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Straight to work

President Bartone on the case, p6

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In this issue

Cover pic: Dr Bartone meets with Health Minister Greg Hunt. Photo by Odette Visser.

National Conference photos by Lightbulb Studio

My AMA Presidency – Local inspiration, global aspiration

BY AMA PRESIDENT DR TONY BARTONE

Addressing delegates ahead of being elected as your President at National Conference last month, I shared with them the inspiration for becoming a doctor and why I chose General Practice as my specialty.

My vocation came from personal experience – from my family, from my home.

When I was young, there was a period of time when my father was ill, very ill, and our family doctor would come to our home to visit my father and care for him.

My father was confined to bed for weeks, and the doctor would always visit our home and provide care, skill, compassion, and comfort ... and confidence for a good outcome. Yes, my father recovered, and remained active for another 40 years.

But the experience stayed with me.

It inspired me. I wanted to help people. I wanted to be a doctor, a family doctor, a GP. My ambition was to help people who needed health care. And that is what I did.

Having reached my goal of becoming a GP, over time I wanted to extend my role to the broader population through better health policy, and to my fellow doctors and medical students to help them be the best doctors they could be. Just like my parents' family doctor who helped my father and his family all those years ago.

That is what I have strived to do as a long-term member of the AMA, as Victorian President, as Federal Vice President, and now as President. The same inspirations and motivations drive me and shape my advocacy.

I want to make a difference. I will make a difference.

All Australians have a right to quality health care, and it is up to the AMA to provide the leadership and the ideas to defend our world class health system and make it even better.

There are many challenges facing the health system, our profession, and our patients. Some of these challenges are new, but many have been around for years, even decades, as successive governments have failed to implement long-term solutions, investment, or plans. Sadly, electoral fear will always outweigh great ideas.

Meanwhile, public hospital waiting lists continue to blow out. Private health insurance is becoming increasingly unaffordable for our patients.

There are enormous bottlenecks in the training pipeline. And there is a continuing struggle for some doctors around their own health and wellbeing.

We are still seeing variable access to care in country towns and rural areas. The lack of access for services to those with mental health issues or needing quality aged care services or care.

And General Practice has been systematically starved of funding - tearing at its heart; wearing it down; putting at risk its world class outcomes in primary care. Its very survival is at risk, as we are seeing in other parts of the world.

General Practice - the 'cornerstone' of primary care - must not just survive, it must grow and prosper. It must become rock solid. If it doesn't, the other pillars of our health system will crumble.

That is why I will have General Practice and GPs at the heart of my advocacy as AMA President.

General Practice was the number one topic in my meetings with Health Minister Greg Hunt and Shadow Health Minister Catherine King within days of my election.

It has been at the core of just about every media interview I have conducted since National Conference. As has access to care for our patients, training our increasing graduate workforce, and, importantly, the health and wellbeing of our colleagues.

The memory of the family doctor who looked after my father will be with me every day of my Presidency.

The experiences of my patients who every day have to confront or navigate a complex under-resourced system will provide the context.

The many members who rely on our Association will be my motivation.

The many key mentors and leaders who have moulded me will augment my advocacy.

The value of quality General Practice at the local community level will drive AMA policy and advocacy over the next two years to achieve nationally consistent, positive, and well-funded outcomes for all our GPs and their patients.

My hope is that it will lead to international acclaim for our health system, built on the bedrock of high-quality, value-for-money General Practice.

Gaps in the *Four Corners* program

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

One should not be surprised that the recent *Four Corners* program regarding 'out of pocket' medical expenses was unbalanced. I know it caused concern for many doctors who felt unnecessarily maligned by the program. There was no mention of the fact that 88.5 per cent of all medical services in Australia are provided with no-gap and another 7.1 per cent of medical services provided with a known gap, which in the March 2018 quarter averaged only $95.08. This data is publicly available from the Australian Prudential Regulatory Authority (APRA), which oversees private health insurance – so very easy to get by anyone from their website.

The *Four Corners* program only briefly suggested that high gaps may be a function of inappropriately low MBS rebates and private health insurance coverage rather than egregiously high fees. What about the hospital gaps? There was also a lamentable lack of recognition that modern, high quality medicine (which is what everyone wants) is expensive. If a doctor has been committed enough to become one of the best in their field, then there needs to be some recognition of this. High quality medical care will never be achieved if doctors become solely price takers (whether from Government or funds). We do not expect this of other professional groups or tradespeople, but the political rhetoric has been so relentless over many years that free health care is now regarded as an immutable right.

It's curious how the quest to make medical care as cheap as possible seems to ignore that this can only jeopardise quality – like anything else! We either accept the cost of good healthcare outcomes or potentially endure suboptimal care. This is not acceptable to doctors or patients and nor should it be – so let's please have this conversation about funding health care in a fair and balanced manner that reinforces the value of high quality medical care.

Insurance companies made good money. The same publicly available APRA reports which detailed a marginal drop in private health insurance (PHI) rates (for hospital care) to 45.5 per cent of the Australian population also lets us know that the profit before tax of the PHI sector was $1.824 billion for the year up to March 2018! Hmmm, not too bad. Convenient to disregard the dubious nature of some private health insurance products sold through beguiling and possibly deceptive advertising. Convenient to disregard that rebates to patients plummet to woefully inadequate MBS levels if a doctor charges only $1 over the fund's unilaterally declared fee. Much better to deflect attention to the doctors!

For the most part, private hospitals seem to be going well. Ramsay Healthcare is the largest operator of private hospital beds in the country and it has recently posted a half-year profit to December 2017 after tax of $288 million (increased 7.5 per cent on the previous corresponding period). The position of the private hospitals is, however, a vexed one. They do go to great lengths to stress that they have no control over what a credentialled doctor does – but this is not entirely true. Moreover, the private hospitals should be honest with their conflict. Constraining a doctor's scope of activity is not in their best financial interests. They therefore have to navigate a precarious path between deflecting blame for gaps (which they significantly generate themselves) but to not ostracise doctors. Many have also reduced medical leadership in recent years which weakens clinical governance.

Although the ethics and professional standards espoused by the Colleges, quite eloquently stated by Dr John Batten – the President of the Royal Australasian College of Surgeons – on the program, are almost universally adhered to, the short arm of the Colleges will, I suspect, unfortunately not reach effectively to manage outlier doctor behaviour practised by a mere couple of percent. We must agree that booking fees, over-servicing and disproportionately large fees that do not reflect skill, training or expertise, have no place in our practice. The Australian Commission for Safety and Quality in Healthcare is publishing more atlases of variation – the data is mounting and can be ignored to the profession's irrevocable peril. The outlier few must be gently persuaded to return to the fold, if not by peer pressure, then by more stringent means.

Cultural change can be led by the profession – individual doctors at every institution and practice modelling ethical behaviour and supporting colleagues to always do likewise. Medical leadership that promotes positive peer review is crucial, but cannot happen if (private) institutions abandon their responsibility to support this profession-led, collective effort. Colleges and Professional Associations clearly must help. Solutions might differ depending on location, discipline and institutions. But do it now we must, as this problem is ours to solve. Any imposed 'solution' is unlikely to be at all palatable or flattering.

National Conference heralds changes

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "National Conference was a great success. The Standing Orders of Conference were amended on day one to allow all AMA member delegates to participate in, and vote on, the business of the Conference excluding the election of President and Vice President, which is reserved to the appointed delegates."

Another National Conference come and gone and with it the election of the next President and Vice President of your AMA. Dr Tony Bartone (President) and Dr Chris Zappala (Vice President) take up their positions as the incoming leaders for the next two years. As the first GP President for four years, Dr Bartone has outlined his commitment to working in the interests of general practice and its patients, especially on the issues that are highly relevant to general practice such as access to mental health care, and access to aged care.

National Conference was a great success. The Standing Orders of Conference were amended on day one to allow all AMA member delegates to participate in, and vote on, the business of the Conference excluding the election of President and Vice President, which is reserved to the appointed delegates.

The afternoon of day one brought together a panel of six past Presidents of the AMA, interviewed by the most recent President, Dr Michael Gannon. The past Presidents reflected on the big political issues of their time – ranging from the medical indemnity crisis of the early 2000s to e-health and scope of practice boundary disputes with pharmacists.

Day two of Conference was spent in debate on a number of policy motions that had been brought forward from the Councils of Federal Council and some State AMA Councils. The policy motions were wide-ranging and at times controversial. Delegates debated the benefits of e-cigarettes as a smoking cessation device; the condemnation of inappropriate billing practices such as split bills and booking fees; the role of doctors in dispensing pharmaceutical or other therapeutic products; and the value, or otherwise, of prevocational research in contrast with clinical experience in the training pathway.

Day three brought the elections after a soapbox session when delegates put forward their views to colleagues on a number of issues. Given the large number of candidates for election in 2018, a number of briefings by candidates were held throughout the Conference to inform delegates before the final vote.

For the Federal Secretariat, the change in President is a little like a change of Government. The Secretariat does not know in advance who the incoming President or Vice President will be, or the focus of their election manifesto. It is a reflection of the professionalism of the Secretariat that the new President is promptly and comprehensively briefed in the days following the election and work continues uninterrupted.

National Conference also brings with it a changeover in the Board and Federal Council. I have previously announced the declared and elected positions on Council. I am pleased to welcome Dr Rosanna Capolingua and Dr Danielle McMullen to the Board. They take the place of Prof Geoff Dobb and Dr Elizabeth Feeney, respectively. Drs Dobb and Feeney have been long-time contributors to Federal and State AMAs and played a key role in the transition to the new governance structure in 2014. On behalf of members I thank them for their service.

New President hits the ground running

New AMA President Dr Tony Bartone has wasted no time since being elected to lead the Association for the next two years; holding a string of media interviews, policy discussions, and political meetings to ensure the voice of the nation's peak medical group is clearly heard.

Dr Bartone was elected President on the final day of the AMA National Conference, held at Canberra in May.

He replaces Dr Michael Gannon, whose two-year term expired with the conclusion of the National Conference.

Dr Bartone has promised to fight for GPs, represent all medical professionals, and build the AMA's membership and influence.

He also signalled an intention not to go easy on politicians and policy makers.

One of his first meetings was with Federal Health Minister Greg Hunt, who congratulated Dr Bartone on his election.

"Our Health Minister needs to understand the time for rhetoric is over. We need to see real action now," Dr Bartone told conference delegates.

"We will have a Federal Election in the next year, and I am ready for any early election call."

The President also met with Shadow Health Minister Catherine King, as well as other MPs and political offices.

His media diary has remained full from day one.

Dr Bartone meets with Shadow Health Minister Catherine King.

"General practice has been systematically starved of funding, putting at risk its very survival," he said.

"The AMA, under my leadership, has the solutions. A GP President will send a message."

Dr Chris Zappala, a thoracic physician from Queensland, was elected Vice President to replace Dr Bartone.

The AMA has also already released policy statements and endorsements under the new leadership regime.

CHRIS JOHNSON

AMA endorses *Uluru Statement from the Heart*

The AMA Federal Council has endorsed the *Uluru Statement from the Heart*, which calls for a First Nations Voice in the Australian Constitution.

Regarded by some as the "most important piece of political writing in Australia in the past two decades", the *Uluru Statement* was the result of a gathering of Indigenous elders and academics inviting non-Indigenous Australians to walk with them to create a better country.

The Federal Government rejected the Statement shortly after its release a year ago.

But the AMA has thrown its support behind the document.

AMA President Dr Tony Bartone said the AMA had for many years supported Indigenous recognition in the Australian Constitution, and that the *Uluru Statement* was another significant step in making that recognition a reality.

"The *Uluru Statement* expresses the aspirations of Aboriginal and Torres Strait Islander people in regard to self-determination and status in their own country," Dr Bartone said.

"The AMA is committed to improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

"Closing the gap in health services and outcomes requires a multi-faceted approach.

"Cooperation and unity of purpose from all Australian governments is needed if we are to achieve meaningful and lasting improvements.

"This will involve addressing the social determinants of health - the conditions in which people are born, grow, live, work, and age.

"Constitutional recognition can underpin all these endeavours, as we work to improve the physical and mental health of Indigenous Australians."

The AMA announced its endorsement of the *Uluru Statement* during National Reconciliation Week.

Anti-Racism Statement

The AMA Federal Council has also formally adopted a new Anti-Racism Statement as AMA policy.

In doing so, Dr Bartone said the AMA acknowledged that an ongoing and shared commitment across organisations, governments, and individuals was required to eliminate racism in health care.

He said the Anti-Racism Statement demonstrates the AMA's commitment to opposing racism across the health care industry and in Australian society.

"We support a healthcare system that provides equity of access to quality care for all Australians," Dr Bartone said.

"The AMA is the peak advocacy body for all doctors working in Australia, and we represent a diverse range of individuals.

"The medical workforce is made stronger through the inclusion of people from diverse backgrounds who bring unique skills, perspectives, and networks to the health industry.

"Racism and discrimination have adverse, often very significant effects, and can contribute to the health burden of medical professionals and their patients.

"Racism can occur in both direct and indirect forms, including casual or everyday racism and implicit or unintentional racism, and can be experienced by a patient from their healthcare provider, by a healthcare provider from their patient, or between healthcare providers.

"Relationships in the workplace with superiors, colleagues, and patients must be free from bias, discrimination, and racism."

The Statement was produced by the AMA's Equity, Inclusion, and Diversity Committee, which was established in 2017 to support a culture that recognises the values of respect, equity, and inclusion.

Dr Bartone said international medical graduates from many different countries, cultures and faiths make a vital contribution to the delivery of health care in Australia, particularly in rural and regional locations.

In 2016, there were 12,495 reported overseas trained doctors in Australia.

"It is vital that doctors and medical students are aware of, and sensitive to, cultural differences in their dealings with colleagues," Dr Bartone said.

"Sensitivity and understanding of the diversity of patients must also be at the forefront of doctors' minds when delivering health care.

"There are aspects of the healthcare system that can be inadvertently exclusionary, and may deter some individuals from seeking health care."

The AMA also recognises that systemic and interpersonal racism has a detrimental effect on the growth and retention of the Aboriginal and Torres Strait Islander medical workforce.

CHRIS JOHNSON

The AMA Anti-Racism Statement is at https://ama.com.au/equity-inclusion-and-diversity

AMA's highest honour for the doctor who wrote the book

The doctor who wrote *John Murtagh's General Practice* – the pre-eminent reference textbook for general practitioners, medical students, and registrars – has been recognised with the AMA's highest honour, the AMA Gold Medal.

Outgoing AMA President Dr Michael Gannon announced Emeritus Professor John Murtagh AM as the Gold Medal recipient at the AMA National Conference in Canberra.

"Professor Murtagh's contribution to medicine and general practice as both a doctor and an educator in Australia is incomparable," Dr Gannon said.

"He is the highly acclaimed author of several internationally adopted medical textbooks, including *John Murtagh's General Practice*, which is now in its sixth edition, and has been translated into 13 languages since it was first published in 1994.

"Yet his medical career did not start immediately. Professor Murtagh originally started his working life as a secondary school teacher, teaching maths and science in country Victoria, having completed degrees in science and education at the University of Melbourne.

"In 1961, he retrained, fulfilling his childhood ambition to become a doctor. He graduated with an MBBS from Monash University in 1966, as one in a class of the first intakes at the newly established medical school.

"In 1988, he completed his Doctor of Medicine, with his thesis, *The management of back pain in general practice*.

"While studying medicine, Professor Murtagh met his wife Jill, a fellow medical student, and after completing their medical studies, they took over the general practice at the Neerim South Hospital in country Victoria – John providing the surgical skills and Jill the anaesthetics.

"Combining his love of teaching and medicine, training visiting Monash medical students at Neerim South was a natural fit. He was invited to write educational programs for the Royal Australian College of General Practice (RACGP), and to provide a rural teaching base for the Department of Community Medicine at Monash University.

"In 1979, he relocated to Melbourne to accept a full-time senior lecturer position at Monash University.

"During the 1980s and 1990s, as medical editor for the RACGP's *Australian Family Physician* publication, Professor Murtagh introduced new features, including *Brain Teaser, Practice Tips, Patient Education,* and *Cautionary Tales*.

"Professor Murtagh later developed these journal articles into published books, following an approach from McGraw-Hill publishers.

"In 1991, McGraw-Hill requested that Professor Murtagh write a new type of medical textbook, one that defined the nature and content of general practice.

"Using chapters based on symptoms, rather than disease categories, and building on the diagnostic model he developed, the textbook – *General Practice* – was pitched in the way that undifferentiated disease presents in a GP's consulting rooms.

"In 1993, he was appointed Professor of General Practice and Head of Department at Monash University, a position he held until his retirement in 2002.

"Post-retirement, Professor Murtagh continues to teach both undergraduate and postgraduate students, provide lectures to doctors around the world, and write medical books and – lately – Flashcards, morphing from books to apps.

"He was made a Member of the Order of Australia in 1995 for significant services to medicine, particularly in the areas of medical education, research, and publishing, and was awarded the inaugural David de Kretser Medal from Monash University in 1996.

"The RACGP has named its library in his honour, and the Department of General Practice at Monash has named the its *Annual Update Course for General Practitioners* after him.

"In 2007, he was awarded the AMA Victoria Gold Medal for services to medicine.

"Emeritus Professor John Murtagh AM has rendered outstanding services to the practice of medicine and, without question, is deserving of the award of the Gold Medal of the Federal AMA."

MARIA HAWTHORNE

President's Award for rural trailblazer

A country GP with decades of service to both his community and the State and Federal AMAs has been recognised with one of the AMA's highest honours, the President's Award.

Dr David Rivett OAM, a GP in the Batemans Bay area of the New South Wales south coast since 1975, was the inaugural chair of the AMA Council of Rural Doctors, and the first AMA Federal Councillor for Rural Doctors.

Announcing the award at the AMA National Conference in Canberra, outgoing AMA President Dr Michael Gannon said Dr Rivett was particularly known for his contribution to general practice and rural medicine.

"Dr Rivett has been a trailblazer for rural medicine at both the State and Federal levels of the AMA," Dr Gannon said.

"He was the Chair of the AMA Council of General Practice from 1999 to 2004, and was the inaugural Chair of the AMA Rural Reference Group from 2005 to 2009, staying on in the role when the group was renamed the AMA Rural Medical Committee.

"He became the first AMA Federal Councillor for Rural Doctors in 2015, and also chaired the newly formed AMA Council of Rural Doctors until 2016.

"In 2007, Dr Rivett was honoured with the Medal of the Order of Australia (OAM) for outstanding service to rural and remote medicine.

"He has been a passionate advocate for better access to quality health services for country Australians throughout his career, and for encouraging doctors to train and work in regional and remote areas.

"His commitment to rural medicine stems in part from the wide variety of work a rural doctor can do – from delivering babies to performing autopsies, and from stitching up chainsaw wounds to removing maggots from a hospital patient's ear.

"Dr Rivett sums up the versatility, camaraderie, and good humour that is so essential in rural and remote practice, and he is an outstanding recipient of the President's Award."

The President's Award may be made to a person, not necessarily a medical practitioner, who, in the eyes of the AMA President, has made an outstanding contribution toward furthering the objectives of the AMA.

Past recipients include: Dr Bernard Pearn-Rowe, an advocate for GPs; Dr Paul Bauert OAM, the Director of Paediatrics at Royal Darwin Hospital and an advocate for the health and welfare of Indigenous Australians and children in immigration detention; and Dr Graeme Killer, a Vietnam veteran who has devoted his life to the care of Defence Force personnel and veterans.

MARIA HAWTHORNE

Motions carried and lost on the conference floor

The AMA's position on e-cigarettes was one of the many policy issues to be debated at National Conference, and resulted in opposition to vaping remaining intact.

The debate also resulted in new President Dr Tony Bartone reiterating the AMA's stance during his first major newspaper interview in the top job.

Dr Bartone told *The Australian* there would be no change – "absolutely none" – in the AMA's position.

"When the evidence comes through and it can be shown to be a therapeutic aid to cessation from smoking, that's when we will sit down and significantly look at our position and move in line with the evidence that's presented," he said.

The e-cigarettes motion was the only one to be lost on the floor of National Conference, after it was suggested by some delegates that the Association should support a controlled introduction of e-cigarettes as a harm-reduction measure.

Policy debate motions that passed at National Conference included to:

- Develop policy that encourages Local Hospital Networks to fund targeted GP-led primary care services designed to reduce preventable hospital admissions and re-admissions;
- Consider the reputational impact that 'booking fees' and split bills have on the wider medical profession;
- Call on the Commonwealth, and State and Territory Governments to fund sufficient additional training posts required to meet the needs of the National Rural Generalist Pathways and agrees that these should be quarantined for the NRGP;
- Support the position that doctors should not dispense pharmaceutical or other therapeutic products unless there is no reasonable alternative and, where dispensing does occur, it should not be undertaken for material gain;
- Call on all Australian jurisdictions to recognise that enabling clinical lead and providing adequate time and resources is the means to both improve public hospital performance and to ensure attention is not diverted from high value care initiatives;
- Call on the learned Colleges to ensure appropriate emphasis is placed on the importance of broad experience in a variety of clinical fields for selection into vocational training, and correct the current overemphasis on non-clinical qualifications and courses which is to the detriment of well-rounded trainees;
- Further investigate how Medicare could be redesigned to support the central of role of GPs in providing long-term healthcare;
- Undertake a nationwide survey of members to ascertain their views on limited registration in transition to retirement and retirement;
- Establish practical recommendations that could be implemented into the healthcare system to address the underlying systemic factors that impede the health system's ability to adequately address gender equality;
- Reiterate support for equal opportunity in the medical workforce;
- Support access by people with a mental illness to NDIS assessors with appropriate skills in psychosocial disability and cultural awareness;
- Support further investigation into environmental sustainability measures that could be incorporated into health care across Australia;
- Fund the development and maintenance of a reworked AMA schedule of fees with ongoing indexation firmly embedded in it, that is transparent, meaningful and defensible;
- Note the UK case of Dr Hadiza Bawa-Garba and its implications for doctors in Australia;
- Consider the distortion to competition between exclusively private practice specialists and public hospital specialists with rights of private practice; and
- Call on the Commonwealth Government to adopt... the Modified Monash Model of Classification for all its workforce and funding programs except where it can be demonstrated that MMM inconsistent with the policy objectives of a program.

CHRIS JOHNSON

AMA Award recipients

Excellent choice for Excellence in Healthcare Award

Professor Elizabeth Elliott AM receives her award from Dr Gannon.

The recipient of the AMA Excellence in Healthcare Award 2018 wants to know how she can use it to build greater awareness for a very worthy cause.

Professor Elizabeth Elliott AM FAHMS was presented with her award by outgoing AMA President, Dr Michael Gannon, at the AMA National Conference in Canberra in May.

Professor Elliott is a pioneer in research, clinical care, and advocacy for Fetal Alcohol Spectrum Disorder (FASD) and was named the winner of the AMA Excellence in Healthcare Award 2018 during the opening session of the Conference.

FASD is caused by prenatal alcohol exposure and is recognised as the leading preventable cause of prenatal brain injury, birth defects, and developmental and learning disability worldwide. There are lifelong consequences for children born from alcohol-exposed pregnancies.

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.

Professor Elliott was nominated for the award by the National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD), the first and largest organisation dedicated to FASD in Australia.

Over the past 20 years, FASD has evolved from being a little-known, poorly recognised, and misunderstood condition to becoming a major strategic focus for Commonwealth and State Health Departments.

"I am really delighted to be acknowledged, but I really accept the award on behalf of all the children and families I work with, and of course a lot of dedicated clinicians," she told *Australian Medicine.*

"I guess for me it's particularly nice that the group that nominated me was the national organisation.

"I read something that said this was an opportunity to highlight this cause so I'm very keen to find out how to use the AMA network to raise awareness.

"We need to raise awareness of (1) the fact that are still lots of women who drink during their pregnancy not knowing they might harm their unborn child, and (2) there are lots of doctors who are very reluctant to ask pregnant mothers about their drinking.

"They don't want to upset the doctor-patient relationship, and yet women tell us they want to be asked. They want clear advice. In fact many of them tell us they want to be told not to drink during pregnancy. They want a clear message from doctors."

Professor Elliott is a Distinguished Professor in Paediatrics and Health at The University of Sydney School of Medicine and a NHMRC Practitioner Fellow. She has been a passionate advocate for raising awareness of FASD for more than 20 years.

In presenting her the award, Dr Gannon said Professor Elliott played a significant leadership role in developing the *Australian Guide to the Diagnosis of FASD* and online training modules, new clinical services, a national FASD website, and a national FASD register.

"She chaired the Australian Government's National FASD Technical Network and is Co-Chair of the NHMRC Centre of Research Excellence in FASD, and Head of the NSW FASD Assessment service," Dr Gannon said.

"She was lead clinician in the Lililwan study on FASD prevalence in the Fitzroy Valley and has published extensively on FASD.

"She contributed to WHO, NHMRC, and RACP alcohol guidelines and has been a keynote, invited, or scientific presenter at more than 300 conferences nationally and internationally.

"Professor Elliott is a true pioneer in the FASD field and has contributed to the development of Australia's response to FASD, through addressing aspects of health policy, health care delivery, education, and health awareness in the work she has undertaken.

"However, FASD is only one component of Professor Elliott's work, which includes disadvantaged children in Immigration detention, with rare disorders, and living in remote Australia.

"In 2008, she was made a Member of the Order of Australia (AM) for services to paediatrics and child health and, in 2017, she received the Howard Williams Medal from the Royal Australasian College of Physicians (RACP) – its highest award – for her contribution to paediatrics in Australia and New Zealand.

"Much of her work has been undertaken voluntarily, and has strengthened Australia's health systems and their capacity to respond to FASD.

AMA Award recipients

... continued from page 11

"Her efforts have improved health care services in FASD and changed health outcomes for children and families living with, and affected by, FASD.

"She is a worthy recipient of the AMA Excellence in Healthcare Award."

CHRIS JOHNSON

War zone gynaecologist named AMA Woman in Medicine

Professor Judith Goh AO receives her award from Dr Gannon.

AMA Woman in Medicine 2018, Professor Judith Goh AO, has described receiving her award as a great honour and privilege.

Adding that it was acknowledgement for the work of a dedicated team of health professionals, Professor Goh told *Australian Medicine* the award would also help build awareness for the plight of women's health.

"We often live quite comfortably in Australia but for most women around the world, surviving their pregnancy is not taken for granted," she said.

"So this is great recognition. But we don't do these things to be recognised. We do it because we want to do it."

Professor Goh is a dedicated gynaecologist who volunteers her time treating women in war zones and Third World countries.

She was named the AMA Woman in Medicine 2018 at the AMA National Conference in May.

She is a urogynaecologist who has devoted her career to women's health. Her next stops are Bangladesh, Myanmar, and some African countries.

A world-renowned surgeon who has spent approximately three months every year for the past 23 years training doctors in Third World countries in repairing vesico-vaginal fistula – a devastating injury that can occur following prolonged, obstructive labour – Professor Goh was noticeably touched by the honour.

In presenting her the award, outgoing AMA President Dr Michael Gannon noted that Professor Goh's nominators – colleagues from the Australian Federation of Medical Women and the Queensland Medical Women's Society – have described her career as both humbling and inspirational.

"Since 1995, Professor Goh has donated her time and expertise, working abroad several times a year as a volunteer fistula surgeon in many parts of Africa and Asia, including Bangladesh, Sierra Leone, Ethiopia, Tanzania, Uganda, the Democratic Republic of Congo, and Liberia," Dr Gannon said.

"Professor Goh runs the twin projects, *Medical Training in Africa and Medical Training in Asia*, via the charity, Health and Development Aid Abroad (HADA), using funds raised to help pay for women's surgeries such as the correction of genital tract fistulae and prolapse, while training the local staff in these areas.

"To carry out her work within a dedicated team of professionals, Professor Goh often has to brave political unrest, and perform surgery in challenging environments, as well as deal with the emotional and social injuries to her patients due to war, rape, domestic violence, poverty, shame, and grief.

"Her work has changed lives for the better for hundreds of affected women, correcting their often long-standing and preventable obstetric trauma, including vesico-vaginal and recto-vaginal fistulae, with the minimum of overhead costs to maximise the reach of her services.

"Professor Goh uses her time abroad to upskill local practitioners in this area of medicine, and to raise awareness of the underlying causes of chronic complications of birth trauma, including poverty, lack of education, lack of awareness, and the subordination of women in some cultures.

"In 2012, she was made an Officer of the Order of Australia (AO) 'for distinguished service to gynaecological medicine, particularly in the area of fistula surgery, and to the promotion of the rights of women and children in developing countries'.

"Her humble dedication within this field of women's medicine, and her brave and generous service to women all over the world, is inspirational, and very worthy of recognition as a recipient of the AMA Woman in Medicine Award."

Professor Goh said many women felt ashamed after delivering stillborn babies.

"In some places it is seen as a failure. There is even violence against them in some communities. We are building a community where lot of women can come together and feel supported," she said.

"In our country we no longer really say 'mother and child are well' after a baby is born. It's taken for granted, so the first question is how much did the baby weigh.

"But there are so many places in the world where this cannot be taken for granted."

The AMA Woman in Medicine Award is presented to a woman who has made a major contribution to the medical profession by showing ongoing commitment to quality care, or through her contribution to medical research, public health projects, or improving the availability and accessibility of medical education and medical training for women.

CHRIS JOHNSON

APY Lands medical student awarded scholarship

Pirpantji Rive-Nelson addresses National Conference after receiving the 2018 AMA Indigenous Medical Scholarship.

A medical student who makes patient education films in Pitjantjara language, and who plans to provide health care to the people of Central Australia, is the recipient of the 2018 AMA Indigenous Medical Scholarship.

Pirpantji Rive-Nelson, from Alice Springs, is a final-year medical student at the University of Queensland. He is attending the Rural Medical School in Toowoomba and he plans to return to Central Australia to work as a clinician.

Outgoing AMA President Dr Michael Gannon presented Mr Rive-Nelson with the scholarship at the AMA National Conference in Canberra in May.

The AMA Indigenous Medical Scholarship was established in 1994 with a contribution from the Commonwealth Government.

The AMA is seeking further donations and sponsorships from individuals and corporations to continue this important contribution to Indigenous health.

Mr Rive-Nelson told *Australian Medicine* he felt honoured to receive the scholarship.

"It's great. It serves two purposes for me," he said.

"It is a bit of a pat on the back for my efforts, in terms of medicine being quite a gruelling degree and you're getting constant feedback and always told to improve in many areas.

"So it's kind of nice to get a pat on the back and know that I'm on the right track. So that's been great.

"And also to be given the opportunity to come down here to meet some of the bigger players in the medical community. That's a bit of a treat.

"I think people where I am from will definitely notice it, but I don't think people will understand the gravity of it and the fact that the AMA is the peak governing body for medicine in Australia. But people will recognise it as an achievement and will be very pleased to see it.

"At the end of the day it definitely bolsters my confidence in medicine in terms of keeping me on track."

Upon receiving the award, Mr Rive-Nelson said his aspirations included a fulfilling and challenging career practising medicine in Alice Springs Hospital, inspiring youth of Central Australia to pursue health careers, and to take on leadership and advocacy roles within Central Australia and national healthcare organisations.

"Many Indigenous Australians of Central Australia do not speak English as a primary language, and seeking health care from the Alice Springs Hospital is a daunting experience," Mr Rive-Nelson said.

"Therefore, I hope to actively assist Pitjantjatjara-speaking patients, and my colleagues, by being a clinician who is able to navigate both languages and cultures competently."

Mr Rive-Nelson is also making short patient health education material in Pitjantjara language, including a YouTube video on kidney disease, which won an award from the University of Queensland.

Fewer than 300 doctors working in Australia identify as Aboriginal and/or Torres Strait Islander – representing 0.3 per cent of the workforce – and only 286 Indigenous medical students were enrolled across the nation in 2017.

Dr Gannon said Mr Rive-Nelson was a deserving recipient of the $10,000 a year Scholarship.

"Pirpantji Rive-Nelson is a respected member of the University

AMA Award recipients

... continued from page 13

of Queensland medical school, and of the tri-State region comprising the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, the Ngaanyatjarra Lands, and the Central Lands Council lands," Dr Gannon said.

"He grew up in communities including Irrunytju, Pipalyatjara, and Kalka, and has been exposed to a traditional life that most young Indigenous people can only dream of.

"He is a Wati – a fully-initiated man – and many of his family are Ngangkari – traditional bush doctors. Pirpantji will be the first initiated Pitjantjatjara Wati to become a doctor in the Western medical model, and he will be able to collaborate with Ngangkari to share knowledge and better outcomes for the health of the Central Australian community.

"The significant gap in life expectancy between Indigenous and non-Indigenous Australians is a national disgrace that must be tackled by all levels of Government, the private and corporate sectors, and all segments of our community.

"Indigenous people are more likely to make and keep medical appointments when they are confident that they will be treated by someone who understands their culture, their language, and their unique circumstances. Mr Rive-Nelson is that person."

More information is available at https://ama.com.au/donate-indigenous-medical-scholarship

Mr Rive-Nelson's kidney health video can be viewed at https://www.youtube.com/watch?v=cgljvo0oQTo

CHRIS JOHNSON

Army captain named Doctor in Training for 2018

An Army captain with a passion for the health of the people of the South Pacific and for the welfare of her junior colleagues has been named the AMA Doctor in Training of the Year 2018.

Dr Mikaela Seymour, a general surgical principal house officer at the Sunshine Coast University Hospital, graduated from Griffith University in 2015 with a Masters of Medicine.

Outgoing AMA President Dr Michael Gannon said Dr Seymour had built up an impressive record of community service and advocacy at such an early stage of her career.

"Dr Seymour somehow manages to combine her hospital work with her role as an associate lecturer at the University of Queensland, her service with the Australian Army as a Captain in the 2nd Health Support Company at Gallipoli Barracks, and

Dr Mikaela Seymour upon being named Doctor in Training 2018.

volunteer work in remote Papua New Guinea," Dr Gannon said.

"Alongside all this, she is currently undertaking her Masters of Surgical Sciences at the University of Edinburgh.

"Dr Seymour is also a member of the AMA Queensland Council of Doctors in Training (AMAQCDT), chairs the Junior Medical Officers Forum of Queensland, is a previous deputy chair of the Australasian Junior Medical Officers Committee, sits on the Medical Workforce Advisory Committee to the Office of the Chief Medical Officer, and is on the Hospital Accreditation Committee for Queensland Prevocational Medical Education.

"Her busy schedule started early - not only was she the president and treasurer of the Griffith University Medical Society, she was also the secretary of the Queensland Medical Students Council, and a student representative on AMAQ Council.

"At the same time, she completed the Longlook Rural Education Program, and was an Australian College of Rural and Remote Medicine (ACRRM) Rural Placement Scholar.

"It's no wonder that, upon graduation, Dr Seymour was awarded the Dean's Prize for Contribution to the Community.

"In her final year at Griffith University, she was selected for the Queensland Rural Medical Education Placement to Western Province, the largest and most remote province in Papua New Guinea.

"The experience impressed upon her the need for timely surgical access as a fundamental universal health care right, regardless of location.

"She has returned to Papua New Guinea five times to volunteer as a doctor in training, studying alongside PNG specialists and volunteering on the YWAM medical ship, delivering primary health care to some of the most remote villages of PNG.

"Dr Seymour also supervises University of Papua New Guinea medical students during their rural placements.

"While volunteering at Kiunga District Hospital, Dr Seymour was shocked by the impact that critically low anti-malarial supplies were having on patient treatment.

"In 2017, she coordinated a malaria prescription service and record database of anti-malarial use. This simple intervention has been proved over the past year to have a real clinical impact on patient outcomes, and is now supported financially by Rotarians Against Malaria.

"In December 2017, Dr Seymour was selected by the Lowy Institute, with support from the Department of Foreign Affairs and Trade (DFAT), to attend the Australia-Papua New Guinea Young Leaders Dialogue in Port Moresby to lead the discussion on health issues, specifically the shared health risks and evolving non-communicable disease burden facing both countries.

"In addition to her humanitarian work, Dr Seymour is a passionate advocate for junior doctor quality supervision and training, and for the wellbeing of doctors in training.

"She helped coordinate the AMAQCDT 2017 Resident Hospital Health Check, which surveyed 465 doctors in training in Queensland, and has been used as a tool for prevocational doctor advocacy, particularly regarding bullying and harassment.

"In the words of the 12 junior doctors who signed their names to Dr Seymour's nomination for this award, the AMA is at its best when it represents the youngest of its profession and the most vulnerable patients in Australia.

"Dr Seymour is the purest example of a young leader within our ranks who advocates for the welfare and training of her junior colleagues, and provides care to those less fortunate.

"She conducts herself with the greatest humility and represents an individual who deserves much greater endorsement for the work she quietly undertakes."

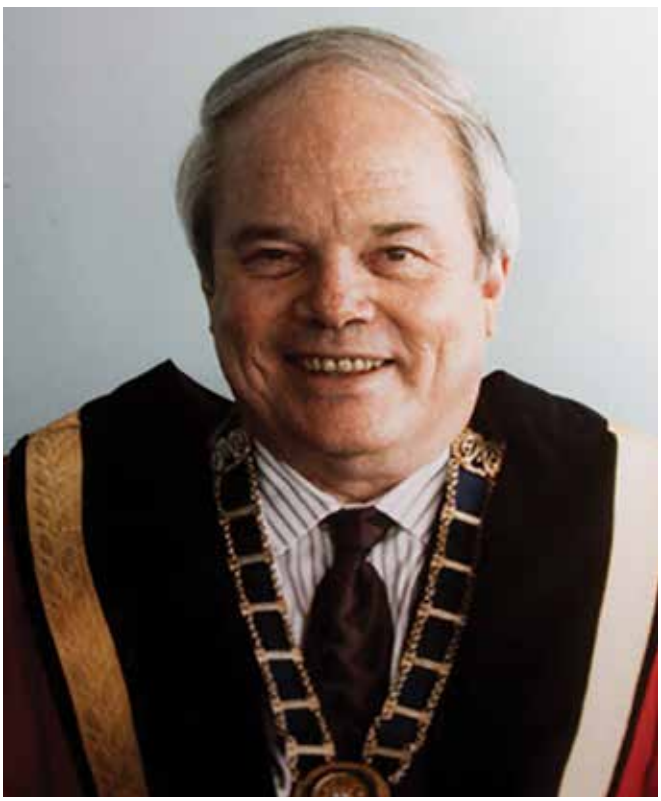
Dr Seymour was presented with her award by Dr John Zorbas, the outgoing chair of the Federal AMA Council of Doctors in Training, at the Leadership Development Dinner at the AMA National Conference in Canberra.

MARIA HAWTHORNE

OBITUARY

Dr Bruce Shepherd AM 1932 - 2018

A giant of medicine



Dr Bruce Shepherd AM was a larger-than-life character with vision, passion and the persistence to achieve the seemingly impossible.

He was such a legendary force in medical politics, that if you spoke of "Bruce" in medical circles, everyone would know exactly who you meant.

Bruce was my friend and mentor and he exerted a pivotal influence on my career.

I first met Bruce in 1981 when I was an intern, newly returned from maternity leave and assigned to a surgery term at Mona Vale Hospital. Bruce was the senior orthopaedic surgeon for the hospital and he was railing against what he saw as a fundamental threat to the independence of the Australian medical profession, and our ability to maintain clinical excellence and to protect the doctor-patient relationship. This would become a familiar mantra as he led the NSW orthopaedic surgeons in protest against excessive bureaucratic interference in the doctor-patient relationship, and later as President of the AMA (NSW) and then the Federal AMA. Bruce had trained in the UK and he had seen the impact of nationalised health care, and he refused to let it happen here.

He held an unshakable belief in the need for a medical profession independent of government control so that we could serve only our patients and no one else: "*Umberima Fides*", he said – always act in the utmost good faith.

By the end of May 1984, when Bruce was President of the Australian Society of Orthopaedic Specialists (ASOS) which he founded, discussions with government failed and some 70 orthopaedic surgeons resigned from their prized honorary positions in public hospitals. Then NSW Premier, Neville Wran, in meeting Bruce said: "Dr Shepherd, you represent the last independent group in our society and as such I move to control you."

State legislation was introduced threatening that any doctor who stayed resigned would be banned from ever working in a public hospital for seven years.

This backfired on the Government, causing the protest to spread, as many hundreds of surgeons and anaesthetists joined the protest with resignations rising to 1500. Eventually the NSW Government was forced to find a solution.

That bitter dispute was a turning point for the medical profession, creating a new awareness of the threat of bureaucratic domination of clinical practice.

Bruce never returned to the public system, but beyond his patients he gave an enormous amount of time to nurturing and teaching young trainees and fellows. Indeed, one of his characteristics was always to encourage young people to believe in themselves and to find their own potential.

Bruce became President of the AMA (NSW) in 1987, and served as President of the Federal AMA from 1990 to 1993.

Dr Brendan Nelson AO was Dr Shepherd's Vice-President and was later elected as Federal AMA President. Brendan recalls: "More than anything else he gave me confidence in the belief I could make a difference to my profession and my country."

Bruce was certainly a straight-talker, his wisdom delivered with an often colourful turn of phrase.

In reforming the AMA's bureaucracy as President, Brendan said he rang Bruce to ask his opinion of a senior staff member about whom he had doubts. Bruce told Brendan:

> *"You're right mate. He's never bled for anything he believes in.*
>
> *In life you have to surround yourself with people possessed of two qualities.*
>
> *The first is that they are prepared to bleed for something in which they believe. That you share their cause is less important than being prepared to bleed for something.*
>
> *The second is to look for people who are overenthusiastic - much better to hose them down twice a day than have to stick ginger up their bums to get them moving."*

Such was the complexity of the man he would lend himself as easily to a liberal social cause as being a poster boy for conservatism.

Some of the more conservative members of the medical profession were surprised when Bruce made it clear that he wanted them to support me to become AMA President. It was irrelevant to him that I was a woman, or that I had a wife, and he told the "doubters" that it shouldn't matter to them either. He believed in me and that was that.

Bruce would call me regularly during my AMA presidency to share his views on the issues of the day. But he would never tell me what to say or do. He let me know that he trusted my judgment.

While his public persona is the tough negotiator and fearless protector of the independence of the medical profession, Bruce had a heart of gold.

Bruce's two adored children Penny and Daniel were born profoundly deaf. Bruce made it his mission to find world's best practice for teaching deaf children to communicate. Bruce and his late wife Annette travelled to America to study an early intervention method for speech and language, which they brought back to Australia.

Long before cochlear implants and confronting medical orthodoxy, they gave their all to bring first Penny and then Daniel into the hearing world.

In true Bruce Shepherd style, he saw the bigger picture and established a program in the grounds of Sydney University, which later became known as the Shepherd Centre. This fundamentally transformed the lives of these children and their families. Now, almost 50 years later, the Shepherd Centre has enabled more than 2000 children with hearing loss to develop the ability to speak and to be able to integrate into the wider community, because Bruce refused to listen to those who said they never would.

Last year, I attended the graduation of children from their pre-school program. These children would now be able to attend regular schools because of the communication intervention they had been able to receive, thanks to the vision and passion and generosity of Dr Bruce Shepherd. You could see on the faces of those children and their proud parents what his legacy has meant to them.

In 1991 Dr Shepherd was awarded an Order of Australia for this work.

Bruce's interest in the future of our profession continued to burn bright. Even our conversations over the past year quickly turned from family news to medico-political discussions.

Dr Bruce Shepherd AM passed away, fittingly, on the opening day of AMA National Conference 2018, and on the anniversary of the surgeons' walkout in 1984. He would have smiled and made a toast to that timing.

BY PROF KERRYN PHELPS AM, AMA PRESIDENT 2000-2003
WITH DR BRENDAN NELSON AO, AMA PRESIDENT 1993-1995

AMA National Conference 2018 Picture Gallery

More pics of conference to follow in upcoming editions of AusMed.

GPs retain access to 30202

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

> "When the AMA Council of General Practice (AMACGP) first heard this news, it was met with disbelief. This procedure is most commonly performed by GPs and the published Taskforce recommendations were seen as disrespectful of the skills of GPs and contrary to the interests of patients."

Members generally expect the AMA to be leading the charge in the media on issues that matter in the health system and, while our advocacy often makes the headlines, much of our good work goes on in the background. While the latter approach might be low key, it can still make a very big difference to day to day general practice.

One good example was the release of the MBS Review Taskforce recommendations that would have excluded GPs from claiming the cryotherapy MBS item 30202 for the removal of malignant neoplasms in favour of Australian Medical Council recognised dermatologists and plastic surgeons.

When the AMA Council of General Practice (AMACGP) first heard this news, it was met with disbelief. This procedure is most commonly performed by GPs and the published Taskforce recommendations were seen as disrespectful of the skills of GPs and contrary to the interests of patients.

On closer inspection, the Taskforce recommendations also appeared to go much further than the original recommendations made by the Taskforce's Dermatology, Allergy and Immunology Clinical Committee.

While the Clinical Committee was concerned that best practice was not being observed regarding confirmation by histopathology, it did not recommend that GPs should no longer access item 30202. To support best practice, it recommended tightening the definition of 'specialist' in the item descriptor in so far as it related to confirmation of malignancy, and called on relevant colleges to encourage best-practice use of pathology. It also called for the monitoring of high volume users to ensure appropriate requesting of pathology.

The AMA has good relationships with the Department of Health, allowing us to raise this discrepancy with the Department and to get a timely response. The AMA also has significant expertise in the operation of item numbers, allowing us to challenge the reported recommendations of the Taskforce and highlight the impact on patients.

Following these representations, the Department ultimately conceded that an error had been made during the publication of the Taskforce's finding on the Department's website and that it would make it clear that the Clinical Committee's recommendation had been adopted in full.

This means that GPs have not been excluded from claiming MBS item 30202.

One wonders whether this error would ever have been picked up, if not for the AMA. What a detrimental impact this could have had on patient care, particularly in rural and remote areas, and what a blow to GPs trying to provide best care, if this had been implemented on 1 November as announced. The anticipated delays in patient treatment this would have caused could have been devastating for the prognosis of patients with malignant lesions.

Effective advocacy is about much more than just complaining or being angry. It is about high-level access, sound arguments, technical expertise, vigilance and a good dose of diligence. Your AMA has many years of experience in Canberra and is uniquely positioned to win these types of arguments with the bureaucrats – something I am very grateful for.

Taming the nuclear tiger

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

With incredibly dangerous nuclear games on our doorstep, I offer you a new phrase: The Doomsday Competition.

There are several competitors: global climate change, rampant influenza or a hitherto unknown, but highly contagious and virulent, virus, atmospheric pollution with small particles, conventional wars and unmanageable population growth.

But the competitor that trumps (no pun intended) all others is nuclear war. And despite growing global awareness of the threat of nuclear war and its potential consequences, it receives little discussion in Australia.

Now for a (non-nuclear) test!

Did you know that the 2017 Nobel Peace Prize went to the International Campaign to Abolish Nuclear Weapons (ICAN)?

You probably did not, because it received scant media attention, despite the recipient, a critically important founding member of that organisation, being an Australian. The citation for the award read "for [ICAN's} work to draw attention to the catastrophic humanitarian consequences of any use of nuclear weapons and for its ground-breaking efforts to achieve a treaty-based prohibition of such weapons".

ICAN grew out of the International Physicians for the Prevention of Nuclear War (IPPNW) and was launched in 2007. Dr Tilman Ruff, a public health physician from Melbourne, is prominent in the organisation.

ICAN, as Wikipedia tells it, is a "global civil society coalition working to promote adherence to and full implementation of the Treaty on the Prohibition of Nuclear Weapons." The campaign helped bring about this treaty. As of 2017 it has 468 partner organisations in 101 countries".

The medical presence, first in IPPNW and now in ICAN, is substantial. There is no subtlety about the effects of nuclear weapons and no question about the health hazard they pose to human survival.

It is easy to feel powerless in the face of such a threat, but the work of IPPNW since 1953, when in the face of the threat of nuclear annihilation, it was credited with a major contribution to the UN Limited Nuclear Test Ban Treaty in 1963.

Lachlan Forrow, a doctor, Tilman Ruff, and Setsuko Thurlow, a Japanese–Canadian nuclear disarmament campaigner who survived the atomic bombing of Hiroshima in 1945, wrote about what was achieved by IPPNW in a recent Perspective paper in *The New England Journal of Medicine*. "When the Cold War ended in 1991, the [Doomsday] Clock was set back to 17 minutes to midnight," they said. But now,

> *....nuclear disarmament has stalled: today, nine countries — Russia, the United States, France, China, the United Kingdom, Pakistan, India, Israel, and North Korea — maintain nearly 15,000 nuclear weapons. Almost 20 years after warnings were published ... about the dangers of "accidental nuclear war," nearly 2000 weapons remain on "launch-on-warning" hair-trigger alert, despite the growing vulnerability of weapons systems to cyberattack.*

Forrow, Ruff and Thurlow continue:

> *The urgency of ICAN's work was recently highlighted when the Bulletin of the Atomic Scientists moved its Doomsday Clock forward to just 2 minutes to midnight, the highest level of danger since 1953 and 5 minutes closer to midnight than when concerns about U.S. and Soviet preparations for nuclear war sparked the founding of IPNNW.*

ICAN applies to nuclear weapons a proven strategy for making progress toward the elimination of other inhumane and indiscriminate weapons, such as biologic and chemical weapons, antipersonnel land mines, and cluster munitions. This approach can be summarised as stigmatise, prohibit, and eliminate.

In each case, weapons that cannot be used without unacceptable consequences have first been prohibited in an international treaty, which has laid the foundation for their progressive elimination.

ICAN has rapidly grown into a global campaign coalition of nearly 500 partner organisations in more than 100 countries – with the goal of uniting all sectors of civil society, in partnership with governments, to work toward complete nuclear disarmament.

A "limited" nuclear war involving 100 Hiroshima-size nuclear weapons (less than 1 per cent of the current stockpile of weapons) "would ignite massive confluent fires that would release millions of tons of smoke and soot into the atmosphere.

"Such pollutants would cause substantial global cooling, drying, and darkening for more than a decade, disrupting food production worldwide and putting more than 2 billion people, the majority of them in Africa and Asia, at risk of death from starvation."

The hands on the Doomsday Clock now rest at two minutes to midnight, the most dire it has been. Doctors can draw attention to the humanitarian and health disasters following nuclear war. The ICAN approach is to use these health consequences to lead the debate which will, in turn, change policy – as it did with land mines.

To be frivolous for a moment, we might say if ICAN, then WE can!

Here's to our new AMA President – and to sustained rural focus

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

The AMA Council of Rural Doctors (AMACRD) congratulates Dr Tony Bartone on winning the election for AMA President. I am glad I was able to nab him just after his victory. I promised that I would be in touch soon. Why? Well, of course to discuss rural issues. Rural health, rural doctors, rural funding, unique rural challenges. From the AMACRD viewpoint.

> "Rural doctors are isolated, our misuse of alcohol and other drugs are is a higher rate than our urban colleagues. We are in situations where to have a local GP would be an invasion of both the doctor's and patient's privacy."

We know he is sensitive to our uniqueness. Here are a few things that the wider community should also be aware of.

- Rural doctors are isolated, our misuse of alcohol and other drugs is at a higher rate than our urban colleagues. We are in situations where to have a local GP would be an invasion of both the doctor's and patient's privacy. Please help destigmatise and talk about our mental health needs. Mandatory reporting has worked against us, and the new COAG discussions do not fill us with confidence.
- In rural Australia, gender inequity and racial discrimination is normalised and unrecognised. Female doctors are criticised for the needs of their family, for even considering pregnancy.
- We are not specialists, we are generalists. Even the rural specialists here are generalists of their specialty. You know, a Jack or Jill of all trades. We make mistakes but so do specialists. In fact, our urban specialists makes amusing mistakes when they come Outback. Yes that is scabies, no, don't freak out. Yes that is a 14-year-old Type 2 diabetic. Yes it is nearby, just 600 km away.
- We need more funding support to be effective.
- Please encourage us to submit abstracts to rural events. Promote the leaders on our Council so they are invited to the podium at rural conferences. Our Council is strong, and getting stronger.
- The AMA Council of Rural Doctors has voices from around Australia. A past member just won the AMA President's Award.
- We would love to meet more often.
- If the AMA President or the Vice President are invited to a rural event, please advise us.
- Consider an AMA-sponsored Rural Doctor Award.

We challenge any doctor to visit a remote colleague. Bunk down in their spare bedroom, lock yourself behind the two sets of metal cages needed to keep you and yours safe as you sleep. Grab some sticks to ward off dogs if you go for a walk. Remember a torch. Shop at one of our 1000h to 1400h grocery stores, see the condition and price of lettuce. Travel in a four-wheel-drive, cuss as you get bogged. Cast your eyes on the most gorgeous sunsets in the world. Be a GP locum for one day at a practice in Tennant Creek, lay your stethoscope on the pulsatile chest of a 25-year-old Aboriginal lad with RHD. Feel the horror of knowing he will not see his 30th birthday. Go fishing and OMG, catch a crocodile.

See the beauty and the ugliness of Remote Australia.

As AMA Vice President the past two years, Dr Bartone teleconferenced with us, the Council of Rural Doctors. We greatly appreciated his attention and contribution. Now that he is President we don't want to let him go. We want to continue to see his face at our videoconferencing. His presence in our meetings is valued.

Again, we congratulate our new President. We have great hopes for his presidency and we stand with him.

Gender equity – we found the will, but have we lost our way?

BY DR TESSA KENNEDY, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

Gender inequity remains a significant challenge within the medical profession, as in much of our society. We've had gender parity among medical students since 1990, yet the trickle up approach hasn't worked. Progress to parity at supervisory and leadership levels has stalled. There are large gender pay gaps for equally trained and skilled professionals in all craft groups. And even where women doctors are primary breadwinners for their families, they tend to shoulder a greater burden of childcare and domestic work.

No doubt there's been a cultural shift in recognising the importance of equitable and diverse participation and representation. We also know that young people now broadly hold very equitable ideals for how work and family demands will be shared. But we've too often assumed that by saying gender equity should happen, that it simply will.

So why aren't best intentions enough?

This passive assumption ignores the context of the systems in which we work, which were built for medical men and the women supporting them at home. The literature suggests that equitable expectations are derailed when they start to clash with workplace policies, which remain rooted in traditional gender norms, which are most obvious after a couple has a child. Existing policies ensure that the path of least resistance is the traditional one: for women to take the majority of responsibility for child bearing and rearing, while men remain fully engaged in the workforce.

Common problems with current workplace policies, and therefore targets for change, include:

- Inequitable parental leave (in health, specifically almost non-existent paternity leave);
- Lack of support for return to work during lactation;
- Lack of accessible childcare, especially to meet the demands of shift and on call workers;
- Inflexible training pathways, and inequitable access to flexible arrangements; and
- Lack of access to relief cover for employees on parental leave, and a requirement for individual departments to recruit and fund any relievers.

To be clear, this is not just a women's issue. We feel the brunt of it professionally, but these inequitable policies sell all of us short on one side of the equation or the other.

So how can changing something like parental leave help find greater balance in our reality? Let me give a personal example.

My first baby is due in August. Where I work in NSW, female medical officers can access 14 weeks paid maternity leave, yet men are entitled to just one week of paid paternity leave. If my partner were a doctor, that's not much of an incentive for him to take on parenting while I gets back to my career. In fact the path of least resistance would be for me to continue to stay home beyond 14 weeks if neither of us would get paid to anyway, and if childcare is an issue it's more likely to be me who returns part time. Again, because at that point in the decision tree, despite our ideals, traditional gender norms are maintaining along the path of least resistance.

Luckily, my partner is not a doctor. He works for a tech company that has prioritised gender equity as part of its professional culture, and uses its systems to create this ideal.

At his company, every new parent is entitled to three months paid parental leave. If you are the person giving birth to a child, you get an additional six weeks of paid recovery leave. To me, this neatly defines an equitable workforce policy: it recognises a biologically imperative difference in our responsibilities, but doesn't overstate it, and seeks to enact equality wherever possible.

Practically, it means my family is more able to realise our aim of equal parenting and workforce participation. I will return to work full-time after six months to get on with my second fellowship while my partner not only supports that transition, but up-skills to be an equal parent and home-life participant in years to come. Our culture will be defined by the system in which it exists.

For those of you who support gender equity in your hearts but find it hard to action in your departments, I hope you will join me in addressing these practical barriers which are likely to see the best bang for your well-intentioned buck.

Building a medical culture that is safe and nurturing

BY ALEX FARRELL, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

I am often told that when it comes to changing culture, students are the way forward. This year I've sat in countless meetings with reassurances that our problems will be solved, because the younger generation will eventually reach the top.

The medical students of Australia are extraordinary. But that is a huge burden to place on our shoulders alone, without the structures to support us. We have the least power, and often the most to lose.

'Generational change' is a myth when the problems lie in a system that the upcoming generations are still trained to conform to. They will continue to perpetuate that culture, unless it is actively disrupted. We need support from you, doctors who have power in the system, to help us change it.

To begin, gender inequity is alive and well in medicine today. It starts in medical school. Every female student will recall a time they were told to avoid specialties that aren't 'family friendly'. I've spoken to students told that "there's no point teaching them how to suture, because they are just going to become a GP anyway"; to a student whose supervisor was well-known to either bully or flirt with their female students, and told she was lucky to be picked for the latter.

It's what we call unconscious bias. Women need to work harder to prove themselves, because they don't fit the leadership image we expect to see, whether in an operating theatre or hospital boardroom. It's not really about gender or sex, it's about power and authority, and who we see holding it. Women are underrepresented in nearly every position of medical leadership.

The truth is, most doctors involved in lower levels of sexism and harassment aren't malicious. They think they are being helpful, or flattering, or telling a harmless joke. The behaviour builds, and the lack of accountability builds, and, for the few with bad intentions, the opportunities to abuse power builds too.

The same goes for all vulnerable groups. Earlier this year, I spoke with the student representatives of the Australian Indigenous Doctors' Association, and heard their stories of daily stereotyping and racism, of being told they had taken the place of someone who "actually deserved to be in medicine".

We know most students mistreated during their medical training don't report it. They don't know how, and they're afraid of what might happen.

"We are taught from our first year that whistle-blowing in medicine is career suicide"

"My supervisor could be my examiner"

"I tried. The university told me it was the hospital's responsibility, the hospital directed me back to the university"

The responsibility to speak up lies with you. To take colleagues aside if they might be crossing lines. To create systems in hospitals where reporting doesn't put students and staff at risk. To demand consequences.

When it comes to mental health, there is one area where students and senior doctors often don't see eye to eye – resilience.

Resilience has become a dirty word. It's a word that has been overused, at the worst times. Resilience takes students at their darkest point, and tells them they should have been stronger. It acknowledges that the medical training environment is flawed, but insists the answer is fixing students, rather than seeking larger change. So instead, let's talk about what they are being resilient against.

Sixty per cent of students have witnessed mistreatment in medical education. Most of the time, this comes as belittlement, condescension or humiliation.

Doctors spend years learning to practise medicine, but are expected to teach with no training at all. You hold the power to impact the lives of your students everyday. It only takes a moment to say 'good job', to answer a question, or explain how to improve next time.

I believe that we can build a medical culture that is safe and nurturing, but it can't wait 20 years. It has to start now, and it has to come from the top. In the way you teach, in the way you lead, and in the systems you influence, be part of that change. I promise, we will do you proud.

This is an edited version of the AMSA President's address to the AMA National Conference.

Mr Hunt, are we there yet? Continuing the public hospital funding journey

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

By the time of this column's publication, we may have had some further information from the Federal Minister for Health Greg Hunt, at the AMA's National Conference, although the Budget is pretty fresh. We know public hospitals are fundamental to Australia's overall health system, dealing with greater than six million admitted patient care episodes and around 92 per cent of emergency admissions in any one year. Nonetheless, we experience chronic underfunding partially because of near stagnant growth in financial support. This has been going on for just too long; we all feel the pressure day in, day out. We know under-funding is building to crunch point.

AMA's *2018 Public Hospital Report Card* shows bed numbers per 1000 population are static; performance, basically, is plateauing at best; waiting lists, you know the sorry truth about that and our patients are suffering! My December 2017 *Australian Medicine* column criticised the Council of Australian Government's (COAG) savage imposed financial penalties where avoidable re-admissions or hospital-acquired complications are deemed to have occurred. The AMA's *2016 Safe Hours Audit* shows that in public hospitals, 53 per cent of doctors are at "significant risk" of fatigue with dangerous fatigue levels being reported across a raft of specialty groups.

So, the effect of underfunding is cumulatively adding up to seriously affecting our, and the system's, ability to perform optimally for our patients, and our own health and wellbeing is at stake. That's why the 2018 Budget decisions matter; it's about what the future holds for public hospital medicine. Without vital new investment, required infrastructure, and human resource capacity, an appropriate standard of result cannot happen.

Reflecting on AMA's pre-budget submission, what we have said is that the Budget must fully fund, for the medium to long term, internal capacity building and expansion of their integrated care responsibility. Not to penalise an already underfunded sector via that sneaky COAG device that will redirect otherwise committed funds. The AMA also says States and Territories must be fully compensated for any loss in private patient revenue and any funding decisions must not dilute support for patients electing private treatment. Mr Hunt has said he intends to look at these private patient issues so we don't yet know where Government is headed.

Despite the known pressure on public hospitals, the new 2020-25 Hospital Funding Agreement ratchets up this financial pressure on hospitals even further. Within existing levels of Federal funding, the Agreement will require public hospitals to implement new measures to cut waste, increase productivity and extend their responsibilities to engage in the care of chronically ill-patients post discharge to reduce overall admissions.

I agree integrated care is essential – but this work requires new Federal funding to pay for the hospital and primary sector resources required to deliver it. The public hospital funding in the 2018 Federal Budget was nothing more than the amount forecast over the forward estimates to maintain funding at current levels.

There are many laudable new funding initiatives out of this budget, to name some: a rural doctor workforce/training package, increased support for aged care in the home, and mental health/suicide prevention services, new research investment and (perhaps laughable!) the "unfreezing" of Medicare indexation. However, the Budget lacks consideration of how any savings from the Government's yet to be finished MBS reviews will be re-invested into public health, and we still wait on needed big structural reform. There must also be funds to urgently begin development of a national medical workforce strategy. On that, your Council of Public Hospital Doctors is working through the AMA to encourage all jurisdictions to cooperate more closely in their planning and coordinating of our future medical workforce to meet Australia's future healthcare needs.

There's an election coming; maybe this year; and Labor has promised an additional $2.8 billion '*better hospitals*' to fund target reducing elective surgery waiting times and increasing emergency department bed numbers. Your CPHD will be looking to score both major parties as they release more health policy and keep a watching on eye on any moves to change public hospital private practice arrangements. We must push for the government to match Labor's pledge and make Government fund for growth, not just, as it has been, keeping pace with activity. It's matching funding with growth and having a workforce plan that really matters!

Ethical cost of dispensing doctors

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

Amid the review of the AMA *Position Statement on Doctor's Relationships with Industry 2012*, delegates at the recent AMA National Conference debated the ethics of doctors dispensing pharmaceuticals. They supported a motion that doctors should not dispense pharmaceutical or other therapeutic products unless there is no reasonable alternative and, where dispensing does occur, it should not be undertaken for material gain.

> "But there is clear potential for doctors who make a profit from dispensing to (inadvertently or otherwise) overprescribe certain treatments, potentially causing harm to patients …"

Current AMA policy advises that doctors should not dispense pharmaceuticals or other therapeutic products unless there is no reasonable alternative. Prior to 2010, the AMA position included an additional qualification that doctors should not dispense for material gain, should it be required (material gain refers to making a profit over and above recovery costs, such as the cost of purchasing, storing and disposing of the products).

In 2010, the words "for material gain" were removed from the policy, opening the way for doctors to make a profit from dispensing. The Ethics and Medico-Legal Committee (EMLC), responsible for coordinating the policy review, believes this particular position places doctors in an actual or perceived conflict of interest and that the AMA should return to its former position not to dispense for material gain. Reinstating the qualifier of 'material gain' removes the perception (and any incentive) that doctors profit from prescribing or recommending therapeutic products to patients (a clear conflict of interest).

As Chair of the EMLC, I introduced the National Conference session on dispensing, outlining a range of issues for delegates to consider. First and foremost, it was important to acknowledge that general practitioners feel under assault by pharmacists encroaching into their space, for example by providing vaccinations and sickness certificates, and some GPs may feel returning to a position that opposes doctors making a material gain from dispensing is a surrender to the pharmacists.

But there is clear potential for doctors who make a profit from dispensing to (inadvertently or otherwise) overprescribe certain treatments, potentially causing harm to patients, undermining the quality use of medicines and contributing to the inappropriate use of healthcare resources.

Further, any model for prescribing where the assessment and sale of a product is inextricably linked (for example, as used by hearing centres) introduces a conflict of interest and undermines the advice provided to patients and their trust.

While some doctors will argue they can manage their own conflicts of interest, the AMA's *Guidelines for Doctors on Managing Conflicts of Interest in Medicine 2018* states:

> *Doctors will often face uncertainty as to whether they have an actual or perceived conflict of interest and, if so, what actions, if any, need to be taken in response. A doctor should recognise that they are ultimately not in a position to make this determination and should either seek the advice of, or delegate the decision to, an independent party.*

Because of the massive power differential in the doctor-patient relationship, the patient is not in a position to decide for themselves whether or not the doctor has a conflict of interest when prescribing a treatment.

While an individual doctor might feel indignant that anyone would doubt their ability to properly assess and manage their own conflicts of interest, a doctor's financial interest in dispensing clearly has the potential to impair objectivity and professional judgement. It would only require a few proven instances of material gain leading to inappropriate prescribing and dispensing to seriously damage the trust in all doctors.

As the AMA, we consistently highlight the conflicts of interest of pharmacists who sell a wide range of therapeutic (and other) products to consumers - Should we be in a race to the bottom to do the same? And would any financial gain be worth the cost - in loss of trust by the community? Thankfully, our National Conference delegates said "no".

AMA ramps up its aged care advocacy

BY DR ANDREW MULCAHY, CHAIR, AMA'S MEDICAL PRACTICE COMMITTEE

It only takes a skim of the media headlines to know that the aged care system is failing older people. Many reported cases of poor quality care are a result of delayed medical care and neglect, and AMA members are deeply concerned for their older patients. There have been multiple inquiries and reviews into the system in the past couple of years. Government are well aware of the issues and, while there was a $5 billion funding increase in the aged care 2018-19 budget, more urgently needs to be done.

The AMA is responding to its members' concerns by ramping up its aged care advocacy. In November 2017, the Medical Practice Committee (MPC) conducted a survey on AMA member experiences and perceptions of aged care to inform future AMA policy. In April 2018, a new Position Statement, *Resourcing Aged Care,* was released. This Position Statement focuses on workforce and funding measures required for a good quality aged care system, and draws from the learnings of the aged care survey.

Aged care calls for adequate resourcing to ensure doctors are supported to deliver medical care to their older patients. One such measure includes appropriate remuneration to cover the opportunity cost of leaving a surgery to visit patients in Residential Aged Care Facilities (RACFs). The AMA also advocated for this policy change at the MBS Reviews' General Practice and Primary Care Clinical Committee (GPPCCC). Dr Richard Kidd (Chair, Council of General Practice) and AMA Federal Secretariat called for increased MBS rebates for GP RACF attendances, telehealth consultation items for GPs, and for the Practice Incentive Program (PIP) Aged Care Access Incentive (ACAI) to remain.

MPC, with input from the Council of General Practice, has lodged six aged care submissions this year alone. These include:

- Aged Care Workforce Strategy Taskforce – The Aged Care Workforce Strategy;
- Australian Aged Care Quality Agency – Draft Standards Guidance (for the new Aged Care Quality Standards);
- House of Representatives Committee on Health, Aged Care and Sport - Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia;
- Medical Services Advisory Committee – New mobile imaging services for residential aged care facilities;
- Aged Care Financing Authority – Respite Care; and
- Department of Health – Specialist Dementia Care Units.

In addition to the House of Representatives Committee on Health, Aged Care and Sport for the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia submission, Dr Tony Bartone and Dr Kidd gave evidence at a public hearing in May. Dr Bartone and Dr Kidd highlighted that AMA members have major concerns that the current aged care system is failing older people, and called for more appropriately trained aged care staff, especially registered nurses, in RACFs. Dr Bartone and Dr Kidd also highlighted that doctors need to be recognised and supported as a crucial part of the aged care workforce to improve medical access, care and outcomes for residents.

In addition to the Aged Care Workforce Strategy Taskforce submission, Dr Bartone recently attended both Aged Care Workforce Taskforce Summits. The summits are aimed at engaging stakeholders in developing a strategy for ensuring aged care workforce growth to meet older people's needs. Dr Bartone highlighted that the current aged care workforce does not have the capacity, capability and connectedness to adequately meet the needs of older people.

MPC aged care advocacy efforts were also reflected in several Budget announcements, including:

- the establishment of an Aged Care Quality and Safety Commission ($nil);
- investment in rural aged care ($40 million);
- improvements to My Aged Care website access ($61.7 million) and faster Aged Care Assessment Team (ACAT) assessments ($14.8 million);
- improved access to specialist palliative care services in RACFs ($32.8 million);

Federal Council communiqué

BY DR BEVERLEY ROWBOTHAM, CHAIR FEDERAL COUNCIL

The May meeting of Federal Council is condensed to one day immediately before the start of National Conference. While shorter in length, the breadth of matters brought to the Council remains significant. The meeting was the last for outgoing President, Dr Michael Gannon, and several other members - Drs Susan Neuhaus, Gary Geelhoed, Robyn Langham, Lorraine Baker, Stuart Day, Andrew Mulcahy, and John Zorbas. As a result of the election of incoming President, Dr Tony Bartone, and Vice President, Dr Chris Zappala, Drs Brad Frankum and Gino Pecoraro also completed their terms. All have been substantial contributors to the work of Federal Council, in some cases over many years.

Dr Gannon provided an overview of his last weeks in office with highlights including a tour of remote Indigenous communities with the Hon Warren Snowdon, the Federal Budget with its wins for workforce, and attendance at the Council meeting of the World Medical Association in Riga.

The Secretary General's report highlighted several wins in the Federal Budget which were the result of AMA advocacy. Most important among these was the introduction of a comprehensive medical workforce package. This included the establishment of the Murray Darling Medical School Network with a number of participating medical schools offering end-to-end rural medical school programs; an expansion of prevocational GP places for doctors in training; additional GP training places earmarked for rural generalists; and an emphasis on supporting doctors undertaking training in rural areas.

A major win in the Budget was the overhaul of bonded medical places which will apply to all new participants from January 2020. Existing BMP and MRBS participants have the choice to opt in. The changes offer more certainty and flexibility in how return of service obligations can be satisfied. Federal Council heard that the Secretariat is receiving calls from members expressing their delight in the life-changing outcomes from these announcements.

The AMA's sustained advocacy for workforce reform included a medical workforce and training summit held in March 2018. An important theme from the summit was the need for a whole of government approach to planning the future delivery of health care and for all governments to collaborate more effectively on workforce planning, training and coordination.

Federal Council noted AMA activity on issues impacting on practice including medical indemnity reforms, private health insurance reforms, the ongoing MBS review, and reports on the significant engagement with aged care policy reform.

AMA ramps up its aged care advocacy

- a new mental health service for older people living in RACFs ($82.5 million); and
- 14,000 additional home care packages (plus 6000 additional packages as announced in the Mid-Year Economic and Fiscal Outlook) ($1.6 billion).

However, more needs to be done to ensure older people receive quality care. 20,000 additional home care packages makes a small dent in the 104,602 people currently on the waiting list. The Productivity Commission stated in 2011 that the aged care workforce must quadruple by 2050 to meet demand, but there was no mention of a workforce strategy in the budget. MPC is waiting with bated breath for the Aged Care Workforce Strategy to complete its work (by the end of June 2018).

MPC will continue advocating for a better quality aged care system. 2018 will see the introduction of four additional aged care Position Statements, covering topics such as the health of older people, palliative care, clinical care, and innovation in aged care. So watch this space.

AMA aged care Position Statements and submissions can be accessed through: https://ama.com.au/advocacy/aged-care.

The AMA's public health advocacy remains a consistently strong area of activity. Federal Council received an advanced draft of the Position Statement on social determinants of health, and received updates from the working groups on child abuse and neglect, and health literacy.

The Ethics and Medico-Legal Committee continues its revision of the AMA's Position Statement on *Medical Practitioners' Relationships with Industry*. It has commenced a review of the Position Statement on *Conscientious Objection*.

Federal Council agreed with a recommendation from the AMA's Taskforce on Indigenous Health that the AMA sign on to the joint statement by non-Indigenous Australians in support of the Uluru Statement from the Heart.

Federal Council adopted the AMA Anti-Racism Statement which addresses racism in the medical workforce, and expresses support for good medical practice that reflects the cultural needs and contexts of patients.

The Council of Doctors in Training is working on the development of standardised questions to support State and Territory AMAs to run hospital health checks which measure and report on how well health services are meeting State-based industrial agreements and/or accreditation standards for doctors in training.

The Council of Private Specialist Practice has been considering a proposed website to support transparency of doctors' fees. The Council noted the complexities of such a site and expressed its view that the site must be government-controlled. The Council also noted its concerns that such a website would be unmanageable if its aim is to capture every fee charged by a privately-billing doctor. Council acknowledged that there is a strong desire in government, and from consumers, to improve fees transparency and support patient awareness.

The Council of General Practice reported on the success of AMA advocacy in the Government deferring the introduction of the Practice Incentives Program Quality Improvement Incentive, which would have left many practices financially worse off. Five incentives scheduled to cease on 1 May 2018 will now continue until 30 April 2019.

The MBS Review, through its general practice and primary clinical care committee, is examining funding for GP visits to residential aged care facilities, including funding for telehealth consultation items. AMA advocacy has resulted in the referral to the MBS Review of consideration of funding for wound care items in general practice.

The Council of Public Hospital Doctors reported on its consideration of the impact of technology on workplaces, and the future of work and workers. Further analysis will be undertaken to look at potential industrial implications including task substitution, medico-legal issues, obsolescence, and outsourcing.

The Council of Rural Doctors outlined additional work that the AMA should undertake in considering rural doctor health, including longer working hours, lack of access to resources and professional support, professional and geographical isolation, and limited team support. The Council noted the work underway by the AMA subsidiary, Doctors' Health Services Pty Limited, in sponsoring a trial of telemedicine consultations for rural doctors.

At the Annual General Meeting of members held on the day following the meeting of Federal Council, members voted unanimously to create a new position on Federal Council for a representative of Australia's Indigenous doctors, nominated by the Australian Indigenous Doctors' Association, and who is a member of the AMA.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Disease and wounds get Ministerial attention

Health Minister Greg Hunt at the AMA National Conference

Health Minister Greg Hunt used his AMA National Conference address to commit funding towards wound management and Human T-cell Lymphotropic Virus-1 (HTLV-1) programs.

As the keynote speaker at conference's opening day, Mr Hunt praised the AMA, gave thanks to outgoing President Dr Michael Gannon, and repeated the Federal Government's long-term health plan for the nation.

He wound up his remarks by announcing the new funding initiatives.

The Federal Government will provide $8 million to form a taskforce, in collaboration with the States and Territories, to combat emerging communicable diseases such as HTLV-1 in remote communities, he said.

Led by the Commonwealth's Chief Medical Officer, Professor Brendan Murphy, the taskforce will bring together Aboriginal communities, relevant health providers, researchers, clinicians and all levels of Government.

The taskforce will investigate enhanced responses to communicable diseases, including the drivers behind the emerging prevalence of HTLV-1, a blood-borne virus, in remote communities.

It will do this in close collaboration with Aboriginal communities and develop a roadmap to respond to this issue, the Minister said.

"In terms of Indigenous health, one thing that is an unacceptable national shame is the level of transmissible sexual diseases," Mr Hunt said.

"So the STIs and infections are at an unacceptable level. We will be investing $8 million to ensure that there is a response to the HTLV-1 virus. That's working with Indigenous communities, under the leadership of the Chief Medical Officer and (Indigenous Heath Minister) Ken Wyatt."

In relation to wound management, Mr Hunt recognised that it was a personal passion of many doctors.

He told conference delegates that the Government would embark on a comprehensive wound management program.

"I am referring wound management to the Medicare Taskforce for consideration," he said.

"Secondly, there will be $1 million in relation to a wound management pilot program under the primary healthcare system. And thirdly, it will be the first priority of the new health system's translation program under the MRFF (Medical Research Future Fund)."

The Minister also committed to legislating in the coming months with regards to medical indemnity, to ensure universal coverage and a level playing field.

That comment was received with instant applause from the conference floor.

Another welcome remark was his insistence on ending the mandatory reporting practice.

"Our doctors... are under stress, under challenge and always facing difficult issues that affect their own mental health," he said.

"We will continue to work, and I am utterly committed, to ending the mandatory reporting practice.

"We have worked together. There are one or two States who still have some issues, but on our watch, in our time, that will become a reality that every doctor who wants and needs help will be able to seek that help without fear."

In closing, the Minister thanked Dr Gannon for his work as the AMA President.

Calling him a friend, Mr Hunt described Dr Gannon in terms of Olympic sports.

"More a decathlete meets Greco-Roman wrestler," he said.

"He is skilled at close quarters grappling and he usually ends up pinning his opponent.

"But at the end of the day, he's a fine doctor, a fine leader, and above all else, a fine person."

CHRIS JOHNSON

Cancer warnings mooted for every Canadian cigarette

The Canadian Government is considering placing health warnings directly on individual cigarettes.

Health Minister Ginette Petitpas Taylor used World No Tobacco Day to describe the idea as "bold" and said it was being looked into.

The proposed measure is being studied by Canada's Health Department officials, she said.

"Some people have suggested the idea of putting a warning on individual cigarettes and using what we call sliding shell," Ms Petitpas Taylor told the Tobacco Control Forum.

"I have to tell you these ideas are being studied and I also have to tell you I really like them. They are quite bold.

"When I look at the rates of tobacco use, we have certainly come a long ways, but I personally believe a lot of work needs to be done in this area."

Canada has followed Australia's lead in legislating for plain packaging of cigarettes. New laws there should kick in by the end of the year, the Bill having recently received royal assent.

As was the case in Australia, the new packaging rules were bitterly fought by the big tobacco lobby, but it will nonetheless be illegal for cigarette packets to carry logos, promotional information, or branding.

Placing health warnings on individual cigarettes would be a leap further, but one that is being welcomed by health groups and anti-tobacco campaigners.

The Canadian Cancer Society praised the Health Minister's comments on the individual warnings.

"The tobacco companies place the brand name and logos on the cigarette themselves, it's a very good way to communicate with consumers," said the society's Rob Cunningham

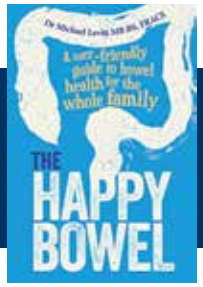
"Under plain packaging, they will no longer be able to have that, so it is a great idea to have a health warning."

Mr Cunningham suggested a single word like "cancer" or "emphysema" printed on a cigarette could be highly effective.

CHRIS JOHNSON

The Happy Bowel

Dr Michael Levitt, Fremantle Press, RRP: $24.99



REVIEWED BY **CHRIS JOHNSON**

June is Bowel Cancer Awareness Month, an annual initiative of Bowel Cancer Australia.

The aim is to use the month to highlight that although bowel cancer is Australia's second deadliest cancer, from which more than 80 Australians die every week, it is also one of the most treatable cancers if detected early.

Dr Michael Levitt MBBS, FRACS is not acting as part of the awareness month, but through Fremantle Press in Western Australia has released a timely book about looking after the bowel.

A fundraiser launch will raise money for bowel cancer research.

The Happy Bowel is not a book about bowel cancer by any means. It is, as its sub-title states, a user-friendly guide to bowel health for the whole family.

Because, when push comes to shove, there is nothing as fundamental as a well-functioning bowel.

That's Dr Levitt's view and this easy-to-read 190-page offering decisively makes that case and is as entertaining as it is informative.

A respected surgeon, Dr Levitt has restored hundreds of patients to bowel health and happiness, and is acclaimed as a leading authority on bowel disorders.

He is a colorectal surgeon who won a Centenary Medal in 2003 in recognition of his work raising public awareness and understanding of colorectal cancer. He is also the director of St John of God Healthcare and the chairman of the Colorectal Cancer Research Fund Advisory Committee.

The Happy Bowel addresses questions from how the bowel works, the relationship between the bowel and the brain, bowels and gender difference and the relationship between our habits and beliefs and good bowel function.

It looks at what to do when fibre, water and exercise are not enough, and it includes case studies and a comprehensive FAQs section. In the process, Dr Levitt answers patients' most pressing questions and he reveals some golden rules for getting the best out of your bowel.

Promoted as an essential resource for all practitioners' waiting rooms, it seems an excellent way to educate patients in good bowel function and help them learn more about their bowel health.

A nationwide hunt has been launched to find the heroes working in GP practice teams.

Launched by the medical newspaper *Australian Doctor*, the competition is intended to celebrate the fundamental role of all staff members in the care of patients, families and communities.

"We thought it would be a great way for people to hear the true life stories about what GP teams are doing, the differences they are making to people's lives," said Dr Kate Kelso, *Australian Doctor* medical editor.

"This is about nurses and receptionists, about the practice mangers keeping the business afloat and about GPs themselves.

"We've already had entries from doctors writing about their receptionist dealing with vulnerable, marginalised patients experiencing extreme anxiety and stress in the waiting room, stories of nurses preventing serious harm. But this is about anyone in the team and it can be serious and it can be funny."

Australian Doctor is offering a $5000 holiday voucher to the winning hero, $5000 to the GP nominating their hero and $2000 Good Food voucher so the winning doctor can take their team out for dinner.

It's urging entrants to send their nomination along with an account of their colleagues' heroics to competition@australiandoctor.com.au.

Entries close on 22nd June 2018.

Seriously (and hilariously) scarred for life

BY DR SUE BELPERIO

Pic: Wilson and Lewis Photography

When our perennially accident-prone son was 21, he fell off his pushbike while riding to an important musical workshop at the Adelaide Festival Theatre. He had not a scratch on his body, and his vital signs were entirely stable, so it was not immediately obvious to either parents, both anaesthetists, that anything was seriously wrong.

His only complaint was a slightly sore left shoulder. After a few hours with a painless soft abdomen and totally normal observations, he suddenly became acutely pale, and peripherally shutdown. With outward calm and inward terror, I dialled 000 and was placed on hold.

Despite the assistance of his brother and partner, he collapsed while we attempted to get him into the car. It wasn't until we had laid him out supine in the back of my car that I was taken off hold from 000. Knowing what a life and death situation this was, I decided to make the five-minute dash for the nearest hospital, St Andrew's, rather than explain my probable diagnosis to the ambulance and then wait for an uncertain period of time for one to materialise.

Upon arrival, his blood pressure was still normal and the accident and emergency specialist told me that he suspected a vasovagal. Holding up his pale cold fingers, I implored them to consider a ruptured spleen, and as such, was granted an abdominal CT scan just to 'reassure' me. The rest is history.

Our son had behaved like a child with shock, which obscured the gravity of his situation to the adult emergency physicians. He was then retrieved to the trauma centre at the Royal Adelaide Hospital, where additional resuscitation occurred. On the brink of total cardiovascular collapse, with a rapidly rising pulse rate, he finally made it into theatre about five hours after the accident. He underwent a three-hour laparotomy followed by a splenic embolisation to stop the ongoing bleeding. This was not the type of theatre he was supposed to be in that day!

Devastated that he had missed his festival theatre event, and being a consummate composer with a degree in Composition, he did the only sensible thing he could: From his ICU bed, he asked for a notebook and pencil, and he started jotting down ramblings and documenting his journey throughout the entire hospital experience and beyond.

The result was a cabaret show, *Scarred For Life*, which premiered at the 2017 Adelaide Cabaret Fringe, receiving three five star reviews. The show then returned to the 2018 Adelaide Fringe Festival where several more five star reviews were garnered, followed by the Adelaide Fringe Best Cabaret Award for Week Three. Josh's show even earned the attention of Andrew Bolt, who summed it up with "Man Falls Off Bike, Becomes Star".

However, the real as yet untapped audience for this show lies with the medical and nursing professions, who need to hear about this patient experience. Josh's physical and psychological scars are laid bare along with his soul in an hour of original music and lyrics "that is equal parts Minchin and Mozart" (Scenestr).

Now, *Scarred For Life* is travelling to Melbourne, for two shows only on August 4 at Chapel Off Chapel. Here, Josh's show becomes act one, and he teams up with talented local Melbourne performers Damon Smith and Adam Coad who present their original show *Mental As Everything* as the second half of the evening's complementary entertainment. Both showcase physical and mental health, and both are funny and poignant. "Inspiring, heartwarming and exactly what a night at the theatre should be!" (*Glam Adelaide*).

Don't miss this one-off opportunity, a must-see for the medical and nursing professions: bookings via Chapel Off Chapel live link:

https://chapeloffchapel.com.au/show/mental-as-everything-scarred-for-life-double-bill/ or phone 03 8290 7000.

Produced by Under The Microscope Theatre, further enquiries to matthew@underthemicroscopetheatre.com

The Royal Wedding

BY DR CLIVE FRASER

It's been a few weeks now since Meghan Markle and Prince Harry exchanged vows.

Debate about the monarchy aside, I have got to say that there were many memorable moments for me from the Royal Wedding.

While Meghan's smile shone so brightly, I must admit that seeing her proud mother alone in the pews also brought tears to my eyes.

As did the Kingdom Choir's rendition of *Stand By Me*.

How appropriate it was to have a hymn written in 1905 by the son of a slave sung in St George's Chapel.

And though Ben E. King popularised the song and John Lennon reprised it, I don't think there will ever be a better version than the Kingdom Choir's.

To declare to the world that they "won't be afraid" may be useful for two young people who face a life-time of scrutiny from the world's press.

Another magic moment for me was the sight of the Royal Wedding cars ferrying the wedding party.

In particular the arrival of Meghan and her mother in a 1950 Rolls-Royce Phantom IV.

This was the Queen's first Rolls-Royce and the first of 18 Phantom IVs produced between 1950 and 1956.

Under the hood was a 5.7 litre straight 8 originally matched to a four speed manual gearbox.

When originally delivered to the then Princess Elizabeth, it was Valentine Green with a red stripe.

But it was re-painted in Royal Claret and Black in 1952 when it became a State car.

In 1955, the gearbox was changed to a four speed automatic and along the way cloth seats replaced the leather.

Unlike other Rolls-Royce, the Queen's Phantom IV has a kneeling Spirit of Ecstasy on top of the radiator and this mascot is replaced with a lion whenever the car is used in Scotland.

HJ Mulliner & Co of West London built the body, which is just under 5.8 metres long, 2.0 metres wide and 1.9 metres high.

With imposing dimensions like these the Phantom IV would always have a majestic presence.

And if one Phantom IV is never enough, the Queen also had another, as did three other members of the Royal Family.

Three other Phantom IVs were bought by General Franco of Spain and the rest all found homes in the Middle East.

It says a lot about Rolls-Royce that after 68 years the Phantom IV is still a magnificent vehicle.

But as befits a wedding, Meghan (and her Mum) still stole the show.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

A quartet that sure has the swing

BY CHRIS JOHNSON


promotional pic

When a Louisiana-born jazzman comes to town, it is well worth venturing out on a cold winter's evening to hear him play.

Saxophonist Branford Marsalis, who has been referred to as "arguably the most respected living U.S. jazz instrumentalist," has just concluded his latest short tour of Australia with his quartet.

Those of us who braved the weather for one of his 90-minute concerts were soon warmed up by some cool jazz on a cold night.

The Branford Marsalis Quartet is jazz at its ultimate best.

Marsalis switching effortlessly between tenor and soprano sax, bass player Eric Revis, drummer Justin Faulkner and pianist Joey Calderazzo are four cool cats (to unashamedly coin the jazz-beatnik lingo of yesteryear).

These guys know the rules of music so well that they can break them with ease and precision – and never lose the complete attention of their audience.

Jazz isn't for everyone. Some people are missing out.

Marsalis's jazz is simultaneously accessible and intricate. Immensely enjoyable at every level.

Opening with Revis's composition, *Dance of the Evil Toys*, the quartet gently tiptoed into a timid stream before immersing themselves and the auditorium with a flood of syncopated bliss, full of energy and vigour.

The show continued as it began, with quiet numbers growing increasingly louder, faster, and more frantic.

Each band member taking their solo turns and showing off in style.

At one point, Calderazzo seemed like an enraged madman on the keys as his sound became more and more compelling.

Revis's double bass playing was outstanding. And you would have to travel a long way to see jazz drum soloing on anywhere near a par with Faulkner's.

Through it all, bandleader Marsalis played a mix of suavely understated and dramatically over-emphasised saxophone to the delight of everyone.

In between classy original compositions, there were nods in style and song choices to a few well-known jazz greats – Armstrong, Coltrane, Ellington, Bechet – and some not so known greats (Andrew Hill's *Snake Hip Waltz*, for one).

Long, winding, improvisations where sometimes it seemed like each instrumentalist was playing his own thing (because he was), came together like clockwork. Such is the magic of good jazz.

Marsalis is a generous bandleader, allowing each member ample limelight while remaining secure in the knowledge of his own brilliance.

And brilliance isn't overstating it.

The encore of Ellington's *It Don't Mean a Thing (If it Ain't Got that Swing)* was the perfect way to end a perfect show. Complete with much-appreciated indulgent solos, the Branford Marsalis Quartet proved to all that the swing is something they possess in abundance.

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