AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Health Budget a safe one

But some glaring omissions, p7

Iconic AMA House sold, p10

INSIDE

President's final column, p3
Workforce strategy needed, p8
Next Secretary General named, p9
AMA presidential candidates, p13
The long history of pot, p19
Unhealthy air worldwide, p31

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AMA LEADERSHIP TEAM

President
Dr Michael Gannon

Vice President
Dr Tony Bartone

In this issue

National News 7-18

World News 31-32

Health on the Hill 29

Research 30

Columns

3 PRESIDENT'S MESSAGE
4 VICE PRESIDENT'S MESSAGE
6 SECRETARY GENERAL'S REPORT
12 FEDERAL COUNCIL COMMUNIQUÉ
19 PUBLIC HEALTH OPINION
20 GENERAL PRACTICE
21 RURAL HEALTH
22 PRIVATE SPECIALIST PRACTICE
23 TO THE EDITOR
24 DOCTORS IN TRAINING
25 AMSA
26 FINANCE AND ECONOMICS
27 INDIGENOUS TASKFORCE
28 MEDICAL WORKFORCE
32 THEATRE
33 WINE
34 MOTORING
35 MUSIC
36 MEMBER SERVICES

Cover pic: Dr Michael Gannon talks to reporters on Budget night.

Two years of non-stop action

BY AMA PRESIDENT DR MICHAEL GANNON

> "As President of the AMA in Western Australia before being elected to the Federal role, I thought I knew a bit. I saw the move to Canberra as maybe a 'step up'. I was wrong. It is like moving from the fifth floor to the top floor of a multi-storey skyscraper … on a very fast elevator."

If I was ever to be asked how to make two years disappear before your very eyes, I would answer authoritatively from experience: "Get yourself elected Federal President of the AMA."

As the end of my term as President of this amazing organisation draws near, I look back fondly and with pride at the events, incidents, agreements, arguments, successes, and adventures that are part and parcel of this job – for those who have gone before me and for those to follow.

Being AMA President puts you at the centre of health policy and politics in the nation's capital, more so than almost any other role in advocacy and lobbying in this country.

As President of the AMA in Western Australia before being elected to the Federal role, I thought I knew a bit. I saw the move to Canberra as maybe a 'step up'. I was wrong. It is like moving from the fifth floor to the top floor of a multi-storey skyscraper … on a very fast elevator.

The number of policy issues to grapple with is multiplied many times. So too the number of meetings. You must deal personally, often face to face, with Ministers, Shadow Ministers, MPs and Senators from across the political spectrum. Plus their staff. And their departments and bureaucrats. You are on first name basis with the Prime Minister and the Opposition Leader. Yes, the AMA President is in the game.

So, what have I done with this influence? Quite a lot, in fact.

It is hard to focus on a single event or decision as the standout, however. You have to look at the range of issues. They are all connected.

But you would have to start with the lifting of the freeze on Medicare patient rebates. Sure, we did not get the dream result – an immediate lifting of the freeze across the board. Six years (or perhaps 30 years!) of 'catch-up' indexation would have been nice. But it was a significant political win. It signalled a seismic shift in how the Government dealt with the AMA and the medical profession.

The PM's decision to move Greg Hunt into the Health portfolio was clever and inspired. The new Minister wanted to work with us literally from hour one, and that relationship has grown, matured, and endured. It has delivered results for the profession. I hope that it continues with my successor.

We succeeded in fundamentally shifting the focus and diminishing the threat of the Indemnity Review. We have a key role at the heart of the MBS Review. We are a guiding voice in the review of Private Health Insurance. We were instrumental in the after-hours reforms. We steered the redesign of the Practice Incentive Program (PIP) in the right direction.

The AMA protected the interests of both GPs and pathologists in the ongoing discussions on pathology collection centre rents. We ensured there was no clawback by the Government on the hard-won reforms of medical indemnity in the early 2000s.

We stuck with the evidence and supported the TGA on the upscheduling of codeine, against a well-funded and well-organised campaign from the pharmacy sector. And we achieved the right outcome for patients.

Every single day, I have pointed to the importance of prevention and public health, of GPs, of public hospitals, and the private health system to the health of Australians.

The AMA was prominent in the highly-charged campaign for marriage equality, and conducted ongoing support for the health of asylum seekers. We released significant position statements on firearms control, obesity, addiction, women's health, the NDIS, child health, Diagnostic Imaging, and men's health.

We remained vigilant on immunisation.

We continued our proud tradition of advocacy on Aboriginal and Torres Strait Islander health.

… continued on p5

So much done, so much to do

BY AMA VICE PRESIDENT DR TONY BARTONE

As this is my last column for *Australian Medicine* in my current role as Vice President, I thought I would take the opportunity to reflect on the past two years, as well as look to some of the challenges ahead for the AMA.

There has been a change in the health narrative over the past two years. This has been on many levels, especially from a Federal Government attempting to become more consultative. We have consistently engaged with Government for the most part. On numerous occasions, it has been happy to acknowledge the role we have played in helping to shape policy.

However, this now needs to ratchet up into a more strategic relationship focussing on outcomes and actions. We must leverage this going forward. They must step up to the plate and deliver.

There have been certain events or areas of advocacy I wish to highlight during the last two years as Vice President. The Medical Workforce and Training Summit was one of them. The need for such a summit was identified early in the work plan of the Medical Workforce Committee. Together with the Council of Doctors in Training and the Secretariat, it was able to bring together key leaders, including many College chairs, jurisdictional representatives and other stakeholders.

The first since 2010, the summit identified areas of consensus, including affirming there was no need for further medical schools, and looked at the thorny issues of workforce distribution and lack of coordination in workforce planning and training between Commonwealth and State governments. It gives impetus to our call for a national medical workforce strategy as a matter of priority.

The elevation and resulting urgency around the issue of mental health and wellbeing of medical professionals was a key pivotal movement. Events such as the Forum on Reducing Risk of Suicide in the Medical Profession, as well as the session at last year's National Conference, which shone a spotlight on doctors' health and wellbeing, clearly emphasised its critical importance and need for a solution. This issue is clearly very complex and multi-faceted. It is in need of more research, especially around data and greater understanding of the aetiological drivers. It is, however, in need of robust funding to progress various support programs and interventions to support doctors' wellbeing.

The session on *Tackling Obesity* at National Conference last year and, the subsequent advocacy and media on the sugar tax later in the year, helped to highlight the enormity of the issue from a behavioural change and public health perspective.

We have also released many other significant public health position statements. The process of reaching these positions served to highlight the strength and depth of the AMA policy machine. The AMA is well served in this regard. Our people are our greatest asset. The depth of analysis contained in the Public Hospital and Private Health Insurance report cards certainly further exemplifies this factor.

The launch of the Safe Hours campaign and report in 2016 showed how complacency is perhaps setting in, and how extreme and dangerous levels of work hours are still not uncommon in the workplace. The incongruity between rostered excessive work hours (including significant amounts unpaid) and rhetoric about doctors' wellbeing cannot be greater. Our national voluntary code of practice is a signpost of the change required in the time ahead.

We have also had a very busy time over the past two years with a variety of other issues: from codeine upscheduling to medicinal cannabis and managing the incessant thirst of media in regards to information. There continues to be a huge workload ahead of us. There always will be. There is much unfinished business.

This includes continuing to wade through the quagmire of private health insurance and associated OOPs (out-of-pocket costs), including the focus on a fees comparison website. The Professional Practice Framework recommendations and implementation will need scrutiny and collaboration during implementation to safeguard rural access, as will concerns regarding practice viability and other unintended consequences.

Securing significant meaningful improvement in GP funding remains imperative. Incentivising for quality; acknowledging prevention along the whole of life journey; as well as recognition for GP facilitated downstream savings across the whole budget, need to be recognised and appropriately remunerated.

Aged care will also remain a key focus, as four additional position statements will be added to the recently released *Resourcing Aged Care Position Statement*. With many

So much done, so much to do

parliamentary reports and inquiries completing, or about to, this remains an area of key reform for the Government and key concern for the community. How we care for our elderly says a lot about us as a society and remains core business for us going forward.

The release of the Position Statement on Mental Health has forged new potential opportunities for advocacy, especially for step-down access, acute hospital beds, and mental health community support services to help GPs manage patients back in the community and be involved in the discharge planning in a meaningful way.

Of course, there are many other areas where we need to continue our significant advocacy. Closing the Gap, implementing the recommendations of our two previous report cards on Indigenous health is essential.

The MBS review also remains a key area going forward. The promise of modernising the MBS into a fit-for-purpose 21st century framework is perhaps taking significantly longer than Government expected. It remains a key area of concern to ensure transparency and to ensure that any savings are reinvested into new items. The digital health record implementation promises a lot to health outcomes and savings, but it will need to overcome the problems of utility and engaging with all clinicians, as well as perennial concerns about privacy.

The AMA has continuously sought to influence health policy at the highest levels; achieving some excellent outcomes for doctors, patients, and the Australian community. It has been an enormous honour to serve our AMA as your Vice President and I thank you all for your support and assistance over that time.

Two years of non-stop action ... from page 3

Perhaps some of the more significant achievements of my Presidency relate to the health and the ethics of the medical profession.

I stood by the AMA's carefully-constructed position on euthanasia and physician-assisted suicide during sometimes heated community debate in five States. I promoted the AMA's leading role in doctors' health services, including securing a positive mandatory reporting outcome from COAG, and I have prosecuted the AMA's strong stance in getting rid of bullying and harassment within the profession and the broader health sector.

I contributed to health on the global stage, being elected to the Ethics Committee of the World Medical Association, and helping to develop policies on the impact of climate change on human health, women's health, the promotion of universal health care, end of life care, and the formal review of the Declaration of Geneva.

This is just scratching the surface of what has come my way as AMA President.

I did not need an alarm clock the whole two years. My dawn chorus was the Australian media. Rarely a morning went by without a call from a breakfast news program. Calls to Perth from east coast media during daylight saving were a highlight. Indeed.

It has had a personal cost, being away from family often, and sometimes for long periods of time. The haters will hate. Neither the critics nor, in fairness, the fans seem to understand the hundreds of hours, involving many different people, of thought, research, endeavour, and debate that go into our policies and position statements.

I have enjoyed great support from many people. I have had people seek to undermine me. I have spent hundreds of hours on aeroplanes. It has been tough.

But it has also had many, many benefits on the personal and professional front. Yes, I had fun.

Would I do it all again? Without a doubt.

The busy month of May

BY AMA SECRETARY GENERAL ANNE TRIMMER

May is the busiest month in the AMA calendar. Not only does it bring the AMA National Conference and, every two years, the election of members of Federal Council and of course the President and Vice President as part of the Conference, but it also brings the Federal Budget.

When the AMA agreed in 2017 to the Federal Government's staggered lifting of the freeze on Medicare items, we knew that it would not address the impact of the years without indexation. However, it did set a timeline for the lifting of the freeze, and as importantly, it has allowed the AMA to negotiate with the Government on many other policy areas.

By the time this edition of *Australian Medicine* is published we will know what is offered in the 2018 Budget. The AMA's core areas as set out in its pre-Budget submission lodged in late 2017 include funding for primary care; reforms to private health insurance; improved medical care for the aged; support for medical workforce and training; and retention of the medical indemnity insurance schemes. The funding commitment for public hospitals has been brought forward on the COAG agenda with funding agreements now signed with all but two States.

The AMA has been involved over the past 18 months with the Private Health Ministerial Advisory Committee which has been working its way through reforms to improve the value proposition for private health insurance. The reforms incorporate standardised coverage across tiers of insurance with gold, silver, bronze, and basic benefit cover. In late April/early May the Department of Health began consulting on the definitions for the designated clinical treatment in each level of cover and it is here that the reforms become challenging. The risk is that treatment pathways could become disjointed with different treatments in the same admission falling into different levels of cover.

The AMA will continue to advocate for improvements to avoid these consequences.

Federal Council

Elections have been completed for the contested positions on Federal Council. The successful candidates are:

Area NSW/ACT	Dr Saxon Smith
Area Qld	Dr Shaun Rudd
Area Vic	Dr Jill Tomlinson
Anaesthetists	Dr Andrew J Miller
Paediatricians	Dr Paul Bauert
Pathologists	Dr Beverley Rowbotham
Psychiatrists	Dr Steve Kisely
Surgeons	Dr Owen Ung
GPs	Dr Richard Kidd
Private specialists	Dr Julian Rait
Rural doctors	Dr Sandra Hirowatari

These members, together with those with uncontested positions, will take up their positions on Federal Council following National Conference. The elections this year were strongly contested which shows a healthy interest in the work of your AMA. There are many opportunities for interested members to become involved through committees in their State/Territory AMA and Federal AMA.

Four directors of Australian Medical Association Limited stand down from the board at the end of May. Dr Elizabeth Feeney and Professor Geoff Dobb are not standing for a further term. Both were among the original directors following the governance reforms in 2014 and have been significant contributors to the AMA for many years. Dr Iain Dunlop and Dr Peter Sharley have been reappointed. The incoming directors are Dr Rosanna Capolingua and Dr Danielle McMullen.

The annual report of Australian Medical Association Limited is available for members to access at 2017 Annual Report. I look forward to reporting to members at the Annual General Meeting to be held in Canberra on 25 May 2018.

Health Budget safe and steady

The AMA has labelled the 2018-19 Health Budget as "safe and steady", but adds that it is notable as much for what is not to be found in it as it is for what is included.

Treasurer Scott Morrison has delivered a Federal Budget with an eye on the next federal election, promising tax relief for middle Australia, significant infrastructure investment and more funding for aged care.

On the health front, the establishment of a new 21st century medical industry plan to create more jobs and support more medical research projects is a major commitment.

This Budget includes an extra $1.4 billion for listings on the PBS, including medicines to treat spinal muscular atrophy, breast cancer, refractory multiple myeloma, and relapsing-remitting multiple sclerosis, as well as a new medicine to prevent HIV.

The Government will also provide $154 million to promote active and healthy living, including $83 million to improve existing community sport facilities, and to expand support for the Sporting Schools and Local Sporting Champions programs.

It has dismissed a proposal for a single and separate Murray Darling Medical School, in favour of a network, in what AMA President Dr Michael Gannon has described as a better approach.

Mr Morrison said the plan was to get more doctors to where they are needed through a new workforce incentive program.

"This plan includes the establishment of a new network of five regional medical schools within the broader Murray Darling Region," Mr Morrison said when delivering his Budget Address to Parliament on May 8.

Dr Gannon said many of the rural health initiatives outlined in the Budget are a direct response to AMA rural health policies and the AMA Budget Submission.

"We welcome the Government's strong focus in this Budget on improving access to doctors in underserviced communities, particularly rural Australia," Dr Gannon said.

"The decision to reject the proposal for a stand-alone Murray Darling Medical School, in favour of a network, is a better approach with the Government instead pursuing a policy that builds on existing infrastructure to create end-to-end medical school programs.

"However, while the Government has made a welcome commitment not to increase Commonwealth-supported medical school places, it has taken the unnecessary step of compensating medical schools with additional overseas full-fee paying places.

"This will not address community need, and instead simply waste precious resources."

Dr Gannon said overall, the Government had delivered a safe and steady Health Budget, which outlines a broad range of initiatives across the health portfolio.

Necessary funding to aged care, mental health, rural health, the PBS, and medical research, were all welcome commitments.

"But some of the bigger reforms and the biggest challenges are yet to come," he said.

"Due to a number of ongoing major reviews, this Budget is notable as much for what is not in it as for what is in it.

"The major reviews of the Medicare Benefits Schedule (MBS) and private health are not yet finalised, and the ensuing policies will be significant.

"We are pleased that indexation has been restored to general practice and other specialty consultations, but new and considerable investment in general practice is missing.

"Also, the signature primary care reform – Health Care Homes – did not rate a mention."

Health Minister Greg Hunt described the Budget as a "record investment in health" and pointed to a previously announced commitment from the Federal Government to public hospitals.

"The Government will deliver more than $30 billion in additional public hospital funding under a five-year National Health Agreement, with funding increasing for every State and Territory, every year," Mr Hunt said.

But Shadow Health Minister Catherine King said the Budget failed the health test.

The Government was persisting with a plan to cut $715 million from hospitals over the next two years, she said.

"Their hospital cuts are putting doctors, nurses and hospital staff under increasing pressure; forcing delays in surgeries; and making emergency department waiting times even worse," Ms King said.

CHRIS JOHNSON

National medical workforce strategy urgently needed

Federal, State and Territory governments must urgently begin developing a strategy for a national medical workforce.

The AMA made that call in the lead-up to the Federal Budget, and immediately following the release of the AMA Medical Workforce and Training Summit 2018 outcomes report.

AMA President Dr Michael Gannon said the Council of Australian Governments (COAG) must now commission a national medical workforce strategy in order to meet Australia's future healthcare needs.

The strategy must address workforce challenges facing Australia's medical professionals.

"We are providing all our governments with solutions," Dr Gannon said.

"We now need to see the Commonwealth and the States and Territories cooperate more closely in planning and coordinating our future medical workforce.

"While the Commonwealth is responsible for funding medical schools and general practice training, and has programs to support medical training in community and private settings, the majority of medical training still takes place in State and Territory public hospitals.

"No single level of government can solve current medical workforce challenges on its own. Unless we have greater genuine cooperation between jurisdictions, the challenges and problems will remain unresolved."

Commissioning a national medical workforce strategy is a key recommendation of the AMA's Summit report. Other issues raised by the Summit included: the need to better support generalism; a focus on matching training with community need; more opportunities for specialist training in rural areas; the development of a strong rural training pathway; and supporting careers in undersupplied specialties.

The Summit, which was held in March and reported in May, brought together more than 80 leading stakeholders to discuss priority medical workforce challenges.

These challenges included the maldistribution of the medical workforce, workforce shortages in some specialty areas, and the lack of prevocational and specialist training places for medical graduates once they have left medical school.

It has been 14 years since the release of the last national health workforce strategy, the *National Health Workforce Strategic Framework*.

"Our governments cannot continue to work in isolation of each other on this vital issue," Dr Gannon said.

"There is a lot of effort going into medical workforce planning and coordination at different levels of government, but none of this work is joined up. And the objectives are often different.

"A national medical workforce strategy, developed with strong input from the profession, is critical to getting all stakeholders on the same page to achieve policies that will deliver the future medical workforce that the community needs.

"Australia does not need any more medical school places. We have seen record growth in medical student numbers, well above the OECD average.

"The former Health Workforce Australia projected a potential medical workforce oversupply in the years ahead.

"The Summit participants clearly recognised that the focus needs to shift away from increasing medical school places towards giving medical students more opportunities to train in rural areas.

"We need to deliver postgraduate training places in the areas and specialties where they are most needed."

Dr Gannon said Australia needed smarter policy than we have seen from governments in the past.

"COAG is key to setting united future planning," he said.

"Simplistic ideas like the opening of a new medical school or the importation of more doctors from overseas are not the solution to our long-term medical workforce requirements.

"This mindset is driven by short-term political gain, rather than the long-term health needs of our communities."

The Summit report is at https://ama.com.au/medical-workforce-training-summit

CHRIS JOHNSON

New Secretary General announced

The AMA has appointed Dr Michael Schaper as its next Secretary General.

Dr Schaper will take up the position in late July. He will replace Anne Trimmer, who will leave the AMA in August at the completion of her five-year term.

"Dr Schaper will join the AMA from his current position as Deputy Chairman of the Australian Competition and Consumer Commission (ACCC), a position he has held since 2008."

Dr Michael Schaper

Dr Schaper will join the AMA from his current position as Deputy Chairman of the Australian Competition and Consumer Commission (ACCC), a position he has held since 2008.

AMA President Dr Michael Gannon said the AMA Federal Council and AMA Board were delighted to secure the services of Dr Schaper, who has considerable background and experience in business, government, and academia.

"Dr Schaper is exceptionally qualified and very highly regarded across a number of peak sectors in the Australian community," Dr Gannon said.

"His intimate knowledge of the workings of government, business, and the tertiary education sector makes him the ideal leader for our talented and hardworking Secretariat in Canberra.

"The interests and concerns of AMA members, the medical profession, and every Australian who has contact with the health system will remain in very capable hands," Dr Gannon said.

Chair of the AMA Board Dr Iain Dunlop, who oversaw the national recruitment process, said Dr Schaper's business background will be invaluable for the Association.

"Like all member organisations, the AMA needs a solid financial base upon which to embark on its vital policy and advocacy activities," Dr Dunlop said.

"Michael's impeccable inside knowledge of politics, government, regulation, and the business world will ensure that the AMA's reputation as one of the nation's most successful lobby groups is preserved."

Dr Schaper has a PhD in Management and a Master in Commerce, both from Curtin University.

He has chaired or served on a number of Ministerial advisory committees, and been an adviser to various State and Federal Ministers and Members of Parliament, including the Cabinet Office of the Western Australian Government and the office of a previous Federal Treasurer.

As a manager, he has been the head of both the Bond University and Murdoch University business schools, CEO of a community business advisory centre, and was the Small Business Commissioner for the Australian Capital Territory.

JOHN FLANNERY

Chairman of the Board explains the sale of AMA House

AMA House

The AMA has sold its headquarters in Canberra to EG Funds management for $15.6 million. The contract was settled in March and the new owners have taken possession. The AMA retains naming rights of AMA House and remains the primary tenant of the building.

EG plans to invest in a comprehensive energy efficiency upgrade of the building.

Dr Iain Dunlop, Chair of the AMA Board, sat down with *Australian Medicine* to discuss the reasoning behind the decision to sell AMA House.

"The idea to sell was more concerned with husbanding members' funds," Dr Dunlop said.

"It is a relatively old building and it would be too expensive for us to make it a modern Class A building. We are far too heavy into property. Real estate is not our core business and we were far too reliant on rental income.

"We will keep our pre-eminent position in the building, with naming rights. It was less important to have a fixed building – especially in this digital world.

"Having gone through the exercise of selling the AMPCo building in Sydney a couple of years ago, we then turned our attention to these offices.

"The Investment Committee of the Board decided that the AMA should not be heavy into property. Now is a good time and it has proved to be an excellent time to sell. We got a good price and the people who bought it are prepared to spend on it and upgrade it. Make it the best B building in the Parliamentary Triangle.

"It is great for us as tenants and for our staff.

"There are people who say you must not sell the farm, but the opposing view is to stick with what you are good at."

With the sale of AMA House, the organisation loses much of the space it had occupied in the building.

While retaining naming rights and being the primary tenant, the AMA has lost access to the other floors it occupied in the building.

Level three was where the Federal Council met quarterly. Conference rooms will now be rented in nearby hotels for the meetings.

"The unexpected thing for many of our Federal Councillors was that we were giving up our third floor and meeting space," Dr Dunlop said.

"By any commercial measure, it wouldn't be reasonable to keep it – to rent back that floor – for the minimal use that we make of it.

"The sale was announced at the AGM and there was minimal objection and minimal comment.

"Our presence is still in Canberra and, but for losing our occasional presence on the third floor of the building, it would appear that nothing has changed."

There is one other small inconvenience the sale of AMA House has caused.

"We now have to find more space on the 4th floor for photos and name plaques of all our distinguished Past Presidents and award winners," Dr Dunlop smiled.

CHRIS JOHNSON

AMA House a perfect location for headquarters

AMA House under construction

AMA House was constructed throughout 1990 on a special 99-year lease block on the edge of what is known as the Parliamentary Triangle in Canberra.

The Parliamentary Triangle is the largely ceremonial precinct in the nation's capital and straddles the part of Lake Burley Griffin where some of Australia's most significant institutional buildings find their home on its banks.

The High Court, the National Gallery, the National Library, the National Science and Technology Centre (Questacon), the National Archives, the Treasury, Old Parliament House and, of course, Parliament House are all located in the Triangle – as is the Aboriginal Tent Embassy and Reconciliation Place.

Other Federal Government departments are also located either inside or close to the Triangle, with a smaller triangle within the precinct known as the Parliamentary Zone on the lake's southern shore.

AMA House is located on the edges of the Triangle's official boundary and within close walking distance to Parliament House.

It was a longstanding ambition of the AMA to have a national headquarters in Canberra.

The Federal Secretariat at that time had been working out of a building in Sydney owned since 1924 by the Australasian Medical Publishing Company (AMPCo, publisher of the *MJA*), but which was sold in 1989 to The University of Sydney.

> "Once in its new home, the Federal Secretariat quickly created AMA departments with expertise in general practice, medical fees and medical insurance, public relations and communications, public health and hospital and health funding."

During the construction period, Federal Secretariat staff occupied an office in Queanbeyan, on the NSW-ACT border just a few kilometres from where the organisation's new home was being built.

During this period, the AMA also adopted a new national logo and launched a new national journal, *Australian Medicine* (this publication).

On March 7, 1991, AMA House was officially opened in Canberra by the highly esteemed biologist Professor Sir Gustav Nossal, who was also an AMA member.

At the time of its opening, Dr Bruce Shepherd was the AMA Federal President and Allan Passmore the Secretary General.

Once in its new home, the Federal Secretariat quickly created AMA departments with expertise in general practice, medical fees and medical insurance, public relations and communications, public health and hospital and health funding.

Staff for the most part were all located on the third and fourth (top) floors of the building.

In recent years, housing of staff was reduced exclusively to the fourth floor, with the third floor used for membership workshops and meetings of the Federal Council.

Offices were leased out to other organisations and businesses on the remaining floors.

With the sale of AMA House, the organisation retains naming rights and the exclusive lease of the fourth floor.

CHRIS JOHNSON

Snippets

Nobel Prize Winner for Leadership Development Dinner

Nobel Prize Winner Associate Professor Tilman Ruff is the keynote speaker at the AMA Leadership Development Dinner on Friday, May 25 at the National Portrait Gallery in Canberra. He is Co-President of International Physicians for the Prevention of Nuclear War (IPPNW, Nobel Peace Prize 1985); and founding international and Australian Chair of the International Campaign to Abolish Nuclear Weapons (ICAN), awarded the Nobel Peace Prize for 2017 *"for its work to draw attention to the catastrophic humanitarian consequences of any use of nuclear weapons and for its ground-breaking efforts to achieve a treaty-based prohibition of such weapons".*

President in good company

AMA President Dr Michael Gannon recently attended the World Medical Association Council Session in Latvia. Environmental health, reproductive health, pandemic influenza, nuclear weapons, and telemedicine were just some of the agenda items discussed. Dr Gannon can be found in this pic, just left of centre in a middle row (kind of).

Women remembered on Anzac Day

Picture courtesy of the Australian War Memorial

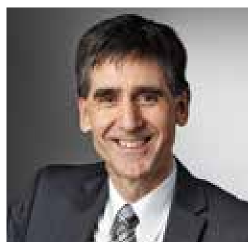
Senior member of the AMA, and retired colonel, Associate Professor Susan Neuhaus became the first woman to deliver the Anzac Day dawn service address at the Australian War Memorial in Canberra.

She used the occasion to highlight the often overlooked role of women in the armed services and in particular the Australian Defence Force.

Her full speech can be found at: https://www.awm.gov.au/commemoration/speeches/DawnService2018

Time to elect a new President and Vice President

Elections for AMA Federal President and Vice President will be held during the AMA National Conference weekend in Canberra. The following pages contain campaign/information articles written by candidates who nominated for these positions before *AusMed's* early print deadlines.



Dr Tony Bartone MBBS FRACGP MBA FAMA

Nominating for the position of AMA President

The opportunity to serve as Federal AMA President at a crucial time for our association, our health system and the community we serve, is indeed one that is not taken lightly. Nor should it.

As a proud member of our AMA, I humbly but emphatically seek your support to do so.

Most of you will know that I am a GP. My family GP was a strong role model from a young age and crucial in that calling. I have spent my professional life in many different general practices of varying size and structures. An MBA and a national management role with 450 GPs adds to a long-term intricate understanding of primary care and ultimately led to my initial AMA committee 12 years ago, the last six years involving leadership positions including the last two years as Vice President.

The decision to run has many layers, including a desire to give back, given the expertise and networks amassed over the past. Furthermore, a deep desire to listen, engage and assist, combined with an underpinning need for strategic leadership add to the aspiration. Mounting concerns confronting us in our world class health system augment the call. Concerns such as:

- Eroding access, equity and affordability, especially rurally and regionally;
- The relentlessly squeezing of practice viability;
- Extremely low value yet increasingly unaffordable private health insurance policies and the resultant patient exodus;
- A training pipeline bottleneck with a frustrating lack of post graduate training places; and
- The continual long-term disinvestment in general practice tearing at its heart.

Solutions of course must be advocated, including the appropriate funding, especially for public hospitals, for a significant ramping up of post graduate training places; investing in rural end-to-end training and restoring value and affordability to private health insurance just to name a few. Long-term strategies and investment in mental health and aged care policy framework are also an imperative and part of the quest.

My passion for general practice is often associated with rhetoric about its importance as the corner stone of primary care. This will not ensure quality outcomes. Measly rebate increases are not the solution. Off-the-cuff comments by the Minister will not progress its cause. A section of our membership is at risk in the current climate. Investment in general practice, which rewards quality longitudinal patient-centred care, is sorely needed.

Let me be very clear, there are many other important reasons as to why I am seeking to lead our association.

I am very passionate about mental health and well-being of our colleagues. Of course it's complex. More needs to be done to ensure the future security of our overworked poorly supported workforce. There is no place for bullying, harassment and discrimination in our work place culture; my time as Victorian President will attest to my commitment.

It is time for the Minister's words to become concrete actions; to articulate a long-term vision, and a robust preventive health strategy.

We know that a Federal election is due within 12 months or so.

The imperative of membership penetration continues to remain a concern. The importance of an equal member value proposition for all our members is critically paramount, as is the importance of strong, vibrant State and Territory AMAs; serving members locally. This is unfinished business – a challenge which will require bilateral understanding, the mutual desire and will to progress it.

With your continued support, I will continue to listen and engage with all our members; leading your AMA as it continues to champion our world class health system, defending patient outcomes and professional satisfaction in serving them.

Thank you.

Professor Brad Frankum OAM BMed(Hons) FRACP

Nominating for the position of AMA President

As a consultant physician specialising in immunology and allergy, I divide my time between a fractional staff specialist role at Campbelltown and Camden Hospitals, and my private specialist practice at Narellan NSW.

In addition, I run an immunology and allergy clinic at the Tharawal Aboriginal Medical Service in Campbelltown. I also serve as the Executive Clinical Director of Campbelltown and Camden Hospitals.

I have extensive experience in the university, public hospital, and Medical College sectors, and have been a board member of the Southwest Sydney LHD since its establishment. I have been involved in the teaching and training of thousands of medical students and young doctors.

Fourteen years ago, I realised the importance of 'being a part of the conversation'.

The Campbelltown and Camden crisis was a lightning rod, and a significant reminder that doctors need to be at the centre of healthcare decisions.

If we fail to be present, and if we allow non-medical professionals to have absolute control over hospitals, patients, and our healthcare system, then we must accept the consequences.

Many factors led to the crisis and, looking back, we need to heed the conditions that contributed to that situation – there was explosive population growth, a dearth of health funding and resources, and a complete lack of Government support.

When our hospital was accused of poor standards of care and a litany of other failings in the early 2000s, the State Government and the media at the time were only too keen to scapegoat the clinicians in order to deflect from the chronic neglect the whole of the south-west of Sydney had suffered from successive governments and the bureaucracy.

People's careers were in tatters, and those of us demanding due and fair process were subject to serious intimidation.

It was only with the unwavering support of the AMA that I was able to lead the clinicians to stand up to what amounted to the tyranny of the government at the time.

Out of the mess, and really against the odds, we now have the biggest hospital in NSW at Liverpool, a $632 million upgrade occurring at Campbelltown to grow to a 900-bed facility over the next 10 years, and a very successful medical school at Western Sydney University in its 11th year, producing very fine medical graduates.

This episode taught me the value of the AMA, as well as the importance of standing together as a medical profession to advocate on behalf of doctors, patients and a better healthcare system. It led me to join the Council of AMA (NSW), where I have held numerous positions – most recently serving as President.

The lack of imagination and vision in health policy on both sides of politics should be of great concern to all of us.

The AMA can elevate the debate and promote a vision for health and exert great influence at the next Federal election. At times like these, it is the duty of the AMA to step up and demand more imagination and focus on health from politicians who would prefer to coast along with conditions just tolerable enough so that few complain loudly. We owe it to our members and patients to speak up, because if we don't no one else will.

In the next AMA Federal Election, I will be running on a ticket with Dr Jill Tomlinson from Victoria for Vice-President. Jill and I will work extremely effectively as a team. Jill will bring a range of skills to the position across a range of issues. She has been a strident voice against harassment, a great supporter of junior doctors, and has great knowledge of the application of digital technology.

I believe that together we can provide a strong voice for the AMA.

Dr Gino Pecoraro MBBS FRANZCOG

Nominating for the position of AMA President

My name is Dr Gino Pecoraro and I'm asking for your vote in the AMA National Presidential election.

Australia's stressed healthcare system needs an upgrade. The ideal time for change is now, with Government reviewing the MBS and private health insurance value and affordability.

Our largely State-funded public health facilities are struggling to meet increasing demand and need ongoing additional funding. Private sector access is increasingly more expensive with non-indexed Medicare and PHI rebates causing greater out of pocket costs.

Some form of indexation (ideally one supported by the AMA) must be embedded in legislation. In this way, rebates can start to reflect the true cost of accessing services and keep medical care affordable.

Ensuring our GPs are adequately paid will help them give patients the time needed to deliver quality care and disease prevention. Ultimately, this will keep patients out of already crowded hospitals and save the health system money.

Similarly, PHI providers need to understand that their moves towards managed care models will not be tolerated and that patient choice of doctor and hospital must be protected in all policies.

Decreased demand for public hospital outpatient and inpatient services means money can be redirected to other areas e.g. emergency department waiting times and chronically underfunded mental health services.

Medical student numbers have radically increased without an increase in the number of postgraduate training positions. No more medical schools are needed. What students and doctors-in-training really need are an increase in the number of fully-funded postgraduate training positions. These positions need to be in the disciplines and locations where shortages exist.

Relocation support needs to be provided for these doctors and their families.

The AMA President is expected to be the public face of the organisation and deliver our members' policies to parliamentarians, the medical profession and the general public.

My extensive experience in medical politics is what makes me the best candidate, and includes:

- Senior roles with RANZCOG (Council, Board and Examinations);
- Ongoing association with the University of Queensland;
- 2010 Queensland AMA President and Board Member; and
- Current Federal Council representative for Obstetrics and Gynaecology.

I have been instrumental in the Federal Council's formation of the Council of Private Specialist Practice, developed to serve a previously underrepresented part of our membership. I have acted on the AMA's behalf to put a stop to the National Maternity Services Framework, which had been formed without a single doctor on the committee. I continue to represent the AMA on multiple Government committees.

An AMA President must be an effective communicator. I'm a seasoned media performer with 25 years' experience encompassing print, radio, television and online platforms.

I continue to write columns for newspapers and magazines as well as having produced and presented State and national television shows. I have experience in live breakfast, drive and talkback radio.

My eight years' experience on Federal Council means I fully understand the workings of both our organisation and the Government departments we seek to influence.

Candidates for Vice President appear on the following pages. PLEASE NOTE: Print deadlines for this edition of *AusMed* fell before the cut-off date for President and Vice President nominations. Any nominations that may have arrived after the print deadline will appear with the others on *AusMed* online.

Dr Jill Tomlinson

MBBS(Hons), PG Dip Surg Anat, FRACS(Plast), GAICD

Nominating for the position of AMA Vice President

We are at a critical period of change in health. We are asked by Government and the community to do more with less. Healthcare costs are rising. Technology is changing how we practise, offering opportunities but also challenges. Our profession faces significant cultural change.

The AMA must remain relevant and engaged in this time of change. It needs a strong leadership team who will deliver advocacy, political representation and passion to do better for our patients and for the profession.

If elected, I will make digital strategy a key priority. Within the AMA, this means improving communication and engagement with members by expanding digital services and addressing barriers at State and Federal levels. The AMA must be where doctors are, and must support a strong AMA in every State.

Within the health system, a focus on digital strategy means strong advocacy for systems and programs that work for doctors, not create work for doctors. This is not just about My Health Record, it's about real time prescription monitoring, secure messaging, data use and security, accessibility, interoperability, care co-ordination, the digital determinants of health and the regulatory and administrative burden on doctors. We must get digital systems right, or else – as we've seen with hospital constructions across the country – billions are spent but the final product doesn't address the needs of patients or doctors.

Preventable illnesses associated with obesity are literally killing our patients. We need a radical, whole of community approach to the problem – one that drives meaningful change. We must advocate for public health improvements and make real investment in general practice, which is the most efficient part of the health system and has been neglected for too long. We must improve mental health care, aged care and veterans' services. We must reduce inequality, and Close the Gap. We must be inclusive, and support equity and diversity. It's the fair thing to do but it's also in the best interests of our patients and the profession.

We must address workforce issues, including doctor and training position maldistribution. We must support medical students and doctors in training who are increasingly struggling to manage the overwhelming demands of training and service delivery. We must improve access to flexible training and end discrimination on the grounds of pregnancy, mental illness, disability, parental leave and return to work. We must advocate for marginalised individuals and groups that cannot speak for themselves.

We must fight for an independent profession. Patient care suffers when health funds control access to care or make decisions for patients; corporatisation increasingly affects general practice, radiology and pathology.

I seek your support and your vote at National Conference. I seek your advice and insights into how we can improve health in Australia as, while I have a vision for the AMA, I do not claim to have all the answers. And most importantly, I seek your enthusiasm, passion and engagement – only by working together will we achieve the best outcomes for our patients and the profession.

Dr Chris Zappala

MBBS (Hons), AMusA, GCAE, MHM, MD, FRACP

Nominating for the position of AMA Vice President

The AMA represents an extremely diverse group of professionals and as such our focus and efforts evolve and change to reflect contemporary need.

The enervating effects of bulk-billing and enforced five-minute consultations puts high-quality medicine in jeopardy. General practice has been progressively disinvested despite all the talk about augmenting community based care and preventing hospital re-admission. The Federal Government must understand that many of their objectives for the health of Australians will be realised if they invest properly in general practice. I accept we must also convince GPs that the AMA understands this and holds it as a priority.

The maldistribution of the workforce has not been solved by an exponential increase in medical graduates. Despite clear AMA policy regarding rural training hubs, appropriate industrial/MBS schedule recognition and bespoke rural/regional training models, we still have a problem. Until this is solved we will continue to endure nefarious role substitution models which pander to other tribal groups and damaging medical over-supply in some areas.

Oversupply forces public hospital doctors into a vulnerable enterprise bargaining position and poses a threat to private medicine and our professional credibility from possible over-charging/over-servicing, fee splitting and selling fringe medical services. This data is being released by those who wish to subjugate or cheapen doctors, so the AMA needs to be leading the discussion in order to shape perception and potential solutions.

Exorbitant graduating workforce numbers compound upon the burgeoning group of vulnerable junior doctors. They should be assured of transparent and fair selection and examination processes with open knowledge of workforce trends. The AMA has a clear need to strengthen relationships with Colleges and move us collectively in this direction.

It is not protectionism to want to preserve the freedom of decision-making for doctors and the ability to charge a fee commensurate with training/expertise and the service provided. This preserves high-quality medicine. Pharmacists, non-medical endoscopists, optometrists all encroach on the medical domain with no decisive rebuttal. We are not being enlightened 'team players' if we allow medical practice in the future to be harder, less rewarding or diminished in any way.

The public hospital system struggles under perpetual funding shortfalls and a blinkered rigidity that focuses predominantly on targets of dubious relevance to clinical outcomes. This partly relates to operational inefficiency but also politically expedient emphasis on spurious initiatives. Any evolution that simplifies hospital funding and reduces the cost-shifting game would be welcome.

Our Association's membership worryingly continues to decline, which jeopardises our collective ability to influence. Only the AMA can bring the profession together and has the expertise to achieve medicopolitical outcomes that improve the daily working lives of doctors. Membership must be cheaper and we can engage better through cohesive action amongst the entire AMA family and an expansion of our digital/online capability.

As always, there is much to do. We need the entire AMA family to be effective and united in promoting thoughtful initiatives at every level. There are too many external threats for us not to be at our most potent, but the AMA will need to do things a little different to achieve this. Hopefully, as AMA Vice President, I can contribute to this.

Your AMA Federal Council at work

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

Name	Position on council	Committee meeting name	Date
Dr Chris Moy	Federal Council Area representative for South Australia & Northern Territory	Australian Digital Health Agency My Health Record Expansion Program Steering Group	8/8/217 & 7/12/17
Prof Mark Khangure	Member of AMA Federal Council and AMA Health Financing & Economics Commttee	ADHA My Health Record Diagnostic Imaging Programme Steering Group	5/11/17
Dr Richard Kidd	Chair - Council of General Practice	My Aged Care Gateway Advisory Group	05/03/18
Dr Richard Kidd	Chair - Council of General Practice	PIP Advisory Group	09/03/18
Dr Richard Kidd	Chair - Council of General Practice	DVA Health Provider Forum	12/04/18
Dr Richard Kidd	Chair - Council of General Practice	PIP Advisory Group	13/4/2018
Dr Tony Bartone	AMA Vice President	TGA Consultative Committee	10/04/18
Dr Gino Pecoraro	Federal Council Member - obstetrician/ gynaecologist	National Strategic Approach to Maternity Services Advisory Group	06/03/18
Dr Beverly Rowbotham	Chair of Federal Council	ADHA My Health Record Pathology Steering Group	23/04/18

OBITUARY

Neville Maurice Newman 9 July 1923 – 27 April 2018

Neville Newman was born in Sydney on July 9, 1923, to Horace and Ella Kate (Dids) Newman and spent his school years at Scots College, Sydney, where, in addition to this academic studies, he played rugby union and rowed for the School.

In 1941, aged 17, Neville was admitted to study Medicine at the University of Sydney and resided at St Andrew's College, where he went on to be Treasurer and President of the student body and also Senior Student in 1945. 1941 was the first year of the war-time accelerated medical course, in which the clinical years were compressed by reducing the breaks between semesters. Neville therefore graduated in 1945 with MB BS with second class Honours, after spending his clinical years at Royal Prince Alfred Hospital (RPAH).

His preclinical years were punctuated by summer holidays spent in a Mills Bomb manufacturing facility or out in the country picking fruit. He also played rugby union for the University of Sydney, being awarded a Blue in 1943.

In 1946, Neville began his residency at RPAH. Then, after a short period as an assistant in general practice, he moved to a training position at the Royal Alexandra Hospital for Children. This was the beginning of a long career in Paediatrics.

On May 10, 1948, Neville married Peg Friend, a nurse he had met at RPAH and in 1949 they moved to London so that Neville could continue his paediatric training. After a series of jobs in the Middlesex group of hospitals and several training courses, Neville passed the Fellowship exam of the London Royal College of Physicians in 1951. He was then able to obtain a paediatric registrar position at the Hillingdon Hospital, Uxbridge.

With one small daughter and a son on the way, Peg and Neville decided to return to Australia in October 1952, moving to Hobart in May 1953 to join the private paediatric practice of Arch and John Millar. This was a demanding job, with office consultation during the day and home visits all over Hobart and surrounds, every evening and often on unpaved suburban streets. Two more daughters were born in Hobart.

In 1962, Neville was awarded a Fulbright Fellowship to Johns Hopkins Hospital, Baltimore, Maryland, USA, where he took part in a developmental study of children from birth to five years of age, with Dr Janet Hardy. The whole family went with him from May 1962 to September 1963.

During this year in Baltimore, Neville developed his love for newborn babies. He was able to bring back with him a specialised three-way tap which allowed efficient exchange transfusion of babies with jaundice due to Rhesus incompatibility. For these exchange transfusions, Neville perfected the cannulisation of the umbilical vein.

On his return to Hobart, Neville began to specialise in Neonatology, attending most of the caesarean sections and multiple births.

In 1964, he was appointed Senior Paediatrician at the Royal Hobart Hospital (RHH), a practice which included neonatology and paediatric oncology. However, not long after this, John Millar retired. This meant that Neville was left as the sole paediatrician in Southern Tasmania until Dr Graham Bury arrived in Hobart in 1975 to set up a second paediatric practice.

In 1975, Neville was appointed as Senior Lecturer at the University of Tasmania and began his research into Sudden Infant Death Syndrome (SIDS) together with Drs David Megirian and John Sherry.

In 1980, Neville retired from private practice to become the Inaugural Director of the Neonatal Intensive Care Unit in the Queen Alexandra Division of the RHH, a position he held until his retirement in December 1989. During this time Neville continued his research into SIDS and in 1992 was awarded an Advance Australia Award for outstanding contribution to Medical Research into Sudden Infant Death Syndrome.

In retirement, Neville continued his interest in Medicine and was made a life member of the Tasmanian Branch of the Australian Medical Association.

Neville was lovingly cared for in the later years of his life by his family and in 2015 moved into St Andrew's Village, Hughes, ACT. He died peacefully on April 27, 2018, aged 94.

Neville was a leader and innovator in Neonatology, a researcher and a wonderful father. His service to the community was immense. He will be sadly missed.

By Jane Twin B Med Sc, MBBS, FRCPA
(Dr Newman's daughter)

The long history of pot

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

Cannabis has a long history, as writer Agata Blaszczak-Boxe tells it in a 2017 *Live Science* article.

"From the sites where prehistoric hunters and gatherers lived, to ancient China and Viking ships, cannabis has been used across the world for ages … The history of cannabis use goes back as far as 12,000 years, which places the plant among humanity's oldest cultivated crops … Burned cannabis seeds have been found in kurgan burial mounds in Siberia dating back to 3,000 B.C., and tombs of noble people buried in Xinjiang region of China and Siberia around 2500 B.C. have included large quantities of mummified psychoactive marijuana."

Her article examines a report on the history of cannabis by Bernie Warf, a professor of geography at the University of Kansas in Lawrence: "For the most part, it was widely used for medicine and spiritual purposes during pre-modern times. For example, the Vikings and medieval Germans used cannabis for relieving pain during childbirth and for toothaches."

This helps put the current discussion about the legal use of cannabis in context.

Blaszczak-Boxe's article reminds us (as Warf points out) that there are two types of cannabis: "There is *Cannabis sativa*, known as marijuana that has psychoactive properties. The other plant is *Cannabis sativa L*. (The L was included in the name in honour of the botanist Carl Linnaeus.) This subspecies is known as hemp; it is a non-psychoactive form of cannabis, and is used in manufacturing products such as oil, cloth and fuel." She also draws attention to a second psychoactive type of cannabis *Cannabis indica* that was identified by the French naturalist Jean-Baptiste Lamarck.

Blaszczak-Boxe notes that: "Both hemp and psychoactive marijuana were used widely in ancient China. The first record of the drug's medicinal use dates to 4000 B.C. The herb was used, for instance, as an anaesthetic during surgery, and … by the Chinese Emperor Shen Nung in 2737 B.C."

Cannabis came to the Middle East with the development of east-to-west trade routes, brilliantly and engagingly described in Peter Francopan's *The Silk Roads*, about 2000 years B.C., and from there to Europe. Warf said: "Cannabis seeds have also been found in the remains of Viking ships dating to the mid-ninth century".

Cannabis arrived in the US in the early 20th century. American attitudes to cannabis were formed, it is said, by Mexicans fleeing the Mexican Revolution who were: "Frequently blamed for smoking marijuana, property crimes, seducing children and engaging in murderous sprees." By 1937 it was a criminal offence in all the US to possess marijuana.

With such a history, it is hardly surprising that it is difficult to arrive at an un-conflicted position about marijuana in our society. But its history surely supports therapeutic trials for pain relief. Recreational use remains contested territory. It is difficult to separate the pharmacological effects of serious use of cannabis from the sociological consequences that follow from using an illegal substance.

A quick trawl through websites relating to marijuana confirms this ambiguity. For example, a US site called AddictionCentre states: "The psychological consequences of prolonged marijuana abuse aren't completely understood. Some studies suggest that marijuana addiction may increase the chances of developing mental disorders such as depression, anxiety, motivational disorder and schizophrenia." Heavy-handed law-n-order approaches risk lumping marijuana with other more dangerous drugs, creating rather than solving problems.

Encouragingly, trials underway in Australia may help clarify its medical role. With $9 million from the NSW Government, three such trials in NSW aim to assess its ability to:

1. Reduce seizures in children with severe treatment-resistant epilepsy, through a partnership with the Sydney Children's Hospitals Network
2. Improve appetite and appetite-related symptoms in adult palliative care patients with advanced cancer
3. Prevent chemotherapy-induced nausea and vomiting in adult patients where standard treatments have proven ineffective.

There are other trials in Australia and internationally. As well, pharmaceutical research continues to clarify the role of different chemicals in marihuana, the cannabinoids, including THC (delta-9 tetrahydrocannabinol) and CBD (cannabidiol). Worries are expressed about a Big Pharma takeover.

Both THC and CBD have the potential to relieve pain, and CBD also has anti-inflammatory properties. THC accounts for the highs of marihuana. A web-based cannabis support line states that CBD on the other hand has an anti-psychoactive and anti-psychotic effect, possibly even relieving anxiety.

Tensions exist between those who recommend plant cannabis rather than pharmaceutical cannabinoids. Only well-constructed trials can resolve these questions. It is encouraging that such trials are underway.

Health Care Homes – are they off track?

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

Recent comments by former AMA President Dr Steve Hambleton, who led the Government's Primary Health Care Advisory Group, have highlighted that the Government's Health Care Homes Trial has hit troubled waters. It is no secret that practices have dropped out of the trial and patient sign-ups are well below target.

While supporting the concept of the Health Care Home, the AMA has had concerns with the implementation of the trial from the very start. It seems that these were not misplaced, and it is hard to see how problems with the trial can be turned around – even with the goodwill of the profession.

The target of 65,000 patients for the HCH will not be reached any time soon, which has serious implications for the collection of base line data. This work is fundamental to the evaluation of the trial and is supposed to be completed by 30 June 2018. On current indications, it is hard to see how this baseline data could realistically be a valid foundation for any comparison of future outcomes.

So, what are the barriers affecting the trial's full implementation and threatening the validity of its evaluation?

Well, in the AMA's view, the funding provided under the trial is inadequate. GPs are being asked to be innovative and pro-active, and to deliver a greater range of services to patients with no additional funding.

In a move away from fee for service, practices will receive a bundled payment for this care to divide up with their GPs and other staff.

This represents a new way of doing business for most practices, with the potential for disputes and extra compliance costs. Contractual relationships also become uncertain. While the Government has released accounting and taxation advice to the effect that HCH funding will not affect the existing relationship between practice and practitioner, many GPs remain wary of the potential consequences.

The unavailability of the risk stratification tool at the outset of the trial made it difficult for practices to undertake an accurate cost benefit analysis before signing up. Practices need to understand the implications of the move to bundled payments, including the likely costs of caring for eligible patients and how this might compare to the funding being provided by the Government.

While the new bundled payments system being trialled allows GPs to bill the MBS for care that is not related to a patient's chronic condition, the distinction is often unclear. Does a wound care consultation relate to a patient's underlying chronic condition or not? Everyone is aware that the Department of Health is monitoring billing practices under the trial and no one wants to fall foul of billing rules.

Being a Health Care Home, effectively involves a systemic whole-of-practice change. Some of those practices involved are already well down the path of patient-centred, multidisciplinary team care, under-pinned by data-driven quality improvement. Others are not, and significant changes are required to be in that space.

Other issues include shared care plans. There are concerns about patient privacy because of the requirement for the whole health care team to be given access to the entire shared care plan. This is problematic if a patient does not want their podiatrist knowing they have a mental health condition.

We also know that general practice is one of the most computerised professions. However, that is not necessarily the case for other health professionals within the care team – making use of a share care plan something that is outside their systems capability and their normal clinical workflow. Getting engagement in any activity outside of clinical workflow is going to be difficult, particularly where funding does not support it.

Under the bundled payment model, we also know that there is pressure on practices to devolve work to the least cost provider. For many GPs, this is a very significant issue. While team-based care is now part of everyday general practice, the fear of effectively losing meaningful responsibility for the care of a patient is a real concern for GPs.

The Medical Home model of care is a good one and still represents the way forward for general practice in this country. It revolves around a GP led model of care and, with proper data collection, is a vehicle that can demonstrate the value of general practice in the health care system.

However, the current HCH trial is clearly struggling and unless it is given more time and additional investment, its results could well spell the end of what is conceptually a very sound health policy.

Rural mass trauma

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

In the wake of two devastating multiple trauma incidents in Canada, my mind went to a multiple victim trauma that occurred in one of the little rural towns I was working in.

Three multiple victim trauma incidents, one rural, one urban and one I personally attended in the Outback.

Rural

6 April 2018: Outback Canada, good daylight driving conditions, bus transporting an ice hockey team versus semi-trailer (B double). Dry, tar sealed, rural road, snow on fields, 16 dead, 13 injured. 30 km away are two small rural hospitals, staffed by GPs. The injured arrived there first. Five hours from time of the accident, the injured first make it to a trauma centre 250 km away, by multiple choppers, fixed wing and road. Five hours. A long time but as it turns out, most of the boys died on the scene, so the time made little difference.

Urban

23 April 2018: Yonge Street, one of the busiest, longest streets in Toronto. The carnage occurred after 1300h. 10 dead, 14 injured. Nearby, less than 10 km away, is the largest trauma centre in Canada. In less than an hour, they were able to gather three trauma surgeons, one orthopaedic surgeon, a neurosurgeon and multiple other doctors. Their ICU has 181 beds. They called Code Orange at 1347h. The first injured arrive shortly after 1400h. Forty-five minutes. Some went straight to the Operating Rooms. This hospital had run multiple simulations and table top sessions. The teamwork was impeccable.

My experience

23 March 2014: Remote WA unsealed road, Landcruiser versus ditch, no seat belts, 15 people whose ages ranged from three to 70. One dead, 13 injured. This town was a remote community with 1500 people, five doctors in the community, only one ED doctor rostered, four others available somewhere. The accident occurred about one hour away from our hospital, we had one ambulance. Many had to be left at the accident site. At the site, there was unforgiving heat, little water, confusion, pain. Three doctors came in to help. At the hospital, the most critically injured patient (who did not make it), was in the only resus bay. Management was complicated with a consulting doctor on telehealth and the doctor on the ground calling out orders. Later we found that another occupant in the vehicle suffered a splenic injury. For others, spinal cord injuries were feared.

What's the same?

- Critical illness does not respect geography;
- FIRST principles regardless of location. ABCDE;
- Teamwork;
- Our inner terror, our outer calm;
- The noise; and
- The aftermath.

What is different?

- The tyranny of distance;
- The problem of smallness, fewer of us, less mobile coverage, less resource (like ONeg blood);
- We are not specialists, not surgeons, anaesthetists, FACEMs;
- We may know the injured, they are us;
- We are treating a person where a familiar attachment exists; and
- More trauma deaths with rural and especially remote traumas.

Rural doctor, what you can do to prepare? Rehearse. Simulate. When you go into your rural hospital, crack open the crash cart, touch the ETT, find and turn on the paddles, locate the chest tube set up, where is the RIC pack, IO gun? Do this alone then in a team. Take a trauma management course. We are lucky in Australia to have two choices: ETM Course and ESTM. In North America it is ATLS. If you have internet, we have online resources: lifeinthefastlane.com, resus.me, college resources. Thank you for being there, you are not alone.

Here is a good approach to help with both being prepared and later in the debrief:

Dr Tim Leeuwenburg, a rural generalist from Kangaroo Island, SA, says:

"Many people think that success in a resus is due predominantly to their clinical knowledge and skills. All that stuff we learn at medical school and in postgraduate training which pertains to the patient.

While this is certainly, true, experienced clinicians realise that understanding three other domains - self, team and environment are important.

... continued on page 23

Collaboration and transparency are required at critical time in PHI reform

BY ASSOCIATE PROFESSOR JULIAN RAIT OAM, CHAIR, AMA COUNCIL FOR PRIVATE SPECIALIST PRACTICE

The Council of Private Specialist Practice (CPSP) met face to face in April in a joint meeting with the Health Finance and Economics Committee (HFE), chaired by Associate Professor Susan Neuhaus.

The AMA has always believed collaboration and transparency are key to delivering outcomes that are both practical for the profession, and just as importantly, supportive of our patients. Both CPSP and HFE are currently leading the AMA through significant and far-reaching health reforms in a number of areas, so a joint meeting was an opportunity to ensure our responses are connected and take a whole of system view.

The agenda tackled recent developments from the Government's review of Medical Indemnity insurance and public hospital funding, while including an informative presentation from the CEO of the Independent Hospital Pricing Authority; upcoming COAG negotiations around hospital funding agreements; details of the Australian Commission on Safety and Quality in Health Care's Atlas of Health Variation; and of course, the work of the Private Health Ministerial Advisory Committee (PHMAC) were discussed. The latter included a lively exchange on the latest developments on out-of-pocket costs and private health insurance product design.

I encourage members to read Prof Neuhaus's latest *Australian Medicine* opinion piece on quality and safety-based funding which details much of CPSP/HFE's discussions on the Federal Government's questionable plan to penalise certain hospital events.

However, with respect to private health, PHMAC is now at the implementation stage of private health insurance product design and clinical definitions. Some would be aware that the PHMAC Secretariat had publicly released the Issues Paper, *Gold, Silver, Bronze and Basic*, where clinical definitions have been assigned under each category of cover.

CPSP and the AMA more broadly have advocated for simplified, better value private health insurance products for consumers. Simpler products translate to no surprises, less out-of-pocket costs, and more informed patients.

In this context, CPSP/HFE reviewed the proposed classifications, noting while the proposed model is intended to make products easier to compare, it is far from perfect and needs considerable consultation and improvement. Indeed, to 'operationalise' these definitions and what they cover, PHMAC Secretariat has also mapped some of the relevant MBS item numbers under each of the 'clinical definitions'.

But this first version appears to pose a significant risk to patients who may not be covered for services which are included within common clinical pathways.

For example, patients with some policies appear covered for the removal of cancerous lesions, but they will not be covered for having the incision repaired – as this part of the service is considered 'plastic and reconstructive' and currently sits under a higher policy category.

It is evident that the current draft highlights the tension between value and affordability. Consequently, our concern is to ensure that any new scheme doesn't worsen the situation for patients by putting some services currently in lower level policies into future gold level policies.

Thankfully the Department has approached select stakeholders, inviting them to examine their draft mapping of MBS items against each clinical definition, and by extension each insurance category.

The AMA has looked for feedback from our committees, our State and Territory AMA branches, some of the hospital peak bodies, and the Colleges in our response.

At first glance there appear to be gaps in the mapping that could have a negative impact if they were implemented. Furthermore, the mapping appears to be independent of the MBS Review, which has spent countless hours understanding how items are used individually and in combination to treat patients, which specialties use them and in what setting, and the range of procedures or services they cover.

The AMA has repeatedly called for the MBS Reviews to be informed by consultation with clinical experts familiar with the MBS and its application. Therefore, we feel strongly that the placement of MBS items under such definitions must be handled with the same rigour. The allocation of MBS items to clinical definitions ultimately determines the value proposition of private health insurance, when a patient is covered for a service, and when a benefit will be received. And of course, as the MBS Review rolls on, the items will change – and this will again need to be reflected in updated MBS item allocations for clinical definitions underpinning Gold, Silver and Bronze insurance policies.

TO THE EDITOR

Congratulations for supporting a breastfeeding working mother

Below is a letter sent to Dr Jill Tomlinson following an article that appeared in AusMed on April 16, 2018. AusMed sought and received permission from both Dr Tomlinson and the ABA to publish the letter in this edition.

Dear Dr Tomlinson

Firstly, congratulations on the birth of your daughter, Anna.

It was fantastic to see the Australian Medical Association supporting you and Anna at the recent Federal Council. Returning to work is recognised as one of the barriers for many mothers to continue breastfeeding.

The Australian Breastfeeding Association (ABA) members and volunteers have campaigned for a number of years for the inclusion of breastfeeding within anti-discrimination laws and paid maternity leave.

To see women such as yourself supported by AMA underlines that our work does make a difference and shows Australia that breastfeeding mothers can participate in the workplace when the right supports are in place.

ABA would like to offer to support you further in your breastfeeding relationship with a personal membership to our Association.

ABA provides evidence-based information, peer to peer support, advocacy, health professional education and, in your case, a Breastfeeding Friendly Environments program. This program supports employers to support their employees returning to work after having a child.

If you would like to take up this offer please let me know and we will arrange for a membership.

Again, congratulations and we wish you and your family every happiness.

Arianwen Harris
ACT NSW Branch Office Administration Officer
Australian Breastfeeding Association

Editor's note: *Dr Tomlinson had already been gifted an ABA membership by a colleague and so will, with the agreement of the ABA, "pay this gift membership forward" to the person most likely to be the next breastfeeding AMA Federal Councillor.*

Rural mass trauma

... from page 21

I learned this from renowned 'resuscitologist' Dr Cliff Reid and team of SydneyHEMS

To break that down:

Self – It's important to understand the impact of stress on yourself and how you manage the resus. Cognitive overload, bandwidth limitation and the sympathetic surge of stress can degrade performance.

Team – There is an old phrase: "What's spoken is not heard, what's heard is not understood, what's understood is not actioned." On ETM we teach the use of a 'shared mental model', of frequent summarising of key action points...and we emphasise the use of 'closed loop' communication. If a 16-year-old can 'close the loop' at the Maccas's drive through when ordering fast food, we should be able to do the same in a complex resus.

Environment – This is often under-appreciated. The importance of 360 degree access to the patient, of good lighting, of working in an ergonomically appropriate position, can all impact on the success of a resus.

So - STEP UP – Think **self, team, environment** and **patient**. Read more at RESUS.Me from Cliff Reid - resus.me/analysing-resu... or come along to one of the ETMcourses run across Australia/New Zealand."

Collaboration and transparency are required at critical time in PHI reform

... from page 22

To that end the AMA has stated strongly to the Department and Minister Hunt's office that a longer, more rigorous process will be needed to properly develop this work. And it simply cannot be done in isolation of the expertise available from the Colleges, Associations and Specialist Societies.

Without doing so, arguably the most critical component of the private health reforms will fail, and ultimately our patients will suffer. Our role is to call loudly and strongly for that to be avoided.

Rural health – isn't it time we brought in the specialists?

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

It's been a welcome change to see rural health, and the rural health workforce, front and centre of the national policy debate of late. Sadly, while the acting Prime Minister's advocacy has been well meaning, it demonstrates a lack of understanding of the medical workforce and the medical training pathway.

> "Undoubtedly, there is massive maldistribution between metropolitan and rural areas for all facets of the medical workforce, including both general practitioners and specialists."

Undoubtedly, there is massive maldistribution between metropolitan and rural areas for all facets of the medical workforce, including both general practitioners and specialists. The Medical Practitioners Workforce Report from 2015 states that in metropolitan areas, there were 442 FTE (generalists + specialists) per 100,000 population, in stark contrast to 263 FTE per 100,000 population in remote areas. Interestingly, the supply of general practitioners in these areas is 136 FTE per 100,000 population, greater than the national average of 112 FTE. What this demonstrates is that our remote workforce is driven by a generalist model of care and, to this end, it is heartening to see a commitment to a rural generalist pathway by both the accreditation bodies for general practice, as well as from the Federal Government.

This will aim to improve the quality of care delivered in remote areas and the numbers of GPs in regional areas as well. This is the type of pathway that will actively increase the numbers of qualified medical practitioners in remote locations – more medical schools will simply dump more interns and residents, without the ability to practise individually, into a saturated training market without foreseeable exits that have any direct pathway to rural practice.

What this will not change is specialists practising rurally and regionally, and therefore access to specialist care. The specialist workforce changes substantially outside metropolitan areas – the FTE per 100,000 population halves from metropolitan areas to inner regional, drops further to outer regional and are extremely scarce in remote areas. Regional areas see both more complex patients with multiple comorbidities - higher levels of smoking, obesity, being sedentary, using alcohol excessively and high blood pressure relative to their city counterparts (Australia's Health 2016, AIHW). Mortality is 1.2-1.4 times higher outside of the city, and the most common cause of death is coronary artery disease.

On a broader scale, this speaks to the need for GPs skilled in population health and preventive care, but what about those who are sick now? We need specialist training programs to deliver skilled medical practitioners – cardiologists, lung physicians, endocrinologists, gastroenterologists, surgeons of all descriptions – in the right practice settings to deliver care where and how it's needed. Primary percutaneous coronary intervention for heart attacks has been the accepted gold standard treatment since the 1990s – every regional setting needs access to 24/7 cath lab services. Cancer services being delivered close enough to home that patients don't have to choose between moving or treating their cancer. Haemodialysis availability and delivery of nephrology care for the same reasons. No one should have to choose between living in regional Australia and the best health care our system can deliver.

Regional specialist trainee pathways have been buzzwords for years. There are rotations – in my cardiology training program we spend four months rurally, as do many other programs – but there aren't entire pathways. You can't spend internship and residency rurally, without having to come back to the city for most or all of your basic and advanced training. There's certainly no surety for your family or spouse to plan lives, careers and schools, and good luck to you if you both happen to be medical (which surely would be the dream for most regional or rural towns!) and want to work close enough together to live together. It can be done – but it needs to be substantially easier than it currently is. The time is ripe for all Colleges to pursue formalising these pathways, and State and Federal Governments to appropriately fund and support them. The precedent has been set with the rural generalist pathway – the next step, the future advocacy from the National party, should be all about rural specialists.

Instead of sinking millions into a new medical school that will turn out freshly made interns without anything to contribute – forcing even more doctors out of clinical careers at great expense to the public hospital system – why not get the specialists rural and regional communities need directly to them, with the right tools, to solve the disparities in mortality that are unconscionable today?

The advocacy voice of medicine, preserving the idealism

BY ALEX FARRELL, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

A few weeks ago in April, more than 200 medical students gathered at Hyde Park and marched through the streets of Sydney. Their message was simple – that detention harms health, and the Federal Government should allow a group of independent medical experts to undertake a comprehensive assessment of the health and other needs of the refugees and asylum seekers. It was the coming together of over 10 student organisations, headed by AMSA's Crossing Borders, and many, from doctors to grandmothers, joined them.

> "Doctors do not practise in a vacuum, and almost always the ailments presented in hospital and in clinic are inextricably linked to social and environmental factors outside of the realm of medicine alone."

This year, as President of the Australian Medical Students' Association, I have been lucky enough to meet and speak with medical students from all around Australia. One trend in our member engagement has consistently surprised me. Medical students don't become members of AMSA because of the advocacy we do for them around workforce or medical culture and wellbeing, but rather the advocacy we do for others.

As I write, AMSA's Code Green team is in Bonn, Germany, at the United Nations Framework Convention on Climate Change Conference, bringing a focus on the Australian and global health ramifications of climate change. Students are lining up at blood banks as the annual AMSA Vampire Cup blood drive urges medical students, alongside their friends and families, to donate blood. AMSA Rural Health is speaking out on what is needed to level the playing field and support the health of rural communities.

I want to celebrate these students, and ask: How do we preserve this passion and energy into our professional years?

There can be resistance against doctors stepping outside of clinical medicine to advocate. But the role of a doctor ceased to be limited to treatment of a single patient's health conditions a long time ago. Primary care, preventive medicine, the social determinants of health – today's medicine recognises that our patients are not isolated from their surroundings. Doctors do not practise in a vacuum, and almost always the ailments presented in hospital and in clinic are inextricably linked to social and environmental factors outside of the realm of medicine alone.

Where social issues intersect with health, there is a role for the medical world to speak up. During the marriage equality plebiscite, the use of online mental health support services for LGBTIQ+ teens increased by up to 40 per cent. At a time when the validity of so many people's identities was up for public debate and scrutiny, I heard countless stories of gratitude for the AMA's strong supportive stance. This was a health issue, and knowing that Australia's doctors were standing with their queer patients made a difference.

When doctors step into advocacy, they step forward as community leaders. Doctors have always been attributed a larger role in health and society than their clinical practice would necessarily entail. A core privilege of the medical profession is the trust that comes with it, a belief that our voices are altruistic, reliable and evidence-based. That provides a powerful platform from which doctors can work to address the environmental issues behind many illnesses devastating patients. Doctors have the ear of the most vulnerable Australians, and with that comes a responsibility to speak on the issues that affect their health.

AMSA works hard to equip medical students with the practical experience and tools to continue being advocates after they graduate – be it through media, representative organisations, political engagement or simply attending a march. Idealism is not just for the young. There are social challenges facing our nation's health that can be changed. The collective voice of our profession is formidable; let's make sure students and doctors alike continue to use it.

Safety and quality or cost savings

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

Since my last piece, significant momentum has gathered for quality and safety based funding. The Federal Government is in the process of implementing a series of measures which will financially penalise hospitals for failing certain quality and safety standards. While consultation on pricing and funding options for avoidable readmissions is underway, pricing for sentinel events and hospital acquired complications (HACs) will both be in effect by July 2018. These measures have been developed under the guidance of the Independent Pricing Authority (IHPA) and the Commission on Safety and Quality in Health Care. The Health Financing and Economics Committee, along with the Council of Private Specialist Practice recently had both organisations present at our April face to face meeting.

There is no doubt that the AMA supports efforts to reduce potentially avoidable adverse events in hospitals and improve patient care. However, the notion that simply deducting funding from an increasingly under-resourced public health system will improve safety and quality in hospitals is fundamentally flawed. Though the Commission states on its website that the evidence is "equivocal," a deep dive into the literature reveals another story.

Several schemes have been implemented globally, trying to achieve similar ends. A recurring theme in these studies – with the bulk of research in this area stemming from the UK and Us – is that negative incentive structures alone do not lead to long term improvements in quality and safety outcomes. Of those that did demonstrate modest improvements, most were not maintained in the long term, with a paper published in the NEJM by Kristensen et al. in 2014 suggesting a 'spill over effect', resulting in worsening outcomes in unmeasured areas outside of the studies. Causality is also hard to prove with improvements also attributable to data collection mechanisms and regular feedback.

One successful program in the US involved the implementation of cost neutral measures which saw rewards for best performers in parallel with penalties for poor performers. Here, funds were redistributed – not withdrawn – leading to a 15 per cent reduction in hospital acquired conditions. Another successfully implemented UK incentive scheme involves the use of 'best practice tariffs', where payments to hospitals for care are based on 'best practice', instead of average costs as is the case in Australia.

What this suggests is that, at the very least, any savings created by a penalty scheme need to be reinvested in hospitals to encourage idea sharing and the development of targeted quality and safety strategies.

More broadly, it's important to recognise that pay for performance incentive schemes are designed to drive behaviours where actions and rewards are easily linked and are founded on the behavioural tendencies of individuals. Applying such strategies to hospital networks as a whole assumes health service providers change behaviours in response to financial levers applied to the wider health network.

Top down, non-targeted pay for performance schemes, such as those being implemented here, have in my opinion, little chance of driving quality and safety improvements. The delivery of acute hospital services is complex, involving the collaboration of multiple stakeholders, not least among them administrators, nurses and doctors. Expecting these parties to drive improvements in care, while simultaneously reducing the funding which allows them to operate, is unsustainable.

If both Federal and State Governments wish to see improvements in safety and quality, they must resource their hospitals to do so. This could be achieved by empowering providers with funding to achieve long term improvements, engaging with health care providers to form targeted solutions for particular goals, and embracing technology to allow for timely and relevant data to be used by providers to improve practice.

The reality is that errors are rare. And where errors do occur in hospitals, it is often because hospitals lack resources, not because health care providers aren't motivated to improve their practice. More is needed to drive health care improvements and this starts with safety and quality specific funding, and implementation that is co-designed with clinicians. Otherwise, any new measures will be seen for what they really are; cost savings and nothing more.

Visiting remote Indigenous communities in the Northern Territory

BY AMA PRESIDENT DR MICHAEL GANNON

Last month I was invited to accompany the Hon Warren Snowdon MP, Member for Lingiari and Shadow Assistant Minister for Indigenous Health, to the Northern Territory to meet with local Aboriginal leaders, medical and other health staff.

I saw first-hand the unique challenges that exist in providing primary health care services in the remote Aboriginal communities of Kintore and Utopia.

The Pintubi people of Kintore and the Alyawarra and Anmatjirra people of the Utopia region, separated by hundreds of kilometres, nonetheless share a history, having both returned to their traditional lands to re-establish their communities in the 1980s.

Both suffer from insufficient functional housing and overcrowding. Both have high levels of food insecurity, including limited access to affordable, healthy food and a consistent potable water supply.

Both communities have crippling levels of diabetes and resultant kidney disease, as well as other chronic diseases and communicable infections.

Both communities are serviced by dedicated, generous and passionate health staff who are committed to improving the health of the communities they serve.

Both communities have used their passion and connection to art to drive self-determination for their people.

These communities are proud, with many examples of resilience and empowerment. But the reality is that they face significant and complex challenges.

Funding for local health services remains inadequate. Something as simple as the maintenance and repair of air conditioners, far more than a luxury in the searing heat of central Australia, can cost more than $60,000 per year. Costs associated with transferring a patient to Adelaide for tertiary level care fall on the local health service. It is cost effective to pay for loved ones to travel with patients to Alice Springs, in doing so providing not only comfort, but reducing the rate of discharge against medical advice. However again the costs of transport and accommodation come out of fixed budgets.

It is difficult to attract skilled medical and other health professionals to work in remote areas, and it can be even harder to get them to stay, with many working on a fly-in-fly-out basis or only on short term contracts.

It is also logistically challenging to provide healthcare in remote communities. While the Commonwealth Government has just announced that they will fund a major expansion of the sealed road to the Urapuntja health service in Utopia, many of the outreach communities, like Kintore, can only be reached by air or via unsealed roads. While rain is necessary and often welcomed in the Northern Territory, it can also isolate communities from services, including the Royal Flying Doctor Service.

The need for haemodialysis in remote Aboriginal communities is extremely high. I was amazed to find out on my tour of Alice Springs Hospital that it is the largest dialysis service in the southern hemisphere. Leaving family and country to be treated in town is problematic.

Connection to culture is important to the health and wellbeing of Indigenous people and is known to produce positive health and life outcomes. Aboriginal people need to be supported to stay in the communities where they are connected to their land, culture and families.

Western Desert Dialysis, better known as Purple House, is an Aboriginal-controlled dialysis service based in Alice Springs that has established dialysis units in remote communities, including Kintore, as well as providing support to other remote communities like Utopia.

I was already familiar with the inspiring story of how Aboriginal artists from across the western desert grouped together and painted artworks that raised more than $1 million to allow Purple House to begin their community dialysis service. They operate across nine remote communities in the Northern Territory and Western Australia. As well as permanent chairs in these locations, they also provide a mobile dialysis service via their Purple Truck which drives to remote Aboriginal communities.

I gained a deeper understanding of local health issues and the challenges that doctors and nurses face in delivering health services in remote areas. I was truly impressed by the passion, commitment and dedication of doctors, nurses and other health staff who work tirelessly in very challenging environments.

I found that each community has their own unique challenges, but the overall messages that I heard was one of survival and determination. Aboriginal people in remote areas continue to face great adversity, but within each of these communities I saw patient, resilient, strong-willed and determined local Aboriginal people taking control of their own health – with some positive outcomes occurring.

Building the future medical workforce

BY AMA VICE PRESIDENT DR TONY BARTONE

The AMA, the peak professional organisation representing Australia's doctors, has an impressive record of leading the health policy debate by bringing together disparate organisations to find ways to solve difficult issues.

This was on display again when we had more than 80 of the people who mattered gather recently to consider one of the biggest health challenges confronting Australia — how do we build a sustainable medical workforce that will deliver the right number of highly trained doctors in the disciplines and regions where they are needed?

On 3 March 2018 we assembled in Melbourne doctors in training, representatives of prevocational and vocational medical training organisations, medical schools, Colleges, health organisations, State AMAs and Commonwealth, State and Territory health departments for the AMA Medical Workforce and Training Summit.

This was our first medical training summit since 2010, where practical solutions to address the crisis in prevocational training were put forward.

March's summit had an ambitious agenda covering the shortage of vocational training places, the distribution of the medical workforce, the under and over-supply in some specialties and the long-standing imbalance between generalist training and sub-specialisation.

I had a clear sense that participants wanted to have their concerns heard and a strong desire to find solutions to put to policymakers. Audience polling was used to identify strategies to address issues raised during discussions.

Unsurprisingly, there was consensus that we do not need any more medical schools, and the focus must shift instead to solving the maldistribution of doctors and shortages in specialty areas and address community need by supporting extra prevocational and vocational training places.

There was also an extremely strong feeling that we need a whole-of-government approach to plan future care delivery, and for all governments to collaborate more effectively on workforce planning, training and co-ordination to meet that critical need.

Amazingly, on that last point, it's over 15 years since Australia last had a national medical workforce strategy. I believe we must seize this opportunity to use the areas for action identified at the summit to drive a new national strategy with buy-in from the Commonwealth and the jurisdictions.

Any less is not only a disservice to the growing exodus of graduates into the highly stressful postgraduate training pipeline, but also to the Australian community poorly served with timely access to appropriately trained world-class doctors.

A detailed report on the outcomes from the day has been circulated to the participants. Some of the ideas and strategies put forward will be used to drive the AMA's ongoing advocacy on medical workforce and training.

My thanks to the Medical Workforce Committee, the Council of Doctors in Training and Secretariat for bringing this important event to fruition, as well as to the presenters and participants.

The final report of the Medical Workforce and Training Summit is available at: http://www.ama.com.au/medical-workforce-training-summit

Visiting remote Indigenous communities in the Northern Territory ... from page 27

Because of my clinical background, I have long been familiar with the concept of Developmental Origins of Health and Disease (DOHaD). Diagnosis of Type II Diabetes in childhood is as remarkable as it is tragic. The sheer scale of pathophysiology I saw demands a focus on Social Determinants of Health. Of course this informs the AMA's work nationally on alcohol, nutrition, sugar taxation and other aspects of preventive health. But on the ground health services, provided with funding according to need, are required now.

I am extremely grateful to Warren Snowdon for making the visits to these two communities possible and accompanying me on the trip. I am hopeful that we will see further progress made in improving outcomes for Aboriginal and Torres Strait Islander people across Australia, determined that the AMA will maintain its leadership in advocating for improvements to the health outcomes of Indigenous Australians.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Positive change for remote sufferers of end-stage kidney disease

The AMA has welcomed the Federal Government's recent announcement of Medicare changes to give greater dialysis access to remote Indigenous Australians.

The changes, announced in April, are due for implementation in November this year. The Government has agreed to fund a dedicated Medicare item number for the treatment. It was recommended by the taskforce reviewing all 5,700 items on the Medicare Benefit Schedule (MBS).

During a recent visit to the Northern Territory, AMA President Dr Michael Gannon saw how the introduction of an MBS item number for remote dialysis will make huge difference to Aboriginal and Torres Strait Islander communities with a high rates of kidney disease.

Aboriginal and Torres Strait Islanders are almost four times as likely to die with chronic kidney disease as a cause of death than non-Indigenous Australians, and about nine in 10 Indigenous Australians with signs of chronic kidney disease are not aware that they have it.

Although the Alice Springs Hospital has the largest haemodialysis facility in the southern hemisphere, it depends on patients failing to show up for appointments to keep running.

By contrast, the Purple House outpatient dialysis centres in Alice Springs and Kintore have 100 per cent attendance rates.

The Government's recent announcement means the Purple House service will be able to claim for Medicare funding, where as previously they have had to rely on private donations and fundraising.

"It's very difficult to deliver services to small, remote communities, but quite simply as a nation, we need to," Dr Gannon said.

"Keeping people on country for treatment, rather than forcing patients and their extended families to come into Alice where accommodation might be difficult or expensive, is another example of something that requires a bit of thought and substantial investment to start things up, but they are cost-effective programs."

Purple House CEO Sarah Brown said the announcement came after years of hard work by Aboriginal communities.

Dr Gannon and Warren Snowdon MP visiting the remote Purple House outpatient dialysis centre in Kintore, Northern Territory.

"They proved it was a howling success and now Medicare has agreed that it's the best way to provide services for this group of people," Ms Brown told ABC Radio.

Dr Gannon also believes visits like his recent trip to the Northern Territory are an important means to strengthen the AMA's advocacy role.

"It's another example of what the AMA can do. We are the organisation that has the ear, perhaps not as often as we'd like, but we have the ear of the people who make decisions in this country.

"I meet regularly with Minister for Indigenous Health, Ken Wyatt. I meet regularly with Minister for Health Greg Hunt. We speak to the Opposition. We speak to the Health Department in Canberra.

"That's one of the things that we can do. We can talk to the people on the ground, we can talk to doctors, nurses, other health staff on the ground, and we can take those messages to Darwin, to Canberra, where those decisions are made, and ultimately where the money comes from."

The Medicare Benefits Schedule review taskforce was established in 2015 and has provided the advice for nearly all of the additional Government funding for Medicare, on top of what is provided for in the Budget.

MARIA HAWTHORNE AND MEREDITH HORNE

Research

Fatty fish is the good oil

Fatty fish gives you good cholesterol, according to a new study from the University of Eastern Finland.

The research, published in *Molecular Nutrition & Food Research*, found that eating fatty fish increases the size and lipid composition of HDL particles in people with impaired glucose metabolism.

HDL lipoprotein is commonly known as the good cholesterol, although the health effects of HDL particles actually are dependent on their size and composition.

The changes in the size and lipid composition of HDL particles caused by fatty fish make them beneficial for cardiovascular health. The study also found that camelina sativa oil decreases the number of harmful IDL particles.

The researchers studied the effects of camelina oil and fatty fish intake on the size and composition of cholesterol-carrying lipoproteins.

Earlier studies have shown that large HDL particles are associated with a reduced risk of cardiovascular diseases, whereas a small HDL particle size may increase the risk.

The IDL lipoprotein is the precursor of LDL, which is also known as the bad cholesterol. Research has shown that long-chain omega-3 fatty acids found in fish have a beneficial effect on lipoprotein size and composition. Camelina oil is rich in alpha-linolenic acid, which is an essential omega-3 fatty acid.

The study involved 79 Finnish men and women aged between 40 and 72, and with impaired glucose metabolism. Study participants were randomly divided into four groups for a 12-week intervention: the camelina oil group, the fatty fish group, the lean fish group, and the control group. People in the lean and fatty fish groups were instructed to eat lean or fatty fish four times a week, and people in the camelina oil group were asked to use 30 millilitres of camelina sativa oil daily.

Participants in the control group were allowed to eat fish once a week, and the use of camelina oil and other oils containing alpha-linolenic acid, such as rapeseed oil, was prohibited.

The researchers found that eating fatty fish increased the size and lipid composition of HDL particles, and that the use of camelina oil decreased the number of harmful IDL particles. Both of these changes can reduce the risk of cardiovascular diseases. Eating lean fish, however, was not associated with changes in the number, size or composition of lipoprotein particles.

CHRIS JOHNSON

Research hub for eating disorders

A new collaborative partnership between NSW researchers has resulted in the launch of Australia's first research hub for eating disorders.

The InsideOut Institute for Eating Disorders will be the team's home and will be totally dedicated to eating disorders.

Earlier diagnosis, improved evidence-based treatment and ongoing support during recovery for people living with an eating disorder will be the focus of the centre's research.

In launching the Institute in April, NSW Mental Health Minister Tanya Davies described its renewed research agenda as "really exciting".

"We've worked closely with the Institute since 2013 to deliver the country's first dedicated Service Plan for Eating Disorders and it's been a game-changer for improving the care we provide patients and families," she said.

The NSW Government has committed more than $400,000 per year to the Institute for the continued implementation of the NSW Service Plan for Eating Disorders, which includes specialist training for frontline staff and workforce development.

An additional $1.2 million has also funded ongoing projects. The Institute, formerly known as the Centre for Eating and Dieting Disorders, is a collaboration between Sydney Local Health District and the University of Sydney.

Federal Health Minister Greg Hunt praised the Institute's commitment to helping the more than one million Australians living with an eating disorder.

"Bringing eating disorders out of the dark and into the light of public discourse is essential to drive change and I applaud the InsideOut Institute's mission to further transform the Australian treatment landscape for eating disorders," Mr Hunt said.

Institute Director Dr Sarah Maguire said launching the Institute was an important step in driving forward a national research agenda for eating disorders.

"Eating disorders have one of the highest mortality rates of any mental illness – fortunately, they are solvable. Our research work will explore innovative treatments and better ways to intervene with early intervention," she said.

CHRIS JOHNSON

Unhealthy air around the globe

Nine out of 10 people across the world are breathing bad air, according to new data from the United Nations, which is calling on all member States to urgently do something about it.

The latest World Health Organization air pollution study found that more than 90 per cent of the global population is breathing in poor quality air.

Air pollution is responsible for seven million deaths a year.

While the problem affects people everywhere, it is those living in poorer countries who suffer the most.

Exacerbating the problem was the fact that more than 40 per cent of the global population work in their own homes with dirty cooking fuels and polluting technologies.

The use of dirty cooking fuel is a major source of household air pollution and contributes to 3.8 million premature deaths each year.

Outdoor air pollution is linked to 4.2 million fatalities annually.

"Air pollution threatens us all, but the poorest and most marginalised people bear the brunt of the burden," WHO Director-General Tedros Adhanom Ghebreyesus.

"It is unacceptable that over three billion people – most of them women and children – are still breathing deadly smoke every day from using polluting stoves and fuels in their homes."

The study found that more than 90 per cent of air pollution-related deaths occur in low- or middle-income countries, and mostly in Asia and Africa.

WHO has described the situation as a "very dramatic problem we are facing" and warned that improvements made in addressing the situation were not even keeping pace with population growth in many parts of the world.

Strokes, heart disease, lung cancer and respiratory infections such as pneumonia are rising due to air pollution.

Cities in the Middle East, North Africa and South-East Asia were found to have the highest ambient air pollution with some levels more than five times higher than what is considered safe.

WHO has called on governments everywhere to take strong and measurable action to reduce air pollutants and thereby improve the health of their citizens.

CHRIS JOHNSON

World study proves exercise good for mental health

Everyone knows exercise is good for your health, physical and mental.

New findings from an international collaboration of researchers, however, has revealed that physical activity can protect against the emergence of depression, regardless of age and geographical region.

Researchers from Brazil, Belgium, Australia, USA, UK and Sweden pooled data from 49 unique cohort studies of people free from mental illness that examined if physical activity is associated with a decreased risk of developing depression.

In total, 266,939 individuals were included, with a gender distribution of 47 per cent males, and on average the individuals were followed up after 7.4 years.

Once the data was extracted they found that compared with people with low levels of physical activity, those with high levels had lower odds of developing depression in the future.

Physical activity had a protective effect, they found, against the emergence of depression in youths, in adults, and in the elderly and across geographical regions.

The geographic regions studied were in Europe, North America, and Oceania.

Australians researchers involved in the study were from Western Sydney University's NICM Health Research Institute, the Black Dog Institute and UNSW Sydney.

Dr Felipe Barreto Schuch, from Universidade La Salle in Brazil, was the lead author and said the study was the first global meta-analysis to establish that engaging in physical activity is beneficial for protecting the general population from developing depression.

"The evidence is clear that people that are more active have a lesser risk of developing depression," Dr Barreto Schuch said.

"We have looked at whether these effects happen at different age groups and across different continents and the results are clear. Regardless your age or where you live, physical activity can reduce the risk of having depression later in life."

Co-author Dr Simon Rosenbaum, Senior Research Fellow at UNSW Sydney and the Black Dog Institute, said: "The challenge ahead is ensuring that this overwhelming evidence is translated into meaningful policy change that creates environments and opportunities to help everyone, including vulnerable members of our society, engage in physical activity."

The findings in *Physical Activity and Incident Depression: A Meta-Analysis of Prospective Cohort Studies* were first published in the *American Journal of Psychiatry.*

The researchers say further studies are warranted to evaluate the minimum physical activity levels required and the effects of different types and lengths of activity on subsequent risk for depression.

CHRIS JOHNSON

Farcical play has serious side

Pic by Shelly Higgs

If there was one fictional short story from the 19th century that helped open discussion about mental health it would have to be the absurd yet powerfully clever *Diary of a Madman* by Russian author Nikolai Gogol.

Written in 1835, the story of a low-level public servant's descent into insanity was ahead of its time and has proved to be an important sociological tool that helped psychologists more accurately diagnose schizophrenia in a time when such diseases were not widely studied.

Because it is one of the first accounts, albeit fictional, of schizophrenia, it emerged as an important reference tool for researchers and even today plays a vital role in the study of the history of the treatment of mental illness.

The story itself, however, is brilliant and engaging on every level.

Gogol's masterpiece easily translates into a dark comedy perfectly designed for the stage.

And the good folk at Canberra's intimate Street Theatre have done just that with it.

A short season of *Diary of a Madman* opens at the Street on June 2, playing through to June 16.

Award-winning actor PJ Williams portrays the protagonist Poprishchin, who slaves away in relative anonymity while yearning for his existence to be acknowledged – by his colleagues, his superiors and by a beautiful woman.

Written, and therefore acted, as diary entries, this narration of the life of the story's hero (anti-hero) is filled with laughter, tragedy, rage and rapture. Originally set in St Petersburg at the time of the Tsar, it depicts alienation in society extremely well.

While Gogol's story has long been recognised as a powerful dissection of mental disintegration, it was also hugely influential on a generation of writers who followed.

And if the Street Theatre is true to form, their production will be nothing short of outstanding.

Bookings and more information on (02) 6247 1223 or through www.thestreet.org.au

CHRIS JOHNSON

Bird in hand, digging for gold

BY DR MICHAEL RYAN

1

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The Adelaide Hills, some 30 minutes north of Adelaide, is one of the most picturesque and accessible wine areas in the world. The warm climates of Barossa and McLaren Vale hover nearby but swelter in the summer, resulting in big bold super Aussie wines.

Ranging 400-600m above sea level, places the Adelaide Hills in to the cooler climate category but still allows the fruit to ripen. Andrew Nugent and his Father Michael, founders of Bird in Hand winery, recognised the desirability of a slower ripening process thus leading to elegance and structure. The Bird in Hand vineyard derives its name from the old gold mine formerly on the 80-acre site.

Andrew studied agriculture at Roseworthy and was drawn to viticulture. He had a clear vision of wanting make world class wine. With a methodical metred plan, the family owned company is an internationally award-winning winery. Massive export trade, a wonderful onsite restaurant and other facilities including a concert stage featuring rock, jazz and classical events makes this a truly a 5-gold star industry leader.

The Nugent family is close, encompassing all involved with the winery. While some have found their calling in medicine, Andrew and Justin Nugent help the flight path of Bird in Hand. Justin has shone in his brief of marketing and sales export. Justin believes that one of the keys to success of Bird in Hand was the development of olive production in the early days. Restaurants became familiar with the superior product of olives and olive oil. He believes this imprinted the Bird in Hand brand in the gastronomic circles and facilitated the insertion of the wine portfolio.

Grapes grown include Shiraz, Cabernet Sauvignon, Merlot, Chardonnay, Sauvignon Blanc and Italian varieties such as Montepulciano, Nero D'Avlo, and Arneis. Riesling is grown in the Clare Valley and Pinot Grigio/Gris is sourced from around the Adelaide Hills region.

Four tiers of wine exist. Two in Hand for every day drinking, Bird in Hand for that higher end occasion, The Nest Egg for cellaring and long-term maturation. The Tribute series is made only in certain vintages and represents the crème de la crème of the portfolio.

Kim Milne MW is the master wine maker. A graduate of Roseworthy, he travelled to New Zealand and was instrumental in the international development of Villa Maria. He is a Sydney Wine Show judge and was Australian winemaker of the year in 2014 and 2015. Dylan Lee and Jared Stringer with multi regional and international experience round out this formidable wine making team.

The Bird in Hand team excel in clonal selection for grape varieties, appropriate use of new and vintage French oak and have the uncanny knack of expressing many facets that make up the local terroir. When you drink Bird in Hand, you are tasting the passion and vision of the whole family.

WINES TASTED

1. Bird in Hand Adelaide Hills Sparkling Pinot Noir 2017

Light Salmon pink in colour with nice bead. Strawberries and cream in a bottle. Enjoy as an event starter.

2. Bird in Hand Adelaide Hills Pinot Rose 2017

Pale pink colour, with strawberries into cherries. Balanced fruit and acidity with very fine tannin from a few hours skin contact make this a great Rose'. Enjoy with Gravlax salmon.

3. Bird in Hand Adelaide Hills Chardonnay 2017

Pale yellow. White peach, lemon citrus and slight yeasty notes. Wonderful fruit, acidity and restrained oak make this a cracker.

4. Bird in Hand Adelaide Hills Shiraz 2016

Dark garnet colour, plums, olive, spice on the nose, abundant fruit supported by restrained tannins. Cellar 10 years.

5. Bird in Hand Adelaide Hills Cabernet Sauvignon 2016

Ruby with purple hues. Savoury Cassis notes with tobacco and violet notes. Voluptuous fruit integrated with bold tannins that create an outstanding wine. Cellar 12 years.

At your service?

BY DR CLIVE FRASER

I can still remember my first lecture as a medical student back in 1976.

The elderly physiology professor had some very good advice for us which we might just put into action when we would (hopefully) graduate six years later.

He said: "There is only one thing you need to remember about medicine. That is, if you can't make the patient better, don't make them worse."

That statement has stuck with me throughout my career and I regret that there have been times that I haven't always lived up to it.

Indeed the very first real live patient that I met had suffered a terrible stroke after having a carotid angiogram for what were simply tension headaches.

Nevertheless the longevity of people will usually be extended by good quality medical care with a focus on prevention.

I treat my car the same way and I am not afraid to say that I try to do as much of the maintenance myself.

With service intervals now being annual and after 15,000 kilometres, that is a long time between inspections for tyres and brakes etc.

As a student I worked as a bowser boy in a service station.

Yes, I did pump petrol back then because customers weren't allowed to do so.

But I also checked tyre pressures and fluid levels every time the customer's car fuelled up.

Fast forward to 2018 and we only check some of those things once a year and we pay handsomely for the privilege.

Perhaps the worst car servicing experiences I have had have been at dealerships.

There was my Ford where I was charged for new spark plugs even though the original ones were still in situ.

There was my Mercedes where it left the dealership with less oil than it went in with.

When I went back and complained that there seemed to be something amiss with the oil transfusion I was told that all was in order.

Somehow, miraculously, the oil level had crept up to normal even though I was told that they did not need to add any oil on my second visit a day later after my service.

Did they think I was an idiot?

Worse still was that I had paid in 'units' and not in 'hours or minutes' for my car to leave their dealership with its oil level on the add mark.

But, my worst experience was with a car that sports a propeller on its emblem and was made in Munich.

It was at the dealer for another simple oil and filter change.

Travelling back on the Bruce Highway the cacophony of noise coming from under the bonnet led my partner to pull over and call the RACQ.

Only to find that the cover over the motor was unsecured, and easily fixed.

Once again, 12 months later the car was back at the BMW dealer for another oil and filter change.

This time after the 'service' my partner noticed that the bonnet wasn't sitting right.

It wouldn't go down, but even worse it wouldn't go up.

As the car was still driveable there was no need to call the RACQ and after an hour-long struggle I managed to lift the bonnet upwards.

Sitting on top of the motor I found an expensive re-chargeable torch.

My car had gone into the dealership without a problem, only to leave with one.

Not one to complain, I rang the dealership the next day about the torch and they apologised profusely.

In particular, they wanted me to bring the car back to them the next day (100 kilometres each way) to fix the problem that I had already solved.

This is called out-boarding of quality control and mentioning it will lead to a barrage of threatening litigation for me for having said so.

Either way, I was not inclined to complain about my car just going in for a service and leaving the dealership with a problem that they had created.

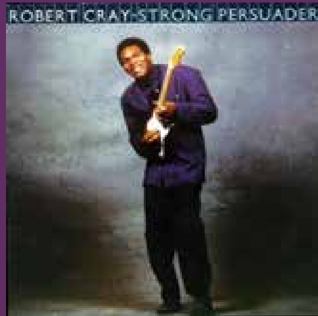
I simply asked them to leave the charger for the re-chargeable torch under the bonnet the next time the car was serviced as the torch wasn't of any use to me without it.

Suffice to say I have never been back.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com



Classic blues album deserves its place in history

BY CHRIS JOHNSON

Bluesman Robert Cray is currently touring Australia with his band. He is not so well known in the mainstream these days, but he retains a dedicated following of diehard blues fans. I'm one of them and after booking my ticket, I got to thinking about how influential one of his albums from the 80s was to popular music.

So many blues LPs have been cut-through albums for me, but if I had to name a standout it would certainly be Robert Cray's 1986 offering *Strong Persuader.*

While the 60s saw white boys from Britain produce some outstanding blues recordings (and also drag their black delta blues heroes out of obscurity), by the end of the next decade the music was largely returned to its own niche genre.

The 80s soared with legendary blues rockers – Stevie Ray Vaughan, Jeff Healy, Johnny Winter, George Thorogood, to name just a few.

But then Robert Cray came along with his fifth studio album *Strong Persuader* and suddenly the blues was (for another sweet season) mainstream music once again.

Remember, its release was the best part of two years before B.B. King joined forces with U2 to record the massive hit *When Love Comes to Town.*

B.B. King was by then an extremely well-known blues musician and collaborating with what was the biggest band on earth at the time, brought the blues to a wider audience.

But it was Robert Cray who reminded the world how cool the blues is. At the same time, he gave it a fresh and contemporary treatment which all added up to a recipe for success.

It is easy to see why *Strong Persuader* was such a huge international hit. It went two times platinum in the US and platinum in Australia alone.

This LP is contagious. The song writing is nothing short of brilliant and the performance outstanding.

One single from it *Right Next Door (Because of Me)*, which gave the album its name, is wickedly clever. A young Bob beating himself up as he sits alone in a hotel room listening to a couple breaking up in the next room: "It's because of me. It's because of me. She was right next door and I'm such a **strong persuader**."

I Guess I Showed Her, another single from the album, is bitter sarcastic denial at its best: "Room 16 ain't got no view, but the hot plate's brand new. I guess I showed her." And ending with: "Now she can have the house, and she can keep the car. I'm just satisfied staying in this funky little motel..... I'm so mad..."

The biggest hit from the album was *Smoking Gun*, another suspicious-cheating-on-me number that borders on the paranoid. The same goes for the excellent *Foul Play*: "Her old boss quit two months ago. She came home all smiles that day. She says they hired a younger man. But I suspect foul play."

The other non-single tracks were all just as good –*Nothing But a Woman, I Wonder, New Blood, Fantasized, More Than I Can Stand,* and *Still Around*: "Did my best to love you, now do your best to leave."

The album is full of songs about love, sex, infidelity, hooking up and breaking up – just what we want from a blues album.

As wonderful as the lyrics are on every one of the songs (and Cray didn't pen them all himself), the instrumentation excels. I read in an interview somewhere Cray saying he doesn't go much for effects on his guitar. There is classy brass and keyboards throughout the album, but it is Cray's clean Stratocaster sound that shines on every track. He certainly knows his way around a fret board. And wow, can he sing!

I saw Cray and his band play the album live not long after its release. It was mesmerising. I have seen him a number of times since. The guy has charisma on record and on stage.

This album deserves its place high up on the list of blues classics, but also as one of the best albums of any popular music genre.

I couldn't stop playing it back in the day and I still take the vinyl out of its sleeve on a regular basis for a good workout under the needle.

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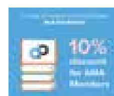

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