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Meet Greg Hunt

New Health Minister speaks exclusively to *Australian Medicine,* p6

INSIDE

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In this issue

Chris Johnson is *Australian Medicine's* new Editor.

Chris is a Walkley Award winning journalist who has spent the past decade covering federal politics from the Canberra Press Gallery in Parliament House, most recently as the bureau chief for Fairfax Media.

New Minister Promises Healthy Relationship with AMA

BY AMA PRESIDENT DR MICHAEL GANNON

Following a busy holiday period spreading important public health messages, the AMA is primed for a big year of policy and advocacy.

Following the resignation of Sussan Ley, the Prime Minister has appointed one of his most senior and experienced Cabinet Ministers, Greg Hunt, to take on the challenging Health portfolio.

This is a sure sign that the Government takes health policy very seriously, and the Prime Minister wants to turn health policy – which many commentators say almost brought the Government down at the last election – into an asset for the Coalition ahead of the next poll.

I have already had phone contact with the new Minister, including the first telephone call he made after the announcement. This was followed up with a genuinely engaging and candid face-to-face meeting with Minister Hunt in Melbourne.

At this meeting, the Minister confirmed the Prime Minister's strategy of appointing a senior Cabinet Minister to restore the Government's health credentials. Key to this strategy is building a trusting and honest relationship with the AMA.

I want Greg Hunt to be true to his word – to be the Minister for GPs. But he must understand the need to build bridges with all doctors and everyone who works in the health system. It also means winning back the confidence of voters. And this means fixing the Coalition's health policy platform well ahead of the next election.

In the Minister's mind, the fix has started.

It is clear that the Minister has done a lot of reading since his appointment, with the AMA Budget Submission on his reading list.

The Minister told me he considers the AMA an important sounding board as the Coalition realigns its health policy focus and develops the right policies. And so does the PM.

Minister Hunt has said repeatedly that he does not only intend to listen, he wants to and needs to hear, and hear clearly, the messages and advice coming from doctors and their patients.

It is obvious he has heard what the AMA is saying in its Budget Submission.

He acknowledges that the Government knows that lifting the freeze across the MBS and restoring adequate indexation is important in regaining the trust of the medical profession.

He is aware of the importance of getting things right with pathology and diagnostic imaging.

The Government knows the importance of adequate and certain funding for public hospitals.

They know that more needs to be done on prevention, Indigenous health, mental health, and the obesity epidemic.

I told the Minister that the AMA wants to be a genuinely positive force in helping the Government improve its image and reputation on health policy.

The AMA is committed to helping shape better policy on private health insurance and the Health Care Home trial.

We are committed to cooperating on the range of MBS reviews. There will need to be give and take. We are agreeable to helping to identify savings and efficiencies in the MBS, but only where and when quality patient care is not compromised.

I made it clear to the Minister that any savings must stay in the health portfolio, with greater investment in general practice a desirable outcome.

This first meeting was open and honest, and it is clear that Minister Hunt wants to make his mark in the health portfolio. We are off to a great start. Genuine consultation is guaranteed.

The challenge for the Minister, and the PM, is to push this goodwill and commitment through Cabinet in the form of quality, fully funded policy that will appeal to the profession and patients – voters.

I also had the chance to catch up with Shadow Minister Catherine King while in Melbourne. This relationship remains friendly and productive, especially with the Opposition's commitment to lift the Medicare freeze already on the table.

The ALP has invited me to attend their Health Policy Summit, and they are happy for the AMA to ask the tough questions about Labor's health policies.

This was reaffirmed during my first face-to-face meeting for the year with Opposition Leader Bill Shorten in Perth recently.

Mr Shorten reiterated his intention to engage doctors across the system in helping to construct ALP health policy.

Having met a number of times now, I can say that the alternative Prime Minister and I share a vision to see a health system that all Australians can be proud of and feel safe in, even if that has the potential to neutralise some elements of health policy as a party political issue.

This successful series of high level meetings to kick off 2017 places the AMA well and truly at the centre of health policy discussions from now until the next election.

The Ides of January

BY **AMA VICE PRESIDENT DR TONY BARTONE**

"For GPs, I want to be their Health Minister." Health Minister Greg Hunt, January 2017

In recent years, January has been a turbulent month for the Health Minister of the day.

In January 2015, newly appointed Minister Ley had to interrupt her holidays to put an end to the co-payment Mark 2 proposal.

Almost exactly two years later, Minister Hunt is sworn in and, in his first public statement, emphatically proclaims he wants to be known as the Minister for GPs.

So what do GPs want from their new Health Minister?

No prizes for guessing top of the list.

GPs want Minister Hunt to end the MBS freeze immediately, restore indexation to patient rebates, and restore them to parity – that is, to the level they would have been if the freeze had not been effectively in place since 2013.

After being promised revolutionary new funding for a new care model, robust investment in the Health Care Home (HCH) trial would also tick a number of GP wish list entries. On the eve of the roll-out, a policy that promises so much may fail or falter because of inadequate penny-pinching support of the HCH.

GPs want a reliable and robust e-health solution to assist them in their care of their patients. A solution that will securely support electronic messaging and communication between all health providers and hospitals, and which will avoid duplication of services and unnecessary wastage of scarce resources and improve the efficiency of transfer of clinical care along the patient journey.

Rural and remote GPs would look to a robust e-health system to narrow the tyranny of distance. In addition, they in particular would cry for increased infrastructure funding to assist them in their practices.

GPs are crying out for assistance in access/options to manage their mental health patients. They want access to step down programs to manage acute crisis patients returning to the community, and also access to 'outpatient' type services to assist in management of difficult patients who are not quite crisis, but out of scope for routine practice care.

We need aged care services that reflect an ongoing commitment to reliable continuous primary care options for residents of aged care facilities – services that reflect the extra impost and time required to visit and manage these patients, many of whom are frail and lack mobility.

GPs would welcome increased funding for palliative care services uniformly across the country, and an assurance that conversations and interactions about palliative care and advanced care direction were appropriately funded.

The GPs who commit to educating the next crop of GPs would applaud due recognition for this vital but often underappreciated role. For far too long, there has been a significant financial disincentive against the noble art of mentoring and teaching our next generation of GPs.

We need funding for the AMA's community residency proposal, which would provide all junior doctors with the opportunity to experience and understand General Practice, regardless of their final intended professional calling in medicine.

Of course, there are numerous other items that, in the general sense, would add to the quality of care and patient outcomes that GPs would achieve in their day to day treatment rounds.

Reducing hospital waiting lists for Out Patient Department services and elective surgeries, launching obesity and nutrition public health initiatives with related support and advisory services, and incorporating non-dispensing pharmacists in general practices would be good for starters.

Overall, I believe GPs want more than token acknowledgement of the integral role they play in the maintenance and efficacy of Australia's primary care system, which underpins our world-class health system.

This acknowledgement must be backed by appropriate funding of general practice, recognising the specialist roles GPs play in the management of their patients.

GPs should not be subject to continual cuts and lack of investment, and constantly being asked to do more for less amid erroneous claims that health spending is out of control.

General practice provides efficient value for money care.

Genuine investment in general practice will allow practice principals to invest in their infrastructure and staff, and improve the quality and efficiency of outcomes and the take-up of innovation and technology in their practices.

A busy year ahead in medical politics

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "It remains to be seen whether Minister Hunt will retain the previous Minister's interest in undertaking reviews across the health sector, and whether he will take a more strategic approach to health reform"

A new year and a new Minister for Health with the appointment of Greg Hunt to replace Sussan Ley. It remains to be seen whether Minister Hunt will retain the previous Minister's interest in undertaking reviews across the health sector, and whether he will take a more strategic approach to health reform.

The AMA is actively involved in the reviews that are underway, including through representation on the Private Health Ministerial Advisory Committee (PHMAC) and its working groups. PHMAC is looking at a range of issues identified by former Minister Ley during the last election campaign and in her negotiations with private health insurers over last year's premium increases.

These issues include the simplification of private health insurance cover into gold, silver and bronze categories, with greater uniformity of coverage in each category. Going hand in hand with categorisation, one of the working groups is looking at standardising clinical terminology, which varies greatly in the descriptions used in coverage and exclusions in private insurance policies. The initial recommendations will go to Minister Hunt mid-year, assuming that he retains the PHMAC.

The MBS Review continues with new clinical tranches to be announced shortly. The AMA's initial response to the MBS Review was to keep a watching brief, but as the outcomes from the most recent reviews become known, there is increasing uncertainty among members about the direction of the reviews. A recent call by the AMA has brought forward members with an interest in working with the secretariat to help shape increased AMA engagement with the reviews.

In early March, the AMA is hosting a meeting that brings together representatives of the medical colleges, associations and specialist societies to receive an update from the Chairs of the two major reviews – Dr Jeff Harmer who is chairing PHMAC, and Prof Bruce Robinson who is chairing the MBS Review Task Force.

Members are encouraged to provide feedback on their observations of the work of both reviews, which have the capacity to significantly impact on private medical practice.

In January, the AMA lodged its Pre-Budget Submission with the Government, setting out the AMA's priority policy issues for Government attention. Members will not be surprised that the lifting of the Medicare freeze is the number one item on the list, noting that the ongoing freeze across general practice, pathology, diagnostic imaging and other specialist services will increasingly impact patients and potentially the availability of services.

Other issues identified in the submission include funding for public hospitals, the roll out of the Health Care Home policy, medical indemnity (which is also under the spotlight at present following proposed changes announced in the Mid Year Economic Fiscal Outlook), palliative care, and a range of public health investment initiatives. The submission can be read in full on the AMA website. https://ama.com.au/budget-submission

All of these issues and more point to a busy year ahead in medical politics. I look forward to working with members on these issues during 2017 and as always invite your feedback to the secretariat.

Good health hunting

Health Minister Greg Hunt speaks exclusively to *Australian Medicine*

AMA President Dr Michael Gannon with Federal Health Minister Greg Hunt

Greg Hunt isn't kidding when he says he has been closely linked to the medical profession all his life.

From the moment his appointment was announced, the new Federal Health Minister was quick to ensure all Australia knew about his pedigree.

His mother was a nurse, his wife is a nurse, and he has many close friends and neighbours who are doctors and other medical professionals.

But wait, there's more.

"I have an uncle who has been a dentist into his late 70s and my grandmother was one of Victoria's first female pharmacists," he told *Australian Medicine*.

"So I was brought up in the medical world. There is always an enormous amount to learn, but I'm fortunate to be surrounded – not just at the national level, but with a lot of close family and friends – by what I think is as good a medical profession as there is."

So perhaps Health Minister is Greg Hunt's destiny.

Not if you go by his track record and take note of his ambition.

The health sector can be certain Mr Hunt will devote great levels of time, effort, energy and skill to his lofty new role. But his destiny could be even higher.

Those close to him share a similar view: "Greg wants to go all the way... and he just might get there one day."

Turn to the task currently at hand and it is clear that Greg Hunt wants to be the very best of health ministers.

Prime Minister Malcolm Turnbull placed a huge load of responsibility and cast a massive vote of confidence in appointing Mr Hunt to the Health portfolio in the wake of Sussan Ley's resignation.

Already a long-serving Cabinet Minister, he brings to the new job a wealth of experience and the respect of his colleagues.

He has at times been controversial, and he hasn't always got things right.

As Environment Minister in 2013 he quoted Wikipedia (to much ridicule) as his reference source for claiming the link between climate change and the growing number of bushfires wasn't so strong.

The $500 million national innovation fund he recently set up as Industry Minister has just been sent back to the drawing board by Innovation Science Australia.

And he argued in his first speech to Parliament in 2002 for the adoption of a more US-style healthcare system, where the Government takes far less responsibility.

Yet he has a record of achievement and – so far – he is saying the right things to the medical profession.

He has pronounced his "fundamental commitment" to Medicare, the Pharmaceutical Benefits Scheme and private health insurance.

Health Minister Greg Hunt at the Peter MacCallum Cancer Centre where he announced grants for medical research.

"We are committed to all three of them. That's a very important point," he said.

"The Labor Party created Medicare and all credit to them. Then there's the PBS. The PBS was brought in by Menzies.

"Then there's private health insurance, which was brought in by Menzies and then saved, after the rates dropped to 30 per cent, by John Howard and (former health minister) Michael Wooldridge.

"We (the Liberal Party) have created two of the three federal rocks that have been the foundation stones of the system and we are fundamentally committed to all three of them."

Such a fulsome expression of commitment to Medicare is necessary for the Turnbull Government to repeatedly make, after having been walloped in last year's election by the "Mediscare" campaign executed by Labor.

But beyond that controversial issue, Mr Hunt has given himself the task of being the "Minister for GPs", for which doctors will hold him to account.

"My very first call after being announced was to (AMA President) Michael Gannon and that was conscious and deliberate," the Minister said.

"I think the AMA is the absolute cornerstone of the medical profession and the sector in Australia.

"I think of it as a profession and a sector, not as an industry. I don't think that's the right way to characterise it. That undersells what it is. It's a vocation.

"As part of that, what I have developed and agreed with the Prime Minister is that we will create a long-term national health plan. We're looking out to 2030. That will be built on four pillars.

"The first pillar is Medicare, universal health and support for the medical profession. I think it's important to emphasise that we're committed to an increase in funding for Medicare every year.

"And we're committed to patients having access to doctors and nurses, having access to drugs and having access to hospitals on a universal basis. That's universal access to doctors, to medicine and to hospitals.

"The second thing is strengthening the hospital system and that's both the public and the private. I think you find that they are increasingly interdependent.

"The third pillar is mental health and preventive health. The figures in Australia are astonishing. I knew before this, because our family experienced mental health challenges."

Mr Hunt is comfortable now talking about the mental health issues he witnessed growing up.

But there was a time when he wasn't so keen to share his family's experience.

"My mother had bipolar and manic depression. The last time I saw her, she was in care in a federal health institution in Melbourne in the early 1990s," he said.

"That's when she passed, and I didn't talk about that for two decades. I was the typical Australian male and I didn't talk about it.

"And one day something happened and I did and it was quite a moving experience. It was only then that I really began to discover just how widespread this is.

Good health hunting

... from page 7

"Coming into the portfolio, what that they told me – and I checked and rechecked the figures – is that about four million Australians each year either have chronic or episodic mental health challenges.

"That's a huge portion of the population and what that says is, it's normal.

"The first message I want to get out is that there are many, many people who have done great work about destigmatising it, but I want to be able to say to people that it's normal and it's right to seek help.

"But then, what I want above all else is to deliver more frontline mental health workers, not just for youth but also for seniors. Right across the spectrum because it affects all ages, all ethnicities, all demographics.

"Mental health is a huge part of this going forward and the PM and I are just tied together on this idea of preventive health and mental health as a unified program. And Indigenous health, in particular, falls into both of those elements."

The fourth of the new Minister's pillars is medical research.

He applauds the long and strong tradition of medical research in Australia, pointing out that many women have pioneered and excelled in the field.

As an example of his commitment to medical research, the Minister points to the recent World Cancer Day round of announcements.

Visiting the Peter MacCallum Centre in Victoria, Mr Hunt announced $125.3 million funding grants for research into cancer, Alzheimer's disease, mental health and Indigenous health issues, among a long list of projects.

"These are going towards medical breakthroughs," he said.

"The five-year grants will enable highly experienced researchers to work together to tackle difficult problems in health and medicine.

"So that's the broad direction where I'm heading. And along the way I'm engaging the AMA in the long-term plan. The only way this works is as a partnership."

On the topics doctors want to hear more about, however, the Minister isn't giving too much away – yet.

On lifting the Medicare rebate freeze?

"I am deeply aware that this is of immense importance to doctors. I'll underline deeply aware," he said.

"I am working on the long-term national health plan and I won't comment on any specific measures right now, but the first two areas are Medicare and the medical profession.

"I've had a very constructive engagement with Michael Gannon and the AMA on this so far. So I'll just say that I am deeply aware."

On Health Care Home Trials?

"Yes, yes, yes. I've discussed that with Michael Gannon and what I do want to do is get input into it and make sure it reflects the desires and proposals of the profession."

And on making grounds in Indigenous health?

"Like I mentioned, Indigenous health is research and preventive health. Getting the early stage treatment, getting kids' engagement in sport and healthy habits. There is a lot of work that can be done on early intervention."

In 2016, Mr Hunt was named the inaugural Best Minister in the World by the World Government Summit for his work in developing a long-term sustainability plan for the Great Barrier Reef.

An ambitiously-named gong for which he was applauded abroad and somewhat mocked back home.

But he was nothing if not a high profile minister while in the Environment portfolio.

In July last year he was appointed Industry, Innovation and Science Minister.

And now he has been thrust into the harsh and often unforgiving world of health politics.

Inside Cabinet, he will have to prioritise the constant demands from the health sector for more funding, against a chorus of restraint from Finance and Treasury ministers.

"The key to this is to be an advocate for the profession. An advocate for health," Mr Hunt said.

"I'm fortunate to have been in the Cabinet or shadow cabinet longer than anybody other than Julie Bishop and I'm on a par with Peter Dutton.

"That gives me the capacity to make the argument. I won't win every argument and I certainly won't make false promises, but I'm sure going to fight for the profession."

CHRIS JOHNSON

New focus on Indigenous Health

Some jobs come with a weight of expectation like no other.

Take the Federal Member for Hasluck, Ken Wyatt, for instance.

He was the Assistant Minister for Health and Aged Care when Sussan Ley was the Health Minister.

Now, with Greg Hunt the new federal Health Minister, Mr Wyatt has been promoted to Minister for Aged Care and Indigenous Health.

That makes him the first Indigenous MP to ever be a federal Minister for Indigenous Health.

And the Indigenous community has taken note.

"There is an incredibly high expectation from the Aboriginal and Torres Strait Islander community that I will get things right from their perspective and that they will be involved in the shaping of policy and jointly involved in the setting of some key directions," Mr Wyatt told *Australian Medicine*.

"That was extremely evident at the Kimberley Suicide Prevention forum where Pat Turner (CEO of the National Aboriginal Community Controlled Health Organisation) asked about the stewardship of that roundtable forum.

"I made the point that the previous Minister Ley had chaired it and I would talk about that stewardship with Minister Hunt.

"And she came back with the comment that was endorsed by three or four others that 'you are our senior Indigenous member within Government, you understand the community, you understand the challenges we face, you understand our points of frustration and you have the working knowledge of what communities have said over a lengthy period of time. So we are looking to you to influence the agenda and to be a key negotiator'.

"It is a significant statement of expectation that I doubt would be put on the shoulders of any other minister who has had responsibility for Aboriginal health.

"The point Vicki O'Donnell from Derby Aboriginal Health Services made is 'our hopes lie in you as an Indigenous man'."

That is a significant responsibility on one man. Mr Wyatt suddenly finds himself as a pioneer. The first Indigenous MP on the Commonwealth executive.

Prior to entering Parliament in 2010 he was a senior public servant dealing with Aboriginal health and education.

He had been a director of the Offices of Aboriginal Health in WA and similarly in NSW. He was also the Director of Aboriginal Education in WA.

Prime Minister Malcolm Turnbull praised Mr Wyatt for his public service work when appointing him to his new role, saying his past experiences would serve the new Minister well.

Minister for Aged Care and Indigenous Health, Ken Wyatt

Australia's Indigenous community also seems to think the shoe fits. An Indigenous person in charge of progressing Indigenous health is in itself progress.

"But if I step back and I think of the reforms that we have achieved in many areas over the years, we always look to senior Indigenous public servants to be the advocates for the changes that we needed in our communities in any sphere of government," Mr Wyatt said.

"And this is a step up from that to where you have an Indigenous Minister responsible for Indigenous health.

"So yes, there is an expectation that I will champion the requirements for change.

"If we look at the issues in Aboriginal health and the health of Aboriginal and Torres Strait Islander people, we still have a way ahead of us yet.

"But as far as making a real difference, I think it is not just me; it is about harnessing the energy of the health system. It is harnessing the energy and commitment of the royal colleges; it's about working in partnership with the AMA.

"I have got a great friendship with (AMA President) Michael Gannon. I have enjoyed our conversations when we have been out at events and I see him as a friend.

"One of the first things that I really want to get into place is to ensure that there is access to primary health care at the early stages of any illness.

"It is a practice we need to embed in all Aboriginal and Torres Strait Islander families, instead of waiting."

CHRIS JOHNSON

Dr Google making house calls

Search engine Google has launched new digital "health cards", containing verified medical information about more than 900 conditions, in a move the AMA said was long overdue.

The conditions range from common complaints like coughs, infections and rashes, to more serious concerns, including tonsillitis, coeliac disease and snake bites.

Each digital card lists the symptoms and causes, and recommends the next steps the patient should take.

Google health cards program manager Isobel Solaqua said the cards were not intended to provide medical advice, but to offer more qualified information than users might otherwise find online.

"We know that cases can vary in severity from person to person, and that there are bound to be exceptions," Ms Solaqua said.

"We developed this feature to help people find the information they need more quickly and easily."

About one in 20 Google searches is for health-related information, leading to the potential for misdiagnosis and unnecessary worry, or dangerous complacency.

AMA President Dr Michael Gannon said it was a positive development.

"We know that it's already a very common reason for people to get on the web, and they can often get some very useful information," Dr Gannon told *Triple J*.

"But the use of search engines – and the term Dr Google entered our vernacular at least 10 years ago - often leads people to be a lot more anxious.

"To see higher quality information afforded to patients can only be a positive."

AMA Vice President Dr Tony Bartone agreed, telling the national *Macquarie Radio* network that people did not always know the reputation of the sites they were looking at.

Some medical information sites were of dubious quality, others were funded by special interest groups, and some were just plain wrong, he said.

"It's a long-overdue improvement in the quality of the information that Google is providing," Dr Bartone said.

"The health cards are vetted by Google Health doctors, essentially from the Mayo Clinic, I believe, and they're vetting the veracity of the information.

"But what we need to remember is that it's information only. It's not a cookie cutter approach to self-diagnosis, and even the manufacturers of this program, the developers, have said that it's not to be used as anything else other than just a source of information."

Dr Bartone said the health cards could form the basis of a discussion with the patient's GP or specialist.

"Nothing beats the time-honoured tradition of the laying of hands ... the observation and the information that's gained from visual inspection and assessment," he said.

"I'm constantly reminded of the words of my medical school teachers who said: 'More mistakes are made by not looking than not knowing.'

"Nothing beats a face-to-face consultation, especially when we've got a set of symptoms that are causing the patient concern and have been present for a while, and don't fit the usual bill."

MARIA HAWTHORNE

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

Jetlag drug remains prescription-only in Australia

The jetlag treatment melatonin will remain prescription-only in Australia amid fears parents could misuse the drug for children with behavioural issues.

The Therapeutic Goods Authority (TGA) rejected an application to exempt melatonin from Schedule 4 of the Poisons Standard after considering evidence that it could be misused as a long-term treatment for sleep disorders and discipline problems.

Melatonin, which is available over the counter in the United States, Canada and Europe, is a naturally occurring hormone, produced by the brain's pineal gland.

It helps coordinate the body's sleep cycle by acting on cells in specific areas of the brain and helping to bring about sleep, with blood levels increasing after the onset of darkness and peaking in the middle of the night.

It is a popular choice for international travellers as it can be used to "re-set the body clock" after travelling through different time zones.

The applicant argued that melatonin is freely sold as a food supplement overseas, and that it can be imported online from international retailers, raising concerns that there is a risk to consumers when buying such products from unverified sources, some of which are in high dosage strengths of up to 10 mg.

But the TGA's Advisory Committee on Medicines Scheduling ruled that there was a possibility of indiscriminate use or misuse by consumers, the potential for underlying sleep conditions not being diagnosed or managed properly, and potential for interaction with other drugs.

"There is also potential that unscheduled melatonin could be used in children, which also poses a potential for misuse, eg for long-term treatment or in children with behavioural/discipline issues," the Committee said.

Complementary Medicines Australia (CMA) said it was disappointed by the ruling.

"Melatonin, at appropriate doses, has been found to be safely and effectively used to alleviate the symptoms of jetlag, helps to reduce the time it takes to fall asleep, and helps reset the body's sleep-wake cycle," CMA chief executive officer Carl Gibson said.

"Melatonin has been available for more than 20 years in the US dietary supplement market, where it is used by approximately 5 percent of the population."

Mr Gibson said a large and growing number of Australians were purchasing melatonin via online channels under the personal importation scheme.

"Products purchased online from overseas are not subject to the same regulations as those enforced in Australia, which means there may be no surety that the product contains what it says it does," he said.

"Because, for now, melatonin remains prescription-only in Australia, we recommend that people seek the advice of a qualified healthcare professional [before purchasing online]."

MARIA HAWTHORNE

Time to reduce reliance on international doctors

It is time to reduce the health system's reliance on overseas trained doctors, with record numbers of Australian trained medical graduates unable to obtain hospital training placements, AMA President Dr Michael Gannon says.

As *Australian Medicine* reported on 6 February, more than 200 locally trained graduates missed out on training spots this year, leaving them in limbo after years of study.

The AMA last year recommended removing all medical professions from the Skilled Occupations List, which stipulates the professions that should be considered for work visas.

Dr Gannon said Australia was self-sufficient now.

"Certainly, we didn't use to train enough doctors," Dr Gannon told 3AW.

"If I reflect on when I was back in medical school, there were about 1,200 doctors coming out per year. There was an underinvestment in local medical training, which meant that we were – and remain to a large extent – reliant on doctors trained overseas to fill those gaps.

"Now we've got something like 3,700 doctors coming out each year, and we've got the ridiculous situation where we've got people who are trained in Australian medical schools, understand our system, are proficient in English, understand our unique health system – but there's not enough internships for them.

"One of the points we keep making to Government is that they need to invest in the training programs but the internship's even more important, because if you don't satisfactorily complete your intern year, you're not fully registered as a doctor."

Dr Gannon said that hospitals still relied on doctors from overseas to fill junior medical officer positions, but needed to look at how they were treating the junior doctors.

"What happens a lot sadly across Australia, no health department is perfect, but they haven't always shown those junior doctors the due respect they're worthy of, and give them leave to study for exams. That's an integral part of being a junior doctor," he said.

"They don't give them holidays, they don't give them leave – some of them can't get leave to get married – and a lot of them will leave.

"Now, that's an issue for individual health departments to manage their staff a little bit better, but surprise, surprise – they get resignations and they need to look for doctors overseas."

There was also the moral dimension of taking doctors from developing countries, he said.

"If you take a doctor to work in a rural town in Australia that's got a population of 4,500, you might be taking a doctor away from a population in Africa or Asia that looks after 15,000 people. So there's that moral dimension as well," Dr Gannon said.

The Rural Doctors Association of Australia (RDAA) said the Australian health system was still reliant on overseas trained doctors.

"The reality is that if we did not have these doctors, there would be numerous towns and communities across Australia suffering without a local medical service," RDAA President Dr Ewen McPhee said.

MARIA HAWTHORNE

INFORMATION FOR MEMBERS

Global Alcohol Policy Conference

Registrations will shortly open for the international Global Alcohol Policy Conference (GAPC 2017). The conference theme of *Mobilising for Change – Alcohol policy and the evidence for action* builds on previous efforts to translate evidence into action. The conference also seeks to capitalise on the increasing momentum to stop alcohol related harm. The conference is being co-hosted by the Foundation for Alcohol Research and Education (FARE), Public Health Association of Australia (PHAA), National Alliance for Action on Alcohol, and Global Alcohol Policy Alliance and will take place over three days from Wednesday 4 to Friday 6 October 2017 at the Pullman Albert Park, Melbourne, Victoria. The conference will explore a range of themes and involve a diverse range of local and international speakers. Further details about GPAC 2017 are available from: http://www.gapc2017.org.au/

Workshop for Aboriginal Health workers

> "The fact that RHD still occurs in Australia today is a national shame. It is a disease of poverty. It should not be occurring here in Australia – one of the world's richest nations" – *Dr Gannon*

Preventing, controlling and managing acute rheumatic fever (ARF) and rheumatic heart disease (RHD) in Australian Aboriginal and Torres Strait Islander people will be the focus of a two day conference in Adelaide next month.

RHD Australia, in conjunction with the SA RHD Control Program will host the seminar for health professionals, students and people who work in Indigenous communities.

The event comes just weeks after AMA President Dr Michael Gannon launched a plan to eradicate RHD, and called on all levels of government to make a serious commitment to close the gap for Aboriginal and Torres Strait Islander people.

"The fact that RHD still occurs in Australia today is a national shame. It is a disease of poverty. It should not be occurring here in Australia – one of the world's richest nations," Dr Gannon said.

RHD begins with infection by Group A Streptococcal (Strep A) bacteria, which is often associated with overcrowded and unhygienic housing.

Dr Gannon said that political will is needed to improve the overcrowded and unhygienic conditions in which Strep A thrives and spreads; to train doctors to rapidly and accurately detect Strep A, ARF, and RHD; and to provide culturally safe primary health care to communities.

The AMA's Report Card sets out a practical plan – with an achievable and affordable target date – to eradicate Rheumatic Heart Disease (RHD) from Aboriginal and Torres Strait Islander communities.

"Australia has one of the highest rates of RHD in the world, almost exclusively localised to Indigenous communities.

"Indigenous Australians are 20 times more likely to die from RHD than their non-Indigenous peers – and, in some areas, such as in the Northern Territory, this rate rises to 55 times higher."

The AMA calls on governments to work in partnership with Indigenous health bodies, experts, and key stakeholders to develop, fully fund, and implement a strategy to end RHD as a public health problem in Australia by 2031.

The South Australia RHD Education Workshop 2017 will be held on March 29-30 at the South Australian Health & Medical Research Institute.

ODETTE VISSER

Obituary – Dr Pauline Wilson

Dr Pauline Wilson passed away on 9 January 2017 after a 58-year career of service to medicine, 56 of them in the Northern Territory. She will be missed by many current staff of the NT Health Department and the broader community.

Dr Wilson came to Darwin in 1953 as the first Australian medical student to complete an elective in the northern capital. She returned to Darwin Hospital and the Health Department in 1958, after two years practice in Adelaide.

Some of her early duties were a reflection of the frontier times. These included being a Quarantine Health Inspector, and climbing rope ladders to board vessels and inspecting refuelling planes; Medical Officer of the Prison (Fannie Bay Jail), regularly surveying the adequacy of the gallows should the need arise; and the Commonwealth Medical Officer of the East Arm Leprosarium in the days when Aboriginal leprosy was relatively common.

She was awarded an AM for Public Health Services to Leprosy and Tuberculosis in 1994.

She had a commitment to Aboriginal health, conducting community health clinics in remote communities, around Darwin, and at the Old Bagot Hospital.

She was a Past President of the Australian Medical Association (NT Branch) and was awarded a Fellow of AMA in 1993.

Pauline was also Regional Director of Health, Top End NT; and Medical Superintendent of the Royal Darwin Hospital. From 1994 until 2013, she was in general practice at Humpty Doo. She was a member of three Medical Colleges.

Dr Wilson was an inspirational role model for all those who aspired to undertake this great and honourable career in health service to others, and in particular to young women entering medicine, demonstrating an impressive capacity for simultaneously having a family of nine children and a profession.

Dr Wilson was a very private person, with great humility, compassion, professionalism and a quiet unruffled demeanour. She sought no accolades. Her legacy is tremendous, and much of it unnoticed.

She supported the development of an excellent and leading health service, which equipped many of our current and former health professionals to train and thrive and lead their own programs of work. She was also a significant role model in her own family, and unsurprisingly many of them went on to undertake careers as doctors, nurses, a physiotherapist, a paramedic, and a social worker.

Her legacy lives on, and is treasured.

DR BARBARA BAUERT, AMA NT

Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTH:

Name	Position on council	Committee meeting name	Date
Dr Gino Pecoraro	Obstetrician/ Gynaecologist representative on FC	Stakeholder interview - National Maternity Services Review	17/01/2017
Dr Chris Moy	AMA Federal Councillor	Consultation National Digital Health Strategy, Australian Digital Health Agency	12/12/16
Dr Richard Kidd	AMACGP Chair	Consultation National Digital Health Strategy, Australian Digital Health Agency	12/12/16
Dr Kean-Seng Lim	Member AMACGP	Consultation National Digital Health Strategy, Australian Digital Health Agency	12/12/16
Dr Jill Tomlinson	AMA Federal Councillor	Consultation National Digital Health Strategy, Australian Digital Health Agency	12/12/16
Dr Janette Randall	AMA member (not on FC)	Medicine Safety Program Steering Group, Australian Digital Health Agency	8/12/16
Dr Richard Kidd	AMACGP Chair	Health Care Home - Payment Mechanism Working Group	18/11/2016
Dr Kean-Seng Lim	Member AMACGP	Health Care Home - Patient Identification Working Group	11/11/2016
Dr Sandra Hirowatari	AMACRD Chair	Rural Stakeholder Roundtable	16/11/2016

INFORMATION FOR MEMBERS

AMA Public Health Awards 2017

Call for Nominations

The AMA is seeking nominations of people or groups who have made an extraordinary contribution to health care and public health.

Recipients will be invited to attend the 2017 AMA National Conference in Melbourne in May 2017, where the awards will be announced and presented. The AMA may contribute to travel costs for recipients to attend the presentation.

In the year following the presentation of the awards, recipients will have the opportunity to participate in interviews with interested media, and engage in AMA supported activities promoting their work in their field of expertise.

All awards are presented subject to a sufficient quantity and/or quality of nominations being received in each category.

Nominations are sought in the following categories:

AMA Excellence in Healthcare Award

The AMA Excellence in Healthcare Award is for an individual, not necessarily a doctor or AMA member, who has made a significant contribution to improving health or health care in Australia. The person may be involved in health awareness, health policy or health delivery.

The recipient of this award will be an individual who has made a major contribution to health care in Australia in one or more of the following criteria:

- showing ongoing commitment to quality health & medical care;
- contributing to medical research within Australia;
- initiation and involvement in public health projects or health awareness campaigns;
- improving the availability & accessibility of medical education and medical training;
- advancing health & medical issues in the political arena;
- promoting awareness of the impact of social and economic issues on health;
- contributing to community needs as a health care provider; and/or
- improving health care services in any field.

Nominations for this award can be submitted by any member of the community.

Recent previous recipients of this award include Associate Professor John Boffa, Ms Donna Ah Chee, Associate Professor Smita Shah, and Dr Mehdi Sanati Pour.

AMA Woman in Medicine Award

The AMA Woman in Medicine Award is for a female member of the AMA who has made a major contribution to the medical profession by:

- Showing ongoing commitment to quality care;
- Contributing to medical research within Australia;
- Initiation and involvement in public health projects;
- Improving the availability and accessibility of medical education and medical training for women; and/or
- Contributing to medical politics.

This award is presented to a female member of the AMA. Nominations for this award may only be made by a member of the AMA.

Recent previous recipients of this award include Associate Professor Diana Egerton-Warburton, Dr Joanna Flynn AM, and Professor Kate Leslie.

INFORMATION FOR MEMBERS

AMA Women's Health Award

The AMA Women's Health Award goes to a person or group, who does not necessarily have to be a doctor or female, but who has made a major contribution to women's health by:

- Promoting and contributing to public health initiatives;
- Initiating, participating and promoting health awareness campaigns;
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of women's health.

Nominations for this award can be submitted by any member of the community.

AMA Men's Health Award

The AMA Men's Health Award goes to a person or group, who does not necessarily have to be a doctor or male, but who has made a major contribution to men's health by:

- Promoting and contributing to public health initiatives;
- Initiating, participating and promoting health awareness campaigns;
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of men's health.

Nominations for this award can be submitted by any member of the community.

AMA Youth Health Award

The AMA Youth Health Award goes to a young person or group of young people, 15-27 years of age, who have made an outstanding contribution to the health of young Australians by:

- Promoting and contributing to youth health initiatives;
- Initiating, promoting or participating in youth health awareness; and/or
- Development of youth health promotion programs.

Nominations for this award can be submitted by any member of the community.

Nomination Information

Nominations will be reviewed by a judging panel consisting of the Federal AMA President and two members of AMA Federal Council, after a shortlisting process undertaken within the secretariat. Award recipients will be informed as soon as possible after the panel has made its decision.

Nominations for each award must include:

- a personal statement by the nominator describing the merit of the nominee/s in relation to the criteria for the relevant award;
- a current Curriculum Vitae for the nominee/s; and
- any additional supporting documentation relevant to the nomination.

Nominations, including all required documentation, should be submitted electronically to awards@ama.com.au.

Please read the criteria for each award thoroughly, and ensure that your nomination clearly states which category you are putting the nominee forward for.

Nominations are open from 1 February 2017, and the closing date for receipt of nominations for each award is **COB Wednesday 19 April 2017**.

Restoring value

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

While I expected a number of changes to come to pass this year, the installation of a new Minister for Health was not one of them. Greg Hunt, appointed to the role, following Sussan Ley's resignation, has said he wants to be a health minister for GPs and re-establish the value of our role.

I do not believe the value of our role has ever been doubted by the community, but I do agree he needs to send a strong signal to general practice that the Government believes in our worth. This needs to be more than just lip service, with a real investment in the work we do.

> "Government is all too often intent on looking to general practice for savings on current expenditure rather than focussing on the value of care being provided and building on this"

The AMA Council of General Practice last year developed a new position statement, *General Practice in Primary Health Care 2016,* which provides the vision for general practice into the future that will ensure the value of general practice to the health system, the community and as a career.

While some don't like the term "gatekeeper" in describing the role of GPs, the fact remains that as first medical contact we have a profound effect on our nation's health outcomes and health expenditures. Patients being able to access quality general practice is key to ensuring the sustainability of the health system. General practice is an investment, not an expense.

Despite this, Government is all too often intent on looking to general practice for savings on current expenditure rather than focussing on the value of care being provided and building on this.

Minister Hunt has to convince his Cabinet colleagues that this approach needs to change. If he wants a vision for general practice, he would be well advised to take a look at our Position Statement. It outlines the key elements of a high quality and sustainable general practice, covering access, funding, the importance of a regular GP, working in well-coordinated teams, research and a commitment to safety and quality.

Critically, the position statement sets a target for GP funding. We know that GPs are managing more problems and spending more time with patients in each consultation than they did a decade ago as patients, particularly those who are older or have chronic diseases, present with multiple reasons for their visit.

Despite this, funding for general practice is not growing to match rising demand.

Commonwealth Government funding for GP services currently stands at about 8 per cent of the total Government health budget and the AMA proposes that this figure should be lifted over time to a target of around 10 per cent, as part of an effort to re-orientate the health system to focus more on general practice and primary health care, with long-term savings to the health budget anticipated in return.

The AMA also calls for a dedicated stream of funding for general practice research. Currently, about 2 per cent of National Health and Medical Research Council (NHMRC) grants are directed to supporting primary health care research, including general practice.

This figure is woefully inadequate, and is well below the contribution of general practice and primary care to the broader health system. If we are to demonstrate the value of our care and innovate, this needs to be lifted to around 8 per cent of the NHMRC's grants budget.

Your AMA will be working hard throughout the year to ensure that the interests of general practice are well represented. Your message that the MBS freeze needs to be lifted has been heard loud and clear and we are pressing the case very strongly. Looking beyond the freeze, we also need to protect the long term future of general practice and we have a strong policy platform to guide our advocacy.

Your membership adds strength to our voice and I encourage you to share your voice with us on issues of interest as covered in *Australian Medicine* and *GP Network News* via the social media or email icons on each article.

A new Health Minister in town

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

2017 has begun well. Greg Hunt, the new Federal Health Minister, brings to the portfolio considerable political expertise and energy. He also brings a demonstrated capacity to handle complex portfolio challenges and life experiences that have sensitised him to big challenges in long-term care and the challenges facing family members who are health care professionals. He will need time to come to terms with health and we should be careful not to overload him with expectations.

I read recently an article that constructively defended President Donald Trump's Tweeting! The central argument was that presidents (or ministers) are not really the developers of policy. True, they sign off on policy proposals, but the detail of policy is not really the main game that they play. The policies are developed by the administration and specialist departments whether the subject is health, immigration or trade. But a Tweet maybe all a president may need to say.

Think of *Yes, Minister* or *Yes, Prime Minister*! In all the 22 episodes of the former (1980-1984) and the 16 of the latter (1986-1988) who did the policy hard yards? Not James Hacker! Whenever he had a policy idea, Sir Humphrey Appleby and Bernard Wooley would connive, cajole, placate and keep the ship of state on course – at least as they saw it! I am confident Mr Hunt is no James Hacker and that although he will face similar challenges, he will manage them far more capably!

Now of course there are ministers who drill down into the detail and seek to micromanage to their cost – one of Kevin Rudd's remarked-upon traits that did little to secure his success. Jimmy Carter as US President became mired in policy detail and lost the game, while Eisenhower and Reagan floated above the detail, smiled a lot and won the day.

There are serious messages here for the incoming Minister. I recall a conversation with a former hapless Health Minister in which he lamented towards the end of his tenure that he came to the job believing that there were levers that he could he pull that would make things happen. He found the levers but he said when he pulled them absolutely nothing happened.

This is not, in fact, to say that ministers or presidents are irrelevant or without power. It is, though, to ask in what way they are important and what can they do to make a success of the portfolio. Three things stand out.

First and foremost, the Minister needs to lead, to convey a sense of destiny and optimism and assure the tens of thousands of people working in health care that they are doing worthwhile work and are recognised. This was a major element in the success of Jillian Skinner, former Health Minister in NSW. The human element is critical. Go and meet the practitioners, managers and support staff. Find out what makes them tick. Encourage and enthuse them about the value of health care and the humane society to which it contributes. Don't sit in your office waiting for gravy-train passengers to come with glossy proposals about how they can fix things – for a price.

Second, ministers can give directions to the vast machinery of health service management. This is less a matter of pulling levers than it is of saying what our goals and values are and then letting the people who develop the policy get on with it. Mumbled words and confusing signals about cutting costs and pursuing an agenda of financial efficiency without concern for health outcomes as though health care was the same as a factory making boxes is exactly what we don't need.

Does the Minister wish to see an agenda for the effective and sustainable provision of primary care? If yes, say so – no ifs and no buts and not necessarily much detail. The Minister needs to say – I value primary care because it is the central to managing the changing pattern of disease we are experiencing.

The Minister also needs to make clear what he thinks about prevention. In 2014 the relatively new Australian Preventive Health Agency disappeared without trace because of a ministerial grenade lobbed through a front window. Such folly in the presence of so much illness and suffering that can be prevented is ridiculous. The Minister does not have to set the preventive policies but rather support and endorse those that are developed within his or her department. The policies may need to be sold to fellow politicians (one of Obama's weak points) and the community and health professionals. Fine. That is the business of politics. Watch the film *All the Way* about LBJ and see how he negotiated civil rights legislation through Congress.

Beside understanding that our health services depend upon the commitment of thousands of people of their lives to this task and getting to know them and articulating an enthusing vision for health and giving direction to those who develop policy, the Minister, like a monarch, can give encouraging gifts every now and again. The gifts need not be expensive. Fixing the absurd arrangement whereby Medicare reimbursements are not indexed would be one such gift. It is arbitrary, punitive, uncreative and plain silly.

If this problem is fixed, lots of people will rejoice and who knows what the goodwill Mr Hunt will have just won that may enable him to deal with far bigger and more important matters.

It's OK to not be OK

BY DR JOHN ZORBAS, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

When I started medical school, I was taught that there'd be challenges along the way. I was taught to work hard; it's a hybrid mix of art and science that can be mentally demanding. I was taught to always put the patient first; the patient is the centre of almost everything we do and the answer to most of our problems. I was taught how to progress, how to prepare for my career and how rewarding it could be. I definitely was not taught that by the time I'd become an advanced trainee, I would have lost a number of friends to the diseases of depression and anxiety, in all of their forms. Suicide is not a word we use often, and when we do it's always in hushed tones, as if it's an inconvenient drunk guest at a Christmas party who will eventually leave if we just don't pay it any attention. Unfortunately for us, that's just not how mental health works.

Doctors in training evolve within a system that is rigid and mechanical. From the starting gun in first year medical school, you're either good enough or you're not. I've written before about our current models of assessment having either 'green' lights or 'red' lights. There's a distinct lack of 'orange', and therefore minimal opportunity for meaningful remediation and development before we hit a 'red' light. This is simply one aspect of the system, but there are others just as simplistic and inflexible. Part time work is practically non-existent, and for those returning from illness, there are no graded return to work programs available. It is not uncommon to be rostered on unsociable and unsafe working hours, which then has a knock-on effect to life outside of work, sometimes with fatal consequences.

I believe that this system is allowed to propagate because of an unhealthy culture within both our profession and the workplace. If our hospitals were companies, the board of directors would be personally liable for a whole host of issues of negligence, and yet we hold the shopping mall to a higher standard of governance than we do our hospitals. I have worked for a number of not just good, but outstanding employers. I have worked under excellent directors of medical services and heads of departments. When things work well, our culture works well and this tone almost always come from the top down. Our system fails terribly, however, when things go wrong.

When the system fails us by rostering us unsafely and we hire an inadequate number of staff to provide a health service, we accept it as a personal failing of our ability to practice our profession. When we fail assessments, the system does not encourage us to critique our failure and improve our performance, but rather to blindly double our efforts because there must be something wrong with us when compared to our colleagues. When the system fails our patients and they come to harm because of poor governance, we see it as a personal failing of the oath we took on graduation. And when people ask us if we are OK, the answer is almost always "yes". In such a system, how can you afford to answer otherwise?

What I'd like to state in this article, unequivocally, is that it's OK to not be OK. If you aren't coping in your current job, then you need to stand up and let people know, and conversely when our colleagues do so we need to recognise it as a system failure rather than the incorrect and simplistic view of a doctor who can't hack it. Every single doctor in training at some point of their career has felt despair, anguish, fear, excitement, disgust and anger in their job, and those who tell you otherwise are simply liars. To borrow from the wit of Tim Minchin, we're just "monkeys in shoes", and if we're not special then we shouldn't expect superlative performance from all doctors, all of the time. You're allowed to have bad days. You're allowed to have a number of bad days. You're allowed to have so many bad days that you become ill. And we should support each other without question when this happens.

If things aren't working the way they're supposed to, it may be because you're working in the wrong workplace. It may be because you've chosen the wrong specialty. It may be because you live in the wrong State! Pause. Stop. Take a moment to stand back from the race and think about how you might change your trajectory. It's OK to not be OK, because chances are you're not the only one. And each time we acknowledge that, we're one step closer to a system that can support us through these times, rather than hindering us.

Support services:

drs4drs www.doctorportal.com.au/doctorshealth/

Australasian Doctors' Health Network www.adhn.org.au/

Promoting the health and well-being of junior doctors www.jmohealth.org.au/

Doctor Health Advisory Service www.dhas.org.au

Lifeline https://www.lifeline.org.au/

Growing up Digital and Practising In Real Life (IRL)

BY **ROB THOMAS**

> "It's interesting how seamlessly I feel technology permeated our lives. I can't imagine living without a smartphone, but just 10 years ago they were an entirely new concept"

Medical students are digital natives. Writing this, I sit here on my laptop, an engineering marvel, wirelessly connected to the entire world and playing a new mix of Deep House on YouTube. A new generation is being born into the world who won't know why we say "hang up the phone" – when did you last hang a handset on the wall-mounted keypad, and what exactly was the use of the hash before the hashtag?

It's interesting how seamlessly I feel technology permeated our lives. I can't imagine living without a smartphone, but just 10 years ago they were an entirely new concept. We use technology without thinking every day – Geolocation technology to get to work, an in-built high-definition camera to catalogue our every brunch date, and we use IT to study.

If there's one thing young medical students are experts in more than technology, it's studying. We've spent basically our whole lives doing it – often in a continuous fashion, from the time we're five until around 30 for the fastest pathways. In that time, we each develop and refine our study methods. Four years ago I used Word docs to write notes, then I discovered Word docs could have tabs within them, and then I actually discovered OneNote.

As much as it annoys us, technology goes out of date faster than long-life milk. We constantly get notifications to update, or we become obsolete. We need to update because things are always improving – always faster, often smaller, and sometimes revolutionary.

In a field like medicine, there are several reasons why technology may not be taken up as quickly as possible. Firstly, there is tradition – the tried and true didactic learning styles that may or may not have worked for the current generation of doctors. Many guest lecturers, and even associate professors still choose this style – yes they use data projectors and PowerPoints when their predecessors used light projectors and photo slides, but the teaching is basically the same. What might be harder is to fully embrace technology – harnessing the interactivity of the world in which we already live.

The second reason that medicine will always have some aspect of in-person teaching is the nature of the job. Every day you live life in the real world – you talk to real human beings, with real problems, and often you need to intervene in a real life way. On me becoming a medical student, my mother – a physiotherapist for more than 20 years – said to me, "Never forget to put your hands on the patients". What she was basically saying is that medicine is tactile – your human interview skills and your physical examination are your bread and butter. They are not only diagnostic; your people skills are often as therapeutic as any new intervention.

The thing about education technology research, is that it goes out of date along with the technology. In medical practice, we have to keep an open mind for new research advances – thinking like this leads to marvellous things like spray-on skin, the cochlear implant, or the use of stem cells in spinal cord injuries. We have to keep an open mind, while not straying too far from the tried and true path. For example, at this stage there is no fully interactive technology that students believe is an appropriate substitute for cadaveric anatomy teaching. But maybe soon there will be.

As future health professionals, we must ensure that our connections to technology don't damage our connections IRL. I sincerely hope medicine and medical education can walk the line, keeping an open mind for new updates while teaching us the basics of being a human doctor.

Email: rob.thomas@amsa.org.au
Twitter @robmtom

AMA fully engaged in review of medicines regulation

BY **DR CHRIS MOY**

Should new drugs with the potential to save lives be fast-tracked for sale in Australia, even if their safety and efficacy is not yet fully known? Should government vetting of advertisements for complementary medicines be dropped in favour of industry 'self-regulation'?

These questions and more were considered in a review of medicines and medical devices regulations in 2015.

As doctors, we rely on the independence and expertise of the Therapeutic Goods Administration (TGA) to ensure that the medicines we prescribe and the medical devices we use to treat patients meet appropriate standards of quality, safety and efficacy.

This means we can focus on treating patients, confident that these medicines and devices have passed stringent and independent assessment processes, rather than undertake our own research to check the validity of data provided by industry.

So the AMA was fully engaged in the review, submitting three submissions based on advice from the Medical Practice Committee as well as meeting with the review panel.

In 2016, the Government announced it would go ahead with a raft of reforms recommended by the review, which made 58 separate recommendations aimed at improving and streamlining current regulatory processes.

The good news is that the reforms include many advocated for by the AMA, including improving post-market monitoring systems by establishing more device registries, increasing the transparency of medicines scheduling processes and decision-making, and strengthening the TGA's powers to pursue advertising breaches.

The TGA is now moving quickly to implement the reforms. In the last three months it has released five consultation papers canvassing options on possible ways to proceed and seeking comments on the best way forward.

The AMA, with Medical Practice Committee advice, has focused on proposals most likely to impact on doctors and their patients.

The most significant consultation proposals and our key points are summarised below. All the AMA's submissions to the TGA are available in full on our website. [https://ama.com.au/advocacy/medicines]

Expedited approval pathways for prescription medicines to bring new medicines to the Australian market more quickly without introducing unacceptable risks

The AMA supported a proposed 'priority review pathway' which would reduce the time to process new medicine applications, because it would be limited to situations where the new medicine: treats a life threatening or seriously debilitating disease; addresses an unmet clinical need; and has a complete data dossier demonstrating substantial advantage over existing treatments.

The AMA also supported a proposed 'provisional approval pathway' for new medicines that also meets the above requirements, but rather than a complete data dossier, there is only promising evidence from early data.

We decided to support this proposal on the basis that the benefits to patients from earlier access would need to outweigh the risks, and provisional registration will be time limited and automatically lapse unless sponsors meet conditions imposed by the TGA, including additional post-market safety and efficacy data leading to full registration.

However, our submission raised questions about how the provisional status of a new medicine will be clearly communicated to patients and how the TGA proposes these medicines will be monitored given the higher risks.

Accelerated assessments for new medical devices which address life threatening or debilitating conditions

The AMA supported the TGA's proposed approach because a full dossier of supporting data would still be required and the focus is on changes to the TGA's administrative processes to achieve faster approval times.

Improvements to over-the-counter medicines advertising regulations

The AMA supported most of the proposed changes to the regulations dealing with the advertising of over-the-counter (OTC) medicines (these do not apply to any S3, S4 or S8 medicines which cannot be advertised directly to patients). The changes will improve the complaints management system for reporting and dealing with advertising breaches and strengthen the powers of the TGA to apply and enforce sanctions and penalties.

However, the AMA opposed the replacement with an industry self-regulation model, of the current pre-vetting of OTC medicine advertisements by an independent committee administered by the TGA.

The year that was. The year ahead

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

2016 proved to be a pivotal year for the role of ethics in the AMA. For the first time, the AMA consulted directly and extensively with members on one of the most sensitive and potentially divisive ethical issues in medicine, the role of the medical profession in euthanasia and physician assisted suicide.

> "From the outset, the AMA made a conscious commitment to ensure that all members were directly engaged and provided with a range of opportunities to express their views during the policy review process"

From the outset, the AMA made a conscious commitment to ensure that all members were directly engaged and provided with a range of opportunities to express their views during the policy review process. We also made the conscious decision to ensure that the entire review process including the member survey results and all Federal Council discussions and decisions were made transparent to members.

While not every member is going to agree with the policies outlined in the *Position Statement on Euthanasia and Physician Assisted Suicide 2016*, I hope our commitment to consultation and transparency reassures each member that we are sincere in engaging your views on issues of ethical importance to the medical profession.

While the euthanasia and physician assisted suicide policy review certainly dominated the ethics agenda in 2016, several ethics and medico-legal guidelines for members were updated as well, including the *Ethical Guidelines on Independent Medical Assessments 2010*, *Ethical Guidelines for Doctors Acting as Medical Witnesses 2011. Revised 2016*, and the *Guidelines on Medical Certificates 2011. Revised 2016.*

The *Position Statement on the Doctor's Role in Stewardship of Health Care Resources 2016* was also finalised in 2016. It focusses on avoiding or eliminating wasteful expenditure in health care, maximising quality of care and protecting patients from harm while ensuring affordable care in the future.

The year ended with the approval of an extensive update to a foundational AMA policy document: the *Code of Ethics 2004. Editorially Revised 2006. Revised 2016.* Reviewed for the first time in 10 years, the updated Code will be released shortly.

2017 looks to be another busy period of review of AMA ethics policy. We have a number of ethics (and medico-legal) based policies up for review covering issues such as genetic testing, human cloning, patient examination and professional boundaries.

The review of AMA policy on medical practitioners' relationships with industry will be particularly challenging, covering issues such as managing real and potential conflicts of interest, industry sponsored research, industry-sponsored meetings and activities, hospitality and entertainment, promoting industry interests, product samples, dispensing by doctors and relationships with industry representatives.

The review of AMA policy on organ and tissue donation and transplantation will be a highlight of the year. Addressing issues such as donor choice (and consent systems), public education, donor families, living donors, organ and tissue allocation, consent to transplantation, organ trafficking, workforce and infrastructure, and quality and safety, the review will include a panel discussion session on organ donation at this year's AMA National Conference in Melbourne.

The AMA has also adopted a range of World Medical Association statements and declarations. This year, we will be reviewing the update of the (AMA adopted) *WMA Declaration of Tokyo Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment.*

If you have any questions regarding the AMA's current ethics agenda, please refer them to ethics@ama.com.au.

AMA ethics-based position statements, reports, guidelines and other publications, including the Member Consultation Report on the Review of AMA Policy on Euthanasia and Physician Assisted Suicide, can be found on the AMA website under Ethics & Professionalism at https://ama.com.au/advocacy/ethics-professionalism.

Another year of complex issues ahead

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

Last year was a busy year for public hospital doctors, both as a Council and in the broader industrial/political context. Key issues for 2016 included the ever-present Rights of Private Practice, workplace well-being, personal safety and privacy for doctors, health funding (overlapping with private health insurance changes and the impact any fallout may have on public hospital workload) and the Productivity Commission inquiry into Australia's human services including public hospitals.

Public hospital doctors remain in the front line of public health matters, including disaster management, as expectations and demonstrated productivity continue to increase with greater pressure on terms and conditions, such as a real reduction in equivalent spending power through loss of the previously highly advertised salary packaging opportunities. It is difficult to predict on which issues we will need to focus as the year progresses, but I raise a handful of key issues that are likely to take up some of our time in the year ahead.

End of life care

Last year saw much debate about end of life issues and no doubt that will continue this year. The AMA has raised the issue of recognition of the special work done by doctors and other health professionals involved in end of life care, but there are issues of potential discrimination of employees on both ends of end of life care to be managed.

Federal Council considers end of life care needs to be patient-centred and generally involves a range of medical professionals. It is relevant to people of all ages and across all settings of care throughout Australia. More support is needed in the over-stretched palliative care workforce to ensure consistency of quality and access to services. More specifically, doctors working in end of life care circumstances require appropriate support to address their own wellbeing, including appropriate medico-legal protections and certainty when providing end of life care in accordance with recognised good medical practice.

Standards Australia Technical Committee review on security for health care facilities

I have been invited to take part in the Standards Australia review of the Australian Standard on security in health care facilities. This ties in with our work on the AMA *Position Statement on Personal Safety and Privacy for Doctors*. I'll be working with a technical committee to review AS4485 1997 Parts 1 and 2 Security for health care facilities. This is an important standard, the outcomes of which are likely to provide guidance for the review of the position statement, as well as governance advice for public hospitals in the increasingly violent presentations to public (and private) hospitals, occasionally related to illicit drug consumption.

Diversity in the medical workforce

With the release of the AMA *Position Statement on Equal Opportunity in the Medical Workforce*, the AMA has called for targets to increase the proportion of women in health leadership positions, and the number of Aboriginal and Torres Strait Islander people in the medical workforce.

The medical workforce, of which public hospitals comprise a large part, particularly in the training years, should reflect the diversity of the patients for which it cares. The AMA recognises that there is an under-representation of women in leadership positions in the medical workforce, and an under-representation of Aboriginal and Torres Strait Islander people throughout the health care sector.

Federal Council, supported by your Public Hospital Doctors' Council, considers there should be realistic and merit-based targets in place to address these issues and medical workplaces should have a range of strategies in place to attract doctors from diverse backgrounds.

Medicare Benefits Schedule (MBS) review

The MBS Review Taskforce released its consultation papers in 2015, setting out the background and context for the MBS Reviews. The Taskforce Review is a two-year plan, due to wrap up in mid-2017.

The Review has reported on Tranche 1, which included recommendations from the MBS Principles and Rules Committee. The AMA provided some specific feedback on the report but at this stage will generally defer to the relevant Learned Colleges and Specialty Associations for comment on

One door closes, another opens

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

We all know this concept. It usually means something bad happens, and a door we wish stayed open didn't and it slams closed. Sometimes trapping our fingers, hurting, as that treasured door closes. There usually is an element of surprise, lack of control, unfairness and pain.

A door closes: Health Minister Sussan Ley is forced into resignation last month, someone dear to us dies or leaves us, we receive a life-threatening diagnosis, a critical appointment is missed.

During these painful events, it is hard to see the upside. Instead we feel loss, betrayal, grief. We live in the spiralling thought loops of what if and if only. We mire in the past. We go through the Kubler-Ross stages of grief (denial, bargaining, anger, depression, acceptance).

One door closing: Sussan Ley, such a public and painful door going SLAM. This surprise, it caught her at the side of her face. It caught us all by surprise. The pain of leaving a ministry with projects on the table, her heart in those projects. The pain in the altruism of stepping back so the distraction of an inquiry would not glue up her Ministry. The disappointment for us in the AMA and rural Australia for losing a Minister with a strong rural background.

A door opens: something better happens, events that could not possibly occur if that other door did not close. It does not feel like it right now but through the open door there is safety, laughter, optimism, a new adventure. During this phase, we cannot see much past the door, it is uncharted territory. Hindsight is 20-20 but the future is like looking through a mist.

The Health Ministry door opens: new Minister Greg Hunt. We have gained the man who received last year the Inaugural Best Minister in the World award at the World Government Summit. The criteria for this award is innovation, leadership, impact and reputation. He has a vested interest in mental health, has played a crucial role in reducing carbon emissions, he is passionate in his view to create the best health care system in the world.

A collateral consequence of this Ministry shuffle is new Minister for Aged Care and Indigenous Health, Ken Wyatt. This heralds the appointment of the first Indigenous person to be appointed to the Commonwealth Ministry. Congratulations Ken.

Rural Doctors note: Gastroenterologist Dr David Gillespie, our champion, the Assistant Minister of Rural Health has now been titled Assistant Minister of Health.

In the meantime, the Farrer electorate gets Sussan Ley's undivided attention, hopefully less stress in her own stomping grounds. Thrive, Sussan.

For those of you who have had a door closed, I wish for you a future a hundred times better when you pass through the new open door.

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individual items. This is an issue upon which the CPHD will be keeping a close watch as the review approaches closing.

Asylum seeker health

Always a contentious issue, late last year the AMA raised concerns with a Senate committee about health care on Nauru and Manus Islands amid concerns that many asylum seekers and refugees are being denied appropriate and timely health care.

Due to undue secrecy, accurate information is difficult to obtain, so the AMA has called for independent oversight of the health care provided to asylum seekers. The Senate inquiry is due to report in March 2017.

With some "controversy" over our now former Health Minister, we hope that the incoming Minister will value the work of public hospitals, their doctors and other staff and engage appropriately with us on relevant issues. I wish you a successful year ahead and look forward to working with you on these and many other issues, as we enter an "interesting" time which appears will involve "alternative facts".

AMA position on three major public health issues

BY AMA PRESIDENT DR MICHAEL GANNON

In January, the AMA released three significant position statements that addressed major public health issues in Australia.

The AMA's new Position Statement, *Australian Centre for Disease Control (CDC)*, called on the Government to make Australia a world leader in science, medicine, and research by establishing a CDC.

We are the only country in the OECD that does not have an established national authority delivering scientific research and leadership in communicable disease control, and we must join other developed nations in playing a global role in combating infectious diseases and other potential threats to the health of its people.

Diseases and health threats do not respect borders. There are emerging problems of controlling communicable diseases within Australia's borders, and a CDC would provide a national focus on current and emerging communicable disease threats. The prevention of epidemics, pandemics, and other threats, and the capacity to conduct national responses, must be undertaken by an appropriately funded and staffed CDC.

The CDC would deliver effective communication of technical and surveillance information, and work with the States and Territories to manage the allocation of public health workforces and resources to tackle emerging and current threats. It would coordinate Australia's vital work with other countries to build international public health capacity through expanding and managing communicable disease surveillance, prevention and control, environmental health, and health awareness and promotion.

Thankfully we haven't yet faced fatal epidemics and infectious disease threats, but we do know that when we do face one, our current capabilities would be severely stretched.

The AMA Position Statement, *Blood Borne Viruses*, called for needle and syringe programs (NSPs) to be introduced in prisons and other custodial settings, to reduce the spread of Blood Borne Viruses (BBVs) including hepatitis B and C, and HIV.

Prevalence of BBVs is significantly higher in prisons, and custodial facilities provide a unique opportunity to protect the health of inmates. BBVs are a major health problem in our prisons, which is no surprise given that many people are in custody for drug-related offences in the first place. All the evidence shows that harm minimisation measures, such as access to condoms and lubricant, regulated needle and syringe programs, and access to disinfectants such as bleach, protects not just those in custody, but prison staff too.

We want to reduces the likelihood of someone being discharged from prison with an untreated BBV, and spreading it in the outside community. The AMA supports NSPs as a frontline approach to preventing BBVs. Prison-based NSP trials have been shown to reduce the risk of needle-stick injuries to staff, and increase the number of detainees accessing drug treatment, while showing no adverse effect on illicit drug use or overall prison security.

Our BBV Statement also calls for greater emphasis on prevention, reliable and affordable screening, immunisation, and treatment, with stronger referral pathways, and greater investment in specialist services. We also call for specific resourcing and management of HLTV-1, a relatively unknown BBV that affects Aboriginal people in central Australia.

The *Firearms - 2017* position statement created a lot of media, although it was apparent that many of the critics hadn't actually read the AMA's position, which was an update of the 1996 version.

The AMA position hasn't changed much in the 20 years since the National Firearms Agreement was introduced after the Port Arthur massacre – gun ownership laws should be tightened, and a national, real-time firearms register should be established.

We have always acknowledged that there is a legitimate role for guns in agriculture, regulated sport, and for the military and police, but gun possession in the broader community is a risk to public health.

In the nearly 21 years since Port Arthur, gun deaths in Australia have halved, thanks to the National Firearms Agreement. However, there are still hundreds of thousands, if not millions, of guns held illegally in Australia, and most gun-related deaths in Australia are suicides within the families of gun owners.

These three position statements have been well received and supported by stakeholders and the public and are important additions to our public health policies.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Suicide prevention trial extended

A $46 million suicide prevention trial will be extended to Darwin, Central Queensland, Western New South Wales and Mid-West Western Australia, where suicide rates are higher than average.

Health Minister Greg Hunt, who has promised to make mental health one of his main priorities in the portfolio, announced the expansion of the Suicide Prevention Trial Sites on 6 February, two weeks after he was sworn into the role.

"Each year, more than 3,000 Australians take their lives, and the suicide rate for Aboriginal and Torres Strait Islander people is around twice that of non-indigenous people," Mr Hunt said.

"This is an individual tragedy in every case, but it is a national crisis. What we have been doing has made things better, but it is not good enough and it has to be better still."

The four new sites join the already announced trial areas of Brisbane North, North Coast New South Wales, North Western Melbourne, Perth South, Townsville, the Kimberley, Tasmania, and country South Australia.

Each trial site will run for three years and receive approximately $3 million to deliver a locally-tailored response.

The funding will be administered by local Primary Health Networks, in consultation with the local community and local government.

"Preventing suicide is a complex problem, and a one-size-fits-all strategy for dealing with the challenge may not be the best approach," Mr Hunt said.

"The causes of suicide, and the resources needed to prevent it, will vary from town to town, and from region to region.

"The resources needed to tackle suicide in a regional farming community in drought may be very different to the resources needed to tackle suicide in inner city Sydney.

"I won't make a false promise about overnight changes, having only just started, but I will make a guarantee that in every one of these trial sites, the goal is to improve services, to reduce waiting times, to make sure that we have better outreach."

MARIA HAWTHORNE

Colleges to select graduates for GP training

The Government has heeded AMA calls for greater professional control over GP training arrangements, announcing that the two general practice colleges will handle the selection of medical graduates for the Australian General Practice Training (AGPT) program.

Assistant Minister for Health Dr David Gillespie has announced that the Government will spend $220 million a year on the AGPT, a post-graduate vocational training program.

The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) will administer the selection process, bringing them into line with other Australian specialist medical colleges and the way those colleges select trainees.

"[This] will provide the GP colleges with a greater role in the management and conduct of GP training," Dr Gillespie said.

"Our Government has a great respect and confidence in both of the colleges, and this is yet another fine example of the crucial and vital health workforce reform that we will achieve in order to deliver better GPs to all Australians."

The AMA has consistently called for change since its 2014 GP Training Forum, which was held in response to reforms to GP training announced in the 2014-15 Budget.

Through the AGPT program, medical graduates undertake three to four years of full-time training in urban, regional and rural locations, with 50 per cent of registrar training occurring in rural and remote areas of Australia.

Training is predominantly conducted in medical practices and hospitals, and is delivered by accredited medical supervisors and a network of nine Regional Training Organisations, in accordance with the standards of the RACGP and ACCRM.

Graduates will pay an application fee. Applications open in April and successful registrars will commence training in 2018.

MARIA HAWTHORNE

Research

Researchers call for independent testing of herbal medicines

Australians may be putting their health at risk by using potentially dangerous "natural" herbal remedies, researchers have warned.

Lack of regulation, the inclusion of unidentified ingredients – some illegal or even toxic – and the mistaken belief that "natural" means "safe" were just some of the perils, the authors wrote in the *Medical Journal of Australi*a.

With 69 per cent of Australians estimated to use complementary medicines, and more than half of those not telling their doctors, there was a risk of unwanted side effects and dangerous interactions with prescribed medicines.

"Rather disturbingly, the answer to the question – 'What are the risks to the Australian community from herbal products?' – is that we simply do not know," the authors, led by Professor Roger Byard, chair of pathology at the University of Adelaide, said.

The authors called for the Therapeutic Goods Administration (TGA) to consider requiring manufacturers to have samples independently tested.

The lack of reported side effects in traditional societies has often been cited as evidence of the safety of herbal products, the researchers said.

But a lack of systematic observation meant that even serious adverse reactions, such as kidney failure and liver damage caused by plants from the Aristolochia species, extracts of which are used in some herbal weight loss and joint pain relief formulations, were unrecognised until recently.

The researchers warned of several potential dangers, including:

- adulteration with pharmaceutical agents, 'presumably added to increase the apparent efficacy of the herbal product', exposing users to the risks of ingesting uncontrolled amounts of these drugs, of allergies to undisclosed ingredients such as antibiotics, and of interactions with prescribed medications;
- substituted plant ingredients, which may be deliberate if the original plant is difficult to obtain or expensive, or the result of misinterpreting or inaccurately transcribing names or formulas in texts;
- the presence of toxic substances, from both animals and plants, as well as heavy metals and pesticides;
- inadequate processing; and
- pharmaceutical interactions, with herbal medicines potentially enhancing or reducing the effects of prescribed medications, or eliciting unpredictable idiosyncratic effects.

"It may be appropriate for the TGA to require manufacturers to have samples independently tested before placing them on the market," the researchers said.

"Legal action should be considered in cases of non-compliance with applicable regulations, and preparations containing illegal substances should be banned."

But the peak body representing complementary medicine producers and importers said that products on the Australian market already met stringent tests, and the problem arose from products purchased online from overseas.

Research

"Australia has some of the most stringent regulations in the world for herbal products, as for all complementary medicines on the Australian market," Complementary Medicines Australia (CMA) chief executive officer Carl Gibson said.

"Products are required to be entered on to the Australian Register of Therapeutic Goods (ARTG), which is maintained by the TGA. Unless entered on the ARTG, these products cannot be legally imported, exported, manufactured or supplied to consumers in Australia.

"Concerns raised by the authors, such as adulteration with pharmaceutical agents, inadequate processing, and the presence of toxic substances, have been known to affect products purchased online from overseas, which are not subject to the same regulations as those enforced in Australia."

Online purchases of complementary medicines should only be made on the recommendation of a qualified healthcare professional, or from a known and reputable source, Mr Gibson said.

MARIA HAWTHORNE

Detecting Parkinson's – over the phone

A US tech start-up is developing machine-learning algorithms that may help clinicians diagnose neurological conditions like Parkinson's or Alzheimer's disease, just by listening to a patient's voice.

New Scientist magazine has reported on the work being done by Canary Speech to train its algorithms to detect vocal cues that distinguish someone with a particular condition from someone without the condition.

Canary Speech is using audio data from hundreds of millions of phone calls collected by an unnamed American health insurer over the past 15 years to look for vocal markers associated with Alzheimer's such as hypophonia, a softness of speech resulting from lack of coordination over the vocal muscles.

The calls are labelled with information about the speaker's medical history and demographic background, allowing

Canary Speech to monitor individuals over a period of years.

While the use of the information would appear to raise privacy concerns, Canary Speech CEO Henry O'Connell said that the health insurer had "express permissions" in place to allow it. However, stricter UK data protection laws may prevent Canary Speech running a similar project there.

Vocal indicators of neurological conditions have been studied for decades, but the use of machine-learning algorithms to aid diagnosis is a recent development.

If algorithms can be used to detect symptoms in the voice earlier, treatment can start earlier.

At this stage, the technology is being developed with a view to using it in a clinical setting, to help diagnose the conditions.

However, patient privacy advocates are concerned that the technology could be used to screen callers, influence insurance premiums, or track or diagnose a condition without telling the patient.

Before Obamacare – the US Affordable Care Act – came into effect, insurers often denied coverage to people with Parkinson's or Alzheimer's.

Under Obamacare, insurers were prevented from denying benefits or raising costs because of a pre-existing condition, but the Act's future is uncertain under the Trump administration.

MARIA HAWTHORNE

Doctors want best of Obamacare saved

American doctors have called on Congress to improve Obamacare without taking away what's best about it.

In early February, doctors who treat women and children, as well as general practitioners, lobbied Senate offices to make the case for keeping important aspects of the Affordable Care Act. And they rebuked Republicans in Congress for talking up repeal without having a plan for replacement in place.

NBC News reported that five medical organisations issued a statement pointing out that currently-insured individuals should not lose their coverage as a result of any action or inaction by policymakers.

The groups said that acceptable reform must continue to ensure access to comprehensive, safe, and affordable care.

The Republicans have vowed to repeal and replace the 2010 Affordable Care Act, former President Barack Obama's signature policy, but have not established a coherent plan since winning the election.

The American Academy of Pediatrics, American Academy of Family Physicians, the American Congress of Obstetricians and Gynaecologists, the American College of Physicians, and the American Osteopathic Association say they have a road map for lawmakers.

"We urge Congress and the new administration to preserve essential coverage, benefits and consumer protections as established by current law, including the Affordable Care Act (ACA); we also acknowledge the need for additional reforms and improvements to address continued barriers to care and ensure a health care system optimised for patients and their physicians," they said.

Meanwhile, the country's leading doctors group, the American Medical Association (AMA), is urging Republicans to take steps to ensure that people do not lose their health insurance once Obamacare is repealed.

The AMA wrote a letter to Congressional leaders in January calling for the gains in coverage from Obamacare, which has expanded insurance to 20 million people, to be preserved.

"In considering opportunities to make coverage more affordable and accessible to all Americans, it is essential that gains in the number of Americans with health insurance coverage be maintained," AMA CEO Dr James Madara wrote to leaders in both Parties.

"Consistent with this core principle, we believe that before any action is taken through reconciliation or other means that would potentially alter coverage, policymakers should lay out for the American people, in reasonable detail, what will replace current policies.

"Patients and other stakeholders should be able to clearly compare current policy to new proposals so they can make informed decisions about whether it represents a step forward in the ongoing process of health reform."

The AMA's position is at odds with the Republicans' current plan, which is to move forward with plans to repeal Obamacare without a replacement, but delay repeal going into effect for a few years to buy time for drafting an alternative. This is causing internal rifts in the Party.

The AMA says that Obamacare is "imperfect" and that it would favour policies if they increased coverage, choices, and affordability.

The American Hospital Association has warned of an "unprecedented public health crisis" from people losing coverage under Obamacare repeal.

JOHN FLANNERY

Guns backfire in US

Early this month, the Republican-led House of Representatives voted 235-180 to repeal a regulation that made it harder for people with a mental illness to buy guns.

The regulation, instituted in the final days of the Obama administration, required agencies to share information about people with mental illness who were considered incapable of managing their disability benefits.

Critics, including the National Rifle Association, said the regulation cast too wide a net.

CNN reported that Democrats complained that repealing the rule would lead to more gun violence.

The Senate is expected to pass the National Rifle Association-backed measure soon, and President Donald Trump is expected to sign it.

The AMA *Position Statement on Firearms 2017* is at https://ama.com.au/position-statement/firearms-2017

JOHN FLANNERY

Former WMA President Dr Margaret Mungherera dies

Dr Margaret Mungherera – 25/10/1957 - 4/2/2017

Former World Medical Association president Dr Margaret Mungherera, a medical trailblazer in Uganda, has died at the age of 59.

Dr Mungherera, a forensic psychiatrist and the first African woman to head the WMA, was being treated for cancer in a hospital in India when she died on 4 February, World Cancer Day.

Uganda Medical Association President Dr Fred Bisso said Dr Mungherera had put Uganda on the global medical map.

"It is a very big blow to us as a fraternity," Dr Bisso said.

"We hope the country learns from this huge loss to put our own health sector in such a state that it can take care of our own people."

WMA Secretary General Dr Otmar Kloiber said Dr Mungherera fought her cancer bravely and still attended as many WMA meetings as she could manage.

"A psychiatrist by education, a public health activist by nature, a determined advocate for the people of Africa by conviction, she was a marvellous physician leader on the global stage," Dr Kloiber said.

"For many of us, she has been more than a colleague, as she has been a friend, teacher and companion. The WMA remains grateful for her service to our community."

AMA Secretary General Anne Trimmer said many AMA members would remember her from her attendance at the AMA National Conference in 2014.

Former AMA President Dr Mukesh Haikerwal, who worked with Dr Mungherera when she was WMA President and he was WMA Chair of Council, said he was "devastated" at the news of her death.

After studying in Kampala and London, Dr Mungherera began her 31-year medical career as a registrar at the Butabika National Referral Hospital, before becoming a consultant psychiatrist at the Mulago National Referral Hospital.

She taught clinical forensic psychiatry to undergraduate medical students and psychiatric clinical officers, and developed the Forensic Psychiatry course for post graduate doctors specialising in psychiatry.

As a part-time consultant, she developed and ran mental health services for Sudanese refugees in Northern Uganda. The services were subsequently integrated into the national service.

In 2012, she was appointed clinical health of the Directorate of Medical Services at Mulago National Referral Hospital, where she remained until her retirement in 2015.

Announcing her retirement, Dr Mungherera called for better pay for medical personnel in East Africa and Uganda, saying many medical professionals were forced to seek work in other countries because of low pay and poor conditions.

As a senior consultant, she said, she was earning 2.3 million Ugandan shillings (AU$840) which was later raised to 2.8 million shillings (AU$1020), which also included fuel for her car and her driver's pay.

"If I can earn such an amount after working for over 30 years, what about those who are joining the field?" she said.

She served as the president of the World Medical Association from October 2013 until October 2014, and also served as president of the Uganda Medical Association.

In November 2012, Dr Mungherera received an Honorary Doctor of Philosophy from Kampala International University in recognition of her "historical achievements".

Asked that year how she would want to be quoted for years to come, she replied: "Women in Uganda can have a place in the leadership of the medical profession, not just in Uganda but also internationally."

She was a founding member of Uganda Women Medical Doctors' Association, and was the first woman to be elected president of the Uganda Medical Association.

At the time of her death, Dr Mungherera was the chair of the International Association of Medical Regulatory Authorities.

Dr Mungherera is survived by her husband, two sisters and three brothers, and her parents.

MARIA HAWTHORNE

Female Genital Mutilation in Decline

New evidence from the Population Research Bureau (PRB) in Washington suggests that the number of women and girls who have undergone female genital mutilation (FGM) is declining in many countries, with girls less likely to be cut than previous generations of women.

The latest PRB report includes updated estimates for 16 countries based on surveys since 2014. In 12 of those countries, the percentage of women aged 15 to 49 who have been forced to undergo FGM declined compared to the results from surveys conducted between 2003 and 2011.

In one-third of countries with data, FGM is half as common among young women (ages 15 to 19) than among middle-age women (ages 45 to 49).

The steep decline in prevalence among young women in some countries suggests that efforts to end FGM are yielding results, says Elizabeth Leahy Madsen, PRB program director.

"The drop among young women reflects positive winds of change. Fewer families appear to be choosing to have their daughters cut."

For example, in Burkina Faso, where nearly 90 per cent of women in their 40s have been forced to undergo FGM, and it typically occurs before the age of 5, the low prevalence rate among young girls (14 per cent for ages 5 to 9; 5 per cent for those under age 5) provides evidence that more families are abandoning the practice.

Education appears to be a key factor in reducing the prevalence of FGM. In many countries, daughters of women who have some schooling are much less likely to undergo FGM than daughters of women with no education.

While the share of women forced to undergo FGM appears to be declining in many countries, population growth means that the absolute numbers of women and girls worldwide who have undergone this harmful practice will continue to increase. Recent global estimates suggest that at least 200 million women have undergone this procedure.

JOHN FLANNERY

Yellow Fever in Brazil

The US Centers for Disease Control and Prevention has issued a travel alert about the spread of yellow fever in Brazil, warning people that they need to be vaccinated before going to affected areas.

The CDC is also advising that there is a shortage of yellow fever vaccine.

According to the World Health Organisation (WHO), the outbreak has killed at least 40 people and possibly more than 80 people. WHO says the mosquito-borne virus has infected more than 400 people.

Brazilian health officials say it's also killing monkeys, with more than 400 deaths already recorded.

It's the worst outbreak of the mosquito-borne virus in Brazil since 2000, and it's affecting parts of Brazil that had not been at risk of yellow fever spread in decades.

The CDC advises that anyone nine months or older who travels to these areas should be vaccinated against yellow fever.

People who have never been vaccinated against yellow fever should not travel to areas with ongoing outbreaks.

The vaccine can itself cause side-effects, sometimes serious, so the CDC says older people, pregnant women and others with weakened immune systems need to check with a doctor before being vaccinated.

Yellow fever is a relative of the dengue and Zika viruses, but is far deadlier. But it's also the only virus in the family that has a good vaccine to prevent it.

JOHN FLANNERY

Ho Ho HOBART – it's always Christmas

BY DR MICHAEL RYAN

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My wife is a travel agent. So I don't get much say in where we go for holidays. Sure we sometimes get good deals and upgrades but not all places we go to have vineyards. So you can imagine my reply when the wife said we are going to Hobart over Christmas and New Year. With over 20 wineries in the area I played hard to get for about 5 minutes.

They have been planting vines in Tasmania since 1840. The pioneer was Bartholomew Boughton making an award winning fortified table wine. Some 110 years later Claudio Alcorso planted vines at Moorilla estate and became a trail blazer. Moorilla estate is still a winery but is home to the amazing MONA-art gallery.

The wine regions around Hobart include Coal River, Derwent Valley and the Southern region. It is generally a maritime temperate climate, with some of the vintages varying greatly. For the technically minded there is 918-100 heat degree days, 5.9 hours of sunshine per day, 570mm of annual rainfall with a mean January temperature of 16.8C. It doesn't sound quite right for Australian viticulture.

Due to micro-climate variation the area can produce aromatic whites and savoury reds. Riesling, Sauvignon Blanc and Chardonnay dominate the whites. Pinot Noir is king of the reds but there's an amazing Cabernet Sauvignon, Merlot and Shiraz in selected pockets of terroir.

The Coal River region has the township of Richmond with the oldest functioning stone bridge in Australia. The Richmond bakery is the Nirvana of all baked goods including the best Curry Scallop pie I have ever eaten- so I had a second one. The tummy was now lined and some tastings were about to start.

First stop was **Pooley Wines** founded in 1985 at the Cooinda Vineyard site. In 2004 they purchased the Butchers Hill vineyard site. Pinot Noir, Chardonnay, Riesling, sauvignon Blanc, Gurwurtztramnier Cabernet Sauvignon and Merlot are produced.

The **2015 Butchers Hill Pinot Noir (1)** is a show stopper. Bright Garnet in color with a nose rich in red fruits balanced by savory earthy overtones. The palate is driven by restrained fruit but with an elegant flowing structure of tannin and acid. 2-3 years in a bottle will enhance this wine that will cellar for 10-15 years. Tasmanian Venison pie would match it well.

Domaine A, just 5 minutes north of Richmond, is an iconic producer of Cabernet Sauvignon. It has been at the top of Langton's wine classification since its inception. Peter Althaus, a former Swiss engineer, searched tirelessly for a site to satisfy his vinous quest. The north facing Stoney vineyard site stands as an anachronism with a very sunny frost free terroir. Whilst his Domaine A Cabernet is the revered wine, the more affordable **2014 Stoney Vineyard Cabernet (2)** is bang for your buck. Deep purple colour, nose of bright cassis, savoury herbs and vanillin oak and a juicy fruit palate with moderate tannins. It will cellar for 4-5 years. Have with a braised lamb shoulder.

In the Sothern region is **Home Hill Vineyard**. Established in 1992 with plantings of Pinot Noir, Chardonnay and Sylvaner. The **2014 Home Hill Estate Pinot Noir (3)** is a great example of how the terroir can change in a very short distance. The area is slightly colder and wetter than say Coal Valley. The Estate Pinot Noir is light red in colour and has the strawberry, red fruit spectrum. Some whole bunch ferment gives it its spicy brambly characteristics. The fruit on the palate is seductive with well layered tannins. Drinking now and for a decade. Have with porcini risotto.

If you can't produce a cracking Tasmanian Riesling, give up as a wine maker. One of my favorite stops was the **Bangor Winery and Oyster Shed**. My daughter and I consumed at least 3 dozen oysters every day. The 2015 Bangor Riesling was a very pale lemon in color. The nose of citrus and melon was delightful with amazing crisp fruit and acidity. Have with a dozen oysters and another.

The Chicken Tax

BY **DR CLIVE FRASER**

Subaru Brumby (1978 - 1994)

On 20th January 2017 Donald Trump took over the reins of the US Presidency.

He promises to protect US manufacturing by imposing heavy tariffs on imported goods, particularly cars coming from Mexico.

This isn't the first time this has happened with President Lyndon B Johnson imposing a 25 per cent tariff in 1963 on imported light trucks.

LBJ's tax was also on potato starch and brandy and occurred in response to a decision by France and Germany to impose a tariff on the importation of chicken from the USA.

Thus the so-called 'Chicken Tax' began and it still exists on imported light trucks today.

In Australia our light trucks are mostly made in Thailand, but in 2016 the US made Ford F-Series is still America's top-selling vehicle (820,799 were sold) helped along by a hefty tariff on imported competitors.

So in 1978 in the midst of a US Trade War along came Fuji Heavy Industries with a popular utility called the Brat (in the US) and the Brumby (in Australia).

The lateral thinkers at Subaru thought that if they fitted two seats in the utility tray that would make the Brat/Brumby a passenger vehicle and a tariff of only 2.5 per cent would be applied.

Well, that ploy worked until 1985 when the welded in rear seats were finally discontinued.

Fast forward to 2017 and Australia and there seem to be Subaru Brumbys cropping up everywhere.

I've just been on a central Queensland cattle property where I found two of the beasts.

The first one was bought new in 1989 for about $14,000 plus on road costs.

Standard equipment included a bull-bar and a radio-cassette player.

It's done 282,000 kilometres. It has no rust and it still runs like a dream.

It might have an over-heating issue because of a 28 year old radiator cap not holding the pressure, but every morning it started and every day it went wherever we pointed it over the roughest terrain.

Sure the paint was faded and a respirator was required if the blower fan was turned on as years of dusty debris flooded the cabin.

But every dial, switch and knob still worked. Not bad after nearly three decades sitting in the Queensland sun.

Checking out the cargo area this Brumby also had the jump seats fitted.

But there were no seatbelts. Not to worry because the seats weren't bolted down either as they were from a Nissan and cost $2.

After all this Brumby wasn't registered and never left the farm.

The jump seats were surprisingly comfortable and it was advisable to hang on tightly when travelling in the rear.

After spending the day mustering and spraying weeds in the Subaru Brumby it came back to The Shack every evening to rest.

Just before putting the old girl to sleep I was reminded by its owner to wind up the windows to discourage various species of snake from slithering into the car and relaxing under the dashboard.

I must say that I never forgot this ritual lest I find a Carpet Python or a King Brown dropping onto my legs in the morning.

So if owning one Brumby is a good thing wouldn't it be better to have another one for spares.

Well the owner does have a second car that doesn't run (just in case).

But the more I looked at the second car the more I realized that it shouldn't be euthanized and that it still had potential as a restoration project, and not just as an organ donor.

After 28 years a Subaru Brumby in reasonable condition is still worth about $7,000.

This equates to annual depreciation rate of 2 per cent which proves that in terms of residual value the Subaru Brumby was probably the best value motor vehicle purchase of 1989.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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