AUSTRALIAN
Medicine
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# Addressing addiction

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# Bonded Medical Places Scheme should be scrapped

BY AMA PRESIDENT DR MICHAEL GANNON

The AMA has strongly opposed and questioned the Bonded Medical Places (BMP) Scheme since its inception.

In the latest chapter of our long-running campaign against this flawed and failed policy, I have written to Assistant Health Minister Dr David Gillespie again emphasising our ongoing concerns.

All the available evidence shows that bonding programs are ineffective.

We have recently seen signs that the Government – or at least the bureaucracy – has acknowledged that bonding is 'a dud'. The 2015/16 Budget saw significant changes that abolished the Medical Rural Bonded Scheme (MRBS) and cut Return of Service (ROS) requirements for future BMP graduates.

According to the Department of Health (DoH) in evidence to Senate Estimates, the Budget change reflected the lack of success of longer bonding periods under the BMP and MRBS schemes.

DoH said that the best available evidence about program effectiveness shows that people who undertook 12 months training in a rural area were more likely to return to those rural areas. It was a significant admission of the failed design of extended ROS arrangements under both the MRBS and BMP schemes.

The evidence shows that recruiting students from a rural background and/or providing early exposure to rural practice are key to the recruitment of more doctors to rural areas.

The Government actually used this evidence to make sound policy decisions in the establishment of an Integrated Rural Training Pipeline, based around Regional Training Hubs, rurally-based General Practice rotations for junior doctors, and the expansion and targeting of the Specialist Training Program.

The prospect of a national rural generalist pathway also holds great promise.

The AMA was then shocked to learn that, despite this evidence, the Government is actively considering increasing the ROS for future BMP graduates, and sought advice on this policy at a recent Rural Roundtable Meeting.

I told Assistant Minister Gillespie that putting more emphasis on a scheme that has not delivered any meaningful results for rural Australia – a policy that is not supported by international evidence, or even his own Department – represents a significant policy failure.

Contrary to widely-held perceptions, there are no meaningful incentives attached to the BMP scheme. Participants are required to repay their HECS in full.

The design and implementation of the BMP scheme, particularly with respect to extended ROS arrangements, also fails to acknowledge that people's circumstances can change dramatically from the time they enter medical school to the period when they must complete their ROS.

The BMP scheme also has a very poor reputation among stakeholders, as acknowledged in the Mason Review of Australian Government Health Workforce Programs.

It is seen as coercive and does not provide support for participants. BMP participants suffer a stigmatising perception as 'second rate' students who failed to meet the requirements for a non-bonded Commonwealth Supported Place (CSP).

People in rural and regional Australia deserve highly-skilled doctors who become integral parts of their community, and who are committed to a long-term career in rural Australia. Importing large numbers of International Medical Graduates (IMGs), while offering them little pastoral and professional support, has been used as a "band-aid" measure.

The AMA Council of Rural Doctors has consistently opposed the BMP scheme because rural doctors understand that the recruitment of a reluctant workforce will do nothing to solve the problems of health care delivery in rural and regional areas.

Medical students and graduates who entered the BMP scheme prior to 2016 are now treated very differently and face a much longer ROS than more recent BMP entrants.

This is unfair and inconsistent with the previous administration of the BMP scheme, where contract changes were traditionally offered to all existing participants.

This simply adds to the poor reputation of the BMP scheme, and fuels dissatisfaction with the scheme among participants.

More and more doctors have and will withdraw from the scheme. DoH advises that 413 original BMP participants have withdrawn or breached, significantly greater in number than the 9 who have completed their ROS, and the 135 who are undertaking their ROS.

Closing the gap in health outcomes between metropolitan and non-metropolitan patient cohorts is a priority for the AMA. Enhancing support for IMGs working in rural areas and increasing the number of Australian graduates working bush are important. But bonding is not the answer to workforce maldistribution.

The BMP is not working. It should really be scrapped. If the Government is intent on keeping it, at least it needs to be made fairer, and simplistic proposals to increase the ROS period for new entrants need to be put in the bin.

# Working hours still need addressing

BY AMA VICE PRESIDENT DR TONY BARTONE

The AMA recently released its latest *Safe Hours Audit* report and it was certainly an eye-opener. Though for those at the front line it probably came as no surprise.

The audit, undertaken in 2016, shows there has been no overall improvement since the last report was issued in 2011. There has certainly been an improving trend since the audits first began in 2001, but it appears things have slowed down in recent years.

This is disturbing.

What the latest audit shows us is that one in two doctors at public hospitals are still working hours that put them at a high risk of fatigue.

Working long shifts, double shifts and too many shifts can only translate into higher levels of stress and fatigue for doctors and ultimately has the potential to put patient care at risk.

We are talking about doctors' health and wellbeing. Invariably doctors are routinely missing lunch breaks, missing meal breaks, having to withhold toilet stops. They're working consecutive shifts, often back to back.

What we're seeing here is a system that would not be tolerated in any other industry. Employers have an obligation to provide a safe workplace for their staff and for others who frequent the workplace.

Hospitals and community health practices are no exception to this rule and, as such, administrators and management have an obligation to ensure safe working environments to protect our key resource – our doctors – as well as the patients they care for.

If we do that then, obviously, it will lead to improved productivity, improved outcomes, improved patient experiences, and better life expectancy and outcomes for doctors themselves.

It is clear that the system is under stress. The system overall is functioning at peak capacity and with no accessible relief valve.

Numerous research reports from overseas confirm that errors are occurring under such difficult conditions.

It is clear that ultimately the journey of the patient through the health system is also being retarded. Things are not being coordinated in an efficient way because of tiredness and because of fatigue. This is both frustrating and disappointing, especially when we have got a limited amount of health resources and a limited budget. Hospitals absolutely need to ensure they are really performing at peak efficiency.

Doctors genuinely and routinely report back to me of having a situation of feeling tired, of perhaps falling asleep at their terminal while doing the notes. It is certainly not an environment that you want to have a vulnerable population – our patients – being exposed to in a routine manner.

The report found that intensive care physicians and surgeons are working long hours more routinely than other doctors in other parts of the profession. So they are particularly at risk. Obstetrics and gynaecology is another specialty that was highlighted for working high stress long hours.

It is important to note that it's not just the hours they work, it's the un-rostered overtime that also goes into the mix. These doctors are rostered on for long hours but then, because of their duty of care, because the system is not coping under the stress, they're staying back longer and then working later and later. And then they go home to families… and very commonly hours and hours of study and exam preparation.

Registrars are often working the highest percentage in terms of those hours worked. This is not work-life balance, this is not good for their future, and this is not good for their long-term wellbeing. The latest report reveals that it is a problem right around the country.

Every hospital jurisdiction should look at the AMA's *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors.*

This is an agreed guide but it's not a mandatory guide. It looks at flexible work practices and arrangements and is a guide in terms of safe rostering.

This issue is about rostering smarter and more efficiently. It is not necessarily about working drastically fewer hours.

Doctors understand their responsibility and they want to learn. The need for training comes with the expectation that there is a need to work a certain number of hours.

The 2016 Audit is a timely report. Doctors do want to provide the best care they possibly can for their patients. But they can't do this if their own health is constantly under threat due to the shifts being demanded of them. Let's hope the system does not fall asleep at the wheel on this one.

# AMA at the forefront of a future Australian health system

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "While there have been calls for greater transparency of doctors' fees, there is no evidence that additional information will impact on either the level of private health insurance premiums, or patient out-of-pocket costs."

One of the health policy issues of interest to members is that of doctors' fees and patient out-of-pocket costs. Both have come under scrutiny as part of a Senate inquiry into the value and affordability of private health insurance and out-of-pocket medical costs.

The AMA has made a submission to the inquiry that will be made public in due course by the Senate committee. The AMA's submission emphasises the dual nature of the Australian health system with public and private sectors working together.

The private health sector is a significant contributor to health care delivery. In 2014-15, 42 per cent of all hospital separations were funded by private health insurance; 50 per cent of separations were public patients; and the remainder were self-funded. The AMA submission focuses on the reduction in value of private health insurance, through exclusions and other restrictions, which has been a factor in the increased contribution by patients to the cost of their treatment.

The AMA points out that while costs of service provision have continued to increase, benefits have remained unchanged since indexation was first frozen in 2013. While re-indexing commenced in July 2017, MBS items related to specialist procedures will not be indexed until 2019. This too has added strain on the cost of service provision by medical practitioners.

Notwithstanding this, 86.6 per cent of services for hospital treatment were provided with no gap, and 6.5 per cent of services with a known gap in the March quarter of 2017.

Medical expenses are a relatively small proportion of total outlays by private health insurers at around 16 per cent. While there have been calls for greater transparency of doctors' fees, there is no evidence that additional information will impact on either the level of private health insurance premiums, or patient out-of-pocket costs.

The AMA strongly supports the giving of informed financial consent.

Members will have received information about the process for the 2018 nominations and elections to Federal Council. One of the important entitlements of a member is the right to nominate for, and vote for, representatives on Federal Council, which is the peak policy-making body of the AMA.

As a consequence of the changes to the AMA's Constitution in 2016, a member may be part of as many practice groups as are relevant to their practice. The practice groups are: general practice, private specialist practice, rural doctors, public hospital doctors, and doctors in training.

The State and Territory AMAs appoint eight of the members of Federal Council. The President and Vice President are elected at National Conference. The representative of Australian Medical Students' Association is appointed by that organisation. The remaining positions on Federal Council are elected by the membership – 16 specialist representatives; five practice group representatives; and five area representatives.

I urge you to review your Federal AMA profile to ensure you are listed appropriately in advance of the nomination and election process that will start early in 2018.

# Substance abuse needs mature policy approach

The AMA has called on the Federal Government to treat substance abuse and other behavioural addiction problems within the community as a high-level priority to address.

Substance dependence and behavioural addictions are chronic brain diseases and people affected by them should be treated like any other patient with a serious illness.

AMA President Dr Michael Gannon said while the Government responded quickly to concerns about crystal methamphetamine use, with the *National Ice Action Strategy*, broader drug policy appears to be a lower priority.

"I don't think we need to underestimate the cancer in our society that methamphetamine causes. It's destroying lives, it's destroying communities, it's destroying families," Dr Gannon said.

"But we can acknowledge that and at the same time reflect on the carnage that legal drugs still cause.

"Twelve per cent of Australians are still smoking. It's the only habit that kills over half of its regular users and certainly impairs the health of the remainder.

"And alcohol; it's a difficult conversation. So many of us enjoy a drink. Not many of us would think that we are problem drinkers. But if you look at how deeply inculcated in our society drinking alcohol is, you start to get an idea about the potential harm it causes."

Given the consequences of substance dependence and behavioural addictions, the AMA believes it is time for a mature and open discussion about policies and responses that reduce consumption, and that also prevent and reduce the harms associated with drug use and control.

"Services for people with substance dependence and behavioural addiction are severely under-resourced. Being able to access treatment at the right time is vital, yet the demand for services outweighs availability in most instances," Dr Gannon said.

"Waiting for extended periods of time to access treatment can reduce an individual's motivation to engage in treatment."

Substance abuse is widespread in Australia. Almost one in seven Australians over the age of 14 have used an illicit substance in the past 12 months, and about the same number report drinking 11 or more standard alcoholic drinks in a single session.

Substance use does not inevitably lead to dependence or addiction. A patient's progression can be influenced by many things, such as genetic and biological factors, the age at which the use first started, psychological history, family and peer dynamics, stress, and access to support.

The AMA recently released its *Harmful Substance Use, Dependence, and Behavioural Addiction (Addiction) 2017 Position Statement*, pointing out that dependence and addiction often led to death or disability in patients, yet support and treatment services were severely under-resourced.

The costs of untreated dependence and addictions are staggering. Alcohol-related harm alone is estimated to cost $36 billion a year.

Those affected by dependence and addictions are more likely to have physical and mental health concerns, and their finances, careers, education, and personal relationships can be severely disrupted.

Left unaddressed, the broader community impacts include reduced employment and productivity, increased health care costs, reliance on social welfare, increased criminal activity, and higher rates of incarceration.

About one in 10 people in Australian jails is there because of a drug-related crime.

Dr Gannon said the Government's updated *National Drug Strategy* was disappointing because no additional funding had been allocated to it, meaning that measures requiring funding support were unlikely to occur in the short to medium term.

"The recently-released *National Drug Strategy 2017-2026* again lists methamphetamine as the highest priority substance for Australia, despite the Strategy noting that only 1.4 per cent of Australians over the age of 14 had ever tried the drug," he said.

"The Strategy also notes that alcohol is associated with 5,000 deaths and more than 150,000 hospitalisations each year, yet the Strategy puts it as a lower priority than ice."

Dr Gannon called on the Government to focus on the dependencies and addictions that cause the greatest harm, including alcohol, regardless of whether some substances are more socially acceptable than others.

"General practitioners are a highly trusted source of advice, and they play an important role in the prevention, detection, and management of substance dependence and behavioural addictions," he said.

"Unfortunately, limited access to suitable treatment can undermine GPs' efforts in these areas."

Behavioural addictions also include pathological gambling, compulsive buying, and being addicted to exercise or the internet.

Like substance dependence, they are recognised as chronic diseases of the brain's reward, motivation, memory, and related circuitry.

Go to: https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017 to read the full Position Statement.

CHRIS JOHNSON

# Breast or otherwise, new mothers need support

Non-breastfeeding mothers need greater support to help them feed their babies without being made to feel guilty, the AMA insists.

Releasing the AMA's *Infant Feeding and Parental Health 2017 Position Statement* recently, AMA President Dr Michael Gannon said new parents who did not breastfeed their infants should be supported in their efforts to ensure their children receive optimal nutrition.

Breastfeeding may not be the best choice for all families, and there must be a balance between promoting breastfeeding and supporting mothers who cannot or choose not to breastfeed.

"Mothers may feel a sense of guilt or failure, and it is important that their GPs and other medical practitioners reassure them about the efficacy and safety of formula feeding, and work to remove any stigma," Dr Gannon said.

"Although it is different in composition, infant formula is an adequate source of nutrients. Parents seeking to bottle feed their infants need support and guidance about how much and how often to feed their infant, how to recognise when to feed their infant, and how to sterilise and prepare formula."

Hospital-based milk banks provide a valuable source of nutrients for infants with a clinical need for donor human milk, such as those who are premature or underweight.

Informal breastmilk sharing arrangements that occur without medical oversight pose significant risks to infant health, including the transmission of harmful bacteria or communicable diseases.

Parents should be educated about the potential harms of sourcing unpasteurised and untested milk for their infants, to ensure they are able to make informed decisions.

Dr Gannon noted that breastfeeding was the optimal infant feeding method, with current Australian guidelines recommending exclusive breastfeeding until six months.

But mothers and other caregivers who cannot or choose not to breastfeed must have access to appropriate care and assistance to formula-feed their children.

"There's no doubt that breast is best, and in Australia, 96 per cent of new mothers start out breastfeeding their baby," Dr Gannon said.

"Babies who are breastfed are at less risk of infection, sudden infant death syndrome, and atopic diseases like asthma, eczema, and hay fever.

"The maternal antibodies in breastmilk help to protect infants before they are old enough for their first childhood vaccinations.

"Babies who are breastfed are less likely to become obese or develop type 2 diabetes as children and teenagers, and are less at risk of high blood pressure.

"Breastfeeding helps mothers bond with their babies, recover from childbirth, and regain their pre-pregnancy body weight, and it is also associated with reduced risk of some cancers.

"Yet we know that many mothers do not persist with breastfeeding. Only 39 per cent of infants are exclusively breastfed to four months, and just 15 per cent to six months."

This highlights the need for more support to allow mothers to extend the duration of their breastfeeding if they wish to, Dr Gannon said.

Women can be discharged from hospital as early as six hours after giving birth, long before their milk has come in.

The AMA President said they should only be discharged when they are physically and emotionally ready to return home.

The Position Statement calls for doctors, medical students, and other health professionals to be appropriately trained and educated about the benefits of breastfeeding, including how to support mothers who experience difficulties with breastfeeding.

It also notes that parents should be aware that anatomical difficulties, such as colic, tongue tie, or feeding and swallowing disorders, occur in both breast- and formula-fed infants. Parents should consult their general practitioner for support and referral to appropriate medical care.

The Position Statement says that postnatal depression is estimated to affect one in seven new mothers in Australia, and women who are unable to breastfeed in line with their intentions may be at increased risk.

However, there is limited access to specialised mother and baby units, and women who are waiting to access these services need to be monitored and supported in the interim.

The full Position Statement https://ama.com.au/position-statement/infant-feeding-and-parental-health-2017 can be viewed on the AMA's website.

CHRIS JOHNSON

# Medical aid to refugees – an international example

To escape the cold of Canberra, my wife and I headed off to the Middle-East – Israel, including the West Bank, and to Petra in Jordan.

When I first visited Israel more than a decade ago, the on-going conflict between Syria and Israel was an ever-present threat. These two bordering nations have been in a formal state of war since 1948. They have fought three wars and countless skirmishes. Syria still does not recognise Israel and if you have an Israeli passport (or even a visa stamp) you are denied entry into Syria.

On my previous trip I travelled up to the Golan Heights. This is a disputed region, two-thirds under Israeli control with the remainder under Syrian rule. A buffer zone is designed to maintain peace. I looked (with trepidation and from a safe distance) from one warring country into another.

The Syrian civil war has, however, drastically reshaped the relationship between the Syrian and Israeli peoples, a realignment that has come about mostly through medical and humanitarian aid.

Over the past year, media reports have surfaced about the extent of medical aid and treatment being provided to Syrian refugees fleeing the horrific and barbaric civil war that has destroyed a once beautiful country. My wife travelled to Syria just before the war erupted and described a magnificent and mostly peaceful nation, steeped in a rich history, and one that warmly embraced visitors.

Recently, the *New York Times* reported on the extent of Israel's *Operation Good Neighbor* which operates (literally) along the Israeli-Syrian boundary in the Golan Heights. The Times detailed how Syrian doctors (surely the bravest of people) coordinate the care refugees need, which is then provided by Israeli medical teams. Working with the Free Syrian Army, patients (and their families) are transferred across the military lines to Israeli hospitals or medical centres via military ambulance. Some wounded go directly to hospitals in northern Israeli towns.

It is reported that Israel has treated more than 4,000 Syrians injured in the civil war. The costs of treating Syrian refugees is split between the Israeli Ministry of Defense, the Ministry of Health, and by the treating hospitals. The cost runs into the millions.

Israeli officials estimate that their aid is reaching about 200,000 Syrians, including displaced families housed in tent cities on the international border. They are also funding and equipping medical clinics.

One of the inspirational people behind the medical relief efforts is Georgette Bennett, founder of the Multifaith Alliance and a daughter of Holocaust survivors. The Alliance's mission is to "raise funds to provide humanitarian relief to Syrian war victims, heighten awareness of the growing dangers of inadequate responses to the Syrian humanitarian crisis, and plant the seeds for future stability in the region by fostering people-to-people engagement".

Through the efforts of Georgette Bennett, the Multifaith Alliance is helping the most desperate people flee one of the cruellest conflicts the modern world has witnessed. Ms Bennett told media that the cooperation between Israel and Syria is "a great glimmer of hope coming out of this tragedy".

What is most inspiring is how medical aid and treatment is breaking down decade old animosities and hatreds. On the Multifaith Alliance website are stories from Syrian refugees.

"It was a very big shock to me. Syrians were brought up to fear Israelis as the devil who wants to kill us and take our land," said a Syrian humanitarian worker.

One refugees summed the situation up this way:

"Israel is doing exactly what it must do. It is not taking part in the war, but is helping wounded Syrians who need help. And it's not only the government. Israelis are helping Syrian refugees in Jordan, in Greece, Serbia, North America. No one would have blamed the Jews and the Israelis if they had said it was not their problem. That is, by the way, what many Arabs and Arab countries did. The Gulf States, for example, shut their doors to Syrians – and these are the countries that call themselves friends of Syria."

Another said: "It has struck a chord with a lot of Syrians. This is supposed to be our enemy."

I can only hope that the bloody Syrian conflict ends soon and the plight of Syrian refugees is recognised world-wide. I also hope that other Middle-East countries take Israel's approach and provide medical and humanitarian aid to those injured and affected by this war.

SIMON TATZ
AMA DIRECTOR, PUBLIC HEALTH

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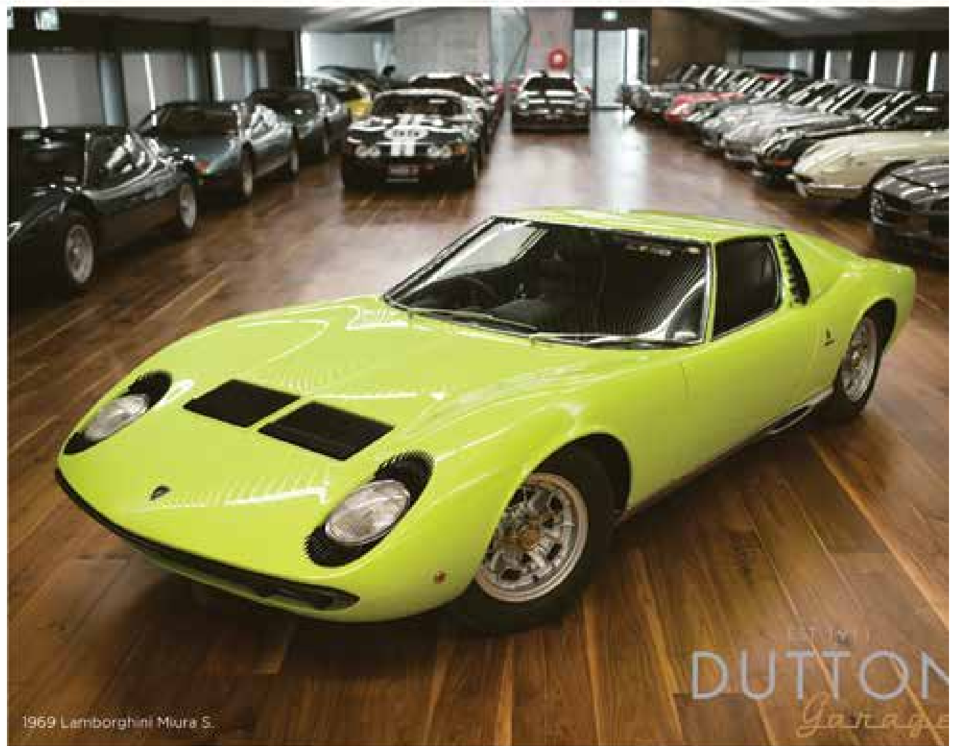

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# AMA delivers submission to Government review into aged care facilities

The AMA has submitted its views on the Federal Government's regulatory activities applying to quality of care in aged care residential facilities.

The *Oakden* report shed light on a wide range of issues facing aged care. AMA members have reported that the occurrences at the Oakden Older Mental Health Service were not isolated incidents – indicating a problem with the current aged care system.

The proportion of Australians 65 years of age and over is predicted to increase to 18 per cent by 2026. It is also predicted that 900,000 Australians will have dementia by 2050, almost triple the 342,800 recorded in 2015.

It is evident that the health care needs of residents in residential aged care facilities (RACFs) are increasing in complexity.

The majority of Aged Care Funding Instrument (ACFI) assessments indicate a "high" need of care across all three assessment categories (activities of daily living, behaviour, and complex health care). The Government must ensure the sector has the capacity to provide quality care for this growing, more complex, ageing population.

The issues at Oakden were brought to the attention of the Northern Adelaide Local Health Network when a client was admitted to an Emergency Department with significant bruising to his hip. A person's health status is a significant identifier for the quality of an aged care facility or home service. When serious health issues arise, aged care issues are commonly noticed.

Medical practitioners – whether at the Emergency Department, or consulting patients at an aged care facility – may have a unique opportunity to identify issues with the quality of an aged care home or signs of elder abuse.

Medical practitioners are also the second highest profession Australians trust and should be considered part of the aged care workforce to increase quality of care.

Many points made in the submission have been previously made by the AMA, and they are not newly arising issues in the aged care sector. The AMA has been advocating for some time to ensure medical and nursing care for older Australians, including lodging submissions to the multiple aged care reviews that have occurred recently.

In this submission, the AMA argues that:

- Medical practitioners should be included as part of the aged care workforce to ensure residents of aged care facilities are receiving quality care;
- Aged care needs funding for the recruitment and retention of registered nursing staff and carers, specifically trained in dealing with the issues that older people face;
- The aged care sector needs a contemporary system that embraces information technology infrastructure for patient management;
- A contemporary IT system for medication management will reduce the risk of polypharmacy, and in turn reduce the likelihood of cognitive impairment, delirium, frailty, falls, and mortality in RACFs;
- There needs to be clear, specific, and confidential complaints referral pathways in each RACF so information on complaints processes are easily accessible to both residents and staff;
- There needs to be increased awareness of mental health issues to include funding for appropriate mental health services in the ACFI assessment process; and
- The aged care system needs an overarching, independent, Aged Care Commissioner who provides a clear, well-communicated, governance hierarchy that brings leadership and accountability to the aged care system.

Many of these issues need to be reflected in specific accreditation standards that have a strong focus on health. In particular, an "access to medical care" standard should be introduced. To receive funding from the Federal Government, an aged care facility must pass accreditation standards that are assessed by the Australian Aged Care Quality Agency.

The AMA recognises that these standards will vary with the introduction of the single set of aged care quality standards, however, there are several required improvements that should be included in the new standards.

For some standards a flexible approach is adequate, as different services have different capabilities and capacities. However, this may lead to inconsistencies between each assessor, or the assessment process not picking up on vital signs of incompetence.

Standards that relate to medical care should not be subject to interpretation to ensure quality care is received. RACFs must be aware of their specific responsibilities.

Residents should have access to, and their medical needs met by, qualified medical practitioners. Rather than vague standards that say RACFs should ensure compliance with all relevant legislation, a medical care standard should reflect aspects of the National Safety and Quality Health Service Standard.

People living in aged care facilities should have access to the same quality health services as other Australians. The AMA has been advised that currently, RACFs (with the exception of facilities that provide acute services) do not have to comply with these standards.

The current policy settings do not support GPs working after hours, neither does it acknowledge the benefits of continuity of care. AMA members report that continuity of care goes generally unacknowledged in many RACFs and a resident's management plan is not well known. This creates an environment where the default step for RACF staff may be to refer the patient to an ED.

One concept worth considering is an MBS item for phone consultations with a nurse or carer from an RACF to incentivise doctors to be on call after hours. This could in turn increase the number of doctors who make themselves available out of normal business hours and reduce costs in comparison to reimbursing a GP physically-attended consultation. In addition, the care of patients' regular GP would avoid unnecessary referrals to the ED and the associated triage issues.

AMA members have reported cases where registered nurses are being replaced by junior personal care attendants, and some RACFs do not have any nurses staffed after hours. This presents significant communication difficulties.

A recent survey identified low staffing levels in residential aged care as the main cause of missed care. The Government must ensure that aged care facilities are not restricted due to a workforce shortage. The decline in the proportion of nurses and enrolled nurses needs to be reversed to ensure residents are provided with timely and appropriate clinical care. This is critical to the success of the aged care system.

While the Government's complaints process is seeing improvements, there also needs to be a focus on the RACF's internal complaints process. The culture in many RACFs discourages making complaints, and this was especially seen at Oakden – where staff complaints were answered with bullying and harassment from management. The Government needs to ensure that the privacy and confidentiality of both aged care staff and consumers are protected when making a complaint.

Aged care staff should be properly trained on the ethical, medical and legal issues that can arise from using a restraint, and also educated on ways to improve the aged care environment through ensuring a friendly physical space, and through social and staffing structures.

In order for the aged care system to evolve, we must also consider that, like the broader health system, aged care impacts upon State, Territory, and Federal Governments. However, there is a lack of coordination between the levels of jurisdiction. Aged care is the purview of the Commonwealth but when a health complication arises, residents are often transferred to a hospital which is the responsibility of the State or Territory Government. This means that the States often bear a financial cost resulting from issues that arise in a Commonwealth-run aged care environment.

The Australian aged care system is heavily regulated and, with reform underway, regulation may increase over time. Without adequate financial support, guidance, and accountability from the Government, RACFs and other aged care services will continue to struggle to meet these complex regulations.

CHRIS JOHNSON

**The full submission can be viewed at: https://ama.com.au/submission/ama-submission-review-commonwealth-government%E2%80%99s-regulatory-activities-applying-quality**

## AMA President Dr Michael Gannon will address the National Press Club on Wednesday, 23 August 2017.

The National Press Club is Australia's leading forum for discussion and debate and for major statements on politics and public policy. Decision makers, Australian political leaders, foreign heads of state and leaders from all fields of society are among the speakers at the National Press Club.

Dr Gannon will use his National Press Club address to outline the AMA's priorities for health reform, and suggest the types of health policies that the major parties should take to the next election, which could be as early as next year.

The thawing of the Medicare freeze has cleared the health policy landscape – dominated since 2014 by debate over co-payments and the freeze – to allow public discussion about major issues such as public hospital funding, private health insurance, primary health care, public health, aged care, mental health, and medical training

Tickets for the event can be bought online: https://www.npc.org.au/speakers/dr-michael-gannon-2/. The National Press Club is located at 16 National Circuit, Barton in the ACT. Because this is a televised event, guests are asked to arrive from 11.30am, with lunch served at 12 noon and Dr Gannon's speech due to commence at 12.30 and conclude by 1.30pm.

For those unable to attend the event, Dr Gannon's address will be broadcast live on ABC and ABC News 24 and also streamed live online on ABC News 24. The address will also be available on iView.

# Latest Medicines Australia 'transparency reports' coming soon

Another set of reports on health practitioners who receive payments from pharmaceutical companies will be published on 31 August this year.

Since August last year, details of such payments have been made publicly available every six months.

> "Since 1 October 2016, pharmaceutical companies have only been able to enter into relationships with health practitioners who consent to this information being published."

Since 1 October 2016, pharmaceutical companies have only been able to enter into relationships with health practitioners who consent to this information being published.

Medicines Australia member companies, which include innovative pharmaceutical companies such as Bayer, Pfizer and Janssen, published the first ever reports listing individuals and details of payments in 2016.

The current Medicines Australia Code of Conduct requires pharmaceutical companies to publish details of certain categories of payments made to registered health practitioners (such as medical practitioners, nurses and pharmacists).

The categories of payments that must be published include fees for speaking engagements, consultancies, board and committee attendance, and sponsorship or grants for educational activities.

The AMA fully supports these transparency measures.

During the first reporting period, individuals were able to withhold consent for their information to be made public in line with Australian privacy legislation. Around one third of practitioners receiving payments withheld their consent.

However, since 1 October 2016 that has no longer been possible.

A full list of the categories of payments publicly reported and the detail included in the reports is available on the AMA website at: https://ama.com.au/article/medicines-australia-new-code-conduct-what-it-means-medical-practitioners

Links to each company's first report are available on the Medicines Australia website at: https://medicinesaustralia.com.au/code-of-conduct/transparency-reporting/previous-transparency-reports/educational-event-reports/member-company-reports/

AMA Vice President Tony Bartone said he didn't believe that in Australia there was any adverse impact on prescribing behaviour arising from pharmaceutical company payments or educational events.

"Firstly, in Australia, unlike the US where most of the studies about pharma influence on doctor behaviour are conducted, there is a clear separation between prescribing and dispensing," Dr Bartone said.

"Doctors prescribe medicines but pharmacists dispense the medicines. Doctors get no financial benefit from prescribing one brand of medicine over another and there is no way for a pharmaceutical company to track which doctors prescribe which brand.

"Any financial benefit is gained by pharmacists who, with the patient's agreement, can substitute one brand of medicine with another. While doctors are able to tick the 'do not substitute box' on prescriptions, this occurs in less than 3 per cent of prescriptions.

"Secondly, the Federal Government, through Medicare, has a sophisticated audit and compliance system for determining whether or not a doctor is prescribing medicines according to listed indications (the circumstances under which a medicine can be prescribed to attract a PBS subsidy) and/or is prescribing differently to their peers.

"It has a strong financial incentive to control health care expenditure and investigate and act on inappropriate prescribing by individual doctors.

"And finally, medical practitioners are highly trained health professionals. They are trained to think independently and to make decisions in the best interests of the patient. They prescribe appropriate medicines based on the clinical needs of their patients."

In Australia, under the Medicines Australia Code of Conduct (which applies to pharmaceutical companies), payments for educational events are strictly controlled.

# Latest Medicines Australia 'transparency reports' coming soon

For example, all costs associated with meals provided to health professionals attending educational events must be publicly reported. The maximum spend allowed per head is $120, but more than 10 years of public reports show that the actual average spent is only around $45 a head.

"It is illogical to believe that attending an hour-long pharmaceutical company educational event where some sandwiches are served has sufficient influence to overturn years of a doctor's medical training, as well as the ethical imperative to put patients' needs first," Dr Bartone said.

"It is in the best interests of patients that medical practitioners are fully informed about new or improved medicines. The AMA supports the delivery of this information by pharmaceutical companies.

"New and improved medicines save lives and improve the quality of life for Australians with illness.

"Legitimate and ethical relationships between pharmaceutical companies and individual medical practitioners provide a public benefit.

"The AMA actively participated in the development of Medicines Australia's current Code of Conduct, which regulates the behaviour of pharmaceutical companies and provides substantial transparency of relationships by publicly reporting on payments made to individual health practitioners."

CHRIS JOHNSON

# 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 Tony Bartone** | Vice President | ACSQHC Primary Care Committee | 1/8/2017 |
| **Dr Kean-Seng Lim** | AMACGP Deputy Chair | Independent Review - Accessing Medicare Numbers | 26/7/2017 |
| **Dr Richard Kidd** | AMACGP Chair | PIP Advisory Group | 14/7/2017 |

# Encouraging organ donation

The rate of Australian organ and tissue donation is rising, but there remains plenty of room for improvement.

That is the message the AMA is keen to send to all Australians and it has used DonateLife Week to urge more people to register as donors.

With this year's theme being *Make Your Decision Count*, the DonateLife Week, July 30 to August 6, highlighted community awareness about the importance of organ and tissue donation.

In 2015, Australia ranked 20th nation in the world, with 18.1 donors per million population. In 2016, the Australian donation rate rose to 20.8 donors per million people, and resulted in 503 deceased organ donors donating to 1447 transplant recipients.

This represented a 16 per cent increase in organ donors.

AMA President Dr Michael Gannon said the major catalyst for increasing the rate was conversation and education.

"We have to get people talking more openly about the benefits of organ donation, and their personal wishes to be a donor," Dr Gannon said.

"People should make their choice regarding organ and tissue donation known to their family members and friends.

"Even if a person has registered as an organ and tissue donor, their family will be asked to confirm their wishes and give their consent.

"If a person is not registered, the family will still be asked to give their consent to donation, but evidence shows a significantly higher family consent rate where a person has registered to become an organ and tissue donor."

Research by the Organ and Tissue Authority shows that:

- 91 per cent of families agreed to donation when their loved one was a registered donor;
- 71 per cent of families agreed to donation when they knew their loved one's decision;
- the national average of family agreement to donation is 62 per cent; and
- 52 per cent of families agreed to donate when their loved one had not registered or discussed their donation wishes.

The OTA led the DonateLife Week with strong support from the AMA.

Dr Gannon said one organ and tissue donor can help more than 10 people by saving a life, improving the quality of life, and restoring bodily function.

"The AMA strongly encourages all individuals to consider becoming an organ donor, discuss their views with their family, and record their wish on the Australian Organ Donor Register," he said.

To access the Australian Organ Donor Register, go to: https://register.donatelife.gov.au/

CHRIS JOHNSON

# Organ donation – should Australia adopt an opt-out system?

BY DAVID TARRANT

The statistics paint a stark picture. More than 12,000 Australians suffer each year while they are on transplant waiting lists or dialysis. Six Australians will die in August alone while waiting for an organ transplant, a grim reminder of the limitations of the healthcare system in the face of overwhelming demand and scarce supply.

> "Recent international studies have demonstrated that implementation of an Opt Out system of organ procurement would increase donation rates by 50 per cent."

But is the organ donation system merely indicative of a failure by the Government to enact smart legislation that goes some way to overcoming societal apathy towards registering as an organ donor?

It has become evident that Australia's current opt-In organ procurement legislation has failed to correct the disparity between the number of people on organ transplant waiting lists and the number of organs available for transplantation. A number of factors have been identified which potentiate this ever-widening gap. Primarily, the aforementioned societal unwillingness to registering as an organ donor, followed by potential donors' families denying consent when donation is requested, and the reluctance of health care professionals to request that the deceased patient's organs be donated.

Australia is ranked 20 in the world for organ donation. We are behind countries such as Croatia, Spain, Portugal and Italy. Recent international studies have demonstrated that implementation of an Opt Out system of organ procurement would increase donation rates by 50 per cent.

Spain has been most successful in implementing "soft" opt-out legislation there, sustaining the highest rate of organ donation in the world for the past two decades. Implementation of the Spanish model opt-out legislation in Australia could result in an additional 1,400 Australians receiving a transplant every year.

Think about the impact of that on the healthcare system in terms of primary, hospital and allied health care, and the associated effect on patient flow.

Notwithstanding the advantages of an opt-out system for those individuals on organ transplant lists, nevertheless implementation of an opt-out system in Australia requires examination of several ethical issues. Whilst Australian law states that there is no property in a dead body, the potential for a negative impact upon individual autonomy must be considered.

Despite proponents of presumed consent suggesting that implementation of an opt-out system could improve individual autonomy, a number of authors are sceptical of this claim. However, when weighing limits of personal autonomy against the concept of benefits to society in terms of giving back to the community, under a communitarian-based approach, the number of lives that could be saved as a result of the enacting opt-out legislation could be preferable to society.

If implementation of a national "soft" opt-out organ donation legislation is proposed in Australia, enactment of this type of legislation must be prefaced by comprehensive publicity and education programs, focusing on both the general public and health care professionals. In conjunction with these amendments to legislation, Australia should adopt an individual hospital-based approach to organ donation as described under the "Spanish model".

Australia must act now to implement these changes. People will continue to die until the disparity between organs required and those available for organ transplantation is rectified.

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

*David Tarrant is a lawyer and a registered nurse. He completed his Honours thesis on organ donation, which was published in the NSW Operating Theatre Nurses Association Journal, and has also drafted papers on related issues (in collaboration with his colleagues at Carroll & O'Dea Lawyers). Prior to embarking on his legal career, David worked in hospitals in Tamworth, Sydney and London. Following completion of his Graduate Diploma in Clinical Practice, he was awarded the Anne Carrodus Memorial Prize for excellence in clinical practice.*

# Best place to be when there is an adverse reaction

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

Vaccination is one of the most successful and cost-effective health interventions. GPs know that while vaccinations are generally safe, very occasionally a patient will have an immediate adverse reaction. This occurred recently in my practice and highlighted why general practice remains the best place to receive a vaccination.

Best practice dictates that vaccination should be provided by a medical practitioner or by a nurse under the supervision of a medical practitioner. However, the efforts of other health professionals, such as pharmacists, to get involved in providing vaccinations, leaves me concerned at the potential consequences for patients. Opting for convenience, patients may not understand the benefits of care from a medically trained practitioner, who has the facilities and clinical capacity to identify and manage a rapidly evolving adverse reaction.

In my example, a child who had received their 12-month immunisation experienced facial redness and swelling at the injection site within two minutes of receiving the vaccine. We were well equipped to respond accordingly.

The speed of the reaction had us monitoring for the development of any breathing difficulties, which thankfully did not arise. However, had the child gone into anaphylaxis we were equipped and skilled to immediately respond. The child was administered 2ml orally of a corticosteroid and monitored.

The adverse reaction was also promptly reported and the child's parents provided with information and a plan of management, including what this might mean for future vaccinations. Now that the reaction has been recorded in the child's medical record, we will ensure even closer medical supervision is provided at the 18-month immunisation.

As GPs, we owe it to the parents of the children we care for, to ensure that questions they have about immunisation are answered honestly and backed up with scientific evidence such as that provided in the Australian Academy of Science's *The Science of Immunisation/Questions and Answers.*

As family doctors we are the most trusted source of advice for parents, see the vast majority of children a number of times per year during their first six years and deliver almost three-quarters of all their vaccinations. We have significant opportunity during this period to embed within the family construct the value of having a regular GP.

Last month the AMA's Family Doctor Week highlighted the important role GPs play in caring for the community. Immunisations, in many cases, provide important opportunities to check in on our  patients and see how they are faring. Not only is immunisation an important part of preventive health care, it provides the opportunity to speak to people about their other health care needs

Despite what must have been a very worrying experience for the young child's family, I know the standard of care we delivered was best practice. They saw the value of GP care first hand and I have little doubt that this family will be back to see me again, safe in the knowledge that quality is at the heart of everything we do as GPs.

Don't let her drink dirty water

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

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

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

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

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

Water Health Life
Basic Needs. Permanent Solutions

# Let's be clear about what health policy produces

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

Australian health policy is fragmentary. Some bits make sense; others – if you accept that the purpose of our health systems is to help sick and injured people and to prevent illness and accidents – are wide of the mark.

The "helping" transaction, principally between doctor and patient, gets reduced, by bureaucratic policy-making, to dollar measurement. The "customer" (no longer a "sufferer" patient) is an alert, informed, inquisitive individual, competent to comparison-shop about the dollars and make decisions in their best medical interest.

This is a seriously misguided view of health care. Doctors take account of the vulnerability and degree of "illness" of each patient – physical, emotional, social and economic. These factors affect patients' ability to comparison-shop between hospitals and doctors, and to make (wise?) choices.

Think back to when you or a close family member was sick; you wanted the best care and the best doctor, especially one whom you know and who knows you.

Productivity is complex, measured primarily in dollars. Other measurements are, at best, "flaky". At its heart, productivity concerns the simple goal of job efficiency. When the product is a material good – shoes, cars, groceries – we can find ways, through outsourcing or technological change, to increase productivity, ie throughput (which can be measured) and measurable cost.

Years ago, I witnessed the automation of the aluminium smelting industry near Newcastle… one man in an air-conditioned shovel machine replaced many workers who had filled the smelting pots with bauxite.

But there are roles, especially interpersonal relations, which do not lend themselves to this type of efficiency gain through substitution. Medicine has a mixture of activities, some highly technical (such as biochemical measurements, where machines are progressively doing better than we can) and those where human relations are paramount (think of psychiatry).

For decades, until he died in May, William Baumol, economist at New York University's Stern School of Business, had an interest in these distinctions. Musicians, teachers and doctors are among those for whom human interactions are crucial. These aspects of their work are not amenable to efficiency reform. Mozart's string quartet No 4 demands the same human effort and emotion to produce (and to listen to) today as it did way back in 1772.

Baumol's 2012 book, *The cost disease: why computers get cheaper and health care costs don't*, gives an account of this distinction.

You might think – and I would agree – that a patient's consultation with a specialist would be considered a primarily human interaction, as is the referring doctor's choice of specialist. Exploring options for this choice is surely personal, between the referring doctor and the patient, involving the specialist's personality, expertise, special interests, location, and which hospital they work or operate at.

The discussion about referral could, in some respects, but only in some, be better informed if there were readily available information about the specialist's clinical record and co-payment policy.

But what could the ACCC have been thinking in promoting a referral process where the patient could take their referral letter to any consultant of their choice or to any outpatient clinic? That all of medicine, not just the technical aspects, can be made more efficient by dehumanising it?

The "Occupy Health Policy" assumes that the private sector can do everything more efficiently than the public and that the "outputs" can be measured in dollar terms. The 'bean-counters' overlook the values which doctors and nurses place on caring for individual patients, and which leads many to work far beyond what they are paid to do.

By all means, let's use technology to best advantage and look at appropriate pricing for technologically-assisted health care. Choosing Wisely and similar campaigns lead in this direction, as does the review of MBS items to ensure that consultations, investigations and procedures do, indeed, provide 'health' value for money. But to believe that a "bizonomic" solution will fit the human side of Medicine is like seeking a technological replacement for members of an orchestra and their audience. Do that – focus on the money and not the purpose of health care – and you will wreck it.

# No, we do not have a CT scanner

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

The term “Ivory Tower” refers to an erudite and learned institution considered to be an ultimate source of expertise but who is out of touch with the realities of life and hardships on the front line. For rural doctors, it sometimes feels like our colleagues in metropolitan locations do not quite understand life in the Outback.

> “I hope for their understanding of our resources and what it is like to be distant from equipment, consultants, good internet and other supports.”

I make calls to the Ivory Towers frequently for assistance. At the outset, I am hoping against hope that I do not have go through a little Australian geography lesson to the harried young registrar on call overnight for the intake requests. I hope for their understanding of our resources and what it is like to be distant from equipment, consultants, good internet and other supports.

Sometimes we are lucky and the voice from the Ivory Towers has experienced life in the Outback. These individuals can commiserate with our work and are sensitive to our need for support. However, here are some of examples of the conversations I have had as a rural doctor:

“Hi, I am calling from (e.g.) Ngaanyatjarra, that’s pronounced ‘nununduda’. If Australia is a kidney bean, then a little to the left of dead centre of the bean is where I am calling from. You know, “the desert”. I don’t imagine you have been here but you’d see Uluru on the way. Also the canyon (sorry the “gorge”) that is voted the best gorge in all of Australia. Never heard of it? Kings Gorge (sorry canyon). On my drive through the “Lands”, we saw and saved a little thorny devil. No, I am not being cheeky, that is the name for those cute little creatures.”

“No, I have not obtained a CT scan of the brain. We are a 24-hour road trip to the nearest CT scanner. Either “Kal” (i.e. Kalgoorlie) or “Alice” (i.e. Alice Springs) is about the same distance. That is WHY I am calling you.”

“Hi, I am calling from Northwest WA. I need to ask you to take on this patient for ORIF of femur. I am calling interstate because doctor in Darwin, NT, you are about nine hours by road away but Perth is 36 hours by road and by air requires a jet aircraft to transport my patient because a prop plane will have to refuel.”

“G’day, I am calling from mid-size town, QLD. Yes, we do have a CT scanner in this town! … but the only person who mans it works normal banker’s hours. I realise that for you to give me good advice, we need that image of the fracture but it is a bumpy road to the CT scanner and requires an ambulance trip to the scanner and then back again. We also need to wake up the one and only radiographer who has to work a full day tomorrow. Could you take this patient on by retrieval because the time and effort in getting a local CT scan is not worth the amount of pain it will cause given the patient will likely need to be transported anyways?”

“Sorry doctor in Brisbane, I have not done platelet count. That is not included in our point-of-care testing. Yes I know, the coags are important, will an INR do for you?”

“Good Evening, I am calling from Aurukun. No that is not in India, it is a town in the Cape, within Australia, in fact we are just a little Northwest of you. Looks close on Google maps but in fact we are about 24 hours by road, but no matter, the roads are flooded, there is a river going over it this season. No I have not obtained an ultrasound of the testicle because the only ultrasound person here is me and I have not been trained in testes. That is why I am calling you.”

“No, Dr in Adelaide, I have not done a BNP, I cannot do that here by istat.”

“Thank you for sending Flying Doctors to me see in Ringers Soak. Now, I need to get out to the air-strip now to chase the kangaroos off the runway. Ringers Soak? Well, it is a little south of Halls Creek. No, not Falls Creek. No, not Halls Gap.

“Thank you for sending Careflight to me. We need to now drive to the flooded road, get our little tinny out to punt our patient across the new creek, by the way, did you know that we have lots of crocs here? They like creeks and feeding at night. Hope they are not hungry. On the other side we have signalled for a 4 wheel drive on meet the tinny to transfer our patient to the airstrip on the other side of the flood. Wish us all luck and good torches.”

Thank you, Ivory Towers, for taking our calls and not rolling your eyes at us. Thank you for your patience and for understanding the Australian Outback. Come visit us sometime, we can take you fishing (just not in the creek with the crocs).

# This bondage isn't right

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

There's a key difference between bondage and bonding. One is a contract between two or more parties, requiring informed consent, and designed for the mutual benefit of all involved. The other is a terribly flawed stick that the Australian Government seems intent on bashing medical graduates with, in a poorly informed attempt to provide a rural workforce.

In Australia, we have two medical bonding programs: the Bonded Medical Places (BMP) scheme and the Medical Rural Bonded Scholarship (MRBS). There are several different versions of these schemes, if you count the number of different contracts that now exist since their inception, but they can broadly be summarised as follows. The BMP scheme provides participants with a Commonwealth Supported Place (CSP) in medical school in exchange for a return of service of one to six years in rural and regional Australia. The MRBS scheme provided participants with a CSP in medical school and by the time it was axed a scholarship of $26,310 a year in exchange for six continuous years of work as a specialist in rural and regional Australia. Sounds simple enough, but the more you dig, the more you realise just how bad a deal this is for these future doctors and the patients they're supposed to be serving.

You see, the first major flaw in this plan is that bonding just doesn't work. Funnily enough, if you force someone to do something on your terms in an uncertain and inflexible manner, it turns out that people don't appreciate the experience and they don't come back. When bonding in medical school was first conjured up, the AMA provided evidence that similar schemes overseas, especially in North America, had failed to provide any form of sustainable medical workforce. More than 13 years have now passed and an exceedingly small number of scheme participants have completed their return of service. In fact, more participants have withdrawn or breached their agreement than those who have completed their return of service. Not exactly a ringing endorsement.

Compare this with the other measures and programs that are supported by the AMA. We know that having a rural background significantly increases your chance of going rural, and we have strongly supported increasing the quota of students from rural backgrounds. We floated the idea of Regional Training Networks in 2014, to help allow those who wanted to work and stay rural obtain fellowship in a more sustainable manner and reduce infrastructure duplication in what is already a resource poor area of medical training. We supported the Prevocational General Practice Placements Program and, following its abolition by the Abbott Government, subsequently developed an alternative proposal for a Community Residency Program (CRP), to enable doctors to have meaningful rural experiences in their pre-vocational years, while they work out exactly what career they want to pursue. And we have long supported an increased rural focus in the Specialist Training Program (STP), allowing registrars to be adequately funded to work in rural areas on progression to fellowship. It's a suite of measures that encourages positive experiences and supports trainees along their often complicated and difficult path.

But the Government has chosen to focus on draconian bonding schemes. Let's explore the MRBS for a second, mostly as initially on paper it looks very attractive. You take a 17-year-old undergraduate student and you promise them $26,310 tax free and a place in medical school for a return of service. Sounds reasonable. Except what 17-year-old understands Medicare? Hell, how many healthcare workers and bureaucrats even understand Medicare? Do we adequately explain to them that leaving the scheme will result in a 12-year ban from Medicare, effectively killing their medical career there and then, simply because of a change in their life situation and circumstances? Do we explain to them that as they train to become a rural general practitioner, they will be effectively forbidden from working in the city for short periods of time, preventing them from upskilling in crucial rural skill sets such as emergency medicine, obstetrics and anaesthetics? Do we explain to the orthopaedic trainee that they only have 16 years from the start of medical school to complete their requirements? Caveat emptor is one thing, but conscriptive blackmail is another.

And even if you are one of the few to complete your return of service, just how happy will you be at the end of it all? What doctor, having had to deny themselves the opportunities of personal and professional development at the behest of such an authoritarian scheme, will look kindly on rural Australia? When you take away mastery, autonomy and purpose, you're left with a bitter, angry human. That's not the kind of person that rural Australia deserves.

The AMA Council of Doctors in Training is continuing to lobby government to adjust the BMP and MRBS for the good of its participants and the Australian public that it purports to serve. Nobody is arguing that a return of service isn't owed, but it certainly shouldn't function like this. If you or someone you know is affected by these schemes, we'd like to hear about it. Please contact me at cdt.chair@ama.com.au and let's see if we can't loosen the bureaucratic nipple clamps, just a little bit.

# Internship uncertainty – It's time for a national application process

BY DOUG ROCHE, VICE PRESIDENT (EXTERNAL) AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Right now, final year medical students are receiving offers of internship from hospitals around the country. For each student, this follows a long process from considering which hospitals to preference, to preparing applications, and finally submitting them. However, with a shortage of internship positions, it's uncertain as to whether many students, particularly international students, will even get to the point of receiving an offer.

Final year students who miss out on an offer in the initial round are put in an extremely difficult position. Many of these are full-fee-paying domestic or international students, and have invested $300,000 and a substantial portion of their life to get to this point, at which inadequate foresight in workforce planning has led to the prospect of never becoming a fully qualified doctor.

The shortage of positions means that students are advised to apply to multiple States and Territories (jurisdictions) to maximise their chances of obtaining an offer. For this year's intake, almost 1200 students applied to multiple jurisdictions.

Such duplication incurs a number of costs, not just the direct cost to the jurisdiction. The principle cost is one of time and effort for the applicant. Internship applications occur during a busy year of clinical placements when most candidates are sitting final exams. They're also trying to balance the extracurricular commitments needed to remain competitive for specialty training program selection, on top of maintaining healthy connections with friends and family.

For those who wait many months to receive an offer, the system is hampered by multiple offers being made to the same individual, increasing the time and level of uncertainty involved. The complexity is further increased by the different application systems implemented by each jurisdiction.

For domestic graduates, all States except Victoria offer a ballot-based system. The Victorian system, merit-based but termed 'employer choice', requires candidates to apply to individual hospital and health services.

There are broader harms to a merit-based internship process too. Metropolitan hospitals pride themselves on being able to select the "creme de la crème" of graduates. This results in a system where gaining employment at a top Melbourne hospital is a sign of success in and of itself, thus attracting high-achieving graduates who may not necessarily have only been attracted to metropolitan practice in the first place.

At the same time, outer metropolitan, regional and rural hospitals are filled with the remainder of students, many of whom, due to the preferencing system, are international students. Rural health becomes unnecessarily stigmatised as the option of last resort.

Given the importance of filling all available positions in a timely fashion, a national audit is conducted five times throughout the year. This involves each jurisdiction submitting their data on applications and offers. These data are then compared and candidates who are holding multiple offers are identified and asked to select one offer.

The situation for international students is unconscionable. International students are not guaranteed an internship, and job prospects are the major cause of stress in most international students' lives. The transparency with which universities advise prospective international medical students of this fact varies considerably between institutions.

AMSA surveys show that 83 per cent of international students want to stay and work in Australia, and 85 per cent of these students are interested in working in regional and rural Australia. They are well acculturated to the Australian health care system. A national process would likely accelerate offers for international students and relieve some of the uncertainty associated with becoming fully qualified.

The solution to these problems is neither complex nor particularly costly. A national internship application process would involve one portal through which students apply, receive, accept and reject offers. AMSA has been calling for such a system since 2012.

For students, a streamlined national process would relieve a great amount of the pressure of becoming a fully qualified doctor. While ideally priority systems and methods of application would be aligned, this isn't a necessary prerequisite for a national system. A computer algorithm would be able to take into account the differences between State and Territory preferencing system. The number of final year students racing against the clock to find an internship before the end of the year would be drastically reduced.

The benefits of a national process are not only to the individual student, but to jurisdictions as well. Administrative burdens of conducting a different scheme in each State and Territory

# Public Hospital Doctors role central to AMA

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

> "I hope more doctors based in public hospitals, particularly those with a Specialist qualification, will choose to identify in the public hospital doctor membership category as opposed to their medical craft group if they have one, when it comes to identifying their AMA membership as you will be invited to do soon, and thus remain engaged with the CPHD."

I'd like to state my thanks for all the input and interest from PHD members at our recent National Conference. It was invigorating to experience your enthusiasm for the many issues directly affecting public hospital doctors. An important issue about which I do want to remind you is actually how you "describe" yourself for AMA membership purposes. In order to keep the CPHD vibrant and relevant to key issues, we must have a solid base. Today we can choose our membership category more accurately. I hope more doctors based in public hospitals, particularly those with a Specialist qualification, will choose to identify in the public hospital doctor membership category as opposed to their medical craft group if they have one, when it comes to identifying their AMA membership as you will be invited to do soon, and thus remain engaged with the CPHD.

## Vale Dr Patrick Pritzwald-Stegmann

Multiple issues are before the CPHD. None is more relevant than safety in the workplace. On July 21, a Memorial Service was held for AMA member Dr Patrick Pritzwald-Stegmann, who died after substantial time ventilated in one of our ICUs after an alleged "coward's punch" received in the foyer of a Melbourne metropolitan public hospital resulted in a profound brain injury. This is now a Coroner's and police matter. I am regularly horrified at the experiences of violence in our community and our workplaces, but this is all the more poignant for me as Patrick was a recent close colleague of mine with whom I had worked extensively.

There are many intersecting issues in our community, most of which lead to the public hospital system. They include mental health issues, whether acute, chronic or acute-on-chronic, illicit drug use, perhaps loading up on mental health issues, increased passive tolerance of greater violence in and by the now metropolises (as opposed to tight-knit communities), and a general lack of respect for those providing any type of community service. Emergency service providers and our colleagues and other healthcare workers in emergency departments

# Internship Uncertainty – It's Time for A National Application Process

would be minimised, and a national audit would no longer be necessary as multiple offers would be impossible. Hundreds of hours of work by departmental staff would be saved.

One of the great difficulties we face is that it's impossible to track students as they flow through the fragmented system. Universities, AMSA and jurisdictions rely on reports of individual students and the somewhat delayed results of the national audit. We have no way of knowing how many graduating doctors fall through the cracks, and are forced to either take up an internship overseas or forfeit medicine as a career.

Australia is far behind in the implementation of a centralised process for internship applications - similar systems already exist in the US, UK, New Zealand and Canada. The US, UK and Canada have vastly more complex jurisdictional arrangements than Australia, and yet their 'match' systems are well-established.

It's time for State, Territory and Commonwealth health ministers and departments to show some leadership in this area. The medical workforce challenges Australia faces are only going to compound. A National Internship Application Process would be a relatively simple step to addressing these, while creating a more certain future for the students on whom Australia's future health relies.

# Public Hospital Doctors role central to AMA

... from page 23

face the brunt, but it is throughout the public hospital system. I note that our population is growing remarkably, we have generated profound productivity improvements, but there remains a yawning gap of lack of public hospital capacity investment to match the essential hospital requirements of the complex, multi-system, elderly and/or obese, chronic illness sufferers. It is readily observable how "house full" messages contribute to patient frustration, then anger and venting in our workplace. It was equally offensive to see lauding of "this is what 182 blows to the head looks like" related to a recent violent "sport" designed to inflict brain injury. It is easy to see some might link these ingredients, resulting in an unsafe workplace for us.

In perhaps a curious coincidence, I am now chairing an Australian Standards committee revising the standard Security for Health Care Facilities. It will be a template for consideration of security risks for any and all health care facilities in Australia. Its origin related to large public hospitals, but changes in technology and hospital interventions means security issues are everywhere that medicine is practised, including hospital-in-the-home and all points travelling between, patient record security, medication and medical gas security, microorganism security, IT security, food security, let alone staff safety and security. I will be pleased to receive your thoughts on this topic. Obviously not everything will be totally relevant to all, but in these days of terrorism and bioterrorism, it will be a useful tool for risk analysis. It will be a sad day if every part time medical point of care in a high rise tower through to our major teaching hospitals needs to have the same security we now take for granted on getting to the airside of an airport, surveillance cameras or requires trained and authorised security personnel with Tasers and policing powers comparable to Protective Service Officers.

Of note, none of the above may have prevented Patrick's injury, or some of them may have caused the alleged perpetrator to pause.

## Public Hospital Funding

It is clear an expansion and greater funding of public hospital's is required to meet the increasing demand, separate to security investments. This is about to accelerate in my view as more reduce private health insurance due to increasing premiums coupled with increasing mortgage, energy and education costs pressures. An important discussion will be how best to use the now billions of tax dollars shoring up publicly listed health insurance companies' profits and employee bonus payments, whilst squeezing the marketplace and offering frequently inadequate products to bamboozled patients seeking a tax break.

Recently the Government rejected a proposal to abolish the private health insurance rebate and effectively take funds it saves from that, along with hospital funding, to provide a standard benefit for services, regardless if they happen in a public or in a private hospital. This would effectively take Commonwealth funds from public hospitals and force patients to pay more for coverage. This would reduce the amount the Commonwealth contributes to the cost of public hospitals to a paltry 35 per cent. The 42 or 43 per cent funding we're getting from the Commonwealth now is not sustainable for future public hospital operation.

A 35 per cent share would be a disaster in the super-stretched public system and in the private system for that matter. In recent years we've seen the Commonwealth's share of funding to public hospitals drop below 45 per cent with a formula that only relies on growth in CPI and population. The AMA's Public Hospital Report Card shows that performance in the system, such as wait times in the emergency department or for elective surgery, are not improving, or indeed are going backwards. So we can be thankful that this reduction has been ruled out.

But with consideration of the way hospitals are funded, we need to focus on priorities and things that might work in the hospital system. This especially includes quality and safety initiatives as well as increasing the utility of secondary hospitals or in the community. We must put more resources into primary care prevention as a long-term strategy for reducing the rate of increase of pressure on public hospitals.

Let's hope governments see sense and realise that proper health care is a sound investment and saves money in the long term, and that engaging with doctors is the only way to develop sound health policy. I look forward to discussing these and other issues with you in upcoming CPHD meetings and other events.

# AMA's successful stand for sensible and safe pathology testing

BY PROFESSOR ROBYN LANGHAM, CHAIR, MEDICAL PRACTICE COMMITTEE

One could be forgiven for thinking that he AMA thinks little of pharmacists, given the nature of the media reports around the recent successful AMA campaign to stop Amcal pharmacies ordering unnecessary pathology screening tests.

The truth is quite the opposite. The AMA greatly respects the valuable contribution pharmacists make in improving the quality use of medicines. Pharmacists working with doctors and patients can help ensure better medication adherence, improved medication management, and also help in providing education about medication safety.

"The AMA agrees that pharmacists' expertise and training are under-utilised in a commercial pharmacy environment where they are necessarily distracted by retail imperatives."

The AMA agrees that pharmacists' expertise and training are under-utilised in a commercial pharmacy environment where they are necessarily distracted by retail imperatives.

That is why the AMA is fully engaged in the current review of pharmacy remuneration and regulation being undertaken by an independent panel appointed by the Federal Government.

In a comprehensive submission to the panel lodged last year, the AMA was supportive of alternate models of funding being explored that would encourage and reward a focus on professional, evidence-based interactions with patients. Our submission also supported ongoing funding of effective and cost-effective pharmacist medication management programs, particularly those targeting Aboriginal and Torres Strait Islanders, and a relaxation of the restrictive pharmacy location rules.

The panel has now released an interim report revealing its likely recommendations to Government on the future of pharmacy funding and regulation.

The proposed recommendations pick up on many of the AMA's suggestions and concerns, and, if implemented, would radically improve the transparency of pharmacy funding and refocus government investment on evidence-based and cost effective services.

Unsurprisingly, the Pharmacy Guild of Australia is highly critical of the report, slamming it as "without merit", "ill-considered", "threatening" and "undermining" as well as stating it has "serious concerns about the true intention of the review".

Some of the key recommendations supported by the AMA include:

- banning the sale of homeopathic products from pharmacies altogether;
- physically separating other complementary medicines from "pharmacy only" (schedule 2) and 'pharmacist only' (schedule 3) in pharmacies to better help consumers understand that these medicines have not been assessed for effectiveness in the same way as S2, S3 and prescription medicines;
- moving the funding of pharmacist services programs from the Guild-controlled Community Pharmacy Agreement to other government funding streams to improve transparency and facilitate coordination with other primary health care programs;
- removing current bureaucratic barriers to medicines programs and pharmacy services that hinder access to indigenous Australians; and
- changing the pharmacy location rules with potential to improve options for pharmacy co-location with general practices.

The AMA is very supportive of the interim report and lodged a favourable submission in response in July.

Unfortunately, the Guild has already brokered a deal with the Coalition Government to shelve any changes to location rules in the foreseeable future. It will be interesting to see what appetite the Government has for taking up the panel's final recommendations, particularly given the next Federal election date is not so far away.

# Relationships with industry

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

A major priority for the AMA's Ethics and Medico-Legal Committee (EMLC) will be the review of the *Position Statement on Medical Practitioners' Relationships with Industry 2012*. The statement provides guidance for doctors on maintaining ethical relationships with "industry", including the pharmaceutical industry, medical device and technology industry, other health care product suppliers, health care facilities, medical services such as pathology and radiology, and other health services such as pharmacy and physiotherapy.

The current Statement encompasses the following sections:

- medical education;
- managing real and potential conflicts of interest;
- industry sponsored research involving human participants including post-marketing surveillance studies;
- meetings and activities organised independent of industry;
- meetings and activities organised by industry;
- hospitality and entertainment;
- use of professional status to promote industry interests;
- remuneration for services;
- product samples;
- dispensing and related issues; and
- relationships involving industry representatives.

Doctors' primary duty is to look after the best interests of their patients. To do so, doctors must maintain their professional autonomy, clinical independence and integrity, and have the freedom to exercise professional judgement in the care and treatment of patients without undue influence by third parties (such as the pharmaceutical industry or governments).

But what happens when the impetus to change the relationship with industry comes from within the profession itself? For example, the AMA's current policy on doctors and dispensing states that:

> *11.1 Practising doctors who also have a financial interest in dispensing and selling pharmaceuticals or who offer their patients' health-care related or other products are in a prima facie position of conflict of interest.*
>
> *11.2 Doctors should not dispense pharmaceuticals or other therapeutic products unless there is no reasonable alternative. Where dispensing does occur, it should be undertaken with care and consideration of the patient's circumstances.*

In recent years, we have heard from members who believe this position is too strict and doctors should be able to dispense pharmaceutical products, arguing that it's more convenient for patients and leads to better compliance. For example, patients may be more likely to fill their prescriptions onsite at the doctor's office than if they have to go offsite to a pharmacy. In addition, the doctor is there to answer any questions relevant to the prescription which will reduce pharmacy call backs and waiting times.

Historically, the AMA has strongly advocated that doctors do not make money from prescriptions. Allowing doctors to dispense pharmaceuticals or other therapeutic products (other than in exceptional circumstances) would be a fundamental shift in this position – but is that a sufficient reason not to change it?

After all, dispensing pharmaceuticals or other therapeutic products is not in itself unethical so long as it is undertaken in accordance with good medical practice. Unfortunately, however, there can still be a strong perception of a conflict of interest, particularly if doctors are making a profit rather than just recovering costs. So for many doctors – but more importantly our patients and the wider community who are our ultimate judges – this is a line which should not be crossed.

These are the types of issues the EMLC will consider in reviewing this policy and we will endeavour to seek members' views during the process.

The EMLC will also be developing an overarching policy on managing interests, highlighting the potential for professional and personal interests to intersect, and at times compete, during the course of a doctor's career. While a real, or perceived, conflict of interest is by no means a moral failing, it is important that doctors are able resolve any potential for conflict in the best interests of patients.

The *Position Statement on Medical Practitioners' Relationships with Industry 2012* is accessible on the AMA's website at https://ama.com.au/position-statement/medical-practitioners-relationships-industry-2010-revised-2012. If you would like to suggest any amendments to the current Statement, please forward them to ethics@ama.com.au.

# Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

## Critical attention given to doctors' health at COAG

Federal, State and Territory Health Ministers met in Brisbane this month at the COAG Health Council to discuss a range of national health issues.

During broad ranging discussions it was agreed to amend mandatory reporting provisions for treating health practitioners. Doctors should be able to seek treatment for health issues with confidentiality. They also acknowledged that protecting the public from harm is also important.

The resulting COAG communique said: "A nationally consistent approach to mandatory reporting provisions will provide confidence to health practitioner that they can feel able to seek treatment for their own health conditions anywhere in Australia."

AMA President Dr Michael Gannon commended the decision, saying: "It has been acknowledged that there needs to be a change, that there's a problem.

"Healthy doctors take better care of their patients.

Other items discussed by Health Ministers included:

### Family violence and primary care

The Health Ministers agreed to seek further advice from Primary Health Networks on existing family violence services, including Commonwealth, State and NGO service providers in their regions, with a view to developing an improved whole-of-system response to the complex needs of clients who disclose family violence.

This is supported by evidence given by Professor Kelsey Hegarty at the Victorian Royal Commission into Violence, when she said: "PHNs and other alliances across the health services sector have a significant role to play in supporting practitioner training about family violence."

### Fifth National Mental Health and Suicide Prevention Plan

Health Ministers endorsed the *Fifth National Mental Health and Suicide Prevention Plan 2017-2022* and its Implementation Plan.

Federal Health Minister Greg Hunt said it stood out from previous plans with its focus on eating disorders and suicide prevention, keys areas that had been raised by lobbyists.

"The prevalence and the danger of (eating disorders) is still dramatically understated in Australia," he said.

"The reality is that this is a silent killer, particularly women can be caught up for years, so there is a mutual determination to make progress."

The plan will also focus on improving Aboriginal and Torres Strait Islander mental health and suicide prevention, reducing stigma and discrimination, and better coordinating treatment and support programs.

### The National Psychosocial Supports Program

The 2017-18 Budget allowed for the establishment of a National Psychosocial Supports Program that aims to provide flexible, targeted services to people with severe mental illness resulting in psychosocial disability who are not eligible for the National Disability Insurance Scheme (NDIS).

The Health Ministers agreed to establish a time-limited working group to progress a National Psychosocial Supports Program to reduce the community mental health service gap, improve mental health outcomes and reduce the inequity in service availability.

### National Digital Health Strategy and Australian Digital Health Agency Forward Work Plan 2018–2022

The COAG Health Council gave the green light to the National Digital Health Strategy. Currently, 5 million Australians have a My Health record – this strategy aims, among other things, to expand this non-compulsory offer to all Australians by 2018.

### Expanding the public reporting of patient safety and quality measures

Ministers agreed that the Australian Commission on Safety and Quality in Health Care (ACSQHC) would undertake work with other interested jurisdictions to identify options in relation to aligning public reporting standards of quality healthcare and patient safety across public and private hospitals nationally.

The Australian Institute of Health and Welfare last month highlighted the gaps in reporting and, in some areas, the lack of data altogether, saying: "There is no routinely available information on some aspects of quality, such as the continuity and responsiveness of hospital services."

MEREDITH HORNE

# Research

## New App set to assist with pain monitoring for dementia patients

A point-of-care assessment app designed to help detect pain in people with dementia has gained approval for use as a medical device in Australia and Europe.

The Electronic Pain Assessment Tool (ePAT) is a mobile application tool, which has evolved from research undertaken by Curtin University over the past four years that aims to assess and monitor pain in people who cannot communicate verbally.

ePAT now has gained regulatory approval for its device and will roll out the app in Australia this year, in Europe next year and then aim to have US regulation by 2019.

The regulatory approval follows a peer-reviewed study confirming the validity and reliability of ePAT in people with moderate to severe dementia that was accepted for publication in *Journal of Alzheimer's Disease* (JAD) in July this year.

Curtin University's Professor Jeff Hughes, the co-inventor of the app said: "Our vision to ensure no person who cannot speak will suffer in silence with pain is closer to being a reality."

The ePAT app works by taking a 10-second video of the patient's face and analysing it in real time for micro-expressions that indicate the presence of pain.

It combines this with information also captured through the app on non-facial pain cues, such as vocalisations, behaviours and movements, to calculate a pain severity score.

Both residents and care staff stand to benefit, Professor Hughes said.

"For people with dementia, it's a more reliable way for their pain to be assessed and hence a reduced likelihood that it will go undetected or unmanaged," he said.

"It offers residential aged care staff looking after people with dementia a simple reproducible means of assessing and monitoring pain.

"This should result in better pain management and a reduction in pain related behavioural problems, in turn decreasing the need for psychotropic medications," Professor Hughes said.

The Australian Institute of Health and Welfare data shows 342,800 Australians were estimated to have dementia in 2015. Based on projections of population ageing and growth, the number of people with dementia will reach almost 400,000 by 2020, and around 900,000 by 2050.

MEREDITH HORNE

## Rehydration study shows water still best choice

A Griffith University study has found that once food is consumed, water should be the drink of choice for most of us following a workout.

Ten endurance trained athletes aged between 18 and 30 cycled intensively for one hour on four separate occasions as a part of the small study that has been published in the peer-reviewed scientific journal *Physiology and Behaviour*.

Participants were provided with one beverage to drink as they desired following the exercise. The beverages included water (used on two of the trials), a carbohydrate-electrolyte (sports drink) Powerade or the milk-based drink Sustagen Sport.

In addition, on two occasions during recovery, the participants were given access to a variety of food which could also be voluntarily consumed.

"The fluid provided from all beverages was equally well retained, despite different consumption volumes, and resulted in participants' body weights returning to near pre-exercise levels," said Associate Professor Ben Desbrow from Griffith's Menzies Health Institute Queensland.

"The findings from this study demonstrate that the consumption of food following exercise plays an important role in causing fluid retention when different beverages are consumed. The

take home message was that when participants consumed a fluid containing calories (i.e. the Powerade or Sustagen Sport trials), their combined energy intake from the drink and food was greater than on the water trials."

Associate Professor Desbrow said it was imperative, when making post-exercise nutrition recommendations, to consider beverage selection within the context of an individual's broader health targets.

"For those with a weight loss goal, a calorie-free drink such as water is the perfect choice," he said.

"It rehydrates equally effectively as other beverages, without supplying additional energy."

MEREDITH HORNE

INFORMATION FOR MEMBERS

# Specialty Training Pathways Guide – AMA Career Advice Service

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

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

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

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

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

Information on the new website includes:

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

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

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

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

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

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

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

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

# Philippines HIV cases rapidly rising

The United Nations reports that the Philippines is home to the fastest growing rate of HIV/AIDS in all of the Asia-Pacific.

The country's own Secretary of Health, Paulyn Ubial, has cited UN data (from UNAIDS) during a recent media conference in a bid to encourage more Philipinos to use condoms during sex and to volunteer for HIV testing.

In the past six years the Philippines has recorded a 140 per cent increase in new HIV/AIDS infections.

A total of 10,500 Filipinos were infected with HIV at the end of last year, with most new infections detected among young men.

This rate is a jump from the 4,300 cases recorded in 2010.

In May this year there were 1,098 new instances of HIV infections detected in the Philippines, which is the highest number of cases since 1984 when infections were first reported.

UNAIDS regional support team director for Asia-Pacific, Eamonn Murphy, said the Philippines could avert the growing the health threat and all but wipe it out by 2030 if the Filipino Government focussed its attention and resources on the people and locations in the country most at risk.

Eighty-three per cent of new HIV cases occurred among males who have sex with males and transgender women who have sex with males.

Two out of three new HIV infections are among 15 to 24 year-old Filipino men, who reportedly have little awareness of HIV, including its symptoms and treatment.

CHRIS JOHNSON

# Publically funded contraception set for challenge by the Trump administration

With the politics in the United States still playing out on the Affordable Care Act, the White House has reportedly moved forward with a plan to cut a provision that was introduced to protect women's reproductive rights.

The Affordable Care Act expanded contraception coverage to about 55 million women with private insurance coverage.

The Trump administration is expected to amend the Federal regulation that requires employers to provide health insurance plans that offer preventive care and counselling – which the US Department of Health and Human Services has interpreted to include contraception – at no cost.

The expected Presidential executive order will allow any business or organisation to request an exemption on religious or moral grounds.

The Obama administration issued regulations allowing religious employers to opt out of offering contraceptive coverage. However, affected employees were then covered directly by their insurers.

Gretchen Borchelt, Vice President for Reproductive Rights and Health at the National Women's Law Center, has said that hundreds of thousands of women could lose access to their birth control "if this broad-based, appalling, and discriminatory rule is made final".

Many family planning advocates are concerned that this policy shift will see a result to an increase in abortion rates across the US. Recent research by the Guttmacher Institute suggests that improved contraceptive use, resulting in fewer unintended pregnancies, likely played a larger role than new state abortion restrictions in the decline between 2011 and 2014.

The American Congress of Obstetricians and Gynaecologists has issued a statement that denounces any plan to roll back contraception coverage, saying that any move to decrease access to these services would have a damaging effect on public health.

"Contraception is an integral part of preventive care and a medical necessity for women during approximately 30 years of their lives.

"Since the Affordable Care Act increased access to contraceptives, our Nation has achieved a 30 year low in its unintended pregnancy rate, including among teens.

"Unintended pregnancies can have serious health consequences for women and lead to poor neonatal outcomes," the statement reads.

MEREDITH HORNE

# Report warns blindness set to rise

A new study published in *Lancet Global Health* warns the number of blind people across the world is set to triple within the next four decades.

The research predicts cases will rise from 36 million to 115 million by 2050, if treatment is not improved by better funding.

A growing ageing population is behind the rising numbers.

Some of the highest rates of blindness and vision impairment are in South Asia and sub-Saharan Africa.

Although the percentage of the world's population with visual impairments is actually falling, according to the study, the global population is growing and so the number of people with sight problems will soar in the coming decades.

Analysis of data from 188 countries suggests there are more than 200 million people with moderate to severe vision impairment.

That figure is expected to rise to more than 550 million by 2050.

"Even mild visual impairment can significantly impact a person's life," said lead author Professor Rupert Bourne, from Anglia Ruskin University in Cambridge.

"For example, reducing their independence...as it often means people are barred from driving."

He said it also limited people's educational and economic opportunities.

The worst affected areas for visual impairment are in South and East Asia. Parts of sub-Saharan Africa also have particularly high rates.

The study calls for better investment in treatments, such as cataract surgery, and ensuring people have access to appropriate vision-correcting glasses.

Professor Rupert Bourne said that interventions provide some of the largest returns on investment in eye health.

"They are some of the most easily implemented interventions in developing regions because they are cheap, require little infrastructure and countries recover their costs as people enter back into the workforce," he said.

In Australia, the CEO of the Fred Hollows Foundation, Brian Doolan, spoke to the research, saying that more needs to be done for social development, targeted public health agreements and accessible eye health facilities.

"The strategies being used around the world have been shown to work, all we need is to get them to the right scale to address the growing global need," Mr Doolan said.

According to Mr Doolan, the leading cause of blindness worldwide is poverty, followed by gender.

The report also indicates Aboriginal and Torres Strait Islander people are still three times more likely to be blind than other Australians. Most blindness in Australia is due to readily preventable or treatable causes of vision loss, including cataract, diabetes, refractive error and trachoma.

The AMA continues to call on the Federal Government to correct the under-funding of Aboriginal and Torres Strait Islander health services, including programs to limit preventable blindness.

MEREDITH HORNE

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

# BMA agenda reflects UK national affairs

Dr Mark Porter

The United Kingdom in late June was dominated by headlines about Brexit, terror attacks, and the Grenfell Tower fire.

When AMA President Dr Michael Gannon arrived in Bournemouth for the British Medical Association (BMA) Annual Representatives Meeting (ARM), he discovered that the BMA was responding to the major events rocking the British population and the political landscape.

These national concerns, which dramatically affect UK doctors and patients and the National Health Service (NHS), were put into perspective in the final speech to the BMA of outgoing Chair Dr Mark Porter.

Condemning the tragic terror incidents in Manchester and London, Dr Porter praised the efforts of doctors, nurses, and emergency service workers.

"They ran towards danger, as others were urged to run for it," Dr Porter said.

"They responded to suffering with compassion and unity.

"And they distilled years of experience into the vital minutes that mattered for their patients.

"I am so proud to work alongside them in the health service. I want to thank them on behalf of the whole profession."

Turning his attention to the recent close-run UK election and the electoral impact of health policy, Dr Porter delivered a blistering attack on Government neglect of the NHS.

"We still have one of the best healthcare systems in the world. It treats more patients than ever before, and deploys treatments of which I could only have dreamt when I qualified as a doctor," Dr Porter said.

"But after years of underinvestment, with a growing ageing population, and despite the extraordinary dedication of its staff, it is failing too many people, too often.

"So how can Ministers have let this come about?

"It is because we have a health service that they view from high windows in Whitehall, or on a sanitised photo opportunity, but which patients all too often see from a trolley rather closer to the ground.

"I'd like those Ministers to imagine, just for a moment, what it's like to be on one of those trolleys. To be one of those patients who hoped their needs would be met, no matter who they are or where they live."

Hard hitting stuff. But Dr Porter was just warming up. He then turned his focus to Brexit.

"Colleagues, closing down our borders would close down our health service," he said.

"We give politicians our vote and our trust. It's way past time for them to step up.

"They need to take responsibility, not just for how the NHS is funded but for those who staff it. Like the 10,000 NHS doctors who qualified in another European country.

"Many came here as students. They wanted to give their working lives to the health service. They were drawn by the values of the NHS and now embody those values. But they have been left with fundamental worries and doubts about their employment rights and long-term future in this country.

"Ensuring their rights, which has been the BMA's consistent call since the [Brexit] referendum, will rightly be a priority in negotiations but the Government's fine words need to be turned into actions.

"Treating these doctors with justice and respect is not a matter of charity; it is a matter of practical necessity and of moral obligation. We simply wouldn't have a health service without them. And even if we did, I wouldn't want to work in it."

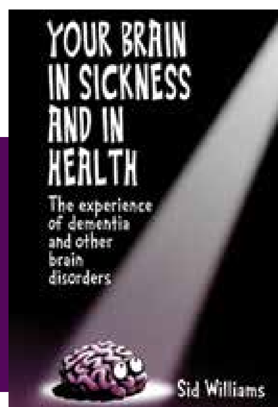
Dr Porter also highlighted the unique impacts that Brexit would have in Northern Ireland, where health services currently operate efficiently in a cross-border model with the Republic of Ireland.

The impact on medical students and young doctors has been duly noted and advocated by the BMA.

Dr Porter spoke with passion and purpose about his five years as BMA Chair, and equally passionately about the contemporary issues affecting the medical profession and the NHS. He received a long and loud standing ovation.

All the while, the fallout – personal, societal, political – of the human tragedy of the Grenfell Tower fire ran as an undercurrent to the ARM – just as it did with the whole UK community.

JOHN FLANNERY




# Your Brain in Sickness and in Health

## The experience of dementia and other brain disorders

**By Sid Williams**

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REVIEWED BY **CHRIS JOHNSON**

Understanding Alzheimer's disease, dementia and other brain disorders is hardly a simple thing for clinicians, let alone for the non-medically trained who are coping with afflicted loved ones.

This book was written for both.

Dr Sid Williams, formerly an Associate Professor at the University of Sydney, is a pioneer in providing and developing education and support services for people with dementia and their families.

He was made a Fellow of the Australian Medical Association in 2004, after having served on the AMA's Committee on Care of Older People between 1995 and 2003.

In 2014, Dr Williams received the Ian Simpson Award from the Royal Australian and New Zealand College of Psychiatrists for his outstanding service to the community, patients and colleagues.

He has worked for more than 40 years with people suffering dementia.

In short, Dr Williams knows his stuff.

And that is most evident throughout the pages of this book.

Written with clinicians – particularly GPs – in mind as well as the lay reader, this offering does an excellent job of explaining in a straightforward manner the nature of Alzheimer's disease as well as other brain disorders.

It could serve equally as a text book as well as a compelling read.

Behaviours and experiences are revealed and explained, including numerous accounts of real people and case studies.

With 14 chapters plus a lengthy and detailed references section, the book delves into the topic in some depth.

Yet the clarity of Dr Williams's prose – his ability to explain a point or present an example in an engaging manner – makes the tome somewhat of a page turner.

Chapters detail the symptoms and treatment of brain disorders but there is also plenty of space dedicated to the way people without dementia perceive, understand and respond to those who are afflicted with it.

A revealing section is Chapter 12, entitled A*n ill brain in an ill body: Acute confusion – delirium; attention skills and functions.*

"When someone's body is ill, their brain may also be ill," Dr Williams writes.

"If their brain is ill, they may have difficulty functioning. They may have a pattern of problems and deficits in function that is now called delirium."

He then goes to some length explaining how people react to the condition, what difficulties it presents and how it is related to other disorders.

By using real life case studies, from his own vast experience, it reads almost like he is unlocking some mysteries of the brain's most confounding diseases.

The book also touches on false beliefs associated with brain pathology.

Most of the sub-topics throughout all the chapters are quite eye-opening.

At the very least, this book is extremely informative. But it is so much more than that.

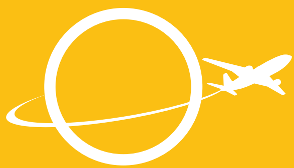
*Your Brain in Sickness and in Health* is destined to become a trusted go-to volume on the subject of brain disorders.

Dr Williams describes his approach to this work exquisitely in the book's introduction.

"The general portrait of humankind, whether affected by brain pathology or not, which I hope emerges from this book, is, in my eyes, one of remarkable beauty, grandeur, and subtle texture," he writes.

"One that weds nature and nurture and has exemplary power in understanding development through life, the potential transcendental qualities of human relationships, human consciousness, and extraordinary human achievements in science, technology, art, and music.

"And this is not to mention ordinary day-to-day individual, family and community life, which is, to my mind, both remarkable and beautiful."



# Getting to the heart of it in New Caledonia

BY CHRIS JOHNSON

In 1999 French aerial photographer Yann Arthus-Bertrand published a book titled *Earth from Above*. It was the culmination of a five-year, five-continent, 60-country, UNESCO-sponsored study of the planet.

The stunning photographs throughout the book included such marvels as Mt Everest, Mammoth Hot Springs in Yellowstone National Park, a flock of red ibises in Venezuela, and a caravan of camels in Mauritania.

All of the photos depicted the beautiful and fragile state of the world, presenting Planet Earth from a unique perspective – the view from above.

The photos of some of Earth's most brilliant landscapes were taken from helicopters, hot-air balloons and other light aircraft.

The book was translated into 24 languages and sold more than three million copies. It is now in its fourth edition (including the special 10th anniversary edition).

One of the many features to make this book such a gorgeous standout was the photograph Arthus-Bertrand chose to place on its cover.

A massive mangrove swamp naturally forming an almost flawless heart shape edging against the barrier reef of New Caledonia's largest island Grande Terre was the perfect choice.

The book – its cover – made this intriguing site an instant global attraction.

The Heart of Voh is now recognised around the world and is a worthy inclusion for anyone's bucket-list.

Situated on the north-west coast of Grande Terre, it is a four-hour drive from the capital Noumea just to reach the township of Koné, which is the gateway to the attraction.

It is more than worth the effort of getting there.

The Heart of Voh can be viewed from a 400m high lookout on Mt Kathépaik, which involves a two-hour return trek.

But the best way to view this spectacular sight is how Arthus-Bertrand captured it – from the air.

That is what my partner and I chose to do during a last-minute, spur-of-the-moment short visit to France's gem in the Pacific, New Caledonia.

With only a few days on the island, we made Noumea our base and created our itinerary from day to day.

Beautiful beaches, incredible snorkelling, great dining, and fun nightlife were all on our doorstep and we made the most of it all without having to drive anywhere.

Then came the question of the Heart of Voh.

"That's a long drive."

"We would have to go there and back in one day."

"Looks stunning in the brochures."

"Long drive."

"We'd have to leave here while it's still dark."

"Who knows when or if we'll ever get back here?"

"It does look like it would be incredible."

"A lot of money."

"Would be worth it."

"A long drive."

"Let's hire a car."

"Let's."

And so off we went, leaving at dawn on an exciting adventure that turned out to be even more rewarding than we had anticipated.

We arrived at Koné tired after the long drive, but we soon perked up once we saw the twin ultra-light aircrafts that were to carry us above part of the turquoise lagoon of New Caledonia.

A World Heritage Site since 2008, the New Caledonian lagoon is the largest in the world and encased by a barrier reef beyond belief.

The Heart of Voh

Blue Hole

PHOTOS BY MARIA RIVAROLA

Because ultra-light aircrafts – at least the high-performance microlight Virus Short Wing Pipistrel planes we were taking advantage of – can only fit one passenger and a pilot, we had what's known as the Duo Flight.

The Duo Flight involves separate aircraft leaving together, flying over the same area and in visual contact with other as well as audibly through helmet microphones.

It is a shared experience – together apart.

These planes are the fastest two-seaters in the world and are capable of covering 200km in just 45 minutes.

Our flights were an hour long, allowing us ample time to inhale the gorgeousness below.

Immediately after take-off the enormity of the natural beauty was evident.

Where to look first? Too much to see. Great problem to have. No problem at all.

I spotted an adult humpback whale with her calf, both breaching on the reef.

My pilot was stunned as he radioed the other plane and we all flew in for a closer look.

"First of the season," he said.

"You are so lucky. We have been looking for whales for the past couple of weeks and have not seen them until today."

Watching humpbacks from above as they frolicked in the water and suddenly (and repeatedly) burst out of it was quite the sight. Lucky indeed.

The reef provides spectacular views and in itself was a highly memorable experience.

But there was so much more to see.

As we approached the mangroves from above, there were many unusual giant shapes protruding.

The swamp had formed one formation that looked like a giant turtle. Another was named Snoopy by the pilots because it resembled the famous Peanuts comic strip character.

But then my pilot called over to my partner in the other plane and told her that I had actually snuck up to the coast the day before and carved out this huge heart below just for her.

"Yes I did!" I laughed through the microphone.

She didn't buy it.

The Heart of Voh is every bit as stunning as the photographs suggest.

We circled it for quite some time and I heard myself repeating the words: "Wow. Wow. Wow."

It takes its name from a nearby commune called Voh.

Inside the natural heart-shaped mangrove swamp is a weather monitor of some description. Our pilots told us that was the heart's pacemaker. Laughs all round.

As if that wasn't enough for one day.

The flight also took in breathtaking views of the Blue Hole – a sprawling 200-metre-deep hole of water inside an otherwise relatively shallow coral reef.

Stunning doesn't begin to describe it. I think I was even more impressed by Blue Hole than I was by the Heart of Voh.

On the flight back to the airstrip, the pilots made sure we still got to explore the reef from the sky.

We spotted stingrays and turtles from above... but couldn't find the whales again.

A Go-Pro attached to one wing of one plane gave us a visual record of the flight to take home.

We couldn't have asked for a better experience.

To make the most of our hire car and our time in New Caledonia – and to make sure we were completely exhausted by day's end – we chose to drive back to Noumea the long way, crossing the island and two mountain ranges to take in more picturesque views and some villages of the indigenous Kanak.

New Caledonia offers so much to see and do, but we had so little time.

I think we chose well.

# Jazzing it up gypsy style

BY CHRIS JOHNSON

Django Reinhardt

It was late one balmy night during a recent overseas holiday to Noumea (see this edition's travel pages), wandering around the marina when we heard it.

Live music calling to us from a nearby restaurant.

It was a German restaurant-bar. But New Caledonia is French and this music was typical of the traditional French gypsies.

It was gypsy jazz – or as the French call it, manouche.

We wandered over with enough time to have a drink at the bar while this three-piece outfit played their last few tunes for the night.

I had forgotten how much I enjoyed listening to gypsy jazz music.

It is fast, feel-good and contagious.

And this was the genuine article. We were in French territory, after all.

Two guitarists and a violinist made their instruments sing from the restaurant's alfresco dining area and the music permeated throughout the whole establishment.

I sneaked a peak to check if the guitarists were playing genuine gypsy jazz instruments.

They were. Of course they were.

Gypsy jazz guitars are built considerably different to most other acoustic guitars.

Their sound holes are either round but much smaller than the typical acoustic, or they are a D-shape hole.

These types of sound holes serve to create a more crisp sound; a bark even.

One style for rhythm and the other for high-pitched solo noodling.

The most famous champion of gypsy jazz music was Django Reinhardt, the Belgian-born, Romani French guitarist and composer who died in 1953 but is still regarded as one of the greatest musicians of the twentieth century.

Django (he belongs to that rare club where the mention of his first name alone lets most people know who is being referred to) lost the use of two fingers on his left hand as a very young man when they got burned in a caravan fire.

That did not stop his guitar playing. It merely served to help him create his own style of playing, which would become known as hot jazz guitar and later as gypsy jazz.

He revolutionised the guitar's appeal and potential.

A guitar teacher of mine once chastised me for complaining that my hands were not big enough to make the most of my instrument's fret board.

"No excuse!" the teacher scolded.

"Django didn't have two of his fingers and he became one of the best guitarists in the world."

In Paris in the 1930s, Django formed the Qunitette du Hot Club de France, which included master violinist Stéphane Grappelli.

Both men shot to enormous fame because of their inventive approach to jazz music.

I have a whole collection of Django Reinhardt records on vinyl – most featuring Grappelli – but it had been a while since I had put any of them on my turntable.

That changed after my chance encounter with a cool trio in Noumea.

I didn't speak to these musicians or even learn what they called themselves. But I enjoyed their sound.

It got me to thinking about gypsy jazz in Australia.

The style has quite a following here.

Brisbane and Melbourne probably have the biggest and most vibrant scenes of the music in the country. Sydney does okay too. And there are few good gypsy jazz clubs around.

There is also a number of excellent music festivals in Australia that feature artists and bands in the genre.

We have some quite brilliant home-grown gypsy jazz musicians – Jon Delaney, Peter Baylor, Ewan MacKenzie, Hank Marvin (not THAT Hank Marvin), Mimosa, Spyglass Gypsies, and Ultrafox – to name just a few.

Some outfits have singers while some are purely instrumental (which is how I prefer my gypsy jazz).

A frequent visitor to our shores is Django's great-nephew Lulo Reinhardt, one of the most outstanding jazz guitarists in the world today.

I saw him play live in a club once and was gobsmacked at his musicianship and proficiency.

For someone who loves both kinds of music – rock AND roll – seeing and hearing a gypsy jazz trio in New Caledonia was quite refreshing.

And it was a reminder that Django would have probably loved Led Zeppelin if he had lived long enough to hear them – but he would have also played the strings off of Jimmy Page.

# Blended

BY DR MICHAEL RYAN

1

I picked a grape, I picked another. I picked its cousin, instead of its brother.

Picked more, a brother from another mother. Picked the ring-ins, All different no bother.

Great in singles celebrated, but the sum of parts anticipated.

No single vineyard intended, wine from the hand of man, Blended!

In the spirt of trying to keep my writing fresh I thought I would blend some words together to introduce the topic of wine blending. It can be a vigorously debated topic between puritans who impress the importance of single vineyard, single variety and vintage with the winemaker being a steward rather than a master. On the other hand blended wine is often called the "wine makers wine".

2

Blending has occurred since the beginning of wine making. The great Bordeaux's are various combinations of merlot, cabernet sauvignon, malbec, petit Verdot, cabernet franc. Champagne is a blend often of Pinot noir, Chardonnay and Pinot Minuer.

In a way like great perfume houses, the skill of blending to have a commercially stable product out ways the art of expression. Penfolds would have to be the greatest blenders in the world.

3

Australians have become self-educated and excelled in the skill of blending. This has often come about by the lack of grape to make commercial quantities. Max Schubert wanted to make a great Bordeaux blend but there wasn't enough quality Cabernet Sauvignon. Lucky we swim in a lake of Shiraz. So Penfolds Grange has become a blend of Shiraz and Cabernet with only a handful of pure Shiraz vintages.

Australians love affair with its unique Shiraz Cabernet blend has been perpetuated by great wines like Yalumba Signature and Penfolds 389. Australians blending of white grapes Semillon and sauvignon blanc, originating in Western Australia , has produced some truly mouth-watering and cellar worthy wines. The old Houghton's White Burgundy

Shouldn't the mantra be- Make it to taste good? Extrapolating from the Rhone blends of Grenache and shiraz, Australian wine making icon Charles Melton pioneered the GSM blends of Grenache, Shiraz and Mouvedre. Who would have thought adding white to red would work? Viognier can be added to shiraz to lift its aromatics. Then of course dichotomies exist such as adding Shiraz and pinot noir, as done by the late Maurice O'Shea.

The public gets what the public needs. The wine maker is allowed 15 per cent of a different variety, year and geography but still call it a straight wine. Mathematically it is possible to end up with only about 60 per cent of what is labelled.

My mate Dave Lehman of David Franz wines loves his self-entitled wine – The Larrikin. He has orphaned parcels of grapes that remain in the same proportion each year and in a sense, it is a hybrid – use what the vineyard gave you but tweak it with a desirable ratio.

Some of the more exotic blends in Australia have included Tempranillo and Touriga Nacional, Nebbiolo and Barbera and Sangiovese, Cabernet, Nebbiolo and Shiraz.

## Wines to try

**1 S.C.Panell Tempranillo Touriga McLaren Vale 2015**

If you can find this aromatic spicy red that balances the fruit of Tempranillo and the slight grittiness of the Touriga. Plush fruit and good structure- have with "fully charged" Spanish meatballs.

**2 Quealy Pobblebonk Mornington Peninsula 2015**

Is made from Moscato Giallo and Riesling blended with Friulano, Pinot Grigio and Chardonnay. Intense aromatic wine with notes of florals over melons and grapefruit. Lively white on the palate with mild acidity. Have with some oily fish such as sardines.

**3 Mt Mary Quintets Yarra Valley 2013**

Dr John Middleton's baby started in1971. Bordeaux varieties of Cabernet Sauvignon, Merlot, Cabernet Franc, Petit Verdot and Malbec are used. Complex deep purple colour. Complex berry fruits, hints of cabernet dust and layers of brambly notes. Full flavour, restrained in its attack but supported by obvious tannins.

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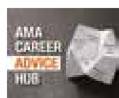


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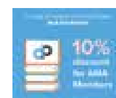


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