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AMA ACT welcomes the class of 2013 to the ANU Medical School

AMA ACT President, Dr Andrew Miller welcomed the class of 2013 as future members of the profession at a reception last week.

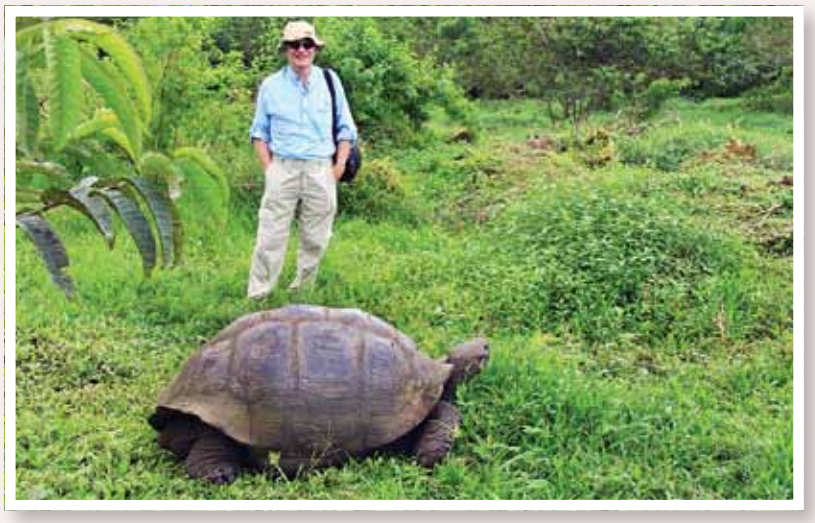
Mr Ben Veness, President of the Australian Medical Students Association also attended and thanks were extended to Investec and Ms Michelle Gianferrari, for their sponsorship of the event.

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

The news today that Pope Benedict XVI has decided to resign will I have no doubt stimulate discussion about the role of seniors in our society (and our profession), as the more particular implications for the Catholic Church are attended. It may be said that he will now diminish and go to the west; but the complex issue of testing one's capacities and competencies remains a challenge to us all. The current medical registration regime has very effectively clipped the wings of many retired doctors. There is no doubt that there comes a time when the daily grind becomes too burdensome; and we decide to move away from active practice. Medicine can be a harsh and demanding mistress. We all, nevertheless, carry a wealth of experience and knowledge; and many dismay to see that wasted. I am aware of a number of retired doctors who tutor for medical schools; and others who work with organisations and on boards that require medical registration for participation. There is currently no AHPRA registration classification that covers this type of altruistic service. I hope that a way can be found to address this issue so that we can continue to benefit from that active participation of these valued members of our profession; and plan to raise these issues within the AMA.

I was honoured to attend the AMA welcome to the first year medical student intake for ANUMS last Thursday. It was great to see those shining faces, and I wish them well through their careers. Mark (now Dr) Russell, our AMA Leadership award winner from the class of 2012 was there to show that there is life after the care free days of uni, and before the grey hair!



Back to work now, and the customary greeting "did you get away over Christmas" is starting to wane. In fact, I did. I was fortunate to be able to travel to the Galapagos Islands and spend a week cruising there. I have always wanted to see them for myself, and now having been there I can understand how an unconventional mind might start to question the prevailing wisdoms. These remote rocks in the western Pacific are home to an extraordinary collection of unique creatures; the place is definitely a global treasure and deserves no less an important place in our scientific history than Galileo's telescope.

I was greeted shortly after my return by one of those phone calls that had me immediately yearning for a simpler life amongst those iguanas and boobies. It went something along the lines of "my pharmacist told me that if you filled out the prescription properly the pills would have cost me less". The drug in question required an authority prescription to be eligible for a PBS subsidy, but the indication for which I was prescribing it was not an authorised indication. I had made this clear to the patient at the time of prescribing and had also advised them of the likely cost of the drug. What this pharmacist was apparently advocating was nothing less than fraud. I have had a similar call recently when the suggestion was also made that if I had issued an authority script for what would have been an off-label use of a medication, the patient could have saved a lot of money!

The next question that I often asked is "do you mind if I get the cheaper drug from the chemist?"

The issue of generic substitution remains a thorny one. There is no doubt that our national pharmaceutical expenditure is huge and growing; and it is important that we as prescribers carefully consider where the true benefits of our prescribing lie. I admit to "ticking the box" for some selected more complex medications. I remember contacting a generic manufacturer regarding a difficult adverse reaction that a patient was suffering; only to be told to "contact Roche; they will give you that information". The question lies, however, as to whether the benefit from generic prescribing is returning to the PBS or being leached into pharmacy and generic manufacturer profits.

Reforms to PBS funding arrangements brought in in 2007 and progressively introduced until 2012 were designed to ensure that pharmacists did not profiteer from generic substitution; and that subsidies paid to pharmacies for dispensing discounted generic products have been reduced. The ABC Health Report on 26 November last year highlighted that, whilst generic manufacturers are reporting a reduction in profits, the cost savings could have been much greater. The PBS system-wide negotiated price for off patent medications has not reflected the market changes that are occurring overseas, most particularly just across the ditch. In addition, the official discount regime that sought to reduce subsidies paid to pharmacists where they could access discounted supplies has not reflected the market strategies the generic manufacturers have put in place so that pharmacies have a real financial incentive to substitute and reap the benefits of a greatly increased profit margin. Even if the box is ticked.

I find myself wondering *"are we supposed to be on the same team or not?"*

I think that the answer has come through loud and clear in recent months that the pharmaceutical industrial organisations (the PSA and Guild) see us as patsies, and are ambitious for the business opportunities that come from encroaching on our scope of practice. And that is the defining

difference. I know many dedicated local pharmacists who provide a valued and selfless service to their communities, but like so much of health care these days, the larger business interests are starting to close in and it is the business opportunities that they see. I have no doubt at all that the push to provide vaccinations from pharmacies has nothing to do with community access; there is no altruism here. There is an opportunity for profit. I have been alarmed to see in blogs on services such as the 6 Minute News, where some of our profession have said that providing vaccinations is time consuming and could be efficiently performed by others, and tracked through the PCEHR. I have to differ.

Everyone needs a medical home. It is here that their health care can be coordinated; that appropriate efficiencies can be made and comprehensive records maintained. I know that the PCEHR is "PC" (in this case "patient controlled") but the legislation is clear that ownership of patients' records lies with them regardless of where they physically reside. Perhaps I am betraying my age; but I don't believe that an ethereal record is the same. Clearly the government agrees because they have been careful to point out that the E-health record is no substitute for complete contemporaneous locally maintained medical records. That medical home is with your family doctor, not some drop-in convenient pharmacy.

These rude awakenings have reminded me that the summer break is now receding fast behind us all and the tasks for 2013 are demanding attention. Most proximate of these is the next VMO contract negotiation round. We are caught here in a cleft stick. With changes to legislation some years ago we were prevented from collective bargaining. I can remember my ACT Health contract arriving on my desk in those days with a "sign here…or not" directive. That was the sum total of negotiation that happened. After dogged lobbying, the profession won back the right to collective bargaining with the latest iteration of the Health Act. The catch is that 50 eligible VMOs need to nominate a bargaining agent for it to be able to sit at the table and negotiate for them. The AMA has been at that table (except for the brief hiatus) since 1984, and has a wealth of experience and resources to bring to the negotiations. More recently the VMO Association has moved into the field. The unfortunate consequence of this has been an effective splitting of the vote that now means that it and the AMA must each get 50 nominations. There are only 260 VMOs in the ACT with contracts with the health directorate. Our advice is that not all of these would be eligible to nominate a bargaining agent because of the nature of their agreements. The field has suddenly become very tight and we find ourselves in the position of having to compete, rather than complement each other in the negotiating process. Either the legislation will need to be changed or a new relationship developed between these organisations. My message is clear. The AMA has the track record of involvement. It has always brought to the negotiations its full industrial and legal resources to the VMOs' side of the table. Its staff and members have the experience necessary to bring about a satisfactory outcome.

Finally, I would like it to be formally recorded here that I was able to successfully resist any temptation to plant a presidential posterior on any wild life in the Galapagos.

Aspiring doctors losing ground on pay rates

Starting salaries for medical graduates are growing more slowly than for many of their peers as governments clamp down on health spending.

Figures compiled by Graduate Careers Australia show that the median starting salary for medical graduates rose by just 2.5 per cent last year, compared with an average gain among all graduates of 4 per cent.

While medical graduates remain among the best remunerated in the country – with a median starting salary of $60,000, compared with the national average of $52,000 – data show their advantage over graduates from other fields is slowly being eroded.

Dentistry graduates remain the best rewarded, with a median starting salary of $80,000, rising to almost $97,000 for those in private practice, closely followed by optometry graduates, whose median annual salary jumped almost 13 per cent to reach $79,000 last year.

Graduates in the earth sciences enjoyed a similar surge in earnings to reach a median starting salary of $73,000 – putting them third in the ranking of graduates earnings, well ahead of fourth-placed engineers ($63,000) and fifth-placed medical graduates.

While medical graduates are not the best paid, traditionally they have enjoyed the best employment prospects, and this continued to be the case last year.

The Graduate Careers Australia study showed that more than 98 per cent were in full-time work within four months of completing their undergraduate degrees.

By contrast, just 54 per cent of graduates with visual or performing arts degrees found full-time jobs in the same period.

But the virtual guarantee of work for medical graduates is threatened by the failure of governments to provide enough pre-vocational internships to match the growth in medical school places in recent years.

In November last year a shortfall of 162 internship places was only partially averted by a hastily arranged deal between the Commonwealth and several State and Territory governments to provide an extra 116 positions, leaving 46 graduates in limbo.

With the number of graduates set to swell even further this year, there are fears that without a permanent solution negotiated between the Commonwealth, State and Territory governments, hundreds of aspiring doctors may be denied the opportunity to complete their education, a great cost both to themselves and the community.

Top 10 median graduate starting salaries

Discipline	Median starting salary ($)
Dentistry	80,000
Optometry	79,000
Earth sciences	73,000
Engineering	63,000
Medicine	60,000
Mathematics	57,000
Education	56,000
Physical sciences	55,000
Law	53,000
Computer science	52,500

Source: Graduate Careers Australia

THE NOTICE BOARD!

Come celebrate pain in Canberra!

AUSTRALIAN PAIN SOCIETY 33rd Annual Scientific Meeting

17-20 March 2013 – Canberra

A Sentinel Event in a Centenary Year – "Persistent Pain: A National Challenge"

Hear **Geert Crombez** of Netherlands talk of "Beyond fear of pain-threats and opportunities" and "Attention to pain and its disabling consequences", **Rollin Gallagher** of the United States talk on "Pain management in the cross-hairs: documenting failure and precipitating change" and "Managing pain in wounded warriors". There is excellent work on basic neurosciences, the building blocks of pain and its control, by **Jurgen Sandkhuler** of Vienna/Hamburg, – "Novel actions of opioids on nociception", and intriguingly "New insights in central pain processing and neuroplasticity".

For further information: www.dcconferences.com.au/aps2013

Student prize winner 2006 – Sarah Koffmann writes for Canberra Doctor

When I was first asked to write a piece for Canberra doctor about what I've done since graduating, I felt dismay that I didn't have a long list of achievements or exotic destinations I had travelled and worked in. I'm "Just a GP Registrar" came to mind.

As I started the process of writing however, I realised I have in fact done quite a bit since graduating and am very happy with how my career and life in general is progressing.

Winning the AMA leadership award at our grad dinner in 2006 took me completely by surprise.

I had contemplated not even going as my father was very sick having just started chemo for terminal stomach cancer. He lived with me, my husband and our 2 year old daughter during this time and caring for him whilst studying fourth year med was quite consuming to say the least. In the end we did go and my dad came too – in a wheelchair with his chemo infusion running. Winning the award with dad there was a very proud and special moment.

I commenced my intern year the following January at TCH. Dad was going OK for a while but only made it to August that year. He died, as my mother had 18 months earlier, at Clare Holland house here in Canberra. I was 18 weeks pregnant with my second daughter when he died. So intern year was a challenge for all the usual reasons plus a few more. After maternity leave, I completed my intern year part time.

I did the usual resident year at TCH and landed myself an SRMO job in O&G. I had always been interested in GP, O&G and emergency medicine as possible career options. I went in to that SRMO job with an open mind and open eyes. It was a chance to "try before you buy". I loved it. The excitement, the emotion, the ethics, the surgery. It is a fascinating and rewarding job. But it also comes at a great cost. Not so much to the doctor I believe, but to their family. Being a doctor is a very special and privileged job. But in my opinion, it is ultimately still just a job. During my oncology term as a medical student I met a man who was dying of his cancer. He was a career man. He held my hand crying and said "Sarah, I have 300 days of sick leave owing. I don't think I have that many days left to live. I spent too much time at the office". He didn't survive the week. His words have always stuck in my mind.

I guess losing both my parents during my medical training changed my perspective on many things- including medicine- and has ultimately influenced how I approach my own life and my patients.

For me, my husband and my children are the priority and I didn't think I could put them first if I pursued obstetrics- at least at this stage in my life. A side issue to this decision was the fact we were now living on 40 acres, 40 minutes outside Canberra and we hope to always live on rural property. Being on call for obstetrics meant either moving closer to the hospital or staying "in town" during those times.

So with O&G on hold for now, I left the hospital that had been my training ground for 9 years and entered general practice. I am pursuing both the RACGP and ACRRM pathways. I've spent the past year working in general practice two days per week, 1-2 shifts per week in the Queanbeyan hospital emergency department as a CMO, one day a week as an O&G surgical assistant in the private sector and am also involved with teaching clinical skills to ANU medical students. We have three daughters (the third being born during my second SRMO O&G year) and our fourth (and final) child is due in March (another girl no doubt!!).

General practice is very satisfying. I am constantly amazed and humbled by my patients and what they bring before me. It is a relentless and exhausting job at times and I'm not sure I will ever work full time in it. Having worked in the Canberra region since graduation has meant that I have developed quite a good professional network and have an understanding of local services. This helps a great deal when managing and advising my patients. Being able to call and speak directly with local specialists whom I know and have worked with to ask for advice is wonderful. I feel I have a good understanding of both the tertiary and the primary level of care and can therefore help my patients to get the best out of the system as they deal with their individual health needs.

I recently attended the ACRRM Conference in Fremantle WA (as exotic as it gets for me) which was as close to a religious epiphany as I've ever had. The doctors were inspiring. They are hardworking, dedicated, enthusiastic, resourceful yet very human, everyday people who are passionate about what they do. Some of them were very seasoned yet not in the least jaded or cynical. They were still excited about their work- even after all those years. They seemed to have the balance right and it confirmed for me that I am doing the right thing for me.

I love my job(s). Every day as I drive home through the countryside, dodging kangaroos, I think about how lucky I am. The mix of general practice, surgical assisting, teaching and ED work (any of which would be draining on a full-time basis) provides a great balance. Outside of work we manage the farm complete with angora goats, alpacas, horses, too many kangaroos, too many weeds and 3 and 3/4 "pet humans".

People often ask me when I'll be "finished" training. I'm in no hurry. Given that I hope to be working part time in general practice, surgically assisting, teaching medical students and working in the ED when I'm "finished", I kind of feel like I'm already living the life! Between drenching and shearing goats, trimming alpaca teeth and toenails, taking the girls to pony club, gymnastics and swimming lessons, I imagine I'll finish my GP training…eventually.

My dad always said that you'd know you were in the right job if you'd get out of bed in the morning and go to work, even if you wouldn't be paid for it. He was right. Getting paid is icing on the cake.

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

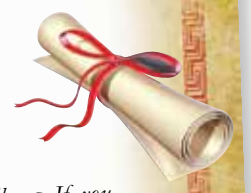
Maurice LeGuen 2007

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.*

Jabs in pharmacies wrong: AMA

The AMA has objected to proposals to allow pharmacists to administer injections without big improvements in training and the imposition of strict conditions and controls.

Responding to Draft Practice *Guidelines for the Provision of Immunisation Services in Pharmacy* by the Pharmaceutical Society of Australia (PSA), the AMA said it could not support legislative changes to allow pharmacists to administer injections until such procedures were included in core pharmacist training, and were not just an adjunct.

The AMA clashed with pharmacists late last year on this issue when a national pharmacy chain offered patients discounted seasonal flu vaccines administered in the store by a qualified nurse.

AMA President Dr Steve Hambleton said at the time that vaccinations, including the annual flu jab, should only be administered by a GP and not performed in a local chemist.

"The AMA has a lot of concerns with pharmacies offering vaccinations," said Dr Hambleton. "There is no privacy. Patients need to be made aware of possible side effects and discuss their medical history. What private room can a pharmacy offer a patient?"

Dr Hambleton said any nurse who administered a vaccination must be able to diagnose anaphylaxis.

"I want to know who will deliver the needles, they need specific training. What questions are asked before the vaccine is administered? And where will they record the information?

"This fragments the health record, because then we have patients coming into the GP to say they had some kind of needle at a chemist."

The AMA said the PSA's draft guidelines aligned with the principles promoted in the AMA Position Statement – *Vaccinations Outside of General Practice – 2011*, but could be further improved by:

- ensuring appropriately qualified and authorised registered nurses also held a statement of proficiency in CPR;
- pharmacies were able to demonstrate adherence to vaccine management policies and protocols; and
- ensuring consumers were asked if they had a regular GP and, if so, if they would consent to that GP being provided with a copy of their vaccination statement.

Dr Hambleton said vaccinations provided outside of general practices should be subject to the same proficiency and safety and quality requirements as those provided within a general practice.

Mark Russell wins AMA ACT Leadership Award for 2012

Winner, Mark Russell with finalists Buddhima Nanayakkara, Nicholas Baxfield and Stuart McKnown with Iain Dunlop following the awarding of the prize for leadership.

Immediate past president, Dr Iain Dunlop presented Mark Russell with his prize at the 2012 Graduation Dinner held in December at Australia's Parliament House.

The nominations for Mark Russell attested to his leadership skills across several student-related endeavours as well as to his professionalism, dedication, communication, organisational and collaborative skills as well as to his outstanding commitment to student advocacy and to student representation more generally.

Mark is now undertaking his intern year at Canberra Hospital.

Dr Dunlop also presented finalists – Stuart McKnown, Nicholas Baxfield and Buddhima Nanayakkara – with certificates to recognise their nomination for this significant prize for student leadership.

Spirituality and Medicine: Mutually Exclusive? Does spirituality have a place in medicine?

Dr Richard Scott, a seasoned General Practitioner in Margate, UK, has recently been presented to the General Medical Council for expressing his religious beliefs to a patient in his clinic. Dr Scott allegedly told a teenage patient suffering from depression that demons were haunting him. He was issued a warning for this statement, which was reported to have 'crossed the line'.

The case was labelled somewhat of a farce, as the teenage boy was unwilling to give witness or testimony. The boy's mother lodged the original complaint to the General Medical Council (GMC). Questions have been raised as to whether the young teen was even upset by the doctor's comments.

Dr Scott in a statement said "The panel has chosen to believe a patient with massive and multiple problems against a doctor of 28 years' standing, embedded in his local community with hundreds of testimonials from other patients of his.

"Whether it was reiki, acupuncture or even Islam, that particular doctor would not be in our position now. I think they are discriminating against Christians. I am both angry and disappointed in my professional body."

Most people will argue that comments like this are completely unacceptable in a medical context, even if it is something that is strongly believed to be true by some.

But should spirituality and faith be rejected in medical consultations? Research has proven that faith and spirituality should be an important part of our healthcare as medical professionals.

The healthcare profession currently cares for patients through consideration of their family, community, culture and lifestyle, but do not usually consider spirituality. Why is this? Many people would say that spirituality, faith and religion have no bearing on a patient's health and recovery, but studies suggest otherwise.

Two thirds of patients have medical decisions influenced by religious beliefs and 76% of people admit to having had spiritual or religious experiences. Despite being labeled as a secular society, most Australians have had spiritual experiences or hold religious beliefs.

The GMC code of good medical practice informs doctors of the best way to care for their patient. It states that *"Good clinical care must include:– adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors)"*. Spiritual history is not mentioned directly here but can be implied as part of psychological and social factors. GMC ought to specifically mention the importance of spiritual factors in the patient's history.

Point 7 of GMC's Good Medical Practice mentions: *"You must treat patients with respect, whatever their life choices or beliefs."*

Point 8 describing good clinical care says *"If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor."*

Point 33 describing the maintenance of trust in the profession says: *"You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress."*

These points are relevant to Dr Scott's case and how he should have approached the situation. Doctors cannot discriminate, exploit or cut off patients due to either the doctor's or the patient's religious beliefs. The GMC gives more detail on personal beliefs and medical practice, mentioning the importance of spiritual beliefs, how beliefs may affect altered treatment plans, and maintaining respect for both doctor's and patient's own spiritual beliefs. The GMC expects doctors… *"to be prepared to set aside their personal beliefs where this is necessary in order to provide care in line with the principles in Good Medical Practice."*

The final point for doctors regarding patient's spirituality made by the GMC emphasizes the importance of *"acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs."*

It seems that doctors aren't accounting for spirituality as much as they should. An American study found that 'faith in God' was ranked second most important factor in treatment by patients and families experiencing lung cancer. Doctors, however, ranked it to be the least important factor in treatment. Doctors must understand the positive effects that spirituality and faith have on treatment.

A significant relationship has been discovered between a patient's spirituality and their illness prevention, coping, recovering, clinical outcome and overall experience of health and pain. If this were not something that medical professionals were paying attention to, then I would question the integrity and reliability of doctors.

Of the studies published by 1990, 81% showed a positive correlation between personal faith and health outcomes, 15% showed a neutral correlation and only 4% showing a negative correlation. Some of the studies included investigations in the areas of heart disease, cancer, cerebrovascular disease, pain and depression.

One study found a significant difference between the low health outcomes of people with low spirituality compared to better health outcomes in patients with moderate or high spirituality score. This spirituality scoring was based on measuring experiences classified as spiritual by the patient. It concludes that "family physicians may find that considering the spirituality of their patients informs, enhances, and adds a new dimension to clinical practice".

Another study found a strong significant relationship between religiosity measured by church attendance and overall mortality. Randomised control trials have shown that "spiritually augmented therapies were more successful than non-spiritual conventional therapies in reducing patients' depressive symptoms, improving treatment and adherence, and minimizing the risk of relapse". Increased religious involvement in teenagers and Australian school students shows a decrease in risk behaviors such as sexual activity, depression, smoking, alcohol and drug use.

How does religion and spirituality help people's health and mortality? Hypotheses suggest that it gives people purpose and meaning in life, provides significant social support, encourages healthy lifestyles, and provides a coherent belief system and moral code. These things all result in a drive to pursue life through difficult health circumstances, as well as maintaining a healthier lifestyle.

The need for knowledge of spirituality and its effect medically is evidenced through a huge increase in the number of studies being undertaken in this area over the past 20 years. In 2001, over 1200 research studies involving health, religion and spirituality were recorded. More research still needs to be undertaken, because spirituality, faith and religion are very difficult factors to test and measure for research.

Australia is one of the most multicultural countries in the world and therefore has a range of religions and different spiritual beliefs. However Australia is also one of the most secular countries in the world, with many people claiming to have no spiritual beliefs. The Australian Bureau of Statistics has shown that the number of people

with no religious beliefs has increased from 15% to 22% between 2001 and 2011, particularly in the younger generation. This is a significant change and the trend is expected to continue. One question to be asked is whether this trend is beneficial or detrimental to the health of Australian patients?

The medical community in Scotland appreciates the importance of spirituality. In the Patients' Charter Scotland, the National Health Service takes an active role in spiritual care by stating that "the NHS is expected to make every effort to provide for the spiritual needs of patients and staff." Australian healthcare systems can be complimented for its provision of chaplaincy at hospitals, but could more be done?

The role of the doctor is to care for the illness of the patient. Illness includes physical, mental, social and spiritual components. Illness can have a huge impact on the heart and soul of a person, and often brings about spiritual experiences. Dr Richard Scott may not have addressed his patient in the appropriate way, but there can be no condemnation for Dr Scott's intentions to care for his patient's spiritual wellbeing. All doctors should be aware of their patient's spirituality and encourage patients to explore their own spiritual beliefs, as evidence has supported a positive medical outcome in these patients.

Rhys Cameron

At the time of submitting this for Canberra Doctor, Rhys Cameron was a year 1 student at the ANU Medical School. This is an edited version of his Professionalismand LeadershipCourse (PAL) paper. The full text and references are available from the author on request.

Governments must work together to make every health dollar count

AMA Federal Budget Submission 2013-14

AMA President, Dr Steve Hambleton, called on the Federal Government to use the May Budget to prioritise health spending on programs and services where there is strong evidence of direct benefit to patients and to take urgent action to minimise the red tape burden on doctors and other health professionals.

Dr Hambleton said there must be greater cooperation and honesty between all levels of government to ensure that every health dollar delivers a tangible benefit to patients and the community.

"The National Healthcare Agreement appears to be fraying at the edges with the Federal versus State blame game re-emerging over hospital funding," Dr Hambleton said.

"The Federal Government has put more money into health – through current public hospital funding under the *National Healthcare Agreement*, and future funding under the *National Health Reform Agreement* and other more targeted Agreements.

"These Agreements have been signed by all governments, yet we are now seeing fingers being pointed over who is to blame for cuts to services at the local level.

"All our governments must put the interests of patients first.

"We must build capacity in our public hospitals. Funding must be better targeted, patient-focused, and clinician led. This will require unprecedented cooperation between the Federal and State Governments.

"The complete pipeline of medical training needs to be properly funded to ensure we have a medical workforce in sufficient numbers to meet future community need. This will involve some long-term vision and planning, not stop-gap year-by-year solutions.

"Money should be going to GP Infrastructure Grants, not GP Super Clinics. The Grants are delivering real benefits to general practices and their local communities. The Super Clinics are a bad idea that is getting worse and wasting valuable health dollars.

"Planning is needed to allow primary care, led by general practice, to cope with the growing demands of chronic disease in the community.

"The Government has announced major policies in the areas of aged care and mental health. Where there is evidence that things can be done better, the Government must take the advice of clinicians at the front line and shift or re-prioritise funding accordingly.

"This same principle should be applied to e-health. The AMA supports the PCEHR – it can make a real difference to the continuity of care for patients.

"But the legal framework for the PCEHR has imposed additional red tape on practices. The Government can alleviate this by assisting practices to navigate the complex pathways and requirements necessary for them to participate.

"We must also proceed consultatively on the National Disability Insurance Scheme (NDIS). The priority must be on timely quality care, not litigation. The AMA has some concerns that are still to be resolved.

"And the Government must preserve and build on its commitment to improving Indigenous Health outcomes.

"The AMA Federal Budget Submission 2013-2014 provides sensible and affordable recommendations for a stronger health system.

"We may not have the environment for significant new health funding, but we have an urgent need for some smarter thinking on how precious health dollars are allocated and spent.

"The funding must find its way to the patient," Dr Hambleton said.

The AMA Federal Budget Submission 2013-14 is at https://ama.com.au/federal-budget-submission-2013-14-lets-make-every-health-dollar-count

AMSA calls for improved support for future doctors in its budget submission

The *Australian Medical Student's Association* (AMSA) President, Mr Ben Veness, in their submission to the Federal Government recommends Government use the May Budget to increase funding for undergraduate medical education to ensure Australia's next generation of doctors receive a high quality medical education.

"High quality medical education and support for students is vital to maintaining Australia's world-class health care system," Mr Veness said.

"The 2011 Base Funding Review Report found significant under funding of medical education.

"Medical student numbers have grown substantially over the past couple of years and as a result medical schools are being chronically under-funded.

"The number of commencing medical graduates has more than doubled in the last decade, up from 1660 in 2000 to more than 3500 last year.

"The hospitals that employ these graduates are also under strain, and must get the extra support they need to see these students through their post-graduate training.

"The Federal Government must maintain the high standard of medical education expected by the Australian community by increasing funding for undergraduate medical education.

"We don't want a repeat of last year, where a last minute bailout by the Federal Government was needed to prevent medical graduates from being forced overseas to complete their training.

"The Federal Government must ensure that medical graduates receive the high quality post-graduate training they require to become the doctors the community needs."

AMSA's submission has also outlined recommendations to increase Australia's rural health workforce; ensure medical students have adequate financial support; foreign aid commitments are upheld and Indigenous health students are supported.

The AMSA Pre-Budget Submission is available at www.amsa.org.au

AMA public hospital report card

Dr Steve Hambleton launched the AMAs annual public hospital report card recently. The AMA Public Hospital Report Card uses the most recent data published by the Commonwealth government, and provides a consistent analysis of public hospital activity over time.

This 'time series' information is not made available in government reports.

Beds and capacity

The report reveals that despite almost 10 per cent more Commonwealth funding over the period 2009-10 to 2010-11, there has been no real change in performance measures for public hospitals and little progress towards COAG targets and against key capacity and performance measures, the Australian public hospital system is not meeting the clinical demands being placed on it.

The report card shows this is clearly not the time to reduce public hospital funding.

The Report Card shows that the number of public hospital beds per capita, which is the strongest measure of capacity, is static. There are only 2.6 public hospital beds for every 1000 people, which has not changed since 2009-10.

While 872 new beds were opened across Australia in 2010-11, these clearly offset previous closures (as evidenced by no change in the number of beds per capita).

There has been no change in the capacity of public hospitals to admit patients to wards from emergency departments more quickly, or to perform more elective surgeries.

Average bed occupancy rates are also an indication of capacity. Public reporting of average occupancy rates at 5pm would illustrate the capacity for hospitals to admit patients the following day for elective surgery and to deal with overnight emergencies.

In 2012-13, Commonwealth payments to State and Territory governments for public hospital services will be less, as a result of adjustments for population estimates and a health cost index.

Late last year, State and Territory governments announced their own funding cuts for public hospitals.

The AMA considers that it is unacceptable for any government to introduce reductions in funding as it can only further reduce capacity in the system.

If public hospitals are to stand any chance of meeting the needs of the community and performing according to the agreed standard, both levels of government have to take full responsibility for providing the required funding.

Emergency departments patients seen within clinically recommended times

- Every State and Territory performed well below the national performance target of 80% for public hospital emergency department Category 3 patients. These patients should be seen within 30 minutes.
- Performance nationally was only 66%, which means that over a third of these patients were not seen within the recommended time.
- The national target of 80% will be even more difficult to achieve if there is no increase in public hospital capacity.

Patients treated within four hours

- In this year's report card performance against the National Emergency Access Target is included, where patients presenting to public hospital emergency departments need to be either admitted, discharged or referred for treatment within four hours.
- Nationally, in 2011-12, 64 per cent of all emergency department visits were completed in four hours or less, well short of the 90 per cent target to be achieved by the end of 2015.
- Only WA met (and in fact exceeded) the first interim National Emergency Access Target. NSW, Vic and the NT did not even meet their baseline for this performance target.

Elective surgery: the hidden waiting list

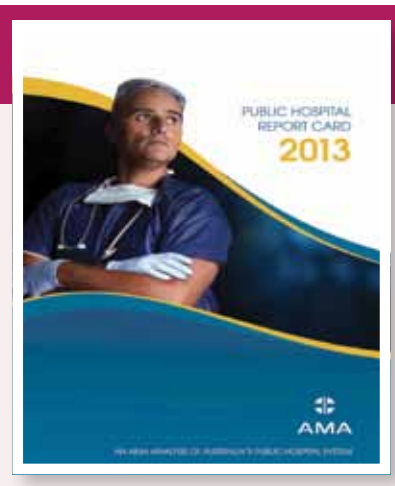
The true story about waiting times for elective surgery in Australia's public hospital system is hidden. There are people who are waiting to see a specialist to be assessed for surgery who are not counted in waiting list data.

The clock only starts on waiting times for elective surgery when a patient has seen a specialist and is booked for surgery. Someone who has waited a year for their hip replacement surgery, according to the 'official' count, may already have waited an additional six months from the time they received a referral from their GP to the time they first saw a specialist.

It is important for GPs to know this type of information so they can discuss alternative options with their patients.

COAG's own expert panel recommended that State and Territory governments should measure and report on the real waiting time for elective surgery – that is, the time patients have to wait between a referral from their general practitioner to the time they actually receive their surgery.

It's disappointing that COAG ignored this advice and has only flagged it 'may' consider measuring the real waiting time for elective surgery in a future health agreement.



Only when this time is measured on a consistent national basis will we know the true waiting time and demand for elective surgery.

Performance

- The number of public hospital elective surgeries performed in 2011-12 across Australia was 661,707. This was an increase of around 5.5% over the number of elective surgery admissions in 2010-11 (627,184).
- 2.7 per cent or 17,866 of the patients admitted for elective surgery in 2011-12 waited for more than a year for their elective surgery.
- The Report Card estimates that while 81% of category 2 elective surgery patients (those who should be admitted within 90 days) were admitted on time, this is well below the new performance benchmark of 100% set by COAG.
- State and Territory governments will have to make a vast improvement to meet this target by 2016.
- Median waiting times for elective surgery have substantially deteriorated over time. In 2011-12 the median waiting time was 36 days, no change from the previous year. Ten years ago the median waiting time was only 27 days.

Expenditure

One of the AMA's key aspirations for health reform was an end to the blame game. Unfortunately, in recent times there has been much blame levelled at governments by governments about withdrawal of funding. The Report Card provides a chart showing how the government shares of public hospital expenditure change over time.

Regardless of what the expenditure data shows, the performance indicators show that the public hospitals are not keeping pace with demand. The blame game should end.

Public reporting of performance data

The AMA Report Card provides the perspective of the medical practitioners who work in public hospitals.

There is now a range of new government organisations involved in different aspects of the health and hospital system, including: hospital pricing (IHPA); funding (National Health Funding Body); performance (NHPA); and safety and quality (ACSQHC).

Each of these organisations has a specific focus for their individual reporting. The number and frequency of reports on specific aspects of the health and hospital system will no doubt continue to increase.

But the growing availability of more and more specialised information comes at a significant cost: the ability to easily consider the overall performance of key aspects of public hospitals using year on year comparison.

Currently there is no clear picture from government of the overall performance of the system.

This AMA Public Hospital Report Card shows performance over time – rather than at a single point in time.

It is hoped that new agencies established to provide greater transparency of funding and performance will provide meaningful reports to inform government decisions.

The full report is available at www.ama.com.au or by calling the AMA on 6270 5419.

A list of the data sources are also available on request.

Who bought the pen that wrote my prescription?

The ethics of medical practitioners accepting pharmaceutical sponsorship is a controversial issue within the medical community. It was estimated that in 2000, pharmaceutical companies spent AU$1 billion on marketing with a large proportion spent on giving medical practitioners free drug samples, stationery and invitations to pharmaceutical funded medical events. This article aimed to identify the various potential ethical issues with medical practitioners receiving gifts and make suggestions on how they could be addressed.

Current Regulations

Pharmaceutical companies are allowed, under their code of conduct, to gift stationary and to sponsor or run medical education events. For continuing medical education, the primary intent must be enhancing medical knowledge. Drug samples however, are not specifically mentioned in the code of conduct which shows a lack of transparency in the handling of pharmaceuticals. This leaves an area of ambiguity in the supply of drugs to medical practitioners and their use. The AMC good medical practice states that medical practitioners have to recognise that pharmaceutical company marketing can influence them and must be transparent if this interest could affect patient care.

Positive Impact on Clinical Decision Making

Education to medical practitioners is usually provided in the form of pharmaceutical marketing by representatives: offering drug information and samples, providing endorsed gifts and stationery, and finally, sponsoring of external conferences and in-house events.

Obtaining free gifts with drug information and drug samples could remind the medical physician about the availability of new drugs and their indications. A popular argument in favour for distributing free drug samples to medical practitioners is to educate and to allow patients to trial the drug for its efficacy without financial loss. By providing free drug samples to a patient during a consultation, it has the potential to break brand loyalty but more importantly, improve treatment compliance, particularly in low income patients. Furthermore, before switching to a new drug, free drug samples could be used to determine whether it's more efficacious then the previous drug.

Sponsoring of educational events could be for in-house meetings such as grand rounds as well as wholly pharmaceutical run events. Nonetheless, there is a responsibility to provide unbiased evidence-based medical education. Disappointingly, only in-house meetings have content that is independently determined by the organiser with minimal input from pharmaceutical sponsor(s). Sponsorship of continued education provides medical practitioners a convenient and time-efficient opportunity to remain up to date with current therapeutics and allows medical practitioners to attend presentations from influential people in their field without the financial burden.

Negative Impact on Clinical Decision Making

One of the greatest concerns in regards to pharmaceutical marketing was the change of prescription patterns. Thirty-three to sixty-nine percent of medical practitioners from various international studies have self-reported changes in prescription patterns upon receiving drug samples. Those who denied being influenced reported that they believed their colleagues were more likely to be affected.

Pharmaceutical companies play on the medical practitioner's best qualities of being altruistic. Despite the medical practitioner's ethical duty of beneficence, by accepting free samples, they may feel bound by a sense of reciprocity to the pharmaceutical companies. Studies have shown that practitioners were more likely to continue prescribing the drug that a sample has previously been supplied for. Even if the medical practitioner does not specifically prescribe the sample drug, they may feel more obliged to prescribe other drugs from the same company.

One intention behind accepting drug samples by medical practitioners is to pass them onto patients who cannot afford them. Unfortunately, the pattern of free sample distribution in the United States has shown that it's often the patients who could afford drugs that received the free samples. What was most concerning was that some medical practitioners have reported giving low-income patients free samples even though it was not the best drug of choice for that disease.

Free drug samples also promote status quo bias where patients stay with a pharmaceutical agent, experience minimal side effects and see little reason to change. With the increasing prevalence of chronic health issues, status quo bias may commit a patient to years of subsequent prescription for the same drug which is no longer free, even if other optimal cost-effective treatments were available. Medical practitioners are also vulnerable to the status quo bias as it is easier to prescribe one drug that they know works for their patients rather than many alternatives.

Sponsorship of educational events clouds an already hard task of independently weighing up the evidence provided. Although pharmaceutical companies are required to present their evidence for new drugs in an unbiased fashion, it is inevitable that bias could occur. Potential biased presentations and the lack of clear statements of conflict of interests could further confuse medical practitioners on current correct medical practices.

Potential Impact on the Health System

Increasing brand name exposure to medical practitioners via small gifts may influence their preference to prescribe branded drugs over generic drugs. In the long term, more branded drugs will be prescribed instead of generics leading to increased government expenditure through the Pharmaceutical Benefits Scheme leading to redistribution of scarce resources from other needs.

Suggested Solutions

The relationship between the pharmaceutical industry and medical practitioners is essential for the delivery of medicine. Therefore, it would be unreasonable to ban all distribution of drug samples or pharmaceutical-funded continuing education. Instead, there should be greater transparency in the relationship between the two parties. Financial disclaimers should be made clear for continuing education programs and specific regulation regarding free drug samples needs to be devised. Ceasing to receive gifts could reduce marketing costs of pharmaceutical companies, there-by making them more affordable for the public.

Conclusion

Although free drug samples, small gifts and sponsoring of events have benefits attached to them are ethical dilemmas. Improved frameworks and guidelines set by professional regulatory bodies for medical practitioners to interact with pharmaceutical companies are needed to respect the professions' independence and clinical judgements made for patient care.

Michael Ardern, Jae-Gon Yoo, Yi Fan Tang

At the time of submitting this for Canberra Doctor, Michael Ardern, Jae-Gon Yoo and Yi Fan Tang were 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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Revalidation: Burden or Benefit?

Revalidation seems destined to become one of the buzz words of 2013, even though the year has just started. The International Association of Medical Regulatory Authorities defines it as "…the process by which doctors have to regularly show that they are up to date, and fit to practise medicine. This will mean that they are able to keep their licence to practise."

The Medical Board of Australia have advised that they are considering the introduction of cyclical revalidation for those who wish to continue to practise medicine in Australia.

The justification they provide is that revalidation has been introduced in other "jurisdictions around the world". However, many of these have very different systems for medical education and training, and the credentialing and maintenance of medical registration.

Importantly, in our context, what might be the cost and the benefit to Australian health consumers?

As an indication of what might be envisaged, it is instructive to look at the revalidation process that came into operation in the United Kingdom from 3 December 2012.

There, revalidation will run over a five-year cycle that involves an appraisal process and the collection of a portfolio of evidence to demonstrate that the necessary standards are met.

Each medical practitioner has a 'responsible officer' who assesses the portfolio and reports to the General Medical Council (GMC) on the doctor's fitness to practice.

Responsible officers and other medical leaders are the first to go through the revalidation process, and are expected to complete it by March.

Under the new system, revalidating doctors will need to provide the following information when they present for appraisal: evidence of continuing professional development, quality improvement activity, significant events, feedback from colleagues, feedback from patients, and a review of complaints and compliments.

The GMC's *Good Medical Practice Framework* sets out the areas that should be covered in the medical appraisal, all twelve of them. They are all very worthy attributes, there is no question about that. But compliance will have a cost.

The British Royal Colleges have estimated that for full-time doctors employed by the National Health Service, this will equate to 15 per cent of their time, not including study leave, and will need to be included in job plans.

To this must be added the time taken by the responsible officers in preparing for the appraisals, undertaking interviews and preparing reports.

The interview to be conducted as part of the appraisal is unlikely to be brief, with the GMC indicating, "…your appraiser will be interested in what you did with the information and your reflections on that information, not simply that you collected it and maintained it in a portfolio. Your appraiser will want to know what you think the supporting information says about your practice, and how you intend to develop or modify your practice as a result of that reflection."

Again, a worthy objective, but teasing out these reflections will add time and complexity to the appraisal. The appraisers will need training to perform their role consistently and ensure the objectives of appraisal are met – at a further cost.

To this needs to be added the cost of the bureaucracy needed to track and record the appraisals, and a process for those whose appraisal is deemed unsatisfactory.

Quite a burden, so there should be a corresponding demonstrated benefit to patient health.

However, my literature search on 'revalidation' failed to come up with any trial to demonstrate such a benefit.

The Australian system already has multiple safeguards to ensure that medical practitioners are safe to practise: Australian Medical Council (AMC) accreditation of undergraduate medical courses; a structured and supervised intern year; AMC-accredited College vocational training programs; rigorous examinations; ongoing registration that is dependent on continuing professional development and recency of practise (with these being subject to audit); in-training assessments for doctors in training; regular appraisals for specialists working in the public hospital system; credentialing and re-credentialing for specialists working from private hospitals; and so it goes on.

The Medical Board of Australia has said it is time to begin a conversation on revalidation.

Sceptics define a 'conversation' as a pseudo-consultation process conducted by Government and quasi-Government bodies to justify a predetermined outcome.

Let's hope that isn't the intention in this instance.

The Board also indicate that their approach will be evidence-based.

The first piece of evidence needed from the many jurisdictions that have adopted revalidation is that of improvement in patient-centred outcomes.

Without such evidence, revalidation will be a burden without benefit.

The momentum behind revalidation may be irresistible, but if there is no evidence of patient benefit, let's be clear that introduction of Medical Board-based revalidation has no more justification than any other fashion.

Application of revalidation across all health professions covered by the Australian Health Practitioner Regulation Agency – there appears no justification for limiting it to just medical practitioners – is an overhead cost our health system doesn't need without clear evidence of benefit, particularly when every dollar is needed for direct patient services.

Geoff Dobb

Professor Geoffrey Dobb is the AMA Vice President.

This article was originally published in "Australian Medicine"

Government assists concession card holders with their unwanted bulky goods

The ACT government is currently conducting a trial of a bulky waste household collection service. Your patients may be interested to know that if they are a pensioner or concession card holder they are entitled to one free bulky waste collection under the ACT Government trial.

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- An ACTION Gold Card
- A Department of Veterans Affairs Gold Card
- A Seniors MyWay Card(available to everyone over the age of 75)
- Things to know about the service
- It is a collection of bulky items such as furniture, whitegoods, TV, computers, large electrical appliances, items from the garage such as lawnmowers, tools etc.
- There is a maximum amount of 2 cubic metres which can be collected, please note a maximum of 10 pieces can be collected within that limit and nothing can weigh more than 46kg
- The service is not a rubbish removal service, and they will not take away garden waste, household rubbish or building rubble.
- Items need to be outside on the day ready for pickup.
- The Concession Card will need to be sighted at the time of pick up.

For more information call 6249 7974 or visit www.thegreenshed.net.au and look for the Bulky Waste pick up service.

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UK Government losing doctor friends

According to a report in a recent edition of "Australian Medicine", relations between the British Medical Association and the British Government have grown decidedly frostier over the Government's intention to use funding to dictate how 36,000 GPs in England and Wales are to look after their patients.

The Government's move will come about through changes to what is called the 'GP contract'.

These changes include that, from next April, practices will no longer receive the annual Quality and Outcomes Framework (QOF) payment for administrative tasks such as medical record-keeping unless they boost services for people with dementia and frail elderly patients, use technology to monitor patients' long-term health problems and improve online access to Government programs.

The Government says that the changes will mean that GPs will be rewarded for earlier diagnosis and better care of dementia patients and people with long-term conditions. It has given GPs until the end of next February to respond.

The BMA has protested that the Government has not considered the impact of its changes on general practices, which "are already under huge workload pressure. We have real fears that [they] will result in an even greater load at the same time as forcing through a reduction in core funding".

The GP contract had enabled GPs to benefit their patients clinically and to be at the forefront of delivering care that had kept pace with technological advances, it said.

This had led to thousands of patients benefiting from early diagnosis and treatment that had saved lives. Moreover, some programs to which the Government wanted GPs to improve patient access did not exist everywhere in the country.

The BMA promised to analyse the details of these "complex proposals" and said that it was open to "real dialogue" with the Government about their impact.

But relations between doctors and Government have been disturbed by the abrupt way in which the Government made its decision. Changes to the GP contract for doctors in Scotland (where the health system is different) were agreed in a consultative atmosphere.

But the Government walked away in October from months of negotiations with the BMA over the GP contract for England and Wales, opting instead to force the changes through.

Doctors have also been infuriated by the Government's decision to scrap a Cabinet subcommittee, promised by it in Opposition and set up by it soon after winning office, specifically to tackle major health problems such as obesity, smoking, alcohol abuse and health inequality.

The committee was intended to bring together 19 ministers responsible for 13 departments with interests – however tangential – in public health policy.

A government spokesman denied that the decision would downgrade public health, which would now "be brought into the broader domestic policy committee".

But the word around Whitehall is that the committee was a dud; it had been difficult to interest ministers from other than health portfolios and had actually convened only a few times.

"We hope that Ministers intend to engage in a meaningful discussion, and that they will listen and act on concerns that are raised, particularly where their proposals are unworkable or will lead to unintended consequences," the BMA said. "We would be extremely disappointed if this consultative process was a rubber stamping exercise for their existing plans."

Claims that measles is 'marvellous' rubbished

A book claiming that contracting measles can be a "good thing" for children has been strongly condemned by AMA President, Dr Steve Hambleton.

The book, *Melanie's Marvellous Measles*, written by Brisbane-based anti-vaccination campaigner Stephanie Messenger, is aimed at "educating children on the benefits of having measles, and how you can heal from them [sic] naturally and successfully".

According to Ms Messenger, who claims one of her children died as a result of a vaccination, the book takes "children on a journey to learn about the ineffectiveness of vaccinations and to know that they don't have to be scared of childhood illnesses like measles and chicken pox".

The front cover of the book, self-published through Trafford, depicts a happy girl in a garden with a rash on her stomach.

Dr Hambleton told *news.com* the publishers of the book "should be ashamed of themselves".

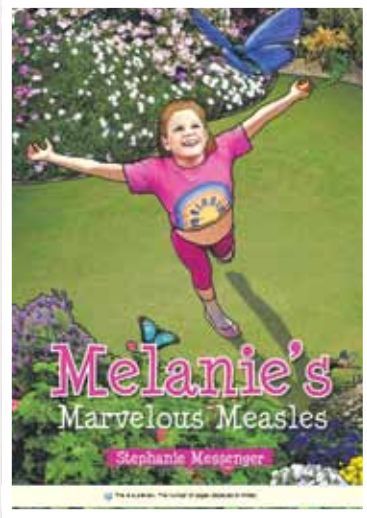
"Last time I saw a kid with measles with a rash, they were carried into the surgery and the child looked like a rag doll. The mother was terrified," he said.

Dr Hambleton said measles could lead to potentially fatal complications such as encephalitis, and could not be cured – as the book suggests – by carrot juice and melon.

"Any publication that suggests getting the illness is safer than getting the vaccination is patently wrong and misleading, and the publishers should be ashamed on themselves for the picture they've allowed to be put on the front cover," he said.

The medical and scientific communities have recently intensified their efforts to provide accurate information about the benefits and risks of immunisation in the face of a rash of misleading and alarmist claims about the dangers of vaccination.

In November the AMA endorsed publication of the booklet *The Science of Immunisation: Questions and Answers*, which was produced by the Australian Academy of Science to dispel myths and misinformation about the dangers of vaccination.



In a recent article at *The Punch*, world-renowned Australian research biologist Sir Gustav Nossal condemned the arguments of anti-vaccination activists as "fatally flawed", and last month the New South Wales Office of Fair Trading gave the anti-vaccination lobby group the Australian Vaccination Network two months to change its name, judging it to be "misleading and a detriment to the community".

Copies of *The Science of Immunisation: Questions and Answers* booklet can be obtained by contacting the AMA, either by email at: media@ama.com.au OR by writing toAMA Public Affairs, AMA House, 42Macquarie Street, Barton, ACT, 2600

VALE

The President, Dr Andrew Miller, Board, Members and Staff of the AMA ACT extend their sincere condolences to the families, friends and colleagues of Brian Treloar, Reginald Kitchen and Peter Rea.

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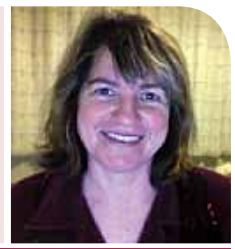

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