

A U S T R A L I A N

# Medicine

The national news publication of the Australian Medical Association

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**AMA**

ISSUE 27.02 - FEBRUARY 16 2015

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

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*Australian Medicine* is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

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## AMA LEADERSHIP TEAM



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Associate Professor  
Brian Owler



**Vice President**  
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# Patients are paramount

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

“This is something the AMA will fiercely resist. Not because doctors don't like being told what to do, but because it will compromise the care of their patients”

Spend time with any group of doctors and it quickly becomes apparent that their focus is to achieve the best possible outcomes for their patients.

Whether it is a GP in Geraldton or an ophthalmologist in Macquarie Street, all have as their overriding purpose the health of their patients.

The same motivation drives doctors, through groups such as the AMA, to advocate for policies and measures that protect or improve health, whether it be ensuring equitable access to care, cutting down on smoking and drinking, upholding vaccination programs or trying to tackle climate change.

It is not always easy.

For months last year the AMA worked hard to convince the Federal Government of the need for Australia to join the international effort to combat the Ebola outbreak in West Africa.

The international response, though belated, was crucial in slowing the epidemic to the point where it is now close to a standstill. The teams of Australian health workers that have been deployed in Sierra Leone have played their part in achieving this great outcome.

The AMA took this position, not because there was something in it for the medical profession, but because it was the right thing to do.

As doctors, we cannot just stand by while people – wherever they are – die needlessly.

We also know that, in this interconnected world, it is far better for our own patients if we can stop the outbreak at its epicentre rather than allow it to develop into a trans-continental threat.

The stand taken by doctors and the AMA on these and many other issues is but an extension of the commitment made by doctors to their patients that they will do all that they can to ensure the best possible health outcomes.

Too often this underlying truth gets lost in the political hurly-burly.

But it is something that patients know and appreciate. That is why the medical profession is held in high regard – it is regularly rated as among the most trustworthy.

Such trust is not easily given – it has to be earned.

And that is what doctors in the GP clinics, the specialist practices, and the hospitals do every day by striving for the best for their patients.

It is why the AMA is so concerned to protect the independence of the doctor-patient relationship.

There are worrying signs that the private health funds want to move to a system of managed care, where they dictate the treatment patients receive.

This is something the AMA will fiercely resist. Not because doctors don't like being told what to do, but because it will compromise the care of their patients.

It is doctors, who know their patients well, and who are equipped with years of training and experience, who can best judge the appropriate clinical care.

The AMA has already been busy this year advocating for better health policy, and we will have much to say and contribute in the coming months.

But throughout, our focus will be the same as that of doctors across the country – what will provide the best health outcomes for patients.



## Making sure doctors continue to be heard when and where it matters

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

The beginning of a new year is a time of optimism as medical graduates across Australia embark on their internships, and thousands of medical students commence at university.

However, the future for the class of 2015 and those who follow is becoming increasingly uncertain.

The number of students enrolling in Australian medical schools has soared in the past decade, in response to community need. But the proportionate expansion in vocational training opportunities – essential to every new doctor – has not materialised.

Already, the careers of many junior doctors have stalled because of insufficient places along the medical training pipeline. We face the real prospect of underemployed and unemployed doctors.

Unless there is a significant increase in resources for training, much of the money invested by taxpayers in extra medical school places will be wasted, as frustrated graduates look to pursue opportunities abroad.

Compounding this problem, our ability to resource medical training has been hampered by the Federal Government's decision to abolish Health Workforce Australia (HWA) and absorb its functions into the Department of Health.

Last year HWA, overseen by the National Medical Training Advisory Network, had started work on a National Training Plan, but the work appears to have lost momentum.

This year, the AMA will maintain pressure to reinvigorate work on the National Training Plan. In addition, we will work with the learned Colleges and professional societies to give the profession and junior doctors the best available information to help them make effective career choices.

The AMA will also be advocating for significant improvements in end of life care, which is another area of importance to the Australian health care system.

The Grattan Institute recently reported that 70 per cent of Australians want to die at home, yet only 14 per cent do so. Despite their wishes, about half of people die in hospital and a third in residential care.

We can, we should, and we must, do much better in this area.

Helping people spend their final days at home is more comforting and less stressful for them and their loved ones. It can also mean better (and less expensive) care. At-home care

means fewer unnecessary tests and treatments, and it reserves scarce hospital beds and emergency departments for those who would benefit from their use.

“GPs, and the community services they coordinate, are central to achieving this. They are best placed to ensure their patients receive the care they need to be able to stay at home”

GPs, and the community services they coordinate, are central to achieving this. They are best placed to ensure their patients receive the care they need to be able to stay at home.

Already, the AMA's End of Life Working Group has, in consultation with Palliative Care Australia, developed a road map for action, and there will be significant developments this year.

In 2015, we will also be working to ensure that alcohol harm reduction remains at the top of the nation's public health agenda.

Last year's AMA National Alcohol Summit highlighted the enormous harm caused by excessive drinking, and how deeply such behaviour was embedded in our national culture.

The staggering costs of alcohol-related harms are evident throughout Australia – road trauma, domestic violence, chronic disease, mental illness, children born with the immense burden of Foetal Alcohol Spectrum Disorder. No family, school, community, occupational or age group is spared.

There is much that can be done across the spectrum of advertising, pricing, education and treatment services.

These are among the many issues confronting the medical profession and the Australian community as a whole in 2015.

We have already shown this year that we can achieve serious changes for the better. The President and I, along with the entire leadership team of the AMA, will continue to work to ensure that the medical profession's voice is heard, when and where it matters.



## Big year ahead for AMA and its members

BY AMA SECRETARY GENERAL ANNE TRIMMER

With 2015 starting where 2014 ended, with significant concern about the Government's health policies, or lack thereof, the year is already shaping up to be another demanding one on the policy front.

The AMA has received hundreds of letters and emails from members, and non-members, expressing unhappiness with the Government's announcements on changes to the Medicare rebate. While the decision to change the rebates for Level A and B GP consultations has now been reversed, the Government has a long way to go to regain the trust of doctors, general practitioners in particular.

“During 2015, the AMA will be enhancing its membership database to tailor the messages that are sent to each member, ensuring that you receive the information most relevant to your interests and your practice”

For the AMA, 2014 was a year of considerable change as a new governance model was adopted and implemented, providing a skills-based corporate board to manage the strategy and financial affairs of the company which is Australian Medical Association Limited. The Federal Council and its committees are focused on medico-political debate, using the forum of Council meetings to contribute at an early stage to the development of policy before a wider consultation with members.

If 2014 was the year of change, 2015 is the year during which the foundations are laid for the future development of the AMA. This development will be based significantly on strengthened member engagement. In late December, the AMA launched a new website which gives members the ability to log in, update their contact details, and navigate seamlessly across all AMA digital platforms, including *Australian Medicine*, *Medical Journal of Australia*, and *doctorportal*.

During 2015, the AMA will be enhancing its membership

database to tailor the messages that are sent to each member, ensuring that you receive the information most relevant to your interests and your practice.

The membership survey conducted in 2014 is informing our member engagement, as are the results of focus groups with non-members. The information from these discussions is almost as important as comments from members in understanding what draws a doctor to join, and remain a member of, the AMA.

The AMA's member profile shows a loyal following from those doctors who joined early in their careers and who have remained staunch members ever since, together with a new cohort of younger members.

The AMA remains unique in representing all specialties and types of practice, whether employed in the public hospital system, or practicing privately, and whether in the early stages of a career or approaching retirement. Our aim is to better understand the needs of different member groups and ensure that the AMA's advocacy, communications, and benefits are relevant and appropriate to each segment of the membership.

The recent proposals to change Medicare rebates have highlighted this, with many doctors writing to say that this is the first time they have taken up the invitation from an AMA President to write in with their views. These views have been expressed eloquently and passionately. At the heart of the messages from general practitioners is the offence they have felt that the Government has so little regard for their services.

This view was personally conveyed to the new Health Minister, Sussan Ley, by AMA President Brian Owler at their recent meeting. I know it has also been communicated directly to local Members of Parliament around the country by doctors and their patients, with clinics and surgeries becoming the focal point for a very vocal campaign. No wonder the policy was reversed.

The current environment, in bringing renewed focus on Medicare, creates a suitable backdrop to this year's AMA National Conference, which has as its theme, *Medicare: midlife crisis*. More on the Conference to follow in future editions.

We trust you enjoy the return of the hard copy of *Australian Medicine*. Your comments are invited, as they are on all AMA activity.

# Govt tries to re-set on health



Kicking off on a new foot: AMA President Associate Professor Brian Owler meets with Health Minister Sussan Ley at her Parliament House office on 22 January

The Federal Government may be open to compromise on its plans for a mid-year \$5 Medicare rebate cut for general patients as Health Minister Sussan Ley has commenced talks with the AMA about longer-term health reform.

As the Minister sought to re-build the Government's relationship with the AMA and other key health groups, she flagged in a meeting with AMA President Associate Professor Brian Owler on 22 January that, although the Government at this stage remained determined to implement the \$5 rebate cut for general patients and to extend the freeze on Medicare rebate indexation through to mid-2018, she was open to a reconsideration of the Government's general policy direction.

A/Professor Owler, who met with Ms Ley a week after her dramatic decision to dump her predecessor's plan for a \$20 rebate cut for GP consultations lasting less than 10 minutes, said that the Minister "reiterated the fact that she is open to looking at the proposals in general, and will be informed by the process of consultation over the next few weeks".

The AMA remains opposed to both the rebate cut and the indexation freeze, and nervous Coalition MPs are urging the Government to be cautious about persisting with policies that could yet again put it on a collision course with doctors and patients.

A/Professor Owler said he welcomed the Minister's willingness

to discuss improvements that can be made to the health system overall.

"One of the things that we talked about was the need for a longer term strategy, to look at much more complex ways that we deal with savings in health that are probably more challenging, but require a longer term commitment," the AMA President said.

"I think the whole health care system needs to be considered together. It's not just about general practice - we want to make sure we have an integrated system with our hospital system, whether it be public or private, specialists and GPs. I think it's really important that we don't focus on just that issue."

Since coming to office 17 months ago, the Abbott Government's health policy has been dominated by attempts to introduce a co-payment for GP services to act as a "price signal" for patients.

It was forced to dump its original proposal for a \$7 co-payment in December last year when it became apparent it did not have support in the Senate, and Ms Ley last month scrapped proposed changes to rebates for GP Level A and Level B consultations amid a firestorm of criticism from the AMA, GPs, patients and other health groups

A/Professor Owler said that if the Government's goal was to hold down growth in health spending, it should invest in primary health care.

"I think we need to make sure that general practice continues to be the cornerstone of our health care system. General practice is the key to sustaining our health care system in the future," he said.

In a promising sign, the AMA President said that Ms Ley made it clear in their meeting that she "clearly recognises the importance of general practice".

Earlier this month, the AMA held a series of meetings with GPs around the country to get grassroots feedback on the issues concerning doctors and ideas for reform.

A/Professor Owler encouraged the new Health Minister to take similar soundings from the medical frontline.

"It's really important, I think, for the Minister to get out and talk to GPs...on the ground, and hear from them in a range of practice settings right across the country. I think that will inform a lot of her thinking," he said.

ADRIAN ROLLINS

# Doctors rally over health reform concerns



Tasmanian GPs meet on 1 February in Hobart to discuss health reform

Dozens of Tasmanian GPs angered by the recent direction of the Federal Government's health policies voiced their concerns at a meeting organised by the AMA early this month.

The Hobart meeting, which was addressed by AMA Vice President Dr Stephen Parnis and AMA Tasmania President Dr Tim Greenaway, was the first of several convened by the AMA during February and attended by hundreds of doctors.

The meetings, originally planned as rallies to demonstrate against the \$20 cut to shorter GP consultations that was to have come into effect on 19 January, are instead being used as an opportunity for GPs to share ideas and concerns about the Federal Government's health reform agenda.

AMA President Associate Professor Brian Owler, who personally

attended meetings in Sydney and Brisbane, said although the Government had taken the \$20 cut to Level B consultations of less than 10 minutes off the table, it was still pushing ahead with a \$5 rebate cut for most patients from 1 July, and planned to extend the freeze on rebate indexation until mid-2018.

Professor Owler said the surviving changes were worrying because of their potentially serious effects on primary health care.

He said the meetings, which were held in Tasmania, Victoria, South Australia, New South Wales, the ACT, Queensland and Western Australia in the first two weekends of February, were an important opportunity for GPs to share ideas and inform the AMA's discussions with Health Minister Sussan Ley in coming months.

"I appreciate the significant feedback that GPs have given me over recent weeks in response to the Government's plans. I have been able to put many of these concerns directly to the public and politicians, and they have been heard loud and clear," the AMA President said.

He said the AMA was committed to working collaboratively with Government to develop sensible health policy, and expressed confidence that Ms Ley was committed to taking "a new and refreshing approach" to discussions about health reform.

ADRIAN ROLLINS

## Bulk billing mostly for the ill, less well off

Patients who have a chronic disease, have a concession card or are on lower incomes are more likely to be bulk billed than the better off, underlining AMA warnings that any changes to Medicare rebate arrangements need to be undertaken with care.

A University of Technology, Sydney, study, published in the 2 February edition of the *Medical Journal of Australia*, found that illness and capacity to pay were factors affecting whether or not a patient was bulk-billed, while the length of a consultation was not.

Of 2477 patients surveyed for the study, 71 per cent reported that their most recent visit to the GP was bulk billed. Of these, 53 per cent had a household income of less than \$80,000 a year.

Underlining the influence financial capacity has on bulk billing, more than 60 per cent of those not bulk billed had an annual household income above \$80,000.

"Our results indicate that there are associations between patient characteristics and bulk-billing, and between general practice characteristics and bulk-billing," the researchers from the UTS Centre for Health Economics Research and Evaluation (CHERE) concluded.

"This suggests that caution is needed when considering changes to GP fees and Medicare rebates because of the many possible paths by which patients' access to services could be affected."

The findings back AMA arguments that the Government needs to drop crude Medicare rebate cuts and indexation freezes and adopt a much more sophisticated and comprehensive approach to health reform, including investing in primary health care in order to achieve long-term health savings.

ADRIAN ROLLINS

# Flawed complaints process undermines health and care



Doctors who are the subject of patient complaints are being left traumatised by the experience, causing many to change the way they practise in ways that may compromise patient care, research has found.

Research published in the journal *BMJ Open* has found significant levels of depression and anxiety among medical practitioners who have had a complaint made about them.

The study, involving 7926 doctors, found that 17 per cent of those who were currently or recently the subject of a complaint were moderately or severely depressed, and 15 per cent reported moderate or severe anxiety.

Alarming, doctors who currently or recently had complaints against them were twice as likely to consider hurting themselves or contemplate suicide.

The *BMJ* study found that not only did being the subject of a complaint affect a doctor's health, but it could also have a significant impact on how they practised.

The vast majority of doctors who had been embroiled in a patient complaint reported adopting a defensive approach to how they practised, while 20 per cent reported feeling victimised, almost 40 per cent felt bullied, and 27 per cent took more than a month off work.

While the findings were based on doctors who have gone through the British complaints process, Dr Penny Browne, Senior Medical Officer at the medical defence fund Avant, said the

results were "virtually identical" to a similar study conducted in Australia in 2006.

Dr Browne said the way patient complaints were handled in Australia risked making doctors "a second victim", causing them an enormous amount of stress and undermining their health.

And she warned the complaints process also had the perverse consequence of affecting the quality of care and patient safety.

"We have seen that it changes the way people practise," Dr Browne said. "You might think that it's a good thing to make them more aware and alert to potential errors. But it makes them practise defensively, and that may not be a good thing."

She said doctors scarred by the process often over-ordered tests, were over-vigilant with their patients, experienced difficulty making decisions, and found it harder to trust patients.

Dr Browne's warning follows calls from the AMA for an overhaul of the system to make it fairer, more timely and effective for both doctors and patients.

The complaints system is being examined as part of a review of the National Registration and Accreditation Scheme for Health Professions being conducted by former head of the West Australian Health Department Kim Snowball, and both the AMA and Avant have made submissions urging for major changes in the way complaints against doctors are handled.

The AMA has called for improved triaging of complaints and notifications, greater transparency and fairness, and changes to make the scheme more responsive to medical practitioners and accountable to the medical profession.

AMA Vice President Dr Stephen Parnis said the notification process was often arduous and lengthy, with more than 30 per cent of investigations still open after nine months.

Dr Parnis said it was disappointing that the findings of the Snowball review, which is expected to report in the next couple of months, had been pre-empted by the Australian Health Practitioner Regulation Agency, which last year released an action plan of changes.

He said AHPRA wanted more information to be provided to complainants, and a greater focus on improving the experience for consumers, when "in fact, efforts need to be directed to improving the investigation process - that is, the practitioner experience. Medical practitioners and consumers, equally, want a regulatory scheme that is timely, fair, transparent and effective."

ADRIAN ROLLINS



# Pharmacists try to inoculate against competition



Pharmacy's peak bodies have intensified their push for pharmacists nationwide to be given the authority to provide flu vaccinations by the time winter arrives.

As negotiations on the next multi-billion-dollar five-year Community Pharmacy Agreement become more focused, the Pharmacy Guild of Australia told *Six Minutes* it was working to have pharmacist-administered vaccinations available in all states, something Pharmaceutical Society of Australia President Grant Kardachi said may happen by the time the flu season hits.

"Most states are now in the process of activating the appropriate legislation," Mr Kardachi told *Six Minutes*. "I would expect all our jurisdictions to be ready to go for this coming winter."

His comments followed the announcement by South Australian Health Minister Jack Snelling said that pharmacists in his State would soon be allowed to administer influenza vaccinations.

"The easiest way to prevent catching the flu is to get a vaccination every year, but many people have difficulty finding the time to book an appointment with their GP," Mr Snelling said. "Allowing pharmacists to directly administer the flu shot will encourage a greater uptake of the vaccine in 2015".

The idea was first trialled in Queensland, and Western Australia and the Northern Territory have already legislated to allow pharmacists to conduct vaccinations, while a Victorian parliamentary inquiry has recommended a trial be held in that State.

In anticipation that the remaining states and territories will soon follow suit, the Pharmacy Society of Australia has released revised vaccination guidelines for pharmacists nationwide.

Mr Kardachi said the guidelines detailed the policies and protocols that needed to be followed to ensure pharmacists

provided vaccinations safely and effectively.

But the AMA has raised serious concerns about the move.

Chair of the AMA Council of General Practice, Dr Brian Morton, said it was inappropriate for pharmacists to provide vaccinations, and the idea that it would free up GPs to provide other care was misguided.

Dr Morton said when patients came in to get a flu injection, it was often an opportunity for GPs to look at other aspects of their health, such as the management of chronic conditions like diabetes and heart problems.

He cautioned that pharmacists might vaccinate a patient without informing their GP, fracturing the continuity of care, and warned that because pharmacists did not have the knowledge and experience to identify anaphylaxis and allergic reactions in patients receiving vaccines, lives could potentially be put at risk.

The expansion of pharmacy services to include vaccination is part of a broader push by pharmacists to increase their scope of practice in the face of weaker profits from drug sales and mounting focus on rules that shield the sector from competition.

A competition policy review commissioned by the Abbott Government and led by economist Professor Ian Harper last year recommended scrapping rules that insist only registered pharmacists can own pharmacies, and that new outlets cannot be built within 1.5 kilometres of an existing pharmacy.

The rules effectively prevent the major supermarket chains from opening in-store pharmacies.

The Government has so far shown little interest in deregulating the pharmacy industry, but the issue has been put on the national agenda at an awkward time for the sector.

The current five-year Community Pharmacy Agreement, under which 5000 pharmacies are being paid \$15.4 billion to dispense medicines under the Pharmaceutical Benefits Scheme and provide other programs and services, expires in the middle of the year, and negotiations on a new deal are well underway.

While the Government is keen to hold down spending, the sector is trying to justify an increase by establishing a bigger role for pharmacists in the provision of health care.

This month the Pharmacy Guild launched a television and online campaign to promote community pharmacy.

ADRIAN ROLLINS

# Continued dispensing has started – but you wouldn't know it

More than a year after pharmacists were given the power to dispense medications without a prescription under so-called Continued Dispensing arrangements, the take-up has been underwhelming.

Health Department figures show that, in the first nine months after Continued Dispensing came into effect across most of Australia, barely one in 10 pharmacies had exercised their new-found authority, and the total drugs issued accounted for a tiny fraction (0.0016 per cent) of all medicines dispensed under the Pharmaceutical Benefits Scheme.

When it was first implemented in late 2013, Continued Dispensing was hailed by pharmacists as a way of helping make sure patients took their medicine by giving those unable to see their doctor to get a prescription renewed the option to instead go direct to a chemist to get their medication.

But in the nine months to 30 June last year, there had been just 2390 valid transactions carried out under the new arrangement, involving 779 pharmacists and 532 pharmacies.

The number is particularly small given that Continued Dispensing has been in place in most of the nation's most populous states - New South Wales, Victoria, Western Australia, South Australia and Tasmania - since September 2013, in the ACT since November of that year, and in the Northern Territory since May 2014. Queensland is the only State where it is not yet in force.

So far, only oral contraceptives and statins can be obtained under the arrangement. Continued Dispensing can only be

used where there is an immediate need for the medicine, where it would be impractical to obtain a prescription, the use of the medicine by the patient is well established and has been subject to clinical review within the previous 12 months, and the medicine is considered safe and appropriate for the patient.

Continued Dispensing has been particularly touted as a way to relieve both women and doctors of the burden of having to obtain regular prescriptions to take the pill, and the Department's figures show this has been the most commonly used feature of the arrangement.

The Department reported that 992 (41.5 per cent) of all Continued Dispensing transactions involved oral contraceptives, while the lipid modifier Atorvastatin accounted for around a quarter (26.2 per cent), Rosuvastatin 22.1 per cent, and Simvastatin 8.3 per cent.

Encouragingly, the Department found there had been few breaches of the Continued Dispensing provisions. It identified just 61 occasions (2.5 per cent of all transactions) on which pharmacists had issued drugs not covered under the arrangement.

Nonetheless, it appears some pharmacists in Queensland have been over-eager – the Department reported 11 instances where pharmacists in the State had dispensed medicines without a valid prescription, putting them in the regulator's sights.

ADRIAN ROLLINS

## INFORMATION FOR MEMBERS

### Help us tackle alcohol-related harm

In October, the AMA hosted a National Alcohol Summit, hearing first-hand from experts around the country on the country's shocking rates of alcohol-related harm.

Australia's young people are particularly at risk.

Every day, 160 Australian teenagers turn to alcohol and drug support services across the country asking for help, and every week, on average four Australians 25 years or younger die, and a further 60 are hospitalised, because of alcohol-related injuries.

Building on the AMA's efforts to raise awareness about alcohol-related harm, and to raise money for youth drug and alcohol

services, a team of committed Federal AMA staff have pledged to abstain from alcohol, sugar, caffeine or digital media for the entire month of February.

We invite our members to make a donation to show your support and help us reach our fundraising target.

Go to [febfast.org.au](http://febfast.org.au) and click on the 'sponsor a friend' button. You can find Australian Medical Association under the FebFast team tab.

Donations are tax deductible, and all funds raised will go to youth support and advocacy services and family drug support.

# Stem cell cowboys bring the watchdog sniffing

The medicines watchdog has been warned that any move by it to regulate the therapeutic use of autologous stem cells could ruin Australia's chances of becoming a world leader in the development of regenerative technologies.

The Therapeutic Goods Administration is considering a range of options to tighten regulation of stem cell therapy following concerns that patients are being lured into trying expensive and unproven treatments that may be unsafe.

People with conditions including arthritis, Parkinson's disease, multiple sclerosis, strokes and paraplegia are being charged up to \$10,000 for procedures involving the reinjection of stem cells extracted from their fat deposits and blood, despite a lack of scientifically verifiable evidence that such therapies work and are safe.

Among the complications and adverse events that have been documented are the growth of bones in the eyelid of a woman who had cosmetic eye treatment, and the secretion of fluid into the spine of a woman eight years after cells from her nose were transplanted to her spinal column.

The use of autologous stem cells (those harvested from one part of a patient and used therapeutically in another part) is well established in some areas of practice, such as with skin grafts and bone marrow transplants.

So far this has occurred without formal oversight by the TGA, but an explosion in their use for a wide range of other conditions has raised concerns that a lack of regulation has left patients vulnerable to exploitation and harm.

"Treatments are being offered for diseases such as osteoarthritis (and charged for) with little or no supporting evidence," the TGA said. "Patients are potentially exposing themselves to risk for no definable, demonstrable benefit."

In addition, the lack of formal oversight means there is no obligation to report adverse events.

In a discussion paper, *Regulation of autologous stem cell therapies*, released last month, the TGA invited comment on a range of options from leaving current arrangements unchanged through to subjecting all such therapies to TGA assessment.

Writing in *The Conversation*, Megan Munsie and Martin Pera of Stem Cells Australia, backed regulatory changes to curb many of the questionable applications of autologous stem cell therapy.

But Melbourne Stem Cell Centre medical director Dr Julien Freitag said going down this path was unnecessary and risked stifling the development of a world-leading regenerative technology industry.

Dr Freitag, who is leading a clinical trial into the use of autologous stem cells to treat knee osteoarthritis (see 'Australian's bend knee for breakthrough therapy', p27), said regulations were already in place to hold to account practitioners who used stem cell therapy unethically, and what was needed was greater clarity about the roles and responsibilities of the various regulators.

He told *Australian Medicine* that practitioners who applied treatments without being able to provide evidence of their safety and efficacy, and who practised outside their area of clinical expertise, were already liable to sanction from either the Australian Health Practitioner Regulation Agency or the Medical Board of Australia.

"If the clinician is unable to show appropriate levels of safety and that they are acting within their area of expertise...they should face investigation and prosecution by the appropriate regulatory authority."

"The strength of the current legislation is that it places the responsibility of therapy production and administration solely on the treating clinician," Dr Freitag said. "If the clinician is unable to show appropriate levels of safety and that they are acting within their area of expertise...they should face investigation and prosecution by the appropriate regulatory authority."

He said the fact that this had not already occurred was due to the confusion the currently existed among AHPRA, the Medical Board and the medical profession as to who was responsible for regulation, something that could be addressed by clarification that the TGA did not have an oversight role.

Dr Freitag warned that any change to the current arrangements would threaten the ability of Australian clinicians and scientists to be involved in world-leading clinical trials of autologous stem cell treatments.

"We have real potential, under current regulations, to be world leaders in regenerative technologies," he said. "[Imposing TGA oversight of therapies] will only serve to delay and prevent the development of cell-based therapies within Australia."

ADRIAN ROLLINS

# Community action to help achieve AMA's zero toll goal



AMA President Associate Professor Brian Owler has long advocated for improved road safety, as the face of New South Wales' long-running *Don't Rush* campaign.

Now he has convened a working group to bring a national focus to the issue of improving road safety.

The President's Road Safety Working Group, which first met late last month, brings together distinguished clinicians from around the country, including orthopaedic surgeons Robert Atkinson from Adelaide and Andrew Oppy from Melbourne, general surgeon Fred Betros from Mt Druitt in Sydney's West, AMA Western Australia President Michael Gannon, AMA Northern Territory President Robert Parker, Professor of Paediatric Surgery at Westmead, Danny Cass, anaesthetist Sandy Zalstein from Tasmania, and South Australian cardiologist Bill Heddle.

Mr Heddle and Mr Atkinson, in particular, bring with them a wealth of experience regarding road safety. Both have served on the AMA South Australia Road Safety Committee for many years – Mr Heddle has been its chair since 2007 – and have overseen projects which have demonstrable success in reducing the road toll.

One of these projects, a community road safety program in Millicent, showed how community-led initiatives to address

local issues can reap real results. For the project, the Millicent community was given the power to make decisions about local traffic issues, and the result has been a cut in road fatalities and injuries.

AMA SA Road Safety Committee members have also campaigned successfully for a maximum 80 kilometres an hour speed limit in the Adelaide Hills and, after a decade of lobbying, succeeded in having major constraints on the car licences of young males enshrined in legislation.

Though the national road toll is falling, doctors regularly see the terrible consequences of serious and fatal accidents, for both the victims and their families and friends.

Much has been achieved, but the AMA Road Safety Working Group wants to help achieve the goal of zero fatalities on the nation's roads.

The Working Group is looking at a range of strategies, including graded licensing systems, enhanced safety measures for vulnerable road users such as pedestrians and cyclists, and how to replicate the successful South Australian model of community-led road safety measures in other states and territories.

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SUSAN PARKER

# 2015 Australia Day Honours List

Many AMA members were recognised for their services to medicine and to the community when Australia Day Honours were awarded last month. Here are the details of the recipients and their citations.

## Victoria

### Companion (AC) in the General Division

#### Professor John Watson Funder AO

For eminent service to medicine, particularly to cardiovascular endocrinology, as a renowned researcher, author and educator, to the development of academic health science centres, and to mental illness, obesity, and Indigenous eye-health programs.

### Officer (AO) in the General Division

#### Professor Peter Robert Ebeling

For distinguished service to medicine in the field of bone health, through academic contributions and research initiatives in a range of administrative, executive and professional roles.

### Medal (OAM) in the General Division

#### Dr Franklin T K Chew

For service to the Chinese community of Victoria, and to medicine.

### Associate Professor Robert Ian Smee

For significant service to medicine as a radiation oncologist, and through professional organisations and leadership roles.

### Professor John Douglas Watson

For significant service to medicine in the field of neurology, to medical education and administration, and through mentoring roles.

### Officer (AO) in the General Division

#### Associate Professor Phillip David Stricker

For distinguished service to medicine and medical research, as a leading urologist, a robotic surgery pioneer, a teacher and mentor, and as an advocate for prostate cancer awareness.

### Medal (OAM) in the General Division

#### Dr Roderick Graham Bain

For service to veterans and their families.

## Queensland

### Member (AM) in the General Division

#### Dr John Robert BURKE

For significant service to medicine in the field of paediatric nephrology as a clinician and administrator, and to professional medical associations.

### Medal (OAM) in the General Division

#### Dr Walter Barry WOOD (life member)

For service to medical education, and to the community.

## Western Australia

### Member (AM) in the General Division

#### Dr Stuart Malcolm Miller

For significant service to medicine as an otolaryngologist, through leading contributions to medical foundations, and to photography.

#### Dr Malcolm Victor Dunjey

For service to medical administration, and to the community.

#### Mr Neville John Basset

For significant service to the community, particularly through executive roles with the Royal Flying Doctor Service of Australia.

## New South Wales

### Member (AM) in the General Division

#### Associate Professor Raymond Garrick

For significant service to medicine in the field of chronic pain management, and to medical education as an academic.

#### Dr David Golovsky

For significant service to medicine, particularly in the fields of urology and fertility.

## ACT

### Member (AM) in the General Division

#### Dr Andrew Robert Reid

For significant service to sports medicine through executive roles with professional organisations, and as a voluntary medical officer.

SANJA NOVAKOVIC



# AMA in the news

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

## PRINT

### **Back to the waiting room for reforms, Sydney Morning Herald, 17 January 2015**

Recently appointed Health Minister Sussan Ley plans to dump contentious cuts to GP rebates for short visits. AMA President A/Professor Brian Owler said no issue in recent memory has provoked the anger among doctors and patients that this rebate cut has.

### **Co-payment in some form still on agenda, Australian Financial Review, 17 January 2015**

Health Minister Sussan Ley said some form of GP co-payment is still on the Government's agenda despite an embarrassing backdown on GP rebates. The AMA has welcomed the government backdown as a victory for grassroots GPs and patients.

### **Libs speak out over GP 'affront', The Australian, 19 January 2015**

Anger is welling within Liberal ranks over the failed push to cut GP rebates, with MPs urging caution on the introduction of a co-payment. AMA President A/Professor Brian Owler was sceptical of extending a co-payment to specialists, but was open to consultations with government.

### **Knives still out over GP rebates, The Daily Telegraph, 21 January 2015**

A planned \$5 cut to GP Medicare rebates could be reconstructed as the federal government gears up for crunch talks with the Australian Medical Association. Health Minister Sussan Ley is scheduled to meet AMA bosses for a fresh round of consultations on the government's vexed Medicare reforms.

### **Lib MPs fear rebate backdown, The Australian, 20 January 2015**

Tony Abbott is being urged to abandon plans to cut the Medicare rebate by \$5, as government MPs warn against fighting an unwinnable political battle that plays into Labor's hands. The AMA also remains opposed to the \$5 rebate cut.

### **Doctors groups expect deal on \$5 co-payment, The Australian, 23 January 2015**

Doctors groups are hopeful a fresh approach by new Health Minister Sussan Ley will see the Government strike a compromise on its proposed \$5 cut to the Medicare rebate. AMA President A/Professor Brian Owler said the Minister was open to looking at the proposals.

### **Calls to reform 'racket' by adding to nurse duties, Weekend Australian, 24 December 2014**

AMA President A/Professor Brian Owler has rejected the suggestions that devolving GP functions and responsibilities to nurses, pharmacists and others would deliver health savings.

## RADIO

### **A/Professor Brian Owler, ABC NewsRadio, 19 January 2015**

AMA President A/Professor Brian Owler discussed comments by former GP Andrew Lamming, who believes that doctors seeing more than 10 patients per hour cannot be delivering quality medicine. AMA President A/Professor Brian Owler said it depends what the doctor is doing for those 10 patients in the hour.

## TELEVISION

### **A/Professor Brian Owler, SKY News, 19 January 2015**

AMA President A/Professor Brian Owler talked about the Government's backdown on a \$20 cut to the Medicare rebate. A/Professor Owler said we need to discuss health policy to improve health care.

### **A/Professor Brian Owler, ABC News 24, 22 January 2015**

AMA President A/Professor Brian Owler held a press conference discussing his meeting with new Health Minister Sussan Ley and the \$5 Medicare rebate cut.



## Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
<b>Dr Andrew Miller</b>	AMA WA Vice President	PBS Authority medicines review reference group	13/4/2015
		PBS Authority medicines review reference group	13/11/2014
<b>Dr Brian Morton</b>	AMA Chair of General Practice	PIP Advisory Group (PIPAG) Teleconference	3/2/2015
		UGPA	26/11/2014
		PSRAC Meeting	28/11/2014
<b>Dr Kean-Seng Lim</b>	AMA Member	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Group	1/12/2014
<b>Ms Anne Trimmer</b>	AMA Secretary General	Working Group for Cosmetic Services	2/12/2014
		PSRAC Meeting	28/11/2014
<b>Dr Robyn Langham</b>	AMA Federal Councillor	ACCC pre-decision conference on Medicines Australia Code of Conduct reauthorisation	28/11/2014
<b>Dr Saxon Smith</b>	AMA NSW President	Clinical Care Standards Advisory Committee meeting	26/11/2014
<b>Dr David Rivett</b>	AMA Federal Councillor	Rural Classification Technical Working Group	25/11/2014
<b>Dr Chris Moy</b>	AMA Federal Councillor	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Group	20/11/2014
<b>Dr Andrew Miller</b>	AMA Federal Councillor	PBS Authority Medicines Review Reference Group	13/11/2014



# AMA in action

The AMA had a busy Christmas period and start to 2015 driving a national campaign to convince the Federal Government to overturn its widely-despised plan to slash the rebate for GP consultations of less than 10 minutes by \$20.

AMA President Associate Professor Brian Owler met new Health Minister Sussan Ley just hours after she was sworn in on 23 December. A/Professor Owler and other senior AMA officials including Vice President Dr Stephen Parnis and Council of General Practitioners Chair Dr Brian Morton backed up the

AMA's advocacy in the corridors of Parliament House with numerous media interviews and appearances to drive the message home.

Following Ms Ley's welcome decision to scrap the \$20 cut, A/Professor Owler was one of the first health leaders to take up the Minister's invitation for greater consultation and discussion about the way ahead for health policy.

ADRIAN ROLLINS



A/Professor Owler at the American Medical Association headquarters in Washington DC in December



AMA President A/Professor Brian Owler meets with new Health Minister Sussan Ley hours after she is sworn in



A/Professor Owler (c) and Dr Brian Morton (l) at the United General Practice Australia meeting late last month



A/Professor Owler warns Government of doctor fury about looming Medicare rebate cut





Health Minister Sussan Ley meets with AMA President A/Professor Brian Owler, AMA Chair of General Practice Dr Brian Morton and other members of United General Practice Australia at AMA Federal office in Canberra on 28 January



Let's talk: Health Minister Sussan Ley meets with AMA President A/Professor Owler at her Parliament House office soon after dumping planned changes to the Level A/B GP consultation rebates



AMA President A/Professor Brian Owler welcomes the Federal Government's shift to a more consultative approach on health policy



## \$20 rebate cut overturned, but much more to do

BY DR BRIAN MORTON

Government moves at the very end of last year to implement a \$20 cut to patient rebates for most GP consultations of less than 10 minutes saw the AMA tirelessly working over the Christmas/New Year period to reverse the planned change, including giving GPs the tools that they needed to be part of this campaign.

This advocacy was key in the Government's last-minute decision to ditch the cut and undertake to consult the medical profession about sensible and appropriate reform - something they should have done from the start.

It was pleasing to see how outspoken GPs were on this issue.

It takes a lot to stir GPs to political action, but the Government's policy clearly galvanised GPs to fight for the viability of their practices and their capacity to deliver quality patient care. Their willingness to do so will no doubt be tested further this year.

The AMA will need your engagement on a number of issues as this year progresses. I encourage you all to stay abreast of events as they unfold - there are always issues affecting general practice. We will help you to do so through emails from the President, as well as through *GP Network News*, *Australian Medicine* and our website ([www.ama.com.au](http://www.ama.com.au)). Use the forums we provide, like [www.doctorportal.com.au](http://www.doctorportal.com.au), to share your views.

With the \$5 cut to rebates for most consultation items for general patients and the freeze on MBS indexation until July 2018 still on the table, our advocacy will be ongoing in an effort to prevent these measures being implemented.

Instead of continuing to attack patient care at its most efficient and effective

delivery point, the Government would be wise to invest in reform solutions that support preventive medicine and quality care.

Currently, the AMA is preparing its proposal to support the integration of pharmacists into general practice. This is a perfect example of how the Government could better invest in GP-led quality care and the continuity of patient care, rather than its fragmentation.

There will be a number of issues that the AMA will be called to provide feedback on this year. Your responses to each of these as they arise will help to inform the AMA position.

The Government is currently considering the recommendations of the After Hours review, which are yet to be made public. If changes are to be made, the AMA will be there to advise how they can be effectively implemented.

The Government is also considering the findings of the Diabetes Care Project, also yet to be released, and is looking at how the Chronic Disease Management items can be reformed to ensure the use of these items is better targeted. This latter is one area where the Government has at least tried to talk to the profession about how it can better support comprehensive and coordinated care and the management of chronic disease.

By April this year we should know the successful applicants to establish the various Primary Health Networks across the nation. The promise is they will work directly with GPs to improve and better coordinate care across the local health system. The AMA will be monitoring this, and looks forward to hearing your experiences as the PHNs begin their work.

### INFORMATION FOR MEMBERS

## Free tool to track registration requirements

The AMA has developed a free online tool to help doctors to keep track of the information they need to meet the Medical Board of Australia's annual continuing professional development (CPD) requirements.

Each September, practitioners, when renewing their Medical Board registration, may be required to provide evidence they have complied with the Board's CPD requirements.

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;
- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and performance appraisals; and
- Log hours spent on online learning, reading journals, teaching and other activities.

The system keeps a tally of hours, enabling practitioners to keep track of what needs to be completed before the end of the registration year.

The Tracker has been developed taking full account of the requirements set out in the Medical Board's Continuing Professional Development Registration Standard.

The service is free to AMA members. Non-members can subscribe for an annual fee of \$250.

To register for the product, visit: <http://cpd.ama.com.au>



# The ongoing training battle - where to in 2015?

BY DR DANIKA THIEMT

As an Australian Doctor in Training (DiT), you are unlikely to be naive to the medical training and workforce planning issues facing our profession.

As our medical graduate numbers have doubled over the last decade, so have the training concerns of our current DiT workforce.

Increased graduate numbers have resulted in bottlenecks at key points in the training pipeline, which has made access to high quality prevocational and vocational training positions increasingly uncertain.

This time last year my predecessor, Dr James Churchill, commented on how critical 2014 was for advocacy on the medical training pipeline.

With the looming loss of Health Workforce Australia (HWA) and the formation of National Medical Training Advisory Network (NMTAN), the future of medical workforce planning was uncertain and we entered 2014 with trepidation.

The Council of Doctors in Training spent the year as the driving force behind national workforce planning, giving voice to the concerns of our trainees and lobbying key Government and training stakeholders to plan for the coming generations of doctors.

While we are still advocating for a sustainable and efficient medical training system, we hope that our voice is beginning to be heard.

The problem of future workforce planning is by no measure solved, and this will continue to form the backbone of the Council's advocacy efforts in 2015.

With these challenges in mind, CDT will spend 2015 focused on training, starting with the AMA CDT Trainee Forum to be held in Sydney this month.

The Forum will look at the role of 'modern day' trainees and their place within the health system.

We will look at the role of the service registrar and lead a (hopefully) spirited debate about their value in our current training environment.

We hope to inspire discussion around new and innovative ways

to train, with special focus on the upcoming Review of Medical Intern Training and an in-depth view of the struggles of the ever-increasing prevocational trainee cohort. We will collaborate with the Australian Medical Council in their work on revised Standards for Specialist Medical Education, continuing our fight for access to quality vocational training. To round out these discussions, we will host the annual Trainee Soapbox to hear about the big issues facing our vocational trainees in 2015.

“The AMA is here to represent you and we need you to help us shape what the AMA and what CDT needs to be”

These discussions, these reports and these debates will shape the CDT agenda in 2015, and will direct the Council in our advocacy for the year to come.

The AMA is here to represent you, and we need you to help us shape what the AMA and what CDT needs to be.

If you are not yet a member, please join.

For the AMA to continue to be a powerful voice advocating for Doctors in Training, we need to be united and we want you standing by our side while we fight for our training.

Finally, as incoming Chair of the AMA Council of Doctors in Training, I would like to thank Dr James Churchill, Dr Julian Grabek and the 2014 Council for their tireless work last year. The hard work of the Council and the ever-dedicated AMA staff resulted in a year of fantastic outcomes for Australian DiTs, and has placed us in a great position for the coming year.

For those of you who are moving on with your careers, you will be missed, and for those returning to the Council in 2015, I look forward to working with you again.

I look forward to meeting as many of you as I can over the coming year and working with you to represent Australian Doctors in Training.



# Are we closing the gap?

BY PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR  
PUBLIC HEALTH, UNIVERSITY OF SYDNEY  
EDITOR-IN-CHIEF, *MEDICAL JOURNAL OF AUSTRALIA*

A gap of 10 or more years separates life expectancy for Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

It has provoked soul-searching and guilt throughout the 40 years since this stark figure was first declared. It tends to wobble as statistics are revised, but it remains our clearest indicator of the mortality gap between first and subsequent nations in Australia.

The gap has motivated medical and public health action from practitioners, health service managers, research workers, politicians, advocates, and Aboriginal and Torres Strait Islander peoples. Despite the volume of this action and the many millions of dollars spent on attempts to bridge it, the gap persists, though smaller than it once was.

Analyses as to why the gap is there and what we can do to reduce it frequently gravitate back to the poorer social opportunity experienced by Indigenous people, and the less health-sustaining environment in which they live.

These social factors include distance from major urban centres, though many Indigenous people live in or around our cities. But remoteness from employment opportunities, education, fresh food, and health care is a major concern.

Strenuous efforts have been made in relation to tobacco and alcohol control, immunisation, skin infections, and the detection and treatment of diabetes and renal failure. Infant mortality rates have fallen, a well-recognised sign of improving health more generally.

The Closing the Gap initiative, an inter-government program begun in earnest in 2008, is due to report again soon.

Its pedigree can be traced to 2005 when Tom Calma, the then Aboriginal and Torres Strait Islander Social Justice Commissioner, published his *Social Justice Report 2005*. In it, he called on the governments of Australia to commit to achieving equality for Indigenous people in the areas of health and life expectancy within 25 years.

The following year a campaign was launched that attracted public attention and morphed into a program endorsed by the

Council of Australian Governments (COAG) following the 2008 National Apology to Aboriginal and Torres Strait Islander Peoples.

The program committed the State, Territory and Commonwealth governments to six goals, including:

- closing the gap in life expectancy within a generation (by 2031);
- halving the gap in mortality rates for Indigenous children younger than five years by 2018;
- ensuring access to early childhood education for all Indigenous four-year-olds in remote communities by 2013;
- halving the gap in reading, writing and numeracy achievements for children by 2018;
- halving the gap for Indigenous students in Year 12 (or equivalent) attainment rates by 2020; and
- halving the gap in employment outcomes between Indigenous and other Australians by 2018.

To help achieve this, the governments pledged to spend around \$1.6 billion over four years, as well as investing in Indigenous early childhood development.

More than half a billion dollars was committed to the National Partnership Agreement on Indigenous Early Childhood Development, concentrating on early learning, support for mothers and more. Thirty-eight Children and Family Centres were to be established, “offering integrated early childhood and parenting services”. It was claimed that “all centres are on track to be established by 2014”, and when the next report on Closing the Gap is published soon, we will know whether this happened.

There are not many problems – perhaps mental health is a similar one – that defy our ability and willingness to solve them. The reasons are always complex and find their origin in our beliefs and attitudes, the way we organise our society, what we value. If we really wanted to solve these problems we probably could. In the meantime we have to be satisfied with formal incremental efforts such as Closing the Gap.

Let's hope the next report on its progress carries good news.



# Aspiring doctors face different strokes

BY JAMES LAWLER

Outside of my medical studies, I work for a youth organisation as a residential worker, looking after adolescents who live in out-of-home care.

Many of these kids come from incredibly unfortunate backgrounds, but are cared for by a team of people aiming to see them grow into the best adults they can be. It's a great job for myself as a medical student, as I get a real insight into just how much health is socially determined, and how the "doctor's orders" filter down into the real lives of their patients. It keeps me grounded, to say the least.

"The end of 2014 saw a record number of medical students graduate, and in January a record number of intern doctors began in hospitals around Australia"

Recently, I was sitting in a meeting with my colleagues when I discovered that during my shifts the way one of the kids behaved around me was markedly different to the way he behaved around the other carers. My team leader remarked, "James, it's because he knows you're studying to be a doctor. And so [he] treats you differently. For better and for worse."

This kind of perspective is easily lost as a medical student, but it helped me reflect on the political landscape for the Australian Medical Students' Association (AMSA) for 2015.

The end of 2014 saw a record number of medical students graduate, and in January a record number of intern doctors began in hospitals around Australia.

Data is still trickling in, but it appears that every student who hung around until December was able to secure an internship, although the slow allocation process seemingly led some people to execute their plan B and go overseas.

The victories which have been won in fighting the #interncrisis have been enormous, and although there is still more work to

be done on medical training, the community's belief that public investment in training doctors is critical for Australian society has forced governments to act.

The Federal Government reacted even more acutely to pressure from doctors when it backed down from proposed Medicare rebate cuts last month.

News articles showing doctors planning rallies across the country in the name of equitable patient care has strengthened belief in the community that doctors will advocate for the health of Australians. It is wonderful to see the Government stepping back to undertake consultations with doctors and other health groups - something which should have occurred in the first place.

Of course, there remain many issues that need to be addressed. One is Curtin University, which every year seems to announce plans for a medical school.

On the face of it, it might seem to be a smart investment in the future health workforce. But any new medical school would in fact be poor policy.

There are already a record number of medical students graduating, and the West Australian Government would be better off investing money to attract doctors to work in the State rather than setting aside money for a new medical school, which will only provide Australia with more students than it can train.

AMSA is strongly opposed to more medical schools, and I will present our view to governments in the coming months.

I'm looking forward to my year as the President of AMSA, both in working for a community of medical students who are keen to develop policies and campaigns to improve the wellbeing of the Australian community, and to work with the AMA.

*James Lawler is a medical student from the University of Newcastle, and is the President of AMSA for 2015. The AMSA executive is based in NSW this year, and comprises students from the University of Newcastle, the University of New South Wales, the University of Western Sydney, and the University of Notre Dame. Follow on Twitter @jmslwr and @youramsa.*



## The Coalition has lost the plot on general practice

BY DR DAVID RIVETT

The recent proposal, since dumped, for savage cutbacks to general practice patient rebates underscores the current Government's lack of understanding of general practice and the vital role it plays in improving the nation's health, despite being on a shoestring budget.

Since its inception, the Medicare patient rebate has been reduced in real terms annually by corrupted indexation, which in no way reflects rising practice costs, including wages and rents, nor the consumer price index.

When I once asked a Health Minister to justify this, the best I could get from them was lower indexation reflected costs less efficiency gains in general practice. In other words, GPs were getting lower and lower rebates to drive them to work faster and faster to keep their doors open.

Then 'hey bingo', some bright spark in Government suggested a 10-minute or less speeding penalty.

Rather than address the inherent problem created by the use of an inappropriate indexation formula and its inevitable flow-on results and find a sound solution (as was proposed by the Medicare GP Consultation Item Number Review Group of which I was part), some harebrained individual, whose sole focus was on slashing and burning, brought to Cabinet a "simple Simon" solution.

To those with no concept of how general practice runs, the proposed \$20 rebate cut may, at first glance, appear to have had some merit. But it would have made the eight or nine minute consultation a loss leader, and it would have hit experienced and skilled GPs who have been in practice for years, the hardest. Statistics show that such doctors reach a diagnosis and formulate a thorough management plan with greater accuracy in a much shorter time than those with lesser experience. Surely this is what quality care is about.

This was a plan with no public benefit, purely a cost-cutting exercise.

It certainly galvanised local GPs in my area, and at an urgently convened meeting we agreed to strongly support the AMA and Royal Australian College of General Practitioners' campaigns to overturn it, with poster displays, patient involvement via letters and e-mails, a meeting of local doctors with the local Federal Member, and possibly a "Save Medicare candidate" at the next Federal Election.

Thankfully, common sense prevailed and the 10 minute cuts were ditched following a tide of alarm among GPs and demonstrably strong AMA leadership. It now remains to overturn the July 1 \$5 rebate cut and the freeze on Medicare Benefits Schedule indexation.

GPs are angry and fed-up and, I believe, are prepared to fight politically.

### 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](mailto:generalpractice@ama.com.au)



# Health funds try for more than nip and tuck

BY ASSOCIATE PROFESSOR ROBYN LANGHAM

Last year there were a number of developments in private health insurance that will affect medical practitioners, and it is important that the AMA is ready to respond with considered positions.

At its first meeting, the new Medical Practice Committee joined with the Health and Economics Committee in reviewing the AMA's existing position statements and resolutions to ensure they were still relevant to current issues.

AMA President Associate Professor Brian Owler has met with most of the private health insurers in the last few months, and has strongly argued how important an independent doctor-patient relationship is in making decisions about the most appropriate patient care.

“... in January we sought feedback from AMA members involved in private practice about potentially anti-competitive behaviour affecting either them or their patients”

Obviously, ‘pre-assessment’ processes are unacceptable to the AMA.

The AMA agrees with the insurers that neither they nor Medicare should pay for services that are for purely cosmetic purposes. But the AMA considers that this issue needs to be dealt with on a case-by-case basis, rather than a systemic approach that might ensnare procedures that are not just about cosmetics. Following AMA advocacy at least one insurer, BUPA, has abandoned plans for such a classification system.

The AMA is also working with the Department of Health on definitions of cosmetic surgery and plastic and reconstructive surgery that will reduce ambiguity about when a Medicare benefit, and therefore a private health insurance benefit, is payable.

While the Australian Society of Plastic Surgery has signed an agreement with Medibank Private and BUPA on an ‘alternative’ pre-assessment process, we need to consider carefully what precedents this sets and the risks it poses to medical practitioners and their patients.

On the issue of questionable private health insurer practices, in January we sought feedback from AMA members involved in private practice about potentially anti-competitive behaviour affecting either them or their patients.

Each year, the Australian Competition and Consumer Commission reports to the Senate on private health insurers and anti-competitive practices; the AMA is always invited to make a submission. This year, the ACCC is focusing on information provided to consumers that limits their ability to make informed decisions about health funds and policies.

We had an excellent response, with many members writing detailed accounts of the confusion and hardship inflicted on patients by misleading and incomplete health fund information, as well as the many hours their administrative staff devote to investigating and confirming insurance cover held by patients. This was invaluable in informing our submission.

At its most recent meeting, the AMA Federal Council identified a number of priorities for action on private health insurance, including:

- better private health insurance products – so that there is good coverage of the care and treatment that people actually need, and transparency of products for patients so that they know what they are covered for;
- medical benefits – to maintain a doctor’s right to set their own fee, but with improvements on quality assurance and improved outcomes;
- hospital contracts – to ensure the sector remains viable; and
- primary care – so that funding arrangements apply to all patients with private health insurance, regardless of which practice they use.

For more information about the approach the AMA is taking on private health insurance, read the President’s speech to the Private Healthcare Australia Directors Day on 12 November (see transcript at <https://ama.com.au/media/ama-speech-ama-president-a-prof-brian-owler-private-healthcare-australia>).

I encourage you to email any views or suggestions to [president@ama.com.au](mailto:president@ama.com.au)

*Associate Professor Robyn Langham is the Chair of the Medical Practice Committee.*

# 5 little-known reasons why pharmacists should not be playing doctor

BY DR EDWIN KRUYTS, GP, GOLDEN BEACH MEDICAL CENTRE

*Dr Kruids blogs at the Doctor's bag (<http://doctorsbag.wordpress.com/>). This article was first published on 29 January, 2015, and can be viewed at: <http://doctorsbag.net/2015/01/29/5-little-known-reasons-why-pharmacists-should-not-be-playing-doctor/>*

So there is a budget crisis. There's also a new Health Minister. And, here it comes, community pharmacies are negotiating over a multi-billion-dollar deal with the Government: the Community Pharmacy Agreement sets out the Government funding pharmacists receive for dispensing PBS medicines.

Put these ingredients together and what do you get? Answer: community pharmacists who want to be doctors – oh sorry – who want to be paid for what they think are the easy parts of a doctor's job. Oops, wrong again: they want to deliver 'better and more cost-effective health outcomes'.

If it's up to the Pharmacy Guild, pharmacists will be:

- filling repeat prescriptions to 'free up doctors time';
- treating 'easy' minor ailments;
- giving more vaccinations (such as a flu-shot for \$25, with no Medicare rebate);
- doing 'easy' health checks, screening and preventive health services; and
- giving mental health support.

Sounds great, doesn't it?

At first glance, this improves access to health services and saves taxpayers bucket loads of health dollars. This can't go wrong! Maybe not.

Here are five reasons why role and task substitution by pharmacists will fail:

## 1 Avoiding the doctor is probably not going to help

A repeat prescription or a vaccination is a valuable opportunity for a family doctor to screen for, and treat, health issues before they escalate. This is one of the strengths of general practice. If people don't come in because they get their cholesterol or blood pressure scripts from the pharmacist every six months, this system will fail. It will worsen health outcomes and drive up costs. Is that really what we want?

## 2 We are treating people (not ailments)

People are more than the sum of their ailments. Over the years, there have been many attempts to replace the doctor with algorithms, machines and computers, and they have all failed. The human body and mind are complicated. Take the nurse-practitioner clinics trialled in the ACT. They created duplication and resulted in more emergency department presentations.

## 3 Don't put the cart before the horse

If it's improved access or multi-disciplinary care we're after, then strengthen general practice. Unfortunately, the opposite is happening: practice nurse support has been cancelled, and I won't mention the Medicare rebate cuts and freeze.

## 4 Disruption is not innovation

A common mistake is to assume that disruption is the same as innovation. Disruptive services – like those suggested by community pharmacists – may be simple or convenient, but the quality will be poorer. A recent study showed that only three out of 32 fish oil supplements contain what the label says; I believe pharmacies should focus on evidence-based medication advice and quality control of over-the-counter drugs.

## 5 Conflicts of interest

A question we should ask is: can the person who is selling the drugs give independent health advice? Pharmacies face reduced profits because the Government has set lower prices for generic medications under the price disclosure arrangements. Although it is understandable pharmacies are looking for other income streams, it is unlikely that the proposal by the Pharmacy Guild is a win-win solution.

Playing doctor may be good for the pharmacist, and possibly for the health budget in the short-term, but not for the health of Australians. It will hinder GPs in the effective delivery of care and will eventually increase costs. There is value in team work, but only if we work together.







# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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Research Council, found there was little if any evidence that most of the therapies work, according to a draft of the report obtained by *The Australian* under Freedom of Information laws.

“Based on the evidence considered within the context of this review, there were no health conditions for which there was reliable, high quality evidence that any of the natural therapies considered were clinically effective,” the report found, according to *The Australian*.

“For a few modalities (Alexander technique, massage, tai chi, yoga) there was low to moderate quality evidence that these natural therapies may improve certain health outcomes for a limited number of clinical conditions.

“However, in most cases the quality of the overall body of evidence was not sufficient to enable definite conclusions regarding the clinical effectiveness of these therapies to be drawn.”

The damning findings are likely to have put rebates for insurance policies that provide cover for such therapies in the Government’s cross-hairs, particularly given rapid growth in the number of claims being made for such treatments.

Figures compiled by the Private Health Insurance Administration Council show natural therapies have been one of the fastest-growing areas for health fund pay-outs.

In documents obtained by *The Australian*, the Council reported that in the 10 years to 2012-13, the number of natural therapy sessions covered by insurers surged 241 per cent, and fees charged by natural therapists soared by 358 per cent.

The Baggoley review was commissioned by the previous Labor Government when it became concerned about the rapid growth in insurance pay-outs for treatments it considered of dubious clinical value.

At the time, private health insurers were paying out about \$90 million a year on claims for treatments including aromatherapy, ear candling, crystal therapy, homeopathy, iridology, kinesiology, reiki and rolfing.

In ordering the review, the Labor Government raised the prospect of making such therapies ineligible for the private health insurance rebate, potentially saving around \$30 million a year.

There is speculation the Coalition Government is considering a similar move as it hunts for savings in the lead up to the next Budget.

ADRIAN ROLLINS

## Emergency target dropped as cuts bite



A nationally-agreed target to cut hospital emergency department waiting times is under threat as Federal Government health funding cuts bite.

The New South Wales Government has walked away from a national agreement aimed at ensuring that, by the end of this year, at least 90 per cent of emergency department patients would be admitted, referred or discharged within four hours, while the Queensland Government has its commitment under review.

The 90 per cent National Emergency Access Target was part of a National Partnership Agreement struck between the Commonwealth, State and Territory governments in 2011, which promised Federal incentive payments for health systems that reached agreed performance benchmarks.

But doubt was cast over commitments made under the Partnership Agreement after the Coalition Government dumped the system of reward payments as part of sweeping cuts to hospital funding in last year’s Budget.

In the Budget, the Commonwealth disavowed public hospital funding guarantees made under the National Health Reform Agreement and reduced the indexation of post-2017 funding to CPI plus population growth, changes the AMA estimates will strip \$20 billion from the public hospital system in the next five years.

The ability of the states and territories to be able to reach the 90 per cent NEAT target already appeared doubtful.

In its *2014 Public Hospital Report Card*, the AMA revealed that, in 2012-13, just 67 per cent of all emergency department patients nationwide were admitted, referred or discharged within four hours, a slight improvement from the previous year, but still well short of the 90 per cent target.

In NSW, the performance of emergency departments has improved but, as at last October, only 75.5 per cent were dealt with within the four hour target.

NSW Health Minister Jillian Skinner announced on 12 January that hospitals in her State will aim at a more modest target for this year of 81 per cent of patients, pending the results of a Queensland review of the 90 per cent target.

“The Queensland Government has advised State and Territory health ministers it is reviewing the 90 per cent target,” Ms Skinner said. “The states and territories believe this review will help determine if 90 per cent is a clinically-safe and appropriate long-term goal. “Ministers are yet to receive the Queensland report.”

The breakdown in the NEAT target has raised the prospect that other commitments about hospital performance made under the National Health Reform Agreement may also slide.

The Federal Government is overhauling how hospital performance is measured.

Early last year it secured the agreement of the nation’s health ministers that the National Health Performance Authority should report on benchmarks around rates of infection and elective surgery and emergency response times. However, following the Budget cuts, this work has been deferred.

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ADRIAN ROLLINS

### Medicare reprieve for pro athletes

Professional athletes and sporting codes have been given an extra three years to make arrangements to cover their own health costs following yet another backflip by the Federal Government on health policy.

In one of his last acts as Health Minister and Sports Minister, Peter Dutton late last year intervened to reverse an earlier decision to block elite sportspeople from getting publicly subsidised health care for illness and injury.

In a surprise announcement, the Federal Government declared last year that from 25 May 2014 professional athletes would no longer be eligible for Medicare benefits for medical services “where it is directly related to their employment”.

But in November, Mr Dutton exercised his ministerial discretion to suspend the change, allowing sportspeople injured in the course of their work any time between 25 May last year and 30 October 2017 to claim Medicare benefits.



However, the Government remains committed to forcing professional athletes off publicly-subsidised health care.

In a letter explaining the decision, Department of Health Acting Assistant Secretary Dr Megan Keaney said it was the Government’s “continuing view...that in the longer term these expenses should not be subsidised by the Australian taxpayer”.

“This Direction provides sporting codes with time to put in place suitable insurance arrangements so that at the end of this period sporting clubs and codes are fully responsible for meeting the costs of their players’ medical treatment, where appropriate,” Dr Keaney wrote.

The Health Department official suggested sports groups look at organising their own insurance, develop suitable products in consultation with the insurance industry, or possibly arrange to have professional athletes covered by State-based workers’ compensation schemes.

In a hint that the original decision to scrap Medicare eligibility for professional athletes had not be fully developed before it was announced, Dr Keaney said the three-year phase-in period would allow the Health Department to develop a definition of “professional sportsperson”, as well as allowing sporting codes and clubs to collect and analyse data on the Medicare claiming patterns of elite athletes.

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ADRIAN ROLLINS



# Research

## Hope new wave antibiotics could doom superbugs

Researchers are working on a new class of antibiotics that may help stem the rise of superbugs that threaten to make even relatively minor injuries and common infections deadly.

Scientists at the University of East Anglia have discovered a weakness in the defence mechanism of a major group of bugs, gram negative bacteria, that could be the target of a new wave of antibiotic drugs.

The target of their attention has been the cell membrane used by gram negative bacteria, which include common and potentially deadly germs including *E.coli* and *Klebsiella pneumoniae*, to protect themselves from the human immune system and antibiotics.

They have identified a set of molecules called lipopolysaccharides that are crucial to forming the membrane. It means researchers can now look at developing drugs that target these molecules, preventing the membrane from forming and leaving the bacteria vulnerable to the body's immune response.

Research leader Professor Changjiang Dong told *The Independent* newspaper the finding provided "the platform for [an] urgently needed new generation of drugs".

Importantly, the discovery raises the possibility of developing antibiotics to which bacteria cannot develop resistance. The researchers said that, because the drugs would not need to enter the bacteria cell itself, the bacteria may not have the opportunity to develop resistance, bringing the evolution of superbugs to a halt.

The potential breakthrough has come none too soon, given mounting international alarm about the proliferation of superbugs resistant to existing antibiotic treatments.

The World Health Organisation has warned that antibiotic resistance is "a growing public health threat of broad concern... [that] threatens the achievements of modern medicine".

"A post-antibiotic era – in which common infections and minor injuries can kill – far from being an apocalyptic fantasy, is instead a very real possibility for the 21st century," the WHO said.

In its latest update on the worldwide incidence of antibiotic resistance, the organisation reported that "very high rates of resistance have been observed in bacteria that cause common health-care associated and community-acquired infections (e.g. urinary tract infection, pneumonia) in all WHO regions".

The WHO said that, in many areas, clinicians were having to



use drugs forming the last line of defence against bacterial infections.

"High proportions of resistance to third generation cephalosporins reported for *E. coli* and *K. pneumoniae* means that treatment of severe infections likely to be caused by these bacteria in many settings must rely on carbapenems, the last-resort to treat severe community and hospital acquired infections," it said.

"Of great concern is the fact that *K. pneumoniae* resistant also to carbapenems has been identified in most of the countries that provided data, with proportions of resistance up to 54 per cent reported."

Professor of Microbiology at Kingston University, Mark Fielder, told *The Independent* the discoveries made by the East Anglia research team were exciting because of the potential development of a new generation of antibiotics that may stall the superbug threat.

But he sounded a note of caution, warning that the effectiveness of even this new generation of drugs may eventually become compromised by bacterial resistance.

"I think because [the new drugs would be] attacking such a vast area of the organism, the potential for mutation might be slowed, but I don't think we could ever say it won't evolve," Professor Fielder said.

ADRIAN ROLLINS

## Australians bend knee for breakthrough therapy

Australian researchers are running two of the world's largest clinical trials of a stem cell therapy that promises to be a major advance in the prevention, treatment and management of osteoarthritis.

Scientists from the Melbourne Stem Cell Centre are recruiting candidates for a trial of two techniques that involve the injection of mesenchymal stem cells into the knee joints of people with medial compartment arthritis.

So far, 10 subjects have been recruited for the privately-funded trial, and principal study clinician and sports physician Dr Julien Freitag said the early indications were promising.

Dr Freitag said several of the participants receiving stem cell treatment had reported a noticeable reduction in pain and improvement in mobility, though he added it would be some time before preliminary data was available.

Dr Freitag, who specialises in the treatment of osteoarthritis, said the decision had been taken to trial the therapy following promising results from an earlier South Korean study that had found the injection of stem cells had been associated with an increase in cartilage volume.

"That was very exciting," he said. "That was the first real indication of disease modification just using injections."

Dr Freitag said osteoarthritis had been the "poor sister" to rheumatoid arthritis, which was the focus of most research effort, and treatment was limited to pain management rather than tackling progress of the disease.

He said stem cell therapy offered the prospect of not just managing, but treating the condition through regrowth of cartilage volume.

"We may well have found something that can modify the disease's progress and may prevent or delay joint replacement," the researcher said.

This is significant, not least because of the increasing incidence of knee joint replacement among patients younger than 60 years. Currently, around 30 per cent of such patients need to have a second replacement within 10 to 15 years because of wear and tear on the joint, bringing with it increased risk of poor outcomes and greater complications such as infections.

Because the trial is being privately funded and the treatments being assessed are costly – around \$10,000 per patient – the number of participants has been limited to 40 in each group.

Dr Freitag said using such a small sample (which nonetheless makes this the largest such study yet undertaken of the therapy

in the world) meant the subjects had to be as alike as possible in order to minimise variables.

To ensure a relatively uniform sample, strict criteria have been imposed. To be eligible for the trial, participants must:

- have a single symptomatic knee joint;
- have a medial compartment grade II-II arthritis;
- be 18 years of age or older;
- have nil autoimmune mediated arthropathy;
- have no history of cancer;
- not be pregnant; and
- not be immunodeficient.

So far, the researchers have recruited 10 participants, and hope to have reached the target of 40 participants by the middle of the year.

Participants successfully enrolled in the trial will have all treatments funded.

Those randomly allocated to the control group will, at the completion of data collection, be offered crossover to the most successful therapy at no charge.

Both trials are registered with the Australian and New Zealand Clinical Trial Registry.

For further details, contact Dr Freitag at Julien.Freitag@mscc.com.au

ADRIAN ROLLINS

## A pain in the gut

The gut is one of the biggest organs in the body and, because it is involved in generating the body's immune response, it is also one of the areas worst affected by chemotherapy.

Between 60 and 80 per cent of patients being treated with chemotherapy experience side-effects in the gut, depending on the dosage and type of chemotherapy used.

But, University of Adelaide researchers think they have found a treatment method to counteract the chemotherapy side-effects on the gut.

The researchers believe an immune receptor could be to blame for intensifying a patient's reaction to chemotherapy.

Lead author and PhD student Hannah Wardill said that while the treatment of cancer itself is usually seen to be of prime importance, chemotherapy can and does have severe side-effects for patients, such as diarrhoea, abdominal pain and, in some cases, sepsis.

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# Research

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“Our research has focused on the immune receptor known as Toll-Like receptor 4 (TLR4), which has been implicated not only in the development of gastrointestinal symptoms, but also appears to control people’s sensitivity to pain,” Ms Wardill said.

“In our laboratory studies, we found that TLR4 sets up an inflammatory response that is exacerbated by chemotherapy.

“By knocking out the TLR4 receptor, we saw improvements across all key markers of gut toxicity, as well as signs of reduced pain.

“Treatment for [gut] symptoms [in chemotherapy] is limited and often not effective. Side-effects of chemotherapy can cause multiple, co-existing health problems which greatly reduce the patient’s quality of life and impact on the long-term outlook for patients.”

Co-author and PhD student Ysabella Van Sebille said that toxicity from chemotherapy continues to be under-reported.

“Toxicities associated with chemotherapy are a major concern within the field of supportive care in cancer, but we still don’t understand the full extent of the problem,” Ms Van Sebille said.

“Our research has highlighted the potential to treat multiple side-effects of chemotherapy by targeting TLR4 which, if successful, could streamline system management.

“The ultimate aim of our studies is to help find a way to mitigate the adverse health problems caused by chemotherapy, which could lead to improved overall care for patients. So far, TLR4 seems to be a promising target for future research.”

KIRSTY WATERFORD

## Caffeinated soft drinks are addictive - research

Food companies are making it harder for people to ditch soft drinks from their diets by adding addictive caffeine to many of their products.

Researchers from Deakin University have found that caffeinated soft drinks are addictive, contributing to the nation’s serious weight problem.

Caffeine is a widely consumed, mildly addictive chemical that occurs naturally in coffee, tea and chocolate, but is added to soft drinks. It is estimated that more than 60 per cent of soft drink consumption is of caffeinated beverages.

For the Deakin study, 99 participants aged between 18 and 30 years were randomly assigned to either a caffeinated or non-caffeinated soft drink group. Participants were told that the study was testing the palatability of a lemon flavoured soft drink to mask



the study’s true purpose. Over 28 days, participants were allowed to consume as much of the soft drink as they wanted.

On average, participants in the caffeinated drinks group drank on average 419ml per day, compared with an average 273ml a day among the non-caffeinated drink group.

A separate group of trained flavour testers found no difference in flavour between the caffeinated and non-caffeinated drinks.

Lead researcher Associate Professor Lynn Riddell said that participants could not taste the difference between the caffeinated and non-caffeinated versions of the soft drink, challenging claims made by soft drink manufacturers that caffeine was used as a flavour enhancer.

“Our findings clearly show that caffeine as an additive in soft drinks increased consumption and, with it, sugar calories, and that is a significant public health issue given the prevalence of obesity,” Associate Professor Riddell said.

“That caffeinated soft drinks were also more liked than the non-caffeinated soft drinks at the end of the intervention supports previous studies that suggest caffeine promotes liking and consumption via sub-conscious influences that may be related to reversing caffeine withdrawal symptoms.

“Additive compounds such as caffeine that promote consumption via sub-conscious influences work against efforts to minimise energy consumption.

“This research supports the ongoing need for caffeine to be tightly regulated as an additive in the food supply, as it appears to be an ingredient for over-consumption.

“The increasing consumption of nutrient-poor, high energy foods and drinks is a major contributor to the continuing problems of overweight and obesity,” Associate Professor Riddell said.

The study was published in the *British Journal of Nutrition* and was supported by a Diabetes Australia Research Trust grant.

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KIRSTY WATERFORD

## Patients get a head start on skull repair

Patients suffering severe damage to their skull will be able to recover more quickly and safely using technology developed by a team of Sydney biomedical engineers to produce bone replacement implants.

Sydney University researchers worked with a Sydney neurosurgeon to create a 3D fabrication technique that enables clinicians to produce a patient-matched antibiotic-eluting bone replacement implant in a matter of days – rather than several weeks, as is currently the case.

Biomedical engineering institute program manager and lecturer at Sydney University, Dr Philip Boughton, said that serious head trauma can lead to significant loss of skull bone. The current procedure requires a surgeon to temporarily stretch and stitch the remaining skin flap around the wound and wait until a suitable implant can be produced.

“Our new rapid templating method makes it possible to generate patient-matched, safe, sterile cranioplasty implants using antibiotic infused polymer-based bone cement within days of receiving patients into emergency care,” Dr Boughton said.

“Conventional titanium mesh or plate cranioplasty implants take weeks to be ready (partly due to terminal sterilization processing), and cannot be readily trimmed or adjusted in surgery if necessary.

“The technique we have developed creates an anatomic template from clinical imaging. Bio-compatible polymer bone cement is anatomically formed within surgery within a sterile envelope using the anatomic template. A lot of consideration went into ensuring we could reliably form the anatomic cranioplasty with good tolerance and finish.

“It is important to note that most patients who undergo bone replacement implants don’t have any bone that is salvageable, and are highly prone to contamination and infection,” he said.



“Not only is the technique we developed sterile, but the bone cement gradually releases antibiotics to help reduce the risk of infection in patients. This is not possible with currently available titanium or 3D printed implants.

“In practice, this new approach is a very user-friendly, not to mention cost-effective, option,” Dr Boughton said.

Associate Professor James Van Gelder, Director of Neurosurgery at Concord Hospital, who worked with the researchers, said that existing 3D printed implants were weaker, and were associated with a higher risk for contamination that can lead to infection or inflammation.

“Anatomical matching of patient’s skull bone is important for improving a patient’s quality of life post-operation,” Dr Van Gelder said.

“With this new technique we are able to create a sterile template of the patient’s damaged region, then in a sterile environment apply bio-compatible polymer bone cement to that patient’s specific template to produce their personalised implant.”

The technique has already been used on several patients with success.

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KIRSTY WATERFORD

# WHO overhaul after Ebola catches it short

World Health Organisation chief Margaret Chan has announced major changes to the global health body, which has been sharply criticised for its slow response to the Ebola outbreak that devastated west Africa.

Ms Chan admitted that the epidemic, which has so far left more than 8640 people dead out of almost 22,000 infected, laid bare “inadequacies and shortcomings” in the way the UN agency operated.

“Ebola is a tragedy that has taught the world, including the WHO, many lessons,” she told the WHO Executive Board on Ebola late last month. “This was west Africa’s first experience with the virus, and it delivered some horrific shocks and surprises. The world, including the WHO, was too slow to see what was unfolding before us.”

The virus’s unexpected appearance in west Africa early last year caught local doctors, national health authorities and multilateral organisations such as the WHO flat-footed, and although non-government groups like the Red Cross and Medecins Sans Frontieres voiced mounting alarm at the scale of the outbreak, it took the WHO and the international community a long time to grasp the seriousness of the situation and begin to deploy the resources needed to bring the outbreak under control.

By September, the US Centers for Disease Control and Prevention was warning of the risk that more than a million people might be infected by the end of 2014.

But, following an intense local and international effort, including thousands of local doctors, nurses and health workers as well as almost 60 foreign medical teams comprising 2000 staff to operate 66 Ebola treatment centres and 27 laboratories, UN officials declared last month that the outbreak had passed a “tipping point” and may soon come to an end.

By late January, the weekly tally of new cases in the three West African countries at the centre of the outbreak had dropped to its lowest point in months, making health workers increasingly confident the deadly outbreak was petering out.

Hopes that the epidemic may soon be over have been bolstered by the commencement of a trial of a vaccine whose development has been fast-tracked.

A team led by researchers from Oxford University have begun the clinical trial, involving 10,000 people, of a vaccine developed in collaboration with researchers across several countries.

Lead researcher Professor Adrian Hill of Oxford University’s Jenner Institute told the ABC that such a rapid development of a vaccine was unprecedented.

“I think it’s unique. I don’t think anybody has ever taken a vaccine into a human being for the first time and then four months later was describing a trial in 10,000 people, which is an efficacy trial of the same vaccine to see if it can go forward for licensure. That is really unusual,” Professor Hill said.

“... the outbreak was also a demonstration to governments of how important having a robust health system was”

There are predictions that the epidemic in Liberia could be over by the middle of the year, while the Sierra Leone aims to make the country Ebola-free by the end of May.

But the effects of the outbreak appear likely to be long-lasting.

Dr Chan announced changes in the way the WHO operates, indicating that the regional structure adopted by the organisation had gone too far, and operating procedures, tools and frameworks for risk assessment had to be standardised across the organisation.

In addition, she said, recruitment had been too slow given the scale of the emergency, and WHO needed to strengthen its workforce by increasing the pool of expertise it could draw on, such as field epidemiology.

But Dr Chan said the outbreak was also a demonstration to governments of how important having a robust health system was.

“This is one of the biggest lessons the world learned last year. Well-functioning health systems are not a luxury. [They are] the cushion that keeps sudden shocks from reverberating throughout the fabric that holds societies together, ripping them apart,” the WHO Director-General said.

ADRIAN ROLLINS





# A passage to India

BY DR MICHAEL RYAN



2012 Sula  
Sauvignon Blanc

2011 Sula Dindori  
Reserve Shiraz

2009 Savatere Pinot  
Noir Beechworth

In a classic scene from the cult British comedy *Fawlty Towers*, long-term hotel resident The Major reminisces about how he “took a girl to see India.....at the Oval, ...she stole my wallet”.

Well, actually, my wife took me to India to donate money we had raised for our charity, Maggie’s Dream Catcher, which aids medical care in the north of the country.

We spent two weeks in the world’s second most populous nation, staying in palaces and dining in high-end restaurants. But we also saw, and were moved by, the plight of the poor thronging city slums, schools and hospitals.

For all the world, it appeared a diametrically opposed world of indulgence and poverty. Or so it would seem.

The key to India is the people. The warmth of every beaming smile said welcome, which made me feel accepted. So much so, that by the end of our visit I found my head doing a slight waggle when asked a question that I wasn’t sure of.

The country also has an emerging wine industry.

I spent a tasting session with Ankur Chawla, winner of the best sommelier in New Delhi. He taught me about India’s wine growing regions, the largest of which lies in the central west highlands of Maharashtra state. Here, the vineyards are all above 800 metres to take advantage of the cooling effect of altitude.

Further south, the Bangalore region of Karnataka State is also prominent, while the Himachal region in the north is an emerging area with high ranges and cooling influences. The timing of the dreaded monsoon, when grapes are ripening, probably makes the Hunter Valley’s rain problem seem like a drop in the ocean.

The white wine that emerged as a genuine contender

to tempt western palates was the **2012 Sula Sauvignon Blanc**. Apart from its fresh white peach and gooseberry nose, it has a funky yeasty bouquet with a generous mouth feel and subtle fruit acidity. It would probably suit a coconut prawn curry. The reds reflect a youthful industry: sweaty characteristics are mingled with, and slightly distract from, the spicy berry notes of well-ripened fruit. The **2011 Sula Dindori Reserve Shiraz** was enjoyable, and reminded me of some early Hunter Valley reds that needed taming.

I also took some Australian wine to share. The **2009 Savatere Pinot Noir Beechworth** was a worthy travelling companion. Keppel Smith’s low cropped, unfiltered, French oak mistress exuded soft cherry fruits with spicy brambly second tier nuances. The palate was lean with the complexity of integrating tannins, acid and lingering fruit. The Indian tasters were spellbound.

At breakfast, I discovered the *India Sommelier Wine* magazine. This was a great snapshot into what the wine drinker is being told.

In India, wine is for the very wealthy, those aspiring to be wealthy, and social climbers.

And spirits, it seems, are consumed with great gusto, as made clear in an amusing account of an Indian dinner party.

Guests were invited to arrive at 8.30 pm, though apparently this really meant 9.30 pm. There ensued two or more hours of straight whiskey drinking, followed by a meal at about 11pm or midnight – which was, surprisingly, not accompanied by more drinks.

The article’s writer was shocked when he went to a European-style dinner party, where guests arrived at 7.30pm, drank a selection of wines that matched the dishes being served, and managed not to fall asleep in their Biryani.



# Mini Cooper S Restoration (Part 1)

BY DR CLIVE FRASER



By the time most of us reach 45 years of age, we're definitely on the downhill run.

Hypertension, glucose intolerance and worn joints are all starting to take their toll.

On average, we can expect maybe another 40 years and many visits to medical providers to keep us going.

Very few cars will ever reach the age of 45, and those that do are like the centenarians of the auto world.

By that age there are definitely going to be a few reliability issues, but some owners love their cars so much that they will not spare a cent in embarking on a full restoration.

I have a friend with a 1970 Mini Cooper S who spent many years, countless hours and an un-publishable amount of money restoring his car back to its original showroom condition.

He has given me some very good advice on how to approach such a task.

For starters, he bought the car with the intention of restoring it.

That is, he chose a car that was worth spending the time and effort on, not just a car that was old and still in one piece.

The Mini will always be a classic, but he meticulously ensured that his car was a real Mini Cooper S, and not a Mini Deluxe that had been doctored up with an "S" badge.

The car had been fitted with some after-market options by a previous owner, including mags and a sports steering wheel.

All of this would have to go as in this restoration the car would be returned to the exact way it was when it left the factory.

The Mini was tired-looking and the motor ran roughly.

Its previous owner said, "It just needs a tune-up", but the truth was that the cylinder-head was cracked.

After so many decades that wasn't a problem, as everything was going to be completely re-built anyway.

The Mini was completely stripped down to its components and many bits were stored in the rafters and some parts even under the bed (for example, the windscreen).

The body was sand-blasted back to bare metal and, like an archaeological dig, this exposed quite a few issues - namely rust, dents and previous poor quality accident repairs.

But, worst of all, someone in the past had tried to strip the paint off with an angle grinder, leaving deep score-marks in the metal everywhere.

These marks would show up through the new paint job and would need to be carefully filled with priming paint. Fortunately, Minis were made of thick steel.

Unlike modern cars, Mini body panels were lapped together outwardly with the seam covered by a U-shaped bead. Water invariably sat in this space, so there were plenty of places where rust needed to be excised.

With the body-work restored, and with the help of a good mate, the car was re-painted to its original red colour and, for the first time, it was possible to see that this job might just end up being completed, one day.

*To be continued.*

Safe motoring,

**Doctor Clive Fraser**

doctorclivefraser@hotmail.com

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**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.

## Not a member?

Join now to discover the representation, services, resources and benefits available to members:

[www.join.ama.com.au/join](http://www.join.ama.com.au/join)

# RESTORE SIGHT FOR JUST \$25



## Donate now to help Fred's work live on

In developing countries, the operation to cure cataract blindness can cost as little as \$25. Your donation will help The Fred Hollows Foundation build on our record of restoring sight to well over one million people since 1992. Like Fred, we tackle problems head on with our sleeves rolled up. But we urgently need your help. Each year an additional 1-2 million people lose their sight. 75% of cases are avoidable.

Please give today so that others may see. Just \$25 can help restore sight. Donate now to help Fred's work live on.

**1800 352 352** [www.hollows.org.au](http://www.hollows.org.au)



Yes, I would like to make a gift of:

\$25  \$50  \$100  \$200  My choice \$ \_\_\_\_\_

Or I will make a regular monthly gift of:

\$25  \$50  Other \$ \_\_\_\_\_ (minimum \$15 per month)

until cancelled in writing by  Credit card OR  Direct debit  
(Direct debit authority will be forwarded)

MY DETAILS Please print clearly

Title: \_\_\_\_\_ First name: \_\_\_\_\_ Family name: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb/Town: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone H/W: (\_\_\_\_) \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

### PAYMENT OPTIONS

Cheque/money order (payable to The Fred Hollows Foundation)

Charge my credit card

Visa  Diners  AMEX  MasterCard

Card No: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_

Please send details on making a gift to The Foundation in my Will

Complete coupon and post to: Reply Paid 75965 BURWOOD NSW 1805  
(no stamp required) or fax to 02 8741 1999.

Donations of \$2 and over are tax-deductible. If for any reason you do not wish to receive appeal updates, please contact us (details above).

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The Fred Hollows  
Foundation