AUSTRALIAN
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Aussies trust health workers

Morgan Poll finds respect for doctors and nurses at all time high, p7

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AMA

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In this issue

Cover pic: Health Minister Greg Hunt shows his appreciation for doctors.

National Conference photos by Lightbulb Studio

Maternity Review a wasted opportunity

BY AMA PRESIDENT DR MICHAEL GANNON

After months of behind-the-scenes activity and growing angst from the profession, the AMA went public in June with our outrage over the process for the planned new National Framework for Maternity Services (NFMS).

The Framework is doomed to fail due to inadequate stakeholder consultation and the spectacular failure to adequately engage expert obstetric, general practice, and other crucial medical specialists in its development.

Following an agreement at the April 2016 COAG Health Council meeting, the Queensland Government was tasked to lead the project to develop the NFMS, under the auspices of the Australian Health Ministers' Advisory Council (AHMAC).

The AMA first became aware of the NFMS project in December 2016 – eight months after it commenced, and without any direct contact from AHMAC's Maternity Care Policy Working Group (MCPWG) or its consultants – and we have raised concerns about the project ever since.

The AMA's concerns are shared by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the National Association of Specialist Obstetricians and Gynaecologists (NASOG).

It is outrageous that specialist obstetricians and GPs have been marginalised in this process. You could be forgiven for thinking it a joke.

Obstetrician-led care is an essential tenet of Australia's maternity system. There is clear and compelling evidence that shows that obstetrician involvement translates into lower mortality rates and fewer complications, not to mention lower costs.

When issues and problems arise during labour, it is invariably an obstetrician who is called on to assume responsibility and manage care, working to ensure the best possible outcome for mother and baby.

The AMA is pleased that midwives were strongly represented on the Working Group responsible for drafting the NFMS. They are key members of the maternity team.

But not involving a single obstetrician in a 12-member group tasked with looking at maternity services is like conducting a law and order review without talking to the police.

AMA members have reported maternity services and outcomes in their respective States have deteriorated under the current National Maternity Services Plan.

Obstetricians are concerned that not enough is being done to ensure women have access to high quality, collaborative models of care. Despite this, the consultation undertaken to develop the NFMS has neglected to actively engage specialist medical practitioners who are at the centre of care for mothers and babies.

The draft Framework, which was released for public comment in March 2017, lacked substance and provided no guidance for public hospital maternity services about what high quality care should look like.

The NFMS is shaping up as a lost opportunity to achieve the best possible maternity care for mothers and babies in Australia.

GPs, too, have been ignored in the process.

GPs not only routinely offer obstetric services in outer metropolitan, rural, and regional areas, but deliver antenatal and postnatal care to thousands of Australian women. There was not a single GP representative appointed.

Further, there is no acknowledgement that best practice care of mothers involves anaesthetists, obstetric physicians, psychiatrists, pathologists, and haematologists, none of whom were invited to assist in the development and drafting of the NFMS.

The AMA wants to see a strong NFMS. It must be developed in genuine partnership with the medical profession and its peak bodies. These are the medical professionals who deal with maternity services, day in and day out.

They've seen what works, and they know where the system is not working well. Their experiences and views should have been at the table, from the beginning.

Inviting them to a consultation a month before completion of the draft NFMS does not seem a genuine attempt to listen to experts at the coalface of maternity services.

The AMA has called on COAG, AHMAC, and the NFMS Working Group to formally and genuinely engage with the medical profession – obstetricians in particular – before there is any further policy development or public reporting on the Framework.

The health of mothers and their babies deserves a thorough and professional Framework to ensure the best possible care.

Medicinal cannabis – still a lot of misinformation

BY **AMA VICE PRESIDENT DR TONY BARTONE**

It seems hardly a week goes by without a news story on medicinal cannabis or a media interview request on the subject.

However, despite all of the information, the amount of misinformation in the general community is significant and at times is very concerning. Many in the media believe that it is currently possible to go to your local GP and have medicinal cannabis prescribed for chronic pain. If not; why not? Presumably the patient would then go down to the local pharmacist and have it dispensed. Journalists are amazed when told that there are both State and Federal government laws and restrictions that still present significant barriers and that these restrictions need to be adhered to.

Medicinal cannabis certainly has had a very political and community driven introduction in this country. Things have been moving quickly, beginning with the passage of legislation in November 2016 involving the Therapeutic Goods Administration. Since that time, medicinal cannabis no longer falls under Australia's most stringent of schedules – reserved for dangerous drugs – thereby allowing for provisions to be put in place to use cannabis on medical grounds.

Just this month we have had a Senate vote to increase the ease of availability of all forms of medicinal cannabis for terminally ill patients. Some have described this as a political stunt and posturing. In essence, moves in this space are happening so quickly that it is quite likely opportunities and processes are evolving that render the recent Senate amendments potentially unnecessary.

More importantly and perhaps of more concern is that the usual guidelines and requirements for the introduction of new medications seem to have been forgotten in respect of medicinal cannabis. It seems that safety and concern for rigorous, clinically proven guidelines are dispensed with – all in the name of compassion for a patient population who are just as deserving of the same standard of care as the rest of the community when it comes to safety and harm minimisation. It seems that all the tenets of our world-class system have been forgotten and are suddenly archaic and of little value in the face of a voracious community perceived need. This is spurred on by numerous media stories featuring long-suffering patients and their families who are forced to access the illegal black market.

Under the TGA Special Access Scheme, some forms of medicinal cannabis are already available. This scheme provides for the import and supply of an unapproved therapeutic good to individual patients on a case-by-case basis.

What also has been forgotten in all of this is that there is a significant amount of State legislation to be complied with. The States and Territories will decide whether medical cannabis will be made available – and more importantly, which type of patients will be able to use it. Some States and Territories have indicated they will list the conditions (e.g. QLD: Legal for specialists to prescribe for some patients; NSW: Available for adults with end-of-life illnesses; VIC: Available for children with epilepsy) The TGA is currently undertaking significant amount of education and information sharing with the medical community. This is especially necessary when a large portion of the media reporting is on access to prescribers and the relatively small numbers of prescribers or applications to prescribe. This is not surprising when clinical guidelines are in a state of evolution and there is uncertainty among many doctors about who should be eligible. Right from the beginning we have also maintained that there needs to be great clarity around how the medical cannabis system will operate. There is a paucity of information from the Government, which is adding to the confusion.

The AMA has many other concerns. So much still remains to be clarified. Information about either the dosage or form of medicinal cannabis needs to be available to patients. In countries that have medical cannabis (Canada, Holland, Israel) there are only a few types of cannabis available and they are packaged and dispensed like any other pharmaceutical product, with information on strength, use, dosage etc. The different types of cannabis are prescribed for designated medical conditions. It is not yet clear how medical cannabis will be dispensed. Is it to be dispensed through pharmacies, secure home delivery or from nominated GPs?

It is also not yet clear who will be able to approve medical cannabis prescribing and whether doctors will need to undertake additional training to become an "approved" cannabis prescriber/dispenser. The AMA has been told that modules are being created for doctors, but we don't know exactly how or where this will be implemented.

There are some pharmaceutical cannabis products already approved by TGA (like Sativex) and controlled and standardised herbal cannabis, such as the products produced in the Netherlands. The system may be so convoluted and complicated for patients and prescribers that it won't be able to fulfil the reason it was established and patients may continue to use the black market.

All good in the HOD

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

During June I had the opportunity to attend the annual meeting of the House of Delegates (HOD) of the American Medical Association (AmMA). It provided a fascinating insight into the challenging health policy issues in the US as well as the democratic decision-making processes of the AmMA.

The AmMA operates as the umbrella organisation for organised medicine in the US. It represents approximately 25 per cent of all registered physicians and is the primary voice for the profession in its advocacy to the Federal Government. The HOD meeting brings together delegates from across the profession as representatives of State and regional medical societies, and specialist medical societies. The medical students are also well-represented and are among the most articulate and passionate speakers.

Perhaps unsurprisingly many of the themes of the HOD meeting parallel key issues faced by the medical profession in Australia – the nature of health insurance coverage and lack of access to health care; the inadequacy of electronic health record systems; the burnout experienced by doctors including depression and suicide.

AmMA supported the introduction of the Affordable Care Act (ObamaCare) which caused significant division within the membership. However, it was clear from the debates that the delegates remain strongly in support of improved coverage and are concerned by the legislation put forward by the Trump administration (the American Health Care Act) to substantially amend ObamaCare. While the legislation is unlikely to make it through the US Senate, at least in its current form, the proposal would have the effect of removing cover for some 23 million Americans, an outcome that would be completely unacceptable in Australia.

The Australian health system was referred to approvingly in several debates during the meeting as an example of mandated public coverage but with the option of additional private cover. One of the resolutions passed during the meeting was for the AmMA to call for public cover in circumstances where there was no other option. As the health insurers consolidate market share there is a concern that more patients will be left without cover.

The biggest recent advocacy win for the AmMA was when it combined with other lobbies to successfully challenge a series of planned mergers of health funds which would have had a direct impact on availability of cover. As outgoing AmMA President, Dr Andrew Gurman, stated, this was a major win for patients, physicians and the entire health care system as a result of a physician coalition led by the AmMA and several other representative medical societies.

The HOD meeting was an exercise in democracy with multiple reports and resolutions put before delegates for adoption, amendment, or rejection. This followed two days of committee meetings during which the resolutions were worked up by the delegates in eight separate committees and then reviewed by caucus meetings of each of the delegate groups before debate in the HOD. The business of the HOD was admirably managed by its Speaker, Dr Susan Bailey, with humour and discipline. All in all an informative and educational experience.

Medicinal cannabis – still a lot of misinformation

The recent Senate vote effectively means the Senate has supported an amendment to therapeutic goods laws to change category A of the Special Access Scheme for cannabis. The effect of this will speed access to medicinal cannabis for people with a terminal illness. What this means is that from now on, a patient can go and see a doctor who can order medicinal cannabis for that patient if they have a terminal illness. If medicinal cannabis is not available in Australia, they can obtain it from overseas. This is most concerning in terms of guaranteeing safety and efficacy of the product imported. Doctors will only need to notify the TGA within a 28 day period.

What is needed is for the current consultative processes between TGA, Federal and State Governments with the appropriate stakeholders to continue. A lot has been achieved in a very short space of time. However, safety and reliability of product as well as clear clinical guidelines for use need to be firmly developed and supported by clear information sharing and training of doctors concerned. Politics should not be allowed to influence and certainly media and community information needs to be facilitated so that expectations do not exceed practicality.

AMA voicing concern over some political moves

Two issues dominating recent health policy discussions have seen the AMA at the forefront of political debate, expressing concerns over the direction of some processes and decisions.

The medicinal cannabis and maternity services debates have kept AMA President Dr Michael Gannon a familiar face around Parliament House in Canberra, explaining doctors' views to Government and the media.

Medicinal cannabis

After a surprise result from a Senate vote in June, terminally ill patients with a doctor's prescription will be able to get faster access to medicinal cannabis and be allowed to import three months' worth of their own personal supply of the drug.

The Greens pushed for changes to Government restrictions and they found support from Labor, One Nation and some independents.

But Health Minister Greg Hunt, who with his Government colleagues tried to stymie the move, said the outcome could put lives at risk.

He said the changes could open the way for questionable and unregulated products to be introduced to the market, as well as making it easier for criminals to access drugs.

"It is unfortunately a reckless and irresponsible decision," Mr Hunt said.

Dr Gannon agrees, saying the AMA was disappointed with the move.

"You've already got a situation where doctors are querying exactly how effective medicinal cannabis is. If you in any way put any doubt in their minds about the safety, you're simply not going to see it prescribed by many doctors," he said.

"We remain concerned about potential diversion into the general community. And let's not forget, we're talking about cannabis. We're talking about a substance that, used in the form it's used by most people, is a major source of mental illness in our community."

Dr Gannon said the AMA was satisfied with the process put in train by the Government through the Therapeutic Goods Administration.

"The TGA's got a process in place. Let's support that careful process to make sure what is used is perfectly safe."

The binding vote, which passed in the Senate 40 to 30, means medicinal cannabis will be put on the TGA's Category A list, giving qualifying patients priority and faster access.

Dr Michael Gannon at Parliament House, Canberra.

Maternity Services

The AMA is also warning that the planned new National Framework for Maternity Services (NFMS) is doomed to fail due to inadequate stakeholder consultation.

Describing the process as spectacular failure to adequately engage expert obstetric, general practice, and other crucial medical specialists in its development, Dr Gannon said opportunities for improvement are being lost.

Following an agreement at the April 2016 COAG Health Council meeting, the Queensland Government was tasked to lead the project to develop the NFMS, under the auspices of the Australian Health Ministers' Advisory Council (AHMAC).

The AMA first became aware of the NFMS project in December 2016 – eight months after it commenced, and without any direct contact from AHMAC's Maternity Care Policy Working Group (MCPWG) or its consultants.

The AMA has raised concerns about the project ever since.

In June, however, Dr Gannon, an obstetrician, said it was outrageous that specialist obstetricians and GPs had been marginalised in the process.

"You could be forgiven for thinking it a joke," he said.

"Obstetrician-led care is an essential tenet of Australia's maternity system.

"But not involving a single obstetrician in a 12-member group tasked with looking at maternity services is like conducting a law and order review without talking to the police.

"The NFMS is shaping up as a lost opportunity to achieve the best possible maternity care for mothers and babies in Australia."

CHRIS JOHNSON

Australians trust their doctors

Health professionals remain at the very top of the Australian public's regard, according to the latest Roy Morgan Image of Professions Survey.

The 2017 poll revealed nurses, doctors, pharmacists and dentists all rank in the top six professions people trusted the most.

The survey specifically asked respondents to rate 30 professions in regards to honesty and ethical standards.

Nurses rated the highest at 94 per cent, which is up two per cent since last year's survey, and doctors came in second at 89 per cent (up three per cent).

They were followed by pharmacists on 84 per cent (down two per cent), while dentists came in at number six on 74 per cent (up four per cent).

Ranked between pharmacists and dentists are school teachers and engineers.

Languishing at the bottom of the survey are union leaders, TV reporters, Federal and State MPs, talk-back radio announcers, stockbrokers, insurance brokers and real estate agents.

Taking out the two very last places are advertising people, rating only five per cent, and car salesmen on a mere four per cent.

Sixteen professions decreased in the public's esteem since last year, 12 professions increased (including doctors and nurses) and two professions remained unchanged.

Chief executive officer of Roy Morgan Research, Michele Levine, said the survey showed that the Australian public retained a high regard for their health professionals – particularly when compared to other professions.

"For the 23rd survey in a row Nurses have retained top spot (on 94 percent) ahead of several other medical professions, including Doctors on a new record high of 89 percent and Pharmacists on 84 per cent," she said.

These are the main findings of a Roy Morgan telephone survey conducted on the nights of May 22-24, 2017, with 648 Australian men and women aged 14 and over.

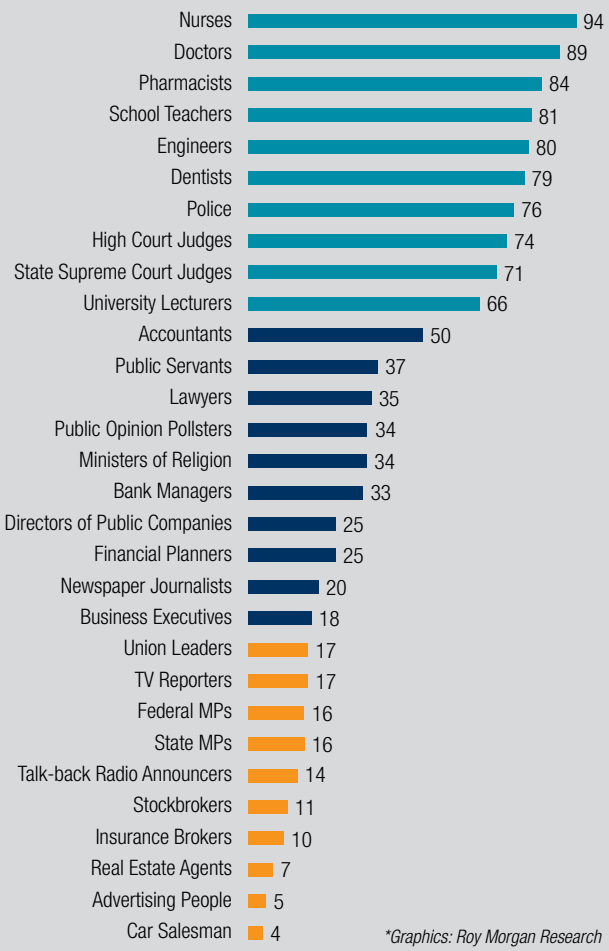
Respondents were asked: "*As I say different occupations, could you please say – from what you know or have heard - which rating best describes how you, yourself, would rate or score people in various occupations for honesty and ethical standards (Very High, High, Average, Low, Very Low)?*"

The full results of the survey can be found here:

https://www.roymorgan.com/findings/7244-roy-morgan-image-of-professions-may-2017-201706051543

CHRIS JOHNSON

% of Australians aged 14+ rating the profession as 'very high' or 'high' for ethics and honesty



**Graphics: Roy Morgan Research*

AMA Members recognised in Queen's Birthday Honours

More than 30 AMA Members from across the nation were recognised in this year's Queen's Birthday Honours list for service to medicine and the community.

The AMA congratulates them all on their recognition and thanks them for their service to the health of the nation.

Six AMA Members were made Officer (AO) in the General Division:

Professor Gordian Fulde, of Dover Heights, NSW, for distinguished service to emergency medicine as a clinician and administrator, to medical education, and the community as an advocate for a range of public health issues.

Dr Catherine Green, of East Melbourne, for distinguished service to ophthalmology as a clinician, through executive roles with national and international professional groups, to research and education, and to eye health care programs in the Asia-Pacific.

Professor Mohamed Khadra, of Chatswood, NSW, for distinguished service to medicine in the field of urology as a surgeon, clinician, and mentor, to rural and remote medical education, and to literature as an author and playwright.

Professor Angel Lopez, of Menindie, SA, for distinguished service to medical and scientific research in the areas of immunology and cell biology, and through innovative developments in cancer treatment, particularly acute myeloid leukaemia.

Professor Donald St John AM, of Malvern, Vic, for distinguished service to medicine, and to medical research, as a gastroenterologist, to innovative public health cancer screening programs, and as a mentor of young clinicians.

Professor Jeremy Wilson, of Bondi Junction, NSW, for distinguished service to medicine as a pancreatologist, to medical administration and clinical governance, to education as an academic, researcher and mentor, and to professional associations.

Eight AMA Members were made Members (AM) in the General Division:

Professor Peter Colman, of Kew East, Vic, for significant service to medicine in the field of endocrinology, particularly diabetes research, patient education and clinical management.

Dr John Leyden, of Mosman, NSW, for significant service to community health as an advocate for patient support networks and research into neuroendocrine cancer.

Dr Timothy Mooney, of George Town, Tas, for significant service to medicine through a range of multiple practice roles, to doctors in rural and remote areas, and to the community.

Dr John Moran, of Murwillumbah, NSW, for significant service to medicine in northern NSW, to medical administration and education, and to the community.

Associate Professor Rosemary Nixon, of Ivanhoe East, Vic, for significant service to community health in the field of occupational dermatology, as an academic and researcher, and to professional standards.

Dr Nicolas Radford, of Melbourne, Vic, for significant service to medicine as a nephrologist, to the management of medical complications during pregnancy, and to professional standards.

Dr Raymond Snyder, of St Kilda West, Vic, for significant service to medicine, particularly as an oncologist, to cancer research, and to professional and service delivery organisations.

Professor David Wattchow, of Bedford Park, SA, for significant service to medicine as a gastrointestinal surgeon, the medical education, to professional societies, and as a benefactor.

Sixteen Medal (OAM) in the General Division:

Dr David Coles, of Carwoola, member in ACT, for service to medicine, and to rowing.

Dr Allan Cook, of Airlie Beach, Qld, for service to medicine as an orthopaedic surgeon.

Dr Terence Coyne, of Auchenflower, Qld, for service to medicine as a neurosurgeon.

Dr Robert Craig, of Tennyson, SA, for service to medicine as a cardiologist.

Dr Roger Davidson, of Strathfield, NSW, for service to medicine, to education, and to the community.

Associate Professor Alan De Costa, of Parramatta Park, Qld, for service to medicine, and to the community of far north Queensland.

Associate Professor Ronald Dick, of Brighton, Vic, for service to medicine as a cardiologist.

Dr Geoffrey Harding, of Sandgate, Qld, for service to musculoskeletal medicine.

Dr Richard Herlihy, of Leura, NSW, for service to medical professional support organisations.

Associate Professor Thomas Jobling, of Brighton, Vic, for service to medicine, particularly to ovarian cancer research.

Dr John McLaren, of Cowra, NSW, for service to the community of Cowra, and to medicine.

Dr Robert Rogers, of Kew, Vic, for service to the community as a general practitioner, and through support for asylum seekers and refugees.

Dr Mehdi Sanati Pour, of Mildura, Vic, for service to medicine as a general practitioner in Mildura.

Dr David Starte, of Northbridge, NSW, for service to medicine as a paediatrician.

Associate Professor Gwynne Thomas, of Camberwell, Vic, for service to medicine in the field of nephrology, and to the community.

Dr Roger Welch, of Southport, Qld, for service to ophthalmology.

MBS Taskforce Review reports released

The Department of Health has released for public consultation, six clinical committee reports from the Medical Benefits Schedule Review Taskforce.

They were released on June 7 as the first deliverable of a revised 2017 Workplan.

These have been long awaited, and much delayed. This six are predominantly from the first and second tranches and include:

- Renal medicine;
- Spinal surgery;
- Dermatology, allergy and immunology;
- Urgent after-hours primary care services; and
- The diagnostic imaging clinical committee – pulmonary embolism and knee imaging

The MBS Review was announced in April 2015 and with more than 30 clinical committees and working groups across six tranches, there is still got a long way to go.

The AMA has stated its support for the vision of the MBS Reviews and has committed to working with the Government to deliver on agreed final recommendations arising from the MBS Review, in conjunction with the relevant sectors.

Going forward, the AMA will continue to identify areas to improve the review process, and recommendations where we feel they fall short, or are inappropriate.

From an AMA perspective, the support for the vision of the MBS review is contingent on the review being clinician-led, with a strong focus on supporting quality patient care.

The review must therefore have:

- a clear and overarching vision and specific direction for the Australian healthcare system to guide the final outcomes of the reviews;
- specific and quantifiable aims;
- the direct involvement of specialist Colleges, Associations and Societies;
- full transparency of the individual reviews as they progress and the decisions that will come from them; and
- the ability to add new items to the MBS.

The AMA welcomes the start of the consultation process – a critical component of getting any changes to the MBS right is ensuring that the profession has deep involvement.

The recommendations are in draft form, subject to further consultation and are not yet Government policy.

Members who feel that there are significant or technical issues relating to the proposed changes should raise them with the relevant society, college or association. They will be well placed to engage and represent each specialty and engage with the review on a technical level. Some colleges have already sought feedback from their profession already.

For our part, the AMA is committed to working with the medical colleges and societies as we review the recommendations, to ensure there is general acceptance by the profession, and that the proposed structure reflects best practice.

Engagement with the profession on the principles and rules that underpin the review process also remains a priority for the AMA, as we seek to ensure there is general acceptance, understanding and engagement.

Finally, the AMA Secretariat is also working with our member-based MBS Working Group – the group provides close insights to the reviews and guides AMA's positions for public commentary. We also want to acknowledge and thank these members who volunteer their time and expertise to the review process.

It is important to note that fee structures and measures for implementing new items have not yet been specified. No doubt, that will be a contentious period, considering all 5,700 items will eventually go through the review and many will need a new fee structure alongside a new descriptor.

It will not all be smooth sailing. However, the review is an opportunity to ensure that high quality models of care are provided for in a modernised and "future proofed" MBS. Ultimately it will be up to the Government to determine what the final changes are to the MBS, however, the consultation period is an opportunity for the whole profession to have their say – including to call out inappropriate recommendations.

To that end, clinical committees will consider feedback from stakeholders on this round of changes up until 21 July 2017. They will then provide advice to the Taskforce before making recommendations to the Health Minister for consideration by the Government.

We can expect further MBS Review consultation reports to follow, with rounds two and three likely to commence in July and August, at which point the AMA will again publicise the opportunity to be involved.

But now is your opportunity to provide feedback on these six reports. For those wishing to provide feedback directly to Government, visit www.health.gov.au and click on 'Medicare Benefits Schedule Review – have your say'.

CHRIS JOHNSON

AHPRA strategy for advertising compliance and enforcement

The Australian Health Practitioner Regulation Agency (AHPRA) has commenced a new strategy to encourage compliance with the requirements under the National Law as a result of a significant increase in the complaints about advertising.

The AHPRA strategy is risk based. It is targeted according to the risk to health by the activity under scrutiny. The response is designed to be proportionate to the risk to the community. It is hoped that early and low level intervention will correct most issues, without need for significant compliance action.

If someone is found to be advertising incorrectly, and it is low risk to the public, AHPRA will contact them in writing in the first instance and ask that they change their advertising. The person will have 60 days to check and correct their advertising. Further non-compliance may result in a condition being placed upon a practitioner's registration or the relevant National Board taking disciplinary action.

The Health Practitioner Regulation National Law (the National Law) includes provisions about advertising regulated health services to help protect the public.

The provisions are broad, they cover anyone who advertises a regulated health service, including registered health practitioners, non-registered health practitioners, individuals and bodies corporate.

If you are advertising a regulated health service, your advertising must not:

- be false, misleading or deceptive, or likely to be misleading or deceptive;
- offer a gift, discount or other inducement, unless the terms and conditions of the offer are also stated;
- use testimonials or purported testimonials about the service or business;
- create an unreasonable expectation of beneficial treatment; or
- directly or indirectly encourage the indiscriminate or unnecessary use of a regulated health service.

The Medical Board of Australia has guidelines for advertising regulated health services, which can be found here http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

There are also specific guidelines for medical practitioners who perform cosmetic medical and surgical procedures, which can be found here http://www.medicalboard.gov.au/News/2016-09-29-revised-registration-standards.aspx

JODETTE KOTZ

Many challenges identified with the NDIS

A study undertaken by the Productivity Commission to review the costs of the National Disability Insurance Scheme (NDIS) has released a position paper to outline the Commission's early thinking on NDIS costs.

The position paper, *National Disability Insurance Scheme (NDIS) Costs*, identifies many issues that have been raised with the Productivity Commission by the AMA and others.

The purpose of the position paper is to seek feedback on the Commission's preliminary conclusions, and on any additional issues that should be considered before the public release of the final study report.

Productivity Commissioner Angela MacRae said while NDIS costs were still on track the NDIA had identified early cost pressures that needed to be managed for the full scheme.

The Productivity Commission warned of a cost blow-out because more children than expected were signing up to the scheme.

The report suggested the Government would also need to re-examine policy to address emerging workforce shortages.

The AMA believes the Productivity Commission position paper is comprehensive and important. This included that AMA raising with the Productivity Commission's concerns about Primary Health Networks (PHNs) not being able to purchase psychosocial services.

PHNs are services that coordinate supports, such as employment, housing, independent living and community participation, for people with severe and persistent mental health issues who have complex needs. As mental health funding is transferring to the PHNs, it is reasonable to expect that, at a minimum, PHNs provide both clinical and psychosocial care, as needed.

The AMA also noted that there are situations where NDIS restrictions may result in some vulnerable people ending up in more costly and less appropriate health care.

The AMA submission to the Productivity Commission expressed support for investment in community mental health services which provide GPs with enhanced referral pathways, and service options, especially for those with low to moderate mental health problems or who need support in managing their day-to-day activities.

The final Productivity Commission report will be provided to the Australian Government in September 2017.

MEREDITH HORNE

Your AMA Federal Council at work

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

Name	Position on council	Committee meeting name	Date
Dr Roderick McRae	AMA Federal Councillor	Clinical Definitions Working Group - Private Health Ministerial Advisory Committee	19/4/2017
Dr Stuart Day	AMA Tas President	Working group on improving the notification process	5/4/2017
Dr Kunal Luthra	AMA Member	Working group on improving the notification process	5/4/2017
Dr Antonio Di Dio	AMA ACT Vice President	Working group on improving the notification process	5/4/2017
Dr Tony Bartone	Vice President	Working group on improving the notification process	5/4/2017
Dr Gino Pecoraro	AMA Federal Councillor	Expert Advisory Group - revalidation consultation	19/4/2017
Dr Richard Kidd	AMACGP Chair	Health Sector Group	17/5/2017
Dr Richard Kidd	AMACGP Chair	DVA Health Consultative Forum	17/5/2017
Dr Richard Kidd	AMACGP Chair	United General Practice Australia (UGPA)	18/5/2017
Dr Tony Bartone	Vice President	National Medical Training Advisory Network	5/5/2017
Dr Andrew Mulcahy	AMA Member, proxy for Vice President	National Medical Training Advisory Network	17/2/17
Dr John Zorbas	Federal Councillor, AMACDT Chair	National Medical Training Advisory Network	17/2/17

AMA joins in notifications workshop

From left to right: Mr Matthew Hardy, Mr Martin Fletcher, Dr Kunal Luthra, Dr Antonio Di Dio, Prof Anne Tonkin, Dr Joanne Katsoris, Mr Luke Toy, Dr Tony Bartone, Dr Stuart Day, Ms Jodette Kotz, Dr Joanna Flynn, Ms Kym Ayscough

The following is from the official communique issued following the workshop

Senior leaders from the AMA, the Medical Board of Australia (MBA), and the Australian Health Practitioner Regulation Agency (AHPRA) met on April 5 for the third consecutive year to discuss how notifications are managed in the National Registration and Accreditation Scheme.

The workshop focused on improving timeliness of managing notifications in an environment where notification numbers are increasing. It also focused on the experience of practitioners who have a notification made about them. The AMA provided very clear advice to the MBA and AHPRA about the impacts of notifications to individual practitioners.

The MBA was represented by Dr Joanna Flynn, Chair of the MBA, Dr Peter Dohrmann, Chair of the Victorian Board of the MBA and Professor Anne Tonkin, Chair of the South Australian Board and member of the National Board. AHPRA was represented by Martin Fletcher, CEO of AHPRA, Kym Ayscough, Executive Director – Regulatory Operations, Matthew Hardy, National Director of Notifications and other senior AHPRA staff.

The AMA was represented by Vice President Dr Tony Bartone, as well as Dr Stuart Day, President AMA Tasmania, Dr Antonio Di Dio, Vice President, AMA ACT, Dr Kunal Luthra, AMA Victoria, and Luke Toy and Jodette Kotz from the secretariat.

Participants acknowledged that the notifications system has an important role in protecting the public and in promoting confidence in the medical profession. All participants valued the opportunity to contribute to strengthening this system.

The AMA was pleased to learn about significant improvements that have been made in managing notifications, including improved timeliness and improved communication with practitioners. The AMA acknowledged the willingness of the MBA and AHPRA to respond to the concerns previously expressed by the AMA. One of the initiatives in the past year was the introduction of an ongoing survey of notifiers and practitioners who have been the subject of a notification. While there have been significant improvements to date, the survey highlighted areas for ongoing focus.

Timeliness of dealing with notifications

Despite an 18 per cent increase in notifications received to the end of Quarter 3 of 2016-17 compared with 2015-16, there were significant improvements in the completion rates of cases with an increase of 34 per cent over the past 12 months. A key focus has been reducing the timeframes at the assessment and investigation stages. This work has resulted in a reduction of the average time a case spends in assessment from 60 days to 45 days, and a reduction in the average time a case spends at the investigation stage from 328 to 298 days, over the last 12 months. Reducing the time taken to complete this work remains a key focus of the workshop and of AHPRA's improvement strategies.

While there were many initiatives that have contributed positively to this reduction, two major pilot programs appeared to provide an opportunity to streamline the system significantly. These pilots are:

1. The triage pilot that started in South Australia and is now being used to help manage large numbers of notifications in Queensland. The triage process involves a Committee assessing a notification within days of it being received. The Committee decide whether it can be closed early or whether additional information is necessary. They also provide early clinical input to support a streamlined investigation. The triage process has resulted in a 33-day reduction in average assessment time frames in Queensland.
2. Early clinical discussion where a practitioner who is facing an allegation of unsatisfactory performance is invited to discuss the notification with a medical practitioner employed by AHPRA. The practitioner is accompanied by a representative of their professional indemnity insurer. The early data indicates that it is a helpful intervention as it allows the practitioner to explain the circumstances of the notification to another medical practitioner, which can ultimately improve a Board's understanding of the issues raised in a notification. Potentially, it will reduce incidences of prolonged investigation.

Workshop participants were impressed by the early data on both these approaches and will be keen to learn of further progress with these initiatives.

The impact of notifications on practitioners

The MBA and AHPRA acknowledged that despite the fact that around 70 per cent of notifications result in no regulatory action, many practitioners regard being the subject of a notification as a catastrophic event.

The potential impact of notifications on junior doctors was particularly profound. The Doctors in Training cohort view a notification as a very serious event. They are concerned about the impact of a notification on their career. Prospective employers regularly request details about any history of notifications, even if no regulatory action was taken. Concerns have also been expressed that junior doctors may not seek help when they are in difficulty because they fear that a mandatory report will be made to the MBA.

Participants acknowledged that practitioners were concerned about mandatory notifications and vexatious complaints. AHPRA and the MBA advised that their evidence does not support a view that mandatory notifications were being made inappropriately. The AMA remained concerned that the mandatory notification provisions were dissuading practitioners from seeking help when needed for fear of the ramifications. The number of clearly vexatious complaints is very, very small. AHPRA and the Board have committed to commissioning further research on this issue.

The workshop also explored the implications of the Board issuing a caution to a practitioner. Cautions are not listed on the Register of medical practitioners but employers are informed about them at conclusion of the notification and ask about whether their employees have been subject to regulatory action. Therefore, the caution can become public in the sense that the employer is aware of it and can impact on the future employment of medical practitioners. The impact on practitioners who are in an employment arrangement is much greater than for those working only in private practice. It was agreed that the policy intent behind the use of cautions did not anticipate this consequence. AHPRA and the MBA agreed to explore how cautions are applied.

All parties agreed that there needs to be a focus on the mental wellbeing of practitioners, including when they are the subject of a notification.

Feedback from practitioners

AHPRA presented information from their survey into the notifications experience. The results provided clear opportunities for AHPRA and the MBA to improve engagement with practitioners. The vast majority of respondents felt that they understood the outcome and the reasons for the MBA's decision, however many respondents did not feel that they were regularly updated on the progress of their notification. AHPRA has agreed to review how and how often they update a practitioner.

On a pleasing note, a large majority of practitioners agreed that they were satisfied with the outcome of their notification.

Summary

The AMA commended the MBA and AHPRA on their willingness to listen to concerns and take action. There have been many initiatives over the past 12 months that have contributed to reducing time frames for notifications although more still needs to be done.

The group concluded that it is valuable to review and reflect on the progress made so far and to continue to robustly discuss options and opportunities to improve the notifications system.

The group agreed to hold another workshop in 12 months, and to include updates of progress on the current work in the regular AMA/MBA/AHPRA meetings.

More from the AMA National Conference 2017 Photo Gallery

Family Doctor Week

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

AMA Family Doctor Week 2017

YOUR FAMILY DOCTOR: ALL ABOUT YOU

Later this month we will again celebrate AMA Family Doctor Week, paying tribute to hard working GPs across the country. This year's theme is *Your family doctor: all about you*, sending a clear message to the community about the holistic care provided by GPs and the critical role we play in working with our patients to ensure that they get the best care possible.

Our patients place a great deal of trust in us. This can be seen in recent figures released by the Australian Institute of Health and Welfare, with nearly 80 per cent of patients having a preferred GP. Over 90 per cent of patients provided positive feedback on their interactions with their family doctor, something we should be proud of.

Given the pressures that general practice has been under over the last few years I think results like this demonstrate the strength, focus and commitment of our nation's hard working general practitioners.

While the AMA would clearly have preferred to see the MBS indexation freeze lifted immediately in the last Budget, at least there is now a commitment from the Government to ease this over time. The debate on indexation has largely drowned out any discussion about support for general practice, so there is now at least the opportunity to sit down with the Government and other parties to talk about a stronger focus on primary care and real measures to reward quality general practice.

The new Health Minister, following strong advocacy by the AMA, clearly appears to understand the key role played by general practice. This will need to translate into real action at the coal face. In this regard, the AMA is involved in several key policy discussions including Primary Health Networks, Health Care Homes, an opt-out My Health Record and the PIP Quality Improvement Incentive. These need to deliver the support that GPs need to ensure our patients can access quality care, when and where they need it.

The MBS Review has also released its interim report on access to GP after-hours services. These are a critical part of the health system, but there are growing concerns about the commercialisation of the sector and the potential breakdown in the link with a patient's usual GP. We need to ensure access to medical care in after-hours period where there is a genuine patient need, as part of a collaborative model that ensures continuity of patient care.

Achieving the best health outcomes we can for our patients drives us all, but we often don't have the data to test how we are performing. As we see reform within the health sector, the outcomes we achieve for our patients are going to be increasingly of interest to those who primarily fund our services. Quality data will be a key driver of improvements in the provision and delivery of health care. The AMA is working to ensure measures of outcome are meaningful, appropriately framed, and utilised, and do not add to administrative burden of busy general practices.

With GP coordinated team based care, Australian general practice will continue to deliver world leading outcomes for our patients. But we can't do it alone and the AMA will continue to work with Government to ensure it understands it has to invest in general practice to deliver better health outcomes and health expenditure savings for the future.

WHO change at the top

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

Tedros Adhanom Ghebreyesus is not a household name

Nor for that matter is the World Health Organisation, to which, last month he was elected to lead as Director-General for the next four years.

Tedros, as he is known, is not medically qualified — the first such person to lead the WHO — but has a PhD in Community Health. He comes from Ethiopia, where he has served as Minister for Foreign Affairs and for Health. In his late 50s, he has an impressive track record of health service development in his home country, an especially remarkable feat in such an economically and environmentally challenged nation.

The appointment of directors-general at WHO has become increasingly political, but also, ironically, more transparent. As Laurie Garrett, an eminent health journalist from the New York-based Council for Foreign Relations put it: "This year, by the time the Seventieth World Health Assembly opened on May 22, the electioneering [among candidates for the director-generalship] evidenced many of the trappings of a typical high-level campaign in a Western democracy, including professional campaign staffing, social media messaging, last-minute rumours and mudslinging, speeches, handshaking marathons, and last minute rabble-rousing fêtes.

"The election was held on May 23. According to the voting rules, each country was limited to four individuals inside the assembly hall in the Palais des Nations [in Geneva], where all emailing, tweeting, and texting was strictly *verboten*.

"Locked into the hall, the delegates for the 186 nations that qualified to cast written ballots—by virtue of being up-to-date on their WHO dues and being physically present in Geneva—cast three rounds of votes while hundreds of media and assembly attendees milled about outside, hoping for news. The new rules dictated that a candidate had to win a 66 percent majority, which Tedros (who led every round) achieved on the third vote, handily defeating second-place [David] Nabarro [of the UK]. The votes were cast by secret written ballots, placed inside boxes and hand-counted by WHO officials."

The WHO has huge responsibilities for global health and well-being, but we hardly notice. Western politics has become so polarised and focussed on individuals that global activities and events — with the exception of climate change, tensions with Russia and North Korea and terrorism — get little oxygen in our conversations.

But the state of health of much of the earth remains poor. And it is for this reason that WHO — even though it has its own political rough and tumble — is so important to securing a humane future for the planet. Its leadership is vital, setting the tone and doing the work.

The cookie jar is empty

But it has been held to ransom by major contributors to its coffers to do things which would selectively benefit themselves. The WHO's finances are in bad shape. Its annual budget is around the $2 billion mark. As an organisation, it has had terrible troubles with near-bankruptcy, fierce competition from groups such as the Gates Foundation, the World Bank and the International Monetary Fund, each with its own, often narrow, agenda and barrels of cash, and immense pressure from industries — food, private medicine and pharmaceutical giants, to name but three.

With Trump's plan to cut contributions to anything truly international that is not an anabolic steroid boost for the US, the contribution from its principal international donor looks set to fall. Our falling foreign aid funding follows the same path. The capacity of the WHO will, nevertheless, somehow need to be strengthened as part of global readiness for the next pandemic. This will require economic engineering of a high order.

WHO has survived many vicissitudes in its 69 years. Tedros clearly has intelligence, experience and leadership skills, together with wide political support within the organisation. The world's health care is wobbly at present. He will need good proprioception and vision to keep his balance! Let's wish him well.

Professional groups to alleviate isolation

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

I know there are times you feel isolated, not "lucky" enough to have the amenities and support found in more populated areas.

I'd like to point out a unique, not often thought of advantage of being Rural. A strength our urban colleagues must miss.

Unlike other specialties or craft groups, we have an array of Professional Associations - all with "Rural" in their name.

- AMA Council of Rural Doctors (AMA -CRD)
- Royal Australian College of GPs- Rural (RACGP-Rural)
- Australian College of Rural and Remote Medicine (ACRRM)
- Rural Doctors Association of Australia (RDAA)
- National Rural Health Alliance Inc (NRHA)
- World Organisation of Family Doctors (WONCA Rural)

What can it mean to you, these Rural focus interest groups? Of course these good organisations can counter the isolation, the unique challenges of Rural health, workforce, training and services. But more than this, they are your family. Like family there is love, loyalty and yes friction between siblings. Family takes effort and work. Families also get together and have parties.

When you "belong" to a cohort, there is a sense of the need to contribute, to participate, to "pitch in". When something good happens to your association, even though you did not do the work behind the accolade, there is still a sense of pride and the wish to boast about an achievement. Also when you belong, you earn the right to be (self) critical and to whinge.

You can choose to join one, two or all of the above groups. Even joining all of them might seem a lot of money, but put it into perspective. You are Rural, at times isolated, at times not feeling heard or recognised. You do not pay daily for parking and/or a cup of espresso coffee.

What is the cost not to belong to one, some or all of these Rural Associations? You miss out. Your voice is louder with the microphone under your lips. Issues you struggle with daily, you remain unaware that others had the same struggle (think dogs, scabies, RHD, lack of fresh vegetables). You remain isolated, in your silo, working hard, alone. Do you have a "go-to" professional secretariat to ask about legal, political or membership issues? I do, and I have spent countless hours being supported by them. If you attend their conventions or get togethers you pay NON-MEMBER fees. What a horrible word, non-member.

Aren't you lucky you CAN belong to these groups? They exist for you.

ps... I belong to four of them.

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

Climate change begets change

BY ROB THOMAS, PRESIDENT AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

> "It's alarming to think that it has taken decades for the vast majority of the population to accept the existence of climate change and its anthropogenic origin."

Climate change is an issue which requires drastic and immediate action. These are words we have now heard for several years and yet very little governmental action has occurred to this effect. Unfortunately, the indirect and future unavoidable impact of climate change on health is not immediately evident, but it is no less troubling. The recent decision by President Trump to pull out of the Paris Accord – the largest commitment to curb the threat of global warming – promises an uncertain future.

It's alarming to think that it has taken decades for the vast majority of the population to accept the existence of climate change and its anthropogenic origin. Even still, climate change denial is present in politics, far exceeding the evidence base required for action. I encourage you to look at sites like sceptical science if any myths still need busting for yourself.

Perhaps the greatest barrier to tackling the issue has been the pace of technological revolution in the 21st century, but this is also the key to securing the future. As we all know, prevention is far better (and more cost effective) than cure, and it is only through useful change management principles that practice can be improved.

There are already many negative effects of climate change on human health, including heat-related illness, increased incidence of natural disasters and respiratory disease. Changing climate patterns in the future may well threaten food and water security, of which Australia is particularly vulnerable, and communicable diseases such as malaria or dengue have been shown to have the potential to spread. The health cost associated with burning coal has been estimated at $2.6 billion per annum.

Among this gloomy picture, there are actions we can all take that have a real impact. I'm reminded of a friend's recent capacity to be a change champion, by asking the question about switching to LED lights in the hospital he worked in. Despite this not being his particular domain, and despite him repeatedly being told that a change wouldn't be possible, he eventually made the case for the lights. While they are not only more efficient use of electricity, they have been shown to be more cost-effective and reliable.

Another way that we might effect change is by putting our money where our mouth is. Divestment is a process where you no longer use a service that funds fossil fuels. While having little direct monetary impact, divestment has the opportunity to raise public image of the issue of fossil fuel investment, putting pressure on banks to change their practices. Luckily, there is often an available and similarly-priced alternative for divestors, and the process can be surprisingly simple.

In your hospital, clinic, or in your personal life small changes can make big differences. The simple act of encouraging the use of keep cups as opposed to disposable (and often non-recyclable) coffee cups has the capacity to reduce landfill waste. Encouraging carbon offset programs for carbon-heavy practices holds merit.

Climate change is everyone's problem. It's silent and slow, but requires fast and sustained action. It is time to walk the talk and look at how to be part of the change to curb the change.

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Indigenous Medical Workforce

BY **AMA PRESIDENT DR MICHAEL GANNON**

> "Central to this is increasing the cultural competency of our doctors and health professionals, and more importantly, supporting more Aboriginal and Torres Strait Islander people to become doctors."

With Aboriginal and Torres Strait Islander people experiencing more than twice the burden of disease than their non-Indigenous peers, it is vital that Australia's medical workforce is well equipped to meet the unique health and cultural needs of Aboriginal and Torres Strait Islander patients.

Central to this is increasing the cultural competency of our doctors and health professionals, and more importantly, supporting more Aboriginal and Torres Strait Islander people to become doctors.

It is well known that Indigenous doctors have a unique ability to align their clinical and socio-cultural skills to improve access to services, provide culturally appropriate care, and ultimately improve health outcomes for their Indigenous patients. And it is well documented that Aboriginal and Torres Strait Islander people are more likely to visit a doctor if they are Indigenous.

Yet in 2014 there were only 261 medical practitioners in Australia who identified as Aboriginal or Torres Strait Islander, a number well below population parity.

Growing the Indigenous medical workforce is a long-term process, and requires change at all stages of the medical education and training continuum. Over the past decade, there has been a steady increase in the number of Indigenous students graduating from medical programs, yet very few of these graduates continue on to specialist training pathways.

There is already an emerging disparity between the number of medical graduates and the number of specialist training opportunities available, and Indigenous graduates in particular face further barriers that keep them from successfully pursuing further training. Current evidence shows that increased financial hardship, a lack of appropriate role models, and insufficient information and promotion of specialist options are all acting to prevent Indigenous enrolment in Medical Colleges.

It is clear that there must be an improvement in the recruitment and support for Indigenous graduates pursuing specialist medical qualifications.

The AMA recognises that there is already some great work being done in this area by many of the Medical Colleges, who are implementing Indigenous specific pathways and programs, as well as having a range of scholarships available for Indigenous graduates. These measures increase the opportunity for Indigenous graduates to access these valuable services.

But there is still more than can be done.

More information on how to access these programs and promoting the pre-requisites for entry will make the application process clearer, and help to smooth the pathway for participation in specialist training. Establishing more scholarship opportunities, like the AMA Indigenous Medical Scholarship, across all areas for Indigenous trainees could help remove the financial barriers faced by Indigenous students and assist them to achieve their career aims.

And growing the number of Indigenous Trainees and Fellows can have a positive flow-on effect, increasing the critical mass of Indigenous doctors that is essential for long-term change within the medical workforce, and encouraging more graduates to follow in their footsteps.

Specialist training providers must find more ways to support Indigenous medical graduates to help achieve a diverse workforce that can adequately respond to the needs of Indigenous patients and communities. This will be crucial in helping to close the gap in health and life expectancy outcomes for all Aboriginal and Torres Strait Islander people.

AMA win to keep the Medical Board of Australia strong

BY ASSOCIATE PROFESSOR SUSAN NEUHAUS, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

Earlier this year, the Council of Australian Governments' Health Council released a proposal to allow the appointment of a community member to become chair of the Medical Board of Australia.

> "The person who occupies this position needs to be able to consider complicated matters that require a detailed understanding of the medical profession."

By way of history, when the Queensland Government reconstituted the State Medical Board in 2014 it appointed a chair from a different profession. This created consternation and significant loss of confidence in the work of the Board among Queensland medical practitioners.

The chair of the Medical Board of Australia is a very influential and challenging position. The person who occupies this position needs to be able to consider complicated matters that require a detailed understanding of the medical profession. The AMA believes that the chair should remain a medical practitioner.

We raised our concerns with the Health Council's proposal with the Minister for Health and Sport and his advisors on numerous occasions. This was a joint Federal AMA and State AMA effort. All of the State AMAs raised this issue with their respective Health Ministers and the Queensland AMA was in constant contact with the Queensland Health Minister - due not only to the problems previously encountered in Queensland, but because the changes would be made through the Queensland Parliament first, before being passed in other states.

The AMA also worked closely with other professions, Nurses and Midwifery, Dentistry and Optometrists, who supported our position against this proposal. Combined, our associations represent the vast majority of registrants under the scheme.

The AMA is delighted that the proposal has not been included with the amendments to the National Law currently before the Queensland Parliament. This is great outcome for the medical profession. However we still remain concerned that this proposal may be reconsidered, and introduced in later bills into the Queensland Parliament in August this year. As such, the AMA will continue to advocate on behalf of our members on this very important issue.

Devil in the detail for visa reforms

BY AMA VICE PRESIDENT DR TONY BARTONE

The Federal Government's decision to overhaul temporary skilled workers visas caught many of us by surprise, and has once again drawn attention to the medical workforce.

Under the reforms, 457 visas will be abolished and transitioned to a new multi-stream Temporary Skills Shortage (TSS) visa system by March 2018. The new visas will have tighter conditions and include a smaller number of eligible occupations. It will also be harder to progress to permanent residency from the new visa class.

The new arrangements include the mandatory requirement for labour market testing, and the AMA was advised recently that this will include doctors. We have said all along that this is essential to ensure that the increasing number of locally trained doctors have enough opportunities to work, train and develop their careers.

The AMA cautiously welcomed the new arrangements when they were announced in April, but as is often the case, the devil is in the detail when government programs are reformed, and we are concerned that they have created uncertainties with the pathway to permanent residency for International Medical Graduates (IMGs) and full fee-paying medical students already working or studying in Australia.

The new TSS visa system is split into short-term and medium-term streams. Short-term visas will be granted for two years for those in an occupation on the newly created Short-Term Skilled Occupation List. Only one extension of a further two years will be available.

The short-term visa also has no pathway to permanent residency, which has left some international medical students uncertain about their future.

Medium term visas will be issued for four years for those in an occupation listed on the new Medium-Long Term Strategic Skills List (MLTSSL). This stream focuses on strategic medium to long-term skills gaps. For medical-related occupations, the MLTSSL retains most of the specialties that were on the Skilled Occupation List that until now has been used by the Government for independent skilled migration to meet the medium to the long-term skills needs of the economy.

Unfortunately, it is unclear how IMGs already here on a 457 visa might be affected if there are changes to occupations listed on the short-term and medium-term streams some time in the future.

From our perspective, it is essential that the above uncertainties are ironed out, and existing 457 visa holders continue on the same terms and conditions under the new arrangements so that those who have been working towards permanent residency are not disadvantaged.

Many IMGs have chosen to settle in Australia and are now working towards permanent residency, which can often be a very lengthy process due to the rigorous requirements they must satisfy to achieve general and/or specialist registration. I know from personal experience that these IMGs are contributing greatly to the health care system, especially in under-serviced areas. Changing the immigration rules for this group would be very unfair.

I'm also hoping that an effort will be made to refine the medical specialties on the short-term and medium-term occupation lists that have been put in place for the new visa system. The Department of Health had previously recommended the removal of all specialties from the former Skilled Occupation List, which the AMA backed strongly as Australia is producing enough locally trained doctors.

Until the visa changes are bedded down and their implications become clearer, it appears likely that most medical occupations will stay on the new lists.

We will continue to advocate most strongly that the medical occupations on these lists target only those areas where there is demonstrated workforce need, especially as it is likely that State and Territory health departments will seek to use the current settings despite the need to properly fund the additional postgraduate training positions that are so urgently needed for the large number of medical graduates facing a difficult and uncertain future.

AMA lobbying extensively for a sustainable health system

BY ASSOCIATE PROFESSOR JULIAN RAIT

> "Many members would be aware that there a number of specific health initiatives underway – each of which will have varying degrees of impact for private practitioners."

The Council of Private Specialist Practice (CPSP) met at Melbourne Airport on June 10 for its first face-to-face meeting since the Council's inception in 2016. This offered the opportunity to discuss a range of pressing issues and policy changes, as well as prepare for a series of forthcoming inquiries and reviews.

Many members would be aware that there are a number of specific health initiatives underway – each of which will have varying degrees of impact for private practitioners. In that light, CPSP members have discussed a number of recent developments to inform the Federal AMA's advocacy strategy.

In particular, there is no doubt that the media, and by extension the broader population, have been questioning the value and affordability of private health insurance. Government, industry, hospitals and the medical profession are all looking for improvement in the value proposition. And of course, all have different perspectives on how this might be achieved.

Notwithstanding the AMA's stated support for many of these health reforms, CPSP's discussion centred on initiatives to directly assist private practitioners to maintain a more balanced and sustainable health system.

This started by considering AMA's ongoing contribution to the private health insurance product redesign, which is currently under consideration by the Government-led Private Health Ministerial Advisory Committee (PHMAC).

While PHMAC conversations have largely been conducted in confidence, it is widely acknowledged that substantial problems exist with the current PHI products. So the development of PHI policies that offer more comprehensive coverage, with clear clinical definitions, and fewer exclusions and carve outs would likely restore the public's faith in private health insurance. CPSP was able to propose a number of examples that could contribute to the PHMAC process, via the President, as Government considers a more enduring solution.

Another emerging risk is the increased focus of public hospitals on private patient revenue. Unfortunately there have been a number of media reports and an AIHW report that indicate that private patients in public hospitals are being prioritised. Unfortunately this appears to have produced shorter wait times for elective surgeries for privately insured patients when compared to public patients of public hospitals.

However, it is clear in discussion that controlling this situation is a more complicated task than it would appear in media reports. Consequently CPSP resolved to work with the relevant committees within the AMA to further discuss the detail of any new policy initiatives. In particular, CPSP acknowledged that the rights of private practice within the public hospital system are a well-established part of the remuneration of staff specialists. Furthermore, public hospitals, much like the private system, require a more sustainable funding stream. We believe that both sectors need to be well funded in order to have a sustainable health system. Consequently, any future COAG funding agreement for public hospitals needs to be linked to PHI product design – particularly noting the greater uptake of public hospital only insurance policies.

Also looming on the horizon is the upcoming Senate inquiry into the value of private health insurance and out-of-pocket costs. Therefore, CPSP took the opportunity to review and strengthen the AMA's suite of policies relating to appropriate billing practices, and to reinforce the view that our profession endeavours to be fully compliant with informed financial consent for our patients.

AMA lobbying extensively for a sustainable health system

In considering the Senate inquiry, it has also been an opportunity to emphasise the role of the AMA Fees List and how this supports our members to decide on their fees in daily practice, and counter certain media case studies reporting on patients who have suffered significant 'bill shock'.

And while the AMA does not, and cannot support the charging of excessive fees, it was recognised that the complicated nature of PHI policies and the increasingly complex nature of the MBS schedule all contribute to these billing problems. However, we also appreciate the potential risks of single billing and the potential of managed care – solutions that unfortunately are likely to be floated during the forthcoming policy debate.

Finally, proposed reforms of the medical indemnity support schemes will likely cause concern for our members. Many, if not most, doctors will sadly remember the indemnity crisis of 2002 – and no one wants to return to such an era of escalating indemnity premiums and uncertain policy cover. While the MYEFO reductions to some of the indemnity schemes have caused some uncertainty, the forthcoming full review of these indemnity schemes has the potential to cause even more concern as to the future of private specialist practice in Australia.

The AMA has been lobbying extensively and, even though the terms of reference for the review have not been released, we have been reassured that the review will not simply be a 'cost saving' exercise. Despite that, CPSP took the opportunity to discuss potential reforms to the indemnity schemes, including those surrounding universal cover, as part of our advance preparation for the development of a comprehensive AMA response.

Therefore it appears that it will continue to be a busy year for health policy debates and for the AMA's continuing advocacy to improve the security of private practitioners. And if you have views on indemnity, on private health insurance, or on medical fees and out-of-pocket costs that you would like to see raised by CPSP, then please feel free to email Miss Eliisa Fok at the AMA secretariat as follows efok@ama.com.au so that the CPSP can consider such additional items.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Call to action to end elder abuse

The Government is considering recommendations to come out of a long-running Federal inquiry into elder abuse.

The Human Rights Commission has made a call on all Australians to recognise the rights of older people and end the abuse and neglect so many of them face.

The call comes as the Australian Law Reform Commission (ALRC) releases its findings and recommendations following a 15-month Federal Inquiry into elder abuse.

The report, *Elder Abuse - A National Legal Response*, is the result of 117 national stakeholder meetings and more than 450 submissions.

The Age Discrimination Commissioner, Dr Kay Patterson AO, said the report was a seminal piece of research that has the power to change lives. She also believes the report puts all Australians on notice (in particular those working with older people) that they have a responsibility to understand what elder abuse is and to commit to its elimination.

"The report contains 43 recommendations and my plan is to work with Governments and stakeholders to drive the adoption of these recommendations. This includes a national plan to protect the rights and well-being of older Australians with a goal to end elder abuse," she said.

Elder abuse includes psychological or emotional abuse, financial abuse, physical abuse, neglect and sexual abuse. It has a devastating impact on individuals, families and communities across the country.

ALRC president Professor Rosalind Croucher said the framework could be used to implement wide-ranging reform.

"In developing the recommendations in this report, we have worked to balance the autonomy of older people with providing appropriate protections, respecting the choices that older persons make, but also safeguarding them from abuse," Professor Croucher said.

One of the key recommendations in the report is implementing a national study to examine how common elder abuse in Australia is – to research the overall number and severity of incidents of elder abuse and neglect in Australia.

The report did not examine the impacts of elder abuse on health and well-being. Also not included in the report is whether providing inappropriate health care is a form of abuse.

Law Society of NSW President Pauline Wright also welcomed the report and its recommendations, noting increasingly older Australians were facing abuse which could be in the form of physical, psychological, emotional, financial, sexual abuse or neglect.

"Sadly, financial abuse also frequently occurs, often perpetrated within families or by someone known to the victim such as a friend, carer or neighbour," Ms Wright said.

"Measures to prevent financial abuse are particularly critical given the rise in Australia's ageing population and the increasing number of Australians living with dementia."

In a statement, Attorney-General George Brandis said the Turnbull Government would carefully consider the recommendations and work across portfolios to develop a response.

The AMA believes that family and domestic violence (FDV) is unacceptable in any circumstances. A recent position statement by the AMA points out that elder abuse is a less well covered form of family and domestic violence. It too can be physical, but also involves psychological and financial abuse. A copy of the position statement can be found at: https://ama.com.au/position-statement/family-and-domestic-violence-2016 .

MEREDITH HORNE

Research

Single biggest health burden is cancer attributed to tobacco use

Cancer accounts for about one-fifth of Australia's health burden, with tobacco use the biggest contributor, newly released figures reveal.

The Australian Institute of Health and Welfare (AIHW) has released research based on data sourced from the 2011 Australian Burden of Disease that shows cancer was the greatest cause of health burden in Australia, accounting for around one-fifth of the total disease burden.

AIHW's burden of disease analysis is more than merely counting deaths or disease incidence and prevalence, burden of disease analysis takes into account age at death and severity of disease for all diseases, conditions and injuries, in a consistent and comparable way.

"This (burden) is calculated in terms of years of life lost due to early death from cancer, as well as the years of healthy life lost due to living with the disease," AIHW spokeswoman Michelle Gourley said.

Almost half (48 per cent) of the total cancer burden in 2011 is from five cancers — lung, bowel, breast, prostate and pancreatic cancers. However the single biggest burden — and almost one-quarter (22 per cent) of the total cancer burden can be attributed to tobacco use.

The report states that most (94 per cent) of this burden was due to dying prematurely, with only a small proportion of the burden due to living with a cancer diagnosis. Even though fewer people die from cancer than cardiovascular disease, the burden of cancer deaths is higher.

The AIHW report also found that Indigenous Australians experienced 1.7 times the cancer burden of non-Indigenous Australians. In particular, Indigenous males experience 2.3 times the lung cancer burden of non-Indigenous males, and Indigenous females 2.6 times the lung cancer burden of non-Indigenous females.

Australians living in rural Australia were also shown in the report to face a higher burden, especially the burden of lung, bowel, prostate and pancreatic cancers.

"Indigenous Australians experienced a cancer burden 1.7 times that of non-Indigenous Australians, and the gap was particularly notable when it came to lung cancer," Ms Gourley said.

Further, poorer Australians found themselves with an increased rate of cancer burden, with people in the lowest socioeconomic group experiencing 1.4 times the cancer burden of people in the highest group. In particular, the rate of lung cancer burden in the lowest group is almost twice the rate in the highest group.

This report presents detailed findings on the burden due to cancer in Australia using results from the Australian Burden of Disease Study 2011.

MEREDITH HORNE

Australian molecular microbiology students' breakthrough in TB

Australian researchers and students at the University of Queensland are using their innovation to tackle tuberculosis (TB) – one of the world's leading infectious-disease killers.

University of Queensland students have identified promising inhibitory compounds during a molecular microbiology practical course this semester.

TB is the leading cause of death due to an infectious agent globally killing approximately two million people each year.

Mycobacterium tuberculosis, the bacterium responsible, currently infects over one third of the world's population and, although most cases respond to standard antibiotic therapy, drug resistant strains are on the rise and new antibiotics for TB are urgently needed.

Students at the University of Queensland's School of Chemistry and Molecular Biosciences have discovered five or six compounds that inhibited growth in a harmless bacterium related to TB.

TB research head Dr Nick West said it appears that students have identified some very interesting compounds and resulted in further research now being a reality.

"There has not been a new general use anti-TB drug for 50 years," Dr West said

The students were undertaking a UQ microbiology course in which they screened a compound library for inhibitors of TB, working through 7000 random compounds.

Dr West said the exciting breakthrough came when they realised a small number completely inhibited the bacteria.

TB resistance will be raised at the upcoming G20 summit this month in Hamburg, Germany, and there is hope that political will can be fostered to tackle antimicrobial resistance (AMR) and turn the tide on tuberculosis.

This comes on top of a resolution by the United Nations General Assembly late last year that moved to ensure UNGA hold the first-ever high-level meeting on the fight against tuberculosis in 2018.

MEREDITH HORNE

US kids dropping vaping and smoking

American teenagers are turning away from e-cigarettes, sparking fresh hopes that youth smoking in the United States could be on the decline.

Overall tobacco use dropped among teenagers last year, but the use of e-cigarettes fell dramatically, according to the Centers for Disease Control and Prevention's annual report on youth and tobacco.

The report found that 11.3 per cent of high school students used e-cigarettes in 2016, compared with 16 per cent the year before. It is the first drop recorded.

Only 8 per cent of high school students smoked cigarettes last year.

Just over 20 per cent said they had used "any tobacco product". That includes cigarettes, cigars, pipes, chewing tobacco and small, leaf-wrapped cigarettes, as well as e-cigarettes.

Both percentages are the lowest on record.

President of the non-profit Campaign for Tobacco-Free Kids, Matthew Myers, described the results as "unimaginable, extraordinary progress" and said almost 30 per cent of young people smoked cigarettes in 2000.

"This is a change of a cosmic nature that has the potential to dramatically impact lung cancer, heart disease, asthma and other problems," he said.

But with the Trump administration already delaying enforcement of some tobacco regulations, health agencies are concerned there could be a weakening of the rules about the use and sale of e-cigarettes and other tobacco-related products.

Fears are that any such moves could reverse the progress being made in encouraging teenagers to resist the smoking habit.

Robin Koval, chief executive of Truth Initiative, a non-government organisation focussing on tobacco use by young people, said the new report suggested Americans could be "well on our way to finishing smoking for good".

She said the rapid decline in e-cigarettes among teenagers suggested much of their use had been experimental and that the current offering of products was less appealing than it had once been.

Senior author of the CDC report, Brian King, said the decrease in e-cigarette use was likely a result of several factors, including efforts by the government and public health groups to educate young people about possible hazards of the products.

He said that while e-cigarettes don't contain some of the harmful substances in conventional cigarettes, the inhaled vapour usually contains nicotine, which is highly addictive and can harm the adolescent brain, as well as ultrafine particulates and heavy metals.

Mr King also said declines in tobacco use could be due to increases in State and local tobacco taxes.

He added that the inclusion of e-cigarettes in antismoking rules banning smoking in restaurants and bars could also be contributing to the decline in the use of the products.

The US Government and a number of non-government organisations have mounted effective campaigns warning about the dangers of smoking.

The Food and Drug Administration stamped its authority on the regulation of e-cigarettes in 2016. But in May this year, it delayed for three months the enforcement of some regulations.

The delay came as the vaping and tobacco industries launched a forceful and strategic effort to wind back, through both legislation and litigation, the FDA regulations.

CHRIS JOHNSON

Yemen cholera outbreak claims one life every hour

The rising number of suspected cases of cholera resulting from a severe outbreak in Yemen has passed 100,000, the World Health Organization (WHO) reports.

Cholera is affecting the most vulnerable. Children under the age of 15 years account for 46 per cent of cases, and those aged over 60 years represent 33 per cent of fatalities.

Cholera, an acute enteric infection, is caused by the ingestion of food or water contaminated with the bacterium Vibrio cholera. It can kill children within just a few hours. Cholera should be an easily treatable disease when there is access to functioning medical services.

WHO believes that cholera is primarily linked to insufficient access to safe water and proper sanitation and its impact can be even more dramatic in areas where basic environmental infrastructures are disrupted or have been destroyed.

Humanitarian partners have been responding to the cholera outbreak since October 2016. However, Yemen's health, water and sanitation systems are collapsing after two years of war. The risk of the epidemic spreading further and affecting thousands more is real as the water hygiene systems are unable to cope.

The UN Office for the Co-ordinatior of Humanitarian Affairs (OCHA) Jamie McGoldrick said the fast spreading epidemic in Yemen was "of an unprecedented scale".

Mr Goldrick also fears that hundreds of thousands of people are at a greater risk of dying as they face the "triple threat" of conflict, starvation and cholera. He believes the cause is clear.

"Malnutrition and cholera are interconnected; weakened and hungry people are more likely to contract cholera and cholera is more likely to flourish in places where malnutrition exists," Mr Goldrick said.

More than half of Yemen's health facilities are no longer functioning, with almost 300 having been damaged or destroyed in the fighting.

Systems that are central to help treat and prevent outbreaks of the disease have failing in Yemen. Fifty per cent of medical facilities no longer function. Some have been bombed and others have ground to a halt because there is no funding.

The International Committee of the Red Cross (ICRC) Director of Operations Dominik Stillhart said: "Hospitals are understaffed and cannot accommodate the influx of patients – with up to four people seeking treatment per bed. There are people in the garden, and some even in their cars with the IV drip hanging from the window."

Local health workers, including doctors and nurses have not been paid for eight months; only 30 per cent of required medical supplies are being imported into the country; rubbish collection in the cities is irregular; and more than eight million people lack access to safe drinking water and proper sanitation.

UNICEF is reported to have flown in over 40 tonnes of medicines, rehydration salts, intravenous fluids and other life-saving supplies to treat approximately 50,000 patients in Yemen.

MEREDITH HORNE

Research reveals alarming medical workforce gender inequality in Ireland

The Irish Medical Organisation (IMO) has released research that shows Irish female doctors face many unfair challenges due to their gender, including bullying and family pressures slowing their career progression when compared to their male equivalents.

IMO President Dr Ann Hogan said: "It is obvious from the research that gender still continues to impact on careers in the medical profession with family considerations often affecting female practitioners to a greater extent than their male colleagues."

The research showed nearly half (46 per cent) of female medical practitioners have delayed having children for reasons related to their careers in medicine, compared to just 19 per cent of male medical practitioners.

Eighty-five per cent of female doctors do not believe that existing workplace supports adequately provide for an opportunity to balance medical workloads with family commitments. Seventy-one per cent of male doctors agree with this.

The report also found 28 per cent of female NCHDs report having experience gender-based bullying in the workplace during the last two years, while 6 per cent of male NCHDs report the same.

"It is obvious that female doctors' experiences of gender-based bullying, harassment, and sexual harassment differ greatly from male doctors' experiences. This is an indictment for our profession and must be addressed," Dr Hogan said.

Unfortunately the findings of the IMO are mirrored in many countries. A recent report published in the *Journal of the American Medical Association (JAMA)* found a third of women physicians reported being sexually harassed while for men, the number was 4 per cent.

The AMA believes that sexual harassment in the medical workplace is unacceptable. Sexual harassment affects physical and mental health, and undermines performance and professionalism in the workplace. Further, sexual harassment can influence career choice and career progression.

A copy on the AMA position paper on sexual harassment in the medical workplace can be found at: https://ama.com.au/position-statement/sexual-harassment-medical-workplace.

MEREDITH HORNE

Paradigm shift in monitoring and improving brain health

The world's most prestigious gathering of medical practitioners in functional medicine and integrative care hosted a symposium in Los Angeles recently, featuring today's greatest revolutionaries in changing how we view and treat brain health.

The Annual International Conference of the Institute for Functional Medicine chose scientifically-disruptive and broadly-acclaimed neuroscientist Dr Michael Merzenich to address its plenary session.

Dr Merzenich unveiled a revolutionary approach to monitoring, maintaining and improving brain health. The system uses apps and digital therapies.

Dr Merzenich is the Chief Scientific Officer of Posit Science, maker of BrainHQ brain exercises and assessments.

He joined Alzheimer's experts Dr Dale Bredesen (of UCLA and the Buck institute) and Dr Rudolph Tanzi (of Harvard and Massachusetts General Hospital) for a discussion of the application of neuroplasticity to dementia.

The theme of the conference was The Dynamic Brain: Revealing the Potential of Neuroplasticity to reverse Neurodegeneration.

Dr Merzenich discussed research supporting the idea that we can systematically harness brain plasticity and drive positive changes in brain systems through plasticity-based training.

"Breakthroughs in technology and science will permit people to monitor their brain health on a daily basis and take appropriate action to maintain their brain health using a device they already carry in their pockets," he said.

"A phone with apps to assess current condition, to suggest holistic interventions, and to deliver the right brain exercises. This technology already exists, and all the pieces are coming together."

Dr Merzenich believes we are in the midst of a paradigm shift regarding how we view and treat most aspects of brain health.

"We don't have a magic pill to prevent or cure heart disease, and instead look to behavioural changes to reduce risk and early interventions to address symptoms," he said.

"There is a rapidly growing consensus among thought leaders that we need a similar approach to cognitive disorders and improvement. This approach will include nutrition, physical exercise and environmental factors – but the single most important elements will be lifelong monitoring of brain health and appropriate plasticity-based brain exercises."

Dr Merzenich is professor emeritus at University of California San Francisco, where he maintained a research lab for three decades. He ran the seminal experiments that led to the discovery of lifelong plasticity – the ability of the brain to change chemically, structurally and functionally based on sensory and other inputs. He pioneered harnessing the power of plasticity in the co-invention of the cochlear implant, which has restored hearing to 100,000s of people living with deafness.

Dr Merzenich also pioneered the application of plasticity in the development of plasticity-based computerised brain exercises, which have helped millions of people.

CHRIS JOHNSON

Blitzed: Drugs in Nazi Germany

by Norman Ohler

ISBN: 9780141983165

REVIEWED BY **SIMON TATZ**

The rise of Adolf Hitler and Nazi Germany has been analysed, documented and researched for almost a century now, and until recently one assumed there was little if any new evidence to be uncovered.

Blitzed: Drugs in Nazi Germany, by Norman Ohler, became an international sensation when it was published last year. Ohler's ground-breaking and cleverly written research centres on two aspects of the Third Reich: the use of methamphetamine by the German military, and the role of Adolf Hitler's personal physician, Dr Theodor Morell.

German pharmaceutical companies such as Merck, IG Farben and Bayer were world leaders prior to WWII, and Germans were huge consumers of what are now illicit drugs, including cocaine and heroin. Three German pharma companies (Merck, Boehringer and Knoll) controlled 80 per cent of the world cocaine market in the 1920. But it was the Temmler factory that Blitzed focus on. Tremmler began producing Pervitin, a methamphetamine pill, in 1937. It soon became a staple of German civilians, then the military. They even manufactured a 'meth' brand of chocolates to make 'housework more fun.' Each chocolate was equivalent to a modern day 'hit' of crystal meth.

Dr Otto Ranke, who became a meth addict himself, oversaw the widespread supply of Pervitin to the Wehrmacht and Luftwaffe. According to Ohler, it was the use of methamphetamine that allowed German tanks to sweep through France as troops stayed awake for two to three days and required little, if any food. The Blitzkrieg was supported by the enormous consumption of these Pervitin meth pills. In the Battle of Britain, Germany's airpower inferiority was countered by providing their pilots with tablets that kept them awake for days on end. German pilots flew endless mission until they 'burnt out' and suffered the effects well known about excessive methamphetamine use.

Pervitin doses to the military ran to over one million per month in 1941, with civilian use put at 1.5 million units per year. Dr Ranke, Director of the Research Institute of Defence Physiology, ordered 35 million Pervitin tablets for the Western Front campaign, while the German Labour Front placed orders for 260 million, then 390 million, Pervitin tablets.

Nazi doctors knew the dangers of meth use and addiction, however they ignored the warnings because it enabled the Nazi war machine, at least initially, to sweep through Europe.

The more fascinating part of Blitzed is the role of Hitler's personal physician, the mysterious Dr Morell. Despite being interrogated by the Americans after the war, his scrawled personal notes on Hitler haven't been fully examined. Morell concocted a substance called 'Vitamulin', which was derived from rosehip powder, dried lemon, yeast extract, refined sugar and skimmed milk. He marketed this to Hitler and the SS. Hitler, a vegetarian whose diet was mainly salads and vegetables, apparently gained little benefit from the vitamin tablets (and later intravenous injections) but he certainly relied on the Eukodal (Oxycodon) as well as methamphetamine and cocaine his physician prescribed. Hitler was obsessed with his own health and ensuring he had the stamina to lead the war, and Blitzed describes the descent into increasing drug addiction.

In August 1941 Hitler first became seriously ill, and Dr Morell's vitamin concoctions failed to improve his health. Here is the point where steroids are first used, followed by dolantin, an opioid similar to morphine. Dr Morrell is described as a proponent of polypragmasia - the use of multiple therapeutic modalities to manage a single condition.

Blitzed provides a wealth of fascinating medical research material, much of which lay hidden in archives and not assessed until recently, on the way hard drugs affected decision making by Hitler and the SS. One example is Dunkirk, where Goring's morphine addiction is attributed to his delay in pursuing the British, thus allowing the famous Dunkirk evacuation.

The evils of Nazi Doctors have been well documented before, however this research has been on their victims and the inhumane experiments carried out in concentration camps and elsewhere. Blitzed – which reads more like a thriller - reveals the role of the personal physician and military doctors in disseminating methamphetamine, steroids, cocaine and morphine to both the architects of the Final Solution and the Third Reich, and the troops who carried out their orders.

Noonan and Schaupp excel once more

BY CHRIS JOHNSON

Some musical collaborations are so wonderfully exquisite, they are worth revisiting and reinventing over and over again.

The Katie Noonan, Karin Schaupp collaboration is one such union and thank heavens for that.

In 2011, the two Queenslanders who each enjoy spectacular but separate musical careers, shared the stage across Australia with their performances of *Songs from the British Isles*, for which they also recorded an eight-track EP.

The shows were as were sold out as they were stunning.

The following year came a full-length album from the duo titled *Songs of the Southern Skies* featuring their interpretations of some of Australia's and New Zealand's best known classical, folk, jazz and pop songs.

They were joined on that offering by guest artists of the calibre of Icehouse's Iva Davies; Gurrumul; the Living End's Chris Cheney; Clare Bowditch and others.

The album received two ARIA awards and was accompanied by two national tours.

Now, the Noonan-Schaupp venture continues with *Songs of the Latin Skies* and is a beautiful journey through the great South American songbook.

Australia got to know Noonan when she emerged as the mesmerising songstress fronting indie-pop band George, before she continued sharing her incredible voice in other jazz, pop and classical trips.

Schaupp is a classical guitarist of outstanding ability and international acclaim – and provides the most compelling of instrumental accompaniment to Noonan's voice. Schaupp also performs a solo guitar medley.

On stage, the two are captivating. They are engaging and sublime.

The new album is being supported by a current national tour (I had the pleasure of seeing them at Canberra's intimate Street Theatre); delighting audiences with original arrangements of both well-known and obscure Latin American music.

The arrangements are from their mates – some of Australia's most accomplished musicians such as Richard Charlton and Doug de Vries.

The 13 tracks cross from the ancient and traditional to the modern and popular and visit Brazil, Argentina, Peru and more.

Desafinado, Wave, Canta Mais, Seguranca, La Muerte del Angel and all of the tracks chosen for this work have never before sounded like this.

These songs are simply gorgeous the way these two incredibly talented musicians perform them.

Katie Noonan and Karin Schaupp were meant to perform and record together.

On stage or on record, this is superb music.

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