

A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

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AMA LEADERSHIP TEAM



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Dr Michael Gannon



Vice President
Dr Tony Bartone

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Life-changing issues demand serious attention

BY AMA PRESIDENT DR MICHAEL GANNON

In recent months, we have seen concurrent discussion on two different social and health issues – namely euthanasia/physician-assisted suicide and marriage equality/same-sex marriage.

Perhaps the reason they have been grouped together is because of the support that both these issues have from the so-called progressive left, and the presumed opposition of so-called conservative religious forces.

Despite this, the two issues could not be more different.

Exactly how and when euthanasia became a progressive left issue is difficult to understand. A societal change that threatens the most vulnerable people, those without a voice, while prioritising the rights of the individual might appear to be ideologically closer to the right.

It has long been recognised that doctors who are closest to providing end-of-life care are those most likely to be opposed to physician-assisted suicide. The AMA's own member survey, which informed the 2016 update to our Position Statement showed that the groups most likely to favour a change are younger doctors and those who rarely treat dying patients.

While we did not actively survey our members on marriage equality (a decision that has been criticised by those opposed to it), our Position Statement on this issue enjoys the broad support of the profession. The commentary for and against it reflects the great diversity in the medical profession. The AMA position is most popular among young doctors.

I have no doubt that legislating for marriage equality would be a positive move for our community. It will remove one of the final vestiges of discrimination against a minority in our society. It will further legitimise civil unions that already exist. It is a vote for love, and a vote for family as the fundamental unit of social support in society.

Discrimination has negative mental and physical health outcomes. While not all members agree, the AMA supports legislation of marriage equality.

On the contrary, the proposal for Voluntary Assisted Dying (VAD) in Victoria, or any other form of euthanasia/physician-assisted suicide in New South Wales, Western Australia, or elsewhere, would be a negative move for our society. It would be a victory for fear over hope, and would in no way enhance the provision of quality end-of-life care.

The way we look after our elderly is simply not good enough. It is a stain on our society that we do not invest in aged care like we invest in, and celebrate, technological advances in medical procedures and new pharmaceuticals.

Elder abuse is real, and it happens every day.

The sick, the elderly, the disabled, the chronically ill, and the dying must never be made to feel they are a burden. They reflect a diversity in our society that is every bit as important as the LGBTIQ community.

Patients receiving high-quality palliative care rarely, if ever, request euthanasia/physician-assisted suicide. The VAD committee in Victoria was tasked with implementing Recommendation 49 of the Upper House committee report. The first 48 recommendations might have been better put first. Euthanasia/physician-assisted suicide makes us a poorer society, not a richer one.

I disagree with those opposed to marriage equality. No one is harmed. There are no casualties. It need not threaten religious freedom, and it is something generous and positive that the community can do in support of, and in partnership with, a minority group – a group that includes our sons and daughters, brothers and sisters, friends, and work colleagues.

On the other hand, euthanasia/physician-assisted suicide in no way makes our society safer or better. In other parts of the world, the legislation has been changed so it can be used against vulnerable groups. In the Netherlands, and Belgium, it has been extended to involve children. In other jurisdictions, it can be used against the disabled and the demented.

Unlike marriage equality, end-of-life care is an issue for the majority of the population.

While not all our members agree, the AMA opposes any interventions that have as their primary intention the ending of a person's life.

I ask the Parliamentarians and the people of Australia to think deeply and deliver positive choices that make us a richer society, a better society, a more caring and ethical society.

Resolving these two critical areas of public debate is an opportunity to show exactly how much we care about our fellow citizens.

*This article first appeared in **The Huffington Post Australia** on 20 September 2017*



Lessons to be had from this year's flu season

BY AMA VICE PRESIDENT DR TONY BARTONE

You would have to be living under a rock to have missed the scale of this year's influenza activity. So much so that the AMA was mentioned and quoted in a recent edition of the *New York Times*. The reporting was accurate and well written and, while that is great for our organisation, the topic of the article should be raising a few questions for us in this country.

Titled *Why Australia Wasn't Ready for a Dangerous Flu Season*, the piece describes "Australia's carefree attitude towards preventive medicine" and says such an attitude "may have met its match" in this season's flu. It highlights the historically high number of cases being reported in some States, and associated number of deaths (including some tragic stories which have attracted media attention in the past few weeks). However the *NYT* article says alarm bells are ringing across the nation. The same alarm has also crept into a number of the daily media reports and headlines.

These are some of the facts.

So far this year (late September), more than 175,000 influenza cases have been reported in Australia. The number is likely to be revised higher once the backlog of notifications from certain jurisdictions is entered. That is a huge hike from the 91,000 cases reported last year and it more than doubles the average annual number of cases reported in the last five years.

There are a large number of "A untyped". These are almost certainly H3N2 – the predominant virus this year which seems to have undergone some genetic change. It is hard to know how significant the genetic changes in the virus are and what that means and we await the findings of the World Health Organization team at the Doherty Institute. There remains little doubt that this has been a factor this year.

Of concern is the high number of (mainly H3N2) cases in vaccinated people over 65. Vaccine effectiveness in the elderly is traditionally poorer than the young. However this year it seems to be even worse.

The community has had a misconception about what influenza is. It is not the common cold. Combine that with the "she'll be right" attitude, and a culture in this country that doesn't really respect having time off work because of the flu, and you have some of the other drivers behind this year's numbers. The Australian character does not give this dangerous virus its due respect.

The AMA is on the record declaring this country to have been "woefully unprepared" for our flu outbreak. We have placed a lot of the blame on the low rate at which Australians have flu shots.

Fewer than ten per cent of Australian children receive flu vaccinations, while in the United States it is almost 40 per cent.

According to data released by the Royal Children's Hospital in Melbourne, less than a third of Australian parents planned to have their children immunised against the flu this season. A whopping 88 per cent of them said they were unsure about the safety of the flu shot.

This is most alarming. Past adverse reactions to a certain brand of vaccine in young children are still lingering no doubt but we must inform, educate and encourage everyone we can.

The Health Department here does a good job at raising awareness about the need for influenza vaccinations – and high risk groups get their shots for free.

But perhaps the messaging should be clearer and not just targeting the very old and the very young.

The only way you can prevent complications from influenza is vaccination. It can show no respect for age or health.

In recent days there has been a call from certain quarters and media commentary around expanding the NIP vaccine to other age groups. We await the appropriate study and research and cost benefit analysis and ultimately the advice of the CMO. Despite this call we know that WA provides free vaccine to the under 5s and we provide it to Indigenous children under 5 in the NIP. Take up is about 10 per cent in both these groups.

The question to be asked, is whether expanding the NIP to provide vaccine to other age groups will get significantly increased take up.

The Commonwealth has also confirmed it is examining ways to provide a more potent vaccine for the elderly, in whom there is evidence this year of a significant number of cases in people who have been vaccinated.

Anti-vaccination campaigns have created misinformation and confusion in the Australian public.

We as doctors must do all we can to counter those





Patient choice fundamental in dual system

BY AMA SECRETARY GENERAL ANNE TRIMMER

A key plank of AMA policy and advocacy is support for the dual health system in Australia, with robust and sustainable public and private systems. International commentators often cite this balance of public and private, with access to care by all Australians, as an ideal model.

One of the components of the private health system under consideration by the Federal Government is reform of private health insurance to contribute to the long-term viability of the private health system.

For the past year the Private Health Ministerial Advisory Committee (PHMAC) has been examining aspects of private health insurance. While the deliberations of the PHMAC are confidential, a communiqué is published after each meeting and is available for download on the Department of Health website.

One of the complaints about current private health insurance arrangements that the AMA receives from members is when patients are scheduled for procedures only to discover that their private health insurance does not cover them for the procedure. The issue of coverage is one of the areas of focus for PHMAC with modeling to deliver value and certainty to patients.

An element of coverage certainty is to standardise clinical language so that every policy uses the same terminology. Another is to improve transparency on what clinical items are covered within each policy type. This avoids the multiplicity of exclusions and excesses that apply now. Clearer, consistent coverage will increase the value proposition for policy holders.

The Federal Government has committed to delivering reduced premiums to make private health insurance more affordable.

Recent media reports suggest that this will come from further reductions in the reimbursement paid by private health insurers for medical devices. While delivering savings to private health insurers, the implications for flow-on effects need also to be considered.

The other area where the Government has identified potential savings is in the use of private health insurance to fund private patients in public hospitals. The Government is consulting on this issue at present. The AMA submission can be read at <https://ama.com.au/submission/private-patients-public-hospitals>.

The AMA recognises the very legitimate rights of patients to use their private health insurance including in circumstances where it provides the appropriate clinical care, or where the public hospital is the most appropriate option. Patient choice is a fundamental feature of the Australian health system, which includes the option for patients to use their private health insurance in a public hospital.

These issues highlight the complexity of reform to private health insurance. Private health insurance is a significant financial commitment and must deliver, not just affordability, but also value to the patient.

Because private health services are only one part of the dual system in Australia, the equally vexed issue of adequate funding of the public system will shortly come to the fore as negotiations begin between the Federal Government and the State and Territory Governments for the next National Health Reform Agreement.

Lessons to be had from this year's flu season ... from page 4

campaigns and keep our patients fully aware of the consequences of ignoring the need for immunization.

The Commonwealth will be currently under tight timelines to make decisions about the formulation and production of next year's vaccine. The question of a high dose or adjuvanted vaccine for the elderly for next season will certainly be part of

that discussion.

We don't want to see is another *New York Times* article next year pointing out that this year's horrendous flu season provided no lessons for Australia. More importantly, we want to avoid preventable unnecessary suffering and misery of a hostile flu season.

COAG should adopt WA model on mandatory reporting



The AMA has called on the Federal and all State and Territory governments to follow Western Australia's example when it comes to reporting doctors seeking treatment for mental health and stress.

The WA Government's model exempts treating doctors from mandatory reporting requirements.

The AMA's submission to the Council of Australian Governments (COAG) Health Council recommends adopting the WA model.

COAG's Health Council has released a consultation paper on delivering nationally consistent laws on mandatory reporting provisions.

The consultation follows concerns that current laws requiring treating practitioners to notify authorities about doctors who seek help, are a major barrier to doctors accessing the care and

support they need.

The Health Council's consultation paper put forward four options.

AMA President Dr Michael Gannon said the WA model was the best option.

"Doctors deserve the right to access health services, just like their patients," Dr Michael Gannon, who is from WA, said.

"Doctors and other health workers are at greater risk of mental illness and stress-related problems, yet the current laws inhibit many from seeking treatment for a mental health condition because they fear for their medical registration.

"The mandatory reporting laws have a twofold effect – some people will not seek help at all, and those who do may not divulge all the necessary information to receive appropriate care.



“Doctors and other health workers are at greater risk of mental illness and stress-related problems, yet the current laws inhibit many from seeking treatment for a mental health condition because they fear for their medical registration.”

“The AMA is extremely concerned that we have a situation now where doctors may be avoiding appropriate health care, putting both themselves and their patients at risk.

“We know this. Doctors have told us. We have lost too many colleagues and friends to the scourge of mental illness. The figures compel us to act.”

Dr Gannon said the AMA welcomed the recent COAG decision to develop a nationally consistent approach to mandatory reporting.

He said of the four options to consider in the consultation paper, there was one clear standout.

“The AMA's view is clear. We need a model that addresses the issues currently stopping doctors from seeking the treatment they need,” Dr Gannon said.

“We need a model that we know for certain will work, while still protecting patients. We need a model that can be adopted nationally.

“The AMA believes the current model in WA is the right one. It is a proven model. It has given doctors the confidence to seek the help they need and there is no evidence that it has diminished patient safety in any way.

“It is also a model that was recommended in the Independent Review of the National Registration and Accreditation Scheme, a Senate report, and a number of academic studies.

“It in no way stops the medical profession's ethical and professional responsibilities to report a practitioner who may be placing the public at risk.”

Delegates at the AMA National Conference in May were unanimous in seeking amendments to the National Law, so as to not dissuade medical practitioners from seeking necessary

medical treatment of assistance.

Options that simply reword the current legislation, or seek to maintain the status quo, Dr Gannon said, will do nothing but condemn doctors to continue to suffer in silence.

Data from the Australian National Coronial Information System shows that doctors and other health workers have the highest suicide rate among Australia's white-collar workforce. Between 1 January 2011 and 31 December 2014, 153 health professionals died as a result of suicide.

An extensive study of more than 12,000 doctors by Beyondblue in 2013 revealed that 34.3 per cent cited concerns about their medical registration as a barrier to seeking treatment for a mental health condition.

The Western Australian Parliament accepted the medical profession's arguments, and the Western Australian National Law contains an explicit exemption from mandatory reporting for treating doctors.

Australian Health Practitioner Regulation Agency (AHPRA) annual report figures show that mandatory notifications have risen in Western Australia since the exemption came into effect – from 12 in 2011/12 to 37 in 2015/16.

“Now is the opportunity to address the problem once and for all – because healthy doctors are best placed to help patients,” Dr Gannon said.

“Anything less puts both doctors and patients at risk.”

Submissions to the consultation process closed on September 29 and the COAG Health Council will consider the matter at its meeting in November.

CHRIS JOHNSON

Suicide rates decrease, but still the leading cause of premature death

About eight Australians died by suicide every day in 2016, sobering statistics from the Australian Bureau of Statistics (ABS) show.

A total of 2,866 people died from intentional self-harm last year, a decrease of 161 from 2015, but the death rate of 11.7 per 100,000 persons was the third highest in the past decade.

“Aboriginal and Torres Strait Islander people are approximately twice as likely to die by suicide than non-Indigenous Australians.”

And while suicide accounts for only 1.8 per cent of all deaths in Australia, the people it kills tend to be young – accounting for more than one in three deaths (35.4 per cent) of people aged 15-24 and more than one in four (28.6 per cent) of those aged 25-34.

“In 2016, suicide was the leading cause of death among all people 15-44 years of age, and the third leading cause of death among those 45-54 years of age,” the *Causes of Death, Australia, 2016* report said.

“The median age at death for suicide was 43.3 years. This compares to a median age of 81.9 years for all deaths.”

Aboriginal and Torres Strait Islander people are approximately twice as likely to die by suicide than non-Indigenous Australians.

Suicide Prevention Australia (SPA) chief executive Sue Murray called for sustained investment in prevention efforts.

“We are encouraged by the reported decrease, increased funding, support across Parliament, and focus on regionally driven suicide prevention over the past year,” Ms Murray said.

“Many organisations and communities are working hard to implement locally driven prevention plans, focusing on priority issues such as primary care and care following discharge from our hospitals, as well as trialling innovative whole-of-community solutions.

“We will continue to encourage all working in suicide prevention to hold their focus on making the deep systemic and social changes needed.”

Lifeline Research Foundation executive director Alan Woodward said the figures represented the immense and overpowering challenges experienced by many Australians, from loneliness and relationship breakdown to economic hardship and mental illness.

“These issues are reflected in the million requests for help received by Lifeline’s 24/7 crisis support and suicide prevention services each year,” Mr Woodward said.

“Our message to people who might be struggling is that tough times do pass.”

The ABS figures also showed the highest number of drug-induced deaths since the late 1990s, with a death rate of 7.5 per 100,000. Most of the 1,808 deaths were associated with prescription drugs such as Benzodiazepines and Oxycodone.

Heart disease continues to be the leading cause of death, although the number and rate of death from heart disease and stroke continues to decline.

At the same time, death rates from other diseases such as dementia are increasing. Dementia is now the leading cause of death among Australian women.

Cancer accounted for almost 30 per cent of the 158,504 deaths in Australia in 2016, with lung, colorectal, breast, and prostate cancers the biggest killers.

The full report can be found at www.abs.gov.au

24/7 crisis support information can be found at:

- Lifeline 13 11 14 www.lifeline.org.au/gethelp
- Suicide Call Back Service 1300 659 467 www.suicidecallbackservice.org.au
- Kids Helpline 1800 55 1800 www.kidshelp.com.au
- MensLine 1300 78 99 78 www.mensline.org.au
- *Beyondblue* 1300 22 4636 www.beyondblue.org.au
- Qlife 1800 184 527 www qlife.org.au

MARIA HAWTHORNE

Extra home care packages welcome, but more needed urgently



The AMA has welcomed the Government's announcement of 6,000 extra high-need home care packages, following the release of the *Legislated Review of Aged Care 2017* Report, but says more packages are desperately needed.

Health Minister Greg Hunt and Aged Care Minister Ken Wyatt announced the extra packages, along with the long-overdue announcement of \$20 million to go towards fixing the inefficient My Aged Care information system last month.

AMA Vice President Dr Tony Bartone said he was pleased that the Review, led by retired senior public servant David Tune, had adopted a number of the AMA's recommendations, particularly around improving the My Aged Care information technology system.

But he said that the 6,000 extra home care packages, while welcome, fell well short of demand.

"The *Home Care Packages Program Data Report* released today notes that at 30 June 2017, there were 53,750 people seeking home care who had not yet been assigned a home care package," Dr Bartone said.

"While the extra places are welcome, they won't go far in tackling the enormous backlog of applications.

"These are for people who are being cared for in the community, and their carers are doing it tough. It's one thing to improve the IT system, but we still need beds and packages."

Dr Bartone said the AMA was a strong supporter of digital health for the delivery of better health care, but the IT technology has to work.

"In its submission to the Review, the AMA outlined the multiple inefficiencies with My Aged Care," he said.

"In its current form, My Aged Care cannot satisfactorily handle electronic referrals from GPs, forcing them to resort to outdated methods like fax machines.

"The online form for an ACAT referral is not linked with clinical software, so it can't be auto-populated with the GP's clinical records, or be directly saved to the patient record.

"Instead, it has to be saved as an external document and attached, creating a significant administrative burden for already time-limited GPs.

"The AMA has repeatedly raised these concerns with the Department of Health, both through the Review, and through direct communication with the Department.

"Improving communication with My Aged Care contact centre staff is essential to avoid missing vital information on a patient's application form, which has considerably delayed care in the past. The Tune Report recommends that the National Screening and Assessment Form should be revised.

"The Government has predicted that the proportion of Australians aged 65 years of age and older will increase to 18 per cent by 2026.

"The aged care workforce needs to be properly equipped with the appropriate tools to deal with the challenges that this ageing population will bring."

The AMA's submission to the Review is available here: <https://ama.com.au/submission/ama-submission-department-aged-care-legislated-review-2016-17>

The *Legislated Review of Aged Care 2017* Report is available here: <https://agedcare.health.gov.au/legislated-review-of-aged-care-2017-report>

CHRIS JOHNSON

Patients' ability to use private cover in public hospitals must not be curtailed

The AMA is advising the Federal Government to reject any policy proposals that limit patients' ability to use their private health insurance for treatment in a public hospital, warning that such a move would restrict patient choice and further disadvantage public hospitals.

In its submission to the Government's paper, *Options to reduce pressure on private health insurance premiums by addressing the growth in private patients in public hospitals*, the AMA strongly rejects all of the options proposed.

AMA President Dr Michael Gannon said the options would have a negative impact on the health system and should be dismissed out of hand.

"The options raised in this paper would simply reduce the level of funding available to public hospitals in favour of private health insurers, and significantly reduce the health care choices available to privately insured patients," Dr Gannon said.

"Patient choice is a fundamental feature of our health system, which includes the option for patients to use their private health insurance in a public hospital.

"There are very good reasons why a patient may choose to use their private health insurance for treatment in a public hospital.

"In regional and rural areas, there may be no other option available due to the lack of private sector services.

"Public hospitals are also equipped to handle the most complex of cases and, in many cases, may represent the most appropriate clinical setting for treatment.

"It may also be the most cost effective option for a patient, particularly in light of the growing number of private health insurance policies with exclusionary features or excesses and co-payments.

"A patient may also wish to be able choose to be treated by a doctor who they have previously seen or know.

"There are also significant benefits that flow to public hospitals.

"In a constrained funding environment, the supplementary revenue generated from private patients makes an important contribution towards the recruitment and retention of medical practitioners, improved staffing, teaching, training, and research, and the purchase of modern new equipment.

"All these resources support and enhance the delivery of high quality care to public and private patients alike."

Dr Gannon said the private health insurance lobby was guilty of blatant hypocrisy.

"On the one hand, the industry is offering and promoting public hospital-only private insurance policies, but at the same time objecting to more and more of their members opting to use their insurance in a public hospital," he said.

"Insurers and governments only have themselves to blame for patients increasingly choosing to be treated as a private patient in a public hospital.

"The private health insurers offer a bewildering array of products, with varying levels of cover and many exclusions, which often leave patients confused and shocked when they find out that common medical procedures are not covered by their expensive insurance policy.

"This is compounded by the stagnation of the indexation of the Commonwealth Medicare Benefits Schedule (MBS) and medical fee schedules offered by the private health insurers.

"On top of this, public hospital funding has failed to keep up with community demand for services, with the Commonwealth and the States and Territories guilty of under-delivering in this area for many years.

"If the Government and the private health insurers want to see fewer patients opt to use their private health insurance in a public hospital, we will need to see significantly improved long-term funding for public hospitals, private health insurance policies that meet the common medical needs of consumers, and clear articulation of the different levels of coverage so that they are easily understood by consumers.

"If there is evidence of cost shifting, or concerns that private patients are jumping the queue in public hospitals, this needs to be addressed through stronger provisions and improved compliance arrangements in future COAG Hospital Funding Agreements.

"The development of a durable solution to this issue needs to be proportionate, and considered in the context of broader private health insurance reforms and future public hospital funding arrangements.

"This will require extensive consultation, including with the States and Territories which, in relation to private patients in public hospitals, appear to have had very limited input to date."

The AMA submission is at <https://ama.com.au/submission/private-patients-public-hospitals>

MARIA HAWTHORNE

Medical Students call for clearer pathways for reporting sexual assault

The Australian Medical Students' Association (AMSA) has raised serious concerns about recent incidents of two medical students falling victim to alleged sexual assaults at Royal Darwin Hospital.

AMSA, the peak representative body for Australia's 17,000 medical students, believes that both the historical institutional culture of dominance in medicine and lack of clear reporting pathways are to blame for the ongoing problem of sexual harassment and assault.

While two doctors have been stood down over the separate incidents at Royal Darwin Hospital and clinical placements have been suspended in the department, AMSA says there is a desperate need for wider action to see an end to this behaviour.

"Unfortunately we continue to hear of stories of sexual harassment and assault of students on clinical placements. It is not uncommon; however, more often than not, it goes unreported. The stories we see in the news are only scraping the surface of a much larger systemic problem," AMSA President Rob Thomas said.

Rob Thomas believes that there are many reasons that students feel they are better off not reporting experiences of sexual harassment and stems from: a lack of satisfactory mechanisms of addressing inappropriate behavior; fear of reprisal; and a negative impact on their studies.

Recently at the request of Australia's 39 universities, the Australian Human Rights Commission has conducted a national, independent survey of university students to gain greater insight into the nature, prevalence and reporting of sexual assault and sexual harassment at Australian universities.

The Australian Human Rights Commission found that across all university settings, the Commission found that women were three times as likely as men to be sexually assaulted in 2015 or 2016 and almost twice as likely to have been sexually harassed in a university setting in 2016.

The Commission's research also revealed that most students who were sexually assaulted or sexually harassed at university in 2015 and 2016 did not make a formal report or complaint to their university.

Rob Thomas says the problems associated with medical students reporting sexual assault is exacerbated because they:



"exist in an awkward interim space between the university where their degrees are accredited and hospitals where they undertake their clinical placements."

The result is that the dual reporting structures of each institution's sexual harassment policies are often either inaccessible or difficult to enforce. AMSA believes that the solution requires a cooperative and independent process between Universities and health services.

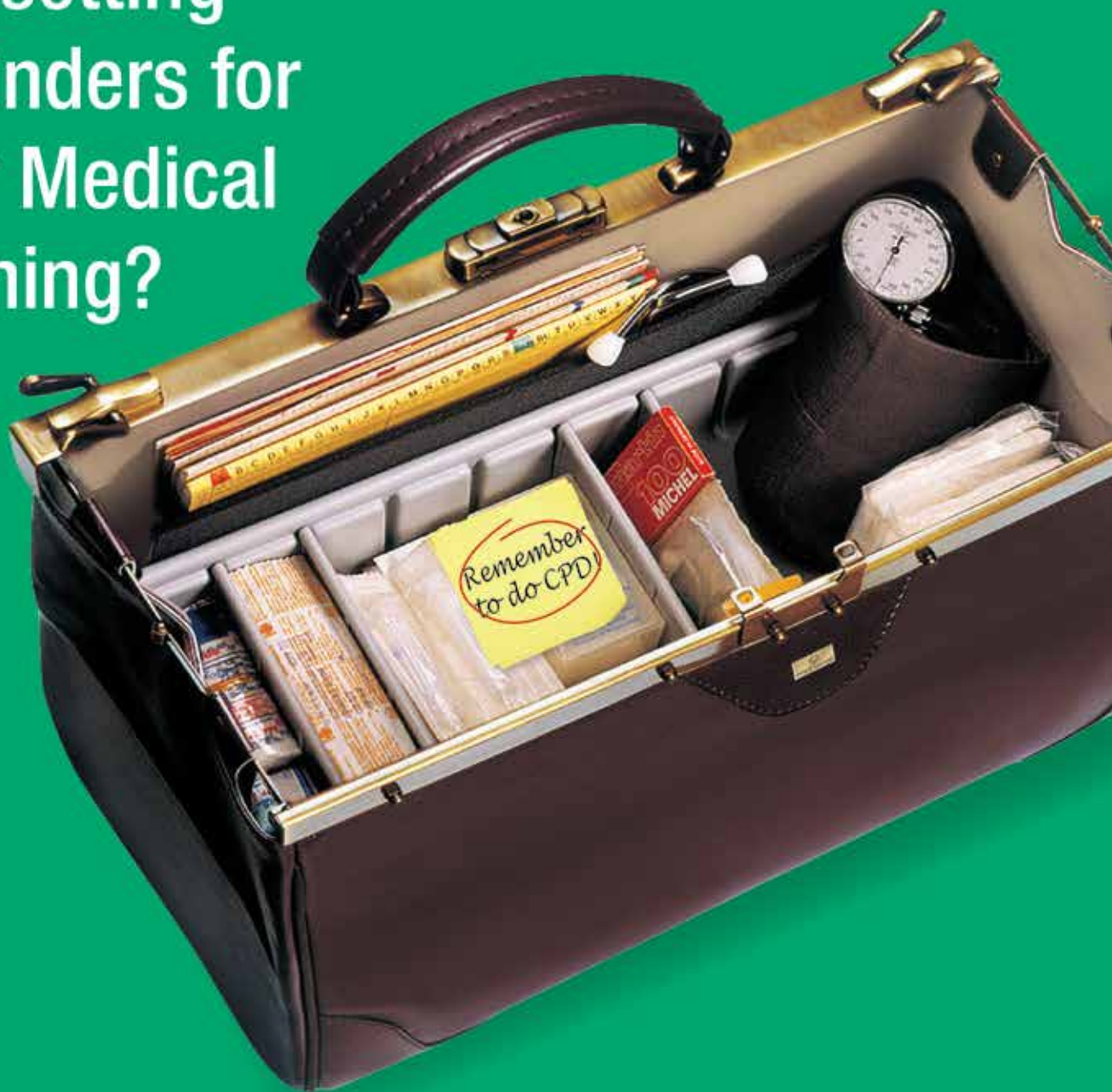
An important part of changing this side to the culture of medicine will be improved knowledge, access and effect of incident reporting structures and mechanisms for dealing with inappropriate behaviour.

According to current statistics, one in three Australian women over the age of 15 will experience physical violence, and almost one in five will experience sexual violence. Living safe and free from violence is everyone's right; reducing violence is everyone's responsibility.

The National Sexual Assault, Family & Domestic Violence Counselling Line for any Australian who has experienced, or is at risk of, family and domestic violence and/or sexual assault is: 1800RESPECT (1800 737 732).

MEREDITH HORNE

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Nation-first pill testing trial at Canberra music festival

Australia's first pill testing trial will be held at a music festival in Canberra later this year, prompting applause from drug reform advocates but concern from the Federal Government.

Revellers at the Spilt Milk festival in November will be able to have their illicit substances tested for purity and authenticity, and will have the option of safely disposing of the pills if they turn out to be not what they thought they had purchased.

ACT Health Minister Meegan Fitzharris said the testing would be provided free by the Safety Testing and Advisory Service at Festivals and Events (STA-SAFE), which is led by Harm Reduction Australia, Australian Drug Observatory, Noffs Foundation, DanceWize and Students for Sensible Drug Policy.

A similar proposal for another festival in May was denied.

Ms Fitzharris said the decision had been made after careful assessment of the STA-SAFE proposal, and of pill testing schemes in New Zealand and Canada.

"We need to find the right balance between letting young people know it's illegal to take drugs, they can be very harmful, but also being realistic because we've seen deaths at festivals, five in 2015 alone, so if that helps to keep people safe, it's worth doing," Ms Fitzharris said.

"Pill testing means young people who are considering taking drugs can be informed about what's really in their pills, and how potent they are, and it creates an opportunity to remind them of the risks before they make the final decision to take a drug."

While the AMA has always supported a range of drug harm minimisation measures, AMA President Dr Michael Gannon raised concerns that the trial might send the wrong message.

"We do need to do better but we also need real evidence that something works," Dr Gannon told *The Project*.

"And the last thing we would want to do is give people a false sense of security about taking illegal drugs cooked up in someone's bath tub."

The AMA is concerned that pill testing does not entirely remove the risks associated with taking illicit drugs, as people react to drugs differently, and may also be influenced by the amount of drug consumed, gender, age, weight and other substances consumed such as alcohol.

The announcement coincided with the launch of a new national TV and online advertising campaign cracking down on ice and party drugs, aimed at school leavers who are preparing to celebrate the end of their school education.



Federal Health Minister Greg Hunt said while the pill testing trial was a matter for the ACT Government, the Federal Government did not support it "as a matter of principle".

"Saying that any drug is okay is not okay," Mr Hunt told *Weekend Sunrise*.

"People can have a reaction to any drug. There are no safe illicit drugs, and I think that's a very important message."

Festival goers will be able to attend a medical tent and provide a sample of a drug to be tested using laboratory grade equipment for free.

After receiving the results, the person will have the option of keeping the pill or discarding it in an amnesty bin containing bleach.

Regardless of the test outcome, trained drug counsellors will warn festival goers about the health risks of illegal drugs.

Dr David Caldicott, an emergency medicine specialist and advocate for Harm Reduction Australia, said the move would stop people taking drugs and prevent deaths.

Research from overseas programs showed up to 60 per cent of people who had their pills tested went on to throw them away, he said.

ACT Chief Police Officer Justine Saunders said ACT Policing supported the program and had been actively working with ACT Government and stakeholders.

"ACT Policing will be patrolling the festival to ensure patrons enjoy the event in a safe environment," she said.

"Police will not enter the health facility that contains the pill testing station unless requested to do so by festival organisers, security staff or emergency services or in response to an emergency situation."

MARIA HAWTHORNE

Former Presidents support marriage equality



Professor Brian Owler, Dr Steve Hambleton, Professor Kerry Phelps, Dr Bill Glasson, Dr David Brand, and Professor Brad Frankum at the rally in support of marriage equality.

Seven former Federal AMA Presidents, dating back to 1998, have gone public to support the *AMA Position Statement on Marriage Equality*, and to campaign for a Yes vote in the postal ballot on the basis that marriage equality is a health issue.

The high profile medical leaders – Dr David Brand [AMA President 1998-2000], Professor Kerry Phelps AM [2000-2003], Dr Bill Glasson AO [2003-2005], Dr Mukesh Haikerwal AO [2005-2007], Dr Andrew Pesce [2009-2011], Dr Steve Hambleton [2011-2014], and Professor Brian Owler [2014-16] – all recorded personal messages for a video that is being strongly supported on social media and YouTube by doctors and medical students and members of the public.

Dr Brand, Professor Phelps, Dr Glasson, Dr Hambleton, and Professor Owler followed up their video messages by leading the AMA Doctors' Rally for Marriage Equality in Martin Place, Sydney,

on 16 September.

The former Federal Presidents and AMA NSW President, Professor Brad Frankum, took turns to tell the rally of more than 200 doctors and medical students why they supported marriage equality.

Professor Frankum said it is an issue of human rights and inclusiveness.

“But it is certainly a health issue. Discrimination in any form has health consequences,” Prof Frankum said.

Dr Glasson said we should have acceptance of diversity.

“We are a diverse country in terms of sex, religion, social ideology. And that diversity should remain and make us stronger. And so, on this issue, this will even make our country even stronger and bind us closer together,” Dr Glasson said.





Doctors and medical students rally in Sydney in support of marriage equality.

A long-term campaigner for marriage equality who was forced to marry her partner, Jackie, overseas, Professor Phelps also stressed it was a health issue, and shared her own experiences of campaigning for equality for more than 20 years.

"It's something that is important to us as a profession, and to the health professions generally. Marriage equality is an issue for ourselves, our colleagues, our patients, our friends, our families," Professor Phelps said.

The love of family and respect for colleagues were at the heart of the message conveyed by Dr Hambleton.

"This is all about all sorts of people we engage with every day. This is about friends I went to uni with. It is about our colleagues at work. It is about our neighbours. It is about our brothers and sisters. And sometimes it is about our children," Dr Hambleton said.

"My own daughter has found her life partner and hasn't been able to stand up in front of her family and friends and colleagues and make that commitment publicly."

Dr Brand said that some would argue that social issues are not something that doctors should be involved in, "which is just crazy".

"Unemployment, homelessness, education, even climate change, are all social issues that are going to have an impact on health over time. We need to see marriage equality as a really crucial, important issue for a marginalised and picked-on part of our community," Dr Brand said.

Rounding out the speeches, Professor Owler told the crowd that marriage equality is all about freedom from the negative health impacts of discrimination, bigotry, and hatred – something the LGBTQIT community is all too familiar with.

"It is about the freedom of two people to declare their love for each other, to have it celebrated by their family and friends. This is about freedom to have that love accepted by the community and for that love to be recognised under Australian law," Professor Owler said.

Dr Haikerwal and Dr Pesce could not attend the rally, which was organised by AMA NSW, but sent messages of support. AMA NSW also provided the resources and personnel to produce the video of the former Presidents' messages.

JOHN FLANNERY

Indigenous health, an AMA priority



Dr Jeff McMullen, Dr Michael Gannon, Charles Davison, and Karl Briscoe

The Federal Government needs to broaden its thinking when it comes to addressing the healthcare needs of Aboriginal and Torres Strait Islanders, because the current situation is unacceptable, according to AMA President Dr Michael Gannon.

Addressing the Australian Indigenous Doctors' Association (AIDA) conference in the Hunter Valley in September, Dr Gannon said Indigenous doctors were vital to the health of Indigenous Australians.

"The AMA has said time and again that it is simply unacceptable that Australia cannot manage the health care of the first peoples, who make up just three per cent of our population," Dr Gannon said.

"When it comes to Indigenous health, the Federal Government needs to broaden its thinking.

"For too long now, people working in Indigenous health have called for action to address the social issues that affect the health of Aboriginal and Torres Strait Islander people.

"Education, housing, employment, sanitation, clean water, and transport – these all affect health too.

"This is clearly recognised in the Government's own *National Aboriginal and Torres Strait Health Plan 2013-2023*, yet we continue to see insufficient action on addressing social determinants.

"One message is clear – the evidence of what needs to be done is with us. There is a huge volume of research, frameworks, strategies, action plans and the like sitting with governments – and yet we are not seeing these being properly resourced and funded. We do not need more paper documents. We need action.

"The AMA recognises that Indigenous doctors are critical to improving health outcomes for their Aboriginal and Torres Strait Islander patients.

"Aboriginal and Torres Strait Islander doctors have a unique ability to align their clinical and cultural expertise to improve access to services, and provide culturally appropriate care for Indigenous patients.

"But there are too few Aboriginal and Torres Strait Islander doctors and medical students in Australia."

AIDA used its conference to celebrate the organisation's 20th anniversary and had a conference theme of Family – Unity – Success.

Dr Gannon congratulated AIDA on the anniversary, noting that it had "come a long way".

He said Aboriginal and Torres Strait Islander people face adversity in many aspects of their lives.

"There is arguably no greater indicator of disadvantage than the appalling state of Indigenous health," he said.

"Aboriginal and Torres Strait Islander people are needlessly sicker, and are dying much younger than their non-Indigenous peers.

"What is even more disturbing is that many of these health problems and deaths stem from preventable causes.

"The battle to gain meaningful and lasting improvements has been long and hard, and it continues.

"I am proud to be President of an organisation that has for decades highlighted the deficiencies in Indigenous health services and advocated for improvements.

"While there has been some success in reducing childhood mortality and smoking rates, the high levels of chronic disease among Indigenous people continue to be of considerable concern.

"For the AMA, Aboriginal and Torres Strait Islander health is a key priority. It is core business.





Dr Michael Gannon addresses the AIDA Conference

"It is a responsibility of the entire medical profession to ensure that Aboriginal and Torres Strait Islander people have the best possible health.

"It is the responsibility of doctors to ensure that patients – all patients – are able to live their lives to the fullest."

This year, the AMA's *Report Card on Indigenous Health* – to be released in November – will focus on ear health and hearing loss.

Aboriginal and Torres Strait Islander people in Australia suffer from some of the highest levels of ear disease in the world, and experience hearing problems at up to 10 times the rate of non-Indigenous people across nearly all age groups.

Hearing loss has health and social implications, particularly in relation to educational difficulties, low self-esteem, and contact with the criminal justice system.

The report card will be a catalyst for Government action to improve ear health among Aboriginal and Torres Strait Islander people.

Dr Gannon told the conference that at every opportunity, the AMA highlights the issues of housing, clean water, transport, food security, access to allied medical services, and other social determinants that contribute to chronic disease and act as barriers to treatment and prevention.

And he said the AMA will continue advocating for an increase in the number of Indigenous doctors in Australia.

"The AMA has been a persistent, sustained, and powerful voice on Indigenous health for decades," he said.

CHRIS JOHNSON

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Cutting funding does not promote quality

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

Since the introduction of the Practice Incentive Program (PIP) the nature and number of incentives have been regularly reviewed and modified. The AMA has generally supported this so that the PIP remains fit for purpose as general practice and health care delivery evolves. However, in recent years, the PIP has been conveniently targeted by Government in the quest for budget savings or to fund other programs.

“With over 5,400 practices participating in the program and around 83 per cent of general practice care in Australia provided by PIP practices, the reach of PIP is extensive.”

With over 5,400 practices participating in the program and around 83 per cent of general practice care in Australia provided by PIP practices, the reach of PIP is extensive. PIP payments are a critical component of practice funding and when that funding is cut – it hurts.

In a sector that is already underfunded, changes to the PIP can mean the difference between a profit and loss. It can make it even harder to deliver quality care and it undermines within the profession the value of accreditation and the benefits of professional standards of practice.

The PIP over the last two decades has helped to drive initiatives such as:

- the computerisation of practices and active use of practice data and systems to improve the quality of patient care;
- improved vaccination and cervical screening rates;
- ensuring access to after hours services and attendances at aged care facilities;
- encouraging rural proceduralists to maintain their skills;
- ensuring medical student exposure to general practice;

- encouraging practices to employ and utilise the skills of practice nurses; and
- enhanced care for those with specified chronic conditions.

In March 2018, if all goes to plan, five PIP incentives will be replaced with a Quality Improvement Incentive. The new incentive aims to support continuous quality improvement. The incentives that will be replaced are the Quality Prescribing, Cervical Screening, Asthma, Diabetes, and the Aged Care Access.

While this new incentive has the potential in time to see general practices better rewarded for quality improvement, the penny pinching approach by Government threatens its success. Instead of investing new money in the new incentive, the Government has chosen to rob Peter to pay Paul.

Indeed, if the funding pool from ceasing incentives is anything to go by, we estimate many practices will be worse off under the Government's planned reforms, a scenario the AMA has consistently warned of.

The AMA has taken this issue up with the Minister for Health. An outcome where practices are effectively penalised for taking steps to improve quality in their practices is health policy gone mad. Practices will desert the PIP and, what started out as a good idea, will be completely undermined by the insistence on a cost neutral approach to reforms. It's a false economy that fails to recognise the benefits of further investing in quality general practice.

The introduction of changes to the PIP e-health incentive should have been an important lesson in how not to implement changes to the PIP. In the absence of new money, the Government simply tried to tack on a new requirement to upload shared health summaries to the MyHealth record. Predictably, many practices pulled out or failed to meet new targets.

Confidence in the PIP is now at an all-time low. Unless the Government rethinks its approach to the QI incentive, it risks further undermining the PIP and adding more financial pressure to an already stressed sector that is the backbone of our health system.



Rural diseases – in a league of their own

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

The very first patient I attended in this country was during my heaven-sent locum on Kangaroo Island. She came to me with razor blade cuts on her face arms, legs, and on the remnants of her work clothes with a shredded logo.

“Good Grief” whatever happened?” I thought she was in some rural gang fight where they massacred each other with razor knives. The answer? “The koala wasn’t as sedated as we thought it was!”

She was a park ranger capturing some of the overpopulated diseased koalas and treating their chlamydia ophthalmopathy and sterilising the little sweeties to prevent further over population. I quickly learnt that koalas have two thumbs per limb. Each one with razor blades on the tips.

This first patient was one of the reasons I am still working rural Australia ten years later, and that story has been told countless times to my medical colleagues in Canada.

So here is a collection of rural clinical presentations that urban doctors may never encounter and certainly won’t found in textbooks.

Twenty-one-year-old male, acute STEMI. Why? Black magic. The neighbouring village and their medicine man took umbrage to something this fellow did and the destructive spell was cast. No diabetes, hypertension or dyslipidaemia, just black medicine. Frighteningly powerful. Like voodoo and once the victim believes, the STs elevate and the troponins rise.

“I broke my toe, Doc.

“How did you do it?”

“I kicked a coconut.”

Apparently those coco ‘nuts’ land on the ground like a boat landing on its keel. Out of the ‘keel’ the root spikes downward but the coconut still looks like a lost footie, still has not formed the ‘sail’ out the top end of the ‘boat’ which will later be the tree. My advice? Don’t kick it. Australian roots are very stubborn.

“However did you get that deep knife cut into the palm of your hand?”

“I was fishing with my hand reel and I caught a croc. He got my

fish, think it was a barra, a big one”.

“You tell my son to stop painting himself with the sap of that bad tree.”

This is a sad example of self-mutilation by unhappy or self-actualising Aboriginal teens. This tree is found in the wilderness in the Top End and is well known by Aboriginal peoples. The sap of the tree burns their forearms and ritualistically they will burn their arms similar to the familiar forearm slashes we see in the city. Lots of keloids.

The babe is 27 weeks, the umbilical venous catheter is too big and so is the neonatal mask, it is four hours until retrieval gets here.

“Congratulations you have had periods now for over a year, how are you managing with the monthlies? Using pads or tampons?”

The wide-eyed response is: “What are those?”

Now doctor, how to manage women’s business in the Outback when monthly periods are a matter of shame, to be hidden and not discussed?

Mango season, get ready for the mango rash. Looks like sulphuric acid burns. You don’t even need to touch the tree, the spray from the harvest will burn you.

A typical URTI, I percussed the lung fields. Later I found out: “Don’t go to that doctor, she beats up your back!”

“I have been a teacher in the Outback for the past 6 years. I am depressed. At first it was easy to make close friendships with the other Kartiyas* here. But then they left, so I re-invested in establishing new friendships, and now they left. Now I have stopped trying. It is hopeless to keep trying.” Not exactly a job for an SSRI (selective serotonin reuptake inhibitors).

“I ate too much ants... now I got a gut ache.” I ask you doctor, what is the treatment? PPIs? H2 antagonists or a good bowel clean?

Not in textbooks. Welcome to rural Australia.

(*Kartiya = Top End Aboriginal word for us Westerners.)



Non-communicable disease: will we rise to the global challenge?

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

Non-communicable diseases, or NCDs, include heart disease, diabetes, chronic obstructive pulmonary disease, mental illness and cancer and are today's heavy hitters everywhere, displacing communicable diseases from the top ranks of causes of lost productive years of life worldwide, including in low- and middle-income countries.

"Tobacco control is the cheapest strategy and, when well done, actually makes money"

These disorders dominate our clinical agenda in Australia and other high-income countries. For example, a document entitled *The 2022 GP* from the UK College of General Practitioners neatly summarises their effects:

"Though patients with long-term conditions account for around 29 per cent of the population, they make up 50 per cent of all general practice appointments, 64 per cent of all outpatient [visits] and 70 per cent of all inpatient bed-days, as well as 70 per cent of the total health and social care spend in England. That means that 30 per cent of the population accounts for 70 per cent of spending."

Given the frequency of chronic diseases and the effort needed to manage them, it is no surprise that the search for ways to prevent them occupies the attention of those responsible for providing and paying for services, summarised in the goal to 'keep NCDs out of hospital.'

But in low- and middle-income countries, where money spent on health care is a tiny fraction of what we spend - \$60 a year per person in India, \$70 in Sierra Leone, compared with \$6000 in Australia - where these diseases are equally common as here, prevention is the only show in town for which tickets are within the budget. Tobacco control is the cheapest strategy and, when well done, actually makes money.

In regard to prevention, Australia is a hero on the international stage. According to figures from the Australian Institute of Health and Welfare, cardiovascular disease death rates fell from 831 per 100,000 people in 1968 to 183 per 100,000 in 2009, a fall of 78 per cent. Similar falls occurred simultaneously in North America and other wealthy countries. Studies of why this

has occurred usually suggest that about half the fall is due to prevention and half - more lately - follows improved care. What is especially good to see is that deaths have come down in a major way among people of working age.

Tobacco control is a central plank in prevention of heart disease and stroke, as well as cancer. Australia is the envy of the world. In 2010, only 1 in 7 (14 per cent) Australians aged 14 and older smoked daily, compared with about half of all adults in the 1950s.

Beyond tobacco the picture is mixed. Alcohol consumption has increased, and its relation to heart disease is ambiguous at low dose. The quality of our food has improved and the Australian diet has changed in ways that we all notice in the supermarket and restaurant in the direction of fostering better health, with an abundance of salt-, sugar- and fat-reduced products. The market has voted in favour of healthier food. But has this really contributed to better heart health?

Those venturing into the field of nutrition and chronic disease do so with great bravery. Food and agriculture are such huge commercial enterprises that vested interest will always intrude into policy conversations seeking to make healthy choices easy, say through clear and simple food labelling. I recall hearing how the US salt industry (yes, salt!) was lobbying hard against salt reduction in processed food. Then there is the sugar industry, the corn syrup industry and so on. It is a veritable mine field where absolutely unarguable data supporting an intervention are hard to find in one's defence.

Measuring nutritional patterns is devilishly difficult compared with tobacco consumption. Surveys of Australian nutrition patterns in the past twenty years have shown that, while malnutrition remains largely confined to people and places of poverty, the average consumption of fruit and vegetables still falls seriously short of recommended levels. For example, 85 per cent of us don't meet the recommendation for vegetables, and only 50 per cent of us eat enough fruit.

The same trends apply to our children. School-based nutrition programs show considerable promise and evidence of effect in reducing child obesity. Increasing research and knowledge on the epigenetic influences of maternal and early childhood nutrition, for example by Fiona Stanley and colleagues in Perth, on subsequent risk of obesity, diabetes and heart disease is pointing with ever more urgency to the need for action by all of us, and a serious policy response for those at high risk, such as our Aboriginal communities.



According to the UN Food and Agriculture Organisation, Australians ate about 40 kilograms of beef per person in 2007, just ahead of the US. Adding in pig and poultry, we were the third highest nation of meat eaters. Those who eschew beef have virtue on their side when one considers the contribution of beef flatus to methane levels and hence, to global warming. Prudence suggests that we should all seriously reduce our portion sizes, the amount of salt and sugar we eat and alcohol we drink, and reduce the amount of meat we consume.

Rates of people who are overweight and obese are continuing to rise in Australia, and the nation currently has one of the highest rates of obesity in the world. In 2007–08, 1 in 4 adults and 1 in 12 children were obese.

Preventing the NCDs is not adequately informed by science, in

my view.

There is much more to learn about nutrition and its consequences for NCDs and how these are mediated. In the meantime, we can take comfort from the achievements to date – that tobacco can be controlled, that our diet can be relieved of unnecessary volume, fat, salt and sugar, and that we have an increasingly effective armamentarium of medical and surgical approaches for managing these problems.

Cost is a huge constraint. If we are to take global climate change seriously we should surely turn our minds also to how we can secure a global future where the burden of NCDs is lower. Like dealing with global warming, this may cost us money to achieve an equitable global solution.

*This article first appeared in **Australian Medicine** on 15 June 2015.*

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It's time to recognise the value of medical training

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

We're all aware of the critical disconnect between graduating medical student numbers and upstream training places. Undoubtedly the training bottleneck has arrived and is one of the most significant challenges facing Australia's medical workforce. However, there's another, more insidious assault on medical training that hasn't garnered the same level of attention – the failure of activity-based funding (ABF) to recognise the value of teaching, training and research (TTR).

With ABF benchmarking used to decide what hospitals get paid per patient care episode, budgets and the need to drive efficiency in processes have become an increasingly important focus. Certainly, we must look to curb the ever-growing health spend by using our resources efficiently, however teaching and training are vital components of hospital work currently left out of the ABF model. This separation from the rest of hospital funding has led to the steady erosion of learning opportunities in preference for 'service provision'.

The implementation of ABF models in our hospitals has pushed us to see more patients in less time, leaving doctors in training with reduced time per patient and diminished opportunity for the experiential learning afforded to our seniors in their formative years. Emergency department four-hour rules, the rise of acute medical and surgical units and the ongoing push to drive down the length of admission have created fragmented patient journeys where it is rare for a doctor in training to see a patient from their acute presentation through to resolution and discharge, especially if their issues are complex or rare. Front-line emergency DiTs are increasingly being used by hospitals as a triage service with the most important question being 'destination' rather than 'diagnosis'. There is little time here for deliberation and thorough investigation, and this holds true for senior doctors just as it does juniors. Already pushed for time, hospital consultants are also asked to see more patients, increase procedural efficiency and teach the growing hordes of students, leaving little time to engage with already overburdened doctors in training in learning opportunities.

So, as we grapple with how many training places short we look to be, we must also question the quality of training we are delivering. It is a failure of the ABF model that TTR have been left out in the cold. Hospitals must have a budgetary incentive to

strive for high-quality, integrated methods of teaching, and that incentive is missing under current block-funding arrangements. Just as we have a responsibility to provide service to our patients, the health system has a responsibility to provide doctors in training with adequate teaching and training to allow us to deliver the outstanding level of patient care our society expects.

Almost five years ago, the AMA convened a meeting of relevant parties including the Medical Colleges, the Medical School Deans and Health Workforce Australia to discuss how TTR could be included in ABF structures for hospitals. That meeting identified TTR as core business for the Australian health system and argued it should be viewed as an investment in sustainable, quality health care. Recommendations were delivered to the governing body for activity based funding, the Independent Hospital Pricing Authority (IHPA). Reports from that meeting can be found here: <https://ama.com.au/article/activity-based-funding-teaching-training-and-research>

In August this year, the IHPA released a public consultation document on the 'Development of Australian Teaching and Training Classification' (https://www.ihipa.gov.au/sites/g/files/net636/f/development_of_the_australian_teaching_and_training_classification_-_public_consultation.pdf). Despite the AMA highlighting the need to incorporate TTR into the core business of hospitals five years ago, there has been little action since and we're still some way off this happening.

There is a lack of sophistication in the approach to medical training, with the current proposed classification system failing to even account for differences between prevocational and vocational trainees. The slow pace of progress fails doctors in training, our hospitals and our health system. The Council of Doctors in Training has written to the IHPA to highlight our concerns surrounding the proposed classifications for teaching and training.

As we look to properly establish medical training in the ABF system, our recommendations have changed little since 2012, and we've again stressed that it is imperative TTR are made cornerstones of our health system, not line items short-sightedly sacrificed in the drive for cost-effective service provision.



There's no such thing as a free lunch

BY PHOEBE MACINTOSH-EVANS, POLICY OFFICER, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Over the course of this year, I have been the lucky recipient of (conservatively) a dozen free lunches. They're always the same: I walk in, eyes instantly drawn to the platters of food trying to suss out the delights provided for me today. But alas, I'm initially blocked by an agile pharmaceutical representative leaping in front of me. "Let me give you one of my pens," they tell me, prompting me to then sign my name on a list to demonstrate that people are engaging with the prospect of free food. To my young medical student mind, unburdened by the tonnes of pharmacology knowledge my seniors possess, it's just a free lunch and a free pen and a free notebook, and some free knowledge.

"The medical profession is arrogant, many of us have the belief that we are immune to the bias of sponsorship, considering this attack on lunch an insult to their integrity."

And yet for years many organisations – AMSA and the AMA included – have been waging a war against what is said to be the coercive nature of pharmaceutical knowledge. But does it – could it – genuinely influence the way a doctor or a medical student were to prescribe? In the grand scheme of things, is my management of future patients going to be affected by the circumstances surrounding how I came about the sandwich I ate for lunch on Wednesday?

Fundamentally, we know advertising and sponsorship works. Personally, I know this because some of the decisions I have made are profoundly and identifiably swayed by the sponsors that I've had significant exposure to. More concretely though, a 2014 survey of students and trainees in the US identified a relationship between higher exposure to pharmaceutical marketing and reduced knowledge of evidence based prescribing, with greater likelihood to select brand name pharmaceuticals. This is repeatedly exemplified amongst doctors as well as students, with another study finding that practitioners

who saw pharmaceutical reps frequently had significantly higher total prescriptions than those visited less.

And yet despite this evidence my free lunches and the pharmaceutical sponsorship game remain unimpeached.

The medical profession is arrogant, many of us have the belief that we are immune to the bias of sponsorship, considering this attack on lunch an insult to their integrity. It seems though that the issue with pharmaceutical sponsorship is much greater than just the way it may subtly influence a doctor's clinical decision making. Research funded by pharmaceutical companies and used to support the uptake of their products are both less likely to be published and more likely to report favourably on their sponsored products than research funded by other sources.

This sort of systematic bias can exaggerate the benefits of treatments – one study looking at low quality industry funded trials found this to be an average of 34 per cent. Furthermore, trials comparing drugs always seem to favour that which is industry sponsored; with higher doses that make a drug appear more efficacious against its comparator given at doses outside of the usual range, with a rapid spikes in dosage or routes of administration that are perhaps not the most appropriate.

At a glance, these results appear compelling and irrefutable. In a climate where evidence based medicine is hailed as the key to optimal patient care amongst time-poor professionals and statistically challenged students, it is genuinely unsurprising to think that the practiced pitch of a pharmaceutical rep would leave a mark. The pharmaceutical sponsorship industry exists and thrives because this works, and it does influence our patterns of thought and the way we treat.

We need to be cautious of the way we accept offers of sponsorship; it is difficult for us to personally rationalise the genuine impact of this exposure, and it is nearly impossible for an individual to identify the changes in their prescribing. It might seem like a small, almost inconsequential impact, but over the course of our careers we see hundreds of thousands of patients. But an adverse event to any one of these patients is not worth it. The only solution? Buy your own lunch.



Medical Practice Committee welcomes new Chair

BY DR ANDREW MULCAHY, CHAIR, MEDICAL PRACTICE COMMITTEE

In my first article as the new Medical Practice Committee Chair, I think it's worthwhile reminding AMA members how much goes on behind the scenes in developing, updating and revising the AMA's policies and positions.

“As the leading medical professional group in Australia, the AMA is the first port of call – for Government, the media and the general public – on advice and opinions about health care.”

As the leading medical professional group in Australia, the AMA is the first port of call – for Government, the media and the general public – on advice and opinions about health care.

It's essential then that we are on the front foot with a ready, well-reasoned and thoroughly researched response so that we maintain our credibility and our high profile, premier position.

The Medical Practice Committee (MPC) is one of several groups within the AMA tasked with providing advice on the development of policy and advocacy strategies. MPC's responsibilities range across the whole spectrum of issues related to the day-to-day practice of being a doctor.

This scope of responsibility is therefore very broad, but here's a sample of some of the topics MPC will consider and progress over the next twelve months.

A substantial body of work will be reviewing four AMA position statements covering aged care issues such as funding models, palliative care, medical care in residential aged care facilities and community based aged care. AMA position statements act as the key reference point for the AMA in responding to new policy proposals so it's important that they are regularly reviewed to ensure they are up-to-date, relevant, and reflect current AMA thinking.

The AMA's position statement on Pathology is also due for an update, and we also plan to develop a new position statement on Diagnostic Imaging, given its recent prominence in health funding debates.

MPC provides the main oversight to the MBS Reviews. While specialist colleges, societies and associations are rightly best placed to provide expert clinical input to the reviews, the AMA has an important role in ensuring the process is transparent, evidence-based and robust. This requires ongoing scrutiny and occasionally strong AMA intervention.

MPC also steers the AMA's policy on e-health. It developed the AMA's positions and advocacy on the My Health Record – including its switch to an opt-out model – and continues to provide advice on the development of specific record types and optimising their usability for doctors.

New and emerging issues also need to be proactively considered and policy positions developed as they evolve. Genomics is an expanding field raising significant funding allocation, practice, and ethical issues. Similarly, the increasing practice of subcontracting the assessment of patient tests to off-shore, non-Australian registered health practitioners raises potential liability and indemnity concerns.

Of course, MPC also has to respond quickly to immediate questions. For example, it provides the bulk of advice on how the AMA should respond to the Therapeutic Goods Association's reform program – so far resulting in the AMA lodging nine submissions informed by MPC advice. Upcoming is a proposal that Schedule 3 medicines (pharmacist only) can be advertised as the default position, rather than as the exception under current regulations. More controversial proposals are scheduled for consultation in the coming months.

So the MPC's future agenda is full, varied and definitely challenging over the year ahead.

Finally, I'd like to thank Professor Robyn Langham and acknowledge her three year stewardship of MPC. I'm grateful that she has agreed to stay on as a committee member to continue to share her expertise and insights.



Private health insurance lobby guilty of hypocrisy

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

Private Health Insurance is a current topic of interest to Federal Council, with reviews and submissions having been presented. AMA, with its diverse views and interests, must contemplate the distinction between private medicine and the self-serving private health insurance industry, with its tax-payer subsidised high profits for local and overseas shareholder owners and (apparently guaranteed) executive performance bonuses.

It is clear that if the current arrangements were invented today, they would be laughed out of the building, from the tax-payer subsidy of very high private income to the invention of “junk” policies, borrowing the term from the financial bond markets, and much based on poorly comprehended avoidance of a taxation stick.

With falling rates of membership due to assessed high cost and poor value, and routine stiff premium increases annually, the private health insurance lobby has tried to lay much of the blame for its woes on the public hospital sector. Instead of critically examining the value of its own products, it has decided to attack the rights of patients for having the temerity to use the private health insurance for which they have paid in a public hospital.

In its efforts to be seen as doing something to address premium increases, the Federal Government has leapt on the insurers’ almost pathetic sob story and responded with the release of a paper titled: *Options to reduce pressure on private health insurance premiums by addressing the growth in private patients in public hospitals*.

As always, the landscape has changed in response to alterations in payments for healthcare. All the options raised in this paper would simply reduce the level of funding available to public hospitals in favour of private health insurers, and thus significantly reduce the health care choices available to patients possessing private health insurance, the very customers of the same private health insurers seeking to maintain their own privileged lifestyles.

Lead by expert advice from the Council of Public Hospital Doctors, the AMA has rejected out of hand any policy proposals that limit patients’ ability to use their private health insurance for treatment in a public hospital, warning that such a move would both restrict patient choice and further disadvantage public hospitals.

There are very good reasons why a patient may choose to

use their private health insurance for treatment in a public hospital. In regional and rural areas, there may be no other option available due to the lack of private sector services. Public hospitals are generally equipped to handle the most complex of medical care requirements and, in many cases, may represent the most appropriate clinical setting for best outcome medical treatment.

In a constrained funding environment, the supplementary revenue to public hospitals and salaried medical practitioners (and generally without any out-of-pocket charges to the patient, such that those practitioners accept the arbitrary scheduled payments invented by the various health insurers based on their own interests) generated from private patients makes an important contribution towards the recruitment and retention of medical practitioners, improved staffing, teaching, training, and research, and the purchase of modern new equipment.

Put simply, the private health insurance lobby can’t have it both ways. On the one hand, the industry is offering and promoting public hospital-only private insurance policies, but at the same time objecting to more and more of their members opting to use that very insurance in a public hospital. It is thus guilty of blatant hypocrisy.

The reality is that Insurers and governments only have themselves to blame for patients increasingly choosing to be treated as a private patient in a public hospital.

The private health insurers offer a bewildering array of products in the tens of thousands, with varying levels of cover and many exclusions, requiring high intelligence to be able to decipher and comprehend. On top of this, public hospital funding has failed to keep up with community demand for services, with the Commonwealth and the States and Territories guilty of under-delivering in this area for many years. This is well laid out in the AMA’s *Public Hospital Report Card* – worth another visit to digest its information.

It is little wonder then that public hospitals are choosing to promote the option for patients to be treated privately and that patients are taking it up eagerly. The answer to the Government’s dilemma is simple – fund our public hospitals properly and make private health insurers offer patients quality products that don’t leave them with unexpected “bill shock” when they are treated in a purely private system.



AMA evidence to the Inquiry into the life insurance industry

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

In September, the AMA gave evidence at the Parliamentary Joint Committee on Corporations and Financial Services' *Inquiry into the Life Insurance Industry*. The AMA, along with representatives from the Australian Health Practitioner Regulation Agency (AHPRA), the Medical Board of Australia (MBA) and the Royal Australian College of General Practitioners (RACGP) (herein 'the participants') responded to a range of questions on the interaction between doctors and the life insurance industry. Questions primarily focused on the disclosure of patient information including medical records and the implications of life insurer requests for genetic test results. Prior to the public hearing, the AMA responded to the Committee's Questions on Notice in relation to independent medical examiners.

"During the hearing, the participants raised specific concerns regarding inappropriate requests by insurance companies for doctors to hand over full patient medical records."

During the hearing, the participants raised specific concerns regarding inappropriate requests by insurance companies for doctors to hand over full patient medical records. Such a request places the doctor in a difficult position as the range of content in a patient's medical record may not be relevant to the insurance claim, may include sensitive information or may include the doctor's personal notes or 'aide-memoirs'.

In such circumstances, the doctor must decide whether to simply comply with the request for the full medical record or try to contact the patient to discuss what information, if any, the patient is willing to disclose and in what format. While this may be 'ideal' practice, doctors, particularly GPs, are often time poor and may not be remunerated for such discussions. It was also brought to the Committee's attention that a patient's medical records may contain sensitive information about their family members as well.

The participants emphasised the real risk that patients may not

fully disclose their medical history, or may forego attending a doctor altogether, for fear such information may adversely affect their insurance premiums or claims.

The participants agreed that the regulations relevant to life insurers' requests for patient information should be tightened so that insurers are only allowed to request specific, targeted information and not make blanket requests for patients' full medical records. In addition, the patient's consent to disclose their personal health information to an insurer should be recent and relevant to the issue at hand (eg. not the broad, generalised consent to release personal information that everyone gives when applying for insurance cover).

The participants agreed there should be greater public education for consumers regarding consent and disclosure of personal health information to life insurers. Further, doctors should be appropriately remunerated for having relevant consent discussions with patients.

Specific concerns were raised in relation to disclosing a patient's genetic test results to their insurer. Currently, a person applying for life insurance must disclose to the insurer any medical information, including the results of genetic tests, known to them that might impact on their application. The AMA highlighted that many genetic tests are predictive in nature and the results do not necessarily guarantee a person will develop the condition that is being tested.

Genetic tests that provide information on the risk of developing a particular condition can be extremely beneficial to a person's health care (and that of their biological family members as well) – allowing them to take greater advantage of preventive health measures, screening and lifestyle modifications. Doctors do not want patients deterred from undertaking such testing due to fears it may affect their life insurance premiums.

Although not specifically relevant to the Inquiry, the AMA advocated that doctors, in particular GPs, need more education and training in relation to providing genetic counselling, interpreting genetic test results and assessing the accuracy and validity of direct-to-consumer genetic tests (eg. those a consumer can buy online or at the chemist).

The committee is currently due to report on December 7.



Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Greater recognition and response for treating eating disorders

Federal Health Minister Greg Hunt has launched the Butterfly Foundation's National Agenda for Eating Disorders.

The Butterfly Foundation will receive an additional \$1.2 million over the next two years to roll this out nationally through the National Eating Disorders Collaboration.

The goal of the National Agenda is to ensure Australia has a national approach to help people with eating disorders and to establish a bank of information around what works, so people suffering from this disease can access the best treatment for their needs.

The Agenda was developed in consultation with Australia's eating disorders experts and those with a lived experience of an eating disorder.

Launching the National Agenda in September, Mr Hunt said that the Federal Government was committed to bringing together State and Territory governments and industry to deliver a consistent response in treating and supporting people with eating disorders.

The Government in the Budget this year announced it will provide almost \$3 million for more support and better treatment for people suffering from eating disorders.

Eating disorders not only affect an individual's relationship with food, but also body image, confidence, mental health, and overall health.

In May, Minister Hunt requested the Medical Benefits Schedule Review Taskforce investigate options for Medicare coverage for the treatment needs of those people with an eating disorder, including physical, psychological, behavioural, nutritional, occupational and social needs. The aim is to increase the skills of health professionals to identify and respond to eating disorders through a nationally consistent approach.

The Butterfly Foundation's Chief Executive Christine Morgan believes this is critical because currently the foundation believes that only 25 per cent of Australians with an eating disorder currently seek treatment.

"The Agenda addresses critical areas of health system reform and identifies the priorities needed to provide access to evidence-based multi-disciplinary treatment and dosages to any Australian with or at risk of an eating order," Ms Morgan said.

Mr Hunt also announced funding of \$1.7 million to support expansion of the 1800 ED HOPE national helpline, allowing 1800 ED HOPE's hours to be increased so it remains open from 8am to midnight seven days a week. This expansion will happen by February, 2018.

The telephone helpline is the only of its kind in Australia.

The Butterfly Foundation welcomed the support for the hotline saying they are committed to: "Ensuring there is no divide between those who can afford treatment and those who can't."

Ms Morgan said the announcement marked a milestone in Australia's recognition and response to people living with an eating disorder.

"The launch of the first National Agenda for Eating Disorders, coupled with the Minister's restated commitment to a review of Medicare to more comprehensively cover the needs of those with eating disorders, constitutes the policy realignment that has been sadly lacking to date," she said.

The Butterfly Foundation has also recently launched an Australian-first Youth Intensive Outpatient Program in Sydney, a low cost program, costing families \$120 per patient per week over the 10-week program.

The AMA expressed support for a nationally coordinated approach in order to develop effective and consistent practices in preventing and addressing the incidence of unhealthy body image and eating disorders. The AMA's position paper Body Image and Health can be found here: <https://ama.com.au/position-statement/body-image-and-health-2002-revised-2009>

Anyone needing support with eating disorders or body image issues is encouraged to contact Butterfly's National Helpline on 1800 33 4673 or support@thebutterflyfoundation.org.au

MEREDITH HORNE



Research

Calls for internet addiction to be recognised as a medical condition



Pathological internet addiction that triggers deviant behaviour on social networking sites (SNS) should be recognised as a disorder needing treatment, according to Dr Mubarak Rahamathulla, from Flinders University.

Dr Rahamathulla, a senior lecturer in social work at Flinders University has also called for more research into intervention therapies.

In Australia internet addiction is currently not recognised as a clinical disorder.

In 2008, China became the first country to declare internet addiction a clinical disorder, Internet Addiction Disorder (IAD).

Dr Rahamathulla believes that because individuals with the condition will not be clinically diagnosed, they are not offered support and treatment, which causes enormous additional psychological strain, and can lead to problematic deviant behaviours in cyberspace.

His research into general strain theory, where negative experiences in life can result in problem behaviours and deviance, finds a very high likelihood that internet addiction sufferers will vent their frustrations through problematic online

behaviours. He says this can be expressed in an anonymous way through SNS, creating social and psychological problems for other internet users and the wider community, and lead to possible crimes.

“Our research argues that individuals with internet addiction may feel victimised and so will feel compelled to engage in a range of deviant behaviours in SNS to vent their emotional strains,” Dr Rahamathulla said.

Adult respondents in the study also reported that their online sexual correspondence through SNS are adversely affecting their real-life relationships.

While monitoring and blocking deviant behaviour is possible on such social networking sites as Facebook, Instagram, Youtube and Twitter, anti-social activity can go unhindered on private mobile messaging applications such as Facebook Messaging, WhatsApp and Google Play.

AC Nielsen estimates that in 2016 Facebook subscriptions have grown to near 2 billion people, and mobile messaging applications came second to Facebook in 2015 and are still expanding. Dr Rahamathulla’s study suggests these more private one-on-one communication channels present increased opportunities for aberrant behaviour, or trigger addictions that generate negative expression.

“The rapid shift from more public social networking to private mobile messaging communications increase the frequency of SNS use, bringing with it possible psycho-social consequences of heavy use of SNS,” Dr Rahamathulla says in his latest research paper.

However, rather than blaming the internet, he says the process that leads to pathological internet needs closer examination, identification and acknowledgement as a condition needing attention.

Dr Rahamathulla reports in his research there is currently no reliable data available to deeply analyse the nature of internet addiction.

General strain theory of Internet addiction and its association with deviant behaviours in social networking sites (SNS), by Dr Rahamathulla, has been accepted for publication in the Journal of Information, Communication and Ethics in Society.

MEREDITH HORNE





Be cautious about fad gluten-free diets

Researchers from the University of Newcastle (UON) have highlighted potential risks of following a gluten-free diet, urging the community to only drastically change their eating habits if formally diagnosed with coeliac disease.

Led by Dr Michael Potter from the Hunter Medical Research Institute, a new narrative review published in the *Medical Journal of Australia* stresses the adverse effects of changing to a gluten-free diet after a self-diagnosis.

Aside from being more expensive and often challenging in a social setting, there is evidence a gluten-free diet can adversely affect human health.

The study found a gluten-free diet may negatively affect cardiovascular risk factors such as total cholesterol levels, weight gain leading to obesity, glucose intolerance and blood pressure.

UON researchers say their report raises concerns about self-diagnosis for gluten intolerance with those who incorrectly attribute adverse physiological symptoms to wheat ingestion and unnecessarily subject themselves to a gluten-free diet.

Research found that of people self-reporting gluten or wheat sensitivity, only about 16 per cent show symptoms when subjected to a clinical trial to replicate the response.

The UON research is supported by a recent American study that found evidence unnecessarily following a gluten-free diet could place you at a higher risk of developing Type 2 diabetes.

In a study conducted by the American Heart Association over the

span of 30 years, researchers found that out of those eating 12 grams or less of gluten per day, the ones who ate most gluten had a lower Type 2 diabetes risk.

The American Heart Association believes that gluten-free diets have become popular for people without these conditions, though there is lack of evidence that reducing gluten consumption benefits long-term health.

"Gluten-free foods often have less dietary fiber and other micronutrients (such as vitamins and minerals), making them less nutritious, and they also tend to cost more," said Dr Geng Zong, a Research Fellow at Harvard School of Public Health.

"People without celiac disease may reconsider limiting their gluten intake for chronic disease prevention, especially for diabetes."

Coeliac Australia estimates that one in 70 Australians have coeliac disease, but 80 per cent are undiagnosed and symptoms of coeliac disease vary considerably.

Coeliac Australia warns there are a number of tests and treatments for allergy, intolerance and coeliac disease that are used in the absence of any scientific rationale. These tests and treatments have been shown to be unreliable when subjected to careful study.

Unproven testing methods for coeliac disease provide misleading results, delay correct diagnosis and lead to unnecessary and ineffective treatment cautions Coeliac Australia.

MEREDITH HORNE



Don't let her drink dirty water

malaria, typhoid, dysentery, cholera, diarrhoea, intestinal worm infection, ... dirty water can kill.

6,000 children are dying every day – and it's because they don't have clean water. So they're forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

The good news is, problems like dirty water can be solved. You can help children access clean water through World Vision's Water Health Life program by providing practical and effective solutions.

From \$39 a month your support will help drill boreholes, protect water sources and provide health and hygiene training. You'll be helping communities to make long-term changes that ensure a clean water supply and basic sanitation.

Stop dirty water killing children, support Water Health Life:
visit worldvision.com.au or call 13 32 40.

Water Health Life

Basic Needs. Permanent Solutions

World Vision Australia is a Christian organisation pursuing freedom, justice, peace and opportunity for everyone in this world. ABN 28 004 778 081. RFL 3199 C10313 A981 R27



United Hatzalah and the success of the ambucycle



On a hot August night in Jerusalem, a motorcycle with flashing lights sped past our outdoor dining table. It looked like an emergency pizza delivery. The motorcycle was actually a United Hatzalah motorcycle ambulance, or “ambucycle” as they are known.

The story of this service and how it originated is an example of innovative emergency health care that some other cities around the world are now adopting.

“As a teenager, Eli Beer witnessed a terrorist attack on a domestic bus and saw traditional ambulances stuck in urban traffic, arriving too late to save some victims.”

United Hatzalah is a not-for-profit entity that provides emergency medical care to all people regardless of ethnicity or religion. It was founded by Eli Beer, a former Jerusalem ambulance officer.

As a teenager, Eli Beer witnessed a terrorist attack on a domestic bus and saw traditional ambulances stuck in urban traffic, arriving too late to save some victims. Anyone who has been to a major city, especially in the Middle-East, Asia and the sub-continent which were not designed for the influx of millions of motor vehicles, buses and trucks, would be familiar with the type of traffic chaos that can leave ambulances stuck in ‘jams’.

At a young age, Eli Beer began what is now United Hatzalah, a community-based medical responder model. He didn’t invent this concept, but he was the first person to turn it into a free national model. United Hatzalah services include a fleet of specially equipped “ambucycles” that are fitted with almost everything a traditional ambulance carries except for a backboard, stretcher, chair, and bed. Ambucycles have an average response time of three minutes. The 3000 plus medics operating these motorcycles are now Israel’s primary first responders for most medical emergencies. The medics are all volunteers and comprise Jews, non-Jews, Muslims and Christians.

The ambucycles can easily maneuver through Jerusalem’s maze of streets and crowded pedestrian walkways, and even use non-traditional paths to reach emergencies. They use an advanced GPS tracking technology – Moskowitz Lifecompass – that is now the basis for an app that alerts security forces when a person is in distress or kidnapped.

The advanced GPS tracking is vital because Jerusalem has a new light rail system that prevents motor vehicles from easily accessing sections of the city. Traditional ambulances are forced to negotiate narrow streets, illegally parked vehicles and cannot get into small thoroughfares and the like.

The free services don’t just use ambucycles, they now have ambubtractors, first responder push bicycles, an ambuboot and even jet skis that enable medics to reach patients, regardless of the environment, location or terrain.

From what I’ve read, the United Hatzalah community-based responder model is now being used in 10 countries, and there are plans to set up an operation in India soon. They say that their services, including their applications and technologies, can be downloaded by anyone for free. They also provide free transport to hospitals.

Since their inception, United Hatzalah claim to have treated over two million patients “and never once did any of them receive a bill for services” said their founder.

SIMON TATZ
AMA DIRECTOR PUBLIC HEALTH

The world is running out of antibiotics

The World Health Organization has confirmed in a new report that there is a serious lack of new antibiotics under development to combat the growing threat of antimicrobial resistance.

The report, *Antibacterial agents in clinical development – an analysis of the antibacterial clinical development pipeline, including tuberculosis*, reveals there is a serious lack of treatment options for multidrug- and extensively drug-resistant *M. tuberculosis* and gram-negative pathogens, including *Acinetobacter* and *Enterobacteriaceae* (such as *Klebsiella* and *E.coli*).

This is alarming because these pathogens can cause severe and often deadly infections that pose a particular threat in hospitals and nursing homes.

Most of the drugs currently being developed are modifications of existing classes of antibiotics and are only short-term solutions. The report found very few potential treatment options for those antibiotic-resistant infections. This includes drug-resistant tuberculosis which kills around 250,000 people each year.

Dr Tedros Adhanom Ghebreyesus, Director-General of WHO, believes antimicrobial resistance is a global health emergency.

“There is an urgent need for more investment in research and development for antibiotic-resistant infections including TB, otherwise we will be forced back to a time when people feared common infections and risked their lives from minor surgery,” Dr Tedros cautioned.

WHO has also identified 12 classes of priority pathogens which can cause common infections such as pneumonia or urinary tract infections but are increasingly resistant to existing antibiotics and urgently in need of new treatments.

The report identifies 51 new antibiotics and biologicals in clinical development to treat priority antibiotic-resistant pathogens, as well as tuberculosis and the sometimes deadly diarrhoeal infection *Clostridium difficile*.

Among all these candidate medicines, however, only eight are classed by WHO as innovative treatments. There are also very few new oral antibiotics being developed, despite these being essential formulations for treating infections outside hospitals or in resource-limited settings.

“Pharmaceutical companies and researchers must urgently



focus on new antibiotics against certain types of extremely serious infections that can kill patients in a matter of days because we have no line of defence,” explained Dr Suzanne Hill, Director of the Department of Essential Medicines at WHO.

To counter this threat, WHO and the Drugs for Neglected Diseases Initiative (DNDi) have set up the Global Antibiotic Research and Development Partnership (known as GARDP), with Germany, Luxembourg, the Netherlands, South Africa, Switzerland and the United Kingdom of Great Britain and Northern Ireland and the Wellcome Trust recently pledging more than €56 million.

“Research for tuberculosis is seriously underfunded, with only two new antibiotics for treatment of drug-resistant tuberculosis having reached the market in over 70 years,” Dr Mario Raviglione, Director of the WHO Global Tuberculosis Programme said.

WHO believes that new treatments alone will not be sufficient to combat the threat of antimicrobial resistance, and is developing guidance for the responsible use of antibiotics in the human, animal and agricultural sectors.

The AMA believes the over-prescribing of antibiotics is a threat to the wellbeing of Australians as we remain one of the highest consumers of antibiotics in the industrialised world. The AMA also encourages antibiotics to be responsibly prescribed.

MEREDITH HORNE

TO THE EDITOR



If it's all the same with you, I'm happy with my doctor thanks

I recently had my two scripts filled at Amcal and was a bit taken back by the lady behind the counter when I picked them up. She asked me quite a few questions in an aggressive manner including:

Do you take any other medications?

Are these the only two?

Are you sure?

How is your blood pressure?

Do you find the medication works?

Do you get your cholesterol level checked?

Do you get blood work done?

While I am sure the woman meant well, I don't know her from Adam. I do not care to discuss my health in a public place such as a busy chemist store with gawd knows who in hearing distance. She didn't introduce herself, was she a pharmacist? I was beginning to get the feeling I was in some sort of sales pitch.

When she commented that not all doctors in this area are vigilant with ordering blood work, I stopped the conversation and

said that I go to a group of very good physicians who oversee my health care.

I found this bombardment of questions from an unknown person confronting and inappropriate. My concerns include:

1. Lack of privacy.
2. Lack of introduction – what are her credentials?
3. Insulting to the medical community in this area.
4. Some people may find themselves talked into getting unnecessary expensive lab work done – their signage for HbA1c testing and renal function offers was very prominent.
5. The aggressive tone of her questions. Perhaps I was wearing a stupid face and it took answering three questions to convince her that I know how many pills I take a day.

There is a huge difference between a medical degree and one in pharmacology. I feel that Amcal is overstepping the line.

Karen Henderson
Kempsey, NSW





The end of the road?

BY DR CLIVE FRASER

1990 Subaru Brumby

In human years, 27 is rather youthful and still regarded as a young adult.

But in the motoring world, 27 years old is geriatric and well past your automotive use-by-date.

The average age of our Australian automotive fleet is 10.1 years.

Our Tasmanian cousins obviously take better care of their cars with their fleet averaging 12.6 years.

The rougher roads and longer distances of the Northern Territory shorten the life of their vehicles which on average last only 9.1 years.

So what was I doing driving another ageing Subaru that left the Ōta Japanese production line in 1990.

Well a hint of what was happening was contained in my recent column about the iconic Subaru Brumby.

Readers may remember that the collectability of this model was 'on trend' following my last column.

A colleague has just snapped up another Brumby (his third) and it was my pleasure to drive it to its final resting place on a remote Central Queensland cattle property.

As it was unregistered and 400 kilometres away from its new home there was that small problem of: "How do you get it there?"

Transporting it on the back of a flat-bed truck would have cost more than my colleague had paid for the car.

But with an \$85 Queensland Transport 'Permit to Move' certificate we were off and running.

One of the conditions of that permit is that the car must travel directly to the new address and I was just a bit worried when I over-shot a rendezvous with the support vehicle and briefly headed back a kilometre or so towards where I had just come from.

I've got to say that driving 400 kilometres without number plates was a very un-nerving experience.

I expected to be stopped by every police officer who passed, but they all seemed glued to their Automatic Number Plate Recognition (ANPR) screens which meant that without registration plates my vehicle glided past like a ghost in the night.

ANPR is designed to detect licence plates that have been



cancelled, reported as stolen, or whose owners are wanted in connection with a crime or have a history of drink or drug-driving.

Without any number plates I could apparently rest assured that I would remain anonymous and go un-noticed.

Spending six hours in the Subaru's cabin did give me plenty of time for reflection and exploration.

I noticed that there were quite a few knobs missing from the dashboard, but I found every one of them conveniently rolling past my feet on the floor or under the seat.

The only thing that didn't work in the Subaru was the air conditioning which would never be used on the farm anyway.

The old Subaru could still comfortably cruise at 110 km/h and still returned 7.6 l/100km, or 37 mpg in the old money.

Not bad for a motor that had done 282,000 kilometres.

As I drove off the tarmac for the very last time it was just a little like saying goodbye to a child leaving home.

From now on there would be no more road rules, RACQ or road-side assistance.

But once I was through the farm gate I felt the little Subaru surging ahead as if it had found a new lease on life.

It was, after all, not really the end of the road.

But just the start of another journey.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

Tommy thrills at the Opera House

BY CHRIS JOHNSON



Australia has no greater guitarist than Tommy Emmanuel. Full stop. End of story.

In fact, he is probably the best guitarist in the world.

In his hands, he can make a single acoustic six-string sound like an orchestra.

And he can make an entire audience stop breathing.

So it is only fitting that one of the world's finest musicians should perform on the stage of one of the world's finest concert halls.

Tommy Emmanuel and the Sydney Opera House belong together.

It is not the first time Tommy has played the Opera House and hopefully it won't be his last.

But, as he said during his September 30 concert, he always knew that was where he wanted to be.

"I couldn't have imagined how it would be possible that I would one day play in the Opera House," he said.

"But I did imagine it. As a ten-year-old boy I saw myself here."

The guitar has been Tommy Emmanuel's life and his dedication to the instrument has certainly been rewarded.

If the long gone Mississippi bluesman Robert Johnson really did sell his soul to the devil in the 1930s in exchange for better guitar skills, then Tommy Emmanuel must have done a deal with a more powerful entity – because his prowess on the instrument is truly out of this world.

Tommy has thrilled audiences across Australia and around the globe with his fast and furious picking, his gentle meanderings over the fret board and his sheer brilliant musicianship.

These days he resides in Nashville, Tennessee but he regularly returns to Australian shores to the delight of home grown audiences.

His most recent appearance at the Sydney Opera House was Tommy Emmanuel at his outstanding best.

His blend of classy instrumentals and the occasional song he put his voice to (he doesn't sing a lot but he sings really well), worked a treat.

So did the mix of styles he chose to perform.

From the traditional old-world *Deep River Blues*, to *Guitar Boogie*, to a jaw-dropping Beatles medley, to a wealth of his original tunes, the concert was mesmerising from start to finish.

Tommy uses the whole guitar, to make it percussive as well as melodic. The sounds he draws out of his instrument are amazing.

As always, Tommy gave more than a passing nod to his hero the late Chet Atkins.

He played a few of Atkins' numbers to honour the man who gave Tommy one of his own greatest honours.

In the 1990s, Chet Atkins named Tommy Emmanuel a Certified Guitar Player – a formal recognition Atkins gave to only five people.

Tommy uses the CGP honorific with pride. He earned it. He is as proud of that as he is the other letters after his name – AM, for being named a Member of the Order of Australia in 2010 for services to music.

On this tour, Tommy brought with him another CGP, Nashville's Steve Wariner, who not only opened the show but returned to join Tommy onstage for a few numbers during the main act.

Together, the duo played a chillingly beautiful rendition of *Wichita Lineman*, in tribute to the recently passed Glen Campbell.

But for more than two hours it was Tommy Emmanuel standing (and sometimes sitting) alone on the stage of the Opera House. Alone with his guitar. The world at his fingers.



Brennan Wines – from a New York state of mind

BY DR MICHAEL RYAN

1



Family enterprises always ooze passion with artistic flare, dutiful care of the end product and boundless enthusiasm.

The Brennans have excelled in these areas of winemaking since Murray Brennan, the father, purchased a landholding in 1994. Originally from the 'foreign region' of Auckland, and an oncologist, Murray had been smitten by the Central Otago's rugged beauty - particularly the wine potential of Gibston Valley.

There, the high quality fruit from the hand-planted, handpicked vineyards was sold to another high quality producer, Peregrine Wines. But then Murray travelled to the United States to expand his training in oncology. While there, he met and married a New Yorker and his son, Sean, was raised in the US. Eventually, in 2006, Murray returned from his overseas sojourn to take up the position of winemaker.

Sean had worked in wine retail in New York, and had also helped out with some in both the US and Australia. He gained his vinous university degree from Roseworthy in Adelaide. Two years of working in a relatively cool climate with significant grape diversity stood him in good stead for his Otago return.

The Otago vineyard is surrounded by some iconic yet collegiate neighbors. Vali Wines and Mt Rosa are a stone's throw away. The soils in the region are alluvial with glacial schist. These features can add minerality to already complex flavours.

Pinot Noir is dominant, taking up eight of the 10 hectares of planting. Other varieties include Pinot Grigio/Gris, Chardonnay, Riesling, Muscat, Gewürztraminer and Otago's only Tempranillo.

Sean is a fanatic in the vineyard. The "off season" is still a busy time, with attention to detail and maintenance that will give next vintage its best chance to shine. All grapes are handpicked and the sorting process begins in the vineyard as individual bunches are directed into different pathways that will ultimately result in a wine of high quality.

Having had a predominately New York upbringing, it is easy to sense the American influence. New York itself is about being big, not gross, individual but not gaudy,

and full of confidence. In general, the wines have great fullness of fruit, rich flavors and robust structure.

The philosophy of slow but deliberate growth will steer Brennan Wines into a sound future. The first US exports have begun. A standalone Riesling will be released. Zinfandel is being planted - all inspired by that Hudson River line.

WINES TASTED

1. 2015 Brennan B2 Trio Gibston

Light green to yellow colour. White peach, some rose petals, grassy notes with hints of Chinese 5 spice. Fresh fruit flavor on the anterior plate with mid palate acid. Plush aromatic wine to have with white Castella.

2. 2015 Brennan B2 Pinot Noir Rose (70% Pinot Noir, 30% Tempranillo)

Spicy cherry notes with a hint of bramble. Fresh, smooth fruit flavors that ebb and flow. Supported by subtle tannins that allow the wine to pair with a range of foods such as chicken mushroom vol-au-vent.

3. 2015 Brennan Tempranillo

Dusky red in color. Youthful, flirtatious nose of dark cherry fruits, spicy plums and hints of earthy florals. Ample fruit flavors with white pepper spices. Medium tannin structure. Have with some mild Sopressa

4. 2015 Brennan B2 Pinot Noir

Dark red in color. Powerful bouquet of dark berry fruits, spicy savoury notes, with secondary floral herbal nuances. Powerful fruit ascends on the palate and is sustained by masculine grippy tannins. An excellent wine with duck and abalone risotto.

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