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Don't lose sight of your patients – AMA says Optometry Board puts glaucoma patients' care at risk

The AMA is advocating that Australian Health Ministers reverse a decision by the Optometry Board of Australia to allow optometrists to independently manage patients with glaucoma.

AMA President, Dr Steve Hambleton, said that the decision puts comprehensive quality care of glaucoma patients at risk.

"The Optometry Board decision goes against the advice of the Pharmaceutical Benefits Advisory Committee (PBAC) and against the wishes of the peak glaucoma support group, Glaucoma Australia," Dr Hambleton said.

"Glaucoma is known as the 'sneak thief of sight', and one in 10 Australians over 80 will develop the disease.

"It is a complex disease that comes in many forms, and requires highly specialised care over time.

"The Optometry Board has shown that is out of step with best practice care for patients with glaucoma.

"PBAC recognises the importance of optometrists confirming diagnoses of glaucoma with ophthalmologists, and the need for these two health professions to work together to manage patients with glaucoma, and also recommends the sharing of information with the patient's GP to complete the clinical team.

"Glaucoma Australia wants the current arrangements for the detection and management of glaucoma to be maintained.

"Yet the Optometry Board has given the green light for optometrists to go it alone in caring for glaucoma patients.

"This is an irresponsible decision by the Board and it must be reversed immediately," Dr Hambleton said.

On 21 March 2013, the Optometry Board of Australia released revised guidelines for optometrist use of schedule medicines.

The Optometry Board asserts that optometrist *"competency standards address differential diagnosis and treatment options …"*

In its submission to the Optometry Board, Glaucoma Australia stated:

Independent and ongoing management of a glaucoma patient by an optometrist alone has the potential to increase the likelihood of missing disease progression on the one hand or to over-treat glaucoma suspects on the other. Glaucoma Australia believes the best option from a patient perspective is the current system where optometry is the logical first port of call for the Australian community to be comprehensively assessed for signs and symptoms of glaucoma, with an ophthalmologist confirming that diagnosis and then discussing and initiating treatment.

In a Fact Sheet, the Optometry Board states that it considered *"the practical limitations of the requirement (under the previous guidelines) for participation in a documented shared-care or management plan with an ophthalmologist"*. The AMA asserts that no evidence of the *"practical limitations"* was provided to the Board in the submissions made to its consultation paper.

The table below shows the anti-glaucoma medicines that the Optometry Board of Australia has listed for optometrists to prescribe independently, compared to other regulatory arrangements and the NHMRC Guidelines:

Medicine	PBS Listing	NHMRC Guidelines	Australian Register of Therapeutic Goods
Apraclonidine	medical practitioners only	2nd line treatment	Listed
Betaxolol	Shared care with, and diagnosis confirmed by, ophthalmologist	1st line treatment	Listed
Bimatoprost	Diagnosis confirmed by, and shared care with, an ophthalmologist	1st line treatment	Listed
Brimonidine	Shared care with, and diagnosis confirmed by, ophthalmologist	2nd line treatment	Listed
Brinzolamide	Shared care with, and diagnosis confirmed by, ophthalmologist	2nd line treatment	Listed
Carbachol	Not listed	3rd line treatment	Listed
Diprivefrin	Not listed	Not listed	Not listed
Dorzolamide	Shared care with, and diagnosis confirmed by, ophthalmologist	2nd Line treatment	Listed
Latanoprost	Shared care with, and diagnosis confirmed by, ophthalmologist	1st line treatment	Listed
Levobunolol	Not listed	1st line treatment	Listed
Pilocarpine	Shared care with, and diagnosis confirmed by, ophthalmologist	3rd line treatment	Listed
Timolol	Shared care with, and diagnosis confirmed by, ophthalmologist	1st line treatment	Listed
Travoprost	Shared care with, and diagnosis confirmed by, ophthalmologist	1st line treatment	Listed

Potential systemic side effects from beta-blocker eye drops (eg Timolol) include bronchospasm, hypotension, bradycardia, heart block, masked hypoglycaemia, adversely affected lipid profile, impotence, fatigue, depression, reduced exercise tolerance, fainting, confusion, and alopecia.

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TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

I have just returned from a brief holiday in the apple isle, walking on the Freycinet Peninsula. Just experiencing a few days without mobile phone contact was refreshing. While there I met an interesting young man. He was the guide for our group; and extraordinarily enthusiastic and knowledgeable. He had completed a certificate IV course in tourism in Tasmania 18 months previously after spending his years after school doing casual labouring jobs with, by his own admission, no real future and no plans. Since obtaining his qualification he had been working on a number of the "Great Australian Walks" as a guide. This qualification had been transformational. I looked up the course today. It costs $1900, not allowing for textbooks and equipment.

I am old enough to remember another facet of the Hawke years, one not mentioned by Simon Crean and Martin Ferguson. I am recalling the "Clever Country" campaign; and find myself contrasting this with the recently announced higher education and self-education savings measures announced by the Gillard government to help fund the Gonski report-inspired secondary education expenditure increases.

I have had 3 children attend university, in a variety of courses; and a 4th just start this year. I have been struck by the reduction in face to face teaching that prevails these days compared with our own BC (before computer) years in tertiary education. Part of the drive to on-line education is, I am sure, a cost-saving measure. I recently had a colleague describe the training in a medical course (at another university I hasten to add, not ANU) as "teach yourself medicine". I find myself asking just what, other than meaningless jargon, is an "efficiency dividend" in education, and how does one reap it?

I have also just paid my registration for my college annual scientific meeting. To meet my CPD requirements for continued registration I need to attend this conference because it will provide a large slab of CPD points (not all that I need, but a significant contribution). The registration cost was over $1200 for 5 days. The exotic resort is Darling Harbour. The cheapest accommodation will still push me over $2000 expenditure; and that without eating anything or travelling.

I have read the Treasurer's press release, euphemistically titled "Reforms to self-education expense deductions". I wonder about our junior doctors and the fees that they must pay as they undergo advanced training, for exams and courses; about the cost of journals and texts.

The AMA is taking the only stand that is reasonable in these circumstances; one of firm opposition. It will be interesting to see if the government is willing to listen.

And I think about our young guide in Tasmania; and how he and so many others like him who are not sheltered by HECS may hope to make opportunities for themselves so that they don't have to be the ones sweeping the floors while 457 visa holders work the plum jobs (to paraphrase our Prime Minister's appalling misrepresentation of our health sector work force). The clever country would seem to be dumbing down.

A senior bureaucrat said to me today "just another stupid decision". I couldn't agree more.

The news about these taxation changes has served to overshadow another "conversation" that we are told we will need to have. Appropriate really considering the company it keeps. This concerns "revalidation" of medical professionals. Whilst the Medical Board of Australia has indicated its intention to work consultatively with the profession in its conversations with us, the public rhetoric revolves around protection of the community from bad doctors.

The most often quoted source is Bismark MM, Studdert D (Realising the research power of complaints data. *NZ Med J 2010;123:12–1*). Here a study of complaints databases found that 3% of doctors were responsible for 49% of complaints. Now, there is little doubt in my mind that we as a profession have great difficulty dealing with problematic colleagues. The community perceives these as a failing in systems designed to ensure that quality standards are preserved. What Bismark has highlighted is that it is possible to identify doctors at risk of persistent poor practice. They did not advocate a profession-wide process. Gallagher TH, Levinson W (Physicians with multiple patient complaints: ending our silence. *BMJ Safety and Quality Online 2013; 10.1136/bmjqs-2013-001880*) in a reasoned editorial have argued that the keys are found in collegiality, local activism and performance monitoring. They also cite Egener B.(Addressing physicians' impaired communication skills. *J Gen Intern Med 2008;23:1890–5*) who states that these "frequent flyers" are characterised by a lack of insight.

None of this has convinced me that a profession-wide revalidation process will achieve the espoused outcome. If we are not careful the burden of meeting statutory requirements will become a significant impediment to productivity. The UK experience is suggesting that a disturbing number of work hours; up to 15% or more, may be expended undergoing revalidation activities.

The debate will happen, that much is out of our control; so it is most important that we engage actively. This will happen at a political level with the AMA, but we also need to ensure that our colleges come on board as well.

I also think it important for each one of us to "act local" by engaging at a personal level with our colleagues, to support and mentor.

In terms of acting locally, I would like to report that the VMO contract negotiations are progressing as expected. This means that we have made substantial progress towards defining the essentially irreconcilable differences between ourselves and the offer from ACT Health Directorate. This means that arbitration is pretty much inevitable. The negotiations have been conducted professionally and in good faith. I hope that all the parties involved in the upcoming salaried doctors EB negotiations will conduct themselves in a similar manner. The AMA-ACT has been requested to act as representative by a number of salaried doctors and so plans to be at the table as the process unfolds.

The AMAs involvement in the fundamentals of employment and contracted services is core business for the AMA and I'd encourage salaried and privately practising doctors who are not yet members to join up and reap the benefits that belonging to the largest independent medical association in the country can offer.

For some time out, I thoroughly recommend Tasmania as a holiday destination. Our lodge accommodation on the Freycinet Peninsula had a policy of showcasing local products. The food and wine had travelled very few kilometres to our tables. The quality was excellent. The walking was suitably strenuous, but while looking at where I was putting my feet I found an amazing variety of fungi! My new photographic fad; Tasmania aifunghi.

A final sad note though. Daryl Lawrence, wife of well-known Canberra anaesthetist, Dr Hugh Lawrence, died recently following a long journey with cancer. We, at AMA ACT and Canberra Doctor, send Hugh, his daughters and son and extended family members our heartfelt condolences at this very sad time.

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The history of the Port Phillip Medical Association Minute Book – 1846-1851

166 years ago the tradition of medical associations was founded in the form of the Port Phillip Medical Association (PPMA).

The original Minute Book of the PPMA is the most treasured document in the archives of AMA Victoria and a replica is available for purchase.

Three years ago it was painstakingly restored and its pages photographed. Since then, a team of dedicated volunteers, Drs Walter Heale and Peter Lowe and Associate Professor John Hart, has transcribed the contents and compiled a detailed and absorbing history of the Association.

Established in 1846, the PPMA predated both the British and American Medical Associations and was the forerunner of the Victorian Medical Association, the Medico Chirurgical Society and the Medical Society of Victoria.

The Minute Book covers the period from the PPMA's inception to its disbanding in 1851 (some of its members reformed six months later as the Victorian Medical Association).

The minutes provide a fascinating insight into the thoughts and concerns of our medical pioneers, and many of the issues they addressed – quality of care, medical ethics, education, billing and so on – still echo today.

These early practitioners, despite their isolation, kept abreast of developments in medical practice, and there is an account of an early demonstration of the use of ether as an anaesthetic.

Recognising that the copperplate script and the idiosyncrasies of 19th century English at times present challenges for the reader, the contents have been fully 'translated' and are provided on CD alongside the digital replication of the Minute Book. The third component of this fascinating package is the history of the PPMA

It details the historical context of the Association, a summary of its activities over the five years it existed and biographical notes on its founding members. The final product is a tribute to the many volunteers who have contributed to the project's completion.

The digital replication of the original Minute Book, its transcription and the history of the PPMA are now being made available to all members of AMA Victoria and will certainly be a valuable addition to the bookshelves of everyone with an interest in the medical profession and its history.

"The book is of great interest because it reflects Victorian society at the time, including how much doctors earned per patient – a guinea in 1848, which translates to about $4–5,000 in today's terms," says Dr Segal, former AMA Victoria President and honorary archivist.

"In those days, medical treatment was for rich people only. Seeing one patient per day was sufficient for a doctor to keep himself (and they were, for the most part, male) in great comfort – but doctors would see up to five. This workload stands in stark contrast to that of the GPs of today, who have ever-increasing patient loads and limited spare time in their working days.

The leisurely working hours doctors kept in those days gave them plenty of spare time, and this meant there was room for community involvement. Many became upstanding members of their local communities – mayors, for example, or philanthropists. "In a sense they were visionaries, because they devised the rules for medical associations well before any other medical group in the world," says Dr Segal. "They were pioneers who influenced their peers in the UK and US – their ideas and the rules they created were solid."

One of the achievements of AMA Victoria's 'founding fathers' was to devise a standard set of fees based on the UK scale. This ensured that an equitable schedule of fees was established from the outset, and reinforced the status of the profession. The group also defined the boundaries of the professional association, agreeing that the AMA would not act as a regulator (like the Medical Board, for example) or set ethical standards. As with all fledgling organisations, there were disputes and transgressions. The first big fight broke out over 'hazing', which was the pinching of another doctor's patient – a heinous crime in those days. Another dispute took place over a president who died and left the entire medical library in private hands. The association sued his estate to reclaim these precious medical books, which were at that time (in the absence of the plethora of media now available for learning and teaching) fundamental to medical practice, and were shipped on a yearly basis from the UK.

Dr Segal says that the book should be of great interest not only to anyone with an interest in early Victorian history, but also to those who wish to understand how medical societies function. "All doctors should read this because it explains the ethics and boundaries by which we work as doctors, and how they evolved. An understanding of this process will make junior doctors better doctors and should be compulsory for students. "It gives us all the knowledge of where we've come from as doctors."

The complete package is available for sale for $24.50 (incl. GST, p&p).

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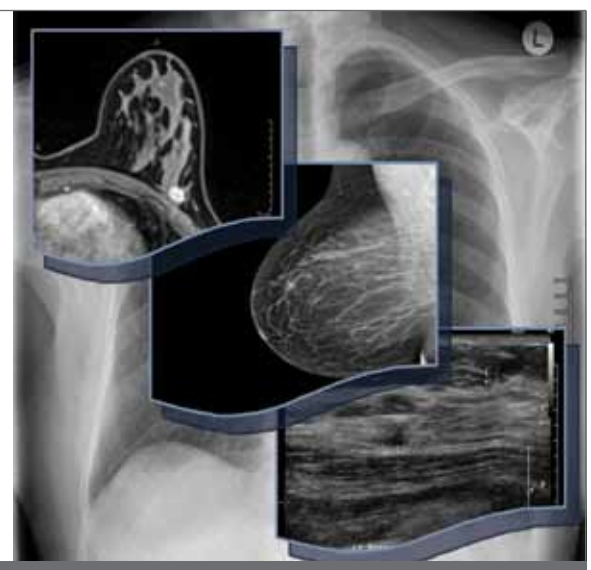

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Medical training a casualty of education expense reforms - AMA seeks meeting with Treasurer

Doctors face the difficult choice of paying higher out-of-pocket costs to pursue life-saving medical training courses or cutting back on these types of courses as a result of self-education expense reforms announced by the Government over the weekend.

Under the reforms, the tax deduction for work-related self-education expenses will be limited to $2,000 per person from 1 July 2014.

AMA President, Dr Steve Hambleton, said the Government has created a huge disincentive for doctors to pursue specialised education that could help save lives and improve the quality of life for many Australians.

"Medical training courses are very detailed and do not come cheap," Dr Hambleton said.

"Australia has some of the most demanding medical training courses in the world, and the Medical Board of Australia and the Medical Colleges require doctors to maintain their skills through continuing professional development.

"A $2000 cap on tax deductions self-education expenses for doctors falls well below many basic course costs.

"For example, the Australian and New Zealand Surgical Skills Education and Training (ASSET) program costs $3280, the Care of the Critically Ill Surgical Patient course costs $2735, and a GP attending a Clinical Emergency Management Program (CEMP) workshops can face combined costs of over $3000.

"Many doctors will undertake more than one course a year in order to maintain and improve their qualifications.

"Australian doctors also travel overseas to learn about the latest medical research and innovations, innovative surgery techniques, and advances in overall patient care.

"Self-education costs for doctors are very high.

"The Government's proposed reforms will hit junior doctors, salaried doctors, GPs and other specialists, and patients.

"We urge the Government to reconsider these ill-informed changes," Dr Hambleton said.

Feedback from local junior medical staff highlights real concerns about this new ill-conceived initiative of government.

You probably already knew this, but research has confirmed chicken pox vaccine is saving children's lives

The widespread introduction of a chicken pox vaccine in Australia in 2006 has prevented thousands of children from being hospitalised with severe chicken pox and saved lives, according to new research from South Australia.

In a national study of chicken pox admissions at four participating Australian children's hospitals, researchers found the number of children hospitalised with chicken pox or shingles had dropped by 68% since 2006.

Prior to the chicken pox vaccine being available, each year Australia had an estimated 240,000 chicken pox cases, with 1500 hospitalisations and between 1-16 deaths.

The study also shows that of children needing hospitalisation for severe chicken pox, 80% had not been immunised.

The research was led by Associate Professor Helen Marshall from the University of Adelaide and Women's and Children's Hospital, and researchers of the Paediatric Active Enhanced Disease Surveillance (PAEDS) product.

"These results are a very strong endorsement of the impact of chicken pox vaccine being available for children through the national childhood immunisation program, and of the need to immunise all children against chicken pox," said Associate Professor Marshall.

"A higher level of immunisation would have spared most children from severe chicken pox, which in a few cases required intensive care treatment. Based on the results of our studies, this is now mostly preventable", said Associate Professor Marshall.

[The PAEDS network was established to provide accurate and timely data on paediatric conditions of public health importance and requiring hospitalisation. PAEDS is coordinated by the Australian Paediatric Surveillance Unit and the National Centre for Immunisation Research and Surveillance in Sydney and funded by the Federal Department of Health and Ageing. PAEDS collects data from major paediatric hospitals in SA (Women's and Children's Hospital), WA (Princess Margaret Hospital), NSW (The Children's Hospital at Westmead) and Victoria (Royal Children's Hospital).]

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Time to address student mental health

The Australian Medical Students' Association (AMSA) has released its Student Mental Health and Wellbeing Policy, which calls on the Federal Government to work with Australian universities to address the significant mental health burden afflicting Australian youth. Despite their high burden of disease only 23 percent of those with a mental health disorder access health services.

Australian Institute of Health and Welfare data shows that more than a quarter of 16 to 24 year olds experience a mental health disorder over a 12 month period.

Acting AMSA President, Richard Arnold, said when launching the Policy, "that the Federal Government is aiming for 40 percent of 25 to 30 year olds to hold a Bachelor degree by 2025. This means at least 40 percent of Australia's youth should pass through a tertiary institution, creating an ideal opportunity for the institutions to help prevent mental health conditions or provide access to early intervention.

"Students who suffer from poor mental health are less likely to perform well at university, which will impact on their long-term productivity and contribution to the Australian economy.

"Research and intervention now, will benefit the Australian community and economy into the future."

The full policy can be found at www.amsa.org.au/adovcacy/official-policy

CPSC and ACCC warn of poison dangers with liquid laundry packets

WASHINGTON, D.C. – The U.S. Consumer Product Safety Commission (CPSC) and the Australian Competition and Consumer Commission (ACCC) are urging parents to take immediate action to ensure their family is not exposed to the hazards posed by liquid laundry packets or capsules.

Young children who are exposed to the highly concentrated, toxic detergent are at risk of serious injury.

Reports of incidents in the United States and Australia have prompted the product safety agencies to warn parents about what can happen if these products are not used safely. Children who have ingested detergent from the packets have required medical attention and hospitalization for loss of consciousness, excessive vomiting, drowsiness, throat swelling, and difficulty breathing. Eye contact has also resulted in reports of injury, including severe irritation and temporary loss of vision.

"Poison call centres across Australia have received more than 85 calls in the last 18 months relating to exposure to these laundry capsules," said ACCC Deputy Chair Delia Rickard. "The experience in Australia is consistent with an international trend, where most cases have involved a child aged five years or younger."

The number of incidents, in a relatively short period of time, suggests that children are highly attracted to the packets, which can resemble play items. The soft and colourful product can be easily mistaken by a child for candy, toys, or a teething product.

Water, wet hands, and saliva can cause the packets to dissolve quickly and release their highly concentrated toxic contents. Parents and caregivers are urged always to handle the product carefully and with dry hands.

If swallowed or exposed to the eye:

- immediately call the Poisons Information Centre on: 13 11 26.
- if swallowed, rinse as much of the detergent as possible from the mouth.
- if exposed to the eye, flush the eye with water for at least 15 minutes.

"The ACCC has been working closely with industry association Accord Australasia to improve the safety and packaging of these products. With the assistance of Accord, industry has acknowledged our concerns and has signalled that changes will be made. Expected changes include the redesign of the product and outer packaging so it features prominent warning labels and consistent safety information," said Ms. Rickard.

For more information about product safety in Australia, vist www.productsafety.gov.au, follow the ACCC on Twitter at www.twitter.com/ACCCProdSafety or call the ACCC Infocentre on 1300 302 502.

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What's the AMA doing for General Practice?

This report from Kambah GP, Dr Suzanne Davey, is a summary of the February 2013 meeting of the AMA's Council of General Practice. The Council members come from across the nation to discuss issues of importance to general practice, general practitioners and patients.

Further information of any of the issues highlighted below can be obtained from Dr Davey or from the AMA ACT Secretariat.

- **Support for RACGP initiatives.** Federal AMA President, Dr Steve Hambleton thought that the AMA should support the RACGP initiatives re funding for training and no loss of chronic care funding, in this election year.
- **The GP/Hospital Integration Position** statement is to be upgraded from the 2006 version, taking into account the ageing population with its chronic disease burden and the pivotal role general practice plays in long term patient management. The AMACGP is to ask the Federal Secretariat to develop a new position statement on discharge summaries.

This fits in with outcome of the ACT Clinical Senate meeting that I attended on in December last year on Clinical Handover.

Issues were raised by hospital specialists that they could not contact GPs by phone because of the trouble they had getting through on GP phone switchboards and in particular because of the part time hours many GPs worked, limiting their availability for direct phone communication. I brought up the issue that hospital discharge summaries now contain reams and reams of results with very little analysis of what the patient's actual diagnosis was, with a future plan of action. It was thought that this was because the most junior member of the team wrote the discharge summary, and that this person often lacked understanding of what actually went on during the patient's admission. It would be preferable for the Registrar or Specialist to write the discharge summary.

- **PCeHR:** There have been 62,000 patient registrations out of a possible 20 million.

DOHA has advised that 4,200 general practices have registered HPI-O by late January 2013, as a precursor to being able to claim eHealth PIP payments. This is more than 90% of practices previously claiming the eHeath PIP. Secure messaging remains a difficult issue. The AMA has put in a Federal Budget submission emphasising that practising clinicians should oversee the implementation, evaluation, and adjustment of the PCeHR, as clinicians are currently being squeezed out of the decision-making.

- **Barriers to clinical teaching** were discussed, noting that currently only 10% to 20% of vocationally registered GPs teach or are accredited to teach.

The percentage of PIP practices hosting medical students has declined since last year from 19.9% to 16.2%. The AMA has proposed that the PIP be doubled, the federal government called upon to expand the GP infrastructure grants program, and that new initiatives be identified and developed to encourage and support more GPs to teach.

- **Revalidation:** The concept of revalidation is seen as inevitable by the Medical Board. The AMA Executive Council wishes to engage with the Medical Board on the issue. In particular, it wishes to introduce the concept of professional responsibility for addressing risky behaviour directly with colleagues on the basis of avoiding the need to make a mandatory report. Several points were made. Older doctors should change their practice style so that they see fewer patients and spend longer on each consultation. Multiple tools should be used to assess doctors, looking for panhypocompetence.
- **IMGs:** a discussion paper on IMGs was presented which stated that IMGs would continue to made up a large portion of the Australian workforce, and that the AMA should endeavour to find out what their needs were and how best to support them.

Note was made of the AMA nationally run **Career Advisory Service** based in the AMA ACT which supports IMGs seeking jobs with information, resume and interview advice and career counselling.

- **Bulk billing Fact Sheet:** DOHA has reiterated that no charge can be made where a service is bulk-billed.

In particular:

(a) a charge cannot be made for dressings to be used either in the consultation or for use at home if the service is bulk-billed; and

(b) a registration fee cannot be charged to attend a practice if the consultations are to be bulk-billed

The AMA encourages doctors to set their fees based on their practice cost experience including consumables that are used as part of the service.

- **DHS Large practice Compliance project:** DHS believes that some larger practices (4 or more doctors) are not complying with MBS item number billing and is to investigate billing practices in these practices.

The AMA has pointed out that medical practitioners may not have autonomy over billing practices, diagnostic requests and referrals in larger practices. The AMA states that consideration needs to be given as to the set-ups/drivers/systems that put medical practitioners at risk of non-compliance.

The AMACGP thought DHS's so called **"education" letter to be sent to GPs** was overly threatening and punitive, and Steve Hambleton was to write to DHS accordingly. (An edited version of this letter is included in this edition of Canberra Doctor).

- **The Medical Home:** The AMA supports the internationally held concept of the "Medical Home" where the patient identifies with a personal GP within a nominated general practice as the provider of primary health care to that person. The AMA supports voluntary registration of a patient with a particular practice, but not capitation or compulsory registration.
- **Private Health Insurer's:** AMA supports efforts to bring role of GPs more centrally into PHI's current primary care focussed programs.

Discussion of ehealth business solutions to facilitate non face to face interactions between GP and patient and be able to change for them: - AMA will update position statements on ehealth after asking secretariat to investigate pros and cons.

- **The 2013 Family Doctor Week promotion will focus around the slogan:** Your Family Doctor Your Medical Home. (Canberra Doctor will again celebrate regional GPs in its annual Family Doctor Week edition in July 2013).
- **Chronic Diseases items review:** DOHA is seeking input from AMA about developing a better funding model for managing chronic disease. Apparently there is exploitation of chronic disease management item numbers by other than usual doctor charging for them. AMA has developed a Chronic Disease Management Plan with which it will brief DOHA. There is no more money available- just a fairer redistribution.
- **Medicare Locals:** In view of the Opposition's lack of clarity re Medicare Locals, the AMACGP is to ask Federal Council to call on the opposition to commit to an independent review of Medicare Locals, if elected. The AMA remains concerned that MLs in their current form will consume health funding that could be better utilised by GPs in delivering services to patients, and that the MLs will have a focus which extends beyond primary care and support of GP service delivery, so that primary care resources may, in fact, be directed away from general practice.

Dr Suzanne Davey
Chair, AMA ACT GP Forum & ACT AMA representative to the AMACGP

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Billing accurately under Medicare

Medicare Australia is writing progressively to all health practitioners in Australia throughout 2013 reminding of the responsibility to bill accurately under Medicare.

The letter, which may have already been received by some practitioners, reminds that "you are responsible, as an eligible health practitioner, for your billing, and you may be asked to substantiate claims made to Medicare using your Medicare provider number or in your name. This is the case regardless of who provides the administration for the billing, or the nature of your business relationship with the practice."

The letter reminds that when you bill under Medicare:

- Australian law determines the rules for billing under Medicare
- If you bill under Medicare, you must fulfil the requirements of the MBS
- You are legally responsible for services claimed under Medicare when they are billed under your Medicare provider number or in your name
- It is also your legal responsibility to ensure that any patient referrals or requests for services that will be claimed under Medicare are medically necessary for the treatment of the patient
- Medicare has sophisticate ways to detect possible inappropriate practice or incorrect claiming. We may undertake compliance audits or reviews under the Practitioner Review Program where we detect billing of concern
- If service has been billed incorrectly under your Medicare provider number or in your name you will be responsible for the repayment of benefits in excess of what should have been paid. These excess benefits are a debt owed to the Commonwealth, and we are legally obliged to recover these debts; and
- Administrative penalities may apply.

The letter recommends that you

- Ensure items billed for services you provide are in accordance with MBS requirements
- Review your billing at your practice to identify and correct processes that may put you at risk of billing incorrectly under Medicare
- Ensure you are able to substantiate all claims made under your Medicare provider number or in your name, and
- Advise Medicare if you are aware of incorrect Medicare payment by completing the Voluntary acknowledgment of incorrect payments form available at humanservices.gov.au/health professionals>DoingbusinesswithMedicare>Compliance>IMCA resources

medicare

Warning issued by infectious diseases experts to stay away from bats

Infectious diseases experts at a major international infectious diseases conference have issued a stark warning for people to stay away from bats, after releasing details of the treatment of an 8-year-old boy in Queensland, Australia, who died from Australian Bat Lyssavirus (ABLV) earlier this year.

Dr Joshua Francis and Dr Clare Nourse (Paediatric Infection Management Service, Mater Children's Hospital, Brisbane, QLD) and colleagues issued the warning at the Australasian Society for Infectious Diseases (ASID) meeting held recently in Canberra.

ABLV was first identified in Australian bats and flying foxes in 1996 and remains common in both animals, though human infection is extremely rare. Two adult cases were confirmed in 1996 and 1998, and followed a similar disease course to rabies before being fatal in both cases. One was a woman bitten by a flying fox after trying to remove it from a child, the other a carer who looked after these animals. Other lyssavirus strains circulate in bats in the USA and Europe, and multiple cases of human infection, and subsequent deaths, have been reported. Thus this warning issued by experts applies to wherever bat or flying fox populations exist.

There is no proven effective treatment for lyssavirus infection in humans. Only experimental treatments have been applied, such as the antiviral amantadine and other measures such as maintaining sedation and glucose balance, which have not been shown to be effective. Once the disease has progressed, it is almost always fatal.

The 8-year-old boy is just the third reported case of ABLV and the first in a child. At the ASID meeting, Dr Francis described what happened to the 8-year-old boy, who was bitten during a family holiday to northern Queensland in December 2012. The boy did not tell his parents he had been bitten, and three weeks later began to suffer convulsions, severe abdominal pain and fever, followed by progressive brain problems, with intermittent periods of lucidity. The boy was intubated and ventilated while doctors frantically tried to establish what was wrong with him. Analysis of his brain and spinal fluid were normal at first, but on day 10 of his admission increased levels of lyssavirus were detected. The boy's neurological condition deteriorated, characterised by symptoms such as abnormal movements, and he then went into a coma. Treatment with amantadine was unsuccessful, and he tragically died on February 22, 2013.

Dr Francis says the warning has been issued not just for the danger from bats themselves, but the risk, however remote, that the disease can spread between humans. He says: "Human to human transmission of lyssaviruses had not been well documented, but it is theoretically possible. Local and international guidelines recommend post-exposure prophylaxis (PEP) for

anyone who has had skin or muscosal contact with saliva or neural tissue from an infected person. This involves immunoglobulin treatment and vaccination. Following the diagnosis, we identified 175 potential contacts of the boy, and of these five household members and 15 healthcare-workers were offered PEP."

He concludes: "ABLV has proved fatal in all cases reported to date. There is a need for increased public awareness of the risk associated with bat contact. In short, people should stay away from bats. For anyone exposed, PEP is effective at preventing progression to disease, and should be considered as soon as possible in all cases that constitute a potentially significant exposure..

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It was a real pleasure to know that our day hospital was closely supervised by a professional project manager, Shaun. This relieved a lot of stress involved in a new business venture. I have subsequently engaged Shaun in other projects including our full house renovation completed in February 2012"

- Dr Roger Lee, Gastroenterologist & Endoscopist, ACT Endoscopy

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Study shows that measles can spread beyond those seated immediately around an infectious person on aeroplanes

New research published at the recently held Annual Scientific Meeting of the Australian Society for Infectious Diseases (ASID) in Canberra demonstrates that direct contact tracing of aeroplane passengers seated immediately around an infected person, as is currently recommended in Australian and other international public health guidelines, is not an effective strategy to prevent further cases. The research is by Dr Gary Dowse, Communicable Disease Control Directorate, Department of Health, Perth, WA, Australia, and colleagues.

Not much data exists regarding measles transmission during aeroplane travel, or the effectiveness of contact tracing. In this study, Dowse and colleagues analysed the risk of transmission associated with infectious measles cases who travelled on flights to or within Australia. The authors obtained information from all state and territory health authorities in Australia on measles cases notified in Australia in the period Jan 2007 to June 2011, and who were likely to have been infectious or infected while travelling on aeroplanes.

The researchers identified 45 infectious cases who had travelled on aeroplanes, involving 49 separate flights (some had connecting flights). 20 secondary infections (people who were infected by the primary cases and became ill in the 10-14 days after the flight) occurred in people on 7 of 49 flights on which infectious cases travelled. Secondary cases occurred on 7 of 36 international flights and none of the 13 domestic flights that infectious cases had travelled on.

Most of the primary cases were Australians who were infected overseas, in a range of countries – primarily developing countries in SE Asia and Asia where measles transmission remains endemic, but also in some European countries, including the UK, which have had measles epidemic activity in recent years. Almost all the secondary cases were also Australian.

Nine (45%) of the secondary cases were seated within 2 rows of the index case, while 11 cases (55%) were seated outside 2 rows, beyond the range of seats for which contact tracing is currently recommended. Secondary transmission was more likely to occur when primary cases were in young children, and where there were multiple infectious cases travelling. "Because of delays in diagnosis and notification of cases, and the additional time to access flight information, only 31% of flight manifests were available to health authorities within 5 days of travelling," says Dr Dowse. "This means that in most cases it was too late to provide vaccine or immunoglobulin that might prevent illness in exposed passengers who were found to still be susceptible to infection." The delays identified do also have implications for the timeliness of being able to contact trace people potentially exposed to other infectious diseases, which may be more serious than measles..

The authors say that the results show that, despite secondary measles transmission occurring in 1 in 5 international flights with infectious cases, the risk was not clearly related to seating proximity and contact tracing was ineffective, especially given delays in diagnosis, notification, and accessing flight manifests. Dr Dowse says: "We recommend that direct contact tracing to identify susceptible people exposed to measles cases on aeroplanes should not be undertaken routinely, and other strategies should be considered."

He concludes other strategies could include using general media alerts identifying flights on which passengers may have been exposed, and which provide advice as to what passengers should do (such as see their doctor promptly if they think they have not been vaccinated as there may be time to be protected, or if they develop symptoms consistent with measles). Another possible strategy would be to consider SMS messaging or email alerts to all passengers on an affected flight, if airlines can provide such details (or send messages on behalf of health authorities if they are unable to release such information).

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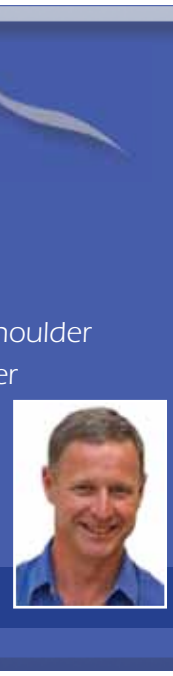

THE NOTICE BOARD!

AMA Practice Managers Network

TOPIC: ACT Work Health and Safety Legislation.
WHEN: 6 pm Wednesday 8 May 2013
VENUE: AMA ACT 42 Macquarie St Barton.

A representative from Worksafe ACT will give a presentation on recent changes to the ACT Work Health and Safety legislation.

This session is open to practice managers and senior staff of AMA ACT members.

If you would like to attend this meeting, please RSVP by Friday 3 May to membership@ama-act.com.au

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2012 AMA Junior Doctor Training, Education and Supervision Survey

Quality clinical training, education and supervision in public hospitals underpin medical education in Australia and should be seen as an investment in the future health care for Australian communities.

The 2012 AMA TES survey of junior doctors delivers mixed results for public teaching hospitals in Australia. While there are indications that the medical education system is coping despite large increases in training capacity, there is significant room for improvement in a number of areas.

The AMA is calling for:

- Increased educational oversight for prevocational doctors beyond PGY2+, with increasing integration of unaccredited registrar posts into vocational training;
- Recognition and development of the role of junior doctors as teachers and trainers with the provision of education and resources to develop the teaching skills of junior doctors;
- Improved provision of flexible working hours by both employers and vocational training providers;
- The urgent development of an articulated clinical academic pathway for medical students, trainees, senior doctors and existing clinical academics;
- The exploration of robust and transparent funding models for teaching and training, ensuring that investment in these activities is adequate with indexed, protected funding; and
- A framework for measuring the quality of medical training. This should include consideration of a national training survey, development of key performance indicators, and inclusion in the National Health Performance Authority's performance and accountability framework.

The AMA Junior Doctor Training, Education and Supervision (TES) survey – conducted during June and July 2012 – received 1,112 detailed responses from junior doctors about their medical training experiences in the public hospital system.

AMA President, Dr Steve Hambleton, said that the survey delivered mixed results for public teaching hospitals in Australia.

"Quality clinical training, education and supervision in public hospitals underpin medical education in Australia," Dr Hambleton said.

"Medical training must be seen as an investment in the future health care for Australian communities.

"The AMA TES survey provides clear guidance from the training coalface about what needs to be done to maximise the benefits from that investment.

"We must invest strongly to provide better support for our public teaching hospitals to maintain the key teaching and training roles and to preserve quality, safety and good patient outcomes.

"The survey indicates that the public hospital system is doing its best to support medical education in the face of growing numbers of medical students and junior doctors, but the system's capacity is being stretched.

"The system is working best for junior doctors in the structured environment of internship and vocational training.

"But junior doctors working in unaccredited roles or in unstructured training programs are less satisfied with their training experience.

"There is room for significant improvement in providing quarantined time for research, support for part-time or flexible hours, and providing teaching skills for junior doctors.

"Immediate significant investment is needed to ensure the quality of medical education and training for the burgeoning medical training pipeline."

The AMA Junior Doctor Training, Education and Supervision (TES) survey isavailable from www.ama.com.au

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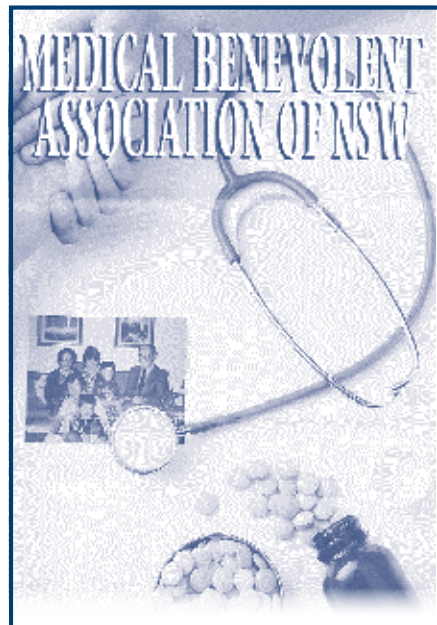


Assisting Canberra Doctors and their families too!

The Medical Benevolent Association is an aid organisation which assists medical practitioners, their spouses and children during times of need.

The Association provides a counselling service and financial assistance and is available to every registered medical practitioner in NSW and the ACT.

The Association relies on donations to assist in caring for the loved ones of your colleagues.

For further information please phone Meredith McVey on 02 9987 0504

Criminal Negligence for Medical Professionals after Patel v The Queen [2012] HCA 29

By Kate Mahoney

In 2003 Dr Jayant Patel arrived at Bundaberg Base Hospital appointed as a Senior Medical Officer. Within a week he was appointed the Director of Surgery despite having no specialist registration in Queensland.

In May 2005 the Queensland Government launched an Inquiry into all Queensland Hospitals commencing with Bundaberg Base Hospital. The Commissioner found that Dr Patel caused 13 deaths and many serious complications in the operations he performed.

The Inquiry also uncovered systemic problems in the administration of Queensland Health, the Medical Board of Queensland and the Bundaberg Hospital relating to Dr Patel's appointment. The Commissioner recommended further investigations including a police investigation into Dr Patel's actions.

In 2010 Dr Patel was convicted of three counts of manslaughter and one of grievous bodily harm and sentenced to 24 years incarceration in total. On appeal in August 2012, the High Court quashed the convictions on the basis that there had been a substantial miscarriage of justice in the running of the trial. Dr Patel has been acquitted of one charge of manslaughter in a re-trial while outstanding charges remain.

The charges of manslaughter and grievous bodily harm broadly related to: performing a colectomy on a 75 year old man with diverticulitis complicated by bleeding from the rectum who subsequently died; a colectomy on a man with pre-malignant abnormalities of the bowel; two oesophagectomies, one on a 46 year old man with advanced renal failure on haemodialysis and another on a 77 year old man with oesophageal cancer, both of whom died shortly afterwards. There are also outstanding charges of fraud relating to changes to medical records.

The case

The High Court heavily criticised the Queensland Director of Public Prosecutions (DPP) for its carriage of the matter, including, the relevance of evidence brought, how the evidence was led, and for not trying each charge separately. The DPP's evidential focus was Dr Patel's broad lack of professionalism including his bedside manner. Unfortunately because the evidence was so broad, they were unable to show which specific actions led to the patient harm and lines of causation were muddled. Furthermore, on day 42 of the trial the DPP substantially changed its case to include an allegation that the recommendation of the surgical procedures was criminally negligent, after it had been revealed that in general the surgeries performed had been conducted reasonably competently.

Criminal negligence

The crux of the case is what actions by a doctor might amount to 'criminal conduct' as opposed to 'civil negligence'. Section 288 Criminal Code (Qld) specifically refers to medical professional conduct and is curiously couched in terms of negligence. It is an interesting example of the intersection of traditionally separate principles of law in an area that remains illusive.

The High Court clarified some of the uncertainty in relation to the law of criminal negligence in the medical setting by creating an objective test:

'The test does not require that the accused have an appreciation of, or an indifference to, the risk created by the conduct in question. The only criterion necessary is an intention to do the act which inadvertently causes death.'

Implications

Retrials in respect to many of the outstanding charges have commenced.

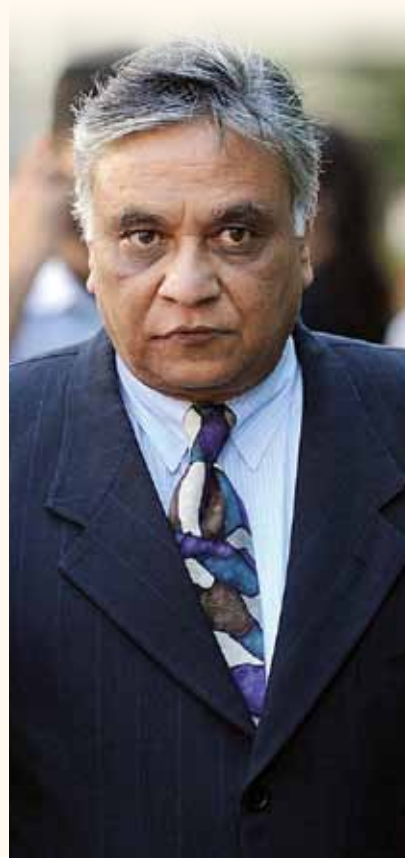
Notably, in preparations the DPP has experienced complications in formalising their pleadings.

While it is tempting to blame them for the problems, it highlights that that criminal negligence is a little tried area of the law and one which is largely unsettled, meaning that there are no clear rules to formulate clear lines of causation upon.

This reflects the difficult nature of finding medical professionals guilty of criminal conduct if acting within the scope of their practice. On the one hand it is important to have medical professionals practising without fear of prosecution, on the other, it is important for the public to have confidence in the professionals treating them without the profession being undermined. The tangible implications for the medical profession will doubtless be revealed over the coming months-following the outcome of the further prosecutions, particularly if the test in the High Court is effectively applied.

Kate Mahoney (LLB/IB) is a second year student at the ANU Medical School. Kate has worked as a legal officer with the Commonwealth and as a solicitor in Canberra.

References available from the author on request.



A boost in the fight against the killer on our doorstep

An initiative to stop the spread of TB in Australia, and reduce its impact on our neighbours.

A $2.5 million, six-nation initiative to fight tuberculosis has opened at the Centenary Institute, Sydney. It brings together over 14 institutes.

Tuberculosis (TB) once killed more Australians than cancer. In 2011 we saw just four deaths. But the fight against TB is getting harder, and our nearest neighbour, PNG, has more than 70 times the cases.

The Centre of Research Excellence in TB Control (TB-CRE) links researchers in six countries to improve TB control, with the ultimate goal of eliminating TB transmission in Australia, and contributing to the world-wide campaign to eliminate TB by 2050. It is funded by the NHMRC, the National Health and Medical Research Council.

"In the late 19th Century tuberculosis was the leading cause of death in Australia—20 times deadlier per capita than all cancer conditions today put together," says centre director Professor Warwick Britton.

TB remains a threat in the 21st century as new varieties of the disease which are deadlier and harder to treat have taken hold across the globe. The TB crisis in PNG illustrates the problem.

Papua New Guinea has the highest TB burden in the Pacific region with over 14,500 new cases diagnosed a year. The incidence of TB in the nation, which occurs at a rate of 434 cases per 100,000 people, is more than 70 times higher than in Australia.

Some of the worst cases are treated here in Australia. A young woman with extensively drug-resistant TB has become a medical refugee in Cairns. Originally from Daru Island, a few hundred kilometres north of Cape York, the woman spent a year in quarantine and died in March this year.

The threat is not only to developing countries. "Australia's aging population and high numbers of people with chronic health conditions increase our vulnerability as a nation," says the University of Sydney's Associate Professor Jamie Triccas, a chief investigator for the centre.

Despite these threats Australia is uniquely positioned to lead multi-national research into the prevention, detection and management of TB within the Asia pacific region and beyond. The new centre hopes to establish Australia as a powerhouse for TB-based research.

The new Centre is working to:

- Develop new vaccines.
- Improve TB prevention, particularly for vulnerable children.
- Develop ways of finding new cases faster and start treatment sooner – reducing the risk of transmission.
- Track, map and understand the spread of the disease.
- Tackle the ethical and legal barriers of TB control such as establishing the rights of people with drug-resistant TB who pose a risk to others.

(The centre is a collaboration between: Centenary Institute, University of Sydney, Woolcock Institute for Medical Research, University of Melbourne, Vietnam, Indonesia, WHO/Fiji, China and New Zealand)

More details and a full list of collaborators at: www.tbcre.org.au and www.centenarynews.org.au.

First Anniversary of the John Curtin Medical Research Foundation

The John Curtin Medical Research Foundation was launched in March 2012 to support and advance human health through scientifically researched discoveries, medical education and practice at The Australian National University.

On 7 March 2013, The John Curtin Medical Research Foundation celebrated its first anniversary with a dinner at Old Parliament House with guest speaker Nobel Laureate Professor Peter Doherty.

Approximately 140 guests shared the Foundation's vision that today's medical treatments are a product of yesterday's medical research, and today's research will produce the treatments of the future.

Chief Minister Ms Katy Gallagher highlighted the need for collaboration in the area of medical research, education and practice and congratulated the Foundation with bringing together the key players in public and private medical research areas.

ANU Vice-Chancellor Professor Ian Young emphasised that the vision of the Foundation closely aligns with the University's aim to be a national and international leader in research, addressing the major issues facing humanity and the nation. Professor Young made it clear that the success of both the University and the Foundation lies with its community of scientists, staff, students, alumni and friends.

This year's fundraising target for the Foundation, a much needed multiphoton microscope was introduced by MC Mr Hugh Riminton. Mr Riminton explained that this cutting edge piece of equipment will help ANU researchers contribute towards a solution for some of the world's biggest health issues through their studies in cancer biology, immunology, metabolic and cardiovascular diseases and neuroscience.

Chair of the Foundation Dr Cameron Webber expressed his gratitude to the Board of talented and energetic individuals who have volunteered their time and efforts to raise awareness for the need of non-traditional funding to support medical research at the ANU.

For more information on The John Curtin Medical Research Foundation please visit http://jcmrf.anu.edu.au/

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NOTICE OF ANNUAL GENERAL MEETING

The Annual General Meeting of the **AMA (ACT) Limited** will be held on Wednesday 15 May at the Hotel Brassey, Belmore Gardens, Barton, commencing at 7.00 pm.

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For confidential information about these and other GP roles available in south east NSW, please contact SNSWML Workforce Manager Sue Berry on 4475 0812 or sberry@snswml.com.au or visit snswml.com.au/careers.

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