AMA List of Medical Services and Fees has been updated to reflect the 1 May 2017 Medicare Benefits Schedule (MBS) items. The update includes MBS changes since 1 November.

The changes are available in the following electronic formats; a *Summary of Changes – 1 May 2017* PDF, a CSV file for importing into practice software, as well as the Fees List Online Database where members can view, print or download individual items or groups of items to suit their needs.

To access this part of the website simply enter your username and password by clicking on the  symbol in the right corner of the blue task bar at the top of the AMA homepage and follow these steps.

- 1) From the home page hover over **Resources** at the top of the page. A drop down box will appear. Under this, select **Fees List**.
- 2) *For the PDF and CSV* – Select first option, **AMA List of Medical Services and Fees – 1 November 2016 (Members Only)**.
- 3) Download the **CSV** (for importing into practice software) or **Summary of Changes PDF** (for viewing).
- 4) *For the Fees List Online Database* – the database can be accessed directly via <http://feeslist.ama.com.au/>

Also available to members is the AMA Fees Indexation Calculator, this allows you to calculate your own fee increase based on your individual cost profile. To access the AMA Fees Indexation Calculator, follow these steps:

- 1) From the home page hover over **Resources** at the top of the page. A drop down box will appear. Under this, select **Fees List**.
- 2) Select AMA Fees Indexation Calculator (Members Only)

Members who do not currently have a username and password should email their name, address and AMA member services number to [memberservices@ama.com.au](mailto:memberservices@ama.com.au) requesting a username and password.

# Moving with the times – a new online, member focussed AMA Fees List for 2017

Medical fees are increasingly becoming an issue of both medical and mainstream media scrutiny. For our members, one of the challenges with fee setting has of course been the ongoing Medicare freeze – it has put pressure on practice viability, as medical practitioners bear the burden of inflation and increased costs of running practices, without the corresponding adjustment being made to the MBS and the patient rebate.

“The AMA’s position has always been that medical practitioners should use their own judgement to charge an appropriate fee for a medical service.”

The AMA’s position has always been that medical practitioners should use their own judgement to charge an appropriate fee for a medical service.

Furthermore, the AMA takes the view that a medical practitioner should determine in each individual case what is a fair and reasonable fee – taking into account the cost of delivering the service, the circumstances of the case and the patient. There is no doubt that the cost of running medical practices varies across the country, as do overheads such as rent, electricity and insurance.

For many members, the AMA’s List of Medical Services and Fees (Fees List) is a critical aid in providing guidance on what fee to charge.

You may not be aware that the Fees List was first produced as a book in 1973, and (with the exception of 1978) has been updated yearly. In 2016 it was still provided in book form, supplemented via CD-ROM and a limited online website.

We recognise that the Fees List remains a major member benefit. But we also know that in the 21st century, primarily making it available as a small print book is not a productive, innovative or helpful format for modern practice. As such, the AMA Board took the decision that 2017 will see the AMA Fees List become entirely digital and we will discontinue the printed book. The decision was largely influenced by the dated platform on which the Fees List is built.

However, this is not just a case of switching off the printed format.

The new online offering will be via a dedicated, new look website. It will be more user-friendly, will provide the capacity to search for a fee via a number of criteria, and will have a range of other helpful features and guidance as it matures. The Fees List will continue to be available for download, and in the existing file formats previously available via CD-ROM. For those who may wish to print parts or all of the Fees List for offline use, a PDF will continue to be available online for that purpose.

The intent for the new website is that it will be user-centred, have an intuitive navigation structure and be accessible on multiple platforms – computer or tablet. As part of this transition, we will also be investigating ways to simplify the importing capabilities into medical practice software, where possible.

The move to an online only offering will also provide the opportunity to update the Fees List throughout the year, as ongoing changes are made to the MBS. This will be important as the MBS Review rolls on, as it is likely to result in the biggest update to the MBS in decades.

The AMA is using the upgrade to introduce new purchasing options via licensing arrangements, and to open it up to those previously not able to purchase it – a major criticism of the current arrangements.

Noting that the Fees List is also the benchmark for medical fees set under various State Government regulations such as those which set the fees for workers compensation claims, we want to ensure that there are options for non-AMA member medical practitioners who may need access to particular items, from time to time, to charge for services provided to patients in these circumstances.

Of course, AMA members will continue to receive full access through the improved online format. To that end, we will be asking how you currently use the Fees List, what features you would like to see in an online offering, and other features you would like to see considered as part of the new website.

To start the conversation, please follow the link to a short survey: <https://www.surveymonkey.com/r/amalist>

ANNE TRIMMER, AMA SECRETARY GENERAL

## OBITUARY

# Bertel Sunstrup

24 January 1931 – 22 April 2017

On the 24th of January 1931, Bert was born in Wondai Queensland. His early days were spent in Gympie.

He went to 'Shore' Grammar School in Sydney and graduated MBBS at Sydney University. He did his residency in Launceston and Hobart Hospital before joining Dr Gunson at the Northern Suburbs Medical Clinic in 1958. During this time he (like many GPs) also gave the anaesthetics for the surgeons in both the private and public hospitals. Bert then accepted the Registrar job for the Launceston branch of the Peter Mac Callum Radiotherapy Unit working with Dr Harry Holden.

After a few years he went to England and obtained his 'Radiotherapy/Oncology' qualification. Bert returned to the Launceston Hospital to work with Dr Holden and then took over the Radiotherapy/Oncology unit when Dr Holden retired. In 1986 the unit name was changed to the Holman Clinic after its founder in 1928-32.

In his profession Bert witnessed a lot of pain, despair and suffering on a daily basis. He was a dedicated and inspirational clinician who always listened with compassion to his patients being mindful of their difficulties especially in coping with everyday challenges with cancer.

In the 1990s Bert "fought Tooth and Nail" to stop the bureaucrats from transferring the Radiotherapy/Oncology Unit to Hobart. He was steadfastly determined and presented irrefutable arguments that we must continue to treat the patients with all forms of cancers in the North of Tasmania. Were it not for him there would be no clinic in the North. Thankfully the Government agreed to keep the Holman Clinic at the Launceston General Hospital

In 1983 Bert purchased a farm in Pipers Brook and started a vineyard with the help of his wife Anne, her sister Jill and son Christopher. His wine 'Dalrymple' soon became well received and they won many medals at the wine shows.

Bert's other significant interest was skiing. When he returned to Tasmania he married Anne, a registered nurse, had three children. They built their own shack in the Ben Lomond Ski Village. He was a wonderfully entertaining, witty and generous man who had some great parties in their shack. Bert and Anne soon joined the Ben Lomond Ski Patrol and he was promoted from Patrol Doctor to President and eventually to Life Member. Once again it was his infectious energy and enthusiasm that encouraged many to join the patrol and keep the skiers safe and, if injured, to provide them with the correct treatment before they left the mountain.

I loved talking with Bert we shared the same values and had similar aspirations and concerns. He was better informed than I in history and would constantly come up with some interesting trivia.

All past, present and future patients in the North of Tasmania and in particular the Launceston General Hospital are indebted to this friendly, unassuming and dedicated man.

I am certain that his children; Katrina, Ingrid and Christopher as well as his medical colleagues will keep his spirit and legacy alive.

PROFESSOR BERNI EINODER A.M.  
Director of Surgery at LGH 1984 to 2014

## INFORMATION FOR MEMBERS

## Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

# Imbalance in supply of rural doctors continues

The Australian Medical Students' Association (AMSA) has expressed its concern by the recent Government announcement it will support 50 medical student places to open a new medical school at the Sunshine Coast University Hospital.

AMSA has called for increased funding of long-term regional specialty training places, rather than the establishment of new medical schools to address the current medical workforce maldistribution.

“The Government’s announcement comes with no detail as to how exactly these places are to come about, but it is believed there will be no further increases to the number of Commonwealth Supported Places (CSPs).”

The Government’s announcement comes with no detail as to how exactly these places are to come about, but it is believed there will be no further increases to the number of Commonwealth Supported Places (CSPs). It is AMSA’s understanding that support for the new medical school bypassed regular departmental approval processes.

AMSA President and local Sunshine Coast medical student Rob Thomas said: “With Government modelling forecasting an oversupply of 7,000 doctors by 2030, AMSA also believes that it would be irresponsible for the places on the Sunshine Coast to come from new international places.

“The reasoning behind the announcement was that the new medical school at the Sunshine Coast will address local workforce shortages. However, according to the Government’s own modelling, the Sunshine Coast is not in workforce shortage or a regional area. Internships on the Sunshine Coast continue to be oversubscribed.

“This is a solution in search of a problem. The real problem that we face is the disparity in the distribution of doctors between metropolitan and rural and regional areas. A key reason why this disparity exists is that those interested in becoming doctors in

rural areas are forced back to the city for most, if not all, of their training.”

Jenna Mewburn, AMSA Rural Health Co-Chair and a final year medical student studying in Wagga Wagga said: “I’m a rural background student who wants to live and work rurally in the future, but at present I will likely have to return to the city to pursue specialty training.

“This will likely fall at a time where I’m looking to lay down roots, making it increasingly difficult to return rurally in the future. Initiatives throughout medical school already exist, including rural origin entry quotas and rural clinical school placements. While there is evidence to support the success of these programs in contributing to the rural workforce, what we need is more quality specialty training places to be funded nationwide.”

AMSA, in conjunction with its Rural Health Committee will continue to advocate for increased speciality training places as a more effective alternative to new medical schools.

The announcement comes at a time when the Federal Government has announced a new decentralisation push, requiring all Ministers to justify whether agencies within their portfolios should remain in the big cities. All Federal Ministers will be required to report by August to Cabinet, detailing which of their departments, entities or functions are suitable for relocation to a regional area.

The Australian Medical Association in its recent submission *Assessing the distribution of medical school places in Australia* to the Department of Health, highlighted that redistributing medical school places, on its own, will not improve workforce shortages.

Further, the AMA believes that the Government needs to take a longer-term view and recognise that unless additional postgraduate training places in rural areas and undersupplied specialties are made available, addressing workforce shortages in these areas will remain an elusive goal.

The AMA remains committed to supporting doctors in ways to address the imbalance in the medical workforce supply, particularly in regional and remote Australia, especially as it is a contributing factor to the lower health status and life expectancy for people living in these areas.

MEREDITH HORNE

# Clearing the air on pollution

AMA President Dr Michael Gannon has gone public to clear the air about the AMA's position on pollution and climate change following misinterpretation in some quarters of his comments about the closure of the Hazelwood power plant in Victoria.

Dr Gannon strongly promoted the AMA's long-held policies on pollution and climate change and health, and raised the need to be conscious of the health impacts of significant changes that affect local communities and families.

He said that, as a responsible health advocate, he raised the issue of care and concern for the people who lost their jobs because of the Hazelwood closure, and the broader impacts on their families and communities.

"I acknowledged the long-term effects of pollution in the Latrobe Valley, and cited the work of doctors, led by Doctors for the Environment Australia (DEA), in highlighting the health effects of pollution in other incidents, including the Morwell fire in 2014," Dr Gannon said.

"I raised the very real outcomes that stem from unemployment such as mental health, loss of self-esteem, alcohol and drug misuse, domestic violence, self-harm, suicide, and on it goes.

"These health effects are well documented in scientific studies around the world.

"I believe that governments and industry must be aware of, and make plans for, the impacts of transition – from employment to unemployment, from old energy sources to new energy sources, and for the ongoing impact of climate change on public health.

"It is a good thing for the AMA to responsibly point out the health impacts and societal impacts on many levels, at varying degrees, from situations like the Hazelwood closure. This is part of our job as a leading and respected health advocate.

"AMA advocacy is very broad and very deep. It has to be. No other medical or health organisation in the country can even come close to initiating or influencing change across the health system and society.

"We speak out on issues as diverse as workplace bullying and harassment, Indigenous health, women's health, men's health, end of life care, family and domestic violence, female genital mutilation, concussion in sport, and firearms.

"These issues cover many facets of society and many ideologies. Some are regarded as progressive, some are conservative, but most are controversial – and therefore potentially divisive.



"We do this on top of our other core business – Medicare, the PBS, public hospital funding, the PSR, medical workforce, private health, rural health, doctors' health, and the broad range of public health issues.

"The AMA has to always tread a fine line, and we do that willingly. And so it is with contemporary issues like climate change, pollution, air quality, and renewable energy.

"The AMA believes that climate change poses a significant worldwide threat to health, and urgent action is required to reduce this potential harm.

"We have been vocal about the need for urgent government action, and have repeatedly called for the development of a National Strategy for Health and Climate Change.

"The AMA Position Statement on *Climate Change and Human Health 2015* is a very strong document. It was developed from the ground up, with input from AMA members at grassroots level around the country.

"The evidence is clear – we cannot sit back and do nothing," Dr Gannon said.

Dr Gannon urges AMA members and all doctors to visit the AMA website to stay abreast of the AMA's political advocacy and broad policy agenda.

JOHN FLANNERY



# PM to address national conference

## The Wide World of Health – Challenges, Threats, and Opportunities



**Prime Minister Malcolm Turnbull will address the Saturday morning session of the AMA National Conference, as the event's keynote speaker.**

Don't miss out on the opportunity to attend the 2017 AMA National Conference at the Sofitel on Collins, Melbourne, from 26– 28 May, for a rare and unique glimpse into medico-politics, global health issues and contentious contemporary health policies. The AMA National Conference provides a platform for Australia's leading doctors to share their ideas on the way ahead for Australia's health system and to discuss themes and events in global health.

This year's Conference agenda features a number of sessions that reach beyond the local horizon. We have a range of experts who will be presenting and debating 'big picture' factors that influence our health system and health systems around the world. These include:

- **Tackling Obesity** – experts will present a range of perspectives around the global obesity epidemic and possible solutions, with a special focus on how AMA policy can help the Government respond in a meaningful way.
- **Threats Beyond Borders** – an interactive panel discussion on potential infectious diseases and threats that cross our borders, and the possible role of a National Centre for Disease Control (CDC) in Australia.
- **Improving Australia's organ donation rate** – Australia is a world leader in achieving successful organ transplant outcomes, but our organ donation rate needs to increase to match world leaders. This session will examine the ethical and practical considerations related to Australia's lagging organ donation rate.
- **Doctors' Health and Wellbeing** – discuss initiatives and examine current and emerging issues related to doctors' health and wellbeing, during medical training and in their professional careers.

### Dealing with Bad Health News Masterclass – Limited Places Only

In conjunction with the 2017 AMA National Conference, the Pam McLean Centre will provide a pre-conference masterclass open to all doctors on Thursday 25 May, also held at the Sofitel on Collins, Melbourne.

The masterclass on '*Dealing with Bad Health News*' will be an interactive, evidence based full-day masterclass designed to provide a safe learning environment for participants to explore different communication approaches to help patients deal with bad health news.

Under the guidance of an expert facilitator, Professor Stewart Dunn (Director, Pam McLean Centre), participants will develop skills in interpreting human behaviour by improving the way they recognise, identify and respond to emotional reactions.

**This is an accredited activity for RACGP Category 1 and ACRRM Core PDP points.**

#### Pre-conference masterclass - details

- Time: 9:30 – 5:00
- Date: Thursday, May 25, 2017
- Venue: Sofitel, 25 Collins Street, Melbourne, VIC 3000
- Tickets: Conference attendees - \$660, AMA members - \$770, non-AMA members - \$880

**For more information and Conference registration log onto: <https://natcon.ama.com.au/> or contact the Conference organisers at [natcon@ama.com.au](mailto:natcon@ama.com.au).**



## One size does not fit all

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

The profession-led system of standards for general practice in Australia has served GPs and our patients very well. They are uniquely tailored to the needs of general practice and our patients and while, from time to time there has been disagreement over some aspects of these standards, they are generally well accepted.

That's why the AMA continues to watch with real concern the Australian Commission of Safety and Quality in Health Care's increasing interference in this space.

"There remains deep concern that the Commission is trying to deliver a 'one-size-fits-all' solution, particularly as it is now moving to take the standards it has developed for hospitals and day surgery and try and adapt these to primary health care."

Spurred on by a recommendation from the 2010/11 Australian National Audit Office (ANAO) review of the Practice Incentives Program, which said that the Department of Health needed a means to better inform itself about the quality of general practice accreditation, the Commission appears to have decided to use this as an opportunity to expand its influence and control.

During earlier consultations the AMA raised concerns with the direction the Commission was taking. There remains deep concern that the Commission is trying to deliver a 'one-size-fits-all' solution, particularly as it is now moving to take the standards it has developed for hospitals and day surgery and try and adapt these to primary health care. There is no long-term guarantee that the Commission will not try and wrap general practice up within these arrangements as well.

General practice has led the way in developing an appropriate accreditation model, with assessment against standards undertaken by accrediting agencies who know and understand general practice. The standards are informed by an expert committee and general practice stakeholders.

They are regularly reviewed to reflect contemporary practice

and designed to focus on continuous improvement and delivery of safe and high quality care. One can't help but come to the conclusion that the ACSQHC is trying to empire build, at the expense of many years of good work.

If other sectors need the ACSQHC's assistance in progressing accreditation, I don't have any argument with their involvement. However, general practice does not need to be included in the Commission's inevitable one-size-fits-all approach.

Without some clarity on the Commission's intentions we are standing on the edge of a very slippery slope. Are we going to end up with multiple sets of standards applicable across a sector? Are general practices going to be able to choose whether to be assessed against the NSQHS Standards or the RACGP's Standards? Will they have to comply with both?

Will standards be weakened so as to encompass other health services within the primary care sector? Or will the Standards applicable to hospital care be transposed on to general practice and primary sector health care services? Can you imagine how much trust you would engender in your patient if you were required to wash your hands with alcohol up to five times in a consultation?

Are we going to see a shift from our system of voluntary accreditation to one forced upon us by the Commission? What impact will that have on schemes that provide vital additional funding for general practice and support for infrastructure and quality improvement, such as the PIP, PNIP and the GPRIP. Will the Commission ignore the diversity of general practice and play into the hands of larger players? Will the focus of health care become more about ticking a box than the actual provision of quality of care?

We know that, for now, current accreditation arrangements for general practice remain largely intact, although the Commission has succeeded in having them modified and brought within its own frameworks. We are one step away from the ACSQHC trying to take total control, which is something that all GP organisations need to worry about and protect against.

One size does not fit all, yet despite this we know that it is the way that bureaucracies tend to try and work.



# Immunisations in pharmacies

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

Controversy swirls around this topic. I sounded out several colleagues, including pharmacists.

**An infectious disease physician:** “(I see) no fundamental reason why not ... under certain conditions: they keep recipients on site for 15 mins to make sure they do not suffer anaphylaxis; they [are] trained to resuscitate; they record the vaccination and report to the Immunisation Register and to the recipient’s GP and provide the recipient with an appropriate record. It might suit ... families lacking access to bulk-billing GPs or who can’t organise appointments.”

**An interested physician** recognised this contentious issue, mainly because it disrupts GP-patient relationships.

“I’ve never been convinced (by the AMA), especially (regarding) flu vaccine – where adults >65 and parents of school-age children (need) GP appointments at convenient times. Pharmacists are well-equipped for following procedures, including cold-chain logging and record-keeping.”

**Pharmacists** recognised the risk of commercial pressures. Some saw pressure from the corporate chains which dominate retail pharmacy. They spoke of decreasing professional satisfaction, rather as can be heard said in general practice about corporatisation.

Westmead Hospital’s chief pharmacist, David Ng, helped set up the first pharmacy program in South Australia. He wrote: “There has been a pharmacy influenza immunisation program in several (American) states since the 1990s. South Australia and Queensland ... introduce[d] enabling legislation and training programs several years ago, followed by NSW in 2015. Queensland has extended (these) programs to measles and pertussis.

“This service is underutilised because [there is no] MBS (rebate) and ... the need for two pharmacists to be present for one to administer vaccine.

“Large chains ... circumvent this by introducing contract GPs or nurse immunisers.

“... the system does not appear ready for a major influenza pandemic!”

## An academic perspective

Professor Iqbal Ramzan, Dean of Pharmacy at the University of Sydney, commented: “Falling vaccination rates ... pose a public

health threat ...all health professionals [must] maximise vaccine coverage.

“Most jurisdictions allow pharmacists (with) approved training to provide influenza vaccination. While there may be some disquiet within the medical fraternity, pharmacists have the requisite theoretical knowledge and, with training, the skills required to administer vaccines. Pharmacies offer easy access ... this also provides GPs with valuable time to discuss complex issues with their patients.”

To their credit, pharmacists have established sophisticated training and operating procedures. Accreditation is recognised for best practice.

## The facts of the matter

A recent paper, *Evaluation of the first pharmacist-administered vaccinations in Western Australia: a mixed-methods study*, by H Laetitia Hattingh and colleagues reported on 15,621 influenza vaccinations administered by pharmacists at 76 community pharmacies in 2015.

They found “no major adverse events; less than 1 per cent of consumers experienced minor events, which were appropriately managed. Between 12 per cent and 17 per cent eligible [for] free influenza vaccinations chose to have it at a pharmacy.

“A high percentage was delivered in rural and regional areas [where] pharmacist vaccination facilitated access. Immuniser pharmacists reported feeling confident ... and [felt] that services should be expanded to other vaccinations.”

The authors concluded: “Vaccine delivery was safe. Convenience and accessibility were important. There is scope to expand to other vaccines and younger children; however, government funding needs to be considered.”

This is a work in progress. While risk is often part of treatment, its acceptability there is because we can see readily that the risk of doing nothing is greater. This is not as clear in relation to prevention where the risk of developing the condition is vague and located somewhere in the future. But discussions of this sort are an essential part of our national immunisation program’s public acceptability. Whoever does the immunising must be prepared to have it with those being immunised.



## No Stroke Untreated

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

At our recent meeting, the AMA Council of Rural Doctors received with great interest a presentation on the Victorian Stroke Telemedicine program, which is successfully delivering equity of access to acute stroke care for people living in regional Victoria.

We all know the ugly face of Cerebrovascular accident (CVA) as we encounter it too often in regional and remote Australia. Of the 55,000 new strokes that occur each year in Australia, 23,000 occur in regional areas. However, in comparison to urban centres, we often deal with this devastating presentation with the knowledge we will not be able to image, diagnose and treat the stroke in time to salvage the cerebral damage.

This may be our Mum, but we will not be in time to start the tissue saving clot busters, endovascular clot retrieval (catheter removal of a clot) is a dream away. Why? It is the reality of living in the bush, the mobile cellular ability to call 000, the distance to the hospital, the flooded out roads, and the limitations of the ambulance services.

If we are fortunate enough to have a CT scanner in our town, we do not have the fortune to have an in-house radiographer to work the CT scanner 24/7. We are GPs out here, we are not neurologists, obvious CVAs are easy to diagnose but out of 100 stroke-like presentations only 50 will be strokes. Once diagnosed, we can be five hours to the nearest tertiary centre by RFDS, Careflight, or chopper.

Luckily here in Australia we find groups of stubborn people who will not take such scenarios as insurmountable. Five years ago, no-one outside of the urban areas received stroke thrombolysis. Now, with the guidance of Professor Chris Bladin, a Melbourne neurologist, and the Victorian Stroke Telemedicine (VST) program, the state of Victoria is able to say the following:

- 94 per cent of Victoria is within 1 hour from state of the art stroke care. 16 regional centres in all;
- More than 1400 telehealth consults for stroke evaluation have been performed;
- Of those, 1 in 5 calls result in stroke thrombolysis - some regional hospitals are now thrombolysing patients for the first time with the assistance of VST consultants;
- 70 patients of the 1400 have been referred for endovascular clot retrieval;

- Treatment is safer when delivered with the help of a consultant neurologist, with a 60 per cent decrease in post thrombolysis complications;
- There has been a 130 per cent increase in patients with acute stroke treated under 60 mins of hospital arrival; and
- There has been a 30 per cent decrease in treatment time – e.g. door to CT, door to stroke thrombolysis times.

How do they do it? The answer is stubbornness, good ol' Australian stubbornness. This involved a trip to Germany to see how they do it over there. With 16 made-for-purpose telehealth gizmos the stroke specialist can remotely examine patients at the bedside, view PACs, make clinical notes, and speak to distressed families, all in one machine.

It involved gathering a cohort of neurologists from Perth to Christchurch to man the on call phones 24/7. It meant interrupted meals out and gym work outs to be 'Triple A', Affable, Available and Able. It meant surmounting suspicion that early thrombolysis was ineffectual. It meant quelling the initial objections from local ED doctors that they did not need a hotshot urban neurologist to diagnose a stroke. It was an attitude of 'we can do this' and 'we can do this together'.

The Victorian Stroke Telemedicine people have a dream for us. They want to roll this out to become Australia wide. The future Australian Telestroke Network (ATN), with the goal of 'No Stroke Untreated'.

The AMA Council of Rural Doctors was really impressed with the VST program presentation and the results being delivered to patients. However, it clearly needs more support if it is to become a truly national initiative. It needs the backing of governments, and it will require State and hospital support for the on-call neurologist and other staff needed to man this program.

That means recognition by the funding system, the hospital administration to allow for State wide privileging of the on call neurologist. We need to put their 1-300 number on the wall and we need to call them. It requires our support so that we can thank them later for looking after our Mum who just had a stroke.



## Changing our professional culture – what can we do as individuals?

BY DR KATHERINE KEARNEY

Culture is defined as the “total of human behaviour patterns and technology communicated from generation to generation” (New Webster’s Dictionary). How do you define yourself within the broad umbrella of medicine? Are you a doctor, and connect broadly with other doctors as colleagues, or do you feel a stronger association with your fellow nephrologists, cardiothoracic surgeons or general practitioners? Who do you consider your peers and your fellow professional representatives to the broader community? How does that influence your interaction with other doctors, other healthcare professionals and healthcare delivery systems?

“What is our professional culture, and what impact is it having on the health and wellbeing of doctors, broadly speaking?”

Healthcare delivery is a team sport. Broadly speaking, our teams can be as large as our entire hospital operational staff, to “geriatrics team C” with a few consultants, a registrar and an intern. To make it easier for ourselves, we often choose to identify with those closest to us in personality and in daily interactions. I believe it is important to think about the broader profession and our professional culture. What is our professional culture, and what impact is it having on the health and wellbeing of doctors, broadly speaking?

Undoubtedly, medicine is a culture of high achievement and has always been so. High stakes selection processes are becoming universal given the enormous numbers of doctors in training entering the prevocational system as interns, approximately 3,300 in 2015 (MTRP report). It is becoming the norm that trainees have committed early, and committed fully to pursuing a wide range of extracurricular activities such as research, audits, extra qualifications like graduate diplomas or masters, sit on committees relevant to their future goals and have lofty achievements outside of medicine in their hobbies; climbing mountains, volunteer work, high level sporting achievements.

The pressure is immense, amongst a group that is naturally

incredibly high achieving. I’ve certainly heard statements from tremendously successful senior colleagues that they would never have gotten onto their training pathway in the current era. Relentless accumulation of accomplishments does not necessarily make for a happy, fulfilled person nor a superior clinician – we see this in disconnects between CVs full of achievements and a lack of correlation with clinical success. I’m as guilty as anyone else at relieving my anxiety about the future of my career by punishing schedules of extracurricular activities. What are truly important achievements to us individually, and how can we bring clarity by appropriately setting personal and professional goals?

Throughout most training pathways, there are high stakes barrier assessments – some of which, such as physicians college exams, are only held on an annual basis. A failed assessment reverberates around hospital and medical community and has a huge impact on the trainee. With this increasingly competitively environment for training positions, as well as failing being challenging personally for those who’ve failed at little in their lives, it can feel like the this stumble means heading to the back of the pack. Differentiating clinical competence from assessment success is very important.

What can we do as individuals to change this perception? Firstly, challenge our own preconceptions about what the journey to success looks like. There are always dead ends and wrong turns, in choosing training pathways or places of employment.

There are many doctors with happy, fulfilled lives and careers who took the opportunity to change tack from surgical training or physician training to pursue general practice or radiology. These stories aren’t talked about enough. We can help each other raise our sights, see the forest for the trees, and change paths to something that is more fulfilling.

We can advocate for complete training programs in rural and regional areas. We can advocate for linking training pathways to workforce requirements, as well as better production and availability of data on what the actual workforce looks like – so we might be able to see our place within it.

Being a doctor is a lot more than just practicing medicine. We are part of a profession, and it’s up to all of us to contribute to making our profession a more supportive place to learn and grow.



# It's time for a tax on sugary drinks

BY PATRICK WALKER

Soft drinks are fast becoming our nation's vice; our go-to drink choice that's more bitter than it is sweet. Sugar-sweetened beverages (SSBs) are packed full of calories, yet provide no additional nutritional value or health benefits, and are a major factor driving obesity in Australia and overseas.

Consider your average 600ml bottle of Coca-Cola – for most people, a single serving. That bottle might cost you \$3 from your local supermarket, and contains approximately 64g of sugar.

“Sugar-sweetened drinks are Australians' largest source of free sugar intake, perhaps adding flavour and energy to our day, but certainly nothing more.”

For the average person, this alone exceeds the WHO recommendation that no more than 10 per cent of your dietary energy should come from free sugars. Not that we're paying much notice to this recommendation, though – most of us exceed it on a daily basis, and SSBs such as that \$3 bottle of coke play a large role in this.

Sugar-sweetened drinks are Australians' largest source of free sugar intake, perhaps adding flavour and energy to our day, but certainly nothing more. Sugar is only one factor of many that predispose to overweight and obesity, but plays a considerable role that merits attention. A 2006 systematic review, for example, found SSBs to be a 'key contributor' to the obesity epidemic, calling for prompt public health strategies to discourage consumption.

In total, 63 per cent of Australians are now overweight or obese, a staggering four-fold increase on 1980 levels. Perhaps more concerning is the fact that one in four children exceed the upper limit of normal for BMI, and many of these kids will continue on to become overweight or obese adults. Most people know that overweight and obesity lead to an increased risk of cardiovascular disease and stroke, diabetes, certain cancers, and a multitude of other diseases. But something that's often

overlooked is their economic toll.

In 2005, data from the Australian Diabetes, Obesity and Lifestyle study put the total direct cost at \$21 billion, with the figure ballooning out to \$56.6 billion when indirect costs are factored in. Other estimates are more moderate, but the evidence is clear: our waistlines are costing us billions.

Compare that to the \$500 million in additional revenue that a well-designed SSB tax could raise annually, as well as bringing about a 15 per cent reduction in SSB consumption and a resulting 2 per cent reduction in the prevalence of obesity.

The link between SSBs and weight gain is well established, as is the link between weight gain and poor outcomes – both health and economic. But where does a tax fit in? And why target SSBs?

Let's start with the first question. Put simply, price affects consumption. The more things cost, the less likely people are to buy them, particularly products with elastic demand such as SSBs. We saw this with tobacco and alcohol, with increased taxation dramatically reducing consumption. Now is the time to move this strategy to SSBs.

A 2013 meta-analysis on the impact of increased price on SSB consumption found that demand does indeed drop, leading to beneficial health outcomes. Further, the effect is more pronounced for people with low income, due to increased price elasticity. Given these people suffer disproportionately from overweight, obesity, and non-communicable diseases, this means they have the most to gain.

As a discrete and well-defined group of products that provide minimal nutritional value, SSBs are an easy practical target for sound fiscal policy. WHO has publicly recommended an SSB tax, and many countries, including Mexico, France, Denmark, Hungary, Norway, and the USA, have implemented a tax to generally good effect.

Data from Mexico is particularly promising, the tax reducing consumption by an average of 7.6 per cent a year since its introduction in 2010. In low SES households, this figure reached 17 per cent by the end of 2014. Back home, Australian modelling suggests that a 20 per cent tax could significantly reduce SSB consumption, and there is evidence to suggest that while SSB purchasing would drop, overall drink sales would be unaffected.



## It's time for a tax on sugary drinks

This is important for two reasons: first, it makes commercial cooperation significantly more likely, removing an important obstacle to implementation; but secondly, and perhaps more importantly, it means people of low SES wouldn't simply have to fork out more money in their weekly shop, instead being able to switch to alternative, less sugary drinks.

Australia led the way on taxing tobacco and alcohol. We now have a chance to join other nations around the world, and take responsibility for the enormous impact SSBs have on our health. This alone won't solve the obesity epidemic, but it is an important tool in the array of public health strategies we need. The AMA quite rightly advocates a 'whole-of-society', multi-

measure approach to tackling the growing issue of obesity, and a tax on sugary drinks is an important part of this.

The health of our nation depends on us taking affirmative action in this space. The clock is ticking. We can't afford to wait until it's too late.

*Patrick Walker is the 2017 Policy Officer for AMSA Global Health, and was a contributing author to the AMSA policy on Global Food & Nutrition (2016), which, amongst other recommendations, advocated for the implementation of a tax on SSBs.*

**Twitter:** @patrickjwalker

**Email:** patrick.walker@amsa.org.au

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## Training hubs for healthy country communities

BY AMA VICE PRESIDENT DR TONY BARTONE

Regional and rural communities face a range of disadvantages when compared to their city counterparts, not the least which is getting timely access to a doctor.

People living in these areas often have to travel significant distances for care, or endure a long wait to see a GP close to where they live. Getting to see other specialists can be even more difficult.

“The overall distribution of doctors is skewed heavily towards the major cities, which means that regional and rural areas are affected by workforce shortages more acutely.”

Inequalities such as these mean that they have lower life expectancy, worse outcomes on leading indicators of health, and poorer access to care compared to people in major cities. Death rates in regional, rural, and remote areas are higher than in major cities, and the rates increase in line with degrees of remoteness.

The overall distribution of doctors is skewed heavily towards the major cities, which means that regional and rural areas are affected by workforce shortages more acutely.

The problem is not a shortage of medical graduates. With medical school intakes now at record levels, we do not need more medical students or any new medical schools – something which the AMA and the Government can agree on.

What is needed are more and better opportunities for doctors, particularly those who come from the bush, to live and train in rural areas.

The evidence shows that they are the most likely to stay on and serve their rural community when they qualify.

Until now, the approach of Federal Governments of all political persuasions to getting younger doctors to the bush has been bonded workforce programs.

This has failed miserably because it did not address the underlying causes of medical workforce shortages, nor make the

practice of medicine in areas of medical workforce shortage any more attractive.

I’ve met bonded graduates who decided to buy their way out of the deal.

Though many medical students have positive training experiences in rural areas, progression through prevocational and vocational training often requires a return to the cities.

At this point many trainees develop the personal and professional networks that are not easy to leave. Not surprisingly, many of these trainees are less able to return to practise in under-serviced areas.

Three years ago the AMA developed a significant proposal to address these problems – regional training networks. We see these as vertically integrated regional networks of health services and prevocational and specialist training hubs.

The networks would build on existing infrastructure and enable junior doctors to spend a significant amount of their training in rural and regional areas, only returning to the city to acquire specific skills.

We believe that regional training networks can improve the distribution of the medical workforce distribution by enhancing generalist and specialist training opportunities, and by supporting prevocational and vocational trainees to live and work in regional and rural areas. It is an idea whose time has come and supported by many players in the rural health space.

I was therefore very pleased when the Government announced last month that it will establish 26 regional training hubs across every state and in the Northern Territory, costing about \$28.6 million.

According to the Government, the hubs will integrate health services, the medical colleges and other training organisations to increase postgraduate medical training opportunities.

It will be important that the Government works closely with the Colleges and other stakeholders to ensure the program helps to provide the regional vocational training places that are so badly needed.

There is a long way to go before the shortage of doctors in the bush is fixed, but nonetheless, this initiative is an important step in the right the direction. I believe it could make a real difference to access to medical care for regional and rural communities if implemented properly.





## Health Financing – building a framework for the long-term challenge

BY ASSOCIATE PROFESSOR SUSAN NEUHAUS, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

Health financing is Health Financing and Economics Committee's (HFE) principal responsibility and central to HFE's terms of reference. As HFE members will attest, health financing is the largest, most complicated, and all pervasive topic that the committee has the privilege of dealing with.

At its meeting on 1 April 2017, HFE considered the critical elements of current health financing arrangements and the developments and trends likely to impact on those arrangements.

HFE discussed how to build a framework for long term health financing arrangements that are fair, robust and sustainable, and deliver certain and sufficient funding for health care, now and into the future.

This is a challenging task. Health financing is a very complicated policy area. There have been a number of reviews into the system over the years which have discussed (with varying rigour and results) issues surrounding managing costs within components of the health system, with a view to sustainability over the longer term. The overall success of these reviews in terms of lasting, positive improvements has, however, been limited and there have been both overlaps and gaps in their terms of reference.

Public understanding of health financing issues, and the public's preparedness to consider changes to arrangements for health care, are also limited. Many commentators took this as a key lesson of the 2016 Federal Election. They considered that governments will find it difficult to develop, legislate and implement significant reforms in health without public suspicion of potential impacts on basic Medicare arrangements. Framing a new approach to health financing is clearly not a task for the short-term.

HFE agreed the long-term health financing conversation should be framed in terms of the future health system in 2035. The conversation will need to include all significant stakeholders – organisations and people with a direct interest in the financing of health care, with a view to arriving at a broad consensus on a fair, affordable and sustainable system, and one that takes into account predicted changes in health care needs, advances in medical technology and new information and health management platforms. Consumers should be involved in the conversation.

As a starting point, HFE decided that the AMA could facilitate a discussion around the health system, which could include signalling a number of possible pathways but would not singularly propose a solution.

HFE members noted there is a need to create a space for this discussion that is free of the usual criticisms and stakeholder-

positioning that have plagued other reviews and policy processes.

This conversation needs to focus on cost management and obtaining value. It could canvas issues such as whether the health system needs to provide all possible health care to all people at vast and accelerating expense, or should it manage costs by some method.

There needs to be an understanding of the cost drivers going forward, particularly technology and the ageing population, and a national conversation about the level of service we want our health system to deliver in the future.

The conversation should also encompass specific issues identified by HFE members.

These include the need to not only consider efficiency in clinical settings such as hospitals, but also consider efficiency within administration departments, given the growth in these departments within the hospital sector.

Primary health care needs an increased investment, with an understanding of where future pressures and the value of future primary care interventions could be.

The contribution of private health insurance to the overall health system and health financing arrangements also needs to be considered as part of this discussion, particularly given the increasing amount of Government and private spending propping up the industry.

Supporting this work, it would be useful to have a review of the programs run by Government to ascertain which ones are producing good outcomes.

HFE recognised that large-scale change is not likely in the near future. The vision for the future health system must be beyond the three year election cycle. Support from all political parties will be necessary to prevent undermining of solutions.

An important overall outcome of this work should be a 'vision' for health financing arrangements that should allow the AMA to be able to hold any Government into the future to account.

The vision also needs to speak to AMA members (and other health care providers) that may be disillusioned or feel abandoned by current arrangements, whether working in general practice, public or private hospitals.

If you have views on how health financing arrangements should change, please contact me. HFE will welcome your input.



# The Lighthouse Project

BY AMA PRESIDENT DR MICHAEL GANNON

“The aim of the Lighthouse Project is to help close the gap in cardiovascular disease between Indigenous and non-Indigenous Australians through the provision of evidence-based, culturally safe care for acute coronary syndrome.”

Last year, when the AMA released its 2016 Report Card on Indigenous Health, it set out a plan for governments to eradicate Rheumatic Heart Disease (RHD) from Australia by 2031. Since the release of this Report Card, the AMA has been a part of growing efforts to reinforce to our political leaders that RHD must be stamped out, and that other cardiovascular health outcomes for Aboriginal and Torres Strait Islander peoples must be improved.

As part of our efforts to improve the cardiovascular health of Aboriginal and Torres Strait Islander people, the AMA has become a founding member of an END RHD Coalition – an alliance of six organisations with a vision to see the end of RHD in Australia, we participated in the inaugural Close the Gap Parliamentary Friendship Group which focussed on the enormous impact of RHD, and we recently met with the Australian Healthcare and Hospitals Association (AHHA) to discuss the Lighthouse Project – a joint initiative of the AHHA and the Heart Foundation to improve outcomes for Aboriginal and Torres Strait Islander peoples experiencing coronary heart disease.

The aim of the Lighthouse Project is to help close the gap in cardiovascular disease between Indigenous and non-Indigenous Australians through the provision of evidence-based, culturally safe care for acute coronary syndrome. With cardiovascular disease being the leading cause of death among Aboriginal and Torres Strait Islander people, and a major contributor to the gap in life expectancy between Indigenous and other Australians, it is imperative that the AMA and other health and medical organisations are actively engaged in this area.

It is unacceptable that Aboriginal and Torres Strait Islander people, who represent three per cent of the entire Australian population, are 1.6 times more likely to die from coronary heart disease than their non-Indigenous peers. It is also unacceptable that Aboriginal and Torres Strait Islander people are less likely to undergo vital coronary tests and procedures once admitted to hospital.

It is clear that the hospital system must better respond to the

unique health needs of Aboriginal and Torres Strait Islander patients. Hospitals have an important role to play in improving access to care and addressing disparities for Aboriginal and Torres Strait Islander peoples. This is where initiatives such as the Lighthouse Project are extremely valuable.

During Phase 1 of the Lighthouse Project, cultural competence, having a skilled workforce, appropriate governance and the use of clinical care pathways were identified as four key areas of best practice for improving care for Aboriginal and Torres Strait Islander peoples with Acute Coronary Syndrome. In Phase 2, a quality improvement toolkit was developed and implemented in eight public hospitals across Australia.

Through Phase 1 and Phase 2 of the Lighthouse Project, these public hospitals have achieved culturally safe environments and enhanced staff capacity to respond to the unique needs of Aboriginal and Torres Strait Islander patients, and have reported improved relationships with Indigenous patients and communities.

The Lighthouse Project must be seen as a positive example of how gains in health outcomes can be achieved for Aboriginal and Torres Strait Islander people. I am pleased that the work of the Lighthouse Project will continue, with the Commonwealth Government recently announcing that \$8 million has been provided to support Phase 3 of the Lighthouse Project, which aims to extend the project to 18 hospitals across the country and allowing it to reach nearly one in every two Indigenous patients admitted to hospital for a cardiac condition.

Eliminating inequities in health service provision to the Aboriginal and Torres Strait Islander population is vital, and it is encouraging to see that the great work of the Lighthouse Project is being recognised. By increasing cardiovascular health outcomes for Aboriginal and Torres Strait Islander peoples, we can reduce mortality rates, increase life expectancy, and help close the unacceptable health gap that exists between Indigenous and non-Indigenous Australians today.



# Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

## Better broadband needed for rural, regional health



Limitations in the roll out of satellite technology are impeding the take-up of the National Broadband Network (NBN) in regional, rural, and remote areas, the AMA has told a Senate committee.

In a written submission to the Joint Standing Committee on the NBN, AMA President Dr Michael Gannon said that all Australians, regardless of where they live or work, should have equitable access to high-speed and reliable internet services.

“Country Australians must have access to NBN services that enable them to conduct the same level of business via the internet as their city counterparts,” Dr Gannon said.

“These NBN services must also have the capacity to meet their future internet needs.

“This is particularly important for providers of vital health services. Data allowances and speeds must be sufficient to enable two-way applications for e-health and telehealth, including the transfer of high-resolution medical images, medical education, videoconferencing, Voice over Internet Protocol (VoIP), and other applications.

“However, it is widely acknowledged that there are significant cost, data allowance, and speed differences between fixed and satellite broadband services, putting some regional and remote areas at a significant disadvantage.

“While NBNCo (nbn) has advised the AMA that it is looking at how some of these issues can be addressed for critical

services like health care, changes are yet to be detailed at this time.”

Dr Gannon said that nbn had advised the AMA that it was working to identify medical facilities and general practices within the satellite footprint in rural and remote areas that would qualify as Public Interest Premises (PIPs), and therefore be granted access to higher data allowances.

“This is a small step in the right direction, but the AMA remains concerned that, even as PIPs, these medical facilities will still not have sufficient data allowance to be able to fully utilise the e-health and telehealth opportunities that are taken for granted in metropolitan areas,” he said.

Last month, Minister for Regional Development and Regional Communications Fiona Nash announced that Medicare rebates will be paid for rural and remote Australians to access psychological counselling through teleconferencing.

Senator Nash said that mental health was a significant issue in rural and remote areas, but lack of easy access to a nearby psychologist often meant mental health issues went untreated.

“It’s difficult and sometimes impossible for rural and remote Australians to attend face-to-face counselling,” Senator Nash told the National Press Club.

“Today, I announce rural and remote Australians will, for the first time, have access to psychology through teleconferencing paid for by Medicare.

“This will mean rural and remote Australians can use Skype, FaceTime or video calling to access psychologists and psychiatrists all over Australia from their home or a local medical centre.”

Many Australians who were going without mental health treatment will now receive it, Senator Nash said, praising Health Minister Greg Hunt for delivering the first outcome from the Regional Australia Ministerial Taskforce.

Despite criticism of the speed of the nbn’s SkyMuster satellite service, Senator Nash said it was fast enough to deliver the service, and said people in the bush understood that they were not going to have the same internet speeds as their city counterparts.





# Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

“For those wondering, high definition video conferencing requires internet speed of just 1.5 megabits a second. A typical Sky Muster plan delivers enough data for 66 hours a month of high definition video conferencing,” she said.

“Regional people are very pragmatic. They know they are not going to get the same equivalence across a whole range of areas their city cousins do, but they want access to services so they can get on their lives.

“The (internet) speed you are going to get in the western parts of Queensland is not going to be the same that you get in the CBD in Brisbane.

“They (rural Australians) get that ... as I am travelling around and talking to people in the regions, I’m not talking about the speed, I’m talking, ‘Can you do what you want to do in the regions through your internet connection?’

“By and large, most of them are happy with the service they’ve got.”

MARIA HAWTHORNE

## Close the Gap Parliamentary Friendship Group – an observation

The AMA joined the inaugural meeting of the Close the Gap Parliamentary Friendship Group, held on March 30 at Parliament House.

Convened by Greens Senator Rachel Siewart, ALP Senator Malarndirri McCarthy, and Liberal MP Lucy Wicks, the meeting aimed to raise awareness among key decision makers about the scourge of Rheumatic Heart Disease (RHD) on Aboriginal and Torres Strait Islander peoples.

Worldwide, RHD affects more than 30 million people, with Australia’s Aboriginal and Torres Strait Islander people having among the highest rates of this debilitating disease.

The fact that RHD is occurring in Australia, and the fact that we need to reinforce to our political leaders that they need to do something about it, is symptomatic of consecutive government failures to listen and act. RHD is a disease of poverty and it should not be seen in Australia.

Yet Aboriginal and Torres Strait Islander people, particularly children, continue to suffer from RHD every day. Penny, a young patient advocate from Oenpelli in Arnhem Land, is one of those children. Penny was diagnosed with RHD at around ten years of age, and many of her family members are living with RHD as well – her mother, uncle, aunty, and cousin. While it is unacceptable that RHD is even occurring in Australia, it is intolerable that it is affecting whole families.

RHD can be usually resolved if it is detected early, but people are being treated for the condition when it is too late. Dr Bo Remenyi, a paediatric cardiologist in the Northern Territory described how she sees a new case of RHD being diagnosed among Indigenous children every second day – this is about 150 new cases per year.

RHD is no longer a public health problem in Australia. This issue was solved for the majority of Australians about 50 or 60 years ago with the introduction of penicillin and better living conditions. RHD is now a political problem.

In the words of Dr Remenyi: “We have a surgical solution for a political problem. Australia needs a paradigm shift – we need to move away from surgical solutions.” We need to invest in prevention, and double the number of doctors and health workers on the ground – Aboriginal and Torres Strait Islander communities have the smallest health workforce in Australia. This is highly disproportionate, particularly when the health needs of Aboriginal and Torres Strait Islander people are two to three times higher than their non-Indigenous peers.

Part of the solution to addressing RHD is educating members of the community about skin infections, and how they can lead to Acute Rheumatic Fever, and then to RHD if they are not quickly treated. But most of all, there needs to be a strong will to put RHD in the history books.

The community, health professionals, people working laboratories, public servants and most of all, governments, are all responsible for helping to make this a reality. Our political leaders need to show leadership and take action to work with health professionals and communities to rid Australia of RHD.

ALYCE MERRITT, INDIGENOUS POLICY ADVISER AMA



# Research

## Resistance exercise could be a new 'prescription'

A new study by Griffith University's Menzies Health Institute Queensland has linked resistance exercise with boosting your immune system and aiding in injury health.

Until this study was undertaken, little was known about the impact of resistance exercise.

Published in *Immunology Letters*, the researchers examined 16 previous studies undertaken during 1989-2016 that investigated participants undertaking a single session of resistance exercise encompassing various exercises.

"We combined the data from all relevant scientific publications, including two of our own original articles, to conduct a stringent systematic analysis of the resistance exercise research," said Dr Adam Szlezak from Griffith's Menzies Health Institute Queensland.

The study found that both high and low dosages of resistance exercise increased the immune system's surveillance potential in the participants in a similar way to that of aerobic exercise, much like drugs can.

"We found that both high and low dosages of resistance exercise increased the immune system's surveillance potential in the participants in a similar way to that of aerobic exercise. Even a low dose of thumb resistance exercise increased the number of key white blood cells in the circulation," Dr Szlezak said.

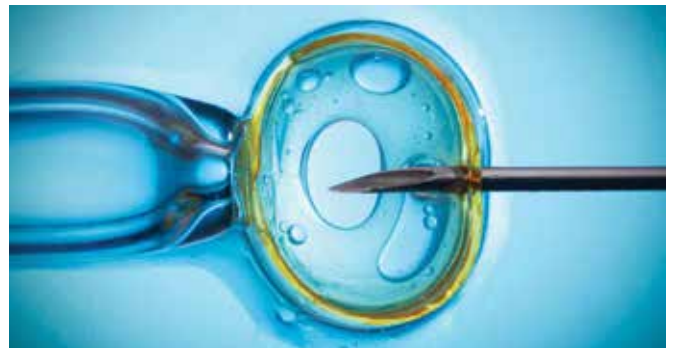
The research suggested that resistance exercise appears to improve immuno-surveillance similar to that of moderate intensity aerobic exercise, regular moderate intensity 20-45 min work-outs in the gym may provide similar protection against upper respiratory tract infections (URTI).

Now that we know that different resistance exercise doses can result in distinct biological responses, much like drugs can, we now need to see if these responses can be used to reduce risk of URTI, as well as improve recovery from illness and injury, said Dr Szlezak.

The research also suggests that GPs should recommend that their patients abstain from all forms of exercise in the hours prior to blood collection for requesting full blood counts due to its impact on white cell count.

MEREDITH HORNE

## Gender stereotypes not good enough to support embryo gender selection



A recent paper published in the *Journal of Bioethical Inquiry* fully supports the updated Assisted Reproductive Technology (ART) guidelines to not support the use of sex selection techniques for non-medical purposes.

Dr Tamara Kayali Browne, a lecturer in health ethics and professionalism at Deakin University, who wrote the paper, believes that: "Professional organisations and policymakers like the NHMRC should stand for evidence-based policy which promotes rather than undermines gender equality, and which promotes rather than undermines autonomy."

The National Health and Medical Research Council (NHMRC) release of their revised *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research, 2017 (ART guidelines)* maintained their advice that in Australia parents can only select the sex of their embryo if it is to prevent the transmission of a serious genetic condition.

The reasons are clear, Dr Browne believes.

"The evidence currently available has not succeeded in showing that the gender traits and inclinations sought are caused by a 'male brain' or a 'female brain'," Dr Browne said.

"Sex selection is not merely a symptom of gender essentialism but serves to perpetuate it."

The ART guidelines provide contemporary ethical guidance and framework for the conduct of ART in the clinical setting and was overseen by the Australian Health Ethics Committee (AHEC), with advice from an expert working committee to oversee a number of complex ethical issues including sex selection for non-medical purposes and surrogacy.

The AHEC notes in the report that Victorian and Western





# Research

Australian legislation currently prohibits sex selection for non-medical purposes.

All other jurisdictions are silent on the issue. The report expresses support for states and territories to enact uniform legislation

MEREDITH HORNE

## App set to change general practice medicine through information sharing

An Australian software company has developed an app designed to better connect GPs with patient healthcare information.

MediTracker was recently launched nationally after its creation by Precedence Health Care

The largest network of medical practises in Australia, IPN medical centres, has officially announced it will roll out the MediTracker app to all of its practices – eventually allowing up to two million patients to have access to their medical data held on their regular GPs' medical record.

MediTracker also links to Apple Health, Google Fit and wearable health devices such as blood pressure monitors and activity trackers, so health measurements can be shared, subject to consent, with a patient's care team of GPs, allied health and specialists.

The Primary Health Care Advisory Group's (PHCAG) 2015 report, *Better Outcomes for people with Chronic and Complex Health Conditions* examined the fragmented nature of healthcare and the need for a greater continuity of care.

Included in the report were recommendations to change the current Australian model of health care so that: "Patients are activated to maximise their knowledge, skills and confidence to manage their health, aided by technology and with the support of a health care team."

Highlighted in the report also was the need for improving patient outcomes through 'continuous and comprehensive care' in support of a GP led patient-centred care pathway.

The CEO of Precedence, the app's development company, Professor Michael Georgeff, said the app was a: "Simple communication tool that gives GPs a way of making sure their patients have the correct information they need.

"It is ideal for patients living with a chronic disease or a complex health condition as it enables them to accurately recall all their medical information after hours, when they are away from home,

in emergencies or dealing with different care team members."

The app does not retrieve GP notes, documents or record marked confidential.

MEREDITH HORNE

## Technology set to change children's health

A national initiative, *My Health Record*, has been designed to help the access and sharing of information to improve children's health outcomes by using a digital platform.

The new children's digital health network, the National Collaborative Network for Child Health Informatics, is a collaborative project between eHealth NSW, Sydney Children's Hospital Network and the Australian Digital Health Agency (ADHA).

*My Health Record's* aim is to be patient centred and clinician friendly so as to support integrated care for children and their families. It will also enhance the quality of clinician care through improved decision making tools, including a child's safety in an emergency.

*My Health Record* will be a digital summary of a patient's medical information including diagnosis, outcomes, medications, reactions and allergies. Clinical documents added by healthcare providers could also include Shared Health Summaries and Hospital Discharge Summaries.

Parents choose what information gets loaded onto their child's record. They also control what information stays on their child's record and who can access the information. The patient's record will be part of a national system that will travel with each child.

Accessing and sharing information about their children's health using a new technology platform will enable parents to accurately keep track of their children's healthcare that can be easily shared with healthcare providers.

"This can improve their ability to access health services and enhance their experience of health services because their providers have real-time information about each child's health status, immunisation status, and interaction across the entire health system. The work of the Network will help us realise this vision," said ADHA Chief Executive Tim Kelsey.

Because *My Health Record* is a part of the Australian Government's Digital Health Agency it is protected by security and safety laws at a nationally recognised level.

MEREDITH HORNE

# World Medical Association meets in Zambia



The World Medical Association Council meeting gets underway in Zambia



AMA President Dr Michael Gannon (R) with Dr Steven J. Stack – Immediate Past President, American Medical Association and Dr Heidi Stensmyren – President, Swedish Medical Association



His Excellency Mr Edgar Lungu – President, Republic of Zambia

AMA President Dr Michael Gannon represented Australian doctors at the 206th World Medical Association Council meeting.

Medical practitioners from national medical associations around the world gathered to debate a number of key issues in Livingstone, Zambia on April 20 to 22. The event was attended by almost 200 delegates from more than 30 national medical associations.

Medical cannabis was one of the key discussions at the meeting. A Position Statement was developed to be presented at the WMA's General Assembly in October.

A debate also took place on proposals to revise the WMA's long-held policy on boxing so as to include safety regulations until a ban could be put in place. A recommendation to revise the policy

at the General Assembly was agreed.

The Council agreed they needed to update their position on availability and effectiveness of in-flight medical care, along with the idea of allowing physicians to provide emergency care during flights without fear of legal reprisals.

Discussions also took place on bullying and harassment in the medical workplace; updating ethical advice on hunger strikes for doctors; armed conflicts; medical education; alcohol; and water and health.

All new policy proposals will be forwarded to the General Assembly.

WMA leaders heard from the Confederation of Latin American National Medical Associations (CONFEMEL) that restrictions on the professional freedom of physicians to practice medicine was



## World Medical Association meets in Zambia

leaving patients without basic medical care. They reported that medical prescriptions and laboratory tests were being restricted, leading to disappointed and sometimes angry patients.

Dr Ketan Desai, President of the WMA, said: 'We have been told that doctors in Venezuela feel helpless to resolve the situation, which is getting worse day by day. Junior doctors in particular are having to face angry patients and are often suicidal.

"For the sake of patients and physicians in Venezuela this situation cannot be allowed to continue. We urge the Government of Venezuela to allocate the necessary resources to the health care system and to ensure the independence of physicians to allow them to deliver high quality medical care to their patients. At the moment patients' fundamental rights to health are being violated."

WMA is now considering sending a delegation to Venezuela to express support to local doctors as well as report on the situation.

Extreme concern was expressed by the WMA as well as calling for the immediate release of a Turkish doctor, Dr Serdar Küni who is jailed in Turkey for providing medical treatment to alleged members of Kurdish armed groups.

Dr Küni, a respected member of the local community, and former chairperson of the Şırnak Medical Chamber was the Human Rights Foundation of Turkey's representative in Cizre. He has remained detained since his arrest last October and

is awaiting trial. Concerns have been raised by human rights organisations regarding his access to a fair trial and fair hearing rights at that trial.

The WMA believe the case of Dr Küni is one example among many of arrests, detentions, and dismissals of physicians and other health professionals in Turkey since July 2015, when unrest broke out in the southeast of the country.

The WMA moved an emergency resolution that condemned such practices that: "Threaten gravely the safety of physicians and the provision of health care services. The protection of health professionals is fundamental, so that they can fulfil their duties to provide care for those in need, without regard to any element of identity, affiliation, or political opinion."

It added: "The WMA considers that punishing a physician for providing care to a patient constitutes a flagrant breach of international humanitarian and human rights standards as well as medical ethics. Ultimately it contravenes the principle of humanity that includes the imperative to preserve human dignity."

The United Nations Security Council has declared, states should not punish medical personnel for carrying out medical activities compatible with medical ethics, or compel them to undertake actions that contravene these standards.

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MEREDITH HORNE

## UK follows Australia's lead on plain pack smokes

Britain has introduced plain packaging for tobacco cigarette products sold in that country.

And Oxford's Cochrane Tobacco Addiction Group says its research involving a review of more than 50 experimental studies, suggests the move will likely have a significant impact on the prevalence of smoking.

Experts from the Cochrane Review say plain packaging appears to diminish the appeal of tobacco and help reduce the practice of smoking.

Some of that evidence comes from observing the Australian experience. In 2012, Australia became the first country in the world to implement standardised packaging of tobacco products, when the then Labor Government successfully enacted plain packaging legislation.

Data collected since then shows the measure has resulted in an extra 0.5 percent a year decline smoking numbers.

"We are not able to say for sure what the impact would be in the

UK, but if the same magnitude of decrease was seen as was observed in Australia, this would translate to roughly 300,000 fewer (UK) smokers," said Jamie Hartmann-Boyce, a Cochrane Review researcher.

British legislation on plain packaging for tobacco came into full effect from May this year.

Cigarette packs must have a uniform colour and font and carry no logos apart from health warnings.

The Cochrane team analysed 51 studies.

"Our evidence suggests standardised packaging can change attitudes and beliefs about smoking," Mr Hartmann-Boyce said.

"And the evidence we have so far suggests that standardised packaging may reduce smoking prevalence and increase quit attempts."

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CHRIS JOHNSON





# Are you in the market for a hardtop?

BY DR CLIVE FRASER

## Cyclone Debbie versus three Volvos

At 2PM on Tuesday 28th March 2017 Tropical Cyclone Debbie crossed the Queensland coastline at Airlie Beach.

With wind speeds of 190 km/h and peak gusts of up to 270 km/h there was always going to be a lot of damage from the Category 4 cyclone, and the popular resort islands of the Whitsundays were hardest hit.

At the moment that Cyclone Debbie crossed the Queensland coast my surgery was over 1,000 km to the SSE and I was still enjoying sunny skies.

I'd just left my beloved 1997 Volvo V70 wagon at a local repairer for some maintenance.

Having learnt to ignore whatever politicians say and being unable to read the sign language, I didn't heed Wednesday's warnings from our Premier to stay at home all day on Thursday.

But I did try to postpone my bookings, all to no avail.

By 5PM I'd finished my clinic to start on paperwork and my dictation.

At that moment, the power went out.

I soldiered on with a torch, but then decided it was time to go home, only to find that my loan car was trapped in the car park as the electric gate wouldn't open.

Two hours later and I was finally on my way.

The worst of the bad weather was over, but there were trees down everywhere.

By Friday morning there were clear skies again, so I decided to recover my V70.

I wasn't really ready for the damage I encountered at the mechanical workshop when I discovered that a 30 metre tall gum tree had fallen in the storm on top of at least three Volvos.

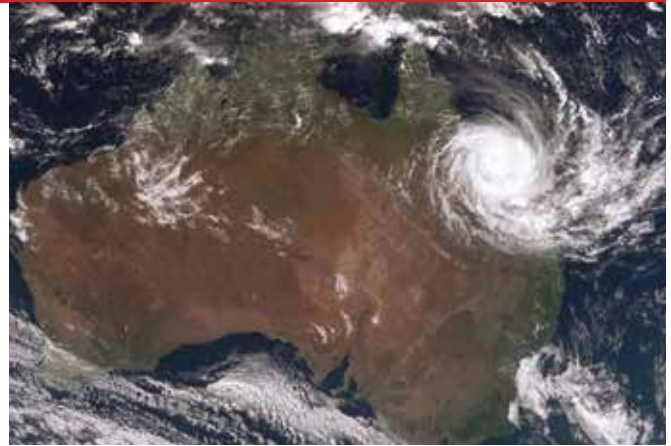
Like an anxious parent I scanned the yard for my car.

I couldn't see it among the foliage. Surely it wasn't under the mass of branches in front of me?

After 20 years of ownership would I finally be saying goodbye to my V70.

Well the anxiety was unwarranted because my car was intact some distance from the fallen trunk.

But how did the other Volvos fare under such a mass of wood and leaves?



Surprisingly well was my observation.

They all had broken windscreens, front and back.

The roofs were dented, but none were crushed.

And yes, true to Volvo's claims, all of the doors still opened.

The scene reminded me of that wonderful 1971 Volvo advertisement which showed seven Volvo 140's stacked on top of one another.

The theory was that Volvos had six steel pillars supporting the roof and that each one could support the entire weight of the vehicle.

On paper, six cars could be stacked on top of a Volvo.

It was a marketing masterpiece when Volvo was being criticized for boxy styling and staid dynamics.

Fast forward to today and there is still no ANCAP fallen gum tree crush test.

If there was I could confirm that all of the Volvos would have passed.

So I thought that I would introduce more real world testing into this column.

I'll be looking in particular at how the technology in modern cars enables them to avoid collisions with feral pigs, and what happens when one hits a kangaroo.

Please send your stories of other non-ANCAP collisions to [doctorclivefraser@hotmail.com](mailto:doctorclivefraser@hotmail.com).

Safe motoring,

**Doctor Clive Fraser**

[doctorclivefraser@hotmail.com](mailto:doctorclivefraser@hotmail.com)

# Where there's smoke there's fire

BY CHRIS JOHNSON



What do you get when you put a small bunch of musos, some of them senior diplomats and journalists in previous lives, together in the same room?

They put on such a romping great live music show that they turn it into an album – that's what you get.

At least that is what happened in the case of Den Hanrahan and the Rum Runners, whose latest offering *Smoke and Mirrors* is one of the coolest and most original independent Australian live album releases to emerge for some time.

Americana, Australian style is the best way to describe the music this band makes. But whatever the genre, it rocks.

And rock they did at the Oddfellows Hall in Yass, NSW on July 16 last year. So much so, that a live recording of the night's concert has just been released on CD and iTunes.

Independent acts are where the music scene is at these days, with some outfits putting out world class albums at highly professional production levels, but with an earthy, organic feel.

That's *Smoke and Mirrors* in a nutshell.

The songs are outstanding – most written by bandleader Den Hanrahan, whose influences (Steve Earle, Bob Dylan, Johnny Cash, Hank Williams and Ryan Adams, to name just a few) shine through on every track.

Switching seamlessly between the fast and furious, and chilled and intimate, the 13 tracks on this album are as good as anything you might hear coming out of Nashville or New York.

They are cleverly written, intelligent songs so catchy that when performed live, audiences can't help but get up on their feet.

That vibe oozes throughout this live recording and translates into a feel-good experience even when listening to it in the car or living room.

Picking the best songs on any album is highly subjective and in this instance quite difficult.

But my choices are Track 2 *No Diesel* and Track 5 *Nothing*. Having said that though, every track is excellent.

Hanrahan is a Bathurst boy, the son of the one-time local mayor there, and after training as an electrician, completed a degree in music composition and theory from Southern Cross University, Lismore.

He plays guitar and banjo ferociously – matched by the perfect voice for his style of song. His acoustic guitar solos are show stoppers.

The other Rum Runners include Dave O'Neill, who can play the strings off of anything with strings. The former Artistic Director of the National Folk Festival, (and now a music teacher), O'Neill has a long pedigree in the music industry, having toured internationally with the likes of Eric Bogle, the Bushwackers, Battlefield Band and others.

O'Neill dazzles on fiddle and mandolin, with some of the best solos you will ever hear.

Peter Logue is a former Canberra Press Gallery journalist, and was the chief political correspondent for the *Australian* and *Daily Telegraph* newspapers – and was once the President of the National Press Club.

Always the musician, Logue is still remembered for leading drunken singalongs on Bob Hawke's VIP planes during prime-ministerial overseas trips of the day.

A multi-instrumentalist, Logue brings a classy piano accordion and a warped sense of humour to the Rum Runners.

Zena Armstrong, also a former journalist who escaped to the Department of Foreign Affairs and Trade to become a senior diplomat posted to China, plays the Bodhran in the band and on the album.

Understated yet always setting the pace, Armstrong's smooth Bodhran playing adds another refreshing dimension to the band's sound.

On upright doghouse bass is the wildly talented Matt Nightingale, a sound engineer and television post-production supervisor.

Nightingale's own Redbeard mobile studio recorded and mixed this album. He also co-produced it with Hanrahan.

In the Rum Runners, Nightingale is amazing on bass and harmonies and adds the cool element before he even plays a note.

Highly in demand as a bass player, Nightingale also plays with Heath Cullen and in the Blackmountain String Band.

Which all adds up to a mix of exceptionally talented musicians who have put together one very nice live album. It is well worth a listen.

## ***Smoke and Mirrors***

**Den Hanrahan and the Rum Runners**

**Available at [DenHanrahan.bandcamp.com](http://DenHanrahan.bandcamp.com)**

**[www.denhanrahan.com](http://www.denhanrahan.com)**



# It's only natural

BY DR MICHAEL RYAN

1



Historically, no one can lay claim to inventing wine. Archeological evidence can trace wine to Georgia approximately 8000 BC. Fermented fruit juice would have given our ancestors the necessary mind sway, enhanced lateral thinking and creativity. With all those impurities, it also would have given some gargantuan hangovers.

So these would have been the first natural wines. The wine making process is a “natural” process: Yeast and sugar producing alcohol. The modern winemaker navigates his cargo on the right course to give a clean drinkable Beverage. These wine makers have many strategies to enhance the predictable outcome. Preservatives like sulphur dioxide, alcohol level control, temperature control and hygienic bottling all help.

2



But there is a growing movement of the so called natural winemaker following a minimalistic ethos. Nostalgia runs deep in the human psyche and a yearning for things past seems to have some currency. The minimalist process can begin in the vineyard and be organic or more involved as biodynamic. One of my wine making mates vineyard was rather untidy one vintage and I suggested that he had let it go a bit. His out was, “no, I’ve gone organic”.

The natural wine movement had its most notable supporter in the 40s from Beaujolais; Jules Cauvet. The concept was to give the most true expression of fruit and hence the Terroir. The natural wine has the following characteristics – no or minimal sulphur, natural yeasts, no pH adjustment, no filtration and fining.

3



So the wines can be quite different in color, lighter than expected reds. Some of the whites appear darker. The wine is often slightly cloudy. Small aberrations of funky elements of Bretynomyces and yeast notes with partial oxidation can actually enhance the wines bouquet. Some of the whites with lots of skin contact develop and orange hue.

New oak and small barrels are frowned upon. Some producers turn to the use of Amphorae. These are large clay pots as you would see in classic Roma art. The clay allows for micro

oxygenation, is inert, has good temperature control and seems to reduce the activity of unwanted microorganisms.

Overall there is a push in the wine world to have more elegant wines. The old jammy Barossa Shiraz oozing acid and tannin is becoming less desirable. Less ripened fruit with more acidity and less oak or in particular French oak are winning more wine awards these days.

## Wines Suggested

### 1. 2015 Domaine Simha Rhana Coal River Tasmania Riesling

Handpicked, wild yeast ferment picked in a biodynamic cycle. Slightly cloudy yellow hue. Nose of Lime, cut grass and spice. The palate is broad for a Riesling and the unfinned, unfiltered nature seems to impart a desirable textural component. Made by Nav Singh in Tasmania. This is real Avant garde wine that will not please all palates. But if one accepts that this wine is what it is then you will get the nature of it.

### 2. 2013 Trofeo Estate Mornington Pinot Noir

Aged for 12 months in terracotta and unfinned. A cloudy light garnet color. The nose smacks of primal fruit with raspberries, and hints of some stalky notes. The palate is generously bold and swells over the palate with seamless tannins.

### 3. 2016 Quealy Amphora Friulano Mornington

an Italian grape variety that has had 8 hours of skin contact and slow maturation in An amphora. Cloudy pale yellow. Funky nose of pear spices and flowers. Full up front fruit with lengthy acidity. An interesting food match with balsamic prosciutto figs.

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[www.ama.com.au/careers](http://www.ama.com.au/careers)



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