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Zero tolerance

AMA, profession vow to stamp out sexual harassment, p4

INSIDE

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In this issue

Cover: (L to R) Australian Sex Discrimination Commissioner Elizabeth Roderick, Sexual Harassment Policy consultant Avril Henry, AMA President Associate Professor Brian Owler and Dr Diana Semmonds, Board Director, Royal Australia and New Zealand College of Ophthalmologists at the AMA Sexual Harassment round table.

Taking action on harassment

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The AMA last week convened a high level Roundtable meeting in Canberra to confront the issue of sexual harassment within the medical profession.

More than 40 medical profession leaders – including the Presidents and/or senior representatives of the Medical Colleges, trainee representatives, and medical students – attended the meeting.

> "We know that sexual harassment is under-reported, but we also know that it exists and must be acted upon. A number of projects have already commenced to seek opinion and provide an opportunity for members of the profession to speak up"

The Sex Discrimination Commissioner, Elizabeth Broderick, and Susan Pearce, the Acting CEO of the NSW Health Education and Training Institute, addressed the meeting and participated in proceedings.

Having resolved to confront the scourge of sexual harassment, it is fair to say that the profession is learning. Last week's meeting was about continuing that learning process and setting an agenda of work for the profession over the coming months.

We know that sexual harassment is under-reported, but we also know that it exists and must be acted upon. A number of projects have already commenced to seek opinion and provide an opportunity for members of the profession to speak up.

It is clear that we need to review the processes for making a complaint about sexual harassment and the process that follows.

We applaud the Royal Australasian College of Surgeons for convening an independent expert panel to review their processes. There is no doubt that this will also inform other Colleges and organisations. We all eagerly await the recommendations of the expert panel.

For trainees, there is convergence of the roles and responsibilities of Colleges and employers, such as State Health Departments. We need to ensure better coordination between these groups. We must make the complaints process clear and accessible to trainees.

Many people have concerns about the safety of accessing these processes. Apart from the stigma and shame that those making the complaint may feel, there is concern about the repercussions that may follow such a complaint. This must change.

We need safe environments that all members of the profession can access to discuss their concerns about the behavior of colleagues, and be able to voice complaints without fear of recrimination. This needs to be followed by action, with due process, and protection of the complainant.

We spent time yesterday discussing the need for cultural change. There is no doubt that education about bullying and harassment is important, particularly in the early years of medical education. Here there is a role for universities and our educators.

The soon-to-retire Chief of Army, General David Morrison, recently said: "*The standard of behavior you walk past is the standard that you accept*". Immediate and effective cultural change must start from the top.

Organisations such as the AMA and the Medical Colleges have a key role to play. At the coalface, whether it be in the operating room or the clinic, we need to make sure that we have leaders that set the tone and call out bad behavior when we see it.

Last week's meeting was just the start of the process of cultural change and strong action against harassment in all its forms within our profession.

We have an agenda, and we have commitment to bring about change. We will work diligently to enhance our profession and protect all of the individuals who make such valuable contributions to the profession and to our patients. And we will report regularly on developments.

The following organisations were represented at the Roundtable:

- Australian Medical Association (AMA)
- Sex Discrimination Commissioner, Australian Human Rights Commission
- Medical Board of Australia
- NSW Health Education and Training Institute

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Taking action on harassment

... from p4

- Royal Australasian College of Surgeons
- Australian and New Zealand College of Anaesthetists
- Australasian College for Emergency Medicine
- Australasian College of Dermatologists
- Royal Australian and New Zealand College of Radiologists
- Royal Australasian College of Physicians
- Royal Australian and New Zealand College of Ophthalmologists
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal College of Pathologists of Australasia
- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian College of General Practitioners
- Royal Australasian College of Medical Administrators
- Royal Australian College of Dental Surgeons
- College of Intensive Care Medicine of Australia and New Zealand
- Australian College of Rural and Remote Medicine
- Australasian College of Sports Physicians
- AMA Council of Doctors in Training
- Australian Medical Students' Association
- Committee of Presidents of Medical Colleges
- Neurological Society of Australasia
- Australian Society of Anaesthetists
- Australasian College of Sports Physicians
- Australasian Faculty of Public Health Medicine
- Australian and New Zealand College of Neurologists
- Australian Orthopaedic Association
- General Practice Registrars Australia

INFORMATION FOR MEMBERS

CALL FOR NOMINATIONS FOR AMA AWARDS

Nominations for the AMA Excellence in Healthcare Award, AMA Woman in Medicine Award, AMA Women's Health Award, AMA Men's Health Award, and AMA Youth Health Award are now open.

The awards will be presented at the AMA National Conference in Brisbane on 29-31 May 2015.

There are many members of the medical community who do extraordinary work and that these awards are a way to recognise their valuable contributions to health and society.

The awards are:

The AMA Excellence in Healthcare Award

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

AMA Woman in Medicine Award

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

AMA Women's Health Award

The AMA Women's Health Award goes to a person who does not have to be an AMA member, doctor or a female, but is somebody who has made a major contribution to women's health.

AMA Men's Health Award

The AMA Men's Health Award goes to a person who does not have to be an AMA member, doctor or a male, but is somebody who has made a major contribution to men's health.

AMA Youth Health Award

The AMA Youth Health Award goes to a young person between 15-27 years who does not have to be an AMA member or doctor, but has made an outstanding contribution to youth health in Australia.

The selection criteria for each award can be found at https://ama.com.au/article/ama-awards-2015

The closing date of nominations is Wednesday 22 April 2015.

Nominations can be emailed to ama@ama.com.au or call 02 6270 5400 for more information.

For more information about the AMA National Conference 2015 visit https://ama.com.au/nationalconference

No frivolity among the frequently ill

The vast majority of patients who are the heaviest users of GP services suffer from complex and chronic health problems and are typically older, sicker and poorer than other Australians, ground-breaking research has found.

As the Federal Government clings to the idea of imposing a "price signal" on patients to discourage unnecessary doctor visits, a detailed investigation has found that those who see a GP most frequently are generally quite unwell, have long-term health conditions that are complex and difficult to manage, and are much more likely to be admitted to hospital.

Altogether, the analysis by the National Health Performance Authority (NHPA) found that almost three millions Australians see a GP at least 12 times a year, including around 950,000 who visit a doctor more than 20 times.

In addition to seeing GPs much more than the average, these very high and frequent attenders are also heavy users of other health services, including having multiple pathology tests, radiology examinations and visits to specialists.

Unsurprisingly, such patients are also relatively expensive to care for.

According to the NHPA, the 2.9 million patients who saw GPs 12 or more times a year cost the system $6.5 billion – around 41 per cent of non-hospital Medicare expenditure – for GP, specialist, pathology, diagnostic imaging and allied health services.

In all, the Authority estimated Medicare annually spent an average of $3202 on those who saw GPs more than 20 times a year, compared with $1850 for patients who visited a doctor between 12 and 19 times a year, $993 for above-average users (between six and 11 visits a year), $551 for occasional users (four to five visits) and $257 a year for low users (one to three visits).

In an attempt to damp down on Medicare expenditure the Government has unsuccessfully sought, through various forms of a co-payment, to introduce a "price signal" to discourage those it regards as seeing their doctor unnecessarily.

But the AMA said the NHPA report showed that the idea that a significant number of patients – particularly those who attended most frequently - were seeing GPs on a whim was wrong.

"Contrary to what was implied by some in the recent debate over co-payments, these patients are not frivolous users of the health system," AMA President Associate Professor Brian Owler said. "It shows that the people who most frequently attend their GP are generally unwell, and have complex and chronic conditions."

The NHPA report found that those who saw a GP 12 or more times a year typically had at least one chronic health complaint, and almost 30 per cent had three or more long-term conditions - the most common being arthritis, osteoporosis, heart and circulatory problems, though long-term injuries, asthma, diabetes and mental health disorders were also prevalent.

> Patients whose care is well managed and coordinated by their usual GP are less likely to cost the health system more in the long run because their GP-coordinated care will keep them out of hospital

Such patients usually rated their health as no better than fair and, as a measure of the severity of their illness, between 30 and 40 per cent reported visiting a hospital emergency department during the year, and they accounted for 60 per cent of all adult patients admitted to hospital at least four times in a 12-month period.

A/Professor Owler said the experience of these patients underlined the important role played by GPs in co-ordinating care and keeping patients out of hospital as much as possible by helping manage their conditions in the community.

These types of patients are consuming significant health resources, and there is a significant need to target these patients with extra support, coordinated by their usual GP," he said.

"Patients whose care is well managed and coordinated by their usual GP are less likely to cost the health system more in the long run because their GP-coordinated care will keep them out of hospital.

"Supporting general practice to continue managing these patients – who are growing in number each year - is an investment in health care that can help make the health system more sustainable."

The AMA is expected to use insights from the NHPA report to urge the Government to increase investment in general practice as part of reforms to improve the efficiency and cost effectiveness of Medicare.

ADRIAN ROLLINS

Medicare rebate freeze 'co-payment by stealth'

Patients could be left close to $10 out of pocket every time they see a GP if the Federal Government persists with plans to freeze Medicare rebate indexation until mid-2018.

As private health insurers urge the Federal Government to allow them to provide cover for GP visits, Sydney University researchers have warned family doctors will have to slug their non-concession patients extra to make up for losses caused by the rebate freeze.

In a study published in the *Medical Journal of Australia*, researchers from the Family Medicine Research Centre estimated that the freeze would cause a 7.1 per cent drop in GP rebate income in the next three years, the equivalent of a shortfall of $124.96 for every 100 consultations next financial year, rising to $384.32 per 100 by 2017-18, as the value of the rebate fell ever-further behind rising practice costs including wages, rent and utilities.

AMA President Associate Professor Brian Owler has urged the Government to dump the freeze along with all its other unpopular co-payment policies in order to provide space to consider other pressing health issues, including hospital finding, mental health care, e-health, workforce planning and Indigenous health.

Given that GPs were likely to continue to bulk bill patients with concession cards, the Sydney University researchers said non-concession patients would have to be charged proportionately more to make up the difference. They predicted the additional charge would rise from at least $2.74 per visit in 2015-16 to an extra $8.43 a visit in 2017-18.

The estimates, which the researchers said were conservative, suggest the rebate freeze will result in even greater patient out-of-pocket costs than the Government's original $7 co-payment plan and a subsequent $5 cut to the Medicare rebate – both ideas that have been dropped following outcry from the AMA, consumers and other health groups.

Grattan Institute Health Program director Professor Stephen Duckett said the rebate freeze would result in "a co-payment… by stealth".

Professor Duckett said the most GPs were in no position to absorb the scale of income cut caused by the freeze, and faced two choices – increase how they charged patients already being hit with out-of-pocket expenses, or start billing bulk billed patients.

He said that for the many practices that currently bulk billed all their patients this policy would force them into making a big step involving introducing new procedures for issuing receipts, issuing bills and handling cash.

The Sydney University researchers, led by Christopher Harrison, warned that increased bad debts, the costs of implementing new billing systems and the probability that many non-concession patients would continue to be bulk billed because of financial hardship, meant it was likely the additional charges would be even higher.

"Public discussion has mainly focused on the now retracted $5 reduction, and the freeze has received far less attention," the study authors wrote. "Yet, with time, it will have a greater impact…nearly double the amount."

They cautioned that their estimates could understate the scale of any possible extra charges: "There is no way we can predict the amount GPs will charge once they are forced, for economic reasons, to introduce a co-payment",

"The freeze will result in Medicare savings; however, patient out-of-pocket expenses will be higher than these savings because GPs will need to charge more than their lost income to recoup the additional implementation and operational costs," they said.

The Government is continuing to grapple with ideas about how to gouge savings from Medicare.

Health Minister Sussan Ley, who has undertaken wide-ranging consultations with the AMA, doctors, other health groups and consumers, has reiterated the Government's commitment to sending a "value signal" to consumers.

Private health insurers, particularly Medibank Private, are pushing the Government to consider lifting the ban on cover for non-hospital primary health care.

Shadow Health Minister Catherine King said such a change would be tantamount to dismantling Medicare.

"Allowing private health insurers to enter general practice would create a two-tiered health system, with health insurance members able to jump the queue," Ms King said. "It would also open the door to US-style managed care, with health insurers able to interfere in the relationship between doctors and patients."

ADRIAN ROLLINS

Missing hospital beds a mystery

The AMA has raised concerns that critical information regarding hospital bed capacity has been omitted from a report showing a remorseless increase in demand for hospital services.

The Australian Institute of Health and Welfare has reported that public hospital admissions have been growing by 3 per cent a year since 2009-10, and reached 5.7 million in 2013-14. Over the same period, the nation's population increased by an average 1.6 per cent a year.

AMA President Associate Professor Brian Owler said the growth in admissions highlighted concerns that current public hospital funding arrangements were becoming increasingly inadequate in supporting public hospitals to cope with growing demand.

A/Professor Owler said that for this reason it was critical that data about the availability of public hospital beds – information traditionally included in the AIHW report – be publicly available.

"The number of beds is key information about the capacity of our hospital system to meet the community's needs for acute medical care, and it is a mystery why it is missing. The AMA hopes to see bed number statistics in future reports," the AMA President said.

The AIHW report shows that private hospitals have been shouldering an increasing share of the health care burden. Since 2009-10, admissions to private facilities have been growing by an average 3.6 per cent a year, and in 2013-14 they provided four million of the nation's 9.7 million admissions that year.

But, possibly reflecting the tendency for patients with more critical and complex needs to attend public hospitals, the public system provided an average of 3.3 days of patient care per admission, compared with an average of 2.3 days in the private sector.

Underlining the importance of efforts to stem the rise of obesity and other lifestyle-related illnesses, the AIHW report found that dialysis for kidney disease was single most common reason for a person to go to hospital, accounting for 1.3 million admissions in 2013-14.

In a result that should worry cost-conscious governments, the report showed that such admissions were outstripping overall admission growth, increasing by an average of 3.9 per cent a year since 2009-10.

The findings come amid increasing concern about the effect of Commonwealth cutbacks to public hospital funding.

In last year's Budget, the Government announced measures that will rip $20 billion out of hospital funding in coming years, including the renunciation of spending guarantees and a reduction in the indexation rate to inflation plus population growth. These cuts were compounded last December when the Government revealed a further $941 million reduction in spending on hospitals over the next four years.

A/Professor Owler said it was disappointing the AIHW report had not addressed the likely effect of these funding cuts.

"On top of the missing bed numbers, the report does not provide forecasts about the future facing our public hospitals under the Commonwealth Government's reductions to overall public hospital funding," he said.

"While there is a year-on-year funding increase, the amount of that increase is reducing at each Budget update. It is not keeping pace with increased demand, and is clearly inadequate to achieve the capacity needed."

A/Professor Owler said the switch to a lower indexation rate from 2017-18 "will create a totally inadequate base from which to index future funding for public hospitals."

ADRIAN ROLLINS

Plans to put doctors to the test

Doctors could face more regular and stringent aptitude tests as part of proposals being considered by the medical profession regulator to make sure patients are shielded from sub-standard care.

The Medical Board of Australia has commissioned an international review of arrangements used by countries to ensure medical practitioners provide safe and ethical care throughout their professional career.

The review is the latest step in the Board's plan to address concerns that the current regime may not be rigorous enough.

> "Proposals to introduce a revalidation scheme in Australia are controversial, with concerns it will impose a regulatory burden on the medical profession out of all proportion to the scale of the problem"

While Australian doctors must meet registration standards and participate in continuing professional development activities, the Board has pointed to the results of Canadian research to suggest that the performance of more than 1350 currently registered Australian practitioners might be unsatisfactory.

"We started a conversation about revalidation in Australia in 2012 as part of our commitment to making sure doctors… maintain the skills to provide safe and ethical care to patients throughout their working lives," Medical Board Chair Dr Joanna Flynn said. "Commissioning this research will help make sure that the decisions the Board makes in future about revalidation are effective, evidence-based and practical."

Proposals to introduce a revalidation scheme in Australia are controversial, with concerns it will impose a regulatory burden on the medical profession out of all proportion to the scale of the problem.

Dr Flynn told the AMA National Conference in 2013 that of 95,000 registered practitioners in Australia, less than 5000 were the subject of complaints each year, and only a small number of these were upheld and resulted in regulatory action. The Conference was told that just 3 per cent of doctors were the source of 49 per cent of complaints.

But she said the complaints system by itself was not sufficient to provide assurance that all practising doctors were competent, citing examples where doctors continued to work despite being the subject of multiple complaints.

Dr Flynn told the conference that to maintain the trust of the public, the medical profession had to accept the need for a system that verified the competence of practitioners.

"We will need to do something beyond what we are currently doing," Dr Flynn said, adding that claims that CPD programs provided sufficient assurance were unconvincing.

"Can you assure me that everyone who has done your CPD program is actually competent and practising at a reasonable standard?" she asked. "My sense is that, for most CPD programs, they don't do that, or at least, not to a high enough level of certainty."

The regulator said the Medical Board did not have any preconceived ideas about what an Australian revalidation system would look like.

In 2012, Dr Flynn said many countries had begun to undertake more formal cyclical processes of revalidation for doctors, and the Board needed to consider if current arrangements were sufficient or "do we need to take on the bigger challenge and… devise an evidence-based, multifaceted, valid and cost-efficient way to ensure that every registered practitioner demonstrates that they continue to be able to meet the standards that both the profession and the community expect? It is time to begin that conversation."

The Board has commissioned the Collaboration for the Advancement of Medical Education, Research and Assessment at Plymouth University Peninsula Schools of Medicine and Dentistry to conduct the research.

In particular, it has asked the researchers to assess evidence about the effectiveness of revalidation regimes in countries similar to Australia, identify best practise and any gaps in knowledge, and propose a range of models for possible adoption.

The Board is due to receive and consider the study in the second half of the year.

See also: 'The validation of doctors, or how to spot the bad apples' pp30-31

ADRIAN ROLLINS

Form guide to cutting red tape

The AMA has declared war on unnecessary bureaucratic red tape, issuing guidelines for the design of medical forms and reports that gather critical information in a way that minimises the burden on doctors.

In the course of their daily practise, medical practitioners are required to fill out multiple forms for Government departments including Centrelink, the Department of Veterans' Affairs and State and Territory WorkCover authorities, with research showing GPs spent an average of 4.6 hours a week on red tape in 2011 - valuable time that the AMA said could otherwise be spent with patients.

The AMA said that although much of the data provided was vital in helping determine patient entitlements, and could have serious consequences for the effective provision of medical services, often forms also asked for details that were repetitive, extraneous or unnecessarily intrusive in nature, and could be dropped or amended without affecting the quality of information provided.

"We understand that organisations depend heavily upon the accurate completion of medical forms to determine patient entitlements," AMA Vice President Dr Stephen Parnis said. "Unfortunately, many fail to appreciate the real time implications for doctors having to complete these forms. The key is to focus on obtaining necessary information that is easily accessible, and which does not require doctors and medical practices spending excessive time filling in forms."

"Doctors prefer spending time on patient care, not bureaucracy," Dr Parnis said.

The AMA has set out 10 standards that it is asking Government departments and other organisations to take into account when designing medical forms.

These include ensuring that doctors are asked to supply only essential information, that patient privacy is protected as much as possible, and that the forms be available in an electronic format compatible with, and available through, existing medical practice software.

In addition, the AMA said forms must carry clear notification that doctors can charge a reasonable fee for their services.

The Association said that in designing forms, government departments and other organisations often failed to take into account the implications for doctors, and suggested that forms be field tested under the supervision of a representative of the AMA or other medical organisation prior to their release.

"The AMA believes that medical forms can be designed in a way that captures the necessary information in a more simple and concise way," Dr Parnis said. "Our Guide can help organisations design forms that do not impose unnecessary red tape and compliance costs on busy doctors."

ADRIAN ROLLINS

AMA Guide to 10 minimum standards for medical forms

1. The form is available in an electronic format that is compatible with existing electronic general practice medical records software.
2. Forms are distributed through medical software vendors. Access to forms does not require web surfing during consultations, nor form-filling online.
3. The form has a clear notation that states that medical practitioners may charge a reasonable fee for their services and whether the services are eligible for rebate by Medicare or other insurers.
4. Demographic and medical data can be selected to automatically populate the electronic form with adequate space being provided for comments.
5. Only information essential for the purpose is requested and must not unnecessarily intrude upon patient privacy.
6. Forms do not require the doctor to supply information when a patient can reasonably provide this in their own right.
7. A copy is saved in the patient electronic medical file for future reference.
8. Data file storage size is kept to a minimum.
9. Prior to their release, forms are field tested under the auspices of a recognised medical representative organisation such as the AMA and the RACGP, in association with the MSIA (Medical Software Industry Association).
10. Consideration should be given to future compliance with encrypted electronics transmission capability, in line with new technologies being introduced into general practice.

Patients left stranded by health cover gaps

Patients are being forced into last-minute cancellations of vital surgery to repair eyesight, fix dodgy knees and hips and reconstruct hands, faces and chests ravaged by cancer because of unexpected gaps in their private health cover.

The AMA has called for private health insurance policies that exclude basic and common procedures to be banned, after a survey of AMA members found insurance companies are increasingly marketing policies with exclusions and caveats that patients do not fully understand, and which are forcing them to forego common procedures like cataract surgery, hip and knee joint operations and reconstructive breast, face and hand surgery.

In a submission to the Australian Competition and Consumer Commission on the private health insurance industry, the AMA said health funds were engaging in sharp practices that left consumers confused and unaware of major gaps and shortfalls in their cover.

"There is a significant disconnect between most consumers' understanding of the services and rebates they are entitled to under their private health insurance policy and the reality of what their product provides," the submission said.

It complained that insurers presented their products in a poor and confusing manner, and often they were explained incorrectly by frontline staff.

"The combined effect means that consumers have limited ability to 'shop around' and compare products, and to fully understand the products they have purchased," the AMA said. "It is usually only at the time when people need to have medical treatment in a hospital that they first comprehend that their insurance policy is deficient."

The number of policies being sold with exclusions and minimum benefits has accelerated as premiums have increased. A decade ago, just a third of policies had restrictions, exclusions or higher excess, but they account for around a half of all policies held now.

The Australian cited Private Healthcare Australia figures showing more than 985,000 policies were downgraded between February 2012 and December 2014, and the number is expected to surge higher following the latest average 6.2 per cent premium increase that came into effect on 1 April.

In its submission, the AMA said many practitioners were concerned that insurers were deliberately allowing people to take out health policies unlikely to suit their health needs, such as selling cover that excludes psychiatric care to patients with a chronic psychiatric condition.

In addition, firms are marketing changes to policies without fully explaining the consequences for consumers.

One doctor surveyed by the AMA reported that, "I've had patients who were told their premiums would not rise this year, but did not understand this had only happened because they had been shifted to a policy with exclusions. The detail was in the fine print".

Insurers faced particular condemnation for marketing 'public hospital only' policies, which the AMA said were of no value to consumers.

One doctor observed that, "consumers are being sold a non-existent service because they wait the same amount of time for admission as public patients, and they are usually unable to choose their doctor. In some states or regional areas it's completely useless because surgeons just can't offer that service".

In its submission, the AMA called for such policies to be withdrawn from the market.

The AMA reserved special condemnation for the pre-approval processes used by private health funds to try to dodge their obligations.

Under the Private Health Insurance Act 2007, private funds are required to pay benefits for hospital treatment for which a Medicare rebate is payable.

But AMA reported that some insurers were adopting a virtually default position of refusing to pay a claim, forcing patients to complain and challenge the decision.

"The two largest private health insurers are circumventing their obligations under the PHI Act by rejecting the payment of private health insurance benefits prior to procedures being performed," the submission said. "In a situation where the...insurer refuses to pay, it is only the patient who has standing to pursue payment...through the courts. The reality is that few patients will do so."

The AMA has called for policies that exclude common procedures, or provide cover only for treatment in public hospitals, to be banned.

ADRIAN ROLLINS

Health at the core of closing the gap

AMA President Associate Professor Brian Owler has warned that governments need to increase their investment in health in order to close the yawning gap in life expectancy and wellbeing between Indigenous people and other Australians.

In a veiled swipe at the Federal Government's policy focus on school attendance and employment in Indigenous communities, A/Professor Owler told a major international conference on the social determinants of health that too often the importance of wellbeing was overlooked.

"Health is the cornerstone on which education and economics are built," the AMA President said. "If you can't go to school because you or your family are sick, truancy officers won't work. If you can't hear because of otitis media, you won't learn. If you miss training opportunities because of depression or ill health, you won't progress to employment. You can't hold down a job if you keep having sick days."

His remarks to a British Medical Association symposium on the role of physicians in addressing the social determinants of health came a month after Prime Minister Tony Abbott admitted that the nation had fallen behind on meeting most of its Closing the Gap targets.

While there has been some improvement in the life expectancy of Aboriginal and Torres Strait Islander people, Indigenous men still on average 10.6 years earlier than other Australian males, and the gap for women is 9.5 years.

In his speech, A/Professor Owler said that in many respects the term 'social determinants of health' was misconstrued, because health was in fact a determinant of social and other outcomes.

He said the fact that chronic and non-communicable diseases and other preventable occurrences such as suicide, trauma and injury accounted for a major proportion of the gap in life expectancy underlined the need for greater investment in health care, particularly Aboriginal community controlled health services.

"While those with chronic disease need to be cared for, prevention, particularly in the early part of life, is the key if we are going to see a generational change in health outcomes," A/Professor Owler said.

He said hard-earned experience showed that health was fundamental to closing the gap, as was the need to work in partnership with Indigenous communities themselves.

"There have been many examples of governments trying to address the social determinants of health – but often they have failed," he said, referring to policies including building inappropriate housing and taking children from their families.

The AMA President said any attempt to improve Indigenous health needed to acknowledge the fundamental importance for Aboriginal and Torres Strait Islander people of their connection with the land, and understand that in many Aboriginal languages health was a concept of social and emotional wellbeing rather than a physical attribute.

He told the London conference that this was one of reasons why the AMA was a foundation member of the campaign to achieve constitutional recognition for Indigenous Australians.

"Constitutional recognition is a vital step towards making Aboriginal and Torres Strait Islander people feel historically and integrally part of the modern Australian nation," A/Professor Owler said. "Recognising Indigenous people in the Constitution will improve their self-esteem, their wellbeing, and their physical and mental health."

Prime Minister Tony Abbott has taken a personal interest in Indigenous affairs, concentrating responsibility for many Indigenous policy areas within the Department of Prime Minister and Cabinet and overseeing the development of the Indigenous Advancement Strategy.

Priorities for the Strategy include improving school attendance, boosting Indigenous employment and improving community safety.

A/Professor Owler said these were all worthy aims, but the Strategy overlooked the central importance of health.

"What is missing from the core of the IAS is a focus on health," the AMA President said. "Health underpins many of these outcomes. We need to get the balance right and we, the AMA, need to ensure that health is seen as a foundation to these outcomes."

He said that "spending on health is an investment. Investing in health must underpin our future policies to Close the Gap, and to address what is, for Australia, a prominent blight on our nation".

ADRIAN ROLLINS

Cosmetic patients could face wait before going under knife

Patients who want face lifts, breast implants, liposuction, botox injections and other cosmetic procedures will face a mandatory cooling off period under guidelines being considered by the medical profession watchdog.

Horror stories of botched operations, life-threatening post-operative infections and unexpected complications have sparked concern about the level of accountability and consumer protection in the burgeoning cosmetic surgery industry, estimated to be worth around $1 billion a year.

The Medical Board of Australia, which regulates the medical profession, has released draft proposals to improve public safety, including a seven-day cooling off period for adults, a three-month cooling off period and mandatory psychological assessment for patients younger than 18 years, explicit treating practitioner responsibility for post-operative care, and mandatory face-to-face consultations before the prescription of botox and other schedule 4 cosmetic substances.

Medical Board Chair Dr Joanna Flynn said the proposals, which are open for public comment, have been drafted in acknowledgement that cosmetic surgery differs from other medical procedures because it is entirely elective, is usually initiated by the patient, is undertaken to improve appearance rather than address a medical need, is performed outside the public hospital system, and usually paid for directly by the patient.

Its move is in response to a report from the Australian Health Ministers' Advisory Council, which warned that consumers were taking an increasingly casual attitude to cosmetic surgery despite the fact that it was a significant intervention that carried risks and complications.

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Cosmetic patients could face wait before going under knife

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"If the cosmetic procedure is performed by a medical practitioner without the appropriate training, or in a facility that does not have the appropriate staff or equipment, or the post-operative care is inadequate, the outcome can be far more devastating than unmet expectations," the Board warned. "The outcome may be a serious complication resulting in disfigurement or death."

Concerns about the standard of care have been underlined by recent inquests in Victoria and South Australia which found that two young women died of complications arising from liposuction surgery following inadequate post-operative care.

In addition, state regulators have received numerous complaints about problems including bleeding, pain and infection through to scarring, nerve damage, gross deformity and psychological distress.

Even where cosmetic procedures were carried out skilfully and safely, the nature of the undertaking made it more prone to patient dissatisfaction than many other specialties, according to a report from the-then Health Quality and Complaints Commission in Queensland.

The Commission reported that plastic surgeons were twice as likely to be embroiled in disputes about informed consent as any other specialty, and speculated that this might be due to the "elective nature of cosmetic procedures and the costs associated [which] may contribute to higher patient expectations and lower tolerance for poor outcomes".

The Medical Board cited data from medical indemnity insurers showing practitioners who perform cosmetic procedures are subject to higher number of claims than other practitioners, and noted that MDA National ranked cosmetic surgery just below obstetrics and neurosurgery in terms of risk.

The Medical Board said there were several shortcomings to current arrangements which exacerbated these problems and exposed consumers to increased risk.

It said the fact that patients could directly request cosmetic surgery rather than seek a referral from a GP meant they missed out on an important source of advice on possible risks and benefits, as well as alternatives.

The Board voiced concern that the quality of patient assessment in the sector was variable, and was at risk of being compromised by commercial considerations.

"Given the information asymmetry [between doctor and patient], the sometimes unrealistic expectations of consumers, and the commercial relationship between the medical practitioner and the patient, it may be difficult for the medical practitioners to objectively determine the appropriateness of a cosmetic procedure, and whether it is in the best interests of the patient," the Board said.

It said that informed consent was a critical step before a patient decided to proceed with cosmetic surgery, underlining the need for a cooling off period.

While noting that the Australian Society of Plastic Surgeons has specified a minimum 10-day cooling off period for cosmetic procedures in its code of conduct, the Board bemoaned the lack of a consistent nationwide guide for consumers or practitioners.

> "This means that a consumer can proceed with a major, irreversible elective procedure without fully appreciating the risks, the likelihood of complications, the variable outcomes and the cost..."

"This means that a consumer can proceed with a major, irreversible elective procedure without fully appreciating the risks, the likelihood of complications, the variable outcomes and the cost," the Board said.

It said complaints data supported the view that some consumers went ahead without fully appreciating the risks involved, suggesting informed consent processes in these instances were inadequate or poorly done.

"It is critical that the consumer who seeks a cosmetic procedure...is fully informed and has time to consider all the factors before deciding to give consent," the Board said.

"Available data and evidence suggest that there are consumers who are making rushed decisions to have major, irreversible elective cosmetic procedures without fully understanding all the factors."

The Board's discussion paper ca be viewed at http://www.medicalboard.gov.au/News/Current-Consultations.aspx

The closing date for submissions is 29 May, 2015.

ADRIAN ROLLINS

Homeopathy cops a concentrated dose of doubt

Homeopathic treatments have no proven value and people who use them instead of seeking scientifically verified therapy could be putting their health at risk, according to a damning assessment by the nation's premier medical research organisation.

The National Health and Medical Research Council said a rigorous assessment of more than 1800 scientific research studies found "no good quality evidence" that homeopathic treatments were any better than taking nothing.

"All medical treatments and interventions should be underpinned by reliable evidence," NHMRC Chief Executive Warwick Anderson said. "NHMRC's review shows that there is no good quality evidence to support the claim that homeopathy works better than a placebo."

> The finding, which has drawn the ire of advocates of complementary medicines, follows a lengthy inquiry by the Council

"The main recommendation for Australians is that they should not rely on homeopathy as a substitute for proven, effective treatments," Professor Anderson said.

The finding, which has drawn the ire of advocates of complementary medicines, follows a lengthy inquiry by the Council.

Homeopathy involves the administration of highly diluted substances, and has been claimed as a remedy for a wide range of ailments, including potentially fatal illnesses such as malaria and HIV.

But the NHMRC found that of 225 scientific studies that investigated the effectiveness of homeopathy, most reported that claims homeopathy worked better than a placebo were not substantiated.

The Council said the few studies that did claim to find evidence homeopathy was effective were small or of poor quality: "These studies had either too few participants, poor design, poor conduct and/or reporting to allow reliable conclusions to be drawn on the effectiveness of homeopathy".

But, despite such scepticism about its effectiveness, complementary medicine has become big business.

It is estimated that about two-thirds of Australians use some form of complementary medicine, such as vitamins, herbal products, and therapies such as homeopathy, kinesiology and yoga, and last financial year private health funds paid out $164 million in benefits for natural therapies.

Peak industry body Complementary Medicines Australia has disputed the NHMRC's findings.

Chief Executive Carl Gibson said the industry was "very disappointed with the position taken by the NHMRC, especially when a number of independent experts in the sector have expressed strong concerns with the methodology of the review".

Mr Gibson said the NHMRC failed to include a homeopathic expert on the review panel, and its research was shoddy, selective, based on flawed evidence and ignored the opinions of experts.

But the NHMRC's findings reflect AMA concerns about the use of complementary medicines.

In a Position Statement (https://ama.com.au/position-statement/complementary-medicine-2012), the AMA said there was "limited efficacy evidence" regarding most complementary medicine.

"There is a substantial gap between the use of complementary medicine and the evidence to support that use," the Association said. "Evidence-based, scientific research, in the form of randomised controlled trials, is required to validate complementary medicines and therapies for efficacy, safety, quality, and cost effectiveness."

The Association cautioned that the use of complementary medicines could actually be harmful, warning that "unproven complementary medicines and therapies can pose a risk to patient health, either directly through misuse, or indirectly if a patient defers seeking medical advice".

The advocacy group Friends of Science in Medicine said the NHMRC report confirmed what many scientific and public health experts had maintained for years, that "not only does homeopathy not work, if it did, chemistry, physics and physiology could not".

"In short, the continued promotion of homeopathy would represent a commercial scam preying on the gullible," the group's President, Professor John Dwyer said.

Professor Anderson advised patients considering using homeopathy to first consult a registered medical practitioner, and "in the meantime keep taking any prescribed treatments".

ADRIAN ROLLINS

Plain message is that tobacco pack controls work

> "These results should give confidence to countries considering plain packaging that plain packs not only reduce [the] appeal of tobacco products and increase the effectiveness of health warnings, but also diminish the tobacco industry's ability to use packs to mislead consumers about the harms of smoking"

Tobacco plain packaging is working to encourage smokers to kick their habit and dissuade young people from taking it up, according to the most comprehensive evaluation of the reform yet undertaken.

Just days after Britain and Ireland followed Australia's lead by passing laws requiring that tobacco products be sold in plain packaging emblazoned with large health warnings, a *British Medical Journal* analysis of 14 peer-reviewed studies has concluded that the public health measure is "delivering on its hypothetical promise".

"The evidence suggests that plain packaging is severely restricting the ability of the pack to communicate and create appeal with young people and adults," paper's authors, Professor Gerard Hastings and Dr Crawford Moodie, both of the University of Stirling, said.

Not only was plain packaging effective in reducing the appeal of tobacco products, the authors said a cross-sectional tracking survey of smokers showed plain packaging caused them to think more about quitting the deadly habit.

"Plain packaging in Australia has been a casebook example of effective tobacco control – a policy measure driven by evidence, carefully designed and implemented, and now rigorously assessed," Professor Hastings and Dr Moodie wrote. "Plain packaging is beginning to deliver on its promise."

Professor Melanie Wakefield, a Principal Research Fellow of the National Health and Medical Research Council, led the evaluation published in the *BMJ*, and said its findings were the "first comprehensive set of results of real world plain packaging, and they are pointing very strongly to success in achieving the legislation's aims".

"These results should give confidence to countries considering plain packaging that plain packs not only reduce [the] appeal of tobacco products and increase the effectiveness of health warnings, but also diminish the tobacco industry's ability to use packs to mislead consumers about the harms of smoking," Professor Wakefield said.

The endorsement of the reform has been welcomed by both sides of politics.

Assistant Health Minister Fiona Nash said she was "extremely pleased" by the *BMJ* findings, which drew in part on research commissioned by the Commonwealth Health Department.

Senator Nash said plain packaging had played a part in driving the daily smoking rate among Australians 14 years and older down to 12.8 per cent.

Plain packaging legislation was introduced by the previous Labor Government with bipartisan support, and Shadow Health Minster Catherine King said only the tobacco industry thought the measure was a bad thing.

The industry, which has been fighting a bitter battle to have the Australian legislation overturned ever since its introduction in 2012, dismissed the *BMJ* analysis, and reiterated its claims that plain packaging laws have simply forced smokers onto cheaper cigarettes and fuelled trade in illicit tobacco products.

Philip Morris Limited Director Corporate Affairs Chris Argent said the research had measured perceptions of plain packaging rather than its impact on behaviour, and claimed tobacco excise increases were largely responsible for any changing in smoking habits.

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Plain message is that tobacco pack controls work

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"The fact is that smoking rates in Australia have been declining steadily since 1991, well before plain packaging was implemented, and there has been no significant deviation in that trend since plain packaging was implemented," Mr Argent said.

Professor Hastings and Dr Moodie admitted that, because plain packaging was introduced as part of a wider package of measures including larger health warnings, mass media campaign and tax increases, it was hard to separate out the effects of each measure.

But they said the picture that had emerged from the 14 studies included in the evaluation suggested the policy was working and, just as significantly, that industry warnings of a surge of trade in cheap and illegal cigarettes were unfounded.

"There is no evidence for either effect," they said. "Average inflation-adjusted recommended retail prices actually increased for cigarettes in all price segments...there was no decline in the percentage of smokers purchasing from convenience stores, no indication of increased purchase from overseas, online or duty-free, [and] no evidence of an increase in the consumption of illicit 'cheap white' cigarettes."

, both experts in marketing, said that in addition to their immediate effects, plain packaging laws were important in the context of imminent major advances in the use of packaging to promote products.

They said multiple technologies were being developed which would turn packets into multi-sensory billboards for products.

Packs are already being produced that play music, pre-recorded messages and other noises, emit scents and are phosphorescent.

Professor Hastings and Dr Moodie said conductive inks were also being used that allow for cheap electronic circuits to be incorporated into cardboard, with the potential for cigarette packs to carry moving images, or to be capable of communicating with consumers through their mobile phones, smart watches and glasses or other devices.

"Whatever direction these innovations take, it is clear that the marketing power of the pack is only going to increase. So governments which do not act on plain packaging today will have a bigger problem to tackle tomorrow," they said.

The *BMJ* study "Death of a salesman" can be viewed at: http://tobaccocontrol.bmj.com/content/24/Suppl_2/ii1.full

ADRIAN ROLLINS

Best laid plans reduce patient discomfort and distress

The AMA has called for the widespread use of palliative care plans to ensure residential aged care residents with life-limiting illnesses are not subject to unnecessary pain and distress.

Amid concerns that the terminally ill are often being unwillingly hospitalised, the Association has proposed that palliative care plans be widely adopted in residential aged care facilities to ensure care is provided consistent with the wishes of patients and their families.

In an updated Position Statement, the AMA warned that the acute model of care, in which priority is given to treating disease and preserving life, "does not necessarily respect the needs of patients living with life-limiting illnesses, and can impose additional unnecessary pain and distress".

It said the palliative approach in aged care settings recognised that health care "should not be based on diagnosis alone. The aim…is to maximise quality of life through appropriate needs-based care".

There has been renewed attention on the care provided to terminally ill patients, particularly the elderly.

The enormous cost of hospital care has increased the focus on efforts to support patients in other settings, including home and aged care facilities.

But public hospital physician Dr Karen Hitchcock, writing in the Quarterly Essay, criticised what she saw as a tendency in the health system to all-too-readily write elderly patients off.

Dr Hitchcock wrote that sometimes practitioners were overly quick to assign patient to palliative care prematurely, and said that although the goal of care directives and treatment plans – to empower patients - was morally sound, in practise it might have unintended and adverse consequences, including heightening the readiness not to treat, and playing on the desire of vulnerable patients not "to be a burden".

But AMA Vice President Dr Stephen Parnis, an emergency physician, said research by the Grattan Institute showed that 70 per cent of Australians wanted to die at home, including in their aged care facility, and palliative care plans were a way of helping achieve that.

"Transferring residents of residential aged care facilities to acute care settings when their condition deteriorates can often impose unnecessary pain and distress," he said. "It may also not necessarily respect the needs of patients living with life-limiting illnesses, who prefer to receive palliation within the residential aged care facility."

Palliative care plans helped ensure aged care home staff, GPs and specialists knew when a patient was not to be automatically transferred to hospital for invasive or burdensome treatment, Dr Parnis said, adding that care should be provided on the basis of need, rather than diagnosis alone.

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Best laid plans reduce patient discomfort and distress

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"The AMA would like to see the introduction of templates for palliative care plans in aged care. Palliative care plans are an excellent way to ensure that everyone involved in the person's care follows the same agreed approach."

In addition to helping the provision of palliative care plans, the AMA said aged care homes had a role to play by ensuring the ready access of doctors to their patients and medical files, and that staff had the right skill mix to provide quality care at all hours – something seen as important in reducing the need to transfer residents to hospital.

ADRIAN ROLLINS

A matter of restraint

Patients should only be restrained as a last resort and restraints must never be used simply for the convenience of staff or to help them manage workloads, the AMA has advised.

A Senate inquiry into dementia care last year raised concerns of "a troubling trend in which there is an increased use of restraints as a management tool for [dementia symptoms]," and Alzheimer's Australia claimed 140,000 nursing home residents were being restrained with drugs.

The Chair of the Senate inquiry, Australian Greens Senator Rachel Siewert, said the committee heard evidence that medication, locked rooms and physical restraints were all measures used to restrain dementia patients, including where they were used "for convenience and the protection of facilities, rather than the clinical needs of the patient".

In Position Statement released last month, the AMA said that although the use of restraints for such purposes was unacceptable, there were circumstances where they were appropriate.

But it cautioned patients should only be restrained only after careful consideration and consultation, and having exhausted all reasonable options.

The AMA said the decision of whether or not to use a restraint involved finding a balance between the patient's right to self-determination and protection from harm, and the possibility of harm to others.

While ultimately it was a call for the treating doctor, the AMA said the decision should be arrived at through a process of request, assessment, team involvement and consent.

"The prime purpose of restraint should be the safety, wellbeing and dignity of the patient, and should take into account any previously expressed or known values or wishes," the Position Statement said. "In the short-term, the welfare and protection of others, and the statutory occupational health and safety obligations on employers, must also be considered."

Where restraints are used, they should be of the least restrictive nature possible, and their use should be viewed as a temporary solution.

While mention of restraints often conjures images of patients strapped to beds, the Senate inquiry found that increasingly it involved the use of psychotropic drugs or locked rooms.

But the AMA advised the use of such drugs to reduce distressing symptoms, or as a specific treatment for delirium, anxiety, depression, psychosis or symptoms of dementia, "does not constitute restraint, and they should not be withheld".

AMA Vice President Dr Stephen Parnis said there was a clear distinction between using such drugs to treat a patient with a diagnosed illness and using them for the sole purpose of restraint.

"Psychotropic medications are a clinically appropriate treatment for older people with medical conditions such as anxiety, depression, psychosis and dementia," Dr Parnis said. "They can be very effective in assisting a person to become settled in their environment."

But he said restraints – chemical or otherwise – should only be used as a last resort, and for the shortest possible period, and argued that their use could be "considerably minimised" by ensuring there were adequate resources, that staff were appropriately trained in how to engage with residents, and facilities were designed to minimise stress.

The Position Statement can be viewed at: https://ama.com.au/position-statement/restraint-care-people-residential-aged-care-facilities-2015

Most of the revisions to the Position Statement were informed by the 2012 Department of Health and Ageing *Decision Making Tool: Supporting a restraint free environment in residential aged care*, which is available at: ///C:/Users/jflannery/Documents/Downloads/Decision+Making+Tool+Supporting+a+Restraint+Free+Environment+in+Residential+Aged+Care.pdf

ADRIAN ROLLINS

New strains force late start for flu vaccination program

Doctors and patients will for the first time have access to single-dose vaccines covering the four most common flu viruses amid concerns a mutated strain that wreaked havoc in the northern hemisphere could take hold in Australia.

The Therapeutic Goods Administration has approved nine vaccines, including, for the first time, three quadrivalent formulations, as preparations advance for the roll-out of National Seasonal Influenza Immunisation Program from 20 April.

The TGA said the vaccines approved for the program provided coverage for two new strains following expert advice about the prevalence of different types of infections in the last 12 months.

The World Health Organisation and the Australian Influenza Vaccine Committee have recommended that vaccines this year cover one existing and two new strains – the California H1N1-like virus that has been in circulation since 2010, the Switzerland H3N2-like virus and the Phuket 2013-like virus.

In addition, the quadrivalent vaccines, FluQuadri, FluQuadri Junior, and Fluarix Tetra, will cover the Brisbane 2008-like virus.

Drug company Sanofi Pasteur, which manufactures two of the quadrivalent vaccines, said they were well tolerated and provided additional protection because they covered both B strains of the influenza virus as well as the two A strains – compared with trivalent vaccines that covered both A strains but only one B strain.

The national immunisation program, which usually commences in March, had been held back a month as manufacturers have scrambled to produce sufficient stocks of the vaccines.

"The double-strain change has resulted in manufacturing delays due to the time it takes to develop, test and distribute the reagents needed to make the vaccine," a Health Department spokesperson said. "The commencement of the program is being delayed to ensure sufficient supplies of influenza vaccine are available from at least two suppliers in order to mitigate the risk of administration of bioCSL's Fluvax to children under five years of age."

The AMA and other health groups expressed alarm last year over revelations that 43 infants and toddlers were injected with Fluvax in 2013 despite warnings it could trigger fever and convulsions.

The TGA has repeated its advice that Fluvax is not registered for use on children younger than five years, and that it should only be used on children between five and nine years following "careful consideration of potential benefits and risks in the individual child".

Fluvax will be supplied with prominent warning signs and labels to remind practitioners that it should not be administered to young children.

In a stroke of good fortune, the delay in the vaccination program has coincided with a relatively quiet start to the flu season, with reports that influenza activity has so far been weaker than that experienced at the same time last year.

The Health Department and the TGA said that, despite the delay, they do not expect any flu vaccine shortages, and the Government has committed $4.5 million over the next five years to provide free flu vaccination for Indigenous children aged between six months and five years.

The Government has also renewed the contract of the Australian Sentinel Practices Research Network, based at the University of Adelaide, to undertake national surveillance of flu-like illnesses.

The network, which has been operating for more than a decade, collates information from more than 200 GPs and medical practices across the nation to provide health authorities with an early warning of developing outbreaks. Its information is used in conjunction with data from hospitals.

ADRIAN ROLLINS

Germanwings tragedy prompts mandatory reporting calls

The AMA has warned that calls for the mandatory disclosure of information about the mental health of airline flight crew could dissuade troubled pilots from seeking necessary treatment.

There have been proposals to require treating doctors to report airline pilots and flight engineers who have mental health problems following the deliberate downing of a Germanwings airliner carrying 150 passengers and crew in the French Alps late last month.

> "Investigators have concluded that 27-year-old co-pilot Andreas Lubitz deliberately flew the Airbus A320 plane into the side of a mountain on 25 March after locking the plane's captain out of the cockpit. All on board were killed"

Investigators have concluded that 27-year-old co-pilot Andreas Lubitz deliberately flew the Airbus A320 plane into the side of a mountain on 25 March after locking the plane's captain out of the cockpit. All on board were killed.

It has been reported that Mr Lubitz suffered bouts of depression, was concerned about his eyesight, and had received treatment for suicidal tendencies before obtaining his pilot's license.

Last week Germanwings' parent company Lufthansa revealed that Mr Lubtiz had notified the company of his struggle with depression during his pilot training course in 2009.

The case has prompted some to call for laws requiring medical practitioners to report pilots being treated for mental illness to aviation authorities.

But the AMA and other medical experts have questioned the necessity or usefulness of such a measure.

Australasian Society of Aerospace Medicine President Dr Ian Cheng told *Medical Observer* that Designated Aviation Medical Examiners who conducted compulsory annual pilot health checks were already legally obliged to report any significant health condition.

Dr Cheng said that for years many pilots with depression hid their problem for fear of losing their license until Australian aviation authorities decided several years ago to allow pilots to continue flying after a depression diagnosis, as long as they were receiving treatment and met strict conditions.

AMA Vice President Dr Stephen Parnis warned against any rush to institute mandatory reporting obligations for airline pilots receiving medical treatment.

"Doctors may disclose information about a patient's medical record if they judge there is a serious threat to the life, health or safety of an individual or the public," Dr Parnis told *Medical Observer*. "The last thing we want is a shopping list of things requiring mandatory reporting. That would undermine the confidence of the patient in the doctor."

The AMA Vice President said mandatory reporting rules for medical practitioners had been blamed for deterring some doctors from seeking help, and there could be a similar risk with such rules for pilots.

Revelations that Mr Lubitz had notified Lufthansa about his battles with depression is likely to intensify the focus on how to best monitor and manage pilots with mental health issues.

ADRIAN ROLLINS

AMA in the news

YOUR AMA HAS BEEN ACTIVE ON POLICY AND IN THE MEDIA ON A RANGE OF ISSUES CRUCIAL TO MAKING OUR HEALTH SYSTEM BETTER. BELOW IS A SNAPSHOT OF RECENT MEDIA COVERAGE.

PRINT

E-health record scheme a $1b flop, *Hobart Mercury*, 27 February 2015

The botched Personally Controlled Electronic Health Record program has been operating for nearly three years but fewer than one in 10 Australians has one. AMA President A/Professor Brian Owler said the scheme remains in limbo, and to have spent that much money and yet still not have anything of widespread value was terrible.

Upfront payments for doctors, *Australian Financial Review*, 3 March 2015

Health Minister Sussan Ley could end Medicare's universal "fee for service" approach and pay GPs a lump sum per patient, rather than for each visit. Ms Ley has been in constant contact with AMA President A/Professor Brian Owler about potential changes to Medicare.

Dumped policy to cost $1bn, *The Australian*, 4 March 2015

Tony Abbott has dumped the GP co-payment but maintained a freeze on Medicare payments to general practitioners. AMA President A/Professor Brian Owler warned the freeze would force bulk billing rates down and increase out-of-pocket expenses for private health insurance policyholders.

Medicare rebate freeze to stay, *Australian Financial Review*, 4 March 2015

The Federal Government will keep more than $1 billion by freezing indexation of Medicare rebates, but has dumped the GP co-payment. AMA President A/Professor Brian Owler welcomed the decision to axe the co-payment, but said keeping the Medicare rebate indexation freeze was lazy reform.

Ley rules out bulk billing means test, *Australian Financial Review*, 5 March 2015

Health Minister Sussan Ley has ruled out means testing bulk billing as fix in the search for savings to replace the dumped $5 GP co-payment. The Minister said the Government will persist with its search for policies that would impose a value signal on Medicare. AMA President A/Professor Brian Owler said he was happy to co-operate with Ms Ley but did not agree a price signal had a place in primary care.

Don't be shy about health, *MX Sydney*, 5 March 2015

New research shows Australians are still choosing to suffer in silence, instead of talking about an awkward health problem. AMA Chair of General Practice Dr Brian Morton said self-treating basic conditions is fine, but alarm bells should ring if the conditions are recurring.

Co-payment could still happen as GP gap-fee option considered, *The Age*, 9 March 2015

Despite declaring its Medicare co-payment dead, the Government is considering proposals to give GPs the option of charging gap fees for bulk billed patients. AMA President A/Professor Brian Owler said the AMA had long supported such a change, which he said would benefit patients who are currently privately billed.

Why we can't keep trusting celebrity diet books, *Women's Weekly*, 10 March 2015

AMA Vice President Dr Stephen Parnis said we live in an era where people sometimes equate celebrity with expertise, which is not the case. At best, alternative health and diet advocates may advocate something which is supposed to be therapeutic, but actually has no effect. But, at worst, it can be dangerous, he warned.

'Price signal' would hit old, poor hardest, *The Age*, 19 March 2015

Patients who visit the doctor most often tend to be older and poorer than those who visit their GP less, and would be hardest to hit by the introduction of a price signal. AMA President A/Professor Brian Owler said the data undermined the arguments of some proponents of a Medicare co-payment.

Valley of the unwell, *The Herald Sun*, 19 March 2015

The Goulburn Valley has emerged as the sickest spot in Victoria, with more than one in six residents seeing a GP more than 12 times a year. AMA President A/Professor Brian Owler said the report showed people who most frequently visited their GP have complex and chronic conditions.

AMA in the news

YOUR AMA HAS BEEN ACTIVE ON POLICY AND IN THE MEDIA ON A RANGE OF ISSUES CRUCIAL TO MAKING OUR HEALTH SYSTEM BETTER. BELOW IS A SNAPSHOT OF RECENT MEDIA COVERAGE.

ake vaccination law, *The Sunday Telegraph*, 22 March 2015

The Sunday Telegraph has launched a national campaign for pregnant women to get free whooping cough boosters in the third trimester. AMA President A/Professor Brian Owler called on Federal Health Minister Sussan Ley to fund the boosters.

Call to name medical 'bad apples', *Sydney Morning Herald*, 24 March 2015

Medical specialists who charge exorbitant fees should be named and shamed in a bid to rein in excessive charging. AMA Vice President Dr Stephen Parnis said more doctors than ever were accepting fees set by private health insurers, and almost 90 per cent of privately insured medical services were delivered with no out-of-pocket cost to the patient.

Doctors to anti-vaxxers: you're endangering kids, *The News Daily*, 24 March 2015

AMA Vice President Dr Stephen Parnis told The News Daily that anti-vaccination groups don't know better than the weight of evidence from the medical and scientific profession.

Misogyny in medicine: don't put up with it, *The Age*, 25 March 2015

AMA President A/Professor Brian Owler said he was proud of Australia's medical profession and added it was challenging to hear assertions that doctors were acting in unacceptable ways, particularly when it came to sexual harassment.

RADIO

A/Professor Brian Owler, 666 ABC Canberra, 18 February 2015

AMA President A/Professor Brian Owler talked about the proposed $5 cut to Medicare rebates and the prospect of a $5 co-payment for GP visits still on the table. A/Professor Owler said the idea floated by the Federal Government had not been raised with him.

Dr Stephen Parnis, Radio Adelaide, 23 February 2015

AMA Vice President Dr Stephen Parnis said he was concerned about the Trans-Pacific Partnership trade agreement and what it could mean for affordable health care, with fears it could raise the cost of drugs and limit access to biological agents used in treatments.

A/Professor Brian Owler, 666 ABC Canberra, 3 March 2015

AMA President A/Professor Brian Owler discussed the Federal Government's decision to abandon the GP co-payment. A/Professor Owler said it was a good result for GPs and their patients because the policy was poorly designed.

A/Professor Brian Owler, Radio National, 3 March 2015

AMA President A/Professor Brian Owler talked about the Federal Government dumping the Medicare co-payment. A/Professor Owler said the AMA would not support a mandatory price signal, but did not see it as unreasonable for patients who can afford it to make a modest contribution to the cost of their care.

A/Professor Brian Owler, 4BC Brisbane, 31 March 2015

AMA President A/Professor Brian Owler talked about the Federal Government changing aviation rules to require two people in a cockpit at all times. The AMA is not sold on the idea of doctors who treat pilots being able to break doctor-patient confidentiality if they think a pilot is unfit to fly.

TELEVISION

A/Professor Brian Owler, ABC News 24, 3 March 2015

AMA President A/Professor Brian Owler talked about the Government dumping the GP co-payment. A/Professor Owler said the tragedy of this whole negotiation period was that other pressing health issues had been neglected.

A/Professor Brian Owler, Sky News, 3 March 2015

AMA President A/Professor Brian Owler discussed the dumped Medicare co-payment and the Medical Research Future Fund.

A/Professor Brian Owler, Channel 9, 17 March 2015

AMA President A/Professor Brian Owler discussed suggestions that teenagers should undergo a psychological assessment before any cosmetic surgery. A/Professor Owler said cosmetic surgery was the source of a number of patient complaints.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

GP training confusion: call for urgent talks

The AMA has voiced "grave concerns" about the Federal Government's handling of far-reaching changes to general practitioner training under the shadow of looming doctor shortages.

AMA President Associate Professor Brian Owler has written to Health Minister Sussan Ley seeking an urgent meeting to discuss the implementation of changes to GP training announced in last year's Budget.

A/Professor Owler warned the Minister that the medical profession was "fast losing confidence in the process, and history shows that the last time GP training was reformed by the Government it took many years to recover".

In its 2014-15 Budget, the Federal Government abolished General Practice Education and Training (GPET) and the Prevocational General Practice Placements Program (PGPPP), axed funding to the Confederation of Postgraduate Medical Education Councils and absorbed Health Workforce Australia and GPET within the Health Department.

Under the sweeping changes, the Health Department will have responsibility for overseeing GP training.

The changes have stoked warnings that, combined with cuts to valuable programs and fears of massive hikes in student fees, they pose a serious risk to the quality and viability of general practice training, placing the profession at long-term risk.

Concerns have centred on the short time frame to implement the changes, the Department's lack of experience in managing training programs, and the profession's loss of supervision over training.

A/Professor Owler said expert AMA representatives who have been consulting with the Government and Health Department on the implementation of the changes have been alarmed by on-going delays and a lack of detail being provided by the Department on crucial matters such as the funding of professional oversight and governance arrangements.

"Unfortunately, we are now in a position where we simply do not know what the structure and delivery of GP training will look like beyond 2015," the AMA President said in his letter to Ms Ley.

He said briefing papers provided by the Health Department for those attending its stakeholder meetings were "generally scant on detail and do not adequately deal with key issues, such as the future role of the GP Colleges".

A/Professor Owler said the overwhelming view in the medical profession was that the Colleges should be given responsibility for the governance and management of GP training.

Anxiety about the changes has been heightened by predictions the nation could face a critical shortage of doctors in the next decade.

The ageing of the GP workforce and the struggle to attract students to specialise in general practice has contributed to forecasts of a shortfall of 2700 doctors by 2025 unless there is a major investment in training.

Last month Health Minister Sussan Ley re-announced the allocation of $157 million to extend the life of two medical training programs – the Specialist Training Program and the Emergency Medicine Program - through to the end of 2016.

Ms Ley said the programs were being sustained for an extra year while the Government continued to consult with the medical Colleges and other stakeholders about reforms to come into effect in 2017.

"This consultation will focus on in-depth workforce planning to better match investments in training with identified specialities of potential shortage and areas that may be over-subscribed into the future," the Minister said. "Workforce planning is something that doctors and health professionals have been raising with me during my country-wide consultations to ensure those areas of expected shortages are addressed sooner rather than later."

But Shadow Health Minister Catherine King condemned what she described as a "short-term fix".

Ms King said the Government had thrown the entire field of specialist medical training into chaos by delaying confirmation of contracts just weeks before candidate interviews were due to commence.

Ms King warned that any cut to funding to specialist training would result I fewer specialists working in areas where they are needed most.

ADRIAN ROLLINS

Govt urged to back successful training scheme

The AMA has urged the Federal Government to extend the life of a scheme that has delivered a major boost to medical specialist training in rural and 'non-traditional' settings.

The Australian National Audit Office has reported that the Medical Specialist Training Program (STP) set up by the Rudd Government to help stave off a looming shortage of medical specialists has been a success, filling 833 training positions since 2010 – almost 90 per cent of them outside the major

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teaching hospitals and 40 per cent of them in rural and regional areas.

But the scheme is due to wind up by the end of the year unless there is a further injection of funds, prompting AMA President Associate Professor Brian Owler to call for on the Government to renew its commitment to the program.

"The AMA believes the ANAO endorsement of the STP should allow the Department of Health to immediately finalise funding arrangements beyond 2015, which is a matter of urgency," A/Professor Owler said.

The program was set up at the start of the decade amid warnings the nation was facing a shortage of medical specialists, particularly in general surgery, pathology, radiology, dermatology obstetrics and gynaecology, without a substantial increase in training positions.

While most specialist training positions are provided by State and Territory governments at public teaching hospitals, since 2000 these have been supplemented by the Commonwealth, which boosted the number of positions it funded from 360 in 2010 up to 900 by last year.

Under the expanded scheme, the Federal Government typically provides between $100,000 and $153,000 a year for each full-time position, with such training taking from between three to six years to complete.

The Audit Office found that the scheme has been well-subscribed, reporting that 93 per cent of training positions have been filled. Last year, 467 people applied for 150 grants.

It said the Health Department's decision to funnel the grant funds through the specialist colleges, and to seek the advice of the colleges and state health services in the selection of applicants, had contributed to the success of the scheme overall.

"The STP has been successful in utilising non-traditional settings to expand the number of training positions for specialist trainees, with 89 per cent of STP-funded positions being located in non-traditional settings," the Audit Office said, adding that the expanded range of work environments provided for trainees through the program had improved the quality of training.

"Overall, the additional specialist trainee positions funded by the STP have boosted the availability of specialist services, including in regional and rural areas," the ANAO said.

A/Professor Owler said the STP had "added value" by increasing the number and range of training opportunities.

"Under the STP, specialist trainees have the opportunity to see and treat conditions that are not common in public hospitals," he said.

But the Federal Government, which is the throes of framing its second Budget, has yet to commit the extending the scheme beyond this year, adding to concerns about the adequacy of training arrangements for doctors.

Rapid growth in the number of medical graduates has outpaced increases in places further along the training pipeline, and there are fears that the absorption of Health Workforce Australia into the Health Department will undermine efforts to improve medical workforce planning, raising the risk that doctor shortages, particularly of specialists, may get worse.

HWA warned in 2012 that the nation faced a shortage of 2700 doctors by 2025 without improvements and increases in medical training, particularly in rural areas and in specialties such as radiology, psychiatry, pathology, ophthalmology, obstetrics and gynaecology.

ADRIAN ROLLINS

Multi-billion dollar pharmacy deal falls foul of audit

Negotiations on a fresh multi-billion dollar funding deal for the nation's pharmacies have been overshadowed by revelations of spiralling taxpayer handouts, cost overruns and inadequate government oversight.

An investigation by the Commonwealth Auditor-General has found significant shortcomings in the operation of the current $15.4 billion Community Pharmacy Agreement, under which the Federal Government has paid out $13.8 billion to chemists to dispense medicines through the Pharmaceutical Benefits Scheme.

In a scathing assessment of the administration of the Agreement, the Auditor-General found a $200 million shortfall in expected savings, a $300 million blow-out in pharmacist incentive payments, and the diversion and re-allocation of more than $13 million of funding without ministerial approval.

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"The Department of Health's administration of the Fifth Community Pharmacy Agreement has been mixed, and there is a limited basis for assessing the extent to which [it] has met its key objectives, including the achievement of $1 billion in expected savings," the report said. "A number of key government negotiating objectives for the 5CPA were only partially realised, and there have been shortcomings in key aspects of Health's administration at the development, negotiation and implementation phases."

Health Minster Sussan Ley, who is set to begin negotiations with the Pharmacy Guild of Australia on the next five-year Community Pharmacy Agreement, said the findings were deeply concerning.

Ms Ley said the Auditor's revelations raised serious questions not only about the Health Department's administration of the agreement, but also negotiation of the current agreement by the previous Labor Government, which signed off on it in 2010.

"These serious allegations seem to be just another example of Labor's culture of secret handshakes, winks and nods and general incompetence in Government," the Minister said. "Labor was either complicit or incompetent in their oversight of these alleged failures in proper process and ministerial accountability, and they must answer these serious questions."

Shadow Health Minister Catherine King called on Ms Ley to commit to making public the details of her forthcoming Community Pharmacy Agreement negotiations and publishing detailed costings.

The Auditor-General's report has come at a highly sensitive time for the industry, which is not only negotiating a new Community Pharmacy Agreement but is also pushing hard to expand the range of services pharmacists are allowed to provide, including flu vaccinations and health checks.

The Pharmacy Guild earlier this year launched a multi-million dollar advertising campaign in an effort to boost the public standing of pharmacists.

But the message risks being undermined by revelations that chemists add up to eight different charges and mark-ups to the cost of a prescription, including dispensing, dangerous drug and container fees. News Limited has reported that these accumulated charges can inflate the price of a box of 112 aspirin from $1.10 at the wholesaler to $13.31.

The Guild's image risks being further tarnished by findings that $5.8 million provided to it by the Commonwealth to fund professional development programs has instead been diverted into financing a "communications strategy" without ministerial approval, and that most of the $7.3 million given by the Government to encourage electronic prescribing has been used for other purposes.

The Health Department has accepted Auditor Office recommendations to improve its administration of Community Pharmacy Agreements, including more stringent account keeping and documentation standards.

But the Guild said the Auditor-General had not made "any adverse findings" regarding its role in administering the agreement.

ADRIAN ROLLINS

Who gets the pharmacy billions

Almost one in five community pharmacies raked in more than $1 million from taxpayers in dispensing fees, incentive payments and other entitlements last financial year, a Commonwealth Auditor-General report has shown.

In a rare glimpse into the public funding arrangements for retail chemists under the multi-billion dollar Community Pharmacy Agreement, the Auditor-General found that 941 of the nation's 5371 retail pharmacies received more than $1 million in Government payments in 2013-14, while a further 500 received between $800,000 and a $1 million.

On average, pharmacies received $12 from the Government for every prescription they filled in 2013-14.

In all, the Auditor-General found that of the $15.4 billion going to pharmacies under the current Community Pharmacy Agreement, $11.6 billion comes from the Commonwealth in remuneration payments, $2.2 billion comes from the pockets of patients in direct co-payments, $950 million is disbursed from a Government fund for medicine wholesalers and $663 million is provided for professional development programs.

Worryingly, given the scale of the largesse, the Auditor-General found significant flaws in the Health Department's administration of the scheme, including an inability to accurately track medicine costs and pharmacy remuneration.

The Auditor-General sought to fill this gap by using Department of Human Services data to calculate the value of

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Pharmaceutical Benefit Scheme and Repatriation Schedule of Pharmaceutical Benefit prescriptions.

It found that, for 2013-14, the "actual cost of prescriptions was $459 million higher than the sum of the cost components as derived by Health".

"Health has been unable to identify actual expenditure on the components of pharmacy remuneration for a growing number of prescriptions subsidised by the Australian Government," the Auditor-General said.

Among the findings, the Auditor-General reported that the Premium Free Dispensing Incentive, introduced to encourage greater uptake of generic medicines by compensating pharmacists for dispensing drugs that do not have the premium of branded medicines, is being claimed regardless of whether or not a substitute was provided. The incentive, worth $1.50 per prescription, is automatically paid on 4500 (83 per cent) of PBS branded items.

These and other findings have fuelled accusations that tight restrictions on pharmacy ownership and location have undermined competition in the industry and created outsized profits for a select few at enormous cost to patients and taxpayers, with some calling for an inquiry into the sector.

Under current laws, pharmacies must be owned by a licensed pharmacist, and new pharmacies are not allowed to open within 1.5 kilometres of an existing outlet. The rules have effectively blocked other retailers, particularly the major supermarket chains, from entering the industry.

Pharmacy ownership is tightly held – of around 27,000 registered pharmacists, fewer than 4000 own stores.

But the Pharmacy Guild of Australia has vehemently rejected what it said were attempts to portray pharmacies as "millionaire factories", instead insisting that many are instead under significant financial pressure.

"It is offensive and unacceptable that this false impression of profiteering should be put about at a time when the Guild is negotiating a new five-year Community Pharmacy Agreement with the Government to ensure local pharmacies remain viable," the Guild said. "Community pharmacies are under stress, and this kind of vicious, prejudiced and ill-informed journalism is reprehensible."

ADRIAN ROLLINS

Pharmacies could feel hot breath of competition

The AMA has argued patients will be the winners if proposals to abolish arcane rules stifling competition in the pharmacy sector are adopted.

Chair of the AMA Council of General Practice Dr Brian Morton said recommendations from the Government's Competition Policy Review to remove restrictions on the ownership and location of pharmacies would improve patient access to medicines.

The Review, chaired by prominent economist Professor Ian Harper, found that rules that prevent new pharmacies opening within 1.5 kilometres of an existing outlet and require that only pharmacists can own a chemist shop did nothing to enhance access to medicines or improve the quality of advice to consumers.

"Current restrictions on ownership and location of pharmacies are not needed to ensure the quality of advice and care provided to patients," the Review concluded. "Such restrictions limit the ability of consumers to choose where to obtain pharmacy products and services, and the ability of providers to meet consumers' preferences."

The Pharmacy Guild of Australia has rejected the assessment, arguing that current arrangement have served patients and the community well.

"We believe that pharmacies should be owned by small business people trained in universities, trained in the art of pharmacy, and we don't think that they deserve to be in huge supermarkets that don't have your health care as number one priority," Guild President George Tambassis said.

But Professor Harper said industry opposition to allowing supermarkets to provide pharmacy services had been undermined by the fact that a Queensland pharmacy that incorporates an IGA outlet recently received an industry award.

He told ABC Radio that "the pharmacy industry has no difficulty with supermarkets being inside pharmacies. They've just awarded a prize for a pharmacist in Queensland who's allowed IGA Express to open up a business inside the pharmacy. That doesn't seem to be the issue."

Professor Harper said rules on location and ownership did not apply to medical practices or private hospitals, and "we see no reason why they should apply to pharmacies either".

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He said there was no intention to change the authority to dispense medicine, which would always remain the prerogative of "licensed professionals".

But the Review said current anti-competitive rules did nothing to improve access to medicines, particularly for people living in remote and rural areas.

It said Government could use community service obligations and tenders for the provision of pharmacy services in under-served areas to ensure rural patients had access to prescription drugs, noting that the "supply of medicines in remote areas is already partly conducted through channels other than retail pharmacies, including through Aboriginal health services. That is unlikely to change, even if the current pharmacy location and ownership rules are reformed".

Fears metadata laws may compromise patient confidentiality and trust

The AMA has raised concerns the Federal Government's contentious data retention laws could be used to compromise patient privacy and potentially undermine the doctor-patient relationship.

AMA President Associate Professor Brian Owler has written to federal MPs including Attorney-General George Brandis, Communications Minister Malcolm Turnbull, Shadow Attorney-General Mark Dreyfus and Shadow Communications Minister Jason Clare raising concerns about the potential for the laws to be used to gather detailed information about a person's medical condition and health status.

"Metadata can potentially be used to create a profile of an individual based on access to health services," A/Professor Owler wrote. "This might include the services they may call, emails to and from health providers, SMS appointment reminders and the like. When aggregated, this information could reveal a great deal about someone's health status."

Under the laws, telephone companies and internet service providers are required to retain the details of every electronic communication they handle, including the identity of a subscriber and the source, destination, date, time, duration and type of communication. The information stored, known as metadata, does not include the content of a message, phone call, email or an individual's web-browsing history.

Under the legislation, passed with bi-partisan support late last month, 85 security and policing agencies will have access to an individual's metadata for up to two years after it is created.

The Government has argued that the laws are crucial to thwarting terrorist activities and preventing serious crime, and has sought to reassure the public that the powers would be used carefully and sparingly.

But law experts and civil liberties groups have raised fears about scope for intrusion on individual privacy.

University of New South Wales law professor George Williams wrote in The Age that the laws would "permit access to the data of every member of the community. Where, for example, the information relates to doctors and their patients, or lawyers and their clients, a government agency will not need to gain a warrant, or to consider whether accessing this information is in the public interest."

In his letter to the MPs, A/Professor Owler noted that the Law Council of Australia had also expressed concern about the detail of the legislation's wording, "including with regard to potential access to health information".

Greens Senator Penny Wright, who was among those who opposed the legislation, warned the measure could have the effect of deterring people from seeking medical help, including online support services.

"With [the] increasing use of online services for mental health, there is a serious risk that this Bill will undermine people's trust in these online services, with a flow-on risk to access to mental health services and the mental health generally," Senator Wright said in *Australian Doctor.*

A/Professor Owler has told senior Coalition and Labor MPs they need to address such concerns "to assure people and health professionals alike that the privacy of health information remains protected".

ADRIAN ROLLINS

In brief

Country-of-origin food labels 'months away'

The introduction of more stringent country-of-origin food labelling may be months away as the Federal Government undertakes extensive research and consultation and works on ways to implement the measure without falling foul of international trade rules. Industry Minister Ian Macfarlane told Parliament the Government was holding stakeholders workshops and conducting market research, and was investigating the use of bar codes and smart phone technology to increase information available to consumers. But the Minister warned the Government also faced "some hard work" to ensure any changes complied with World Trade Organisation rules. "The bottom line is to give consumers the information they are calling out for, without imposing excessive costs on industry," Mr Macfarlane said.

Sports doping

Health Minister Sussan Ley has condemned the injection of "unknown substances" into athletes in pursuit of sporting success following the AFL Anti-Doping Tribunal's finding regarding doping allegations at the Essendon Football Club. The Tribunal ruled last week that it was "not comfortably satisfied" that 34 current and former Essendon players had violated anti-doping rules. But Ms Ley said, regardless of this verdict, a review by Dr Ziggy Switkowski had found the club had a "disturbing pharmacologically experimental environment". "Any injection of unknown substances into athletes in order to push the boundaries of sporting achievement is unacceptable," Ms Ley said. "It shows a complete disregard for player safety and welfare. This sort of reckless behaviour at an elite level sends a dangerous message to amateur players, coaches and officials".

Defence veteran mental health

The Senate has launched an inquiry into veteran mental health following revelations of widespread depression and distress among returned armed forces personnel. The Senate's Foreign Affairs, Defence and Trade References Committee has been directed to investigate the prevalence of mental illness and post-traumatic stress disorder among veterans and examine how they are cared for, including access to appropriate support and services and the extent of homelessness and suicide. The Committee is due to report in February next year.

New consumer health advocate

A former head of the Australian Medicare Local Alliance has been appointed to lead the Consumers Health Forum. Leanne Wells, who was most recently with the ACT Medicare Local, is the Forum's new Chief Executive Officer following the departure of Adam Stanevicius, who served in the position for a year.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Revalidation of doctors, or how to spot the bad apples

BY DR EDWIN KRUYS IS A SUNSHINE COAST GP WHO BLOGS REGULARLY ON MEDICAL ISSUES AT DOCTORSBAG.NET.

The post was first published on 30 March 2015, and can be viewed at http://doctorsbag.net/2015/03/30/revalidation-of-doctors-or-how-to-spot-the-bad-apples/vaccination-37921

Wouldn't it be great if we could spot the bad apples before we consume them? Or even better: before they become bad? In recent years medical regulators around the world have been exploring ways to identify doctors who are performing poorly.

In the UK all apples are tested once a year via a process called revalidation. But some have said it will not detect poor doctors as its main purpose is to gain patients' trust. Others say it is meant to demonstrate what good apples look like. But one thing is for sure: Revalidation is labour-intensive and expensive.

> About 5000 doctors a year are considering to leave the UK, and many come to Australia. Bureaucracy is one of the reasons they emigrate

"There is indeed an additional time cost," said GP Dr Paresh Dawda in Australian Family Physican. "The appraisal meeting was usually 3 hours in length, and on average it took another 5 or 6 hours to collate the evidence and complete the forms, which is in keeping with an average of 9 hours found in the revalidation pilots."

Then there are the training, time and wages of the appraisers, usually doctors too, the administrative staff, extra regulation, log books, documents, IT… Revalidation has become an enormous enterprise, costing $186 million a year, mainly because of added pressures on doctors' time.

It seems logical that, before a country embarks on an operation like this, the problem it is trying to solve has been defined and the solution is effective.

So what's the problem?

According to the Medical Board of Australia, evidence from Canada shows that 1.5 per cent of doctors are not good enough. The Board has translated this figure to Australia, and thinks that more than 1350 doctors could be performing unsatisfactorily. Other research indicates that just 3 per cent of doctors are the source of 49 per cent of complaints.

Several safety mechanisms are already in place: at the moment, Australian doctors must meet the Medical Board's mandatory registration standards, including for recency of practice and continuing professional development. Doctors can be subject to random compliance audits.

Although a majority of Australian doctors seems to support competence checks, there are serious questions about the UK-style revalidation process.

At a conference in 2013 Medical Board of Australia Chair, Dr Joanna Flynn admitted that "the problem that a revalidation-style system would help solve was not yet defined".

But Dr Flynn questioned the current continuous professional education system: "Can you assure me that everyone who has done your CPD program is actually competent and practising at a reasonable standard? (…) My sense is that, for most CPD programs, they don't do that, or at least, not to a high enough level of certainty."

What's the Medical Board up to?

"We started a conversation about revalidation in Australia in 2012," said Dr Flynn in last month's media release, "as part of our commitment to making sure doctors in Australia maintain the skills to provide safe and ethical care to patients throughout their working lives."

The Board has asked the University of Plymouth to answer some questions on revalidation. At first glance this seems a sensible approach.

Dr Flynn: "We have commissioned this research to find out what is working well internationally, what is in place in comparable health care systems, and what principles the Board should consider in developing revalidation in Australia. (…) this research will help make sure that the decisions the Board makes in future about revalidation are effective, evidence-based and practical."

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Revalidation of doctors, or how to spot the bad apples

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It appears the Medical Board has already made up its mind. The research findings will be considered by the Board in the second half of 2015. I am certainly looking forward to the results and conclusions, as well details about cost and setup of the study.

The Camera revalidation research website of the University of Plymouth doesn't give any answers away: "The research team is currently undertaking an ambitious programme of research involving three interlinking studies to explore and understand revalidation in all its complexity."

Putting the cart before the horse

The question is, of course, is revalidation the right solution? Are there other options? One could argue that this should have been considered before spending tax dollars on an overseas research project.

Professor Breen, from the Department of Forensic Medicine at the Monash University in Melbourne, said in the Medical Journal of Australia: "There is little to support the idea of simply transposing the UK system to Australia. Despite some local failures of medical regulation and hospital governance, there has been no widespread loss of faith of the community either in its doctors or in the regulatory system."

"The Medical Board of Australia would be wiser to start afresh by asking and answering two questions — namely, is there a problem with medical registration in Australia that needs attention, and, if so, what should be done to fix the problem?

"The medical profession in the UK appears to have accepted revalidation, albeit reluctantly, as representing the price to be paid for maintaining the existence of the GMC and for regaining public trust after a series of regulatory failures.

"It has been claimed that revalidation will not reliably detect poorly performing doctors, and many commentators have pointed out that revalidation would not have identified Dr Harold Shipman."

Immediate past-president of the AMA, GP Dr Steve Hambleton had second thoughts, too. In MJA Insight he said: "We need to make sure we maintain our currency and continue to improve health outcomes, but in terms of value for money, making everybody go through a 5-yearly process of 360-degree evaluation is not needed in the Australian health system."

Both Professor Breen and Dr Hambleton suggested there are better ways to deal with the bad apples. Database analysis could be one solution. Other options are targeted revalidation and a revamp of the existing CPD program and accreditation. Some have argued that the focus should be on the workplace, not just on health professionals.

Journalist Paul Smith from *Australian Doctor* magazine was, as usual, spot on when he wrote: "(Doctors) may argue that targeted revalidation has greater merit than what they may see as carpet-bombing the entire profession."

Red-tape stress

"Recently I cried at work," posted Dr Adrienne Garner on the BMA blog. "Why? Because the evening before I'd been notified that my appraisal, submitted after hours of work, had been unsubmitted by my appraiser as it was 'not sufficient for revalidation."

"I was gutted. My mind churned with a mixture of thoughts ranging from anger to fear, through frustration and disappointment. Sleep had been impossible."

Under revalidation appraisals became a form of policing the profession.

Many studies show that doctors are more likely to experience psychological distress and suicidal thoughts than the general community, and there is a high rate of burnout. Pastoral care and self-reflection are important. But when they are part of a policed regulatory framework, they become a stressor in itself – which defeats the purpose.

Former Coventry GP Dr Gaurev Tewary, now working in Australia, posted on a social media platform: "I was an appraiser in the UK. My overall impression is this: Appraisals used to be fun and interesting and mainly pastoral. You did them to help people and I enjoyed supporting the profession. Under revalidation it became a form of policing the profession."

About 5000 doctors a year are considering to leave the UK, and many come to Australia. Bureaucracy is one of the reasons they emigrate.

We must become better at dealing with bad apples, but health care is already a highly regulated industry, and the last thing we need here in Australia is more regulation, red tape and stressed-out doctors.

I hope the Medical Board will work with the colleges and the AMA to explore better options.

Research

Algae could be behind deadly disease outbreak

Researchers are investigating whether blue-green algae is driving a dramatic upsurge in the incidence of motor neurone disease (MND) in the Riverina.

Scientists suspect the algae, which blooms intermittently in inland waterways, could be behind an exceptionally high cluster of MND cases in the irrigation farming region in recent decades.

The issue came to the attention of researchers following a sharp increase in the number of MND-related deaths in the area in the past 25 years.

One of the investigators, Macquarie University Professor of Neurology Dominic Rowe, said the numbers of MND deaths had jumped from one in 500 fatalities in 1986 to one in 180 in 2011.

The urgency of the research has been underlined by the fact that more than 90 per cent of motor neuron diseases have no known cause or cure. The disease kills motor neurons in the brain and spinal cord, progressively paralysing the body.

Professor Rowe said blue-green algae was one theory they were chasing.

“This is a theory that’s been around 30 years. It has only been revitalised in the last couple because of the increase,” Professor Rowe said. “If blue-green algae is a trigger we need to know what happens.”

Suspicion that blue-green algae may cause MND is not new. A study last year by researchers from the University of Technology Sydney and the Institute of Ethnomedicine in the United States found a link between the ingestion of food or water contaminated by blue-green algae and motor neurone disease.

Blue-green algae or cyanobacteria produces a neurotoxic amino acid called ß-methylamino-L-alaine or BMAA. The researchers discovered that BMAA mimics an amino acid called serine that is used to make human proteins.

Lead author of the study, Dr Rachel Dunlop from the University of Technology Sydney, said the similarities between serine and BMAA mean that when the toxin is present in the body it can be mistaken for serine and incorporated into human proteins. This damages the proteins and inhibits their function, eventually causing the death of the cell.

“Common among all neurodegenerative diseases is the problem of clumps of proteins overloading cells and forcing them to ‘commit suicide’,” Dr Dunlop said.

“This research reveals that BMAA can also trigger this process.”

BMAA was originally identified in Guam after the Indigenous people, the Chamorros, were found to develop motor neurone disease up to 100 times more often than other people. The Chamorros used seeds from cycad palms to make flour, and regularly ate fruit bats, which also ate the seeds. Both these foodstuffs contained BMAA.

Since then, research has revealed increased incidences of MND in people who live near lakes with frequent cyanobacteria blooms, among consumers of contaminated shellfish, and in soldiers deployed during the First Gulf War, because the desert sands they walked over had a crust of cyanobacteria.

Dr Dunlop said the research showed just how important it was for people to avoid contact with algal blooms.

“Blue-green algae is ubiquitous in Australia but not everyone has motor neurone disease, so there are likely other factors involved in triggering the disease,” Dr Dunlop said. “But when people are warned to stay away from blue-green algae they should heed the warning.”

The research by Dr Dunlop was published in the journal *PLOS ONE*.

KIRSTY WATERFORD

Research

Red light for cancer's free ride

Researchers are on the verge of developing a new range of cancer-fighting drugs following the discovery of a technique to prevent the spread of cancer through the body.

Scientists working in collaboration with Karyopharm Therapeutics Inc., a clinical-stage pharmaceutical company, have developed an advanced Exportin-1 inhibitor, KPT-330, that curbs – and in some instances prevents – cancer from interfering with the body's defences against damaged DNA.

In a human cell, the nucleus contains DNA and acts as a control centre, while proteins are produced and recycled in the surrounding cytoplasm. In healthy cells, proteins are constantly being transferred between the nucleus and the cytoplasm.

Cells use various transport proteins to ensure the proteins get to where they need to be. The most well-known is Exportin-1, which transports more than 200 different proteins. Among Exportin-1's passengers are tumour-supressing proteins which, while in the nucleus, are able to detect damaged DNA and trigger cell death.

However, some cancers disrupt Exportin-1's normal functioning by transporting anti-cancer proteins out of the nucleus and into the cytoplasm, preventing them from carrying out their cancer-supressing work.

Lead researcher Professor Dirk Daelemans, said that developing KPT-330 into a drug was challenging because they needed to be able to verify that it only affected exactly what they wanted it to target and nothing else.

"We knew that the molecule KPT-330 attaches to a particular amino acid, a building block of the Exportin-1 protein," Professor Daelemans said. "Thanks to the latest developments in gene technology, we were able to modify that particular Exportin-1 amino acid in cancer cells.

"The result? The key no longer fit in the lock and KPT-330's anti-cancer effect disappeared. This was the proof we needed to show that this molecule acts exclusively on the Exportin-1 taxi and no other targets.

"This technique can be used to develop other anti-cancer drugs as well, which bodes very well for the discovery and development of future cancer drugs."

The research was published in *Chemistry & Biology*.

KIRSTY WATERFORD

Born in USA gives green card for prostate

Australian treatments for prostate cancer are under review after it was revealed American men are much more likely to survive the disease than their Australian counterparts.

In an unexpected result, a Cancer Council NSW study has found that prostate cancer deaths in the United States have plunged by 50 per cent since the early 1990s, compared with a more modest 30 per cent drop in Australia over the same period.

The Council said that if Australia had achieved a similar rate of decline in mortality, the deaths of around 11,000 men could have been avoided in that time.

Cancer Council epidemiologist Associate Professor David Smith speculated that different ways of treating the disease could be a major cause for the discrepancy.

"Prostate cancer is the most common cancer diagnosed in Australia and we have the highest incidence rates internationally," Professor Smith said. "However, while there has been a notable drop in the death rates, there is still a lot of room to do better."

A/Professor Smith said there had clearly been progress in controlling the cancer, most likely because of advances in treatment, though the precise reasons were still unclear.

According to researchers, the fall in the mortality rate has occurred too quickly to be a direct result of increases in testing.

Professor Smith said that further research was needed to try to find out why the discrepancy in survival rates between Australia and the US had developed. He said this would include understanding the effects of screening for prostate cancer, the timing of diagnosis, treatment methods, referral patterns and long-term follow-up in order to discover what combination of factors helped save lives.

"Continued effort should be placed on providing evidence-based care in relation to prostate cancer screening treatment, monitoring, ongoing follow up and supportive care," Professor Smith said.

"We also know that men from regional and rural Australia have the poorest outcomes, so addressing inequality issues according to where men live is of great importance."

It is estimated that there will be 25,000 new diagnoses of prostate cancer each year in Australia by 2020, and more than 200,000 men will be living with the disease.

KIRSTY WATERFORD

Research

Under the microscope

MS patients put the pedal to the metal

University of Sydney researchers have designed an exercise system that may slow the progression of multiple sclerosis (MS) by helping people with the devastating condition improving the mobility of their leg muscles. The research team adapted a bike previously developed for people with spinal cord injuries that uses electrical stimulation to activate contraction of the major leg muscles, forcing the pedals to rotate. The research team are currently undertaking tests to assess the benefits that can be gained for those with advanced MS. Lead researcher, Dr Che Fornusek, said early trials showed a lot of promise.

New DNA Screening Test for bowel cancer

A new non-invasive screening test is being recommended for detecting bowel cancer. The faecal immunochemical test (FIT) is an accurate, non-invasive screening test that detects whether there is any occult blood in the stool. Professor Graeme Young from the Royal College of Pathologists Australasia said that the FIT test could reduce expectations that upon reaching 50 years of age people should have a screening colonoscopy. Professor Young said such procedures were best reserved for those with symptoms or who were in high risk groups.

Take a walk after eating

Going for a walk after eating a meal could help prevent older Australians from suffering falls caused by a sudden loss of blood pressure. Researchers from the University of Adelaide were trying to better understand post-prandial hypotension – a fall in blood pressure seen within two hours of eating a meal. The condition commonly affects elderly people, usually after breakfast, and can make them feel tired and dizzy. The researchers said that older people with post-prandial hypotension who should be encouraged to walk intermittently at a normal pace for at least 120 minutes after a meal to prevent reducing blood pressure. Professor Renuka Visvanthan from the University of Adelaide said walking, coupled with other practical strategies such as drinking a glass of water with meals, may help older people avoid the consequences of post-prandial hypotension.

LETTERS

Dear Editor,

In response to the article 'Hospital funding squeeze intensifies' in the March 2015 edition of Australian Medicine which referenced the National Efficient Price Determination for 2015-16, the Independent Hospital Pricing Authority (IHPA) determines the National Efficient Price (NEP) based on activity and costing data obtained from jurisdictions.

The NEP is then used to support the nationally consistent system of Activity Based Funding (ABF) agreed to by all Australian governments in the National Health Reform Agreement in 2011.

Your article refers to the decrease in the NEP between 2014-15 and 2015-16 of 0.7 per cent. This was based on the fact that the average cost per National Weighted Activity Unit (NWAU), which measures units of public hospital activity, had decreased across Australian hospitals in recent years as efficiencies were realised in public hospitals across the nation.

In your article, you raised concerns over IHPA's practice of back-casting. This is the process in which IHPA adjusts the previous year's NEP for any methodological changes introduced in the most recent years.

This process is transparent to all nine Australian governments, a range of national stakeholders, including the Australian Medical Association, and the general public.

Once the NEP is adjusted for year-on-year methodological change, there has been a 3.0% increase between the 2014-15 and 2015-16 NEP. This is an accurate reflection of the increase in the efficient cost of public hospitals throughout Australia.

Yours sincerely,

Shane Solomon
Chair
Independent Hospital Pricing Authority

When a complaint is made – improving the AHPRA notification experience

BY DR STEPHEN PARNIS, AMA VICE PRESIDENT

AMA Vice President Dr Stephen Parnis (second from left), Medical Board of Australia Chair, Dr Joanna Flynn (next to Dr Parnis), AHPRA Chief Executive Martin Fletcher (facing the camera) and other doctor representative meet to discuss improving the notification process.

No-one likes being the subject of a complaint.

For conscientious practitioners, it can be extraordinarily stressful and unpleasant.

For years the AMA has been active in working with the regulator to improve the operation of the national registration and accreditation scheme for the health professions.

Since the National Scheme's commencement on 1 July 2010, the serving Federal AMA President has met at least twice a year with Dr Joanna Flynn, Chair of the Medical Board of Australia (the Board) and Martin Fletcher, CEO of the Australian Health Practitioner Regulation Agency (AHPRA).

The AMA has used these meetings to have honest and open discussions about how the scheme is working and its future directions, and the Board and AHPRA have been responsive to our feedback.

The AMA has always maintained a keen interest in the cost of the scheme.

We have been able to provide considered input into the development of, and revisions to, the registration standards and other guidance documents produced by the Board to regulate the professional practice of medicine.

The AMA shares the Board's objective to protect the public by using minimal regulatory force to manage the risk posed by the practice of some practitioners. Punishment is not part of its goal.

In preparing its submission to an independent review of the scheme, the AMA last year surveyed members about their experiences.

The overwhelming response was that, after initial teething problems, the registration process has bedded down - though the experience with investigations of notifications was problematic. Members commented that:

- there was a lack of clarity and transparency regarding the process and decision-making;
- there was ineffective and inefficient vetting of complaints and notifications;
- investigation processes were overly complex and broader in scope than the notification;
- the duration of some investigations and the length of time matters took to be finalised was problematic;
- the limited information provided to the medical practitioner about the details of a notification, and the consequent disadvantage in responding to allegations, was concerning; and
- procedures did not afford due process – short timeframes to provide additional information and responses, and disparities in sharing information between the notifier and the practitioner under review.

There is no doubt that lengthy investigations are detrimental

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When a complaint is made – improving the AHPRA notification experience

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to the wellbeing of practitioners and colour consumer views about the effectiveness of the process.

Not only this, but fragmented, unnecessary and drawn out processes increase the costs of the scheme.

Rather than wait for the outcomes of the independent review, the AMA offered to provide senior, experienced clinicians to work with the Board and AHPRA to analyse the notification and investigation processes to streamline them to improve the practitioner experience.

We felt this was important given the volume and complexity of medical notifications.

The Board and AHPRA welcomed the idea to strengthen work underway to improve the timeliness and process for managing notifications.

At a workshop held on 5 March, Dr Flynn, Mr Fletcher and senior AHPRA staff met with AMA representatives including myself, Associate Professor Susan Neuhaus (general surgeon and surgical oncologist), Dr Roderick McRae (anaesthetist), and Dr Antonio Di Dio (general practitioner). Dr Jonathan Burdon, a respiratory physician, was unable to attend but provided input.

There was common commitment to constructive change and a spirit of goodwill.

The workshop kicked off by identifying what a good system would look like from the practitioner perspective. This included:

- timely and sensible vetting of notifications and complaints;
- arrangements for dealing with vexatious complaints quickly, and an alternative mechanism for assisting the complainant to resolve their dispute where there is otherwise no risk to the public;
- early and personal contact with the practitioner to advise that a notification had been received, acknowledging the impact this can have on practitioners, and explaining how the process will work;
- recognition by colleagues and employers that notifications are not evidence of sub standard practice but are a 'fact of life' of medical practice, with investigations being carried out in the interest of public safety;
- a process that assists the practitioner to gain insight, and supports them to remedy their practice if it is lacking;

'The AMA shares the Board's objectives to protect the public by using minimal regulatory force to manage the risk posed by some practitioners': AMA Vice President Dr Stephen Parnis

- a process that quickly and fairly addresses unsafe and poor practice, fairly and appropriately;
- that practitioners be afforded confidentiality during the investigation and decision making; and
- that there be clear and accessible information about the notifications process to inform practitioners about what to expect.

At the workshop, de-identified case examples were used to identify where processes fail practitioners and to explore improvements.

Summarised below are actions that can be taken to improve the practitioner experience and the operation of the scheme.

Regulatory principles

The regulatory principles that the Board and AHPRA staff use to guide their investigations and decision making will be included in the guide for practitioners and be attached to the initial letter the practitioner receives about a notification. The principles are available on the AHPRA website at http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx.

Initial assessment response

The letter that invites the practitioner to provide an initial response to the notification will include information about when they will be advised that there will be no further action or an investigation will take place, or any other action that is available to Board. The letter will also provide contact details for a person that the practitioner can follow up with.

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The letter will provide the practitioner with reassurance that the process is not intended to punish practitioners, that the notifications process is part of the arrangements for protecting the public, and that due process will be followed.

Reflective lessons

In cases where investigations result in no further action, the Board will look at the factors that were known when the notification was received, and consider how these might inform the notifications vetting process.

The Board will also consider what other methods it can use to assist the practitioner to understand the issue that contributed to the notification being made, and steps that he or she could take to improve the quality of practice.

Investigations beyond 12 months

The workshop identified that there can be several reasons why investigations may not be completed within 12 months, such as waiting for the outcomes of simultaneous investigations, coronial inquiries, court cases etc. In these situations, the practitioner will be provided with more frequent information about how their matter is progressing, in order to help them understand the reasons for the delays.

General information for the public will be published about the most common reasons for lengthy delays in resolving notifications.

Transparency about decisions where a Board member is professionally associated with the practitioner being reviewed.

The Medical Board and AHPRA have clear processes in place to manage potential conflicts of interest. AHPRA and the Board will explain to the practitioner how these issues are dealt with by the Board when concerns about this arise.

Expert reports

A policy will be developed to generally provide the practitioner with export reports obtained about them, except when there are specific risks associated with doing so.

Assessment costs

The Medical Board will clarify that travel costs of the practitioner to attend assessments required by the Board are paid by the Board.

Reworking letters to practitioners

The AMA and AHPRA will continue to work together to improve the letters that are sent to practitioners.

Feedback from practitioners

AHPRA will explore a cost effective mechanism for systematically obtaining feedback from practitioners about how they feel they were treated during an investigation.

Information about options for the public

AHPRA will develop information for the public that sets out the options that people have if they have a grievance, and how they can pursue them.

Update the Guide to Notifications

The AMA and AHPRA will work on updates to the *A Guide for Practitioners: Notifications in the National Scheme* to provide practitioners with more information about the investigation and decision-making processes.

The AMA believes these changes to improve the practitioner experience will, in turn, enhance the process for those making notifications.

I would like to reassure all AMA members and the broader profession that, while the scheme has had its teething problems, this is to be expected when eight schemes covering 10 different practitioner groups are brought together. The scheme is now being consolidated and improved.

The AMA wants the profession and the general public to have confidence in the scheme. To achieve that, the scheme must be fair, timely, transparent and effective.

I am satisfied that, even before last month's workshop, the Board and AHPRA were making improvements to the scheme. The workshop has meant that those changes are better informed.

I would like to thank Dr Flynn and Mr Fletcher for their efforts to work with the AMA. The fact that both of them attended the workshop for the full day, along with their senior staff, is testament to their desire to make the scheme the best it can be.

The AMA will continue to work with the Board and AHPRA over the coming months to improve the practitioner experience.

Threat to lifesaving drug lifted

Millions of patients in developing countries have had their access to a lifesaving drug preserved after the Chinese Government abandoned a controversial bid to have the widely-used anaesthetic ketamine scheduled as a narcotic drug by the United Nations.

In a decision greeted with relief by public health experts around the world, China last week deferred for a year a proposal for the United Nations Commission on Narcotic Drugs to classify ketamine as a controlled drug amid concern about growing abuse of the medicine for recreational purposes.

Chinese authorities have become increasingly alarmed about the illicit use of ketamine, where it often goes by the street names ket, Vitamin K or Special K, and had proposed that it be put in the same schedule 1 category as psychedelics such as LSD, making its supply and use subject to heavy restrictions.

It would have meant that any countries wanting to purchase the drug faced an annual limit on how much they could import, and severe restrictions on who could administer it.

Medical experts including the World Health Organisation and the World Medical Association warned the change would have been a disaster for billions of patients in developing countries, where ketamine is the only viable form of short-term pain relief.

Ketamine is one of the most commonly used anaesthetics in the developing world because it is cheap and easy to use. It is injectable, which means it can be administered by doctors and nurses in even basic settings and, because it does not interfere with coughing and gag reflexes, patients do not have to be intubated. It is also valued in cases of traumatic injury and shock because it raises blood pressure.

The WHO had strongly advised the Commission to reject the proposal on public health grounds, arguing that to schedule the drug would have the practical effect of denying its use to millions who undergo lifesaving surgery in developing countries every year, such as caesarean sections.

World Medical Association President Dr Xavier Deau said that although the desire to tackle the recreational abuse of the drug was understandable, scheduling it would make it unavailable and increase the suffering of people "in the most difficult of clinical circumstances".

"We know from experience with other anaesthetics, especially pain medication, that the scheduling of drugs effectively prevents their use, and that patients in poor areas and in rural settings are then unable to receive treatment with those drugs," Dr Deau said.

Instead of scheduling ketamine, the WMA said it would be better to tackle the problem of illicit use by tightening controls on the drug's supply through prescriptions and by the pharmaceutical industry.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Global Conference on One Health

Medical practitioners and veterinarians are being brought together at an international conference intended to foster greater collaboration between the professions.

The World Medical Association and the World Veterinary Association have jointly organised the Global Conference on One Health to be held in Madrid on 21 and 22 May.

The WMA said the conference aimed to bring together veterinarians, physicians, students, public health officials, non-government organisations and other participants to strengthen links and communications between the professions in order to "improve the different aspects of health and welfare of humans, animals and the environment.

The conference will include sessions on zoonotic diseases, antimicrobial resistance, natural disaster managements and human and animal exposure to environmental hazards.

Conference details can be viewed at: http://www.wma.net/en/50events/20otherevents/80onehealth/index.html

Turkish doctors stand up to intimidation – and win

A Turkish court has dismissed Government action against doctors who rushed to the aid of dozens of people injured during the Gezi Park protests in Istanbul in 2013.

In a result seen as significant for safeguarding medical neutrality in conflict zones, a court has directed that legal action launched by the Turkish Ministry of Health against the Ankara Chamber of Medicine, part of the Turkish Medical Association, be dropped.

Two members of the Chamber, Dr Selcan Yüksel and Dr Erenç Yasemin Dokudağ, were charged with "praising a criminal, insulting religious values and damaging a mosque" after coming to the assistance of protestors injured in violent clashes with police.

Several people were killed and around 3000 injured during the protests, which began as a rally against a proposed park redevelopment but quickly turned into full-blown country-wide protests against the rule of then-Prime Minister Recep Tayyip Erdogan.

Dr Yüksel, of İstanbul Medical School's Çapa Hospital, said she had to get off a minibus at Kabataş on the day of the incident because the roads had been blocked. When she saw injured people being taken to the Bezm-i Alem Valide Sultan Mosque, she ran to their assistance, acting on her "doctor's reflexes," according to the Today's Zaman report.

Dr Yüksel told the court: "There were people under the influence of tear gas, people who had been hit by canisters, people who had broken limbs and people bleeding. I entered the mosque to help people as a doctor with training in treating trauma and general surgery. There were a lot of people. If we hadn't helped them, many people would have died, or people with broken body parts could have lost limbs."

The prosecution was launched as part of an attempt by the Government to crack down on dissent, and drew international condemnation, including from the AMA and the World Medical Association.

The AMA Federal Council last year passed a resolution calling on the Turkish Government to drop the charges, and AMA President Associate Professor Brian Owler said he made representations to both Prime Minister Tony Abbott and the Turkish Ambassador to have the case dropped.

A/Professor Owler said it was AMA policy that doctors provide care impartially and without discrimination, and that they should not be impeded, prosecuted or punished in fulfilling this ethical obligation.

World Medical Association Chair of Council Dr Mukesh Haikerwal and President Dr Xavier Deau said the prosecution of the doctors had been an "assault on humanity and an attack on the autonomy of our profession".

"On the other hand, this case and others have proven that there are still judges that have remained independent and brave enough to exercise their duties loyal to the law and not the aspirations of the Government," they said. "The Turkish people can be proud of their doctors, lawyers and judges who live up to values of justice and humanity, and who withstand the forces of intimidation and segregation."

ADRIAN ROLLINS

Medical teams return from Vanuatu

Australian medical teams last week began pulling out of Vanuatu after having completed their mission to provide critical emergency health care and assistance after tropical cyclone Pam cut a swathe of destruction across the small Pacific island nation.

The Federal Government said the 27-member Australian Medical Assistance team was returning to Darwin after helping assist in the treatment of 1341 patients at the Port Vila Central Hospital and 26 medical evacuations from outer islands.

The Australian contingent also included the Urban Search and Rescue Team which carried out urgent repairs to the Port Vila Central Hospital in the immediate aftermath of the storm to ensure it could begin to provide care as soon as possible. The team also assisted in repairs to a further six health clinics and 27 schools and colleges.

Health Minister Sussan Ley said demand for health services had eased and was now at a level that could be managed by local health authorities.

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Medical teams return from Vanuatu

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But the task ahead of the island nation remains huge.

Though only 11 people died in the storm, its fury has left large parts of the country facing a massive clean-up.

The cyclone unleashed winds of speeds up to 250 kilometres per hour, and the category-five system caused widespread devastation in Vanuatu's southern provinces of Shefa and Tafea.

In its wake, 75,000 people were left in need of emergency shelter, and 96 per cent of food crops were destroyed.

So far, Australia has provided temporary shelters and tarpaulins for 13,000 people, and the Australian Defence Force is helping in the distribution of humanitarian supplies from the Red Cross, the United Nations, the Australian Government and non-government organisations.

Foreign Minister Julie Bishop said the Government would work closely with Vanuatu and other countries and organisations involved in the recovery effort, including New Zealand, France, Britain, the UN and the Red Cross, as the focus shifted from emergency response.

ADRIAN ROLLINS

APRIL HEALTH EVENTS

The dates and events listed are major awareness days, conferences, weeks and months related to health. If you know of an upcoming national health event please email the details to ausmed@ama.com.au

Sun	Mon	Tue	Wed	Thur	Fri	Sat
29	30	31	**1** INational Smile Day Go Blue for Autism in April	**2** World Autism Awareness Day	**3** Good Friday	**4**
5	**6** Easter Monday	**7** World Health Day	**8**	**9**	**10**	**11** World Parkinson's Day
12 Run for the Kids - Melbourne	**13**	**14**	**15** National Wear Green for Premmies Day	**16**	**17** World Haemophilia Day	**18**
19 MS Melbourne Cycle World Osteopathy Awareness Week	**20**	**21**	**22**	**23**	**24**	**25** Anzac Day
26	**27**	**28**	**29**	**30**	1	2

AMA Member Benefits

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

AMA members requiring assistance can call AMA member services on **1300 133 655** or **memberservices@ama.com.au**

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

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

Careers Advisory Service: Your one-stop shop for information and resources to help you navigate through your medical career.

CPD Tracker: Record your continuing professional development (CPD) online with the AMA's CPD Tracker, a free service for members.

Amex: American Express is a major partner of the AMA and offers members special discounts and extra rewards on a range of credit cards, merchant services and offers for existing AMA cardholders.

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

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

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

OnePath: OnePath offers a range of exclusive insurance products for AMA members.

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

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

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