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Let's improve Indigenous ear health

Launching the 2017 AMA Indigenous Health Report Card, p6

INSIDE

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In this issue

Thank you from the Editor

As we come to the end of my first full year as the Editor of *Australian Medicine*, I would like to thank all of our writers, photographers, contributors, designers and printers who have made the task of producing this magazine such a success. Everyone's contribution is greatly appreciated. I would also like to thank all of *Australian Medicine's* readers. May you all enjoy a relaxing year's end. *Australian Medicine* will continue to file stories online, but our next edition will not be until February 2018. See you then. Merry Christmas. Happy Holidays.

Chris Johnson

Cover: Dr Michael Gannon and Minister Ken Wyatt launching the 2017 AMA Report Card on Indigenous Health.

The wide world of AMA advocacy

BY **AMA PRESIDENT DR MICHAEL GANNON**

As I launched the latest AMA Indigenous Health Report Card with Indigenous Health Minister Ken Wyatt recently – in a week when the AMA was featuring prominently in the media due to our advocacy on asylum seeker health, euthanasia, and other issues – I had cause to reflect on the breadth and depth of AMA policy and lobbying.

I am now entering the final six months of my two-year term as national President. It is quite remarkable the number and variety of issues that I have been called to comment on – to lead on – as the head of one of Australia's highest-profile and most respected professional associations and lobby groups.

It is a rewarding and satisfying role that has been filled admirably by my predecessors as President, and no doubt by those who will follow me.

There is no other organisation in the health and medico-political sectors that can cover social and health topics from hospital funding to vaccination to IVF to primary care to same sex marriage to the wellbeing of asylum seekers in our care on Manus Island.

Governments look to us for policy guidance, the media seeks us out for opinion, and the public expects us to provide commentary, common sense, evidence, comfort, and reassurance.

AMA leadership in policy and advocacy carries much risk and responsibility. We must often walk a fine line. It is not in our interests to over-reach on any issue. Much of our work takes place in private, behind the scenes. We do what is necessary to get the best result for the people we represent. Our goal is always about substance - getting results from careful, skilful, and quiet diplomacy and negotiation. It is not about making a noise.

AMA advocacy covers many areas, but there are important boundaries. There needs to be a clear health component for the AMA to speak out. And all public commentary must be based on established AMA policy, which is developed with intellectual rigour and careful consideration of the evidence – reflecting the needs of our members, our profession, and our patients.

Our evidence-based policies and positions do not always satisfy everyone. That is not possible.

In recent times, we have witnessed lively discussions within our membership – and the broader community – about the major political and social issues of marriage equality, asylum seeker health, and euthanasia.

It is refreshing that the internal and external debates around AMA policy have been largely respectful and honest. These issues all have human health at their core, and we have advocated accordingly – with evidence and policy built on extensive consultation.

Not everyone has agreed with us or supported us. But we have put forward our case, and acknowledged the views of others.

This style of AMA advocacy extends to all our work.

We have been strongly engaged in the ongoing Government reviews of the Medicare Benefits Schedule (MBS), private health insurance (PHI), and after-hours primary care.

We are in the middle of the negotiations around public hospital funding, mandatory reporting, the Health Care Homes, the MyHealth Record, and medical indemnity.

The AMA remains a proud advocate on Indigenous Health with our Report Card and Taskforce, and key role in Closing the Gap.

We are at the forefront of influencing reforms in mental health, rural health, preventive health, women's health, child health, global health, medical training and workforce, aged care, and palliative care.

Almost daily, the AMA is asked to comment on matters of the day. These include tobacco and e-cigarettes, methamphetamine abuse, obesity, nutrition, alcohol and drug abuse, domestic violence, concussion in sport, exercise, climate change and health, air quality, tick-borne diseases, cosmetic surgery, medical tourism, the upscheduling of codeine, task substitution, and bullying and harassment in the medical profession. And the list goes on.

The AMA's policy book is thick, but it is full of facts. It is full of evidence.

Our advocacy is broad, bold, and ongoing. And it matters.

I wake up every day so proud that I am a doctor. I am very proud to be your President. The past 18 months have been exciting, and sometimes daunting. I look forward to continued achievement and success over the next six months. There is still so much to be done to keep our health system delivering for the Australian people.

I promise to continue to work tirelessly on behalf of you and your patients. You might catch me with the phone off temporarily at the Test matches in Perth and Melbourne.

On behalf of the Federal AMA, I wish you all a safe, happy and healthy Christmas and a relaxing summer holiday period. I hope that you get some rest. You deserve it.

The year ahead: A year of promise?

BY **AMA VICE PRESIDENT DR TONY BARTONE**

It certainly has been a very busy and eventful year wherever you look in the arena of medico politics. This against a backdrop of increasing nervousness and instability up on the Hill and the possibility of an earlier than planned federal election adding intense flavour. Indeed, an election is becoming increasingly more likely with each new breaking news story.

Currently, and in the last few months especially, a number of issues continue to require persistent and intense lobbying and will do so for the foreseeable future.

Consensus of the States on the vexed issue of mandatory reporting is one such issue which continues to require intense advocacy. It seems that in many jurisdictions the penny just has not yet dropped, failing to realise the significant barrier it poses to doctors seeking help at an earlier point in their condition. Agreement between States and Territories is crucial for a national framework consistency and for the health and well-being of all doctors.

The up-scheduling of codeine also is proving difficult to reach jurisdictional consensus. Increasingly we are finding ourselves defending the actions of an independent regulator, the Therapeutic Goods Administration, in removing codeine form the over-the-counter shelves; a decision based solely on evidence regarding efficacy, safety and the threat to patients in terms of the significant risk of codeine dependency and harm.

With so much misinformation in the market place and media the battle for the hearts and minds of patients and consumers has been difficult but may be turning our way as we speak, but the politicians are yet to be firmly convinced. It is disappointing that an argument about health safety, and efficacy of pain relief and management, is being so difficult to mount against a backdrop of vested commercial interests.

Medical indemnity remains on significant watch for the AMA, which has lodged its submission to the First Principles review into the Indemnity Insurance Fund (IIF).

The MBS reviews continue at, some might say, a glacial pace. Although supportive of the thrust and principles of the review there are a few worrying concerns especially in the extent or relevance of the clinical consultation process and remains an area of extremely close scrutiny.

The Medical Workforce Committee has been clear in highlighting the workforce issues. Lack of appropriate training opportunities in regional and remote Australia continues to be a significant dilemma and one needing further intensive work and collaboration.

We continue to be a strong voice in the private health insurance debate. We argue that private health insurers need to improve the value of the product they are offering Australians. They must offer clear, easily understood policies that give Australians security in the knowledge that they will be covered at their time of need. Insurance needs to cover the items that people expect it will; such as mental health and pregnancy.

Most importantly, insurers need stop blaming others for their problems.

Aged care is clearly another area desperately crying out for direction. A solution is needed to the lack of quality care options for many senior Australians requiring permanent care. Any solution will need to be multi-pronged and structured. Our submission to the aged care inquiry argues that medical practitioners should be included as part of the aged care workforce which will significantly struggle to meet the rapidly growing demands and needs of this sector and in the process; ensure residents of aged care facilities are receiving quality care.

Additionally, aged care needs funding for the recruitment and retention of registered nursing staff and carers, specifically trained in dealing with the issues that older people face. The system also needs an overarching, independent, Aged Care Commissioner that provides a clear, well-communicated, governance hierarchy that brings leadership and accountability to the aged care system.

The obvious other large area of concern and work for the coming year is the public hospital system and its funding. Appropriate and timely access to public hospitals, especially to the disadvantaged and those who cannot afford care otherwise, is fundamental. Funding must be commensurate with the need to ensure this. The Review can't be used as a stick to punish poor performers.

We have been active in dealing through many issues surrounding the implementation of Health Care Homes during the early phase of the trial. We were crucially active in calling for the delay to the implementation of the trial in the face of lack of time and resources to prepare for the significant change required. This is more than just an alternative payment mechanism for primary

AMA – a voice of many

BY AMA SECRETARY GENERAL ANNE TRIMMER

Elsewhere in this edition of *Australian Medicine* is a report on the November meeting of Federal Council. One question often asked of the Federal AMA is to explain how policies are developed and position statements adopted. It can be seen from the report that Federal Council deals with some weighty issues. Major topics at the most recent meeting included a discussion to shape AMA advocacy on transparency of medical fees and a briefing on the roll out of the NDIS.

Policies and position statements are developed through the councils, committees and working groups of Federal Council, and are brought to the Council for debate and adoption. Many policies are subject to vigorous debate. Once they are adopted they provide guidance for the public commentary of the President and Vice President.

At its most recent meeting Federal Council adopted unanimously a resolution asking questions of the Federal Government about the management of the health of the asylum seekers and refugees on Manu Island. Issues such as this attract a lot of correspondence from members and non-members alike who see the AMA as the natural voice for its leadership of doctors.

This is consistent with the AMA's mission of leading Australia's doctors and promoting Australia's health. I outlined in my last column the strategic objectives agreed to by the Federal AMA Board for the period 2018-2020.

Among those objectives is a commitment to member engagement. In keeping with that the Federal Council and the Board have resolved to change the way National Conference is structured in 2018 to open the floor of the Conference to debate on issues of interest and relevance to members and the broader community.

The middle day of the Conference will be given over to debate on issues that will be canvassed with the State and Territory AMAs and the Practice Group Councils within Federal AMA. Under the AMA's Constitution the role of National Conference is advisory only. However these debates will provide an opportunity for direct input into policy development.

The debates will be coupled with the traditional soapbox session on the final morning of the Conference that precedes the election of the next Federal President and Vice President.

The change in structure will facilitate participation not only by the appointed delegates from the State and Territory AMAs, Federal AMA Practice Groups and Federal Council, but also those members who register to attend.

On a personal note, I have advised the Federal AMA Board of my decision not to renew my contract when it expires in August next year. The Board has commenced the search for my successor with advertisements published in early December. There is still plenty to do before then so it isn't time for farewells yet!

The year ahead: A year of promise?

care. Ultimately it will be about ensuring improved quality outcomes for patients with an ever increasing burden of chronic and complex disease. However it will need time, support and leadership to achieve the necessary endpoints.

E-Health is an area of significant implementation as it enters the new strategic direction of 'opt out'. Ongoing reports about privacy concerns are unfounded. But there is a need for better communications and education. E-health is a vital enabler for quality clinical outcomes and this current project is too important to fail. It must be adequately and appropriately resourced and supported, to ensure that its useability remains paramount

Many, perhaps most, of these issues will continue to be fought for and supported long and hard in 2018. The Minister has signalled a number of waves of reform and no doubt the 2018/19 budget is well into the early planning stages. It might be too much to ask for but now, more than ever, a visionary long-term strategy for health is required.

It will need to be one that meaningfully rewards prevention activities with no shortage of issues and problems, especially in primary care. Smoking, alcohol, obesity and mental health preventative care activities are all underfunded and crying out for more money.

An early election, however, could make brave, long-term, visionary policy extremely unlikely. This will no doubt require more strategic and intensive engagement with current and future policy makers to ensure that our politicians and policy makers are not just 'kicking the can down the road' in 2018.

Coordinated approach needed to improve Indigenous ear health

Ear health is the focus of the 2017 AMA Indigenous Health Report Card, with doctors calling on all Governments to works towards ending chronic otitis media.

Releasing the Report Card in Canberra on November 29, AMA President Dr Michael Gannon challenged the Federal Government and those of the States and Territories to work with health experts and Indigenous communities to put an end to the scourge of poor ear health affecting Aboriginal and Torres Strait Islanders.

The Report's focus on ear health was part of the AMA's step by step strategy to create awareness in the community and among political leaders of the unique health problems that have been eradicated in many parts of the world, but which still afflict Indigenous Australians.

"It is a tragedy that in 21st century Australia, poor ear health, especially chronic otitis media, is still condemning Indigenous people to a life sentence of hearing problems – even deafness," Dr Gannon said.

"Chronic otitis media is a disease of poverty, linked to poorer social determinants of health including unhygienic, overcrowded conditions, and an absence of health services.

"It should not be occurring here in Australia, one of the world's richest nations. It is preventable.

"Otitis media is caused when fluid builds up in the middle ear cavity and becomes infected.

"While the condition lasts, mild or moderate hearing loss is experienced. If left untreated, it can lead to permanent hearing loss."

Dr Gannon said that for most non-Indigenous Australian children, otitis media is readily treated, but for many Aboriginal and Torres Strait Islander children, it is not.

Estimates show that an average Indigenous child will endure middle ear infections and associated hearing loss for at least 32 months, from age two to 20 years, compared with just three months for a non-Indigenous child.

The Report Card, *A National Strategic Approach to Ending Chronic Otitis Media and its Life Long Impacts in Indigenous Communities*, was launched in Parliament House by Indigenous Health Minister Ken Wyatt

Mr Wyatt commended the AMA on its 2017 Report Card.

Over the past 15 years, he said, the AMA's annual Report Card on Indigenous health has highlighted health priorities in Australia's Aboriginal peoples and communities.

"Reports can be daunting and they can be challenging," the Minister said.

"But above all, they can be inspiring."

Mr Wyatt said it was a tragedy that the most common of ear infections and afflictions were almost entirely preventable.

Yet left untreated in Indigenous children, they had lifelong effects on education, employment and well-being.

"It's not somebody else's responsibility. It's the responsibility of all of us," he said.

"Hearing is fundamental."

Shadow Indigenous Health Minister Warren Snowdon also commended the AMA on its report.

He said the Government and the Opposition worked collaboratively on Indigenous health issues.

"We're not interested in making this a point of political difference, we're interested in making it a national priority," he said.

Green's Indigenous Health spokeswoman Senator Rachel Siewert welcomed the Report and stressed the importance of addressing Indigenous health issues.

Australia's first Indigenous surgeon, ear, nose and throat specialist Dr Kelvin Kong, who is also the Chair of the Australian Society of Otolaryngology Head and Neck Surgery's Aboriginal Health Subcommittee, received the report with enthusiasm.

He said cross-party support on this issue had been "phenomenal".

Dr Gannon said the AMA wants a national, systematic approach to closing the gap in the rates of chronic otitis media between Indigenous and non-Indigenous infants and children in Australia.

The Report calls on Governments to act on three core recommendations: namely, that a coordinated national strategic response to chronic otitis media be developed by a National Indigenous Hearing Health Taskforce under Indigenous leadership for the Council of Australian Governments (COAG); that the wider impacts of otitis media-related developmental impacts and hearing loss, including on a range of areas of Indigenous disadvantage such as through the funding of research as required are addressed; and that attention of governments be re-directed to the recommendations of the AMA's 2015 Indigenous Health Report Card, which called for an integrated approach to reducing Indigenous imprisonment rates by addressing underlying causal health issues.

The AMA Indigenous Health Report Card 2017 *A National Strategic Approach to Ending Chronic Otitis Media and its Life Long Impacts in Indigenous Communities* can be found at https://ama.com.au/article/2017-ama-report-card-indigenous-health-national-strategic-approach-ending-chronic-otitis

CHRIS JOHNSON

Urgent action and honest answers demanded re Manus Island refugees

Asylum seekers refusing to leave the Manus Island Detention Centre. (Pics supplied by Refugee Action Coalition)

The AMA has demanded answers from the Federal Government over the wellbeing of refugees on Manus Island.

And it called for an independent group of medical experts to assess the health situation of those still there.

During its November meeting, the AMA Federal Council unanimously passed a motion calling on the Government to provide comprehensive transparent reporting of the health and wellbeing and living conditions of the asylum seekers that were then still residing at the closed detention centre there.

Papua New Guinea officials subsequently forcibly removed the last of the men, more than 300, who had refused to leave the centre. They were taken to other camps on the island.

Initially, hundreds of asylum seekers had refused to leave the decommissioned centre even after services had been cut in a bid to force them to move. They shut themselves inside the closed facility and ignored orders from both the Australian and PNG governments to vacate.

The men had staged protests inside the centre.

The United Nations labelled the situation a “looming humanitarian crisis.”

Australia shut the centre and withdrew doctors and other staff, as well as proper food supplies, power, clean water and medical services.

The AMA had already called on the Government to treat the men

Urgent action and honest answers demanded re Manus Island refugees

A broken well.

humanely, amid conditions on the island being described as "chaotic and dangerous".

The issue was subsequently discussed at great length after Federal Council members merged on Canberra to determine issues pertinent to the AMA and its policy direction.

The welfare of the asylum seekers on Manus Island dominated debate.

AMA President Dr Michael Gannon said the Government could not shirk its responsibilities in relation to the asylum seekers.

"The AMA has made many representations on this matter, both publicly and in private but, with a worsening and more dangerous situation emerging on Manus, the Federal Council strongly believes that urgent action and answers are needed," Dr Gannon said.

"We strongly urge the Government to take note of our call and respond accordingly.

"These men have escaped from dangerous and, for some, life-threatening circumstances, and are now in the care of the Australian Government.

"It is our responsibility as a nation with a strong human rights record to ensure that we look after the health and wellbeing of these men, and provide them with safe and hygienic living conditions.

"The AMA stands ready to work with the Government to select an expert group of doctors with the appropriate specialised skills and experience to independently assess and report on the health of these asylum seekers, and report back to the Government and the Australian people."

Prime Minister Malcolm Turnbull urged the men to move and he is criticised anyone who had encouraged them to stay.

And Immigration Minister Peter Dutton remained characteristically hard-line in relation to the situation.

Spokesman for the Refugee Action Coalition Ian Rintoul said PNG authorities had overturned containers of collected rainwater, destroyed wells, and punctured water tanks in a bid to drive the men out.

He described the tactics it as "bully-boy raids and wanton vandalism".

Following is the full text of the motion unanimously passed by the AMA Federal Council:

Preamble:

The World Medical Association (WMA) *Statement on Medical Care for Refugees, including Asylum Seekers, Refused Asylum Seekers and Undocumented Migrants, and Internally Displaced Persons (IDPs) states that:*

Physicians have a duty to provide appropriate medical care regardless of the civil or political status of the patient, and governments should not deny patients the right to receive such care, nor should they interfere with physicians' obligation to administer treatment on the basis of clinical need alone.

Physicians cannot be compelled to participate in any punitive or judicial action involving refugees, including asylum seekers, refused asylum seekers and undocumented migrants, or IDPs or to administer any non-medically justified diagnostic measure or treatment, such as sedatives to facilitate easy deportation from the country or relocation.

Physicians must be allowed adequate time and sufficient resources to assess the physical and psychological condition of refugees who are seeking asylum.

National Medical Associations and physicians should actively support and promote the right of all people to receive medical care on the basis of clinical need alone and speak out against legislation and practices that are in opposition to this fundamental right.

Urgent action and honest answers demanded re Manus Island refugees

AMA Motion:

The AMA Federal Council expresses its grave concerns about the health and wellbeing of the refugees and asylum seekers currently residing on Manus Island. The AMA calls on the Australian Government to provide comprehensive answers to the following questions, which relate directly to the health and wellbeing of these men, for whom Australia has responsibility under international law:

1. What are the healthcare arrangements, both physical and mental, in place for the men on Manus?
2. Do the men have access to all essential medication, vaccinations, basic hygiene, clean and safe drinking water?
3. Are there measures in place to deal with the significant risk of violence breaking out between the men and the locals on Manus?
4. Is the accommodation being provided for the asylum seekers and refugees at a standard acceptable to the UNHCR?

Further, the AMA calls on the Federal Government to facilitate granting of access by the Government of PNG to Manus Island for a delegation of Australian medical professionals, to be appointed in consultation with the AMA, to assess these issues in an independent fashion. This would include access to the detainees, as well as the PNG officials administering the facilities.

An appropriate delegation would include a psychiatrist, public health expert, general practitioner, and an infectious diseases physician.

The purpose of the delegation is to make an independent assessment and to make public the findings of its inspections and interviews to assure the Australian public that the Australian Government has done all that is possible to protect the health and wellbeing of the asylum seekers and refugees.

CHRIS JOHNSON

INFORMATION FOR MEMBERS

Thank you for being an AMA member

This year, with your support, the AMA has accomplished many improvements for the profession and for patients in Australia. Only a sample of those wins for the profession are listed below:

After AMA calls for a national approach to deal with doctor suicide rates, Health Minister Greg Hunt announced at the 2017 AMA National Conference in Melbourne that the Government will invest in mental health programs for doctors. The Government will provide $1 million to specifically support mental health and reduce suicide in the health workforce, with a particular focus on doctors.

Following intense lobbying and public advocacy by the AMA, the Government announced the lifting of the Medicare rebate freeze on bulk billing incentives for GP consultations on 1 July 2017, and this will be followed by the freeze being lifted for standard GP consultations from 1 July 2018.

In 2017, the AMA's Public Health Report Card highlighted the growing crisis facing public hospitals, and the need for more adequate and certain funding. The Report Card also shows that, against key measures, the performance of our public hospitals is virtually stagnant, or even declining. It made clear that without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment.

By belonging to the peak body for the medical profession, you Are supporting the AMA in leading the fight for your professional interests and to improve the health of Australians.

AMA membership gives you a voice to influence health policy, as well as unmatched resources to support you throughout your career, including trusted advice, services, representation, professional development, events and networking.

Renew your tax-deductible membership now to support our advocacy for coordinated, quality patient care and to maintain a powerful professional voice at the decision-making table. You can renew by logging in here: https://ama.com.au/join-renew or by contacting your State/Territory AMA.

The AMA thanks you for your ongoing support as a member.

Australia says yes to equality

The AMA has welcomed the strong YES vote from the same sex marriage national postal survey.

A significant 61.6 per cent of respondents voted yes in the voluntary poll, with the results announced on November 15.

All States and Territories voted in favour of marriage equality.

Following the Australian Bureau of Statistics' announcement of the result, AMA President Dr Michael Gannon said the Federal Parliament had been sent a clear signal.

Parliamentarians must now heed the overwhelming message from the Australian people and legislate for marriage equality, he said.

"It is time to end the discrimination and lift the health burden from our LGBTIQ population," Dr Gannon said.

"The AMA clearly expressed its support for same sex marriage with our *Position Statement on Marriage Equality* earlier this year.

"Along with the majority of Australians, as shown by the survey result, the AMA believes that two loving adults should be able to have their relationship formally recognised.

"This is not a debate about same sex parenting or religious freedom or the school curriculum. It is about ending a form of discrimination.

"There are evidence-based health implications arising from discrimination.

"Discrimination has a severe, damaging impact on mental and physiological health outcomes.

"People who identify as LGBTIQ experience substantially poorer mental and physiological health outcomes than the broader population.

"They are more likely to engage in high-risk behaviours such as illicit drug use or alcohol abuse, and have the highest rates of suicidality of any population group in Australia.

"LGBTIQ Australians are our doctors, nurses, teachers, politicians, police officers, mothers, fathers, brothers and sisters and they deserve the same rights as every other person."

Following the result's announcement, openly gay Liberal Senator Dean Smith immediately introduced a bill to legalise same-sex marriage.

Debate on the bill began in the Senate the very next day.

"I never believed the day would come when my relationship would be judged by my country to be as meaningful and valued as any other. The Australian people have proven me wrong," Senator Smith said.

"To those who want and believe in change — and to those who seek to frustrate it — I simply say:

"Don't underestimate Australia. Don't underestimate the Australian people. Don't underestimate our country's sense of fairness, its sense of decency and its willingness to be a country for all of us."

Dr Gannon said the AMA wanted to see an end to all forms of discrimination against LGBTIQ Australians.

He said it is now up to our Parliament to act and he hoped to see matter resolved before the end of the year.

"And we urge all Australians to respect the rights of LBGTIQ people, their families, and friends," Dr Gannon said.

"More than 25 other countries have already passed same sex legislation. Australia should join them."

The Government delayed the return of the House of Representatives by a week to allow the Senate to pass a bill to make marriage legal.

MPs were put on notice to then expect the Lower House to sit for as long as it takes to deal with the issue.

"The Australian people expect their Parliament to respect the clear mandate of the marriage survey and legislate for marriage equality before the end of the year," said Leader of the House Christopher Pyne.

But while the Government used the same-sex marriage bill and the dual citizenship fiasco as its excuse to cancel a week of Parliament, the Opposition, the Greens and some independents insisted the delay was to avoid losing a vote for a royal commission into the banking sector.

With the Nationals' Barnaby Joyce and the Liberals' John Alexander both exiting Parliament due to their dual citizenship, the Government had no majority on the floor of the House of Representatives until after by-elections in December.

CHRIS JOHNSON

GPs are tops – ABS latest stats

Australians still love their local doctors.

At least that is the finding of the latest Australian Bureau of Statistics (ABS) data, which shows that patients around the nation are satisfied with their GPs.

The ABS's latest *Patient Experiences in Australia Survey* reinforces previous findings that Australia's dedicated GPs are meeting increasing demand and providing quality services.

GPs attracted a very high satisfaction rating from patients in the survey.

The survey produced positive results for medical specialists and emergency department doctors as well, but GPs are the doctors who have the most frequent contact with patients.

According to the survey, 83 per cent of Australians saw a GP in the last 12 months and around 78 per cent of patients have a preferred usual GP.

AMA President Dr Michael Gannon described the results of the survey as outstanding.

"Importantly, the proportion of people waiting longer than they felt acceptable for a GP appointment decreased from 23 per cent in 2013-14 to 18 per cent in 2016-17," Dr Gannon said.

"Of those who patients who saw a GP for urgent medical care, 75 per cent were seen within 24 hours of making an appointment.

"The survey shows that cost is not a barrier to accessing GP care, with only 4 per cent of respondents saying that they at least once delayed seeing a GP or did not see a GP when needed due to cost.

"Of those patients who saw a GP in the last 12 months, 92 per cent reported that the GP always or often listened carefully to them, 94 per cent reported that their GP always or often showed them respect, and 90.6 per cent reported that their GP always or often spent enough time with them.

"These results are outstanding when you consider the pressure under which our GPs are working today."

Dr Gannon said GPs are a critical part of the health system, and they must be valued and supported.

General practice remains under significant funding pressure due to cuts by successive governments, he said, but GPs continue to provide high quality and accessible primary care services across the country.

"When people are sick, they want to see a GP," Dr Gannon said.

"As the Government looks to shape the future of our health system, it needs to build its investment in general practice, which remains the most cost effective part of the system."

CHRIS JOHNSON

Fees List finalised

The AMA has enhanced a key member benefit, with the launch of the AMA Fees List online in October. The new website has replaced the previous book and CD-ROM formats, making setting medical fees faster and more user friendly than ever before.

The new Fees List includes the annual 1 November 2017 indexation rates.

Since 1973, the Fees List has been a critical aid for AMA members by providing an important reference guide on medical fees. The Fees List is an original work owned and administered by the AMA Secretariat.

In moving online this year, the Fees List has been enhanced with number of features in to make referencing AMA Fees fast and easy for any medical discipline. This includes:

- Interactive dashboard to find, search and save AMA fees
- Search function that links directly to AMA and MBS item descriptions
- Customised user profile with options to save, download or print favourite items
- Fee calculator tools including a new Anaesthesia fee calculator
- Ability to print parts of, or full PDFs of the Fees List
- Online tutorials and help tools
- Mobile and tablet compatible
- Full PDF and CSV downloads.

The move to the online format has also enabled the Fees List to be updated throughout the year, as ongoing changes are made to the MBS as a result of the MBS Reviews.

All financial AMA members will continue have free, unlimited access to the Fees List online and its many features. We have also introduced new purchasing options and licensing arrangements for select third party groups, such as hospitals, workers compensation agencies and health insurers who reference the AMA fees or provide assistance to AMA members with their billing.

The Fees List is primarily an AMA member benefit and whilst the AMA's aim is to provide guidance on fair and reasonable medical fees, the AMA does not permit the unauthorised use of the Fees List by billing agencies and software companies for clients who have not purchased the list themselves - due to the risk of copyright infringement of AMA intellectual property.

Of course, many members use these agencies to support their billing operations, which may require providing the AMA rates to these services for their individual billing purposes.

The new Fees List website has been launched at a time when medical fees are under increasing medical and mainstream scrutiny. Medical practitioners are currently challenged with setting appropriate medical fees, amidst the backdrop of a frozen Medicare schedule. The result is that the MBS has not kept pace with the realistic costs of running a viable, quality practice.

The AMA encourages medical practitioners to use their own judgement to charge an appropriate fee for a medical service. Medical practitioners should satisfy themselves in each individual case as to a fair and reasonable fee, having regard to their own practice cost experience and the particular circumstances of the case and the patient.

More information on how the AMA Fees List can assist in setting, licensing and Terms of Use can be found on the Fees List website feeslist.ama.com.au

The next Fees List update is scheduled for 1 December and will include the 1 November MBS changes.

For login assistance please contact Member Services on memberservices@ama.com.au or 1300 133 655. For all other queries, please contact feeslist@ama.com.au

ELIISA FOK
POLICY ADVISER, MEDICAL PRACTICE

Royal Commissions must spark changes for treatment of young people

Two recent Royal Commissions have inquired into systemic and institutional failure to protect vulnerable young people. The formula is roughly consistent. Both inquiries, Royal Commission into the Protection and Detention of Children in the Northern Territory and Royal Commission into Institutional Responses to Child Sexual Abuse, began with an initial exposé which generated enough public outrage to force a Government response.

> "In both cases, the subsequent investigations uncovered layers of abuse and neglect far more pervasive than anybody could have ever imagined."

In both cases, the subsequent investigations uncovered layers of abuse and neglect far more pervasive than anybody could have ever imagined. What remains to be seen, is the extent to which these Royal Commissions generate enough momentum to result in meaningful and positive change.

The findings of the Royal Commission into the Protection and Detention of Children in the Northern Territory are abhorrent. Children as young as ten serving custodial sentences in conditions that could not be deemed appropriate for any child, let alone some of our most vulnerable.

The final report of the Royal Commission delivered 43 recommendations, all with a subset of more detailed recommendations. In essence, the Report demands a drastic overhaul of the entire juvenile justice system.

A major finding from the Royal Commission is the relationship between Fetal Alcohol Spectrum Disorder (FASD) and juvenile incarceration. FASD occurs as a result of fetal alcohol exposure, and results in lifelong neurodevelopmental impairments. At present, we do not know the extent of its prevalence in Australia but it is thought to be endemic in some custodial settings.

Overseas studies have found that young people with FASD are almost 20 times more likely to enter the criminal justice system than their peers. Unsurprisingly, this carries a significant financial burden for both adult and youth justice systems. The relationship between FASD and the criminal justice system is dual in that FASD increases the likelihood a person will come into contact with the system, and then subsequently impedes their ability to navigate it. A particularly troublesome aspect of FASD is that many of its manifestations can simply appear as disobedience or behavioural problems to the untrained eye.

Young people are not routinely screened for FASD upon entering the juvenile justice system, and the Commission was told there are currently no plans to implement such an initiative. The Department of Health maintains that rates of FASD within the Northern Territory custodial settings are likely to be relatively low due to the high proportion of alcohol-free communities in the NT. However, the Commission received expert advice to the contrary, suggesting that as many as a third of all of the young people in youth detention could have FASD.

While there is no cure for FASD, behavioural and education interventions can improve outcomes for people with a diagnosis of FASD. Routine and psychosocial support are both beneficial to people with FASD, yet if the findings of the Royal Commission are anything to go by, these were not on offer to any of the young people in the care of the Northern Territory detention and protection systems.

In 2016, the AMA released a position statement *Fetal Alcohol Spectrum Disorders (FASD) – 2016*. The statement calls for strategies to identify and support people with FASD who come into the education, criminal justice and child protection systems consistent, broadly similar with the findings of the Royal Commission.

So far, these calls remain unmet.

It is vital that the findings of the recent Royal Commission are not simply a catalyst for collective shame, but for meaningful and positive change. Remorse and reflection can do very little for the young people in the youth justice system, and those that are yet to enter it, but they stand to benefit a lot from systemic changes to the youth criminal justice system.

BY GEORGIA BATH
AMA POLICY ADVISER

Federal Council communiqué – meeting of 17 and 18 November

BY DR BEVERLEY ROWBOTHAM, CHAIR FEDERAL COUNCIL

Federal Council meeting in Canberra. (Photo by Odette Visser)

Federal Council met in Canberra on 17/18 November. The meeting came in the midst of the political uncertainty arising from measures to deal with the citizenship status of federal politicians, the voluntary assisted dying debates in the parliaments of Victoria and NSW, and the strong majority poll in favour of same sex marriage reform announced during that week.

The President reported on his activities over the past three months since the last meeting of Council in August. Among the highlights were his attendance at the meeting of Confederation of Medical Associations in Asia and Oceania (CMAAO) in Tokyo in September and the Council meeting and General Assembly of the World Medical Association (WMA) in Chicago in October. The WMA adopted a modernised version of the Declaration of Geneva which was also adopted by Federal Council at its November meeting.

The Secretary General's report focused on the breadth of submissions, Parliamentary committee appearances, and inquiries to which the secretariat has responded in the last few months, continuing a trend observed throughout 2017.

These included a submission on the security of Medicare cards;

Federal Council communiqué – meeting of 17 and 18 November

several reviews of training funding arrangements and workforce distribution; improving Medicare compliance; secondary use of Medicare data; coordinated advocacy with State and Territory AMAs to change the requirements for mandatory reporting under the National Law; medical indemnity changes; codeine scheduling changes; and ongoing negotiations with Minister Hunt on several issues including the future funding of after hours GP services.

The AMA's engagement with the MBS Review process and the Private Health Ministerial Advisory Committee continue. Federal Council noted the release by Minister Hunt during October of the first tranche of reforms to private health insurance. Key reform areas remain under review including the scope of benefit cover in the proposed gold, silver, bronze, and basic policies; insurance cover of private patients in public hospitals; and a process to improve transparency of medical fees and out of pocket costs. This latter subject was a focus for discussion by the Council in one of its two policy sessions.

In considering an approach to improved transparency of medical fees and out of pocket costs, Federal Council noted the Government's proposal to establish an expert working group to consider the most effective way to communicate medical fees and out of pocket costs. Federal Council also noted that informed financial consent was key but not uniformly practiced. Federal Council reiterated its position statement in support of doctors charging an amount appropriate to the service and the patient, while condemning excessive charging. Federal Council agreed principles to guide AMA input into the expert working group.

Federal Council noted the array of AMA's public health advocacy including an appearance before a parliamentary inquiry into e-cigarettes and consideration of the AMA's broader tobacco advocacy. Federal Council approved two public health position statements, one dealing with nutrition and the other, road safety. The Council passed unanimously a motion calling on greater transparency of the conditions under which the asylum seekers and refugees on Manus Island are being held and offering an independent assessment by doctors of the health situation.

Continuing areas of public health policy attention include men's health, sexual diversity and gender identity, and social determinants of health. A new working group was established to review the AMA position statement on drugs in sport.

> "The Equity, Inclusion and Diversity Committee of Council reported that it proposes to publish an annual report on progress to achieve equity, inclusion, and diversity in the AMA."

Federal Council received a presentation from Scott McNaughton, General Manager of Participation Pathway Design with the National Disability Insurance Agency (NDIA) in the second policy session. Councillors were interested to learn about the role of medical practitioners in providing NDIS assessments; and the processes to access appropriate medical and psychosocial supports for people with mental illness. The presentation provided essential information and highlighted the steps underway by NDIA to fully implement the NDIS.

The Equity, Inclusion and Diversity Committee of Council reported that it proposes to publish an annual report on progress to achieve equity, inclusion, and diversity in the AMA.

Federal Council received a report on the successful forum in October on reducing the risk of suicide in the medical profession which was convened jointly by Federal AMA, AMA NSW and Doctors Health Services Pty Limited. The two key themes that came from the forum were the impact of culture and the need for compassion. A full report will be published in due course.

At the conclusion of the meeting the Secretary General reminded Federal Council that 2018 is an election year for positions on the Council, with a call for nominations to go out to all voting members in February. Federal Council draws its standing from its representative structure, with representation of members from across the country, and all specialties and stages of practice.

AMA PHN member survey

In response to the recommendations of the Hovarth Review into Medicare Locals (the Hovarth Review), the Government established 31 Primary Health Networks (PHNs) across Australia, commencing in July 2015. These replaced Medicare Locals (MLs) that were established by the previous Labor Government.

The fundamental purpose of PHNs is similar to that of their predecessors "to facilitate improvements in the primary health system, promote coordination and pursue integrated health care." However, GPs are expected to play a more central role in PHNs than they did in MLs. PHNs are also expected to focus more on improving the linkages between primary and hospital care.

In 2013, leading up to the Hovarth Review, the AMA conducted a survey of GP members to gauge their views on the performance of MLs. More than 1,200 GPs participated in that survey, with members particularly critical of their engagement with GPs and the extent to which many had failed to help improve patient access to primary care services. This survey formed the basis of AMA submission to the Hovarth Review, which recommended significant reforms including a more central role for GPs.

The AMA recently conducted a similar survey to provide members with the opportunity to give us their views on the performance of PHNs to date. Participants were provided with a number of statements and, were asked to select the options (strongly agree, mostly agree, neither agree or disagree, mostly disagree, or strongly disagree) that best reflect their opinion.

A total of 399 GPs participated in the survey, which represents a much smaller sample size than the 2013 survey. Nonetheless, it does provide a snapshot of the views of those members who participated in the survey and the results should be used to provide helpful guidance on areas where PHNs need to increase their focus.

The survey results are summarised as follows:

- Understanding of the role and functions of PHNs:
  - 61.5 per cent of respondents indicated that they have a reasonable understanding of the role and functions of PHNs (comparative data is not available for MLs).
- Information about activities and services:
  - 47.9 per cent of GPs surveyed believe they have not been kept informed about the work their PHN is undertaking and the services it supports (48.9 per cent for MLs).
- GPs access to information and events of relevance:
  - 51.4 per cent indicated that they have not been provided with information and access to events of relevance to day to day practice (57.8 per cent for MLs).
- PHN engagement with local GPs:
  - 62.6 per cent indicated that their PHN had failed to engage and listen to them about the design of health services needed in the local area (68.8 per cent for MLs).
- Practice staff access to useful and effective education and resources:
  - 46.3 per cent of GPs surveyed indicated that their practice staff have not been provided with access to useful and effective education and resources (comparative data is not available for MLs).
- Valuing GP contribution:
  - 52.8 per cent believed that their PHN does not value or recognise the inputs of local GPs (60.8 per cent for MLs).
- Timing of meetings and information sessions:
  - 46.1 per cent indicated that their PHN was holding meetings and information sessions at times that were not easily attended (52.4 per cent for MLs).
- Supporting targeted programs for disadvantaged groups:
  - 50.6 per cent indicated that their PHN has not been supporting well targeted programs that could help patients, particularly those who are disadvantaged (comparative data is not available for MLs).
- Facilitating services that complement existing general practice:
  - 52.8 per cent indicated their PHN is not focused on facilitating services that complement existing general practice services s (comparative data is not available for MLs).
- Practice support for MyHealth Record:
  - 57.4 per cent indicated that their PHN had not provided effective support for practices to implement the MyHealth Record (56.6 per cent for MLs re PCEHR).
- Access to psychological services:
  - 48.0 per cent indicated that their PHN had failed to improve patients' access to psychological services (48.9 per cent for MLs regarding improved Access to Allied Psychological Services (ATAPS)).

AMA PHN member survey

- Accessible mental health services for ATSI patients:
  - 35.5 per cent of GPs surveyed indicated that their PHN had not facilitated appropriately funded and accessible services to meet the mental health care of Aboriginal and Torres Strait Islander (ATSI) patients (comparative data is not available for MLs).
- Delivery of mental health and suicide prevention services and supports to ATSI patients:
  - 43.3 per cent of GPs surveyed indicated that their PHN had not been able to improve the delivery of mental health and suicide prevention services and support to ATSI patients (comparative data is not available for MLs).
- Access to services for patients requiring mental health care, but who are not eligible for National Disability Insurance Scheme (NDIS) packages:
  - 52.7 per cent indicated that their PHN had been ineffective in facilitating for the needs of patients requiring mental health care, but who are not eligible for NDIS packages (comparative data is not available for MLs).
- Psycho-social supports for patients with mental health problems:
  - 55.9 per cent indicated that their PHN had been unable to ensure effective and timely psycho-social supports to patients with mental health problems (comparative data is not available for MLs).
- Overall PHN performance:
  - 58.0 per cent indicated that their PHN had not improved local access to care for patients (73.0 per cent for MLs).
- Overall delivery of primary care:
  - 62.6 per cent indicated that their PHN had not improved the capacity to deliver better quality healthcare overall (71.6 per cent for MLs).

PHNs have an important role to play in improving the integration of health services within primary health care, enhancing the interface between primary care and hospitals, and ensuring health services are tailored to the needs of local communities. They have the potential to have a strong impact on aged care services, mental health outcomes, chronic disease management, Indigenous health services, and services for the disadvantaged.

The AMA believes that for PHNs to be successful they must: have a clear purpose, with clearly defined objectives and performance expectations; be GP-led and locally responsive; focus on supporting GPs in caring for patients and working collaboratively with other health care professionals; have strong skills based Boards; be appropriately funded to support their operations, particularly those that support the provision of clinical services; focus on addressing service gaps, not replicating existing services; not be overburdened with excessive paperwork and policy prescription; and be aligned with Local Hospital Networks (LHNs), with a strong emphasis on improving the primary care/hospital interface.

They should focus on the following areas:

- Population Health - Identifying community health needs and gaps in service delivery; identifying at-risk groups; supporting existing services to address preventive health needs; and coordinating end of life care.
- Building General Practice Capacity - Supporting general practice infrastructure to deliver quality primary care through IT support; education and training of practices and staff; supporting quality prescribing; training to support the use of e-Health technology and systems; enhancing practices capacity and capabilities to embrace the principles in being a medical home to their patients, and facilitating the provision of evidence-based multidisciplinary team care.
- Engaging with Local Hospital Networks (LHNs)/Districts - Identifying high risk groups and developing appropriate models of care to address their specific health issues (e.g. those at high risk of readmissions, including non-insulin-dependent diabetes mellitus, congestive cardiac failure, chronic obstructive pulmonary disease, and other chronic diseases); and improving system integration in conjunction with local health networks.

Given that PHNs are still a relatively new feature on primary care landscape, the jury is still out on the performance of PHNs. The AMA believes that they should be given every chance to succeed and intends conducting the same survey in a couple of years' time to see how much of a difference they are making for GPs and their patients.

DR MOE MAHAT
MANAGER POLICY
AMA GENERAL PRACTICE SECTION

Can safer surgery be legislated?

BY DR PETER SUBRAMANIAM

In June, a Royal Australasian College of Surgeons Queensland Audit of Surgical Mortality report sparked Queensland government action that may trigger new federal and state laws for public reporting of patient safety data across public and private hospitals. By August, Queensland had released a discussion paper and its push for such standards nationally was supported by federal and state health ministers at COAG Health Council. The Council tasked the Australian Commission on Safety and Quality in Health Care to work with 'interested jurisdictions' on such standards and to incorporate the work into national performance and reporting frameworks.

Compliance with audits of surgical mortality like the Queensland report is a mandated professional practice requirement for all surgeons while all public hospitals and almost all private hospitals already participate in the audits. So, the question doesn't appear to be hospitals' compliance with public reporting of performance data on patients admitted to hospital under a surgeon. The relevant questions seem to be what constitutes metrics of patient safety-oriented surgical performance and whether legislation can protect patients' safety.

What are the metrics of patient safety-oriented surgical performance?

Patients admitted under a surgeon in a hospital are treated by a surgical team regulated by the hospital's organisational framework that is part of a public or private hospital network. So, correctly, the metrics of patient safety-oriented surgical performance are metrics of the effectiveness of both surgical team performance and organisational performance of the hospital and its parent organisation. Only if both sets of metrics are reported will the public be fully informed about whether the hospital, public or private, is effective at protecting their safety.

This concept of patient safety-oriented surgical performance is backed by evidence. Patient safety depends on effective surgical team communication and adverse events by individual surgical team members are typically rooted in faulty systems and inadequate organisational structures. This evidence is reflected in local experience of more than 33,000 cases over eight years reported in the Australian and New Zealand Audit of Surgical Mortality National Report 2016. Its key points include that surgical team communication is a key element of good patient care and delayed inter-hospital transfers of patients with limited reserves can significantly affect surgical outcomes.

So, metrics of patient safety-oriented surgical performance must show effective surgical team communication as being timely decisions and actions to prevent, diagnose and treat surgical complications and deteriorating patients e.g. prompt resuscitation and surgery for postoperative bleeding. Likewise, such metrics must also show effective hospital and parent organisational systems enabling surgical teams' decisions in a way that protects patient safety e.g. prompt inter-hospital transfers, timely ICU bed and OR access, safe working hours and staff levels.

Can legislation protect surgical patient safety?

The results of the Australian and New Zealand Audit of Surgical Mortality suggest surgical patient mortality represents a segment of Australia's aging population who are at the extreme of life with co-morbidities that are a stronger predictor of death than the type of surgery. When an acute surgical condition supervenes, they have a rapidly shrinking window of opportunity with almost a quarter being irretrievable. They are prone to surgical complications which often leads to cardiac or respiratory failure with rapid deterioration and death. Nonetheless, surgical mortality in Queensland and nationally has been improving over the last eight years so it is difficult to envisage how new legislation will add much to improving surgical patient safety.

Is legislation necessary?

In 2016, a number of NSW private hospitals did not participate in the audit of surgical mortality despite compliance by all public and private hospitals in all other jurisdictions through the system funded by all State and Territory Governments. If legislation is to bring private hospitals in line with this public reporting system, it should be directed specifically for this reason. If it is to improve surgical patient safety or to inform patient choice, it is not clear how it will improve on the current public reporting system supported by governments. If a national performance and reporting framework is being developed, it should be directed at metrics of surgical team and organisational performance.

It remains to be seen if Government will be surgical in its approach to patient safety.

Dr Peter Subramaniam MBBS MSurgEd FRACS is a cardiothoracic surgeon in Canberra who is currently pursuing a Juris Doctor law degree at the Australian National University. He established the Australian and New Zealand Cardiac and Thoracic Surgeons national cardiac surgery database in the ACT as well as the multidisciplinary ACT Cardiac Surgery Planning Group. He also has extensive experience in undergraduate and postgraduate surgical education.

Views expressed in the above Opinion piece are those of the author and do not reflect official policy of the AMA.

The evil you cannot see

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

Concern about air quality in Australia popularly centres around two topics: exhaust stacks from city road tunnels and climate change. Neither are as critically important as the effects of small particle pollution.

Beijing: we have a problem

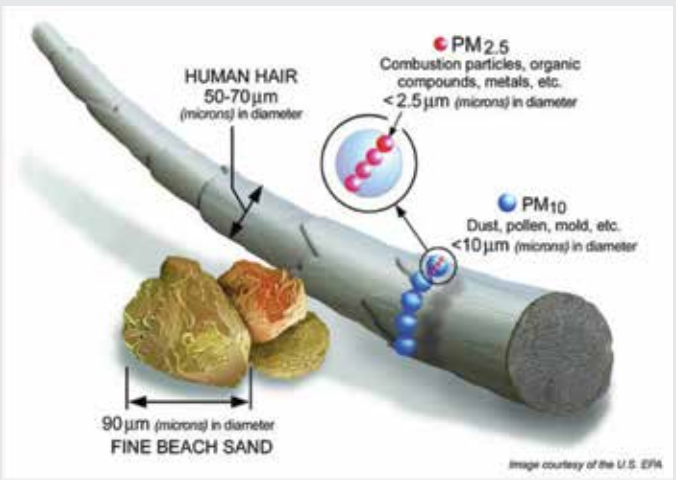
In China, massive problems were noted in Beijing recently due to massive levels of pollution attributable to very small particles. Even though currently we don't have anything like the challenges facing China it is wise to be well-informed about what is happening in other countries because of our interconnectedness.

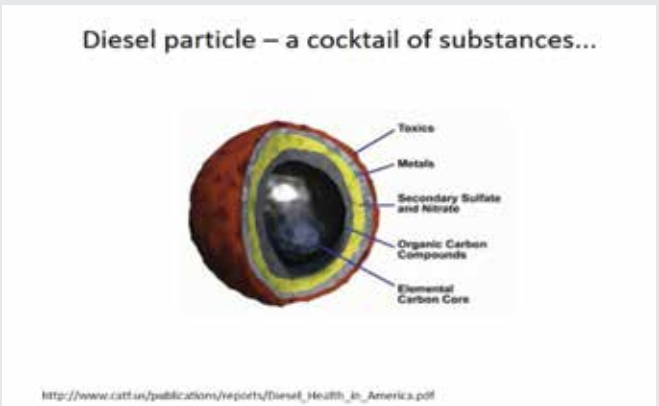
The consequences of small particle pollution can be immediate as well as long-term. They can rank with acute causes of illness like infections and with cigarettes causing heart disease and cancer over decades.

Estimates provided by the WHO, the American Heart Association and the Global Burden of Disease team hover around three million deaths a year due to these small particles that are less than 2.5 microns in diameter: for comparison a human hair is 50-70 microns in diameter.

These particles are so light that they dance, free of gravity, in our air. Slipping through the nose and throat, they penetrate our lungs where they can pass like oxygen into our blood stream. They are known as atmospheric particulate matter 'PM2.5'.

They do not cause the pollution we can see, although they travel with it. The small diameter of these particles enables them to penetrate to the deepest recesses of the lung unimpeded by the lung's standard defences. There they can cause local damage or slip into the blood stream. It is this easy access to the whole body via the blood that accounts for their effects on the heart and other organs.





The countries most at risk of problems due to small particle air pollution are clustered around the Middle East and Asia. More generally affluent countries in Europe and in the Americas are not nearly so badly affected.

Oh oil – is this another of thy stings?

Saudi Arabia and Qatar have the highest annual average concentrations of small particle as so much of their energy requirements are met through the use of fossil fuels - desalination plants, air conditioners and other devices designed to manage the ferociously hostile heat all run on oil.

How can such small particles rob us of health? Small particles are a very mixed group – they can be made of a gas. Diesel particles are like tiny meteorites – they have a solid carbon core surrounded by two layers of chemicals. Both the mechanical irritation caused by the particles and the chemical impact of them can cause damage. Small particles can destabilise coronary artery plaques leading to thrombosis.

By comparing the death rates of communities exposed to different levels of small particles, and taking into account differences in other risk factors such as cigarette smoking, the GBD group have attributed millions of deaths each year attributable to small particle pollution.

The evil you cannot see

Their research is the most sophisticated, but depends on death statistics that are often incomplete or of poor quality, meaning that all estimates are provisional. But research 1996 done by Doug Dockery and his Harvard research group in six major US cities where health and pollution data are less problematic demonstrated the level of justifiable concern about small particles.

They found no level of small particle pollution that was entirely without risk. So the WHO 'safe' standards are pragmatic, rather as our 'safe drinking' levels of alcohol consumption do not mean that even small amounts of alcohol are free of health effects. The American Heart Association, the AHA, has taken a deep interest in small particle pollution, partly because the majority of deaths attributed to it are deaths from heart disease. After looking at all the studies the AHA concludes that larger particles are not associated with an increased risk of death, just the evil tiny ones that you cannot see.

Don't jog – walk more

What can be done? The measures that have successfully rid our skies from large particle pollution – clouds of black smoke and high levels of sulphurous pollution – will help reduce the levels of small particle pollution. Moving from diesel to natural gas for large motor vehicles in the long term would be a welcome move. Renewable energy may reduce the production of small particles – you would need to ask someone else.

In the meantime, by following air pollution indexes, patients with existing lung or heart disease should be warned not to exercise vigorously or unnecessarily on days when the small particle levels are high.

The atmosphere is not indifferent to our fuel-burning activities Small particle pollution is yet another example of how important it is to assess our activities to see what cost we are imposing on our environment.

Thunderstorm asthma

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

> "Anyone who suffers seasonal hay fever is also at risk. It is important that our at-risk patients understand this and know how to minimise their risks and manage any symptoms if they experience epidemic thunderstorm asthma."

With then end of the year fast approaching, there are many joys that this time of year brings, but also many hazards. One such hazard is increased risk of thunderstorm asthma. It is now just over a year since the disastrous thunderstorm in Victoria that triggered a mass asthma emergency, with 8,500 people requiring hospital care and ten sadly losing their lives.

While Victorian hospitals featured prominently in the Victorian response, we also know that many patients accessed GP care and advice, including through after hours GP services.

Research is being conducted to better understand why epidemic thunderstorm asthma events occur. It is believed that grass pollens swept up into the clouds as a storm forms, absorb moisture and then burst open filling the air with small allergen particles. Unlike the larger grass pollen grains that cause hay fever, these particles are small enough to be drawn deep into the lungs. The irritation caused resulting in swelling, narrowing and additional production of mucus in the small airways of the lung, making it very difficult to breath.

Symptoms are quick to come on and typically involve wheezing, chest tightness and coughing, much like asthma.

As GPs, it important to be aware that it is not just people with asthma or a history of asthma that are susceptible to a thunderstorm asthma event. Anyone who suffers seasonal hay fever is also at risk. It is important that our at-risk patients understand this and know how to minimise their risks and manage any symptoms if they experience epidemic thunderstorm asthma.

Thunderstorm asthma is now recognised as a serious health threat and over the last year a range of resources have been made available to GPs to assist them in preparing their patients for the grass pollen season and any epidemic thunderstorm asthma event.

GPs should make sure they are up to date with the recommendations in the Australian Asthma Handbook and can undertake the free NPS Medicinewise Clinical E-Audit *Asthma Management – supporting patients to achieve good control*. This tool will help you improve the individual management of your patients by identifying risk factors, reviewing asthma control, adjusting management and reinforcing the benefits of maintaining an up-to-date written asthma action plan.

The National Asthma Council Australia has also made available a range of resources for GPs and other healthcare professionals in the event of another thunderstorm asthma event, which can be accessed here. These include information papers on epidemic thunderstorm asthma and managing allergic rhinitis in people with asthma and advice on preventative treatment.

In addition, the Asthma Australia website also contains general information about asthma which may be of use to GPs, including how to prepare for and respond to an asthma emergency. They also have specific resources for health professionals.

The key is ensuring at-risk patients understand the risks, know how to reduce them, and have an action plan for responding to symptoms.

This will be my last column for 2017, with the year seeming to go very quickly due to the never-ending advocacy of the AMA on GP issues. On behalf of the Council of General Practice I will take this opportunity to wish you all a safe and happy time with family and friends over the holidays.

Rural health in retrospect

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

As the second Chair of AMACRD, I feel that despite being a relatively new group within the AMA, we have much to be proud of. So, as 2017 turns into 2018, I look at the circumstances that surrounded us, and am glad to note that we have worked hard, we have little victories we can take credit for.

So, Rural Doctors, I invite you to commemorate all our work in the year 2017, but also to note the challenges that lay ahead.

First off, I want to address the slow internet in the Outback. We are getting attention concerning this slowly (but steadily) and have advocated consistently for improvements.

- NBN Co attended an AMACRD meeting at the time of the rollout of Skymuster II and had a good opportunity to hear our stories. We advocated to end the data drought by increasing bandwidth, reducing the cost per gb to make our data needs more affordable. We know that NBNCo has now announced larger satellite data allowances and intends giving medical practice 'public interest premises' status, which should improve data allowances and speed even further.
- We made a submission to the Productivity Commission for the Telecommunications Universal Service Obligation, some of which we were pleased to see was included in their Final Report
- Council members appeared before the Joint Standing Committee on the NBN, making a case for improved access to superfast broadband by describing in vivid stories what internet is like for us. I am told the stories were received with amazement.

Workforce Distribution continues to be an issue. Despite the influx of new medical graduates, there are still unfilled workforce needs in rural Australia. The concept of maldistribution is on the minds of everyone who is trying to solve this problem.

- AMA has been invited to the Distribution Workforce Working Group. This group will meet frequently to advise the Minister of Health and the Rural Stakeholders Forum with recommendations.
- We have also updated the AMA Rural Workforce Initiatives Position Statement to reflect the current state of our workforce and to offer solutions: new wet behind the ears medical graduates, bewildered overworked International Medical Graduates (IMGs) feeling unappreciated, rural health still far behind but eager to catch up.
- The Government has provided funding of up to $93.8 million from 2015-16 to 2018-19 to implement three components to support the rural pipeline that included: *Regional Hubs; Rural Junior Doctor Training Fund; and Specialist Training Programme.*

Infrastructure is an area where we have had some wins, but we cannot afford to relax on this front. Hospital, clinics and toilets all need walls, doors and privacy.

- Following AMA advocacy, the Government, as part of the 2016/17 Federal Budget, announced a redesign of the Rural and Remote Teaching Infrastructure Grants (RRTIGP) to create a more streamlined Rural General Practice Grants Program (RGPGP) which intends to improve uptake. AMACRD provided input to inform the Department of Health revision of the RRTIGP. The AMA will push for continued infrastructure grant funding.
- Closure of services in hospitals, especially maternity services is the trend. However there are some "wins" in Queensland with their Rural Generalist program bolstering rural obstetrics.

In the past, Rural Health has been pushed into the background, but we are beginning to see it given some attention by the Government.

- Recently at an international rural medical conference I was eavesdropping on North American attendees. They were impressed with the focus that Australia has on rural health. To quote, "They think rural health is so important they have a Federal Minister for Rural Health!"
- Now we have even gone a bigger step forward. We have a National Rural Health Commissioner, Professor Paul Worley. That should impress the International Rural community. It took an act of parliament to create this arms-length Commissioner separate from the governing bodies and he is one of us. We will have an advocate, speaking on our behalf. He will be rolling out a national Rural Generalist program and the AMA is keen to work with him.

The vexed issue of Bonded Placements has yet to be resolved, but we are seeing some developments here. .

- The Government is looking at potentially reforming Return of Service (RoS) obligations on doctors working in bonded placements. This issue will continue to be developed into the new year as well. AMA is in discussions concerning this.

Rural health in retrospect

- We need to care for our young, as they are the next generation of doctors. If they are treated like prisoners they will rarely return voluntarily to their former jail cells.

Regarding 2018, AMACRD has additional areas it will be vigilant on including (but certainly not limited to) the following:

- Support for IMGs and doctors who are struggling with Australian Medical Council and Fellowship exams
- Monitor the development of the National Rural Generalist Pathway
- Provide input to Health care Homes, Practice Incentives Program redesign, and Medicare Benefits Schedule Reforms
- Invigilate the application of the Modified Monash Model for Rural Workforce Incentive programs
- Support our new Rural Health Commissioner
- Rural Aged Care
- Foster team work amongst Rural health care providers both medical and allied health
- Monitor the new Rural Junior Doctor Innovation Fund (a tweak on the former Prevocational GP Placement Program (PGPPP)) to see 60 Full time equivalents by 2019.

Although some of these discussions may be uncomfortable, it is essential that we keep rural health in the spotlight. I look forward to continuing to make advancements and am optimistic about AMACRD achieving more victories in 2018.

@drshirowatari

It's about time

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

Wage theft. Let's call it what it is. When you have a contract to do a job, and you do that job, and you don't get paid... that's wage theft. Every fortnight, tens of thousands of doctors-in-training have the work that they've done processed into government payment systems. And every fortnight, tens of thousands of dollars and hours go missing.

The way we pay the majority of our doctors-in-training, and for that matter almost every government employee in the country, is embarrassing. It shouldn't be a hard task. Any organisation that employees people needs to know what these people are doing and how long they are doing it for. Seemingly, this simple calculation was left out of the design plans for almost every HR system I've come across in the public sector. Every fortnight, we face a gauntlet of timesheets and rosters that almost invariably result in everyone getting paid less than they're worth. The system takes its Angel's Share, and I guarantee you it's more than 2%. After this tax is levied, you then receive a payslip. Well, you might receive a payslip. They often don't find you, as was the case when for a quarter of my intern year, my payslips were sent to a regional hospital 600 kilometres away from where I worked in an entirely different health service. And when you do find them, they're indecipherable. There's a series of figures and digits that put the techniques that casinos use to confuse us to shame. If big tobacco ever wants to make a comeback in Australia, they need to talk to big hospital.

Of course, no doctor is going hungry in Australia tonight. These dollars aren't going to decide between life and death. But the dollars aren't the problem. They're a surrogate marker for time, and in our vocation we know that time is more valuable than almost anything in this world. When our patients start talking about the "if only-ies" of their lives, we can't help but reflect on ours. Every hour of your life should be an hour worked and paid, or an hour not worked and not paid; it's not rocket surgery. When we allow unpaid hours to propagate, those are hours that you don't get to spend with your family. They are hours you don't have to prepare for your fellowship exams. They are hours that you don't spend with your friends enjoying your life and theirs, in shared experiences that you'll never forget. They are hours that are taken from you. Stolen from you. Lost to you. Make no mistake about it, there is no greater time vampire than your payslip.

This is a system that hides risk. If you can't accurately capture what your staff are doing, then you can't safely run a health care service. You will be staffed incorrectly. You will be insured incorrectly. Your leave liability goes through the roof, and your overworked underpaid doctors resign as their access to leave slowly erodes. The pennies you save on wages today multiply into the errors and catastrophes of the future. Morale falls while culture crumbles. Come to think of it, the single worst action you could take to harm patients is to shortchange your doctors, your nurses, and every other person that keeps healthcare ticking.

But the worst part of this tragedy is us. We're the enablers. We've been bailing the system out for years, and for what? When the razor gangs make their rounds, it's the ultrasound fellowships and the research posts that go missing. But never the run of the mill registrar and resident positions. And you want to know why? It's because we're cheap. We're extremely efficient, we're too busy to complain and we're terrible at understanding our rights as employees. Meanwhile, everybody wants to talk about resilience and the inherent difficulties we face in medicine that make it ineffably hard to be a doctor. The irony! I can resuscitate a trauma patient with half a liver and no kidneys. I can hold a family meeting for my critically unwell and soon to be departed ICU patient. I can't explain my payslip to you. Let that sink in for a moment, and remember it next time someone lectures you about the inherent difficulties in medicine.

This system isn't the brainchild of some villainous mastermind. It isn't even a direct effort of government to minimise costs. It's just simply evolved in an environment in which we've stood back and allowed it to happen. And it's hard to talk about. There's always someone who wants to make you feel shameful. They want to make it about money, and not about time. Every email you send becomes a less and less wanted intrusion. You're made to feel the villain, and that's just for asking for what is rightfully yours! Every unpaid hour we've been guilted into letting slide just helps to make life harder for all of us, our patients included. We focus so much on the money that we see it as a dirty act, when really it's about time. Let's collectively stop talking about money and start talking about time. This is about fair and due process, and enabling a health system than can actually function.

So next time somebody steals from you, stand up and make yourself heard. If your problem isn't resolved, call the AMA (of which you are no doubt a member, you fine medical citizen you!). If you employ doctors-in-training, take a look at the processes you have around overtime and staffing. If you are a board member for a health service, audit the real hours that your doctors-in-training are working, so that you can appreciate the quantum of the silent risks that your company or service is being exposed to.

When they steal your money every fortnight, they make your life marginally harder. But when they steal your time, they make your life impossible. And you shouldn't stand for that. Your time is priceless.

The future health curriculum

BY ROB THOMAS, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

In many ways, the health system in Australia is on the brink of transformation. From moving away from fee-for-service as with NDIS and healthcare homes, to standardisation of private health insurance, to improving the use of personal data through information technology, disruption is clearly on the horizon.

However, in many ways medical education is still well behind when it comes to revolution. From outdated assessment methods, to courses no longer fit for purpose for the learner or the community, it is interesting to see where change must be made.

> "Through multiple assessments, at different times and through different methods, assessors can more accurately discover the strengths and weaknesses of the learner, leading to a clearer pass or fail."

Thankfully, we have seen this year in both the Australian Medical Council (AMC) and the Medical Deans of Australia and New Zealand (MDANZ), a renewed push to improve teaching and learning into the future. But what might this look like?

I recently attended a workshop by the AMC focussing on the usefulness of programmatic assessment. Programmatic assessment as I understand it is a method of assessment where no one task is designed to 'pass' or 'fail' a learner. Instead, assessments are seen as individual data points that reflect an aspect of the learner's knowledge at a certain time point. Through multiple assessments, at different times and through different methods, assessors can more accurately discover the strengths and weaknesses of the learner, leading to a clearer pass or fail.

While this may sound 'softer' than old school competencies, this may represent the opportune way of ensuring safe practice. No one OSCE or Mini-CEX assesses all aspects of the medical job, but together they give a picture of the learner. The added benefit is that programmatic assessment lends itself to more useful and more personalised feedback. Even through web-based adaptive testing, learners may now receive 'tailored' feedback on their performance. This is starting to gain traction in medicine, in useful teaching tools such as AMBOSS out of Germany. Question banks like those used for the USMLE are fast-becoming a way in which medical teaching is already transforming.

Another crucial part of the future health curriculum is social accountability. I was introduced to social accountability as an issue at the International Federation of Medical Students' Associations (IFMSA) general assembly. Built upon the 5 pillars of equity, quality, relevance, efficiency and partnerships, social accountability in medical school means that students should get taught what they need to benefit their community. This may often go against the university's business interests, in favour of providing education that is most appropriate to the learners. In an Australian context, curricular inclusions of indigenous health in context, treating those from culturally and linguistically diverse (CALD) backgrounds, and even tackling rural health issues falls under this banner. Similarly, medical school needs to be accessible to diverse members of the community, just as healthcare is.

Finally, interprofessional education (IPE) has a long way to go in Australian medical schools. Interprofessional education refers to classes or courses where learners from different health disciplines learn together. Multidisciplinary teams are now the foundation of the health unit in Australia, and yet most new medical graduates couldn't tell the difference between an occupational therapist and a physiotherapist. Early silo-ing may be convenient but it adds to a culture of distrust and confusion, and students co-learning and co-producing their educational experience would be the key to solving this.

These are just a few of the many changes going on in medical teaching now and into the future. For me it comes down to preparation of the learner; and in medicine, we are lifelong learners. With programmatic assessment, social accountability and interprofessional education, we will hopefully continue to see the best doctors, prepared for the needs of our patients.

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MBS Reviews – A long way to go, and a lot of improvement needed

BY DR ANDREW MULCAHY, CHAIR, MEDICAL PRACTICE COMMITTEE

Members will recall that the AMA cautiously welcomed the MBS reviews in 2015, noting it was a far-reaching exercise with an ambitious two-year timeline.

The AMA's support for the MBS reviews has always been contingent on the review being clinician-led and having direct and early involvement of the specialist colleges, associations and societies (CAS). The AMA has called for the review to be fully transparent from decision making through to implementation, and be underpinned by a scientific approach. There must also be scope to add new items to achieve the overall aim of 'modernising' the MBS.

In March, the AMA entered into a compact agreement with the Government for a shared vision for Australia's health system. We committed to support in principle the ongoing operation of the MBS Review Taskforce, including a transparent, consultative clinician-led approach to high-value care and future-proofing the system. During that time the Government extended the review another three years to 2020.

Under the compact, the AMA is committed to work with the Department of Health to deliver on agreed recommendations arising from the MBS Review in conjunction with the relevant sectors. The AMA will continue to identify areas to improve the review process and recommendations.

The AMA's approach to the MBS review has always been to defer recommendations relating to specialty items to the relevant CAS groups, and comment on the broader policy.

Now two years into the review, the AMA is continuing to press the Government to ensure that reviews remain more than just a cost-cutting exercise, or a mechanism to meddle with the scope of clinical decision making.

In this context, the AMA reviews concerning recommendations against a set of key principles to determine if a response to the Taskforce is necessary. This work is undertaken through stakeholder consultation with an AMA Working Group drawing from the broader membership, and the Medical Practice Committee. AMA also facilitates an annual CAS meeting for stakeholders to air concerns and receive information as the reviews progress.

Based on these feedback mechanisms, the AMA has responded to every single MBS review consultation - raising issues from across our membership, while stressing where systematic improvements need to be made. The AMA Secretariat and the President have done this through direct representations with the Health Minister, the Department of Health and in writing to the Chair of MBS Review Taskforce.

In our latest submission to the MBS Review Chair, the AMA highlighted a number clear deficiencies and significant variations in the process adopted by the MBS Review Taskforce and the Clinical Committees.

Noting the commitment made by the profession to sit on the Clinical Committees and Working Groups, the AMA has continued to stress that there must remain absolute transparency of the review process.

In particular: where a decision is being made in contradiction to the advice of the profession, there should be clear evidence and data to support such a decision.

We also called for early engagement of CAS on each of the Clinical Committees to ensure recommendations are practical and consistent. We have called for complete transparency, starting with how Clinical Committee members are selected and details of the Committees' scope of work. Finally, the AMA has strongly recommended the Clinical Committees engage early with other Department areas including the Medicare Compliance and Professional Services Review to ensure that any changes to the schedule are practical for clinicians and do not result in sub-optimal care for patients. We all know a poorly worded MBS item can set up a practitioner to fail.

What we don't want to see is a confusing MBS schedule, with medical practitioners as scapegoats.

With more than half the Clinical Committees yet to be established, there is still a long way to go. The next round of public consultations is expected to occur in February, 2018, commencing with the anaesthesia and oncology reports. The AMA continues to monitor with interest, and encourages the profession and the CAS to engage in the consultation and review process early. The full schedule of MBS reviews can be found on the Department of Health website: http://www.health.gov.au/internet/main/publishing.nsf/content/MBSR-about

In the meantime, the AMA has and will continue to hold up our end of the compact with a commitment to a stronger MBS review. Government must ensure the Review does the same through a significant improvement in the way they conduct it.

The road ahead for 2018

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

Another calendar year has flown. CPHD meets regularly to make sure AMA's positions are informed by those with a Specialist qualification and choosing to self-identify as public hospital doctors. This embraces the Specialist employed experience and the continuing quest for continuous public hospital medical quality and general systems improvement. We have an influencing position that is enhanced by more members taking opportunity to solidify CPHD's base and keep us rich with progressive ideas. Industrial negotiations for employed medical practitioners are currently underway in several jurisdictions, many of which have been impacted by the federal government's alteration of previously understood arrangements related to salary packaging. It will be of acute interest to observe how these negotiations are managed, as most have mandated elections from the time of my writing to October 2018.

COAG – Public Hospital funding Agreement

In July 2017, the States and Commonwealth executed a health care funding Agreement out to 2020. It laudably touts incentives aimed to reduce avoidable sentinel events, hospital acquired complications and avoidable readmissions. However, if a State does not achieve an arbitrary benchmark, the otherwise locked in 45 per cent of their public hospital funding could be at risk (including a slice of an additional $2.9 billion of capped services growth funding).

There becomes a risk that any public hospital not adequately meeting its risk improvement targets, irrespective of cause, will then bear funding cuts, yet still be required to meet the defined Agreement imperatives (thus a potentially downward spiral of 'doing more with less'). Such a hospital would be incentivised to rapidly make change in the hope of reducing its funding loss. Public hospitals may insist members work unsociable hours (for alleged quality & efficiency reasons), roll-out an unmanaged expansion of private practice arrangements (to cover funding shortfalls) and redirect Doctor's clinical support time to the design of new systems (all to avoid the penalties). CPHD will work on these and a host other concerns that require our reasoned and measured response. In 2018, CPHD will monitor against such potentially perverse outcomes that may arise from the underpinning by an ultimately penalty-based regime, let alone the potential for cherry-picking.

Private Practice

For this health care funding agreement round, the Commonwealth seems to have flagged its willingness to consider change to the arrangements applying to private patients admitted to public hospitals. As discussed in October, there are good reasons why CPHD is concerned about any attempt to substantially reform existing arrangements, including availability of specialist clinical skills & equipment, supplementation of public hospital income and breadth of case mix available for optimum teaching, training and research.

CPHD recognises and supports the long-standing rights of public hospital patients who elect to receive services as a private patient, but appreciates there does need to be balance. It is a no-brainer that clinical need, not private/public status, must be the determinant for patient prioritisation and that the patient must be free to make informed choice without unfair inducements or undue pressure to convert to private insurance. Equally, Doctors must be assured of their right to provide care without undue pressure to encourage conversion from public status. CPHD will be at the vanguard of any mooted change agenda.

Personal Safety

In my August *Australian Medicine* piece I expressed how I am regularly horrified at the experiences of violence in our community and our workplaces. Therefore, CPHD motives are obvious in its lead advocacy for better investment in security, awareness, technology and facilities to make all employees safe when at work. It seems to me our response should be health professional holistic rather than just doctor specific (i.e. protecting the team). We still want accessible and personable care for the public so excessive responses are to be avoided (think armed security in Victorian emergency departments previously batted off by AMA because the idea presented more dangers than it solved). CPHD will produce an AMA position to reduce workplace dangers in light of escalating population growth, mental health / substance abuse presentations and the anger born amongst some from frustrations at the lack of public hospital responsiveness and capacity.

Overall, your Council of Public Hospital Doctors is in the business of emerging trend identification and response. No doubt in 2018 some 'curly' policy pronouncement will emerge from government ranks but we are consultative, responsive and equipped to ensure our public patients and our public employed clinical ranks are protected from the excess of public service thought bubbles or political ideology.

I offer season's greetings to all of our AMA membership family. It is important for all to ensure they have a sensible break and attend to personal well-being, family and friends, and to start 2018 refreshed and invigorated. See you in the New Year!

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Government launches online resource to fight antimicrobial resistance

The Federal Government has used Antibiotic Awareness Week in November to launch a new online resource for industry and the community, as part of Australia's ongoing work to tackle the rise of antimicrobial resistance.

Antimicrobial resistance (AMR) occurs when microorganisms, like bacteria, that cause infections resist the effects of the medicines used to treat them, such as antibiotics.

As a result of antibiotic resistance, standard medical and veterinary treatments may become ineffective and infections may persist and spread to others.

The Government's funding commitment to help tackle the rise of AMR is $27 million – including $5.9 million from the landmark Medical Research Future Fund.

The planned AMR website, is one of the first priority areas of the Implementation Plan. It will aim to provide information for the community, health professionals, animal health professionals, farmers, animal owners and the broader agriculture industry.

Australia is one of the developed world's highest users of antibiotics – one of the main causes of AMR. In 2015, Australian doctors prescribed more than 30 million antibiotic scripts through the Pharmaceutical Benefits Scheme.

Many patients are not aware that antibiotics only work against infections caused by bacteria and should not be used to treat viruses like colds, flu, bronchitis and most sore throats.

AMA President Dr Michael Gannon said in a recent ABC interview that AMR is a concern and there needed to be: "Better stewardship in hospitals, better education for GPs, but perhaps most importantly better education for people in the community for them to understand when antibiotics are not only not required, but they're potentially dangerous or risky."

AMR has both a health and economic impact with infections requiring more complex and expensive treatments, longer hospital stays, and it can lead to more deaths.

The World Health Organisation (WHO) believes global urgent change is needed in the way antibiotics are prescribed and used because antibiotic resistance is one of the biggest threats to global health, food security, and development today. Antibiotic resistance can affect anyone, of any age, in any country, including Australia.

WHO also believes that even if new medicines are developed, without behaviour change, antibiotic resistance will remain a major threat. Behaviour changes must also include actions to reduce the spread of infections through vaccination, hand washing, practising safer sex, and good food hygiene.

"A lack of effective antibiotics is as serious a security threat as a sudden and deadly disease outbreak," said Dr Tedros Adhanom Ghebreyesus, Director-General of WHO.

"Strong, sustained action across all sectors is vital if we are to turn back the tide of antimicrobial resistance and keep the world safe."

A recent study published in the *Medical Journal of Australia* shows that antibiotic resistance is on the rise and is present in our communities in Australia.

Lead researcher Dr Jason Agostino from the ANU Medical School said about 60 per cent of drug-resistant staph infections were picked up in the community, so infection control needed to shift from hospitals to the community.

"The problem of infections resistant to antibiotics in our community is not just a theoretical problem that will happen some time in the future – it's happening right now," Dr Agostino said.

Until the early 2000s in Australia, staph infections resistant to antibiotics mostly occurred in hospitals. The researchers found hospital infection rates are improving, with decreased infections in two of the region's largest hospitals.

The study found that patients most at risk of the drug-resistant staph infection in the community are young people, Indigenous Australians and residents of aged-care facilities.

"We also need to improve the way we share data on antibiotic resistance to staph infections and link this to hospitalisation across health systems," Dr Agostino said.

You can find out more about the progress of the Implementation Plan actions in the National Antimicrobial Resistance Strategy Progress Report at www.amr.gov.au.

MEREDITH HORNE

Research

Alcohol damage could start at conception

New research that examines alcohol consumption's long-term negative health effects and how they could starts even from the time of conception has been published.

Published in the *Journal of Developmental Origins of Health and Disease* and the *American Journal of Physiology* is one of the first studies to look at alcohol in preconception rather than during pregnancy.

Professor Karen Moritz from The University of Queensland's Child Health Research Centre UQ said the research using animal models found that exposure to alcohol around conception made male offspring more likely to seek a high fat diet more often as they aged.

"We found that exposure to alcohol resulted in male offspring having a sustained preference for high-fat food, which indicated the reward pathway in the brain was altered by alcohol exposure around conception," Professor Moritz said.

"Surprisingly we found alcohol exposure at this time had no effect on alcohol preference in offspring of either sex later in life."

In the study, which was conducted on rats, the equivalent of four standard drinks was consumed every day for four days either side of mating. Male offspring which were exposed to alcohol in this way developed elevated preferences for foods high in fat.

The *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* has been developed by the National Health and Medical Research Council. No alcohol consumption is their current recommendation for pregnant women, and those who planning a pregnancy.

The dangers of consuming alcohol whilst pregnant are well documented and widely acknowledged. The message that there is no safe level of fetal alcohol exposure has been widely disseminated for the best part of the last decade.

More is emerging about the impact of alcohol consumption prior to conception. A separate but related study by UQ found that male offspring of mothers who had consumed alcohol around conception had five per cent more body fat than offspring of mothers who had not consumed alcohol around conception.

Professor Moritz said the study also found both male and female offspring were more likely to suffer from fatty liver when exposed to alcohol at conception.

"Our results highlight that alcohol consumption, even prior to a fertilised egg implanting in the uterus, can have lifelong consequences for the metabolic health of offspring," she said.

The research highlights the vulnerability of the developing embryo. Previous studies have identified a link between paternal alcohol consumption around conception and epigenetic alterations.

Given that half of all Australian pregnancies are unplanned, the challenge remains reducing alcohol exposure in the early stages of unplanned pregnancies, when the mother may not even know she is pregnant.

The AMA recently raised its concern that the Government's new National Drug Strategy did not focus on alcohol – even though alcohol-related harm alone is estimated to cost $36 billion a year.

AMA President Dr Michael Gannon has called for a national alcohol strategy.

The AMA position statement on Fetal Alcohol Spectrum Disorder is available here: https://ama.com.au/position-statement/fetal-alcohol-spectrum-disorder-fasd-2016

The 2009 *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* can be found here: https://www.nhmrc.gov.au/guidelines-publications/ds10.

GEORGIA BATH AND MEREDITH HORNE

Results of study show first effective intervention against dementia

Researchers in the United States have released a study showing effective intervention aimed at significantly reducing the risk of dementia.

The findings, first released in the peer-reviewed journal *Alzheimer's & Dementia: Translational Research & Clinical Interventions,* were published mid-November following a 10-year study.

It is the first randomised controlled trial to show an intervention effective at lowering the risk of dementia.

According to the article, *Speed of Processing Training Results in*

Research

Lower Risk of Dementia, a computerised brain exercise licenced exclusively by Posit Science, markedly reduced the risk of dementia among older adults over the decade of the study.

Posit Science makes of the online and app brain training platform known as BrainHQ.

The article reports on the latest results from the *Advanced Cognitive Training for Independent and Vital Elderly* (ACTIVE) Study, funded by the National Institutes of Health. That study followed 2,802 healthy older adults for 10 years, as they aged from an average of 74 to 84.

The ACTIVE Study looked at the impact on aging of different types of cognitive training by randomising participants into a control group and three intervention arms:

1) a memory group receiving classroom instruction on memory strategies;
2) a reasoning group receiving classroom instruction on reasoning strategies; and
3) a speed of processing group receiving individualized computerized brain training in a classroom setting.

Participants in the cognitive training groups were asked to engage in a total of 10 sessions of training of about an hour each and conducted over the first five weeks of the study.

All participants were assessed on a number of cognitive and functional measures at the beginning of the study, after the first six weeks, and at the end of years 1, 2, 3, 5 and 10.

Subsets of each intervention group also received four additional booster training sessions in the weeks before the assessments at the end of years 1 and 3.

At the end of 10 years, researchers found no significant difference in incidence of dementia for the strategy-based memory or reasoning training groups, as compared to the control group. However, the speed of processing group engaged in computerized brain training showed a significant reduction in incidence of dementia – with a 29 percent reduction in the hazard of dementia.

“Relatively small amounts of training resulted in a decrease in risk of dementia over the 10-year period of 29 percent, as compared to the control,” said Dr Jerri Edwards, lead author of the article and a Professor at the University of South Florida, College of Medicine.

“And, when we looked at dose-response, we saw that those who trained more got more protective benefit.”

To place the size and importance of this protective effect in context, the researchers quantitatively compared the risk reduction for dementia from the computerised brain training to the risk reduction for major cardiovascular events, (such as heart failure, heart disease and stroke) yielded by blood pressure medications, and found that this non-pharmacological intervention had a two to four times greater protective effect against its targeted disease condition.

“No health professional would suggest that any person with hypertension forego the protection offered by prescribed blood pressure medication,” said Dr Henry Mahncke, CEO of Posit Science.

“We expect these results will cause the medical community to take a much closer look at the many protective benefits of these exercises in both older and clinical populations.”

The newly published results confirm and extend preliminary results first announced last year. Those results used a broader definition of dementia to reflect the under-reporting of dementia in the community. The preliminary results, indicating a 33 percent reduction in risk, relative to the control are contained in this report. However, to be more conservative, the authors now also include and highlight a narrower definition of dementia – restricted to reports of a dementia diagnosis or falling below a cut-point on a standard test. Even with the narrower definition, the effects are substantially similar, with a 29 percent reduction in dementia risk at any given point in time for the overall speed group as compared to the control.

Participants in the computerised brain training group were trained on a highly specific task designed to improve the speed and accuracy of visual attention, including both divided and selective attention. To perform the divided attention training task, a user identified an object (i.e., car or truck) at the center of gaze while at the same time locating a target in the periphery (i.e., car). As the user gets the answers correct, the speed of presentation becomes faster. In the more difficult training tasks, the target in the periphery is obscured by distracting objects.

“This study highlights that not all cognitive training is the same,” Dr Edwards said. “Plasticity-based, computerised, speed of processing training has differentiated itself based both on the data and on the neurophysiological model from which it was developed.”

CHRIS JOHNSON

Terminator says health is collateral damage of fossil fuels

Hollywood actor and former Governor of California, Arnold Schwarzenegger, has used a United Nations gathering in Germany to describe fossil fuels as a public health hazard.

At a sideline event of the 12-day UN climate talks in Bonn in November, Mr Schwarzenegger delivered a well-received speech that issued a challenge to world leaders.

A long-time outspoken environmental activist, the star of such blockbusters as *The Terminator, Total Recall, Collateral Damage* and *Predator*, urged governments everywhere to start labeling fossil fuels with a public health warning.

That health warning should state, he said, that their use could cause illness and death.

He praised the World Health Organization (WHO) for delivering on a 164-nation tobacco control deal in 2003 that resulted in health warnings on tobacco products.

But he added that a similar deal could be reached with regards to oil and coal products.

"Wouldn't it be great now if they could make the same pact with the rest of the world to go and say, 'let's label another thing that is killing you – which is fossil fuels'," he said.

"If you went to a gas station, it says that thing you're pumping into your car is killing you.

"Pollution kills more than nine million people a year. Over 300,000 people will die over the course of this conference. That's the population of Bonn.

"This is a massive tragedy. And as depressing and terrifying as it is, we are not talking about it enough," he said.

WHO Director-General Tedros Adhanom Ghebreyesus called on conference delegates talk about building climate resilient health facilities in their home nations by 2013, which is a stipulation of the Paris Agreement.

He added that more investment was needed in the health sector.

"Climate change strikes at the heart of what it means to be human," Dr Ghebreyesus said.

"Climate change is not a political argument in Fiji and other island nations. It's everyday reality – whether that's in the form of destructive storms, rising sea levels or increased risk of infectious disease.

"These communities need assistance to cope with a world that is changing in front of them."

The Paris Agreement global climate treaty aims to limit rising temperatures to below 2˚C by reducing greenhouse gas emissions.

Fiji presided over the Bonn conference and was also the beneficiary of an initiative launched by WHO and the UN climate secretariat aiming to triple international financial support for action on climate-related health issues in the developing small island nations.

CHRIS JOHNSON

Helsinki for holidays if you are safety conscious

The newly released *2018 Travel Risk Map* reveals threat levels across the globe in three categories – medical, security and road safety.

Produced by security specialists International SOS, the charted risks across the three categories shows that Finland is the safest place on the planet.

Also listed as 'low' threats for medical concern are Norway, Sweden as well as much of western Europe, the US, Canada and Australia.

International SOS say that their Medical Risk Ratings are determined by their assessment of a range of health risks and mitigating factors including: infectious diseases, environmental factors, medical evacuation data, the standard of available local emergency medical and dental care, access to quality pharmaceutical supplies, and cultural, language or administrative barriers.

Group Medical Director of Health Intelligence for International SOS Dr Doug Quarry said that there is an increased understanding of preventative agendas in medical and travel risk mitigation, however organisations need to do more to strategically support their travelling staff.

"A staggering 91 per cent of organisations have potentially not included their travel risk program in their overall business sustainability program and 90 per cent are seemingly ignoring the impact a wellbeing policy could have on their travelling workforce," Dr Quarry said.

The Scandinavian countries also perform well for road safety, possessing a 'very low' risk of a road traffic accident. Countries that Australians visit in significant numbers that have a 'high' road risk include Thailand and South Africa.

Unfortunately the number of Australians who died while travelling overseas rose past 1600 last financial year according to the Australian Government's Department of Foreign Affairs and Trade (DFAT).

DFAT updates their travel advice to countries continuously and urges any Australian travelling overseas to register on the DFAT's Smart Traveller website. This will allow the government to immediately alert Australians of any changes to the situation and know where Australians were if an evacuation was necessary.

Travel insurance remains an area of concern for Australian consular officials. Travellers without travel insurance are personally liable for covering any medical and associated costs they incur. The Australian Government won't pay for your medical treatment overseas or medical evacuation to Australia or a third country.

The latest survey results undertaken by DFAT that looks at how Australians use travel insurance reveals Australians are not adequately using travel insurance, especially when it came to cruises. Half (48 per cent) of recent cruise goers who took out insurance were exposed to the risk of being unknowingly uninsured. This was a combination of those (38 per cent) who took out a general travel insurance policy that may not have adequately covered them for a cruise, and / or those (30 per cent) who were not certain that their travel insurance covered them for all countries their cruise liner visited.

The Australian Government provides regularly updated travel advice to all Australians at http://smartraveller.gov.au/Pages/default.aspx.

MEREDITH HORNE

When I'm sixty-four…

BY DR CLIVE FRASER

1953 Austin A40

In 1958 Sir Paul McCartney was 16 years old when he wrote a song about ageing and relationships.

It had the title, *When I'm Sixty-four*.

The song was eventually released nine years later on the *Sgt. Pepper's Lonely Hearts Club Band* album and it is still one of my favourite Beatles songs.

It immediately came to my mind when a colleague told me about a car that he'd just bought.

It was a 1953 Austin A40 that had been languishing in a paddock under a tree near Warwick for thirty years.

It turns out that the car was under a tree because the tree had actually grown up through the car, and not the other way around.

When my colleague opened his garage door to show me the vehicle waves of nostalgia were flooding my mind as I recalled that this was the very same A40 model that had delivered myself and my three brothers home from hospital as infants.

Whilst childhood amnesia denies me any contemporaneous memory of the vehicle, there are two old family photos of our A40 which through the wonders of projective identification I can place myself in.

But, what about the 2017 A40.

For starters there was the need to negotiate the asking price of $900 down to an acceptable $750.

This was of course a pre-requisite for establishing a positive relationship with an object that was going to consume the best part of the next ten years of my colleague's life and take up a considerable space in his garage.

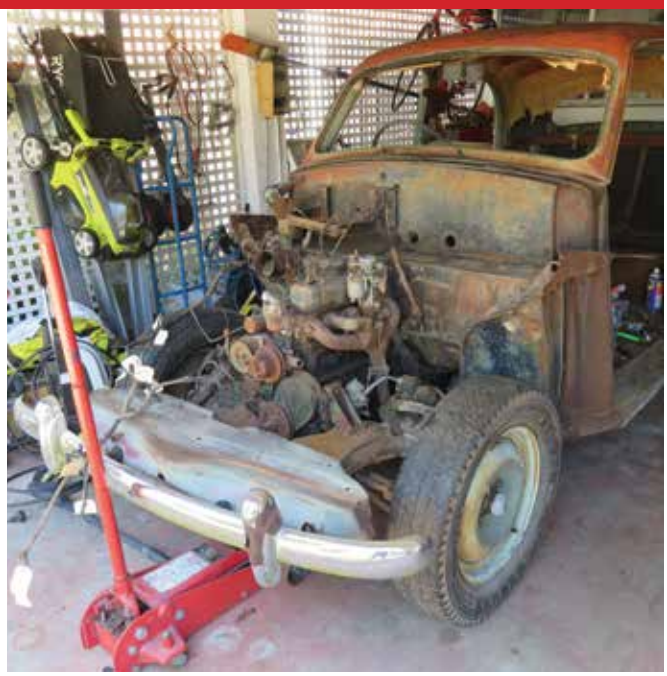
Importantly the old A40 was complete with every nut and bolt still attached.

We stood there marvelling at the Mist Green paint job which even after 64 years could still be seen through the eroded layers.

The seats were stuffed with horse hair and covered with British cow hides and provided an important clue as to how many miles the vehicle had actually travelled.

For my colleague had neglected to check the odometer reading when he decided to buy the vehicle.

After all it was 64 years old and who would care if it had been around the clock, a few times.



Did it even have an odometer?

I scrambled inside the car and through the dusty glass I could see that the car had done 54,768 miles.

We then convened a meeting to discuss the possibilities.

There was no way that those front seats had supported 154,768 miles of buttocks (three times the mileage on the odometer.

The pedals and steering wheel weren't worn either, so the actual mileage of this car was simply 54,768.

With such a low mileage on the odometer we thought that this might be a good predictor of longevity in the drive-train.

I then asked the bleeding obvious question: "Do you think the motor will turn over?"

Seems like the previous owner said that the A40 had been driven to the paddock, but I've always been wary when buying a second-hand car.

A rotating adjustable wrench on the crank-shaft proved that the motor was in fact still functional.

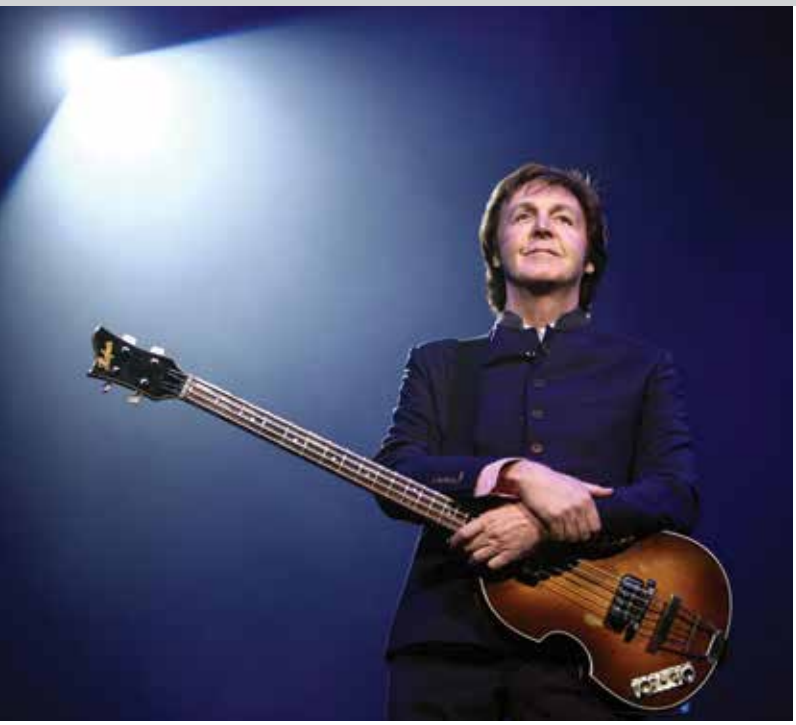
Could this be the start of another 64 years for the A40?

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

Paul McCartney and his welcome return to Australia … finally

BY CHRIS JOHNSON



By the time this edition of *Australian Medicine* arrives hot off the presses, Sir Paul McCartney's One on One world tour would have not only found its way to Australia, it will be almost over.

Because of early end-of-year publishing deadlines, combined with the usual lead times between design, print and delivery, this hard copy edition of *AusMed* won't be able to include a review of one of Macca's Aussie concerts. Do keep an eye out online though, because there will be a review. Sir Paul back Down Under will be too good to miss.

It was 1993 when Sir Paul last performed in Australia, as part of his well-received New World Tour. That tour was his last anywhere for nine years. He had his wife Linda with him then – an integral part of the band and the obvious love of his life – who died five years later from breast cancer.

McCartney was coming back to Australia in 2002. The tour had been announced. But it was cancelled after the Bali bombings, with the feeble excuse that the last thing Australians needed then was a pop concert when they were grieving for the loss of their citizens in that terrorist attack.

His excuse for cancelling didn't add up at all, given the fact Sir Paul not only performed a special benefit concert in New York the month following the Twin Towers attacks there on September 11, 2001 – he organised it, rounded up his celebrity mates to lend a hand, and he even wrote a special song for the occasion.

All is forgiven, Sir Paul. The wait has been far too long, but Australia is pleased you have returned.

And why wouldn't we be?

There is no other way of putting it than this – Paul McCartney is an absolute legend, and rock n roll music would not be what it is today if he had not come along.

It is no myth that even as a young lad, Paul McCartney could produce sweet music from any instrument he was handed. That natural talent simply improved as he aged.

Yes, many musicians (better musicians even) have come along since the Beatles, since Wings, since Sir Paul – but all have been shaped in some form by the music he has penned and performed.

The brilliance of Lennon and McCartney cannot be overstated and neither can McCartney's driving and creative force in that dynamic duo and in the Fab Four generally.

Going by the set lists of his tour so far, audiences will be treated to a superb mix of Beatles' songs. *Let it Be, Love Me Do, Lady Madonna, Yesterday, Hey Jude, Blackbird* and much more of the Beatles' catalogue have featured so far – as well as nods to his former bandmates with *Something* (written by George Harrison), *Give Peace a Chance* (a John Lennon classic), and *I Wanna Be Your Man* (a Lennon and McCartney tune that was sung by Ringo Starr).

Then there are the Wings and McCartney solo numbers that have been pulled out of the bag this tour – *Jet, Live and Let Die, Maybe I'm Amazed*, and *Band on the Run* to name just a few.

There are literally hundreds and hundreds (close to a thousand) songs McCartney has written, either by himself or in collaboration.

At least half of those are instantly recognisable by music lovers across the generations.

Getting to hear and see a few dozen of these momentous songs being performed live by the man who actually wrote and recorded them is a treat that defies description.

McHenry Hohnen wines, single minded

BY DR MICHAEL RYAN

1

Success breeds success. The McHenry Hohnen label, formed in 2004, is a cornucopia of success. The founders David Honan and Murray McHenry are Western Australian wine royalty and their lives are an article by themselves. The success is underwritten by the product with some extremely well made and tasty wines.

David Hohnen started Cape Mentelle in the Margaret river region in 1976. He had worked in California winemaking in 1960. He also established Cloudy Bay in Marlborough New Zealand in 1988.He has the honour of winning back to back '83 and '84 Jimmy Watson trophies for his Cape Mentelle Cabernet. Moet Hennessey spied a quality product and bought him out. This enabled David to team up with Murry McHenry to form McHenry Hohnen wines.

2

Murray McHenry was immersed in hospitality with his family being hoteliers. The passion of the grape was calling and Murry planted 30 hectares of grapes in 1984. In 1998 he established 75 hectares becoming the Rocky Road vineyard. Chardonnay, Zinfandel and Cabernet Sauvignon have been the key grapes. Semillon, Sauvignon Blanc, Petit Verdot, Malbec, Merlot and Shiraz are also grown.

The concept of single vineyard wines is well entrenched. The wines of the single vineyard series are from the Hazel, Burnside and the Calgardup vineyards. Each vineyard imparts its own stamp on the wines. The Hazel is the oldest and generally produces wines of a deeper complexity. The Calgardup is the coolest producing elegant structured wines.

3

From these sites the range includes the Rocky Road Tempranillo Rose, Semillon Sauvignon Blanc, Chardonnay, Cabernet Merlot and Shiraz. The Single Vineyard series include Caldgardup Chardonnay, Burnside Chardonnay, Hazel's Chardonnay, Hazel's Cabernet Sauvignon, Hazel's BDX (Bordeaux Blend) and Hazel's Zinfandel. The Rolling Stone is a Bordeaux blend and is the flagship wine. Some blended cheery wines are made under the Amigos label.

Biodynamic principals are employed in the viticultural process. Some winemakers say it doesn't make a difference. Wine is in some ways a 'living thing' and hence the process that encourages happy healthy vines will always be a superior product. Composting, predatory care of insects, and natural balances of yeasts and bacteria are encouraged. The lunar cycles affecting flowering are respected as well.

Mike Seeger is the driving force of the organic and biodynamic approach. This is encouraged by winemaker Julian Grounds. Having worked in Burgundy, Central Otago, Yarra valley and Margret River Julian has a real appreciation for cool climate winemaking and the sense of terroir.

The wine making process always begins in the vineyard. This sets up the brief on a platter to the wine maker. Natural yeasts are used in fermentation, sometimes wholly or partially. I always believe this helps give the wine a sense of its origin.

They have a tidy cellar door open every day 9:30-4:30. They also have a range of David Hohnen smoked meats worth nibbling on.

WINES TASTED

1. McHenry Hohnen Rocky Road Chardonnay Margaret River 2016

Pale light yellow. An exciting bouquet of stone fruits, lemon, notes of grass with just a hint of lees contact. This imparts a slight funky nose. The palate is flavoursome, with a lean acidic finish. Minimal oak influence and no malolactic fermentation make for a nouveaux style Chardonnay. Have with fish pie.

2. McHenry Hohnen Burnside Margaret River Chardonnay 2016

Light yellow colour. The Nose of this wine is extraordinary. Nectarines, lemon sherbet, oaky notes, and yeast bread like aromas waft like a mirage on a summer's day. Fully juicy anterior palate with structural acidity and French oak round this wine out. No malolactic fermentation is noted. Will cellar 10 years. Scallop and Chorizo Tapas suit.

3. McHenry Hohnen Margaret River Zinfandel 2015

\Rich deep garnet to plum colour. Aromas of, pomegranate, with deep brooding layers of liquorice. This a super fruit bomb of lip smacking flavour supported by some fine tannins and French oak exposure. It flows over the tongue like eggs whites folding in on that Michelin star soufflé. Have with sugar cured beef.

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