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The AMA supports the MBS Review. But if we want a modern MBS, let's go through the evidence. Engage constructively with the medical profession; don't accuse us of doing things that are harmful for patients

- AMA President Professor Brian Owler

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Follow evidence, not myths, in Medicare review

The medical profession is mobilising in the face of what it sees as a Federal Government assault on its integrity to justify savage cuts to the Medicare Benefits Schedule that will boost the Budget bottom line at the expense of patient health.

While reiterating the AMA's support for the MBS reviews (the Government has initiated both the Medicare Benefits Schedule Review and an accompanying Primary Health Care Review), AMA President Professor Brian Owler said the medical profession took exception to the way the discussion had been framed around the idea that there were massive savings to be made because doctors were milking the system by proving unnecessary and unsafe services.

"The AMA supports the MBS reviews," Professor Owler said. "[But] let's not pre-empt the outcome. We seem to have jumped to the conclusion without having done the review and coming up with the evidence before making recommendations."

The blame game

There has been mounting disquiet over the Government's handling of the Review, including the depth of consultation with clinician representatives and claims by Review Taskforce head, Professor Bruce Robinson, that around 25 per cent of all items on the MBS were not backed by evidence, and that experience in the US suggested around 30 per cent of all care was of little worth.

Fears about the direction the Government was taking the Review in were crystallised on 27 September when Health Minister Sussan Ley launched public consultations by arguing that only a tiny fraction of the 5769 items on the MBS had been assessed for effectiveness and safety, and "inefficient and unsafe Medicare services...cost the nation dearly".

Issuing a call for consumers to participate in the Review, Ms Ley said that "30 per cent of expenditure is not necessary, wasteful, sometimes even harmful for patients" – echoing claims made by Professor Robinson.

Professor Owler rubbished the 30 per cent claim as "factually incorrect" and said the comments, and remarks in the Taskforce's Consultation Paper, laid bare the Government's intention to use the Review to cut costs and place the blame on the medical profession.

"We have known for some time that the MBS is outdated, but what we cannot accept is the narrative that has been set up by the Minister for Health, and the Prime Minister, that the profession is somehow using the MBS, performing unsafe and unnecessary procedures, palming patients for financial gain," he said. "This is a direct attack on the integrity of the medical profession. It is an approach that undermines the confidence that patients have in their doctors. It's unacceptable."

Follow the evidence

A day after the Government launched the consultation process, ABC television's *Four Corners* program aired claims that doctors were ordering tests and performing procedures that were of little or no benefit for patients and cost the nation hundreds of millions of dollars each year, including scans for lower back pain, spinal fusion surgery, knee arthroscopies and inserting stents in patients with stable angina.

Ms Ley seized on the television report, which she said had exposed "real – not perceived – waste in health spending", and demonstrated the need for the MBS Review.

The Minister said medical specialists and health researchers appearing on the program had "put their professional reputations on the line to provide important insight into billions of dollars being spent on unnecessary, outdated, inefficient and even potentially harmful procedures".

She rejected claims the Government had launched an attack on the medical profession, and asserted that 97 per cent of MBS items had never been assessed for their clinical effectiveness or safety.

Continued on p4 ...

Follow evidence, not myths, in Medicare review

... from p3

But Professor Owler said the Minister's claim was "quite misleading".

While just 3 per cent of items had been assessed through the Medical Services Advisory Committee process, the AMA President said, "but that doesn't mean that there's not evidence behind all of the other things that we do".

He questioned the need for evidence-based reviews for performing life-saving operations: "I don't need an evidence-based review to say that I should remove the tumour from a child that presents through the emergency department because I know they're going to end up dead within the week if I don't do it"

"There are some things that, yes, we need to evidence-based review, but there are many on the schedule that don't, and saying that 97 per cent doesn't have evidence is quite misleading."

Australia is not the US

He also challenged the uncritical assertion that 30 per cent of health spending was wasted on unsafe or unnecessary medical services.

The claim is based on the findings of a number of studies of the US health system which included not just clinical factors like medical errors and defensive medicine, but also administrative and regulatory overheads, pharmaceutical research and development and lifestyle factors like obesity, smoking and alcohol abuse.

"This figure of 30 per cent...what we do is unsafe or unnecessary, is factually incorrect," Professor Owler said.

"There were two papers from the United States that [concluded there] was probably about 30 per cent of waste in the US healthcare system.

"Somehow that's now been translated to Australia where [our] healthcare spend is about half that of the United States per capita, and we get much better results.

"So, suddenly we're translating figures that seem... not able to be translated to the Australian healthcare system, but people seem to be readily doing it."

MBS reviews nothing new

He said the medical profession had to be "vigilant" about the narrative being used to shape debate about the Review.

Professor Owler said the AMA not only supported the MBS reviews, but had been engaged with successive governments in undertaking them since 1990. He said in the last five years alone, the AMA had participated in reviews covering 26 areas of the MBS.

"Can we save money? Yes, and the AMA's more than happy to engage in that process, but let's actually go through and do the reviews and come up with the evidence before we actually pre-empt what the outcome is and what procedures might have conditions or be removed from the Schedule," he said.

"The risks to patient care from an emasculated MBS are too great to allow this Review to go off the rails."

ADRIAN ROLLINS

MBS timeline

22 April, 2015

Health Minister Sussan Ley announces the formation of:

- Medicare Benefits Schedule Review Taskforce, to be led by Professor Bruce Robinson;
- Primary Health Care Advisory Group, to be led by former AMA President Dr Steve Hambleton

10 July

The terms of reference for the Reviews are released

15 August

AMA hosts roundtable of 60 representatives of specialist colleges and institutes to discuss MBS Review

27 September

MBS Review Taskforce releases Consultation Paper, invites submissions from the public and the medical profession

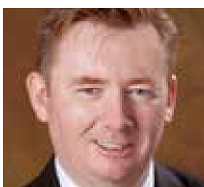
9 November

Consultation process ends

Before end of 2015

Ley says she will have "more to report about how I think the system can be improved...towards the end of the year"

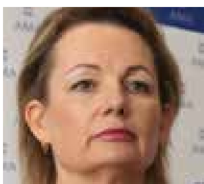
What they said ...


Professor Brian Owler

"The AMA supports the MBS reviews...but I do take exception to the way that the narrative has been shaped so that there are these huge areas of savings to be had, that people are doing inappropriate practice"
- *AMA President Professor Brian Owler, Radio National, 1 October.*

"It's clearly a cost-cutting exercise. If we want a new, modern MBS, engage constructively with the [medical] profession; don't accuse us of doing things that are harmful for patients.

"Come up with something that's going to actually reflect modern medical practice, and reinvest some of the savings into new items"
– *Professor Owler, Sky News, 27 September.*

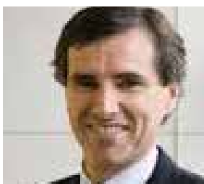

Sussan Ley

"We want to rewrite the Medicare Benefits Schedule because it's outdated. It's cluttered up with items that no longer actually happen in the surgeries and operating theatres around Australia.

"What we have in the MBS is a large volume of items that have not been renewed or refreshed since the early 80s.

"Thirty per cent of expenditure is not necessary, wasteful, sometimes even harmful, for patients.

"Where we realise efficiencies...we will reinvest them back into procedures that are new and innovative. We will also reinvest back into the Government's bottom line"
– *Health Minister Sussan Ley.*


Professor Bruce Robinson, MBS Review Taskforce Chair

"It has been estimated that 30 per cent or more of health expenditure is wasted on services, tests and procedures that provide no or negligible clinical benefit and, in some cases, might be unsafe and could actually cause harm to patients"
– *Professor Bruce Robinson.*

Dr Stephen Parnis

"We need a Schedule that does reflect modern practice. But the Government seems to have gone off the rails. What they're trying to do at the moment...is cut away from the Medicare Benefits Schedule without updating or adding new items numbers, [which] is of profound concern to us"
– *AMA Vice President Dr Stephen Parnis, Sunrise, Channel 7, 28 September.*

Catherine King

"The Minister has made it clear that 'redefining' or 'reviewing' Medicare is simply code for more cuts to health"
– *Shadow Health Minister Catherine King, 28 September.*

Richard Di Natale

"This is where health reform should have begun, instead of trying to shift costs onto patients and the states through Medicare co-payments and cuts to hospital funding. It is crucial that the Government commits to reinvest any savings back into the health system"
– *Greens leader, Senator Richard Di Natale, 28 September.*

Professor Stephen Duckett

"Public subsidy for treatments should be based on assessment of value, so it is right that the Review checks whether the Schedule has kept pace with changed knowledge and practice. [But] it is rare that a particular treatment has no benefit for any patient. Simply de-listing – tasking the test or treatment off the Schedule – is not the right approach"
– *Professor Stephen Duckett, Health Program Director, Grattan Institute, 28 September*

MBS Review Q&A

The claim	The AMA says
Thirty per cent of health spending is wasted on services, tests and procedures that provide little or no clinical benefit and, in some cases, are unsafe and could cause harm.	This is a claim that has been made about the United States health system, and which has been uncritically applied to Australia without any corroborating evidence.
A 2012 study found more than 150 MBS items were of low value or are harmful	The study actually reported that services that were ineffective or unsafe for all patients were "probably quite rare". Instead, the effectiveness of a service varies according to the characteristics of the patient.
Medical practitioners are performing unsafe and unnecessary procedures for financial gain, like ordering scans for patients with lower back pain, and performing spinal fusions.	This is an unacceptable slur on the integrity of the medical profession and undermines the confidence patients have in their doctors. The Medicare data does not say that GPs are referring patients with lower back pain for scans on their first visit, and there is very strong evidence for spinal fusion.
MBS items have never been assessed or amended since the 1980s	The AMA has been involved in regular reviews since 1990 and in the last five years alone has been involved in reviews of 26 areas of the MBS.
The Review is not about cost-cutting.	Health Minister Sussan Ley has admitted that some of the 'efficiencies' realised by the Review will be "reinvest[ed] back into the Government's bottom line".
The Review will enable the listing of new items on the MBS.	Processes to add new items to the MBS are explicitly precluded from the Review. The Government reaffirms the use of the existing lengthy and expensive Medicare Services Advisory Committee process.
"Only patients know if they actually benefit from what happens and get better, or whether they are unwell and incapacitated for a long time for no real improvement" – Sussan Ley	While patients are very capable of reporting on outcomes, such an approach does not take into account procedures and treatments intended to stop people getting sick, such as colonoscopies for patients with a history of colon cancer, or tests to detect and treat diabetic retinopathy.

Government policies driving health divide

More than a fifth of patients in some areas have avoided seeing a doctor or filling a prescription even though they need care, with many saying they are put off by the cost.

Although a majority Australians report little difficulty in seeing their GP, the latest snapshot of patient experience from the National Health Performance Authority shows that in parts of rural New South Wales, Queensland, Western Australia and Tasmania, many people are avoiding or delaying treatment because of cost, running the risk of developing more serious and expensive-to-treat health problems.

Just as worrying, in some areas up to one in 10 say they cannot afford to fill their prescriptions, raising concerns around the management of serious chronic diseases such as diabetes and the treatment of infections.

The results underline the city-country divide in access to affordable care. While Australia-wide it was common for between 15 and 25 per cent of patients to complain of how long they have to wait to get an appointment with their GP, only around 2 to 4 per cent of those in major metropolitan areas said they could not afford to see their doctor, while in rural and regional Australia the rate was two to four times as high.

Chair of the AMA Council of General Practice Dr Brian Morton said strong competition between medical practices in urban areas drove high rates of bulk billing and helped contain patient out-of-pocket charges.

But the relative scarcity of doctors in country areas, and the need for adequate remuneration to recruit and retain them, encouraged lower rates of bulk billing and higher patient charges.

Dr Morton said this was not the fault of individual practitioners, and was instead the result of Federal Government policies including to screw down the value of Medicare rebates and hold back investment in training and support for rural GPs.

Dr Morton said of even greater concern when it came to preventive care was the relatively high instance of patients delaying or forgoing medicine because of expense.

He said patients, particularly those with a number of co-morbidities that had to be managed simultaneously, often faced a hefty monthly pharmacist bill.

For instance, he said, a patient with high blood pressure might be on three different medications which would cost more than $100 a month. If two or more people in a household have on-going courses of drugs, the costs can quickly mount up.

The consequences of foregoing treatment can be severe, Dr Morton said. Patients identified as at risk of heart disease who decide not to take prescribed statins can suffer a build-up of plaque in their blood vessels that can lead to blocked arteries, blood clots and other serious circulatory problems.

Protecting affordable access to care was at the centre of the AMA's campaign late last year and early this year against the Abbott Government's plans for a GP co-payment.

The AMA warned that charging a co-payment would deter many of the sickest and most vulnerable in the community from seeking care, creating the likelihood that their health would deteriorate and need more significant and expensive treatment later on.

And the latest official figures on national health spending suggest the pressure on patients to contribute to the cost of there is increasing.

The Australian Institute of Health and Welfare reported in September that the Commonwealth's share of total health spending has plunged from almost 44 per cent to 41.2 per cent in just five years.

At the same time, individuals and families are shouldering more of the burden. In the past decade, the contribution of patients to the cost of health care has grown by an average of 6.2 per cent a year in real terms.

ADRIAN ROLLINS

'Slash and burn' insurers endanger health system

AMA President Professor Brian Owler has accused the major health funds of destabilising the health system through an aggressive push to cut costs, shirk responsibility and downgrade the value of insurance cover.

While the nation's biggest health insurer, Medibank Private, has struck a peace deal with Calvary Health after the two were at loggerheads over the terms of a service contract, Professor Owler warned the dispute was only part of a broader shift underway that could critically undermine the balance between the public and private sectors that underpins the health system.

The AMA President told the Ramsay Health Managers Conference on the Gold Coast last month that the dispute, which revolved around an attempt by Medibank to force Calvary to accept responsibility for 165 medical events it described as highly preventable, was "a pivotal moment" for the health system.

"This was an attempt by Medibank Private to impose financial sanctions on a provider for events which, although they have some degree of preventability, are an unfortunate, yet integral, part of clinical practice," Professor Owler said. "It was an attempt to impose cost-cutting measures through a commercial contract thinly disguised by the cloak of quality."

The details of Medibank's deal with Calvary have not been revealed publicly, provoking unease about what concessions the private hospital group may have made.

Professor Owler warned that acceding to Medibank's demands could destabilise the health system by creating a situation in which private hospitals refuse to admit patients with complex needs or considered to be at high risk.

"This has the potential to overload our public hospital system. It would upset that important balance between the public and private systems," he said. "There would also be the potential for those patients who required re-admission to be sent to public hospital emergency departments, rather than being re-admitted to the same hospital."

Medibank Private has rejected Professor Owler's concerns, downplaying the significance of its dispute with Calvary.

The insurer's Executive General Manager of Provider Networks and Integrated Care, Dr Andrew Wilson, told *The Australian Financial Review* the changes it had sought were "modest and are about helping to reduce three categories of mistakes that can occur related to a small number of surgical complications, falls in and around hospital wards and hospital acquired pressure sores".

Dr Wilson the insurer's actions were based on a thorough review of Australian and international evidence, "refined in discussions with a number of our healthcare partners, including some of Australia's most respected hospitals".

"From an original list of over 4,500 events in hospitals that lead to unintentional patient harm and after considering the available evidence we have focused on a small number of events where there is good evidence that action can be taken to prevent them or reduce their frequency."

But Professor Owler said the events itemised by Medibank were not mistakes but clinical complications, and was misusing information prepared by the Australian Commission on Quality and Safety in Health Care.

He said that if the insurer was truly concerned about improving the quality of care, it would support the work of the Commission, back improved clinical governance in private hospitals and invest in registries for medical devices.

"If funders, whether it be governments or health funds, are serious about quality, then they need to invest," the AMA President said. "They need to provide the resources, and they need to allow those in the system to drive change that delivers better outcomes. I can guarantee that, if they do this, then doctors, nurses, and managers within the health system will step up. They are only too eager to do it. They just the need the support."

Professor Owler added that insurers were debasing the health system by failing to honour policies and providing cover that was inadequate or, in some cases, "junk".

"We are seeing a systematic downgrading of policies, and in a way that is not transparent to policy holders," he said.

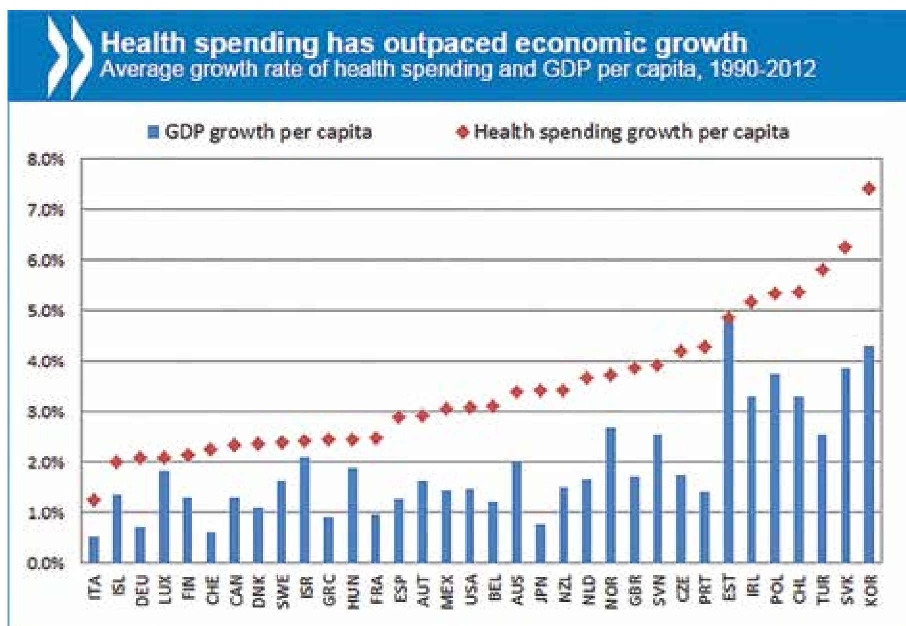
"These tactics to exclude treatments from policies are not about improving the value of the private health insurance product. They are blatantly about avoiding paying benefits for the treatments that people need, and expect to be covered for. "

He said the "slash and burn' approach being taken by some insurers should not be tolerated.

"A key to a sustainable private sector is adequate rates of private health insurance. For that to occur, we need to ensure that private health insurance premiums are affordable - and represent value."

ADRIAN ROLLINS

Families pick up the tab as Commonwealth health spending slows



Government spending on health has slowed dramatically while the health bill for households has increased sharply as the Commonwealth pushes more of the burden of care on to individuals and families.

In a result that undermines Federal Government claims that health funding is 'out of control', an Australian Institute of Health and Welfare report shows that Commonwealth spending grew by just 2.4 per cent in 2013-14 – below the rate of inflation – and its share of total health spending has plunged from almost 44 per cent to 41.2 per cent in just five years.

At the same time, individuals and families are shouldering more of the burden, Institute spokesman Dr Adrian Webster said – non-government funding grew by 5 per cent after inflation.

"Over the decade, funding by individuals was the fastest growing type of non-government funding, growing by an average of 6.2 per cent a year in real terms, compared with 5.3 per cent for all non-government sources," he said.

The figures are in line with other data showing only moderate growth in government health expenditure.

"The sky is not falling in when it comes to Federal Government funding for health," AMA Vice President Dr Stephen Parnis said.

The Commonwealth's Commission of Audit had predicted that Medicare spending would grow by 7.1 per cent per year until 2023-24, but Dr Parnis said the AIHW report and recent Medicare data showing that MBS expenditure increased 5.6 per cent in 2014-15 and just 3 per cent the previous financial year cast doubt on this projection.

"Costs are not escalating in the way that some have suggested," Dr Parnis said. "There is an ethical obligation on health professionals to improve efficiency wherever we can, but this should not be at the expense of undermining the pillars of the health system which have served us so well."

But the Coalition Government appears set to continue with health cuts despite last week's change of leader.

In his first major press conference as Treasurer, Scott Morrison indicated he would maintain the focus of his predecessor Joe Hockey on cutting Commonwealth expenditure, declaring that "we have a spending problem, not a revenue problem".

The Abbott Government implemented major cuts to health spending, including ripping $57 billion from public hospital funding in the next decade and freezing Medicare rebates until mid-2018, contributing to one of the sharpest slowdowns in health spending on record.

Dr Parnis said this was the wrong prescription for Australia's health system.

"The answer is not to cut away at Commonwealth funding for health. It is to ensure that Commonwealth funding achieves greater benefit, and the way we can do that is by having a more modern Medicare Benefits Schedule, and having an understanding that the Commonwealth has a central role in supporting the states on hospital funding," he said.

Earlier this week, AMA President Professor Brian Owler warned the Government's MBS reviews needed to ensure patients had access to the best evidence-based services and procedures, rather than simply being a cost-cutting exercise.

Dr Parnis said the Government also needed to ensure it got maximum value for its support for the private health insurance industry.

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Families pick up the tab as Commonwealth health spending slows

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"We need to ensure that Commonwealth funding for private health insurance extracts maximum benefit for patients in the health system, rather than policies that are designed simply to avoid premium surcharges," he said.

The AIHW found that total spending on health, including from governments, families and private organisations, grew by just 3.1 per cent in real terms in 2013-14, faster than the 1.1 per cent growth recorded the previous financial year, but well below the annual average of 5 per cent recorded in the past decade.

As the Institute figures show, most of this growth was driven by spending by individuals and private organisations, with the Commonwealth's share dropping and that of State, Territory and local governments holding steady.

ADRIAN ROLLINS

Prevention a wise investment for cash-strapped governments: OECD

Governments should invest in health promotion and disease prevention to ensure a recent slowdown in public spending on health is sustained, the Organisation of Economic Co-operation and Development has reported.

A day after the release of figures showing the Federal Government's share of total health expenditure has shrunk and is growing below the rate of inflation, the OECD has issued a report urging developed countries to lift investment in preventive health programs to help contain future growth in health spending.

And, as the value of private health insurance policies come under scrutiny amid concerns raised by AMA President Professor Brian Owler, the Organisation called into doubt the value of government subsidies and rebates for the private health insurance.

"Encouraging private health insurance has not been effective in relieving public budgeting pressures because the public health system continues to cover the cost of the most expensive services and patients," the OECD said.

Health spending has grown faster than economic expansion in all OECD member countries in the past two decades, but has slowed sharply since the global financial crisis – though the OECD warns it is likely to accelerate again unless governments closely monitor expenditure and increase outlays on preventive measures.

The Organisation said health spending was driven by the development of new technologies and services, rising incomes and ageing populations.

It has estimated that public spending on health across the OECD will reach 9 per cent of gross domestic product (GDP) in 2030 and 14 per cent of GDP by 2060 without concerted action.

"Many health systems in the OECD are at risk of not being fiscally sustainable unless substantive policy change occurs," it said.

But Australia appears better placed than many other developed countries.

Figures released by the Australian Institute of Health and Welfare show that public spending on health as a proportion of GDP reached 6.6 per cent in 2013-14, and total health spending was 9.8 per cent of GDP, both around the OECD average.

In return for this spending, Australia has achieved among the best health outcomes in the OECD; life expectancy is equal second in the world behind Japan.

While urging governments to keep a rein on health spending, the OECD nevertheless cautioned against ill-considered restraint measures.

"Unfortunately, many countries reduced spending on prevention following the [global financial] crisis," the OECD report, *Fiscal Sustainability of Health Systems*, said. "While this leads to short-term savings, it has harmful effects both on costs and on health outcomes in the longer term."

ADRIAN ROLLINS

Doctors face annual examination to prove they are up to the job

Doctors would undergo annual appraisals involving assessments of their on-going professional education and acceptance of feedback from peers, supervisors and patients as part a regular process to reaffirm their fitness to practise medicine, under proposals being considered by the Medical Board of Australia.

A study of so-called revalidation regimes around the world commissioned by the Board has found that they enhance patient safety and confidence in the medical profession, and has suggested three alternative approaches based on international evidence and experience.

The least onerous would require doctors to provide an annual account of continuing medical education activities they had undertaken, signed off by a manager or professional body. It would be taken as a demonstration that their medical knowledge was up-to-date, and every fifth year would result in a recommendation for revalidation.

But the researchers said a major drawback of this 'lite' approach was that it said little about a practitioner's fitness to practice, because it did not include feedback from peers and patients.

While a mid-way option would be to supplement directed learning activities with participation in feedback sessions involving a specified number of colleagues and patients, the report authors instead recommended a dual process (Model C) that included both evidence of participation in self-directed and mandatory learning activities, as well as taking part in facilitated feedback sessions involving colleagues, patients and other relevant participants, and a review of patient complaints.

"Model C offers the best model of revalidation informed by the current evidence base, and is most likely to assure both safe and, over time, better practice, to the betterment of patients," the report by the Collaboration for the Advancement of Medical Education Research and Advancement (CAMERA) said. "Model C ensures doctors are both up-to-date and fit to practise, representing a dual approach to revalidation."

Under this regime, doctors would be required to attend a core of continuing medical education events, supplemented by continuing professional development activities of their own choosing. The researchers put particular emphasis on the benefits of blended learning opportunities, where traditional teaching methods are combined with online and other methods of instruction, which they said would "help to incorporate the vast majority of learning preferences...and close the current gap between evidence and practice".

In addition, "all physicians would engage in annual appraisals providing valuable reflective practice opportunities. And a review of patient complaints would provide an additional layer of reflective practice and ensure that the patient voice was both heard and acknowledged".

While the CAMERA report clearly advocates the adoption of Model C, the Board is yet to specify its preference.

Instead, it has appointed University of Wollongong Medical School Clinical Professor Liz Farmer to head an expert group to advise on revalidation and suggest ways to evaluate the effectiveness and feasibility of the CAMERA models.

The work of the expert advisory group will be complemented by a separate Consultative Committee, chaired by the Medical Board Chair Dr Joanna Flynn and including representatives from the AMA, specialist colleges, medical schools and consumers, to provide feedback on issues regarding the introduction of revalidation.

In addition, the Board is commissioning research into professional and community expectations about what practitioners need to do to prove their competence and fitness to practise.

The expert advisory group has been given 12 months to recommend one or more revalidation models, and how it could be piloted.

"Regulation is about keeping the public safe and managing risk to patients," Dr Flynn said, "and part of this involves making sure that medical practitioners keep their skills and knowledge up-to-date."

"The Board is seeking expert advice, as well as feedback from the profession and the community, about the most practical and effective way to do this that is tailored to the Australian health care environment."

The AMA is among groups that have expressed concern about the additional regulatory burden revalidation would impose on already-stretched practitioners, and who would ultimately carry the cost of the process.

But Dr Flynn told the AMA National Conference in 2013 that some form of revalidation regime was unavoidable if the medical profession wanted to continue to enjoy community confidence.

Though only a small proportion of doctors are the subject of patient complaint, Dr Flynn said more was needed to maintain the public's trust, and the CPD program alone was not sufficient.

For more on the revalidation debate, see also *Revalidation: do doctors need it?* (https://ama.com.au/ausmed/revalidation-do-doctors-need-it).

ADRIAN ROLLINS

Review of AMA policy on euthanasia and physician assisted suicide

BY DR MICHAEL GANNON, CHAIR OF THE AMA ETHICS AND MEDICO-LEGAL COMMITTEE

As part of its five year position statement review cycle, the AMA's policy on euthanasia and physician assisted suicide is now due for review. This will be coordinated by the Federal AMA's Ethics and Medico-Legal Committee (EMLC).

The current policy is contained in the AMA's *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007. Amended 2014*, provided in full at the end of this article (it is also available on the AMA's website at https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007-amended-2014).

The current policy states that medical practitioners should not be involved in interventions that have as their primary intention the ending of a patient's life. This position is qualified by clearly stating that the following actions (or inactions) do not constitute euthanasia or physician assisted suicide so long as they are undertaken in accordance with good medical practice:

- not initiating life-prolonging measures;
- not continuing life-prolonging measures;
- not offering futile care;
- the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death (commonly known as the doctrine of double effect).

At this early stage of the review, we invite AMA members to provide your views on the current policy via email to ethics@ama.com.au by COB Friday, 11 December 2015. This initial method of engagement allows members to express their views in an open-ended manner, without the limitations associated with directed survey questions.

This initial engagement is restricted to AMA members only. While all comments will be kept confidential, we ask that you include your name in the response so that we can verify that you are an AMA member.

Member comments will be considered in a de-identified way by the EMLC and Federal Council and will be used to inform the next stage of the review process.

We will keep all members informed of the progress of the review and further opportunities for member engagement.

The *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007. Amended 2014* reads as follows:

1. *The AMA believes that while medical practitioners have an ethical obligation to preserve life, death should be allowed to occur with dignity and comfort when death is inevitable and when treatment that might prolong life will not offer a reasonable hope of benefit or will impose an unacceptable burden on the patient.*
2. *Medical practitioners are not obliged to give, nor patients to accept, futile or burdensome treatments or those treatments that will not offer a reasonable hope of benefit or enhance quality of life.*
3. *All patients have a right to receive relief from pain and suffering, even where that may shorten their life.*
4. *While for most patients in the terminal stage of an illness, pain and other causes of suffering can be alleviated, there are some instances when satisfactory relief of suffering cannot be achieved.*
5. *The AMA recognises that there are divergent views regarding euthanasia and physician- assisted suicide. The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of futile treatment.*
6. *Patient requests for euthanasia or physician-assisted suicide should be fully explored by the medical practitioner in order to determine the basis for such a request. Such requests may be associated with conditions such as a depressive or other mental disorder, dementia, reduced decision-making capacity, and/or poorly controlled clinical symptoms such as pain. Understanding and addressing the reasons for such a request will allow the medical practitioner to adjust the patient's clinical management accordingly or seek specialist assistance.*
7. *If a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide:*
   - *not initiating life-prolonging measures;*
   - *not continuing life-prolonging measures;*
   - *the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.*
8. *Medical practitioners are advised to act within the law to help their patients achieve a dignified and comfortable death.*

A better way to bond

A cut in the return-of-service obligation on new Bonded Medical Places participants should be extended to all existing BMP practitioners, the AMA has said.

Following up on the Federal Government's decision to trim the return-of-service (ROS) obligation to one year, AMA Vice President Dr Stephen Parnis has written to Health Minister Sussan Ley urging her to offer the change to doctors currently operating under the scheme.

Dr Parnis said experience from the Rural Clinical School model showed that the recruitment and retention of doctors in rural areas was improved by limiting the ROS obligation to one year, and if this evidence had influenced the Government's decision, then it made sense for the change to be extended to include all BMP scheme participants, not just new entrants.

"If a shorter ROS means that more people are prepared experience rural clinical practice, and evidence shows this may translate to a longer term commitment, then it would make good policy sense for all BMP participants to be given the choice to take up this option," Dr Parnis wrote. "Retaining a longer ROS for current BMP participants is likely to prove counter-productive as they will simply continue to withdraw from the scheme or buy out their obligations."

The AMA has consistently opposed the Bonded Medical Places scheme as an ineffective solution to the challenge of recruiting and retaining practitioners in rural areas. Its concern has been borne out by Health Department figures showing only 37 practitioners have completed their ROS obligation, while 307 have withdrawn from the program or breached their agreement.

Instead of imposing an obligation, the AMA has proposed programs focussed on recruiting doctors who have lived in the country or providing training in rural areas.

"The AMA is very conscious of the need to encourage more doctors to work in underserviced areas, particularly rural and remote Australia," Dr Parnis wrote. "We know that a having a rural background or training in a rural area are among the factors that are most likely to encourage doctors to take up a career in these locations."

He told the Minister that in the past it had been standard practice to include existing participants in any changes to the BMP scheme, and it made sense, both in terms of equity and "sound policy" to act accordingly on this occasion.

"I urge you to take the same approach to the implementation latest changes to BMP scheme ROS arrangements. The scheme has clear problems and, in this regard, reforms designed to improve its operation and chances of success should be adopted to the broadest extent possible," Dr Parnis said.

ADRIAN ROLLINS

Online PBS Authority system pushed back to 2016

The long-awaited shift to an automated online approvals system for PBS Authority medicines has been pushed back to early next year.

There had been hopes the new arrangement, which is expected to save doctors and patients thousands of hours currently spent waiting for calls to the PBS Authority hotline to be answered, would be in place by the end of this year.

But, although work on the online system is underway, it is not expected to be ready until at least early 2016.

It is a frustrating delay for practitioners, who for years have chafed under the burden of the current cumbersome arrangement, which requires doctors to call a Department of Human Services clerk to obtain authorisation to prescribe almost 50 different types of medicine.

In 2012, almost one in five doctors reported spending more than 10 minutes a day on the phone seeking prescription authority, and 3 per cent said they spent more than 30 minutes a day on the phone to the hotline. At the time, it was estimated that the system wasted the equivalent of 25,000 GP consultations every month.

While the number of drugs requiring authority has been trimmed down, and the Department has streamlined the approval process for many medications, the system remains an administrative burden that the Productivity Commission has recommended should be scrapped.

The AMA has been lobbying for many years for the hotline to be abolished and replaced with an automated online process and, as part of this, has in recent months arranged for Department officials to visit doctors in their workplace to see how software systems are being used to prescribe PBS medicines.

The Department has also used the results of an AMA survey conducted

ADRIAN ROLLINS

Laggard response to climate change leaves Australian defences down

AMA calls for the Federal Government nation to do much more to prepare the nation for the effects of climate change have been backed by a report warning little has been to address its security and defence implications.

Former Australian Defence Force Chief Admiral Chris Barrie (Retired) has co-authored a Climate Council report which warns that the country is lagging behind both the United States and the United Kingdom in preparing its military, and society more generally, for climate change, "exposing Australian soldiers, sailors and airforce personnel, as well as Australia more broadly, to the considerable strategic risk and uncertainty climate change brings".

The report, *Be Prepared: Climate Change, Security and Australia's Defence Force*, echoes many of the concerns highlighted in the AMA's recently updated Position Statement, Climate Change and Human Health, which was released in August.

The Statement warned of multiple risks including increasingly frequent and severe extreme weather events, deleterious effects on food production, increased pressure on scarce water resources, the displacement of people and an increase in health threats such as vector-borne diseases and climate-related illnesses.

The Climate Council report said military forces around the world regarded climate change as a "threat multiplier", because it would exacerbate other stressors such as poverty, economic shocks and government instability.

"For instance…extreme weather and water scarcity contributed to soaring food prices, which saw food riots erupt across Africa and the Middle East in 2008," the report said. "Rising food prices in 2011 have also been identified as one of the factors that destabilised the Middle East, leading to the 'Arab Spring'."

As well as increasing the risk of conflict, the report also warned climate change would increase the vulnerability of the Asia Pacific region, where more than half of the world's worst natural disasters occurred last year.

In its Position Statement, the AMA warned that climate change would have serious direct and indirect health effects, both globally and in Australia.

"The evidence is clear - we cannot sit back and do nothing," said AMA President Professor Brian Owler.

"There are already significant health and social effects of climate change and extreme weather events, and these effects will worsen over time if we do not take action now."

It is a call to action echoed by Admiral Barrie and his co-author, Professor Will Steffen, who noted that both the US and the UK had taken significant legislative and strategic steps to ensure climate change was integrated into their defence planning, leaving Australia as a laggard.

"In Australia, comparatively less action is being taken by the Government," Admiral Barrie and Professor Steffen wrote. "Increasingly, Australia is out of step with its allies in preparing for climate change."

Professor Owler said the Federal Government needed to show leadership in addressing climate change.

The AMA is urging the Government to go to the United Nations Climate Change Conference in December in Paris with emission reduction targets that represent Australia's fair share of global greenhouse gas emissions.

The AMA Position Statement, Climate Change and Human Health, can be viewed at: https://ama.com.au/position-statement/ama-position-statement-climate-change-and-human-health-2004-revised-2015

The *Be Prepared: Climate Change, Security and Australia's Defence Force* report can be viewed at: http://www.climatecouncil.org.au/securityreport2015

ADRIAN ROLLINS

US and China pledge climate action ahead of Paris

United States President Barack Obama and Chinese President Xi Jingping have made a joint declaration committing the world's two heaviest greenhouse gas emitters to action to curb carbon dioxide pollution and promote adaption to the effects of climate change.

In the statement, which will set the tone for the ambition of discussions at the United Nations climate change conference in Paris in December, President Obama reaffirmed the US's Clean Power Plan to reduce CO2 emissions from the power sector to 32 per cent below 2005 levels by 2030, while President Xi announced China would introduce a domestic emissions trading system in 2017 as part of action to lower carbon dioxide emissions per unit of GDP by 60 to 65 per cent from the 2005 level by 2030.

"Last month the White House issued a statement aimed at advancing the political debate about climate change beyond questions of whether or not it was occurring, arguing that it is real, is being driven by human activity and is already underway"

The leaders committed the world's two largest economies to finalise and adopt new stringent fuel efficiency standards for trucks, buses and other heavy vehicles by 2019, and to set tougher fuel efficiency benchmarks for buildings and cities. China will also promote green power dispatch, giving priority to renewable power generation and fossil fuel power generation of higher efficiency and lower emission levels.

In addition, the countries reaffirmed plans to boost international efforts to limit and adapt to climate change. President Obama repeated his pledge to provide $US3 billion to the Green Climate Fund, while President Xi said China would provide ¥20 billion to set up the China South-South Climate Cooperation Fund to support other developing countries to combat climate change.

The joint announcement followed a stark warning from President Obama about the need for concerted international action on climate change.

Last month the White House issued a statement aimed at advancing the political debate about climate change beyond questions of whether or not it was occurring, arguing that it is real, is being driven by human activity and is already underway.

President Obama declared he was committed to leading the fight against climate change by curbing the carbon pollution that is driving global warming, building resilience in American communities to the climate impacts that could no longer be avoided, and driving progress on the international stage.

The US President recently announced a robust set of executive actions and private sector commitments to accelerate America's transition to cleaner sources of energy and ways to cut energy waste.

Earlier in the year, the White House convened a Summit to bring together health and medical professionals, academics, and other stakeholders to empower people and communities with the information and tools they need to protect public health in the face of climate change.

President Obama said that climate change brought with it a host of effects on health that would be felt by all: "You can't cordon yourself off from air or climate".

US Surgeon General Vice Admiral Vivek Murthy told the Summit it was vital that health curricula changed to prepare the next generation of doctors for dealing with the health consequences of climate change.

A recent study by the American Thoracic Society found that seven out of 10 doctors reported climate change is contributing to more health problems among their patients.

President Obama told CNN that, "the good news is that, in addition to having doctors and nurses, public health officials, schools of medicine joining together to raise awareness -- and to, in some cases, impact their practice -- they anticipate, for example, increased asthma instances, and plan ahead of time to deal with those".

"Communities can start planning for prevention and mitigation efforts more effectively, and hopefully the other thing that happens is that families and parents join with these doctors and nurses to start putting some pressure on elected officials to try to make something happen to reduce the impacts of climate change," President Obama said.

KIRSTY WATERFORD

Patients face potentially lethal delays as hospitals struggle

Emergency physicians have warned the public hospital system is at "breaking point", with thousands of patients being forced to wait hours for a hospital bed, clogging emergency departments and preventing ambulances from unloading.

A survey by the Australasian College of Emergency Medicine of all the nation's 121 accredited emergency departments has found that 70 per cent of emergency department patients are being delayed more than eight hours as they wait for beds in other parts of the hospital to become available, adding to evidence of enormous strain in the system.

The survey's author, Associate Professor Drew Richardson, said the result highlighted the extent of the "access block" problem, when a dearth of free beds in the main body of a hospital prevents patients moving out of emergency. The knock-on effect is to clog the emergency department, which in turn means ambulances cannot unload patients.

"These figures...show that too many patients are waiting too long to receive the proper care," A/Professor Richardson said. "They reflect a hospital system that is critically overburdened and that is putting patients into the firing line."

More than half the hospitals in the survey reported that at least one patient had to wait for more than 12 hours for a bed, an outcome A/Professor Richardson said was "completely unacceptable", and should be ringing alarm bells for health authorities across the country.

Evidence indicates that the longer patients are forced to wait in emergency, the worse their health outcome is likely to be. A Canberra Hospital study found that older patients forced to wait more than four hours for a ward bed were 51 per cent more likely to die than those who suffered shorter delays.

The survey's results underline AMA warnings of an impending crisis in the public hospital system as a result of the Federal Government's decision to rip $57 billion from its funding over the next 10 years.

The Federal Government has walked away from the National Health Reform Agreement with the states, cut incentive payments, dump activity-based funding and reduce indexation of its public hospital funding to inflation plus population growth.

AMA President Professor Brian Owler has warned the cuts will have a profound effect on the hospital system, warning that "public hospitals and their staff will be placed under enormous stress and pressure, and patients will be forced to wait longer for their treatment and care".

"Rather than funding the necessary hospital capacity, the Commonwealth has withdrawn from its commitment to sustainable public hospital funding and its responsibility to meet an equal share of growth in public hospital costs," Professor Owler said earlier this year. "Funding is clearly inadequate to achieve the capacity needed to meet the demands being placed on public hospitals."

The AMA's annual Public Hospital Report Card, released in April, showed that although there had been marginal improvement in public hospital performance against Government benchmarks, no State or Territory met the target to see 80 per cent of emergency department Category 3 urgent patients within clinically recommended triage times.

Professor Owler said access block was a particularly concerning issue.

He said that emergency departments were able to meet performance targets for patients who did not require admission to hospital.

"But when they have to be admitted, that is where performance suffers. That is an issue of the capacity of our public hospital system," he said.

Professor Owler warned the system would be hit by "a perfect storm" when lower indexation funding arrangements kick in in 2017-18.

"This will lock in a totally inadequate base from which to index future funding for public hospitals," he said. "State and Territory governments, many of which are already under enormous economic pressures, will be left with much greater responsibility for funding public hospital services. Performance against benchmarks will worsen and patients will suffer. Waiting lists will blow out."

ADRIAN ROLLINS

Combat sport ban call as deadly toll mounts

The risk run by athletes who suffer regular head injuries while playing sport has been underlined by a study suggesting virtually all professional gridiron players in the US suffer a rare but devastating degenerative brain disease as a result of repeated collisions.

As Australian legislators come under increased pressure to ban boxing and other combat sports following the death of a second professional boxer this year, researchers at the US Department of Veteran Affairs and Boston University conducted autopsies on 91 former NFL players and found chronic traumatic encephalopathy (CTE) was present in 87 of them – a 95 per cent prevalence rate.

Researcher Dr Ann McKee, chief of neurophysiology at the VA's Boston Healthcare System, told *The Independent* that, aside from the prevalence of CTE among pro-gridiron players, what was particularly striking was that 40 per cent of those who suffered the disease played in positions where bone crunching collisions were less common – suggesting that repeated smaller blows to the head were more dangerous than big hits.

Even more worrying, the US research suggests CTE is not confined to professional gridiron players. The disease has been identified in 79 per cent of athletes who have played the game at any level, even during high school.

The result is startling because CTE is rare in the general population, and it reinforces concerns that athletes who suffer regular head trauma playing their sport are at higher risk of developing the condition.

Dr McKee told *The Independent* the results showed the extent of the problem, and the risk players of all abilities were running.

"People think that we're blowing this out of proportion, that this is a very rare disease and that we're sensationalizing it," she said. "My response is that where I sit, this is a very real disease. We have had no problem identifying it in hundreds of players."

Already, the NFL has settled a $US1 billion class action with almost 5000 former players over the issue, and in Australia claims that a number of former Australian Rules and rugby players have developed CTE-like symptoms after suffering multiple concussions on the playing field has heightened concerns about the long-term risks of head blows in sport.

The potentially fatal consequences of brain injury suffered in sport were tragically underlined last month when professional boxer David Browne Junior died after competing in a title fight.

Browne was knocked unconscious near the end of a 12-round contest and was rushed to hospital in a critical condition. He was placed in an induced coma and eventually his family made the gut-wrenching decision to take him off life support.

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Combat sport ban call as deadly toll mounts

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His was the second death of a professional boxer this year, after 23-year-old Braydon Smith collapsed soon after losing a WBC Asian Boxing Council fight in March.

The deaths, and the results of the US research, add weight to calls by the AMA for boxing to be banned from the Olympic and Commonwealth Games, and for a prohibition on all combat sports for people younger than 18 years.

In a position statement released last month, the AMA voiced its opposition to all combat sports, arguing that they should be banned.

In the interim, the Association has urged tighter rules and regulations governing combat sports, including that they be undertaken under medical supervision and that doctors be empowered to halt contests.

In addition, the AMA has said gloves should be made larger, the time between weigh-in and bout be extended to 72 hours, make mouthguards mandatory, change scoring methods to reduce the emphasis on head blows and introduce graded time-out periods following significant blows to the head.

AMA Vice President Dr Stephen Parnis said critical injuries were inevitable in boxing.

"One punch can kill - whether you are outside a pub on a Friday night or in a boxing ring - and this is the thing that causes young lives to be ended so traumatically," he said. "People need to be careful and they need to think twice about participating in this sport."

Dr Parnis said the death of Mr Browne Junior had left him "feeling very empty".

"It's a terrible tragedy for a young man with a young family, but the fact that is was entirely avoidable just leaves a real sense of bitterness," he said. "I know they don't intend for this to happen but ... the way that boxing is designed there will be these times inevitably where someone will get bleeding or irreversible damage to the brain and they will either lose their life or end up with brain damage. That is why the AMA thinks that we cannot continue with it [boxing]."

ADRIAN ROLLINS

A life aquatic a perilous one for the middle-aged

Middle-aged men who enjoy a beer while dropping in a line at their favourite fishing hole have become the archetypal drowning victim, according to the latest research on drowning deaths.

Almost a fifth of all drownings reported in Australia in 2014-15 involved men aged between 45 and 54 years and, underlining the dangers of mixing alcohol and water sport, more than two-thirds of those who drowned after drinking had a blood alcohol reading at least four times the legal limit for driving.

While 26 infants and toddlers drowned last financial year, underlining once again the dangers of leaving them unsupervised around backyard pools, rivers, dams and the beach, virtually double that number of middle aged men and women drowned over the same period, as did 36 people aged 35 to 44 years.

Middle aged men are particularly at risk, accounting for 77 per cent of all drowning deaths in the 45 to 54 year age group. A third of all these fatalities occurred on inland waterways, and a quarter involved people who were swimming or "recreating" at the time.

In all, 48 middle aged men and women drowned in 2014-15, 26 per cent more than the 10-year average.

The result has highlighted concerns that many middle aged adults are ignorant of the risks of swimming, fishing and boating, especially in inland waterways.

The Royal Life Saving Society of Australia, which compiled the figures, said more needed to be done to alert fishermen, swimmers and others to hazards including currents, snags and cold water.

Health Minister Sussan Ley said the jump in drowning deaths among middle aged Australians was "just not good enough".

"These men need to be more careful and sensible around the water," the Minister said.

Ms Ley said the Government was committed to promoting water safety and improved awareness of the hazards encountered in inland waterways and along the coast.

"But we all have a responsibility to take better care of ourselves," she said.

There are signs that many are heeding the message and taking greater care around water.

While drownings deaths among the middle aged have jumped, they have decreased across the total population.

Overall, 271 people drowned in 2014-15, 6 per cent fewer than the 10-year average, and the drowning rate has dropped to 1.15 per 100,000 people – down from the long term average of 1.32 per 100,000.

ADRIAN ROLLINS

Daily bread not all it's cracked up to be as global folate shortage hits

Pregnant women have been urged to take folic acid supplements amid concerns that a global shortage will mean common foods such as bread are no longer fortified with the vitamin, which is considered essential to the healthy development of babies.

The nation's Chief Medical Officer, Professor Chris Baggoley, has called on GPs, obstetricians and other practitioners to remind pregnant women and those planning to have children to take folic acid supplements after it emerged that disruption of the global production of the nutrient is set to cause a shortage in the amount available to be used as an additive in bread.

"This global shortage of the production of folic acid means there may not be sufficient supplies to add to wheat flour for making bread for up to 12 to 18 months," Professor Baggoley said. "Pregnant women and those planning a pregnancy should follow the NHMRC recommendations and continue to take a daily folic acid supplement at least one month before, and three months after conception. This is in addition to eating a healthy and varied diet as recommended in the Australian Dietary Guidelines."

Folic acid plays an essential role in helping prevent neural tube defects that can emerge early in pregnancy, and which can lead to conditions such as spina bifida and hydrocephalus.

While pregnant women are advised to take folic acid and eat foods high in folate, such as broccoli, spinach, lentils and peas, five years ago it was decided to improve the exposure of women to the vitamin by making it mandatory to add folic acid to bread-making flour. As a result, three slices of bread typically contain 120 micrograms of folic acid.

Professor Baggoley said Australian bread manufacturers had sufficient folic acid in stock to last several months, but the looming shortage has meant women who are pregnant, or who are planning to have a baby, are advised to take the vitamin as a supplement.

Women have been reassured that the global supply shortage will not affect the production of folic acid supplements, nor its use in infant formula.

ADRIAN ROLLINS

Renowned clinician next *MJA* Editor in Chief

Influential medical clinician and researcher, Laureate Professor Nicholas Talley (pictured), has been appointed as the new Editor in Chief of the *Medical Journal of Australia*.

AMPCo Board Chair Richard Allely said Professor Talley, who is currently Pro Vice Chancellor, Global Research, at the University of Newcastle and a part-time staff specialist gastroenterologist at the John Hunter Hospital, came to the position with a wealth of local and international experience in medical research, practice and publishing.

"Professor Nick Talley is a clinician, educator, writer, author, researcher, and editor, with a strong track record in medical practice, medical education, and medical publishing, in Australia and overseas," Mr Allely said.

As well as having authored 800 original and review articles in peer-reviewed academic journals, Professor Talley is currently Co-Editor in Chief of the international journal *Alimentary Pharmacology and Therapeutics* (a position he will relinquish soon after he takes up the *MJA* post on 1 December), and served for six years as Co-Editor in Chief of the *American Journal of Gastroenterology.*

"He brings significant experience, knowledge and expertise to the *MJA*, and is perfectly suited to guiding Australia's leading medical journal at a time of rapid change, innovation and technological revolution in media and publishing," Mr Allely said.

In addition to his ongoing academic, clinical and publishing work, Professor Talley is President of the Royal Australasian College of Physicians and Chair-elect of the College of Presidents of Medical Colleges.

He also holds several international adjunct appointments, including Professor of Medicine and Professor of Epidemiology at the Mayo Clinic, and Foreign Guest Professor at Stockholm's Karolinska Institute.

Professor Talley's appointment was announced soon after it was revealed that AMA Federal Councillor and former Australian Medical Students' Association President Jessica Dean had been recruited to the Board of mental health organisation *beyondblue*.

beyondblue Chairman Jeff Kennett said Ms Dean's experience as a young doctor would be "invaluable" for his organisation as it sought to work with medical students and practitioners at risk of experiencing depression and anxiety.

Ms Dean has been a member of *beyondblue's* Victorian Doctors' Mental Health Advisory Group, and earlier this year addressed a meeting of senior Victorian doctors, health officials and administrators about the mental health of medical practitioners and the culture in which they work.

ADRIAN ROLLINS

The end of $250,000 degrees – at least for now

The Federal Government has deferred controversial plans to deregulate university fees, providing relief for aspiring medical students fearful the change would have pushed the cost a medical degree above $250,000.

Education Minister Simon Birmingham has confirmed that the higher education reform package designed by his predecessor Christopher Pyne has been taken off the table pending further consultation with the sector.

In a radical proposal unveiled in the 2014 Budget, Mr Pyne detailed plans to cut university funding and deregulate course costs, sparking fears it would push the cost of a medical degree well in excess of a quarter of a million dollars.

But legislation for the change has stalled in Parliament because of strong opposition in the Senate, and Mr Birmingham told a higher education conference on 1 October it had been shelve duntil after the next election.

“With only three months left in 2015, it is necessary to give both universities and students certainty about what the higher education funding arrangements for 2016 will be,” Senator Birmingham said. “Therefore, I am announcing that higher education funding arrangements for 2016 will not be changed from currently legislated arrangements while the Government consults further on reforms for the future. Any future reforms, should they be legislated, would not commence until 2017 at the earliest.”

The Minister’s decision was welcomed by AMA President Professor Brian Owler, who said the prospect of $250,000 degrees would have had damaging effects on the practice of medicine.

“This would have discouraged students from low socio-economic backgrounds from entering medicine, it would have pushed future graduates towards higher paying specialties, and it would have deterred graduates from working in underserviced areas, including rural Australia,” Professor Owler said.

Former Prime Minister Tony Abbott said he was disappointed by the decision to defer the legislation, and told radio 3AW he was “frankly…a little disappointed that more of the people who keep saying we need reform, we need cuts in government spending, did not get behind the 2014 budget”.

But Professor Owler urged the Government go one step further and give assurances that there will be no future blow-out in university fees.

“The Government needs to give students some certainty that education will not be priced out of their reach should the fee deregulation proposals re-emerge after the next election,” he said, adding that the AMA was keen to work with the Government to develop reforms that boost funding for undergraduate medical education without putting the cost of a medical degree beyond the means of most students.

“The new Minister for Education and Training, Simon Birmingham, has declared he wants to consult broadly about future reforms, and the AMA wants medical workforce and training issues near the top of his agenda,” the AMA President said.

The *Higher Education Base Funding Review: Final Report* identified medicine as a discipline that was under funded, both in terms of the resourcing required, and in comparison with the funding provided internationally for medical schools, and Professor Owler said these concerns should inform discussions about changes in the sector.

“Any future reform package must maintain our world renowned system of medical education,” he said.

ADRIAN ROLLINS

Palliative care a growth industry

The ageing population and the increasing prevalence of chronic illness has driven a sharp rise in demand for palliative care in hospitals.

There has been a 52 per cent jump in palliative care-related hospitalisations in the past decade, according to the Australian Institute of Health and Welfare, the majority involving patients with cancer.

The Institute reported that almost 62,000 people were admitted to hospital for palliative care in 2012-13, up from 40,435 in 2003-04, and the overwhelming proportion were, not unexpectedly, were elderly or in late middle age.

Institute spokesman Geoff Neideck said a shift in the pattern of disease afflicting people towards the end of their lives – the growing prevalence of chronic illnesses - contributed to the increased use of palliative care, as did growth in the number of people living into old age.

“As we would expect, palliative care services are accessed more frequently by older people – people aged 75 years and [older] accounted for just over half of all palliative care hospitalisations,” Mr Neideck said.

The report showed that 56 per cent of patients hospitalised for palliative care had cancer, and palliative care was particularly prominent in a treatment of those with certain types of the disease.

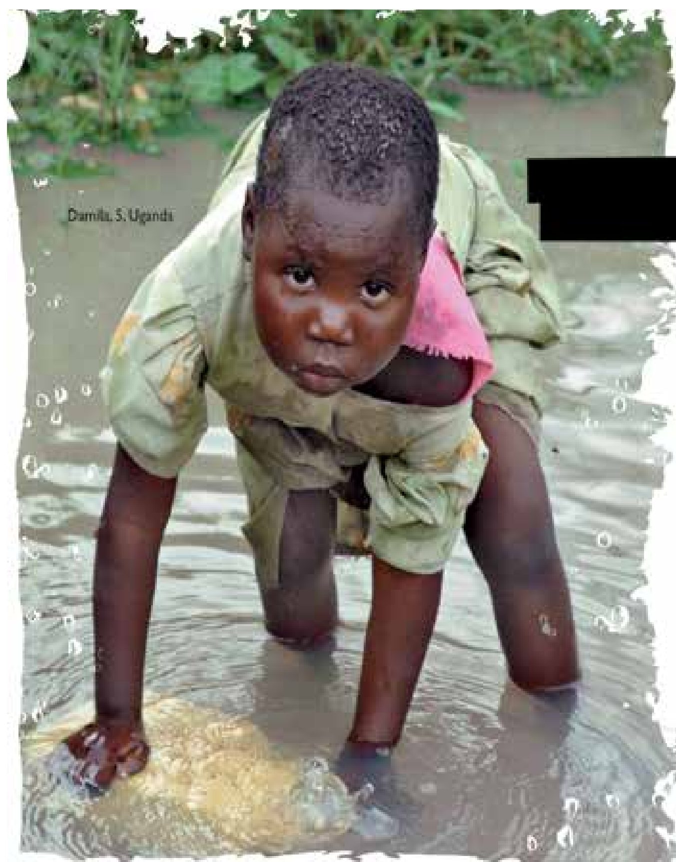
For instance, he said, a third of all hospitalisations related to pancreatic cancer were related to palliative care.

The Institute’s report, *Palliative care services in Australia 2015*, also detailed the sort of medications patients in palliative care were prescribed.

It found more than 51,200 prescriptions were provided to 25,900 patients in 2013-14, 87 per cent of which were subsidised by the Federal Government.

Laxatives were the most commonly-prescribed drug, followed by analgesics and anti-epileptics.

ADRIAN ROLLINS



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Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Ley holds on in Turnbull overhaul

The massive health portfolio has been left largely untouched by the turmoil in Canberra, with Health Minister Sussan Ley retaining her position in the new ministry announced by Prime Minister Malcolm Turnbull.

While Mr Turnbull – who defeated incumbent Tony Abbott in a Liberal Party leadership ballot on 14 September – has made a number of significant changes to the Government's frontbench, Ms Ley, who became Health Minister two days before Christmas last year, has held on to her job. She has not disclosed who she voted for in the leadership contest.

In a move replete with symbolic and substantive meaning, Mr Turnbull has also brought WA Indigenous MP and former senior health bureaucrat Ken Wyatt on to the frontbench as Assistant Health Minister.

In 2010, Mr Wyatt became the first Aboriginal person to be elected to the House of Representatives, and is expected to bring a renewed focus on Indigenous health, having served as WA's Director of Aboriginal Health.

But the new Prime Minister has clipped the wings of Ms Ley's junior minister in the health portfolio, former Assistant Health Minister Senator Fiona Nash, who has had her responsibilities narrowed to rural health after sparking a number of controversies in the position.

Senator Nash's chief of staff Alistair Furnival was forced to resign early last year over allegations of conflict of interest when he directed the Health Department to take down the website for the Health Star Food Rating System and it was subsequently revealed he retained an interest in a lobbying firm that had major food manufacturers as clients.

And television presenter David Koch resigned as head of the Organ and Tissue Authority's advisory council resigned from the position on national television and fired a broadside at Senator Nash after she announced a review of the organisation's performance.

Mr Koch accused Senator Nash of caving into pressure from the ShareLife advocacy group, which he said wanted to "take control" of the organ donation program: "It's an absolute disgrace," he said.

Senator Nash, who is a senior member of the National Party, will help oversee the introduction of a revised classification system, the Modified Monash Model, to guide the allocation of Commonwealth rural health incentive payments.

So far, the upheaval on Government benches has not prompted a significant change in the Shadow Ministry, though two long-serving members of the Labor frontbench – Senator Jan McLucas and Bernie Ripoll - have announced they will step down.

Senator McLucas, who was Shadow Minister for Mental Health, earlier this year declared she would not contest the next election, and said she will resign from the portfolio at the end of the month.

The Senator said this was "the right time" to conclude her work in the portfolio, given her decision to leave Parliament.

Former Wayne Swan Chief of Staff Jim Chalmers and ACT Senator Katy Gallagher have been elected unopposed to the Opposition frontbench to fill the vacancies, and Labor leader Bill Shorten said he would announce the allocation of portfolios following the Labor Caucus meeting on 13 October.

ADRIAN ROLLINS

Aged care handed back to health

Responsibility for aged care has been returned to the Health portfolio and Minister for Rural Health Senator Fiona Nash has been given oversight of indigenous health among changes made to the allocation of roles by Prime Minister Malcolm Turnbull.

In a move welcomed by the AMA, the Federal Government announced on 30 September that Health Minister Sussan Ley would retain her hold on the Sport portfolio and would take on the additional role as Minister for Aged Care.

Mr Turnbull said that giving Ms Ley responsibility for aged care would ensure that ageing was "front and centre with the health portfolio as our population continues to live longer and healthier lives".

As part of the change, aged care functions will be transferred from Department of Social Services to the Health Department.

AMA President Professor Brian Owler said aged care had languished in recent times because taking it out of Health had reduced the political focus.

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Health on the hill

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"It is vital that the health needs of older Australians are considered as a key component of the broader health policy debate, and it is fitting that aged care is back with the Health Minister," Professor Owler said. "Caring for older Australians, whether they live in residential aged care or independently in their own homes, is an integral part of medical practice."

One of the major issues to be tackled in the area is the dislocation of care for people in nursing homes, as well as adequate support for GP-led primary health teams in providing co-ordinated care to enable the elderly to live at home.

"Most older Australians have longstanding relationships with their GP, who is best placed to determine which services will work best for their patient," Professor Owler said. "Early medical assessment is critical to ensuring that older Australians receive the appropriate support to maintain their level of independence before their social and health situation deteriorates.

He said including the clinical opinion of a patient's usual treating doctor in the assessment of their care needs and formulating a care package should be normal practice, not, as is currently the case, an optional extra.

"We also need to see improved processes to allow doctors to manage the provision of straightforward care, such as wound care, for older people still living in their own home," the AMA President said. "The aged care sector must be able to provide the level and quality of medical, nursing, and allied health services required to meet the needs of our ageing population."

Professor Owler said the AMA would seek to discuss these issues and other aged care policy priorities "at the earliest opportunity."

In addition to rural and indigenous health responsibilities, Senator Nash has retained her oversight of drug and alcohol policy and organ donation.

Assistant Health Minister Ken Wyatt will provide support for Ms Ley in aged care.

ADRIAN ROLLINS

Research

Lust for life, or another one bites the dust?

Patients might be forgiven for feeling a little unnerved if "The Final Countdown" is blaring from the speakers when they are wheeled into the operating theatre.

But is it helpful, or off-putting, for those doing the operating? Recent studies suggest both.

A small study, published in the Journal of Advanced Nursing, filmed 20 operations at two British hospitals to observe the music habits of surgeons.

Researchers placed multiple cameras at strategic points around the operating room to observe verbal and non-verbal communication between staff and found that, at times, playing music in the operating theatre can be disruptive and surgeons should think twice about pressing the play button.

Music was played in 16 out of the 20 operations observed, and usually senior doctors were in charge of the play list.

Dance music and drum and bass based music were often played fairly loudly, with popular tracks sometimes cranked up, making talking more difficult. In one operation, a scrub nurse asked the surgeon to turn the music down because she was finding it hard to count how many swabs had been used.

The UK Royal College of Surgeons said if music is played during surgery it must not be distracting.

Lead researcher Sharon-Marie Weldon said that music can be helpful to staff working in operating theatres where there is often a lot of background noise. However, she recommended that there be a considered approach based on discussion or negotiation about whether music was played, the type of music and the volume it was played at.

In a separate study, more than 80 per cent of theatre staff reported that music helped them while carrying out operations.

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The study, published in the *British Medical Journal* late last year, found that music is played between 62-72 per cent of the time in the operating theatres. As with the Journal of Advanced Nursing study, songs were most often chosen by the lead surgeon.

Theatre staff reported that surgical performance was enhanced when music was played, and that it improved communication, reduced anxiety and improved efficiency.

The researchers said that critics often argue that music consumes cognitive bandwidth, reduces vigilance, impairs communication, and proves a distraction when anaesthetic problems are encountered. However, they encouraged surgeons to embrace music in the operating theatre whenever the situation allowed it.

KIRSTY WATERFORD

Mysteries of cancer-slowing gene revealed

Researchers have uncovered the role played by a gene which suppresses the development of cancer.

Discovered by scientists at the University of Adelaide in South Australia, the findings on the activity of the gene WWOX open new opportunities for scientists to find treatments for cancer.

Professor Rob Richards, Head of Genetics and Evolution in the University's School of Biological Sciences said his team worked on the knowledge that in certain types of cancer people with low levels of WWOX protein are more likely to develop cancer and that cancers with low levels of WWOX tend to be more aggressive and less responsive to treatment.

"So a higher level of WWOX activity is definitely a good thing to have but, until now, the role that WWOX plays in cancer suppression has been a mystery," he said.

Professor Richards and his team of researchers, Dr Louise O'Keefe and PhD students Amanda Choo and Cheng Shoou Lee, studied the impact of lower levels of WWOX on cells using a genetic model — the small laboratory fly, Drosophila.

"Our research has shown that cancer cells with lower levels of WWOX had a competitive advantage over those cells with normal WWOX levels, and could outgrow them," says Professor Richards. "This could lead to a more aggressive cancer and worse outcomes for cancer patients — poorer survival rates."

Further research showed that the WWOX gene plays a role in the altered metabolism of cancer cells which are known to use glucose differently to normal cells. Cancer cells tend to use glucose to make more cell 'building blocks' than energy, and this is thought to help them to divide and grow.

"Another set of Drosophila experiments revealed that the WWOX gene helps keep the balance of glucose use in favour of producing energy rather than helping cancer cells multiply," says Professor Richards.

"This difference in metabolism is a key part of how cancer cells have a competitive advantage over normal cells. Low WWOX levels will allow more glucose to be used for these cancer cell 'building blocks'."

The good news is that WWOX belongs to a family of proteins that have enzyme activity – this means WWOX activity can be altered by targeting the enzyme.

"We now have a good idea of what WWOX does in cancer cells and how it acts to help suppress cancer. And we have a potential target to be able to influence that activity to change the properties of cancer cells," says Professor Richards.

The research has been supported by the National Health and Medical Research Council and The Cancer Council of Australia and published in the journal PLOS One.

This story is supplied by The Lead South Australia.

Warm temperatures put heat on ED

Heat-related emergency department visits and deaths surge when the mercury rises above 23 degrees Celsius, according to a US study.

Researchers at Brown University and the Rhode Island Department of Health undertook a detailed statistical analysis of emergency department visits, deaths and weather data, and included possibly confounding factors, such as ozone, to assess the effect of rising temperatures on presentations at hospitals. The ED records included information about whether doctors thought a patient's condition was related to heat or dehydration.

The study suggested that if the population were living with the sort of temperatures the world is expected to reach because of climate change, there will be an appreciable increase in emergency department visits and deaths.

Lead author Samantha Kingsley said the primary finding was

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that as temperatures increase, the number of emergency room visits and deaths increase. But, she said, people were going to the hospital for heat-related reasons at temperatures below what would typically be considered extreme.

The researchers found that while the rate of heat-related ED visits jumped 3.3 per cent on days when the temperature reached 23 degrees compared with those with a high of 18 degrees, they jumped almost 24 per cent when the mercury reached 29 degrees compared with days when the high was 23 degrees. Overall, temperature began to play an independent role in increasing ED visits when the mercury reached or exceeded around 23 degrees.

Senior author and Associate Professor Gregory Wellenius said that people should be aware that heat represents a significant public health threat that needed to be taken seriously, even when authorities did not issue heat warnings.

Interestingly, the researchers found that 18 to 64 year olds made the most heat-related emergency department visits, rather than infants and the elderly, who are considered to be the most vulnerable to heat-related health problems. The researchers were unsure about the reason, but speculated it may be because people in this age group were more likely to be outdoors working or playing sport, and may pay less heed to heat warnings.

Previous studies have linked higher temperatures to increased hospital visits and deaths, but in heat waves the elderly have been most at risk. Earlier this year a heat wave killed about 2000 people in India, many of whom were elderly.

The researchers warned that their finding that ED visits and deaths are greater on warmer days, even if temperatures are only in the 20s, suggests that distress from the heat may become even more common as temperatures rise as a result of global warming.

KIRSTY WATERFORD

Fish oil key in preventing pre-term babies

Taking fish oil supplements can extend pregnancy and reduce complications, according to new research.

While exploring a theory that fish oil might aid brain development in the foetus, South Australian researchers stumbled upon the finding that fish oil extends gestation by an average of two days.

The South Australian Health and Medical Research Institute is now looking to recruit a further 5500 pregnant women to take part in a wider study to test this initial finding.

While the discovery might see reluctant full-term babies requiring come coaxing by induction or caesarean section, it has major implications for preventing pre-term births.

The original study was designed to look at whether omega 3 fats were needed in supplement form during pregnancy to help reduce the risk of post-natal depression and improve developmental outcomes for babies.

Lead researcher, Professor Maria Makrides, said that, "what we found was that it didn't seem to do that, but the really interesting data we found was that we saw this shift in the mean duration of gestation that resulted in a halving of the number of babies born at less than 34 weeks".

"It [fish oil] reduced the proportion of births at less than 34 weeks by about 50 per cent – they are the infants that are most likely to need intensive care, and most likely to suffer morbidities of being born pre-term," Professor Makrides told the *Adelaide Advertiser.*

"They often can't breathe properly, and sometimes do have developmental problems as they grow, so the burden on the child, family, and society if often quite large.

"If we are shifting the gestation then this is a really important outcome."

The study also found that more women required obstetric intervention because their pregnancies were continuing too far beyond term.

The new study will ask women to take a supplement daily, with some women given fish oil and others vegetable oil. Once the women reach 34 weeks gestation they will be taken off the oil.

Professor Makrides said stopping the supplements at 34 weeks will hopefully allow women to get the full benefit of avoiding early prematurity, without extending gestation beyond the expected delivery date.

"This is a safe and cheap potential solution that can easily be applied to everyone," Professor Makrides said.

Pregnant women interest in taking part of the study can call 08 81617458.

KIRSTY WATERFORD

Tobacco cuts a deadly swathe through China

While tobacco companies and their deadly products are under siege in Australia and many other developed countries, the death toll from cigarettes in emerging markets is soaring as they make huge inroads into markets like China and Indonesia.

A study in the peer-reviewed journal Cancer has highlighted the heavy human cost that has resulted, reporting that smoking now causes almost a quarter of all cancers in Chinese men.

The authors of the study said that since the 1980s there had been an explosion in the number of men in China who smoke, to the point that the vast Asian country now produces and consumes around 40 per cent of all the world's cigarettes.

Already, smoking is estimated to cause 435,000 new cancers each year in China (83 per cent of them in men), and researchers warn this will be only the tip of the iceberg as the effects of increased smoking rates now feed through in coming decades.

"The tobacco-related cancer risks among men are expected to increase substantially during the next few decades as a delayed effect of the recent rise in cigarette use, unless there is widespreasd cessation among adult smokers," the research team, led by Professor Zhengming Chen of Oxford University and Professor Liming Li of the Chinese Academy of Medical Sciences, said.

The team analysed the results of a survey of more than 510,000 Chinese men and women conducted between 2004 and 2008, and a follow-up survey conducted after seven years found around 18,000 new cancers among those interviewed.

Underlining the dangers of tobacco, the survey found 68 per cent of men smoked, and they were at 44 per cent greater risk of developing cancer than non-smokers, particularly cancer of the lung, liver, stomach and oesophagus. The increased risk accounted for 23 per cent of all cancers found in people aged between 40 and 79 years.

But, in a result that should spur efforts to get people to quit the habit, the study found the excess risk of cancer had virtually disappeared 15 years after a smoker stubbed out their last cigarette.

Professor Zhengming said getting smokers to dump cigarettes would be the most potent and cost-effective strategies to avoid cancer and premature death "over the next few decades".

The results came as Assistant Health Minister Fiona Nash dismissed complaints by tobacco companies about an increase in the excise charged on their products in Australia, and reaffirmed the nation's commitment to defend the country's world-leading plain packaging laws against legal challenge in international forums including the World Trade Organisation.

Senator Nash said the heavy tobacco excise had helped reduce the proportion of Australians who smoke daily to an all-time low of 12.8 per cent.

Cigarette manufacturers have complained that plain packaging, the hefty excise and other Government measures are fuelling an illegal trade in tobacco, but the Minister said such "scaremongering…[was] no reason to roll back sensible health policies".

ADRIAN ROLLINS

Health workers in crosshairs as Kurdish conflict flares

There is mounting concern about the welfare of civilians in south-east Turkey amid reports health workers and ambulances have come under attack as a conflict between government forces and Kurdish rebels intensifies.

The World Medical Association has appealed to the Turkish Government to restore basic health services to the region amid reports from the Turkish Medical Association that paramedics have been assaulted and ambulances blocked from aiding the sick and injured in a number of cities including Diyarbakir, Cizre, Varto, Yuksekova, Lice and Silvan.

'We are receiving alarming reports from the Turkish Medical Association about ambulances not being allowed to tend to those killed and wounded in the fighting in the city, or take them to hospital," WMA President Dr Xavier Deau said.

"The Government curfew prevented people from going out to buy food and water, and no outside observers are being allowed to visit the city to investigate the situation.

"This lack of basic health care, and the failure to allow health professionals to move freely in the city, is a scandal that must end.

"We urge the Turkish Government to bring a halt to this inhumane situation and to allow health professionals to care for the sick and wounded."

Fighting in the area, which lies close to war-wracked Syria and Iraq, has intensified in the past two months as the central government seeks to contain and eliminate a Kurdish-led insurgency that has claimed more than 40,000 lives since hostilities broke out in 1984.

The fighting has dashed hopes that when the pro-Kurdish Peoples' Democratic Party won 14 per cent of the vote in a national election in June marked an end to the conflict. Instead, both President Recep Tayyip Erdogan and hardline militants in the separatist PKK movement have been accused of stoking tensions, causing a resumption of hostilities that so far are estimated to have left more than 100 soldiers and police dead, and at least as many rebels.

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

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**

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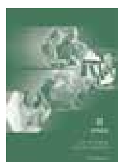

Fees & Services List: A free resource for AMA members. The AMA list of Medical Services and Fees assists professionals in determining their fees and provides an important reference for those in medical practice.

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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