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GUEST EDITORIAL: Ongoing Centenary Legacy – Cancer Chair for the ACT

Professor Christopher Parish writes for Canberra Doctor

For many Canberrans, celebration of the Centenary year included festivals and fireworks, champagne events and historic recreations. For the staff and students of The John Curtin School of Medical Research (JCSMR), at The Australian National University (ANU) and for the medical personnel concerned with cancer treatment and care in Canberra and the surrounding region, especially those at the newly established Canberra Region Cancer Care Centre, a far more long lasting legacy has been achieved – one that we hope will put Canberra on the map as a national and international hub for progress and innovation in cancer research and patient care.

The prevention and treatment of cancer is both a national and international health priority of the highest order. In Australia, cancer has overtaken cardiovascular disease, now killing more people each year than any other single cause. This statistic is reflected internationally, and results in a personal, social and economic burden of enormous proportions. There are more than 115,000 new cases of cancer identified, and 44,000 deaths from cancer in Australia every year. In fact, one in three Australians will develop the disease before the age of 75 and 19% of the health system's budget is spent treating cancer.

The new Canberra Region Cancer Centre at the Canberra Hospital, an initiative jointly funded by the ACT and Commonwealth Governments, will greatly improve the quality of treatment for cancer patients in the Canberra region. However, development of new therapeutic approaches toward the prevention and treatment of cancer is urgently needed, and this is clearly dependent on highly innovative cancer research. As an ongoing benefit of Centenary announcements and celebrations, ANU has partnered with the ACT Government to create a new high-level appointment, establishing the *Centenary Chair in Cancer Research* in order to facilitate world-class cancer research in the Canberra region. The Chief Minister, Ms Katy Gallagher, announced a commitment of $1.5M over three years towards start up funds for the Chair, including contributions towards laboratory set-up costs and support staff, while Vice Chancellor Ian Young has announced that ANU will permanently fully fund the Chair's salary, contributing a further $5M to ongoing support. The Chair will be associated with The John Curtin School of Medical Research (JCSMR), one of the leading medical research institutes in Australia, which has a proud history of achievements in cancer research. The Chair will also be closely linked to the Canberra Region Cancer Centre, and will enhance collaborative projects between Centre clinicians and cancer researchers at the JCSMR.

Following the announcement, an international search was initiated to identify a cancer researcher of the highest level, one who will bring exciting and innovative methods to Canberra, and lead a cutting edge research team, extending our current research efforts and exploring new directions. The state of the art facilities at JCSMR, and the provision of new equipment, including a new intravital microscope expected to arrive at the School early in 2014, coupled with the easy lifestyle of our capital city, have proved attractive to potential candidates for this position. We look forward to the successful Chair setting up a laboratory at JCSMR later this year.

The Centenary Chair will ensure a long-term impact of the centenary celebrations on the health of ACT residents and, potentially, cancer sufferers worldwide. A Centenary legacy indeed, but one which has reach far beyond this city and its surrounds, and will benefit all Australians well into the future.

Professor Christopher Parish
Director, The John Curtin School of Medical Research, ANU

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

2014 is already 10% expended. What a sobering thought. With what time remains I guess a wish list is not too late. Aside from world peace; which seems as elusive as ever, I can list a few.

The issue of "alcohol-driven violence" has occupied a lot of media time recently. I am concerned that this sensationalisation has masked the real cost of alcohol excess; with trauma (road and other); domestic disruption and violence; associated illness; and industrial or economic costs all being overshadowed. I for one do not believe that increased penalties alone are the answer (despite Campbell Newman's wise words). I don't mind being called a wowser if it makes a difference. My wish is for the whole community to accept that responsibility is shared and to make sure our children get an unambiguous message from home (and believe me attitudes to alcohol consumption and excess begin to be laid down very early in life), and school, and from our sporting and other institutions. And governments undeniably have a role; locally with precinct management and licensing laws; and federally with excise, sponsorship and advertising laws. Until we all take ownership of these issues they will not just go away. And it is clear that with powerful lobby groups at play our law makers will need a lot of motivation before they will act. The media may find a new issue but until then we will all continue to pay the cost.

Disappointingly the needle exchange program at the AMC still remains as "pending". It is time enough to have sorted the matter. It seems likely that neither the prison officers union, nor the ANF will bring themselves to agree with any model proposed. The medical officers involved are steadfastly in favour of its introduction. We know that sero-conversions have occurred amongst inmates. The AMA view is that it should just get going, unequivocally, no trials; just launch the program and assess its efficacy and practicality in real time with the previously determined assessment tools.

Now I know that this missive will make me appear bolshie, but I would also like to see our profession move back to the ethos of collective support. As a profession we call it collegiality, but the idea is similar. As a united voice we can sway governments (viz. "scrap the cap"); so why do we find it so hard for specialists to support GPs (and vice versa), and VMOs to support salaried specialists (&v-v); and consultants to support RMOs and trainees. Yet that appears to be a real problem; and it is one that bureaucrats and politicians readily exploit. We have tasted these problems in the ACT in the past, and more than a faint whiff recurs with every industrial negotiation here; but the situation in Queensland is a threat to us all. The contracts proposed by the Queensland government fall a long way short of acceptability on a number of fundamental grounds, including the absence of a binding arbitration process for dispute resolution; provision for arbitrary dismissal; enforced shift work with no provision for consideration of safe working hours standards; absence of a no disadvantage clause and the tying of KPIs to income. If these contracts are allowed to continue they will set a precedent nationally. Whilst you may argue that it is for AMA-Q and the federal AMA to argue this case, the principle of collegiality is one that we should all embrace. The law makers and administrators need to know that the profession can stand together.

Of AMA news lately I am happy to report that the new allied health and GP with special interest directories are taking shape. The former will provide the local medical community with a valuable referral resource where allied health practitioners will be able to make their skills and special interests known. The entries will be vetted with professional organisations and AHPRA to ensure accuracy and that appropriate standards are met. It has always been difficult for general practitioners who have special interests and skills to make them known to their colleagues. The GPSI directory will provide that vehicle; the entries will be vetted for accuracy and to ensure that professional standards are complied with.

For those interested in life on the rural fringe, I can relate a cautionary tale about swimming with kangaroos. And before anyone suggests that I indulge in perverse pursuits with our native wildlife after my wombat vaulting I can assure you that this episode was motivated by pure altruism. The country as I am sure you are aware is parched and our farm no less arid; I have been occupied pumping water for stock and to keep our garden alive (don't get farmers talking about pumps unless you have a comfortable seat); and on my daily walk to the river bank to start the pump our dogs flushed a kangaroo which promptly leapt into the Murrumbidgee followed by our ragtag collection of canines.

Some of you may know that kangaroos will take to water in this way and then hold down, and drown, any dogs that come within reach. Armed with this knowledge, motivated by a concern for all (dogs and roo) I plunged fully clothed into the river. I did get there just in time for our dachshund – only the desperately waving tip of his tail was visible by that stage; and who rewarded my valour by throwing up over me. Wiser heads may suggest that wrestling in a river with four dogs and an angry kangaroo is a task for a younger man. In retrospect I would have to agree.

In the end, after grabbing and losing hold on each of the dogs while fending off the kangaroo I had to remove my shoelaces to tie the dogs together and get them away. The roo did not stop to say thanks; it demonstrated a singular lack of sense by swimming back to the river bank from whence it came, leaving me sitting on a rock with four dogs laced together and shoes retained only by clenched toes, waiting until it hopped off. Mercifully the day was hot so my clothes had more or less dried by the time I squelched through the front door. My superior surgical knot skills meant that it was only another quarter hour and one broken fingernail to untie the dogs. The bruises and scratches have largely healed. Ah, rural bliss?

Right now I am recovering on the picturesque shores of Lake Wakatipu before heading into the wilderness on a six day walk with no mobile phone reception…now that is bliss.

Congratulations to the graduating class of 2013 ...

Photo by: Irene Dowdy ID photographics

At the graduation dinner held in December 2013, the AMA Prize for Leadership was awarded to Justin Rheese. The prize was presented by AMA ACT President Elect, Dr Elizabeth Gallagher.

Other prize winners were:

Alan Peirce: Guan Chong Prize in surgery and finalist AMA Leadership Prize

Carrie-Anne Atkinson, Nyssa Cole, Danielle Medek, Kathleen O'Brien, Megan O'Moore, Julie Styles, Emma Tucker and Alix Vivant: the Population Health Prize

Catherine Greenshields and Ingrid Fewings: South NSW Medicare Local Prize

Daniel Owers: finalist AMA Leadership Prize

Faseeha Peer: Women's Health Prize

Giothini Thirunavukarasu: Cancer Council ACT Pathology Prize

Joseph Choi: Louis Szabo Silver Probe Award

Julie Styles: Mary Potter Award for Excellence

Justin Rheese: Damian McMahon Clinical Skills Prize; Clinical Neuroscience Prize; and the Gareth Long Prize in Orthopaedic Surgery

Kyra Clifton: Psychiatry Prize

Michael Krasovitsky: ACT Medicare Local Excellence in General Practice Award; Guan Chong Prize in Surgery and Graham Wilkinson Prize

Michael Li: Rural Health Prize

Rachael Hocking: Michael Hargrave Prize for Ophthalmology

Scott Mills: Indigenous Health Prize

... and welcome to the 2014 year 1 medical students

The AMA again hosted its annual Welcoming Drinks for the new medical students at the UniPub recently. Dr Elizabeth Gallagher, welcomed the new students and congratulated them on choosing a career in medicine and for choosing the ANU Medical School.

Photos by: Liam Stone

The challenges of mental health treatment among young people in rural Australia – By Aleksandar Misev

Background

Mental health is one of the biggest challenges facing the Australian health system. The disparity in health care in rural areas of Australia compared to urban areas is well documented, and mental health care is no exception. Rural youth in particular have less access to health care, compared to both rural adults and urban youth. This paper will outline challenges faced in delivery of mental health services; some of which are more evident among people living rurally, and others which are more evident among youth. Thus, rural youth face relatively more problems with healthcare than other demographic groups.

Statistics

The prevalence of mental disorders in a person aged 16-24 years in any 12-month period is 26%. Among the general population, the figure is 20%, meaning young people are more likely to have a mental disorder than others. Only 25% of young people with mental health issues access health providers . Untreated mental illness is the main risk factor for suicide in young people.

In 2011, the Australian government committed $1.5 billion over five years to mental health reform, including $491.7 million on children and young people. Whether this will be enough remains to be seen.

General problems

Problems with living rurally for young people include less educational opportunities, employment, and recreational activities. All of these have effects on health outcomes, as individuals with a lack of secondary or tertiary education and few job opportunities are pushed into low socioeconomic status because of their environment rather than their own choice. The stress of deciding whether to move to larger town or city for education or employment purposes or to stay near family and friends is a burden on young people living rurally. In addition to this, lack of adequate recreational activities in many towns can contribute to increased drug use, sexual activity and other risk taking behaviour.

Problems of access

Young people in rural areas have less access to mental health facilities, and there are multiple reasons for this. Distance is one of the biggest issues, as the nearest mental health care provider may be in across town, in a different town or in a capital city, meaning a long or expensive journey could need to be undertaken to attend an appointment. Most young people do not have the ability to make these trips. They may need to take time off school and/or work, which inhibits their learning and/or finances.

Transport further affects this issue – adolescents do not have the ability to drive themselves to particular facilities, and to public transport, in the cases where it is available, may be too expensive or at inconvenient times. Due to the distances involved in many cases, walking is seldom a viable option. Tied in with issues of privacy, many young people are reluctant to ask their parents to transport them to mental health facilities, and working parents may also not have the time to take their children to mental health appointments. Most services in rural communities have limited after-hours availability, which further hinders accessibility to young people who are not able to miss school or work.

Another problem of access is long waiting times for health professionals. Most mental health patients make initial contact with a GP, but in rural areas, the waiting time for a GP consult can range from 3 weeks to 3 months. Not only is this grossly inadequate, it means people who have made the decision or effort to seek mental help are being made to feel helpless and are discouraged from seeking more help due to its difficulty. It also increases the risk that mental health disorders can get worse by the time patients are initially seen, let alone referred, completely undermining the concept of preventative health care, which is the direction towards which the field of medicine has been travelling.

Exacerbating these problems is the fact that few rural GPs bulk bill, meaning the cost for young people presenting to a GP is significant, especially when added to the cost of further referrals to mental health professionals, such as psychologists and counsellors, who are not covered by subsidies on the Medicare benefits schedule (MBS).

Similarly, many mental health referral services have reached the point of saturation, wherein they do not have the manpower or funding to take new patients unless they are at high level risk of harm to themselves or others. A significant amount of mental illness patients presenting to emergency departments endure long waiting times due to a shortage of beds.

Reluctance in help-seeking

There is a preference among young people, especially males, to rely on themselves when encountering problems. This leads to reluctance to seek help, and many mental health patients present rather late, once they can no longer cope with their problems. Lack of communication with support networks increases risk of adverse outcomes such as suicide.

Stigma and Confidentiality

There is still stigma associated with mental illness, and in the context of young people in a rural setting, the main concerns are related to what people in the community (friends, family, health practitioners) will think of an individual seeking help, as negative attitudes and social exclusion are commonplace, which in and of themselves are detrimental to wellbeing, let alone on top of another stressor or mental health condition.

This relates to perceptions of confidentiality, as young people in general have more concerns about whether information relayed to health professionals will be forwarded to others. In a rural area, breaches of confidentiality can result in many peers, family members, and other townspeople knowing private information. Young people are much more likely to turn to trusted sources for help with any mental health problems, and as such it is paramount that health professionals build this trust with young people at all health consultations.

Most mental health services in rural communities are physically located in separate areas rather than co-located with other health providers, such as GP rooms or hospitals, which limits the ability of patients to control their confidentiality within the community.

Will the funding be enough?

Many of the problems facing rural youth regarding mental health (and health and wellbeing in general) are structural, and as such the scope of funding falls short of properly tackling these issues. A wider array of educational and employment opportunities in rural areas would provide stability and allow young people to become more engaged with their communities, thereby decreasing boredom and risk-taking behaviour. Subsidies for small businesses and allocation of increased funding to educational institutions such as universities and technical colleges, as well as investing in the improvement of education delivery at the high school level, would be a start to creating more jobs and giving young people in rural areas the tools needed to prosper in life, and reducing common stressors with implications on mental health.

The Government funding of mental health services such as Headspace and initiatives to increase awareness of mental health among young people is by no means unnecessary, however in the rural setting the utility of such support services is hampered if the underlying causes for poor mental health are not also tackled. If an unemployed teenager develops depression stemming from the fact that they are unemployed, treatment and support from health professionals can only go so far if they continue remain unemployed.

Likewise, increasing availability of public transport and the co-location of mental health services with other health services would allow young people greater accessibility to services they need, thereby increasing initial contact in a group with a vast underutilisation of these services. Following on from this, however, is the need to increase funding for the mental health services, as demand has outstripped supply. The Government, to its credit, did recognise this and allocated a significant portion of its 2011 outlay "to provide additional and sustainable youth mental health centres and reduce waiting times". A move to online access and teleconferencing systems could also be another option for dealing with lack of access to youth in rural areas, especially after hours. Complete unavailability of adequate mental health services after hours is a highly unethical reality, as risk of suicide or harm to others does not solely occur from 9 to 5. Acute physical health needs can be met more or less 24 hours a day through Australia's system of hospitals and ambulances, but there is a gross shortfall in this capacity regarding mental health.

Conclusion

Only with a wide-lensed and considered approach can the challenges around mental health that are facing youth in rural areas be effectively solved. This includes not only supporting mental health services for the treatment of patients, but also tackling the underlying issues that are magnified among young people in rural Australia.

Aleksandar Misev is a 2nd year student at the ANU Medical School. References are available from the author.

Safety Site Program – coming to a site near you

As a result of the folding of the ACT Safety House organisation, ACT Policing Crime Reduction has been exploring the possibility of replacing it with a business based public assistance scheme.

The premise of the Safety Site Program is that any person, regardless of age, gender or other factors, can approach the business to seek assistance with contacting Police.

No further involvement from the business is required other than to facilitate this contact. As a result of a number of engagements with the ACT business and broader community the following businesses and agencies have confirmed their interest in participating in the program:

- Westfield Shopping Centre – Woden
- Tuggeranong Hyperdome
- Australian Pharmaceutical Guild – ACT Branch
- ACT Fire & Rescue
- ACT Ambulance Services
- Australian Medical Association (ACT)
- ACTION Buses

Points of Concern

It is anticipated that targeted businesses are located throughout the ACT.

Some businesses have expressed concern that the Safety Site Program may be seen as a 'drop in centre' or 'permanent refuge' to person's not requiring assistance. These businesses have been encouraged to develop a strategy within their own business environment to ensure that this does not occur.

All businesses have been advised that from an ACT Policing viewpoint unnecessary changes to the way their business is conducted are not envisaged and that generally business should continue as usual.

Contact points for members of the public seeking assistance would be designated by the business; however, it is proposed that these points would be the front desk or concierge desks.

Contact with Police for assistance will occur if it is apparent the matter is a Police issue or the member of the public requests Police assistance. It has been explained that the purpose of the Safety Site Program is to promote 'community relations' and where necessary 'be a contact point for Police assistance'. It is anticipated that the program be 'self-running' with little interference from a Police perspective.

Some of the businesses have suggested that stickers be considered for the Safety Site Program and supplied to participating businesses to promote the program and identify the location as a participant in the Safety Site Program. This will also assist young children to recall the purpose of the location. This is currently being pursued with ACT Policing Media.

Program Promotion

Promotion of the Safety Site Program will be through ACT Policing Media to obtain the most exposure possible for the Program. This campaign will also include promotions at schools and through the various stalls and functions that Crime Reduction members attend. Initial conversations with ACT Policing Media about this activity have commenced.

To assist the promotion of the Safety Site Program while participating in school presentations it is envisaged that Constable Kenny Koala would be utilised to assist in relaying the message of Safety Site to school aged children, similar to his previous promotion of Safety House.

For both school and stall presentations it is proposed that handouts be available to school children and the general public.

Program Commencement

Crime Reduction is currently planning for a February 2014 commencement of the Safety Site Program. It is anticipated that a media campaign will be launched to coincide with the commencement of the Safety Site Program. This campaign will explain the program and the participating sites to the public. Representatives from participating agencies and organisations are expected to be included in the program launch.

If GP practices are interested in being involved? If so, could you please contact AMA ACT CEO, Christine Brill (email: execofficer@ama-act.com.au) and further information will be provided to you.

(copy supplied by ACT Policing)

Water fluoridation – Time to think before we drink?

Introduction

Water fluoridation has only recently come to my attention as a controversial issue. From an attempt to understand this issue I present my own research findings with a consideration of ethical implications of fluoridation. The benefits of mass water fluoridation while still substantial are being questioned in light of the well-known side effect of dental fluorosis and the increased availability of fluoride from other sources. Examination of the ethical, legal and human rights implications of water fluoridation contributed to a well-rounded understanding of the role of water fluoridation in Australia.

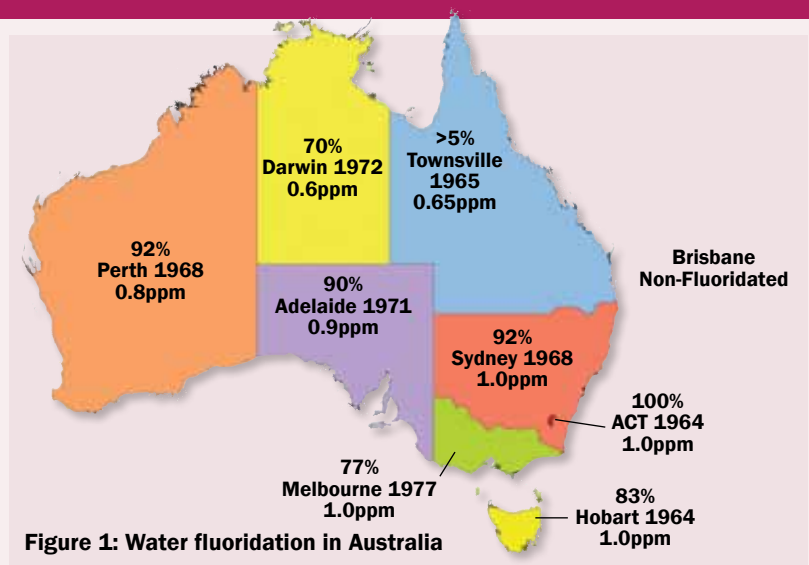


Figure 1: Water fluoridation in Australia

Benefits of fluoridation

It is now recognised that the effect of fluoride is twofold. Firstly, fluoride aids remineralisation of early lesions in tooth enamel preventing them from progressing to cavity. These 'healed' lesions are more resistant to caries attack than other unchallenged sites. Secondly, fluoride has an antimicrobial effect, inhibiting bacteria metabolism and acid production that leads to caries development.

From the original study conducted by Dean and colleagues, the benefits of fluoridation have been widely acknowledged resulting in international uptake of this measure. A number of studies around the world have shown continued reduced rates of dental caries in fluoridated areas compared to non-fluoridated areas. While fluoride is of benefit to all ages, it is most beneficial to children prior to the eruption of permanent teeth giving resistance to future attack (although it also promotes remineralisation and bacterial inhibition in adults).

Those in non-fluoridated areas have also experienced an improvement in dental caries rates, most likely due to the "halo effect". This has been described as benefit of surrounding areas due to food production and water sources in fluoridated areas being introduced to non-fluoridated areas. Hence, the introduction of fluoridation has reduced dental caries in a wider than expected proportion of the community.

Risks of fluoridation

Dean and his colleagues were originally researching the cause of dental fluorosis when the association with reduced dental caries was found and exploited as a prophylactic measure.

Evidence continues to reveal fluoridation has a negative association with caries but a positive association with the prevalence of fluorosis.

Studies done in the United States have shown fluorosis is relatively common. In a recent survey done 1999-2004, only 60.6% of 6-49 year olds had no fluorosis. The largest groups had questionable or mild fluorosis (16.5% and 16% respectively). This rate has increased when compared to similar surveys in the 1980s. These results are higher than the predicted rate of 10% by Dean and colleagues however this is likely due to the increased availability of fluoride over time (as explained below). It has recently been noted in Australia that in some areas dental fluorosis is in decline with the introduction of preventative measures.

The increase in dental fluorosis noted since the 1950s is likely due to the increased availability of fluoride in other sources, particularly toothpaste.

Children are most at risk of dental fluorosis due to their habit of licking and ingesting toothpaste leading to higher than recommended amounts of fluoride ingested combined with the inherent susceptibility of developing teeth. Fluoride in baby formulas was also an important risk factor although this has been neutralised with the industry voluntarily reducing or eliminating fluoride from formula in 1979. Current recommendations suggest children use low fluoride toothpastes (400-500ppm) under parental supervision to ensure a small amount is used with adequate expectoration after to reduce the risk of fluorosis. Since the introduction of these measures there has been a decline in dental fluorosis leaving water fluoridation as the main cause in the modern population.

There is minimal evidence to support fluoride as a cause of other diseases. It has been suggested that water fluoridation is a risk for childhood osteosarcoma however Levy and Leclerc (2011) have shown no correlation by comparing rates of osteosarcoma to state water fluoridation level in the US.

Fluoride has been studied for its possible effects in bone (specifically the prevention of osteoporosis) due to its effect on bone growth. These results have shown some promise when fluoride is given with adequate calcium however there are side effects associated with the required dose for bone effects and without calcium can result in osteomalacia.

Legislation and policy

Fluoridation of water supply Act 1975 in NSW has been followed by all other states (latest in Qld in 2008) which rules public water supplies should be fluoridated (unless there are naturally adequate levels of fluoride in the water supply). In some states this has changed so the decision to fluoridate rests with the local council which has historically held referenda on the subject (although not required to do so).

The Public Health Association has highlighted dental caries as a significant and costly burden to Australia with many vulnerable groups affected. Water fluoridation is seen as an equitable, effective and safe method of the prevention of dental caries although access to fluoridated water varies across the country. The ADA advocates water fluoridation as "the most effective, equitable and efficient measure for achieving reduction in dental caries incidence across a community". Aside from the ADA, the Australian Medical Association, the Cancer Council, Diabetes Australia, Osteoporosis Australia and Kidney Australia all support water fluoridation.

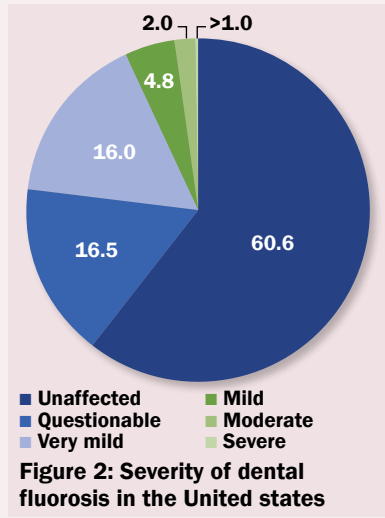


Figure 2: Severity of dental fluorosis in the United states

Ethics

The ethical implications of water fluoridation can be viewed through Beauchamp and Childress four ethical principles of autonomy, beneficence, non-maleficence and justice.

- Autonomy: - Of all the ethical principles, the respect of autonomy is generally questionable in all public health measures. Water fluoridation is a particular example of this due to the difficulty the individual has of opting out of the system if they wish. Forced participation in the program has lead other countries around the world to suspend water fluoridation practices.
- Legislation regarding the implementation of water fluoridation is state and territory based with the responsibility to fluoridate water resting at a state or local level. Recently this has changed in NSW to allow local councils to make the final decision
- Beneficence: - An overwhelming amount of evidence shows fluoridation has a positive effect in reducing dental caries. Dental caries are associated with degradation of teeth, pain and abscess formation which can be avoided with the use of fluoride, showing great respect for beneficence.

– By Marie Mansfield

- Non-maleficence: - This principle can be seen as being respected or abused depending on the point of view. On one hand, dental fluorosis is a possible risk of fluoridation and there is also a risk to the rare individual with fluoride allergy hence there is capacity for harm. On the other, dental fluorosis is a minimal side effect in the community (usually requiring no treatment) and more harm could be caused by not fluoridating water in the form of dental caries by a lack of fluoridation.
- Justice: - Fluoride is available to all individuals in the community and is therefore an equitable method for improving dental health. In Victoria, the prevention of dental caries through water fluoridation is estimated to have saved $1billion in the 25 years since it was introduced through avoided dental costs and time off work and school. Savings made through the introduction of water fluoridation can be spent on other areas of health need showing a respect for justice.

Human Rights

Although there have been some questions about the ethics of mass medication of the population, fluoridation supports the human right to health. According to the WHO it is a primary goal of all community based dental programs to introduce water fluoridation to prevent dental caries thereby respecting the community right to health.

The rights of the individual are balanced with the needs of the government to protect public interests including health. It is therefore in the interest of public health that water fluoridation and its substantial benefits in preventing dental caries is an acceptable compromise to individual right to autonomy.

Conclusion

It is obvious then why water fluoridation remains a contentious issue.

On one hand, it has benefits in terms of preventing dental caries and can be effectively administered to the whole population via the water supply. Ethically, water fluoridation supports Beauchamp and Childress ethical principles of beneficence, non-maleficence and justice as it prevents harm to the patient from dental caries and its associated complications and is equitably distributed in its availability to the population (even those outside the region of fluoridation). It is also consistent with the human right to health and is supported by legislation and public health policy.

On the other hand, these benefits can be achieved through other sources of fluoride (namely toothpaste) and with a reduced risk of dental fluorosis. This is more in keeping with respecting individual autonomy in being able to choose how (and if) they take fluoride and non-maleficence in not doing harm through mass fluoridation.

There are merits and flaws in both these arguments making it difficult to reach a decision. It appears in Australia the main cause of fluorosis has been the combination of water fluoridation and fluoride from other sources and children being most affected. These problems have been effectively dealt with by producing paediatric toothpaste with low fluoride concentrations, improving child tooth brushing practices (including parental supervision) and removing fluoride from baby formulas. The low rates of fluorosis remaining while significant in terms of numbers are of relatively minor concern given the benign nature of fluorosis and the significant benefit of reduced dental caries rates seen in communities with fluoridated water (and their surrounds).

Weighing the evidence, I believe mass water fluoridation is an effective public health measure provided it is supported with adequate education regarding the importance of dental health and fluoride use. It can benefit the whole population where this measure has been adopted. Even when taking into account the risks of fluoridation, it remains in support of human rights and ethical principles further encouraging the uptake and maintenance of this measure.

Marie Mansfield is a year 1 student at the ANU Medical. References are available from the author.

New ACCC online tool helps consumers choose safe sunglasses

The Australian Competition and Consumer Commission has released an online tool to help consumers choose which pair of sunglasses is safest for their eyes.

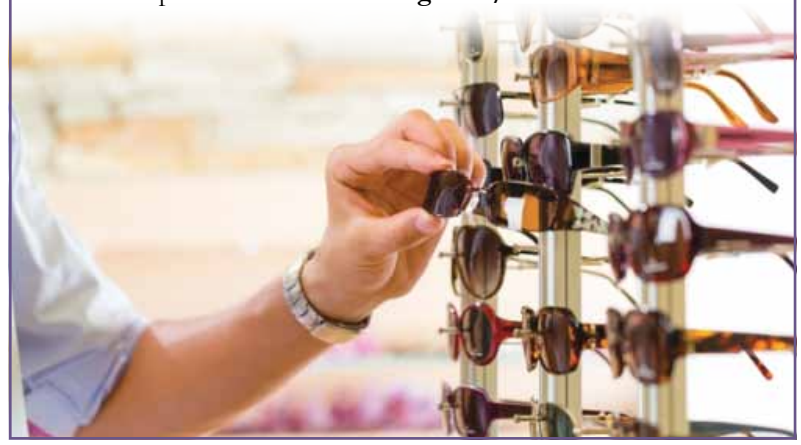
Via a quick survey, the 'Safe sunnies: Which pair should I wear?' tool helps shoppers determine which lens category, the level of UV and glare protection sunglass lenses provide suits their particular needs."

Recent ACCC-commissioned research showed that Australians rate sun protection very highly when choosing to buy sunglasses but over 40 per cent are unaware of the lens category classifications and what they mean.

A particular concern is tinted fashion glasses designed for indoor use or for wearing at night – they may look like sunglasses but offer little UV protection and could be dangerous if worn when driving at night.

Under the Australian Consumer Law, sunglasses must not be sold without correct lens category labelling, among other things. A recent joint product safety survey by the ACCC and state and territory consumer affairs agencies on sunglasses found that almost one in seven products did not comply with the mandatory safety standard.

The tool is available on the Product Safety Australia website at www.productsafety.gov.au/safesunnies



Making Medicare relevant in the 21st century

Addressing a roundtable to mark the 30th anniversary of Medicare, AMA President, Dr Steve Hambleton said primary health care costs were growing much more slowly than those in other parts of the health system, and improving support for GPs in providing care for complex and chronic diseases would ultimately save the nation billions of dollars that would otherwise be consumed in expensive hospital care.

Dr Hambleton opened his address by referring to **recent media reports on the patient co-payment**.

He said, "December and January are traditionally the silly season in the Australian media.

"For health, it has been a very silly season.

"People are speculating about the changes to be made to ensure we have a sustainable health care system.

"These opinions became stories that inevitably focused on Medicare – because for most Australians Medicare is the Australian health system.

"The most notable proposal was the oft-recycled patient co-payment.

"The AMA does not support this concept and we have made our view very well known.

"There are better ways.

"It is interesting that this speculation has come at a time when a new Lancet Commission, when considering global health up to 2035, has recommend that countries should lower the barriers to early use of health services and increase access to disease prevention and minimise the impact of medical expenses.

"While I acknowledge the growth in Medicare expenditure, it is important that any changes do not throw the baby out with the bath water.

"Any changes must be in the context of the long term goal to improve population health, which will deliver real cost savings.

"In terms of spending on medical services, via the Medicare Benefits Schedule, doctors have done their bit over the past decade on containing costs.

"As I have said in other fora, medical services costs are not the problem.

"Here are the facts …

"**Health expenditure:** the proportion of health expenditure on medical services was 18.8 per cent in 2001-02 compared to 18.1 per cent in 2011-12.

"The average annual growth in total health expenditure on medical services in the decade to 2011-12 was four per cent, compared to growth in PBS expenditure of 6 per cent and 9.3 per cent for products at the pharmacy.

"The growth in average health expenditure by individuals on medical services in the decade to 2011-12 was four per cent, compared to 5.3 per cent for PBS medicines and 7.5 per cent for products at the pharmacy.

"The average growth in Medicare benefits paid per service in the decade to 2012-13 was 4.7 per cent, less than the real growth in total health spending of 5.4 per cent in the decade to 2011-12.

"It is clear that the MBS - combined with the private health insurers' schedules - is an effective price dampener for medical services. At least that is what my members keep telling me!

"In terms of access to care – despite the low growth in the Medicare Rebate, today, 81 per cent of GP consultations are bulk billed.

"And 89 per cent of privately insured in-hospital medical services are charged according to the patient's private health insurer's schedule of medical benefits.

"This means that patients had no out-of-pocket cost for their doctor's fee for 93.5 million GP consultations in 2012-13, and over 26 million privately insured in-hospital services.

"When Governments get nervous about spending in health, they have three options: reduce the price they pay; spend more wisely; or collect more revenue.

"I think that the recent focus on price, in terms of the Medicare Benefits Schedule, is a bit misdirected.

"The focus should be on spending that money wisely. Today, Minister Dutton is quoted as saying that we need to invest in the areas of greatest benefit.

"The medical profession stands ready to do its bit in this regard, too.

"Australia must change the way it provides health care, where it provides care, and when it is provided for the major driver of health care costs - non-communicable diseases.

"Medicare needs to facilitate this.

"With the rapid increase in medical knowledge and the rate of change of best practice care, evaluation and change must be part of the medical practitioner DNA.

"In terms of our clinical practice, we are going to have to translate what we know into what we do - and we need the tools to do it.

"We will need to do this in a structured way so that we stop doing the things we do that don't provide real outcomes for the patient.

"Our clinical practice must be about doing the right things at the right time in the right part of the health system.

"Once people get to hospital, their care becomes very expensive.

"Keeping people out of hospital is cheaper and it frees up resources, but it might need an increased investment from Medicare, not a decrease.

"That investment must be sufficient to improve the coordination of primary care services.

"Population Health in the Community – Medicare Locals

The AMA understands the need for community-based health care organisations to improve the coordination of health care outside of the hospital environment.

"Such organisations can help to break down the silos in the non-hospital space, build better links between the hospital sector and community based care, support improved population health, and address gaps in the delivery of primary care services.

"The former Government set up 61 Medicare Locals to undertake this role.

"Despite now having been in operation for a number of years, few Australians understand what Medicare Locals do.

"Many GPs feel disenfranchised by them – and so do almost all community-based medical specialists.

"We have welcomed the incoming Government's review and have made a strong submission, based on frontline medical practitioner input.

"We believe the former Government pursued the wrong governance model.

"They substituted or downplayed the role of GP leaders in Medicare Locals and in their decision-making structures.

"They made the same mistakes that the New Zealand Government made in 2001 when it decided to implement 'skills based boards' that excluded GPs.

"These boards were initially made up of people who, while experienced in governance, did not understand the complexity of health care delivery.

"Clinical leadership was absent in many areas in New Zealand and the models failed to deliver.

"The leadership role of GPs has now been restored.

"The PHOs in New Zealand are now playing a more meaningful role in support of improved health outcomes for local communities.

"In New Zealand, the PHOs are now:

- supporting GPs to focus on population health;
- supporting improved quality in general practice by facilitating information sharing among GPs;
- supporting pro-active management of chronic disease;
- supporting e-health initiatives;
- funding specific initiatives to keep people out of hospital; and
- helping support more sustainable general practice by building improved IT and delivering business support.

These are initiatives that are being built from the ground up and led by GPs, not imposed from the top down.

"We are calling on the Government to overhaul the Medicare Locals model to make them responsive to local health needs and to be fully engaged with GPs, who are the engine room of non-hospital based care.

"**Complex and chronic disease:** The challenges for primary care are growing with our ageing population. Complex and chronic disease represents a huge burden to the health system. It accounts for about 70 per cent of the allocated health expenditure on disease and is estimated to increase significantly in the immediate future.

"This is both a threat and an opportunity for the Medicare of tomorrow.

"Current Medicare-funded chronic disease management arrangements are limited, can be difficult for patients to access, and involve considerable red tape and bureaucracy.

"We need less red tape and more streamlined arrangements allowing GPs to refer patients to appropriate Medicare-funded allied health services.

"We need a more structured, pro-active approach to managing patients with complex and chronic disease.

"The Department of Veterans Affairs is doing some great work in this area with its Coordinated Veterans Care (CVC) Program.

"DVA is supporting GPs to provide comprehensive planned and coordinated care to eligible veterans with the support of a practice nurse or community nurse contracted by the Department.

"The CVC program is a pro-active interactive approach to the management of high acuity chronic and complex diseases.

"It supports GPs to spend more time on these patients on a longitudinal basis. This is something that Medicare currently works against.

"The CVC program recognises the non-face-to-face work required, including regular follow-up to see how patients are going without relying on the patient returning to the surgery.

"We need to look at how we can roll out this type of pro-active approach more broadly.

"It would allow us to invest in a healthier future with better disease management, and prevention of avoidable costly hospital admissions.

"The overall message is that if we as a nation do not wish to spend more on health – and that is the clear message coming from the new Government – than we must spend smarter.

"We must invest in the things that work.

"We must share the knowledge that our various organisations gather from the coalface of health service delivery.

"Above all, we must be spending more time building on the things we agree on – and there are a lot of things that we agree on.

"Doctors are ready to be a major part of the solution.

"GPs are the foundation of primary care – and they save the health system money.

"The GP role in population wellness and, ultimately, cost control must be enhanced by Medicare – not eroded or substituted.

"The AMA strongly believes that 2014 and beyond must be the years of the GP who can deliver the right care at the right time to the right person."

Medicare must rise to the challenge, Dr Hambleton concluded.

GP health checks have impact on risk factors

New research from the University of Adelaide suggests there are ongoing benefits in managing risk factors from annual GP health checks, amid growing international concern that such check-ups do not improve patients' health.

A paper published in the British Medical Journal and a Cochrane review in 2012 have both called into question the validity of annual health checks in the United Kingdom, saying there is no proof that they help to identify disease and extend people's lives. Based on this, there have been calls for all health checks in the UK's National Health Service to be stopped.

However, University of Adelaide researchers have now compared the outcomes of annual health checks performed in a general practice compared with those undertaken in the community or in a workplace.

The review, conducted by PhD student Si Si in the University's School of Population Health, has been published in the *British Journal of General Practice*. This is the first time research undertaken in different settings has been reviewed separately.

"We found that there is no evidence to suggest that health checks outside of general practice, for example at work or in local pharmacies, are doing what they're designed to – prevent disease and reduce mortality," says the leader of the study and Head of General Practice at the University, Professor Nigel Stocks.

"However, in our review, annual GP health checks were associated with a reduction in risk factors, such as blood pressure, cholesterol and weight. In addition, the number of people at high risk of cardiovascular disease was reduced.

"We believe these results reflect the type of care GPs provide to their patients, which is both comprehensive and ongoing. Improvements in risk factors lead to fewer people at high risk which will have benefits in the long term, even if there appears to be no immediate impact on life expectancy. "

Currently the Australian Government pays for free annual GP health checks for people aged 75 and over, and for people aged 45-49 years old, who are at risk for cardiovascular disease, diabetes and cancer.

Professor Stocks says annual health checks have become highly contentious in the UK and some countries in Europe, where there have been calls to stop them.

"In Australia there is growing awareness of these issues, and given the current political and economic climate the situation in the UK is likely to influence Australia's thinking on this matter," Professor Stocks says.

"But we believe it's much too early to make decisions without further evidence. We definitely should not scrap GP-based health checks in Australia, and the UK should look at the issue in some further detail," he says.

The retired doctors luncheon club

About 40 retired doctors and spouses met for a buffet lunch at the Southern Cross Club on Tuesday 4 February.

David Nott, Nobby Elvin, Joan Buchanan, Tony Clarke (standing) and Ellen Hughes at the lunch

Apart from a motion of thanks to Peter Hughes for organising the function, there were no speeches!

A good time was had by all. The next lunch will be held on Wednesday 7 May to accommodate the pressing golf requirements of some potential attendees. The lunches are held alternately on Tuesdays and Wednesdays.

New faces are always welcome. The Association particularly wants to reach out to widows and widowers of deceased doctors.

Please contact Peter Hughes hughespande@grapevine.com.au to have yourself included on the mailing list.

History behind the duty of risk disclosure – By Rachael Heath Jeffery

The decision to consent to medical treatment is predominately made by the patient. This requires the patient to gain adequate information regarding the risks and benefits in order to make a decision.

In 1992, the decision of the High Court of Australia, in the Rogers v Whitaker case, established the fundamental importance of the ethical principle of autonomy. The court found medical practitioners should disclose all material risks to a patient prior to consent for treatment. This decision redefined the practice of medicine in Australia. The decision was controversial at that time as many medical practitioners felt they would have to disclose excessive amounts of risk to avoid litigation.

At present, the required standard of care of a health professional is the exercise of professional judgement, knowledge, skill and conduct at a level that maintains public protection and safety. The decision regarding Rogers v Whitaker was important as it set a precedent for Australia and affirmed the earlier decisions of the Supreme Court of NSW and the Court of Appeal. Following this case, the failure to inform a patient of certain material risks constituted a breach of a medical practitioner's duty of care.

The case involved the respondent, Mrs Maree Whitaker and the appellant Dr Christopher Rogers, an ophthalmic surgeon. The respondent had a 38-year history of severe vision loss in the right eye. This was due to an eye injury at age nine. Vision was still present in the left eye. At 47 the respondent consulted the appellant who informed her that an operation on the injured right eye would improve her appearance, by removing scar tissue, possibly restore some sight and help prevent the development of glaucoma.

Surgery was found by the court to be conducted with appropriate skill and care. The respondent however later developed inflammation in the treated eye, which triggered sympathetic ophthalmia in the left eye. Subsequently sight was lost in the left eye with no improvement gained in the right eye. As a result the respondent had severe bilateral vision loss.

Sympathetic ophthalmia is characterised by a granulomatous intraocular inflammation following surgery or penetrating trauma in the other eye. There is some suggestion that sympathetic ophthalmia is more typical following a non-surgical penetrating injury. This would mean that the respondent's initial penetrating eye injury would have been more likely to trigger sympathetic ophthalmia than subsequent intraocular surgeries. In contrast, others report surgery to be the main risk factor. With respect to the Rogers v Whitaker case, it was the subsequent surgery, which triggered the sympathetic ophthalmia.

The respondent prosecuted the appellant for negligence. Evidence provided at the trial stated that the risk of developing sympathetic ophthalmia was one in 14,000. The court noted that not all cases of sympathetic ophthalmia led to blindness. However, given the respondent's previous history (penetrating eye injury), the risk would have increased slightly. In trial the appellant said, "Sympathetic ophthalmia was not something that came to mind to mention". Consequently the appellant's defence was based on the ground that the risk of sympathetic ophthalmia was very small and hence there was no duty to warn the respondent.

When the case was before the Supreme Court of South Australia, Campbell J established only one item of negligence, which concerned the appellant's failure to warn the respondent of the material risk of sympathetic ophthalmia.

The High Court documented the respondent had 'incessantly' questioned the possibility of surgical complications. Thus the sole liability was founded on the appellant's failure to disclose the risk of sympathetic ophthalmia. This meant the risk of total blindness, although small, was material to the patient's decision and thus the appellant was negligent not to disclose this particular risk.

Prior to this case, the Australian courts had followed the "reasonable doctor" standard established in 1957 from the English House of Lords. In accordance with the "Bolam" principle, a medical practitioner "is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion". In short, "the law imposes the duty of care: but the standard of care is a matter of medical judgement". The standard of care owed to a patient, therefore, is determined by medical judgement. As Lord Justice Scott said, "How can the ordinary judge have sufficient knowledge of surgical operations to draw such an inference (of negligence)".

By way of contrast, King CJ, of the Supreme Court of South Australia, remarked "The ultimate question, however is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law". In Rogers v Whitaker, evidence before the court indicated that many ophthalmic surgeons would not tell their patients about the risk of sympathetic ophthalmia, however the Bolam principle was not applied.

In Rogers v Whitaker, the court drew a clear distinction between whether the operation was performed with the necessary skill (Bolam principle) and the duty of the doctor to warn the respondent of the material risks. Consequently, the Bolam principle no longer applied in Australia after it was rejected by the High Court.

The High Court decided that medical intervention should only be performed following the patient's decision and permission to proceed (excluding emergency situations). Furthermore, the patient's decision must be based on relevant information and advice - "The Law should recognise that a medical practitioner has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it". Hence the court proposed two tests, the first outlines the material risks significant to a reasonable person (objective test) and the second outlines the risks significant to the particular patient (subjective test).

In F v R, King CJ stated that the medical practitioner's scope of risk disclosure will depend on five factors: the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances. This statement depicts a complex doctor-patient interaction and accords with Pellegrino's statement that patients will experience illness and express capacity for choice in different ways dependent upon their values and cultural, personal and social relationships.

The effect of the Rogers v Whitaker decision means that patients have a right to be warned about what they might perceive to be a material risk. Even though the likelihood of sympathetic ophthalmia occurring is very low (1/14000) and may be regarded as immaterial to a medical practitioner, it may still be perceived as a material risk to the patient given the severity of the consequences (blindness). Thus the medical practitioner must consider and disclose significant risks from the patient's perspective. This should be based on what is reasonably known about the patient.

The court allowed exemptions of 'therapeutic privilege' to include unusually nervous, disturbed or volatile patients, emergencies or patients with an impaired ability to receive, understand or evaluate such information. This may justify failure to disclose information, which would harm the patient's health. However Gaudron J implied a duty to provide information even when "no specific enquiry is made". This is significant when dealing with less communicative patients and indicates that the practitioner should still provide information to a patient who does not ask questions.

The outcome of Rogers v Whitaker ensures respect for the patient's right to self-determination to hold views and make choices based on personal views, beliefs and perceived risks. The right to self-determination and bodily inviolability underpins the ethical principle of autonomy. Following the decision, the paternal model of medical care, to make decisions on the patient's behalf, was no longer legally acceptable. This contrasted with the paternalistic and practitioner-orientated approach of the English courts, perceived as excessively reliant on medical evidence supporting the appellant.

…Continued page 13

Introducting the NEW Directory of GPs with special interests

The AMA ACT has been producing the Specialist Directory for the GP community for nearly seven years. This year, we have decided to extend the easy reference guide to inform colleagues of the general practitioners who have diversified into areas of special interest. It is also intended to produce a directory of allied health professionals to whom GPs refer.

If you are a general practitioner with an area of special interest and would like to be included in this new directory please complete and submit the entry form below.

If you wish to "advertise" your special interests, we offer you the opportunity to have a small display advert of 1/8 page (90mm x 65mm) at a cost of $400. This is a discounted price for AMA members and a levy will apply for inclusion of non-members in a group advertisement. For further information on pricing, contact Christine Brill execofficer@ama-act.com.au or 6270 5410 as some conditions apply.

We hope you support this new initiative.

2014 DIRECTORY OF GPs WITH SPECIAL INTERESTS

… a publication of the AMA ACT

AMA (ACT) LIMITED

This new directory of GPs with special interests will be published as a service to ACT General Practitioners and will be distributed with the annual Specialist Directory and the new **Directory of Allied Health Professionals** during Family Doctor Week 2014. Entries must be on this form and returned to the address below no later than 28 March 2014. Late entries will not be accepted. Entries in the directory are at no cost and AMA membership is not a requirement for entry in the directory.

Mail: AMA ACT
PO Box 560
CURTIN ACT 2605

Fax: 6273 0455

Name:

Services offered:
(Please keep this brief and use only accepted abbreviations – eg: DCH, Diploma in Child Health)

Practice Details (1)	Practice Details (2)
Phone:	Phone:
Address:	Address:
Fax:	Fax:
Email:	Email:
Website:	Website:

I am/am not interested in taking a display advert to accompany my listing in the directory.

Signed: _____ Date: _____

AHPRA registration number: _____

Note: In order to be included in this directory,it is mandatory that you are a medical practitioner currently registered with the Australian Health Practitioner Regulation Authority (AHPRA)

NOT FOR PUBLICATION

Contact Phone: _____

A proof of your entry will be sent prior to printing. Please indicate preferred method to receive this:

☐ Fax number:_____ ☐ Email address: _____

Time for a national summit on alcohol misuse and harms

The AMA has called on the Federal Government to convene a National Summit to discuss and assess the evidence and develop effective national solutions to the epidemic of alcohol misuse and harms afflicting local communities right across the nation.

Federal President, Dr Steve Hambleton with Dr Brian Owler (L) (AMA NSW President), Assoc Professor Geoff Dobb (R) (WA) and Dr Stephen Parnis (far R) (President AMA Victoria) meet the press.

The call has the support of Federal Labor, which has said "this is a positive and constructive move by the AMA. As a community, we must stand up against violence in all its form and do what we can to prevent it."

AMA President, Dr Steve Hambleton, said the AMA wants the Government to bring together representatives of all Australian governments, local councils, community leaders, medical and health experts, police, teachers, industry, parent groups, families of victims, and other stakeholders to develop practical nationally-consistent solutions and policies to tackle the harms of excess alcohol use that affect many Australians.

"We have a major national problem that requires a major national solution," Dr Hambleton said.

"The mood of the Australian community on this issue warrants a broad discussion that can introduce solutions that governments need to act on as soon as possible.

"The harmful consumption of alcohol is a complex problem that cuts across different levels of government and many portfolios.

"The AMA wants a whole-of-government approach from all governments that looks at harm minimisation, the marketing of alcohol and how young people are exposed to this marketing, pricing and taxation, venue licensing and opening hours.

"But any policy and regulation must be informed by everyday community experience – from police, doctors and other health professionals, drug and alcohol services, teachers, and the families who suffer from alcohol addiction, misuse, and the associated violence and illness.

"A National Summit, convened by the Federal Government, would bring together the experience, the expertise, and the passion to bring about much-needed meaningful change to Australia's alcohol 'culture'."

Dr Hambleton said that the extent of alcohol-related harms is placing enormous strain on the frontline health system and emergency services.

"A recent survey from the Australasian College for Emergency Medicine shows that one in seven emergency department visits on a Saturday night are alcohol related, and in some areas the rate is as high as one in three.

"On average, one in four hospitalisations of young people aged 15-24 years occurs because of alcohol.

"Hospital emergency staff are regularly confronted with the acute and chronic complications of alcohol."

Dr Hambleton said the AMA is very concerned about the effects of alcohol on young people.

"One in five Australians aged 14 years and above drink at a level that puts them at risk of harm from alcohol-related disease or injury over their lifetime.

"One in three 14 to 19 year olds drink alcohol in a way that places them at risk of an alcohol-related injury from a single drinking occasion at least once a month.

"Young Australians are exposed to an unprecedented level of alcohol marketing and promotions, and there is strong evidence that the more young people are exposed to alcohol advertising, the earlier they start drinking, the more they drink, and the more alcohol-related harm they experience.

"The AMA is pushing for a Parliamentary Inquiry into the marketing of alcohol to young people, and we strongly support the Australian Greens' proposal for a wide-ranging Senate Inquiry into alcohol," Dr Hambleton said.

Background facts

Levels of excess alcohol consumption in Australia

- One in five Australians consume alcohol at levels that put them at risk of lifetime harm from injury or disease; two in five Australians consume alcohol at levels that put them at risk of short-term harm at least once a year.
- More than half (52per cent) of Australian drinkers consume alcohol in excess of the Australian Guidelines, with 26 per cent drinking more than the recommended maximum of two standard drinks per day. One in six Australian drinkers consume more than 11 drinks per occasion on a monthly basis.
- One in three 14 to 19 year olds drink alcohol in a way that places them at risk of an alcohol-related injury from a single drinking occasion at least once a month.
- Many young people drink to get drunk; 45 per cent of current drinks aged 16 to 17 years report intending to get drunk on most or every occasion when they drink alcohol.
- Three quarters of Australians believe that Australia has a problem with excess drinking or alcohol abuse.

The health, social and economic costs of alcohol consumption

The cost of alcohol-related harm in Australia, including harms caused by someone else's drinking, is estimated to be between $15 billion and $36 billion a year. This includes costs to the health system, law enforcement, lost productivity in the workplace, and the pain, suffering and harms to drinkers and those around them. Harms to others include violence, injury, crime and car crashes.

Health

- Every year, alcohol consumption is responsible for over 11,000 hospitalisations among young people aged 15-24 years. Each week, approximately one death and 65 hospitalisations among the under-aged (14-17 years) are attributed to alcohol.
- Alcohol has been causally linked to at least 60 different medical conditions. Longer term health problems associated with risky alcohol use include liver damage, heart damage, and increased risk of some cancers.
- There is growing concern about the impact of alcohol on young peoples' development. Heavy drinking at a young age can adversely affect brain development and is linked to alcohol-related problems in later life.
- Alcohol is a greater factor than speed, fatigue, weather or road conditions in fatal road crashes in Australia and is responsible for more than a third of road deaths.
- Teenagers who drink alcohol to excess are much more likely to

New app to promote the lifesaving and lifelong benefits of immunisation

The AMA and the Australian Academy of Science recently combined the resources of medicine and scientific research at the launch of the Academy's new app, *Science Q&A*, an authoritative evidence-based resource to empower Australians to make informed decisions about immunisation.

The app is a companion to the highly successful Academy booklet, "The Science of Immunisation", launched jointly by the Academy and the AMA last year, which has been circulated to more than 7,000 GPs nationally and accessed by hundreds of thousands of people via the Academy website.

AMA President, Dr Steve Hambleton, and Academy President, Professor Suzanne Cory, said that immunisation saves lives and it is important that all Australians are provided with evidence of the health benefits of immunisation to help them make the right choices.

The launch featured a demonstration of the app, a short animation showing how immunity works, and a tour of a working immunology lab at the Institute.

– AMA

engage in risky sexual behaviour, including having unprotected sex, multiple partners and sex they later regret.

Physical assaults and domestic violence

- One in 20 Australians aged 14 years and over have been physically abused by someone under the influence of alcohol; one in four Australians have been a victim of alcohol-related verbal abuse.
- The association between domestic violence and problematic alcohol use is well established. There is strong evidence that the level of harm associated with domestic violence increases, and results in graver injuries, when alcohol is involved. In addition, an abuser's frequency of intoxication, binge drinking or problem drinking is more closely associated with severity of domestic violence and possibility for injury of a victim, than drinking per se.
- The density of alcohol outlets correlates with the rate of domestic violence. An analysis of alcohol outlet density found a strong relationship between alcohol availability and domestic violence; packaged liquor outlets that sell alcohol for off-premise consumption were particularly implicated.
- The ABS report that, among women who have experienced an assault from a male perpetrator in the preceding 12 months, nearly half (49 per cent) state that alcohol or drugs are a contributing factor. The NSW Bureau of Crime Statistics and Research found that 41 per cent of all incidents of domestic assault reported to the police between 2001 and 2010 were alcohol related. This percentage varied, however, and was as high as 62 per cent in Far Western NSW.
- Nearly half (44 per cent) of all intimate-partner homicides are alcohol related; the majority (87per cent) of Indigenous intimate-partner homicides were alcohol related.
- In a NSW study, two-thirds of patients presenting at an emergency department with injuries from interpersonal violence reported having consumed alcohol prior to the incident; three-quarters of these patients stated that they had been drinking at licensed premises.
- Conservative estimates suggest that the total annual costs of alcohol-related crime in Australia is at least $1.7b; the annual social cost relating to alcohol-related violence (which excludes costs to the criminal justice system) is $187m; and the costs associated with the loss of life due to alcohol-related violent crime amounts to $124m.

History behind the duty of risk disclosure ... continued

...From page 10

The general community attitude that individuals are responsible for making their own decisions is consistent with the High Court's decision. Importantly the High Court's decision also recognises the individual nature and diversity of patient concerns from the 'patient's position' as distinct from a 'reasonable person'. This implies the medical practitioner should know more about the patient's background than the initial presenting complaint.

In Australia there were supporters in the legal and medical profession of the Bolam principle. Some thought it was unreasonable to warn a patient of a 1 in 14000 risk. Following Rogers v Whitaker there were reservations within the medical community regarding increasing cases of litigation against medical practitioners. The decision in Rogers v Whitaker highlighted the balance between the duty of the medical practitioner to inform of the material risks and the patient's responsibility and right to make a choice based on all the relevant information. Thus the patient bears the non-negligent consequences from their choice. As the then Justice Kirby stated 'it is the patient who ultimately carries the burden of the risks'.

According to the then Kirby J, the decision in Rogers v Whitaker reflected changing public expectation with 'the provision of greater information to patients'. There has been an improvement in the general education among patients attributed, in part, to electronic media, greater community discussion of health issues, decline in admiration of professionals and positions of authority and greater recognition of patient autonomy.

The High Court affirmed the same principle stated in Rogers v Whitaker in 2001 regarding Rosenberg v Percival. In this case the respondent alleged they were inappropriately informed of the risks associated with a dental surgical procedure. Further cases have shown risk disclosure applies to seriously ill patients and patients in whom surgery can be safely delayed as illustrated in Karpati v Spira and Chappel v Hart respectively. Ideally risks should be conveyed in percentages where appropriate.

In Australia the case of Rogers v Whitaker has established the standard of care required for disclosing material risks associated with medical procedures. It is now a legal requirement that patients are warned about all material risks concerning their decision. Both Rogers v Whitaker and Rosenberg v Percival illustrate the replacement of a paternalistic, practitioner-centred model by an individual, patient-centred approach to medical care, in particular informed consent. This involves an integrated process of practitioner/patient information-sharing and informed decision-making.

Conclusion

Legally and ethically, medical practitioners are now expected to work in partnership with patients when discussing and making a decision regarding treatment options. The High Court's decision recognises the need for medical practitioners to facilitate a patient's autonomy and ascertain the significance the specific patient attaches to the risks of treatment. The decision placed more emphasis on the patient needs and accords with a general social movement towards greater individual rights.

In Australia, despite the National Health and Medical Research Council's efforts to explain the legal requirements, negligent failure to inform has been alleged in numerous actions following Rogers v Whitaker. There was no doubt, following Rogers v Whitaker, as to the responsibility of the medical practitioner to provide sufficient information to the patient to facilitate, but not coerce, the patient's decision. Here the practitioner should understand the patient's relevant values and convey the possible risks and benefits of any suggested interventions. Failure to understand these societal and legal changes place medical practitioners at a higher risk of liability in negligence.

Rachael Heath Jeffery is a year 1 student at the ANU Medical School. References available from the author.

BOOK REVIEW: Out of the Mountains – David Kilcullen

Oxford University Press: New York
ISBN-13: 978-0199737505
USD 27.95

Each of Dr David Kilcullen's books (*The Accidental Guerrilla, Counterinsurgency*) has expanded in breadth with the evolution of his ideas on modern conflicts.

Out of the Mountains marks out a vast strategic realm arising from the convergence of what he terms megatrends: population growth, urbanization, littoralization and connectedness. In so doing, he escapes what he describes as the binary world of counterinsurgency, and the thesis beginning as an attempt to develop a unified theory of the future conflict ecosystem, in fact becomes a theory of modern civilization and its discontents.

Kilcullen posits that the current and future urban environment will be the ground of conflict.

In a harrowing second chapter, he analyses the Mumbai terrorist attacks, the battle of Mogadishu, the raid on the Kingston garrison community of Tivoli Gardens and concludes with his theory of competitive control.

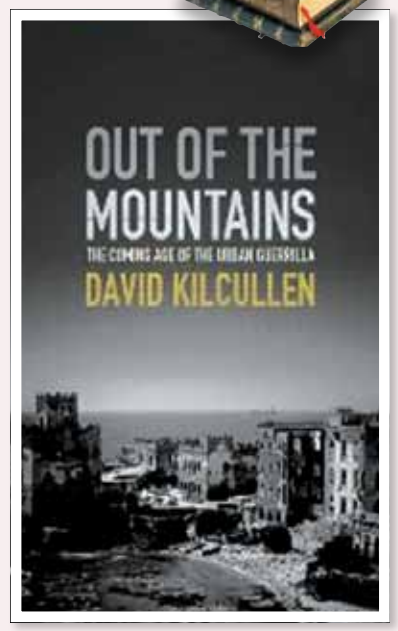
This theory is embedded in his conceptualisation that future conflicts will occur in highly urbanized, coastal regions in which rapid population growth is taking place, in both the developing and developed world.

In brief, his competitive control theory is that nonstate armed groups gain control of the population, via methods varying from coercion to persuasion, by establishing normative systems generating predictability and order (in effect, governing, administering and enforcing suchwise).

This is followed by a chapter describing how such competitive control has been exerted by nonstate actors, including the elements of such normative, essentially governmental systems (usually not a state or national government). In dealing with the connectedness aspect of his thesis, Kilcullen presents a breathtaking analysis of the convergence of existing human and virtual networks in the uprisings within the Middle East (Libya, Tunisia, Syria). He argues, in contradistinction to Evegeny Morozov's scepticism of the effectiveness of virtual networks in The Net Delusion, that the mobilisation of extant groupings, such as soccer militants known as Ultras or other activists via internet and virtual communications can effect uprisings and even in the developed world, such as the London riots. The predicates for such mobilizations may be the existence of liminal, periurban regions in which traditional state governance/enforcement is weak, allowing for nonstate groups to set up their own competitive control mechanisms.

Kilcullen focuses on the application of his ideas to international urban development, using his analyses to map the organic nature of urban environments, as his consultancy Caerus Associates does for governments and NGOs, towards co-designing urban environments to bolster their resilience. He concludes with an Appendix "On War in the Urban, Networked, Littoral".

Out of the Mountains encompasses vastly more than Kilcullen's varied background as a soldier, political anthropologist and counterinsurgency advisor (amongst others). Kilcullen synthesises knowledge from so many fields that it is almost impossible to identify all the original disciplines from which they flow. The result is a breathtaking, iconoclastic intellectual journey worthy of the Ten Thousand in the Anabasis of Cyrus, indeed also towards the shores of the black seas of the future.



Reviewed by: Associate Professor Jeffrey Looi, Academic Unit of Psychiatry and Addiction Medicine, ANU Medical School

AMA Careers Service update

The AMA Careers Advisory Service would like to firstly wish you a Happy New Year and also thank all users for the keen interest shown in the service across the country and internationally.

As we begin 2014 we would like to encourage all medical students and doctors to visit the website and access the range of services available particularly in the lead up to the 2015 Intern and RMO/HMO campaigns which will open in the coming months.

General advice and assistance can be sourced via the Careers website and personal advice and assistance is available via individual consultations with the AMA Careers Consultant via phone, email and face-to-face meetings.

The website includes information on the developing medical career beginning with medical students through to doctors in training and on to GP/Specialists and even addressing the area of career change either within the profession or outside.

The Careers Service provides a resume review, cover letter review and interview skills assistance to both AMA members and also non-members. AMA members receive the benefit of a substantial discount on these services through their membership.

The application tools services have been particularly popular with those applying for Intern and Resident Medical Officer (RMO) positions; however, there has been a recent interest from doctors seeking a career change from clinical to non-clinical roles, full-time practice to part-time practice or a complete change in career and seeking advice on what opportunities are available dependent on their current skill set and experience.

New additions to the website in 2013 included the Doctors in Training Profile page which is currently one of the most popular pages within the website. These profiles outline the journeys of several doctors through their medical career to date in a variety of settings including balancing work, life and family and all that comes with it, a medical career in the Australian Defence Force, the "theatre" life – from emergency to 'The Boy From Oz' and many more. It is thanks to the generous contribution of our local doctors that this page exists and that we continue to seek further contributions to this section of the website in order to continue providing support, advice to our upcoming doctors and an overall good read for all those accessing the website. If you would your journey chronicled on the Careers website, please email the Careers Service for further information.

In order to access any of the services mentioned in this article or to read the Doctor in Training Profiles you can visit the website at http://careers.ama.com.au or contact the AMA Careers Consultant via the hotline 1300 884 196 or email careers@ama.com.au.

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

AMA (ACT) LIMITED

Qantas Club membership rates for AMA members

QANTAS

Joining Fee: $230 (save $140)
1 Year Membership: $372 (save $113)
2 Year Membership: $660.30 (save $214.69)
(all rates are inclusive of GST)

To renew your Qantas Club Corporate Membership contact the secretariat to obtain the AMA corporate scheme number.

For new memberships download the application from the Members' Only section of the AMA ACT website: **www.ama-act.com.au**

For further information or an application form please contact the ACT AMA secretariat on **6270 5410** or download the application from the Members' Only section of the AMA ACT website: **www.ama-act.com.au**

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Ray White.

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PUBLIC NOTICE

Dr Mark Hardy advises that the Surgery at Garran closed on 31 January 2014 due to ill health and retirement.

Patients may request copies of records by contacting *Ochre Health* in Calwell on 6291 0045.

Dr Hardy wishes to express his sincere thanks to all patients and friends of the practice for the last 40 years of a fulfilling career.

Dr Julie Kidd
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PRACTICE RELOCATION

Dermatologist

Dr Catherine Drummond wishes to advise that she has relocated her vulval dermatology practice from Barton to ACT Dermatology, Suite 6, McKay Gardens Professional Centre, 5 McKay Gardens, Turner.

Dr Drummond will continue her paediatric and general medical dermatology practice from Turner.

For appointments phone 6247 5479 or fax to 6247 3621

Dr Colin Andrews, Neurologist

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