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Record spending slowdown shows health not budget problem

AMA President Associate Professor Brian Owler has called on the Federal Government to immediately drop plans to slash $5 from the Medicare rebate following the release of figures showing claims that health spending is growing unsustainably are baseless.

"The Abbott Government has justified its extreme health Budget measures on the basis that health spending is out of control. Clearly it is not," A/Prof Owler said.

The Australian Institute of Health and Welfare has released analysis showing total national spending on health grew by a record low 1.5 per cent in real terms in 2012-13, underpinned by a big 2.4 per cent fall in Federal Government funding. Health's share of the Commonwealth Budget has fallen in the last seven years from more than 18 per cent to 16.1 per cent.

"These numbers clearly demonstrate that there are simply no grounds for taking even more money out of health," A/Prof Owler said.

The figures back the strong stand taken by the AMA against the Government's $7 co-payment proposal and its plans to slice $5 from already-inadequate Medicare rebates for GP, pathology and diagnostic imaging services, and to rip billions out of public hospital funding.

"Australia has one of the best-performing and most cost-effective health systems in the world, and the Government is putting that at risk with its ill-considered and unjustified Budget cuts."

An international comparison found that 9.67 per cent of gross domestic product was spent on health in 2012-13, close to the average among advanced economies, while the average Australian's life expectancy is among the highest in the world.

A/Prof Owler said that, far from being out of control, spending on health – particularly primary care - was remarkably cost-effective.

"The Government should be investing in primary care to keep people healthy and out of hospital.

"It's time for the Government to scrap the $5 cut to the Medicare rebate and take a closer look at the AMA's plan for a co-payment that protects the young and vulnerable, supports quality GP care and provides for a contribution from those able to afford it."

There is a long history of Medicare Benefits Schedule indexation rates that have been well below the contemporary costs of providing medical care. Pathology and diagnostic imaging services have not been indexed for more than 15 years.

As a result, there is a significant difference between the AMA fees and Medicare rebates.

This is further compounded as a result of Government budget measures that mean that most Medicare rebates are last indexed on 1 November 2012 and are not due to be indexed again until 1 July 2016.

There is a 4 year freeze on Medicare rebates.

While the Government indexed some GP services by 2% on 1 July 2014, this will be swallowed up by the healthcare cuts in the 2014-15 Federal Budget.

The AMA is concerned that the Budget measures reduce the Government's financial assistance to patients for their healthcare by shifting costs onto patient through:

- **$5 cut to Medicare rebates** for GP consultations and all pathology and diagnostic imaging services;
- **Removal of bulk billing incentives** for pathology and diagnostic imaging services for all patients. The cost to patients is $3.5 billion in the first three years of implementation.
- **Introducing a $7 co-payment** for GP attendances and all pathology and diagnostic imaging services. Assuming that the $5 rebate is offset by the $7 co-payment, the $2 difference imposes a further cost on patients of around $1.4 billion.
- **No indexation of Medicare rebates** for all medical services. The cost to patients is $1.8 billion over the next four years – including $160 million already saved by the Government in 2013-14 by not indexing Medicare fees on 1 November 2013.
- **Simplifying the Medicare safety net.** The cost to patients is $268 million in the first four years of implementation.
- **Increasing PBS co-payments and the safety net thresholds.** The cost to patients is $1.3 billion in the first four years of implementation.

Capital Conversations with President, Dr Elizabeth Gallagher

Welcome all to this month's edition of Canberra Doctor. Thanks to our editorial board for putting together another informative issue. My column this month is an eclectic mix of local, national and international issues.

At the time of writing, the AMA ACT Advisory Council is due to meet after being newly constituted following our AGM in May. There will be news next month about the meeting. This is a council made up of representatives from all areas of medical practice, and all craft groups within the ACT to raise issues that the AMA needs to be aware of. Trying to get a group of busy doctors together for such a meeting has to be much worse than herding cats! I thank those doctors who have volunteered to be your representatives. I would like to welcome A/Prof Stephen Robson who is the newly elected chair. With that position also comes membership of the AMA-ACT board and I look forward to working with Steve as part of that as well.

The recent report on cancer surgery waiting times issued on the MyHospital website shows that that ACT hospitals are meeting the target for waiting times for cancer surgery. Greater than 90% of surgery being done within 30 days of booking, and the median waiting time has improved between 2011-12 and 2012-13. While waiting times for breast cancer surgery at The Canberra Hospital are twice the peer average, territory wide, the median waiting time is still on target as the majority of breast cancer surgery is done at Calvary Public Hospital. We are also comparable to our peers for bowel and lung cancer surgery which is a very good outcome.

I want to thank those members who provided us with feedback on the rather controversial letter sent by ACT Health regarding the unsatisfactory delay in RFA forms being completed and then received in surgical bookings in our public hospitals. We were able to put together a balanced but firm response offering to be involved in trying to find a way to move forward from what we felt was an unreasonable expectation. We have received a response from Dr Peggy Brown, thanking us for our constructive feedback. By the time you read this, we will have met with the Director of Surgical Services to look for solutions.

The call to review medical marijuana use is gaining momentum and finally seems to be taking on a more logical and sensible structure. All the AMA State and Territory Presidents recently sent letters to our Health Ministers calling for a national approach involving proper regulation and involvement of the TGA rather than the ad-hoc mishmash of proposals being considered at state level. I have been watching the media and have been happy that this national approach seems to be increasingly supported.

Last week I was introduced to the organisation Doctors for the Environment. I met with our local representative Dr Peter Tait who has put together for us an article outlining the interests and policies of this group. One of their big pushes is for the reduction in our dependence on fossil fuels, therefore reducing the public health effects of pollution, environmental degradation and green house gas emissions. They are championing alternative energy sources. One way they have suggested we can all help is by divesting in fossil fuel stocks and shares, therefore helping stop financial support for new fossil fuel projects. I look forward to reading Peter's article.

With the World Health Organisation predicting there may be as many as a million people infected with Ebola by the end of the year, and the first person infected outside Africa diagnosed in the past week there appears no end in sight. The AMA has called for the Australian Government to do more to help control the disease at it source. Currently the Australian Government is refusing to send government sanctioned personnel to West Africa, only money, which organisations such as Medicins Sans Frontiers have described as "utterly inadequate". They say they need people, not money. Australia has no shortage of qualified people who would be willing to go over to help. The excuse is they do not have the capability to evacuate our citizens should they become infected. Surely the Australian Government should be able to make arrangements with any of our allies closer to Africa to take care of our citizens should they become ill. As they already do with injured defence personnel. It seems a poor kind of excuse given the need and extent of this growing crisis. So come on!

By the time you read this I will have come back from my first State Presidents and CEOs meeting. I have no idea what to expect, but hopefully I can report something interesting to you next month!

Ebola: 'Send us medics, not money'

The clamour for the Federal Government to contribute more than just money to international efforts to tackle the Ebola emergency is intensifying, with the AMA leading calls for the urgent dispatch of portable hospitals and fully-equipped medical teams to the epicentre of the outbreak in west Africa.

The rapid spread of the deadly disease in recent weeks – more than 4000 people have died in the outbreak, out of more than 8000 infected – has highlighted the inadequacy of the global response to date, with military and civilian medical teams from the United States, Britain, Europe and other developed countries only now starting to make a difference on the ground.

Until now, the burden of coping with the world's worst Ebola outbreak has fallen on the shambolic health systems of poor west African countries, UN agencies including the World Health Organisation, and humanitarian organisations including the Red Cross and Medecins Sans Frontieres, which have been overwhelmed by the scale of the crisis.

The US Centers for Disease Control and Prevention has warned that more than one million people could be infected with Ebola by the end of the year unless there is a major step-up in global efforts to contain the outbreak.

Early this month, the Abbott Government lifted its contribution to tackling the international public health emergency to $18 million, to be funnelled through the WHO, the Red Cross, MSF and similar organisations.

But AMA Vice President Dr Stephen Parnis is among a chorus of critics who have condemned the response as inadequate and demanded that the Commonwealth do more.

"We welcome the announcement of $18 million, but we think the Government has to do a lot more work, with a lot more urgency, to make arrangements with international partners to enable Australians to get on to the ground," Dr Parnis said.

He said the CDC's estimates meant that half a million people could be dead from Ebola by the end of the year unless countries like Australia vastly increased their effort to control the disease.

The inadequacy of the Government's strategy was laid bare by MSF Australia when it said the extra funding would not help.

MSF has reported it is currently operating at capacity and cannot deploy more health workers, regardless of extra funds.

Instead, it said, there was a desperate need for more fully-equipped foreign medical teams and facilities to be sent.

Foreign Minister Julie Bishop has so far resisted urgings that it coordinate the deployment of Australian medical workers, arguing that it could not responsibly do so without first putting in place evacuation procedures for any Australian health worker who might become infected with the virus.

Ms Bishop said the 30-hour flight time between Australia and west Africa made any such evacuation a near-impossibility.

"I do not have in place a guarantee that should an Australian health worker – sent there by the Australian government – contract Ebola, they would be able to be transported or treated in a hospital either in the region or in Europe," the Minister said. "And until I have that in place we will not be sending Australian health workers."

But Dr Parnis said other countries had already established evacuation arrangements for their nationals, and the Federal Government should negotiate access to these for Australian health workers in case of infection.

He said that, just as Australia was part of an international coalition fighting terrorists in northern Iraq, so it should work with other countries to combat Ebola, including negotiating evacuation procedures for its nationals.

Dr Parnis said there were dozens of highly-trained health professionals, including from Royal Darwin Hospital's National Critical Care and Trauma Response Centre, ready to go to west Africa as part of international efforts to combat the Ebola outbreak.

But their deployment needs to be coordinated by the Federal Government with the World Health Organisation, and include evacuation procedures.

The French Government, through the WHO, has agreed to develop an international protocol for overseeing evacuations, which would in effect mean that foreign health workers of any nationality would be evacuated to the most appropriate place, in accordance with their clinical circumstance.

The emergence of confirmed cases of Ebola outside west Africa – a Liberian man died of the disease in a Texas hospital, one of the nurses caring for him has been diagnosed with the disease and a Spanish nursing assistant was gravely ill after helping care for two missionaries repatriated with the infection who later died – has fuelled fears it could spread internationally.

Dr Parnis said the cases highlighted the fact that modern travel and communications meant no-one could afford to ignore the outbreak, no matter how far away it was.

But he emphasised that, while there was a risk the disease could appear in Australia, the nation's excellent health system was well prepared if it did appear.

Dr Parnis said it was in the nation's self-interest, as well as its duty as a good global citizen, to do everything it could to halt the spread of Ebola at its source in west Africa.

"The best protection against having Ebola here is to stop its spread there," he said. "The Prime Minister talks about global events having an effect on Australian national security. I completely agree, and I think that this is a key example of that, and our action or inaction will be remembered."

Reprinted from "Australian Medicine" with thanks

Future of general practice training

The AMA has developed a set of principles to guide the AMA's future advocacy on GP training, in the context of the Government's reforms announced in the Budget.

The policy was passed by Federal Council at its meeting on 28 August and reflects the broad input from the AMA Council of Doctors in Training; the AMA Council of General Practice; and the AMA forum of GP registrars on the future of general practice training convened in July. The principles state that:

1. The cessation of current arrangements for Regional Training Providers must be deferred to ensure continuity and stability in GP training while proper consultation takes place with the profession about the future structure and role of these organisations or their replacement.
2. The GP training program must remain profession led, governed and managed by relevant GP Colleges and lead to fellowship of one of the existing GP colleges.
3. A fellowship of one of the existing GP colleges must be the only recognised pathway to specialist GP recognition.
4. Training organisations must be accredited by the relevant Colleges.
5. Training organisations must have strong GP leadership and representation at all levels.
6. Training organisations must not be involved in the provision of GP services.
7. The apprenticeship model of GP training must be retained.
8. Common and transparent standards must govern the operation of training organisations, covering areas such as recruitment and selection, recognition of prior learning, appeals mechanisms, practice funding, transfer, registrar support, and registrar remediation.

AMA backs innovative plan to attract doctors to work and live in small country towns

The AMA has released its *Position Statement on the "Easy Entry, Gracious Exit" Model for Provision of Medical Services in Small Rural and Remote Towns,* which supports an innovative plan to attract and retain medical professionals in small country towns.

AMA President, A/Prof Brian Owler, said small country towns across Australia have for decades seen the gradual loss of important services like banks, schools, hospitals, retail stores, post offices, government agencies, and the local family GP.

"Many of these basic services are taken for granted in our cities and larger regional centres," A/Prof Owler said.

"The AMA believes it is important that rural and regional communities continue to have affordable and equitable access to quality health and medical services.

"The *Easy Entry, Gracious Exit* model has the potential to improve access to quality health care in small rural and remote towns that are experiencing a chronic shortage of medical professionals.

"It involves adopting a 'walk-in, walk-out' approach that enables GPs to work as clinicians without having to become small business owners and managers.

"A third party, such as a community or not-for-profit entity, would provide the general practice facilities, including infrastructure and staff, such as a practice manager and a practice nurse.

"The doctor would pay a service fee to the managing entity.

"There is also the option for Visiting Medical Officer (VMO) rights and contracts to be negotiated on behalf of the doctor.

"This model removes many of the obstacles that prevent doctors from establishing or maintaining a country practice for the long term.

"It allows them to stick to their core business – looking after patients.

"The key objective is to ensure the continuity of the practice or practice management structure, rather than the continuity of the individual doctor.

"By removing many of the financial barriers to recruitment, this model will more easily attract doctors to small rural and remote towns.

"Once the doctors arrive in these towns they often find that, while free to leave at any time, the support, financial arrangements, and the interesting medicine is so attractive that they readily remain for a reasonable period.

"The model is already in operation in some towns, and the evidence shows that it is working.

"It has been very successful in expanding and improving the stability of the general practice workforce in the towns involved, achieving an average doctor retention rate of five years, and reducing hospital inpatient and outpatient presentations.

"The AMA would like to see this model more aggressively rolled out to help provide much-needed medical services to small rural communities," A/Prof Owler said.

In developing this Position Statement, the AMA's Rural Medical Committee appreciated the input of the NSW Rural Doctors Network, which implements the model through its not-for-profit organisation, Rural and Remote Medical Services.

One third of Australia's population lives outside major cities. Nearly twenty percent of these

The AMA Position Statement on the "Easy Entry, Gracious Exit" Model for Provision of Medical Services in Small Rural and Remote Towns is available at https://ama.com.au/position-statement/easy-entry-gracious-exit-model-provision-medical-services-small-rural-and-remote

Health gap for disadvantaged people "disturbing"

The gap in quality of health between the most advantaged and most disadvantaged Australians persists, according to new national figures released by University of Adelaide public health researchers.

Levels of smoking, obesity, diabetes, cardiovascular disease and psychological distress are many times greater among the most disadvantaged population, the figures show.

Based on 2011-2013 data from the Australia Bureau of Statistics, the University's Public Health Information Development Unit has provided the latest update about variations in health across Australia on its website:www.adelaide.edu.au/phidu

The figures detail rates of disease and health risks, and highlight differences across a range of socially advantaged and disadvantaged groups. The data are mapped for every council area in Australia, as well as for Population Health Areas designed by the Unit, which are based on suburbs and localities across Australia.

"We are very clearly seeing a widening in the health gap, not only between the 'haves' and 'have nots', but across the population at every step in the social spectrum. This should be of concern to everyone," says the Director of the University's Public Health Information Development Unit, Associate Professor John Glover.

"Almost 25% of people in the most disadvantaged group are still smoking, compared with 12% in the most advantaged group. While smoking rates have fallen across the whole population, they've fallen at a much slower rate among the most disadvantaged. This is a key target group for smoking prevention, and one that is always hit hardest by increases in cigarette prices, which take little account of social and other pressures on disadvantaged people," he says.

"Rates of obesity are 34% for people in the most disadvantaged group, compared with 21% in the most advantaged group.

"The most disadvantaged people also have the worst rates of asthma (12%, compared with 9%), arthritis (17%, compared with 12%), diabetes mellitus (9%, compared with 3%) and cardiovascular disease (19%, compared with 15%)."

Associate Professor Glover says another key indicator is psychological distress, with 17% of the most disadvantaged group suffering from high or very high psychological distress compared with just 7% among the most advantaged group.

"All of these figures paint a very unhealthy, unhappy and distressing picture for those who are doing it tough in our society," Associate Professor Glover says. "We hope that this information will assist governments in developing policies and planning health and other services to address the drivers behind these disturbing outcomes."

THE NOTICE BOARD!

Members sought for Canberra Doctor Editorial Committee for 2015

We are seeking three new members for the committee in 2015 which oversights material for publication in Canberra Doctor. The committee meets approximately 8 times per year and the meetings are usually of one hour's duration. Please consider donating some time to this important function of the AMA ACT to ensure that Canberra Doctor remains relevant to the profession and is truly "for doctors, by doctors" – something we are keen to maintain.

For further information please contact Dr Ian Pryor on 0409 440 364 or Ms Christine Brill on 0407 123 670

Representative sought for Advisory Council

The Council is seeking self-nomination from members in the following craft groups to be appointed to the Advisory Council for the period 2014-2016: emergency medicine, paediatrics and radiology.

Please contact the Chair, A/Prof Steve Robson on 0408 154 048 or Ms Christine Brill on 0407 123 670 if you are interested in taking on this role. The Council meets approximately 4 times each calendar year and provides advice to the AMA ACT Board and via the President, to the AMA's Federal Council.

Medical Cannabis – your opinion sought

Mr Shane Rattenbury, MLA, Greens Member for Molonglo, is seeking your feedback on his proposed draft legislation, as reported in Canberra Doctor.

Feedback is invited to: rattenbury@act.gov.au and the draft legislation is available at:

http://www.legislation.act.gov.au/ca/db_50264/current/pdf/db_50264.pdf

Associate Membership NOW AVAILABLE

International medical graduates who have not yet attained Australian registration are invited to become Associate members of the AMA ACT. Please contact Sue Massey, Member and Partner Relations Manager on 6270 5410 for further details.

AMA encourages broad medical profession and community discussion on end of life care

The AMA has released its new *Position Statement on End of Life Care and Advance Care Planning 2014.*

AMA Vice President, Dr Stephen Parnis, said there should be open and frank discussion in the community about death and dying, including end of life care options, futile treatment, caring and bereavement, and advance care planning.

"Patients with a terminal condition, and their family members and carers where appropriate, should be empowered to participate in managing their treatment at end of life," Dr Parnis said

"This requires effective, ongoing communication.

"Good communication between the patient, their family members and carers, and the health care team should occur throughout the course of the patient's illness.

"This will alleviate fear, confusion, and guilt over the patient's condition, assist with decision-making, and reduce the potential for conflict over the patient's care.

"Doctors should endeavour to meet the patient's care needs and uphold their care preferences, which should guide decision-making and planning.

"Doctors and health care teams will continue to provide care and support throughout a patient's illness, including when the patient moves from curative care to palliative care.

"Quality palliative care is focussed on symptom management and comfort measures that provide physical, psychological, social, emotional, and spiritual support for patients and their family members and carers."

Dr Parnis said that advance care planning is an important means to elicit a patient's wishes and their preference for end of life care in the event they lose decision-making capacity.

"An advance care plan is a process of ongoing reflection, discussion, and communication of health care preferences that may result in oral or written directives, such as an advance care directive.

"Legally competent patients have the right to make health care decisions, including the right to refuse interventions such as life-sustaining treatment.

"Patients with limited or impaired capacity should be encouraged and supported to participate in treatment decisions, consistent with their level of capacity at the time a decision is needed.

"There should be equity of access across Australia to appropriate services including palliative care, respite care, bereavement support, carers' support, and other relevant services for patients undergoing end of life care," Dr Parnis said.

According to the AMA Position Statement, good quality end of life care should:

- ensure the patient is always treated as an individual, with respect, dignity and compassion in a culturally sensitive manner;
- endeavour to meet the patient's care needs and uphold their care preferences, which should guide decision-making and planning;
- strive to ensure that the patient is free from suffering;
- endeavour to facilitate care in the patient's environment of choice, where practical, recognising that a patient's health care needs may change in the course of their condition;
- ensure that the patient's goals and values for end of life care are respected;
- respect the patient's privacy and confidentiality, even after death;
- support not only the physical needs of the patient but also the psychological, emotional, religious and spiritual needs of the patient and their family members and carers;
- empower patients and, where appropriate, their family members and carers, to participate in managing their treatment;
- provide counselling and other support to patients, their family members and carers throughout the patient's condition, including support for family members and carers beyond the patient's death;
- ensure patients and their family members and carers have access to good quality palliative care resources such as educational materials, as well as physical aids in a timely, easily accessible, and coordinated manner;
- recognise the role of doctors, allied health care professionals, carers, and the wider community in working together to meet the needs of patients; and

- facilitate continuity and coordination of care within and between medical, health and community services, including when the patient moves from medical care that is primarily focused on curative treatments to care that is focused on palliative treatments.

The AMA *Position Statement on End of Life Care and Advance Care Planning 2014* is at https://ama.com.au/position-statement/position-statement-end-life-care-and-advance-care-planning-2014

Medical students all dressed up in graduation gowns but nowhere to work

The Australian Medical Students' Association (AMSA) has obtained figures showing that hundreds of medical graduates will not be able to become doctors.

The National Medical Intern Data Management Working Group has completed an audit of offers, and concluded that approximately 240 Australian graduates will not be offered a State or Territory position.

AMSA President, Jessica Dean, said AMSA is very disappointed that such a large number of graduates from Australian medical schools will be unable to practise in Australia.

"As regions of Australia continue to suffer from doctor shortages, it is nonsensical to be wasting another cohort of medical graduates," Ms Dean said.

"Completing an internship is an essential process for a graduate to work as a doctor in Australia. If the Government is serious about correcting the ongoing doctor shortage, it makes sense to completely utilise the graduating Australian workforce.

"These students have spent up to six years immersed in Australian culture, learning our diseases, and training in our healthcare system. They are perfectly suited to serve Australia. They just need to be given a chance."

The shortfall is yet to be finalised. The Commonwealth Medical Initiative (CMI) is yet to offer positions for the 2015 intake. This program was developed for international-born Australian graduates to complete an internship in Australia. While the initiative promised 'up to 100' places, AMSA was disappointed that only 76 were offered last year.

"The CMI initiative is a welcome addition to the medical training landscape. However, the addition of 76 places may still leave over 160 medical graduates who will be forced to take their skills overseas," Ms Dean said.

"Last year, the CMI initiative was oversubscribed with 183 applicants for 76 positions. These graduates not only want to work in Australia, they are even happy to relocate to work in areas of need, especially rural and regional Australia. Isn't this the answer we are looking for?

"By failing to facilitate training opportunities, Australia is allowing itself to become a victim of brain drain."

"Refusing to train local graduates and then filling the deficit with overseas-trained doctors is remarkably myopic.

"AMSA is calling on the Government to invest in the future of health care and provide Australia with the health care system it needs," Ms Dean said.

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The links to access the discounts are hidden behind member authentication, so members will need to be logged in to access the discounts.

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Cutting through the e-smoke

Are e-cigarettes a help or hindrance in the war against smoking? Chuck Thompson looks at the issue

Hello, my name is Chuck, and I'm a smoker. I have battled with nicotine addiction for years – to the point where (much to my disgust) I'd catch myself subconsciously hunting for half-smoked cigarettes on the streets during one of my many failed attempts at quitting cold turkey.

I finally decided to give e-cigarettes a go, and managed to abstain from cigarettes for six months using a nicotine-free e-cigarette.

While I found that the e-cigarette helped alleviate some of the cravings I had, it didn't break my addiction. I still felt the urge to swallow lungfuls of smoke, and the habits associated with smoking (particularly with the first coffee of the day) never went away.

Depending on which side of the fence you sit, e-cigarettes are somewhere between a smoking cessation product that actually works and just another way of promoting smoking.

The recent landmark case that saw a Western Australian e-cigarette vendor fined for selling non-nicotine e-cigarettes has highlighted what our policy makers think about the product – much to the chagrin of some who claim that e-cigarettes aided them in their battle against cigarette addiction.

But before we get into the safety and efficacy of e-cigarettes, it's worth discussing what these products are, how they work, and why health departments and public health officials are worried.

E-cigarettes (or electronic nicotine delivery systems) are battery-powered devices that use a heating element to 'vaporise' a liquid mixture of nicotine, flavouring, glycerine and propylene glycol.

E-cigarette manufacturers have marketed the product as a healthier alternative to smoking, due to the fact that no smoke is produced. Nicotine addicts can therefore get their fix without worrying about tar, carbon monoxide and the swathe of carcinogens that are created from burning tobacco.

In recent years, the e-cigarette industry has evolved from a fledgling market into a billion-dollar-a-year industry; however the idea of a non-combustible nicotine delivery device has existed since 1963. An American named Herbert Gilbert paved the way for e-cigarettes with his "smokeless non-tobacco cigarette" design, which was patented in 1965, but never commercialised.

Gilbert gave up on his product even though he was a heavy smoker, and ultimately quit cold turkey.

The technology hasn't changed significantly from Gilbert's initial design – what has changed however, is the attitude towards this product from Big Tobacco.

Since evidence on the health risks of smoking attracted widespread publicity from the 1950s, Big Tobacco started searching for a 'safe cigarette' alternative. In fact, more than 150 patents related to designing a safe cigarette have been filed in the US and the UK over the past 25 years. Almost all were filed by Big Tobacco.

Over the years, innumerable products have been promoted as less harmful or 'safer' – notably through the 'tar derbies' of earlier decades, which came to an end when it became clear that the much vaunted benefits of low tar products were not real. America's most popular e-cigarette brand (Blu) was purchased by tobacco giants Lorillard in 2012.

They and others have attempted to glamourise 'vaping' by using celebrity endorsements and the same advertising techniques that were once so effective for cigarettes.

According to AMA (WA) President Dr Michael Gannon, this is a major concern. "Some of the world's biggest tobacco companies are now entering the e-cigarette market, and have found the perfect means of promoting smoking behaviour to ex-smokers and teenagers.

"I've noticed a worrying trend where celebrities are not only smoking e-cigarettes, but openly endorsing them to impressionable fans," Dr Gannon said.

"Australia is enjoying a decline in smoking rates, and the last thing we want to see is the re-glamourisation of smoking.

"We need to wait for a comprehensive global analysis on the safety and efficacy of these products before a ban on e-cigarettes can be lifted in WA," Dr Gannon said.

Dr Gannon is not alone in his concern. Education and Research Director of Cancer Council WA, Terry Slevin, recently said: "The priority should remain implementing those measures we know work in reducing smoking and preventing uptake among children.

"Before this product is introduced or promoted, it is very important that the Australian public can be confident that e-cigarettes do not further contribute to health harms of the smoker and that the method is proven to be beneficial in assisting smokers to quit.

"The Cancer Council is therefore keen to see responsibly-conducted high-quality objective scientific research aimed at determining, either way, the safety and efficacy of e-cigarettes," Mr Slevin said.

Public health expert Professor Mike Daube said: "As a public health professional I take a cautionary approach to allowing new products on the market without proper process, and to bypassing proper process whether because of enthusiasm, hype, commercial interests or a combination of the three.

As an experienced tobacco control campaigner, I take a yet more cautionary approach when this entails tobacco industry lobbying and massive promotion that normalises smoking and smoking behaviours."

Prof Daube added that the proper course for any cessation product is to take it to the Therapeutic Goods Administration (TGA), which can determine safety and efficacy, whether a product should be permitted, and if so, under what conditions.

There lies the problem. Not a single e-cigarette manufacturer has approached the TGA to have its product approved.

The TGA's stance on e-cigarettes (both nicotine and non-nicotine) is as follows:

If claims are being made about smoking cessation or alleviation of nicotine withdrawal, then they would meet the definition of therapeutic goods within the Therapeutic Goods Act 1989 and would have to be assessed by the TGA for safety, quality and efficacy before they could be legally marketed for those reasons.

Without TGA approval, e-cigarettes cannot be imported as cessation devices, nor sold as such. However, the products can be imported from overseas as long as the labelling does not state that the product has any therapeutic benefit.

This is of serious concern to Dr Gannon, as products poorly manufactured from overseas could cause some serious health problems.

"Nicotine is a very dangerous substance and is classed a Schedule 7 poison. It is particularly dangerous in liquid form, and can be absorbed through the skin," Dr Gannon said.

The US Center for Disease Control and Prevention (CDC) recently reported on the sharp rise in the number of calls to poison centres involving e-cigarette liquids containing nicotine.

The number of calls rose from one a month in 2010, to 215 a month in 2014. More than half of the calls involved young children under the age of five.

"This report raises another red flag about e-cigarettes – the liquid nicotine used in e-cigarettes can be hazardous," said CDC Director Dr Tom Frieden.

"Use of these products is skyrocketing and these poisonings will continue.

"E-cigarette liquids as currently sold are a threat to small children because they are not required to be childproof, and they come in candy and fruit flavours that are appealing to children."

Some scientists argue that there is a place in cessation programs for e-cigarettes, such as Professor Peter Hajek from London University. Professor Hajek is the lead author of a review on e-cigarettes in the journal Addiction, and recently asserted:

"The evidence we currently have is clear: e-cigarettes should be allowed to compete against conventional cigarettes in the marketplace.

"Healthcare professionals may advise smokers who are unwilling to cease nicotine use

to switch to e-cigarettes. Smokers who have not managed to stop with current treatments may also benefit from switching to e-cigarettes."

This line of thinking is not shared by a range of public health experts in Australia, including Professor Mike Daube.

"I am not, in the Manichaean language that many e-cigarette proponents employ, 'against' e-cigarettes, or a 'prohibitionist'," Prof Daube said.

"There is one exception to this. I am 'against' the totally untested and unregulated products that are being sold, often illegally, by disreputable sales outlets, without any concerns for consumer safety, but with implicit or explicit claims about their benefits.

"That apart, I take a stock-standard public health approach around evidence of safety, benefits, direct and indirect harms and proper process. Only 12.8 per cent of Australians over 14 are now regular smokers. We know what needs to be done to reduce this further; we should be very cautious about allowing in a new product that could pose new harms, as well as normalising smoking behaviour," Prof Daube said.

A significant amount of research needs to be done to determine how effective e-cigarettes are in helping people quit. A paper in The Lancet found that in comparison to current nicotine cessation products, e-cigarettes were no more effective than nicotine patches in achieving abstinence from e-cigarettes.

The long-term effects of inhaling a mixture of glycerol and liquid nicotine are also unknown, and current research on these products is too rudimentary to determine whether or not e-cigarettes are a viable alternative to current cessation products.

Until more comprehensive analysis is done, it's too early to tell if e-cigarettes will be a help or a hindrance in the war against smoking.

Reprinted with permission from AMA WA's "Medicus" and references are available on request to AMA WA.

'Out of sight, out of mind': Smoking rates in young people fall following point-of-sale tobacco display ban

New figures released in the Journal of Nicotine and Tobacco Research show that smoking rates among young people aged 12-24 years fell from 15 per cent to 11 per cent in the 24 months following the ban on displaying tobacco at the point-of-sale.

The report, undertaken by the Cancer Institute NSW following the point-of-sale tobacco ban in NSW in 2010 and QLD in 2011, also showed a decline in cigarette brand awareness. The number of young people able to recall at least one brand fell from 65 per cent to 59 per cent – an important change given the proven association between brand engagement and youth smoking.

The report is the first to assess the medium-term effects of the ban on youth attitudes and smoking behaviour. It suggests that the removal of tobacco displays from retailers has been associated with changes in important beliefs about smoking among adolescents and young adults.

Chief Cancer Officer and CEO of the Cancer Institute NSW, Professor David Currow said it has long been suggested that tobacco product displays effectively advertise tobacco brands, and that exposure to these displays and tobacco marketing is associated with both smoking susceptibility and smoking uptake among youth.

"Point-of-sale tobacco bans are contributing to the de-normalisation of smoking, particularly among youth, who we know are most at risk of being influenced by the power of tobacco branding. This report demonstrates that point-of-sale display bans, as part of a comprehensive tobacco control strategy, are effective. This report joins the mounting evidence that demonstrates our world-leading strategies – including plain packaging, smoke-free policies and mass media campaigns – are making an impact.

"Jurisdictions across the world should consider the banning of retail tobacco displays so that one day in the near future, all tobacco products can be truly out of sight and out of mind," he said.

Another key predictor of youth smoking is the perception of peer smoking prevalence. The report found that in the six to 12 months following the point-of-sale ban, young people were significantly less likely to overestimate the smoking of their peers. The Cancer Institute NSW is Australia's first statewide government cancer control agency. Established under the *Cancer Institute (NSW) Act 2003*, the Institute is responsible for lessening the impact of cancer by reducing cancer incidence, increasing cancer survival, improving quality of life for people living with cancer, and providing expert advice on cancer.

"This further indicates that there is a vital shift taking place among our younger generation. Their awareness and perceptions of cigarettes are being impacted in a positive way, and we can have hope that the burden of smoking related illness and disease across our community may lessen in future, as behaviours continue to change for the better," said Professor Currow.

CHAMPIX® now available twice a year on the PBS

Change to the restriction allows Australian adult smokers who relapse following a course of CHAMPIX to have a second course after six months

"Tobacco smoking is a powerful addiction which kills more than one in two long-term smokers," said Dr Colin Mendelsohn, Vice President of the Australian Association of Smoking Cessation Professionals. "While most smokers understand that smoking is harmful to their health, they are often not aware of the powerful tools available to them in their quit attempts."

Doctors have an important role to play in helping smokers quit. Currently, only 3-5 per cent of unaided quit attempts are successful. However, with counselling and support from health care professionals and the use of optimal stop-smoking medication, this proportion increases considerably.

CHAMPIX works differently to other smoking cessation aids. By acting as a partial agonist at (alpha)4(beta)2 nicotinic acetylcholine receptors, it acts to alleviate symptoms of cigarette craving and withdrawal, while blocking the rewarding effects of nicotine.

The long term efficacy of CHAMPIX has also been demonstrated through 52 weeks (compared to placebo) (OR: 1.35; OR: 1.07-1.70) as well as being generally well tolerated. The most common side effects are nausea, vomiting, fatigue, insomnia, abnormal dreams, headache, constipation, flatulence, dry mouth, dysgeusia and dizziness. Nausea is mostly mild-moderate, occurs early in treatment and may diminish over time.

Cancer Council Australia congratulates France on plain packaging decision

Cancer Council Australia has congratulated the government of France for announcing its intention to introduce legislation for the plain packaging of tobacco products next year, to become effective in 2016.

Chair of Cancer Council's Tobacco Issues Committee, Kylie Lindorff, said France would now become the third country, after Australia and Ireland, to eliminate the use of packaging as a way to advertise tobacco products.

"The tobacco industry will continue to kick and scream and claim that plain packaging won't work, which only further demonstrates how important glossy packaging is to the promotion of the product," Ms Lindorff said.

"The French Ministry of Health and the Government should be congratulated for putting the health of its citizens ahead of the commercial interests of big tobacco companies."

Ms Lindorff said an increasing number of countries were looking at the compelling evidence that packaging is an important form of tobacco advertising, particularly for luring and addicting young people.

"Global tobacco-caused deaths since the introduction of mass-marketed tobacco products are expected to reach one billion this century," Ms Lindorff said. "The sooner we see better controls around the advertising of these products, the sooner we can reverse the trends in preventable deaths globally."

Plain packaging has been mandatory in Australian since December 2012.

The most recent Australian smoking prevalence data, released in July this year, showed the largest single drop in tobacco use since the figures have been collected, with unprecedented reductions in the number of young Australians using tobacco products.

Join the AMA now and pay in 2015

If you are contemplating AMA membership, we invite you to join now and pay nothing until 2015

For full details on the benefits of membership visit **www.ama-act.com.au** and **www.ama.com.au**

To take advantage of this end of year special offer, please contact **Sue Massey** on **6270 5410** or return the application form.

Note the "join online" option is not applicable to this offer.

Australian Medical Association (ACT) Limited

ABN 29 008 665 718

PO Box 560, Curtin ACT 2605
Level 1, AMA House, 42 Macquarie Street, Barton ACT 2600
Phone: (02) 6270 5410 Facsimile (02) 6273 0455
Email: membership@ama-act.com.au

MEMBERSHIP APPLICATION

Personal Details

Given Name(s): _____ Surname: _____

Preferred Name if different: _____

Date of Birth: _____ Male: ☐ Female: ☐

Preferred mailing address: ☐

Home Address: _____

_____

_____ Phone: _____

Preferred mailing address: ☐

Practice Address: _____

_____

_____ Phone: _____

E-mail Address: _____

Web Address: _____ Mobile Number: _____

Qualifying Degrees (Date & Place): _____

Postgraduate Degrees (Date & Place): _____

Registration (Date & Place): _____ AHPRA Number: _____

Practice Information:
☐ Private Practice ☐ General Practice
☐ Salaried Practice ☐ Doctors In Training
☐ Specialist Practice

Previous Membership of the AMA (State & Year): _____

Other Relevant Information (including languages spoken): _____

_____

Review of medical internships

Led by the AMA Council of Doctors in Training, the AMA Federal Council recently reviewed current AMA policy to confirm the principles which should underpin intern training and inform AMA advocacy in the forthcoming review of medical intern training proposed by health ministers at the Standing Council on Health meeting earlier this year.

The implications of the review on the current internship and prevocational model of training could be significant. "While periodic review of medical training paradigms is welcome and necessary for long-term quality improvement, it is critical that the focus of any review is on quality rather than cost savings" said AMACDT Chair, Dr James Churchill.

These principles were recently approved by AMA Federal Council and include:

- Graduates of AMC-accredited medical schools must continue to gain 'provisional' registration upon graduation and be required to complete an accredited 47-week-equivalent internship, excluding leave, prior to gaining 'general' registration.
- An accredited internship must continue to comprise minimum eight-week accredited terms in each of medicine, surgery and emergency medical care, with the remaining time comprised of other accredited terms.
- Terms must meet the requirements of the AMC with respect to what constitutes a medical, surgical or emergency medical care term.

Read more about the AMA's position on Prevocational Medical Education and Training – 2011(https://ama.com.au/position-statement/prevocational-medical-education-and-training-2011).

Why action on fossil fuel is a health issue – By Peter Tait

Why is climate change a health issue?

Even at less than one degree of warming climate change is estimated to cause hundreds of thousands of deaths per annum and many million more suffer severely.

5 years ago the UCL-Lancet Commission said climate change was *"the greatest threat to human health of the 21st century."* Last month an editorial on climate change and human health in the British Medical Journal (BMJ), stated: *"This is an emergency"* requiring *"immediate and transformative action"* with health professionals in the lead. Without urgent action to stop emitting greenhouse gases, we face increased risk from heat waves, droughts, severe weather and this will adversely affect agriculture, physical and mental health.

So what can doctors do about climate change?

Treat it as a health problem, and an urgent one at that. The planet has a fever and the prognosis is not good! We have known the diagnosis for decades and also known the cure, but we have done little or nothing to treat it. But there are so many small things that can be done. For a start, we can all be advocates for a swift transition away from fossil fuels and towards renewable energy. The mining and combustion of fossil fuels harm health directly as well so there will be a large health dividend in transforming our energy system. Solar and wind power are no longer more expensive than new coal and gas. We can reduce the carbon footprint our homes and our practices, eat less meat, take more active transport, and start a veggie garden, think about who we vote for, join DEA… the list is endless.

Why is fossil fuel divestment important?

Divestment seeks to remove the social licence to operate from fossil fuel companies, similar to what was done with tobacco companies and arms manufacturers. It aims to raise awareness of this to regulators and investors. It suggests financial support be transferred from the major cause of climate change and to more healthy energy investments.

How many of us know that the big four banks have invested $19 billion in new gas and coal projects in Australia since 2008? Or that globally 55% of superannuation funds are invested in carbon intensive industries compared to just 2% in low carbon solutions?

The most powerful action to take is to switch to a bank that does not invested in fossil fuels and divest from fossil fuels in your superannuation portfolio. This action is direct and immediate. It is in our control to take our money out of the disease, and put it in the cure.

On a personal level, what do you get out of doing this voluntary work?

Action is the antidote to despair. The latest IPCC report is grim reading. 4 degrees of warming by 2100 is not compatible with industrial civilisation as we know it. This change is happening to my children. We have a decade in which to act. Acting with colleagues and friends is hard but satisfying. We may have time or we may be too late; but if we don't try then we will ever succeed. Anything we do can help. And we may succeed.

What prompted you to get involved in DEA?

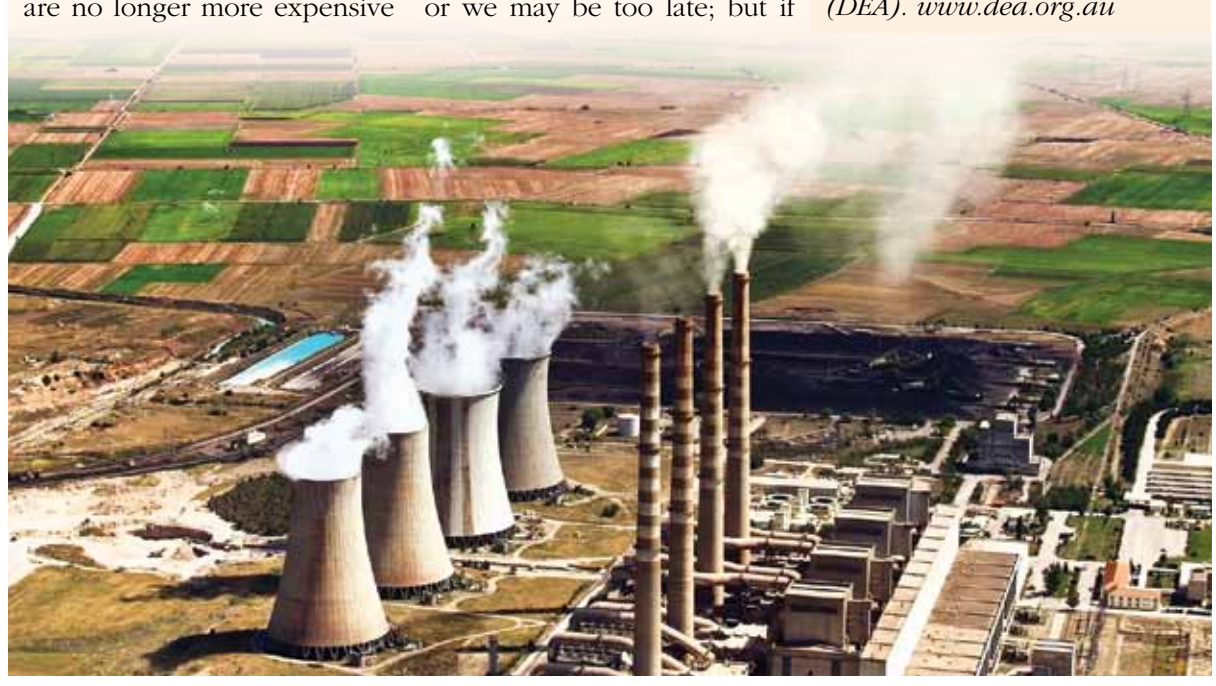
Working in Aboriginal health for many years it was clear that healthy people grow in a healthy society. It is a short step to see that a healthy society needs a healthy ecosystem for clean air, clean water, healthy soil, a secure food supply and a stable climate. Doctors for the Environment Australia provides an opportunity to do something about increasing damage to our environment, and put it in a health context.

What is DEA and what does it do?

DEA is a voluntary health advocacy organisation for doctors and medical students. The fact membership has doubled in the last four years reflects rapidly growing awareness and concern about how environmental issues, especially climate change, impact human health. DEA's current core business is raising awareness about the health impacts of coal, unconventional gas and climate change, but we are also active in biodiversity, sustainable health systems and fossil fuel divestment.

DEA presents evidence-based opinions to government via submissions, inquiries and politician letters/visits, to communities via invited speakers, to the general public via media releases and to our medical colleagues. We have a large active medical student membership who organizes a range of campus activities.

Dr Peter Tait is the ACT representative for Doctors for the Environment Australia (DEA). www.dea.org.au



H20 International Health Summit
Healthy People, Successful Economy

The World Medical Association (WMA), AMA Victoria and AMA Federal will host the H20 International Health Summit in Melbourne.

This summit will allow medical professionals from around the world to come together and put the spotlight on health issues prior to the G20 Leaders' Summit.

We encourage all doctors to come along and contribute to the discussions and be part of this movement to make health a priority for world leaders.

The summit will address:

1. Health as a wise investment
2. The burden of non-communicable diseases
3. Social determinants of health
4. Health effects of climate change and how to tackle these.

Keynote speakers and panelists will include:

Secretary to the Victorian Department of Health, Dr Pradeep Philip
Chair of the World Medical Association, Dr Mukesh Haikerwal
President of the World Medical Association, Dr Xavier Deau
President of the Turkish Medical Association, Dr Ozdemir Aktan
President of the Public Health Association of Australia, Prof. Heather Yeatman.

DATE:
Thursday 13 November and Friday 14 November

TIME: Thursday:
10am to 5.30pm followed by the Gala Dinner from 7pm
Friday: 9am to 5.30pm

VENUE:
Hotel Windsor
111 Spring St
Melbourne, Australia

COST (inc. GST):
AMA Member: $588.00
Non-Member: $882.00
Concession (medical students and retired doctors): $210.00

Registrations close
Monday 10 November
t: (03) 9280 8722 or 1800 810 451
(Country Victoria toll free)

This event is proudly hosted by:

This event is proudly supported by: Victorian Department of Health, NAB, MDA National, Medibank and Avant.

HEALTHY PEOPLE
SUCCESSFUL ECONOMY

H20 INTERNATIONAL HEALTH SUMMIT
13 & 14 November 2014 • Melbourne

REGISTRATION FORM 2014

Return completed forms to:
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F: 9280 8786
PO Box 21
Parkville, VIC 3052

THIS REGISTRATION FORM CONSTITUTES A TAX INVOICE. PLEASE RETAIN A COPY FOR YOUR RECORDS. ABN 76 004 158 614

Title: First name:

Surname:

AMA membership number: (if applicable)

Position:

Organisation:

Contact address:

Suburb: Post code:

Telephone:

Mobile:

Email:

How did you hear about this event? :

Special dietary requirements:

Title: **H20 International Health Summit**

Course date: **Thursday 13 & Friday 14 November 2014**

COST: All costs are GST inclusive

Member:	$ 588.00
Non member:	$ 882.00
Concession (medical students & retired doctors):	$ 210.00
Total payment:	**$**

PAYMENT

○ Cheque (made payable to: AMA Victoria Practice Solutions) or ○ AMEX ○ MasterCard ○ Visa Card

Credit card number: | | | | | | | | | | | | | | | | Expiry date:

Cardholder's name:

Signature:

○ If you do not wish to receive email communications from AMA Victoria, please tick box.

Cancellation Policy: Cancellations made in writing more than two working days prior to the event may receive a refund less 20% administration fee. Cancellations after this point will not be refunded. Substitutes may attend at no additional cost with prior notice.

Account code 1600-5-550

Doctor Portal – new resource for medical practitioners

What is it?

Doctor Portal is a web platform designed to aggregate a suit of highly relevant tools, resources, products, services and information for medical professionals. The platform is linked to the Medical Directory of Australia database and verifies users as medical professionals – only doctors can access the site so you always know you are sharing content or views with a fellow medical professional.

How will Doctor Portal be useful to members?

Medical professionals who use the portal can benefit from the resource by:

- sharing views and sharing content with colleagues
- finding colleagues and specialists for referrals
- accessing current, clinical and medico-political news
- purchasing medical texts and reference books in the online medical book shop
- accessing information resources all in one convenient location such as the GP desktop Toolkit
- searching medical jobs around Australia

Members will also be able to use the site to access discounted product – for example the Fees list is free for members but at a cost to non-members, the GP Desk Top toolkit is only available to members. Down the track we are also adding in:

- UpToDate – due in early September
- AMA Fees list – adding in early September
- Events sign up – adding in late September
- CPD Tracker delivery early 2015

Do members have to pay to access Doctor Portal?

No, Doctor Portal is absolutely free for Australian registered medical professionals. Doctors do have to sign up to make use of the various resource and tools in the site.

Can members access Doctor Portal on the portable devices?

Yes, they can access Doctor Portal on any portable device but please be mindful that the design and space of the site might change to size of the device.

Where do members go for assistance with my login or other technical issues?

For technical questions, please contact support@doctorportal.com.au

Feedback and comments are welcome:

Members can direct their feedback to: feedback@doctorportal.com.au

Breast Check to pay $75,000 for false representations

The Federal Court has ordered Breast Check Pty Ltd (now called PO Health Professionals Pty Ltd) (Breast Check) to pay a penalty of $75,000 for making false or misleading representations about its breast imaging services in contravention of the Australian Consumer Law (ACL).

The former director of Breast Check, Dr Alexandra Boyd, was ordered to pay penalties of $25,000 for being knowingly concerned or involved in Breast Check's contraventions.

Breast Check had represented that breast imaging using a thermography device alone, or in conjunction with a Multi-frequency Electrical Impedance Mammograph (known as a MEM device), could provide an adequate scientific basis for assessing whether a consumer was at risk from breast cancer and the level of that risk, and assuring the consumer that they did not have breast cancer. In March this year, the Court found that these representations were false, misleading and deceptive.

The Court also found that Breast Check had represented that there was an adequate scientific basis for using the devices as a substitute for mammography, when that was not the case. The Court held that this representation was also false, misleading and deceptive.

"It was particularly concerning to the ACCC that Breast Check made such significant health related claims without a proper scientific basis," ACCC Commissioner Sarah Court said.

"If consumers relied on Breast Check's representations instead of using conventional breast cancer investigation methods including mammography, then potentially breast cancers could have gone undiagnosed."

"Consumers are entitled to expect that breast imaging services would be provided in a way that is consistent with credible scientific knowledge," Ms Court said.

In his judgment today Justice Barker stated "The key issue is the potential to divert customers from using a medically recognised form of breast imaging and the harm or potential harm caused by that. Thus, I accept that even if only one consumer has been so diverted to their detriment, the consequences to a person's health may be very serious and at worst fatal. That is not something that can be measured solely in monetary terms and it is of no assistance to say the conduct was only directed to a small number of individuals."

Breast Check, now called PO Health Professionals Pty Ltd, no longer provides breast imaging services.

Last week the Court ordered another breast imaging provider, Safe Breast Imaging Pty Ltd, to pay penalties of $200,000 for similar contraventions of the ACL.

Memo to senate crossbenchers: the AMA does not support the government's GP co-payment model

Amid reports of a possible Budget retreat by the Government, the AMA reiterates that it strongly opposes the Government's proposed co-payment model for GP, pathology, and radiology services, and the planned $5 cut to the Medicare patient rebate.

AMA Vice President, Dr Stephen Parnis, said the AMA is concerned that its position is being misrepresented by the Government in its dealings with the Senate crossbenchers.

"We want to send a clear message to the crossbenchers that the AMA has been a leading critic of the Government's co-payment model since Budget night," Dr Parnis said.

"The Government's co-payment would hurt the most disadvantaged in the community – the poor, the chronically ill, the elderly, and Indigenous Australians.

"To make things worse, the Government plans to take more money from the sickest and neediest Australians by cutting their Medicare rebate by $5.

"We urge the Senate to vote down this callous cash grab from the most vulnerable people in our community. It is bad health policy."

Dr Parnis said the AMA supports co-payments in principle, but only for patients who can afford to pay.

"The AMA has put forward an alternative proposal – at the Prime Minister's request – that protects the vulnerable and provides strong investment in general practice to allow it to meet growing demand from an ageing population and more people with chronic and complex disease.

"The AMA has proposed a health policy that strengthens the health system to provide quality health care for more Australians into the future.

"The Government has proposed an economic policy to heal the Budget bottom line, but which creates cost barriers that will prevent many Australians from getting the health care they need.

"The choice is clear – the Government's co-payment proposal must be rejected," Dr Parnis said.

The AMA's alternative co-payment plan is here: https://ama.com.au/media/ama-model-protects-vulnerable-patients-co-payment-pain

Cancer Council publishes first Australian guidelines on Barrett's Oesophagus and Oesophageal Adenocarcinoma

Cancer Council Australia has published new clinical guidelines which will help provide greater consistency in the management of one of Australia's fastest growing cancers and its known precursor, Barrett's Oesophagus.

The new clinical guidelines for the *"management and diagnosis of Barrett's Oesophagus and oesophageal adenocarcinoma"* are the first of their kind in Australia and are now available on Cancer Council Australia's cancer guidelines wiki.

Industry leaders are hopeful that they will deliver improved health outcomes for patients and help reduce the treatment costs incurred by the health system.

Cancer Council Australia led the development of the guidelines with Professor David Whiteman chairing the multidisciplinary working party. Professor Whiteman highlights that to provide clear guidelines for doctors, it was important to address oesophageal adenocarcinoma (OAC) and Barrett's Oesophagus together.

"The incidence of oesophageal cancer is increasing and we also know that Barrett's is being diagnosed more frequently," Professor Whiteman said.

"Despite their greatly increased relative risk of cancer, 95% of people with Barrett's never develop OAC and 95% of patients diagnosed with OAC have no preceding diagnosis of Barrett's Oesophagus.

"Up until now there has been clinical uncertainty about the best way to manage Barrett's, both at the individual level and across the population, particularly in the Australian healthcare context."

Professor Whiteman said that addressing the prevention and management of both diseases was particularly important given the low survival rates once cancer had developed.

"Survival from advanced OAC is very poor, hence the focus on diagnosing and treating people with precancerous and early cancerous lesions," he said.

"Previously Australian doctors had to look to international guidelines for advice on how to manage their patients, which may not always apply to our health system. We have systematically reviewed the published evidence to develop recommendations for Australian doctors and patients.

"Simply put, the new guidelines provide helpful advice to identify those patients who need close management, from those who can be reassured.

"Clinicians may also be interested to see our recommendations around endoscopy for high-grade Barrett's lesions, which were previously treated with more invasive surgery. We have also outlined recommendations for patient advice."

Cancer Council Australia

Family doctors – the driving force behind healthy Aussie kids

The Royal Australian College of General Practitioners (RACGP) confirms Australian GPs are the driving force behind healthy Australian children, labelled in a recent study as one of the best sources for detection and management of child health development.

A study into the Government's Healthy Kids Check (HKC) initiative and published in the *Medical Journal of Australia* has shown a very high success rate in the detection and management of child health problems at all stages of development by GPs.

Introduced in 2008, the HKC aims to improve health outcomes for Australian children with a health check conducted at the age of four, before commencing school, to detect any physical health issues, lifestyle risk factors and facilitate early intervention strategies.

The study analysed data from 557 children who undertook a HKC between January 2010 and May 2013 and found that whilst 21 per cent of children had problems detected during the HKC, 19 per cent were detected before and 4 per cent after the check.

RACGP study contributor, Dr Evan Ackermann said the results support the notion that GPs are best placed to monitor the health and development of children through continuous care.

"The 19 per cent of children diagnosed with health concerns prior to Health Care Check is conducted is indicative of the important role GPs play in monitoring childhood development," said Dr Ackermann.

"Opportunistic health checks occurred with children during their normal immunizations, and this is a vital component of the GP based immunization program. Children get the benefit of immunization and continued health surveillance from their GP."

The highest number of health issues were detected in children presenting for their Healthy Kids Check with the most common problems found in speech and language (20%), toileting, hearing and vision (15% each), and behaviour (9%).

"Having a formal process is important to ensure children are healthy and ready for their school years, with the identification of any hearing, speech and language or behavioural issues critical in this regard," said Dr Ackermann.

"We know that general practice is the most effective pillar of the Australian healthcare system and that early identification and management is vital to quality health outcomes for Australian of all ages.

"GPs are ideally placed to monitor the overall health of children, taking into account any family health conditions and any observable changes in normal progression of development.

"Any Government initiative that encourages evidence based health checks is a positive one; however parents are encouraged to visit the same GP on a regular basis to make sure there is an element of surveillance over their development."

The study concluded that GPs are diligent in the detection and management of child health problems and that some of these problems were only detected as a result of the HKC.

The RACGP remains committed to continuously advocating for a 'Healthy Profession. Healthy Australia'.

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VALE

The President, Dr Elizabeth Gallagher, Board members and staff extend their sympathies to the family and friends of colleague and life time AMA member *Dr John Crotty* who died recently.

OFFICE SPACE TO LET

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(backing onto Calvary John James Hospital)
56 metres, ground floor, one car space
$21,000 pa ex GST
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Moruya Medical Centre: ROOMS TO RENT

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This busy practice has 6 general practitioners, nurses and several visiting specialists already attending on a monthly basis.

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