Canberra DOCTOR
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AMA ACT congratulates Former President, Dr Iain Dunlop, on his election as Chair of Council

Delegates at national conference voted for two new faces to hold executive office at the AMA whilst at the same time opting for stability at the top of the organisation in what is likely to be a tumultuous period in federal politics, with President Dr Steve Hambleton and Vice President Professor Geoffrey Dobb re-elected to their positions unopposed at the National Conference.

Chairman of Federal Council Dr Iain Dunlop.

Dr Hambleton, a Brisbane GP, and Professor Dobb, Director of Critical Care at Royal Perth Hospital, were each confirmed at the Conference for a third annual term in their respective roles.

But there were changes in other AMA executive positions, after Canberra based ophthalmologist Dr Iain Dunlop successfully challenged Dr Rod McRae as Federal Council Chairman.

The position of Treasurer was contested and won by Anaesthetic craft group representative and fellow Executive member, Dr Elizabeth Feeney.

Dr Hambleton praised retiring Treasurer, Dr Peter Ford and Dr McRae for the dedicated service they have provided to the AMA executive over many years, helping assure the Association's position as one of the nation's most respected and influential voices on medical issues and health policy.

Dr Andrew Miller congratulated all the members of the AMA Federal executive team, and Dr Stephen Parnis (Victoria) and Dr Brian Owler (NSW) who will make up the Executive Council. He said that there was a tide of change which would be completed when the newly appointed Secretary General, Ms Anne Trimmer took up duty in August. Dr Miller said AMA ACT looks forward to re-establishing its good good relationships with the Federal Council and Federal Secretariat.

L to R: Dr Liz Feeney, Dr Iain Dunlop, Prof Geoffrey Dobb and Dr Steve Hambleton.

Dr Miller particularly congratulated AMA ACT immediate past president, Dr Iain Dunlop on his election. Dr Dunlop is the first member of AMA ACT to achieve election to executive office in the AMA and this was to be celebrated. Dr Dunlop will bring his considerable experience of many years in medico politics to the role – all to the advantage of the profession and the Association, said Dr Miller.

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

This is my anniversary column, marking one year in the hot seat. As a rite of passage I have conducted my first AGM; and I have pleasure in reporting that it was a successful night. I took great pleasure in announcing the President's Award recipient, this year Mr Robert Hunt, our treasurer. Robert has volunteered to undertake this role in addition to his already busy professional life as a CPA and CEO to the Australian Institute of Building; and brings much valued financial and strategic skills to our board.

Whilst on the congratulatory theme, I would like to extend congratulations to Dr Iain Dunlop (our immediate past-president) on his election as Chairman of the AMA Federal Council. It is a great thing to be recognised by your peers and entrusted with their confidence.

This is also a sad time when we must record the personal losses suffered by some of our colleagues and members. I am sure you will join with me in extending condolences to Ann Hosking, for the loss of her husband George; John Smiles for his wife Isobel Peter Trenerry on the loss of his wife Naomi.

The board has been dealing with a difficult year for the AMA (ACT), with an extensive renegotiation of our financial relationship with the federal AMA under way. The essence of the relationship between the national body and the smaller AMA branches (ACT, Tasmania and NT) has come under question at a national level. It is all about membership, at the end of the day, and the importance of members of the profession understanding the hard work that the AMA undertakes to support them; and voting with their wallets by supporting the AMA in return by joining and participating in its activities.

Right now your local AMA is conducting the final stages in the VMO contract negotiations; commencing the salaried medical officer enterprise agreement negotiations; lobbying local and federal politicians about health and professional related issues such as the taxation changes to self-education expenses; supporting the AMA national careers service; producing the ACT specialist directory; supporting private and salaried doctors in a variety of industrial and professional difficulties; participating in a wide range of territory government policy and governance committees; working with industry to bring members local opportunities and benefits such as the BMW agreement and our relationship with Experien and Investec; and so on.

The VMO contract negotiations are about to move into arbitration at the end of this month. I think it is safe to say that there are some significant areas of divergence from the offerings from ACT Health and the AMA will be putting a forceful case forward to support our VMO members' contract conditions.

I wish I could say that the salaried doctors' negotiations were going as smoothly. Unfortunately ASMOF has refused to participate in any negotiation meetings that the AMA (ACT) also attends. This is despite the AMA being nominated by a significant number of junior doctors and specialists as their negotiating agent; as provided for in the federal industrial relations legislation environment that operates here in the ACT. I consider this a regrettable and petty action that will only serve to delay any outcomes of the negotiation process as ACT Health is forced to conduct parallel meetings. I am forced to recall the hoary old chestnut (all so sadly familiar in this town these days) that disunity is death. To be quite clear; the AMA (ACT) has NEVER suggested that it should replace ASMOF, or sought to exclude it, or refuse to cooperate with it in industrial negotiations. We have been asked to be there by our members and we will continue to represent their interests vigorously.

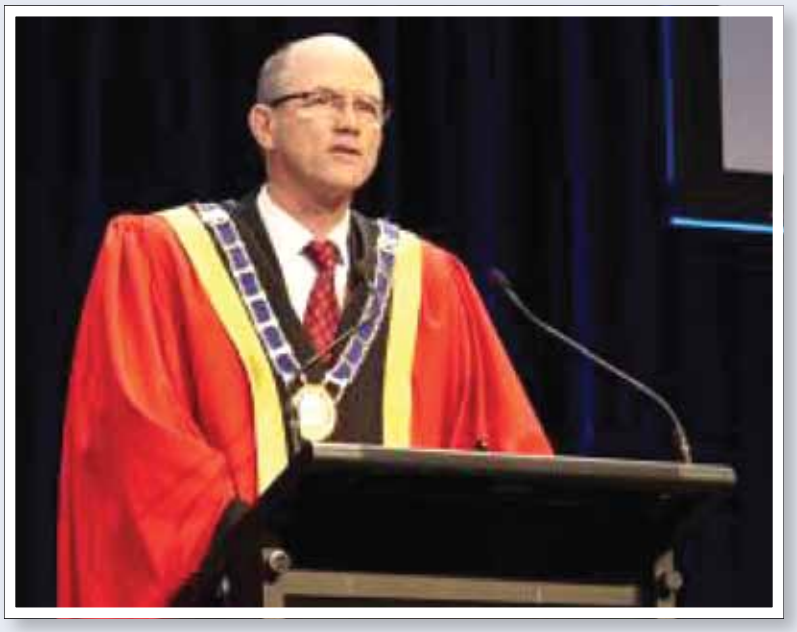
The treatment of tax-deductable self-education expenses has been the focus of a great deal of activity. Last week I have met with our ACT federal members, Gai Brodtmann and Andrew Leigh to voice concerns about the policy changes; and we are preparing a submission for the parliamentary inquiry. We have also brought the matter to the attention of our local political leaders in meetings with Katy Gallagher and Jeremy Hanson, and sought their support in lobbying their federal colleagues. We have added a claim in the VMO contracts arbitration and will make similar claims in the salaried doctors' negotiations to compensate for these changes. These changes run contrary to any conception of supporting excellence; they disadvantage our doctors in training and will restrict opportunities for doctors to improve their skills and knowledge. I can see no community benefit; save a short term electoral kick from thumping the class war drum. In the end we will all be the losers if this foolish policy gets through, as professionals – and as consumers of health care.

We have also been dealing with ACT Health and with our minister, Katy Gallagher, regarding intern placements for next year. The ACT has implemented a controversial preferencing system that offers guaranteed intern places to ANU graduates next year who do not apply for an intern placement outside the ACT. If these graduates seek alternative employment they will not be guaranteed a position, but will come 4th in a priority list. This does seem harsh, however in the last intern placement round, early this year, the ACT offered a guaranteed place to every ANU graduate whilst also ensuring that there were adequate positions to underwrite the offer. Unfortunately what resulted was a fraught recruitment process with graduates progressively declining their positions as they obtained employment elsewhere, so that the final intern positions were not filled here until February, at the commencement of the employment year. At present the situation for 2014 is far from clear, and will depend entirely on the career decisions of overseas students graduating from Australian medical schools. If, as last year, the majority elect to leave the country and seek internships in their home countries then there will be no crisis and most graduates will be likely to achieve employment at or near their place of first preference. If not then there will be a national shortfall in excess of 300 intern places. We don't know yet, and won't for some time. What is urgently needed is a national application process so that small jurisdictions such as ours can adequately and securely plan their medical workforce. This has become a major focus of attention. We are continuing to lobby for 2 year contracts for the 2014 interns at both political and administrative levels.

I am currently reviewing applications for my college's training programme. As I read the CVs of these young doctors, I find myself wondering how the next few years of graduates will be able to obtain the quality supervision and training opportunities that will make them effective and safe clinicians. It is more important than ever before that the profession engages in this debate. Whilst individual doctors undoubtedly extract a personal benefit; the community benefit derived from excellent quality and efficient health care is beyond debate.

Budget decisions will wreak havoc

AMA President Dr Steve Hambleton used his Presidential Statement at National Conference to set the tone for how the AMA will perform during the 'real' Federal Election campaign, which is due to kick off in early August ahead of polling day on 14 September.



It looks like it will be more Rambo than Columbo, as Dr Hambleton cited the Four Horseman of the Apocalypse in his assault on the Government's recent Budget raids on Medicare and medical training.

"Like the Four Horseman of the Apocalypse, four key Budget decisions will combine to wreak havoc on Australian families," he said.

"The Budget contained a quadruple hit on patients that will have long-term impacts on their ability to pay for their health care needs.

"Budget decision number one is to defer indexation of the Medicare Benefits Schedule (MBS) from 1 November 2013 to 1 July 2014 – a freeze of eight months. That's $664.3 million from rebates.

"Budget decision number two is to cap work-related self-education expense tax deductions to $2000 a year.

"This measure, estimated to provide savings to the Budget of $514.3 million, will have a devastating effect on medical education for doctors.

"Budget decision number three is to increase the upper Medicare Safety Net threshold to $2000.

"This means that families that incur high or numerous health care costs in one calendar year will pay more and more without relief.

"This is another $105.6 million of costs transferred to patients!

"Budget decision number four - which just compounds the above - is the phasing out of the medical expenses tax offset, which adds another $963.5 million - taking the extra total cost to patients to over $1 billion.

"The Government is targeting sick Australians to help fix their Budget black hole.

"GPs and specialists cannot absorb these new imposts and will have to pass on costs to their patients.

"This Budget means that people will pay more for their health care every time they visit their doctor, year after year.

"The sicker that people are, the more they will pay.

"For some families, the changes to the Medicare Safety Net mean that they will need to accrue significantly more health care bills before they get financial support.

"At the end of the year, when the same family expects to claim something back on the medical expenses tax offset, they will be told that that has been scrapped too.

"The chronically ill, the elderly, young families, accident and trauma victims, and our war veterans will be among the hardest hit by these life-changing Budget decisions.

"It will almost certainly drive patients towards an already stressed public hospital sector."

The President's speech energised the opening day of the Conference, striking a chord with the delegates whose branches and craft groups know all too well the feeling among their members about the Budget changes.

The core messages from the speech – plus feedback from other sessions at National Conference – will form the basis of the Federal AMA's upcoming *'Key Health Issues for the Federal Election 2013'* document.

Dr Hambleton – aka 'Rambo' Hambo – will set out the Federal AMA's election strategy at the National Press Club in Canberra on 17 July.

AMA appoints new Secretary General

The Executive Council of the Federal AMA has recently appointed Ms Anne Trimmer as Secretary General of the Federal AMA.

Ms Trimmer is currently the Chief Executive Officer of the Medical Technology Association of Australia (MTAA). Prior to joining the MTAA, Anne had an extensive career in the legal profession, practising law as a commercial partner of a major Australian law firm.

Anne has held several leadership positions in professional and educational bodies, including a period as President of the Law Council of Australia, Deputy Chancellor of the University of Canberra, and Chair of the Australian Government's Advisory Council on Intellectual Property.

Anne chairs the Centre of Excellence in Vision Sciences at the Australian National University and is a director of Research Australia and Plan International Australia.

In 2003, Anne was awarded a Centenary Medal for services to law and society.

Anne is expected to commence duties with the AMA in August 2013.

AMA President, Dr Steve Hambleton, said that the AMA is very pleased to have recruited a person of Anne's calibre and experience for the Secretary General role.

The President, Dr Andrew Miller, the Board and Members congratulate

Dr Brian James White OAM

For service to medicine in the field of mental health, and to veterans and their families.

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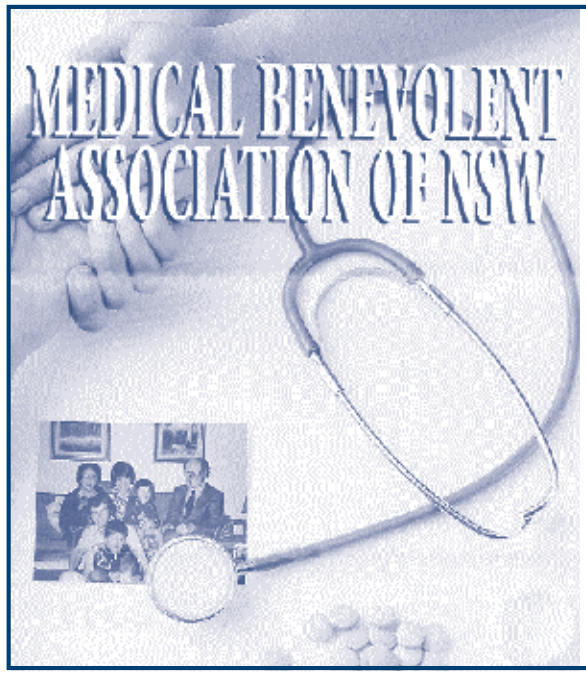

Assisting Canberra Doctors and their families too!

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

AMA Staff Assist

– helping you get the right staff for your practice

AMA ACT is pleased to announce its new service "AMA STAFF ASSIST"

This new fee-for-service initiative has been designed to assist AMA members recruit nursing, admin and book keeping staff.

AMA STAFF ASSIST will advertise the vacancy, assess the competencies required for the position, recommend a minimum salary rate, assess candidates and recommend a short-list of candidates for interview. Following the successful selection of a new staff member, AMA STAFF ASSIST will provide the employing member with a template workplace agreement if desired.

For further details on this new service, please contact Christine Brill on 6270 5419 or by email: execofficer@ama-act.com.au

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2013 national conference delegate, Dr Suzanne Davey,

Dr Davey states at the outset that her account of the National Conference below is by no means a comprehensive one. It is merely her impressions of the talks given by the varied and interesting speakers who presented at the conference.

Political:

Dr Steve Hambleton summarised the May 2013 Budget initiatives as they effect doctors:

1. MBS rebate increases have been deferred for 8 months
2. Tax deductibility of self-education expenses have been capped at $2000.
3. The Out of Pocket Medicare Expenses threshold has been raised to $2000.00 before concessional rates cut in
4. The medical expenses tax offset is being phased out.

Tanya Plibersek, Health Minister reiterated her support for community based health care based on the Medicare Local concept. She promised reform to the system for calculating doctor workforce shortage. She recognised the need to improve emergency and elective surgery waiting times, and increase GP training places. She reiterated her commitment to the PCeHR, plain packaging for cigarettes, and the National Disability Insurance Scheme. She said that the government would spend $35 billion on health care next year and that there was no extra money available to spend more than this amount.

Peter Dutton, Shadow Health Minister said that the core business of the Federal health system was Primary care, and in particular Aged care, with General Practice as the keystone. He said that a coalition Federal Government would not take over State funded public hospitals. He said that it would hold an enquiry into Medicare Locals. He made no commitments regarding the PCeHR, Super Clinics and the tax deductable threshold of $2000 for self-education expenses.

Revalidation:

Dr Joanna Flynn, Chair Medical Board of Australia, explained that the initiative to discuss the concept of revalidation had come from the Medical Board itself, based on the experiences of other countries, rather than having been imposed on the profession by AHPRA. She stated that most medical complaints related to only a small number of doctors. She said that any process of revalidation had to be effective and affordable. She said that any doctor is NOT better than no doctor at all, and that minimum standards must apply so that any registered doctor really is worthy of a patients' trust.

Professor Ron Paterson, Member of the board of the RACP, stated that the current system did not ensure that all doctors were competent. He reiterated that only about 1-2% of doctors were incompetent, based on complaints figures. He stated that age-related decline was an issue that had to be faced. He stated that patients wanted the competence of their doctors guaranteed, and that the profession must guarantee the competence of its members. He said that CPD activities were NOT a proxy for competence.

Professor Sheila the Baroness Hollins, President of the BMA, gave the British experience. In the UK, each doctor must undergo an annual appraisal in which each doctor is required to produce a body of evidence that they satisfy the requirements of Good Medical Practice. This process is supervised by a senior doctor, known as a "responsible officer", and takes place over a 5 year cycle. Doctors need to provide evidence of continuing professional development. They need to quantify improvement activities. They need to document significant events and what the doctor has learnt from the event. They need to document feedback from colleagues, and from patients, and they need to provide a review of complaints and the process of their resolution and how the doctor's practice has been modified, and also any compliments. The role of the BMA is to provide a clear mechanism for dealing with conflicts of interest for the responsible officer.

End of Life Care:

Dr Peter Saul, ICU Director, told us that 90% of Australians are now living to old age. There are rising expectations for care in old age, but, because dementia has a lead time of 25 years, the reality is that very few patients are in a position to organise what happens to them in their end of life care. Most Australians now die in acute care or private hospitals rather than dying at home. In Australia the average person has 8 hospital admissions and 2 ED visits in their last year of life. Dr Saul stated that Acute Care does not manage end of life well, and that "how we die remains in the memory of those who live on". Advanced Care Directives, whilst admirable, are often not available in the acute care situation. We need to set standards of "dying safely" as a system of care so that discussions regarding end of life care take place much earlier, and that the fully informed patient's wishes are written down and then respected.

Professor Michael Ashby, Palliative Care Unit Director, told us that the core task of the Palliative care team was preparation for death. Three barriers arise in this approach: 1. refusal to talk about death, 2. never giving up on cure and 3. palliative care contributing to death. He stated that dying is a natural part of living and an inevitable consequence of having lived. There is no obligation on the doctor to prolong the life of the dying. He said that patients fear bad dying rather than dying itself. His opinion was that the public space should be more orientated to end of life care. Advanced care planning should be widely promoted and Goals of Care Plans should be firmly set in the A&E Departments. There should be a balance between the patient and their family's wishes, and reality. "Modern medicine can give us a longer life and a slower death but it can also keep us alive when we might be better off dead."

Dr Kate Robins-Browne, GP, presented the results of her research into how older people make decisions about end of life care. She found that most people assumed that their "significant other" would know their wishes about dying. Some felt that documentation of these wishes was burdensome and possibly would disrupt family relationships and be binding when the individual might want to change their mind. She felt that the usual GP should always be consulted and involved in end of life care, rather than the generic doctor in the hospital.

The Politics of Health:

A variety of non-medical speakers discussed the fact that 80% of voters say that Health is the most important issue in the coming election, well ahead of asylum seekers and climate change. Australians want access, affordability and quality in their health care. Australia has the 5th highest out-of -pocket health expenses in the world. Health budget costs have greatly increased as a percentage of the total budget. Because of the economic crisis there is no more money in the system for Health. There is a perception in the electorate that the Health dollar has been wasted on Medicare Locals, the PCeHR and the Super clinics.

Neither the Government nor the Opposition have sorted out the Blame Game between the federal and State components of health care provision and costs. It was felt that measurements such as waiting times in hospitals were far too simplistic to assess the health care score-card. Do we want doctors to be the police re costs in the health care system? The decline in public trust in the health care system and other institutions was felt to favour a conservative government.

A Market Economy for Health:

Several speakers discussed whether if was possible to take the politics out of health care, such that the AMA principles of universal access to affordable health care, the independence of the doctor-

summarises the issues discussed

patient relationship, and the patients' rights to unrestricted choice of medical practitioner would all be preserved. The view was expressed that in a future without change, waiting lists would be longer, doctors training and drug costs would increase, the medical workforce would age, and chronic care and dementia care patient numbers would increase such that primary care would be reduced to merely a triaging service. Speakers spoke of the need for a patient centred care model that would empower the patient as the consumer, and a true market economy would come into effect, with private health care providers having a large role in the provision of health at the primary as well as hospital care level. The national Health and Hospital Reform Commission published its final report in 2009. In its Medicare Select service model, all Australians would automatically belong to a government operated health and hospital plan, but could select to move to another plan, which might be operated by a not-for-profit or a private enterprise. Health Plans would receive funds from the Commonwealth Government on a risk-adjusted basis for each person who is a member, so that people would take their universal service entitlements to their Plan. The NHHRC argued that this approach would lead to innovative purchasing, focussing on people's health needs over time and across service settings, rather than on the purchase of individual elements of the service. Providers would be motivated to invest in wellness and prevention, not just service provision.

Health has a Postcode – Society's ills and Individuals' Health:

Several speakers gave their perspective on the health gradient according to wealth in Australia, which is not totally explained by physical access to health services.

Dr Harald Klein, Director, Community Building and Economic Participation, Victorian Department of Human Services, presented very strong evidence that social disadvantage equates to health inequality in every stage of life from birth to old age in all body systems. The socially disadvantaged die earlier, have poorer outcomes in musculo-skeletal diseases and malignancies, and are less likely to present at an asymptomatic stage in all diseases, with consequent poorer outcomes. This social disadvantage translates to increased rates of poverty, lower wages, more occupational stress, more unemployment, increased rates of crime, increased violence, decreased educational levels, more family breakdown and increased risk-taking behaviour such as smoking and excessive alcohol consumption.

Community Paediatrician Professor Victor Nossar pointed out that the human infant is born with 25% of its brain already developed, and that this has increased to 80% by 3 years of age. The quality of nurturing and nutrition in these early years is crucial to the development of the child's brain, and this effect lasts for life. He explained the phenomenon of epigenetics, where early disadvantage turns off certain genes, which remain turned off for life. Good care-giving imparts the quality of resilience in the child. This care giving can be imparted by a variety of care-givers as long as they stimulate and value the child. Thus likeable or cute-looking children are likely to stimulate care-givers to give them better quality attention, which in part, overcomes some of their disadvantage. The 4 year old check does little to influence outcomes for any children!

Dr Mark Kennedy, GP from Corio-Norlane near Geelong, presented some ways in which the effects of social disadvantage could be modulated by attention to community factors such as provision of reasonably priced fruit and vegetables, improved urban playground access, improvements in personal safety on the streets, police services being pro-active rather than reactive, fluoridation of water supplies, easy access to free healthy lifestyle advice, easy access to free healthcare especially chronic care such as diabetes and renal clinics and preventative care such as sexual health clinics, and most importantly, a local voice in community decision making and planning. These outcomes were achieved by local partnerships between residents, government service providers and local businesses and the formation of a Neighbourhood Renewal Community Reference Committee consisting of local community members.

Suzanne Davey
Chair ACT AMA Forum of General Practice
Member AMA Council of General Practice
GP Kambah since 1988

Vitamin D tests and deficiency: new patient resource for GPs

A new patient information leaflet on vitamin D deficiency will be available for GPs to use with their patients. The leaflet is part of a suite of resources developed for the latest NPS MedicineWise educational program on preventive activities in general practice.

Vitamin D testing is one of several medical tests appraised in the program that focuses on preventive health in 40 – 49 year olds. It encourages GPs to prioritise evidence-based risk assessments and tests, and avoid inappropriate testing that may cause more harm than good.

NPS MedicineWise clinical adviser Dr Andrew Boyden says that the vitamin D test is one for which there is a lack of evidence of benefit in people without risk factors for, or symptoms of vitamin D deficiency.

This is in contrast to a range of preventive assessments and tests for which there is strong likelihood of benefit when targeted to healthy people in appropriate age groups, including Pap tests, diabetes risk assessments and absolute cardiovascular risk assessments.

"There has been an increased interest in vitamin D deficiency in recent years, and a ten-fold increase in the number of referrals for vitamin D tests since 2004/2005," says Dr Boyden.

"Current guidelines recommend vitamin D testing in 'at risk' populations, but the consequences of routine testing in low-risk populations are unclear. There are limitations with vitamin D immunoassays, debate about optimal vitamin D levels, and questions about the clinical significance of mild deficiency.

"The RCPA this week announced a new position statement recommending that vitamin D testing is not conducted or recommended as routine screening.

"The new NPS MedicineWise patient information leaflet helps GPs talk to their patients about sensible sun exposure, diet and supplements, and is a useful tool to assist conversations."

The vitamin D information leaflet includes answers to common patient questions including:

- Why do I need vitamin D?
- Am I at high risk of vitamin D deficiency?
- How do I get vitamin D?
- Do I need a vitamin D test?
- When are vitamin D tests less useful?
- What does a vitamin D blood test involve?

It also includes space for patients to record details about their blood test results and whether a supplement is recommended.

The vitamin D patient information leaflet will be available from the beginning of June in GP prescribing software including Best Practice, Genie, Medical Director and MedTech 32, and is also available on the NPS MedicineWise website atwww.nps.org.au/vitamin-d-fact-sheet

For more information about the Preventive Activities in General Practice educational program, and to read about which medical tests make a difference, visit www.nps.org.au/preventive-health

ANU Medical School's global health initiative now 7 years old

The inaugural Fiji Village Project (FVP) fund-raising and awareness event for 2013, took place in mid April.

The FVP is part of the ANU Medical School's global health initiative, 'Engaging Students in a Global-Health Network' (EnSIGN). Now in its 7th year, it is a medical student-run initiative aimed at promoting health in the South Pacific region.

Each year FVP sees a delegation of Australian and New Zealand medical students travel to Fiji and join with students from the Fiji School of Medicine in delivering vital health services and information to under-serviced rural villages. Health objectives in the past have included improvements to water supply and quality, and health awareness through education and promotion of healthy lifestyle practices to both children and adults with a further focus on women's and sexual health. In addition, health screening has played a role, providing general health checks (blood pressure, weight, life style assessments, dental checks, pap smears and breast examinations) and where possible an opportunity to update the communities medical records. The local communities' guide all of these objectives, by identifying and communicating their areas of need.

The project is committed to partnering with the community and initiating lasting health measures that will continue long after the medical students have returned home. It also provides medical students with a wonderful opportunity to see public health in action and put their clinical skills into practice in the real world. Importantly, this project has allowed an avenue to strengthen global relations between Australia, New Zealand and the South Pacific Region.

Seventy keen participants joined in for the "Fiji Village Five" – a 5km walk across the Australian National University (ANU) campus. The walk marked the first of a series of events aimed at raising funds for the 2014 project.

Walkers were treated to perfect autumn weather for the event, which was followed by a BBQ, refreshments and a presentation on the project. The event was well attended by ANU medical students, friends, lecturers, medical practitioners, volunteers of the medical school and our friends from Pasifika Australia. The day was a great success, with positive feedback from many participants who enjoyed the walk and presentation. It was a wonderful opportunity to share the history and vision of FVP.

Fundraising efforts will continue throughout the year with the next event being a themed film night on Wednesday 26 June at Dendy Canberra Centre. The event will feature a swing dancing demonstration by the Swing Katz Canberra, private movie theatre screening of The Great Gatsby with snacks and lollies and prizes for the best dressed attendee. A further fundraising effort in the way of the annual FVP trivia night is tentatively planned for August. For more details, please contact the FVP committee at fijivillage-project@gmail.com

Copy supplied by Steven Sisifa, media officer on the Fiji Village Project Committee, ANU Medical School.

Dirty Ashtray Award 2013
Victoria and Queensland take away the dirty ashtrays

Victoria and Queensland have jointly been awarded the 2013 *Dirty Ashtray* Award for their failure to act on proven tobacco control activities.

AMA President, Dr Steve Hambleton announced the Awards at the AMA National Conference in May.

The *Dirty Ashtray* Award is presented each year in conjunction with the National Tobacco Scoreboard by the AMA, the Australian Council on Smoking and Health (ACOSH), and Action on Smoking and Health (ASH) to put a spotlight on governments who have failed to do enough to stop people smoking. 2013 is the 19th year the Awards have been conferred.

The National Tobacco Scoreboard Award goes to the State or Territory Government that has been the most effective in tobacco control over the past year, and the *Dirty Ashtray* Award goes to the Government that has been least effective.

Dr Hambleton said that some governments have completely dropped the ball on tobacco control over the past year.

"Smoking remains a leading cause of premature death and disease, but we have two governments virtually standing still on a vital public health issue," Dr Hambleton said.

"The Victorian Government has earned the *Dirty Ashtray* title for its failure to take any new initiatives to curb smoking, and its flagging commitment to outstanding and proven tobacco control activities.

"The Victorian Government is the only government without either State-wide bans on smoking in outdoor dining areas, or a commitment to their introduction.

"The Queensland Government has jointly received the award following their lack of investment in tobacco control, with significant funding cuts, no social marketing since May 2012, and a drastically reduced public health workforce.

"The Queensland Government has done little to protect public health policy from tobacco industry interference, with continued investment of public money in the tobacco industry.

"All I can say is shame, Queensland and Victoria, shame."

Dr Hambleton said it's time for all governments to step up their commitment to combat tobacco control if they are to achieve the National Tobacco Strategy, which aims to get Australia's smoking prevalence down to 10 per cent by 2018

"All governments are urged to ensure adequate investment in strong, comprehensive mass media-led campaigns to reduce Australia's smoking prevalence," Dr Hambleton said.

Dr Hambleton said he hopes that the strong message sent out to governments with these awards will speed up efforts to stamp out smoking and, more importantly, encourage people to give up the killer habit.

Other than the two High Commendations and the *Dirty Ashtray* Award for poorest performance, the States and Territories have not been ranked in order of achievement or lack of achievement this year.

Summaries 2013

All States and Territories have endorsed the National Tobacco Strategy, which works to a goal to reduce the prevalence of smoking across Australia to no more than 10 per cent of the population by 2018. This is a worthy and achievable aspiration, but it will only be reached if there is a continuing commitment to action, and to the three main themes:

- sufficient funding at both the Commonwealth and State/Territory levels;
- consistency across all jurisdictions with respect to legislation and policy, with each State/Territory striving to meet demonstrated best practice; and
- robust legislation and policy to eradicate the interference of the tobacco industry in public health policy in line with Article 5.3 of the Framework Convention on Tobacco Control (FCTC) .

Australia leads the world with tobacco plain packaging legislation, but we cannot afford to be complacent. There are worrying signs of lacklustre commitment to the goals of the National Tobacco Strategy, through significantly decreased funding, lack of important legislation and policy, and the absence of safeguards against tobacco industry interference.

In the absence of any major developments since plain packaging (and the lack of any significant action on smoking in the recent Federal Budget), there is no clear overall award for an outstanding jurisdiction. There are, however, two Achievement Awards to recognise the commitment of two jurisdictions – the Australian Government and Tasmania.

The remaining jurisdictions have not been placed in any order, as they were all perceived to fall into the same band of achievement. The strong messages from this year are:

1. urgent action is needed in Victoria and Queensland;
2. there is a very real danger of complacency around the nation. Smoking remains a leading cause of premature death and disease. This is the time for governments to step up their commitment, not to fall behind. All governments are strongly urged to ensure adequate investment in strong, comprehensive mass media-led campaigns; and
3. the Australian and Tasmanian Governments deserve credit for seeking to take further action, and for resisting pressure from Big Tobacco.

Dr Alexandra Markwell and Dr Stephen Parnis holding dirty ashtrays.

Achievement Award (High Commendation): Australian Government

The Australian Government continues to be seen as a world leader in tobacco control, leading and promoting action domestically and internationally. The Australian Government is specially commended for its unwavering commitment to world-first plain packaging legislation, after defending multiple time-consuming legal challenges, as well as acting to reduce the tobacco duty free limit, and crack down on tobacco smuggling and electronic media tobacco advertising.

The Australian Capital Territory (ACT)

The ACT was the first State/Territory to divest from the tobacco industry, and the Minister of Health does not meet with tobacco companies. The ACT Government does not accept donations or sponsorship from tobacco companies or allied interest groups.

The ACT prohibits all point of sale advertising, and bans consumer reward schemes for tobacco products, and has further strong policies on tobacco sales (with bans on vending machines carrying tobacco products).

There are strong policies on protecting non-smokers from the harms of passive smoking.

The ACT Government is urged to increase its commitment to public education campaigns on smoking.

Future directions for tobacco reduction in the ACT (2013-2016)

On "World No Tobacco Day", Chief Minister and Minister for Health, Ms Katy Gallagher MLA outlined the Territory's "Future Directions for Tobacco Reduction in the ACT 2013-2016". In launching the strategy, Ms Gallagher reminded that the ACT has made significant progress in tobacco control and smoke-free environments. Smoke-free policies have applied at Canberra Hospital, ACT Health facilities, Canberra Stadium, Manuka Oval, and ACT schools and colleges. More recent legislation restricts smoking at functions for children and young people and in outdoor eating and drinking areas. In 2011, legislation prohibited smoking in cars when children are present and in 2010 tobacco promotion was further reduced by prohibiting point-of-sale displays, advertising and promotion.

The ACT's daily smoking rate for adults is currently 11.7%, the lowest in the country, compared with the smoking rate for Australia of 15.9%. The ACT government is committed to reducing this rate to below 10% by 2018.

The priority actions areas are:

Restricting access to tobacco:

1. Reducing the number of tobacco licensees in the ACT through increases to tobacco licensing fees
2. Restricting access to tobacco products through amended licence conditions

Restricting places of tobacco use:

1. Outdoor areas at public swimming pools
2. Playgrounds and children's play equipment
3. Sporting fields, tracks and events where children are present
4. Smoking in and around bus interchanges
5. University campuses
6. Building entrances
7. Correctional facilities
8. Smoke-drift in multi-unit developments
9. Environmental tobacco smoke at large public gatherings and events
10. A review of ACT Health smoke-free policy including consultation has commenced.

Ms Gallagher said that whilst tobacco smoking remains the single most preventable cause of death and disease in Australia and that more than 15000 Australians die each year of tobacco-related illness, the strategies will be achieved only if government, non-government agencies and other stakeholders work together collectively to maintain strong partnerships and strengthen the effort to reduce the effects on the population from smoking.

Parents should prove child immunisation: AMA

The AMA has called for parents nationwide to be obliged to fully document their child's immunisation status before they can enrol them in schools and child care centres.

The AMA Federal Council has confirmed its support for tough, uniform national immunisation requirements for parents enrolling children after New South Wales last week passed laws demanding that parents vaccinate their children or register for an exemption before they can attend childcare.

The NSW legislation, the first of its kind in the country, has been introduced following evidence that child immunisation rates in pockets of the State have fallen to levels that leave the population vulnerable to sustained outbreaks of potentially deadly diseases such as measles.

Under the new laws, parents or guardians trying to enrol children in childcare will be required to provide evidence that their child has been fully vaccinated, is on a recognised vaccination catch-up schedule, or has a doctor-approved exemption on religious or medical grounds. To obtain an exemption, parents will have to undergo counselling and make formal statements.

Childcare centres that fail to enforce the new standards face a $4000 fine.

AMA President Dr Steve Hambleton said vaccination rates for infants and very young children were "pretty good", but were trailing off among four and five-year-old children, in some areas dipping below 90 per cent, undermining herd immunity and leaving populations vulnerable to sustained disease outbreaks.

Dr Hambleton said the measure should be effective in giving parents of these older children the incentive they needed to take action and get their children vaccinated, and was not particularly directed at the small minority who had a conscientious objection to vaccination.

"We're not worried about those conscientious objector numbers because they actually aren't growing and they're still below 2 per cent," Dr Hambleton told ABC radio. "We need to get those parents who, for whatever reason, haven't got around to it or just need that extra information to get our immunity up to where we need it.

"There's international evidence that it actually works. It gives those parents a bit of a nudge at a time when they're trying to get their children into childcare to get those rates up."

The AMA has been at the forefront of national action to lift and sustain high immunisation rates, and wants to see similar demands placed on enrolling parents in other states and territories.

Federal Health Minister Tanya Plibersek has put tougher vaccination requirements for parents enrolling children at schools and childcare centre on the agenda of the forthcoming meeting of the nation's Health Ministers, which Dr Hambleton said was a welcome move.

"The Commonwealth's proposal to introduce nationally consistent policy for schools to assess and document immunisation status is welcome," Dr Hambleton said. "The process should also include a pathway so that children who have fallen behind with their immunisations can participate in a 'catch up' program relatively easily."

He said schools would need to be actively engaged in the process to ensure it was workable, and urged cooperation among the Federal, State and Territory governments "to develop a nationally consistent approach to school entry and immunisation to raise childhood immunisation rates".

Australians smoking less and living longer

Australians are smoking less and living longer. That's the word from the COAG Reform Council's fourth report on the National Healthcare Agreement.

Releasing the report at the Australian Medical Association conference recently, Chairman of the council, the Hon John Brumby said that our life expectancy is among the highest in the world and our rates of low birthweight babies and infant mortality are better than OECD averages.

"Overall, there are some very encouraging results which show that the Commonwealth and the States are working well together to provide a strong healthcare system," Mr Brumby said.

The Chairman said that one of the highlights from the report was the continued drop in smoking rates around the country, reported at 16.5% in 2010–11.

"Smoking-related diseases and deaths put a huge strain on our health system, so the continued drop in daily smoking rates is welcome," Mr Brumby said.

The OECD said that Australia has seen 'remarkable progress' in reducing tobacco consumption in the last two decades, but the council notes that the stark difference in smoking rates depending on geographic location or socio-economic status is of concern.

The council's report found that one in three people in the most disadvantaged areas outside major cities smoke, compared to one in five in the most disadvantaged areas within major cities, and one in ten people living in better off areas in major cities.

The report warned that governments also need to do more to tackle obesity with a staggering 63% of Australians either overweight or obese in 2011–12. This is up two percentage points since 2007–08.

"It's concerning to see that so many Australians are overweight or obese but the fact that the situation is getting worse suggests that it needs urgent attention from our governments to prevent flow-on effects across the system," Mr Brumby said.

The council reported a fall in potentially preventable hospitalisations in all States and Territories—including for obesity-related diseases such as diabetes.

The report also showed sustained improvement over five years in emergency department waiting times across all triage categories.

However, five years of data has shown little improvement in elective surgery wait times with results mixed across jurisdictions.

Wait times remain the shortest in Queensland, while improvements have been seen in South Australia, the ACT and the Northern Territory.

The council also reports that 60% of people report that they can see a GP for an urgent appointment within 4 hours, though there has been an increase in the proportion who report taking more than 24 hours to see a doctor.

The council's report on the National Disability Agreement has been released and will be followed early next month with reports on National Agreements on Housing and Indigenous Reform.

Five questions for parents to ask about medical imaging

In light of more evidence of an increased risk of cancer associated with computed tomography (CT) scan in childhood or adolescence, NPS MedicineWise is advising parents that the overall risk is small and that health professionals will only consider medical imaging when it is justified.

A new Australian study investigating the risk of any cancer after a CT scan in childhood or adolescence has so far estimated one extra case of cancer for every 1800 CT scans, about 10 years after exposure.

The risk was highest after exposures in children younger than 5 and increased with each additional CT scan.

NPS MedicineWise clinical adviser Dr Andrew Boyden says that while the increase in cancer risk is relatively small, as a principle it is best to limit exposure to radiation from CT scans, especially in children.

"Medical imaging – including CT scans, x-rays and MRI – can be a very useful tool to help make or confirm a diagnosis or guide treatment decisions," says Dr Boyden.

"But it should only be considered if the benefits for your child are likely to outweigh the radiation risks or other potentially harmful effects, and parents can be reassured that health professionals are well aware of these risks.

"A lot of the time, in situations such as mild sports injuries, imaging won't necessarily help — while at other times depending on the symptoms it can provide critically important information.

"In the situations where imaging is justified it is done using the lowest radiation dose possible. Modern scanners and imaging techniques are able to achieve this more readily than in the past, including with MRI scanning, which does not produce radiation."

If parents or individuals are unsure about medical imaging there are five questions they can ask for reassurance:

- How will the imaging help my child's condition or injury?
- What does the imaging procedure involve?
- Are there any risks associated with the imaging?
- Are there any other options?
- How much will the imaging cost?

There are also some other things parents can do if their child is going ahead with medical imaging.

"Parents can ask the staff at the imaging practice how they will minimise their child's risk from radiation exposure or other possible harms from the imaging test," says Dr Boyden.

"Helping your child relax is also important because movement can blur or disrupt images, especially with MRI. Helping your child stay calm and still may reduce the need for sedation or anaesthesia or for a repeat test in order to get a clearer image."

NPS MedicineWise has information about medical imaging for children, including radiation risks, as part of a new information hub on imaging at http://www.nps.org.au/medical-tests/imaging

Motor Vehicle Finance Structures for Doctors

For a lot of people, purchasing a new car is an exciting event and you may be inclined to choose the car dealers preferred financier to get you on the road sooner. However, this may not be the best options for you. By carefully selecting the best finance structure for your circumstances may save you literally thousands of dollars.

Different finance structures can affect the total cost of the transaction for your new car. People tend to focus their attention on interest rates alone, but that is only one of the many factors affecting the overall cost to you. The main finance structures available to medical professionals include:

- Lease
- CHP or Chattel Mortgage
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Use your Investec credit card to buy a new car and then conveniently roll the expense into a fixed term contract with Investec and you will earn Qantas Frequent Flyer points on your eligible purchases. What's more, you can make your monthly repayments for all Investec finance and loan contracts (excluding overdraft and lines of credit) on the Investec card and you can earn Qantas Frequent Flyer points on the repayments as well.

Each of these finance structures of products will carry different costs and savings in after-tax-dollars. In addition, the fees and charges that you will pay to set up and operate the facility should be added in to the total cost of the finance, not just the interest cost. It is important to speak with a Financial Specialist on the best option for you. "We have over 20-odd years experience in working with medical practitioners, so we know this market in a deeper way than anyone else", says Stafford.

In order to determine which loan structure is right for you, speak with a specialist financer who has an understanding of your financial and business circumstances. Investec Medical & Dental Finance consultants are specialists in advising on these considerations and will work with your accountant and advisors to ensure that you choose appropriate and effective finance.

To find out more contact Michelle Gianferrari on 0414 475 012 or Lynne Kelly on 0420 970 594 or visit investec.com.au/medical

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Canberra Doctor editorial committee chair to call it a day...

Long serving chair of the Canberra Doctor editorial committee, Dr Ian Pryor, has advised the Board that he wishes to step down from the role as soon as a replacement can be found.

Dr Pryor has led the editorial team since 2004 and during this time, it has won the much coveted AMA Best Publication Award in 2007 and 2011.

"Canberra Doctor" celebrates its 25th birthday in 2013 and he believes it is an opportune time to hand on to the next generation to ensure "Canberra Doctor" continues to be written by member doctors for all doctors in the Territory.

Dr Pryor said he greatly valued his time chairing the editorial committee which offered the opportunity to work with colleagues and with Christine Brill, the production manager, to evaluate copy for inclusion, give editorial and policy advice on a range of matters as well as at times providing articles and opinions. He encourages members to take the opportunity to get involved with this special committee which is not unduly time consuming as it meets monthly before each edition to give editorial advice particularly on potential articles. The meetings are enjoyable and interesting and, as getting "Canberra Doctor" to publication is the role of the management team, not the editorial committee, the demands are not onerous beyond some editing of articles at times.

Dr Pryor said it was important that the editorial committee go through a period of refreshment periodically to maintain the sharpness of its focus and that the committee has always been very fortunate to have continuing interest and support from practising and retired members as well as from the medical student fraternity.

Expressions of interest to take on the role or to join the committee should be directed to Christine Brill: execofficer@ama-act.com.au or phone 6270 5410.

50% of Australians who oppose vaccination get their information from the Internet

First ever national survey of Australian attitudes to vaccination

To coincide with the broadcast of **Jabbed: Love, Fear and Vaccines** (SBS ONE, Sunday 26 May at 8.30pm) the first ever national survey* on Australian attitudes to vaccination reveals surprising statistics including half of Australians opposing immunisation get their information from the net. According to the survey those in favour of vaccination consult their GP.

Up until now such surveys had been conducted state by state. This survey reveals a combined snapshot of Australia's opinions to vaccination where although support for immunisation is high, questions and concerns can co-exist.

According to the survey 92% of Australian parents allow their children to be fully vaccinated, whilst 53% express a range of concerns. Younger people appear to be less confident than their parents and grandparents in making their vaccination decisions. Younger people are often relying more heavily on internet research, which is proving to be a powerful tool in the immunisation landscape.

The survey also states that, across the sample, 11% reported that they or someone they knew claim to have experienced a vaccine reaction. Nevertheless overall support of vaccination is high with Australia having one of the highest rates in the world.

Commenting on the survey findings Professor Mark Kendall Group Leader, Delivery of Drugs and Genes Group (D2G2), Australian Institute for Bioengineering and Nanotechnology (AIBN) said *"This national survey of Australian public attitudes to vaccination yields fresh insights into the attitude of public – the parents, the children, the young and the elderly towards vaccines. It drives home an important point: the decisions we make on vaccines, for example whether to get vaccinated or not, hinges upon the information we gather on vaccines and the source of this information.*

It is clear that we the researchers and developers of vaccines need to step up here. We need to work harder in getting the complete information picture of vaccines on the basis of scientific rigour to the public. With the young now sourcing so much information from the internet, we need to package this information based upon science in ways online that are more accessible to them."

Jabbed features interviews with experts including vaccine creators Professor Ian Frazer and Dr Paul Offit, immunology 'super-star' Sir Gustav Nossal, and Dr Peter Fisher, clinical director of the largest alternative health centre in Europe (and the Queen's personal homeopath). Jabbed combines respected insight from the world's leading figures in conventional and alternative medicine, with real life stories of families whose lives have been irrevocably impacted by immunisation. This powerful and confronting documentary is the start of a new conversation about vaccination.

Two and a half years in the making, Jabbed is a game-changing documentary covering one of the most talked about public health topics globally – vaccination. In an attempt to shift the focus from the usual polarised 'pro' and 'anti' vaccine debate, Jabbed digs deeper into the motivations and concerns of ordinary people who are trying to decide how best to protect the ones they love. It deeply explores concerns around vaccines, concerns shared even by parents who choose to vaccinate.

Online education helps you bill the correct Medicare items after removing skin lesions

The Department of Human Services has released new and updated education resources to help you correctly bill Medicare items for the removal of skin lesions.

A new skin lesion removal flowchart helps you select which Medicare items to bill, depending on the type of excision procedure you've performed. It also clarifies the key requirements for items 31205–31335.

An updated quick reference guide explains the key requirements for claiming items 30071 and 31200–31335.

Their new look eLearning program about treating skin lesions under Medicare lets you test your knowledge using case-based scenarios. The program is interactive and structured so you can complete it at your own pace.

To access the online education resources go to humanservices.gov.au/hpeducation

A complete range of eLearning programs and quick reference guides that can help you refresh your knowledge of Medicare billing, claiming and referrals and prescribing under the Pharmaceutical Benefits Scheme (PBS) is also available

For more information:
Web: humanservices.gov.au/hpeducation Email: medicare.education@humanservices.gov.au

medicare

Preventing pneumococcal disease: a vaccine success story

Universal pneumococcal vaccination of young children and older adults has substantially reduced the disease in Australia, according to experts from the Children's Hospital at Westmead. Further, the vaccine program has also contributed to herd immunity.

Writing in the June edition of *Australian Prescriber*, Dr Clayton Chiu and Professor Peter McIntyre say that pneumococcal vaccination has had good success in Australia, and the continued development and refinement of the vaccination is likely to lead to an even further reduction of the disease.

"The highest incidence of invasive pneumococcal disease in Australia is seen among young children, especially those under two years, and in the elderly," they write.

In 2005, Australia implemented universal pneumococcal vaccination of all young children and of all adults aged 65 and over.

"Since this program started, reductions in invasive pneumococcal disease have been seen not only in the groups vaccinated, but also in older children and adults in the age groups who did not receive the vaccine," write the authors.

"This herd immunity that we have seen as a result of the widespread vaccination is extremely important in protecting the population as a whole from infection."

In addition to infant vaccination, pneumococcal vaccination is recommended for healthy non-indigenous adults aged 65 and over, as well as in people with an increased risk of invasive pneumococcal disease – such as people who smoke, those with diabetes or severe asthma, and those with a weakened immune system. Healthy indigenous adults are recommended to have the vaccine from 50 years of age.

Australian recommendations for pneumococcal vaccination are complex. The article summarises and explains these guidelines for use in children and adults, based on the 2013 edition of the Australian Immunisation Handbook.

To read the full article visit http://www.australianprescriber.com/upload/pdf/online_first/pneumococcal_vaccines.pdf

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The effects of antidepressants on emotional experiences in people suffering from depression

Dr John Saboisky and colleagues are currently conducting a research study on the effects of antidepressant medications on emotional experiences.

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Eligible study participants will receive all antidepressant medications and study-related care from the study psychiatrist at no cost.

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