Canberra DOCTOR

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Gifts from medical students for this edition of Canberra Doctor

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

This is the last issue of Canberra Doctor for 2012; so it is time to round off a few of the grittier topics for the year … and to launch into a whole host of new ones for 2013!

PCEHR

We were privileged to host Mukesh Haikerwal at the AMA in his capacity as Head of Clinical Leadership and Engagement with the National e-Health Transition Authority. The fact that Mukesh enjoys that rather cumbersome title at all reflects a victory for the lobbying efforts of the AMA. Without clinical input it is unlikely that the e-Health roll-out would generate anything of utility in patient care. It is a pity that the PCEHR was announced with such a fanfare, and so prematurely, in July. It is clear from Mukesh's presentation that it is still very much a work in progress, but that progress is happening; and that the battle to maintain clinical input into the design and implementation of the system is as vital as ever. The feedback from those who attended the session was positive, although the number of attendees was disappointingly small. I admit to being a little perplexed at the general lack of engagement amongst our colleagues; considering the inevitability of some form of an e-Health initiative (even if there is a change of government) and found myself speculating that as the software issues are sorted (my own provider is still not compliant for one), and the again delayed compliance date for the e-PIP nears, there may be more demand for similar information sessions.

We will attempt to entice Mukesh back next year.

Graduates, internships training and scope of practice

The internship crisis rolled over the nation late in the year; of course the situation came as no surprise to any of us but seemed to provoke an extraordinary game of brinksmanship between the various levels of government across the country. We were lucky here in having a pragmatic territory government that acknowledges the value of local trainees in securing the future of our region's health services. I am sure that they were also aware that the market value of our own medical school's product was on the line if intern places could not be found for all of its graduates.

I hope that we will not be treated to the same national jiggery-pokery next year as we not only strive to accommodate the new crop of graduates, but also continue to train this year's into their PGY2.

This year has also seen a continuation of the trend to interference in and erosion of our profession's scope of practice; with other groups in the health care sector being invited by government to participate more actively. The AMA has argued vigorously that only medical graduates have the scope of knowledge to safely direct these other service providers; against the similarly vigorous lobbying from these other groups for an increase in responsibility. The shortage of medical practitioners and the desire to "increase efficiencies" in health care have been used as supportive arguments by health administrators.

Whilst it is probably undoubtable that there are others in the health care sector who possess nuclei of knowledge or skills that exceed our own; none have the breadth of medical knowledge that enables proper safe effective holistic care. The AMA will continue to argue that our profession must remain the lynch pin of patient care.

I find it extraordinary that in these times when breaking down silos has been for so long the catch-cry, we are seeing government actively step to fracture patient care into so many little parts. Of course the danger in all of this is the diminution of our roles to simple cogs in a wheel. That is a fight that is for every one of us to engage in.

VMO and salaried medical practitioner negotiations

We are due soon to start the business of negotiating the next round of VMO contracts with the ACT Health Directorate. Our local AMA has a unique combination of skills and experience to offer, but requires VMOs to sign delegation authorities for it to act on their behalf. I would urge you all to make that selection so that we can be at the negotiating table on your behalf.

Next year will also see the commencement of negotiations for the next salaried medical officer contracts. Under the provisions of the ACT legislation we were able to successfully participate in the negotiations for the last round and we anticipate being able to contribute actively again.

Any new threats? … or should we see them as opportunities? I call your attention to the article *Over 150 potentially low-value health care practices: an Australian study* in the latest MJA (19 Nov 2012; 197 (10); 556-60) and the associated commentary (pp 538-9). I read this article with considerable disquiet and fear a whole new sea of woes before us. This is a space that we all (and you can be sure the AMA will) watch with great care.

End of 2012 and on to 2013

2012 has been a very difficult year for the staff of Canberra Hospital, marred by tragedies and controversy.I am sure that we all join together in wishing them a happier year next year.

I would like to take this opportunity to thank the staff of our AMA ACT secretariat for their help and support. We have a rare combination of knowledge, experience and dedication that makes our little band so effective.

The Christmas and holiday season will soon be upon us (in case you hadn't noticed the decorations in the shops for the last few weeks!).

For myself, I am crossing another item off the list with a trip to the Galapagos Islands during the break. I have no doubt that I will be able to thrill you with first hand experiences of tool using finches with funny beaks and all sorts of insights into the origins of everything. This of course will immediately date me since everything is outcomes these days.

This, of course, is a time of year when we should all be looking towards our families and friends, and giving thanks for their love and support. May I wish every one of you a safe and enjoyable break; all the time you want with those you love; and a happy and fulfilling 2013.

Health Commitments in 2013 and beyond

Chief Minister and Minister for Health, Ms Katy Gallagher, MLA writes for Canberra Doctor.

With the ACT election now behind us, my focus as Health Minister is once again on our ambitious program to rebuild our health system by boosting capacity and delivering state of the art infrastructure and services to match. I feel privileged to again be leading this program of reform which will continue through the roll out of our election commitments.

We will continue to build capacity and provide more services closer to where people live by funding more beds, more staff and more services. Over the next four years the Government has committed to adding a further 170 beds to our health system, employing more than 500 doctors, nurses and health professionals, and investing $250 million in new health infrastructure projects. Cancer outpatient services will receive an injection of $17 million, General Outpatients a further $10 million and Mental Health an additional $35 million. A further $83 million will be allocated to elective surgery to enable us to provide an extra 5,000 operations, bringing the total number of procedures to 50,000 over the next four years.

These investments are not just about providing more money to do more of the same. We will also be implementing new services and developing new models of care. For instance, we will be establishing a Maternity Assessment Unit to provide for more rapid transfer of women to high level obstetric care and a mobile dental clinic to ensure residents of aged care facilities and special schools don't miss out on dental treatment. Our Emergency Departments are already undergoing redesign projects but we will also take the first steps towards establishing a dedicated paediatric stream in the Canberra Hospital ED, changing the way we triage and treat children presenting to the hospital. Ongoing funding for a Paediatric Clinical Nurse Consultant position will be provided to support this new paediatric response with a dedicated waiting and triage area to be constructed for children and their families.

We all would prefer to see fewer people presenting to our EDs. That's why over the next term the Government will also target unhealthy lifestyles and behaviours to reduce the risk of chronic disease. We have earmarked extra funding to support Aboriginal and Torres Strait Islander smoking cessation programs and will increase the number of smoke-free public places. Our Whole-of-Government Healthy Weight Group has been tasked with reviewing our physical activity and nutrition programs right across Government and looking for new ways to halt the rise in obesity levels. Despite considerable efforts in recent years, our community is getting heavier and a comprehensive whole-of-government strategy is needed to tackle this difficult health issue.

The Government will also continue to provide support for GPs through the highly successful GP Workforce program which funds the pre-vocational GP placement program, the Education Infrastructure Support Grants Payments, the Aged Day Service and the GP Development Fund.

My vision for health, however, is bigger than the buildings and the services provided within them. We are the service heart of this region

and home to a number of pre-eminent health and medical research and teaching institutions. As we enter our second century, I will be seeking to leverage our strengths and exploit opportunities to develop deeper connections between health, education and the economy. This will benefit patients and our health system by providing a pool of highly trained graduates and facilitating collaborations between clinicians and researchers. It will benefit our city, helping to drive our economy by creating jobs and making us a destination of choice for health and medical students.

This vision is already being realised through our partnership with the University of Canberra to build a new sub acute public hospital. Planning is already underway for the new hospital which will include dedicated space for teaching and research. This new facility will not only increase bed capacity once completed in 2017 but will also attract students to Canberra, train new health professionals, foster research and position UC as the premier health university in our region.

The Government is also embracing new partnerships with the ANU – home to the prestigious John Curtin School of Medical Research and the ANU Medical School. With the construction of the new Canberra Region Cancer Centre nearing completion, we have agreed to support the establishment of a new Centenary Chair of Cancer Research to bring globally competitive clinical and research skills to the ACT which will also attract students, engage local clinicians and ultimately benefit cancer patients and families.

The ACT and Federal Governments have also recently reached an agreement to support additional medical internship training in the Territory's public and private hospitals. The ACT will fund an additional five internships in 2013 and in return, the Federal Government will fund an extra ten places in ACT public and private hospitals. These places will increase the supply of highly trained medical professionals in the ACT and ensure more Australian trained doctors remain in our workforce.

These commitments are all aimed at creating highly skilled jobs, delivering new services, harnessing world leading research and technology, and providing jobs of the future that will also deliver new treatments. It is a very full agenda for the next four years but these initiatives will help to create a sustainable and modern health system, with the capacity to support a growing, ageing and ailing population. I look forward to working with the AMA to progress this agenda.

Katy Gallagher MLA
Chief Minister and Minister for Health

Student prize winner 2002 – Tom Turnbull

I have many fond memories of my time at Canberra Clinic School. I graduated in 2003 and spent the last two years of my Sydney University medical degree at The Canberra Hospital. My strongest friendships from medical school come from my time in Canberra. It was a great place where we started the Canberra Clinical Club to enrich our student lives and provide services where they had been missing prior.

There are many memorable moments from the medical personalities of Canberra involved in our teaching … such as anxiously worrying when Simon O'Connor quizzed us on ECG interpretation; the excitement of Terry Gavaghan letting me traverse a colon with a colonscopy flying solo; Graham Reynolds giving us wise tips on how to examine fractious children; feeling sick whilst Jane Dahlstrom performed autopsies with us; Michael Falk telling us that even the cleaner would be able to answer his simple acid base question; and David Hardman singing along to the Mikado in theatre whilst making us memorise the layers of the foot … many funny memories.

I ended up returning to Adelaide for my internship, as I felt I needed my family's support during my internship. Royal Adelaide Hospital was a painful experience starting in general medicine with a sick and absent registrar, many frail and near to death patients and feeling completely overwhelmed with my lack of experience and knowledge.

Thankfully I had some good experiences too and got to meet my local general practice training provider through medical education sessions.

After resident training I entered GP Training and chose to take rural training pathway due to my interest in procedural skills, the extra training year, and for a challenge.

I relished rural general practice and enjoyed working in Clare Valley, and would often find many bottles of wine as gifts and thanks for the hard work. I had the opportunity to deliver the child of my receptionist. Her age is now a time post for when I was last working there.

Later in my training I developed and got approved the first overseas post to Nepal and worked in a hospital in Eastern Nepal with a GP supervisor from Adelaide. I worked in the emergency department and was also involved in the teaching program for medical students. It was a very challenging time seeing such sick patients with very little resources to care for them – but it did encourage me to be involved in medical education when I returned home.

My last post was an advanced skills post in sexual health and HIV medicine. It was an eye opening experience meeting men and women living with HIV infection. I learnt to overcome my own fears and prejudices about HIV and challenged me to provide care to some of the more marginalised in our community.

Through my supervisor in Nepal, Jill Benson invited me to start working at Migrant Health Service in Adelaide. I have learnt a lot about tropical diseases, mental illness associated with living in war-torn countries and learning in more detail the cultures of Africa and the Middle East. I initially thought the building didn't have enough oxygen as I had headaches after every time I worked there, but then I realised later I was getting tension headaches. As I learnt more, and became less anxious, the tension headaches faded thankfully.

I continue to teach at Adelaide University Medical School and enjoy working as a tutor in the clinical skills program with standardised patients to teach students the basic tools of history and examination – It is such a pleasure seeing them start with nothing and become nearly competent doctors!

My other job is at a travel vaccination clinic. I sat the Certificate of Travel Health exam in Budapest and enjoy spending a day a week doing travel consultations and talking to people about their next exciting safari trip through Botswana, or volunteering in Burma, or visiting family in Bolivia. It is a nice respite to the week.

Diversity in medical practice suits my nature and personality so I imagine I will always have a few ideas up my sleeve and few more things I want to learn.

Thanks Canberra!

Where are they now?

Former winners of the *AMA student prize for leadership* write for *Canberra Doctor*.

Tom Turnbull 2002
Heman Tse 2003
Scott Blundell 2004 *
Wenly Chang 2005*
Sarah Koffmann 2006
Maurice LeGuen 2007
Chris Gilbert 2008
Grant Pegg 2009
Steve Peterson 2010
James McCracken 2011

**We'd like to contact Scott Blundell and Wenly Chang. If you can help, please contact Canberra Doctor on 6270 5410 or email: execofficer@ama-act.com.au. Sarah Koffman's article will be in the February 2013 edition of Canberra Doctor.*

Student prize winner 2003 – Heman Tse

I finished my Sydney University MBBS here in Canberra back in 2003, before the inaugural cohort of ANU students. In my final year here, I was fortunate enough to be awarded the AMA ACT student prize for leadership. I must admit, at the time, I was surprised by the nomination and the award. I did not believe that I was the leadership type, but was none-the-less flattered by being selected by my peers.

Working in medicine in the last nine years has bought me lots of unexpected adventures and experiences.

With some trepidation, I left Canberra in 2004 to commence internship at Prince of Wales Hospital at Randwick, Sydney. I ended up spending four years there. To my surprise, 'the big city hospital' was exceptionally friendly and supportive. Having a great pub across the road from the hospital to debrief over a beer on Friday evenings probably helped smooth out misunderstandings during the week.

Another unexpected benefit of Prince of Wales was the numerous secondments to Lismore Base Hospital. I jumped at the chance to work at the regional hospital closest to Byron Bay. I have fond memories of going for a surf in summer after work until sunset over Mt Warning and the Border Ranges.

Despite living 15 minutes walk from the hospital and surrounded by numerous restaurants, pubs and beaches, the hectic Sydney lifestyle eventually got to me.

In a last minute decision, I chose Wollongong to start my Anaesthetics training instead of in New Zealand of all places. I spent a lot of 2008 either studying for primary exams, or going to the beach after work, which probably explained the slow study progress that year.

But it was not long before I heard Canberra calling again. I have heard from colleagues that the ACT had a fantastic anaesthetic training scheme. I jumped at the chance to return here in 2009 to continue my training. Since then, I have spent some time away working in Albury as a secondment. Apart from that, all the modules required by ANZCA could be completed here. With the help and

support of many, many consultants working in our department I successfully completed my fellowship exam last year.

This year I have been at The Canberra Hospital part time as a Provisional Fellow in Anaesthesia and part time working as a Registrar for Capital Region Retrieval Service. Professionally this has been the most challenging year to date. Our exceptional retrieval service covers roughly anywhere within a 300km radius. The breadth and scope of work never ceases to amaze me- from primary missions on trauma victims to medical patients needing intensive care in small country towns. It has definitely been the most challenging job I have done to date. It is only now, towards the end of my training, that I have come to acknowledge that I do indeed have some of those leadership qualities. My leadership skills have certainly come in handy recently in some of the more tricky retrieval jobs.

Over the last nine years, I feel like I've grown up a lot, not just as a doctor but also as a person. Canberra has always been an integral part of the learning phases of my life.

The things that attracted me to Canberra in the first place are still here. It still amazes me that I can encounter kangaroos when I go for a run, walk or bike ride near my place in suburbia. Canberra also has access to the South Coast beaches and the snow, both of which happen to be my favourite places to visit when I am not working.

I intend to head to Perth in 2013 for a Fellowship position at Sir Charles Gairdner Hospital. Hopefully, everything will work out and I can return to Canberra to settle down. Third time lucky perhaps.

Student prize winner 2007 – Maurice Le Guen

After completing medical school at the ANU in 2007 I spent two years in Wagga Wagga as an intern and resident. The Base Hospital provided me with excellent opportunities to develop a broad range of junior medical experience including rotations in paediatrics, intensive care and anaesthetics. Whilst in Wagga I was also president of the RMO society and led the initial development of a medical clinical handover project and managed to squeeze in a couple of fantastic holidays to New Zealand and Far North Queensland.

In 2010 I secured a position as a critical care HMO at Royal Melbourne Hospital. During this year I successfully passed the physiology component of the primary examination of the College of Anaesthetists and gained experience in one of the busiest emergency departments in Australia and a large trauma ICU. Once again I managed to squeeze in some time off which included climbing Mt Kinabalu in Borneo.

In 2011, having enjoyed my junior intensive care experience in particular I became an intensive care registrar at St Vincent's Hospital in Melbourne. I successfully completed the anaesthetic primary examination and spent three months on rotation to the ICU in Alice Springs gaining experience in one of the most remote intensive care units in the world.

In 2012 I've continued progress towards Fellowship for the College of Intensive Care Medicine (CICM) at St Vincent's Hospital. In addition, I am currently completing studies towards a Masters in Public Health from the University of Sydney and am the Victorian Representative on the trainee committee for CICM.

Kayaking Milford Sound New Zealand 2008.

Student prize winner 2008 – Chris Gilbert

Since leaving the ANU in 2008 I have had a diverse range of both medical and personal experiences.

I spent my intern and resident years at Ballarat Base Hospital in Victoria. This proved to be a fantastic learning opportunity with a lot of responsibility and great hands on learning experiences (particularly in ED, O&G, paediatrics and surgery).

As a resident I assumed the role of the President of the Resident's Society during a year in which the hospital sought to cut overtime payments to junior doctors. Having learnt important advocacy skills during my time at ANU, I engaged the AMA early to take up the fight against administrators who were trying to make overtime claims very difficult (despite doctors regularly working overtime).

In addition I spent three months of that year working on Elcho Island, a remote island off the coast of the Northern Territory. This experience gave me a wonderful insight into working remotely in Indigenous communities.

As an ADF sponsored medical student the next year saw me commence my return of service with the RAAF. My partner Kate (who is also a RAAF doctor) and I moved to Richmond, NSW where we began our first year in uniform. The year comprised mostly of military specific training – officer training, followed by aviation medicine and aeromedical evacuation. The highlight was a week spent flying with the RAAF Roulettes where Kate and I got to do aerobatics in formation with each other. Towards the end of the year, we were asked if we would consider being posted to RAAF Tindal the following year. We gladly accepted the challenge knowing that we would be the only two doctors for a base in a fairly remote part of the Northern Territory.

This year has been a challenging year but one filled with multiple learning opportunities and diversity. As well as learning the intricacies of how a RAAF medical facility works, we have had to complete training in aeromedical evacuation with the local search & rescue helicopter (including winch training). We have had the privilege of being the two doctors caring for a small community of RAAF members. In addition I participated in a humanitarian aid exercise in Nepal in August. As with many of the other remote locations in which I have practised medicine, this gave me a great appreciation for the level of health care that we routinely have access to. It also taught me to trust my clinical judgment in an austere environment without imaging and pathology services.

With so many diverse experiences in such a small amount of time, I wonder what further experiences await us next year.

Student prize winner 2009 – Grant Pegg

I am from Central Queensland and it was always my intention to return home to work after graduation from ANU so in 2010 I completed my internship at Rockhampton Hospital. It was great to return home and give something back to a community who had supported me throughout my early years. My intentions weren't solely altruistic however because whilst in Rocky I also had the opportunity to perform lead roles in three local musical productions which included playing Peter Allen in a sold-out season of The Boy From Oz which was an incredible experience.

Away from the stage I was working in the Rockhampton Emergency Department during the devastating 2010/11 floods, which tested our already stretched resources. Rockhampton was cut off by road for several weeks and it was great to see the hospital community pull together to provide an effective crisis response.

Following my internship I worked for 6 months as a psychiatry registrar for the Central Queensland Mental Health Service which was very rewarding. Working as part of a mental health service with such a large geographical catchment was truly eye-opening and I developed a keen interest in mental health during that time.

I then dabbled in anaesthetics before trying a PGPPP placement with Yeppoon Family Practice in Central Queensland – which I thoroughly enjoyed.

At the end of last year I returned to Canberra as a medical officer with the Therapeutic Goods Administration which I have found is an interesting and different way to use my medical skills in the context of the broader picture of public health – not many doctors are aware of this opportunity and it's one I'd highly recommend.

Whilst in Canberra I had the opportunity to perform a cameo role in the ANU Med Revue with a few other past students. As the inaugural director I am immensely proud that this tradition still continues at ANU.

I was successful in gaining a GP training place in 2013 and I intend to return to Central Queensland again to complete my GP terms there. Before then I will be playing Enjolras in Canberra Philharmonic's production of Les Miserables in February (sorry about the shameless plug!).

I still am very much involved with the leadership and advocacy of medical students and junior doctors and I look forward to continuing that throughout my future career as a GP. Thank you AMA ACT for awarding me the leadership prize in 2009 and for providing this opportunity.

Student prize winner 2010 – Steve Peterson

I graduated from ANU medical school in 2010, and with some sadness left the ACT seeking adventure and opportunities to learn in a different environment.

I went to Darwin, so at least the hospital building looked the same! Darwin was a great place for internship. There were only 25 interns at the hospital and we formed a close knit band held together by an active RMO society of which I was the social officer. Running the hospital ball (held outside next to the beach under a setting tropical sun), our fortnightly bar tabs and other activities implicated me in the death of many hepatocytes. However the junior staff knew each other so well outside of work that team dynamics and patient care was improved inside work.

The lack of specialisation in Darwin gave the interns good exposure to a broad range of medical problems. General medicine and general surgery really were just that. The NT's unique demographics though did give me plenty of exposure to wounds, infections and alcohol as well as diseases such as meliodosis and rheumatic fever to which I'd had little exposure in the ACT. The NT's laissez-faire attitude to paperwork allowed an interested junior doctor to travel to remote communities on outreach trips and careflights which were great memories too.

Outside work (which did happen from time to time) was very different from Canberra, both in weather and population. I was recruited at the bedside by a hospital patient to become the doctor for the Tiwi Bombers football club, an Indigenous AFL team based in the remote Tiwi Islands. I would go to their games and attend to their injuries – and not only once the match had started. Once a player turned up

to the game bleeding from the head as his girlfriend had thrown a rock at him! I would also call ahead to my friends in ED if a player was en-route for an Xray so they would get it done quickly before their plane went home! The NT AFL was so keen for doctors, they flew me to the Gold Coast to be the doctor for their under 16 and under 18 teams in a tournament which was a great little weekend as well.

After Darwin I got married (to a fellow ANU medical school graduate) and we decided to try new things and went to Cairns for our second year. We had a one-week wedding and honeymoon in-between contracts and soon found ourselves in Mareeba, a small community an hour from Cairns. That posting, and a similar later posting in Innisfail (1 hour south) gave us regular activities for independent practice free from such meddlesome things as supervision. We learned quick! Cairns broadened our medical knowledge; for example by introducing us to octogenarian and over patients that were very rare in Darwin. At work people are mostly friendly and supportive with plenty of mixing between different disciplines. The hospital oztag team (which I captain) has doctors, nurses, allied health and support staff and whilst we don't win much on the field we work together better at the hospital as friends as well as colleagues.

Next year our travels continue as we move to Newcastle to begin GP training. I hope that our past two years have given us a good platform to begin a career as generalists. Being able to spend our first two years in such interesting and beautiful parts of Australia is a nice bonus as well. The medical world is a big place and I look forward to whatever interesting and hopefully useful roles I will find myself doing in the future.

Student prize winner 2011 – James McCracken

After graduating from the ANU Medical School in 2011, and a brief sojourn in Canberra, Laura (my wife), Ollie (our dog) and I, packed up after four years in the Nation's Capital and headed back down the Hume to Melbourne, where we all (well, not Ollie) moved to Canberra from in 2008.

We moved back to Melbourne as I'd been offered an intern position with Melbourne Health at the Royal Melbourne Hospital, and Laura was heavily pregnant with our first child. However, we left Canberra with a heavy heart, having had a most enjoyable four years, having embraced Canberra, it's quirks and having made some fantastic friends.

So the first year of being a doctor has been a fabulous year. Many long days, long nights, times when you felt you knew something and were doing some good, and times that you felt you weren't. Was I prepared for the year? I think there's only so much you can learn about swimming by standing on the shore.

As I write this, I'm currently on my final rotation for the year, on secondment to the Western General Hospital, in Footscray, knee-deep in general medicine, which is Victoria's answer to geriatrics. It's a great chance to reflect on what's been an incredible year (grand final results aside).

I kicked off at RMH in January doing the deathly rotation of nights. On nights as an intern you cover three surgical wards and two general medical wards. I turned up on my first night, not even knowing where these wards were.

Having been assured that nights weren't going to be "that difficult", my first page was for a MET call that didn't end so well. Nights, as you can appreciate, were a baptism of fire of what it meant to be a junior doctor.

In February, we welcomed Hamish into the world. I was told by a certain Professor that coming home to bath his children was the highlight of his day. Certainly coming home to Ham, and seeing him grow (and now crawl!) are indeed highlights that put everyday into perspective.

My other rotations have included palliative care, certainly a contrast of coming back from leave having had a child. It was perhaps the rotation I was least looking forward to this year, but indeed one I've taken the most away from and was perhaps one of the most rewarding.

From there, I dragged Laura and Hamish to Horsham, about 4 hours west of Melbourne in the heart of the wheat growing Wimmera, for 10 weeks of general surgery. Being a country hospital, the Wimmera Base Hospital was true General Surgery. The surgeons would take out an appendix, repair a fracture, take out some tonsils and perform a hemicolectomy. It was a contrast to working at the tertiary centres of Canberra or Melbourne, but the sense of community was something you'd only find in the country – the little old ladies who come in to take the patients washing for them, that is returned the next day, laundered and ironed, free of charge.

From here I returned to Melbourne for a ten-week stint in RMHs busiest, and most unglamorous surgical unit – colorectal. From there, I headed to the ground floor with the cowboys in ED. Another rotation that I wasn't looking forward to, but is perhaps the most formative and educational. Being at RMH, there were also the nasty things that would come in through the door. RMH and The Alfred take care of 90% of Victoria's road trauma, trauma not just on the road, but trauma for the parents, loved ones and for those who spend many months in rehabilitation.

On top of this, I've also been studying a Masters of Public Health by correspondence through the University of Sydney. I'd always wanted to do an MPH, which has given me a new-found perspective on public health, the aetiology and causes of disease, and the importance of good health policy.

I've not been involved with the AMA this year, aside from being a member, due to other priorities. However, I'm aware of the issues that JMOs face. These include the day-to-day issues, such as unpaid overtime, poor working conditions, and due to the tsunami, difficulty finding HMO 2 & 3 positions, as well as increasing competition for training program positions. I plan to join the AMA CDT next year, and roll up my sleeves, as should all JMOs.

Where to from here? Next year I've signed up for a surgical year at the Royal Melbourne, with view of going into surgical training. I've been very proud to be an ANU Medical School graduate. I don't think I could've been better prepared for the year (though my knowledge of STIs thanks to Prof Bowden was handy, but raised a few eyebrows in ED!).

Medibank defence health contracts

Open letter from AMA Federal President, Dr Steve Hambleton to AMA members

I am writing to give you a quick update on the situation with respect to Medibank Health Solutions (MHS) and the new arrangements it is seeking to implement with respect to the provision of off base specialist services for defence personnel.

Our assessment remains that specialists across the country have largely rejected the contract offer that has been put forward by MHS. According to official Australian Defence Force (ADF) correspondence, as of 20 November, 2329 specialists had been contracted to the new MHS preferred provider network.

This figure is far lower than was implied in an MHS letter received by medical specialists dated 2 November 2012 – which stated that 5000 contracts had been returned. This figure appears to be very misleading.

We understand that because MHS has been unable to meet its recruitment targets a significant proportion of ADF personnel are still being referred to non-contracted medical specialists. In these cases, it appears that the lower schedule of fees set by MHS is not being applied and these specialists are being paid according to previous fee arrangements.

The AMA has met on two occasions with representatives from MHS and made clear the concerns of members. We have also raised your issues directly with the relevant Minister.

The AMA has offered to work with MHS to deliver a more sustainable system that will properly support the provision of medical services to ADF personnel. MHS has indicated that it has taken on board the AMA's feedback and will consider its position.

I also appreciate the time that many members took to complete our online survey concerning the new MHS arrangements. I anticipate that a report on this survey will be released shortly. It will provide more evidence of the low take up of MHS contracts.

Finally, our advice to members with respect to MHS contracts remains the same. You should not feel pressured to sign up to the new arrangements, particularly if you are unhappy with the new lower fee schedule and the associated contract provisions. Those members that are considering signing an MHS contract should, as a matter of good practice, seek independent legal advice on its provisions.

Please feel free to forward this email to your colleagues so that they are aware of the current status of MHS contracts and the work the AMA is doing to deliver sustainable and more equitable arrangements to support the provision of health services to our valued defence personnel.

Yours sincerely
Dr Steve Hambleton
President

How much is your kidney really worth?

Liyan Wang and Yi Deng

Organ transplantation, one of the medical miracles of the 20th century, is the best therapy available for treating end-stage organ failure however, the large increase in patients with organ failure and the shortage of donor organs has led to the development of organ trade. There are a large number of people on the organ transplants waiting list but many die waiting for an organ – In the US, at least 3,000 of those who die each year from kidney failure could have been saved had a suitable kidney donor been available.

Currently, organs can be obtained by altruistic donations from living or deceased donors with no monetary reward – this is the universally accepted route of organ donations – or by buying organs from donors elsewhere. However, the practice of selling organs for money is highly controversial and banned in most countries.

Historically, the general principle is that the human body is *'res nullius'* which means belonging to no one. Therefore, as we have no property rights over the human body, it is not lawful to enter into a contract to sell fresh, unprocessed human tissue. There are laws in countries like Australia which prohibit the selling of human tissue, for example, the Human Tissue Act 1982 states that: 'a person shall not sell or agree to sell tissue (including his own tissue) or the right to take tissue from his body' and *'a person shall not buy, agree to buy, offer to buy, hold himself out as willing to buy, or inquire whether a person is willing to sell to the person or another person tissue or the right to take tissue from the body of another person'*. The Australian Criminal Code also contains similar sections regarding organ removal and deeming it a criminal offense.

However, despite these laws, the huge demand for organs in the rich, developed countries has led to the establishment of an international organ trafficking market where the organ brokers exploit two very vulnerable populations – the poor and the diseased who are desperate for money and for life itself.

Potential recipients, who are desperate for organs, as a last resort, travel abroad to countries like India, China, Pakistan and South Africa to obtain organs through commercial transactions – termed transplant tourism. WHO has estimated that transplant tourism accounts for about 10% of all kidney transplants. The UK Guardian also reported that about 10,000 organ transplants occur every year via organ trafficking – that's more than one per hour! Thus, this then fuels the demand for the human organ black market. The organ broker finds potential donors who are willing to sell their organs and organises transport for the two parties to a particular hospital for the transplantation to occur. The two parties are operated on together and the organ exchange is made. Both the donor and recipient are then monitored, however accounts from donors have said that post-operative care is usually very short and very poor compared to the care received by the recipient, with some cases of the donors dying afterwards.

These vulnerable people who are enticed into selling their organs are often not fully aware of the nature and effect of the procedure and not told of the possible detrimental effects to their health. The act of selling arises out of pure desperation – in India, 71% of paid organ donors were living below the poverty line and desperate for money. They are also only given a fraction of the amount paid by the recipient; only a few thousand of the $70,000 or more paid by the recipient – most of this money goes to the middle man and the hospital.

Research in Egypt, India and Iran has shown that the financial status actually declined following the donation. This may be attributed to the inability to work and perform labour-intensive jobs due to the resultant deterioration in their health – they *"became weaker and tired more easily"*. 78% of individuals spent the money within 5 months on acute needs such as food and clothing thus not giving them any improvement in their overall quality of life but rather disadvantages them in the long term.

Harm is also done to the individual socially and emotionally; they were ashamed to be organ donors and a large majority regretted their decision and would strongly discourage others from *"repeating their error"*.

Organ trafficking has stemmed from the large inequalities between the developed and the undeveloped countries. It breaches human rights principles and allows the wealthy and privileged to exploit and use the bodies of the disadvantaged. The commodification of the human body violates the respect and dignity of a person, treating them as commodities rather than an individual, and puts a price on life. As a result, there are several international standards set regarding organ trafficking which help protect the rights of the vulnerable populations.

The Declaration of Istanbul passed in 2008 along with many other international documents are a greater step forward to preventing further organ trafficking and increases international awareness of the issue. However, in order to prevent increased organ trafficking and transplant tourism, policies need to be aimed at the overarching problems of inequality and the increasing burden of chronic diseases. The main driver behind organ trafficking is the desperation of both those living in poverty and those who are chronically ill. Therefore increasing prevention campaigns as well as encouraging altruistic organ donations from the general public would reduce the need for transplant tourism. Reducing the inequalities between developed countries and undeveloped countries would also reduce the exploitation of the vulnerable. Therefore in addition to laws and legislations that ban organ trafficking and regulate organ donations, more effort is needed to address the basic issues of inequality and better health.

Liyan Wang and Yi Deng are year 1 students at the ANU Medical School. This is an edited version of their Professionalism and Leadership Course (PAL) paper. The full text and references are available from the authors on request.

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Dr Chandra Bala

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personalEYES welcome **Dr Tom Walker** to our Kingston practice

Dr Tom Walker is resuming practice in General Ophthalmology at our Kingston practice.

Dr Walker has recently completed a Masters Degree by thesis from ANU on '*The effect of Xylocaine hydrodissection on posterior capsule opacification after cataract surgery*', which also resulted in the publication of a book and journal article.

He has also undertaken some original research on the scanning electron microscopy of the trabecular meshwork in eyebank eyes with and without intraocular lens implant.

Whilst on sabatical he has also maintained full general and specialist registration, CPD compliance and continued as a member of the Therapeutic Goods Administration Advisory Committee on Prescription Medicines.

Dr Walker has found the academic interlude to be stimulating and rewarding and he is delighted to be able to have the opportunity to resume personalised clinical patient care and looks forward to helping new patients, as well as patients he has treated in the past.

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A step backwards on the path to tuberculosis eradication

Rebecca Delaile and Luani Barge

The closure of Queensland's main tuberculosis clinic has been heralded by one of the state's leading respiratory physicians as an absolute disaster for people requiring care and places a further road block in the road to eradication of the disease. On 7 September the Queensland Health Minister, Lawrence Springborg announced that greater than 2700 full time equivalent jobs would be made redundant. Of these cuts, 1527 are to be made from health districts.

Already, in Townsville this has led to 45 nurses loosing their jobs. The areas of health particularly affected by the cuts are preventative and public health units. With greater than one third of the Queensland health budget being spent on diseases with modifiable risk factors such as smoking and diet, Dr Alex Markwell the president of AMA Queensland, says this will lead to a need for more spending on these diseases in the future. Public health includes immunisation, outbreaks of diseases and contact tracing of people with highly infectious diseases such as tuberculosis.

We believe that government funded health care is a vital aspect of a healthy society. With benefits not just in regards to physical health but substantial economic and social benefits. So why then is the newly elected Queensland government choosing Queensland health as the largest target for job cuts? And why, if saving money is the aim, is the main target in Queensland health public and preventative medicine?

Highly efficacious treatment has been available for decades yet tuberculosis (TB) still remains a major health problem. We were well on the way to wiping out the disease until treatment and management of sufferers was handed over to people without enough expertise, contributing to the development of multi drug resistant (MDR) TB. This is a path Australia cannot afford to go down.

Tuberculosis is an infectious disease caused by the bacillus Mycobacterium tuberculosis which mainly affects the lungs. Without treatment mortality rates are high. The World Health Organisation (WHO) declared TB a public health emergency in 1993 when there were an estimated 7-8 million cases and 1.3-1.6 million deaths occurring each year. By 2010 this had increased to 8.5 – 9.2 million cases with a decrease to 1.2 – 1.5 million deaths. TB is the second leading cause of death from infectious disease worldwide. In 2009 an estimated 9.2 million children were made orphans through loss of their parents to TB. In Australia approximately 1000 new cases of TB are identified every year with higher rates in Indigenous Australians and Papua New Guinean residents. Fortunately MDR TB remains rare in Australia. However, expert management and care such as that provided by the TB control centre in Brisbane is vital.

Tuberculosis is characterized by a late onset of outbreak because it is such a 'slow moving' organism. Spread through the population is slow causing a late epidemic, so while it may look good for the current governments' books in the long-term it will be detrimental not only to the cost of the health-care budget but to morbidity and mortality rates as well.

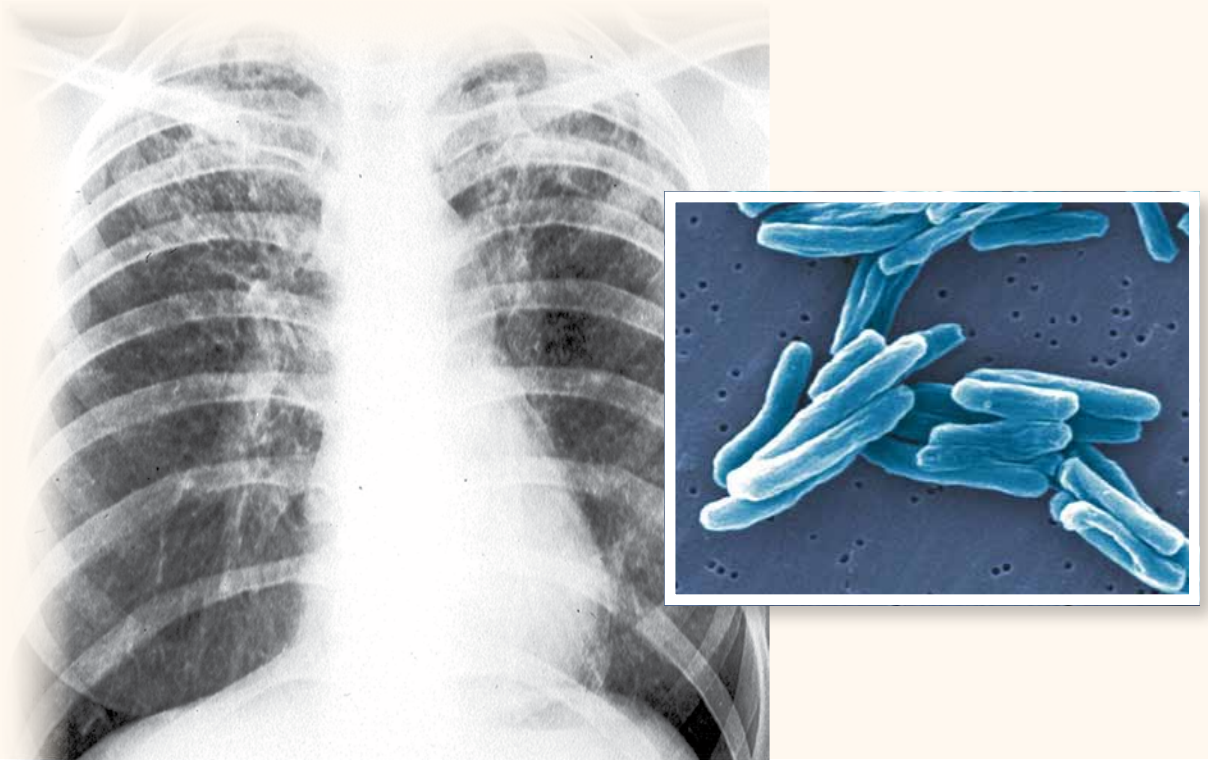
The Bligh government however is not without blame. The closure of the TB clinics in the Torres Strait earlier this year is a major cause of concern for the spread of MDR TB into northern Australia. Papua New Guinea has one of the highest rates of TB in the world with high rates of MDR TB and it is only 150kms from Cape York. Queensland doctors have been treating PNG nationals (who had little or no access to medical care) in the northern islands of Australia, in order to stop the spread of the drug resistant disease into Australia. By closing down these clinics new cases go untreated, people will suffer from lack of and incorrect treatment, which encourages resistance, and the disease will travel down into Australia.

The proposed closure of the Tuberculosis Control Centre (TBCC) in Brisbane as part of the Queensland health 'shake up' is an example of how detrimental health cuts can and will be to our society. By closing the central clinic and moving to a more regional treatment approach the expertise and power needed to combat the rising cases of TB will be lowered with many downstream effects. Regional centres do not have the services available to do contact tracing to the level that TBCC can perform and which is needed if TB control and decline is to be achieved. The resources and level of medical expertise in the TBCC reaches the high standard needed. This will not be found in regional centres.

Regardless of the government in power, the aim should be better health of all demographics of the population, not making the books look good now at the cost of future health.

The Queensland government, which was elected to do best for the people, is doing the exact opposite in its approach to savings in the Queensland health budget. By making major cuts to preventative and public health care, it will in the long run lead to a less healthy population which will lead to increased health funds required in the future. A centre where experts were able to care for and track the treatment and spread of TB is a vital part to making Australia free of MDR TB. Relocating care to smaller health centres that are already overwhelmed and do not have the knowledge and skill to deal with this catastrophic disease.

Rebecca Delaile and Luani Barge are year 1 students at the ANU Medical School. This is an paper submitted for their Professionalism and Leadership Course (PAL) paper.



Time to action on junk food advertising directed at children

Yue Yin

Overweight and obesity in children is a major health concern. Around the world, levels of childhood obesity have been rising for a number of reasons including the fact that children are eating more foods that are high in fat and sugars and spending less time on physical activity.

There is growing evidence that food promotion can directly affect children's food preferences, purchases and what they eat. As a consequence, limiting these kinds of advertisement will certainly significantly reduce the consumption of junk food by children and hence greatly increase their potential health conditions. In this article, the potential harm of junk food on children is discussed. Possible actions to restriction of the junk food advertising targeting on children advertising are proposed.

Introduction

A child is considered obese when his or her body weight falls above the 95th percentile of the standard growth charts; anything between the 85th and 95th percentile is considered overweight. In 2007–08, one-quarter of all Australian children or around 600,000 children aged 5–17 years, fell within these parameters. Studies have also shown that once children become obese they are more likely to stay obese into adulthood and have an increased risk of developing both short and long-term health conditions, such as Type 2 diabetes and cardiovascular disease. The link between obesity and the consumption of junk foods has been widely recognised. Further there is growing evidence to show that children are susceptible to what they see on television. Food advertising directly influences childrens' choices and increases their requests for foods that are high in fat, sugar and salt. The article further concluded that children under 12 did not have the cognitive ability to understand the concepts of marketing. In addition, there's no evidence that industry self-regulation works to restrict junk food advertising to children. That's the unsurprising finding of the Australian Communications and Media Authority's (ACMA) long-awaited report, released December 2011. Consequently, it is the time for the government to take action to restrict the food industry and limit their advertising and marketing strategy targeting on children and adolescence.

Fast food, obesity and the outcomes

Nowadays, it is widely known that junk food is harmful to childrens' health, however people are still quite unclear how harmful it can be, in particular, the cardiovascular risk factors in children are still often overlooked. Children hardly ever check the package for what they are eating. Trans fats are notorious for clogging arteries: they deposit on the walls of the arteries and make them narrower. On top of that, when one has large amounts of salt, the blood pressure increases. The heart has to work overtime to push the blood around; gradually the size of the left side of the heart increases, its walls thicken and the arteries which supply it begin to stiffen. Eventually, children become overweight or even obese. Although it is unusual for children or teenagers to have a heart attack or stroke as a result of atherosclerosis – this is because vessel narrowing, caused by atherosclerosis, takes many years to develop, however, the process of atherosclerosis begins in childhood. For most children, atherosclerosis is mild and progresses slowly. In some children, atherosclerosis worsens rapidly, increasing the risk of heart disease, and less commonly, stroke in early adult life.

Obesity not only has a great impact on an individuals' life and family, it also has a considerable social and economic impact. In 2008, the total annual cost of obesity for both children and adults in Australia, including health system costs, productivity and carers costs, was estimated to be around $58 billion.

The linkage between the advertisements on children's choice on foods

These days, children and adolescents have been viewed as a major market force because of their spending power, their purchasing influence, and as future adult consumers. Multiple techniques and channels are used to reach youth, beginning when they are toddlers, to foster brand-building and influence food product purchase behaviour. These food marketing channels include television advertising, in-school marketing, product placements, kids clubs, the internet, toys and products with brand logos. However, foods marketed to children are predominantly high in sugar and fat and less in nutrition.

While multiple factors influence eating behaviours and food choices of youth, one potent force is food advertising. The results of studies on the influence of food advertising on children's food preferences and eating behaviour have shown consistently that children exposed to advertising will choose advertised food products at significantly higher rates than children who were not exposed; findings from food purchase request studies based on surveys, diaries, experimental trials, and direct observation of mother-child pairs shopping have consistently shown that childrens' exposure to food television advertising increases the number of attempts children make to influence food purchases of their parents.

However, children are far from mature enough to understand the persuasive intent of advertising. Children tend to view advertising as fun, entertaining, and unbiased information. Because of their level of cognitive development, children are viewed by many child development researchers as a population vulnerable to misleading advertising. From early adolescence (11-12 years), children's thinking becomes more multidimensional, involving abstract as well as concrete thought. However, adolescents still can be persuaded by the emotive messages of advertising, which play into their developmental concerns related to appearance, self-identity, belonging, and sexuality.

The possible action that government can take

It is evident in Australia that the foods advertised during childrens television viewing times, particularly in popular childrens programs have higher rates of high-fat/high-sugar compared with the foods advertised during adults viewing hours. Studies also showed that there is widespread parental concern about the volume and methods used by the food industry to market unhealthy food to children. As a response, the government should limit the number of advertisements or even put some effort to end this kind of exposure during the peak childrens viewing times and further to have some restrictions on the content of the advertisement. In addition, Australian government may consider introducing a requirement to include health information on junk food advertising straight after the advertisement.

Conclusion

Nutrition during childhood and adolescence is essential for growth and development, health and well-being. Further, eating behaviours established during childhood track into adulthood and contribute to long-term health and chronic disease risk. With one quarter of children facing the problem of overweight and obesity in Australia, there is an ongoing burden of disease on the Australian society. Since childrens eating preferences can be largely influenced by junk foood advertisements, it is time for the government to take action on restricting these advertisements, encouraging healthier eating habits among children thus promoting a healthier and happier society.

Yue Yin is a year 1 student at the ANU Medical School. References are available on request from the author.

Phone Apps: new and coming soon

Free Pathology Tests App launched for patients and doctors

Patients and their doctors can now get up-to-date information about pathology testing on their smart phones whenever and wherever they need it.

Lab Tests Online-AU, the award-winning, not-for-profit website that provides independent information written by pathologists and scientists has just launched a free app for iPhone with versions for Android (Google Play) phones and Amazon Kindle available in the coming weeks.

"Whether you are a patient looking for answers that might reassure you about your health or a medical or health professional seeking quick confirmation of a test, this new app puts the information into the palm of your hand," Lab Tests Online-AU Chair, Professor Leslie Burnett said.

"If a patient has been asked to have a test by their doctor, they or their carer can easily find out what is being tested and why.

"Understanding the biology of their disease or condition can be very reassuring to people. They don't always take in all the information being given to them, especially if they are under stress. They can use Lab Tests Online-AU in their own time."

Professor Burnett said that research had shown that about one third of Lab Tests Online-AU users were doctors and health professionals. Hospital medical officers in particular were especially keen to be able to have the information available on their phones so they could access information while on the wards.

The Lab Tests Online-AU app is easy to use and offers information on hundreds of pathology tests, diseases and clinical conditions and specimen collection and processing, as well a general overview of pathology laboratories, the way they work and the people who work in them.

It has been developed by the Australasian Association of Clinical Biochemists (AACB) with support from the Royal College of Pathologists of Australasia (RCPA). It has been funded under the Quality Use of Pathology Program of the Commonwealth Department of Health and Ageing.

Lab Tests Online-AU: http://www.labtestsonline.org.au/

To download the free app: https://itunes.apple.com/app/lab-tests-online-au/id574299717?ls=1&mt=8

Health facts more accessible with new iPhone app

A new iPhone app, launched by the Australian Institute of Health and Welfare (AIHW) will allow users better access to health information.

The app, OzHealth, presents the latest facts and figures on the health and wellbeing of Australians.

"Information is presented in a 'fact sheet' format, with each page exploring a different topic in simple, easy to understand language," said AIHW spokesperson Alison Verhoeven.

"Topics include: diseases and conditions (such as cancer and asthma), injury, risk factors, health spending, the use of illicit drugs, alcohol and tobacco, as well as an overview of the health of particular population groups, such as children, Indigenous Australians, and people with low incomes."

Users can 'favourite' particular pages, enabling easy access to topics of interest.

OzHealth also includes a detailed glossary, explaining some of the more complex health-related terms used within the app.

'We've aimed to make our statistical information as user-friendly and appealing as possible, to a wide range of Australians,' Ms Verhoeven said.

'We hope OzHealth will be useful to everyone from medical professionals to high school students.'

The app also features an interactive quiz, allowing users to test their knowledge about Australia's health and health system.

'We foresee this quiz as becoming a valuable classroom tool,' Ms Verhoeven said.

The OzHealth app is a valuable companion to the AIHW's biennial Australia's health publications. The most recent edition, Australia's health 2012, was launched by Health Minister Tanya Plibersek in June this year.

'The main publication was accompanied by a free 'in brief' report, providing a simple summary version of some of the key statistics,' Ms Verhoeven said.

'Summary documents like this, and now the OzHealth app, continue AIHW's commitment to timely, accessible health information.'

The AIHW is a major national agency set up by the Australian Government to provide reliable, regular and relevant information and statistics on Australia's health and welfare.

Is your equipment finance as complex as a triple bypass?

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As you well know, running a practice involves balancing a myriad of priorities. Purchasing equipment is high on the list, but it's often devilishly complicated – it takes specialist expertise to put together a simple and cost-effective solution.

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Fixed vs. variable home loan. What's right for you?

Investec

Since 2008 the one consistent message coming out of the financial world is the state of things is not good.

With all this uncertainty people want to lock in competitive rates for their home loans and that probably accounts for the number of enquiries about the relative benefit of fixed or variable rate mortgages. However, according to Trevor Robertson of Investec, it makes a lot of sense for young doctors and dentists to think about a number of things other than interest rate movements in the future—for example, considering their second home when looking to finance their first.

"For example", says Trevor, "choosing a 100 per cent offset loan that allows you to preserve the debt while paying it down is an important tax consideration for the future if you move out of your first home, but hang on to it as an investment property. For a lot of young medical professionals, it's something that's not really on their radar," he explains. "Many young doctors and dentists will buy an apartment as their first home. Often, they'll have a plan to keep it as an investment property, but will find, when they do so, that it causes them a tax problem. If you borrow $400 000 for your first home, then pay down half of it, then buy another property and hang on to your first one as an investment property, you can't claim a tax deduction on it," he explains. "So if you think your first home may be an investment property going forward, what you should do is leave the initial loan at $400k, and accumulate your repayments in a 100 per cent offset account, so the loan amount is the same but you're only paying the interest. You can then use the money accumulated in the offset account to buy the next property."

"Another advantage Investec has is that we are here to support first time buyers", he explains, "We will loan up to 100 per cent mortgages for approved owner-occupiers."

You will also need to consider what type of mortgage is right for you. There are a number of mortgage types including; standard, basic variable, fixed, split or introductory rate, no-deposit loan, interest-only loan, line of credit loans or offset accounts. "Finding the right option depends on your circumstances, lifestyle and financial goals. However Investec can help you navigate the options", Trevor says.

"We are here to help you think about all the possibilities and to assist you in finding the right solution for your particular needs. The reason Investec can help you make the right decision", Trevor says, "is because, we have over 20-odd years experience in working with medical practioners, so we know this market in a deeper way than anyone else". Adds Investec's Lynne Kelly, "There's a real can do attitude here. We know that many medical professionals have no idea about what's available to them and we spend that time and give them the information they need. I think you'll find others don't do that. I think there's a natural passion for what we do and that adds to the experience in dealing with us."

The Personally Controlled Electronic Health Record: Will it live up to its potential?

by Andrea Nicole Rodrigues

On 1 July 2012, the Personally Controlled Electronic Health Record (PCEHR) system was introduced as a $467 million investment into e-health by the Labor Government.

The PCEHR has been implemented in twelve lead sites throughout Australia and Australians are now able to register for their own PCEHR through the Department of Health and Ageing's e-health website. As one of the recommendations made by the National Health and Hospitals Reform Commission (NHHRC) Final Report, the PCEHR has been lauded as an important step in bringing healthcare in Australia into the age of information technology to improve healthcare delivery and patient safety.

What is a PCEHR?

The PCEHR is a shared summary health record which may be accessed remotely by various healthcare providers and is designed to complement existing clinical records stored in various primary care practices or hospitals. The PCEHR will not contain a patient's full medical record; instead, will comprise salient aspects of a patient's medical history, including medications, immunisations, allergies, adverse drug reactions, pathology results and letters from various healthcare providers, encapsulated in a Shared Health Summary. The PCEHR will also contain Event Summaries submitted by healthcare providers to communicate episodes of care, which capture "key health information about significant health events" that relate to ongoing care of the individual.

Potential benefits

The PCEHR, as described by the National E-Health Transition Authority (NEHTA) and NHHRC, will place patients at the core of the healthcare process and enable them to gain better access to their own health information to facilitate more informed decision-making, especially in the self-management of stable chronic conditions, and therefore lead to better clinical outcomes. Potential benefits stated by patients include having more control over their own care and the prevention of medical errors.

Continued page 18

Retiring AMSA president, James Churchill, writes on the year that was

As Australia's medical students head into exams and the holiday season, the AMSA National Executive has a chance to look back on the year that has been. Without a doubt, medical students have had a roller coaster of a year and, along the way, AMSA has had its hands full with a number of the 'big issues' in medical education.

The storyline of 2012 has been dominated by the internships crisis, with a significant rise in the number of graduates of Australian medical schools and the alarming prospect, flagged from a very early stage, of a shortfall of hundreds of places.

After a hard fought campaign, building upon the efforts of past Executive teams, a series of significant breakthroughs were won at crucial times, with a number of State Governments working constructively with the Federal Government to significantly expand the number of internships for this year's graduating cohort.

The latest of these breakthroughs has been the announcement of 116 new internship places, in public and private settings around Australia, funded jointly by State and Federal Governments. Not insignificantly, as part of this deal, the ACT has committed to providing 15 additional internships, expanding its capacity through innovative new models for pre-vocational training.

While this last-minute deal is a step in the right direction, and clearly a relief for those graduates who may now stay to serve Australia's health needs, it's clear that this is not the end of the problem. Long-term solutions and better coordination of the entire medical training pipeline are desperately needed to avert a looming medical training crisis.

With the release of Health Workforce Australia's Health Workforce 2025 report series earlier this year, health bureaucracies for the first time have robust data to support nationally-coordinated medical workforce planning.

The data clearly indicates that significant challenges await in future years, as the current cohorts of medical students and interns proceed to further training. The current question is whether HWA's new National Medical Training Network will be the mechanism to unify stakeholders in their collective action towards the common goal of a sustainable medical workforce.

This is perhaps the area in which AMSA most appreciates working closely with the AMA, particularly its Council of Doctors in Training.

On the backdrop of this training crisis, it has been reassuring to have had comments from Health Minister Tanya Plibersek and Minister for Tertiary Education, Chris Evans, indicating that new medical schools would be difficult for the Federal Government to support at this time. No doubt those Universities pursuing new medical schools will continue to lobby heavily in the new year.

This year is likely to be significant for the Department of Health and Ageing's major review of medical workforce programs. Students have long held concerns about the current array of rurally-focussed workforce programs, including the Bonded Medical Places scheme and the '10 Year Moratorium', and have repeatedly called for greater focus on positive initiatives such as expanding capacity for rural and regional training (at all levels) and recruitment of rural-origin students.

Shifting from health workforce to medical education, AMSA has appreciated the opportunity to provide detailed feedback on proposed changes to the standards by which medical schools are accredited by the Australian Medical Council.

The standards are a significant driver medical curricula in Australian universities, and have been reviewed in 2012 in response to a rapidly changing health system environments and contexts of medical education.

Whilst it's critical for medical schools to maintain quality experiences in the core medical and clinical sciences, medical students may soon see a much greater focus on learning and teaching for education of the 21st century medical professional.

Advocacy on the 'big issues' is a significant focus of the AMSA National Executive, but students will also look back on another set of highly successful AMSA events: the 53rd National Convention in Perth, the first Global Health Conference in a regional location, Cairns, and the continuation of AMSA's flagship event, the National Leadership Development Seminar in Canberra.

While it seems like only yesterday that the wonderful Victorian team, of which I am a part, took up its role as National Executive, we soon pass the reins to a team from New South Wales, full of energy for another dynamic and exciting year for AMSA.

With a federal election presumably just around the corner, a broader medical training crisis looming and the further development of a new paradigm of funding for teaching, training and research, there'll certainly be much to do in 2013!

Incoming AMSA president, Ben Veness, looks to the year ahead

If you would like to see what a surprised doctor looks like, answer "Accounting." when she asks you (a medical student), "What was your first degree?"

Works every time.

In other ways, too, accounting is finding its way into medicine. Activity-based funding is a good example, being a derivative of the 'activity-based costing' concept that dates as early as 1919, the year Dexter S. Kimball, a Cornell dean of engineering, published 'Cost Finding'.

Unfortunately, our industry of medicine doesn't lend itself as easily to accounting concepts as Kimball's engineering one does. Standardisation is more difficult, and returns on investment are problematic to calculate. What value an Australian-trained graduate over an international medical graduate (IMG), for example?

This is what the current internships crisis boils down to. On the one hand we've under-funded our medical schools and forced them to cross-subsidise my education from a melange of the profits of the engineering faculty and the $60,000 per annum fees of international medical students – and then denied many of these students an internship. On the other, we've welcomed IMGs into districts of workforce shortage.

In a rather unfortunate way, these two hands are shaking for Sana Jesudason, a young woman graduating in New South Wales next year. A 'third culture kid', born to Indian parents in Ireland but raised in Canada, Malaysia and Brunei, and now living in Australia (Taree, no less), Sana is an international medical student. The interesting intersection in her case is that both her parents are IMGs, practicing here as specialists in a district of workforce shortage. Sana wants to be a rural general practitioner, and one of AMSA's priorities in 2013 will be helping her to get there, starting with an internship.

Her poignant story, and others, is profiled on http://interncrisis.org, a website set up by medical students in association with a potent #interncrisis Twitter campaign. Sad enough because of the impact the internships crisis has on them as individuals, their stories are devastating when the lost opportunity for our medical workforce is considered.

Some politicians are starting to get it, with recent supportive speeches in the Senate by Senator Fiona Nash (Nationals) and in the New South Wales Legislative Assembly by Dr Andrew McDonald (Labor), but it's clear that a wider education campaign is required.

In my role as student Councillor of the AMA (NSW), I've been involved in such a campaign this year, in which we've encouraged medical students to buddy up with a senior doctor and meet with their local MP. The AMA has helped to coordinate these visits and wrote a two-page briefing document to prepare the student and doctor, and to leave with the MP. So far, the two most recurrent lessons have been the lack of knowledge of MPs (which says something about how the health ministers have been handling the internships crisis) and the value of having a supportive senior doctor present. AMSA would like to expand this campaign tactic nationally for key issues in 2013.

Fast becoming a frequent flyer, the internships crisis is likely to re-present next year. I really wish it wouldn't, though, as it pains me to spend so much time and effort working to solve a problem that was entirely preventable.

There are lots of other things we want to work on, like waking the whole tertiary education sector up to the need to care about their students' mental health.

We also have another set of amazing events to convene for our students, with the 54th National Convention coming to the Gold Coast, the Global Health Conference returning to Hobart, and the National Leadership Development Seminar in Canberra moving to the first half of the year. New for 2013 will be a National Policy Conference to provide greater opportunity for medical students to engage with, and shape, our policy agenda.

It takes us four, five, or six, years to complete medical school. Last decade, a Coalition federal government, with the States' support, wisely chose to train more doctors by opening new medical schools. Both levels of government now need to work together to plan for the long run, and finish the job, so that we can start doing ours. Trust me, you don't need an accountant to add it up.

Benjamin Veness is President-elect of the Australian Medical Students' Association. He is currently in third-year at Sydney Medical School; his first degree was in accounting.

Canberra first – world leading MRI machine launched in ACT

ACT Chief Minister and Minister for Health, Katy Gallagher, recently launched Canberra Imaging Group's (CIG) newest MRI giving Canberrans and their doctors access to one of the world's most advanced MRIs, the Skyra 3T.

Installed in CIG's Deakin clinic at a cost of around $2.4 million, the Skyra 3T:

- is the first of its kind in the ACT
- enhances health outcomes by supporting greater accuracy and confidence in diagnosis
- enables breast MRI and non invasive prostate imaging, and
- has been granted Medicare eligibility for a range of GP and specialist-referred services.

Speaking at the launch, the Chief Minister said the new MRI was a welcome addition to the regions' healthcare services.

"It's a clear demonstration of the important and complementary role played by public and private health providers in delivering quality health outcomes for our community," the Chief Minister said.

The introduction of two new services—non invasive prostate imaging and 3T breast MRI—have been welcomed by the medical community.

"The Skyra enhances comfort and health outcomes for prostate patients by delivering improved imaging without utilising endorectal coil technology," CIG Chairman and radiologist Dr Raymond Kuan explained.

"3T breast MRI gives greater confidence in diagnosis, allowing doctors to more effectively manage their patients' disease and reduce the potential for unnecessary procedures."

The granting of partial Medicare eligibility to the Skyra means many services are now more accessible and affordable for patients.

GPs can directly refer children under 16 years for Medicare-funded MRI scans for defined clinical indications including head, spine, knee, hip, elbow and wrist—this will expand to adults in November 2013.

Specialist referrals for certain breast cancer examinations and the staging of rectal and cervical cancers and patients impacted by PIP breast implants are also covered under Medicare.

CIG is the largest independent and wholly doctor-owned, imaging group servicing the ACT and southern NSW region.

The launch of the Skyra 3T is part of CIG's long term and ongoing investment and commitment to deliver the highest quality services to Canberra and the surrounding regions.

About the SKYRA 3T MRI

The Siemens Skyra 3T MRI is one of the world's most advanced MRIs. It:

- has a greatly increased signal to noise capability and higher resolution allowing improved scanning techniques
- supports greater accuracy and confidence in diagnosis
- offers improved and non invasive prostate imaging
- enables breast MRI
- offers greater patient comfort with a wide open bore, and
- can accommodate patients weighing up to 250kgs.

Funded under Medicare

Medicare eligibility has been granted to the Skyra 3T for a range of clinical indications:

- GPs are able to directly refer children under 16 years for Medicare-funded MRI scans for defined indications including head, spine, knee, hip, elbow and wrist – this will expand to adults in November 2013.
- Specialist referrals for certain breast cancers examinations and the staging of rectal and cervical cancers and patients impacted by PIP breast implants are also covered under Medicare.

Items funded under Medicare
Specialist referrals: 63464, 63467, 63470, 63473, 63476
GP referrals: 63507, 63510, 63513, 63516, 63519, 63522
PIP implants: 63501, 63502, 63504, 63505

About Canberra Imaging Group

Canberra Imaging Group, the largest private diagnostic imaging service in the Australian Capital Territory and southern New South, is locally owned and operated by radiologists and nuclear medicine physicians who work daily in the practice.

CIG has a commitment to imaging and service excellence and invests heavily in its facilities and staff to ensure it provides high quality comprehensive diagnostic imaging services across its multiple sites. Three of CIG's sites are located on the major hospital campuses of Calvary Hospital, The Canberra Hospital and Calvary John James Hospital. CIG services include:

X-Ray
CT & Cardiac CT
Bone mineral densitometry
Therapeutic intervention
Ultrasound
Angiography
Dental X- Ray
Biopsy
MRI
Mammography
Consultations
Nuclear Medicine

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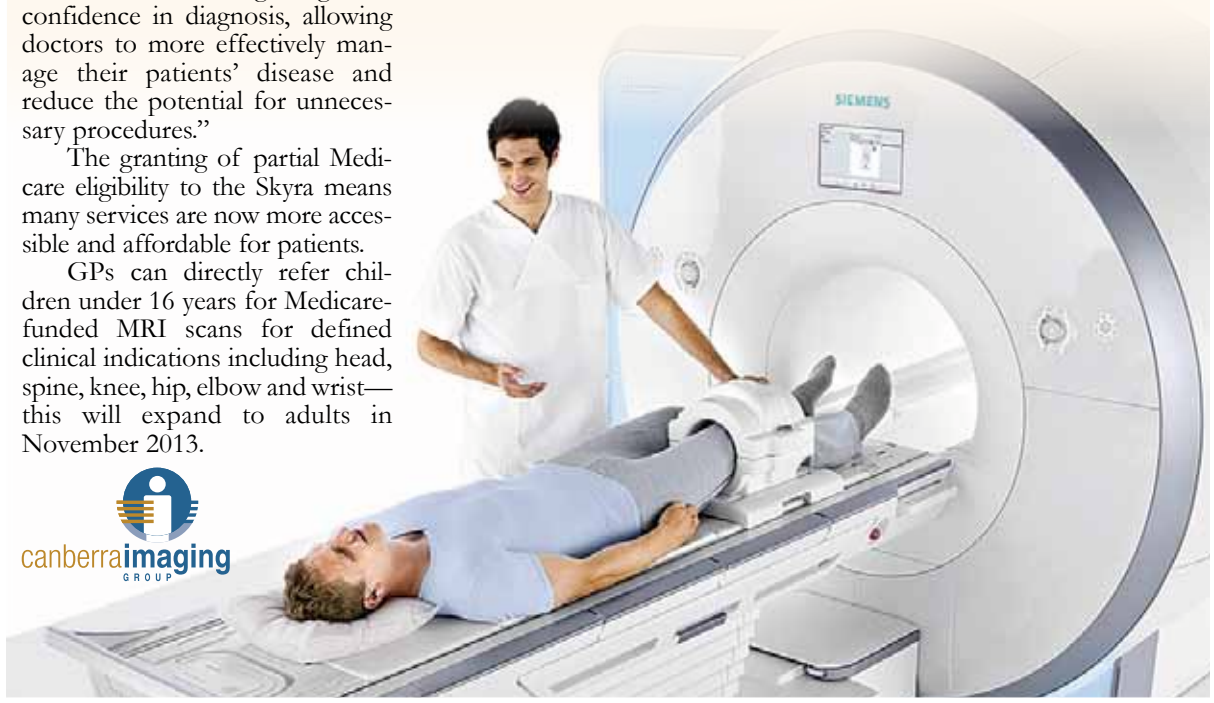

canberraimaging GROUP

Further progress on intern places but big states still holding out

The AMA welcomed the announcement from Health Minister, Tanya Plibersek, that Queensland and the Northern Territory have joined Western Australia and the Australian Capital Territory in reaching agreement with the Commonwealth to fund medical intern places in public and private hospitals.

This brings the total number of additional funded intern places for 2013 to 116 – 84 from the Commonwealth and 32 from the participating States and Territories.

AMA President, Dr Steve Hambleton, said that while the progress to date is very encouraging the career prospects of 64 medical graduates remain in limbo.

"The bigger States have to enter into the spirit of cooperation shown by the other governments and do their bit to fund the nation's future medical workforce," Dr Hambleton said.

"This is not the time for the blame game or political point scoring – it is the time for action and doing the right thing."

The current breakdown is:

- **Queensland:** 40 Commonwealth places, 18 State places
- **Western Australia:** 32 Commonwealth places, 8 State places
- **ACT:** 10 Commonwealth places, 5 Territory places
- **NT:** 2 Commonwealth places, 1 Territory place

Educational Snippet! from Dr Ray Cook

Dr. Suzanne M. de la Monte of Brown University, Rhode Island recently presented to medical officers at the Therapeutic Goods Administration on the concept of Alzheimer's Disease being a primary neurodegeneration with a form of diabetes (Type 3) with brain insulin deficiency and insulin resistance.

She argued on a background of genetic susceptibility that a high fat diet (or other causes of Steatohepatitis) produces modest brain atrophy, and insulin resistance that was likely mediated by ceramides generated in liver or adipose tissue. Ceramides cross the blood-brain barrier and have neurotoxic effects including insulin resistance and Alzheimer's Disease type neurodegeneration.

N-Nitrosodiethylamine (NDEA) (think processed foods, tobacco, water) also causes brain and retinal degeneration with insulin resistance.

In models the effects of high fat diet and NDEA were additive.

A prick in time, saves nine

Lewis Tsang, Haoming Zhou and Christina Unger

Should childhood immunisation be mandatory for enrolment into state primary schools?

When the phrase "herd immunisation" is thrown into public space, the majority think of livestock or farming, switching off almost instantaneously. In medical terms, this is the concept of a population's immunity to an infection, whereby the whole population, or "herd", is protected. Central to this idea is vaccination. Vaccination has proven to be one of the single most successful preventative interventions in medicine. In light of the scientific and historical evidence, it seems obvious that it is advantageous for everyone to be vaccinated. This notion is not however obvious to all, with some members of the Australian population declining to have their children vaccinated. One possible barrier to this is a misunderstanding of how vaccines work, and a misconception contradictory to scientific evidence that they are actually detrimental to health. This belief and lack of understanding could be behind parents' refusal to have their child immunised. How can both a child and the wider community be protected from the increased risk of infection and disease that stem from this misconception? Can the law provide this protection and how do ethics and human rights play a role in this debate?

Whilst there is slight variation in legislation between the states and territories of Australia, immunisation remains non-mandatory for enrolment into primary schools. Upon enrolment, the request for the vaccination status of each child applicant can be requested under the Public Health Regulations Act; however the parents have the right to "conscientiously object" to immunisation. This means that the children without an immunisation history statement will not be prevented from enrolling in and attending school. Conscientious objection allows for exemption on basis of medical, religious or philosophical reasons. Ultimately, this clause in the legislation results in mitigation of the state's right to require vaccinations, in the interest of public health. This provides a definite risk to not only an individual child, but also the other children and the wider community. This is due to the fact that the non-vaccinated children are prone to contracting infections like mumps, thus becoming reservoirs of infection and potentially the source of an outbreak of disease.

There are also various ethical issues that need to be considered when implementing a mandatory immunisation program. The four ethical principles outlined by Beauchamp and Childress need to be addressed. Of course, people will argue over the violation of patient autonomy and that a child should have the right to choose to turn down vaccinations. However, because they are too young to make such judgements, it is their parents or guardians that will make the decisions. Consequently, their beliefs are thrust upon their child, rendering this perception of patient autonomy moot. In terms of beneficence, immunising patients has been shown to be beneficial, priming their immune systems to prevent future infections. The ultimate goal is to protect the child as they come in contact with various exposures; ergo one could argue that by not vaccinating, we are doing them more harm, as their risk of contracting various infectious diseases are substantially higher. Some prime examples are pertussis and diphtheria, which are not normally seen in immunised children. Finally, the argument for equality and justice in this case is that each child deserves the right and opportunity to receive prophylactic treatment. Therefore it can be argued that ethically it would be remiss for the government and public health system to not introduce mandatory vaccinations.

On face value, it appears that the vaccination of children without consent is a direct violation of human rights; opposing article 1 of the Universal Declaration of Human Rights (UDHR) and the ACT Human Rights Act, both stressing the need for consent to medical treatment. However, as a child is legally unable to give consent for medical treatment, it is obtained from the next of kin. But who is to say that parents and guardians are making the right choices on behalf of their children? In accordance with article 18 of the International Covenant on Civil and Political Rights (ICCPR), everyone is entitled to have freedom of thought. This means that without mandatory

childhood vaccination, a child in the community with parents who irrationally oppose vaccination, even in light of the abundance of scientific evidence to the contrary, are left vulnerable to a number of serious and in some cases life threatening diseases. This is a huge violation of the child's right to the best possible standard of health, as clearly stated in article 25 of the UDHR, article 12 of the ICCPR, and article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). Fortunately the ICCPR has placed some limitations upon the right to freedom of thought; one of which is the protection of health and fundamental rights of others. This means that when we are contemplating mandatory vaccination, it is imperative that we consider the right of the child to the best possible standard of health, and the wider community that the unvaccinated child would be putting at risk. This may result in some of the rights of the parent or guardian to be dishonoured.

Parents mean well. We have all known this for a very long time. Whether it be because we ourselves are parents or we have seen how our parents act when we are in danger. The fear of vaccinations is not because they don't want the best for their child. Rather, it is because of a misunderstanding of vaccinations and their benefits. Simply put, it is this ignorance that breeds misconception, ultimately jeopardising the safety of the whole population. Legally, we cannot force parents to vaccinate their child, when ethically it seems like the right thing to do. Perhaps a solution to the problem is to educate parents who have indicated that they do not want their child vaccinated. This in combination with mandatory vaccinations for children entering primary school may be the way forward.

Lewis Tsang, Haoming Zhuo and Christina Unger are year 1 students at the ANU Medical School. This is an edited version of their Professionalism and Leadership Course (PAL) paper. The full text and references are available from the authors on request.

PCEHR...*continued*

From page 15

For healthcare providers, it facilitates effective interdisciplinary care for complex medical problems and chronic disease, especially important in the current ageing population where poor coordination of care between multiple healthcare practitioners has been associated with a higher number of patient-reported medical and medication errors. In a 2009-2010 Australian survey, the potential benefit of the PCEHR most frequently reported by healthcare providers was the ability to provide holistic care for their patients using the most up to date information regarding current diagnoses, medication lists and known allergies.

The PCEHR will also reduce the burden on the health sector and finite health budget by reducing duplication of investigations, visits and procedures.

Problems that have emerged

Issues relating to privacy, security and confidentiality have been at the forefront of the debate against the PCEHR. Patients have expressed concern regarding the exploitation of health data by third parties including hackers, insurance and pharmaceutical companies, government agencies and employers and for this reason, may be reluctant to disclose sensitive information that could be crucial to their management. Patients and healthcare providers alike have reported that they would only be willing to participate in an electronic health record system if the privacy and confidentiality of the health data could be ensured through stringent security measures.

Patients are able to limit access to specific documents within their PCEHR thereby removing it from view by certain or all healthcare providers, even in an emergency, which can hamper effective decision-making on the part of the clinician. Healthcare providers and patients have identified the accuracy of the information contained in the PCEHR as a potential issue in its use in practice and clinicians have stated that this uncertainty would discourage them from relying on the PCEHR for vital information.

Also raised are issues of clinical governance relating to incorrect recording or importation of medication and allergy information from various data sources which could lead to patient harm. As yet, there are no risk management systems in place for detecting informational errors besides clinician vigilance.

The current opt-in system means that healthcare providers will often not find a PCEHR for their patient if they search for one. As of October 17, 2012, only just over 13,000 Australians had registered for a PCEHR. Conversely, the lack of health provider participation will limit the registration for PCEHRs and its use by patients who have one. In addition, the patients most likely to benefit from a PCEHR, namely elderly patients with complex or chronic health conditions may not have the computer literacy to actively register for and manage their own PCEHR to the extent that current proposals require them to. Disparities in access to the internet, broadband technologies, health literacy and cognitive skills may also limit certain population groups such as those living in rural or remote areas or those from lower educational backgrounds from participating fully in the PCEHR system, creating additional inequality in health outcomes.

In a survey of Australian Medical Association members, almost 80% of respondents were concerned about the administrative and financial implications of the PCEHR. The PCEHR will likely create additional work for healthcare providers who will be required to write event summaries of each episode of care to include in the PCEHR and generate a summary from the various pieces of information in a PCEHR to keep the record consistent and up-to-date. The PCEHR will also generate additional workflow in hospitals where medical practitioners already report limited access to computer terminals and place extra stress on junior doctors who will likely bear the bulk of the extra workload.

In conclusion

The PCEHR is one of the first steps towards coordinating the currently disjointed health service in Australia. It has the potential to improve continuity of care, reduce incidence of adverse events and ultimately produce better patient health outcomes. However, one of the greatest limitations to its utility will be its uptake by the Australian public and healthcare providers. Ensuring adequate security of healthcare information will be paramount in encouraging patient opt-in and participation by healthcare providers. It will be interesting to observe how the PCEHR system progresses in the coming years and whether it will live up to its potential to become a ubiquitous tool of practice in Australia.

Andrea Rodrigues is a year 2 student at the ANU Medical School. This is an edited version of her Professionalism and Leadership Course (PAL) paper. The full text and references are available from the author on request.

The Pharmaceutical Benefits Scheme, is it what Australia Needs?

Wasif Rashed Mirza

The estimated population of Australia is growing and like many developed countries the population is ageing.

This has resulted in an increased prevalence of chronic illnesses, and hence pharmaceutical expenditure and therefore an increased need to evaluate the current pharmaceutical system in Australia.

The Australian Pharmaceutical System

The Organization for Economic Co-Operation and Development (OECD) countries' pharmaceutical policies generally focus on three main objectives: making medicines accessible and affordable to patients, containing public spending growth, and providing incentives for future innovation. Like most OECD countries outpatient medicines are predominantly funded by public schemes via taxation, with private insurance schemes only playing a minor role.

In Australia, the Pharmaceutical Benefits Scheme (PBS) subsidises many of the medicines available in Australia. The Pharmaceutical Benefits Advisory Committee (PBAC) makes recommendations based on efficacy and cost effectiveness and The Pharmaceutical Benefits Pricing Authority (PBPA) then negotiates the price with the respective pharmaceutical company. Once an agreement is reached regarding the terms and the price, the Australian government then makes the decision whether it will be listed on the PBS. Co- payments are AUD $34.20 or AUD $5.60 for pensioners and concession patients. For patients who have high medicine needs, the government offers a Safety Net Scheme to help reduce their costs. Once a patient or their immediate family has surpassed a general safety net of AUD $1,317.20 (or AUD $336.00 for Concessional Safety Net) in a given year, they are eligible to receive their prescriptions for the remainder of that year at concession price or for free (for Concessional Safety Net). This reduces the burden of medication costs on the individual and ensures adequate access, thereby reducing socio-economic disparity.

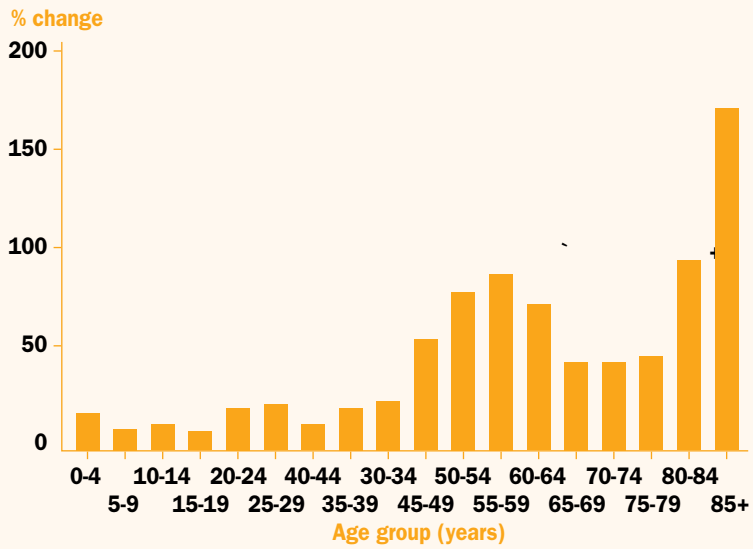

Figure 1: Population Change by age group in the ten year period between 1991 and 2011

Australian Bureau of Statistics. Regional Population Growth Australia. 2011 [cited 10 Oct 2012];

In stark contrast however the United States implements a fundamentally different system in which there is no significant public funding for pharmaceuticals. The United States is considered a free market economy where the pharmaceutical companies, wholesalers and retailers are able to set their own prices for pharmaceuticals. This reduces the availability of medicine to patients who come from a lower socioeconomic background, who are at an increased risk of illness and therefore require more access to essential medicines.

Effect of The PBS on the Expenditure and Utilisation of Medicine.

There has been debate as to whether or not having a publicly funded pharmaceutical system in fact reduces pharmaceutical expenditure, and whether it results in inadequate utilisation of medicine.

In the past the pharmaceutical spending has risen faster than the rate of total health expenditure in developed countries, which lead to the implementation of cost effectiveness analysis as a requirement for new medication. In countries where pharmaceuticals are predominantly funded by private insurance, the insurance providers do not have the leverage to negotiate low prices for pharmaceuticals to the same extent as the PBPA, which can in fact restrict the medication from entering the Australian market unless a satisfactory price is negotiated. In addition to this, some evidence shows that the increase in administration costs of insurance providers contribute almost twice the cost of medications to the expenditure.

Some advocates of the free market system have argued that a public pharmaceutical scheme prevents access to some high cost highly specialised medicines at an individual patient level and therefore an increased potential for less effective treatment with older therapies. However evidence suggests that health outcome are comparable to other developed countries, which have a greater access to high cost and highly specialised medicines. There have also been several arguments stating that a publicly funded system may lead to overuse of unrequired medications, therefore leading to increased expenditure. Studies have shown that implementing a system where there is a small co-payment such as that in Australia can lead to increased accessibility to necessary medicines, while still creating cost-conscious patients, thereby reducing the utilisation of unnecessary medicine simultaneously. Alternatively privatised systems allow the burden of the cost to fall disproportionately to the working poor, the unemployed, and those in small businesses.

The Effect of the Trans-Pacific Partnership Agreement on the Australian Pharmaceutical System

The Trans-Pacific Partnership Agreement (TPP) is the government's highest regional trade negotiation priority. The Australian Government is pursuing TPP outcome that eliminates or at least substantially reduces barriers to trade and investment. This agreement however is believed to establish international norms on pricing regulations for pharmaceuticals, which will lead to an increased availability of new pharmaceuticals in Australia. However the addition of a free trade agreement, if accepted with the United States provisions, may result in an increase in the cost of pharmaceuticals and limit the generic market, and hinder the ability of the current pharmaceutical system to reduce costs to patients.

Conclusion

The Australian pharmaceutical system implements a utilitarian approach in the utilisation of healthcare and therefore benefits the population as a whole. Similar systems in other countries such as New Zealand, and the United Kingdom have shown that this is in fact the best approach to providing adequate access to healthcare. It is therefore important that the current system is maintained despite other interests such as trade agreements. Efforts instead should be taken to improve the current system and ensure its sustainability and effectiveness in the future.

Wasif Mirza, BPharm (Hons) is a year 1 student at the ANU Medical School.

References are available on request from the author.

Diluting the deception: The NHMRC shakes up homeopathy

Emily Rushton, Ben Verstandig

The National Health and Medical Research Council (NHMRC) Strategic Plan 2010-12 identifies the provision of research funding for alternative medicines, particularly homeopathy, as an area requiring reform.

The NHMRC Homeopathy Working Committee is in the process of identification and evaluation of the available evidence on the efficacy of homeopathic treatments. In June 2013, the findings of this review will be released as guidelines to health professionals on recommending these treatments with patients, as well as a position statement to the public on the efficacy of these treatments. Of particular concern is the growing trend of patients with serious conditions delaying treatment with evidence-based medicines in favor of first using homeopathic remedies.

Homeopathy is a branch of alternative medicine founded in the late 18th century by the German physician Samuel Hahnemann.The practice itself is based on the principle that 'like-cures-like' if administered in small enough doses. Commonly sold in Britain for instance are 6C and 30C dilutions, with 30C being both considerably more dilute (1 in 100). It is pertinent to outline here that these substances are so dilute that they are statistically unlikely to contain even a single molecule of the original substance. Professional homeopathic associations have made tenuous links to the writings of historic figures such as Hippocrates and Paracelsus, in order to validate this concept. Homeopathy is claimed to be able to treat a diverse range of conditions, from psychological problems, to chronic disease, to allergy, and is purported to have a use in a trauma setting.

Homeopathy has always been a self-regulated industry in Australia, currently controlled by the Australian Homeopathy Association (AHA). The AHA maintains the Australian Register of Homeopaths (AROH), and practitioners are required to be on this register to attract a private health fund rebate for their services. The regulation of homeopathic preparations however is fraught with loopholes. Preparations are required to be registered with the Therapeutic Goods Administration (TGA) only if dilution is less than or equal to 1000 fold dilution, or contains discernible quantities of ingredients of human or animal origin. Very few preparations fit into this definition, as most are either more highly diluted or do not contain detectable amounts of the 'active' substance. There are currently no homeopathic preparations with proven efficacy registered with the TGA, and all listed preparations that are marketed to the public with claims of efficacy are required to be labeled with the disclaimer 'Homeopathic product without approved therapeutic indications'. The AHA list their 'approved' suppliers of homeopathic preparations on their website, with most publically available preparations sold through pharmacies and health foods shops. The AHA emphasize that remedies made to prescription are available directly from homeopaths, however there is no publicly available regulatory information of what is able to be used in custom preparations.

Early in the NHMRC review process, a document alleged to be the committee's draft position statement on homeopathy was leaked and subsequently published by The Age newspaper. The leaked document stated that the NHMRCs position would be that "it is unethical for health practitioners to treat patients using homeopathy, for the reason that homeopathy (as a medicine or procedure) has been shown not to be efficacious". This tenet echoes the finding of a UK House of Commons investigation into homeopathy, which recommended that funding of homeopathy through the NHS should not continue on the grounds that the government does not endorse homeopathy as an efficacious system of medicine. The report further labels the central dogma of homeopathy – the principle of like-cures-like – theoretically weak, and dismisses the practice of ultra-dilution as scientifically implausible. The coverage of the leaked NHMRC document in The Age coincided with an article in the Journal of Law and Medicine regarding a number of recent deaths attributed to delaying conventional medical treatments in favor of homeopathy.

Multiple systematic reviews (some funded by the NHMRC) have shown that randomised control trials that are of acceptable methodological quality according to Australian standards do not show any value of the homeopathic drugs over placebo. Homeopaths argue that the RCT model is not suitable to the intrinsically individual nature of their therapy, and that this is the reason behind consistent failure to find benefit. However, it is questionable whether homeopathy should be exempt from the same level of scrutiny as conventional drugs. The findings of the NHMRC Homeopathy Working committee should have significant repercussions on the allocation of research funding, and also on the coverage policies of private health insurers

Emily Rushton and Ben Verstandig are year 1 students at the ANU Medical School. This is an edited version of their Professionalism and Leadership Course (PAL) paper. The full text and references are available from the authors on request.

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Disabled competition: Plough through the world of divided sport

by Aicee Dawn Calma and Alexandru Colibaba

Often our society is not very accommodating of illness and disability and hence affected people feel stigmatised as a result of our behaviour. A lot of the misconception stems from the lack of understanding of the nature of disabilities. Disability is a complex phenomenon which encompasses impairments, activity restrictions and participation restrictions that overall affect an individual's quality of life. In Australia, there are various laws that protect disabled individuals from discrimination and harassment. The *Anti-discrimination Act 1992* promotes the rights of people with disabilities and protects everyone against discrimination based on disability. There are also programs implemented that focus on providing opportunities, and assisting disabled individuals in forming networks and in participating in all realms of life. This approach shows a positive attitude towards being aware of everyone's human rights. After all, as stated in the Universal Declaration of Human Rights: "All human beings are born free and equal in dignity and rights".

Likewise, there are also proactive measures implemented on a global scale. It is a well-known fact that playing sports can be a challenging task even to those without disabilities. The Paralympic Games – which were designed for various athletes with physical and intellectual impairment – have grown to be a major sporting event since 1948. These athletes can be selected by a method which is reasonable on the basis of their relevant skills. In 2012, the London Paralympic Games involved 4269 athletes competing from 106 countries. Designed with equality for the wide range of disabilities among participating athletes, the International Paralympic Committee employs a system of classifying athletes based on the nature and severity of their impairment.

However, the classification system has been constantly evolving and has shifted its focus from the impairment itself to the players' abilities. Athletes have to undergo rigorous assessment before being allowed to compete and are assigned a sports class status. Despite the best efforts of the IPC to classify and regulate the competition classes, the wide range of impairments makes it a difficult, if not an impossible task – creating a lot of controversies revolving around the fairness of the system. There have been numerous examples where changes in classification have had dramatic impacts. An example would be the case of Rebecca Chin, who was disqualified in the 2008 Beijing games for being 'not disabled enough' for discus throwing. This illustrates the

complex nature of physical impairments, as well as the possibility of creating injustice within the sports classification. In a broader sense, this also serves as a metaphor which highlights that there is still an invisible barrier between able-bodied and impaired individuals.

The Paralympics as a metaphor of social injustice

Alongside inequalities arising from the inherently complicated classification system, there are also issues concerning athletes that have already been appropriately allocated to classifications. These issues arise from different levels of access to sporting equipment essential to allow them to compete. For instance, the cost of above the knee prosthetics, running blades and specialised bicycles and wheelchairs can be in the range of thousands of dollars. Added to these are the fitting of the prosthetics and maintenance costs that must be considered with the strenuous demands of the competition. Consequently, the overall performance of the athletes depends on the quality of their prosthetic devices. Moreover, further research is crucial in keeping up with the competition – adding further cost. Taking all these factors into consideration, adequate funding for participating in competitions is not a trivial pursuit, but a question of great importance. Athletes from different countries have access to different levels of funding. Given that training and access to prosthetic devices relies on allocated budget, the differences in funding available can potentially lead to an uneven competitive field

What is not apparent in this major sporting event is how it highlights the need for immediate action towards promoting equality in the global society. For the 2012 London Paralympics, the Australian Government has provided funding for high performance programs as well as funding support for broadcast of the event. Elite athletes with disabilities have access to the Australian Institute of Sport facilities. Other commissions projects have also been conducted which are targeted towards educating, training and supporting sport and physical activities for people with disabilities. Meanwhile, on the other end of the spectrum, countries such as Ghana, with economic difficulties and without effective disability policies have been denied the opportunity of participating in disabled sports. Funding differences directly lead to different levels of access and leading to a failure in attaining an equal opportunity goal.

These differences raise further ethical questions, particularly in countries with limited resources. Firstly, should therapeutic enhancement technologies be used to actively help "shift" the normal standards that overlook not only disabled athletes, but also the disabled population as a whole, to one of acceptance to satisfy the principle of beneficence? Secondly, if this is the case, should the allocation of resources for the disabled be moved towards actively promoting capabilities beyond that of an able-bodied individual – as shown in the Paralympic Games? Is there injustice in the overall distribution of benefits and burdens in some countries?

The impacts of this imbalance can also be subtle yet tremendous. Developed countries are able to make international heroes and heroines from their Paralympic players – which in turn promotes social acceptance of the disabled community as a whole. On the other hand, disabled communities in underdeveloped countries are still considered outcasts and burdens in the society.

The recently concluded Paralympic Games in London has left us another subtle yet powerful message that unfortunately, a lot of us will tend to overlook: improving the quality of life of disabled people is not just a matter of providing mechanical aid and therapeutic devices – and this does not only apply in athletics. Promoting equality is an active pursuit that requires cooperation between the government and the society. Economic hardships may be a great obstacle but through effective political reforms, positive outcomes can be achieved – such as raising awareness about everyone's human rights and changing our attitude towards disability. Policies, such as outlined in the *Disability Discrimination Act 1992,* must encourage the general population have positive attitudes towards the disabled community as well as getting them involved in community-based activities. With these laws put into action, a global shift towards unity and equality can be achieved.

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SPF50+ sunscreens set to hit shelves this Summer

Cancer Council says protection only 'marginally better'

A new standard allowing manufacturers to increase the sun protection factor in sunscreens from SPF30+ to SPF50+ and adding improved UVA protection was announced recently by the Therapeutic Goods Administration (TGA). The change is supported by Cancer Council Australia.

The new standard, developed by Standards Australia and Standards New Zealand, is likely to see SPF50+ sunscreens on pharmacy and supermarket shelves by around mid-January.

Chair of Cancer Council Australia's Skin Cancer Committee, Terry Slevin, welcomed the new standard, but warned consumers not to overestimate the new level of protection.

"Despite the big difference in SPF numbers on the label, in fact the new SPF50+ sunscreen offers marginally better protection from UVB radiation, which causes sunburn and adds to skin cancer risk," he said.

"SPF50+ filters out 98% of UVB radiation compared to 96.7% blocked by SPF30. It's not a suit of armour; it needs to be applied just as generously, reapplied every two hours, and used in conjunction with protective clothing, a broad-brimmed hat, sunglasses and shade."

The new standard for SPF30 offers the same protection against sunburn, caused by UVB radiation, as the current SPF30, but is required to have higher UVA protection in order to be labelled broad-spectrum. The sun's UVA wavelengths are responsible for the sun's ageing effect on the skin and also contribute to skin cancer risk.

Mr Slevin said there was no need to throw away your current sunscreen.

"Any sunscreen of at least SPF30 which is labelled as water-resistant and broad-spectrum offers good protection. Manufacturers will be allowed to continue producing and selling their current formulations that meet the old standard. The new standard applies to new products only and is simply a little better.

The Impact of Modern Culture and Ambiguous Language on Attitudes Towards Euthanasia

by Jessica Reeks

The death of one's patient is accompanied by a myriad of emotions on the behalf of the health practitioner. Not least among these is the relief following the success of ensuring the deceased was as comfortable as possible in their last moments. However, even the best of health professionals are left trembling at the thought of delivering the legal, medically necessary dose of analgesia to achieve this aim. As such, this paper will discuss some of the major issues that arise in the euthanasia debate to assist health professionals to deal with similar situations as they arise in the future. This will include a discussion on how the law, ethics and human rights are used to argue for and against this highly controversial topic.

The "death" of a terminally ill patient

Euthanasia is derived from a Greek term meaning "good death". Its modern use however denotes the intentional hastening of death, secondary to the relief of suffering.

Despite universal understanding of the term "euthanasia", very few studies use this language. Instead, assignment of words to describe euthanasia are varied in order to evoke the required response to the author's argument. For example, the term "medicalised murder" has been used to create a greater feeling of wrong-doing to support arguments against euthanasia. Others will use the term "physician assisted suicide" to create the allusion that the physician is merely assisting a patient to carry out their own wishes. Conversely, some authors actually differentiate between euthanasia and physician assisted suicide despite the terms being almost synonymous – the difference being that in the event of the latter, the patient themselves have to administer the means of death.

The influence of modern culture

Ambiguous and confusing terminology further exacerbate the influence of current media presenting a push for the acceptance of euthanasia. In our recent pop culture, films feature euthanasia, normalising the experience while media use emotive language such as "patients hooked to machines" and "people slumped in wheelchairs" to evoke thoughts of poor quality of life and lack of autonomy. Meanwhile, little material is printed opposing euthanasia. This is thought to be due to those opposing euthanasia placing too much confidence in the stability of traditional values.

Indeed, the relationship between traditional values and euthanasia has been well defined in that affiliation with a religious group is negatively correlated with support for euthanasia. The fact that a large portion of Australian society does not identify with a religion may have implications on growing community support for euthanasia. Additionally, community support may also increase due to economic motivations as a result of increased life expectancy and higher rates of chronic disease placing a greater burden on health resources.

Law

Australia remains a country in which euthanasia is illegal in all states and territories. However, for a brief period, the Northern Territory Rights of the Terminally Ill Act (1995) legalised euthanasia before the Federal government overturned the legislation. Additionally, South Australia recently (albeit unsuccessfully) attempted to introduce a bill legalising euthanasia; indicating a shift in changing attitudes towards euthanasia.

Several international nations have legislation supporting either the act of euthanasia or physician assisted suicide. Different legislations allows for varying degrees of doctor assistance, implementing guidelines on who may receive euthanasia and controlling the practise. The inability to control euthanasia is used as an argument against its practise. However, the effective implementation in these nations demonstrates that regulation can be achieved satisfactorily.

Ethics

The lack of Australian legislation in support of euthanasia is supported by medical ethics, originally stated in the Hippocratic Oath as "I will give no deadly medicine to anyone if asked, nor suggest any such counsel". This has since been modified to be included in the Declaration of Geneva (1948) and more recently, the Australian Medical Association Code of Ethics.

Competent patients have the right to refuse treatment, even if this refusal will result in their death. This practises the ethical principle of autonomy. The argument supporting euthanasia also uses the concept of autonomy. It also maintains that euthanasia is a compassionate act, protecting a patient from loss of dignity and/or suffering. However, because suffering cannot be isolated to the patient alone – that the suffering/burden on the family and health staff may also play a role in a patient's decision to die. The role of the media in decision making is also raised, in that patients are required to justify their existence if the message society sends them is that of "we don't want you, we could get rid of you".

Human Rights

Human rights as outlined in the Universal Declaration of Human Rights have been used to argue both for and against euthanasia. For example, the right to life, liberty and security of person (Section III) has been construed for both arguments – the right to life is obviously an argument against euthanasia, while the right to liberty is used by euthanasia proponents to argue the autonomy and thus the right to choose health outcomes.

The same can also be said for the right not to be subjected to torture, cruel, inhuman or degrading treatment. Euthanasia itself can be interpreted as an inhumane treatment, while the loss of dignity experienced by the dependent, terminally ill patient is used as reasons for euthanasia.

Conclusion

It is unlawful, unethical and against human rights to actively kill or to assist an individual to die. However, ethics and human rights arguments can be construed to either support or negate euthanasia debate. These issues will become increasingly prevalent in Australia with increasing burden of disease. Thus health professionals need to be well versed in these issues such that decisions can be made that not only facilitates patient autonomy through patient centred care, but allows the conscience of the health practitioners to be eased knowing that they have practised lawfully and ethically.

Jessica Reeks is a year 1 student at the ANU Medical School. This is an edited version of her Professionalism and Leadership Course (PAL) paper. The full text and references are available from the author on request.

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