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REGULAR FEATURES

The team at *Australian Medicine* wish all our readers a happy and safe Christmas and New Year. May your mobiles ring only for good reasons. After a short break, the first edition of *Australian Medicine* for 2014 will be published on 20 January. Merry Christmas!

AMA: a new structure for a more nimble advocate

BY AMA PRESIDENT DR STEVE HAMBLETON

"This change to the governance of the AMA will free Federal Council to work responsively to policy issues as they arise, and to anticipate future areas of policy interest"

The AMA has taken its first big step toward modernising its governance structure, with the unanimous endorsement of Federal Council at its most recent meeting of a move towards establishing a smaller governance Board.

The changes will create a more agile structure by separating the governance requirements of running a company from the core policy and advocacy focus of the member organisation.

The Board will be responsible for the management of the company, Australian Medical Association Limited, including its finances and statutory responsibilities, while Federal Council remains the central body which considers, and agrees upon policy on behalf of the members.

Federal Council is made up of representatives nominated by each State and Territory AMA, an area representative elected by the members in five geographic regions across Australia, and a representative from each of the specialty groups (previously called craft groups), the Council of Doctors in Training, the Council of Salaried Doctors, and the Australian Medical Students Association. As such it reflects the diversity of doctor interests across the profession and the country.

The President and Vice President elected at the National Conference in May 2014 will become members of the new Board, together with a nominee from each State and Territory AMA, and a nominee of the Council of Doctors in Training. The qualifying feature of the nominated members of the Board is that they must have the skills and experience to contribute to the governance of the AMA. A nominations committee will be established to develop the skills criteria for Board members.

Federal Council not only unanimously agreed to support the new governance structure, but also unanimously agreed to recommend its adoption by the voting members of the AMA at the 2014 Annual General Meeting, to be held in May in conjunction with the National Conference.

This change to the governance of the AMA will free Federal Council to work responsively to policy issues as they arise, and to anticipate future areas of policy interest.

It provides an opportunity for Federal Council to explore different ways of working apart from the traditional committee system, with small working groups and task forces to draw on the expertise and interest of members of Federal Council, as well as the wider membership of the AMA.

If adopted by the voting members in May, there will be a short transition period from the current structure to the new Board to provide sufficient time for the State and Territory AMAs and the Council of Doctors in Training to seek nominations and appoint a representative who meets the skills and experience criteria. Federal Council has expressed the wish to have the new arrangements in place by the end of July 2014.

This change has been discussed for many years, and it is pleasing to see that agreement has been reached on an appropriate pathway to modernise the way in which the AMA is governed. Further information will be sent to members in coming weeks, including a page on the AMA website which will answers member questions about the process.

TO COMMENT CLICK HERE

Obesity - an AMA Priority

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Obesity is one of the key priorities for the AMA and its Public Health and Child and Youth Health Committee.

It is an increasing problem for our health at all ages, from childhood to old age, as Australia relentlessly climbs international league tables for the overweight and obese.

Essentially, Australia's nutrition policy has failed.

A combination of a Federal system that requires a broad consensus across jurisdictions, governments averse to regulating industry, fear of 'nanny state' accusations, and a food and grocery supply chain and retail industry that seems to view even a voluntary food labelling system with suspicion, makes changing this difficult.

The all-pervasive subtle, and not so subtle, marketing of food is successful. The result is that we buy more, and are surrounded by plenty. Many of the most promoted foods and beverages are energy dense.

Human beings are poorly designed to cope with excessive amounts of these foods in our regular diet. The consequences include weight gain, type 2 diabetes, and an increase in the frequency of certain cancers.

The year 2013 marks 10 years since the World Health Organisation warned that "added sugars should make up no more than 10 per cent of target energy intake".

A can of soft drink contains nine teaspoons or more of added sugar. This is highlighted by the 'Rethink Sugary Drinks' campaign, which AMA supports, which is based on a similar US campaign that has increased awareness of the sugar content of these drinks. New York City Mayor Michael Bloomberg has also played a major role in drawing attention to the contribution of excess energy intake to the United States obesity epidemic.

Less obvious is the added sugar in products such as tomato sauce, salad dressings, and even bread.

Getting information on the amount of sugar, fat, salt and energy in our processed foods generally requires a magnifying glass, so consumers can honestly say their choices are based on taste and cost, in ignorance of nutritional value.

The AMA has been a strong supporter of clear, simple, front-of-packet labelling of processed foods and beverages to inform consumers about the nutritional value of what they consume. This is not a magic bullet in the fight against obesity, but it is one plank in a platform.

The AMA's preference had been for a traffic light system of food labelling but, after this was rejected by Australian governments, we participated in a successful two-year process that has led to the adoption of a five-star rating system - the more stars the better the nutritional content – for front of packet food labelling. The stars will be accompanied by a large font information panel regarding the presence of key ingredients.

In June of this year the Legislative and Governance Forum on Food Regulation, bringing together Australian and New Zealand Ministers responsible for food regulation, formally adopted the star system, and marked packets will begin appearing on shop shelves around mid-2014.

Introduction of food stars is to be accompanied by a program of public education to improve nutritional literacy. Ministers hope that the food and grocery industry will voluntarily adopt the front of package labelling system, but will review the extent of uptake two years after its introduction.

The food star system is not a panacea in the battle against obesity, and it is unrealistic to expect that its first iteration will be perfect. No doubt further refinement will occur over time.

Nevertheless, it is extremely disappointing to hear of some push back against the food star system from some sections of the food and grocery industry. Perhaps they believe a change of Commonwealth government will see less support for the introduction of the food star system. The AMA will oppose any indication from the industry that they are stepping back from the system they were a part of developing.

Even if governments ignore the personal cost of obesity, they cannot ignore the costs to the health budget - and these are so great as to convince governments of all complexions of the need to support all measures that hold the promise of reversing the rising tide of the obesity epidemic in Australia.

Energy intake is just one side of the equation that can lead to overweight and obesity, and the AMA also recognises the benefits of regular exercise. These benefits go beyond energy consumption and extend to many other positive effects on our health, as detailed in our *Position Statement on Physical Activity* (https://ama.com.au/position-statement/physical-activity-2006).

We are also examining potential tools that could assist doctors in providing advice to their patients on maintaining a healthy weight.

Obesity and, particularly, childhood obesity, will remain an AMA priority.

TO COMMENT CLICK HERE

Give Indigenous kids a better start in life: AMA

The AMA has intensified the pressure on the Federal, State and Territory governments to commit to a fresh five-year plan to bridge the health gap between Indigenous Australians and the rest of the community.

Speaking at the launch of the AMA's Indigenous Health Report Card 2012-13, *The Healthy Early Years – Getting the Right Start in Life*, AMA President Dr Steve Hambleton said that although there had been progress in Aboriginal and Torres Strait Islander health in recent years, and there were some notable initiatives that were making a difference, there was much more that needed to be done.

Dr Hambleton said the Report Card highlighted improvements in early childhood as a vital, and potentially transformative, area for concerted action.

The AMA President said care and experiences in the early years of childhood left a lifelong mark, and Indigenous children were much more likely to suffer serious stress and adversity than most other Australians, setting them up for a lifetime of health problems.

"In their early years, children need to be safe, have adequate opportunities for growth and development, and have access to adequate health, child development, and education services," Dr Hambleton said. "Many of our children are missing out, but none more so than Aboriginal and Torres Strait Islander children."

He said there had been "some improvements" in recent years, with an increasing number of Aboriginal and Torres Strait Islander children making a successful transition to healthy adult life.

"But there are still far too many who are being raised in community and family environments that are marked by severe early childhood adversity," he warned, adding "this adversity in early life can affect educational and social functioning in later life, and can increase the risk of chronic illness".

Dr Hambleton with (R to L) Assistant Health Minister Fiona Nash, NACCHO Chairperson Justin Mohamed and AIDA CEO Romlie Mokak at the launch of the *AMA Indigenous Report Card*

Dr Hambleton said the field of epigenetics had shown how early life experiences become 'hard-wired' into the body, leaving a permanent mark.

"Early experiences can influence which of a person's genes are activated and de-activated and, consequently, how the brain and the body develop," he said. "Building and providing stable and healthy life experiences in the early years can help break the cycle of adversity. That is our task and our challenge.

"Robust and properly targeted and sustained investment in healthy early childhood development is one of the keys to breaking the cycle of ill health and premature death among Aboriginal peoples and Torres Strait Islanders."

Assistant Health Minister Fiona Nash, who launched the Report Card, recounted some of the bleak statistics regarding Indigenous health, noting that Aboriginal Australians had lower average birth weights, higher rates of chronic disease and shorter life expectancy than the rest of the community.

"Low birth weight and poor health during early childhood put Aboriginal people at greater risk of a range of health problems and learning difficulties that can continue to impact them throughout their lives," Senator Nash said.

The Minister said Prime Minister Tony Abbott had a "deep personal conviction" to improve the lives of Aboriginal and Torres Strait Islander people, and said the AMA's Report Card was an important resource for policy makers.

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Give Indigenous kids a better start in life: AMA

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"Importantly, the AMA's report doesn't simply outline the challenges; it makes practical recommendations about what can be done and this will contribute to Government planning on Indigenous health," Senator Nash said.

Among the AMA's recommendations are:

- a major expansion of comprehensive maternal and child services;
- the extension of the Australian Nurse Family Partnership Program;
- support for families at risk and action to protect infants and young children from neglect and abuse;
- reduce rates of incarceration among Indigenous people; and
- intensify efforts to keep children at school.

The current COAG National Partnership Agreements on Indigenous Health and on Early Childhood Development are due to expire next year, and Dr Hambleton said the Commonwealth, State and Territory government needed to commit to a new five year deal to make sure progress that had been made was built upon, rather than lost.

He also threw the AMA's weight behind the Abecedarian approach to early childhood development, which emphasises learning games, conversational reading and the use of language in daily life.

"It is being used to great effect at the Central Australian Aboriginal Congress in Alice Springs," Dr Hambleton said. "The AMA believes the Abecedarian approach has a strong track record of success and we urge all governments to have a closer look for possible widespread implementation."

The AMA President said there were several other initiatives and programs underway that were achieving "some incredible things" and should be examined closely by governments looking for ideas for what would work.

Among these were the Darwin Midwifery Group Practice, which uses community-based midwives and telecommunications to support Indigenous women through all stages of their pregnancy, transitional programs for Indigenous children entering school in La Perouse, Wollongong and Echuca, and intensive family support services.

Chair of the National Aboriginal Community Controlled Health Organisation Justin Mohamed, who attended the launch of the Report Card, said successes such as these showed what could be achieved.

"Targeted, resources and carefully planned programs deliver real changes to the lives of Aboriginal young people and their families," Mr Mohamed said. "Well-proven programs implemented during pregnancy and in the early years of life can have remarkable benefits in addressing the disadvantage facing our communities and health service providers every day."

He said that although the Report Card highlighted the "mountains of work still ahead" to close the health gap, "we know that by working together we can truly start to see real change for the next generation."

Adrian Rollins

Progress on Indigenous health – but much more to do

Indigenous adults are cutting out smoking in increasing numbers, but many remain dangerously overweight and suffer significantly higher rates of cardiovascular disease and blood pressure problems compared with the rest of the community.

The latest official survey of Aboriginal and Torres Strait Islander health, prepared by the Australian Bureau of Statistics, shows that although significant progress is being made in convincing Indigenous people to quit smoking, they are more likely than most to suffer from a range of serious mental health problems and physical ailments.

The findings reinforce calls by the AMA, National Aboriginal Community Controlled Health Organisation (NACCHO), and other groups for governments to sustain their efforts to close the health gap between the Indigenous community and the rest of the population.

In an encouraging result for health campaigners, the ABS survey of 13,000 Aboriginal and Torres Strait Islander people, conducted in 2012-13, found that 41 per cent of adults used tobacco on a

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Progress on Indigenous health – but much more to do

...CONTINUED FROM PAGE 5

daily basis, down from 51 per cent in 2002 and 44.6 per cent in 2008.

Just as significant, young Indigenous people are increasingly deciding not to take up the habit at all – the proportion of 15 to 17 year-olds who have never smoked has risen from 61 to 77 per cent.

NACCHO Chair Justin Mohamed said the result showed that "investment in programs to stop Aboriginal and Torres Strait Islander people from smoking is reaping rewards".

But Mr Mohamed added that the Indigenous smoking rate remained more than double that of the broader community, meaning there was no room to slacken the effort to encourage more people to quit the habit or resist taking it up in the first place.

The pressing need for sustained effort is amply clear when looking at other measure of health.

The ABS found that two-thirds of Indigenous adults were overweight or obese (as defined by their body mass index), one-and-a-half times the rate of the general population, while almost a third of Aboriginal and Torres Strait Islander children were overweight or obese.

Linked to this, Indigenous adults were, on average, more sedentary than adults in the broader community, with three out of every five defined as physically inactive.

In keeping with these and similar factors, Aboriginal and Torres Strait Islander adults were three times as likely to have diabetes or high blood sugar levels, one in five had high blood pressure, and 12 per cent had cardiovascular disease – 20 per cent more than the general population.

Inaugural Chair of Indigenous Health at the University of New South Wales,

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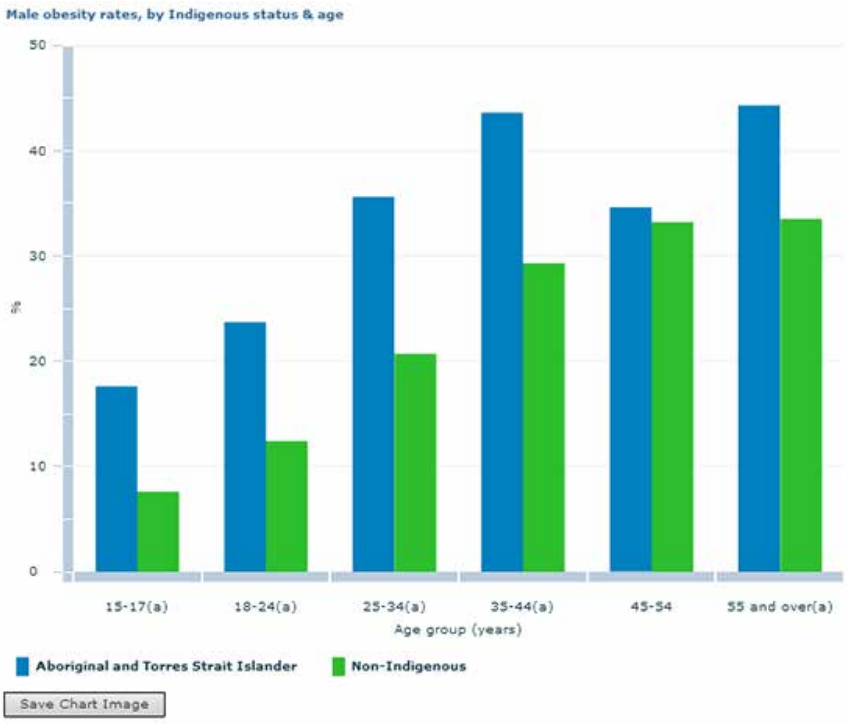

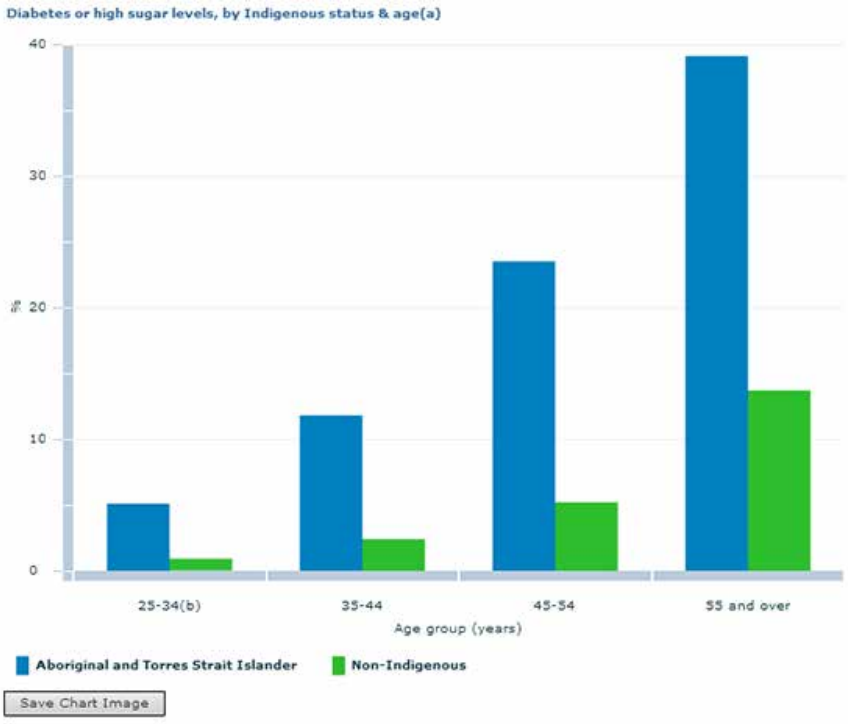

Progress on Indigenous health – but much more to do

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Professor Lisa Jackson Pulver, said that, while the results were concerning, they were not cause for despair.

Writing for the ABC's *The Drum* website, Professor Jackson Pulver said high rates of diabetes and cardiovascular disease in the Indigenous community were the accumulated outcome of a broad range of determinants of health over a significant period of time, and the effect of more recent efforts, such as the Closing the Gap agreements at COAG would take time to be apparent.

"It is too early," she said. "More importantly, the severe disadvantage many of these data reflect reinforces the argument for concerted action and sustained funding over the longer term."

Adrian Rollins

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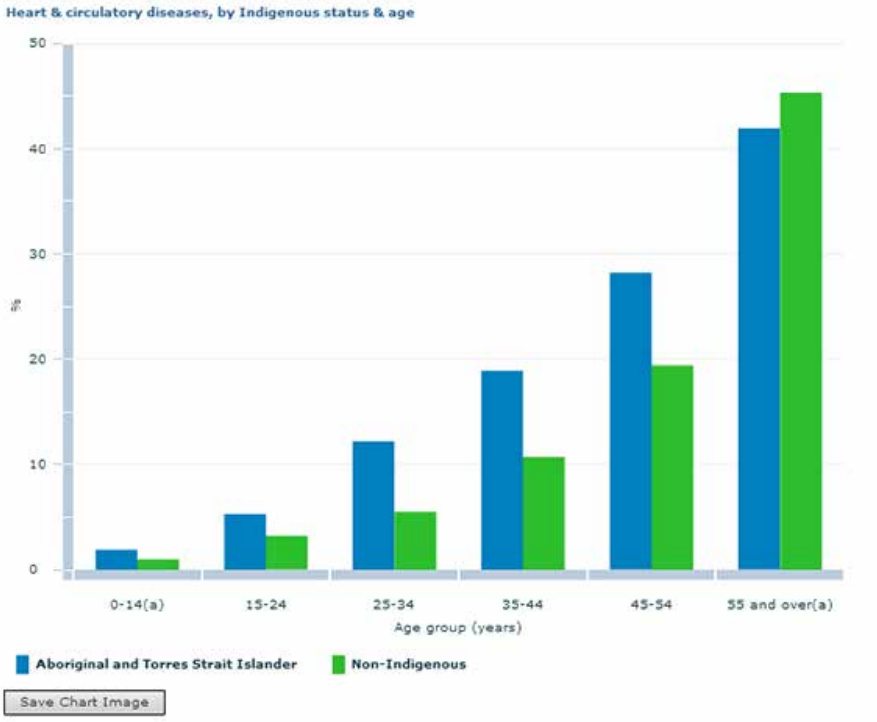

INFORMATION FOR MEMBERS

Christmas a time for hoarding medicines

Could your patients be 'stockpiling' medicines?

The Department of Human Services (DHS) approached the AMA earlier this year seeking advice about how best to discourage patients from this behaviour.

PBS dispensing information suggests stockpiling behaviour happens towards the end of each calendar year. It is likely some patients are 'stockpiling' PBS medicines when they reach their annual PBS Safety Net threshold, so that they reduce their prescription expenses in the following calendar year.

As well as adding unnecessarily to PBS costs, stockpiling is a potential health risk to patients and their families.

DHS originally intended to write to the top 100 PBS prescribers about stockpiling, asking them to examine whether they may be issuing prescription renewals before they are due.

As DHS did not have any information linking high PBS prescribers to patients who stockpile, the AMA advised that a letter from the Australian Government implying that the prescribers were at fault may not address the heart of the problem.

Working together, DHS and the AMA agreed the focus at this time should be on patient education. To that end, DHS has produced a fact sheet that medical practitioners can hand out to patients.

You can now access this patient fact sheet – printed on Australian Government letterhead – on the AMA website at https://ama.com.au/patients-stockpiling-pbs-medicines to support conversations you may have with patients who may be stockpiling.

Conscientious objection not a license to deny treatment

Doctors must always be prepared to provide treatment in emergency situations, regardless of whether or not this might conflict with their personal beliefs and values, the AMA has said, setting a clear boundary on the extent to which practitioners can follow the dictates of their conscience.

But, in a statement of principles to guide conduct, the Association said that "in exceptional circumstances, and as a last resort", doctors may refuse to provide or participate in medical treatments and procedures to which they conscientiously object.

What constitutes a conscientious objection and how it should be applied has become the focus of intense political debate in Victoria, where general practitioner Dr Mark Hobart is under investigation over his refusal to provide a referral for a couple seeking an abortion.

The Medical Board of Victoria is investigating the conduct of Dr Hobart, who has been accused of breaching the State's abortion laws, including a provision requiring that doctors with a conscientious objection to abortion refer their patient to a practitioner with no such objection.

Several anti-abortion Victorian MPs are pushing for the abortion laws to be changed, claiming they force doctors to act against their conscience.

While not addressing the specifics of the Hobart case, the AMA has set out the obligations it believes are incumbent on any practitioner who seeks to exercise their conscience in denying certain forms of treatment.

In a Position Statement released late last month, the AMA said doctors were entitled to personal beliefs and values, like anyone else in the community, and acknowledged that at times these might conflict with peer-based professional practice.

In these circumstances, the Position Statement said, doctors may refuse to provide or participate in (including indirect actions such as providing a referral) treatments and procedures.

But, in the AMA's view, the exercise of such a prerogative was to be heavily qualified to ensure patients were not harmed and their treatment only minimally disrupted, particularly in critical circumstances.

"A doctor should always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with the doctor's personal beliefs and values," the Position Statement said.

The AMA said that any doctor who refused to provide treatment because of a conscientious objection would affect and "potentially disrupt" a patient's access to care.

Because of this, any doctor who with a conscientious objection had an obligation to inform their patients and, where relevant, colleagues, and "not use their objection to impede access to treatments that are legal".

In particular, they should "make every effort in a timely manner to minimise the disruption in the delivery of health care and ensuing burden on colleagues".

In guidance that goes to several of the issues at the centre of the Dr Hobart case, the AMA said a doctor with a conscientious objection was not only obliged to inform a patient of their right to see another doctor, but to "be satisfied the patient has sufficient information to enable them to exercise that right. You need to take whatever steps are necessary to ensure your patient's access to care is not impeded".

In addition, such practitioners should "refrain from expressing your own personal beliefs to your patient in a way that may cause them distress".

At the same time, the Position Statement said, doctors who hold a conscientious objection to certain treatments and procedures should not be treated unfairly or subject to discrimination, and the wishes of patients with conscientious objections should similarly be respected.

In a significant qualification, however, the Association warned that any objection to treatment made on behalf of a patient with impaired capacity, particularly where it was potentially life-saving, warranted "special consideration".

The *Position Statement on Conscientious Objection 2013* can be viewed at: https://ama.com.au/position-statement/conscientious-objection-2013

Adrian Rollins

TO COMMENT CLICK HERE

No political, religious bars to reproductive medicine access: AMA

The AMA has declared that access to reproductive medicine, including family planning services and emergency contraception, should be free of political or religious interference.

As the Victorian Government acted to hose down speculation it would back changes to the State's abortion laws, the AMA issued a statement declaring that doctors with a conscientious objection to abortion could refuse to carry out or assist in such a procedure, but should not act to impede a patient's access to care.

In its *Position Statement on Ethical Issues in Reproductive Medicine 2013*, the Association said all individuals had the right to make their own decision about reproduction and the use of reproductive medicine.

"Access to reproductive medicine should be free from political or religious interference," AMA Vice President Professor Geoffrey Dobb said. "All individuals should be aware of, and have access to, affordable family planning information and services."

The issue has risen to prominence in Victoria recently after GP Mark Hobart refused to provide a referral for a couple seeking an abortion. His conduct is under investigation by the Medical Board of Victoria.

But concerns about a push to curb access to abortion have risen after the Victorian Liberal Party State Council passed a motion to overhaul abortion laws, and renegade balance-of-power MP Geoff Shaw told *The Age* he thought doctors should have a right to follow his or her conscience in not referring women wanting an abortion to a pro-choice doctor.

Victorian Premier Dr Denis Napthine responded unequivocally on the issue in an interview on ABC television.

Dr Napthine said, "As Premier, neither I, nor my Government, have any intention of introducing legislation that would reduce a woman's right to choose.

"This issue was vigorously debated in the community, and settled in the Parliament, in 2008. I have no intention, whatsoever, of introducing, or supporting, legislation that would reduce a woman's right to choose."

In its Position Statement, the AMA said it was "inappropriate" to offer egg, sperm or embryo donors, or surrogates, money or other inducements, though they could be reimbursed for reasonable expenses.

Tackling another ethical dilemma, it said people with impaired capacity should be included in decisions regarding their family planning, "to the extent possible", and doctors should respect the wishes for confidentiality of young people with decision-making capacity.

The Statement emphasised the important role doctors had to play in informing patients about up-to-date family planning options, including the associated risks and benefits.

When discussing options with patients, doctors are advised that sterilisation should be considered an irreversible form of contraception.

The emerging area of genetic screening has raised a range of ethical challenges that are addressed in the revised Position Statement.

The AMA said the use of pre-implantation genetic diagnosis should be restricted to the identification of fatal or seriously and permanently disabling diseases.

"Genetic selection should not be undertaken on the basis of sex (except in order to avoid hereditary sex-linked disease) or on the basis of characteristics or traits that are unrelated to disease," it said.

The Position Statement can be viewed at:

https://ama.com.au/position-statement/ethical-issues-reproductive-medicine-2013

Adrian Rollins

TO COMMENT CLICK HERE

You've got mail: what doctors need to know about using electronic communications in practice

Doctors have been warned to be alert to limitations and risks involved in using information technology to communicate with patients and other practitioners.

The AMA said electronic communications technologies were an increasingly useful tool for doctors, enabling them to conduct consultations with patients unable to attend their practice, and to quickly and efficiently share information and discuss treatments with other physicians.

But it cautioned that medical practitioners needed to be careful in how they used these technologies, to ensure patient privacy was protected, that quality of care was not compromised, and that practitioners did not leave themselves unnecessarily exposed to medico-legal risks.

AMA Vice President Professor Geoffrey Dobb said communication technologies were increasingly being integrated into medical practice, and were potentially a valuable tool.

"Technology-based patient consultations can improve patient access to care and enhance efficiency in medical practice," Professor Dobb said, adding that the ability of doctors to share information electronically could be of great benefit, particularly in coordinating care.

But he said doctors needed to aware of limits to the uses of such technologies, and the risks that they entailed.

"Technology-based patient consultations should complement face-to-face consultations, not replace them," Professor Dobb said. "They should be used as an adjunct to normal medical practice for regular patients of the practice, and they should not be used in a way that fragments the ongoing care of the patient."

Similarly, he warned, doctors needed to be aware of, and manage, the inherent risks involved in receiving and managing large amounts of information electronically.

The AMA has prepared two guides, a *Position Statement on technology-based patient consultations 2013* and a *Position Statement on medical practitioner responsibilities with electronic communication of clinical information 2013* setting out the issues doctors need to consider in using such technologies, as well as practical advice on how to make the most of these tools while minimising the risks involved.

In conducting a consultation via the internet or another form of communications technology, doctors needed to be confident that it is being conducted in a private and secure setting, and that the patient is properly identified, and understands and agrees to the arrangement for electronic-based consultations, including the costs involved.

The AMA said that in setting a fee for such consultations, practices needed to take into account indirect costs, including those involved in providing secure IT infrastructure and data lines, electronic billing arrangements and follow-up services.

In its second Position Statement, the Association warned that the benefits conferred by electronic communications between practitioners came with added risks that can, and should, be managed.

"Secure electronic communication is a priority tool to support doctors coordinating and managing quality care for their patients," Professor Dobb said, but added the transmission of large volumes of data carried with it the danger that important pieces of information may be overlooked or neglected.

"There are inherent risks to doctors of an increased duty of care to patients if they receive large amounts of clinical information electronically, or if they are not aware that they have received certain information electronically," he said.

To help doctors minimise and manage these risks, the AMA has advised doctors sending information to make sure a medical practitioner is identified in the salutation, that the purpose of the transmission is made clear, that only relevant information is attached, that the information is sent directly to a specific practitioner, that only other practitioners involved in the patient's care are included, and that, where the matter is urgent, the transmission is followed by a telephone call.

Doctors receiving information electronically are advised to have a protocol for regularly checking incoming communications, ensure that relevant information is stored with the patient's file, along with a record of any action taken, and that receipt of any urgent communication is confirmed with a phone call.

The *Position Statement on technology-based patient consultations 2013* can be viewed at: https://ama.com.au/position-statement/technology-based-patient-consultations-2013

The *Position Statement on medical practitioner responsibilities with electronic communication of clinical information 2013* can be viewed at: https://ama.com.au/position-statement/medical-practitioner-responsibilities-electronic-communication-clinical

Adrian Rollins

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Risky to rely on foreigners to plug health gaps

Global competition for skilled health workers is intensifying, increasing the urgency of efforts to upgrade the nation's beleaguered medical training system.

The AMA has warned that the country will struggle to meet future health needs unless the Commonwealth, State and Territory governments cooperate in developing a long-term plan that ensures there are sufficient medical students and graduates with access to quality training opportunities to provide necessary care.

In a sobering assessment of the state of the nation's medical training pipeline, the Association said that Government investment had failed to keep pace with growth in demand, leading to mismatches and bottlenecks that were squeezing opportunities for junior doctors and deepening the nation's reliance on an increasingly competitive international market for medical workers to plug workforce gaps.

AMA Vice President Professor Geoffrey Dobb said rapid growth in medical student numbers (from 7746 in 2000 to 16,868 last year) had not been accompanied by an appropriate increase in prevocational and vocational training places, potentially denying many the ability to pursue their training and wasting the large public investment made in their education.

"There is growing pressure on the medical training pipeline, and Health Workforce Australia is projecting that, by 2016, Australia will be facing a shortage of specialist training places unless urgent action is taken," Professor Dobb said. "It takes time to train a high-quality medical workforce – planning for the future must start now."

In its *Position Statement on Medical Workforce and Training 2013*, the AMA said the big expansion in medical schools, which are expected to produce 3830 graduates a year by 2017, provided a "tremendous opportunity" to address concerns about future shortages of medical practitioners and their maldistribution, and to reduce the nation's reliance on International Medical Graduates to fill workforce gaps.

But Professor Dobb warned that, to take advantage of this chance, the Commonwealth, State and Territory governments had to jointly develop a national training plan to ensure sufficient practitioners to meet future need.

The AMA said the plan needed to be supported by accurate data and robust projections, be driven by community need, have adequate funding, be underpinned by the principle of self-sufficiency and be linked to global medical workforce trends.

As a start, the Association said it was essential that there be sufficient prevocational and vocational training places for all locally-trained domestic and international medical students.

To help address medical workforce shortages in rural areas, the Position Statement said the plan should be guided by evidence of what worked, including improved financial incentives, increased training opportunities in rural areas, and voluntary return-of-service obligations. It warned that bonded places did not deliver a sustained increase, and tended to stigmatise rural medicine.

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Risky to rely on foreigners to plug health gaps

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The AMA suggested there be improvements in the structure of training programs, including better integration between prevocational and vocational training. This could entail revised entry requirements and prerequisites for vocational positions.

But it warned that efficiency improvements alone could not deliver the increase in places needed, and the Commonwealth needed to ensure it provided adequate funding.

"[There is an] urgent need for further investment in primary medical education as a result of significant underfunding by the Commonwealth government," the AMA said. "This has led to the uncoupling of international medical student enrolments from community need and an increasing divergence between medical graduate numbers and the number of available prevocational and vocational training posts."

The Association said there should be no increase in full-fee paying places to try and address the looming shortfalls.

Instead, Professor Dobb said, the Commonwealth, State and Territory governments needed to reach agreement on:

- the number of medical school, intern, prevocational and specialist medical training places needed, based on Health Workforce Australia (HWA) analysis;
- the financial contribution each government would make;
- robust benchmarks to measure progress toward providing sufficient training places; and
- the development, in consultation with the profession, of performance benchmarks to ensure quality standards were maintained.

In its Position Statement, the AMA has also backed Health Workforce Australia, amid concerns the agency may be abolished as part of the Abbott Government's cost-cutting drive.

The AMA said HWA was making a valuable contribution to improved medical workforce planning and training, and needed to continue its work.

The Association warned that Australian governments needed to get the training planning right if the nation was to ensure its medical workforce was adequate to meet future need.

"There is currently a worldwide shortage of health professionals," the AMA said. "Chronic deficiencies in skilled labour can seriously impact the strength and sustainability of health systems. There is a strong imperative for Australia to develop a self-sufficient health workforce".

The *Position Statement on Medical Workforce and Training 2013* can be viewed at:

https://ama.com.au/position-statement/medical-workforce-and-training-2013

Adrian Rollins

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

The AMA has developed a free online tool to help doctors to keep track of the information they need to meet the Medical Board of Australia's annual continuing professional development CPD requirements.

Each September, practitioners, when renewing their Medical Board registration, may be required to provide evidence they have complied with the Board's CPD requirements.

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;
- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and perfomance appraisals; and
- Log hours spent on online learning, reading journals, teaching and other activities.

The system keeps a tally of hours, enabling practitioners to keep track of what needs to be completed before the end of the registration year.

The Tracker has been developed taking full account of the requirements set out in the Medical Board's Continuing Professional Development Registration Standard.

The service is free to AMA members. Non-members can subscribe for an annual fee of $250.

To register for the product, please sign up here.

App puts vaccination evidence at fingertips

Authoritative and up-to-date information about vaccination is now available at the tap of a touch screen after the AMA and the Australian Academy of Science jointly launched the Science Q&A app.

The app, developed as a companion to the highly successful information booklet *The Science of Immunisation*, gives parents and other users access to the latest scientific evidence regarding vaccination in clear, straightforward language.

AMA President Dr Steve Hambleton, who launched the app along with Academy President Dr Suzanne Cory and world-renowned immunologist Professor Sir Gustav Nossal, said it would help parents make informed decisions about immunising their children by giving them access to quality scientific evidence.

"It is an important new resource that will help dispel the non-scientific myths and misinformation circulated by anti-vaccination groups in the community," Dr Hambleton said. "The app features strong scientific evidence, clear explanations, and easy-to-understand language that will reassure people, including conscientious objectors, about the safety and efficacy of immunisation."

The AMA and the Academy have been at the forefront of efforts to bolster immunisation rates amid evidence of an alarming decline in protection against potentially deadly diseases such as measles and whooping cough in some areas.

Figures released earlier this year showed that vaccination rates among young children in parts of the country, particularly northern New South Wales and south-east Queensland, have slipped as low as 81.1 per cent – well below the level considered necessary to ensure a level of 'herd immunity'.

The decline in vaccination rates has been attributed, in part, to the spread of misleading and irresponsible claims by anti-vaccination campaigners.

But, in a setback for opponents of immunisation, a New South Wales tribunal last month ordered the so-called Australian Vaccination Network to change its name to more accurately reflect its anti-vaccination stance.

The importance of vaccination has been further reinforced by the Commonwealth, which introduced new rules in August requiring that parents ensure their children are fully immunised, or have an approved exemption, in order to be eligible for Family Tax Benefit Part A supplement.

Dr Hambleton said vaccination had worked to make many serious life-threatening diseases rare, but there was a risk of devastating outbreaks if immunisation levels were allowed to slip.

The AMA President said parents concerned about vaccines should feel free to discuss their fears with the family doctor, and the app provided an additional source of useful and credible information.

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INFORMATION FOR MEMBERS

Changes to veteran health care payment arrangements

Health care subsidy arrangements for defence force veterans injured or who suffered diseases in the course of their service before mid-2004 are being changed.

The Department of Veterans Affairs (DVA) has announced that veterans currently eligible for benefits under the terms of the Safety, Rehabilitation and Compensation Act 1988 (SRCA) will, from early December, no longer have to seek reimbursement from the Department for care costs.

From 10 December, SRCA clients will be subject to normal DVA treatment card arrangements, including the use of the DVA benefits schedule.

The DVA's Principal Medical Adviser Dr Graeme Killer admitted that the change would in some cases result in lower payments to providers.

But Dr Killer said both providers and their patients would benefit from a smoother, faster, and more convenient and consistent payments process.

"Currently, payment for the treatment of SRCA clients is processed through reimbursement arrangements, with an administrative burden for both clients and providers," he said. "This involves seeking prior approval from the DVA for most services, before sending invoices in to either be paid to the treating provider, or as a reimbursement to clients for payments they have made."

Dr Killer said bringing the assessment and processing of payments for SRCA patients in line with those of the broader veteran community would benefit all.

"It is understood that in some situations the use of the DVA schedule will result in a lesser payment to providers," he said. "However, using the card will benefit providers, as there will be greater consistency across procedures when dealing with [the] DVA, faster turnaround in payment for services, and reduction in administrative burden on practices."

Work needed to smooth path of patients in and out of hospital

Lives could be put at risk unless there is increased support for GPs and hospital staff in organising the transfer of patients into and out of hospital, the AMA has warned.

The AMA said hospital readmissions were reduced and adverse events minimised when effective arrangements were in place to make the movement of patients to and from hospital as seamless as possible.

AMA President Dr Steve Hambleton said that patients were increasingly relying on GPs to coordinate their care, particularly when it involved admission to hospital.

Dr Hambleton said that, in order to provide the best possible care, doctors and hospitals needed to ensure there was good communication between them, so that patients received consistent and continuous care.

"When best practice transfer of care arrangements between GPs and hospitals are in place, and adhered to, hospital readmissions are reduced, adverse events are minimised, and patients and care providers have a more satisfactory and positive experience," he said.

The AMA Council of General Practice has developed a Position Statement on *General Practice/Hospitals Transfer of Care Arrangements 2013* which details the steps GPs, hospitals, governments and other organisations should take to ensure that the experience of patients moving into and out of acute or sub-acute care was virtually seamless.

"Continuity is a key tenet of quality care," the Position Statement said.

It advised that when a GP initiates referral to a hospital, he or she had a responsibility to provide comprehensive and legible referral letters containing up-to-date summaries and sufficient information to enable the appropriate assessment

of management of the patient while in hospital.

This should include the main presenting problem and past interventions; other medical conditions and treatments that might have a bearing on hospital care; details of medications; the results of recent investigations; and family and social circumstances.

The Position Statement said GPs should also contact the hospital to get progress reports on their patient, and to anticipate when they might need a post-discharge appointment.

For their part, hospitals needed to ensure that referring GPs were promptly notified of an unanticipated treatments, or where the patient required urgent follow-up care upon discharge.

In addition, the Position Statement said, hospitals needed to ensure comprehensive and accurate summaries - including details of all treatments and medications provided and the results of all tests conducted - were given to the referring GP within 24 hours of discharge, and that the patient had sufficient medication to last until the first post-discharge appointment with their doctor.

The AMA said organisations such as the Local Hospital Networks (LHNs) and Medicare Locals (MLs) should support good transfer or care arrangements.

It said MLs had been set up, in part, to ensure the primary health care services and hospitals worked effectively together, and more needed to be done to build "collaborative pathways" for the transfer of care.

"While some MLs [and] LHNs have commenced work on improving care pathways across various parts of the health system in their areas, this is not happening consistently across Australia, and there is scope for this to be applied across the country," the Position Statement said.

The role and function of Medicare Locals is currently under review by the Abbott Government, and the Australia Medicare Local Alliance seized on the AMA's comments as recognition of the value of its member organisations.

...CONTINUED ON PAGE 16

Work needed to smooth path of patients in and out of hospital

...CONTINUED FROM PAGE 15

"This is coordination at its best from a quality of care, efficiency and productivity point of view, and increasingly, as the relationships and partnerships between LHNs and MLs develop, communities will receive real health benefits from improvements in the patient journey," AML Alliance Chair Dr Arn Sprogis said.

"We also agree there is an urgent need to explore a nationally consistent approach to care pathways between LHNs and MLs, and that there is enough flexibility to ensure care pathways are suitable for local circumstances."

The AMA suggested another health initiative of the former Government currently under review, the Personally Controlled Electronic Health Record System, had the potential to improve transfer of care arrangements.

"A well-developed and clinician-friendly e-health system would go a long way to improving the communication between the various parts of the health system," the Position Statement said.

However, it reinforced concerns that, in its present format, the clinical usefulness of the PCEHR had been undermined by the emphasis on personal control.

"It is paramount that the content of e-health records is accurate, reliable and meets clinical needs, otherwise the e-health records will not be used, and potential benefits from a well-developed system will be lost," the Statement said. "To this end, e-health records must be restructured to engender trust."

Dr Hambleton is part of a three-member panel appointed by the Abbott Government to review the PCEHR and recommend changes to improve its clinical usefulness and adoption by both medical practitioners and patients.

The AMA said the Government also needed to revise the Medicare Benefits Schedule fee structure to provide better support for quality transfer of care arrangements.

It said there needed to be recognition of the time and effort GPs and other practitioners had to devote to organising and coordinating transfers of care, and hospitals had to give their staff sufficient time to produce high quality and timely discharge summaries.

It also recommended that GPs be represented on hospital management committees to ensure the issues and concerns of general practitioners were presented and addressed.

The Position Statement can be viewed at:

https://ama.com.au/position-statement/general-practicehospitals-transfer-care-arrangements-2013

Adrian Rollins

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INFORMATION FOR MEMBERS

What to consider before ditching Warfarin

A guide to help GPs decide whether a patient currently taking Warfarin needs to be switched to another oral anticoagulant has been produced by the Department of Veterans' Affairs.

The guide, *The oral anticoagulant dilemma*, talks practitioners through the issues to consider when assessing whether a patient currently using Warfarin would benefit from being placed on one of three novel oral anticoagulants – Dabigatran, Apixaban and Rivaroxaban – listed on the Pharmaceutical Benefits Schedule.

The guide, prepared as part of the Department's *Veterans MATES* project, has been sent to 7100 GPs who, according to Repatriation Pharmaceutical Benefits Scheme data, treat patients taking oral anticoagulants.

The brochure cautions that patients on warfarin should not be changed onto another oral anticoagulant without careful consideration.

"We need to be careful that marketing promotion and familiarisation programs do not drive a needless trend to switch patients currently taking Warfarin to the new agents for perceived ease of use or claims of superior safety or efficacy," the guide says. "An informed decision and careful patients selection is recommended when considering treatment options, as many patients may not benefit from switching to the new agents."

A companion guide for patients, *New medicines: weighing up the benefits and risks*, will be distributed next month to veteran patients who had been dispensed at least two oral anticoagulant prescriptions between April and July the year.

For more information, including other topics covered by the *Veterans MATES* project, visit: www.veteransmates.net.au

Trade agreement a 'surgical strike' against public health

"... Trade Minister Andrew Robb insisted the Government would not compromise the health care regime or the Pharmaceutical Benefits Scheme in its negotiations"

The AMA has urged the Federal Government to shield the Pharmaceutical Benefits Scheme and public health policy from restrictive trade rules amid fears the United States is pushing for an agreement that would force up the cost of medicine and curb health measures like tobacco plain packaging.

As the final round of talks on the controversial Trans Pacific Partnership (TPP) treaty for the year wrapped up in Singapore last week without resolution, the AMA called for the Government to hold firm against any attempts to impede access to cheaper medicines or hamper public health initiatives.

AMA Vice President Professor Geoffrey Dobb said it was vital that the TPP did not interfere with the operation of the PBS or limit the right of Australian governments to make laws in important areas of public health policy.

There has been mounting concern that the Australian Government was giving ground in the face of strident United States demands for an extension of intellectual property rights for patent holders and provisions allowing corporations to challenge government decisions, including public health policies.

The negotiations for the agreement, encompassing 12 countries on the Pacific rim, including the US, Australia, New Zealand, Canada, Japan, Vietnam and Singapore, are being conducted behind closed doors, but leaked information indicates the US has been pushing hard for increased intellectual property protections, including extending patent law to cover plants, animals and medical procedures, provisions making it easier to "ever-green" patents, and laws to lock up clinical data for biological medical products for 12 years.

In addition, the US has proposed investor-state dispute settlement provisions that it is feared would enable corporations to challenge public health measures such as the imposition of plain packaging laws for tobacco products.

Professor Dobb urged the Australian Government to refuse any provisions that would encroach on national health policy.

"The Government must insist that trade agreements, including the TPP, do not extend the intellectual property rights of patent holders, interfere with the operation of the PBS, or provide foreign corporations with investor-state dispute settlement rights to challenge domestic public health policies," he said.

Documents released by website Wikileaks last week appeared to lend substance to the AMA's concerns, indicating that although Australian negotiators had rejected two US demands regarding pharmaceuticals - to protect clinical data for 12 years and to extend patents where there had been regulatory delays in approval – they were one of the few to accede to the US calls for a medicines annex to the TPP.

But Trade Minister Andrew Robb insisted the Government would not compromise the health care regime or the Pharmaceutical Benefits Scheme in its negotiations.

"There has been a lot of quite ill-informed commentary and speculation regarding our negotiating positions," Mr Robb told *The Australian*. "We have repeatedly said that we will not entertain anything that compromises the integrity of our health system or PBS. The mandate provided . . . by Cabinet is very clear on this."

Intellectual property expert Matthew Rimmer, of Australian National University, warned in *The Conversation* that the terms of the TPP were a "matter of life and death: it will affect access to life-saving medicines, drugs and treatments in developed and developing countries across the Pacific".

Associate Professor Rimmer and his colleague Alexandra Phelan warned that "the US and its allies have proposed measures that would raise prices and reduce competition".

"The TPP is a surgical strike against public health."

Medical charity Medicins Sans Frontieres said the US Government seemed "determined to give pharmaceutical companies more power to raise the cost of medicines for millions of people around the world, while curtailing the power of governments to protect public health".

The Obama Administration had set a deadline to complete negotiations on the pact by the end of this month, but the failure of the latest round of talks, held in Singapore last week, means that negotiations will continue into 2014. The next round is due to commence next month.

Adrian Rollins

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Wise to heed doctor advice: AMA

Patients have been urged to heed their doctor's advice to undertake tests, treatments, referrals and follow-up appointments.

In the face of concerns that some patients are putting their health at risk by ignoring recommendations for further tests, to see a specialists or to make a follow-up appointment, the AMA has issued a Position Statement outlining the responsibilities of both doctors and patients in providing care.

AMA Vice President Professor Geoffrey Dobb said doctors needed to have systems in place to ensure that any referrals for pathology tests, radiology procedures, and other diagnostic tests were properly initiated and acted upon, and that the results were conveyed in a timely manner.

Professor Dobb said these systems, including mechanisms for effective follow-up, recall and reminders, were vital for the provision of high-quality care.

But he said patients also had a role to play.

"While doctors have a duty of care to their patients, patients are encouraged to actively participate in their own health care," Professor Dobb said. "They must be honest with their doctor regarding their own health, make informed health care decisions, and undertake recommended treatments, tests, referrals, follow-up appointments and reminder appointments."

The AMA said that, of course, patients had the right to decline to follow their doctor's advice, but they should do so fully informed of the possible consequences of their decision.

In its *Position Statement on Patient Follow-Up, Recall, and Reminder Systems 2013*, the Association said a patient's informed choice should be respected, but added doctors should advise patients of the benefits and risks of not undertaking a recommended test or following up a referral.

"Where a patient indicates they do not intend to comply with the doctor's recommendation, the doctor should record the discussion in the patient's medical record, including the reasons given by the patients, if any, for not following the advice," it said.

Additionally, doctors should make "a reasonable attempt" to contact patients who have had a clinically significant test result or diagnosis, but have not attended a follow-up appointment.

The Position Statement said how substantial these efforts should be depended on judgements about the seriousness of the medical condition, the risk of delay in receiving treatment, and the significance or abnormality of any tests or reports.

Professor Dobb said that though the informed decisions of patients should be respected, this meant they also carried responsibility for the consequences of their decision.

"While patients have the right not to attend recommended tests, referrals, follow-up, or recall appointments, with this right comes the responsibility for the consequences of that properly informed decision to follow or reject their doctor's advice," he said.

Professor Dobb added that medical facilities, including hospitals and medical practices, "should support patients, doctors, and other health care professionals by having effective and accountable systems for patient follow-up, recall, and reminders".

The Position Statement can be viewed at:

https://ama.com.au/position-statement/patient-follow-recall-and-reminder-systems-2013

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

AMA IN THE NEWS

Your AMA has been active on policy and in the media on a range of issues crucial to making our health system better. Below is a snapshot of recent media coverage.

Print/Online

Forum bid to calm drug fear, *Hobart Mercury*, 30 November 2013

A public forum next week aims to allay fears about the safety of widely used heart medications. AMA President Dr Steve Hambleton said people taking the drugs under national guidelines should stay on them because they reduced the risk of death, heart attack or stroke.

Shaw is right and wrong on abortion laws, *Herald Sun*, 3 December 2013

The AMA has released national guidelines on doctors' personal beliefs, including a clause that doctors must take whatever steps are necessary to ensure a patient's access to care is not impeded.

Alarm as patients quit drug regimen, *Herald Sun*, 3 December 2013

The fallout from the ABC's controversial *Catalyst* program on anti-cholesterol drugs is gathering momentum. The AMA has branded the program sensationalist and the chair of the Australian Advisory Committee on the Safety of Medicines asked the ABC to halt the broadcast of part two of the program.

An unhealthy attitude, *Hobart Mercury*, 4 December 2013

Cancer tops our list of health worries, followed by heart disease. Chair of the AMA Council of General Practice Dr Brian Morton said there was a "brain disconnect" between disease and our personal responsibility to reduce our risk.

AMA call for Bali warning brochure, *The Australian*, 4 December 2013

The AMA and the parents of an Australian who died from methanol poisoning in Lombok want the Federal Government to place warning brochures about bootlegged drinks on flights to Indonesia.

Look beneath the surface on Indigenous health, *Crikey*, 10 December 2013

The Australian Medical Association's annual Indigenous Health Report Card has been released and details a number of promising developments, as well as outlining an ambitious strategy to accelerate the pace of improvement, particularly in early childhood.

Radio

Dr Steve Hambleton, Radio National Canberra, 10 December 2013

AMA President Dr Steve Hambleton discussed the new AMA *Indigenous Health Report Card,* which he launch in conjunction with Assistant Health Minister Fiona Nash. Dr Hambleton said adversity in childhood can increase the risk of chronic disease later in life.

TV

Dr Steve Hambleton, Channel 7 Brisbane, 28 November 2013

Doctors are being asked by the Queensland Government to dob in ageing drivers they believe are unfit to drive. AMA President Dr Steve Hambleton said GPs should not be expected to act as state medical police.

Professor Geoffrey Dobb, ABC News 24 Sydney, 8 December 2013

AMA Vice President Professor Geoffrey Dobb discussed a Federal Government-backed 24-hour health hotline. He said there were other, more productive methods to deliver quality health care.

Dr Steve Hambleton, ABC News 24 Sydney, 10 December 2013

The AMA released a report on the health of Indigenous Australians. The report has been launched in Canberra by AMA President Dr Steve Hambleton and Federal Assistant Minister for Health Fiona Nash.

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AMA in action

It has been a busy final few weeks of the year for AMA officials, with the launch of several major reports and Position Statements, not least the AMA's annual Indigenous Health Report Card, as well as some major developments in health policy.

AMA Vice President Professor Geoffrey Dobb appeared on ABC television to discuss technology-based patient consultations and emergency telephone lines, and also addressed the media regarding the rights of responsibilities of doctors with conscientious objections to certain treatments. Professor Dobb also voiced AMA concerns that the terms of the Trans Pacific Partnership trade agreement could include terms that force up the cost of medicines and curb the ability of governments to act in the interests of public health.

AMA President Dr Steve Hambleton attended the release of the *AMA Indigenous Report Card 2012-13*, which was officially launched by Assistant Health Minister Fiona Nash at Parliament House. The launch was also attended by Chair of the National Aboriginal Community Controlled Health Organisation Justin Mohamed, and Australian Indigenous Doctors' Association Chief Executive Office Romlie Mokak. While in Canberra, Dr Hambleton hosted the final AMA Executive Council meeting of the year, and met with National E-Health Transition Authority Chief Executive Officer Peter Fleming and Secretary of Department of Health Jane Halton.

Late last week Dr Hambleton flew to Melbourne, where he helped Australian Academy of Science President Professor Suzanne Cory and renowned immunologist Professor Sir Gustav Nossal launch an app presenting the latest scientific evidence on vaccines to help parents make informed choices about immunisation.

AMA NSW President Professor Brian Owler, while in Canberra for the AMA Executive Council meeting, met with Assistant Minister for Infrastructure and Regional Development Jamie Briggs to discuss road safety and opportunities for closer collaboration to reduce the nation's road toll.

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AMA NSW President Professor Brian Owler with Assistant Minister for Infrastructure and Regional Development Jamie Briggs

Dr Hambleton with (R to L) Assistant Health Minister Fiona Nash, NACCHO Chairperson Justin Mohamed and AIDA CEO Romlie Mokak at the launch of the *AMA Indigenous Report Card*

AMA in action

AMA Executive Dr Stephen Parnis, Professor Brian Owlder, Dr Iain Dunlop, Dr Hambleton, Dr Liz Feeney and Professor Geoffrey Dobb

Dr Hambleton at the Prime Minister's Christmas Party with Deputy Prime Minister Julie Bishop

Dr Hambleton at the launch of the *AMA Indigenous Report Card*

AMA in action

NACCHO Chairperson Justin Mohamed at the launch of the *AMA Indigenous Report Card*

AIDA CEO Romlie Mokak at the launch of the *AMA Indigenous Report Card*

Dr Hambleton with Assistant Health Minister Fiona Nash

Dr Hambleton with Health Minister Peter Dutton and RACGP President Dr Liz Marles

Dr Hambleton with Secretary of Department of Health Jane Halton and RACGP President Dr Liz Marles

Your AMA Federal Council at work

What AMA Federal Councillors and other AMA Members have been doing to advance your interests in the past month

Name	Position on council	Activity/Meeting	Date
Dr Chris Moy	AMA Member	PCEHR pathology & diagnostic imaging workshops	9/12/2013
Dr Richard Kidd	AMA QLD Representative	PCEHR pathology & diagnostic imaging workshops	9/12/2013
		Gateway Advisory group	2/12/2013
		Home Medicines Review research project advisory panel	11/11/2013
		PCEHR diagnostic imaging workshop	30/10/2013
Professor Geoff Dobb	AMA Vice President	Therapeutic Goods Association meeting on medicine shortages	9/12/2013
Dr Gino Pecoraro	AMA Federal Councillor	TGA Codes of Conduct Advisory Group	3/12/2013
		MSAC Review Consultation Committee for Vulvoplasty	27/11/2013
Dr Roderick McCrae	AMA Member	ACHS Council meeting and AGM	28/11/2013
Dr Steve Hambleton	AMA President	NeHTA eMedication Management Governance Group	27/11/2013
		Professional Services Review Advisory Committee Meeting	26/11/2013
		Therapeutic Goods Association executive meeting	12/11/2013
		MBS Safety, Quality and Sustainability Forum	12/11/2013
Dr Iain Dunlop	AMA Chairman of Federal Council	Professional Services Review Advisory Committee Meeting	26/11/2013
		Health Technology Assessment Consultative Committee	12/11/2013
Dr Brian Morton	AMA Chairman of General Practice	Professional Services Review Advisory Committee Meeting	26/11/2013
Dr David Rivett	AMA Member	IHPA Small Rural Hospitals Working Group	25/11/2013
Dr Ian Pryor	AMA Member	MSAC Review Consultation Committee for Botox Injections	25/11/2013
Dr Brian Owler	AMA NSW President	Patient alert and recall protocol for high risk implantable devices meeting	18/11/2013
Dr Bruce Love	AMA Member	Council of Standards Australia Ltd Annual Meeting	15/11/2013
Dr Michael Levick	AMA Member	PCEHR pathology workshop	29/10/2013
Dr Lawrie Bott	AMA Member	PCEHR pathology workshop	29/10/2013

TO COMMENT CLICK HERE

Thousands more heart attacks predicted because of *Catalyst*

There could be an extra 3000 heart attacks and strokes in the next five years as a result of controversial claims regarding cholesterol and statins in the ABC's *Catalyst* program, according to the Heart Foundation.

In a result it said was "frightening", the Foundation found that almost one in 10 people it surveyed who were on cholesterol-lowering medication reported that they had stopped taking statins as a direct result of watching or hearing about the program.

The finding underlines fears that claims made in the show regarding the danger posed by high cholesterol and the doubts it cast over the efficacy of statins could put lives at risk.

Doctors have reported being inundated with inquiries from patients currently taking statins following the *Catalyst* broadcast, and the ABC's own medical expert Dr Norman Swan blasted the show, warning that "people will die as a result…unless people understand at heart what the issues are".

The Heart Foundation survey of 1094 people on cholesterol-lowering prescriptions, conducted last month, found that the ABC program had caused many taking statins to be confused or anxious about their medication.

Almost 30 per cent said they were initially confused, worried or scared they were taking unnecessary medication after watching the program, a quarter said they had seen their GP about their prescription since the program was aired, and more than a fifth had changed their pill-taking regime, either cutting out statins altogether, reducing the number they take, or stopping and then restarting their use.

Disturbingly, a quarter of those who have changed their use of statins as a result of the show have previously suffered a heart attack or stroke and are considered to be at high risk of a repeat episode.

The Foundation's National Director of Cardiovascular Health Dr Robert Grenfell said the *Catalyst* program had created a lot of confusion and uncertainty about taking statins, and thousands of lives had potentially been put at risk as a result.

"If we look at these survey results as being representative of the whole population, there are potentially 55,000 Australians who have stopped their medication as a direct result of the show," Dr Grenfell said.

"Around 40 per cent of people who completely stopped their medication have either had a heart attack or stroke, have heart disease, or have two risk factors – high blood pressure and diabetes.

"The frightening reality is, if many of these people stay off their medication, we could potentially be looking at as many as 2000 or more heart attacks and strokes over the next five years, and that's a very conservative estimate."

Underlining the reach of the program, the survey indicated that about one in three of the 2.1 million Australians taking lipid modifying medication (about 650,000 people) had either watched the *Catalyst* program, or had read or heard about it.

The Foundation estimated that about 150,000 patients taking statins had seen their GP about their medication as a result of the program, and 130,000 had altered their regime, including around 40,000 who had stopped taking their pills altogether, 45,000 who had stopped and then restarted, and thousands more who had reduced their intake.

Medical studies have shown that taking statins can reduce the risk of heart attack by 30 per cent in people at elevated risk.

Dr Grenfell said it was encouraging that a significant proportion had seen their doctor to talk about their medication, rather than just change it themselves.

The producers of the program have come under intense criticism for presenting only a narrow view of the debates, discussions and research about cholesterol and statins in the global medical community, and for failing to disclose the commercial interests of several people cited on the program who are marketing "alternative" products.

The ABC's Audience and Consumer Affairs Unit is reviewing about 80 complaints made about the program, and is expected to announce its findings before Christmas.

Since hearing, reading about or watching the Catalyst program "Heart of the Matter", have you:

Stopped taking your cholesterol medication	9 per cent
Stopped but then restarted taking your cholesterol medication	9 per cent
Reduced the number of cholesterol medications you were taking	4 per cent
Started taking natural remedies	10 per cent

Adrian Rollins

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Govt injects new life into diabetes battle

One of the world's leading authorities on diabetes and obesity has been appointed to advise the Abbott Government on the development of a National Diabetes Strategy.

Founder and Director of the Baker IDI Heart and Diabetes Institute, Professor Paul Zimmet, together with former Howard Government Minister Judi Moylan, will Chair an expert Advisory Group to assist the Government in the development of policies to help tackle one of the nation's most pressing health issues.

Health Minister Peter Dutton said the Strategy, which was a Coalition election commitment, would look at more targeted use of existing funding for diabetes prevention and management.

Announcement of the Strategy adds to doubts about the future of the Australian National Preventive Health Agency (ANPHA), at least in its current form, as the Government looks to hold health spending down and redirect funds to new priorities.

Mr Dutton said the Government considered it crucial to tackle diabetes.

"More than four per cent of the population have a diagnosed diabetes condition, and a further one per cent have diabetes and don't know it," Mr Dutton said. "This is why the Government is taking steps to develop a national strategy."

The Health Minister said diabetes interacts with and influences other chronic diseases, and "many of these diseases and associated complications can be prevented by targeting shared risk factors such as obesity".

"It is important that doctors and other health professionals are supported by a system that enables them to provide patients with best practice treatment and management of diseases like diabetes."

Consultancy Access Economics in a 2008 report estimated that obesity and related health issues cost the country $58 billion a year.

The Strategy's announcement comes three years after the previous Labor Government unveiled its response to a report from the National Preventative Health Taskforce, which included the creation of ANPHA.

Professor Zimmet, who was a member of the Taskforce, was critical of the Labor Government's approach.

In an article published by *The Conversation* (http://theconversation.com/simple-answers-to-the-obesity-epidemic-block-solutions-7317), Professor Zimmet said obesity and diabetes needed to be tackled as a single issue, and warned that together they were shaping as "the biggest chronic disease epidemic in human history".

But he said that so far governments, and the broader public, had failed to come to grips with the complex nature of the problem, and instead tended to reduce it to the failure of individuals to control their behaviour.

Professor Zimmet said the people and governments tended to think obesity (and associated type 2 diabetes) was the result of slothful and sedentary lifestyles.

He said this view was useful for governments, because it allowed them to devolve most of the responsibility for action to address the problem onto individuals.

But the reality was that the causes of obesity and diabetes were much more complex than this, with such research as had been done indicating that there was a significant biological component.

Professor Zimmet said research in the field was still in its early days, and needed to be significantly enhanced.

Ms Moylan, who resigned from politics at the last Federal election, was a founding member of the Parliamentary Diabetes Support Group, which was established in 2000.

Adrian Rollins

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INFORMATION FOR MEMBERS

Foetal alcohol syndrome

A 20 minute documentary highlighting the dangers of drinking during pregnancy has been produced for public distribution by a Townsville-based charity.

The video, simply titled *Foetal Alcohol Syndrome*, has been produced by the Townsville Hospital Foundation to raise awareness of the dangers of drinking alcohol during pregnancy, including in the Indigenous community.

The DVD, which was produced in collaboration with Townsville Hospital's former Director of Neonatal Intensive Care Dr John Whitehall, provides a compelling insight into the tragic and devastating effects of foetal alcohol syndrome on children, their parents and the broader community.

It includes confronting real-life accounts of the lives of those living with foetal alcohol syndrome, as well as interviews with their mothers and information from doctors and other health professionals.

It is primarily targeted at teenagers and young mothers, and aims to drive home the message that expectant mothers should not drink during pregnancy.

Foundation Chairman Judge Stuart Durward said the DVD was a "very significant" public health information resource aimed at building awareness about foetal alcohol syndrome and changing attitudes and behaviour regarding drinking during pregnancy.

"Our strongest message is that foetal alcohol syndrome and its effects are 100 per cent preventable," Judge Durward said.

For further information, contact Andrea McLeod at Andrea_McLeod@health.qld.gov.au

Australians taking fat chance with their health

Australians are in denial about one of the biggest threats to their health, a major survey has found.

The Healthy Living Index Survey, commissioned by insurer AIA, found that cancer topped the list of health worries for Australians, with 49 per cent nominating developing cancer as their major health concern.

But a substantial majority were relatively unconcerned about the threat to health posed by being overweight or obese, despite the fact this was a far more probable risk to their wellbeing.

The survey of 600 people found that only 29 per cent were worried about the health implications of being overweight or obese, and just 10 per cent were concerned about diabetes.

These are striking findings, because the Organisation for Economic Cooperation and Development reported late last month that Australia had the fourth highest rates of obesity in the world (behind the United States, Mexico and New Zealand), and more than 1.7 million Australians have diabetes.

Chair of the AMA Council of General Practice Dr Brian Morton told the *Daily Telegraph* the finding showed there was a "brain disconnect" in the community between health risks and behaviour.

"We see cancer as out of our control and random, but our consumption of alcohol, what we eat and smoking are all linked to it," he said, adding that people needed to be some "skin in the game" to start taking greater responsibility for their health.

The survey found that most people were conscious of the need to slim down, with 73 per cent indicated that they hoped to lose weight.

But little more than half (57 per cent) were taking concrete steps to improve their diet by drinking more water and eating more fruits and vegetables.

Less than a third said they were trying to reduce the amount of alcohol they drank.

Research presented to a national obesity conference in Melbourne late last month suggests the effects of being overweight or obese can bridge generations.

University of New South Wales researcher Professor Margaret Morris found that the offspring of overweight or obese rats were more likely to become overweight themselves than the descendants of lean rodents.

"Pollutants, obesity, even stress, can alter how genes are expressed in offspring without altering the genetic code," Professor Morris told the *Daily Telegraph*.

Obesity experts said general practitioners had a central role to play in helping prevent and treat obesity, but warned their ability to carry out this crucial work was being hampered by Government policy.

> "We see cancer as out of our control and random, but our consumption of alcohol, what we eat and smoking are all linked to it"

Obesity Australia head John Funder told the *Canberra Times* that GPs were ideally placed to treat obesity co-morbidities such as diabetes, but much of such work was not being done because there was no Medicare Benefits Schedule item for the treatment of obesity.

Adrian Rollins

TO COMMENT CLICK HERE

Don't give up on the morning after pill yet, women told

The nation's peak family planning organisation has backed continued use of the emergency contraceptive pill as "better than nothing", following uncertainty about its efficacy for heavier women.

Sexual Health and Family Planning Australia (SH&FPA) has recommended that women continue to use the morning after pill despite claims it does not work in women who weigh more than 80 kilograms.

As reported in the 2 December edition of *Australian Medicine* (to view, visit: https://ama.com.au/ausmed/morning-after-pill-be-taken-lightly), the Australian medicines watchdog is reviewing use of the morning after pill Norlevo after French-based manufacturer HRA Pharma announced it was planning to issue advice that the medication may not be effective in women who weigh more than 75 kilograms, and is ineffective in women who weigh more than 80 kilograms.

The company acted after assessing the findings of a 2011 University of Edinburgh study of women using emergency contraception.

The SH&FPA said it held consultations with the Therapeutic Goods Administration (TGA) and the International Consortium for Emergency Contraception (ICEC) following HRA Pharma's announcement, and had so far found no grounds to recommend women stop using the morning after pill.

"At the time of writing [29 November], SH&FPA has assessed that there is insufficient evidence to conclude that the efficacy of the emergency contraceptive pill in women with higher BMIs [body mass indices] is reduced to the extent that it should not be offered to these women," the peak body said. "As such, in the absence of an alternative, the emergency contraceptive pill readily available in Australia, which is extremely safe, may still offer some benefit in preventing an unintended pregnancy, and is better than nothing."

The organisation said that, as an overall strategy to reduce the need for emergency contraception, it recommended the use of long acting reversible contraceptives, such as implants and intrauterine devices (IUDs).

It said that, addition to the morning after pill, another emergency contraceptive was the copper IUD, which can be inserted up to five days after unprotected sex, and was the most effective form of emergency contraception.

The organisation said it would continue to consult with the TGA and the ICEC to determine if any changes needed to be made to emergency contraception pill practice.

"Until we have more conclusive evidence, the emergency contraceptive pill and the copper IUD are two suitable options for any woman seeking emergency contraception," it said.

The importance of effective contraception has been underlined by figures, reported in the *Adelaide Advertiser*, showing more than 70,000 women have abortions every year, with estimates that up to 60 per cent of them were using contraceptives at the time of their unintended pregnancy.

The SH&FPA said long acting reversible contraceptives were 20 times more effective at preventing unintended pregnancies than other forms of contraception, but less than 10 per cent of Australian women used such devices.

But the range of such contraceptives available to women may soon increase after the TGA approved the long acting IUD Jaydess, which releases the hormone Levonorgestrel into the uterus for up to three years.

The *Adelaide Advertiser* reported it could become available through the Pharmaceutical Benefits Scheme in early 2015.

Adrian Rollins

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INFORMATION FOR MEMBERS

Indigenous medical student scholarship

The AMA is inviting applications for its $9000 Indigenous Peoples' Medical Scholarship for 2014.

AMA President Dr Steve Hambleton said increasing the number of Aboriginal and Torres Strait Island doctors and health professionals was integral to closing the gap between Indigenous health and life expectancy and that of the rest of the population.

Dr Hambleton said the Scholarship had helped many Indigenous men and women to complete their medical training since its inception in 1995, and was contributing to the growth in the number of medical students from Aboriginal and Torres Strait Island backgrounds.

"There is evidence that there is a greater chance of improved health outcomes when Indigenous people are treated by Indigenous doctors and health professionals," the AMA President said. "The numbers of Indigenous doctors are steadily increasing, but every effort needs to be made to help make it possible for Indigenous people to study medicine."

The scholarship is open to students who are currently enrolled full time at an Australian medical school, and who are eligible for ABSTUDY.

Applications for the scholarship close on 30 January, 2014.

For details on how to apply, visit:

https://ama.com.au/indigenous-peoples-medical-scholarship-2014

Queensland doctors threaten to walk

Queensland's public hospitals are facing a mass exodus of senior medical staff as doctors lash out over the State Government's plans to force them onto individual contracts.

Almost 85 per cent of the 800 doctors who responded to an AMA Queensland survey said they planned either to resign, to reduce their hours or to leave Queensland Health over the terms of the contracts, which have been condemned as draconian and unfair.

AMA Queensland President Dr Christian Rowan told the *Brisbane Times* the contracts compromised patient safety by doing away with fatigue provisions, and denied senior doctors recourse to independent third parties where there were disputes.

Dr Rowan said 90 per cent of the doctors responding to the survey said they believed the contracts would reduce workplace retention, undermine core clinical services, and undermine education, training and research in the public hospital system.

The Australian Salaried Medical Officers' Federation of Queensland has lodged a notice of dispute with the Queensland Industrial Relations Commission, challenging the terms of the contracts.

Ratcheting up the pressure on the Queensland Government, ASMOF's Federal Council has joined the AMA Federal Council in condemning its actions, and has issued a nationwide warning to members about the terms of the Queensland contracts.

The dispute has already attracted international attention.

New Zealand's Association of Salaried Medical Specialists issued an extraordinary warning to its members urging them to consider carefully any offer to work in Queensland.

A spokesman for Queensland Health Minister Lawrence Springborg told the *Brisbane Times* that an Auditor-General's report had identified widespread abuses of current workplace agreements, claiming 1000 doctors earning more than $100,000 had been paid while not performing work.

"We are trying to establish a system in which the remuneration of our senior medical personnel is related to the work they do, not work they don't do," the spokesman said. "In many cases there are doctors who are required to work 40 hours, but the tradition is for them to work their 40 hours across four days, not five, and the fifth is counted as overtime."

The Queensland Government has been warned its drastic actions threaten to recreate the conditions that led to the Bundaberg Hospital scandal, in which an overseas-trained doctor was employed as head of surgery on the basis of a bogus employment history because of difficulty attracting and retaining locally-trained staff.

Federal AMA has urged Mr Springborg to dump the proposed contracts and work with AMA Queensland and ASMOF on employment arrangements that work best for doctors, their patients and the health system.

Adrian Rollins

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INFORMATION FOR MEMBERS

Guide for Practitioners: Notifications in the National Scheme

The Australian Health Practitioner Regulation Authority (AHPRA) has prepared a guide and a series of information sheets to explain to doctors what happens when it receives a notification about a practitioner from the Medical Board of Australia.

The publication, *A Guide for Practitioners: Notifications in the National Scheme*, and the information sheets can be viewed and downloaded at: http://www.ahpra.gov.au/Notifications/Fact-sheets.aspx

The guide for practitioners was written by AHPRA, in conjunction with the various national boards, to explain to health practitioners the complaints process.

AHPRA Chief Executive Officer Martin Fletcher said that the majority of health care practitioners were highly skilled and deeply committed to providing safe care, and acknowledged it could be very confronting for them to be the subject of a notification.

The guide describes what occurs when AHPRA receives a notification from the Medical Board.

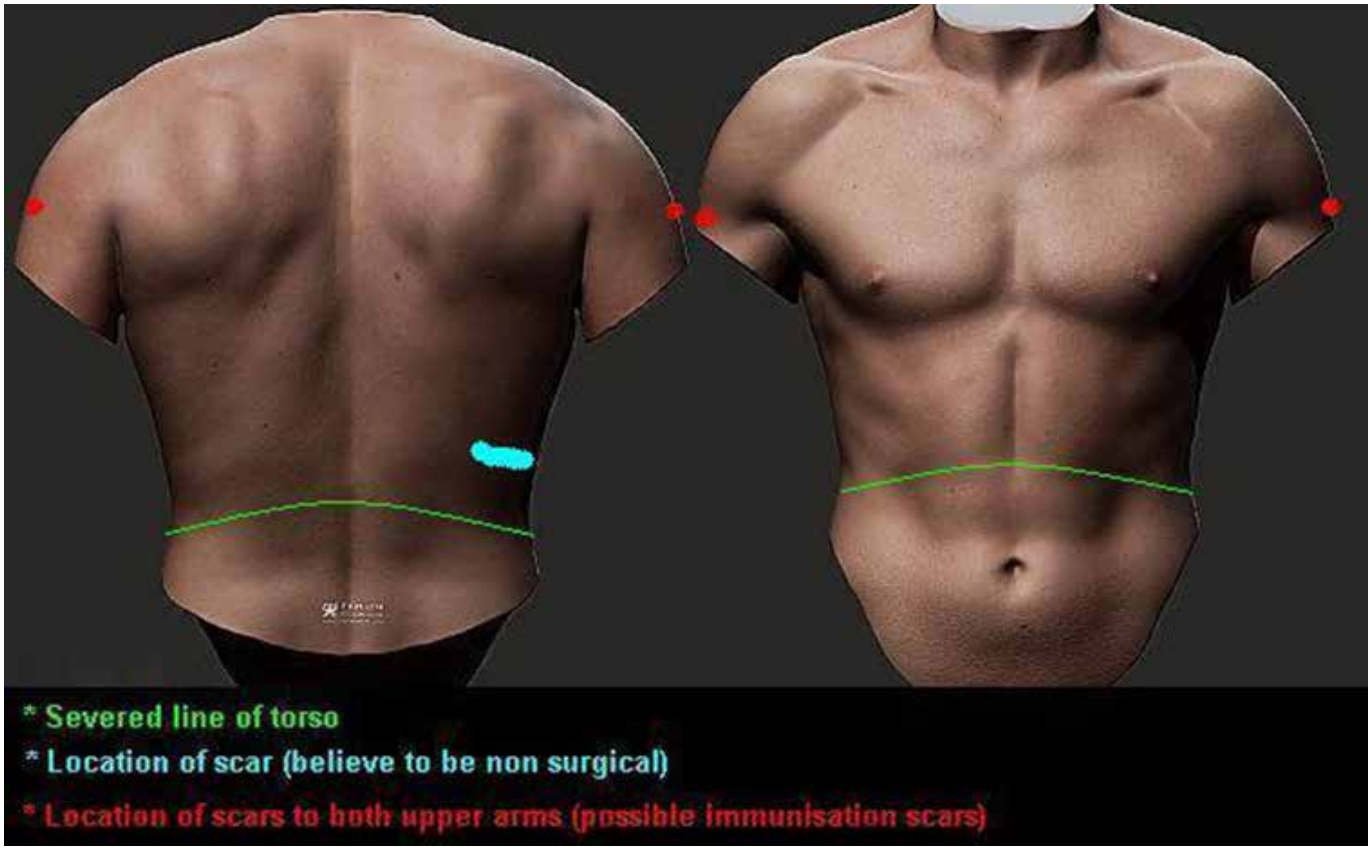
This information will complement the direct correspondence that individual practitioners will receive if a notification is made about them.

The AMA first called for the development of the Guide in its submission to the Senate Finance and Public Administrative References Committee in April 2011.

The document sets out the notification process, including the time limits that apply.

It is intended to enable practitioners to better understand the process and what is required of them, as well as providing a means to verify that their matter is being handled in a manner consistent with AHPRA processes.

Police appeal for AMA help in solving gruesome murder



Queensland police have turned to the medical profession for help in solving a gruesome murder mystery involving a headless torso found alight in farmland near Gympie earlier this year.

Rural fire crews called to a small roadside blaze in a rural area about 10 kilometres east of Gympie on 19 September found the torso of a man, estimated to be aged between about 25 and 35 years, on fire.

The man's head had been severed just above the collar bone, his hands had been removed and his torso and legs from below the ribs had been cut off.

Police said attempts to identify the man had so far failed, and they were seeking help from the medical profession.

"Assistance is sought from members of the Australian Medical Association who may be able to assist in identifying the deceased male," the police said.

Forensic examinations showed the man had been between 180 and 190 centimetres in height. His chest was 109 centimetres, his shoulders were 39 centimetres wide, and his torso was 47 centimetres long.

The police said there were no illicit drugs found in the man's system, but a number of medicine compounds had be detected in samples taken from the body, including:

- Diazepam;
- Nordiazepam;
- Temeazepam;
- trace amounts of Morphine;
- Doxylamine;
- Irbesarten; and
- Quinine/Quinidine.

In addition, the man suffered some calcification of his backbone and had a slight curvature of the spine.

There were no tattoos on the torso, but there were some other distinguishing makes that might help identification, including an old three centimetre scar on the right side of the back, about halfway down.

"The origins of the scar are unspecific, and may be due to an injury or minor surgical procedure," the police said.

The man also had two small circular scars on both shoulders "consistent with marks incurred from immunisation needles".

Police have appealed for any AMA member or their staff who may be able to provide information to contact Crime Stoppers on 1800 333 000.

Adrian Rollins

TO COMMENT CLICK HERE

Insurance bill means abortion pill still costly

Women are still paying almost 10 times the publicly subsidised rate for the abortion pill RU486 because doctors have been hit with a $5000 insurance slug to prescribe the medication.

Almost six months after former Prime Minister Julia Gillard placed the so-called abortion pill on the PBS, cutting its cost to as little as $12, *news.com.au* has revealed that thousands of women are still being charged up to $500 because of insurance arrangements.

According to the report, the nation's largest medical insurer, Avant, requires doctors who want to prescribe RU486 to hold the some level of cover as surgical providers – an additional impost of around $5000 for the typical GP.

As a result, most refuse to prescribe it, forcing women to obtain it from private clinics, where they are commonly charged up to $500 at a time for treatment that includes the prescription, as well as consultations and ultrasounds.

The situation has undermined the previous Government's goal of giving women, particularly in rural and regional areas, access to a safe and cheaper option for abortion, rather than having to travel hundreds or thousands of kilometres for a surgical termination.

Gynaecologist and former AMA President Dr Andrew Pesce was quoted in the report as saying RU486 was an effective medicine if arrangements were in place to ensure women had access to care if complications arose.

Adrian Rollins

TO COMMENT CLICK HERE

Children's Panadol hit by second safety recall

Children's Panadol has been the subject of a second recall in less than a month.

Manufacturer GlaxoSmithKline has issued an alert calling for two batches of Children's Panadol 1-5 years to be returned after detecting greater concentration of paracetamol than specified in a "small proportion" of bottles.

Paracetamol is considered safe and effective when taken as directed, but the Therapeutic Goods Administration warned that overdoses, especially if sustained over a period of several days, can lead to severe side effects.

The two affected batches were dispatched from GSK between September and November. The first has the serial number JR130869 on the carton and 130869 on the bottle. The second has the number JR130697 on the carton and 130697 on the bottle.

"While a small proportion of each batch may contain paracetamol levels that are higher than specified, this does not pose an immediate risk to children when the product is used according to the directions on the label," the TGA said.

The recall follows an alert issued late last month after it was found that the dose markings on some syringes included in Children's Panadol Baby Drops packs were incorrect, potentially causing an overdose.

Adrian Rollins

TO COMMENT CLICK HERE

Christmas cheer can leave some breathless

Asthma sufferers have been warned to be cautious when partaking in the Christmas spirit because of a plethora of hidden allergens that could trigger attacks.

National Asthma Council Australia said common Christmas decorations including candles, trees and other items could easily provoke an attack in the two million Australians who live with the condition.

"Most people are unaware that Cypress and pine trees produce high amounts of pollen, and pollen can trigger hay fever symptoms and asthma, especially when the trees are displayed indoors, the Council's Chief Executive Officer Kristine Whorlow said.

Ms Whorlow said even artificial trees could cause problems, because of the dust and mould they accumulated over several years of storage and use.

She said that, in order to minimise the risk of an attack, people should vacuum and wipe down artificial trees and decorations as soon as they were unpacked.

Ms Whorlow warned that other potential triggers of an attack included dusty decorations and scented candles.

"If you have asthma, it's important to be aware of your asthma triggers and manage them if possible," she said. "Make sure you have your medication with you, and take it as advised by your doctor, even if you are out partying or away on holidays."

Adrian Rollins

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INFORMATION FOR MEMBERS

CONTINUED DISPENSING – FACTS FOR AMA MEMBERS

Pharmacists can now dispense oral contraceptives and statins to patients without a prescription in six out of eight jurisdictions in Australia.

Under 'Continued Dispensing', a pharmacist can supply a standard pack of an eligible PBS medicine to patients who requests it, without requiring a prescription from a medical practitioner.

The Continued Dispensing initiative was developed jointly by the Commonwealth Government and Pharmacy Guild of Australia under the Community Pharmacy Agreement.

The AMA lobbied hard to oppose legislation allowing Continued Dispensing within the Pharmaceutical Benefits Scheme, including writing to all Federal parliamentarians to explain the risks to patients. Despite these efforts, the legislation was passed last year.

Legislation in the ACT, NSW, Western Australia, Victoria, Tasmania and South Australia has now also been amended to specifically provide for Continued Dispensing, and may be passed in the Northern Territory and Queensland in the next few months.

Eligible medicines under Continued Dispensing are:

- oral hormonal contraceptives for systemic use; and
- lipid modifying agents, specifically the HMG CoA reductase inhibitors ('statins'), as listed in the Schedule of Pharmaceutical Benefits

It is important that medical practitioners are familiar with the conditions under which pharmacists can dispense.

The practice guidelines issued by the Pharmaceutical Society for Australia state that pharmacists can supply these medicines by Continued Dispensing if they consider:

- there is an immediate need for supply of the medicine to facilitate continuity of therapy, and it is not practicable for the patient to obtain a prescription for the medicine from an authorised prescriber;
- the medicine has been previously prescribed for the patient, their therapy is stable, and there has been prior clinical review by the prescriber that supports continuation of the medicine; and
- there is an ongoing need for supply, and the medicine is safe and appropriate for that patient.

The practice guidelines state that pharmacists will need to balance the risk to patients of delaying review by their medical practitioner with the benefit of continuity of therapy.

In addition, the pharmacist must:

- be able to identify the most recent prescriber of the requested medicine and their practice address;
- not supply the medicine to a patient if the medicine has already been supplied by any pharmacy by Continued Dispensing in the previous 12 months; and
- advise the patient's medical practitioner within 24 hours that the medicine has been supplied without a prescription.

The AMA recommends you keep a copy of the pharmacist's notification to you about a Continued Dispensing episode on your patient's file.

Please refer to the AMA's fact sheet on Continued Dispensing [https://ama.com.au/continued-dispensing-pharmacists] for more detailed information, including the full list of eligible PBS medicines.

The AMA wants to hear about your experiences with Continued Dispensing. In particular:

- have you been contacted by pharmacists to establish that you have recently reviewed the patient for that medication?
- Is the information provided to you by pharmacists after Continued Dispensing has occurred been useful?
- Has there been an impact on the management of your patient?

Please forward any comments to ama@ama.com.au.

Cambodian experience makes lasting impression

For Melbourne GP Dr Lester Mascarenhas, being one of the few practitioners providing health care to some of Cambodia's poorest communities was a confronting yet inspiring experience.

Dr Lester Mascarenhas with mother and child at the clinic in Prey Thom village, Cambodia

Young boy at the Operation Nightingale rural clinic, Prey Thom village

Dr Lester Mascarenhas was part of a seven-member medical team of volunteers, organised by charity Awareness Cambodia, who visited the south-east Asian country's poorest province, Kampong Speu in September.

We are on a bone-rattling journey in a four-wheel drive over dirt roads dotted with potholes.

Suddenly, the jeep comes to a screeching halt, throwing my colleague, fellow GP Dr Mark Flynn, across my lap.

Around us, foliage glistens in the warm rain, the mountains are shrouded in clouds, and the expectant faces of a several hundred Khmer women, men and children appear. We have arrived.

Pregnant women hold their bellies, elderly men flash us their toothless smiles and children peer shyly from behind their parents.

The scene is reminiscent more of a community social gathering than a clinic. We are in Prey Thom village. It is just 50 kilometres from the capital, Phnom Penh – about a two-and-a-half drive. But it might as well be a world away.

The village is part of Kampong Speu province, which is the poorest in Cambodia.

Awareness Cambodia's Operation Nightingale project – which operates four permanent and two mobile clinics - is the only source of medical care in this impoverished and remote area, and it is two years since the last team of volunteers came through. There is a lot to do.

With me are six other volunteers from Australia – emergency physician and clinical toxicologist Dr Kerry Hoggett, fellow GP Dr Flynn, three registered nurses (Nancy Kennedy, Erin Clapham and Emma Larter) and dentist and Awareness Cambodia Chief Executive Officer Dr Gary Hewett – as well as six local practitioners: three GPs, two dermatologists and a nurse.

Our clinic has been organised by the Cambodian Health Department and we

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Cambodian experience makes lasting impression

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Operation Nightingale volunteer medical team, top row (L to R): Dr Kerry Hoggett, Emma Larter, Nancy Kennedy and Dr Mark Flynn. Bottom roe (L to R): Erin Clatham, Dr Lester Mascarenhas and Dr Gary Hewett

Young girl outside Operation Nighingale clinic in Kompong Speu province, Cambodia

set up in the local school; triage in one room, the pharmacy in another, and the remainder used for treatment.

For the next five hours we work in collaboration with our Cambodian colleagues - doctors, medical students, pharmacy assistants, nurses and Health officials – treating common complaints such as gastritis, skin rashes, cataracts, parasitic infections, draining abscesses, dressing wounds and burns, as well as distributing basics such as toothbrushes, soap, used spectacles and continence aids.

Altogether, we treated 284 patients.

This was just one of three mobile clinics we provided in remote areas, as well as assisting at Awareness Cambodia's four permanent clinics.

After two weeks with Awareness Cambodia I had interesting stories to tell and new friends.

We were a colourful lot – five on the medical team and a dozen or so on the maintenance team [which carries out building and maintenance work at the Sunshine House orphanage]. Among us was a chap had never before visited a developing country, a vegetarian nurse and an emergency department physician with plenty of experience working in south east Asia.

We saw a face of the country that tourists will never see.

Visiting Tuol Sleng Genocide Museum was a memorable experience, as was dancing at the nightclub on the beach in Sihanoukville.

The maintenance team had some very fond memories of spending time with the children at Sunshine House, and we joined the others at Sunshine House towards the end of our trip for the annual Sunshine House concert – performance by the Awareness Cambodia team is compulsory…!

For me, the experiences in the mobile clinics will be the ones that I will always remember.

The valuable lessons learnt from the Cambodian medical students and doctors on how to work when resources are limited; the joy and legacy of sharing knowledge with the medical students and, most of all, the realisation of the pernicious effects of unequal global wealth distribution, where access to the most basic health care is denied to our fellow humans in the developing world.

In Cambodia, life expectancy is 65 years – a dismal 17 years less than in Australia.

As I strive to earn more and more in Australia, my experiences in Cambodia made me ask myself: will my life really be any better if I had more money? Surely, if I was faced with the choice of buying a bigger house or investing my time and money in volunteering with Awareness Cambodia and providing my fellow humans with the health care that is their right, what would I choose? What would you choose?

In September each year, Awareness Cambodia sends a team of up to eight volunteer health workers and 16 maintenance workers to Cambodia for two weeks to conduct clinics and carry out necessary maintenance and building work. Volunteers provide their time and expertise free of charge, and make a $3000 donation to the organisation. Clinical and pharmacy supplies are funded through the Operation Nightingale project.

Those interested in volunteering are invited to attend a meeting and submit an expression of interest. Medical professionals interested in the volunteer program can contact Awareness Cambodia on +61 8 9370 1457 or cambodia@awarecam.org.au.

TO COMMENT CLICK HERE

Protocols will never replace a doctor

BY **DR BRIAN MORTON**

"Proper review and understanding of the service needs real life observation. This includes external auditing and accreditation"

A baby's death, whenever or however it occurs, is a profound loss. This was evident from the recent media coverage of the coronal findings into the tragic death of a six-month-old infant from pneumococcal meningitis in 2010.

The Western Australian coroner was critical of the 24-hour telephone helpline *healthdirect's* protocols after a nurse mistakenly diagnosed the meningitis as a short-term 'tummy virus' that did not require review by a GP or presentation to a hospital emergency department.

The coroner found that the infant would have survived had she been taken to hospital, although the bacterial infection may have caused her significant harm.

At the release of the coroner's report, my AMA colleague Dr David Mountain told the *West Australian* newspaper that "the tragic case showed there would eventually be a problem with a telephone service, no matter what protocols were in place, and it could not substitute for a trained clinician seeing a sick child or adult."

I could not have said it better myself.

The plan to introduce the publicly funded National Health Call Centre Network (NHCCN) was announced by the Council of Australian Governments in 2006. A year later, under the name *healthdirect Australia*, it began the telephone nursing triage system *healthdirect.*

I recall thinking at the time that it was a misconceived attempt by governments to improve patient access to care on the cheap. It was, in effect, replacing doctors consulting patients face-to-face with nurses on the phone following computer-generated protocols.

These days, *healthdirect Australia* contracts to Medibank Health Solutions (MHS) to operate the helpline.

I have more than a passing interest in the effectiveness of telephone helplines – both as a practising GP and as a member of the Department of Health's now-defunct After Hours Primary Care Technical Working Group (TWG). This working group advised the Federal Government on the introduction of the *after hours GP Helpline*, which patients access via *healthdirect.*

I still have doubts on the effectiveness of *healthdirect*, as well as the lack of transparency with the clinical recommendations made by nurses to callers and the GPs manning the *after hours GP Helpline.* We need to be confident that the medical advice provided is appropriate, and the patient is managed correctly.

Along with the AMA, the Rural Doctors' Association of Australia and the Royal Australian College of General Practice were also members of the TWG. For some time we sought the agreement of the NHCCN and MHS to allow us visit a call centre in the after hours period to observe actual calls and how the helpline's protocols and care guidelines were applied. Proper review and understanding of the service needs real life observation. This includes external auditing and accreditation.

Unfortunately, the response to our requests was disappointing. Commercial-in-confidence and privacy issues were used to keep us out of the call centres.

I found the resistance by the MHS to transparency of its processes disturbing. It prevented GPs from advising the TWG on how *healthdirect* detects the symptoms of simple and complex conditions.

One wonders how the service is being monitored if similar conditions are imposed on its audit and quality assurance processes. Further, experience shows that there are inherent dangers in self-auditing.

A computer-generated protocol will never be a substitute for a face-to-face consultation with a doctor.

We would have less need for these helplines if GP after hour consultations were better supported by the Government.

The AMA will continue to press for the re-instatement of the TWG to address problems with after hours care in this country.

TO COMMENT CLICK HERE

Successes, but greater challenges await over the horizon

BY **CHAIR DR WILL MILFORD**

The impending holiday season and accompanying slowdown, as political and departmental offices close for Christmas, provides time for introspection regarding the AMA's (and the AMA's Council of Doctors in Training) successes in the medical training arena this year.

After eighteen months in the Chair role, I am continually impressed by the broad scope of the AMACDT's advocacy, and the gravity with which it is received by the various groups we work with. With my impending departure from AMACDT, the final column for the year is an ideal opportunity to review the success during my term as AMACDT Chair, and preview the challenges that lie in wait for the Council next year.

Medical workforce remains a core issue.

The emergence and ongoing success of Health Workforce Australia (HWA), the bureaucracy primarily tasked with solving Australia's health professional crisis, has been important.

It has overseen the slow evolution of medical workforce planning, with the publication of the Health Workforce 2025 volumes, the formation of the National Medical Training Advisory Network (NMTAN), and the impending production of five-year training plans, completing the transition from data collection to workforce planning.

While HWA was never going to be a panacea, the foundations have been laid for future successes. The AMA has been a strong supporter of the role taken by HWA, and is heavily involved with NMTAN to ensure that it continues to meet these goals.

With more than 100 intern places funded by the Commonwealth Government each year for the next four years, the provision of internships for a greater proportion of international students has been one of the best examples of AMACDT advocacy.

That the 2006 COAG agreement to provide internships for all domestic Commonwealth-supported medical students continues to stand, also demonstrates the power of AMA advocacy. The Australian Medical Students' Association has worked hard for its members, and our partnership with them has been valuable for both organisations.

On a more obscure note, the recent implementation of a suite of standards strengthening medical internships has been another success for AMACDT.

While these changes will not be immediately apparent to most interns, the creation of national standards for intern training programs, and the accreditors of intern training programs, will ensure that intern training is delivered at a high standard around the country.

The addition of outcome statements will also provide current and future interns with clarification regarding the professional goals that they should expect to achieve over the 12 month training period. The Australian Medical Council has had to toil to create this framework, and should be applauded for its persistence.

Finally, the AMA's biggest coup for the year - scrapping the cap - has to be acknowledged as an enormous victory which has staved off significant financial disadvantage to members and non-members alike.

Junior doctors, as one of the groups that would have been most disadvantaged by this decision, must recognise the core role played by the AMA in reversing this terrible policy.

Following on from these successes, a number of new policy fronts have opened up and created new challenges for both the AMA and AMACDT.

Junior doctor mental health and finding a solution to maldistribution are two external challenges, while boosting membership numbers to improve advocacy power will be a challenge internally.

Junior doctor mental health and wellbeing promises to be a crucial issue.

Reports have highlighted the parlous state of doctor mental health and demonstrated that the highest risk period occurs during the transition from medical student to junior doctor. Clearly, factors such as increased career stress, mandatory reporting, rapidly changing workplace expectations and a higher pressure clinical environment, are all exacerbating the already stressful transition from medical school to the workplace.

Some solutions are already in play, but a system-wide shift is needed to create a cultural change in hospitals to ensure that junior doctors feel valued in the crucial roles that they undertake.

Solving maldistribution will not be a 'silver bullet' exercise, but will require a range of strategies.

AMACDT's role will be to ensure that these solutions create longer term increases in the rural workforce and undersubscribed specialties.

The key will be creating a medical workforce tailored to meet demand by crafting appropriate undergraduate experiences and opportunities for training in undersubscribed regions and specialties. Incentives may play a role, but any return to, or increase use of, policies that intend to conscript doctors must regarded as a retrograde step.

Of all the challenges outlined in this column, that of membership is most crucial.

Historically, the AMA's success has relied upon its claim to be representative to the medical profession.

Similarly, AMACDT's role as the peak junior doctor representative body in Australia has relied upon our reputation

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Using e-health wisely to support medical practice

BY **DR STEVE HAMBLETON**

At its recent meetings, the Economics and Workforce Committee turned its attention to two important aspects of e-health and medical practice: medical practitioner responsibilities with electronic communication of clinical information, and technology-based patient consultations.

Our considerations were prompted in part by broader interest in integrating e-health business solutions into medical practice. The Committee was also mindful of the need to ensure that relevant AMA policy was up to date and provided useful guidance for members as new technology becomes more widely used in medical practice.

The EWC developed new position statements on these matters which were approved by Federal Council at its November meeting and are now available on the AMA website.

The Position Statements are available at: https://ama.com.au/position-statement/medical-practitioner-responsibilities-electronic-communication-clinical and

https://ama.com.au/position-statement/technology-based-patient-consultations-2013.

In relation to the electronic communication of clinical information, the Committee recognised that our need to communicate with our colleagues and health care provider organisations will increasingly involve using electronic communications to transmit and receive clinical information.

While the e-health agenda has been swamped by issues around the Personally Controlled Electronic Health Record, secure electronic communication is a priority tool to support doctors in coordinating and managing quality health care for their patients.

The purpose of this Position Statement is to set out our responsibilities as medical practitioners to our colleagues with regards to the electronic communication of clinical information. These responsibilities apply to any clinical information communicated electronically using any technology.

EWC has recognised the inherent risk to doctors of an increased duty of care to patients if they receive clinical information electronically, particularly where this means that medical practitioners may have access to, but not be aware of (and therefore not able to act on), clinical information about patients.

EWC developed the Position Statement to guide medical practitioners using electronic communications for clinical information, firstly to highlight and secondly to minimise, that risk.

EWC also developed a position statement on *Technology-based patient consultations.* This updates and replaces the AMA *Position Statement on Online and other Broadband Connected Medical Consultations 2006.* The AMA Position Statement on Connectivity 2007 has been rescinded, as the clinical messaging and authentication systems sought in that Position Statement have been introduced.

The Committee recognised that technology-based patient consultations can improve patient access to care and enhance efficiency in medical practice.

This Position Statement is a straightforward reckoning of the things to be taken into account when a medical practitioner is providing a consultation to a patient via technology.

It provides relevant information for medical practitioners when considering how to provide and set fees for such services, and for Government in respect of Medicare rebates for patients receiving a technology-based consultation.

One issue that EWC took a good look at was whether such consultations should only be provided where there is an established relationship between the patient and the doctor or practice.

EWC noted that there is no available evidence to support such a requirement, and that mandating such a relationship would also exclude situations that AMA members may already be involved, in such as GP help lines or online medical practice.

The Position Statement makes clear that technology-based patient consultations complement, but do not replace, face-to-face consultations, and should be used as an adjunct to normal medical practice for regular patients of the practice. They should not be used in such a way as to fragment the ongoing care of the patient.

I recommend you take a (brief) moment to read these position statements. They provide very concise, practical and easy-to-understand guidance on the key issues for medical practice in these e-health-related areas.

TO COMMENT CLICK HERE

2014 and all that

BY **PROFESSOR STEPHEN LEEDER**

Recall when you started a new job and you will have sympathy for the new Commonwealth Minister for Health, Peter Dutton, as he comes to terms with what his new job entails.

Health is a huge portfolio and a melting pot for interests and aspirations, whether from the community or from health service professionals, public and private. The constant tussle between the states and territories on one hand and the Commonwealth on the other is rarely far away.

Health was not a major election matter and received little airplay. There was no serious contest of policy, no incisive analyses, and no dramatic announcements about funding, and virtually no fighting.

Yet health, education, and transport are widely perceived by the electorate as top priorities. The Minister can be happy that at least health has not erupted like the volcano of schools education that spewed recently.

But election promises were made in relation to general practice.

We may well see changes that seek to render the Medicare Local development more efficient. Medicare Locals have, as might be expected, performed variably. A review may be timely to see what has worked and what has failed, the better to determine future policy.

But suggestions that Medicare Locals could be rolled into local hospital networks are in serious error.

A long history of antipathy exists between public hospitals and general practitioners.

Independent Medicare Locals guarantee space between the practitioners and the hospitals in which trust can be developed around shared programs of care. Amalgamate the entities and my guess, based on long observation, is that the general practitioners will pick up bat and ball and leave. Coordinated care will require gentle diplomatic handling, patience and goodwill to develop trust.

Much can be done in the current structure of Medicare locals and hospital networks to better integrate care.

It would be a singular, and splendid, achievement to fully enable general practice with information technology. Progress is occurring: I can readily recall when general practice computers were rare. It is time that as a country we took steps to achieve full IT connectivity in our health system. General practice would be a great place to begin.

So changes may occur, one hopes for the better, in general practice.

A second area where the omens are darker is prevention. Muscular self-reliance is currently politically attractive, and the thought of adjusting social structures to support and nurture those who are less fortunate or weak lacks anabolic appeal. Nevertheless, there are serious distortions in our society that are created by the market (no, Hayek, you are not perfect) and they deserve government intervention. I refer to excess dietary fat, salt, alcohol and tobacco.

The National Preventive Health Agency was a brave and novel attempt by the previous Government to build a serious, science-based institution to counter these distortions.

Industry will cry foul, or poor, about the Agency, insisting that if they are prevented from advertising their fat food and alco drinks at sport fixtures civilisation as we know it will end.

These voices are not the voices of the victims, but of the oppressors. They should be resisted and comprehensive national strategies for the prevention of obesity, alcohol abuse and tobacco-associated death and destruction enacted.

The recently announced national plan to combat diabetes is an excellent beginning. Abolishing or castrating the NPHA would be a poor second act, however loud the applause from those with no interest in health.

Health care financing is an unstable policy area and two aspects of this affect the public directly. The first is out-of-pocket (OOP) expenses and the second is private health insurance. The two are, of course, related.

Concerning out-of-pocket costs, the Australian Institute of Health and Welfare used statutory data and the Menzies Centre used Australian Bureau of Statistics direct consumer data to investigate the extent of OOP expense, and found that these payments are about $3500 a year for Australian households, and make up about 20 to 25 per cent of national health expenditure. This surcharge is especially tough on those least able to pay and those with serious and chronic illnesses, as we found through studies of such people through the Menzies Centre and the George Institute.

Encouragement of private health insurance membership was one of the hallmarks of the previous Coalition Government, so changes back to earlier subsidy patterns may be made to encourage greater membership. The subsidy will be drawn from funds otherwise available to support universally-accessible public care. Welcome to 2014.

TO COMMENT CLICK HERE

A shared future for medical education

BY **PROFESSOR NICK HAWKINS, PROFESSOR OF PATHOLOGY AND HEAD OF THE SCHOOL OF MEDICAL SCIENCES AT THE UNIVERSITY OF NEW SOUTH WALES, SYDNEY, AND DR DROR BEN-NAIM, ADJUNCT LECTURER AT THE SCHOOL OF COMPUTER SCIENCE AND ENGINEERING AT UNSW.**

"As we speak, plenty of nimble, global technology players are racing into the medical slides and images space, effectively offering to sell universities e-tools to access their own content"

To educate the best doctors and health professionals for twenty-first century, medical schools must collaborate to share access to digital education resources, rather than persist with the competitive models of the past.

This is not a futuristic aspiration. In Australia, the foundations of a world-first collaborative model for medical and allied health education are already in place.

With the recent launch of the $4.5 million BEST (Biomedical Education Skills and Training) Network, students studying at member universities have been given access to an unprecedented and growing bank of biomedical images and a catalogue of related digital teaching and learning modules, stored in 'the cloud', and shared through the web.

Ensuring every future doctor, from any medical school, has similar instant web access to these powerful learning resources should be a priority for the higher education sector in Australia, and internationally.

Not only is demand rising sharply worldwide for skilled medical and allied health professionals, but clinical practice is becoming increasingly complex due to rapid advances in therapies, medical imaging, biomedical devices and other medical technologies.

Our challenge as educators is to meet that demand as efficiently and effectively as we can.

To understand the benefits of collaboration, we only need look back ten years. Then, every student at every medical school was allocated his or her own precious set of delicate glass slides -- usually 100 or so – and access to a microscope.

Every single slide, tens of thousands a year in each medical school, had to be sliced by hand from equally precious tissue samples that represented the major disease processes that every doctor must understand. Such collections were, and still are, an important part of the foundation of knowledge on which medicine is built.

Similarly important is a doctor's ability to recognise what a disease looks like to the naked eye.

At the University of New South Wales (UNSW) we maintain a Museum of Human Diseases, which exhibits over 3000 specimens of various diseased organs and tissue, preserved in perspex "pots".

Such samples, removed surgically or obtained during autopsies – some of which are now more than 100 years old – are critical in early medical education.

But collections held by individual institutions, no matter how extensive and impressive, have always been limited in scope and access.

In a world where, for example, Google Maps can instantly show us the street view of a house on the other side of the globe, why couldn't we similarly 'zoom in' on the complex, valuable and increasingly hard-to-replace collections of microscopic and macroscopic medical images, wherever they are held in the worldwide?

Shouldn't any lecturer, student or clinician be able to find an image of any condition – say, a rare fracture or a particular allergic reaction – online, and use it in their lecture, for their revision or as a professional reference? Theoretically, yes.

The fine detail in medical images means they are often very large files, which once made them difficult to share and access via the web. But recent advances in cloud storage and faster internet speeds means they can now be pulled down easily using a similar 'tiling' system to Google Maps.

This is the starting point for the collaborative model the BEST Network is building. To date, its founding partners - the UNSW, the University of Melbourne, the University of Queensland, James Cook University, and technology partner, Smart Sparrow, along with professional peak bodies – have launched "Slice" – an open, cloud-based, medical image bank, powered by knowledge discovery and sharing tools. These tools let teachers annotate

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the images, as well as use them in virtual laboratories, online medical cases, and virtual practical classes, on topics ranging from blood typing to snake bite and the diagnosis of urinary tract infections.

In developing these resources, we have had the added benefit of partnering with peak professional bodies, including the Royal College of Pathologists, the Australian Orthopaedic Association and the Royal Colleges of Nursing.

Individual universities or medical schools cannot afford to build, maintain and deliver such digital learning capabilities alone. We need to collaborate extensively to deliver the best possible learning resources to as many medical and allied health students as we can.

The advantages are obvious, and the downsides few.

In recent weeks UNSW medical students have, for example, used the BEST Network's courseware catalogue to review their practical class materials in disciplines as diverse as biochemistry and pathology, by using modules built with the Smart Sparrow adaptive e-learning platform.

The platform, invented at UNSW, makes it easy to build courseware that provides students with a personalised learning experience, in which the content adapts to the pace and level of each individual student.

Back-end learning analytics dashboards give teachers insight into their students' strengths and weaknesses. Our experience at UNSW tells us that adaptive e-learning tools can improve student outcomes in a way that motivates and enthuses our students.

Universities are accustomed to competing against each other in the rankings, and to promoting their own unique reputation to attract the best students.

However, for health care education, we'd like to propose a variation on that model that pools resources for the benefit of all Australian students, while still respecting the individual strengths of each institution.

The BEST Network, initiated through the Commonwealth's NBN-enable Education and Skills Services Program, provides a template for that future. It's now up to us to devise a business model, and a way of working together, that can sustain it.

As we speak, plenty of nimble, global technology players are racing into the medical slides and images space, effectively offering to sell universities e-tools to access their own content. Yet this approach will maintain the siloed privacy of those important stores of knowledge.

The BEST Network will create a not-for-profit subscription model, in which member universities invest annually to build, run and maintain our collective resources. In this way, we can achieve our individual goals without putting these valuable educational assets behind institutional or profit-driven firewalls.

In fact, we could open them up to clinicians and health students all over the world, positioning Australia as a (collaborative) leader in global biomedical education.

To view medical images using Slice go to:

https://www.best.edu.au/slice/featured

To view scenario-based learning modules go to courseware:

https://www.best.edu.au/courseware/featured

For more about the BEST Network, visit:

https://www.best.edu.au/about-best/

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Successes, but greater challenges await over the horizon

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for representing large numbers of junior doctors.

In recent years our growth in membership has not matched the expansion of the medical profession, leaving the AMA and our advocacy efforts in a weakened position.

We need to think about a health system without an AMA.

Consider our victories. With no AMA, how many of today's interns wouldn't have jobs? How much would you be paying for your education? Think about this when you speak to non-member colleagues who have benefited from our activism, but fail to contribute to it.

This column marks my final contribution as Chair of AMACDT.

At the end of the year I stand down as I finish my doctor-in-training years and join the ranks of consultants.

The very able Dr James Churchill, a current intern and past AMSA president, will step into these shoes and continue to work to improve the health system for junior doctors around Australia.

I'd like to thank the AMA, the Council of Doctors in Training and the fantastic AMA secretariat for all their hard work and support during my time as Chair of AMACDT.

Follow Will (and now James) on Twitter (@amacdt) or Facebook (http://www.facebook.com/amacdt)

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Health on the hill

Political news from the nation's capital

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Injection of cash brings relief for anxious cancer patients

The Federal Government has provided a multi-million dollar lifeline for anxious cancer patients and carers who feared restricted access to life-saving chemotherapy treatments at the end of the year.

In a decision greeted with relief by cancer support groups and clinicians, Prime Minister Tony Abbott and Health Minister Peter Dutton announced on 30 November that $82 million had been set aside to cover the costs of dispensing chemotherapy drugs to 150,000 cancer patients from 1 January 2014.

The decision, which Mr Abbott said was part of efforts by his Government to "clean up Labor's mess", ends months of uncertainty for cancer sufferers after the previous Government commissioned a comprehensive review of chemotherapy funding arrangements.

But the extra funds, which provide a $152.66 Government subsidy for each transfusion chemotherapy infusion, will only last until June 30, 2015, leaving patients and carers anxious about longer term arrangements.

Immediate Past President of the Private Cancer Patients Group, Dr John Bashford, said Mr Abbott's announcement was of "immense relief" for cancer sufferers.

"We have absolutely no doubt that the Coalition understands the problem facing every cancer clinic and every patients and their famil[ies]," Dr Bashford said. "[But] we need to see the detail. There was no mention of the details of the long term arrangements."

The Government said funding beyond mid-2015 would "be considered as part of any future agreement for pharmacy services under the PBS".

The issue arose earlier this year when concerns were voiced that cuts in the price of some chemotherapy medicines would make the preparation of chemotherapy infusions commercially unviable.

The preparation and supply of chemotherapy infusions is a niche area of pharmacy practice, entailing significant capital investment and specialised knowledge.

In Australia, fewer than sixty pharmacies (1 per cent of the industry) supplies 80 per cent of all infusions funded under the Pharmaceutical Benefits Scheme (PBS).

Last financial year, the PBS subsidised about 830,000 chemotherapy infusions at a cost of $570 million.

In May, the-then Health Minister Tanya Plibersek announced a comprehensive review of chemotherapy funding arrangements, to be completed by the end of the year.

In the interim, to ensure the ongoing viability of chemotherapy services, Ms Plibersek authorised an additional $60 subsidy for each chemotherapy infusion. The interim increase was set to expire on 31 December.

The review's report was delivered to the incoming Abbott Government in October, and found that PBS price disclosure measures had eliminated "excessive profit margins" for dispensers, but in the process may have cut margins so much that they were no longer sufficient to meet average production and supply costs.

"Data provided by a sample of pharmacies indicate that there may be a deficit in funding," the report said. "However, there are limitations in the verifiability and representativeness of the data due to the small number of data sets and inconsistencies between reported costs."

Under the arrangements announced by Mr Abbott and Mr Dutton, pharmacies and hospitals will receive $154.66 per infusion – a $62 increase from the base fee of $92.66 (which already included a $15 mark-up).

In addition, acting on a recommendation from the report about improving efficiency by reducing complexity and administrative burden, they announced that clinicians would be able to use a patient's medication chart to dispense and claim PBS medicines, freeing them up from completing duplicate paperwork.

Adrian Rollins

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PBS delivers savings but Govt told it could do better

Patients could save up to $12.50 on the cost of one of Australia's most commonly prescribed medicines under price changes announced by the Federal Government.

Health Minister Peter Dutton said that, from 1 December, the cost of 142 drugs used by more than 850,000 patients had been cut as a result of price disclosure rules introduced six years ago.

Among those to experience a price drop will be users of the cholesterol-lowering medication Atorvastatin, who will save up to $12.50 per script. Those using the schizophrenia drug Olanzapine will save up to a $6.70 per prescription, while those taking the anti-depressant Venlafaxine will experience a price cut of up to $10.60.

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Mr Dutton said the price drop of Atorvastatin alone would save patients up to $125 million over the next four years.

The Minister's announcement came just before the release of Australian Prescriber figures showing statins were, collectively, the most commonly prescribed medication in Australia.

The report showed that more than 20 million prescriptions for Atorvastatin, Rosuvastatin and Simvastatin were filled through the Pharmaceutical Benefits Scheme in 2012-13.

The two most common types of statin cost taxpayers more than $715 million in subsidies, including $416 million for Atorvastatin, which has come off patent.

Other commonly prescribed medications included proton pump inhibitors and ACE inhibitors.

The results have added fuel to concerns the PBS is becoming an increasingly unsustainable drain on the public purse: drug subsidies cost $9.2 billion in the year to June 2012.

Prominent health economist Professor Stephen Duckett claims the Government should be driving a much harder bargain with pharmaceutical companies, claiming that it could save more than $1 billion a year simply by paying the price governments in other countries, such as Britain and New Zealand, pay for the same medicines.

Professor Duckett said the price drop secured by the Government for Atorvastatin was not as dramatic as it seemed.

He said while a pack of 30 tablets had fallen from $30.69 to $19.32 in Australia, the same packet in the UK cost $2.84 and in New Zealand $2.01.

Under the price disclosure regime, pharmaceutical companies are required to reveal the prices they charge pharmacists, which are then adopted by the Government in what it will pay to manufacturers.

Industry claims that since the policy was introduced in 2007, it has achieved more than $5 billion in savings.

But Professor Duckett said the price benchmark should be set against what comparable countries pay, not prices within Australia's highly regulated market.

However, Pharmacy Guild Director David Quilty, writing in *The Australian*, said PBS had in recent years been coming in under budget, marking the success of the price disclosure policy and undermining claims the system was unsustainable.

Mr Quilty said the real rate of growth in PBS expenditure was 2 per cent a year, even though the ageing population meant volumes were increasing by 6 per cent a year.

Peak pharmaceutical industry body Medicines Australia, in a submission to the Government's Commission of Audit, said PBS spending as a proportion of gross domestic product was falling.

This showed, it said, that "a lot of the work to make the PBS financially secure in the long term has already been done".

Adrian Rollins

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Drug company hospitality less than lavish

The pharmaceutical industry spent an average of less than $47 on hospitality for doctors attending conferences and seminars it hosted, undermining claims of lavish accommodation and entertainment.

In its latest biannual report on events hoisted for medical practitioners, peak pharmaceutical industry body Medicines Australia has reported that almost 17,000 educational events and 113 advisory board meetings were held in the six months to the end of September, at a total cost of almost $46.5 million.

In all, the industry reported a total attendance of more than 501,000 people, putting the average per person cost of hosting an educational event at $88.74, while each advisory board meeting cost an average of $2281.85 per person.

The results were released as discussions around the disclosure of payments to individual practitioners continue to advance.

The AMA has backed increased disclosure of industry payments in principle, but wants to ensure that the context of each payment is adequately explained to ensure the public is fully informed.

Adrian Rollins

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Medibank sell off a step closer

The Federal Government is pushing ahead with plans to encompass the sell-off of Medibank Private in its first Budget, appointing financial advisors Lazard to undertake a scoping study of the proposed sale.

Finance Minister Mathias Cormann has announced that Lazard Pty Ltd will report by the end of February with recommendations on "all relevant aspects" of the transaction, including the readiness of Medibank for privatisation, the method of sale, timing, regulatory issues and estimated sale price.

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Senator Cormann said the Government was committed to the privatisation of the nation's largest health insurer, which has a 29 per cent share of the market.

But the AMA has raised concerns that the sale could force premiums higher if it leads to a diminution of competition, particularly in the event of a trade sale.

The Association has also flagged fears that the use of debt to fund such a significant purchase could make the new owners financially vulnerable, and that an acquisition by overseas investors could increase Medibank's exposure to potentially destabilising internaiotnal financial market conditions.

But Senator Cormann sought to allay such concerns, saying that the Government's objectives for the sale included that it contribute to a competitive, efficient and viable private health insurance market, that service levels be maintained and that staff are treated fairly, that any residual risks and liabilities to Government are minimised, and that the sale price was maximised.

"Medibank Private is a commercial business operating in a well-functioning and competitive market with 34 competing funds," the Minister said. "As such, there is no compelling policy reason for the Government to continue to own Medibank Private."

He said the scoping study would be completed in time for its "consideration…in the 2014-15 Budget context".

But, Senator Cormann added, "it is important to stress that the Government has not made any decisions yet regarding the timing and structure of any sale".

"We will await the findings and recommendations of the scoping study before making those decisions," he said.

Adrian Rollins

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Pharmacists get vaccination go-ahead

Pharmacists could soon be administering vaccinations after the Pharmacy Board of Australia announced its approval of the controversial change.

In a communique issued on 5 December, the Board said that "in its opinion, vaccination is within the current scope of practice of a pharmacist".

The go-ahead follows a proposal from the Pharmaceutical Society of Australia earlier this year that pharmacists be allowed to administer vaccines.

But the AMA has warned the move is premature, and pharmacists should not be permitted to administer injections until such procedures are included in core training, and were not just an adjunct.

AMA President Dr Steve Hambleton said earlier this year that vaccinations such as the annual flu injection needed to be carried out by GPs, not pharmacists.

"The AMA has a lot of concerns with pharmacies offering vaccinations," Dr Hambleton said. "There is no privacy. Patients need to be made aware of possible side effects and discuss their medical history. What private room can a pharmacy offer a patient?"

The AMA President said those who administered injections needed to be able to identify anaphylaxis and other possible health issues, and having pharmacists do it would fragment medical records.

"We [will] have patients coming into the GP to say they had some kind of needle at a chemist," Dr Hambleton said.

While the Pharmacy Board has given approval for pharmacists to administer vaccines, many fundamental details of arrangements are yet to be finalised, particularly the nature and timing of training.

"Further work regarding competence to do so, standards, training, and where this may take place, will need to be completed before vaccination by a pharmacist will be able to occur," the Board said.

Among the issues to be resolved is whether vaccination training is included in the core curriculum for pharmacists, potentially enabling all to vaccinate, or requires an additional unit of study following graduation.

The Pharmacy Society of Australia welcomed the Board's decision, arguing there was "overwhelming clinical and scientific evidence" that pharmacists administered vaccinations safely and effectively.

There is speculation that Queensland may become the first place where pharmacists vaccinate customers, with suggestions the State Government is considering a trial during the next flu season.

Adrian Rollins

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Research

Latest throw for those with Hurler's syndrome

Researchers have developed a promising new treatment for people with severe disabilities caused by a rare enzyme deficiency.

South Australian scientists have developed a technique that could provide an effective treatment for Hurler's syndrome, an unusual condition affecting around one in 100,000 Australians, and whose symptoms include severe mental and physical disabilities. Those with the condition often die in their early teens.

The disease is caused by a single defective enzyme that is essential for breaking down complex sugars in cells.

University of Adelaide researchers have developed a technique to make adult stem cells produce excess amounts of the deficient enzyme which, they can then use to replace the cells that aren't working properly in people with Hurler's syndrome.

Lead researcher Matilda Jackson said the research had found how to turn adult stem cells into mini-enzyme factories by coupling them with a virus that makes them pump out high levels of the enzyme.

"Those stem cells can then be injected into the blood, where they move around the body and become liver, bone, brain or other cells that start producing the missing enzyme," Ms Jackson said. "They automatically migrate to the areas of damage in the affected individual."

So far, the researchers have been able to measure improvements in brain function, but have yet to complete the analysis to determine if there have been improvements in other organs.

Dr Sharon Byers, who has been supervising the study, said there were currently only two treatments for Hurler's syndrome – costly enzyme replacement therapy or bone marrow transplants, which require a perfectly matched donor. She said while the treatments brought some improvement, neither prevented damage to the brain and bones because not enough of the enzyme reached either of these tissues.

"These stem cells, modified so they produce large quantities of the enzyme that people with Hurler's disease syndrome lack, offer great hope for a potential new therapy," Dr Byers said. "If we can help reverse the disease symptoms, we could see these children able to perform normal tasks, giving them a better quality of life and increasing their life span."

Kirsty Waterford

TO COMMENT CLICK HERE

Gene link to intellectual disability

Researchers have pinpointed a gene that may cause a commonly inherited intellectual disability if affected by a genetic mutation.

University of Adelaide researchers examined the Aristales related homeobox (ARX) mutation in more than 100 families, and found that some of the mutations led to a significant reduction in ARX proteins in the brain.

Almost three per cent of Australians are affected by some kind of intellectual disability, costing the economy more than $14 billion each year. ARX is one of the top four types of intellectual disability linked to the X-chromosome in males.

Researchers found considerable variation in the disability across the families examined, with symptoms always including intellectual disability, as well as a range of movement disorders of the hand and, in some cases, severe seizures.

After testing six genes that the ARX protein interacts with, the researchers found one – a gene likely to be important to early brain development – that was adversely affected by a reduction in the number of ARX proteins.

Lead author Associate Professor Shoubridge from the University

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of Adelaide said the gene plays an important role in setting up architecture and networks in the brain, which can be disrupted by mutation of the ARX gene.

"The discovery of this genetic link is an important step forwards, but there is still much work to be done," Associate Professor Shoubridge said. "We're now looking further at the mechanism of the reduction in ARX protein, and what that means for the brain at a functional level.

"The personal cost to families is enormous, especially in the most severe cases. Being able to unravel why and how these disabilities occur is very important to us, and to the many people whose lives are affected by these conditions."

The research was published in the *Human Molecular Genetics* journal.

Kirsty Waterford

TO COMMENT CLICK HERE

All you need is love – love hormone helps autistic children

Oxytocin, the love hormone, may help autistic children to be more attuned to social cues in others.

Yale University researchers found that autistic children who were given oxytocin showed greater activity in parts of the brain associated with social interaction, including regions that process social information and are linked to reward, social perception and emotional awareness.

Oxytocin is naturally released when we hug or kiss a loved one.

The study examined 17 children with autism, aged between eight and 16 years. Each was given a dose of oxytocin or a placebo, and asked to perform a social and non-social task.

Lead researcher, Adjunct Assistant Professor Ilanit Gordon, a neuroscientist at Yale University, said oxytocin temporarily normalised brain regions responsible for the social deficits seen in children with autism.

"These results may imply that oxytocin makes social stimuli more rewarding and socially salient to children with autism spectrum disorder," Adjunct Assistant Professor Ilanit Gordon said.

She said the hormone seemed to help attune the brain to the difference between social and non-social stimuli. However, she said, the findings did not mean that one dose of the hormone would treat social deficits in people with autism.

"It means that there's a change in the brain that we read as positive and exciting, but we need to learn how to utilise it to create a change in real-life behaviour."

She said that activity in the right amygdala of the brain – the seat of emotions – as well as in the orbitofrontal cortex, which is key to social processing, and the subgenual anterior cingulate, appeared to rise and fall with increased levels of circulating oxytocin, and may begin a process of identifying and measuring doses of oxytocin that are safe and effective in aiding social learning.

Adjunct Assistant Professor Gordon said this was a key step if oxytocin was to become a tool in helping those with autism spectrum disorder were to socialise more effectively.

"Kids with autism might be able to reverse the cascade of effects that may characterise autism: those may start as subtle deficit in social drive and motivation during infancy, prompting these children to interact less, resulting in poorer social skills and brains that develop more and more differently than those of typically developing children," Adjunct Assistant Professor Gordon said

"With oxytocin-aided social skills training, that cascade of developmental differences might be interrupted, or at least blunted."

The research was published in *PNAS*.

Kirsty Waterford

TO COMMENT CLICK HERE

Man at centre of PIP breast implant scandal jailed

The man at the centre of a worldwide scare over the safety of breast implants has been jailed for fraud.

Founder of infamous breast implant manufacturer Poly Implant Prothese (PIP), Jean-Claude Mas, has been convicted of fraud and sentenced to four years imprisonment by a French court, which also imposed a lifetime ban from working in medical services or running a company.

The conviction of the 74-year-old brings to an end criminal proceedings sparked by revelations in 2010 that PIP implants were being manufactured using industrial-grade silicone.

The discovery prompted a global safety alert, including in Australia, where health authorities imposed an immediate ban on the use of PIP implants amid fears rupture could leak toxic substances into the body.

Around 300,000 women worldwide have PIP implants, including an estimated 13,000 in Australia. In its latest update, the Therapeutic Goods Administration has confirmed 490 cases where PIP implants have ruptured, and a further 24 instances of unconfirmed ruptures.

Plans for a class action by Australian women against the company's local distributor were abandoned after it was revealed it had only limited product liability insurance.

During a month-long trial in Marseille earlier this year, former PIP executives admitted using substandard silicon, but Mas denied the implants posed any additional health risk.

The former travelling salesman founded PIP in 1991 and developed into the world's third largest supplier of implants, news agency AFP has reported.

But his operations came under scrutiny in 2010 when surgeons reported an unusual number of ruptures involving his products. Subsequent investigations by French authorities found the company was saving costs by using industrial-grade silicon in 75 per cent of its implants.

The revelation prompted a worldwide ban on the product, including in Australia.

A series of safety reviews and reports has confirmed that PIP implants were more likely to rupture than those of other suppliers, but health authorities have recommended that they not be removed unless a leak is confirmed.

In October, a high-level European scientific committee found that there was no convincing reason for PIP breast implants to be removed unless they had ruptured.

In a conclusion that brought to an end a string of inquiries and reports on the implants, the European Commission's Scientific Committee on Emerging and Newly Identified Health Risks found that there was no "convincing medical, toxicological or other data to justify removal of intact PIP implants as a precautionary approach".

The Therapeutic Goods Administration said the finding was in line with its own assessment and, while it would continue to monitor failure rates of the implant, it was not planning any further investigations.

"Neither implant rupture, nor local inflammation, has been found to be associated with breast cancer or anaplastic large cell lymphoma," the TGA said. "While there are differences in rupture rates, there is no reliable evidence that ruptured PIP implants create a greater health risk than a ruptured silicone implant from another manufacturer."

Nonetheless, the regulator "strongly advised" that where rupture occurred, the implant be removed, adding that widespread concern regarding undetected ruptures meant "there is a need for women with PIP breast implants to seek regular clinical examinations".

A separate report a report by the medical director of United Kingdom's National Health Service, Sir Bruce Keogh, earlier this year found there was no evidence they caused cell damage or genetic mutations.

According to the British study, PIP implants were "significantly more likely" to rupture or leak than other brands.

But the NHS medical director said the idea that PIP implants could slowly leak silicon and other substances into the body over years without being detected was not supported by the evidence.

The British report also sought to allay concerns that any material that leached into the body from a ruptured PIP implant could cause cancer or other serious illnesses.

"PIP implants are not associated with a higher risk of breast cancer or other forms of cancer than other breast implants," it said, adding that, "standard toxicological tests carried out in the UK, France and Australia showed no evidence of cytotoxicity (damage to cells) or genotoxicity (genetic mutations)".

Adrian Rollins

TO COMMENT CLICK HERE

Members' Forum

Here's a selection of what AMA Members have been saying about the latest issues affecting the profession:

AMA President Dr Steve Hambleton said doctors should have confidence in the reformed Professional Services Review scheme, which had been changed and improved with considerable input from the AMA. One AMA member shares their view.

Do these changes alter the deliberate and embedded bias of the legisislation? It allows total reliance on what is recorded in the file to decide what really happened in a consultation, small, statistically invalid samples of patients to be used to make generalisations about how a doctor practices, and to determine penalties. Adherence to edicts such as Benzodiazepines are for short term use only, which is contrary to the reality that most doctors have to deal with, but it puts us in jeopardy every day. My impression, having being a victim of Dr Webber was that the whole system will remain a denial of natural justice when the authorites make up the rules to suit themselves. The AMA was of no assistance to me at the time at all.

Submitted by Tony Michaelson (not verified)

Department of Health figures show that 85 per cent of Australians visited a GP at least once during 2012-13, and two reports have reinforced the leadership role played by GPs in Australia's health system. An AMA member expresses their concern about elderly patients.

I am very concerned about how my elderly patients are going to fare next year when MBS items for chronic disease management, specifically health assessments and enhanced primary care plans are no longer going to be able to be billed at the same time as other items. This either means GPs will again have to do more without getting paid, or that patients will be asked to come back for an extra visit to see the GP, so that these items can be claimed separately from the acute presentation of the patient. At the moment, when a patient who comes to me who has complex care needs attends for any acute event, I take the opportunity to go through their care plan. This has always been a satisfactory approach for patients who don't want to return for another visit. Often these elderly or disabled folk are poor and cannot even afford the travel costs to see their doctor. I certainly would not like to inflict extra burden on our already stressed and disadvantaged patients. With the proposed changes to the item numbers coming into effect from November 2014 that prohibit the co-charging of these items, it would be a step back for chronic disease management and proactive care. Please lobby the Government to change their policy on this.

Submitted by Aline Smith (not verified)

Recent reports suggest that Australian children are consuming less carbonated sweet drink and eating more fruit and vegetables. It has also been observed that rates of childhood overweight and obesity have plateaued. Despite these fairly positive indications, overweight and obesity continue to be a significant public health issue in Australia. One AMA member shares his suggestion.

The development of safe, well-designed walking and separated cycling paths in our suburbs and rural towns is an essential strategy in addressing our obesity and overweight rates. Encouraging students to walk or cycle to school, university or TAFE is a simple but very effective way of ensuring 30 minutes of active exercise daily. Welcoming streetscapes make this experience more enjoyable and has a mental health benefit. Cycle stations, with lock up facilities for bikes, showers and lockers near public transport, allow a cycle and commute habit to build. This not only improves health but reduces road congestion. Coordinated public transport timetables is an essential part of this process. It takes organisation and promotion to make this work. The experience of Amsterdam, Copenhagen, New York and Chicago, for example, shows how successfully people can be drawn to cycling and walking again. Forty per cent of Amsterdamers cycle daily, mainly commuting to work and education.

Submitted by Dr Tim Denton (not verified)

The AMA has called on the Commonwealth to axe the PBS authority prescription system, give doctors a single Medicare provider number, streamline Medicare payments and reform Medicare Locals as part of a review of the role and scope of Government. One member shares their experience with their current provider number system.

I am a pirate psychiatrist providing remote location visits in far north Queensland and I would like to backup with telehealth sessions, on a needs basis, between three-monthly visits from my base in Melbourne. The current provider number system requires me to have a separate number for each location that I visit. It is much more time and cost effective if I have a provider number that follows me around to the half dozen towns that I will be visiting. Is it possible to have a special needs arrangement where the service is being provided to areas of need, at the very least? I would welcome any improvement to the current system so that I can more efficiently provide a service to these areas of need.

Submitted by Dr Jan Steel (not verified)

TO COMMENT CLICK HERE

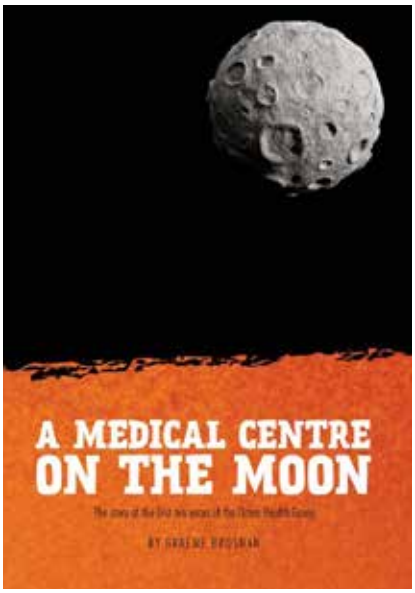
BOOK REVIEW

A Medical Centre on the Moon: the story of the first ten years of the Ochre Health Group

By Graeme Brosnan

AKA Publishing, RRP $24.95, ISBN 9780987203991, pp362

Reviewed by Dr Peter Thomas



People and terrain, the eternal Australian duet, inextricably linked and given voice by two of this country's finest poets.

Banjo Paterson wrote of the blinding glare of the sun, of the saltbush plains that are burnt and bare, by Walgett out on the Barwon side. In his poem "Bourke", Henry Lawson praised great hearts that broke and healed again, the hottest drought that ever blazed could never parch the souls of men.

Looking for a better life, people followed the rivers and the tracks of the early explorers. Most prevailed, some prospered, but it was never easy.

Some settled in central and north-west New South Wales and adjacent parts of Queensland, where towns with mythic resonance grew; Bourke, Brewarrina (simply called Bre by the locals), Walgett ("the gate" to the region), Lightning Ridge (where people worked and often lived underground), Cunnamulla and many more.

The land, nourished by artesian water, reluctantly gave up wealth in pastoralism, in opals and other resources.

Historian Geoffrey Blainey captured the moment, the tyranny of distance he called it, and how distance could lead to a feeling of abandonment.

On the coast, of course, it was much easier.

Equity of access is a tenet of Australian health delivery, universal and free. Fine in principle, but hard to implement when people choose to live remotely.

And it became even harder with the advent of "big medicine" in the 1990s, driven by diagnostic machines, high-tech clinical units and new and powerful drugs unimaginable thirty years before. Professional indemnity crises didn't help either, with the attendant deskilling that followed. The impact on rural and remote towns, medically self-reliant until then, was profound. It became the norm to transport the patient from their home to centres on the coast for even simple treatment, to use aircraft and road vehicles as therapeutic "tools".

This was a reversal of the existing natural order.

Medical relief generally came as short-term locums, or reluctant juniors from city hospitals on a rural rotation or, suspiciously, international graduates.

Into this environment, in the late 1990s, came two young doctors, one from Tasmania, the other a Kiwi. Until then, they were strangers to each other, and arrived in Bourke as locums. Their necessary skills were limited, and they sought further training in anaesthetics and obstetrics.

The totality of the rural experience soon proved seductive to them and they stayed on.

The state Department of Health was slow and proscriptive in meeting their requests for relief, and they felt they could do a better job themselves in organising these and other matters.

Bureaucratic absurdities and the dead hand of managerialism forced them to find a way through.

They were supported by at least one iconoclastic local administrator, probably at the risk of his career.

This highly readable book, whose title evokes the scenery around Lightning Ridge, is the loose chronicle of the formation of the Ochre Health Group, the successful company they established to provide health services to Bourke and, later, the larger environment. Eventual expansion into medical education and training, provision of allied health services, and the establishment of Super Clinics, followed.

It is a jolly read, full of fun, fishing and photos, that doesn't try to hide the determination of the two principals to improve the medical lot of the great hearts of Lawson's poem who live on Banjo's burnt saltbush plains.

More strength to them.

TO COMMENT CLICK HERE

Motorcycle Airbags - "An ounce of prevention"

BY **DR CLIVE FRASER**

Left: Zara Phillips falls from her horse. Above: Zara Phillips protected by airbag jacket

Never having fallen from a horse, I nevertheless have a healthy respect for jockeys who ride them for a living.

It is a long way down to the ground when you're in the saddle, and at speed the likelihood of injury climbs exponentially.

The current record for the world's fastest horse is held by Winning Brew, a two-year-old US filly who, in 2008, covered two furlongs (402 metres) in 20.57 seconds, at an average speed of 70.76 kilometres an hour.

That's mighty fast, particularly compared with the fastest documented human runner Usain Bolt, who covers 100 metres in 9.58 seconds, averaging 38.14 kilometres an hour.

Even at low speeds falling can cause severe injuries, as 46 Australians find out every day when they fall and break their hip.

One in nine of these individuals will then go to a residential aged care facility instead of going back to the family home.

Celebrity status provides no immunity from injury - the Queen Mother fell and broke her collarbone in 2000, and then fractured her pelvis in another fall in 2001, at the ripe old age of 101.

Royal children are renowned for their exuberance, and her great grand-daughter Zara Phillips fractured her collarbone in 2008 when she fell off her beloved horse Tsunami II.

Sadly, Tsunami II broke her neck in the fall, and was promptly euthanased.

In 2010, while training for the Olympic, Zara fell again, this time from High Kingdom.

But on this occasion she was uninjured – she was wearing a high-tech airbag jacket that probably saved her from an orthopaedic appointment.

Ms Phillips was wearing a jacket which inflates when a rip-cord attached to the saddle is pulled when the rider and the horse have parted company.

A CO_2 canister inflates a bladder in the jacket in less than 0.5 of a second, protecting the rider's chest and supporting the neck.

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Motorcycle Airbags - "An ounce of prevention"

...CONTINUED FROM PAGE 48

The bladder remains inflated for about one minute, which is just long enough to get back on your horse.

Our very own Superman (Christopher Reeve) may never have suffered fractures of the C1 and C2 vertebrae if that technology had been available when he fell off his horse in 1995.

Motorcycles travel considerably faster than humans, with the Suzuki Hayabusa reaching speeds of 312 kilometres an hour – at least before speed limiters were installed in 2001.

While no one could seriously think that falling off your motorbike at that speed is survivable, there is a good case for all motorcyclists to wear airbag jackets as well as helmets.

An ounce of prevention from your $200 Motorair airbag jacket may just save your life.

Suzuki Hayabusa GSX1300R	
For	The world's fastest production bike.
Against	There are no roads to match its performance.
This car would suit	Doctors in a hurry.
Specifications	1340 cc 16 valve 4 cylinder petrol 128.4 kW power @ 10,100 rpm 132.6 Nm torque @ 7,600 rpm 6 speed manual, chain drive Top speed 299 km/h (limited) 0-100 km/h in 2.6 seconds (still in first gear) 6.4 l/100 km (combined) $19,290 + ORC
Fast facts	Hayabusa is the Japanese name of the peregrine falcon, the world's fastest bird. Peregrine falcons prey on blackbirds. The Honda's CBR1100XX Super Blackbird was the previous fastest production bike in the world. Motorcycles riders are 20 to 30 times more likely to die in an accident than car drivers of the same age. Zara Phillips was recently spotted riding her horse with a baby bump.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

From graduates preparing their first resume to experienced doctors seeking to carve out a new career path in the Commonwealth public service, the AMA Careers Advisory Service has been on hand to provide practical advice and information.

Since the Service was launched in September 2012, AMA Careers Consultant, Kathryn Morgan, has handled dozens of inquiries from members looking for help and advice on advancing their careers, both within medicine and beyond.

The Careers website, which is at: http://careers.ama.com.au/, gives members access to both general and specific careers advice and information. In addition to direct links to external websites and specific sources of information, the Service also offers practical advice for medical professionals as their medical careers advance.

The Careers Service provides information and support relevant to all stages of an individual's career, from medical students looking for assistance preparing internship applications - particularly writing resumes and covering letters - through to doctors in training who want to brush up their interview skills to give them a competitive edge at all-important medical college interviews.

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

The Service is constantly updating content on its website, including listings of career-related events being staged across the country, and uses feedback from members to help add and develop resources.

Members are encouraged to visit the website, if they haven't done so already, and we welcome feedback, which can be submitted via the online feedback form on the website.

There will be further updates on developments in the Careers Service in coming months as we develop more ways to assist members along their medical career path.

If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

Phone: (02) 6270 5410
1300 884 196 (toll free)

Email: careers@ama.com.au

General Enquiries:
1300 133 655
Web:
www.ama.com.au/amex

General Enquiries:
1300 245 578
Web: www.ama.com.au/memberservices

General Enquiries:
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Web:
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General Enquiries:
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Web: http://www.ama.com.au/node/5292

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Discounts off new Volkswagen and Skoda vehicles for AMA Members*

AMA members can access substantial discounts off the list price of new Volkswagen and Skoda vehicles. **A deal that could save you thousands!**

The discount is model dependant and does not include options and accessories. Please see your local VW dealership for further details on the discount structure.

To access this exclusive offer simply contact AMA Member Services on 1300 133 655 or email memberservices@ama.com.au.

*Please Note: Must be an AMA Member for minimum 3 months prior to vehicle delivery. Cannot be used in conjunction with any other offer.

Great Qantas Club Rates for AMA Members

AMA Member Rates (GST inclusive)
Joining Fee: $230 - save $140
1 Year Membership: $372 - save $113
2 Year Membership: $660.30 - save $214.69

Partner Rates(GST inclusive)
Partner Joining Fee: $190
Partner 1 Year Membership Fee: $320
Partner 2 Year Membership Fee: $570

These special rates can be accessed by members.

If you have any questions about this offer please do not hesitate to contact AMA Member Services via email or phone on 1300 133 655. Call AMA Member Services on 1300 133 655 or email memberservices@ama.com.au

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