AUSTRALIAN
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Drinking until we drop

Time to get serious about the nation's alcohol problem, AMA says, p5

INSIDE

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Cover pic: AMA President Dr Steve Hambleton with (L to R) AMA NSW President Professor Brian Owler, AMA Vice President Professor Geoffrey Dobb and AMA VIC President Dr Stephen Parnis call for National Summit on alcohol misuse.

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Our future's future

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

> "The AMA has worked hard in lobbying all governments to ensure that Australian medical graduates have access to the intern positions they need to meet the requirements for full registration"

The future of the medical profession and the AMA will be in the hands of our new graduates and doctors-in-training. For most of this group it is an exciting time of year, with the start of the intern year, the first year of vocational training or a new rotation within vocational training as a further stepping stone to specialist recognition.

For some, however, the start of the year means an unwanted further year of pre-vocational training or 'service' jobs while polishing up the curriculum vitae to be as attractive as possible to those on the selection panels for vocational training positions in the middle of 2014.

Medicine has always been competitive, from medical school entry, through selection into vocational training - especially in the more 'desirable' specialties - to appointment as a general practitioner or hospital specialist in the location of choice. Now, new pressures are entering the competitive mix and are the frequent talk of the tea room, doctors' common room or while relaxing with friends at the end of the day.

The first and most obvious of these pressures is the increase in the number of Australian medical graduates, up from 2139 in 2008 to 2964 in 2011, with further increases since then. In 2012, 3686 medical students started their course.

The AMA has worked hard in lobbying all governments to ensure that Australian medical graduates have access to the intern positions they need to meet the requirements for full registration. Despite some hiccups along the way, the indications are that intern positions are currently just about matching the number of medical graduates who need one. Hopefully that will continue.

The focus of our advocacy must now move to PGY2, PGY3 and vocational training positions. While the increase in medical graduates has been called a tsunami, the reality is that it is more like a permanent increase in the sea level.

In the recent past, many of the PGY2, PGY3, 'service' registrar and vocational training posts have been occupied by overseas trained doctors to meet the gap between workplace requirements and the output of Australian graduates.

Now, that gap is rapidly disappearing, or has disappeared completely, and the increase in Australian graduates is not the only factor at work. There has also been a freeze on additional appointments as hospitals struggle to meet their budgets, and a reduction in the number of positions available as a result of 'reform' or adjustments to match 'affordable staffing' within the constraints of Activity Based Funding.

A lack of specialist posts available for those who complete their training is also having an impact, as these doctors remain in positions that could otherwise be occupied by vocational trainees. This is particularly the case for those specialties that are largely or wholly practiced in a hospital environment, as our public hospitals, especially, are squeezed.

Medical workforce planning isn't easy. There are strong arguments that Australia has never got it right. This is despite having a number of bodies with responsibility or oversight for such planning. These include the Health Workplace Principle Committee (made up of jurisdictional representatives), the Medical Training Review Panel, which provides an annual report for the Commonwealth Parliament (though it hasn't met for some time now), and Health Workforce Australia.

The Health Workforce 2025 report was a first attempt to draw on current medical workforce information and then, applying a range of assumptions, make future projections about supply and demand. These projections are due to be updated in early 2014, and the outcome will be received with interest.

In the meantime, the main opportunity for coordinating the medical training pipeline lies with the National Medical Training Advisory Network (NMTAN). All doctors, but especially doctors-in-training, need to be very aware of the NMTAN as it starts its work.

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> "In this changing environment there are benefits that can be available through AMA membership - and never has AMA membership been more important"

Our future's future

... FROM P3

Principles that will guide NMTAN include:

- training of the medical workforce should be matched to the community's requirements for health services;
- matching supply and demand for medical training should recognise the changing dynamics of the health care system over time; and
- the medical training system should recognise the balance between today's service delivery demands and providing the supportive environment to meet the training needs of the doctors Australia will need in the future.

The main output from NMTAN is to be a series of five-year rolling medical training plans to inform Government and the health and education sectors. These plans will be provided to health and education Ministers annually to inform decisions on medical student intakes, internship positions and specialty training places. More information is available on the HWA website (https://www.hwa.gov.au/).

NMTAN will be guided by an Executive Committee which will include a representative from the AMA Council of Doctors in Training, together with representatives of governments, universities, Medical Colleges, employers and others. Theirs will be a heavy responsibility for the professional lives and careers of our future medical workforce. It will surprise no one that the AMA will be monitoring their work very closely.

In this changing environment, there are benefits that can be available through AMA membership - and never has AMA membership been more important. These benefits include fraternal support, career guidance and access to advice or mentorship if needed. The AMA can also assist with the human resource related and contract issues that inevitably arise.

The future for doctors in training will be different from today but it should be a better future than today's, not worse, and that has been the AMA's long-term goal.

COMMENT

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.

Nation's drinking binge needs to end: AMA

The AMA has called for a National Summit on the misuse of alcohol amid mounting community alarm about the damage caused by heavy drinking, particularly following a spate of high-profile alcohol-fuelled assaults that have left several young men dead, and others severely injured.

As the NSW Government responded to outrage over public drunkenness and a string of violent attacks in inner Sydney suburbs with a crackdown on pub, club and bottle shop opening hours and mandatory minimum sentences for assaults by people intoxicated by drugs or alcohol, the AMA said it was time for governments, medical and health experts, community leaders, police, industry representatives, parent groups, families of victims and other stakeholders to come together to discuss practical solutions to curb excessive drinking and the harm caused by alcohol.

"We have a major national problem that requires a major national solution," AMA President Dr Steve Hambleton said. "We need leadership from the Federal Government and we need support from the State governments."

The AMA President, speaking at a media conference also attended by AMA Vice President Professor Geoffrey Dobb, AMA NSW President Professor Brian Owler and AMA Victoria President Dr Stephen Parnis, said that although New South Wales' tough new laws would help, they alone would not solve the problem, even if adopted nationwide.

Late last month NSW Premier Barry O'Farrell announced Parliament would be recalled to pass a package of measures to tackle alcohol and drug-related violence, including 1.30am lockouts and 3am last drinks at venues across the Sydney CBD, a statewide 10pm closing time for bottle shops and liquor outlets, a freeze on liquor licenses in the CBD, and a mandatory minimum eight-year sentence for intoxicated people convicted under new "one punch" laws.

"I have been horrified by the continued drug and alcohol-fuelled attacks on city streets," Mr O'Farrell said. "I've heard the community's call for action and I'm confident this package of measures will make a difference."

But the AMA warned that such measures on their own would not be enough to stem the harm caused by alcohol, which would require a much more comprehensive approach.

Professor Dobb, an intensive care specialist, said there needed to be a fundamental change in attitudes toward alcohol.

"What we need is change in the culture we have around alcohol in Australia," Professor Dobb said. "We can't celebrate without having a drink [and] we can't go out for an evening and enjoy a drink without actually drinking to get drunk. We need to change, and we need to involve the whole of the community in this discussion."

Dr Parnis said he could "fill a book with the number of tragedies that I have seen and treated and witnessed that are directly related to alcohol".

The AMA Victoria President, who works as an emergency physician, said the harm caused by alcohol extended from traffic accidents and assaults to the toxic effects of alcoholism, including fatal liver damage.

Dr Parnis said that not only did alcohol exact a high personal toll, its effects were a major burden on the health system, with some nights up to one in three emergency department beds occupied by someone with alcohol-related problems.

"This is well and truly an epidemic," he said. "There is no single fix for this, but there are a number of things we know will make a difference and save thousands and thousands of lives."

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Nation's drinking binge needs to end: AMA

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Professor Owler said he was "very pleased" with the measures announced by the NSW Government, adding that "what we need to see is other governments, particularly the Federal Government, playing their part to make sure there are changes to the culture and attitudes around alcohol".

"To consider this just as a law and order issue is a mistake," he said. "It's not just about the lockouts and earlier closing times. We need to consider this as a preventive health and public health issue. It's about a whole strategy that looks at education, marketing, advertising and our culture and attitudes around alcohol, and how we're going to face up to that as a community."

Dr Hambleton said the harmful consumption of alcohol was a complex problem that required action on multiple fronts.

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

But, Dr Hambleton added, any policy prescription needed to be informed by the everyday experience of those at the frontline of dealing with the effects of alcohol – doctors and other health professionals, police officers, teachers, drug and alcohol services, and families.

The AMA President said the community was in a mood for action on the issue, with a recent survey finding 75 per cent of adults acknowledging the nation had an alcohol problem, and bringing together a wide range of people would help develop sensible and practical solutions.

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

The proposal comes in addition to the AMA's push for a Parliamentary Inquiry into the marketing of alcohol to young people, and its call for the closure of a loophole in regulations that allows alcohol companies to promote their products during television sports broadcasts before 8.30pm.

Adrian Rollins

COMMENT

‘Rooms full of toothpaste and toilet paper’ no place for jab: AMA

The safety of patients could be put at risk under a trial to allow pharmacists in Queensland to administer flu vaccinations, the AMA has warned.

The AMA has written to Queensland’s Chief Health Officer Dr Jeanette Young urging her to withdraw Department of Health approval for a Pharmacy Guild of Australia pilot study under which pharmacists will be allowed to provide influenza vaccinations to people not covered by the National Immunisation Program.

> “The Queensland trial does not meet these requirements, and must cease immediately”

AMA President Dr Steve Hambleton said doctors were extremely worried about the trial because of the potential for serious harm, particularly in instances where patients suffer an adverse reaction to the vaccine.

Dr Hambleton said practitioners who performed vaccinations needed to have specific training, including assessing the safety of the vaccine for each patient and recognising and responding to adverse reactions – knowledge and skills that pharmacists did not have.

“Pharmacies have no proven record that they are safe or appropriate locations for such a private and potentially risky clinical procedure as vaccination,” the AMA President said. “It is not in the interests of patient safety for pharmacists to participate in this irresponsible trial. It could even be dangerous.”

Dr Hambleton said that not only were there concerns about the safety of pharmacist-administered vaccinations, there were a multitude of issues regarding patient privacy, professional indemnity insurance, the appropriateness of facilities, fragmentation of care and the integrity of medical records that meant allowing pharmacists to provide vaccinations was a bad idea.

“Immunisation is a clinical service; it should be done in the clinical setting. It shouldn’t be done in a room full of toothpaste and toilet paper,” the AMA President said on ABC radio. “The AMA believes that general practice is the appropriate location for vaccination, with the procedure conducted by a highly-trained and accredited GP, or by an appropriately trained and qualified practice nurse under the supervision of a GP.”

But the trial has the backing of Queensland Premier Campbell Newman, who said experience overseas suggested it was an idea worth pursuing.

“If you go to New Zealand, to Canterbury for example, the Canterbury health system at Christchurch, you will see far greater involvement by pharmacists,” Mr Newman told the ABC. “Down in New Zealand they have made the call; they’ve said we’ve got some very highly trained people in pharmacies; they’re all university graduates, you know, qualified pharmacists, and they were being used as glorified shop keepers.”

President of the Queensland branch of the Pharmaceutical Society of Australia, Associate Professor Lisa Nissen, talked down the risks of pharmacist-administered vaccinations, arguing her members would be well equipped to handle any adverse reaction from patients to vaccines.

“You don’t need a medical degree to give an injection or to manage anaphylaxis; you need to understand what the appropriate management is, and pharmacists will have appropriate first aid training, CPR training and management in giving adrenalin and managing that anaphylaxis. So as health professionals, pharmacists will be able to manage that situation,” Associate Professor Nissen said.

But Dr Hambleton said it was not clear what the purpose of giving pharmacists vaccination authority was, while the risks in terms of patient safety, continuity of care, integrity of medical records, privacy and medical indemnity were all too apparent.

“What’s the problem we’re trying to solve? You know, our immunisation rates in Queensland are quite high; we are successfully giving people access into their GPs,” he said.

“An online training course, coupled with a one-day course, is not going to equip someone with the ability to diagnose and manage anaphylaxis confidently.

“There’s going to be fragmentation of care and fragmentation of the clinical record. There’s no requirement to automatically notify the family doctor; in fact, there’s no requirement to seek information from the family doctor prior to immunisation.

“How do we prevent duplication of vaccination if there is not an established routine to either seek information from the patient’s usual doctor, or to inform the usual doctor?”

Dr Hambleton said administering vaccinations outside general practice should be subject to the same proficiency and quality requirements as those provided within general practice.

“The Queensland trial does not meet these requirements, and must cease immediately,” he said.

Adrian Rollins

COMMENT

Enhanced Medicare support for GPs key to containing health costs

Dr Steve Hambleton at the 30th anniversary of Medicare

Government efforts to control spiralling health costs must focus on enhancing the role of GPs within the health system, according to AMA President Dr Steve Hambleton.

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

"GPs are the foundation of primary care, and they save the health system money," the AMA President said, citing data showing spending on medical services grew by 4 per cent in the decade to 2011-12, well below the annual 6 per cent increase PBS spending and the 9.3 per cent annual jump in the cost of pharmacy products.

Dr Hambleton said that in the 10 years to 2012-13, Medicare benefits paid per service grew by just 4.7 per cent a year, compared with overall health spending growth of 5.4 per cent a year.

"It is clear that the MBS – combined with the private health insurers' schedules – is an effective price dampener for medical services," he said, adding that 81 per cent of GP consultations were bulk billed.

He said the figures demonstrated how the recent focus on Medicare costs, including the suggestion of a $6 patient co-payment for GP consultations, was "a bit misdirected".

"The focus should be on spending that money wisely," Dr Hambleton said, noting that non-communicable diseases had become the major driver of health costs, necessitating a change in the way the country provides health care, particularly to sharpen the focus on preventive rather than acute care: "Keeping people out of hospital is cheaper, and it frees up resources".

Dr Hambleton said there was already an example of what Medicare in future should look like.

The AMA President said the Department of Veterans Affairs' Coordinated Veterans Care (CVC) Program showed what could be achieved with a proactive approach to care based around GPs.

Under the program, GPs receive support to provide comprehensive planned and coordinated care for veterans, with the assistance of practice or community nurses.

GPs treating patients with chronic and complex diseases are given the resources to spend more time with patients who need it, as well as support following up on patients to ensure their chronic conditons are properly managed.

Dr Hambleton lamented that this type of arrangement, which was delivering real benefits for patients and saving the Government money, was "something that Medicare currently works against".

"We need to look at how we can roll out this type of pro-active approach more broadly," he said. "It would allow us to invest in a healthier future with better disease management, and prevention of avoidable costly hospital admissions."

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

It might need an increased investment from Medicare, not a decrease, he warned, adding that the role of the GP role in safeguarding the health of the population (which would ultimately control costs) must be enhanced by Medicare – not eroded or substituted.

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

Adrian Rollins

COMMENT

Heat mounts on Queensland Health over draconian contracts

The AMA has reiterated its objection to "unfair and unbalanced" employment contracts the Queensland Government is seeking to impose on Senior Medical Officers employed by the state's public hospitals.

In a strongly-worded statement issued late last week, the Federal AMA and AMA Queensland said they remained "steadfastly opposed" to the contracts and strongly advised members not to accept them.

The storm of protest that erupted when the contracts were first unveiled last October has continued unabated ever since, with doctors from around the country and internationally uniting to condemn the new employment arrangements due to come into effect from 1 July.

The individual contracts, the details of which were published by the Queensland Department of Health on its website last week, strip away key employment rights and protections, including fatigue provisions, rest breaks, limits on hours, and unfair dismissal and dispute resolution procedures.

"We maintain that the contract framework is unfair, unbalanced and disadvantages all SMOs," the Federal and Queensland AMAs said in a joint statement, warning that they would compromise the ability of Queensland public hospitals to attract and retain key medical staff, potentially undermining patient care.

"The proposed contracts will discourage doctors from working in the Queensland health system, and this would hurt our patients by further limiting their access to high quality medical services," the statement said.

Already, doctors in New Zealand - a key recruiting area for Australian hospitals – have been warned by their representative organisations to "steer clear" of job offers from Queensland public hospitals, and doctors nationwide have received similar warnings.

As fears of a crisis in public hospital care in Queensland mount, the AMA has called on the Queensland Government to reconsider its approach and enter into negotiations for fairer and more acceptable contracts.

"Both the Federal AMA and AMA Queensland are urging the State Government to rethink its position and reopen negotiations with AMA Queensland," the Associations said in their joint statement. "We will continue pushing for this outcome and we will continue to publicly highlight the unfairness of the current contracts and the damage they will cause our health system."

The AMA has advised members to reject offers to negotiate individual contracts, and has strongly recommended that they refuse to sign anything "until you have seen and read a final copy of the contract".

"Despite numerous requests," the AMA said, "Queensland Health is yet to provide doctors with the key information vital to the contracts - for example, KPI [key performance indicator] requirements, policies applicable to the contract, private practice framework and guidelines, and your individual remuneration."

Both the Federal AMA and AMA Queensland are working closely with other medical groups, particularly the Australian Salaried Medical Officers Federation, to convince the Queensland Government to change its plans.

AMA Queensland said that it was pushing Queensland Health to address a number of key concerns, including the absence of a binding arbitration process for dispute resolution, the capacity for arbitrary dismissal, the lack of a no disadvantage clause, enforced shift work and tier 3 KPIs being tied to income.

Adrian Rollins

COMMENT

It's an honour, no joke

When Brian Morton opened a letter last October asking him if he would accept nomination for an Australia Day honour, his first thought was that someone was having him on.

"I do have this little bit of cynicism from working in medico-politics and I thought, 'Is this a scam?'," said the Chair of the AMA Council of General Practice and former AMA NSW President. "My wife said 'Don't be ridiculous. Look at the paper its on, and the letterhead'."

> "Dr Morton was only fully confident it was not a hoax when he saw his name published in the honours list on Australia Day, showing that he had been made a Member in the General Division (AM)"

Dr Morton was only fully confident it was not a hoax when he saw his name published in the honours list on Australia Day, showing that he had been made a Member in the General Division (AM).

He said that as well as being personally gratifying, the award indicated the high regard in which the medical profession was held.

Altogether, 24 AMA members were recognised in the Australia Day honours list for their services to medicine as well, in many cases, for their work in the broader community.

As Dr Morton observed, many doctors are not only active in their work and profession, but are also involved in a lot of voluntary work aimed at improving the lives of others in their community.

A prime example is Balnarring GP Dr Graham Cato, who was awarded the Medal of the Order of Australia (OAM) for his work in community health and life saving, including being a founding member of the Australian Association of Developmental Disability Medicine, running a weekly clinic at a residential home for the intellectually disabled for the past 34 years and helping develop Victoria's Westpac Helicopter Rescue Service.

Another prominent AMA recipient was Australian National Preventive Health Agency Advisory Council Chair Professor Christine Bennett, who was made a Companion in the General Division (AC) in recognition of "distinguished service to medicine and health care leadership as a clinician, researcher and educator".

Dr Morton said often people were unaware of the work undertaken by AMA members on behalf of the profession and the broader community, and the Australia Day awards were an encouraging reminder that such contributions were valued.

"I don't think non-AMA members, or for that matter many AMA members, really appreciate the fact that most of the people holding committee positions do it without any payment," he said. "The positions are honorary, and it does take time and does take you away from your earning capacity in the practice."

Dr Morton said many doctors active in the AMA were also busy doing other voluntary work for their community, and the Australia Day honours were "a good reminder that doctors do a lot of stuff that is not just about getting money".

Below is a list of AMA members who were included in the Australia Day honours list, along with their citations:

Victoria

Companion (AC) in the General Division

Professor Samuel Frank BERKOVIC AM

For eminent service to biomedical research in the field of epilepsy genetics as a leading academic and clinician, to the study of neurology on a national and international level, and as an ambassador for Australian medical science education.

Member (AM) in the General Division

Dr Harry HEMLEY

For significant service to medicine through delivering health care to the homeless, and as a general practitioner.

Associate Professor Richard William KING

For significant service to medicine as a clinician, educator and administrator, particularly in the areas of health policy development.

Dr Stewart HART

For significant service to medicine as a clinician, particularly in the area of breast cancer research, and to community health organisations.

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It's an honour, no joke

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Medal (OAM) in the General Division

Dr Graham William CATO

For service to community health, and to surf lifesaving.

Associate Professor Bruce Philip WAXMAN

For service to medicine as an administrator, educator and clinician.

Associate Professor Geoffrey QUAIL

For services to medicine, particularly through dentistry. Professor Quail was head of dental and maxillofacial surgery at the Monash Medical Centre from 1981 to 2011.

Public Service Medal (PSM)

Dr Eugenie TUCK OAM

For outstanding public service in the area of health care in correctional services. Dr Tuck spent 26 years of her 47 year medical career as a medical practitioner working in correctional health care providing care to prisoners.

New South Wales

Companion (AC) in the General Division

Professor Christine Constance BENNETT

For distinguished service to medicine and healthcare leadership, as a clinician, researcher and educator, particularly in the fields of child and family health and social policy.

Member (AM) in the General Division

Dr Brian Keith MORTON

For significant service to medicine as a general practitioner, and to a range of professional medical organisations.

Dr Ian Andrew NICHOLSON

For significant service to medicine in the field of cardiac surgery, and through volunteer outreach programs in the Pacific and Africa

Dr Paul Douglas STALLEY

For significant service to medicine, particularly the treatment of bone and soft tissue cancers.

Medal (OAM) in the General Division

Dr Ian James BAGULEY

For service to medicine, particularly brain injury rehabilitation.

Dr Romney Adair NEWMAN

For service to medicine as a physician, and to the community.

Dr James Byrne POLLITT

For service to medicine as a general practitioner, and to the community.

Dr Peter Robert WAKEFORD

For service to medicine, and to the community.

Western Australia

Member (AM) in the General Division

Winthrop Professor Cashel D'Arcy HOLMAN

For significant service to medicine in the field of epidemiology and public health.

Dr William Daniel ROBERTS

For significant service to the community through roles in health administration and as a general practitioner.

Dr Peter Martin WINTERTON

For significant service to youth through a range of child protection roles, and to medicine.

Medal (OAM) in the General Division

Dr Richard Howell WALKEY, deceased

For service to medicine as a general practitioner, and to the community.

South Australia

Member (AM) in the General Division

Dr Vikija ANDERSONS RFD

For significant service to medicine as an ophthalmologist and surgeon.

Dr Graham Francis FLEMING

For significant service to medicine in rural South Australia, and as an advocate in the field of mental health and suicide prevention.

Professor Graeme Paul YOUNG

For significant service to medicine through a range of research, clinical and academic roles, particularly in the area of gastrointestinal health.

Queensland

Member (AM) in the General Division

Dr Vernon Barton HILL

For significant service to rehabilitation medicine and spinal injuries.

Dr Peter Thomas MYERS

For significant service to sports medicine and orthopaedic surgery.

Medal (OAM) in the General Division

Dr Darryl John GREGOR

For service to ophthalmology, and to education.

Dr Christine Ellen TRACEY-PATTE

For service to women's affairs.

ACT

Medal in the Military Division

Dr Leonard BRENNAN

COMMENT

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

INVITATION FOR NOMINATIONS FOR ELECTION TO FEDERAL COUNCIL AS AREA NOMINEES

The Articles of Association of the AMA provide for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Areas:

1. New South Wales and Australian Capital Territory Area
2. Queensland Area
3. South Australia and Northern Territory Area
4. Tasmania Area
5. Victoria Area
6. Western Australia Area

The current term of Area Nominee Councillors expires at the end of the AMA National Conference in May 2014.

Nominations are now invited for election as the Nominee for each of the Areas listed above.

1. Nominees elected to these positions shall hold office until the conclusion of the May 2016 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member in the relevant Area for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA resident in the Area for which the nomination is made.
5. Nominations should be addressed to the Secretary General (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than **1.00pm (AEDT) Friday 7 March 2014**.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words. Such statement will be circulated with the ballot paper if it is approved by the Federal Council.

For a copy of a nomination form or any general enquiries, please contact Nadene Sharpe, Office of the Secretary General and Executive (tel: 02 6270 5460 or email: nsharpe@ama.com.au).

Anne Trimmer
Secretary General
30 January 2014

INVITATION FOR NOMINATIONS

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

INVITATION FOR NOMINATIONS FOR ELECTION TO FEDERAL COUNCIL AS CRAFT GROUP NOMINEES

The Articles of Association of the AMA provide for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Craft Groups:

1. Anaesthetists
2. Dermatologists
3. Emergency Physicians
4. General Practitioners
5. Obstetricians and Gynaecologists
6. Ophthalmologists
7. Orthopaedic Surgeons
8. Paediatricians
9. Pathologists
10. Physicians
11. Psychiatrists
12. Radiologists
13. Surgeons

The current term of Craft Group Councillors expires at the end of the AMA National Conference in May 2014.

Nominations are now invited for election as the Nominee for each of the Craft Groups listed above.

1. Nominees elected to these positions shall hold office until the conclusion of the May 2016 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member of the relevant Craft Group for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Craft Group for which the nomination is made.
5. Nominations should be addressed to the Secretary General (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than **1.00pm (AEDT) Friday 7 March 2014.**
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Anne Trimmer
Secretary General
30 January 2014

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

INVITATION FOR NOMINATIONS FOR ELECTION TO FEDERAL COUNCIL AS SPECIAL INTEREST GROUP NOMINEES

The Articles of Association of the AMA provide for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Special Interest Groups:

1. Salaried Doctors
2. Doctors in Training

The term of Councillors expires at the end of the AMA National Conference in May 2014.

Nominations are now invited for election as the Nominee for each of the Special Interest Groups listed above.

1. Nominees elected to these positions shall hold office until the conclusion of the May 2016 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member of the relevant Special Interest Group for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Special Interest Group for which the nomination is made.
5. Nominations should be addressed to the Secretary General (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than **1.00pm (AEDT) Friday 7 March 2014**.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words. Such statement will be circulated with the ballot paper if it is approved by the Federal Council.

For a copy of a nomination form or any general enquiries, please contact Nadene Sharpe, Office of the Secretary General and Executive (tel: 02 6270 5460 or email: nsharpe@ama.com.au).

Anne Trimmer
Secretary General
30 January 2014

INVITATION FOR NOMINATIONS

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

ELECTION OF EXECUTIVE OFFICERS – CALL FOR NOMINATIONS

The four Executive Officers of the Australian Medical Association Limited for 2014/2015 will be elected at the 2014 National Conference of the AMA to be held on 23-25 May 2014 in Canberra.

The positions to be filled are **President, Vice President, Chairman of Council** and **Treasurer**.

Each will hold office until the conclusion of the National Conference in May 2015.

Any Ordinary Member of the Association may nominate for one or more of these offices.

The electors are the delegates to the National Conference.

Members who wish to nominate are now invited to do so.

Nominations must:

1. Be in writing and addressed to the Secretary General (marked "Private and Confidential");
2. State the position or positions for which the candidate is nominating;
3. Indicate the nominee's willingness to accept the nomination or nominations;
4. Include the names of two Ordinary Members who are nominating the candidate; and
5. Be delivered to:

   Secretary General
   Australian Medical Association
   Level 4, 42 Macquarie Street
   BARTON ACT 2600
   by 1.00pm (AEST) Friday 2 May 2014.

For a copy of a nomination form or any general enquiries, please contact Nadene Sharpe, Office of the Secretary General and Executive (tel: 02 6270 5460 or email: nsharpe@ama.com.au).

Anne Trimmer
Secretary General
30 January 2014

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 Robyn Langham	AMA Representative, Victoria	Medicines Australia Code of Conduct Review Panel	27/2/2014
		Medicines Australia Code of Conduct Review Panel	6/2/2014
		Medicines Australia Code of Conduct Review Panel	17/12/2013
Dr Ian Pryor	AMA Member	MSAC Review Consultation Committee for Inguinal Hernia	3/2/2014
Dr David Mountain	AMA Representative for Emergency Physicians	National Hospital Cost Data Collection Advisory Committee	23/1/2014
Dr Andrew Mulcahy	AMA Representative for Anaesthetists	MSAC Implementation Working Group for Cardiac Perfusion	19/12/2013
		National Hospital Cost Data Collection Advisory Committee	27/9/2013
Dr Richard Whiting	AMA Representative for Physicians	MSAC Review Consultation Committee for Vitamin D and B12/ Folate testing	18/12/2013
Dr Richard Kidd	AMA Queensland Vice President	Aged Care Gateway Advisory group	18/12/2013
Dr Chris Moy	AMA Member	NeHTA Clinical Usability Program Steering Group	11/12/2013

COMMENT

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 no longer have to seek reimbursement from the Department for care costs.

Instead, 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."

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

Private insurance for GPs poses risk to Medicare, *The Saturday Age*, 11 January 2014

Health Minister Peter Dutton opened the door to lifting the long-standing ban on private health insurers paying for GP services. AMA Chair of General Practice Dr Brian Morton said private health insurers should be allowed to cover GP services, but only in a way that is accessible to every patient and GP.

Child diabetes shock, *Sunday Mail Brisbane*, 12 January 2014

Children as young as four years are developing lifestyle-related type 2 diabetes. AMA President Dr Steve Hambleton said it was "terribly shocking" that type 2 diabetes was being diagnosed in children aged younger than 10 years.

Men dose up big on hormone, *Sunday Telegraph*, 12 January 2014

Older men are behind a surge in testosterone prescriptions being used as an anti-aging tonic. AMA President Dr Steve Hambleton said men should be wary of companies offering testosterone as a treatment for andropause.

Killer pill alert, *Sunday Mail Brisbane*, 12 January 2014

A drug approved only to treat severe acne is still being prescribed as a contraceptive pill for Australian women despite a well-documented link to blood clots. AMA President Dr Steve Hambleton said the use of the drug as a contraceptive was one of the most common off-label prescriptions.

AMA in death debate call, *Courier Mail*, 13 January 2014

Experts are questioning whether using expensive and potentially debilitating drugs to win a few extra months of life for terminal patients is better than a natural death. AMA President Dr Steve Hambleton said the debate should be about patient benefit, not cost.

Patients put on hold while GPs forced to call medicine hotline, *Courier Mail*, 13 January 2014

Doctors are demanding the Federal Government scrap a requirement for them to call a hotline to authorise every new prescription for certain Pharmaceutical Benefit Scheme medicines. The AMA said doctors were being plagued by lengthy delays on the hotline.

GPs oppose insurers covering cost of visits, *Canberra Times,* 13 January 2014

Doctors are concerned that proposals to allow private insurers to pay for GP visits might encourage people to change doctors. AMA Chair of General Practice Dr Brian Morton called for a conversation between government, health insurers and the medical profession to ensure that short-term gains did not damage the health system in the long term.

Doctors take a jab at Queensland flu vaccine trial, *Australian Financial Review*, 16 January 2014

A trial allowing pharmacists in Queensland to administer flu vaccinations has upset medical groups, which claim it puts patients at risk. The AMA has called on the State government's Chief Health Officer to halt the trial.

Rip off docs to repay $1m, *Sunday Tasmanian*, 19 January 2014

Doctors who claimed Medicare rebates for up to 500 patients a day have been ordered to pay back $1 million. AMA President Dr Steve Hambleton said sick people should not be discouraged from seeing a doctor.

Doctors back inquiry into alcohol abuse, *Sunday Age*, 19 January 2014

The Australian Medical Association has backed a broad inquiry into the nation's drinking culture, as calls grow for action on street violence after the death of a Sydney teenager. AMA President Dr Steve Hambleton said his members wanted to see discussion on a range of issues around alcohol.

AMA calls for an alcohol summit, *The Age*, 23 January 2014

Doctors will today demand the Abbott Government show national leadership on the epidemic of alcohol abuse by calling a National Summit to change the nation's booze-soaked culture.

Aussie booze warning, *MX Melbourne,* 23 January 2014

Doctors have urged drinkers to stop misusing alcohol amid police revelations that there are more assaults on Australia Day than on any other public holiday. The AMA called for a National Summit of the harms of alcohol misuse.

Mum: your baby is fat, *Courier Mail*, 24 January 2014

Many parents are unable to recognise if their children are overweight and some have lost all awareness of what fat looks like. AMA President Dr Steve Hambleton said it was clear some parents had lost perspective on the size of their children.

Alcohol industry bosses reject summit calls, *The Age*, 24 January 2014

Alcohol industry representatives have rejected the medical profession's call for

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AMA IN THE NEWS

... FROM P15

a National Summit to tackle an epidemic of booze-related harm as grandstanding. The AMA's call for a summit to develop solutions to curb alcohol abuse drew a cautious response from the Government.

Fear NSW booze law may ruins pubs, *Australian Financial Review*, 24 January 2014

A crackdown on alcohol-fuelled violence in NSW could cut revenue at some Sydney pubs by 20 per cent and provoke a wave of foreclosures. The AMA called on the Federal Government to hold a National Summit to look at the community harm caused by alcohol.

Deeper issues fuel cultural binge, *Sunday Mail Brisbane*, 26 January 2014

Australia has a long history of allowing heavy drinking to be tolerated as part of our cultures but this attitude must be changed. The AMA has called on the Federal Government to convene a summit on alcohol-related harm.

Lift drinking age, urges medical chief, *Sydney Morning Herald*, 27 January 2014

A medical expert has warned the NSW Government's radical alcohol reforms will be undermined unless the legal drinking age is raised to 20. The AMA said there needed to be a national debate on the issue.

Radio

Dr Steve Hambleton, Radio National Canberra, 13 January 2014

AMA President Dr Steve Hambleton discussed the precautions people needed to take in heatwave conditions. He advised people to pay attention to weather reports, and gave tips on how to prevent heat-related illnesses in extreme temperatures.

Dr Steve Hambleton, 4BC Brisbane, 15 January 2014

AMA President Dr Steve Hambleton discussed his concerns about a trial that would see pharmacists allowed to give flu vaccinations. He said pharmacists were trained differently to doctors and may not be able to recognise certain conditions.

Dr Brian Morton, Radio National, 15 January 2014

AMA Chair of General Practice Dr Brian Morton talked about the debate between doctors and pharmacists over who should administer flu vaccinations. He said pharmacists were not doctors, and patient safety was an issue.

Professor Geoffrey Dobb, 702 ABC Sydney, 15 January 2014

AMA Vice-President Professor Geoffrey Dobb talked about precautions that people needed to take during heatwave conditions. He urged people to stay hydrated and advised against drinking alcohol.

Dr Steve Hambleton, 666 ABC Canberra, 16 January 2014

AMA President Dr Steve Hambleton talked about the ability of hospitals to handle heatwaves. He said heat-related illnesses were very serious and exacerbated other medical conditions.

Dr Steve Hambleton, 2GB Sydney, 22 January 2014

AMA President Dr Steve Hambleton discussed NSW Premier Barry O'Farrell's plans regarding the consumption of alcohol. He said the AMA had called for a Parliamentary Inquiry into the promotion of alcohol to young people.

Dr Steve Hambleton, 5AA Adelaide, 30 December 2013

AMA President Dr Steve Hambleton discussed a proposal put before the Federal Government's National Commission of Audit for patients to pay a $6 fee for GP visits. He said the AMA was concerned it could discourage people from seeing their doctor, and increase the pressure on hospital emergency departments and ambulance services.

Dr Steve Hambleton, ABC NewsRadio Sydney, 23 January 2014

AMA President Dr Steve Hambleton discussed the AMA's call for a National Summit on alcohol abuse and misuse. He said manufacturers of alcohol need to be part of the solution.

Professor Geoffrey Dobb, 2GB Sydney, 23 January 2014

AMA Vice President Professor Geoffrey Dobb talked about the AMA's call for a National Summit on alcohol misuse. He said that in his work he saw the damage alcohol causes through car crashes, domestic assaults and violence in entertainment districts.

Dr Steve Hambleton, 4BC Brisbane, 23 January 2014

AMA President Dr Steve Hambleton talked about the AMA's demand that the Abbott Government show leadership on the issue of alcohol fuelled violence by convening a National Summit bringing together all levels of government, as well as medical and health experts, police, industry, community representatives and parent groups.

Dr Steve Hambleton, 612 ABC Brisbane, 23 January 2014

AMA President Dr Steve Hambleton called for a National Summit on alcohol misuse and harm. He said doctors were horrified by the injuries, accidents and illnesses that resulted from poor behaviour due to alcohol.

Dr Steve Hambleton, 612 ABC Brisbane, 27 January 2014

AMA President Dr Steve Hambleton discussed a proposed scheme enabling patients waiting for surgery in public hospitals to seek treatment in private hospitals. He said Queensland had been reducing waiting lists by outsourcing patients into the private sector for the past decade.

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AMA IN THE NEWS

... FROM P16

TV

Dr Steve Hambleton, Channel 9 Sydney, 13 January 2014

AMA President Dr Steve Hambleton discussed medical marijuana as a treatment for epilepsy. He said there needed to be scientific trials before a suggested therapy could be said to work.

Dr Steve Hambleton, Channel 9 Sydney, 15 January 2013

AMA President Dr Steve Hambleton discussed the Queensland Government's decision to allow a trial under which community pharmacists could administer flu vaccinations. He pointed out that pharmacists may not be equipped to deal with possible anaphylactic reactions.

Dr Steve Hambleton, Channel 10 Sydney, 19 January 2014

AMA President Dr Steve Hambleton discussed the AMA's proposal for a National Summit on alcohol misuse and the nation's drinking culture.

Dr Steve Hambleton, Channel 10 Sydney, 19 January 2014

AMA President Dr Steve Hambleton discussed occasions when doctors were caught rorting the Medicare rebate system. He said the professional services review process worked, and the number of implicated practitioners represented a small proportion of the 120 million rebate claims processed every year.

Dr Steve Hambleton, Channel 9 Melbourne, 20 January 2014

AMA President Dr Steve Hambleton discussed a proposal being put to the Federal Government's National Commission of Audit decision for a $6 patient co-payment for GP visits as a way to ease pressure on the Medicare budget. He warned some people might decide not to go to the doctor because of such a fee.

Dr Steve Hambleton, ABC1 Perth, 20 January 2014

AMA President Dr Steve Hambleton raised concerns about caffeine-laced energy strips that have just been released. He warned the strips would make it easier for people to overdose on caffeine.

Dr Steve Hambleton, Sky News Australia, 23 January 2014

AMA President Dr Steve Hambleton discussed the AMA's proposal for a National Summit on alcohol misuse. He added that there should be a Parliamentary Inquiry into alcohol marketing, particularly to young people.

Professor Geoffrey Dobb, ABC1 Sydney, 23 January 2014

AMA Vice President Professor Geoffrey Dobb talked about alcohol-fuelled violence and the need to change cultural attitudes towards alcohol.

Dr Steve Hambleton, Channel 9 Sydney, 24 January 2014

AMA President Dr Steve Hambleton discussed childhood obesity. He said parents consistently underestimated the weight of their children and of themselves.

COMMENT

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.

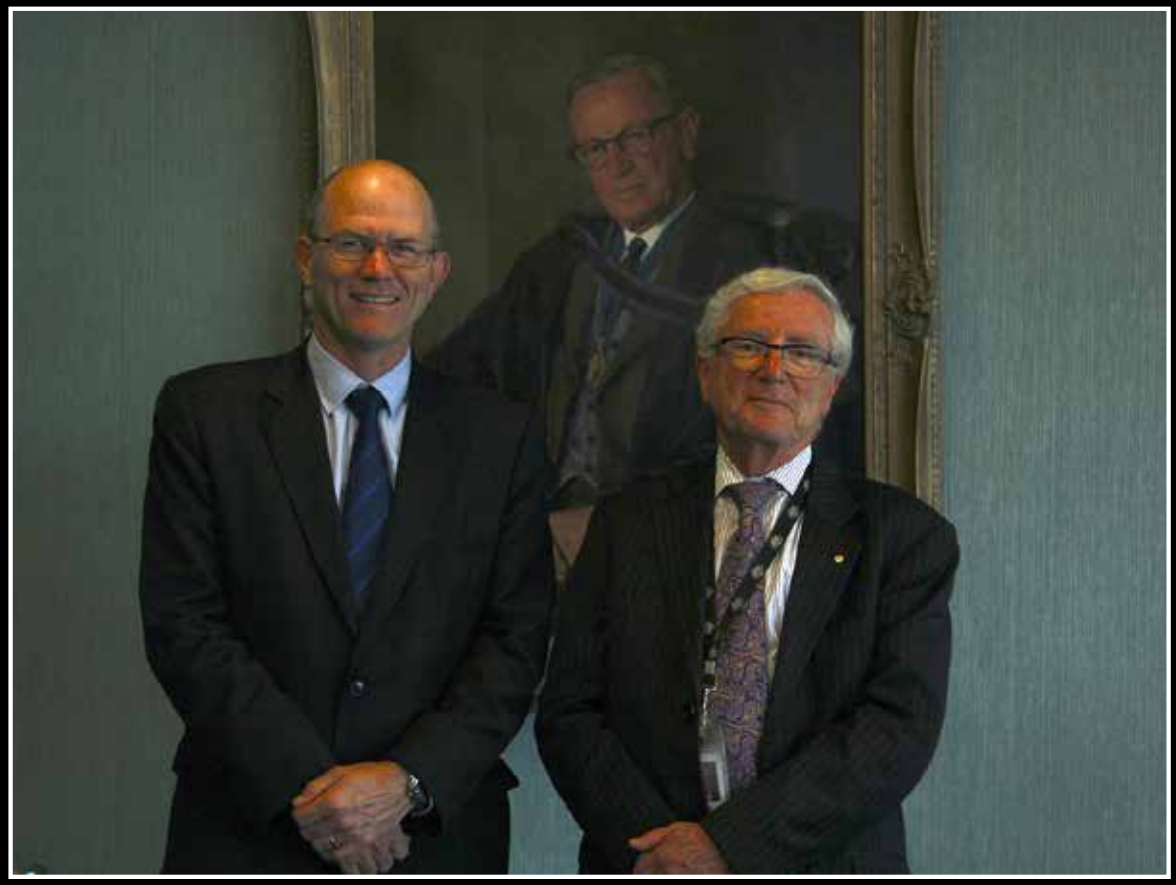
The document sets out the notification process, including the time limits that apply.

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.

AMA IN ACTION

The AMA took the national lead in tackling the harm caused by alcohol when AMA President Dr Steve Hambleton, Vice President Professor Geoffrey Dobb, NSW President Professor Brian Owler and Victoria President Dr Stephen Parnis held a media conference late last month to call for a National Summit on alcohol abuse and misuse. The proposal received national coverage and highlighted the seriousness with which medical practitioners view the nation's alcohol problem. Earlier in the month, Dr Hambleton met with Dr John Horvath, who is leading the Federal Government's review of Medicare Locals, to directly present the AMA's concerns about the network as currently constituted. Dr Hambleton and other AMA officials were also in heavy demand from the media seeking comment on a wide array of issue from health financing and the future of Medicare to meningococcal disease and the use of steroids. During January, former AMA President Dr Mukesh Haikerwal attended a World Medical Association meeting in China, in his capacity as Chair of the WMA Council.

COMMENT



FEBRUARY HEALTH EVENTS

The dates and events listed are major awareness days, conferences, weeks and months related to health. If you know of an upcoming national health event please email the details to ausmed@ama.com.au

Sun	Mon	Tue	Wed	Thur	Fri	Sat
26	27	28	29	30	31	**1** Heart Kids National Awareness Month, Ovarian Cancer Awareness Month, National Red Feb Month, National Raynaud's Awareness Month, FebFest 2014
2 National Neuroblastoma Awareness Day	**3** World Cancer Day	**4**	**5**	**6**	**7**	**8**
9	**10**	**11**	**12** Duchenne Awareness Week	**13**	**14** National Condom Day National Heart Research Day- Nationwide	**15**
16	**17** Australia's Health Weight Week	**18** International Asperger's Day	**19**	**20**	**21**	**22**
23 Ovarian Cancer Australia's Teal Ribbon Day National DonateLife Week	**24** National Sunnies for Sight Day	**25**	**26** Teal Ribbon Day	**27**	**28** International Rare Disease Day	1

Drug giant phases out payments to doctors

Multinational pharmaceutical company GlaxoSmithKline (GSK) will phase out payments to doctors and other health care professionals to speak at or attend medical conferences.

The payments will be phased out over the next two years as part of wider changes to the company's global sales and marketing practices.

GSK also announced that, by the start of 2015, its sales people in Australia will no longer be compensated based on individual sales targets.

The changes come in the wake of a move by the Australian Competition and Consumer Commission (ACCC) last year to give drug companies two years to comply with a more stringent set of rules regarding the transparency of payments and sponsorships provided to doctors.

GSK General Manager Australia Pharmaceuticals, Geoff McDonald, said the company's announcement introduced some of the most significant changes to marketing and sales practices in the industry for some time.

"This builds on the work we have been doing to be more transparent and increase trust in our industry," Mr McDonald said.

"In Australia there is widespread community expectation of increased transparency in commercial relationships between pharmaceutical companies and healthcare professionals, especially in the way our sales employees operate.

"These changes will give greater confidence to the community that our interactions are focused on patient needs."

In a statement, GSK said it would move to end the practice of paying doctors and health care professionals to speak on its behalf about its products or disease areas to audiences who can prescribe, or can influence prescribing.

It would also stop providing financial support directly to individual doctors to attend medical conferences.

Instead, the company would fund education for doctors through "unsolicited, independent educational grant routes".

The company said it intends to work through the practical details of the changes with doctors, medical organisations and patient interest groups to define how they can be implemented effectively and in line with local laws and regulations.

The consultation will begin early this year, with the aim that the changes to be in place across GSK's global business by the start of 2016.

GSK said it would continue to provide appropriate fees to doctors for services related to GSK-sponsored clinical research, advisory activities and market research. The company has committed to disclose the payments it makes to doctors and health care professionals worldwide, and already does so in Australia.

The AMA has supported moves to increase transparency, including reporting of aggregate payments made by drug companies to sponsor health professionals to attend and speak at conferences, as well as to compensate doctors who provide advisory or consulting services.

Last year it called for an interim $500 threshold on the public disclosure of pharmaceutical company payments to individual practitioners.

In its submission to Medicines Australia on a proposed reporting model for industry payments, the Association urged that modest threshold limits be adopted to minimise the administrative burden on industry and practitioners while satisfying public interest in the disclosure of substantive payments.

In its submission, the AMA recommended that all payments and benefits worth more than $25 should be recorded, while the threshold for public disclosure should be set at $500 or more.

Debra Vermeer

COMMENT

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

Anti-vax group struggles to make a name for itself

The Australian Vaccination Network, which argues that vaccination is unsafe and has links to autism, has reportedly struck trouble in its attempts to find a new name after authorities ruled its existing name was misleading.

The Australian newspaper reported that the organisation tried to "reserve" the name 'Australian Vaccination – Sceptics Network', with the Australian Securities and Investments Commission, but failed.

The newspaper reported that in the wake of the failed attempt, other members of the public rushed to register the name, as well as 'Australian Vaccination Skeptics'.

The NSW Department of Fair Trading last year ruled that the anti-vaccine group's existing name was misleading and ordered it to be changed by February.

When the AVN appealed the decision, the NSW Administrative Decisions Tribunal backed the Department, directing the Network to change its name and develop one that accurately reflects its scepticism about vaccinations.

NSW Minister for Fair Trading Anthony Roberts welcomed the Tribunal's decision to make the AVN change its name.

"Fair Trading acted in this matter after receiving numerous complaints, including from the Australian Medical Association, that the AVN name was misleading given its overwhelming focus on the publication of anti-vaccination messages and information," Mr Roberts said.

"The time has come for AVN to find a name which reflects its anti-vaccination stance."

The controversy comes amid fresh warnings that vaccination coverage in some parts of the country is so low that there is risk of a sustained outbreak of serious diseases such as measles and whooping cough.

An outbreak of measles in Victoria last year prompted the AMA Victoria to make a renewed call for parents to vaccinate their children. And health authorities across the country were on alert in December following an outbreak of measles among participants at a Sydney dance competition attended by more than 200 people.

AMA Victoria President Dr Stephen Parnis said in the last 10 years there had been 954 measles cases in Australia.

He said the latest figures from the National Health Performance Authority show there are several areas in Australia where immunisation coverage is below the 93 to 95 per cent coverage required to prevent measles outbreaks.

"People need to understand the dangers associated with measles," Dr Parnis said. "Many older Australians will remember the measles outbreaks which caused devastating illness, deaths and long-term neurological disability, as there was no vaccine at the time.

"This virus must be taken seriously and parents need to vaccinate their children."

He said every vaccine used in Australia had been thoroughly tested for safety and effectiveness, approved by the Therapeutic Goods Administration and was subject to ongoing monitoring and evaluation.

President of the Australian Vaccination Network, Greg Beattie, told the northern NSW based newspaper *The Northern Star* that there was "no truth whatsoever" to reports that the organisation had a failed attempt at finding a new name.

He told *The Northern Star* that the group had reserved a name with the NSW Department of Fair Trading last month, but that five days after they reserved the name, two members of the public registered the same name with the Australian Securities and Investments Commission. The AVN was not certain whether this meant they cannot use the reserved name.

"It's simply an attempt to silence us," he said. "The important thing is that we're going to keep on doing what we do."

Debra Vermeer

COMMENT

Manufacturing problems hit global supplies of key vaccines

Worldwide supplies of several vaccines for chicken pox, measles, mumps, rubella and varicella have been disrupted following a manufacturing problem at a major supplier.

GlaxoSmithKline has advised health authorities around the globe, including the Department of Health, that supplies of all its varicella-containing vaccines have been halted following the detection of a "manufacturing issue" with some batches of its MMRV (Priorix-Tetra) and varicella (Varilrix) vaccines.

Batches of these vaccines had been scheduled to arrive in Australia last month, but have been delayed pending the completion of an investigation by GSK.

The Department said the issue only affected vaccines that had been under production, and all those that have been, or are ready for, distribution in Australia are safe and effective.

The vaccines are used in the National Immunisation Program – Priorix-Tetra is administered to 18 month olds and Varilrix is used for children in secondary school.

But the health authorities said contingency arrangements had been put in place that meant there was not expected to be any disruption to the immunisation program.

"Demand for these vaccines for the National Immunisation Program is able to be met at this stage through existing stock on hand," the Department said. "GSK is assisting by directing its existing stock as a priority to the National Immunisation Program."

It is unclear at this stage when normal supplies will resume, and the Department has sought alternate supplies of the measles, mumps and rubella (MMR) and varicella vaccines.

In addition, the high school varicella vaccination program for 12 and 13-year-olds in Year 7 at high schools in NSW, Victoria and the ACT has been delayed until the latter half of the year.

"The priority is to ensure that MMR and varicella vaccines continue to be available for children at 18 months of age," the Department said.

Adrian Rollins

COMMENT

Households trim spending to cover soaring health premiums

Many households are considering trimming other areas of spending in order to cover the biggest hike in private health insurance premiums in decade, a survey has found.

In a sign of the importance families attach to private health cover, a survey commissioned by comparison service www.comparethemarket.com.au found that 47 per cent intended to cut back on other expenditure in order to be able to afford a 6.2 per cent jump in premiums due to come into effect from 1 April.

Not surprisingly, almost 42 per cent indicated they would shop around for a new policy as a result of the looming increase.

But, in a result that should comfort health funds, just 10 per cent of those surveyed said they would let their policy lapse.

The response belies claims, including those made by the Coalition, that the move by the previous Government to means test the private health insurance rebate would drive many people out of private health cover altogether and send a flood of extra patients into the public hospital system.

Indeed, the survey found that 87 per cent of respondents remained eligible for the full rebate even after the introduction of means testing.

The survey of 1000 adults was conducted by polling firm Pure Profile.

Adrian Rollins

COMMENT

Comprehensive e-health guide for clinicians updated

A key guide to doctors with the mammoth task of transforming their surgery into an e-health practice equipped to use electronic health records has been upgraded.

The National e-Health Transition Authority has issued the E-health Clinicians User Guide as an update on its previously issued version.

It says the User Guide is intended primarily for general practices and private specialists' practices, to help them "understand the national e-health system and related e-health features which have become available in recent updates to desktop software".

The Guide will also help doctors work out what changes may be necessary in the practice so they can benefit from the use of e-health, and how to plan for and implement the changes.

It will assist practices to undertake the necessary once-off pre-implementation set-up steps and verify that the e-health features are operating correctly.

The Federal Government launched its Personally Controlled Electronic Health Record (PCEHR) system in July 2012 with the aim of delivering safer, more efficient and better quality health care.

Patients are able to register for an e-health record, which is intended to be a secure, electronic summary of their important health information. Under its current configuration, patients are able to control which information they want to be included in their e-health record.

But since the system went live, little more than one million people have registered for a PCEHR, and doctors too have been wary, with barely 11,000 shared health summaries having been uploaded by practitioners.

In November, AMA President Dr Steve Hambleton was appointed by the Abbott Government to a three-member panel to review the system and advise on changes to improve its usefulness and encourage greater adoption by patients and the medical profession. The review reported to Health Minister Peter Dutton in December.

In its submission to the review, the AMA warned that the system risked being rejected outright by many doctors unless the emphasis on patient control was scaled backed and the integrity of information contained in the record was assured.

"We support people taking greater responsibility for their own health, and the PCEHR has the potential to assist with this," AMA Vice President Professor Geoffrey Dobb said. "But patient control should not mean that PCEHR cannot be relied upon as a trusted source of key clinical information."

Professor Dobb said that less patient control would not compromise privacy because there were already strong safeguards in the enabling legislation to prevent third parties having access to electronic records without a valid reason, and there were heavy penalties for any breaches.

The AMA also recommended that the PCEHR be an opt-out rather than opt-in system, as this would ensure a high degree of consumer participation and encourage doctors to commit to using the system.

While the latest version of the *eHealth Clinician's User Guide for Medical Practitioners* contains information on how to set up the current e-health features in medical practices, the Transition Authority said the Guide would continue to evolve as new features were incorporated.

"... less patient control would not compromise privacy because there were already strong safeguards in the enabling legislation to prevent third parties having access to electronic records without a valid reason, and there were heavy penalties for any breaches"

Expected new features will include electronic referrals, discharge summaries and specialist letters, as well as electronic medication management, including the electronic transfer of prescriptions and e-diagnostic services.

The system also includes incentives for practices to take up the e-health software.

Debra Vermeer

COMMENT

Scammers lighten wallets rather than waists

The competition watchdog has warned people to beware of weight loss scams when carrying out their new year's resolutions, saying that rather than getting sucked into a fraudulent quick-fix, those looking to lose weight should discuss their options with a health care professional.

Australian Competition and Consumer Commission Deputy Chair Dr Michael Schaper said scammers were experts at preying on people's vulnerabilities and trying take advantage of the good intentions of people to improve their health in the new year.

"Unfortunately, if you fall for this scam, the only place you will feel lighter is your wallet," Dr Schaper said.

The scams usually promise dramatic weight loss for little or no effort.

Dr Schaper said they typically involve an unusual or restrictive diet, revolutionary exercise, a 'fat-busting' device or breakthrough pills, patches or creams. They are advertised online or via mail order with enticing claims such as "lose 30 kilos in 30 days" or "lose weight while you sleep", usually accompanied by bogus before and after pictures.

"These scams suggest that you can achieve amazing results without having to do any extra exercise or even modify your diet," he said.

"They lack any scientific evidence or demonstrated links between the program, food, supplement, gadget or process being promoted – and the result."

The warning comes in the wake of a report from the Organisation for Economic Cooperation and Development late last year that Australia had the fourth highest rate of obesity in the world (behind the United States, Mexico and New Zealand), and more than 1.7 million Australians have diabetes.

As community concerns about the growing obesity levels increase, so do the numbers of weight loss scams being reported.

Last year the ACCC received 173 contacts about weight loss scams – a 50 per cent increase on the previous year. Total reported losses in 2013 were over $20,000, a 70 per cent increase on 2012.

"The most common things being complained about are people engaging in a free trial of a weight loss product then incurring extra charges and being signed up to hidden subscriptions," Dr Schaper said.

"Victims report being unable to contact the billing companies involved, and are therefore unable to cancel the subscriptions or stop the charges occurring. Some victims mention that even if they get a chargeback from the bank, new charges have appeared at a later date."

Dr Schaper also warned that some of the weight loss products or schemes offered by scammers can have serious consequences for people's health.

"Be very careful about advertised offers for medicines, supplements or other treatments, and always check first with a health care professional, such as a dietician or your local GP," he said.

"Remember that there are no magic pills for rapid weight loss, so be very sceptical about claims of effortless, large or fast weight loss. Find out what evidence is used to support claims made for the product and do not rely only on testimonials from people who have used the product, as they may profit from selling you the product and may mislead you to do so."

Dr Schaper said anyone who has resolved to lose weight in 2014 should discuss their options with a health care professional.

Anyone who thinks they may have fallen victim to a scam should contact their bank immediately and report the scam to SCAM watch at www.scamwatch.gov.au/reportascam.

Debra Vermeer

COMMENT

Nation's first Indigenous surgeon sends message of hope in closing health gap

Dr Kelvin Kong with Living Black presenter Karla Grant

Dr Kelvin Kong, an ear, nose and throat specialist who made history when he became Australia's first Indigenous surgeon, says he is filled with hope that ear disease in Aboriginal communities can be brought back to the levels experienced by the wider community.

Dr Kong is dedicated to improving access and resources to remote communities to tackle ear disease and prevent a life of disadvantage for children.

"The amazing thing looking at ear disease in this country is that we live in a dichotomy," he told SBS TV's Living Black program.

"The dichotomy is that in Aboriginal Australia our ear health status is at fourth-world status. Not third-world status. So we are looking at countries like Africa where their health system is deplorable. We're actually getting worse statistics than them."

But Dr Kong said he is hopeful that Government initiatives, such as the Prime Minister's Indigenous Advisory Council, along with efforts by the medical profession working in conjunction with the wider community, can make a difference.

"I really hope we're moving forward and we can decrease the burden of ear disease in Australia and we can see that [the prevalence of] ear disease in Aboriginal communities is back to [that of] the normal population," he said. "Then you're going to see all these kids coming through school and taking on the world."

Dr Kong was inspired to become a doctor by his mother Grace, a nurse, and by his two sisters, who are also doctors. His Chinese father is a general practitioner, working in Malaysia.

"Mum's probably the biggest inspiration for me," he said. "She always has been. She's very humble. She comes from a very humble background. She struggled most of her life … and led by example. She went to university and did a nursing degree.

"She was always driving into us, my sisters and I, saying 'do what you want to do. Don't let anybody hold you back'. "

Dr Kong said he was also influenced in his career by a couple of surgeons he had contact with early in his career.

"They were role models, they were leaders in the community and they led not by bravado but by the work they did and giving back to the community," he said. "And more importantly, the reward that you saw was not so much in what you did but it was in seeing the results for the kids that you operated on, and the experience they got in normalising themselves into the society where they could do whatever they wanted to do."

Apart from his surgical work, Dr Kong is committed to taking up mentoring opportunities with young Aboriginal children.

"Health is one of those big disparities that we see in this country, so we want to make sure that we encourage them," he said. "So, going to primary schools, talking to kids, letting them see that there are Aboriginal doctors out there … going to talk to and mentor these kids. Some of these kids, the talent is incredible. I think I've met our first Aboriginal prime minister in some of these kids I've looked after."

Dr Kong, a strong supporter of the National Aboriginal Community Controlled Health Organisation and Aboriginal Medical Services, has also been a driving force in the introduction of mobile ear surgery units that go to Aboriginal communities.

"To set up a hospital with an ear, nose and throat department at every location is expensive … so why not make it mobile so that you can put all the resources into one establishment, put it on wheels and move it around?"

In the seven years since he first started as a doctor, the number of Aboriginal and Torres Strait Islander doctors has increased from a handful to close to 160, a statistic that Dr Kong warmly welcomes.

"It makes a huge difference (to the life of indigenous Australians)," he said. "An Aboriginal doctor serves as more than just a doctor. An Aboriginal doctor serves a purpose in terms of providing health care, educating the general public, and breaking down professional barriers. You've got to remember that a lot of people grow up in society, particularly the middle class, where they haven't even met an Aboriginal person. So to actually get into the system and permeate through the system is a wonderful experience … and when you times that by 160 or 170 people, it's incredible."

Debra Vermeer

COMMENT

Updated US guidelines on treating menopause

New US guidelines for the treatment of menopause symptoms confirm that systemic hormone therapy is the most effective approach, but there is growing evidence to support non-hormonal treatments, and it is important that all therapy be tailored to the individual.

The advice comes in the updated Practice Bulletin of The American College of Obstetricians and Gynecologists, and refers to the treatment of hot flushes and vaginal dryness in menopausal women.

Dr Clarisa Gracia, Associate Professor of Gynaecology and Obstetrics at the Perelman School of Medicine, University of Pennsylvania, told *Medscape Medical News* (MMN) that the 2014 Practice Bulletin gives new drug information, but identifies no new risks or dangers.

"While the hormone therapy recommendations are similar to prior recommendations, there is more evidence to support non-hormonal alternatives … for the management of vasomotor symptoms," Dr Garcia said.

Those alternatives include selective serotonin re-uptake inhibitors, selective norepinephrine re-uptake inhibitors, clonidine and gabapentin.

"In addition, the document updates newer agents that combine selective oestrogen receptor modulators and oestrogen to reduce negative side effects," Dr Garcia said.

"Additional long-term data are needed to determine risks associated with new agents."

Hot flushes affect between 50 per cent and 82 per cent of US women who experience natural menopause, and between 10 and 40 per cent experience vaginal dryness, MMN reported. The Women's Health Initiative study in the US showed that the major risks of hormone therapy are deep vein thrombosis and breast cancer. An American College of Obstetricians and Gynaecologists Committee Opinion from April 2013 found that giving hormone therapy via a skin patch was safer than with a tablet.

The latest Practice Bulletin points out what to avoid, saying progestin alone increases breast cancer risk, and testosterone provides no benefit (except improved sexual satisfaction), but comes with multiple risks.

It says there is too little evidence to support any benefit from compounded hormones, phytoestrogens, herbal remedies or exercise.

"Because all medications have potential side-effects and risks associated with their use, it is important to weigh the potential risks and benefits of treatment. Therapy should be individualised," Dr Gardia told MMN.

The key recommendations from the updated Practice Bulletin include that: "Systemic hormone therapy, with just oestrogen or oestrogen plus progestin, is the most effective approach for treating vasomotor symptoms".

It also recommends that low-dose and ultra-low systemic doses of oestrogen have less risk than standard doses, and that doctors should individualise care and use the lowest effective dose for the shortest duration.

While there is not enough data to support use of progestin alone, testosterone, compounded hormones, phytoestrogens, herbal supplements and lifestyle modifications, the Bulletin does promote "common sense lifestyle solutions" such as layering clothing, lowering room temperature and consuming cool drinks as ways to cope with hot flushes.

Debra Vermeer

COMMENT

Many women ignorant of ovarian cancer threat

More than half of Australian women mistakenly believe that ovarian cancer, rather than cervical cancer, is detected by a pap smear, a new study shows, a misconception that experts fear could lead women to be less vigilant for ovarian cancer symptoms.

The study, conducted by the Wallis Group for Ovarian Cancer Australia, found nearly a third of women also incorrectly believed that the Human Papilloma Virus vaccine (HPV) prevents ovarian cancer.

Speaking ahead of Ovarian Cancer Awareness Month, which takes place in February, Chief Executive Officer of Ovarian Cancer Australia, Alison Amos, said she was alarmed by the lack of awareness among Australians about ovarian cancer.

She said there was no early detection test for ovarian cancer, meaning it was important that all women were familiar with its symptoms.

"During February, I urge all women to learn and share the symptoms of ovarian cancer and take action if affected," she said.

"The four key symptoms are abdominal or pelvic pain, increased abdominal size or persistent abdominal bloating, the need to urinate often or urgently and feeling full after a small amount.

"If these symptoms are new for women, and they experience one or more of them persistently over a four-week period, they should consult their GP."

While vigilance for the key symptoms is crucial for early detection, the study found that 29 per cent of women surveyed believed that ovarian cancer had no symptoms at all.

The study also found that 27 per cent of women and 40 per cent of men believe that most women diagnosed with ovarian cancer will survive it. However, each day in Australia, four women are diagnosed with ovarian cancer and three women will die from the disease.

Ms Amos said the study's findings demonstrate the importance of communicating the facts about ovarian cancer as widely as possible, which is the aim of Ovarian Cancer Awareness Month.

She urged all Australians to get involved this February by hosting an Afternoon Teal fundraising event and wearing a teal ribbon on Teal Ribbon Day, Wednesday, February 26. To buy a ribbon or find out more, go to www.ovariancancer.net.au

Debra Vermeer

COMMENT

Lifting ad restrictions on medicines a bad idea: AMA

The AMA has condemned suggestions that restrictions on advertising for most schedule 3 pharmacist-only medicines be lifted.

The Australian Self Medication Industry (ASMI), the peak body representing companies involved in the manufacture and distribution of non-prescription consumer health care products as well as advertising and public relations firms, has proposed that current rules barring the promotion of S3 medicines directly to consumers be scrapped, arguing it will improve health.

The organisation claimed that for every $1 spent on over-the-counter medicines in the United States, the country saved between $6 and $7 in health costs, and argued similar savings could be realised here.

"Supporting individuals to be more active and engaged in managing their own health is an important dimension to building a more sustainable healthcare system for the future," ASMI Executive Director Deon Schoombie said. "Expanding self-care will be the key driver to promote this shift in behaviour."

But AMA President Dr Steve Hambleton warned such a change could expose people unnecessarily to harm, and there were very good reasons for the restrictions currently in place.

"Not knowing what you don't know is part of the problem," Dr Hambleton told *Medical Observer*. "If you have a cold and buy Lemsip, and then have a headache and take Panadeine, you can have an overdose situation because people don't realise that paracetomol is in both products."

Citing the results of a study it commissioned, ASMI claimed that around 7 per cent of all GP consultations involved the treatment of minor ailments, and many patients could be diverted from such visits if they had an increased ability to self-medicate.

But Dr Hambleton said this was a dangerous route that could put people in danger.

"We do need a trained health professional to make sure that people are not getting important medicines mixed up, and pharmacists have an important role in interviewing people," he said.

Adrian Rollins

COMMENT

PHI opportunity? Not without risks

BY DR BRIAN MORTON

There has been much criticism recently of the Medibank Private and IPN GP services agreement being trialled currently in Queensland, from me included.

I have publicly called on the Government to step in to stop the partnership amid concerns about the legality of the scheme and the impact it could have on established doctor-patient relationships and clinical autonomy.

> “For any program to succeed, it must recognise the central role of the GP. It must involve GP-led care and measures that support the continuity and quality of patient care”

Under the arrangement, it is believed that Medibank Private has side-stepped the law by covering the administrative costs of IPN rather than the gap on GP services. The Private Health Insurance Act currently stipulates that, as a general rule, out-of-hospital medical services covered by Medicare cannot also be covered by private health insurers. Given that the costs of running a practice, including administrative costs, are incorporated in the fees for patient billed services, it’s not hard to see why I’m concerned about the legalities.

The AMA Council of General Practice (AMACGP) has for some time been considering what role private health insurers (PHI) can play in general practice. The PHIs are only too aware that the answer to reducing costly hospital admissions is in general practice. This is where risks of future chronic health problems can best be identified and addressed. That is why they too are interested in the role they could play in general practice.

PHIs need to work effectively with general practice because it can lead to better patient outcomes. Unfortunately, their track record to date is not good. The various health improvement programs they provide often sideline the patient’s usual GP.

The AMACGP has sought to improve the relationship between PHIs and GPs to enable a more productive engagement. We had extensive discussions with Medibank Private, HCF and BUPA at the AMACGP Executive’s October Policy Day last year, and the AMA will continue to press the need for PHIs to implement programs that are supportive of GPs

The AMA position statement *Private Health Insurance and Primary Care Services – 2006* discusses the risks of PHI expansion into primary care and the types of situations where the AMA would see it as being acceptable.

For any program to succeed, it must recognise the central role of the GP. It must involve GP-led care and measures that support the continuity and quality of patient care. Eligible patients must retain their choice of program participation and of preferred practitioner. Program eligibility requirements must be fair and reasonable for purposes of the program.

To be acceptable to the profession, participating in a program must not restrict practitioners’ rights to set their own fees, result in any compromise of a practitioner’s clinical decisions or to the quality and standards of patient care. Use of services which attract a MBS rebate must not be a pre-requisite to accessing a fund’s program, nor should the program preclude patient access to Medicare. A patient’s choice of whether or not to participate in the program must not affect their access to insurance coverage. The program must not involve any form of fundholding or capitated payments inconsistent with AMA policy.

I would welcome your comments on how you think PHIs could work with and support GPs in keeping their members healthier without reducing the quality and continuity of care, and without the use of fundholding models that lead to rationed care. Email me at gpnn@ama.com.au.

COMMENT

Mental health: when medical students become the patients

BY AMSA PRESIDENT JESSICA DEAN

> “Even without tangible causality, AMSA is committed to maximising the wellbeing of all university students through the prevention and treatment of mental health conditions”

In the coming weeks, students all over Australia will begin the university semester. Of these students, 17,500 may not know it yet, but their mental health is at a considerably higher risk compared with their peers.

This is not because of their past history, or because of their location, but rather because these 17,500 students chose to study medicine. Of these 17,500 medical students, 3500 will be starting medical school for the very first time. Many of these students are entirely unaware that they now carry these additional mental health risks.

In October 2013, mental health organisation *beyondblue* released the results of its nationwide survey of medical students and doctors. The results would have been shocking, if they were not so unsurprising. Some of the key findings included:

- approximately one in five medical students reported experiencing suicidal ideation within the previous 12 months;
- almost half of all medical students reported a minor psychiatric illness, with more medical students than doctors being classified as having a high likelihood of a minor psychiatric disorder;
- levels of very high psychological distress were significantly greater among medical students than in the general population;
- the rates of depression and anxiety are significantly higher in medical students than the general population; and
- one in two medical students will experience emotional burnout.

Medical students may be at an increased risk compared with their peers, but the Australian Institute of Health and Welfare data shows that more than a quarter of 16 to 24 year-olds experience a mental health disorder during a 12 month period – an incidence higher than in any other age group. Mental health is therefore an issue for all tertiary students.

Yet, despite the increased burden of this disease, young people are less likely to seek help, with only 23 per cent of young people with a mental illness accessing health services.

In October last year, just weeks before the release of the monumental beyondblue survey, the National Council of the Australian Medical Students’ Association met and voted on AMSA’s advocacy priorities. At this meeting, the mental health of tertiary students was endorsed as a priority for advocacy in 2014.

As the Mental Health and Wellbeing Campaign begins for 2014, the big unanswered question appears to be: ‘why medical students?’

Naturally, there has been plenty of speculation on this topic. This is understandable, given that identifying a cause could be key to a solution.

Perhaps the experience of medical school is itself responsible: the contact hours are relatively high, the content is expansive, and the clinical exposure can be quite confronting.

Or perhaps the traits of individuals that choose medicine as a career path may be relevant.

At this point, a concrete explanation eludes us.

We therefore await further research in this area, as a more thorough understanding of the specific relevant triggers would allow us a more targeted preventive strategy.

Even without tangible causality, AMSA is committed to maximising the wellbeing of all university students through the prevention and treatment of mental health conditions.

Tertiary education itself provides an opportunity to maximise the health of a large portion of young Australians.

Campus attendance allows access to a supportive environment where health services and education is readily available.

AMSA will work with university faculties to improve the services available and ensure accessibility, while also working directly with students to increase awareness and decrease stigma surrounding mental illness.

COMMENT

AMC and the Colleges, are they part of the problem or part of the solution?

BY DR DAVID RIVETT

> “It was generally agreed that Australia now has enough doctors in the pipeline, and that the core issue now is not numbers but maldistribution”

In early December, AMA New South Wales convened a regional Specialist Workforce Forum in Wagga Wagga. On a 40-degree day, the basic structural flaws bedevilling rural specialist workforce provision were laid bare by an excellent array of contributors. These included the NSW Health Minister Jillian Skinner, her relevant departmental advisors, and multiple College representatives.

Figures were presented showing that, without question, the wheel has turned too far toward the provision of sub-specialists rather than generalist specialists across the training spectrum. Our ratio of sub-specialists to generalists is now the world’s highest.

It was generally agreed that Australia now has enough doctors in the pipeline, and that the core issue now is not numbers but maldistribution.

The concept of a quality regional training continuum across all specialties was broadly embraced as a key part of any solution, with enhanced support for trainees and supervisors, and much better networking given the smaller numbers.

Stupidities galore were exposed, such as doctors in urban-based training positions receiving accommodation, relocation and travel grants for rural rotations, while those based in regional centres received no such grants on urban rotation.

A recurring concern was that the specialist Colleges do not see the rural and regional workforce crisis as being their concern. Nor do they see it being part of their core business to find and facilitate solutions for the provision of specialists to regional Australia.

The Australian Medical Council (AMC) was perceived to have washed its hands completely of any responsibility in corralling the Colleges, which it oversights and accredits, to ensure regional and rural specialist provision.

I would like to know how many members of the AMC Board are from rural and regional Australia, and what its constitution mandates regarding its geographic composition. Workforce standards are an essential of service provision, but so too is the geographic distribution of workforce if non-urban Australia is to be well served.

Any effective solution to the workforce crisis must involve State governments as funders of both training positions and regional training hospitals, Colleges as providers of education to regional trainees, the AMC as the accrediting body of Colleges, and the Federal Minister for Health in advising the AMC and Colleges of their responsibilities for supplying the workforce needs of Australia’s many regions.

This may mean redrafting the constitutions of some of these bodies if they are to continue to receive Commonwealth support and funding.

Additionally, the States must be funded to ensure regional specialist career paths are attractive, high quality, well renumerated, do not have overly onerous on-call responsibilities and do have a certainty of continuity.

What is needed is a champion for rural and regional health to get all the players involved working as a team.

If Darren “Boof” Lehmann can do it to win back the Ashes, then perhaps it is not asking too much for Senator Fiona Nash to deliver a similar miracle from Canberra

COMMENT

BY DR STEPHEN PARNIS

Safety and medical practice – an opportunity for better outcomes

> “We should see safety in the medical workplace as an opportunity to improve, and to lead other staff by example. It should not become a witch hunt or a blame game”

We have all heard a lot about the important topic of safety in the workplace in recent years.

As doctors, we are used to treating patients who have been involved in accidents, including workplace accidents and mishaps. They range from minor trauma to catastrophic injuries. But, as medical professionals, we also need to remain vigilant about our own safety in the workplace.

After treating the often horrific results of workplace accidents, the last thing we want is to put ourselves, our staff, and our patients in the position where any of us might be victims of a preventable adverse event.

Hospitals, clinics and medical practices are inherently risky workplaces. Risks include communicable diseases, exposure to hazardous materials, needle stick and sharps injuries, violence and verbal aggression from patients and co-workers, to name just a few. Injuries can be physical or psychological.

Medical workplaces need to develop a culture of best practice when it comes to safety. This requires constant vigilance, and improvement wherever possible. The complex occupational health and safety laws that exist around the country give us a broad approach, but we know that every workplace is unique and requires its own specific procedures. We should also embrace new products and technology that can assist with safe practice.

Safe practice (for example, washing hands after every patient encounter) involves taking an active approach toward the safety of ourselves and those who work with us. In a fast-paced medical workplace this must involve appropriate supervision of less experienced staff. It also requires easily accessible, practicable policies and procedures to be in place. A systematic approach will give better outcomes - this is the responsibility of employers, supported by all in the workplace. It should not be left to human discretion or error. By then it can be too late.

Let’s face it, while implementation can be time consuming, safety ultimately saves money by reducing productive time lost, and leads to better outcomes for patients. All State health departments, hospitals and general practices have robust, often voluminous policies and procedures on workplace safety, but they need to be considered works in progress. We should not hesitate to flag a policy or procedure which we think needs to be improved. The frequent objection that “we’ve always done it that way” is not good enough when it comes to safety.

There is a great deal of data collected on workplace injuries. *The Work Health and Safety Statistics Report - Incidence rate*, published by Safe Work Australia, indicates that medical workplaces are not the most dangerous workplaces in the country, but they are not the safest either. And we can assume that many injuries go unreported due to factors such as time pressure, embarrassment or unwieldy reporting procedures. We should remember that incident reporting ensures that data is reliable and up-to-date. Data can’t change the fact that an injury has occurred, but it can assist in the development of policy and the allocation of resources to try and make sure it doesn’t happen again.

We should see safety in the medical workplace as an opportunity to improve, and to lead other staff by example. It should not become a witch hunt or a blame game.

Resources and education need to be allocated where necessary to ensure the best possible culture of safety is in place in every medical workplace. Cost should never impede safe practice. When implemented well, good workplace safety improves medical outcomes and ensures a long and healthy medical career.

COMMENT

Restraint in the Care of Older People

BY DR RICHARD KIDD

> "It is a topic that provokes discussion around what are seen as basic human rights, including the right to freedom of movement and liberty ..."

One of the first orders of business for the Committee for Healthy Ageing in 2014 will be a review of the AMA's 2001 *Position Statement on Restraint in the Care of Older People*.

Restraints can be physical, involving the use of equipment such as ties or bedrails, or chemical, through the use of medication. In either case, the use of restraint in health care settings as a preventative intervention with no therapeutic benefit, is a complex issue. The decision to restrain requires careful assessment of the risks a patient's behaviour poses to their own safety, and to the safety of others.

It is a topic that provokes discussion around what are seen as basic human rights, including the right to freedom of movement and liberty, as well as considerations of the dignity of the vulnerable. In these circumstances, making decisions about the best course of action can be difficult. The ultimate aim should always be the welfare and safety of the patient

The AMA's 2001 Position Statement recognised the need for balance between a patient's right to self-determination and the need to protect them from harm.

Since 2001, a growing body of evidence has developed regarding the adverse physical, psychological and ethical consequences of using restraints. There have also been considerable advances in guidance and tools employed across a broad spread of health care settings.

For example, in 2004, the Department of Health and Ageing released a guide document; *Decision Making Tool: Responding to issues of restraint in Aged Care*.

In 2005, the Australian Health Ministers' Advisory Council (AHMAC) resolved that "reducing the use of and, where possible, eliminating, restraint and seclusion" should be one of four priority areas for national action to reduce harm in mental health care.

Since then, the annual Mental Health Services Conference has included 'seclusion and restraint' forums to showcase initiatives and share knowledge, with the ultimate aim of reducing the use of restraint.

Mental Health Services also funded a two-year project (the "Beacon project") which examined international best practice in reducing the use of restraint. The project developed policies, guidelines and staff training aimed at reducing the use of restraint and seclusion in mental health care settings. It also highlighted the importance of thorough, collaborative assessments and debriefing processes to better understand the triggers that give rise to the use of restraints, and how to avoid them.

In more recent years, several Australian states and territories have developed and updated their own regulatory framework around the use of restraint in health care settings.

In Victoria, a Senior Practitioner role was established under the Disability Act 2006 (Vic) to monitor, audit and investigate restrictive interventions in disability practices in the State.

In 2009, the NSW Office of the Senior Practitioner, Ageing, Disability and Home Care released guidelines (*Behaviour Support: Policy and Practice Manual*) that prohibit the use of psychiatric medications as a chemical restraint.

The ACT Health Directorate released new policy in 2011 endorsing and promoting a culture that minimises the use of restraint and seeks to prevent the need for restraint.

The aim of the Committee for Healthy Ageing review is to ensure our position on the use of restraint in the care of older people reflects recent developments.

The review will look into:

- responsibilities in a decision to use restraint;
- the legal and ethical frameworks relevant to restraint;
- the circumstances in which restraint may be legally or ethically required; and
- recognising inappropriate use of restraint.

The Committee welcomes comments from members for consideration during the 2014 review.

Members can view the 2001 *AMA Position Statement on Restraint in the Care of Older People* at: **https://ama.com.au/position-statement/restraint-care-older-people-2001**

COMMENT

OPINION

Indefinite asylum seeker detention shames us all

BY DR MICHAEL GLIKSMAN

> “We know the damage done and, equally, we know the remedy. We would not remain silent in the face of such abuse in any other setting”

“Silence in the face of evil is itself evil. Not to speak is to speak. Not to act is to act.”

– Dietrich Bonhoeffer

In Australia there exists a shameful conjunction between injustice and ill-health involving foreseeable, avoidable and possibly irreparable harm to the innocent.

I speak of the indefinite detention of asylum seekers – children too – charged with nothing, guilty of nothing, in Australia’s Gulag Archipelago stretching from Christmas Island, through our remote deserts and on to tropical islands to our north.

Some children have been there from birth, born in Australia but denied their birthright of citizenship, knowing no crib but one bounded by razor wire. Some are unaccompanied minors, some are orphans. All are denied the benefit of child protection legislation we take for granted.

Doctors as a group are reluctant to enter the political fray, but there is a long established exception to this reluctance: when the health and wellbeing of people are threatened by any policy espoused by any government, of any political flavour.

At the AMA Federal Conference in 2005 an Urgency Motion proposed by myself, seconded by Dr Michael Noel, was passed unaltered. It included the following:

- recognise that the indefinite detention of children is child abuse; and
- release immediately all children detained in immigration detention facilities.

Within days of its passage, the Howard Government announced the release all children in detention, a policy since undone by successive Labor and Liberal Governments. Worse was to come.

Late last year, the Abbott Government disbanded the Immigration Health Advisory Group (IHAG), established by the Howard Government in 2006. Populated by prominent medical and other health professionals, IHAG gave independent, unbiased advice to the Government of the day.

Coming hard on the heels of a highly critical Amnesty International report into conditions at the Manus Island detention facility, it begs the question: what have they to hide? I think we know.

Research recently published in the *Medical Journal of Australia* [https://www.mja.com.au/insight/2013/48/serious-gaps-detainees-health-care] found substantial unmet health needs and high levels of psychiatric morbidity among asylum seekers in detention in Darwin. The lack of transparent independent scrutiny of detainees’ health care was of major concern.

The conditions in Australia’s offshore facilities, where there is now no independent medical oversight, are even worse, including restrictions on essential female hygiene products and access to water in tropical environments!

In an accompanying *MJA* editorial, Australian Human Rights Commission President Gillian Triggs wrote: “..it is often the detention environment itself that causes mental illness.....Accordingly, it is the removal of people from closed detention that will have the most powerful effect in mitigating mental illness.”

Suicide is the leading cause of death among detainees, as one would expect from a policy that leaves people in indefinite detention, unaware of their ultimate fate, some in conditions unfit for human habitation. If we were to design a system sufficiently cruel to promote suicide, this would be it.

Is it by design? Or is it simply the willful indifference, the turning of the blind eye to which Bonhoeffer referred?

The Australian Government is obliged, as a signatory to the UN Convention Relating to the Status of Refugees, to provide the same standard of health care to detainees as is available to the general population. There can be little doubt Australia is in breach of that Convention.

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OPINION

Indefinite asylum seeker detention shames us all

... FROM P33

Out of sight and largely out of mind, Australia is gratuitously harming people almost all of whom, recent history shows, are entitled to refugee status under our international treaty obligations. In our name, Australia's Government is building a legacy to shame us for generations.

Currently more than 1100 children are in indefinite locked detention, their future uncertain, their health and development blighted by the ongoing abuse that is integral to that detention. We should consider our response in the light of Bonhoeffer's declaration, for we too will be held accountable by history for silent acquiescence.

We know the damage done and, equally, we know the remedy. We would not remain silent in the face of such abuse in any other setting. In fact, Australian law would not allow us to.

Our profession needs to send a strong, unequivocal message, one that is true to its tradition.

That is why Doctors For Refugees was brought into existence, with a founding committee that counts a prior State President (Richard Kidd) and a prior State Vice-President (myself) among its members.

We can fight with the angels or stand silent with the devil. As Bonhoeffer reminded us, it is the only choice we have.

** Dr Michael Gliksman* (aka Ming the Merciless @ MGliksmanMDPhD) *is a physician in private practice in Sydney. He is an AMA Federal Councillor, and a member of the Australian Red Cross International Health Law Committee. The views expressed here are his own. Join Doctors For Refugees at https://www.facebook.com/doctors4refugees?fref=ts .*

COMMENT

INFORMATION FOR MEMBERS

Australasian Health Professionals Directory: updated advice to members

Last year the AMA advised members regarding notices they may have received from a group calling itself 'AUAHP Australasian Health Professionals Directory'.

The unsigned cover letter advised recipients to confirm their practice details for inclusion in a directory of health practitioners.

In our opinion it was misleading and contradictory.

It appeared to be confirming a free listing, and stated that "basic data is published free of charge". It induced recipients to sign, but the fine print provided that by signing, they were agreeing to a paid listing for a minimum of three years, at "AUD1300 per year, charged in advance". From the documentation we saw, there was no way to confirm a free listing.

We understand that many practices signed the documentation, thinking they were confirming a free listing. Since then, several practices have been receiving letters of demand with extra costs added.

Our advice

Our advice to members is to retain that correspondence, but ignore the demands for money and not engage with AUAHP further.

We recommend you do not get involved with AUAHP.

Naturally, the ultimate decision on whether to take part or not is yours.

The only address we can find for this entity is in Portugal. It would be extremely difficult to exercise your rights under contract or consumer law if you engage with AUAHP and are later dissatisfied with the service you receive.

Unless you are absolutely certain that you want to be involved in this scheme, we recommend that you do not make any payment or provide credit card details. The more information you give, the more you expose yourself to risk.

If you are being contacted by AUAHP seeking further information, such as credit card details, or payment of any kind, do not pay or provide those details. Contact the Office of Fair Trading in your State or Territory.

Based on what we have seen, it is extremely unlikely that any Australian court would uphold the legitimacy of these agreements.

If you have received different documentation, or have engaged with AUAHP via a different medium, this advice may not apply.

As always, if you have doubts, you should contact the Office of Fair Trading in your State or Territory, the Australian Competition and Consumer Commission or seek independent legal advice.

Health on the hill

Political news from the nation's capital

Experienced bureaucrat heads Mental Health Commission

Former head of the Australian General Practice Network David Butt has been appointed to take over the National Mental Health Commission.

> "The Abbott Government has directed the Commission to review all mental health programs funded by the public, non-government and private sectors"

According to *Australian Doctor*, Mr Butt, who was AGPN Chief Executive Officer for three years before becoming a deputy secretary in the Department of Health, has been appointed as temporary CEO of the Commission during an important time for the organisation.

The Abbott Government has directed the Commission to review all mental health programs funded by the public, non-government and private sectors.

Mr Butt drew attention little more than 12 months ago when he appeared to back suggestions for patients to be voluntarily enrolled with medical practices – and idea associated with concept of a "medical home" for all patients.

The senior bureaucrat is expected to return to his role in the Health Department once a permanent CEO is appointed to the Mental Health Commission.

Adrian Rollins

COMMENT

Psychologist wannabe cops $20,000 fine for dud claim

A woman has been fined $20,000 for falsely claiming to be a psychologist, in the first case to be mounted under recently enacted laws aimed at protecting the integrity of health profession titles.

The Magistrates Court of Western Australia imposed the $20,000 penalty on Jayne Walton of Western Australia after she pleaded guilty to using the title of psychologist and claiming to be a registered psychologist, even though she had not be registered for a number of years.

Ms Walton was prosecuted by the Australian Health Practitioner Regulation Agency (AHPRA) under the Health Practitioner Regulation National Law, which has been adopted by all states and territories to establish uniform country-wide regulation of health professionals.

The judgement was welcomed by regulators as a win for the protection of patients and registered practitioners.

"This successful prosecution will further strengthen protection of the public for clients of psychological services," said Psychology Boar of Australia Chair Professor Brin Grenyer. "The Psychology Board welcomes this outcome as an important contribution to public safety. The public expects that when they consult a psychologist that the person is indeed currently registered."

AHPRA Chief Executive Officer Martin Fletcher said the successful prosecution was an important result in protecting the integrity of the National Registration and Accreditation Scheme, which regulates 605,000 practitioners across 14 professions.

"Registration of health practitioners is a key element of protecting the public under the National Law," Mr Fletcher said, adding that the details of all registered health practitioners can be easily checked by visiting www.ahpra.gov.au.

Mr Fletcher said that if a practitioner did not appear on the list then they were not registered to practise.

Almost 40 practitioner titles covering 14 professions are protected under the National Law, including medical practitioner, nurse, optometrist, pharmacist, physiotherapist, podiatrist, psychologist, radiographer, dentist, chiropractor, Chinese medicine practitioner and Aboriginal and Torres Strait Islander health practitioner.

Individuals found in breach of the Law are liable for fines of up to $30,000, while the maximum penalty for corporations is $60,000.

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Competition czar endorses AMA's role protecting country doctors and promoting rural health

Rural doctors working as visiting medical officers at country hospitals will continue to have top-level industrial representation after the competition regulator gave interim approval for the AMA to negotiate collectively on their behalf.

> "These public benefits have been supported by experiences gained since the granting of the authorisation in 2008"

In an endorsement of the AMA's work in representing rural VMOs, the Australian Competition and Consumer Commission has issued a draft determination to renew the AMA's authority to collectively represent rural GPs providing VMO services in negotiations with health departments across the country.

The AMA's existing authority, granted in 2008, was due to expire later this month, but in its draft ruling the ACCC proposes to extend the arrangement, beginning on 1 March, for a further 10 years.

In applying for an extension of its authority, the AMA highlighted several benefits that had flowed to the broader community since the Association was granted negotiation authority in 2008.

These included more effective representation of rural doctors in their dealings with State and Territory health departments, reduced transaction times and costs for these departments when contracting GPs as VMOs, and improved retention of rural GPs working as VMOs in country public hospitals.

"These public benefits have been supported by experiences gained since the granting of the authorisation in 2008," the AMA said in its application, lodged on 30 October. "There are no appreciable public detriments which have flowed from the authorisation."

The Association said renewal of the authorisation was "vital" for rural GPs, because it would ensure continued legal protection for both them and those who act on their behalf in collective negotiations.

"In those jurisdictions where the authorisation has been relied on [in] the last few years, the AMA has been able to provide experienced industrial officers to negotiate on behalf of the GPs, saving time, money and frustration, and allowing doctors to focus on patient care," it said in the application.

A final determination on the application is expected to be made later in the year.

Adrian Rollins

COMMENT

Research

Wood fires as bad for the lungs as smoking

People breathing in smoke from bushfires may suffer similar damage to those with smoking-related emphysema, according to alarming findings from the Woolcock Institute of Medical Research.

For the first time, laboratory tests conducted on human lung cells have shown that smoke from burning wood can scar and inflame the lungs. The Sydney-based scientists conducting the study said those exposed to smoke from burning wood were at risk of developing chronic, degenerative lung disease.

The discovery raises concerns about the long-term effects of exposure to biomass fuel used for cooking and heating in many developing countries.

Woolcock cell biologist and lead author Dr Brian Oliver said the discovery also sent a timely warning about the dangers of exposure to wood smoke from bushfires and hazard reduction burns.

"There is a message here that the smoke we inhale from burning biomass fuels can do long-term lasting damage to our lungs." Dr Brian Oliver said.

The team tested the effects of wood smoke on human lung cells and found it triggered the release of extracellular matrix proteins which are important in the formation of scar tissue and the production of key inflammatory mediators.

They focused on smoke from biological materials and its potential role in triggering chronic obstructive pulmonary disease (COPD), a debilitating condition that attacks and destroys lungs over time and affects one in 13 Australians aged 40 years and older, with smoking being the primary cause.

In a disturbing finding, Dr Brian Oliver said wood smoke had a similar effect to cigarette smoke in activating human lung cells.

"We take cigarette smoke exposure very seriously." Dr Brian Oliver said.

"Our evidence suggests it might be time to do the same with wood smoke, and try to minimise exposure."

Sanja Novakovic

COMMENT

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 is been on hand to provide practical advice and information.

Since the Service was launched in September, 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

Members' Forum

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

***Australian Medicine* kicked off 2014 by inviting seven leading health advocates and thinkers, including AMA President Dr Steve Hambleton, Chief Medical Officer Professor Chris Baggoley, health policy expert Dr Lesley Russell and World Medical Association Council chair Dr Mukesh Haikerwal to nominate the five most pressing health priorities for the coming year. Here are some reader responses.**

Dr Lesley Russell's comments are most pertinent if we are to improve, at present there are too many perverse incentives, so we neglect those most in need both in Australia and also by other means world wide.

Submitted by Alex Wood (not verified)

Lesley Russell for Health Minister!

My only addition would be understanding and acknowledgement - by health care professionals, by government, and by the public - that medicine cannot cure everything, that we will all eventually die, and that some things are worse than dying. Many of our in-hospital interventions are enormously expensive and yet have little or no chance of achieving any meaningful improvement in our patients' lives.

Submitted by Richard Barnes (not verified)

The AMA has urged the Federal Government to transform the Medicare Locals system into a GP-led network of primary health care organisations amid widespread doctor dissatisfaction with its performance. AMA members share their opinions.

The present Constitution of Medicare Locals, as far as I know, limits GP representation on ML Boards so they cannot exceed 49 per cent. I gather GP representation on ML Boards currently is less than 15per cent. The Constitution needs to ensure that non-GP numbers in the ML Boards do not exceed 49 per cent.

GPs need to be at the forefront if primary care is to be enhanced. GPs must remain the lynchpins of primary care around whom all allied health professionals should revolve.

Submitted by Dr Ahad Khan (not verified)

Complete agreement regarding the GP discipline leading Medicare Locals. These are the doctors involved in providing the care to their communities. They are the ones best suited to co-ordinate such a program.

Submitted by Dr Stephen Withers (not verified)

COMMENT

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

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.

Researchers to get invaluable data from world's trouble spots

Research into potentially deadly diseases such as tuberculosis, HIV and sleeping sickness has been given a boost following a decision by humanitarian organisation Medicins Sans Frontieres to share its medical data.

In a move aimed at improving the treatment and eradication of diseases plaguing some of the world's most vulnerable communities, MSF has announced it will provide researchers with data it has amassed during its operations, including in some of the most inaccessible and war-torn parts of the globe.

Initially, the organisation plans to make available information gathered during its response to outbreaks of sleeping sickness, multi-drug resistant tuberculosis and HIV. MSF said these comprised some of the most extensive clinical and research datasets that it holds.

Eventually, it plans to make data from across the full spectrum of its operations available, subject to strict ethical principles and guidelines, including the protection of patient privacy and medical confidentiality.

"We have an imperative to ensure that the data we collect can be used for the greater public health good," according to MSF Medical Director Dr Leslie Shanks, who was a member of the MSF working group that has developed the policy. "This is particularly important for the communities from which the data originated. Many of these datasets come from populations that are neglected or largely inaccessible due to conflict or geography."

Dr Shanks said that by sharing its data, MSF hoped to encourage and assist advances that it did not have the resources to pursue itself.

MSF said its eventual goal was to provide full open access to some datasets, but to begin with most data would be provided through a managed access process to ensure the safety of individuals and communities it works with was not compromised.

Dr Shanks said she hoped that, by taking this step, MSF might encourage other organisations to consider sharing their data for public health purposes.

Adrian Rollins

COMMENT

Hospital turn off for brain-dead mother

A Texas hospital has taken a brain-dead pregnant woman off life support following a two-month legal battle with her family that sparked national debate about abortion and end-of-life care.

> "The decision raises questions about the validity and enforceability of a Texas law ..."

The Fort Worth hospital late last month acceded to a court order that Marlise Munoz, 33, be removed from a ventilator and other life-saving equipment in fulfilment of her family's wishes.

The decision raises questions about the validity and enforceability of a Texas law that bars medical practitioners from removing pregnant women from life support equipment.

The ugly legal stoush began soon after Ms Munoz, then 14 weeks pregnant, was rushed to the hospital suffering an apparent blood clot in her lungs. She was pronounced brain-dead shortly after arrival, and was put on life support, still carrying her "distinctly abnormal" foetus.

While admitting Ms Munoz was brain-dead, John Peter Smith Hospital insisted the Texas law meant it was legally obliged to keep her body alive.

But State District Judge R.H. Wallace found that the law did not apply because Ms Munoz was brain-dead and, therefore, legally dead.

In a statement, the hospital said that "from the outset, JPS has said its role was not to make nor contest law but to follow it. On Friday, a state district judge ordered the removal of life-sustaining treatment from Marlise Muñoz. The hospital will follow the court order."

The decision ends months of anguish for Ms Munoz's husband Eric, and her parents, who had fought for the right to remove her from life support.

Mr Munoz and his wife were both paramedics familiar with end-of-life issues and knew they did not want to be kept alive by machines in this type of situation, according to a report by KHOU news service.

Adrian Rollins

COMMENT

US struggles to kick the habit as another 70s icon butts out

Smoking rates among America's poor and less educated remain stubbornly high, highlighting concerns that progress in encouraging people to quit the deadly addiction is slowing.

While the overall prevalence of smoking among adults in the United States has declined, from 20.9 per cent in 2005 to 18.1 per cent in 2012, virtually 28 per cent of those living below the poverty line smoke – almost double the incidence of smoking in the broader population, according to a Centers for Disease Control and Prevention (CDC) report.

The CDC study, drawing on the results of 2012 National Health Interview Survey covering 34,525 people, estimates that around 42 million American adults smoked in 2012, including 33 million who smoked every day and 9.1 million who lit up on occasion.

The report was released just days before actor Eric Lawson, who featured as a rugged Marlboro Man in a series of cigarette ads during the 1970s and early 1980s, died from chronic obstructive pulmonary disease.

Mr Lawson was the third Marlboro Man to die from a smoking-related illness, and appeared in an anti-smoking commercial parodying the Marlboro ads as well as speaking out publicly on the harmful effects of smoking.

But although there had been a "significant decline" in smoking rates in the past three decades, the CDC warned that the addiction still remained common and progress in curbing it was intermittent – underlining the size of the task facing the country if it was to reach its goal of reducing the proportion of smokers to less than 12 per cent of all adults by 2020.

The CDC report showed that smoking rates among the particular segments of the community were particularly high. Among those aged between 25 and 64 years the rate was above 20.5 per cent compared with less than 9 per cent among those older than 65 years. Education levels also had an impact – 42 per cent of adults with a graduate education development certificate smoked, compared with less than 6 per cent of graduates and 9 per cent of undergraduates.

Just as striking, more than one in five of those with a disability smoked, compared with 16.5 per cent of those without a disability.

The results show that the United States is behind Australia in discouraging smoking.

A recent Australian Bureau of Statistics report showed 16.3 per cent of adults smoked tobacco daily in 2012, down from 22.4 per cent a decade earlier.

The CDC said its findings showed governments in the US needed to intensify their anti-smoking policies.

"The decline in overall smoking prevalence is encouraging, and likely reflects the success of tobacco control efforts across the country," the CDC said. "However, given the slowing decline in adult smoking in recent years, continued implementation of evidence-based interventions is critical."

It recommended increasing the price of tobacco products, implementing and enforcing comprehensive smoke-free laws, increasing the reach and frequency of anti-smoking campaigns in the mass media and giving smokers more help to quit.

In the first evidence that Australia's path breaking tobacco plain packaging laws may be helping smokers to kick the habit, University of Sydney researchers found calls to Quitline soared by 78 per cent following the introduction of plain packaging.

The authors said they were unable to differentiate between the impact of the increased size of graphic health warnings that appeared simultaneously with plain packaging and plain packaging itself. Either way, they concluded, the increase related to the new appearance of packs and "is not attributable to anti-tobacco advertising activity, cigarette price increases nor other identifiable causes".

Plain packaging, they said, was "an important incremental step in comprehensive tobacco control".

The CDC report did not canvass plain packaging as a policy option, and instead focused on measures which it said had been proven to be effective.

Adrian Rollins

COMMENT

WINE

Taylor-made wines from one of one of the industry's first families

BY **DR MICHAEL RYAN**

Three generations of Taylors ensure that the wines produced from their magnificent Clare Valley vineyards are of the highest standard.

Bill Taylor and his two sons, Bill and John, were already firmly entrenched in the wine industry as merchants when their passion to create their own world-class Cabernets was realized with the purchase of 178 hectares of Terra Rossa soil on the Wakefield River in the Clare Valley in 1969.

The first commercial vintage was in 1973, and two years later their Cabernet Sauvignon won a gold medal in every capital city wine show. The Taylors name became synonymous with quality, and an expansion in 1983 saw them purchase a further 113 hectares. Since then, growth has been rapid, including the addition of 32 hectares in 1989, 161 hectares in 1994 and, most significantly, the 250-odd hectares of the St Andrews vineyard.

Innovation always lays a fertile path for the future. In 2000, all the Riesling produced was sealed under Stelvin screw caps and in 2004 all wines were sealed this way. In 2009, Taylors produced the first 100 per cent carbon neutral wine under its Eighty Acres label.

Seven labels exist, each displaying different philosophies of production. The Promised Land range is meant to be fruit-dominated and ready to drink. Eighty Acres is named after the original farmed block and is 100 per cent carbon neutral. It has lively fruit with some elegant structure. The Taylors Estate range gets more serious expressions of terroir and quality fruit.

The Jarraman range purposively blends the best fruit of two regions. This gives a chance for the single varietal fruit characteristics to shine. The flagship label, only made in certain vintages, is the St Andrews range. These are the most elegant structured wines that give plenty of value for the dollar. The Visionary is named after Bill Taylor, and is an extremely rare Cabernet only produced in exceptional years.

The most fascinating range includes the TWP-Taylors Winemaking Project wines. This range is the result of tinkering with and testing small parcels of less common varieties. Current releases include a Grenache, a Shiraz Mataro and a Cabernet Sauvignon, Merlot, Malbec and Cabernet Franc.

The Taylors are considered one of Australia's first families of wine (there are altogether 13 families that share this honour), and they believe in the expression of terroir, quality and commitment to the wine industry. Exports have been successful, with the notable change in name to Wakefield Wines, because the name 'Taylors' is linked to a Portuguese wine company in international markets.

COMMENT

WINES TASTED

1. Taylors Estate Clare Valley Riesling 2013

A light yellow colour, with sweet honeysuckle and lime florals on the nose. It has a medium weight anterior palate, with a moderate acid backbone. This is a great value example of Clare Valley Riesling and was enjoyed with some fresh Mooloolaba prawns and lime aioli. Cellar three to five years.

2. Taylors St Andrews Clare Valley Chardonnay 2012

Pale yellow colour, with a tinge of green. The nose is complex, with white peach, funky lees and yeast aromas. The palate is lush and broad in the anterior palate with nice acidity. Made in the new mould with hints of malolactic fermentation, but restrained fruit and oak balanced beautifully. Enjoyed with King Island Triple Cream Brie. Cellar five to seven years.

3. Taylors WMP GSM Clare Valley Grenache Shiraz Mataro 2010

A deep garnet colour, with a nose of red currants, rich candied fruits , tobacco leaf and herbal notes. There is generous fruit on the anterior palate with a mild tannin structure. Overall, a luscious wine that opened up over two hours. Enjoyed with some prosciutto and Jamon ham. Cellar six to seven years

4. Taylors St Andrews Clare Valley Cabernet Sauvignon 2009

A deep red-brown brick colour, with a nose of rich, deep cassis and mocha notes, with a background of herbs. The palate is enriched with a full velvety flow of rich fruit flavours. There is very little mid-palate collapse, and the balanced tannins ensure lip-smacking satisfaction. The best value high end Cabernet that I know of. Enjoy with my old favorite – grilled "anything bleeding". Cellar for eight to 10 years.