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AMA model protects vulnerable patients from co-payment pain

As reported in the media AMA President, Assoc Professor Brian Owler, called on the Government to dump its seriously flawed GP co-payments proposal and adopt the AMA model, which exempts the most vulnerable patients from extra cost burdens for their health care.

Speaking from Canberra, Assoc Professor Owler said the AMA has vigorously opposed the Government's proposal since Budget night and has worked to produce an alternative model that is fairer and more equitable.

"The AMA has produced a health policy, not an economic policy," Assoc Professor Owler said.

"Our model is based on the realities of day-to-day medical practice, and our objective is to provide higher quality primary care for all Australians.

"The AMA co-payment model protects vulnerable patients in the community, values general practice to encourage quality care and support prevention and chronic disease management, and it also sends a price signal for non-concession patients.

"We propose a minimum $6.15 co-payment (which aligns with the current bulk billing incentive) that applies to all patients, but the Government will pay the co-payment for concession card holders and patients under 16 years of age.

"Under our model, there will be no cut to the Medicare patient rebate, and there is an incentive for general practices to collect the co-payment.

"The AMA has long supported well-designed and well-intentioned co-payments, and that is what we are releasing today.

"Co-payments already exist. About 20 per cent of GP visits currently attract a co-payment.

"The AMA co-payment model allows GPs the opportunity to spend more time with their patients, provide preventive health care and chronic disease management, and place a value on the essential service they provide.

"It maximises the benefits of high quality primary care in general practice, keeping people well, and keeping people out of more expensive hospital care.

"We are confident that our co-payment model will stimulate robust debate in the community, in the political arena, and in the health sector, and remind the Government of the unfairness, inequity, and electoral unpopularity of its Budget co-payment proposals," Assoc Professor Owler said.

The AMA model has the following key elements: no cut to the Medicare rebate, a minimum co-payment of $6.15 for all patients that will apply to standard consultations. The Government will pay the co-payment for conession card-holders and those under 16, the patient will pay the co-payment otherwise. And there will be an incentive to encourage collection of a co-payment. Under the AMA model there would be some exemptions from the requirement to charge a minimum co-payment, and those are: residential aged care facility visit items, home visit items, chronic disease management items, health assessment items and mental health items.

The AMAs alternative model explained

Background

The 2014/15 Budget proposed the introduction of a $7 co-payment that would apply to the vast majority of Medicare funded general practice, pathology and diagnostic imaging (DI) services, effective from 1 July 2015.

At the same time as it seeks to introduce a Medicare co-payment, the Government is also reducing Medicare rebates received for these services by $5.00.

General patients who need pathology and DI tests will also be hit by the removal of bulk billing incentives for these services.

Key issues with the Government's co-payment model

The AMA has opposed the Government's model for several key reasons:

- Medicare rebates for patients are cut by over $3.5 billion;
- International evidence shows that co-payments hit disadvantaged patient groups disproportionately, unless they are protected by an adequate safety net;
- Patients will face multiple co-payments across an episode of care, which creates barriers to accessing care;
- A poorly designed system of co-payments will make it harder to tackle the growing burden of chronic disease and discourage important preventative health initiatives like immunisation;

...Continued page 3.

AMA President, Assoc Professor Brian Owler and Chair of AMACGP, Dr Brian Morton at the media conference.

Capital Conversations with President, Dr Elizabeth Gallagher

Last week I attended my first AMA Federal Council meeting. The recent adoption of the new constitution means that the business side of running the Federal AMA is now dealt with by the AMA Board, and the Council can concentrate on policy and advocacy. Having not seen how things used to be, I cannot comment on the difference but many of the more established members commented things were a lot more productive, and discussion more robust.

It has been relatively quiet on the home front, (having addressed cannabis legislation and other local issues) in the last issue, so in this column I will let you know about some of the issues on the national agenda, the GP copayment aside too!

One of the issues that the Federal AMA sees as an issue it is going to watch closely over the coming year is the involvement of private health insurers in not just providing insurance but also influencing medical care.We do not want to see a movement towards the US style of managed care.

The strengths of health care in Australia include universality of access, affordability of care and the sanctity of the doctor-patient relationship. While the Government's proposed co-payment threatens the first two principles, the push by insurers into primary health care and also the preapproval of certain surgical procedures threatens the third.

In a recent speech at the National Press Club, AMA president A/Professor Owler drew attention to a number of recent developments which he said were cause for alarm.

Medibank Private is running a trial with general practice provider IPN to give its members priority GP appointments, guaranteed bulk billing and limited waiting time for after hours services in return for paying administrative fees.

If enough insurers and practices get involved in this it will definitely interfere with equity of access for those without insurance.

While the AMA does not discount involvement in private health in some aspects of primary care, such as supporting management of chronic health conditions or preventative care influencing access to appointments is a sure step towards a two tiered system.

There has been talk of insurers in tendering to operate the new Primary Health Networks being set up to replace Medicare Locals. As we know that these companies need to make a profit … Already the Australian College of Plastic Surgeons has raised concerns about Medibank Private requiring preapproval for some procedures and making a decision about whether to fund a procedure based on their own criteria as to what constitutes a cosmetic vs medical procedure. This principle is also being applied to some ophthalmological procedures.

At the council AMSA raised their concerns about the impact of deregulation of university fees on medical education. It has been estimated that after completing a post graduate degree, some students will leave with a debt of $259 000 plus interest.

The AMA has subsequently made a media release highlighting that there is good evidence that high fees and the prospects of significant debt deter people from lower socio-economic backgrounds from entering university.

A high level of student debt is a factor in career choice driving people towards better-remunerated areas of practice and away from less well paid specialties like general practice. One of the strengths of medical education in Australia is diversity in the selection of students, including those from lower socio-economic backgrounds so it is a concern that entry may be based on financial capacity rather than merit.

If any of you are interested, the public consultation paper on the review of the National Registration and Accreditation Scheme prepared by Mr Kim Snowball on behalf of the Australian Health Ministers Advisory Council has been released.

The AMA will be making a submission by the deadline of 10 October. Of particular interest may be the complaints handling process and scope of practice. The paper can be down loaded from www.ahmac.gov.au.

The PEHCR is still on the agenda with Dr Steve Hambledon being appointed to the review panel. Hopefully we will see a way forward at some stage in the near future!

Finally, the Medical Board of Australia has agreed to fund the Doctors Health Advisory Service (DHAS) indefinitely.

There is a move to try and standardise the model of care nationally, but we are hoping the ACT will remain autonomous as there was some talk of being joined with NSW. The AMA is likely to remain the fund holder but will make sure that the services are accessible to all, and at arms length from both the board, and the AMA.

So these are just a few of the snippets our national body is watching. Till next month…

AMA model…*continued*

…From page 1.

- The changes to Medicare rebates for pathology and DI services are far reaching. In relation to DI, for the more expensive tests, general patients will be paying very high upfront costs – well beyond the proposed $7;
- Practices will face significant additional compliance costs to administer the Government's co-payment model, including additional staff time, banking, new infrastructure, EFTPOS costs, late payments and bad debts;
- There are significant practical issues in collecting co-payments, including in pathology, aged care and out of rooms consultations.

A poorly designed system of co-payments has the potential to intensify the pressure on our emergency departments and discourage patients from accessing care from their GP.

General practice is a low cost and efficient part of the health system, and if people delay seeing their GP they may end up needing more expensive interventions, including hospital care. This makes our health system less, not more, sustainable – contrary to the Government's intent.

The AMA and Medicare co-payments

The AMA is not opposed to the principle that people with the means should contribute to the cost of their health care, but it has to be done in a way that is practical, values general practice, and protects disadvantaged patients.

We are ready to support a Medicare co-payment, and have offered to the Government an alternative model that seeks to address the significant issues outlined above.

The AMA's alternative Medicare co-payment model

No cuts to Medicare rebates for patients

Patients value their Medicare rebate, which provides important support when they need to access medical care. The real value of a patient's Medicare rebate has been falling for many years, with indexation failing to keep up with inflation and practice costs. The AMA is opposed to any further erosion in the value of patient rebates and will not support the Government's proposed cuts.

Protection of disadvantaged patient groups

The Government already has a system of concession cards to provide extra support for disadvantaged patients and recognises the need to remove barriers to care for children under 16. Under the AMA model, the Government would cover the cost of a co-payment for these patients in most circumstances.

The AMA model also eliminates the 10 visit threshold proposed by the Government for concession card holders and children under 16 years, which the AMA sees as inadequate.

Helping people with chronic disease, mental health problems and encouraging prevention

Under the AMA model, there would be no obligation on GPs to charge a co-payment for Medicare-funded chronic disease services, health assessments and mental health treatment items. In addition, for concession card holders or children under 16 who access these services, the Government would also cover the cost of co-payments for the standard GP consultations they might need at other times.

Supporting patients with high out of pocket medical costs

Under the Government's model, the Medicare co-payment does not count towards the **Medicare safety net** thresholds, which is unfair on those with high out-of-pocket medical costs. Under the AMA's model, all co-payments would be included in determining whether or not the Medicare safety net has been reached.

Reducing the compliance burden on practices

By eliminating the 10 visit threshold and using well understood and accepted systems to identify disadvantaged patient groups, the AMA's alternative model eliminates much of the red tape that would otherwise be imposed under the Government's model. The AMA model would also restrict the co-payment to standard in-room GP consultations, making it easier to administer.

What services would the co-payment be applied to?

For those patients that do not have a concession card or who are 16 years or older, GPs would be obliged to charge a minimum Medicare co-payment for standard GP consultations in rooms.

This obligation would not apply to:

- Residential aged care visits;
- Home visits;
- Chronic disease management services;
- Health assessments; and
- Mental health treatment items.

For those GP services that are not subject the minimum Medicare co-payment, existing bulk billing incentives would also be retained to encourage access to these services.

Like now, a GP will retain the discretion to charge a higher amount for general patients.

How would the co-payment work for concession card holders and children under 16?

Medicare currently provides bulk billing incentives for GPs to treat concession card holders and children under 16 with no out of pocket costs. The AMA is determined to see that these patients continue to be supported to access GP care.

Under the AMA model, where the GP's fee matches the applicable Medicare rebate plus the minimum co-payment amount, the Government will pay the co-payment on behalf of the patient. In regional, rural and other currently eligible areas, the Government will pay an amount equivalent to the existing bulk billing incentive (currently $9.25).

Like now, a GP will retain the discretion to charge a higher amount, but in this circumstance the Government would not pay the co-payment. Experience shows that the vast majority of patients in this group would face no out-of-pocket costs under this approach.

How much is the proposed co-payment for general practice services?

The AMA has proposed that the minimum Medicare co-payment be fixed at the level of the existing bulk-billing incentive for GP services in metropolitan areas (currently $6.15), with annual indexation applied.

GPs may continue to charge more than this amount, as is currently the case.

How would the co-payment be encouraged?

The Government is determined to send a price signal to patients and it is also important that there is a level playing field for practices.

In circumstances where the Medicare co-payment should be applied and the GP does not charge it, then Medicare will only provide a rebate equivalent to the lower A2 rebate level.

Collecting the co-payment

The AMA recommends the introduction of a simplified billing system that can confirm eligibility for Government payments and simply allow the practice to charge the patient a gap where one is applicable.

Pathology and diagnostic imaging

AMA is open to the application of a co-payment in pathology and diagnostic imaging and has recommended that the Government work with stakeholders towards the achievement of this goal. There are very real practical issues that need to be resolved with respect to the collection of a co-payment as well as the impact on the viability of practices, before any system of co-payments can go ahead.

In this regard, the AMA has proposed to Government that the measure be deferred for at least two years.

At the time of writing this, the Government has rejected the AMA co-payment option.

Sexual health physicians support HIV home test kits

Sexual health physicians from The Royal Australasian College of Physicians (RACP) have welcomed the introduction of HIV home test kits in Australia, saying they are likely to increase testing rates and help reduce the spread of HIV.

Dr Lynne Wray, President of the RACP's Australasian Chapter of Sexual Health Medicine (AChSHM) said allowing the registration and sale of HIV home test kits via the Therapeutic Goods Association (TGA) will reduce the numbers of people purchasing non-regulated and unreliable kits via the internet.

The benefits of HIV home test kits outweigh the potential risks.

"If we are to reduce all new HIV transmissions in Australia by 50% by the end of 2015, we must remove every barrier to HIV testing for those Australians currently undiagnosed," Dr Wray said.

Individuals likely to access home testing may not identify with particular community groups where sexually transmitted infection (STI) health education efforts have typically been concentrated.

"So it's important that appropriate educational resources are developed to target 'hard to reach' populations such as young men that may not identify as gay, migrant groups and Indigenous people," Dr Wray said.

There is also a need to consider how the registration and sale of HIV home test kits will impact on the surveillance and monitoring of HIV testing and positivity rates.

The Department of Health and the TGA should therefore explore options for registering sales levels of HIV home-test kits in Australia, including their location of sale.

Dr Wray acknowledged the potential for invitro diagnostic devices (IVDs) to render higher false results, especially amongst low HIV-prevalence populations.

"These risks can be mitigated by ensuring home test kits have appropriate information about their limitations and highlight the importance of a follow-up test with a general practitioner (GP) or sexual health clinic," Dr Wray said.

The RACP welcomed the Federal Government's national strategy for increased testing and treatment for HIV and other STIs, but said more needs to be done. The RACP also recommends:

- Federal Government funding of rapid 30 minute HIV testing by a GP and at sexual health clinics through Medicare;
- Integrating sexual health into primary care services in rural and remote areas;
- Supporting an increase in the number of S100 drug prescribers in these areas; and
- Working with states and territories on legislative changes to allow patient-delivered partner therapy for the treatment of chlamydia and other STIs across Australia.

HealthPathways – whole of system working

I recently saw a patient with a clinical condition that I don't often see. I knew the right diagnosis, the right treatment and the proper follow up but I spent the next 30 minutes on the phone – waiting for my call to be answered, being hand balled from one hospital department to the next, sometimes losing the phone connection and having to call back.

I was trying to avoid the emergency department but I didn't think they could wait for a routine outpatient appointment, so I was trying to navigate the hospital system and work out the best way to get my patient through the maze.

All GPs have experienced similar scenarios. They are frustrating, make us run late and can make being a general practitioner a difficult task. It is doubly worse for registrars or doctors new to our area. There is no "go to" manual of how to navigate our local health system. We all have our list of essential numbers, piles of important flyers and specialist information we, as GPs, keep "just in case" we need it one day. I absolutely love the referral information and updates from the GPLU newsletters – it would be even better if I could remember where I put the piece of paper when I get a patient with the specific condition!

ACTML, ACT Health and CCCGPT, with collaborating partners NSW Southern ML and Local Hospital District, have embarked on a system improvement process that will hopefully solve some of these frustrating dilemmas. 'HealthPathways' is a web-based portal that will contain practical information for navigating the local health system. At the click of a button GPs will be able to work out the smoothest referral pathway for the patient sitting in front of them, reducing time spent on the phone working out where to send them.

A team of local GPs have begun the task of "localising" pathways that were written by the original HealthPathways team in New Zealand – it can be a challenging task at times, but promises to be rewarding. Being part of the HealthPathways team offers GPs a chance to influence their patient's health journey beyond the doors of their consulting room. GPs are fantastic advocates for their patients, and this is another avenue to advocate for appropriate, smooth and efficient patient journeys.

Some of the pathways are fairly easily written, with local referral lines already clear and working well (as long as you know what they are!). Other pathways are giving GPs, hospital specialists and other health professionals a chance to sit down together and work out a better way of doing things. Often members of the team are not aware of the capacity, and limitations, of the others and through discussion the group can work to improve the patient journey

When complete our local HealthPathways website will be a one stop shop for all the information you need to navigate our sometimes confusing health system for your patients. We hope it will save you from making many frustrating phone calls and having to rummage around in your desk drawers to find that piece of paper.

For further information and to find out how you can be involved contact Leah Puet at l.peut@actml.com.au

Written by Dr Liz Surgiss for the HealthPathways clinical team: Dr Alex Stevenson, Dr Mel Dorrington, Dr Janine Rowse, Dr Martin Liedvogel, Dr David Poland and Prof Walter Abhayaratna.

Results of review into urogynaecological surgical mesh implants

The TGA has completed a review of urogynaecological surgical mesh implants and found that, while there may be a benefit in certain patients there is little evidence to support the overall effectiveness of these surgical meshes as a class of products.

The findings from the review have highlighted the importance of:

- appropriate patient selection
- surgeon experience
- the need for fully informed patient consent.

The TGA has been monitoring surgical meshes since 2008 and has continued to publish information for the public and health professionals, the latest being an announcement of a formal review into urogynaecological surgical mesh implants, published on 28 May 2014.

As a result that review, which has raised a number of concerns, the TGA will now reassess the clinical evidence for each individual mesh implant to determine if they comply with the Essential Principles which set out the requirements for safety and performance necessary for inclusion on the Australian Register of Therapeutic Goods (ARTG).

Where individual meshes are found not to be compliant, regulatory action, such as cancellation or suspension of particular devices from the ARTG, will be pursued. Cancellations and suspensions of medical devices from the ARTG are published on the TGA's website.

TGA review outcomes

The TGA's latest review included analysis of the available published literature, the information supplied with each device and associated training materials provided by sponsors and manufacturers. The Urogynaecological Devices Working Group (established under the Advisory Committee on the Safety of Medical Devices) met in August and October 2013 and provided expert advice to the TGA on this review.

As part of the review, the TGA undertook a literature search of published materials since 2009. The overall quality of the literature was found to be poor. As a consequence, there was an absence of evidence to support the overall effectiveness of these surgical meshes as a class of products. However, the literature did identify the known adverse outcomes associated with their use.

Specifically, the review found that there is some evidence to support the use of urogynaecological surgical mesh devices for the surgical treatment of stress urinary incontinence and abdominal pelvic organ prolapse repair is adequately supported by the evidence.

However, due to the poor quality of the studies undertaken, the evidence to support the use of these meshes for transvaginal pelvic organ prolapse repair, particularly, posterior repair, is not well established.

The TGA review also found that, while adverse events involving these devices are most likely under-reported, the reported complication rate remains low considering many thousands of these mesh devices have been implanted in Australian patients. From July 2012 to 3 April 2014, the TGA received 32 adverse events reports involving urogynaecological surgical meshes. The most frequently reported adverse events were pain and erosion.

The TGA review identified inadequate training/experience for implanting surgeons as a factor in increasing the risk of complications. Certain patients, including those who smoked or were obese, were found to be at higher risk of adverse events and repeated procedures.

The TGA review of each urogynaecological surgical mesh product has begun and findings will be published on the TGA website for the information of consumers and health professionals.

Information for all health professionals

If a patient experiences pain or any other symptom that they suspect is being caused by an implanted urogynaecological mesh, or they have any questions or concerns regarding this issue, refer them to their surgeon.

Information for urogynaecological surgeons

The RANZCOG and the Urogynaecological Society of Australasia (UGSA) have published guidelines on the use of polypropylene vaginal mesh implants for vaginal prolapse.

The guidelines cover the need for:

- informed patient consent
- surgical training
- appropriate patient selection
- reporting adverse events to the TGA

They also include information on patient groups in whom caution should be exercised when considering the use of transvaginal mesh implants.

The expert advice received by the TGA is consistent with the guidance provided by RANZCOG and UGSA that the decision to use mesh should be made on a case-by-case basis and should include a detailed discussion of the risks and benefits of the use of mesh in prolapse repair with each individual patient.

Reporting problems

Consumers and health professionals are encouraged to report problems with medical devices, including all incidents requiring revision. Your report will contribute to the TGA's monitoring of these products. For more information see the TGA Incident Reporting and Investigation Scheme (IRIS).

The TGA cannot give advice about an individual's medical condition. You are strongly encouraged to talk with a health professional if you are concerned about a possible adverse event associated with a medical device.

Breast cancer clinical trials researcher recognised among the world's best scientists

Professor John Forbes AM has been recognised as one of the world's leading scientific researchers, with the release of Thomson Reuters list of "The World's Most Influential Scientific Minds: 2014".

The list is composed of researchers who have published the highest number of articles that rank among those most frequently cited by fellow researchers. Professor Forbes is one of 65 Australians from the international list of 3,215 individuals across all fields of science and one of just seven Australians recognised in the area of Clinical Medicine.

Professor Forbes is the Director of Research at the Australia and New Zealand Breast Cancer Trials Group (ANZBCTG), and is Professor of Surgical Oncology at the University of Newcastle and Director of Surgical Oncology at the Calvary Mater Newcastle Hospital.

Professor Forbes has Chaired and Co-chaired many international clinical trials over the past 35 years, the results of which have led to new and improved treatment options for women diagnosed with breast cancer in Australia and New Zealand and throughout the world. He was the International Study Co-Chair of the IBIS-I and IBIS-II prevention clinical trials which have led to women at increased risk of breast cancer having more options to manage their risk.

Professor Forbes says he is surprised and honoured to be listed among such esteemed scientists.

"This is recognition of our global collaborations in breast cancer clinical trials. I thank all researchers in Australia and New Zealand and worldwide who have contributed to this important area of research. The participation of thousands of women in breast cancer clinical trials has been instrumental and we are very grateful for their shared commitment to improving the outcomes of all women now and for future generations," Professor Forbes said.

"It is an endorsement of the quality of the research undertaken by the ANZBCTG, in what is an internationally peer reviewed process. As a result of clinical trials research, we have made significant improvements to the treatment options available to women diagnosed with or at risk of breast cancer and to survival rates, helping more women to survive their breast cancer long term."

The ANZBCTG is Australia's national organisation dedicated entirely to breast cancer research. It conducts a national clinical trials research program for the treatment, prevention and cure of breast cancer. The research program involves multicentre clinical trials and collaboration with 84 institutions and over 700 researchers throughout Australia and New Zealand and many more globally. More than 14,000 women have participated in ANZBCTG breast cancer clinical trials. The fundraising department of the ANZBCTG is the Breast Cancer Institute of Australia (BCIA). For more information about the ANZBCTG, visit the website www.anzbctg.org.

For further information visit http://thomsonreuters.com/press-releases/062014/Scientific-Minds-2014.

Medical Board of Australia sets fees for 2014/15

The Medical Board of Australia has announced the registration fees for medical practitioners for 2014/15.

The Board has set the registration fee at $715, limiting the increase to the national consumer price index (CPI). The fee covers the registration period for most practitioners of 1 October 2014 to 30 September 2015.

Medical Board of Australia Chair, Dr Joanna Flynn AM, said that limiting the fee increase to CPI reflected the Board's commitment to prudent financial management.

'The Medical Board has set the fee at a level that enables it to meet its regulatory responsibilities under the National Scheme,' Dr Flynn said.

'The fee will enable the Board to honour its commitment to establishing a national doctors' health program, respond to an increasing number of notifications about medical practitioners and continue its work in setting professional standards and supporting patient safety,' Dr Flynn said.

A fees schedule will be published on the National Board's website. Practitioners with a primary place of practice in NSW will pay $630.

More detailed information about the National Board's financial operations will be outlined in the Health Profession Agreement between the Medical Board and AHPRA, which will be published on the Board's website. This agreement sets out the services AHPRA will provide to support the Medical Board to regulate medicine.

The National Registration and Accreditation Scheme is funded by practitioners' registration fees and there is no cross subsidisation between professions.

The registration renewal campaign for medical practitioners due to renew by the 30th of September 2014 will start in early August.

Practitioners should look for the AHPRA reminders to renew registration as confirmation that online renewal is open.

The Board urges practitioners to check their contact details with AHPRA, including their email address, are up to date to make sure they receive registration renewal reminders and other important information about medical regulation.

If there has been no change to your contact details you do not need to do anything. If you need to update your contact details with AHPRA, visit the Online Services login page on the AHPRA website. Use your user ID supplied by AHPRA and secure password, and follow the prompts.

If you do not have your user ID, complete a web enquiry form and select 'Online Services – Practitioner' as the category type.

For more information visit www.medicalboard.gov.au under Contact us to lodge an online enquiry form

For registration enquiries: 1300 419 495 (within Australia) +61 3 8708 9001 (overseas callers). For media enquiries: (03) 8708 9200

Forty five per cent rise in diagnostic imaging tests by GPs according to a new study

A 45 per cent rise in diagnostic imaging tests ordered by Australian GPs is being driven by increasing GP visits, a rising number of problems managed at consultations and a higher likelihood that GPs order imaging tests for these problems, according to a new University of Sydney study released recently.

Based on a long term national survey of 9,802 GPs between 2002 and 2012, the report draws on data from more than 980,000 GP-patient encounter records to assess the extent to which GPs order tests in line with diagnostic imaging guidelines.

"Most imaging tests ordered by GPs comply with expert guidelines," says the report's lead author, Dr Helena Britt. "However, the study indicates that GPs are too quick to order imaging tests during their initial assessment of back problems. GPs are twice as likely to order an imaging test during the initial examination of new back-problems compared to follow-up consultations.

"Expert guidelines advise caution in ordering tests for presenting back problems unless there is a 'red flag' to prompt investigation," says Dr Britt. "'Red flags' can include issues such as major trauma, unexplained weight loss, unexplained fever, history of malignancy, inflammatory conditions and neurological issues. However, patients with 'red flags' account for a small proportion of people presenting with new back problems."

Overall, diagnostic radiology (plain x-rays) was the test type most frequently ordered by GPs (54 per cent), followed by computerised tomography (36 per cent), magnetic resonance imaging (5 per cent) and ultrasound (3 per cent). The study also notes a trend away from diagnostic radiology to CT and MRI orders, in line with changing recommendations in the guidelines.

The four strongest predictors of whether GPs order a diagnostic imaging test are:

- Number of problems managed at the GP-visit – each additional problem managed increases the probability of testing by 41 per cent.
- Type of medical problem managed – particularly musculoskeletal problems, female genital issues, pregnancy and family planning issues.
- Patient characteristics – females, those aged 45 years and older, and new patients.
- GP characteristics – women, GPs aged 35-44 years, those in solo practice, and those in a practice co-located with an imaging service.

In June 2012, the population of Australia was estimated to be 22.6 million people, up from 19.5 million in June 2002.

Like the rest of the developed world, Australia has an ageing population. Between June 2002 and June 2012, the proportion of the population that was aged 65 years and over increased from 12.7% to 14.2%, and this included an increase in proportion aged 85 years or more, from 1.4 % to 1.9% of the total population.

Over the next several decades, population ageing is projected to have significant implications for Australia, including for health. As life expectancy improves, people are living longer with disease, so a greater part of the GP workload will involve management of older patients with multiple chronic diseases.

Australia's health expenditure in 2010–11 was $130.3 billion, an average $5,796 per Australian, and accounted for 9.3% of GDP. Governments funded 69.9%, with the remainder (30.1%) being paid by the non-government sector. Government expenditure on general practice services (including those of the practice nurses) was almost $5.6 billion in the 2011–12 financial year.

GPs are usually the first port of call in the Australian healthcare system. Payment for GP visits is largely on a fee-for-service system, there being no compulsory patient lists or registration. People are free to see multiple practitioners and visit multiple practices of their choice. There is a universal medical insurance scheme (managed by Medicare Australia), which covers all or most of an individual's costs for a GP visit.

In 2011 in Australia, there were 25,056 practising GPs (medical practitioners self-identifying as GPs), making up 25,063 full-time equivalents (FTE, based on a 40-hour week), or 109.7 FTE GPs per 100,000 people.

In the April 2012–March 2013 year, about 85% of the Australian population claimed at least one GP service from Medicare (personal communication, Department of Health and Ageing [DoHA], June 2013). From April 2012 to March 2013, Medicare paid rebates for about 126.8 million claimed general practice service items (excluding practice nurse items), at an average of about 5.59 GP visits per head of population or 6.57 visits per person who visited at least once. This equates to about 2.44 million GP–patient encounters per week. A decade earlier, in the 2003–04 financial year, total Medicare claims for GP–patient encounters numbered 96.3 million, an average attendance rate of 4.3 per head of population.

For further information contact Dr Helen Britt and the report can be downloaded from the University of Sydney's website.

The PAP is going: the HPV test is coming

By Professor Ian Hammond

A big change is coming to cervical screening

In 2016, the Pap test will be phased out in Australia. Pending policy approval by the Australian government it is anticipated that the cervical cancer screening test will transition from the 2 yearly Pap smear for women aged 18 – 69, to a 5 yearly Human Papilloma Virus (HPV) test for women aged 25 –74. An HPV test every 5 years is more effective, just as safe and saves more lives with fewer tests than the current program.

The current Australian National Cervical Screening Program (NCSP) has been very successful. Since the introduction of an organized approach to cervical screening in 1991 the incidence and mortality rates for cervical cancer have decreased by approximately 50 per cent, and are among the best in the world (Fig 1)

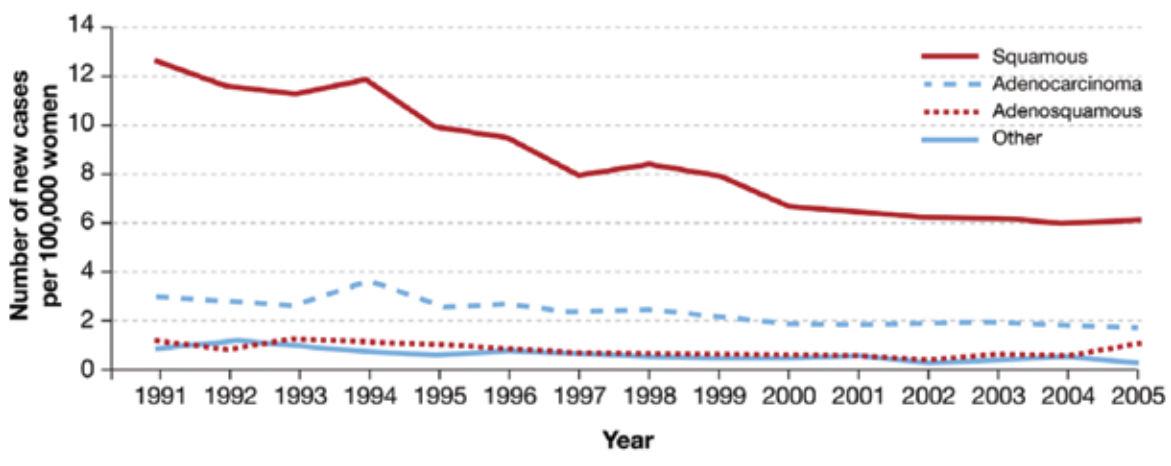
If we are doing so well, why change?

The NCSP now operates in a markedly changed environment including:

- **New knowledge** about the natural history of cervical cancer including HPV as the causative factor; the fact that 98% of HPV infections will regress and that cancer develops from persistent HPV infection.
- **New evidence** about the screening age range and interval with epidemiologic studies demonstrating the safety of an increased screening interval (3-5 years) in other developed countries, and the fact that cervical cancer is rare in young women and not impacted by screening.
- **New tests** such as Liquid Based Cytology (LBC) and HPV testing; LBC has similar efficacy to the conventional Pap smear, but has less unsatisfactory results and is amenable to automated screening technology. HPV testing combined with cytology has been used as Test of Cure following treatment of High Grade Squamous Intraepithelial Lesions (HSIL=CIN2-3) and several studies have confirmed the efficacy of primary HPV screening. A LBC cervical sample can be used for HPV testing and if positive then a reflex cytology can be performed without need for a further visit to the GP, and these tests will determine the need for colposcopy referral.
- **The National HPV** Vaccination Program commenced in 2007 for girls and 2013 for boys, and has already shown a significant decrease in HPV infections in these women with reduced rates of HSIL in women under 25yrs.

Fig 1

Incidence (age-standardised) of cervical cancer by histological type, women 20-69 years, 1992-2005



The Australian program is much more intensive than other countries that screen less frequently and start screening at 25-30 years of age, but have similar incidence and mortality from cervical cancer. This would suggest that we could screen smarter and more efficiently.

What have we done to review the NCSP?

The Australian government commenced a 'Renewal' of the NCSP in late 2011 to ensure the continuing success of the program and that all Australian women, HPV vaccinated and unvaccinated, have access to a cervical screening program that is based on current evidence and best practice. After a rigorous and transparent process, the Australian Medical Services Advisory Committee (MSAC) considered a comprehensive review of the external Evidence and the Economic Modeling reports and their recommendations were publicly released on 28th April 2014.

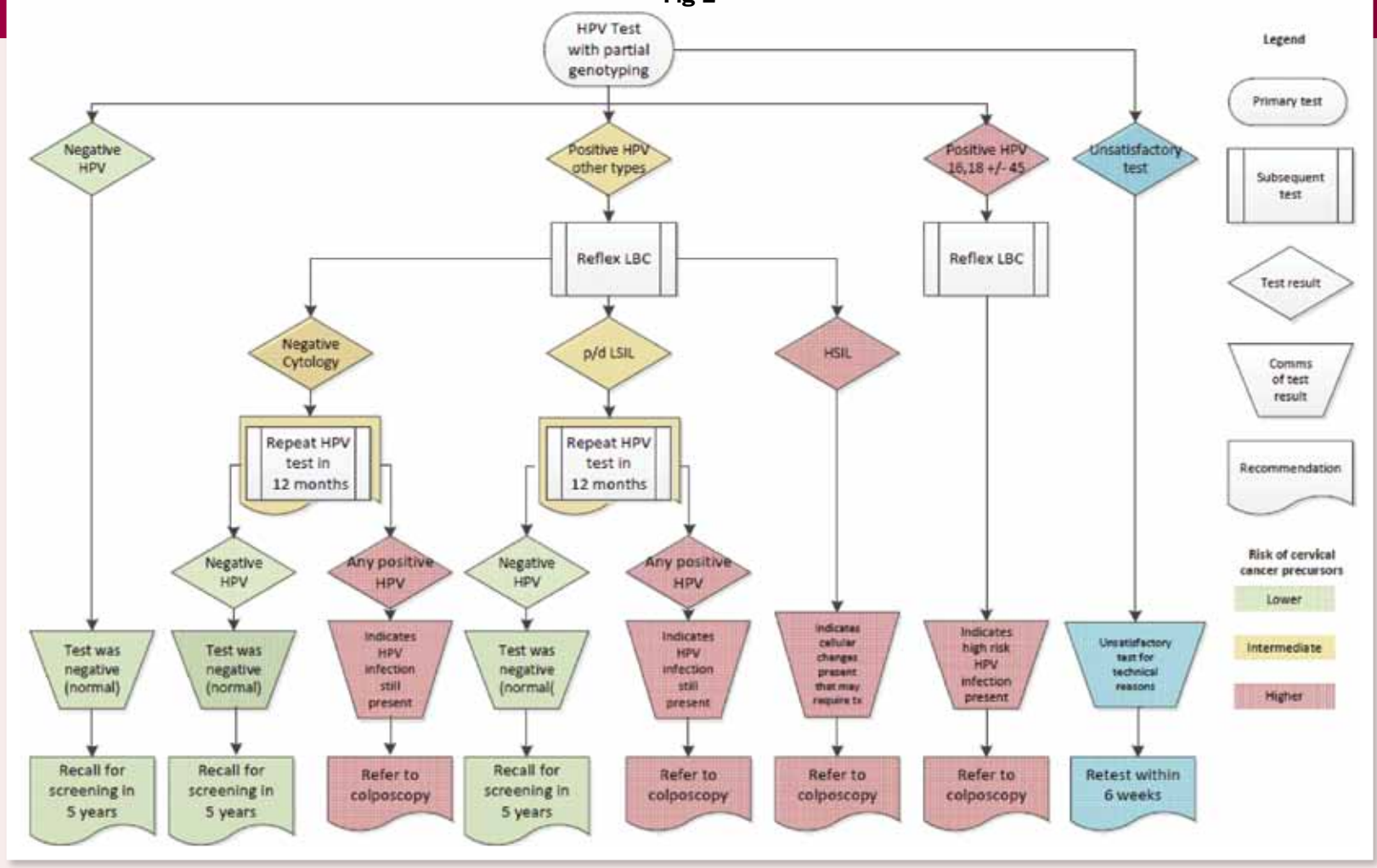
What are the main MSAC recommendations for the NCSP?

- **Five yearly** cervical screening using a primary HPV test with partial HPV genotyping and reflex liquid based cytology (LBC) triage, for HPV vaccinated and unvaccinated women 25 to 69 years of age, with exit testing of women up to 74 years of age
- **Self collection** of an HPV sample, for an under-screened or never-screened woman, which has been facilitated by a medical or nurse practitioner (or on behalf of a medical practitioner) who also offers mainstream cervical screening
- **Invitations and reminders** to be sent to women 25 to 69 years of age, and exit communications to be sent to women 70 to 74 years of age, to ensure the effectiveness of the program
- **Delisting** of the existing cervical screening test MBS items over a 6 to 12 month transition period
- **Women** with symptoms (pain or bleeding) can have a screening test at any age

What does this mean for health professionals and consumers in Australia?

- At least 15% reduction in incidence and mortality from cervical cancer
- A 20% increase in colposcopy referrals but no increase in treatments
- Reduction in lifetime screening tests from 26 to 9-10 per woman
- Women will still need a vaginal speculum examination to have a liquid based sample taken from their cervix
- Doctors will get a laboratory report giving HPV status, the result of reflex cytology where indicated, the level of risk and a *single recommendation for action*.

Fig 2



The algorithm for management after an HPV screening test is shown in Fig 2, and this is subject to review later this year. Changes to the NCSP will need careful communication and some specific issues are discussed below:

Is the longer screening interval and new test safe?

Women need to be confident that the new test is safe and effective. Numerous studies have demonstrated the increased sensitivity of the HPV test and that the likelihood of developing cervical cancer within 5-6 years of a negative HPV test is remote. A recent meta analysis, of 4 randomised controlled European trials of primary HPV testing, has demonstrated 60-70% greater protection against invasive cervical cancers than cytology, with improved prevention of adenocarcinomas.

Is it safe to start screening at 25 years?

Cervical cancer is rare in young women but HPV infection is very common and usually resolves without intervention. Detection of HPV related cytologic abnormalities in younger women has led to unnecessary investigation and treatment of women who are very unlikely to progress to cancer. Screening of women under 25 years has not changed the incidence or mortality from cervical cancer in this age group. In addition, HPV vaccination will continue to cause a significant fall in the number of HSIL abnormalities in young (and older) women, making screening of young women increasingly less effective.

Why consider self-collection for under and never screened women?

It is distressing to note that 80% of cervical cancer cases occur in women who are under or never screened. Aboriginal and Torres Strait Islander women have three times the incidence rate for cervical cancer than non-indigenous women (AIHW 2004-2008). Indigenous women, particularly those from rural and remote communities, represent a significant proportion of the under or never screened. It is hoped that 'self collection' under supervision of a health professional will improve screening participation in indigenous, culturally and linguistically diverse and other groups of under-screened women.

What happens next?

The Renewal process now moves into policy decision and implementation phase including the development of improved data systems, including a possible national or nationally consistent registry system with one record for each woman; safety and quality management programs; workforce and practice changes; and communication and information resources for health professionals and women. The development of educational resources is of critical importance to the success of transition to the renewed program. Details of transitional arrangements will be made available as soon as possible.

IMPORTANT: No changes to the program will occur before 2016 so until then it is business as usual with Pap smears every 2 years, age 18-69yr.

Further information on the MSAC recommendations or Renewal is available at:

www.msac.gov.au

www.cancerscreening.gov.au

Questions can be directed to CervicalRenewal@health.gov.au

Acknowledgment: I thank Dr Tracey Bessell, Director-Screening, Cancer and Palliative Care Branch, Department of Health Australia, for her review and input in the preparation of this article.

Dr Hammond is a member of the Renewal Steering Committee, National Cervical Screening Program

(First published in Medicus (WA) August 2014 and reproduced by Canberra Doctor with permission)

New x-ray imaging developed by scientists

Scientists have developed an x-ray imaging system that enables researchers to see 'live' how effective treatments are for cystic fibrosis.

Published in the American Journal of Respiratory and Critical Care Medicine, the imaging method allows researchers to monitor the effectiveness of a treatment for the life-threatening genetic disorder.

Cystic fibrosis affects many of the body's systems, but most severely the lungs, and currently it can take several months to measure how effective treatment is for the early-fatal lung disease.

Dr Kaye Morgan, lead researcher on the paper from Monash University, said the new x-ray imaging method allows researchers to look at soft tissue structures, for example the brain, airways and lungs, which are effectively invisible in conventional x-ray images.

"At the moment we typically need to wait for a cystic fibrosis treatment to have an effect on lung health, measured by either a lung CT scan or breath measurement, to see how effective that treatment is," Dr Morgan said.

"However the new imaging method allows us for the first time to non-invasively see how the treatment is working 'live' on the airway surface."

Dr Morgan said this x-ray imaging method would enable doctors and researchers to measure how effective treatments are, and progress new treatments to the clinic at a much quicker rate, a key goal of co-authors Dr Martin Donnelley and Dr David Parsons of the CF Gene Therapy group at the Women's and Children's Hospital and the University of Adelaide's Robinson Research Institute.

"Because we will be able to see how effectively treatments are working straight away, we'll be able to develop new treatments a lot more quickly, and help better treat people with cystic fibrosis," Dr Morgan said.

Dr Morgan said the new imaging method, which was developed using a synchrotron x-ray source, may also open up possibilities in assessing how effective treatments were for other lung, heart and brain diseases.

Resistant bacteria on the rise across Australia

A national study led by University of Adelaide researchers has confirmed that antibiotic resistant strains of disease-causing bacteria, such as E. coli, are steadily on the rise in Australia.

The results of the study, conducted for the Australian Group on Antimicrobial Resistance, are published on the website of the Department of Health, which funded the research.

"Emerging resistance in common pathogens is a worldwide phenomenon, and this is a significant issue for healthcare practitioners and their patients," says the lead author of the report, Professor John Turnidge, Affiliate Professor of Molecular and Biomedical Science at the University of Adelaide.

"Compared with many other countries in our region, antibiotic resistance rates in Australia are still relatively low. However, there are some worrying trends in the latest data which, for example, show a doubling of resistance among *E. coli* against some important reserve antibiotics.

"Importantly, this study looked at samples from patients who were not hospitalised, so these are rates of antibiotic resistance out there in the general Australian population," Professor Turnidge says.

Samples were collected at 29 health centres around Australia in 2012, from non-hospitalised patients with urinary infections. The study tested 2,025 species of *Escherichia coli (E. coli)*, 538 of *Klebsiella* and 239 of *Enterobacter*, and the results compared with the previous community study in 2008.

Overall, antibiotic multi-resistance (resistant to three classes of antibiotics) was found in 7.6% of *E. coli* samples compared with 4.5% four years earlier, 5.1% of *Klebsiella* (compared with 4.4%) and 5.4% of *Enterobacter* (4.2% in 2008).

While common strains of *E. coli* can cause urinary tract and other localised infections, some strains of *E. coli* can invade the blood stream and cause septicaemia (blood poisoning), which can result in up to 20% mortality.

"*E. coli* is the species of most concern to us because it's showing a noticeable increase in resistance to one of the most commonly used antibiotics – its resistance to amoxycillin is now at 44%," Professor Turnidge says.

"*E. coli's* resistance is also increasing to one of our last-line oral antibiotics, ciprofloxacin, which has risen from 4.2% to 6.9% between 2008 and 2012. This is despite the antibiotic being restricted to needy cases in the community.

"We're now seeing some *E. coli* resistance to reserve intravenous antibiotics, which practitioners would normally only use once the patient is sick enough to admit to hospital, with blood poisoning for example."

The ANU Medical School Celebrates its 10 Year Anniversary

The Australian National University Medical School (ANUMS) reached an important milestone in 2013 when it admitted the 10th cohort of students to its program.

This was also the year for its re-accreditation with the Australian Medical Council, a process that involved the rigorous review and reflection of all aspects of the school by its faculty and staff. This hard work culminated in the best possible outcome, with ANUMS being granted a six-year re-accreditation. Hence, with much to celebrate over the course of 2014 the school has been marking its 10 year anniversary and acknowledging its achievements in various ways.

Dr Peggy Brown and Professor Nicholas Glasgow.

A highlight of the medical school's celebrations was a spectacular event held at Old Parliament House on Saturday 21 June. In attendance were over 350 members of the school's community, including alumni, current students, teachers, faculty, staff and friends. Indeed, quite a number of the first cohort to graduate in 2007 chose to combine this event with their own reunion and many travelled from all over Australia for the occasion .

Guests at Old Parliament House were greeted to a cocktail party in the salubrious King's Hall. Aboriginal Elder, Aunty Matilda House, gave an engaging Welcome to Country. The Dean of the ANUMS, Professor Nicholas Glasgow, soon invited guests to take their seats in the historic House of Representatives Chamber for one of the highlights of the evening: a comedic, mock parliamentary session. The Chamber seats filled and about half of the guests chose to remain in King's Hall to socialise and enjoy the refreshments. Two massive screens projected the parliamentary proceedings into King's Hall so all could follow the antics in the chamber.

The mock bill before the House of Representatives was the historic ANU Medical School *Funding Appropriation Bill 2014*, proposed by the Prime Minister, who was aptly channelled by Frank Bowden. The bill would in effect see the abolition of the ANU Medical School by the end of the year! An enthusiastic challenge was spearheaded by the Leader of the Opposition, Jane Dahlstrom. The robust debate included insults flung by both sides of the house, there was a shock crossing of the floor, rowdy student protesters caused disruption, and finally the Leader of the Opposition was ungraciously ejected from the Chamber!

A formidable Speaker of the House, played by Katrina Anderson, rose to the challenge of attempting to maintain some sort of control over the lively proceedings. Unruly characters included the Member for Kaftans and Leader of the Copayments Over My Dead Body Party (Amanda Barnard), the Member for Porsche (Al Burns), the Member for Hicks (Duncan McKinnon), the Member for Path Pots (Julia Potter), the Member for Dialectical Materialism and Leader of the Virago Party (Christine Phillips), the Member for Hippie Lifestyles and Furry Animals (Belinda Allen), the Member for Volatile Gases (Simon Robertson), The Member for Multiple Births (David Ellwood), the Member for Action Potentials (Christian Stricker), the Member for Bass (Jan Provis), the Member for Family Planning and Leader of the Senior Parliamentarians Under Tony's Unprecedented Mandate the SPUTUM Party (Shaun Thayer), and the Minister for Hobbit Welfare and Overseas Junkets (Nicholas Glasgow). In the end, the bill was fortunately defeated and Irene Howgego appeared in the Chamber as the Admin Fairy, wearing wings and ringing the (OSCE) bell!


2007 graduating class.

Guests all reconvened in King's Hall for refreshments and Professor Glasgow made a speech acknowledging the 10 year anniversary and thanking the medical school's community. As the Dean's speech drew to a close, he was interrupted by a voice that burst into song from the midst of the guests, then another voice joined in, followed by more… A flashmob of students and alumni filled the hall with the song *Perfect Day* by Lou Reed. The lyrics had been cleverly modified to suit the occasion and the arrangement by Ross Penglase, accompanied by keyboard and cello, echoed beautifully throughout the packed King's Hall. *Perfect Day* was a wonderful conclusion to a memorable evening!

By Jane Dahlstrom and Suzanne McKenzie


Players in the Great Debate.

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Emergency Medicine Foundation's a shocking appeal

Have the heart to save a life!

Combating a killer almost 10 times more deadly than the nation's annual road toll is the first focus of Australia's new not-for-profit emergency medicine organisation.

The Emergency Medicine Foundation has launched a national education campaign aimed at fighting alarming cardiac arrest death rates.

Each year about 10,000 Australians die from sudden cardiac arrest – nearly 10 times more than the annual road toll.

This life saving education campaign was identified by Emergency Medicine Foundation Director Dr Sally McCarthy as a way for the Foundation to have an immediate impact on saving lives.

"Tragically over 50 per cent of heart attack victims die before reaching hospital," Dr McCarthy said.

"We can increase the chance of survival for thousands of Australians just by raising awareness of publicly-accessible Automatic External Defibrillators or 'AEDs' for heart attack victims.

"We want these life saving 'heart starters' to be a conversation starter."

Emergency Medicine Foundation Chair Dr David Rosengren said a recent Emergency Medicine Foundation commissioned survey kick-started the Foundation into action when it found almost half of Australians would not use a defibrillator in a medical emergency.

"One in two Australians said not knowing how to use a defibrillator would stop them from using one, the survey result was worrying to the Foundation and we sprang to life," Dr Rosengren said.

"The first 10 minutes is the most critical time when someone suffers a cardiac arrest. The likelihood of survival is greatly increased if a patient receives CPR and/or defibrillation to restore a normal heart rhythm within this time.

"The machines are automated and only shock the victim if no heartbeat is detected. No one should be put off using one if they have to. AEDs are as easy to use as a fire extinguisher," he said.

"Our message is simple- don't be afraid, defibrillate."

The Emergency Medicine Foundation will be supporting practical research projects and education campaigns such as these being identified by healthcare professionals including specialist emergency physicians and nurses, rural and regional health clinicians, ambulance paramedics, and retrieval specialists.

The busiest frontline healthcare field is the most underfunded medical research specialty area in Australia.

Every year Australian hospital emergency departments have over 7 million presentations, with 19,000 emergency admissions per day impacting 99% of Australians in their lifetime.

The priority of the Emergency Medicine Foundation is to ensure that every person who is unfortunate enough to have a medical emergency anywhere in Australia has the best chance of survival.

The launch of the Emergency Medicine Foundation is underpinned by the success of its founding organisation – the state funded Queensland Emergency Medicine Research Foundation (QEMRF).

For further information visit www.emergencyfoundation.org.au

The passing of beloved Clown Doctor Father Dr Peter Spitzer, aka Dr Fruit-Loop

Beloved co-founder and Medical Director of Australian charity The Humour Foundation, Dr Peter Spitzer, aka Dr Fruit-Loop, died recently in Bowral.

Dr Peter Spitzer was one of the inspirational founders behind the Australian Clown Doctors, who dispense mirth, fun and laughter to over 155,000 sick children, families and hospital staff in 21 hospitals across Australia.

Dr Spitzer, also known as his alter ego Dr Fruit-Loop, was diagnosed with stomach cancer in December last year. Despite his diagnosis, his infectious smile and generosity of spirit continued to lighten the lives of those around him.

Dr Spitzer pioneered a marriage between art and medicine for the first time in Australia, with a vision to take professional performers from stage and put them at the bedside of sick children in hospital. He lived his dream to create and spread smiles where they are needed most, and truly make laughter the best medicine.

Dr Spitzer co-founded The Humour Foundation in 1996. The first Clown Doctors program started in Sydney Children's Hospital in 1997. In 2000 Dr Spitzer led a team of Clown Doctors to East Timor.

Dr Spitzer was a Chief Investigator in the landmark 3-year (2009-2011) NH&MRC-funded SMILE Study to research the impact of humour therapy in dementia care. He lectured and presented workshops on 'Humour in Practice' to health care students and professionals across disciplines, as well as the corporate sector, both nationally and internationally. Amongst other writings, his most recent book is 'Smiles Are Everywhere: Integrating Clown-Play into Healthcare Practice' and is co-written with Professor Bernie Warren from Canada.

Melinda Farrell, CEO of The Humour Foundation, says that The Humour Foundation will keep Dr Peter Spitzer's legacy alive, continuing this work with the same generosity, heart, perseverance and passion that he exemplified and lived by every day."

The Clown Doctors program has impacted the lives of one million since its inception, with countless red nose transplants, 'cat' scans and funny bone diagnoses for sick children in hospital, living out Dr Spitzer's vision over the last 17 years.

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Academy announces two new awards for public health and biomedicine

The Australian Academy of Science recently announced two new national awards named after pre-eminent Australian scientists, Professors Gus Nossal and Jacques Miller.

The Gustav Nossal Medal for Global Health and Jacques Miller Medal for Experimental Biomedicine will be awarded to Australian early- and mid-career researchers.

Academy President Professor Andrew Holmes said: "It is fantastic to be able to honour the tremendous contributions of two living legends in Australian science with these new awards."

"Gus Nossal, a former Academy president, has made outstanding contributions to vaccine research and public health, particularly in the developing world," Professor Holmes said.

"Jacques Miller's contributions to medicine have also been highly significant and led to his election to the Academy. He discovered the function of the thymus, an organ we now know is a fundamental part of the immune system.

"I hope these new medals will encourage our up-and-coming researchers in the fields of public health and biomedical sciences to aspire to similar heights of scientific endeavour."

The awards are open to experimental researchers up to 15 years post PhD.

Both honorific awards were made possible by the generous donation of Sir Marc Feldmann, a Corresponding Member (international Fellow) of the Academy and a prominent Australian immunologist based at the University of Oxford.

Nominations for both awards close 24 September 2014. For more information on both awards and how to nominate a researcher the Academy of Science website www.science.org.au

Compare The Market pays penalty for alleged misleading health insurance advertising

Compare The Market Pty Ltd (Compare The Market) has paid a penalty of $10,200 following the issue of an infringement notice by the Australian Competition and Consumer Commission in relation to claims made in recent advertising promoting Compare the Market's health insurance comparison service.

Between 17 March and 19 May 2014, Compare The Market distributed a letterbox pamphlet in Queensland, New South Wales and Victoria, in which it claimed, *"We now compare more health funds than any other website in Australia" and "Compare more health funds than anywhere else".*

In fact, there were two other websites that compared the policies of more health insurance funds than Compare The Market, including the website operated by the Private Health Insurance Ombudsman.

Compare The Market also made the same or similar representations in other media, including its website, banner advertising, flyers, television infomercials and a digital display in its office foyer.

"Many Australians have private health insurance and misleading representations could affect a significant number of consumers, who are considering switching or signing up to other health insurance providers and may rely on these representations," ACCC Commissioner Sarah Court said.

"The infringement notice was issued in relation to the letterbox pamphlet as the ACCC had reasonable grounds to believe that Compare The Market had made a false or misleading representation about the performance characteristics or benefits of its health insurance comparison service, in contravention of the Australian Consumer Law."

"Emerging consumer issues in the online marketplace, particularly in relation to comparator websites, are a current ACCC priority area as it is critical that consumers are able to make informed purchasing decisions," Ms Court said.

In Australia, there are over 30 insurers offering over 25,000 health insurance products. Commercial comparison websites generally only compare a selection of policies from a range of private health insurers. In comparison, the Ombudsman's Private Health Website enables consumers to compare up-to-date health insurance policies from every private health insurer in Australia.

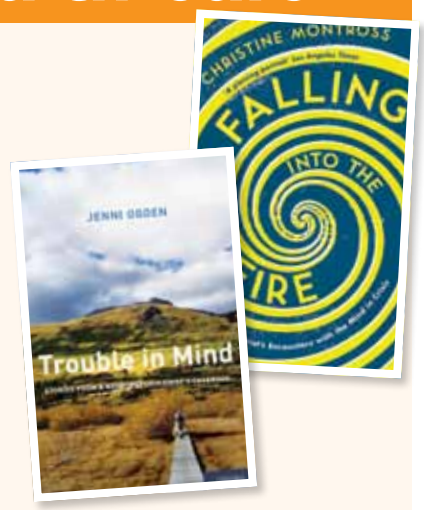
For tips on purchasing a private health insurance policy or switching providers, go to:http://www.accc.gov.au/consumers/health-home-car/private-health-insurance.

The ACCC may issue an infringement notice where it has reasonable grounds to believe a person has contravened certain consumer protection provisions of the ACL. The payment of a penalty specified in an infringement notice is not an admission of a contravention of the ACL.

BOOK REVIEW: Reflections on practice in mental health care

Falling into the fire
– Christine Montross,
Penguin, USA, 2013
ISBN-13: 978-1594203930

Troubled in mind
– Jenni Ogden,
Oxford, USA, 2012
ISBN-13: 978-0199827008



These two very different books are based on memoirs of practice as well as exposition for the general public. However, these books also are worthwhile for health care professionals seeking to reflect upon their own practice.

"Falling into the fire" is an exquisitely written memoir of practice. Intertwined with personal and professional reflections, this book depicts the often harrowing and deeply moving vicissitudes of the patient and physician journey through public mental health care. Dr Christine Montross, the author, is a talented writer and poet as well as public hospital psychiatrist and Ivy League (Brown) clinical academic. The stories are often left without a denouement, as is common when patients and systems of care no longer coincide at the end of an episode. This may be a particular characteristic of the US healthcare system, but of course is a problem faced in even the most comprehensive care systems. Dr Montross also gives glimpses of how her personal and family life both inform and sustain her practice; a salutary insight for young GPs, nurses, psychologists and psychiatrists in particular. In being across the literary and medical worlds, she offers some unique insights, such as her observations of the romanticisation of depression in literary/humanities circles juxtaposed with her experiences of treating patients with severe depression.

"Troubled in mind – stories from a psychologist's notebook" is as outlined, more in the tradition of Oliver Sacks ("Awakenings" and more recently "Hallucinations") elaborately detailed and incisive case series illustrating the varieties of neuropsychological and neuropsychiatric impairments. Professor Jenni Ogden, a clinical and academic neuropsychologist, depicts the travails of her patients with brio and compassion. An update and more detailed exposition of an earlier similar book, the only drawback is that some of the histories are dated, and this is most evident in disorders where there have been considerable recent advances, such as in Parkinson's disease diagnosis and treatment. Perhaps necessarily more clinical and analytic, on account of Prof Ogden's specialised expertise and working in a pioneering fashion in her profession in New Zealand, this book is accessible but not as rich in personal insights as "Falling into fire".

As health professionals entrusted with the specialist care of persons suffering from mental illness, psychologists and psychiatrists seek to navigate with their patients across troubled landscapes within and without. These two remarkable books offer inspiring insights into compassionate health care for the most personal of human travails.

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

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