

A U S T R A L I A N

# Medicine

The national news publication of the Australian Medical Association

# PHI

## Politically Hot Insurance

### INSIDE

Debate heats up, p7

Productivity Commission, p8

Indigenous Medical Scholarship, p11

Australia Day Honours, p12

MBS Review update, p14

UK doctor struck off, p29



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A U S T R A L I A N  
**Medicine**

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## AMA LEADERSHIP TEAM



**President**  
Dr Michael Gannon



**Vice President**  
Dr Tony Bartone

## In this issue

**National news** 7-15

---

**World news** 29

---

**Health on the Hill** 26

---

**Research** 27-28

---

### Columns

---

- 3 PRESIDENT'S MESSAGE
- 5 VICE PRESIDENT'S MESSAGE
- 6 SECRETARY GENERAL'S REPORT
- 16 OPINION
- 18 GENERAL PRACTICE
- 19 PUBLIC HEALTH OPINION
- 20 RURAL HEALTH
- 21 DOCTORS IN TRAINING
- 22 AMSA
- 23 MEDICAL PRACTICE
- 24 PUBLIC HOSPITAL DOCTORS
- 25 ETHICS AND MEDICO LEGAL
- 30 BOOK REVIEW
- 31 MOTORING
- 32 MUSIC
- 34 TRAVEL
- 35 MEMBER SERVICES



# Getting results for our members

BY AMA PRESIDENT DR MICHAEL GANNON

Last year was a very busy and very successful year for the Federal AMA. Your elected representatives and the hardworking staff in the Secretariat in Canberra delivered significant achievements in policy, advocacy, political influence, professional standards, doctors' health, media profile, and public relations.

We worked tirelessly to ensure that health policy and bureaucratic processes were shaped to provide the best possible professional working environments for Australian doctors and the highest quality care for our patients.

Our priority at all times was to provide value for your membership of the AMA.

I would like to provide you with a summary of the work we undertook in 2017 on behalf of you, our valued members.

## General Practice and Workplace Policy

- Our strong advocacy led to a decision to **lift the freeze** on Medicare patient rebates.
- AMA coordination of Doctors' Health Services around the country, with funding support from the Medical Board of Australia.
- Launched the AMA Safe Hours Audit Report, giving added focus to the issue of doctors' health and wellbeing.
- Maintained a strong focus on medical workforce and training places, with the National Medical Training Network significantly increasing its workforce modelling and projection work following sustained advocacy by the AMA.
- Secured a number of concessions in the proposed redesign of the Practice Incentive Program (PIP), as well as a delay in the introduction of changes.
- Lobbied at the highest level for a more durable solution to concerns over Pathology collection centre rents, focusing on effective compliance, and achieving a fair balance between the interests of GP members and pathologist members.
- Led the Reforms to After-hours GP services provided through Medical Deputising Services (MDSs) to ensure that these services are better targeted and there is stronger communication between the MDS and a patient's usual GP.
- Successfully lobbied the ACCC to renew the AMA's existing authorisation that permits GPs to engage in intra-practice price setting, potentially saving GPs thousands of dollars annually in legal and other compliance costs.
- Ensured a proportionate response from the Government in response to concerns over the security of Medicare card numbers, avoiding more draconian proposals that would have

added to the compliance burden on practices, and added a barrier to care for patients.

## Medical Practice

- Fundamentally altered the direction of the Medical Indemnity Insurance Review, discussing its importance to medical practice at the highest level, helping to ensure the review is not used as a blunt savings exercise, and saving doctors and their patients millions of dollars in increased premiums.
- Led a nationally co-ordinated campaign with the State AMAs and other peak bodies to uphold the TGA's decision to up-schedule Codeine.
- Campaigned against an inadequate, poorly conceived, and ideological National Maternity Services Framework, which has now been scrapped.
- Campaigned on the issue of Doctors' Health and the need for COAG to change mandatory reporting laws, promoting the WA model.
- Launched the AMA Public Hospital Report Card.
- Pressed the case for vastly improved Private Health Insurance products through membership of the Private Health Ministerial Advisory Committee (PHMAC), my annual National Press Club Address, an appearance before a Senate Select Committee, and regular and ongoing media and advocacy.
- Launched the AMA Private Health Insurance Report Card.
- Successfully convinced the Government to address concerns with the MBS Skin items, and will continue to do so with the MBS Review more broadly.
- Successfully lobbied for changes to the direction of the Anaesthesia Clinical Committee of the MBS Review.
- Launched a new AMA Fees List with all the associated benefits of mobility and regular updates.
- Saw a number of our Aged Care policy recommendations included in a number of Government reviews.
- Lobbied against the ill-thought-out Revalidation proposal, which resulted in a vastly improved Professional Performance Framework based around enhanced continuing professional development.
- Successfully held off the latest attempt to have a non-Medical Chair of the Medical Board of Australia appointed.

## Public Health

- Launched the AMA Indigenous Health Report Card, which this year focused on ear health, and specifically chronic otitis





## Getting results for our members

media, in conjunction with the Minister for Indigenous Health, The Hon Ken Wyatt AM.

- Led the medical community by being the first to release a Position Statement on Marriage Equality, and advocated for the legislative change that eventuated in late 2017.
- Released the updated AMA Position Statement on Obesity, following a policy session at the AMA National Conference, which brought together representatives from the medical profession, sports sector, food industry, and health economists.
- Launched the AMA Position Statement on an Australian Centre for Disease Control (CDC), which was welcomed by experts in communicable diseases.
- Released the AMA Position Statement on Female Genital Mutilation, which provided a platform for the AMA to engage in advocacy on preventing this practice.
- Released the AMA Position Statement on Infant Feeding and Maternal Health.
- Released the progressive and widely-supported AMA Position Statement on Harmful substance use, dependence, and behavioural addiction (Addiction).
- Successfully lobbied against the proposal to drug test welfare recipients, including a strongly worded submission to a Parliamentary Inquiry on the proposal, which resulted in defeat of the proposed measure in the Parliament.
- Released the AMA Position Statement on Firearms, generating considerable media coverage and interest, in Australia and overseas. Most importantly, it is a factor in Australia maintaining its tough approach to gun control.
- Released the AMA Position Statement on Blood Borne Viruses (BBVs), which called for needle and syringe programs (NSPs) to be introduced in prisons and other custodial settings to reduce the spread of BBVs. This policy has been promoted by other health organisations and saw the AMA create strong ties within the sector.
- Ongoing and prominent advocacy for the health and wellbeing of Asylum Seekers and Refugees, including a meeting with the Minister for Immigration and Border Protection, The Hon Peter Dutton MP, and lobbying on behalf of individual patients behind the scenes.
- AMA lobbying of manufacturers saw a change to the sale of sugar-sweetened beverages in some remote Aboriginal communities, which will improve health outcomes.
- Promoted the benefits of Immunisation to individuals and the broader community. Our advocacy has contributed to an increase in child and adult vaccination rates.
- Provided strong advocacy on climate change and health.

- Consistently advocated for better women's health services.
- Lobbied for the establishment of a No-Fault Compensation Scheme for people adversely affected by vaccines.

We promoted our carefully-constructed Position Statement on Euthanasia and Physician Assisted Suicide during consideration of legislation in Tasmania, Victoria, NSW, and WA.

I had face-to-face meetings with Prime Minister Malcolm Turnbull, Opposition Leader Bill Shorten, Health Minister Greg Hunt, Shadow Health Minister Catherine King, Greens Leader Dr Richard Di Natale, and a host of Ministers and Shadow Ministers.

We organised lunch briefings with backbenchers from all Parties to promote AMA policies.

In July 2017, our advocacy was publicly recognised when the Governance Institute rated the AMA as the most ethical and successful lobby group in Australia.

I met regularly with stakeholders across the health sector, including the Colleges, Associations, and Societies, other health professional groups, and consumer groups.

As your President, I was active on the international stage, representing Australia's doctors at meetings in Zambia, Britain, Japan, and the United States.

The highlight of the 2017 international calendar was the annual General Assembly of the World Medical Association. Outcomes from that meeting included high level discussions on End-of-life care, numerous ethical issues, Doctors' health, and an editorial revision of the Declaration of Geneva.

But our focus remained at home, and your AMA was very active in promoting our Mission: *Leading Australia's Doctors – Promoting Australia's Health*.

We had great successes. We earned and maintained the respect of our politicians, the bureaucracy, and the health sector. We won the support of the public as we have fought for a better health system for all Australians.

We worked hard to add even greater value to your AMA membership.

Already in 2018, we have released new Position Statements on Mental Health, Road Safety, Nutrition, Organ Donation and Transplantation, and Rural Workforce.

It has been a great honour to serve you as President since 2016. I still have five months to go. There is so much more work to do, and it will be done. Along with all the AMA family, I will continue to add value to your membership.



# PHI concerns won't go away by themselves

BY AMA VICE PRESIDENT DR TONY BARTONE

The Government has announced the latest price rise for private health insurance (PHI) premiums, which will kick in from April.

They are going up by almost 4 per cent (3.95%) and will amount to some families paying more than \$140 a year extra for their cover. It is the lowest premium rise since 2001, but it is still well ahead of the inflation rate. Despite health inflation running at a significantly higher rate than CPI (and this is part of the problem), this latest rise continues the trend of many recent years of significant increases. The end result is that some families are going to find this very tough to manage.

Consumer group CHOICE has already put out the call for people to consider whether they should keep their insurance cover. While the AMA does not support calls to drop out of the private system, this does raise the question again of whether patients are getting value for money from their PHI premiums.

PHI is a significant cost for all families and individuals. When increases are running ahead of inflation year-on-year, it adds a significant level of burden. Wages are not growing. Cost pressures are building in the average family budget. Some people who are average weekly wage earners will be looking at their insurance and making a decision on whether to maintain it.

It is a question my patients regularly ask me. They will have to see whether the household budget can sustain these increases; especially if they have a product that's not delivering them any value; especially if they have a product that's too difficult to understand; especially if they have a product that's left them with a nasty out-of-pocket experience.

Imagine how they feel when they find out, after being a member of their fund for years and years, that they are not being covered for a condition they thought they were covered for and at the time when they need it.

This is separate to the public discussion on increasing gap shock directly resulting from the extended freeze for many years of MBS and PHI rebates and in stark contrast to very high levels of "known and no" gap rates of fees charged by private specialists.

If you've got a product that's increasing in cost but still delivering increasingly poor value, well the decision becomes an easier one for a family that's struggling. We know that Australians are opting out at significant rates, and any decision to continue to opt out will ultimately put stress on the entire system, not just the private system but the public hospital system as well.

Essentially, we believe that any policy that fails to deliver what you believe you're covered for, and doesn't have the clarity or the information or transparency about what you've purchased, is a junk policy.

There are a number of policies out there that do no more than

basically cover you for public hospital treatment.

We need to ensure that there is clarity. We need to know that there is consumer information about the type of product – a premium, a middle of the road, and a basic product. There needs to be information about restrictions and any exclusions. We don't support restrictions on policy, and it's important that consumers are fully aware of what they're covered for in any environment and in any situation when it comes to inpatient costs (as distinct from any of the additional outpatient costs) of any health treatment they obtain.

PHI is already the beneficiary of significant tax incentives by the Government. Further attempts to increase the taxation requirements or the taxation demand on Australians to support PHI is only going to deliver less of an attractive option.

Calling for an increase in the Medicare levy still avoids the issue at heart. The issue is one of value. We need a product that delivers more value to the Australian public, to the Australian consumer. Forcing them, by using a stick of an increase in the Medicare levy, is to miss the issue on the table: that the product lacks value. The product lacks clarity, and it lacks transparency.

Consumers need more value, more transparency, more clarity in what they're purchasing, so that when they need their insurance and they make a call on their insurance, they know exactly what they're going to get and they're not left with a nasty surprise. That's the issue on the table. That's what needs to be clarified. Using a stick will only create a further disincentive to maintaining the insurance that's required.

There is currently a review committee underway and the AMA is calling on the Government to ensure that all parties, all stakeholders, sit down and try to improve and clarify for consumers. There are far too many policies out there, with significant restrictions, caveats, exclusions, fine print. It's just too much. You need a double degree to read through those policies.

And there's no point paying years and years of health insurance if, when you really need it, it isn't worth the paper it's written on. It is time for the PHI industry to lift its game – if not voluntarily, then by having its hand forced by Government.

Yes it's true that new technologies, an ageing population and increasing chronic disease rates are also an important part of the ongoing increases in PHI premiums but these are factors putting pressure on the whole health system. It sharply brings into focus the question of investment in prevention in good primary care and the resulting benefits for the whole system. All the pillars of our whole health system need to bear the weight.

Australia has a strong private health sector and we need an insurance system that encourages its use rather than turns consumers away.



## Election year for the AMA

BY AMA SECRETARY GENERAL ANNE TRIMMER

“I encourage eligible members with an interest in the development of AMA policy to consider nominating for one of the elected positions.”

With 2018 now well underway, following a busy holiday season of media and policy statements released by the AMA, attention now turns to preparation for the year ahead and key reports to be released in coming weeks.

This year is an election year for Federal AMA. Voting members will have received an email calling for nominations for the elected positions on Federal Council. There is also an advertisement calling for nominations in this edition of *Australian Medicine*. Federal Council is the primary policy-setting body of the Federal AMA and as such should represent the breadth and diversity of AMA membership.

The elected positions represent:

- Geographic Areas (six positions);
- Practice Groups (five positions); and
- Specialty Groups (12 positions).

Each Practice Group has its own Council with the elected representative of that Practice Group on Federal Council also becoming the Chair of the Practice Group Council. It is for this reason that the specialty of General Practice is represented as a Practice Group rather than a specialty.

I encourage eligible members with an interest in the development of AMA policy to consider nominating for one of the elected positions. A voting member may nominate for one specialty only but may nominate for whichever Practice Group is relevant to their practice (and this may be more than one). For example, a doctor in training working in a rural general practice could be assigned to three Practice Groups – Rural Doctors, Doctors in Training, and General Practice – with an entitlement

to vote for the representative of each of these Groups.

Where there is a contested position, an election will be held during March by electronic ballot. The successful candidates will take up their position on Federal Council following the close of the 2018 National Conference at the end of May. The positions of President and Vice President are elected at National Conference. Nominations for these positions are called in April.

Members may recall the announcement at the 2017 Annual General Meeting of the decision by the Board to sell AMA House in Canberra in order to invest the funds for an improved return on members' assets. Following an international campaign by Colliers, the Board received an outstanding offer for the property in late 2017. It is anticipated that by the time this edition of *Australian Medicine* is published, settlement of the sale will have completed.

The Investment Committee of the Board has been working closely with the AMA's external investment advisers to ensure appropriate management of the sale proceeds. Given the age of the property and the challenging Canberra commercial leasing market, it is anticipated that the external investment of funds will produce better returns. The purchaser of the property has a commitment to improving the sustainability of buildings through improving their energy efficiency and reducing their environmental impact.

AMA retains naming rights to the property and will remain the anchor tenant.

Best wishes for a productive and interesting 2018.

# Debate heats up as PHI premiums rise

Private health insurance continues to dominate political debate, with the Government approving a 3.95 per cent increase in premiums while the Labor Opposition promises to crack down on the industry.

Private health insurance (PHI) premiums will rise by almost \$150 a year for most families from April 1, following Health Minister Greg Hunt's nod to the providers to hike their fees twice as much as the rate of inflation – which last year was about 2 per cent.

The Minister points out, however, that the increase is the lowest since 2001 and would have been much higher if he hadn't reined the insurers in.

Last year's PHI premium increase was 4.84 per cent.

"Already, the significant private health insurance reforms that we announced in October last year have made an impact and they will continue to drive down costs," Mr Hunt said.

The Minister said the Government's reforms included \$6.4 billion every year to the PHI rebate, and \$1.1 billion savings to the prostheses list.

But Opposition Leader Bill Shorten has put the health insurance industry on notice, using an address to the National Press Club to declare that premium increases were out of control and that business as usual could not be sustained.

He said the PHI industry was becoming "a con".

A few days later, the Opposition Leader announced plans to cap PHI increases to 2 per cent for two years in order to save families an average of \$340.

He said Australians were tired of being "ripped off" by premium hikes.

Mr Shorten said his plan was a cost-of-living measure.

"The idea that taxpayers pay \$6 billion a year to the big insurers, the idea these big insurers are making record profits and yet the premiums keep going up and up... can't be sustained," he said.

"Business as usual won't cut it any longer for private health insurance."

The Opposition Leader also promised that if elected, a Labor government would ask the Productivity Commission to review the whole private healthcare industry, with a focus on its value and quality.

Labor's move brought immediate condemnation from the insurance lobby, but high praise from consumer groups.

Prime Minister Malcolm Turnbull accused Labor of trying to

destroy the PHI industry and said Mr Shorten was making up policy on the run.

Mr Shorten and Shadow Health Minister Catherine King rejected the accusation and said private health insurance played an important role in Australia's health system.

"But under Malcolm Turnbull, Australians are questioning the cost and value of private health more than ever," they said in a statement.

"The Turnbull Government is failing to address this crisis and help Australians with the affordability of private health insurance, and as a result, people are walking away from private health altogether.

"Labor is choosing to put Australian families first, instead of the interests of the multibillion-dollar private health industry."

The AMA has been at the forefront of the PHI debate and has repeatedly called for junk policies to be banned.

AMA President Dr Michael Gannon acknowledged Mr Hunt's role in keeping this year's premium hike to a lower rate than has previously been the case, but he said much more needed to be done to ensure consumers were getting value for money.

"Everyone should be asking what they're paying for," Dr Gannon said.

"Too often, patients or their loved ones find out only when they get sick that the cover they've purchased is not fit for purpose.

"There are too many policies where there are exclusions, carve-outs, caveats. The most egregious of these policies are those that tell you that you're entitled to treatment as a private patient in a public hospital.

"Well, if you're an Australian citizen, you're entitled to free treatment in public hospitals, and there's no discernible advantage. I've said many times that I need to be convinced why that's not junk. It's a level of coverage which does not support universal health care, and we think it's a problem."

AMA Vice President Dr Tony Bartone said PHI policies were far too confusing for consumers and there needed to be a simplification.

"Any increase on a product that's not offering value to its consumers has got to be a concern," Dr Bartone said.

"We've been asking for better value products, not products that actually increase in cost."

CHRIS JOHNSON

# GPs highly efficient – Productivity Commission

Medical patients across Australia are highly satisfied with their GPs, according to the latest Productivity Commission report, which also found general practice to be the most efficient component of the health system.

The *Productivity Commission Report on Government Services 2018* has found Australia's general practice sector to be both cost effective and highly efficient.

But the report also shows that Australian Government total expenditure on GP services per person only grew by 80 cents between 2015-16 and 2016-17 – from \$370.60 to \$371.40

AMA President Dr Michael Gannon said the report highlights the funding pressure that general practice continues to operate under, and the pressing need for the Government to deliver new real investment in general practice in this year's Budget.

"A well-resourced general practice sector can help keep patients out of hospital and save the health system money," Dr Gannon said.

"GPs are providing more services for patients as the population gets older and, despite this pressure, satisfaction with these services remains high.

"The next Budget is a genuine opportunity to recognise and reward quality general practice."

Dr Gannon said the Productivity Commission confirmed that the quality and productivity of Australia's GPs is up with the best in the world.

Its report, he said, offered compelling evidence that the Government must provide greater support for general practice.

The number of GP services in 2016-17 was 6.5 per annum per head of population, which is up from 5.9 services per head of population in 2011-12.

"This reflects growing demand for GP services in the community due to the impact of complex and chronic disease, as well as an increase in GP numbers," Dr Gannon said.

"There were 105.9 full service equivalent GPs per 100,000 population in 2016-17, compared to 82.9 per 100,000 population in 2011-12.

"Around 75 per cent of patients could get a GP appointment within 24 hours in 2016-17, which is consistent with previous years.

"Significantly, cost does not appear to be a significant barrier for patients who need to see a GP, with only 4.1 per cent of patients saying that they deferred accessing GP services due to cost."

CHRIS JOHNSON

## Long-term investment for serious reform

The AMA has delivered its Pre-Budget Submission 2018-19 to the Government and released it publicly while calling for a new era of big picture health reform.

In releasing the submission, AMA President Dr Michael Gannon said the Government had a rare opportunity to initiate serious health reform, due to the culmination of a number of key health policy reviews.

But, he said, any reform will need significant long-term investment.

"The conditions are ripe for a new round of significant and meaningful health reform, underpinned by secure, stable, and sufficient long-term funding to ensure the best possible health outcomes for the Australian population," Dr Gannon said.

"The next Budget provides the Government with the perfect opportunity to reveal its health reform vision, and articulate clearly how it will be funded.

"There is no doubt, as shown at the last Federal election, that health policy is a guaranteed vote winner – or vote loser," Dr Gannon said.

"Our submission sets out a range of policies and recommendations that are practical, achievable, and affordable.

"They will make a difference. We urge the Government to adopt them in the Budget process.

"Health should never be considered an expensive line item in the Budget.

"It is an investment in the welfare, wellbeing, and productivity of the Australian people.

"Health is the best investment that governments can make."

The submission can be found at <https://ama.com.au/ama-pre-budget-submission>

It was lodged with Treasury ahead of the Friday, 15 December 2017 deadline.

CHRIS JOHNSON





# AMA Public Health Awards 2018 Call for Nominations

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

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

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

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

**Nominations are sought in the following categories:**

## AMA EXCELLENCE IN HEALTHCARE AWARD

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

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

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

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

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

## AMA WOMAN IN MEDICINE AWARD

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

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

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

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

## AMA WOMEN'S HEALTH AWARD

The AMA Women's Health Award goes to a person or group, who does not necessarily have to be a doctor or female, but who has made a major contribution to women's health by:

- Promoting and contributing to public health initiatives; and/or
- Initiating, participating and promoting health awareness campaigns; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of women's health.

Nominations for this award can be submitted by any member of the community. This award was presented last year to Ms Eleanor Crighton.

## AMA MEN'S HEALTH AWARD

The AMA Men's Health Award goes to a person or group, who does not necessarily have to be a doctor or male, but who has made a major contribution to men's health by:

- Promoting and contributing to public health initiatives; and/or
- Initiating, participating and promoting health awareness campaigns; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of men's health.

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

## AMA YOUTH HEALTH AWARD

The AMA Youth Health Award goes to a young person or group of young people, 15-27 years of age, who have made an outstanding contribution to the health of young Australians by:

- Promoting and contributing to youth health initiatives; and/or
- Initiating, promoting or participating in youth health awareness; and/or
- Development of youth health promotion programs.

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

## NOMINATION INFORMATION

### How are nominations assessed?

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

### How do I make a nomination?

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

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

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

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



## 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
<b>Dr Tony Bartone</b>	AMA Vice President	Aged Care Workforce Strategy Taskforce Summit	04/12/17
<b>Dr Richard Kidd, Dr Chris Moy, Dr Tony Bartone</b>	Chair - Council of General Practice, Federal Councillor, AMA Vice President	My Aged Care Referrals and Health Integration Workshop	29/11/17
<b>Dr Richard Kidd</b>	Chair - Council of General Practice	United General Practice Australia (UGPA)	15/12/17
<b>Dr Richard Kidd</b>	Chair - Council of General Practice	DVA Health Consultative Forum	1/11/17
<b>Dr Richard Kidd</b>	Chair - Council of General Practice	DVA Health Consultative Forum	1/11/17
<b>Dr Tony Bartone</b>	AMA Vice President	National Medical Training Advisory Network	08/12/2017
<b>Dr John Zorbas</b>	Chair - AMA Council of Doctors in Training	National Medical Training Advisory Network	08/12/2017
<b>Dr Richard Kidd</b>	Chair - Council of General Practice	TGA Nationally Coordinated Codeine Implementation Working Group (NCCIWG)	24/1/2018
<b>Dr Richard Kidd</b>	Chair - Council of General Practice	Health Sector Group meeting	13/2/2018
<b>Dr Tony Bartone / Dr Simon Torvaldsen</b>	AMA Vice President / AMA Council of General Practice Councillor	TGA Medicine Shortages Working Group	24/11/17
<b>Dr Tony Bartone</b>	AMA Vice President	TGA Advisory Committee on Medicines Scheduling	21/11/17

# Enthused about Indigenous Medical Scholarship



Dr Kelvin Kong

It is pretty hard to imagine someone being more inspirational than Associate Professor Kelvin Kong.

Australia's first Indigenous surgeon – having qualified as the first Aboriginal Fellow of the Royal Australasian College of Surgeons and specialising in otolaryngology, head and neck surgery – he is passionate about bridging the health gap between Indigenous and non-Indigenous Australians.

Hailing from the Worimi people of Port Stephens, he now practices paediatric and adult ear, nose and throat surgery at Newcastle, NSW. He also lectures there.

His career to date is impressive and he is hugely committed to helping others pursue their own goals. Describing Dr Kong as enthusiastic would be an understatement.

Included in his long list of accolades is the AMA Indigenous Medical Scholarship.

A young Kelvin was the scholarship's recipient in 1997.

Australian Medicine asked Dr Kong how important it was then to receive the award and how it seems now in retrospect.

"At the time it was extremely important," he said.

"It wasn't a huge amount of money, but for me it was. It certainly wasn't a little amount of money, but I wouldn't have cared if it was five bucks.

"The biggest impact it had on me was being recognised by my colleagues and the medical fraternity as someone who is legitimate.

"I was being told that I can make a contribution. I stand very proud as a recipient of this scholarship. I hope it has paid off and I hope those who sponsored it believe their contribution was worthwhile.

"I was mid-career with my studies, year 3-4, and at a time when we are pouring beers, waiting tables and all that kind of stuff just trying to get through.

"This meant I could pay my bills and put food on the table and spend more time trying to feel normal.

"It is important in retrospect to acknowledge the pure fact that the AMA thought that this was a big enough issue to get its Board to recognise and seek to fund.

"That was huge. It says a lot about the AMA as an organisation that it had that vision.

"Medicine is hugely competitive, so to get some acknowledgement is very important. It gave me a lot of inroads into mentorship and leadership and allowed me to contact people with similar values to me.

"Australia is a diverse community and so is its medical community. This was normalising that it's ok to achieve.

"In the Aboriginal community and in the wider community there can be this misconception that people are 'getting in' on the back of them being Aboriginal. The actual fact is, there are a lot of hugely talented people in the Aboriginal community who will make an enormous contribution to medicine.

"That was a great vision and I am eternally grateful for being given that morale boost."

Dr Kong has used his scholarship, and all of the honours that followed, to help him play his part in addressing the disparity – not only in health outcomes, but in career opportunities – between Indigenous and non-Indigenous Australians.

"It is important to acknowledge the disparity of opportunities for people who live in the same country," he said.

"We have a very robust medical industry. I know there is talk of maybe awarding two of these scholarships each year. I think it would be fabulous if there were ten.

"I was asking myself 'how can the AMA enhance this more?' and I thought that maybe one way is by increasing the number of scholarships – increasing the number of donors.

"There is a greater awareness among Australia and the medical community that this is genuinely important and we give value to it. It gives me that boost. It must give donors that boost too.

"We have this disparity in health outcomes, but there is a genuine desire in governments, in associations like the AMA, and in the community to address this.

"I am extremely lucky, first and foremost. I love my profession. I love my work. I love coming to work.

"As a Worimi man, I am heartened that we are as an Australian community seeking to address this disparity.

"I live a fantastic lifestyle. But my mother never had this opportunity, my Nan never had this opportunity.

"They would have done a better job."

He says with a smile.

CHRIS JOHNSON

Information about donations towards the Indigenous Medical Scholarship can be found at: <https://ama.com.au/donate-indigenous-medical-scholarship>



# AMA shines in Australia Day Honours

Former Australian Medical Association President Dr Mukesh Haikerwal has been awarded the highest honour in this year's Australia Day awards by being named a Companion of the Order of Australia (AC).

He is accompanied by the current Editor-in-Chief of the *Medical Journal of Australia*, Laureate Professor Nick Talley, as well as longstanding member Professor Jeffrey Rosenfeld – who both also received the AC.

The trio top a long and impressive list of AMA members to receive Australia Day Honours this year.

AMA Federal Councillor, Associate Professor Julian Rait, received the Medal of the Order (OAM).

A host of other members honoured in the awards are listed below.

AMA President Dr Michael Gannon said the accolades were all well-deserved and made he made special mention of those receiving the highest Australia Day Honours.

“They have dedicated their lives and careers to helping others through their various roles as clinicians, researchers, teachers, authors, administrators, or government advisers – and importantly as leaders in their local communities,” Dr Gannon said.

“On behalf of the AMA, I pay tribute to all the doctors and other health professionals who were honoured today for their passion for their profession and their dedication to their patients and their communities.

“The great thing about the Honours is that they acknowledge

achievement at the international, national, and local level, and they recognise excellence across all avenues of human endeavour.

“Doctors from many diverse backgrounds have been recognised and honoured again this year.

“There are pioneering surgeons and researchers, legends across many specialties, public health advocates, researchers, administrators, teachers, and GPs and family doctors who have devoted their lives to serving their local communities.

“The AMA congratulates all the doctors and other health advocates whose work has been acknowledged.

“We are, of course, especially proud of AMA members who are among the 75 people honoured in the medicine category.”

Dr Haikerwal, who was awarded the Officer in the Order of Australia (AO) in 2011, said this further honour was “truly mind-blowing” and another life-changing moment.

“To be honoured on Australia Day at the highest level in the Order of Australia is beyond imagination, beyond my wildest dreams and extremely humbling,” Dr Haikerwal said.

“For me to be in a position in my life and career to receive such an honour has only been made possible due to the unflinching support and unremitting encouragement of my closest circle, the people who have been with me through every step of endeavour, adversity, achievement, and success.”

CHRIS JOHNSON

## AMA MEMBERS IN RECEIPT OF HONOURS

### Companion (AC) In The General Division



**Dr Mukesh Chandra HAIKERWAL AO**

For eminent service to medical governance, administration, and technology, and to medicine, through leadership roles with a range of organisations, to education and the not-for-profit sector, and to the community of western Melbourne.

### **Professor Jeffrey Victor ROSENFELD AM**

For eminent service to medicine, particularly to the discipline of neurosurgery, as an academic and clinician, to medical research and professional organisations, and to the health and welfare of current and former defence force members.

### **Professor Nicholas Joseph TALLEY**

For eminent service to medical research, and to education in the field of gastroenterology and epidemiology, as an academic, author and administrator at the national and international level, and to health and scientific associations.





## Officer (AO) In The General Division

### **Emeritus Professor David John AMES**

For distinguished service to psychiatry, particularly in the area of dementia and the mental health of older persons, as an academic, author and practitioner, and as an adviser to professional bodies.

### **Dr Peggy BROWN**

For distinguished service to medical administration in the area of mental health through leadership roles at the state and national level, to the discipline of psychiatry, to education, and to health care standards.

### **Professor Creswell John EASTMAN AM**

For distinguished service to medicine, particularly to the discipline of pathology, through leadership roles, to medical education, and as a contributor to international public health projects.

### **Professor Suzanne Marie GARLAND**

For distinguished service to medicine in the field of clinical microbiology, particularly to infectious diseases in reproductive and neonatal health as a physician, administrator, researcher and author, and to professional medical organisations.

### **Dr Paul John HEMMING**

For distinguished service to higher education administration, to medicine through contributions to a range of professional medical associations, and to the community of central Victoria, particularly as a general practitioner.

### **Professor Anthony David HOLMES**

For distinguished service to medicine, particularly to reconstructive and craniofacial surgery, as a leader, clinician and educator, and to professional medical associations.

### **Dr Diana Elaine O'HALLORAN**

For distinguished service to medicine in the field of general practice through policy development, health system reform and the establishment of new models of service and care.

## Member (AM) In The General Division

### **Dr Michael Charles BELLEMORE**

For significant service to medicine in the field of paediatric orthopaedics as a surgeon, to medical education, and to professional medical societies.

### **Dr Colin Ross CHILVERS**

For significant service to medicine in the field of anaesthesia as a clinician, to medical education in Tasmania, and to professional societies.

### **Associate Professor Peter HAERTSCH OAM**

For significant service to medicine in the field of plastic and reconstructive surgery as a clinician and administrator, and to medical education.

### **Professor Ian Godfrey HAMMOND**

For significant service to medicine in the field of gynaecological oncology as a clinician, to cancer support and palliative care, and to professional groups.

### **Dr Philip Haywood HOUSE**

For significant service to medicine as an ophthalmologist, to eye surgery foundations, and to the international community of Timor Leste.

### **Adjunct Professor John William KELLY**

For significant service to medicine through the management and treatment of melanoma, as a clinician and administrator, and to education.

### **Dr Marcus Welby SKINNER**

For significant service to medicine in the field of anaesthesiology and perioperative medicine as a clinician, and to professional societies.

### **Professor Mark Peter UMSTAD**

For significant service to medicine in the field of obstetrics, particularly complex pregnancies, as a clinician, consultant and academic.

### **Professor Barbara S WORKMAN**

For significant service to geriatric and rehabilitation medicine, as a clinician and academic, and to the provision of aged care services.

## Medal (OAM) in the general division

### **Professor William Robert ADAM PSM**

For service to medical education, particularly to rural health.

### **Dr Marjorie Winifred CROSS**

For service to medicine, particularly to doctors in rural areas.

### **Associate Professor Mark Andrew DAVIES**

For service to medicine, particularly to neurosurgery.

### **Dr David William GREEN**

For service to emergency medicine, and to professional organisations.

### **Dr Barry Peter HICKEY**

For service to thoracic medicine.

### **Dr Fred Nickolas NASSER**

For service to medicine in the field of cardiology, and to the community.

### **Dr Ralph Leslie PETERS**

For service to medicine, and to the community of the Derwent Valley.

### **Associate Professor Julian Lockhart RAIT**

For service to ophthalmology, and to the development of overseas aid.

### **Mr James Mohan SAVUNDRA**

For service to medicine in the fields of plastic and reconstructive surgery.

### **Dr Chin Huat TAN**

For service to the Chinese community of Western Australia.

### **Dr Karen Susan WAYNE**

For service to the community of Victoria through a range of organisations.

### **Dr Anthony Paul WELDON**

For service to the community, and to paediatric medicine.

## Public service medal (PSM)

### **Dr Sharon KELLY**

For outstanding public service to the health sector in Queensland.

### **Professor Maria CROTTY**

For outstanding public service in the rehabilitation sector in South Australia.

# Medicare Benefits Schedule Review update

The MBS Review Taskforce continues its work into 2018, with the next round of public consultations expected for release in February.

In the meantime, a number of clinical committees have yet to begin. The Department of Health's MBS Review team is currently accepting nominations from medical practitioners with the relevant background to participate on the following reviews:

- Aboriginal and Torres Strait Islander Health
- Neurology
- Pain Management
- Urology
- Allied Health
- Colorectal Surgery
- Consultation Services
- General Surgery
- Mental Health Services
- Nurse Practitioner & Participating Midwife
- Ophthalmology
- Optometry
- Oral & Maxillofacial Surgery
- Paediatric Surgery
- Plastic & Reconstructive Surgery
- Thoracic Surgery
- Vascular Surgery

The MBS Review Taskforce also has an interest in participants (both specialists and consultant physicians) for the review of specialist consultation items.

The success of the MBS reviews is contingent on the reviews being clinician-led and the AMA encourages medical practitioners with the relevant skillset to consider nominating to the clinical committees. Follow the online links to learn more about the individual items under review by each committee.

For more information or to submit a nomination, contact the MBS Review team.

The AMA's approach has always been to defer recommendations relating to specialty items to the relevant Colleges, Associations and Societies (CAS) and comment on the broader policy. As such, the AMA does not have direct representation on individual clinical committees but supports the commitment made by members who do contribute their expertise to the review.

Through feedback mechanisms involving the CAS, a member-based AMA Working Group and the Medical Practice Committee, the AMA has responded to every single MBS review consultation - raising issues from across our membership, while stressing where systematic improvements need to be made. The AMA Secretariat and the President have done this through direct representations with the Health Minister, the Department of Health and in writing to the Chair of MBS Review Taskforce.

Recent submissions highlighted a number clear deficiencies and significant variations in the MBS review process, signalling a need for absolute transparency from the Taskforce and leadership on the clinical committees through early engagement of the relevant CAS.

This year, the AMA will continue to press Government to ensure the reviews result in sensible reinvestment into the MBS while protecting clinical decision making. It is therefore crucial that each committee has the input of practicing clinicians and consistent, practical advice from the CAS.

The AMA continues to monitor the reviews with interest and update members along the way. The profession and the wider CAS are encouraged to do the same by engaging early with the clinical committees and public consultations. The full schedule of MBS reviews can be found on the Department of Health website: <http://www.health.gov.au/internet/main/publishing.nsf/content/MBSR-about>

For more information on AMA's advocacy with the MBS reviews, contact Eliisa Fok, Senior Policy Adviser, Medical Practice [efok@ama.com.au](mailto:efok@ama.com.au)

.....  
ELIISA FOK  
AMA SENIOR POLICY ADVISER

# Invitation for nominations for election to Federal Council

## AREA NOMINEES

### Invitation for nominations for election to Federal Council as Area Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Areas:

1. New South Wales and Australian Capital Territory Area
2. Queensland Area
3. South Australia and Northern Territory Area
4. Tasmania Area
5. Victoria Area
6. Western Australia Area

The current term of Area Nominee Councillors expires at the end of the AMA National Conference in May 2018.

*Nominations are now invited for election as the Nominee for each of the Areas listed above.*

1. Nominees elected to these positions will hold office until the conclusion of the May 2020 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member in the relevant Area for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA resident in the Area for which the nomination is made.
5. Nominations must be **emailed** to the Secretary General ([atrimmer@ama.com.au](mailto:atrimmer@ama.com.au)). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 2 March 2018**.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters.
7. The ballot will be undertaken by electronic ballot.

The nomination form can be downloaded from [ama.com.au/system/files/AreaNomineeForm.pdf](http://ama.com.au/system/files/AreaNomineeForm.pdf)

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: [lmcdougall@ama.com.au](mailto:lmcdougall@ama.com.au)).

## SPECIALTY GROUP NOMINEES

### Invitation for nominations for election to Federal Council as Specialty Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Specialty Groups:

1. Anaesthetists
2. Dermatologists
3. Emergency Physicians
4. Obstetricians and Gynaecologists
5. Ophthalmologists
6. Orthopaedic Surgeons
7. Paediatricians
8. Pathologists
9. Physicians
10. Psychiatrists
11. Radiologists
12. Surgeons

Note that the General Practitioner Specialty Group is listed for nomination as a Practice Group as it has its own Council, in line with the other Practice Groups.

The current term of Specialty Group Councillors expires at the end of the AMA National Conference in May 2018.

*Nominations are now invited for election as the Nominee for each of the Specialty Groups listed above.*

1. Nominees elected to these positions will hold office until the conclusion of the May 2020 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member of the relevant Specialty Group for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Specialty Group for which the nomination is made.
5. Nominations must be **emailed** to the Secretary General ([atrimmer@ama.com.au](mailto:atrimmer@ama.com.au)). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 2 March 2018**.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters.
7. The ballot will be undertaken by electronic ballot.

The nomination form can be downloaded from [ama.com.au/system/files/SpecialtyGroupForm.pdf](http://ama.com.au/system/files/SpecialtyGroupForm.pdf)

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: [lmcdougall@ama.com.au](mailto:lmcdougall@ama.com.au)).

## PRACTICE GROUP NOMINEES

### Invitation for nominations for election to Federal Council as Practice Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Practice Groups:

1. General Practitioners
2. Public Hospital Doctors
3. Rural Doctors
4. Doctors in Training
5. Private Specialist Practice.

The term of Councillors expires at the end of the AMA National Conference in May 2018.

*Nominations are now invited for election as the Nominee for each of the Practice Groups listed above.*

1. Nominees elected to these positions will hold office until the conclusion of the May 2020 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member of the relevant Practice Group for which the nomination is made. A member may nominate for, and vote in, as many Practice Groups as may be relevant to their practice.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Practice Group for which the nomination is made.
5. Nominations must be **emailed** to the Secretary General ([atrimmer@ama.com.au](mailto:atrimmer@ama.com.au)). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 2 March 2018**.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters.
7. The ballot will be undertaken by electronic ballot.

The nomination form can be downloaded from [ama.com.au/system/files/PracticeGroupForm.pdf](http://ama.com.au/system/files/PracticeGroupForm.pdf)

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: [lmcdougall@ama.com.au](mailto:lmcdougall@ama.com.au)).



## Gap free maternity services – the thin edge of the wedge?

BY DR GINO PECORARO, FEDERAL COUNCIL REPRESENTATIVE – OBSTETRICIANS AND GYNAECOLOGISTS

The AMA has always defended against US-style managed care encroaching into our health system. However, we are now challenged by the emergence of new private insurer led and gap free, full maternity service suite pilot schemes.

Of course, pilot programs are just that, but they can be the genesis from which new monopolies and controls can spring. The AMA can point to a history of attempts by some insurers to compromise universality of health care, through the pursuit of preferential access arrangements or efforts to undermine clinical autonomy (exemplified in plastic surgery where insurers did not cover reconstruction costs for burns and cancer victims). The AMA understands managed care can have many guises – our continued vigilance is required.

The establishment of any pilot scheme will require commercial relationships to be made at the doctor and clinic level – but the capacity for doctors to negotiate terms can be severely limited as a result of large insurers offering only pro forma contracts. We are all time poor, and at first glance the initial offer, or the administrative simplicity of the model may be attractive. But any doctor considering entering such a relationship might wish to consider the following before signing:

- Am I entitled to operate a dual practice model? That is, one business operating under the terms of the insurer contract and another separately operating in a free manner at the doctor's discretion.
- Is my clinical independence protected in writing both now and into the future in the contract, or does the potential exist for clinical independence to be compromised?
- Is the contracted service mid-wife or specialist led? What liability are the signatories exposed to and will the arrangement offer any protections or potentially expose the signatory to more medico-legal risks?
- Are there reasonable opportunities to exit the relationship if my circumstances change or the model does not operate as anticipated? What if there are penalties incurred if the doctor leaves the model, where will they go if they do leave, would there be a restraint clause limiting future practice location after leaving, would there be time frame restrictions on hospital admitting practices?
- Do the amounts paid index regularly over time to keep pace

with ever rising clinical operating costs? Indexation is a must for signed contract inclusion but what indexation formula would apply? Is there a guarantee that any future contracts will be indexed or does the potential for only the first (or entry) contract mandate indexation (leaving the doctor alone to negotiate with the fund for ongoing indexation)?

- Am I willing to forgo fee for service remuneration for fixed 'block' payments and all this entails, both for now and into the future? Remember, ending such a contract may mean it could become harder to slot into another model of funding afterwards.
- Is the insurer's set cost structure (via block payments) ensuring they have a vested interest in delivering the best clinical outcome? If costs rise for the insurer, is it more likely than not that the insurer will seek to undermine care rather than absorb costs in the interest of maintaining quality?
- Am I assured patients maintain appropriate access to care based on their clinical need, have choice and continuity of treating practitioner? This includes pathology, imaging, anaesthetic, paediatric and other surgical assisting. If the insurers have these specialists contracted as well, will there remain opportunity to use alternative providers? Is the logical next step to create vertical integration (a tradition observable overseas) that would finally cement the managed care experience before actually deeming what services and treatments the funds will pay for?
- Are there restrictive business rules imposed? (Forms of controls over the way you manage and run your business to 'fit in' with insurer processes or preferences.)

There is also the question of what happens into the future when the insurer seeks contract renewal after the medium/long term. Once a relationship is formed, the power equation might shift to the insurer because the doctor finds themselves 'locked in'; unable to return to their traditional practice model. This may occur because patients have become accustomed to a particular market price, method of service or the practice set up, which has changed to efficiently accommodate the existing model. If these circumstances apply, the insurer is well positioned to make new demands, with permanent effect, that may not favour the doctor or patients' best interest. Potentially, insurers may seek to pay less and/or become more involved in directing managed care by determining what treatments the patient would receive.





## Gap free maternity services – the thin edge of the wedge?

With any new direction in the delivery of health care, predicting all the pitfalls (and benefits) can be tricky. In the case of no-gap pilots arising in obstetrics and gynaecology, we can look to the US experience and say we should prefer to retain the current Australian system. In saying this, we must be aware that in the craft group of obstetrics and gynaecology, work expectations are changing – public appointment opportunities are becoming more limited, there is some preference to have a genuine work and life balance, and less enthusiasm to run a small business model of practice. In that sense, these new pilots do appear

attractive as they can be perceived as simplifying practice and offering practice opportunities.

Nonetheless, it is important for the profession to consider broader implications; there is an often stated truth that from little things, big things grow. An evolved model has the risks of dictating the nature of treatment, and even artificially inflating the cost of services from ‘non-preferred’ doctors. Therefore, we must defend against all instances of managed care in the interest of our independence and patient outcomes.

### 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](http://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](http://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](mailto: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.



## Proposed incentive missing the mark on quality

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

“Practices are unlikely to implement the internal changes required to take up this incentive if the value of the incentive does not support the effort involved.”

With the proposed start date of 1 March 2018 for the new Quality Improvement Incentive (QII) under the Practice Incentives Program (PIP) fast approaching, the AMA is becoming increasingly concerned that the proposed incentive arrangements are still not settled to the satisfaction of the profession.

Ideally, the QII should be taking us a step closer to rewarding quality care. However, the incentive has been short-changed of its key ingredient for supporting continuous quality improvement in general practices – funding.

The Government is not investing in this incentive, which means it is not investing in better data, quality improvement, or general practice. What it has done instead is pull \$21.2 million out of PIP and sought to move existing PIP payments around. Abolishing the Quality Prescribing, Cervical Screening, Asthma, Diabetes, and Aged Care Access incentives to pay for the QII is a zero sum game and means that many practices will be financially worse off under the new incentive. In fact, for all intents and purposes, it would seem that the Government has lost its grasp of English in that an incentive is supposed to motivate or encourage someone to do something.

Practices are unlikely to implement the internal changes required to take up this incentive if the value of the incentive does not support the effort involved.

What is the Government thinking?

Through this incentive it wants data to better inform its policies and, while that is sensible, many practices are initially going to have to undertake a significant amount of work to improve the quality of their data. In addition, they will have to get up to speed on data governance to ensure that patients' privacy is safeguarded. Patients will need to understand what data will be collected, how the data will be de-identified, what the data will be used for, and who it will be shared with.

If this work is not adequately funded, if the incentive does not provide a return on investment, practices will not take it on.

With this incentive supposedly only a few weeks away, we have no clarity on what the requirements are that practices will be asked to sign up for. We do not know what data will be extracted, whether quality improvement activities are to have a set focus, or how the quality improvement over time will be measured. We don't even know what the dollar value of the incentive will be!

While the AMA is strong advocate for rewarding quality care, the proposed new QII is not fit for purpose. It is underfunded and critical detail is still missing. Practices should not be asked to sign up to a vague program that is likely to leave them worse off.

As the Government's budgetary process rolls on the AMA will be continuing to make it clear to the Minister that the QII is under-funded and under-done. The solution is more time, thought and investment – something current policy settings sadly lack.



## The sugar wars: be careful to define the enemy and choose your weapons

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

The statistics do not support the view that there are big differences in sugar consumption between the fat and the thin. We need to define our enemy clearly in the battle against obesity and stop beating up individual consumers.

The *Sydney Morning Herald* has announced a war on sugar. Its rationale is that we need to combat obesity with all its attendant ills. Good thinking. Sugar may appear to be easy pickings. Beware.

It is vital that sugar consumption by individuals not be cast as the behaviour that we must attack (willpower, my friends, willpower) with all our might to solve the problem of obesity. That will be a waste of energy – no pun intended – and leave the real changes essential for reversing our current trend to a fatter, less healthy community untouched.

Just how critical is sugar to obesity? A study of 132, 479 individuals in the UK, published in the *International Journal of Epidemiology*\* in 2016, analysed their consumption of macronutrients – fat, protein, carbohydrate and sugar – and compared how much energy in the diet of obese versus non-obese individuals came from these food categories. This group was assembled for the UK Biobank genetic study and the current study made use of the comprehensive health data collected on all participants.

Anderson and Pell, the lead authors of the study from the University of Glasgow, made the point that in this study: “Dietary intake was self-reported outside the clinic, which may encourage more truthful reporting, and was collected using a 24 hour recall questionnaire which produce more accurate results than a food frequency questionnaire (the usual approach adopted in large-scale studies).” Their general conclusion was: “66.3 per cent of men and 51.8 per cent of women were overweight/obese.”

Anderson et al wrote: “Compared with [those participants with] normal BMI, obese participants had 11.5 per cent higher total energy intake and 14.6 per cent, 13.8 per cent, 9.5 per cent and 4.7 per cent higher intake from fat, protein, starch and sugar, respectively.” So while the fat folk were consuming more energy than the thin, the excess due to sugar intake between the two groups was quite small. “There is only a weak correlation between absolute energy derived from sugar and from fat. Therefore, targeting high sugar consumers will not necessarily target high consumers of fat and overall energy.”

They concluded that: “Fat is the largest contributor to overall energy. The proportion of energy from fat in the diet, but not

sugar, is higher among overweight/obese individuals. Focusing public health messages on sugar may mislead on the need to reduce fat and overall energy consumption.”

Do these observations mean that we should not include sugar as needing attention in our approach to obesity? Not at all. Many drinks and processed foods are overloaded with sugar and that should change. But it cannot be said to be the main game in obesity, like tobacco is in lung cancer.

Unlike tobacco – a single and inessential commodity – there is no case to ban sugar completely. A sugar tax would make all sugar-containing foods and drinks more expensive and hence less accessible to less affluent consumers who may at present depend on these sugar-laden commodities. It passes the penalty for consuming foods with high sugar content onto the consumer and so a tax would need careful calibration using the criterion of equity. Also, Anderson et al warn of the tendency to substitute one source of energy for another and if the substitute for less sugar is more fat, then we are no further ahead.

The power of the sugar industry – cane, corn and beet – is immense and it is far from squeaky clean when it comes to promoting a healthy diet. It is at the level of production and marketing that our attention needs to focus in creating a healthier approach to sugar.

Encouraging individuals to lobby for less sugar in processed foods and drinks will not be easy but that is what is needed. Blood will be spilt as that battle plays out. But it is to this battle – and not by beating up individuals to reduce their individual consumption of sugar (desirable but neither necessary nor sufficient) – that our efforts should be applied for sustainable community-wide gains.

An international comparison of cost-effective ways of reducing obesity by McKinsey and Co, a consultancy, nominated reducing portion size as the best approach among about 30 useful options. Given the nearly 12 per cent difference in total energy intake between the obese and non-obese participants in the Anderson study, reducing the size of meals we eat by 10 per cent (and we would need the cooperation of restaurants, processed meal manufacturers and others) would seem a wise recommendation.

(\* Professor Leeder is also editor of the *International Journal of Epidemiology*.)



## Look after yourself, for everyone's benefit

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

“Rural doctors on average work longer than their urban counterparts. This means less leisure time, less sleep time and less family time.”

Hey doc, you look tired.

As I get older and more wrinkly, this comment seems to be a more frequent bugbear.

But you know, no matter how tired, it isn't pleasant to be given that feedback – a mirror that states the haggard obvious.

But on the other hand, it touches me that the doctor-patient relationship has flipped a bit where my patient looks at me as someone that needs care. For a moment, they care enough to see tiredness on my face.

Let's unpack this tiredness.

Rural doctors on average work longer than their urban counterparts. This means less leisure time, less sleep time and less family time.

Forty per cent of rural doctors are international medical graduates (IMGs – overseas trained), like me, a duck out of water. The tiredness for us is the added task of “fitting in”. Generally, our nuclear family lives overseas. Australian-based friends have yet to be fostered.

Rural doctors in general do more. This means more to learn, more procedures to become comfortable with, more tasks that simultaneously need to be done with our octopus arms.

Our urban colleagues have a wealth of alternatives to distract, entertain, and rejuvenate themselves. Recently while in Brisbane, I was amazed at the choices of fitness clubs, cinemas, swimming pools, yoga studios, theatre, bike paths. We don't have these energising resources.

Rural doctors generally have less family and friend support. Those luxurious relationships are fostered on a Skype call (if we have internet) or on our rare visits to family over 500 km away. Tired is one thing. Tired and alone makes you want to cry, to give up. Especially after a tough event in the clinic or in the ED.

When we plan a holiday, there is a dread of finding a

replacement, a locum. A weekend break is not a break when it takes one day to leave the Outback, one day to return (if the roads are not flooded). I calculate that it is an investment of over 24 hours to achieve an 18 hour break. Having said that, I did do that long trip to Broome, a trip of 700 km, killing my first kangaroo, saw a movie at the famous cinema there, then went back on Sunday night.

So, what can be done? Well, doctor, I needn't teach you what you counsel your patients daily. In my mind, when we are running on empty the first step is NOT to fill the tank. Why? Because the cycle continues, the problems are not solved.

Here is a different perspective – an age old sequence reworded that some of you will recognise.

The first step is to recognise tiredness, despair, loneliness, heart break, depression, unrelieved stress as conditions that need to be addressed. Now. Admission of a weakness is the first step to strength. Admit that there is a helplessness to solving this by yourself.

Next find someone to help you, someone you can trust. Let this someone not be yourself. Get a GP. Meditation, church, prayer and pastors all are another form of support outside of yourself. Doctors' support programs exist now in all States. In the Outback you have a support that is rare in the cities – the local indigenous Elder, the wise woman or man. Even two States away, I still contact my two “sista-mothers” when I am particularly low.

Then follow the advice given. Let it go, you do not need to be in the driver's seat always. Talk about it. The advice may be difficult, like “say no, or move on”. Or the comment may be “you cannot meditate this away”. Doctors used to being in control find this step difficult. But remember that you have taken the first step of admitting a need for help.

Hey doc, are you looking tired? Wishing you health and recovery, we need you.





## Advocacy and doctors in training: starting fresh and staying passionate

BY DR KATHERINE KEARNEY, CO-CHAIR AMA COUNCIL OF DOCTORS IN TRAINING

“In the current climate, where overtime, overwork, hours and health and wellbeing of doctors-in-training is frequent topic of conversation, DITs often find themselves advocating for our colleagues and juniors.”

It's the start of a new clinical year, and for newly graduated doctors starting internship, the beginning of their medical career. It's a nerve-wracking and exciting time, and prompts reflection on past experiences and what was learnt. Lots of excellent advice has been shared, notably on twitter under hashtags like #tipfornewdocs and #tipsfornewinterns. However, something that is not taught or even well acknowledged as an important part of the doctor in training's (DIT) repertoire of skills is the important role as an advocate that doctors can perform.

Advocacy takes many forms, and scales from an individual patient advocate within the system and within the hospital to public health advocacy on important issues affecting the community. For our patients, DITs regularly perform whatever kind of odd job that doesn't fall within the capacity of anyone else in the healthcare team, or can be called upon to advocate within the hospital, within the healthcare system or within a patient's family or social dynamic. The impact of this on patient care in hospitals, as well as in community roles, is significant. It often gets the patient the right treatment or the right access at that right time. The gratitude of patients when a DIT goes the extra mile is one of those things that keeps morale up when the tough days and tough weeks add up. Being grateful for these opportunities and the satisfaction brought by solving these problems is an important perspective to maintain.

In the current climate, where overtime, overwork, hours and health and wellbeing of doctors in training is frequent topic of conversation, DITs often find themselves advocating for our colleagues and juniors. To know that our colleagues and our seniors have our backs, and will support us, is what makes it possible to do the hard and difficult things when they arise. It's an empowering experience to have someone show up and advocate for you, and it's been the lifeblood of delivering health care for a long time. Isolated, fearful people have poor mental health, and perform at far less than their best. It's a significant part of the challenge of our expanding medical training and non-specialist workforce, and an under-appreciated burden on senior staff in the public hospital system most notably.

I'd encourage anyone not currently doing so to get involved with something bigger than themselves as well. There's a great number of opportunities to become involved in professional organisations, advocacy organisations and other volunteer organisations doing good work for the profession and for specific communities. Being involved expands your perspective, your understanding of what your colleagues actually do, and invites you to share the vision of our healthcare leaders about what health care delivery could look like. Advocacy skills and teaching are well within the grasp of any DIT with an issue they feel passionately about. There's a lot of evidence out there demonstrating the value of medical professionals in administrative roles, and there's a corollary with clinician involvement in policy making as well. The most powerful advocates are clinicians at the coalface – where injustice or inequality is seen, clinicians are obliged to take up that role.



## Make a student's week

BY ALEX FARRELL, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

“You’ll recognise the almost painful amount of enthusiasm a student will put into a job you throw their way – from grabbing a bluey to calling radiology, most students just want to be a helpful member of their team.”

For a medical student or junior doctor, one kind word can get you through the week. This year, as students start clinical rotations, remember that you have more influence than you think.

Placement as a medical student is a strange and wonderful world. It’s where we are finally exposed to the reality of practising medicine, and meet the doctors whom we aspire to be like one day. It is here that we set our expectations for the culture of medicine. We learn that medicine is a place of mentoring, compassion and respect. But it can also be tough, most students will recognise the near universal experience of feeling like a burden to their team.

Students want to work hard, but sometimes it is hard to know what is expected of us, or how we can be of use to our team. You’ll recognise the almost painful amount of enthusiasm a student will put into a job you throw their way – from grabbing a bluey to calling radiology, most students just want to be a helpful member of their team.

As medical students, we are very aware that teaching us takes time from doctors’ already packed days. We understand that treatment must be the first priority, and how frustrating it must be when students slow clinicians down. But like all doctors before us, we have to learn. Supervisors explaining a process or saying that a student did a good job only takes a second, but it can make a big difference to a student’s day.

Medical students will, invariably, get answers wrong. They will make a mess of simple procedures and they will take up time on days when the doctors on their team have none to spare. The supervisor who can tell them not just what they did wrong, but also how to improve, will be the teacher that they remember.

Positive experiences are important. I have heard many students extol an “incredible day”, simply because they felt like they were part of a team or that they could ask questions. Passion for medicine is infectious. In fact, many consultants have told me they are in their specialty because of a particularly influential mentor.

No doubt, it is high pressure being a doctor. Some days, circumstances make it tough to be the best supervisor, but never doubt the amount of good a quick acknowledgement can do for the medical student on your team.

There are great role models and teachers in every ward and clinic. For that we are grateful. Every one of you plays a role in shaping the doctors and medical culture of the future.

So this year, as medical students rotate in and out, keep in mind the doctors whose teaching made you the clinician you are today. Never underestimate the power of some thoughtful advice, a clear explanation, or a kind “you’ll get it next time”. We use your words to guide us, help us start off down the right path.



# New Medical Board *Professional Performance Framework*

BY PROFESSOR ROBYN LANGHAM, CHAIR, MEDICAL PRACTICE COMMITTEE

Should doctors be tested for their fitness to practise on a regular basis? What factors increase the risk of poor clinical performance? How should doctors with multiple substantiated complaints be managed in the long term?

These are just some of the thorny questions the Medical Board of Australia and, as a consequence, the AMA have been grappling with over the last two years as part of an investigation into whether Australia should adopt a system of 'revalidation' similar to that currently operating in the United Kingdom.

The AMA has argued strongly against introduction of the UK model, a model which has proven to be onerous, costly and complex, and undertaken by every single registered medical practitioner on a five yearly basis. The AMA has also advocated strongly against the Medical Board's original revalidation proposal which we considered was too heavy handed and problematic.

While recognising the value of introducing extra measures to improve patient safety, the AMA has urged instead the adoption of an approach that builds on the many systems already in place that support doctors in delivering high quality care. Australian doctors already practise in a highly regulated environment.

Late last year, after a lengthy consultation process, the Medical Board announced it had designed a new *Professional Performance Framework* aimed at ensuring: "that all registered medical practitioners practise competently and ethically throughout their working lives". The Framework replaces the Board's original revalidation proposal.

This Framework is made up of five components.

- The current continuing professional development (CPD) system will be strengthened. This will require doctors to complete at least 50 hours of CPD per year relevant to their scope of practice, and nominating a CPD 'home' of one of the Specialty Colleges, which will then have responsibility to report to the Medical Board if CPD requirements are not met;
- Doctors at most risk of poor performance will be identified and strategies put in place to manage them. For example, increasing age is a known risk factor, so three yearly peer review and health checks are proposed for doctors aged 70 and over who are still providing clinical care. Importantly,

the Medical Board will not be party to any of the data from peer review and health checks unless there is a serious risk identified to patients;

- Doctors with multiple substantiated complaints will be proactively managed including via the introduction of a formal peer review of performance;
- The Board will revise and update registration standards and the code of conduct; and
- The Board will work in partnership with the profession on strategies to further promote a positive culture focusing on patient safety, respect and ongoing improvement.

The Framework will be implemented progressively, with some components such as CPD already largely in place, and other components such as the regular review of doctors aged 70 and over needing further consultation and development.

The AMA recognises that doctors over the age of 70 make a strong contribution to clinical care in our community, but like other potentially high risk professions, it is an opportune time to establish a process to review a person's continuing ability to provide care at that age.

However, the AMA, with the advice of the Medical Practice Committee, will be considering how health and screening checks of older doctors would be best implemented to ensure they are fair and consistent.

The AMA is also concerned about how the Medical Board will obtain data on an individual doctor's performance in order to manage high risk individuals. For example, we oppose open data sharing between medical defence organisations and the Board.

We look forward to working with the Medical Board to ensure the implementation of this Framework is well considered and provides the best outcomes for doctors and their patients.

Full details of the new *Professional Performance Framework* and its consultation and implementation timeframe are on the Board's website.

I encourage AMA members to provide their views on these issues to [president@ama.com.au](mailto:president@ama.com.au). Your comments will help inform AMA advice.



## Technology advancement – not always the panacea for making your life easier

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

I hope all have had a splendid and refreshing break with family and friends. 2018 is set to be a busy year around the nation related to industrial relations. Victoria has just settled its Enterprise Bargaining Agreement under extenuating circumstances, but which has exacted an unbelievable cost which will soon be widely discussed, akin to what transpired some years ago in the upper echelons of Victoria Police. For those continuing with their jurisdictional discussions, my strong advice is to develop a strategy and adhere to it.

Beyond pure, old-fashioned industrial relations, there is to be a Senate inquiry related to the emergence of new technologies in Australia, and their impact on the future of both work and on workers (it reports in June). The AMA is making a submission and your CPHD will be working to consider how we can minimise perverse outcomes arising from rapid change.

You may recall the early prediction that the introduction of a computer-based, 'paperless', office would cause a conundrum for society: how would it manage a consequent huge increase in a workers' available leisure time. I observe that this was staggeringly inaccurate. Instead, an explosion of intra/inter-organisational communication occurred, along with profoundly new work methods, which then created significant additional workload and response pressures, not to mention more paper.

Medical practice is not immune from such implications, but we can prepare to ensure both quality patient care and professional sustainability. To preserve our well-established (and evidence-based) norms, we must establish significant ownership over such mooted technological change. This will enable us to guarantee that patients, and thus the community, will benefit from effective and efficient implementation / integration of technologies, and will ensure medicine remains a safe, attractive and useful career. Like all workers, we too seek job satisfaction and security; reasonable work time commitment; observing good effects arising from our work; having clear purpose when at work; having opportunity for professional growth; having a family and recreation time and receiving a fair day's work for a fair day's pay.

So, what might be the effect of revolutionary technology, including artificial intelligence, for us in the public hospital setting? We are already observing a US model of care outsourcing radiology/medical imaging reporting and analysis all the way to India (teleradiologists). That's perhaps all very well superficially, but what about: the de-skilling impacts locally; quality assurance; uncertain medico-legal liabilities where there is further

intervention underpinned by reporting error; and consideration of the patient being properly served when off-shore analysis might not have access to all pertinent records and information?

There is also another more sinister side to this. In our domestic public hospital context, AMA has already had some industrial experience of representing radiologists who, while rostered On-Call but in fact basically through incremental hospital request over time, have ended up working from home as if on duty, all thanks to current IT capabilities. Home computers (and employer installed equipment) have made activity possible that was previously only 'in the hospital'. This makes it easy for many of us to fall into the trap of never being away from our work. There is incentive for an employer to increase their expectations on us while we are left with our vocational challenge of being unable to stop serving our patients.

Concerns about exploitation and fatigue management are very real, but also our existing payment compensation entitlement framework about On-Call, Recall or overtime have not been designed to accommodate such new ways of "doing things" now enabled through use of new technology. This is an indication that we need to stay on our toes to prevent unfair and unpaid (over) work direction. Remuneration and rostering methods for our enlarged workforce will need modernisation to account for our anticipated expanded work value contributions and requirements.

Medicine and medical practice has always evolved with the expansion of scientific knowledge, and its translation to medical care. In the modern environment of rapid advancement and transformation, the frequency, pace and unpredictability of the consequences of change will likely increase, yet be of a different character to previously experienced adjustment processes. Managing the integration of new technology/artificial intelligence is a new challenge. Technology necessarily changes behaviour, which brings with it a new set of requirements to coordinate new systems of work. We want to guarantee effective communication between us, apply the new technology, and manage the implications for our teams and hospital administration. Employers will need to work with us with early respectful dialogue to ensure there is careful introduction of the new ways of doing things; this so that patient care is not undermined and we are appropriately rewarded.

For CPHD, the challenges we face in response appear to be about ensuring employment rules keep pace and useful new technology/artificial intelligence are effectively implemented/integrated. Both of these fundamentally relate to us being enabled to maintain the high standards of presently enjoyed patient care.





## AMA fully supports Physician's Pledge update

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

As a member of the World Medical Association (WMA), the AMA takes great pride in highlighting the achievements of the WMA as a world leader in the development and promotion of global ethical standards for the medical profession.

While the WMA adopts a wide range of global policy statements on ethical issues related to medical professionalism, human rights, patient care, medical research and public health, it also actively counteracts violations of its ethical standards.

One of the oldest, and most defining, of the WMA's ethical statements is the Declaration of Geneva, often considered a modern version of the Hippocratic Oath.

As examples, the WMA consistently condemns governments and others who threaten to compromise professional autonomy and clinical independence, as well as those who undermine the role of medical neutrality and fail to protect healthcare workers in areas of armed conflict.

One of the oldest, and most defining, of the WMA's ethical statements is the Declaration of Geneva, often considered a modern version of the Hippocratic Oath. Established in 1947, the WMA (of which the Federal Council of the British Medical Association in Australia was a founding member) was particularly concerned with the global state of medical ethics and decided to take on the responsibility of developing ethical guidelines for the world's doctors.

The WMA believed that developing an international oath, or pledge, to be recited upon graduating medical school, would impress upon newly qualified doctors the fundamental ethics of medicine and raise the standard of professional conduct.

Attempting to seek international consensus on a pledge that was relevant to, and representative of, doctors from a wide range of cultural, religious, racial, political and linguistically diverse backgrounds, was challenging, but in 1948 the 2nd WMA

General Assembly officially adopted the Declaration of Geneva to serve that role.

Over the years, the Declaration has undergone only minor amendments, the exception being its most recent iteration. In October 2017, the 68th WMA General Assembly in Chicago adopted the 7th revision of the Declaration, a culmination of a two-year consultation with more than 100 member National Medical Associations, as well as the public.

According to the Chair of the WMA Declaration of Geneva Workgroup, Dr Ramin Walter Parsa-Parsi of the German Medical Association, when reviewing the document, the workgroup considered modern developments in medicine and medical ethics, as well as contemporary WMA policies and international literature.

The Declaration has changed in subtle, but significant, ways. It is now more patient-centred. For the first time, it refers to patient autonomy and dignity and recognises the importance of 'well-being' to patient care. Further, the whole document has been reformatted to emphasise obligations to patients first followed by obligations to colleagues and society.

The updated Declaration better reflects the modern notion of collegiality, while doctors should respect their teachers, it now recognises they should respect their colleagues and students as well. Particularly relevant to the Australian context, the Declaration acknowledges the essential role that physician 'well-being' (and not just health) has on a doctor's ability to provide a high standard of patient care.

In addition, it now refers to sharing medical knowledge for the benefit of the individual patient and wider health care, recognising the duty not just to the individual but the broader health system and society.

The WMA advocates that the Declaration of Geneva, now formally referred to as the Physician's Pledge, be taken up on a global scale. The AMA has formally adopted the updated Declaration of Geneva. It is our hope as well that the Declaration will unite doctors throughout the world by affirming the highest standards of ethical conduct in the profession's service to humanity.

The WMA Declaration of Geneva can be accessed at <https://www.wma.net/policies-post/wma-declaration-of-geneva/>.



# Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

## AMA calls for improved aged care in Australia

The AMA recently submitted to the Department of Health comment on the establishment of the Specialist Dementia Care Units (SDCU) program, urging the Australian Government to improve the quality of Australia's aged care system and invest in aged care reform now to build the foundations of higher quality aged care system.

With an ever increasing prevalence of dementia in Australia, the AMA expressed in its submission support for the Department to consult widely with relevant Colleges and Dementia Australia to ensure the program design achieves a high clinical standard.

The AMA expressed the belief that the SDCU program does not "represent a holistic solution to the many issues surrounding dementia – rather it attempts to deal with one specific issue within the context of the wider problems with Australia's aged care system".

The following recommendations were put by the AMA in the submission to Government:

- An overarching and independent Aged Care Commissioner that provides a clear, well-communicated, governance hierarchy that brings leadership and accountability to the aged care system;
- Medical practitioners need to be recognised as part of the aged care workforce to ensure residents of aged care facilities are receiving quality care;
- Funding for the recruitment and retention of registered nursing staff and carers, specifically trained in dealing with the issues that older people face, such as dementia;
- Access to Medicare-funded mental health services in RACFs that is already available to the rest of the population;
- A contemporary system that embraces information technology (IT) infrastructure for patient management to adequately support the aged care sector;
- 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; and
- Establishment of a clear, specific, and confidential complaints referral pathways in each RACF so information on complaints processes are easily accessible to both residents and staff.

This also includes a recommendation for an introduction of access to medical care.

A full copy of the AMA's submission can be found here:

<https://ama.com.au/system/tdf/documents/AMA%20submission%20-%20Specialist%20Dementia%20Care%20Units.PDF?file=1&type=node&id=47802>

MEREDITH HORNE

## Additional research funding for rare cancers

The Federal Government has announced a \$69 million boost to help medical researchers in their fight against rare cancers and rare diseases.

The funding is aimed at assisting patients who often have few options and poor life expectancy.

Health Minister Greg Hunt said the Government was committed to investing in research to find the answers to these challenges.

"This is a significant boost on the \$13 million that was originally flagged when we called for applications and reflects the incredibly high calibre of medical research that is happening right here in Australia," Mr Hunt said.

The new funding includes more than \$26 million for 19 research projects as part of the landmark Medical Research Future Fund's Rare Cancers, Rare Diseases and Unmet Needs Clinical Trials Program.

These projects will undertake clinical trials for devastating conditions like acute lymphoblastic leukaemia in infants, aplastic anaemia, multiple sclerosis and Huntington's disease.

Researchers at the University of New South Wales will test a vaccine to target glioblastoma, a lethal brain cancer and the most frequent cause of cancer deaths in children and young people.

Another clinical trial at the University of Queensland will evaluate the benefits of medicinal cannabis for people with advanced cancer, and define the role of the drug for patients with cancer in palliative care.

Monash University is researching a new preventive treatment for graft versus host disease following a bone marrow transplant which could halve instances of the life-threatening complication, while a trial by the University of Western Australia to simultaneously compare a range of cystic fibrosis treatments may lead to improved care for this complex disease.

Details of the rare cancer projects that have received funding can be found here: [www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt008.htm](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt008.htm)

MEREDITH HORNE



# Research

## Exercise helps muscles and organs communicate

Researchers have shown, for the first time, why exercise has positive health effects across the entire body.

The new Australian research, published in the journal *Cell Metabolism*, reveals tiny protein-filled packages, called vesicles, are used by our muscles and other organs to communicate with each other during exercise.

Sydney's Garvan Institute of Medical Research undertook the study in collaboration with researchers at the University of Sydney and the University of Copenhagen in Denmark.

The study identified thousands of different proteins that are released into vesicles in our bloodstream – including hundreds that appear to act as signals that we are exercising. Most of the proteins have never before been thought to be involved in communication within the body.

The study analysed the protein contents of vesicles in the blood of people before and immediately after exercise (an hour of cycling) and following a period of recovery. They found many more vesicles in the blood samples of people immediately after exercise than in those at rest or after recovery – and, importantly, many proteins enclosed within the vesicles were present in greater amounts after the exercise bout.

Professor Mark Febbraio, who heads Garvan's Diabetes and Metabolism Division co-led the study. He believes this study showed that there's the potential for a whole world of organ-to-organ messaging going on that has previously only been hinted at.

"We're seeing a big burst of vesicles released when we exercise, and those vesicles contain a different mix of proteins – in other words, a different set of messages," Professor Febbraio said.

"Until now, when researchers went looking for evidence of molecular communications from muscle, they would limit their search to a particular class of proteins, which are known to be released from cells into the bloodstream."

The researchers believe the results have been startling.

Dr Martin Whitham, who also co-led the study, said that: "What we're now seeing is over 5000 identified proteins in the blood that we think are packaged into vesicles – and importantly, only a small proportion (a fifth) of those proteins have a 'postage stamp'.



"That means that there are 4000-plus proteins that have now been identified, that have not before been considered as being involved in organ-to-organ communication. It's really going to change our thinking about how different parts of the body communicate, and what they 'say' to each other."

When the researchers compared the vesicle proteome, they found that more than 300 proteins were significantly different between exercise and rest.

"We think these are the proteins that tissues such as muscles are sending out into the bloodstream, packaged into vesicles, when we exercise – so it's fascinating to look at what those proteins are, and what the purpose of sending them into circulation might be," Dr Whitham said.

Professor Febbraio explains that: "Broadly speaking, we think that tissues are likely to be sending messages that help other tissues respond to exercise and to reap its benefits – so this is an intriguing example where muscle or liver cells could send glycolytic enzymes rapidly to other organs, to help them deal with the increased energy demands that go along with exercise.

"It makes a lot of sense that many of these exercise-liberated vesicles may be emanating from muscle and heading to the liver, because we know that liver function is vastly improved by regular exercise."

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## New test to help seniors keep independence

A major study has been released by Aged Care Minister Ken Wyatt designed to uncover frailty and spark simple interventions to help older Australians maintain their independence.

It comes with a new online test to help detect the signs of frailty while action can be taken.

*The Frailty in Community Dwelling Older People – Using Frailty Screening as the Canary in the Coal Mine* is a landmark report, which surveyed 3000 Australians aged over 65 and found six per cent were frail and 38 per cent were considered pre-frail.

Women were found to be more likely to be frail than men.

Mr Wyatt said he believed the simple FRAIL five-point online test was an important start to people have the opportunity to detect frailty before it hits, allowing them to take action to live better lives, remain in their own homes for longer and avoid potential hospitalisation.

The Minister encouraged older Australians to do the test and follow up with their GP as necessary.

“People classed as frail are more at risk from fall injuries, deteriorating health and premature death,” Mr Wyatt said.

“Importantly, the study recommends that with the right support at the right time, frailty can be halted or even reversed by consulting with health professionals for safe, simple, inexpensive, practical interventions.”

The study was produced by aged care provider Benetas, a large not-for-profit aged care provider based in Victoria and part of Anglicare Australia.

The aim was to validate and implement a simple self-completed tool that can accurately identify frailty. Older people who are at risk of increased dependency and/or mortality can then be identified and provided with appropriate services to keep them well.

The study found 56 per cent of elderly Australians were considered to be robust, with 41 per cent of women classed as pre-frail compared to 34 per cent of men.

Authors of the report believe frailty is generally considered to be a consequence of ageing but not all elderly people are frail.

Frailty describes any person, regardless of age, who is at heightened risk to illness or injury from relatively minor external stresses.

Frailty should be considered a syndrome rather than a disease in itself and can be defined by a number of components – unintentional weight loss, self-reported fatigue, diminished physical activity, and measured impairment (comparative to age-standardised norms) of gait speed.

The study also recommends that, with the right support at the right time, frailty can be halted or even reversed by consulting with health professionals for safe, simple, inexpensive, practical interventions.

These positive changes to decrease frailty risks include taking steps to modifying diet to include more proteins as well as taking vitamin D supplements. Increasing activity, including light resistance exercises and walking, as well as evaluating prescription medication intake, in consultation with your GP, were also recommended by the authors.

Benetas project leader Stephen Burgess said frailty was the “canary in the coal mine” which could help detect a rapid health decline before it happened.

“Frailty, including pre-frailty, is an invisible condition. Many who are frail appear to function reasonably well in the community. As a result, individuals and family members are often unaware frailty is present,” he said.

The FRAIL test is available through the Positive Ageing Resource Centre website. ([www.parc.net.au](http://www.parc.net.au)). At the conclusion of the brief questionnaire, users can print off a personal summary to present to their health professional.

The PARC website is funded by an Aged Care Service Improvement and Healthy Ageing Grant from the Federal Department of Health <http://www.health.gov.au/> and is developed by researchers from Monash University’s School of Primary Health Care <http://www.med.monash.edu.au/sphc/> and Benetas.

.....  
MEREDITH HORNE

# Campaign supports doctor struck off in struggling NHS

Medics in the United Kingdom and across the globe have rallied to support a junior British doctor struck off the medical register following a two-year suspended prison sentence over the death of a six-year-old patient.

In 2015, the Nottingham Crown Court found 38-year-old Hadiza Bawa-Garba guilty of the manslaughter by gross negligence of Jack Adcock, a Down's syndrome sufferer who was admitted to the Leicester Royal infirmary in 2011.

Jack was admitted to the hospital following a heart attack caused by pneumonia-related septic shock.

He died 11 hours after being admitted.

A nurse was also given a two-year suspended jail sentence over the boy's death.

The doctor at the centre of the tragedy, however, was also originally suspended from practising medicine for 12 months.

But in January this year, Bawa-Garba was struck off the register when the General Medical Council (GMC) appealed against that decision.

The GMC called for her total "erasure from the medical register".

This has outraged many working doctors, who insist Bawa-Garba was partly convicted from her own e-portfolio self-appraisal.

They also say she is a victim of the National Health Service (NHS) under stress in the UK.

A crowd funding campaign has been launched to help pay legal costs for the struck-off doctor.

In just a couple of weeks, the campaign raised more than £160,000 in support of Bawa-Garba.

More than 1,500 UK doctors signed a letter expressing their "deep-seated concerns" over how the case was handled and its resulting in the doctor being struck off the register.

Their letter argues that the ruling threatens the open culture that currently encourages doctors to be open and honest in self-appraisals when endeavouring to learn from medical error.

"Dr Bawa-Garba's case has extraordinary ramifications, with large numbers of doctors recognising that her conviction puts all doctors at risk in the context of a healthcare system which is

clearly bearing enormous stress at a national level," the doctors wrote.

"The case also has implications for patient safety across the UK because healthcare professionals will henceforth be reluctant to share knowledge openly or reflect on clinical errors for fear of criminal prosecution."

The campaign, known as CrowdJustice, was set up by three junior doctors aiming to raise money so Bawa-Garba can be: "Offered additional independent expert legal advice in respect to challenging the decision that she be permanently erased from the medical register."

The campaign also hopes to seek advice about her criminal conviction.

Bawa-Garba has also received support from doctors around the world, including Australia.

Bawa-Garba said she was "overwhelmed with gratitude" and plans to employ a top legal team to review both the decision to strike her from the register, and her criminal conviction.

The GMC has defended its decision to ask for the doctor's erasure from the register, but added that doctors should never hesitate to act openly and honestly if something goes wrong.

"We know the strength of feeling expressed by many doctors working in a system under sustained pressure, and we are totally committed to engendering a speak-up culture in the NHS," GMC's chief executive Charlie Massey said in a statement.

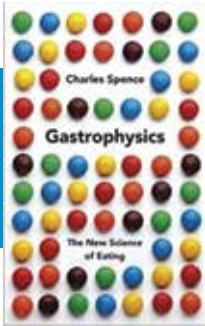
The initial trial heard that Bawa-Garba had mistaken Jack for another patient she had treated that day and had stopped life-saving treatment on him.

Bawa-Garba said that working without a break could have mistakenly led her to believe that Jack was under a Do Not Resuscitate order when he was actually not.

Jack's parents cheered in court at the guilty decision in 2015. They have also welcomed this year's High Court ruling allowing Bawa-Garba to be struck off the medical register.

CHRIS JOHNSON





# Gastrophysics - The New Science of Eating by Professor Charles Spence

REVIEWED BY SIMON TATZ

If you have ever bought take-away coffee in a disposable cup and found it does not taste quite as good as when you sit down and drink it in a mug, the reason is this: smell. If you remove the plastic lid, your coffee will taste better.

Our enjoyment of foods and beverages is not based only on the five basic tastes (sweet, sour, salty, bitter and umami – a Japanese word that has been translated as 'yummy deliciousness' or a pleasant savoury taste); food and beverages are experienced differently because of their smell, sound, sight, touch and how our mind interprets expectations.

In his entertaining book *Gastrophysics*, Professor Charles Spence leads readers through a fascinating journey of eating and drinking, and what makes food 'taste' the way it does.

*Gastrophysics* is described as the "scientific study of those factors that influence our multisensory experience while tasting food and drink". As Spence says: "The pleasures of the table reside in the mind, not the mouth."

The same meal eaten at a three-star Michelin restaurant will be experienced differently if the meal is served at your dining table at home, or eaten on plastic tables at a cheap looking café. How we 'taste' food is as much about the experience of where we taste it.

The experience of dining out in top restaurants affects the way we think of the food consumed. The act of booking and traveling to a 'fancy' restaurant, the location, décor, the music played and even the cutlery and plates, are interpreted by the brain in ways that have an impact on 'taste' and enjoyment.

For example, Spence explains why restaurants using heavier cutlery actually encourage diners to pay more; and why serving a strawberry mousse on a white dish can increase perceptions of sweetness by 10 per cent compared to serving it on a black dish.

*Gastrophysics* defines the relationship between food and sound. Research showed that if potato crisps 'sound' crunchier, then consumers think they are eating something fresh, so manufacturers made crisps with a crunchier 'sound'.

Touch is a factor many in the West do not always appreciate, even though we eat many foods – hamburgers, chips, sandwiches, fruit and so on – with our hands. I once ate at Bukhara in New Delhi, seven times winner of the 'Restaurant

Magazine Award' for Best 50 Restaurants in the World and Best in Asia, and awarded the 'Times Food Award' ten times. President Obama, UK PM David Cameron and Vladimir Putin had previously eaten there.

Bukhara has no cutlery. All dishes are eaten by hand. Knowing the quality of the restaurant and who had eaten there changed the perception of the way food tasted. In many other parts of India, eating with your hands would be anathema to foreigners and we would likely worry about hygiene too much to enjoy the stunning food. For the record, Bukhara was one of the greatest meals I've experienced.

*Gastrophysics* details the science behind expectation. Diners shun Patagonian toothfish but enjoy Chilean sea bass, which are the same. Golden rainbow trout is far more popular than brown trout. What we think we're eating defines our enjoyment and perceptions of taste. As Spence puts it, there's a reason why 'faggots' (meat off-cuts/offal), 'pollack' (fish) and 'spotted dick' (pudding) are no longer menu items.

This also explains why a simple 'pasta salad' sounds boring, but diners in expensive restaurants will pay high prices for 'Neapolitan pasta with crispy fresh organic garden salad'.

There are many examples throughout the book of research into wine and food showing that few people are supertasters who possess the ability to detect bitterness, saltiness, sweetness and other textures. At the other end are people who have 'anosmia' and are unable to detect distinctive flavours, such as coriander.

Many people cannot really tell the differences in wines. The mind reacts to price, location and label. So we think a \$90 bottle of red at a top eatery is much better than the \$15 bottle at the local club. In reality, they could be the same wine, but few of us know the difference.

Smell is also vital to the dining experience. It is the smell of freshly ground coffee which is so appealing to coffee drinkers. But when the barista puts a plastic lid on that take-away coffee, it reduces the smell (the 'orthonasal aroma') and therefore the taste. The same applies to drinking from a bottle or can.

The chapter on airline food is particularly interesting, as Spence explains how aircraft noise affects our perception of food. The answer is simple - wearing noise-cancelling headphones has been shown to improve the taste of airline food!



# Collision avoidance technology

BY DR CLIVE FRASER

As we anxiously enter the age of driverless vehicles I'm aghast to see how many driverless cars already seem to be on Australian roads.

When I'm travelling I notice every day other motorists staring into their laps at their smart phones and not looking straight ahead at where they are going.

They are usually in cars that to the best of my knowledge aren't fitted with adaptive cruise control, lane guidance or autopilot collision avoidance systems.

So I can only assume that there is some sort of app on their smart phone which will alert them if necessary to the need to look up if driver input is required.

I'd say that any car being driven by someone distracted by a smart phone is in my opinion technically "driver-less".

In my practice I see people every week who have been terribly injured by being impacted from someone texting, Facebooking, Tweeting or Instagraming etc.

I'm also very pleased to see how vigorously law enforcement officers breach distracted drivers for doing so.

With so much inattention on our roads it's great to see how much technology is already out there to augment rather than replace driver awareness.

My first experience of this was about five years ago in the car park of my local Volvo dealership to test the laser-based City Safety feature in a Volvo XC70.

The salesman told me to drive straight into a large cardboard box in the carpark.

Hard as I tried, the XC70 just would not let me hit it as sensors mounted alongside the rear vision mirror detected an object in front of the vehicle and braked accordingly.

The system works to avoid collisions at speeds of up to 50 km/h.

Thereafter I've seen radar-based Adaptive Cruise Control appearing in many more affordable models such as Hyundai's i30 Elite.

The technology relies on the Doppler effect and the fact that radio-waves reflect from solid objects.



The vehicle will then adjust its speed +/- apply the brakes depending on the closing distance of another vehicle.

More recently a colleague proudly showed me his new Mercedes GLC 250d SUV which comes standard with Collision Prevention Assist.

In his first week of ownership the GLC's collision avoidance technology successfully helped him to avoid hitting a feral pig which suddenly darted across the road in front of him at mid-night.

But the collision avoidance system proved not to be infallible when he collided with a kangaroo at dusk one week later.

I think Mercedes can be forgiven if their technology works most reliably with pedestrians and walking beasts (cows, horses, sheep, goats etc).

Kangaroos and other hopping animals generally aren't encountered on German autobahns and the software may require some further tweaking.

Whilst all of this technology arguably makes driving safer, none of it should ever replace driver attention.

Safe motoring,

**Doctor Clive Fraser**

doctorclivefraser@hotmail.com

# Gilbert O'Sullivan celebrates 50 years in music with Australian tour

BY CHRIS JOHNSON



The stature of songwriters can be easily determined by the calibre of the artists who record their songs. There is probably no greater tribute to a musician than for another musician to cover their artistic works. Then again, for the audience, there may be nothing better than hearing songs they know so well being performed live by the artists who actually wrote and first recorded them.

Gilbert O'Sullivan has had – and continues to have – the very best of the music industry worldwide record his outstanding and familiar songs. For five decades numbers such as *Clair*, *Get Down*, *Nothing Rhymed* and *Alone Again (Naturally)* have been given the personal touch by a host of megastars.

Diana Krall, Neil Diamond, Michael Bubl  spring to mind immediately. They have all recorded O'Sullivan songs. But they come after legends before them had done the same.

“There are some beautiful ones from earlier – Nina Simone, Peggy Lee, Sarah Vaughan, Bobby Darin. They all recorded some of my songs,” O'Sullivan says from his UK home ahead of his upcoming Australian tour.

“Any cover of a song of mine is a compliment.”

O'Sullivan's songs are beautiful and they have stood the test of time. So many of them remain instantly recognisable today.

It was 14 years ago when Gilbert O'Sullivan was last in Australia and even then he only performed three small shows without a band.

He returns in March for his first national tour of Australia, to help mark his 50th anniversary as a recording artist.

And this time, he will be accompanied by a full band.

“We have two guitars, bass, drums, sax, flute, two girls singing, and me on piano and singing,” he says.

“We've been together quite a few years, since 1990. So we're quite a solid unit. Our shows are typically 2 ½ hours.

“It was great to get to Sydney and do a few shows some time ago, but I've wanted to do it properly for many years.

“Apart from the mail I get from Australians telling me they like my songs, I haven't had that much of a rapport with Australia.

“When I was there in Sydney I was walking down a street, a back lane, and a guy opened up a door and looked at me and said ‘hi Gilbert’. That made me feel right at home.”

It's true that not only are his songs instantly recognisable, but – thanks to his big hair – the Irish superstar is himself easy to pick out of a crowd.



In the 70s and early 80s, he was a huge international star.

But O'Sullivan has typically shied away from crowds – except when on stage performing.

“Performing for me is very special, especially because I get to meet the people afterwards and hear about what they liked or didn't like,” he says.

“You build rapport with your fans that way. I think if you record a song and you are not prepared to tour it is very, very wrong.

“But I'm generally pretty low key. I'm not a red carpet person. I'm not into celebrity. That doesn't interest me.

“I have avoided that kind of life. I have avoided it all. I was once invited to a Paul McCartney reception and I went and it was all very nice, but I didn't even go up and meet him. I'm just not into that kind of thing.

“I was nominated for three Grammys and I didn't even want to go to the awards night. My manager made me go and it was awful. I didn't enjoy the experience at all.

“On stage I am very comfortable and very happy, but privately I'm very shy.

“Some people are born that way. But on stage with my music I am very confident. I lead a pretty normal life. Sometimes you just have to lock yourself away.

“Elton John, now he's a party man. But Bernie Taupin, his lyricist, locks himself away like me. We lyricists are very low key.”

His first hit single *Nothing Rhymes*, he says, will always be dear to him. But it's his more obscure songs that mean the most.

“The special songs for me are not necessarily the big ones. There are some very special ones to me that are album tracks but weren't singles, but which people recognise when I play them,”

he says.

“Then there's the new material. I'm currently making a new album, which should be out in April.

“I know when I'm happy with a song and the process in that regard hasn't changed much. I get a lot of satisfaction from writing a song and recording it. Then it's out of my hands. I hope people like it.

“Technology today is incredible, but it makes no difference at all to me when I'm writing songs. All I need is a piano and a cassette recorder. I actually like cassettes. I just stick it up on the piano and record away. That process hasn't changed at all for me.

“I don't do much analysis of my career. It's been a good 50 years. It's all about the songs. That's what I'm all about, the songs.”

## Gilbert O'Sullivan tour dates:

**Gold Coast**, Saturday 10th March – The Star

**Caloundra**, Sunday 11th March – Events Centre

**Brisbane**, Tuesday, 13th March – QPAC

**Hobart**, Wednesday 14th March – Wrest Point

**Newcastle**, Friday 16th March – Civic Theatre

**Sydney**, Saturday 17th March – State Theatre

**Adelaide**, Tuesday 20th March – Festival Centre

**Mandurah**, Friday 23rd March – Performing Arts Centre

**Perth**, Saturday 24th March – Crown Theatre

**Canberra**, Monday 26th March – Canberra Theatre

**Melbourne**, Tuesday 27th March – Arts Centre Hamer Hall



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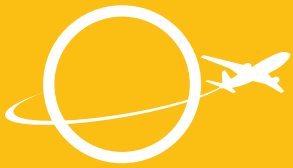
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# Not your average movie set

BY CHRIS JOHNSON



I must confess. I saw all three *Lord of the Rings* movies but still haven't seen one of the subsequent *Hobbit* trilogy of films.

That didn't stop me from suggesting to my teenage daughter that we check out, while on a quick holiday to New Zealand's North Island this summer, one of the locations for filming both epic trilogies.

Hobbiton doesn't have a post code all of its own – it is Middle-earth, after all – but it is a village nonetheless, and a fascinating one at that.

No people live in the village, yet tourists flock to it in order to glimpse where Hobbits once traversed and mingled.

They actually get much more than a glimpse of this reconstructed part of J.R.R. Tolkien's Shire.

Visitors to Hobbiton get transported to another time and place that is at once both magical and real.

Transported is the right word because inspecting Hobbiton can only be done by official tour, with coaches collecting tourists from nearby Matamata and offloading them inside the gates of the picturesque Alexander Farm where a two-hour guided walk begins.

Hobbiton of course is the remains of a large, well-kept movie set, constructed at great expense on a farmland ridge offering breathtaking views.

Peter Jackson "discovered" the site during an aerial search for a suitable rural location for *The Lord of the Rings* movies he was about to produce and direct.

Work began on transforming the land in 1999, with the New Zealand Army shaping a 1.5 kilometre road from the nearest highway to the site.

Facades for 37 Hobbit holes were built, gardens were created, a

bridge, pub and mill erected, and a 26-tonne oak tree fabricated above what would become Bag End.

After *The Lord of the Rings*, the set was rebuilt permanently in 2010 (this time with 44 Hobbit holes) for *The Hobbit: An Unexpected Journey*, which began filming in 2011.

And so it remains today.

Due to copyright reasons, movie sets are almost always torn down once filming has completed. But the Alexander family negotiated to keep the Hobbiton village on their property as a permanent tourist attraction.

*The Lord of the Rings*, *The Hobbit*, Peter Jackson and all things to do with Middle-earth are HUGE in New Zealand. It is only fitting that this monument to it all is kept alive, just a three-hour drive south of Auckland.

To be honest, I wasn't expecting too much. I was delightfully surprised.

The charm of Hobbiton is refreshing. Guides are friendly and informative and there is plenty of opportunity for pics at the doors of colourful Hobbit holes – and even inside one of them.

It is old world and out of this world – a very unique attraction.

Nothing was more refreshing though than at the end of the walking tour to sit down inside the Green Dragon Inn (which actually was torn down after filming *The Hobbit* trilogy and subsequently reconstructed to spec) to have a complimentary ale or cider from the licensed on-site brewery.

You don't have to be a teenager to enjoy Hobbiton. Neither do you need to be a Tolkien disciple. I certainly wasn't. But I have since bought *The Hobbit* trilogy on DVD as a memento for having walked where Hobbits walked and having roamed along the paths of Middle-earth.



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