AUSTRALIAN
Medicine
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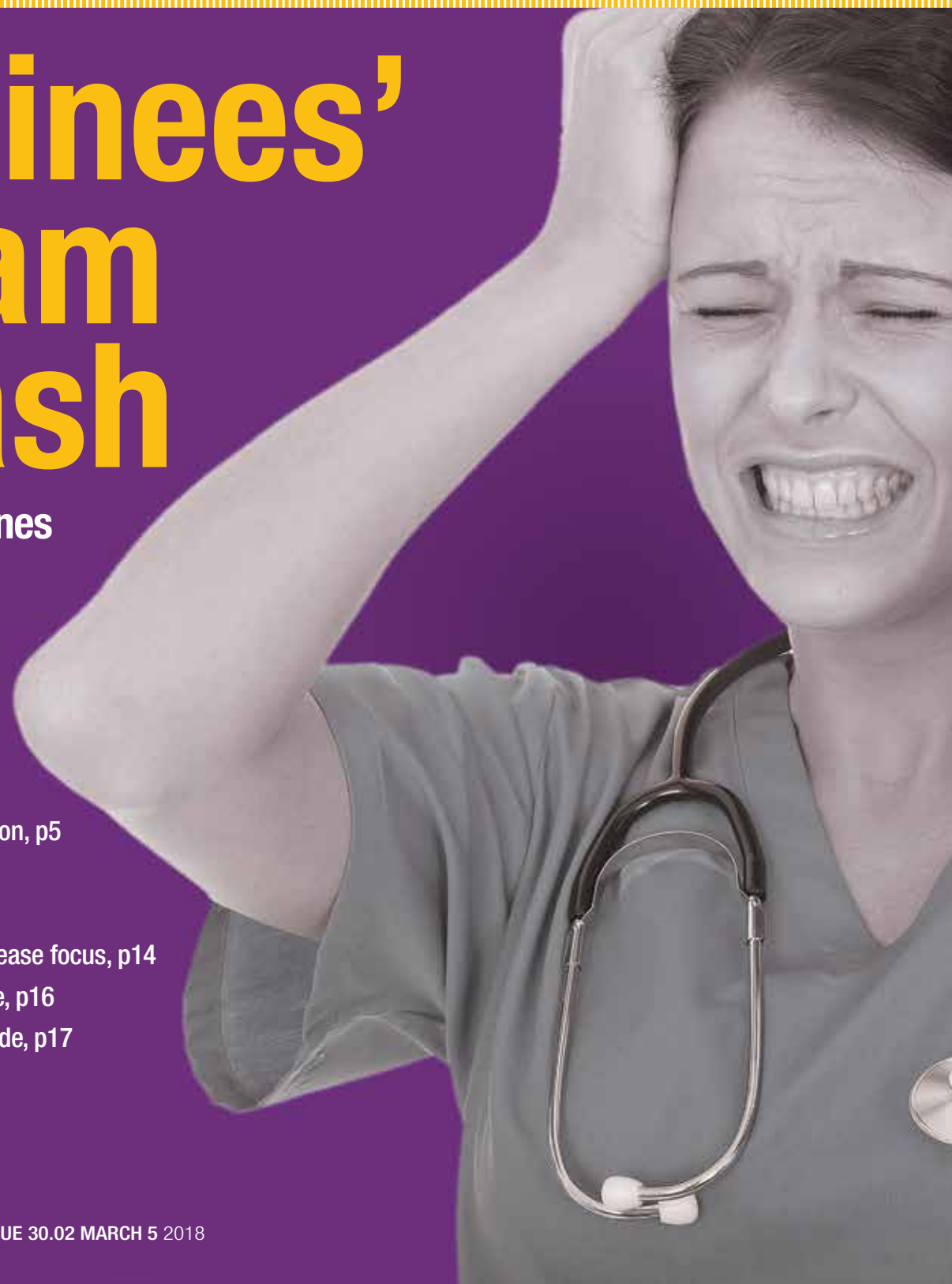
Trainees' exam crash

AMA intervenes to help, p3



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Trainee doctors impacted by RACP exam fail

The AMA has intervened on behalf of trainee doctors around the country, following the distressing mid-test crash of the computer-based Royal Australasian College of Physicians examination.

Following strong interventions from AMA President Michael Gannon and Chair of the AMA Council of Doctors in Training John Zorbas, the RACP has agreed to fully refund the exam fee, to release the questions from the computer-based exam to ensure that no participants were disadvantaged, and to offer a paper-based exam.

Dr Gannon wrote to all State and Territory health departments asking them to accommodate the more than one thousand trainees who had to sit the test again.

“This is a high-stakes examination that trainees spend months preparing for and involves sacrifices in their personal and family lives,” he said.

“The decision by the RACP to call off the exam has caused enormous distress for participating trainees who now face the daunting prospect of having to re-sit the exam.

“While the AMA is very concerned that trainees find themselves in this position and is seeking answers from the College, our main focus at the moment is to ensure that trainees are properly supported and have every chance of participating in and passing the scheduled exam.”

Dr Gannon asked the health departments to allow the trainees extra time for study and revision, and to the sit the rescheduled exam. The dramatic episode had a huge impact on hospital rosters and leave entitlements.

Dr Gannon asked the trainees’ bosses to be understanding of their predicament.

“While some health services may find this challenging, these are unusual circumstances that require a very sympathetic response,” he said.

“I hope you will commit to supporting these trainees, including by directing local health services to do everything possible to help them at this very difficult time.”

About 1200 trainee physicians in Australia and New Zealand

Trainee doctors impacted by RACP exam fail

... from page 3

AMA Council of Doctors in Training Chairman, Dr John Zorbas

had to re-sit the RACP Basic Exam on March 2, after a massive IT failure caused the computer-based written test to be cancelled while they were sitting it last month.

IT company Pearson Vue was employed to conduct the exam on February 19.

A technical fault left a significant number of candidates locked out of the computer based system and unable to complete the second part of the examination after their scheduled break.

Even though some trainees had completed the test, the RACP insisted that all candidates resit the exam and that the cancelled test will not count as an examination attempt.

The Adult Medicine and Paediatric Written Examinations are one exam in two papers. The final score relies on completion of the whole exam, and the complex calculation of pass marks is dependent on this, the College said.

RACP President, Dr Catherine Yelland, apologised to the trainees for the "stress and disruption" caused by the cancellation of the exam and vowed to release findings of an investigation into it.

"We understand that this has been unexpected, stressful and distressing. We have and continue to apologise for this. We encourage all trainees to talk with their supervisors, colleagues, family and friends," she said.

An RACP panel was established to review the issue, including the technical failure of the exam, the College's response, and the impact on trainees – including incurred travel costs, cancelled holidays, and other expenses.

"Many of you have had to make other arrangements when you were looking forward to family events, a holiday or a short break from study," Dr Yelland said.

"We are also aware of the financial implications for trainees."

Dr Zorbas said the system failure had caused enormous stress throughout the medical profession.

"This is an exam that some people have been studying for years for, and for it to come apart at the last minute because of a technical glitch without a backup system in place is incredibly distressing for these trainees," he said on the day.

"Any trainee who finds themselves in distress, any doctor who is just not coping with the situation should contact the Doctors' Help Advisory Service for support.

"And secondly, we want to reassure these doctors that we're speaking to RACP to find out exactly what's gone wrong and make sure there's an open, fair, transparent system in place."

The exam cost each trainee about $1800. The College vowed none would be financially disadvantaged for travelling to the rescheduled test.

A supplementary examination time was also promised also for those who could not sit the test on March 2.

CHRIS JOHNSON

Campaign for a public health approach to preventing child abuse

Every child in Australia deserves to grow up in a home free from harm. Yet year in, year out, we see an increase in the numbers of substantiated child abuse and neglect cases. In 2016-17, nearly 50,000 children were found to have been – or were at risk of being – abused, neglected or otherwise harmed. This is unacceptable.

As medical professionals, Doctors are at the forefront of responding to and treating the consequences of child abuse. Doctors see firsthand how the physical and psychological scars of maltreatment and neglect have lifelong negative effects on children and those who love them. They know that the best possible medicine is to stop this trauma occurring in the first place.

The AMA has long advocated for a public health approach to child protection. Just as we know it is a mistake to position the ambulance at the bottom of the cliff, we know we simply can't wait until problems within families are so severe that the only option is to take children away.

Over the last 20 years, there have been more than 40 inquiries and commissions into the failings of the child protections system. Adopting the principles of a public health model and investing in early intervention and prevention has been a recurring recommendation and repeatedly called for by those of us committed to improving the wellbeing and safety of children.

Many governments have increasingly adopted public health based polices in relation to child protection, as evidenced by the state and federal collaboration on the National Framework for Protecting Australia's Children – a national policy premised on a public health model.

Yet in many ways, the mantra that prevention is better than the cure has failed to translate from political rhetoric into meaningful change. This is most clearly seen in budget breakdowns. Significant and sustained funding for prevention and early intervention has yet to become embedded in Federal and State budgets.

Australian service systems continue to remain reactive rather than preventive, with only 16.6 per cent of total child protection expenditure nationally invested in early intervention and prevention.

Nationally in 2015-16, $2.7 billion was spent on out-of-home-care (accounting for 57.4 per cent of all expenditure on child protection services). This amount has continually increased over the last five years.

If we want to see fewer children coming through our hospital doors with injuries no child should experience, we need to stop tinkering at the edges of a broken system. Significant transformation is needed to get families the help they need, quickly and early on, to prevent the worst from happening. To this end, the AMA has been following the development of an ambitious new advocacy campaign to address the persistent barriers to change.

This campaign, initiated by The Benevolent Society in partnership with more than 20 organisations across a range of sectors, aims to put the wellbeing and safety of children on the public and political agenda. The campaign will be calling for greater Government accountability for improved child wellbeing outcomes and will advocate for adequate funding to ensure that families getting the right support at the right time.

While this campaign is still in its early phases – with a public launch forecast for later this year – the AMA is keeping a close eye on its development and providing input into the campaign objectives.

SIMON TATZ
AMA DIRECTOR, PUBLIC HEALTH

Unacceptable kidney transplant rate for Indigenous Australians

AMA President Dr Michael Gannon has called for urgent attention in addressing the gap between Indigenous and non-Indigenous Australians accessing kidney transplants.

Figures recently released show that Indigenous patients are 10 times less likely than non-Indigenous patients to be added to the waiting list for a kidney donation transplant.

About 13 per cent of patients receiving dialysis treatment in Australia are Indigenous. Only 241 of 10,551 patients with a functioning kidney transplant are Indigenous.

Some renal experts have pointed to a racially-based bias, suggesting some non-Indigenous doctors favour non-Indigenous dialysis patients.

Other specialists in the field insist the gap is not fuelled by racism.

During an interview with the ABC, Dr Gannon said these figures were unacceptable and more needed to be done to ensure Indigenous Australians received transplants when needed.

"I'm shocked by those figures. A ten-fold gap is entirely unacceptable," Dr Gannon said.

"The topic of racism in our health system is an uncomfortable one for doctors, nurses, but it has to be one of the possible reasons for this kind of disparity.

"If there's reasons why Aboriginal and Torres Strait Islanders are not being transplant-listed, they need to be investigated, but the problems need to be fixed."

Dr Paul Lawton, a specialist at the Menzies School of Health Research, told the ABC that while Australian kidney specialists were well meaning, there was a "structural racism" that had led to low transplant rates for Indigenous patients.

"Currently, our system is structured so that us non-Indigenous, often male, middle-aged white kidney specialists offer kidney transplants to people like ourselves," Dr Lawton said.

"It both makes me sad and angry that in Australia in the 21st century, we see such great disparities in access to good quality care."

Indigenous Health Minister Ken Wyatt said he was disheartened with the figures and wanted to focus on building a heightened awareness of the issue over the next year.

According to Kidney Health Australia, about 30 of 800 kidney transplants performed each year are received by Indigenous Australians.

This under-representation can be attributed to a variety of reasons such as comorbidities, delays in listing and significant tissue matching issues. Importantly, the outcomes from transplantation are considerable poorer than among non-indigenous people.

To improve access to transplantation by Aboriginal and Torres Strait Islander renal patients, there needs to be a better understanding of how to address the barriers. There also needs to be improved support services for patients.

Kidneys for transplantation are largely from deceased donors. There are very few living kidney donors in Aboriginal and Torres Strait Islander communities, due to burden of disease and likelihood of comorbidities evident. Increasing live donations or listing more people on the waiting list is very unlikely to see improvements, given the burden of disease experienced and current barriers in the system.

The reasons for poor access to transplantation experienced by Aboriginal and Torres Strait Islander Australians are complex and can be attributed to:

- The greater burden of comorbid illness amongst Aboriginal and Torres Strait Islander dialysis patients leading to fewer patients being judge medically suitable;
- The shortage of living and deceased donors from within Aboriginal and Torres Strait Islander communities;
- The length of time on the waiting list and matching system;
- The challenges in delivering appropriate health services to people living in remote areas who might also have low health literacy and not speak English as a first language;
- The dislocation that follows from moving to transplant centres in distant capital cities; and
- The high complication rate, particularly in terms of early infectious complications leading to poor transplant outcomes, including substantially higher death and graft loss rates.

The poorer outcomes among those who receive transplants are due to higher rates of rejection, less well-matched kidneys, higher rates of infection and infection-related deaths. There are downsides to transplantation.

Prior to transplantation, these include a requirement for significant work up tests and assessments which require visits to major centres. After transplantation there is the prospect of a post-operative stay and side effects away from home and supports. The number of medications usually increases, and there is an increased risk of infections and cancers.

CHRIS JOHNSON AND LUKE TOY

Use your phone, lose your licence

AMA President Dr Michael Gannon on ABC News.

The AMA has for the first time issued a Position Statement on road safety, and in doing so it has called for tougher penalties for people who use their mobile phones while driving.

Those penalties include the loss of licence for up to a year for P-plate and L-plate drivers who use the devices while driving,

Releasing the AMA *Position Statement on Road Safety 2018*, President Dr Michael Gannon said the AMA was committed to advocating for improvements in the way Australians drive, the cars they drive, and the roads they drive on.

"Doctors – along with paramedics, ambulance officers, and nurses – see the tragic consequences of road trauma," Dr Gannon said.

"They see when road safety is ignored and when avoidable accidents occur – accidents that take lives and cause horrific injuries.

"The AMA is particularly concerned about the use of mobile telephones and electronic devices, including navigational devices, in cars.

"Mobile phones and other devices are driver distractions, and a major cause of accidents, trauma, and death."

The AMA supports measures that change driver behaviour. Dr Gannon said the Position Statement aims to help change the culture and mentality about using mobile devices in cars.

"Your driver's licence is a privilege, not a right," he said.

"Drivers who breach the road rules are putting themselves and others at risk, and must face meaningful sanctions.

"Good habits must be ingrained in new, inexperienced drivers. There should be zero tolerance of provisional and learner drivers who use mobile phones or electronic devices, and penalties should include the loss of licence for up to a year."

The AMA is also concerned about pedestrians and cyclists who use headphones, earpieces, or mobile devices.

"Using headphones or mobile devices while walking or cycling on or near roads is a serious safety risk, and is a factor in motor vehicle accidents," Dr Gannon said.

"The AMA is calling for the fundamentals of road rules, including responsibility of pedestrians, to be formally instilled from a very young age through nationwide standards of road safety education.

"On average, three people die on Australian roads every day and 90 are seriously injured – two permanently.

"That represents about 33,900 adults and children every year who are killed or maimed in avoidable incidents, and thousands more who are affected by the trauma of losing a partner, relative, or friend.

"Community-led road safety initiatives, such as Black Spot programs, and identification of local traffic issues have the potential to reduce road fatalities and injuries."

The Position Statement also calls for uniform, national criteria for assessing older drivers. The AMA endorses the joint guidelines issued by Austroads and the National Transport Commission (NTC) in their *Assessing Fitness to Drive: medical standards for licensing and clinical management guidelines. A resource for health professionals in Australia (October 2016)* publication.

"All States and Territories must adopt uniform criteria for assessing the functional ability of older drivers, as the discrepancies between jurisdictions are problematic," Dr Gannon said.

"We also want doctors to be more proactive in helping older drivers to assess their ability and confidence to keep driving.

"Doctors should be providing advice on when to retire from driving. This may require medical examinations or assessments of drivers beyond a specified age."

The AMA *Position Statement on Road Safety 2018* is available at https://ama.com.au/position-statement/road-safety-2018

CHRIS JOHNSON

National architecture needed for mental health

Almost one in two Australian adults will experience a mental health condition in their lifetime, yet mental health and psychiatric care are grossly underfunded when compared to physical health.

Those statistics were the stark reality AMA President Dr Michael Gannon laid out when releasing the AMA *Position Statement on Mental Health 2018.*

In doing so, he called for strategic leadership to integrate all components of mental health prevention and care.

The AMA is calling for a national, overarching mental health "architecture", and proper investment in both prevention and treatment of mental illnesses.

"Many Australians will experience a mental illness at some time in their lives, and almost every Australian will experience the effects of mental illness in a family member, friend, or work colleague," Dr Gannon said.

"For mental health consumers and their families, navigating the system and finding the right care at the right time can be difficult and frustrating.

"Australia lacks an overarching mental health architecture. There is no vision of what the mental health system will look like in the future, nor is there any agreed national design or structure that will facilitate prevention and proper care for people with mental illness."

The AMA has called for the balance between funding acute care in public hospitals, primary care, and community-managed mental health to be correctly weighted.

Funding should be on the basis of need, demand, and disease burden, Dr Gannon said, not a competition between sectors and specific conditions.

"Policies that try to strip resources from one area of mental health to pay for another are disastrous," he said.

"Poor access to acute beds for major illness leads to extended delays in emergency departments, poor access to community care leads to delayed or failed discharges from hospitals, and poor funding of community services makes it harder to access and coordinate prevention, support services, and early intervention.

"Significant investment is urgently needed to reduce the deficits in care, fragmentation, poor coordination, and access to

effective care.

"As with physical health, prevention is just as important in mental health, and evidence-based prevention can be socially and economically superior to treatment."

Dr Gannon said community-managed mental health services had not been appropriately structured or funded since the movement towards de-institutionalisation in the 1970s and 1980s, which shifted much of the care and treatment of people with a mental illness out of institutions and into the community.

The AMA Position Statement supports coordinated and properly funded community-managed mental health services for people with psychosocial disability, as this will reduce the need for costly hospital admissions.

The Position Statement calls for Governments to address underfunding in mental health services and programs for adolescents, refugees and migrants, Aboriginal and Torres Strait Islander people, and people in regional and remote areas.

It also calls for Government recognition and support for carers of people with mental illness.

"Caring for people with a mental illness is often the result of necessity, not choice, and can involve very intense demands on carers," Dr Gannon said.

"Access to respite care is vital for many people with mental illness and their families, who bear the largest burden of care."

The AMA *Position Statement on Mental Health 2018* is available at https://ama.com.au/position-statement/mental-health-2018

CHRIS JOHNSON

Australian Medical Association Limited ABN 37 008 426 793

AMA Public Health Awards 2018 Call for Nominations

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

Recipients will be invited to attend the 2018 AMA National Conference in Canberra in May 2018, where the awards will be presented. The AMA may contribute to travel costs for recipients to attend the presentation.

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

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

Nominations are sought in the following categories:

AMA EXCELLENCE IN HEALTHCARE AWARD

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

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

- Showing ongoing commitment to quality health & medical care; and/or
- Contributing to medical research within Australia; and/or
- Initiation and involvement in public health projects or health awareness campaigns; and/or
- Improving the availability & accessibility of medical education and medical training; and/or
- Advancing health & medical issues in the political arena; and/or
- Promoting awareness of the impact of social and economic issues on health; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field.

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

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

AMA WOMAN IN MEDICINE AWARD

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

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

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

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

NOMINATION INFORMATION

How are nominations assessed?

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

How do I make a nomination?

Nominations must be made by completing the Nomination Form, which must include a personal statement by the nominator describing the merit of the nominee in relation to the criteria for the relevant award. A Curriculum Vitae for the nominee/s, and any additional supporting documentation relevant to the nomination can also be included with the nomination form. The nomination form is available at https://ama.com.au/article/ama-public-health-awards

Nominations should be submitted electronically to awards@ama.com.au. Nominations are open from 19 February 2018, and the closing date for receipt of nominations for each award is **COB Monday 23 April 2018**.

When will I find out if my nomination has been successful?

Awards are presented at the AMA National Conference, which is held in Canberra on 26 -28 May 2018. Award recipients will be notified 2-3 weeks prior to arrange attendance at the ceremony, where possible. The person who made the successful nomination will be notified prior to the ceremony. If your nomination is unsuccessful, you will be notified by email in due course.

Action needed to protect children from too much sugar

The AMA has taken a strong position on sugar, calling for a tax on sugary drinks and a ban on junk food marketing aimed at children.

Releasing its AMA *Position Statement on Nutrition 2018* in early January, the AMA said the tax should be introduced as a priority.

AMA President Dr Michael Gannon said eating habits and attitudes toward food are established in early childhood and so advertising of junk food and sugary drinks to children should be banned.

"Improving the nutrition and eating habits of Australians must become a priority for all levels of government," Dr Gannon said.

"Governments should consider the full complement of measures available to them to support improved nutrition, from increased nutrition education and food literacy programs through to mandatory food fortification, price signals to influence consumption, and restrictions on food and beverage advertising to children.

"Eating habits and attitudes start early, and if we can establish healthy habits from the start, it is much more likely that they will continue throughout adolescence and into adulthood.

"The AMA is alarmed by the continued, targeted marketing of unhealthy foods and drinks to children.

"Children are easily influenced, and this marketing – which takes place across all media platforms, from radio and television to online, social media, and apps – undermines healthy food education and makes eating junk food seem normal."

Dr Gannon said advertising and marketing unhealthy food and drink to children should be prohibited all together, and the loophole that allows children to be exposed to junk food and alcohol advertising during coverage of sporting events must be closed.

"The food industry claims to subscribe to a voluntary code, but the reality is that this kind of advertising is increasing," he said.

"The AMA calls on the food industry to stop this practice immediately."

The Position Statement also calls for increased nutrition education and support to be provided to new or expecting parents, and notes that good nutrition during pregnancy is also vital.

It recognises that eating habits can be affected by practices at institutions such as child care centres, schools, hospitals, and aged care homes.

"Whether people are admitted to hospital or just visiting a friend or family member, they can be very receptive to messages from doctors and other health workers about healthy eating," Dr Gannon said.

"Hospitals and other health facilities must provide healthy food options for residents, visitors, and employees.

"Vending machines containing sugary drinks and unhealthy food options should be removed from all health care settings, and replaced with machines offering only healthy options.

"Water should be the default beverage option, including at fast food restaurants in combination meals where soft drinks are typically provided as the beverage."

The Position Statement says a tax on sugar-sweetened beverages should be introduced.

The recommendations were warmly welcomed by health and children's advocates.

The AMA *Position Statement on Nutrition 2018* is available at https://ama.com.au/position-statement/nutrition-2018 and the key recommendations are listed here.

CHRIS JOHNSON

Key Recommendations:

- Advertising and marketing of unhealthy food and beverages to children to be prohibited.
- Water to be provided as the default beverage option, and a tax on sugar-sweetened beverages to be introduced.
- Healthy foods to be provided in all health care settings, and vending machines containing unhealthy food and drinks to be removed.
- Better food labelling to improve consumers' ability to distinguish between naturally occurring and added sugars.
- Regular review and updating of national dietary guidelines and associated clinical guidelines to reflect new and emerging evidence.
- Continued uptake of the Health Star Rating system, as well as refinement to ensure it provides shoppers with the most pertinent information.

Organ donation – it's vital

The AMA supports organ and tissue donation, and strongly encourages individuals to consider their views on donation and discuss them with their family.

AMA President Dr Michael Gannon stressed that point when releasing, in early January this year, the AMA *Position Statement on Organ and Tissue Transplantation 2017.*

Increased organ donation rates could transform lives as well as save precious healthcare dollars, as organ transplants are more cost-effective than ongoing medical care, the Position Statement says.

Dr Gannon said the opportunity for organ donation was an infrequent event, and comes at an intensely emotional time for families, who will always be asked to make the final donation decision.

"The AMA thanks every organ donor for their generosity, and every donor family for making such a brave and generous decision during a very difficult time in their lives," he said.

"Australia is a leader in organ and tissue transplantation in terms of transplant outcomes, and while donation rates are continually improving as a result of reforms introduced in 2009, there is always room for further growth.

"By increasing Australia's rate of organ and tissue donation, more individuals and their families have the chance to benefit from life-enhancing and life-saving transplants.

"This has a positive impact on the healthcare system as transplantation of organs and tissues, such as kidneys and corneas, is cost-effective compared to the expense of providing ongoing treatment for those on waiting lists."

The updated Position Statement, which was approved at the final meeting of the AMA Federal Council in 2017, continues to highlight issues including:

- the need for a robust ethical framework for donation and transplantation;
- public education and awareness;
- donor families;
- living donors;
- education and support for healthcare workers;
- quality and safety; and
- cultural sensitivities.

It includes a new section on transplant waiting lists, as well as a new section on umbilical cord blood banks.

It also includes expanded sections on allocation of organs and tissues, consent to transplantation, and organ trafficking, transplant commercialism, and transplant tourism.

According to figures in the *Australian Donation and Transplantation Activity Report 2016*, about 1600 people are on the transplant waiting list at any given time. In 2016, 1713 people received donations from 503 deceased organ donors and 267 living organ donors.

Deceased organ donation has more than doubled since 2009 (247 donors), and the number of organ transplant recipients has increased by 81 per cent over the same period (1447 compared to 799).

The number of organs retrieved and transplanted from each donor has decreased from 3.8 in 2009 to 3.4 in 2016.

Kidneys (821) are the most commonly transplanted organ, followed by the liver (314), lungs (196), heart (124), and pancreas (52).

There were 1281 eye donors, a 1 per cent increase on 2015 (1266) and a 39 per cent increase since 2009 (922).

In 2016, there were 7468 notified tissue transplant recipients, up 17 per cent on 2015 (6421).

"Public willingness to donate requires appropriate infrastructure, communication and coordination networks, and specialist staff trained to identify potential donors and support donor families," Dr Gannon said.

"GPs also need appropriate professional education and awareness to carry out their role of raising awareness about organ donation with patients."

The Position Statement acknowledges the debate regarding 'opt-in' vs 'opt-out' models of organ donation, but does not support one model over the other.

It upholds the principle that either system must be based on free, informed donor choice involving the right to choose, as well as to refuse, to be an organ and tissue donor.

The AMA encourages every Australian, regardless of age, to think about becoming a donor.

Those wishing to become a donor should register their consent on the Australian Organ Donor Register at https://register.donatelife.gov.au, and tell their family about their donation wishes.

"In Australia, your family will always be asked to make the final decision," Dr Gannon said.

"So make that very hard decision a little easier for them."

The AMA *Position Statement on Organ and Tissue Transplantation 2017* is available at https://ama.com.au/position-statement/organ-and-tissue-donation-and-transplantation-2017

CHRIS JOHNSON

Encouraging more doctors to go rural

The AMA has released its *Position Statement – Rural Workforce Initiatives*, a comprehensive five-point plan to encourage more doctors to work in rural and remote locations, and improve patient access to care.

The plan proposes initiatives in education and training, rural generalist pathways, work environments, support for doctors and their families, and financial incentives.

It says that at least one-third of all new medical students should be from rural backgrounds.

And more medical students should be required to do at least one year of training in a rural area to encourage graduates to live and work in regional Australia.

In releasing the Position Statement, AMA President Dr Michael Gannon noted that about seven million Australians live in regional, rural, and remote areas, and they often have more difficulty accessing health services than their city cousins.

They often have to travel long distances for care, and rural hospital closures and downgrades are seriously affecting the future delivery of health care in rural areas.

For example, Dr Gannon said, more than 50 per cent of small rural maternity units have been closed in the past two decades.

"Australia does not need more medical schools or more medical school places," he said.

"Workforce projections suggest that Australia is heading for an oversupply of doctors.

"Targeted initiatives to increase the size of the rural medical, nursing, and allied health workforce are what is required.

"There has been a considerable increase in the number of medical graduates in recent years, but more than three-quarters of locally trained graduates live in capital cities.

"International medical graduates (IMGs) make up more than 40 per cent of the rural medical workforce and while they do excellent work, we must reduce this reliance and build a more sustainable system."

The AMA Rural Workforce Initiatives plan outlines five key areas where Governments and other stakeholders must focus their policy efforts:

- Encourage students from rural areas to enrol in medical school, and provide medical students with opportunities for positive and continuing exposure to regional/rural medical training;
- Provide a dedicated and quality training pathway with the right skill mix to ensure doctors are adequately trained to work in rural areas;
- Provide a rewarding and sustainable work environment with adequate facilities, professional support and education, and flexible work arrangements, including locum relief;
- Provide family support that includes spousal opportunities/ employment, educational opportunities for children's education, subsidies for housing/relocation and/or tax relief; and
- Provide financial incentives to ensure competitive remuneration.

"Rural workforce policy must reflect the evidence. Doctors who come from a rural background, or who spend time training in a rural area, are more likely to take up long-term practice in a rural location," Dr Gannon said.

"Selecting a greater proportion of medical students with a rural background, and giving medical students and graduates an early taste of rural practice, can have a profound effect on medical workforce distribution.

"Our proposals to lift both the targeted intake of rural medical students and the proportion of medical students required to undertake at least one year of clinical training in a rural area from 25 per cent to 33 per cent are built on this approach.

Encouraging more doctors to go rural

... from page 12

"More Indigenous people must be encouraged to train and work in health care, as there is a strong link between the health of Indigenous people in rural areas and their access to culturally appropriate health services.

"Fixing rural medical workforce shortages requires a holistic approach that takes into account not only the needs of the doctor, but also their immediate family members.

"Many doctors who work in rural areas find the medicine to be very rewarding, but their partner may not be able to find suitable employment, and educational opportunities for their children may be limited.

"The work environment for rural doctors presents unique challenges, and Governments must work collaboratively to attract a sustainable health workforce. This includes rural hospitals having modern facilities and equipment that support doctors in providing the best possible care for patients and maintaining their own skills.

"Finally, more effort must be made to improve internet services in regional and rural areas, given the difficulties of running a practice or practising telehealth with inadequate broadband.

"All Australians deserve equitable access to high-speed broadband, and rural doctors and their families should not miss out on the benefits that the growing use of the internet is bringing."

The AMA *Position Statement - Rural Workforce Initiatives* is available at https://ama.com.au/position-statement/rural-workforce-initiatives-2017

CHRIS JOHNSON

BACKGROUND:

- **Most Australians live in major cities (70 per cent), while 18 per cent live in inner regional areas, 9 per cent in outer regional areas, and 2.4 per cent in both remote and very remote areas.**
- **Life expectancy is lower for people in regional and remote Australia. Compared with major cities, the life expectancy in regional areas is one to two years lower, and in remote areas is up to seven years lower.**
- **The age standardised rate of the burden of disease increases with increasing remoteness, with very remote areas experiencing 1.7 times the rate for major cities.**
- **Coronary heart disease, suicide, COPD, and cancer show a clear trend of greater rates of burden in rural and remote areas.**
- **The number of medical practitioners, particularly specialists, steadily decreases with increasing rurality. The AIHW reports that while the number of full time workload equivalent doctors per 100,000 population in major cities is 437, there were 272 in outer regional areas, and only 264 in very remote areas.**
- **Rural medical practitioners work longer hours than those in major cities. In 2012, GPs in major cities worked 38 hours per week on average, while those in inner regional areas worked 41 hours, and those in remote/very remote areas worked 46 hours.**
- **The average age of rural doctors in Australia is nearing 55 years, while the average age of remaining rural GP proceduralists – rural GP anaesthetists, rural GP obstetricians and rural GP surgeons – is approaching 60 years.**
- **International medical graduates (IMGs) now make up over 40 per cent of the medical workforce in rural and remote areas.**
- **There is a health care deficit of at least $2.1 billion in rural and remote areas, reflecting chronic underspend of Medicare and the Pharmaceutical Benefits Scheme (MBS) and publicly-provided allied health services.**

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Government focus on rheumatic heart disease

Rheumatic heart disease is receiving serious political attention, as the Federal Government makes inroads into addressing and improving the health of Aboriginal Australians.

Indigenous Health Minister Ken Wyatt has convened a roundtable in Darwin to look at charting a comprehensive roadmap to end rheumatic heart disease (RHD).

The roundtable brought together RHD and infectious diseases specialists, health professionals, Indigenous health advocates, philanthropists, service providers and government agencies.

"RHD and acute rheumatic fever take about 100 Aboriginal and Torres Strait Islander lives each year and many of these are young people," Mr Wyatt said.

"The tragedy is compounded by the fact that RHD is almost entirely preventable, with many organisations, including governments, grappling strongly with pieces of the RHD elimination puzzle.

"Now, through this roadmap we are determined to tackle the whole challenge and eliminate this disease as a significant Indigenous public health problem."

RHD is a long-term outcome of a condition called acute rheumatic fever (ARF), which typically occurs in childhood. As a result of ARF the affected person develops inflammation of the heart valves with resulting damage and malfunction. ARF typically precedes the RHD by decades.

RHD can be usually resolved if it is detected early, but people are being treated for the condition when it is too late. RHD is most accurately diagnosed using ultrasound.

Indigenous children and young adults in the Northern Territory are estimated to suffer from RHD at more than 100 times the rate of their non-Indigenous counterparts. The Kimberley is also an RHD hotspot, with two-thirds of all Western Australian Indigenous people suffering from RHD living in the region.

The Government has allocated $23.6 million under the Rheumatic Fever Strategy over the next four years. It is also working to address the underlying social and cultural determinants that contribute to RHD, including providing $5.4 billion to States and Territories to help them to provide remote housing, under a national agreement. While the Agreement is due to end on 30 June 2018, the Commonwealth has begun discussions with State and Territory Governments on future funding arrangements.

"While RHD affects children and young adults around the world, in Australia it is a sad reflection of the health gap between Indigenous and non-Indigenous children," Mr Wyatt said.

"We know this is a disease of poverty, of overcrowding, of difficulty with access to health services.

"The roadmap will acknowledge there is no single silver bullet to eliminate RHD. We are now looking to tackle all the determinants – including environmental health, housing and education – as we work together to help strengthen these communities against this devastating disease."

AMA President Dr Michael Gannon has repeatedly described the lack of effective action on RHD to date as a national failure; calling for an urgent coordinated approach.

At the launch of the AMA's *2017 AMA Report Card on Indigenous Health*, Dr Gannon said: "Governments must fund health care on the basis of need. There is no doubt whatsoever that funding and resourcing of Indigenous health does not meet the overall burden of illness."

A copy of the AMA's *2016 Indigenous Report Card*, which focused specifically on RHD, can be found at: https://ama.com.au/article/2016-ama-report-card-indigenous-health-call-action-prevent-new-cases-rheumatic-heart-disease

MEREDITH HORNE

Pilot to look at home based palliative care

Taxpayers will fund a trial to provide palliative care services aimed at delivering the right care at the right time while also aiming to reduce hospitalisations.

The $8.3 million pilot program will support people nearing the end of their lives so they can receive better care and treatment at home.

The Greater Choice for At Home Palliative Care program will use the government money to roll out in ten locations around Australia.

The program looks at coordinating patient supported services

Health on the Hill

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including: local GP treatment, palliative, hospital and specialist care support, and community and social services.

People will receive the right care at home, tailored to their own need, which will hopefully mean less trips to the hospital to access these services.

Australians who are coming to the end of their life deserve to have the best care possible.

The program will be administered through Primary Health Networks (PHNs) across Australia, and will be coordinated with local and state services, as well as aged care providers.

The ten PHNs which will take part in the trial include: Brisbane South; Central QLD, Wide Bay and Sunshine Coast; Gold Coast; South Western Sydney; Murrumbidgee; Western NSW; North Western Melbourne; Eastern Melbourne; Adelaide, and Country WA.

The trial runs until June 2020 and interested people and their families, in the trial areas, should contact their GP to discuss joining the program.

Palliative Care Australia estimates that as many as 120,000 Australians may need to access palliative care each year.

MEREDITH HORNE

INFORMATION FOR MEMBERS

Specialty Training Pathways Guide – AMA Career Advice Service

With more than 64 different medical specialties to choose from in Australia, making the decision to specialise in one can seem daunting.

AMA members now have access to a new resource – one designed to assist in making decisions about which specialty pathway to follow. We know that concerns about length of training, cost of training and work-life balance are important factors in making these decisions, and information on the new site will help here too.

The absence of a comparative and definitive guide was raised by our doctors in training and medical students.

Responding to this need from our doctors in training and medical students, the AMA Career Advice Service has developed a comprehensive guide to the specialties and sub-specialties which can be trained for in Australia. The Guide will be updated annually to reflect changes made by the Colleges, and the 2017 update will be uploaded shortly.

The web-based Guide allows AMA members to compare up to five specialty training options at one time.

Information on the new website includes:

- the College responsible for the training;
- an overview of the specialty;
- entry application requirements and key dates for applications;
- cost and duration of training;
- number of positions nationally and the number of Fellows; and
- gender breakdown of trainees and Fellows.

The major specialties are there as well as some of the lesser known ones – in all, more than 64 specialties are available for comparison and contrasting.

For example, general practice, general surgery and all the surgical sub specialties, paediatrics, pathology and its sub specialties, medical administration, oncology, obstetrics and gynaecology, immunology and allergic medicine, addiction medicine, neurology, dermatology and many, many more.

To find out more, visit www.ama.com.au/careers/pathway

This new addition to the Career Advice Service enhances the services already available which include one-on-one career coaching, CV templates and guides, interview skills "tips" and, of course, a rich source of information available on the Career Advice Hub: www.ama.com.au/careers

For further information and/or assistance, feel free to call the AMA Career Advisers: Annette Lane and Christine Brill – 1300 133 665 or email: careers@ama.com.au

Please note current information within the guide relates to 2016 requirements. Information will be updated to reflect 2017 requirements soon.

Let the AMA's Specialty Training Pathways guide help inform your career decisions.

Research

New studies give greater understanding on menopause

One year of hormone replacement therapy may be able to prevent development of depressive symptoms in women who are in the menopause transition, a study published online in *JAMA Psychiatry* has shown.

The double-blind, randomised controlled trial, conducted by University of North Carolina (UNC) School of Medicine found certain women would be more likely to experience the greatest mood benefit of hormone replacement therapy during the menopause transition, which are women early in the transition and women with a greater number of recent stressful life events.

Women are two to four times more likely to develop clinically significant depressive symptoms during the menopause transition, according to the study.

"We know that midlife for women, particularly in the transition to menopause, is a time of substantial elevations in risk for depression," said Professor Susan Girdler, who helped lead the research.

"During the menopause transition, our risk for depression actually increases two to four times. And that's true even for women who haven't had a history of depression early in life."

The participants were randomly selected and put into two separate groups. Over the course of a year, one group received transdermal estradiol on a daily basis, the other a placebo.

The study found more than 30 percent of the placebo group developed clinically significant depression. However, only 17 percent of women who received estradiol developed the same depression symptoms.

Other research published by The University of Illinois (UI) in the journal *Sleep Medicine* suggests addressing menopausal symptoms of hot flushes and depression may also address sleep disruptions.

The UI study also gives women hope that their sleep symptoms may not last past the menopausal transition, said Professor Rebecca Smith, from the Pathobiology Department at the University of Illinois. Professor Smith conducted the study with Professors Jodi Flaws and Megan Mahoney.

"Poor sleep is one of the major issues that menopausal women seek treatment for from their doctors," Professor Mahoney said.

"It's a huge health care burden, and it's a huge burden on the women's quality of life. Investigating what's underlying this is very important."

The study used data from the Midlife Women's Health Study, which followed 776 women aged 45-54 in the greater Baltimore area for up to seven years.

The study found no correlation between the likelihood of reporting poor sleep before menopause, during menopause and after menopause. Meaning, for many women in the study, their reported sleep problems changed as they transitioned to different stages of menopause. For example, women who had insomnia during menopause were not more likely to have insomnia after menopause.

"That's a hopeful thing for women who feel like their sleep has gone downhill since they hit the menopause transition: It might not be bad forever," Professor Smith said.

"Your sleep does change, but the change may not be permanent."

The researchers found that hot flushes and depression were strongly correlated with poor sleep across all stages of menopause.

Those two risk factors vary in reported frequency across menopausal stages, which might help explain why poor sleep also varies across the stages, the researchers said.

Professor Smith believes that the study has shown sleep disturbances in menopause are part of a bigger picture that doctors should be looking at.

"It indicates that when dealing with sleep problems, physicians should be asking about other symptoms related to menopause, especially looking for signs of depression and asking about hot flushes," Professor Smith said.

MEREDITH HORNE

Safer roads have far reaching positive benefits

A World Bank study has found reducing road traffic deaths and injuries could result in substantial long-term income gains for low- and middle-income countries.

The report, *The High Toll of Traffic Injuries: Unacceptable and Preventable*, aims to address the incredibly important link between road traffic injuries and economic growth by quantifying how investments in road safety are also an investment in human capital.

Traffic crashes kill more than 1.25 million people around the world each year and this study reveals the huge economic toll, diminished productivity, reduced growth prospects as well as including the human potential being lost in road traffic injuries.

The study finds that countries that do not invest in road safety could miss out on anywhere between 7 and 22 per cent in potential per capita GDP growth over a 24-year period. The report suggests policymakers need to prioritise proven investments in road safety.

The authors believe the results are important for health planners and public health officials, these results make it clear that road traffic injury prevention should be regarded as a key pillar of the health agenda.

According to the report, deaths and injuries from road traffic crashes affect medium- and long-term growth prospects by removing prime age adults from the work force, and reducing productivity due to the burden of injuries.

The greatest share of mortality and long-term disability from road traffic crashes happen amongst the working-age population (between 15 and 64 years old).

Using detailed data on deaths and economic indicators from 135 countries, the study estimates that, on average, a 10 per cent reduction in road traffic deaths raises per capita real GDP by 3.6 per cent over a 24-year horizon.

Over the period 2014-38, halving deaths and injuries due to road traffic could potentially add 22 per cent to GDP per capita in Thailand, 15 per cent in China, 14 per cent in India, 7 per cent in the Philippines and 7 per cent in Tanzania.

"Inspired by disease impact studies, this it is one of the first systematic efforts to estimate both the potential economic benefits and aggregate social welfare gains of reducing road traffic injuries in low and middle income countries," said José Luis Irigoyen, World Bank Senior Director for Transport and ICT.

"Curbing road traffic injuries would not just be a victory for the transport sector but a significant milestone for global development, with immediate and far-reaching benefits for public health, wellbeing, and economic growth."

The terrible cost of road traffic deaths is not just a problem for developing countries. In Australia, the Department of Infrastructure estimates the economic cost of road trauma is $27 billion per year. And, tragically more than 189,000 people have died on Australian roads since records began in 1925.

The AMA recently launched its *Position Statement on Road Safety 2018* which called for tougher penalties for drivers who text or use mobile phones while driving, including the loss of licence for up to a year for P-plate and L-plate drivers.

President, Dr Michael Gannon said the Position Statement showed the AMA's commitment to advocating for improvements in the way Australians drive, the cars they drive, and the roads they drive on.

"On average, three people die on Australian roads every day and 90 are seriously injured – two permanently," Dr Gannon said.

"That represents about 33,900 adults and children every year who are killed or maimed in avoidable incidents, and thousands more who are affected by the trauma of losing a partner, relative, or friend.

"Community-led road safety initiatives, such as Black Spot programs, and identification of local traffic issues have the potential to reduce road fatalities and injuries."

A copy of the AMA's position statement can be found here: https://ama.com.au/sites/default/files/documents/AMA%20Position%20Statement%20on%20Road%20Safety%202018.pdf

A full copy of the World Bank study, funded by Bloomberg Philanthropies, can be found here: https://openknowledge.worldbank.org/handle/10986/29129

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AMA Member Benefits

AMA members can access a range of free and discounted products and services through their AMA membership. To access these benefits, log in at **www.ama.com.au/member-benefits**

AMA members requiring assistance can call AMA member services on

1300 133 655 or **memberservices@ama.com.au**

Jobs Board: Whether you're seeking a new position, looking to expand your professional career, or looking to recruit staff to your practice, doctorportal Jobs can help you. Discounts apply for AMA members. jobs.doctorportal.com.au

MJA Events: AMA members are entitled to discounts on the registration cost for MJA CPD Events!

UpToDate: UpToDate is the clinical decision support resource medical practitioners trust for reliable clinical answers. AMA members are entitled to discounts on the full and trainee subscription rates.

doctorportal Learning: AMA members can access a state of the art CPD tracker that allows CPD documentation uploads, provides guidance CPD requirements for medical colleges, can track points against almost any specialty and provides access to 24/7 mobile-friendly, medical learning.

Learning.doctorportal.com.au

MJA Journal: The Medical Journal of Australia is Australia's leading peer-reviewed general medical journal and is a FREE benefit for AMA members.

Fees & Services List: A free online resource for AMA members. The AMA list of Medical Services and Fees provides an important reference for those in medical practice to assist in determining their fees.

Career Advice Service and Resource Hub: This should be your "go-to" for expert advice, support and guidance to help you navigate through your medical career. Get professional tips on interview skills, CV building, reviews and more - all designed to give you the competitive edge to reach your career goals.

www.ama.com.au/careers

Amex: As an AMA member, receive no-fee and heavily discounted fee cards including free flights and travel insurance with a range of Amex cards.*

Mentone Educational: AMA members receive a 10% discount on all Mentone Educational products, including high quality anatomical charts, models and training equipment.

Volkswagen: AMA members are entitled to a discount off the retail price of new Volkswagen vehicles. Take advantage of this offer that could save you thousands of dollars.

AMP: AMA members are entitled to discounts on home loans with AMP.

Hertz: AMA members have access to discounted rates both in Australia and throughout international locations.

Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

Qantas Club: AMA members are entitled to significantly reduced joining and annual fees for the Qantas Club.

Virgin Lounge: AMA members are entitled to significantly reduced joining and annual fees for the Virgin Lounge.

MJA Bookshop: AMA members receive a 10% discount on all medical texts at the MJA Bookshop.