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AMA

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Managing Editor: John Flannery
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Contributors: Sanja Novakovic, Debra Vermeer
Graphic Design: Streamline Creative, Canberra

Advertising enquiries

Streamline Creative
Tel: (02) 6260 5100

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42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

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Cover: AMA President Associate Professor Brian Owler talks with Amoonguna community local health centre worker Rekhita Stuart at Amoonguna, 20km south-east of Alice Springs

AMA LEADERSHIP TEAM



President
Associate Professor
Brian Owler



Vice President
Dr Stephen Parnis



BY AMA VICE PRESIDENT
DR STEPHEN PARNIS

Drinks aside, time for action on alcohol

For years the AMA has been a consistent – and insistent – public voice demanding that the nation take its drinking problem seriously.

For doctors, this is no academic exercise. In our work, we are often at the frontline in dealing with the effects of drinking.

As an emergency physician, I encounter on a daily basis the devastation caused by people who drink well into excess. My colleagues in almost every medical discipline share these experiences. In large part, it is this awareness that motivates the AMA to put so much energy and effort into tackling the nation's drinking problem.

In recent times, this has included highlighting the extraordinary lengths alcohol companies are going to, to market their products to the young, including through live sports broadcasts and the use of social media. We have also been lobbying governments to address the availability and affordability of alcohol.

The AMA is not a bunch of wowsers. Responding to the harms caused by alcohol is not about demonising alcohol, or penalising safe and responsible drinking. The AMA recognises that alcohol consumption is a regular part of social life for many Australians, and many who drink do so at levels that cause few adverse effects.

Unfortunately, however, a significant number

of Australian drink so heavily that they put themselves, and those around them, at serious risk.

Though the overall level of drinking has remained relatively stable for a number of years, the harm it causes – not only to drinkers themselves, but also to their families, friends, innocent bystanders and the broader community – has actually been increasing.

It is these harms that are the focus of AMA policy.

For those who might dismiss the magnitude of the problem, consider this: alcohol remains second only to tobacco as a preventable cause of drug-related death and hospitalisation. One-fifth of Australians (20.1 per cent) consume alcohol at levels that put their health at risk. Among young people, the incidence of dangerous drinking is even greater.

Every day in Australia, alcohol is responsible for around 15 deaths and 430 hospitalisations. In 2010 alone, more than 157,130 people were admitted to hospital because of alcohol.

According to the recent *Alcohol's burden of disease in Australia* report, the number of alcohol-attributed hospitalisations and deaths jumped 62 per cent in the decade to 2011.

It is not just drinkers who get hurt.

In all, more than a third of Australians have been affected by alcohol-related violence and nearly three-quarters of the adult population have been adversely affected by someone else's drinking in some way, including through property damage and physical abuse.

“ Though the overall level of drinking has remained relatively stable for a number of years, the harm it causes – not only to drinkers themselves, but also to their families, friends, innocent bystanders and the broader community – has actually been increasing ”

While the link between alcohol and violence is complex, approximately 47 per cent of all perpetrators of assaults, and 43 per cent of all victims, were intoxicated prior to an attack. Alcohol is also a significant risk factor for domestic violence – 44 per cent of all homicides of intimate partners involve alcohol.

Not surprisingly, a majority of Australians want action to reduce the harm caused by alcohol.

It is time governments recognised this and enacted decisive, evidenced-based policies to stem the toll.

AMA demands independent oversight of child detainee care



The AMA and other medical organisations have stepped up their demand that an independent group of doctors be appointed to oversee the treatment of children being held in immigration detention amid disturbing accounts of poor treatment and neglect.

An Australian Human Rights Commission inquiry has been told that children being detained had all medication and medical devices, including hearing aids and glasses, removed and not replaced, and that detention centres lacked basic medical equipment and pharmaceuticals.

The hearing also heard serious claims from Dr Peter Young, the former director of mental health services at detention centre service provider International Health and Medical Services (IHMS), that the Immigration Department sought to suppress information about the extent of mental health problems among detainees on Christmas Island.

Dr Young said the Immigration Department had asked IHMS to withdraw damning statistics about the mental health rates of children in detention.

“The level of acceptance that the environment is the factor that has led to the condition, or is preventing the effectiveness of treatment, is often strongly opposed, and we’ve been told at times that it is unacceptable to state that,” he said at the hearing.

The evidence came as the AMA, the Royal Australian

College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists voiced alarm about the detention of children, and the conditions under which they are being held.

Former AMA NT President and Royal Darwin Hospital paediatrician Dr Paul Bauert said the continued detention of children, and official secrecy surrounding their treatment, was “really worrying”.

“I do not feel these children are being adequately treated, and not at the same standards as the way Australian children are being treated and should be treated,” Dr Bauert told Fairfax Media.

The RACGP said standards for general practice were not being adhered to, and refuted Immigration Department claims that they were.

The RANZCP voiced alarm that IHMS had been instructed to hold back mental health statistics. Dr Nick Kowalenko, Chair of the College’s Faculty of Child and Adolescent Psychiatry, told Fairfax Media the suppression of such data could mean that the Immigration Minister, Scott Morrison, ended up being “ill-informed or ill-advised” on the extent of harm children in detention were suffering.

Earlier this year, information obtained by *The Australian* under Freedom of Information laws showed that the incidence of depression and other serious mental health problems has surged among asylum seekers amid a toughening of the immigration detention regime.

Information compiled by International Health and Medical Services, which is contracted to provide health services at the Department of Immigration and Border Protection’s detention centres, shows that almost 45 per cent of detainees were diagnosed with psychological problems in

AMA demands independent oversight of child detainee care

... FROM P5

the September 2013 quarter, almost double the 23.1 per cent reported with a similar diagnosis six months earlier.

“The pattern shows the negative mental health effects of immigration detention, with a clear deterioration of mental health indices over time in detention,” IHMS said in the document.

The worrying disclosure follows the Federal Government’s decision late last year to disband an independent group of medical experts established by the Howard Government to advise on the treatment of asylum seekers.

In a shock move, the Immigration Health Advisory Group was abolished by the Department of Immigration and Border Protection in late December, at a time when concerns about the adequacy of medical services at offshore detention centres at Christmas Island and Manus Island were multiplying.

The AMA, which had a representative on the Group, has voiced concerns about its abolition and replacement with a sole practitioner, former Army doctor Paul Alexander.

The AMA’s IHAG representative, Dr Choong-Siew Yong, said earlier this year that research showed those in immigration detention faced a significant risk of developing mental health problems.

Dr Choong-Siew said that, unlike imprisonment, immigration detention was indefinite and the outcome uncertain, and “the research is very clear, that the longer you’re in detention, and the greater the uncertainty, the greater the possible psychological harm”.

The AMA has called for the establishment of a “truly independent” medical panel to oversee and report directly to Parliament on health services for asylum seekers being held in detention.

Adrian Rollins



Drinks aside, time for action on alcohol

... FROM P4

Despite the weight of evidence and public support, the alcohol industry continues to deny the magnitude of the problems caused by its products. It persistently dismisses concerns, and seeks to emphasise the nation’s relatively stable rate of alcohol consumption.

But what the industry’s argument ignores is a fundamental change in patterns of consumption. Drinking habits are diverging. Heavy drinkers are drinking more, light drinkers are drinking less, and young people are drinking to excess much more frequently.

The top 10 per cent of drinkers in Australia are downing up to five per cent more alcohol than they were a decade ago. The result, as we know, is more people ending up in hospital with acute illness and chronic disease, more people attacked on the streets, more people suffering violence at home.

We don’t have to accept this and, as a nation, we can no longer ignore it.

That is why the AMA is convening a National Summit on Alcohol-related Harms at Parliament House on 28 and 29 October.

The Summit, which will draw together representatives from all tiers of government, community leaders, medical and public health experts and frontline service providers, police and families of victims, will be focussed on developing real solutions – moving beyond yet another discussion of the issues to identify practical measures and plan how that will be put into place.

The scale and urgency of the alcohol problem demands nothing less.



Co-payment on edge amid fears it could jeopardise Indigenous health gains



AMA President Associate Professor Brian Owler has warned that recent gains in health of Indigenous Australians will be jeopardised under the Federal Government's plans for a \$7 co-payment for GP, pathology and diagnostic imaging services, which would effectively rip millions of dollars out of Indigenous health care.

As the Federal Government continues to assess an alternate co-payment model proposed by the AMA which would protect vulnerable patients while putting a value on GP services, A/Professor Owler kept up the pressure for a fundamental re-think by

highlighting it's potentially disastrous effect on Aboriginal health.

Speaking at the conclusion of a four-day visit to Indigenous communities across the Northern Territory, A/Professor Owler said the high level of disadvantage in these areas meant Aboriginal health services would have no option but to absorb the co-payment themselves, adding millions of dollars to their costs and forcing cutbacks on services vital to sustaining improvements in Indigenous health.

"There's just no way that people in these communities are going to pay \$7 to visit a GP, let alone for pathology and diagnostic imaging," A/Professor Owler said, meaning that if Aboriginal health services wanted to keep on caring for their communities they would have to absorb the co-payment themselves, adding \$14.10 to the cost of each consultation.

Health services visited by the AMA President estimated that absorbing the co-payment on behalf of their patients would cost each of them up to an extra \$750,000 a year, meaning that they would have to cut services and might need to axe staff.

A/Professor Owler's warning came amid signs the Government is willing to contemplate changes to its co-payment proposal in order to secure vital support for the Budget measure in the Senate.

Senior Government ministers have alluded to the possibility pensioners and other disadvantaged patients may be exempted from the co-payment following discussions with key cross bench Senators.

Asked whether the Government would contemplate such exemptions, Mr Hockey told ABC radio that "we are prepared to discuss these things [with crossbench Senators]".

Indications that the Government may be softening its position came during a week in which both Treasurer Joe Hockey and Health Minister Peter Dutton held meetings with independent and minor party Senators to discuss the co-payment and other Budget measures.

A series of gaffes by the Treasurer, including comments last week that poorer people do not drive as much as the wealthy, and a call by former Treasurer Peter Costello for the \$7 co-payment to be dumped, have helped blunt the Government's Budget sales pitch.

But Prime Minister Tony Abbott said on the weekend he was confident that the "vast majority" of the Government's Budget measures would be passed.

"I am confident that, perhaps with an adjustment here, perhaps with an adjustment there, the vast majority of our

Budget measures will get through," Mr Abbott said.

Mr Dutton said last week that the Government's proposed \$7 co-payment model was "a reasonable package", but "we are discussing, obviously, in good faith, proposals that are being put to us by the AMA, by the independent Senators, and we'll let that process run".

Neither the AMA nor the Government has publicly divulged details of the alternate co-payment model proposed by the Association, though A/Professor Owler has repeatedly stressed it involved protection for vulnerable patients, and would not deliver the level of savings provided by the Government's model.

Mr Abbott has flagged the possibility of some protection for nursing home residents, and there has been speculation of broader exemptions for pensioners and others on welfare.

But Mr Dutton last week indicated that was not being contemplated by the Government, at least at this stage.

"When we talk about blanket exemptions... you're talking about almost nine million Australians out of a population of 23 million... so it's very hard to provide blanket exemptions," he told Sky News Australia. "But we are considering looking at the cost implications and the health implications of the proposals that people have put to us.

"It's not to say that the Government's got a predisposition to anything that's being proposed. It's saying that we are looking at

Co-payment on edge amid fears it could jeopardise Indigenous health gains

... FROM P7

the proposals that have been put to us and... if we think it adds value to what we've put on the table, we're happy to have those continued discussions."

So far, the Government is struggling to secure the numbers it would need to ensure the passage of its \$7 co-payment through the Senate. Labor and the Greens are opposed to the measure, and Palmer United Party leader Clive Palmer has so far indicated his party's three Senators would also vote against the proposal, as would independent Senator Nick Xenophon. Other key crossbench Senators Ricky Muir and John Madigan have also expressed opposition to the measure.

A/Professor Owler said that the AMA did not oppose patient co-payments, but could not accept the Government's model because of its likely effect on the vulnerable, particularly Indigenous Australians.

He said important progress was being made in improving Indigenous health, particularly in raising the birthweight

of Aboriginal babies, and the co-payment threatened to undermine such gains.

"We've made tremendous gains in terms of life expectancy and dropping infant mortality and the child death rate for Indigenous Australians," he told ABC News. "[But] if you lose funding you have to cut services. We can't afford to lose frontline staff. Many of our Indigenous health services don't have enough staff as it is."

"What we've seen, talking to doctors on Bathurst Island, what they want is more funding for antenatal care and early childhood intervention so we can actually give kids the right start to life.

"If we do that we know they're much more likely to attend school and perform at school and reach year 10 or hopefully year 12.

"Then they can go out and get a job and break the problems we have in terms of social determinants of health."

Adrian Rollins

COMMENT

Health assessment item clarity imminent

The Department of Health is putting the finishing touches to updated advice about including practice nurse time when claiming health assessment item rebates.

It is understood the Department in coming days will publicly release the criteria, approved by the AMA, that are to be used in determining the eligibility of nurse practitioner time used in preparing health assessments when claiming a Medicare rebate.

The clarification is expected to bring to an end an embarrassing episode for the Government in which it unexpectedly implemented a major change in the criteria for applying the health assessment item rebate before beating a hasty retreat in the face of widespread doctor outrage.

The AMA has been in liaison with both the DoH and Department of Human Services (DHS) ever since to ensure doctors and practices have clear advice and guidance about their eligibility.

The long-standing position of the Department has been that practice nurses and Aboriginal and Torres Strait Islander health practitioners can assist GPs in performing a health assessment, in accordance with accepted

medical practice, and that both GP and practice nurse time can be used to decide which Medicare item would be the most appropriate to bill Medicare for a particular health assessment.

But that understanding was thrown into confusion last month when DHS revised advice in the 2010 Health Assessment Factsheet in a way that created doubt about whether nurse time could still be included when claiming a health assessment rebate.

The DoH scrambled to dispel the uncertainty by issuing a vaguely-worded statement that practice nurses may assist GPs in performing health assessments, but the position remained ambiguous, and the AMA has instead pressed the Department to make a clear and definitive statement.

The updated advice, which is being finalised, is expected to allay outstanding concerns by detailing the precise circumstances in which both GP and practice nurse time can be included, and which Medicare item would be the most appropriate to use in billing Medicare for a particular health assessment.

Adrian Rollins

COMMENT

Owler slams Minister for 'irresponsible' abortion remarks

AMA President Associate Professor Brian Owler has lambasted a senior Abbott Government Minister for lending credibility to claims of a link between abortion and breast cancer.

A/Professor Owler said Employment Minister Eric Abetz had been insensitive and "quite irresponsible" in encouraging the mistaken view that having an abortion was connected with the development of breast cancer during a television interview.

"It needs to be made very clear that there are very robust studies, international studies, which have discredited any link between abortion and breast cancer," the AMA President said. "I think it's very unhelpful, both for people who might be struggling with the concept of termination of pregnancy, which may have a very valid reason, but also for people that have suffered or have family members that have suffered from breast cancer."

A/Professor Owler made his condemnation after Senator Abetz, interviewed on Channel Ten program *The Project*, appeared to lend credence to the views of a controversial US surgeon, Dr Angela Lanfranchi, who argues abortion is linked to breast cancer.

When asked what he thought of Dr Lanfranchi's theories, Senator Abetz replied that "I think the studies, and I think they date back from the 1950s, assert that there is a link between abortion and breast cancer".

When told that the AMA found such claims to be scientifically incorrect, the Senator and Cabinet Minister responded, "Well, there are other organisations that have

differing views, as some of these speakers are clinical professors..."

The issue arose after it was revealed that Senator Abetz was due to host a lunch for Dr Lanfranchi and other people visiting Australia to attend a World Congress of Families conference on 30 August.

But Senator Abetz insisted that his views had been misrepresented.

In a statement, he said he had "studiously avoided" drawing any link between abortion and breast cancer during his interview.

"[I] was cut off before being able to acknowledge that Dr Angela Lanfranchi's views on this topic were not the accepted medical view," he said. "As I pointed out, I am associating myself with the Families conference – the broad aims of which I support. This does not mean that I endorse the views of every single speaker."

But A/Professor Owler said he was "very concerned" that senior members of the Government were associating themselves with the Families conference.

"To have senior members of the Government associating themselves with this particular conference, but particularly pushing some of the discredited theories about linking abortion with breast cancer, the use of the oral contraceptive pill with things like domestic violence, that is very unhelpful, and I think quite an irresponsible position and action for those people in the Government to take," he said.

The AMA President said he had raised his concerns directly with Health Minister Peter Dutton, and had been assured that the views expressed by Senator Abetz were not those of the Government.

“ The AMA President said he had raised his concerns directly with Health Minister Peter Dutton, and had been assured that the views expressed by Senator Abetz were not those of the Government ”

Mr Dutton said he did not believe there was a link between abortion and breast cancer.

"I think the evidence needs to be the driver in this area, and it's clear there is no link," the Minister said. But, he added, "it would be ridiculous to suggest that if you're going to a conference, you must align with every view that's expressed at that conference."

A/Professor Owler said that while members of the Government were entitled to their views on abortion, they had a responsibility not to mislead the community.

"To try and use some sort of link between those topics and a medical condition I think is quite irresponsible for the member of the Government to be doing, and certainly unhelpful for people out there in the community that look towards leaders, including our politicians, to get the right sort of information and credible information," he said.

Adrian Rollins

Hasty and ill-conceived reforms risk huge setback to GP training



The AMA has warned of a huge setback to general practice training, including the wholesale loss of experienced educators, unless the Federal Government slows the pace of its reforms and entrusts the GP Colleges with oversight and management of education programs.

AMA President Associate Professor Brian Owler has written to Health Minister Peter Dutton expressing concern that Government changes including scrapping General Practice Education and Training (GPET) and absorbing its functions within the Health Department, shutting down the Prevocational General Practice Placements Program (PGPPP) and abolishing existing regional training providers (RTPs) and putting their functions out to tender, risk undoing recent successes in rebuilding GP education.

In the letter, A/Professor Owler said the AMA was not opposed to reforms of GP training arrangements, “however, we think your reforms need to be built on a more solid foundation and implemented in a more reasonable timeframe”.

“All of these changes are happening at the same time as the intake to the GP training program is being significantly increased, and there is too much potential for things to go wrong, and for the quality of GP training to suffer,” he wrote.

These concerns have been compounded by the haste with which the Government wants the changes to be implemented. GPET is to be abolished and new RTPs appointed by the beginning of 2015.

The AMA is worried that much hard-won GP training expertise will be lost as a result of the Government’s changes, and has doubts about the capacity of the Health Department to effectively take on the responsibilities expected of it.

A/Professor Owler said the success of the Government’s reforms depended on the Department’s ability to take over from GPET in successfully coordinating GP training – “a role [it] has no demonstrated experience or track record in”.

Not only was the Department being asked to assume responsibility for a completely unfamiliar task, but it was likely to have to do so without the expertise of many of those currently involved in GP training, the AMA President warned.

“We understand that very few Health Workforce Australia staff have accepted offers of employment with the DoH, resulting in a significant loss of expertise and, at the same time, it is also unclear how many GPET staff will come across to the Department,” he wrote.

“These issues, and the Department’s performance in implementing the much smaller Commonwealth Medical Internships initiative, make it difficult for stakeholders to have any confidence in the Department being able to fulfil this role effectively.”

It is not just the capacity of the Department under question.

Hasty and ill-conceived reforms risk huge setback to GP training

... FROM P10

The Government's plans also depend on quickly establishing an effective network of providers to replace the RTPs, something that many doubt will be feasible in the very short time frame set by the Minister.

A/Professor Owler told Mr Dutton that the Government's reforms relied on the goodwill of the existing RTPs in handing over to their replacements, and on their ability to hang onto staff in the interim "despite a very uncertain future".

"Dismantling the RTP structure before robust arrangements are in place for the governance and management of GP training is also premature," the AMA President said. "RTPs have established relationships with practices, expertise and local knowledge that cannot be replaced overnight. In recognition of this, the tender... should be delayed by a further 12 months".

Instead of relying on the Health Department, A/Professor Owler has proposed that the Government give the GP Colleges, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine, assume responsibility for the governance and management of GP training

– an idea backed by the peak group of GPs, United General Practice Australia (UGPA).

At a meeting late last month, UGPA declared that, with their expertise, the Colleges were "best placed" in ensuring the nation's GPs continued to be trained to the highest standards.

A/Professor Owler said such a role for the Colleges would be in keeping with arrangements in other medical specialties.

"The experience of other specialty Colleges shows that they could do this very cost effectively, and with much less bureaucracy than either GPET or the DoH," he said.

The AMA President warned that the Government ran the risk of delivering a huge setback to the nation's supply of quality GPs if it botched its reforms.

"The last time GP training was reformed by the Government, we saw the loss of infrastructure and people that took many years to rebuild," he wrote. "Applications for GP training also plummeted. We want to work with the Government to avoid a repeat of this experience."

Adrian Rollins



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

Put family doctors at centre of primary care networks: AMA

The organisations being set up by the Federal Government to replace Medicare Locals should be led by family doctors and focus on supporting general practice and plugging gaps in care, the AMA has said.

AMA President Associate Professor Brian Owler said the Horvath Review had identified significant problems in the conception and operation of Medicare Locals, and their replacement by Primary Health Networks (PHNs) was an important opportunity to get things right.

"While some Medicare Locals have clearly done a good job in improving access to care, the overall Medicare Local experiment has clearly failed, largely due to deliberate policy decisions to marginalise the involvement of GPs," Associate Professor Owler said. "We can't afford to get it wrong a second time."

But the AMA has expressed concern about the possible involvement of private for-profit organisations, such as health insurers, in operating PHNs.

Late last month, A/Professor Owler sounded the alarm on an apparent concerted push by health funds to assume a greater role in primary health care, warning that experiments such as Medibank Private's contribution to the running costs of some Queensland GP clinics in return for privileged access for its members could pave the way for US-style managed care.

In his review, released by the Government in May, former Chief Medical Officer Professor John Horvath found that the performance of Medicare Locals had been highly variable and inconsistent.

Professor Horvath reported that Medicare Locals had, by and large, fallen short of meeting the "genuine need" for organisations that brought together health professionals and hospitals to fill gaps in services and provide patients with seamless care.

"While there are a few high performing Medicare Locals, a great many are not fulfilling their intended role," he said. "I found lack of clarity in what many Medicare Locals are trying to achieve, with considerable variability in both the scope and delivery of activities. This has resulted in inconsistent outcomes...dispirited stakeholder engagement, poor network cohesion, and reduced sector influence."

A/Professor Owler said GPs needed to be given a central role in the PHNs to ensure such mistakes were not repeated.

"The AMA wants PHNs to be better targeted and more driven by family doctors at the local level," he said.

The AMA President said international experience, including from New Zealand, showed that GP leadership was vital if PHNs were to make a difference and improve patient care and outcomes.

"GPs are generally the first point of call in the health system, and they can provide high quality clinical input as well as first-hand knowledge of where improvements in the health system need to be made," he said.

In its submission to the Horvath Review late last year, the AMA recommended that Medicare Locals be replaced



by a network of primary health controlled organisations that were led by, and responsive to, GPs; that focused on supporting GPs in caring for patients, working collaboratively with other health care professionals; and were not overburdened by excessive paperwork and policy prescription.

The AMA has developed a plan for PHNs that calls for a focus on three broad areas:

- identifying local health needs and addressing gaps in services;
- improving general practice capacity through IT, e-health and training support, and facilitating multidisciplinary team care; and
- engaging with Local Hospital Networks to coordinate care for high risk patients, such as those with multiple chronic conditions.

Under the Government's plans, PHNs will come into operation from 1 July next year.

Adrian Rollins



AMA IN ACTION

AMA President Associate Professor Brian Owler and Secretary General Anne Trimmer gained invaluable first-hand experience of the health problems afflicting many Indigenous Australians and the challenges of providing medical services in often remote and badly disadvantaged communities during a four-day visit to the Northern Territory.

During the trip, A/Professor Owler and Ms Trimmer, together with AMA NT President Dr Robert Parker, visited the Amoonguna community about 20 kilometres south-east of Alice Springs and the Wurrumiyanga community on Bathurst Island, where they met with locals and talked to medical clinic staff about major health issues, the likely effects of the proposed \$7 co-payment and the prospects for further improvements in Indigenous health. During these visits, and in meetings with Indigenous health organisations including the Central Australian Aboriginal Congress (CAAC), the Aboriginal Medical Services Alliance Northern Territory (AMSANT) and Darwin's Danila Dilba Health Service, the consistent message was that further improvements in Indigenous health required a broad-based approach tackling the underlying causes of ill-health – among them poor housing, high rates of unemployment, poor education, literacy and numeracy, alcohol and drug abuse, family and community violence and persistent social dislocation.

During their visit, A/Professor Owler and Ms Trimmer met with NT Health Minister Robyn Lambley and Shadow Health Minister Nicole Manison, as well as NT Health Department Chief Executive Dr Len Notaras, AMSANT Chief Executive John Paterson, CAAC CEO William Tilmouth and Public Policy Director Associate Professor John Boffa. Dr Parker provided invaluable assistance in organising and hosting the visit.

Adrian Rollins

COMMENT



AMA President Associate Professor Brian Owler (C), AMA NT President Dr Rob Parker (L) and Alice Springs hospital emergency department director Dr Steve Gourley (R) outside the revamped hospital emergency department, Alice Springs.

Birthweight gap closing as Indigenous maternal health improves

The number of Aboriginal and Torres Strait Islander babies born with a low birthweight has declined significantly, in a sign that intensive efforts to boost Indigenous maternal health are succeeding.

Figures released by the Australian Institute of Health and Welfare (AIHW) show that the low birthweight rate among babies of Indigenous mothers dropped by almost one tenth (9 per cent) between 2000 and 2011, narrowing in the gap for low birthweight babies between the Indigenous and non-Indigenous populations in Australia.

Nonetheless, Indigenous mothers are still twice as likely as non-Indigenous mothers to have babies of low birthweight (12.6 per cent and 6 per cent respectively).

AIHW spokesman Dr Fadwa Al-Yaman said low birthweight was associated with a range of adverse health outcomes, including newborn death and serious illness and the development of chronic diseases later in life.

Dr Al-Yaman said the drop in the low birthweight rate for Indigenous women had led to a significant narrowing of the gap in the low birthweight rate between Indigenous and non-Indigenous mothers

over the decade.

That narrowing contributes to the progress being made in the Commonwealth, State and Territory governments' Closing the Gap strategy to address the disadvantage faced by Indigenous Australians in the areas of life expectancy, child mortality, education and employment.

Earlier this year, Prime Minister Tony Abbott reported to Parliament that the target to halve the gap in child mortality by 2018 is on track to be met. He said, however, that there had been almost no progress in closing the gap in life expectancy between Indigenous and non-Indigenous Australians, which still sits at about a decade.

The *Birthweight of babies born to Indigenous mothers* report showed that 11,729 Indigenous mothers gave birth to 11,895 babies in 2011, representing 4 per cent of all babies born in that year.

Nearly all (99 per cent) of births to Indigenous mothers in 2011 were live births, the same proportion as for births to non-Indigenous women.

In 2011, 12.6 per cent of babies born to Indigenous mothers were of low



birthweight (less than 2,500 grams), while 86 per cent were of normal birthweight (between 2,500 grams and 4,499 grams) and 1.4 per cent were of high birthweight (4,500 grams or more).

Dr Al-Yaman said a range of factors were associated with birthweight, including maternal smoking during pregnancy, antenatal care and pre-term births.

"Half of all Indigenous mothers who gave birth in 2011 reported smoking during pregnancy, compared with 12 per cent of non-Indigenous mothers," he said.

"The smoking rate among Indigenous mothers fell from 54 per cent in 2005 to 50 per cent in 2011, with a greater fall in the rate among non-Indigenous mothers, highlighting considerable scope for further improvements."

The report also showed that the rate of Indigenous babies being born prematurely fell over the decade.

"In 2011, 12.5 per cent of liveborn babies

of Indigenous mothers were born pre-term, compared with 7.5 per cent of babies born to non-Indigenous mothers, but the gap between the two had narrowed over the decade," Dr Al-Yaman said.

AMA President Associate Professor Brian Owler, who visited a number of Indigenous communities and Aboriginal health services in the Northern Territory last week, said the success in reducing the incidence of low birthweight among Indigenous babies was an encouraging development that showed, with appropriate resources and commitment, governments and communities could achieve real improvements in Aboriginal health.

A/Professor Owler said the result underlined the importance of the nation's governments "keeping the pedal to the metal" and to continue working together in a consistent and coordinated way to improve Indigenous health.

Debra Vermeer

ADHD under-recognised, not over-diagnosed: expert

For the past 20 years Dr David Coghill has been working at the boundaries of understanding child behaviour, helping sort out the distinction between the hijinks and scattiness that are a normal part of growing up with disorders which can lead to lifelong impairment.

It has meant the Scottish-based expert is no stranger to the controversy that surrounds the diagnosis and treatment of attention deficit hyperactivity disorder (ADHD).

As rates of ADHD diagnosis have grown world-wide, so have claims that lazy parents and clueless doctors are turning to drugs to dampen the natural exuberance of children, in the process creating a generation of doped-up zombies.

Dr Coghill, who leads the Developmental Research Group at the University of Dundee's Division of Neuroscience, has heard it all, and is bluntly dismissive of such fear-mongering.

It is true, he told *Australian Medicine*, that the diagnosis of ADHD has jumped in recent years, but from a very low base (in Scotland, from just 0.3 per cent of the child population to around 1.2 per cent), and it was still a reasonably rare condition that was hardly suggestive of an epidemic of over-diagnosis.

Instead, Dr Coghill said, the problem was that many more children had the disorder than were being diagnosed, denying them essential treatment.

He said that in Scotland around 5 per cent of children had ADHD, so the diagnosis rate of 1.2 per cent meant the disorder was being significantly under-recognised and treated.

Most of the concerns about rampant over-diagnosis of ADHD have their origins in the United States. While the American Psychiatric Association estimates 5 per cent of children have the disorder, figures compiled by the Centers for Disease Control and Prevention show that around



11 per cent of American children aged between four and 17 years (6.4 million) were diagnosed with the condition as of 2011, with the rate of diagnosis growing by an average of 5 per cent a year.

In Australia, as in Europe and the UK, rates of diagnosis are lower but, unsurprisingly, are influenced by the diagnostic criteria that are applied.

In the US and Australia, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) is widely used, while in Europe practitioners have largely the World Health Organisation's the International Statistical Classification of Diseases (ICD) as a guide to diagnosis.

DSM embodies a more encompassing approach to the diagnosis of ADHD than the ICD. Mutual exclusivity between ADHD and autism was dropped in DSM-5 released last year, and the age of onset of the disorder was raised from before seven years to before 12 years.

By contrast, ICD 10 takes, Dr Coghill said, a more rigid a restrictive view. It identifies hyperkinetic disorder (which he said was akin to what he would describe as severe, persistent and impairing ADHD), while those with lesser symptoms and impairment described as having ADHD. In population terms, 5 per cent of children have ADHD, of whom a subset of 1.8 per cent have hyperkinetic disorder.

ADHD under-recognised, not over-diagnosed: expert

... FROM P15

Dr Coghill has played a leading role in trying to improve and refine the diagnosis of ADHD, and was central to the development of European guidelines for the assessment and management of ADHD, and has helped devise a program to assist clinicians to use this guidelines in practise.

Ask most people to describe ADHD and they would mention inattention, poor impulse control and hyperactivity.

But Dr Coghill said that, "on its own, that is not enough".

"If you looked across the general population you would say everyone has got some of that, and that is correct," he said, warning that if you relied on these symptoms alone to diagnose the disorder, around a quarter of all children would be classified as having ADHD.

He said that an accurate diagnosis rested not only on a checklist of more than 20 symptoms, but also the level of impairment resulting from this behaviour.

"These symptoms need to be interfering with daily life in a significant way, not

only causing problems at home, but also in one other area of life, usually school."

Dr Coghill said the symptoms of ADHD needed to be present, persistent, to have started early in life and to have caused significant impairment.

It means that accurate diagnosis is not simply a matter of ticking off a list of observed behaviours, but of gathering and assessing information about the patient's life.

"We are very clear in these guidelines that you need to collect not only information about symptoms, but also a child's development; how they are managing broader areas of life," he said.

It means that it is "probably not possible" to make a diagnosis of ADHD in one visit to the doctor, and each consultation was likely to be time consuming.

Dr Coghill acknowledged this as a constraint in the Australian system of primary care, where low fees put the pressure on doctors to churn through

patients as quickly as possible.

Just as important as the diagnosis of ADHD is its treatment.

In the US, medication is considered a first-line treatment for the disorder. In almost as many states, more than three-quarters of children diagnosed with ADHD are being given drugs, according to CDC figures.

Dr Coghill said medication is a front-line treatment for those with severe ADHD.

But he added that evidence, particularly the pivotal Multimodal Treatment of Attention Deficit Hyperactivity Disorder (MTA) study, first published in 1999 and updated in 2009, showed that intensive non-pharmaceutical therapies could be effective as the first line of treatment for those with milder forms of ADHD.

Dr Coghill talked about ADHD diagnosis and treatment with clinicians and researchers in Brisbane, Sydney, Melbourne and Adelaide as part of a four-day visit sponsored by Janssen Pharmaceuticals.

Adrian Rollins



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E-cigarette debate lights up



Debate about the health risks and benefits of electronic cigarettes is intensifying with the publication of a study challenging expert concerns the devices could encourage smoking and slow the rate at which people give up the deadly habit.

The study, published in the journal of the *Society for the Study of Addiction*, questioned calls for e-cigarettes (EC) to be regulated as strictly as conventional cigarettes.

After reviewing all available research on the use, content and safety of EC and their effects on users, the study found that allowing EC to compete with cigarettes in the market-place might actually decrease smoking-related illness and deaths.

"Regulating EC as strictly as cigarettes, or even more strictly, as some regulators propose, is not warranted on current evidence," the authors said.

"Health professionals may consider advising smokers unable or unwilling to quit through other routes to switch to EC as a safer alternative to smoking and a possible pathway to complete cessation of nicotine use."

The controversial finding comes just weeks after medical experts across the world warned against the use of e-cigarettes, citing a lack of scientific evidence as to their health and behavioural effects.

The *Society for the Study of Addiction* study addressed a number of key arguments against e-cigarettes and gathered the available evidence to examine the claims.

It found the evidence did not support the claim that the chemicals in EC cause excess illness and death.

"Health effects of long-term EC use are currently not known and a degree of risk may yet emerge," the authors said. "However, based on the data available regarding the toxicant content of EC liquid and aerosol, the long-term use of EC, compared to smoking, is likely to be much less, if at all harmful to users or bystanders. This is because, unlike cigarettes, EC do not deliver combustion-generated toxicants that are linked to cancer, chronic lung

disease and cardiovascular disease."

The study also found the argument that EC encouraged smokers who would otherwise quit to continue with their habit was yet to be substantiated.

"EC use is associated with smoking reduction, and there is little evidence that it deters smokers interested in stopping smoking tobacco cigarettes from doing so," the authors said.

It found that there was no evidence to support the argument that e-cigarettes were acting as a 'gateway' to smoking for young people.

"Regular use of EC by non-smokers is rare and no migration from EC to smoking has been documented (let alone whether this occurred in individuals not predisposed to smoking in the first place).

"The advent of EC has been accompanied by a decrease rather than increase in smoking uptake by children."

The authors did admit, however, that ongoing surveillance was needed to address this important point.

The study also found that there were no indications that the advance of EC was increasing the popularity of smoking or sales of cigarettes.

They did warn, however, that it was too soon to say whether EC had a positive effect on

reducing the smoking rate in the population.

The authors said more research was needed to monitor the link between EC use and smoking behaviour, as well as on the long-term health safety outcomes of EC use.

The publication of the study comes just weeks after public health experts worldwide urged the World Health Organisation to ignore tobacco industry claims about e-cigarettes and instead focus on the evidence in assessing their health implications.

Leading Australian public health advocates Professor Stephen Leeder, Professor Alan Lopez, Professor Ian Olver, Professor Mike Daube, Professor Simon Chapman and Associate Professor Freddy Sitas were among 129 international public health physicians and campaigners who wrote to the WHO Director General Dr Margaret Chan in support of the organisation's evidence-based approach to electronic nicotine delivery.

The experts warned that the WHO should be wary of the tobacco industry's role moving into and driving the e-cigarette market.

The experts said there was "good evidence" that e-cigarettes released several toxic substances, including carcinogens.

The World Medical Organisation has also previously warned against the e-cigarettes, citing a lack of evidence as to their effects.

In Australia, it is illegal to sell e-cigarette liquids that contain nicotine.

Debra Vermeer

COMMENT

Alcohol kills 15 a day - study



The number of Australians killed or hospitalised because of alcohol consumption has jumped in the last decade, with a new study showing that alcohol causes 15 deaths and hospitalises 430 Australians every day.

Confirmation of alcohol's heavy toll on health has come as the AMA proceeds with preparations for a National Summit on alcohol-related harm as part of efforts to tackle the nation's drinking problem.

The AMA plans to bring together health practitioners, policy experts, politicians

and community representatives to discuss the harm being caused by alcohol and develop strategies to ameliorate the problem.

The big rise in the number of deaths, injuries and illnesses attributed to alcohol has reinforced calls for the nation to re-think its drinking culture and for governments to do more to curb drinking, including increasing taxation, imposing earlier pub and club closing times, and toughening restrictions on alcohol advertising.

AMA Vice President Dr Stephen Parnis last month stepped up calls for a ban on alcohol ads and promotions during live sports broadcasts amid evidence that industry self-regulation had failed and young people were being exposed to a significant volume of messages promoting drinking.

Launching the second annual report of the Alcohol Advertising Review Board in July, Dr Parnis said it was clear that many major alcohol companies were ignoring concerns young people were being heavily exposed to alcohol marketing and promotion, and could not be relied on their own to act responsibly.

During 2013-14 the Review Board, established by the McCusker Centre for Action on Alcohol and Youth and chaired by renowned child health researcher Professor Fiona Stanley, received 209 complaints about alcohol advertising and promotion, 86 of which were upheld in full, and a further 44 upheld in part.

Carlton and United Breweries (CUB) was the most common and consistent source of complaints – accounting for almost 20 per cent of all complaints lodged in the past two years – earning it the dubious distinction of being the first recipient of the Worst Offender Award “for exposing children and young people to extensive alcohol advertising of AFL, NRL and cricket, and for attracting the most

complaints to the AARB”.

The *Alcohol's Burden of Disease in Australia* report, released by VicHealth and the Foundation for Alcohol Research and Education (FARE), shows that 5554 deaths, a 62 per cent jump from 2000, and 157,132 hospitalisations were caused by alcohol in 2010.

Of the 5554 deaths attributable to alcohol in 2010, 3467 were men and 2087 women.

For men, injuries accounted for more than one in three (36 per cent) of alcohol-related deaths, while cancer and digestive diseases caused 25 and 16 per cent, respectively, of alcohol-related deaths. For women, one in three alcohol-related deaths was due to heart disease (34 per cent), followed by cancers (31 per cent) and injuries (12 per cent).

The report, conducted by Turning Point Alcohol and Drug Centre, found that people living in the Northern Territory were three times more likely to die from alcohol use than other Australians.

Victoria had the lowest proportion of deaths attributable to alcohol for both men and women.

Dr Belinda Lloyd, Head of Population Health Research at Turning Point, said the report clearly showed that the long term effects of alcohol aren't just confined to one Saturday night.

Alcohol kills 15 a day - study

... FROM P18

"It is clear that there are both short term and long term harms associated with risky consumption, and we are seeing increasing death, disability, health service burden and social impacts of alcohol across Australia," she said.

FARE Chief Executive Michael Thorn said Australian governments can no longer ignore the urgent need for decisive and effective action to reduce the rising toll.

"A decade ago alcohol was responsible for 3430 deaths per year. Now that figure stands at 5554. Governments can't afford to wait another 10 years to act. Only decisive, evidence-based action will stem Australia's worsening alcohol toll," he said.

Mr Thorn said population-wide measures that address the price, promotion and availability of alcohol would not only save lives but also deliver significant financial savings to cash-strapped governments.

"Alcohol tax reforms, the introduction of earlier closing times and sensible restrictions on alcohol advertising and promotions will not just save lives and reduce the unacceptable level of alcohol harms, it will also reduce the \$36 billion dollar burden those harms represent, a burden carried by the entire Australian community."

VicHealth CEO Jerril Rechter said the study highlighted the social impact of alcohol in Australia.

"We live in a society where getting drunk at many social and sporting events is seen as a normal activity. It's no wonder the harm is increasing," Ms Rechter said.

"VicHealth believes our culture of heavy drinking needs to be challenged. We want to work towards a society where excessive drinking isn't seen as acceptable or normal activity."

Debra Vermeer



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

Telephone triage not a time-saver

GPs and nurses who assess patients by phone before seeing them in person end up spending far more of their time on the telephone rather than cutting down on their overall workload, a British investigation has found.

And it has warned that using receptionists as a barrier to ward off patients seeking same-day consultations might be inappropriate.

The report, *Management of same-day appointments in primary care*, by Justin Osborn and Matthew Thompson, published in *The Lancet*, drew on results from an earlier study by John Campbell and colleagues, entitled, the ESTEEM trial.

The ESTEEM trial compared three approaches to telephone triage of patients seeking same-day, but non-emergency, appointments in the United Kingdom: phone triage by GPs, phone triage by nurses using computer decision support, and usual care, such as a receptionist taking the call.

The study, which involved more than 16,000 patients across 42 medical practices, examined the practice workload in the 28 days after the same-day request, as well as costs and patient satisfaction.

It found that practices where doctors took the triage phone calls had a 33 per cent increase in the mean number of patient contacts per person over the 28-day period. Those

who introduced nurse triage had a 48 per cent increase.

However, the increase in patient contact with the practice did not necessarily translate into face-to-face visits with the doctor.

The ESTEEM trial found the introduction of GP triage actually reduced the number of face-to-face contacts with GPs by about 40 per cent, while nurse triage reduced the number of GP face-to-face contacts by 20 per cent.

This reduction in face-to-face contact with doctors was offset though, by far more phone contacts. GPs experienced a 10-fold increase in phone calls, while for nurses there was a 100-fold increase.

"Therefore, to some extent, the differences in numbers and types of contacts between practices in the three groups represented redistribution of the workload," the researchers said.

All three forms of screening involved similar costs, but patient satisfaction was lower in those practices using nurse triage than in those using GP triage or usual care.

"The fact that GP or nurse triage led to increased numbers of consultations, overall, suggests that the barrier imposed by receptionists or other non-clinical staff fielding requests for same-day consultations might be inappropriate," *The Lancet* report says.

The authors said the findings of the ESTEEM trial echoed those of smaller trials of nurse triage for same-day appointments in general practice, one of which reported a reduction in same-day face-to-face GP contacts, but an increase in routine face-to-face visits to the GP and more phone contacts and face-to-face time with nurses.

"Many primary care practices struggle with ever-increasing demand from patients accustomed to round-the-clock services (and pressure from politicians and policy makers to satisfy this demand)," they said.

"Mere shifting of clinicians into triage roles is unlikely to free them from other duties.

"Another key message is that all triage systems offer trade-offs between different uses of staff in primary care, and none are necessarily better than others.

"Nevertheless, the ever-rising tide of demand for appointments means that we need to find ways to encourage greater patient self-management when appropriate, new forms of consultation or advice (with email or online consultations, or by expanding the work of pharmacists), and research to guide specific triage skills and clinical reasoning in primary care."

Debra Vermeer

COMMENT

Surgery far from the risk it once was



The number of deaths resulting from surgery in Victoria is extremely low and falling each year, an audit of surgical mortality in the State has shown.

The Victorian Audit of Surgical Mortality's

(VASM) sixth annual report presents the results of reviews conducted into 3948 deaths over six years from July 1 2007 to June 31 2013. During that period, more than three million patients underwent

surgical procedures in Victoria.

VASM Clinical Director and practising surgeon, Barry Beiles, said the data showed that surgical mortality was very low at 0.3 per cent, and has fallen with each successive year, despite increasing numbers of operations being performed in Victoria.

"Most surgical deaths in Victoria are elderly patients (85.6 per cent) admitted as emergencies and with other severe health problems," Mr Beiles said.

"As we grow older we have more complex diseases and often more complex surgical procedures that could lead to complications."

Causes of death in elderly patients were often linked to their pre-existing health status and the review process almost always assessed these deaths as not preventable. The most common causes of death reported were cardiac and respiratory failure.

"Providing feedback in these cases is essential to the audit's overarching purpose, which is the ongoing education of surgeons and the improvement of surgical care for all patients," Mr Beiles said.

The audit found that the majority of hospital deaths occurred in the public sector, but said this was not a reflection on the level of care provided. Rather, it was the result of the less complex case-

mix of patients in private hospitals.

Mr Beiles said that trends relating to clinical risk management showed overall improvements in patient surgical care, with monitoring to continue in the three high priority areas of: action to avoid deep vein thrombosis post-surgery; use of critical care facilities post-surgery; and adequate fluid balance management.

But he said that, along with other states and territories, VASM had consistently identified key risk management issues as ongoing areas for improvement. They are: delay in implementing definitive care; poor communication between health professionals, especially for coordination of patient care; operative management issues; and diagnosis-related problems.

The report recommended that surgeons focus on better documentation of clinical events; taking action on evidence of clinical deterioration; improving communication between health professionals; improving awareness of shared care requirements; and improved clinical patient care management before, during and after surgery.

The audit is funded by the Victorian Department of Health and managed by the Royal Australasian College of Surgeons.

Adrian Rollins



BY DR BRIAN MORTON

Family Doctor Week 2014 - wrap up



AMA Family Doctor Week 2014

YOUR FAMILY DOCTOR:
KEEPING YOU HEALTHY

Late July we saw another AMA Family Doctor Week come and go.

The week always passes quickly, but I am glad that we make the time as a profession to remind ourselves and the community about the important role we play in the lives of our patients and in delivering high quality care in local communities. It also allowed us to highlight key issues affecting general practice, and to put forward positive ideas to support the delivery of even better services to the community.

This year Family Doctor Week was celebrated with the theme *Your Family Doctor – Keeping You Healthy*.

The theme had a strong focus on the importance and value of preventative medicine and, throughout the week, the AMA highlighted the benefits of having a regular GP. The AMA discussed preventable health issues and the importance for people to know and discuss their risk factors with their GP.

To assist general practices in educating patients, the AMA developed a video for practices to play in their reception rooms covering a number of key health conditions. It is still available for download from the Family Doctor Week website (<https://ama.com.au/familydoctorweek2014>), and I would encourage you all to make use of it.

The highlight of the week was the AMA President's address to the National Press Club of Australia, where he tackled claims that the health system is unsustainable and highlighted the pivotal role played by GPs in our health system.

It was a great opportunity to emphasise the threats to general practice and health care in this country from policies that are more focussed on returning the budget to surplus than supporting quality health care.

The Government's proposed model for co-payments needs to be overhauled completely and reforms to GP training, including the loss of the Prevocational General Practice Placements Program, require a strong response so that we do not lose professional control of our specialty.

It was also great to see three past AMA presidents, Dr Mukesh Haikerwal, Dr David Brand and Dr Steve Hambleton, attend the speech – each a GP.

GPs are providing high quality, affordable and easily accessible comprehensive health care, and for more than 20 years the AMA has celebrated this during Family Doctor Week.

“GPs are providing high quality, affordable and easily accessible comprehensive health care, and for more than 20 years the AMA has celebrated this during Family Doctor Week”

I am proud to be a GP, and I know we are making a difference to our patients each and every day of the year, and Family Doctor Week is just one demonstration of the AMA's support for our profession and our patients.





BY AMSA PRESIDENT
JESSICA DEAN

“Even though we all came from different backgrounds and spoke different languages, ultimately we are all medical students, and all care deeply about the health of the communities we serve”

Passion and compassion in abundance as medical students worldwide meet



The plenary hall was hot and stuffy; people sat still while sweat dripped from their foreheads; it was 35 degrees and the air conditioning had turned off at midnight.

Yet, even after nine-and-a-half hours of heated debate, even at 2:30 in the morning, the 1000 delegates in the room sat focused and concentrated on the task at hand.

These delegates attended from 117 countries, and it was their duty to represent 1.2 million

medical students worldwide.

I am fortunate to have just returned from sweltering Taipei, where 16 Australian delegates represented the Australian Medical Students' Association at the 2014 International Federation of Medical Students Associations (IFMSA) August General Assembly (GA). IFMSA unites medical students worldwide to collaborate and lead initiatives that will have a positive impact on the communities we serve.

Australian delegates truly immersed themselves in the GA.

AMSA brought three important policies that it successfully shepherded through, on foreign aid, drug reform, and the social determinants of health.

AMSA delegates also ran a pre-GA workshop titled 'Code Blue'. The workshop aimed to empower students to become advocates in the field mental health space, while also providing necessary background training in student mental health, advocacy and leadership.

AMSA won the award for 'Best Project Presentation' for the AMSA Academy course – 'Global Academy'.

This online short course consists of seven modules, and aims to supplement traditional medical education in global health. The course includes written content, lectures from experts in the field, and online quizzes. It covers topics such as global health inequities, resource allocation, health policy and delivery.

To recall just a single memory would be to grossly understate the breadth of the General Assembly experience.

These are just a selection of some of the highlights and memorable moments experienced by AMSA delegates:

- exposure to the experience of different health systems, particularly those that differ so significantly from our own. For example, a delegate who studies medicine in Kenya is expected to not only work autonomously as soon as she finishes medical school, but anticipates the awful experience of having to frequently turn away severely ill patients that simply cannot afford treatment;

Passion and compassion in abundance as medical students worldwide meet

... FROM P23

- having the unique opportunity to learn about the Israeli-Palestinian conflict by listening to representatives from both delegations share their intimate personal experiences. Later in the week, the whole room rose to their feet as a joint position statement was read on behalf of the Israeli and Palestinian delegations, condemning violence and human rights abuses from both sides, and calling for peace. It was then followed by a minute's silence to mourn the victims and the suffering on both sides;
- the smiles around the room when an Australian male delegate hopped down the runway of the 'Miss Medicine' beauty pageant. He wore a kangaroo onesie, and carried a sign reading: *WOMAN ARE MORE THEN THEIR LOOKS*;
- the heartfelt video statement made by the African region on the recent Ebola outbreak, their experiences, and the effect it was having on their communities.

Even though we all came from different backgrounds and spoke different languages, ultimately we are all medical students, and all care deeply about the health of the communities we serve.

Jessica Dean is the President of the Australian Medical Students' Association. Jessica is a 6th year Medicine/Law student at Monash University. She is currently completing an Honours Project in Bioethics at The Alfred. Follow on Twitter @AMSAPresident or @yourAMSA

The link for AMSA Academy can be found here: <http://academy.amsa.org.au/>



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BY DR DAVID RIVETT

Off the table

“Off the table, gone, disappeared” - with these words, Prime Minister Tony Abbott killed off planned changes to section 18C of the Racial Discrimination Act, and one must applaud him on accepting the community consensus that racial and religious vilification is not on.

I am sure every fair-minded Australian wants to hear the same words uttered in regard to the \$7 GP co-payment.

In the 18 months since Medicare last gave another paltry “indexation” to GP MBS rebates, the CPI has risen 4 per cent. The recent indexation of 2 per cent is rubbish. Let us face the facts.

MBS rebates shrink annually in real terms through bogus “indexation”. So why would any sane government slash even more off the patient rebate?

All Treasurers since the inception of Medicare have embraced the corrupt indexation of rebates as a way of saving huge dollars.

When I was AMA Council of General Practice Chair, I confronted several Health Ministers as to the nonsensical indexation, only to be told they fully understood but that the Treasurer welcomed the existing position and would override their

arguments for reform.

It is time every medical practitioner in Australia got angry and said ‘we are not taking it any more’.

If we are to have a universal health insurer, rebates must be determined and indexed by an independent body. And I mean independent of Government and respected by the profession, with its rulings open to challenge and appeal mechanisms.

Cheaper medical care is not better medical care: never has been, never will be.

Australia is not in financial crisis despite Joe Hockey’s futile, lightweight and totally unconvincing bleating.

We do not need to legislate that the poorest and neediest in society find cash before they approach a GP for help and direction.

The GP who provides their care at the Medicare rebate is already doing so at close to a zero income ballgame, but does so because he or she wants to help.

Sadly, our surgery premise rents, staff wages, indemnity fees, Medical Board fees, CME, College fees, do not increase at the same low

“ Sadly, our surgery premise rents, staff wages, indemnity fees, Medical Board fees, CME, College fees, do not increase at the same low rate as the MBS fees ”

rate as the MBS fees.

All these rise in relation to real world costs. MBS rebates are in cloud cuckoo land, totally devoid of reality.

Get angry now and approach your State AMA to say enough is enough. And get non-members to show some gumption and sign up.

Our only chance of victory for a sustainable, non-corruptible Medicare with honest patient rebates is for the profession to be united, stand up and say “we will not take this absolute nonsense anymore”.

COMMENT



Member Profile

Eye-opening images of care



Sarika Gupta

The first moment of life. An infant, its skin blotchy red and white, eyes screwed shut, mouth wide open, yelling out that first breath.

It's an image that doesn't fail to move you despite the familiarity. The photographer, Sarika Gupta, is no ordinary "snapper", however.

She's a medic by training, who has spent the past three years gaining experience in clinical outposts in India, Burma and Papua New Guinea.

In PNG, Ms Gupta worked as part of a Rotary International program undertaking

family planning missions in an effort to target rapid population growth, rising maternal mortality and rising adolescent birth rates.

In northern India, she was part of a Vision Beyond Australia project, operated as part of the World Health Organisation's 2020 program, treating cataract blindness, while in Raxaul (on the Nepal/India border), Ms Gupta worked in the large maternal and child health department of Emmanuel Hospital.

Her intimate portraits are a result of the unprecedented access she has had to the lives of the patients and doctors she got to know during her placements.

Working initially in an ophthalmic clinic in Rajasthan, Ms Gupta said she was shocked by the severity of the diseases people presented with.

"The vision problems were so acute, so far advanced from anything I'd seen in Australia," she said. "As a volunteer, I felt quite disempowered at first. I kept thinking, 'why didn't they seek help earlier?' But many people travel for days to reach the small clinic. We



First breath: the moment of birth for an infant girl delivered at a hospital in Raxaul, India last year

would operate 25 surgeries a day; at best maybe 300 a week, but there were thousands in need. It was quite overwhelming."

For Ms Gupta, photography has been a way of thinking about such experiences.

"It helps me to reflect on what I've done and what I've seen. It's important that the composition tells a story of people's lives, and that I put what I've seen into context," she said.

Since late 2012, Ms Gupta has focussed on obstetrics, working as a volunteer travelling abroad up to three or four times a year while she completes her training.

"The photograph I took of the newborn baby was taken at a Christian-based missionary hospital on the border of Nepal that has a large maternal health department," she said. "The head of the unit was a general surgeon, so they were very pleased to have someone there with an interest in obstetrics, even though I was quite junior!"

But soon after arrival, Ms Gupta faced the realities of childbirth for women who came to the hospital. She was called on to help care for a lot of premature babies and mothers suffering from symptoms of uterine rupture or eclampsia.



Member Profile

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Coming from a background where women are empowered, Ms Gupta said cultural differences around gender was something that she found particularly challenging.

"It's not always easy to accept," she said. "Women are spoken for by their husbands and, in some cases, their fathers-in-law. Without a man's approval to initiate treatment, we are unable to intervene, despite knowing how necessary it might be."

For Ms Gupta, these kind of experiences have helped her to shape her goals: "I want to be in a position where my documenting can gain support for women



in developing countries, bring their stories into the foreground and advocate for women's rights."

At the same time, Ms Gupta hopes that she can act as a role model for some of the women she meets.

"They see that I'm a woman working in a traditionally male role. I want to encourage as many women as I can to pursue education where it's available, so that future generations can take control of their own lives."

An exhibition featuring 48 photographs taken by Ms Gupta during her work abroad will be held at the Queens Street Gallery, 28 Queen St, Woollahra.

The exhibition runs from 18 September to 5 October, and will be open from 11am to 5pm, Tuesday to Saturday.

All proceeds from sales of the images will be donated to Rotary International, Vision Beyond Australia and the Duncan Emmanuel Hospital, Raxaul, India.

For more information, visit: <http://www.sarikaguptaphotography.com.au/>

COMMENT

OPINION

BY JENNY DOUST,
PROFESSOR OF CLINICAL
EPIDEMIOLOGY, BOND
UNIVERSITY

“... as we
widen the
criteria for
who should
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to accurately
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and benefits”

Statins saga shows some of the perils of modern medicine

This article first appeared in The Conversation on 5 August, 2014, and can be viewed at: <http://goo.gl/8maAdf>

A panel convened by medical journal *BMJ* to investigate whether it was right to correct rather than retract two pieces featuring a mistake about side effects from statins has endorsed the journal's decision. The ten-month controversy highlights some recurring issues with how medicine works.

Statins are a class of cholesterol-lowering drugs that have been attracting controversy recently as questions are raised about their effectiveness.

In October 2013, *BMJ* published a study and an opinion piece that both erred when quoting another study. The journal published corrections on both pieces when the issue was raised by Oxford University Professor Rory Collins. And convened a panel to review its decision when Collins called for their retraction.

Overstated side effects

The first of the *BMJ* pieces was an analysis by a group led by Harvard University Medical School's Professor John Abramson arguing against widening the criteria for prescribing statins.

Currently, one in eight of all the people living in England, Wales, Northern Ireland and Australia are taking statins to reduce their cholesterol. Recent UK guidelines recommended widening these criteria, potentially increasing the number of people taking them to one in five.

Abramson's paper argued that in the new group of patients who would be recommended statins, 140 would need to take the drug for five years to prevent one serious cardiovascular event. But, it said, 25 of the 140 (18 per cent) would suffer "side effects ranging from minor and reversible to serious and irreversible".

The other paper was an opinion piece by UK cardiologist Aseem Malhotra that raised questions about the benefit of prescribing the drugs to

healthy people at low risk of heart disease. Malhotra claimed that 20 per cent of patients taking statins have unacceptable side effects.

Collins, who is head of the Oxford University Clinical Trial Service Unit and of the international Cholesterol Treatment Trialists' Collaboration, asked for the papers' retraction on the basis that these rates of side effects were overstated and incorrect.

The *BMJ*'s internal review panel found the risk of side effects published in both of the original papers was based on a misinterpretation of a result in an observational study, but that the journal had done the right thing in correcting rather than retracting the papers.

That's all good and well, but how did this controversy arise anyway? Statins are, after all, one of the most well-studied classes of drugs in history; approximately 200 million people worldwide take them.

Murky areas

So how can it be that there are still such heated arguments about who should be taking them and about their risks and benefits?

As it happens, the controversy highlights some of the problems doctors face when weighing up the benefits and harms for any therapy. The only unusual matter here is that the arguments are being played out in the media rather than the pages of academic journals.

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Statins saga shows some of the perils of modern medicine

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For most treatments, as we widen the criteria for who should get treated, the benefits get smaller. And it becomes more difficult to accurately balance harms and benefits.

While it's generally accepted that treatment decisions should be guided by clinical trials, such trials can underestimate the side effects of drugs. Participants in randomised controlled clinical trials are generally younger, for instance, and healthier than typical patients.

And trial design can cause a systematic underestimate of side effects. Consider the fact that many trials have a run-in period of several weeks before the main trial starts. If participants dropped out during this time, that is, they stopped taking the drug because they didn't want to take it any more or because they had side effects, then they would not proceed to the main trial. So people who are likely to have side effects are often excluded from trial results.

What's more, trials may not measure all side effects. (To ameliorate this, several studies have been set up to try and clarify the side effects of statins, independent of research conducted by the pharmaceutical industry). And sometimes the side effects measured in trials are not fully reported in academic papers.

An international campaign is calling for the data from all trials to be made publicly available so doctors and patients can make better informed decisions about treatments.

What do you think?

Whether the harms of statins outweigh the benefits depends on how you balance those benefits – avoiding heart attacks and strokes – and the risks – possible side effects, and having to take a tablet every day.

A recent study showed that many people value the potential increase in life expectancy from taking statins less than the “disutility” of taking tablets. While another showed exercise works as about as well as statins for preventing cardiovascular disease (as well as having positive knock-on effects on overall health).

Doctors don't want to alarm people but they also don't want to appear uncertain in front of them, so they often don't discuss these issues with their patients.

But the days when doctors – or even worse, expert committees with vested interests – make decisions for patients should be over, particularly when the “patient” is not sick and the drug being taken is to prevent something that may not happen.

For those interested in taking charge of their health a little, here's a beta version of the type of calculator that might help make decisions about risks and benefits, developed by Dr McCormack at University of British Columbia.

And next time you're visiting a doctor, ask questions about treatment decisions. You have the right to know.



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 performance 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.



Research

Avoid antibiotics, cold medicines for coughing youngsters



Short-term coughs in children are often caused by a viral infection and parents should avoid heading to the pharmacy for cough medicine or to the doctor for antibiotics, a new journal article recommends.

The article, by Dr Danielle Wurzel, Dr Julie Marchant and Professor Anne Chang from the Royal Children's Hospital in Brisbane is published in the latest edition of *Australian Prescriber*.

The authors said that cough was the most common symptom presented to GPs and pharmacists in Australia,

with a study finding that one in three respiratory episodes were associated with a doctor's visit and one in four required time off school or work.

Dr Wurzel said that it was not always possible for a doctor to determine the precise reason for a cough in children.

"What we do know is that upper respiratory infections are very common in young children, and it is normal for them to have several uncomplicated infections every year," she said.

"In these cases, over-the-counter cough and cold medicines are not recommended because there is a lack of evidence that they will work, as well as the possibility that they might pose a safety risk, which is why the Therapeutic Goods Administration (TGA) now recommends that they should not be used in children under six years, and only used in children aged six to 11 years on advice from a doctor."

Dr Wurzel said pain relief medicines like paracetamol or ibuprofen might help with other symptoms, and taking honey (in children older than one year) or using menthol-based rubs might help with night time coughing.

"Importantly, antibiotics should be avoided for children who have a cough associated with a mild upper respiratory tract infection, because the cough is more than likely viral in origin."

The study's authors said that a cough related to an upper respiratory tract infection might last between five and seven days or even up to three weeks, and that avoiding

passive smoke exposure could help.

"Of course, there are certain situations where people should certainly seek urgent medical attention, including if the child has rapid breathing, if there is a suspected inhaled foreign body, if the child is very breathless, is vomiting, can't eat, has persistent fever or is very lethargic," the authors said.

Coughs which do not resolve, require further investigation.

The article said appropriate management of childhood coughs depended on accurate assessment. It advised doctors that a patient history should include: cough duration; characteristics of cough; questions about choking episodes and previous respiratory illness; associated wheeze; other symptoms such as weight loss, appetite or rash; and an immunisation history.

For more serious or prolonged episodes of childhood cough, a number of specific diseases should be considered. These include croup, pneumonia, bronchiolitis and whooping cough.

Debra Vermeer

COMMENT

Real food, supplements help the elderly stay healthy

Malnutrition is common among the elderly, but dietitians now say that nutritional supplements could be the answer to improving weight, protein and energy intake in older Australians, helping to avoid illness and unnecessary hospital stays.

In research published in the latest edition of *Australian Prescriber*, accredited practising dietician Anne Schneyder examined ways of improving nourishment in older people at risk of malnutrition.

"Most elderly people eat far less than they did when they were younger, and their energy needs are lower, but the requirements for some nutrients, like protein, calcium and riboflavin are higher," she says.

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"This means that their food has to be more nutritious to meet their needs."

Studies have shown that malnutrition in the elderly can result in significant illness, hospitalisation, the development of pressure ulcers, infection, an increase in falls and fractures, and even death. Unintentional weight loss can also result in a reduction in the ability to care for oneself, loss of mobility and independence, and a poorer quality of life.

The rates of malnutrition in older people living at home are estimated to be as high as 30 per cent, and in aged-care facilities can be as high as 70 per cent.

Ms Schneyder said that for people at risk of malnutrition, using real foods was the first step to improving nutrition.

"Eating small frequent meals and snacks between meals, increasing the nutrient density of meals by adding milk powder, grated cheese, margarine and cream, and having nourishing fluids like milk drinks, smoothies and juice are the main ways to boost protein, energy and nutrients," she said.

But Ms Schneyder says studies have shown that sensible use of nutritional supplements can also help improve weight, protein and energy intake, and quality of life overall.

"There are a number of supplements to choose from, and the most commonly and readily available are milk based," she said.

"Specialised supplements are also available for particular medical conditions such as kidney disease."

Ms Schneyder said that using nutritional supplements could be a valuable addition to the diet for an older person who was malnourished or at risk, but warned supplements should not be used on their own without a comprehensive assessment from a dietician.

"Overall, a good strategy for improving malnourishment in the elderly is about increasing protein and energy intake from food, preserving the enjoyment of food, and importantly, maintaining quality of life."

Debra Vermeer



Blood clot treatment hope for stroke patients

People treated with a blood clot-dissolving drug within three hours of suffering a stroke have a better recovery, with fewer long-lasting or disabling effects, a new study has found.

In a result that underlines the need for a quick response to cases of suspected stroke, an international study published in *The Lancet* involving more than 6700 stroke patients found that those who received the drug alteplase had a 75 per cent better outcome if they were treated within the first three hours of a stroke. The benefit rapidly fell, however, if treatment was delayed by even a few hours.



One of the study's co-authors, Professor Richard Lindley from the University of Sydney, said the study showed that treatment with alteplase significantly increased the odds of a good stroke outcome.

"Alteplase is effective in dissolving blood clots in those who have suffered a stroke, and is particularly effective if it is administered within three hours," Dr Lindley said.

"Previously, alteplase was deemed ineffective and too risky to treat stroke patients who were elderly, diabetic, or had suffered a severe stroke. Doctors were reluctant to use it and these patients were often excluded from treatment.

"However, this study has found that alteplase is an effective emergency treatment for ischaemic stroke patients (strokes caused by blood clots) and should be available irrespective of age, severity, and clinical presentation."

Professor Lindley said the study showed that time is crucial in treating stroke patients. The sooner alteplase was administered, the more effective the treatment.





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Treatment with alteplase within three hours resulted in a good outcome for 259 (32.9 per cent) of 787 patients who received alteplase, against 176 (23.1 per cent) of 762 patients who received a control medication.

A delay of greater than three hours and up to 4.5 hours resulted in a good outcome for 485 (35.3 per cent) of 1375 patients, compared with 432 (30.1 per cent) of 1437 who received the control medication. And a delay of more than 4.5 hours resulted in a good outcome for 401 (32.6 per cent) of 1229 alteplase patients, versus 357 (30.6 per cent) of 1166 who received the control medication.

"This is an important finding considering how disabling a major stroke is for patients, with health outcomes including paralysis, speech impairment, loss of memory and reasoning ability, and coma," Professor Lindley said.

"Prompt treatment with alteplase should be considered for all ischaemic stroke patients, as this treatment has the potential to prevent serious disability after stroke."

The study did find that treatment with alteplase significantly increased the odds of brain haemorrhage, and of fatal brain haemorrhage, within seven days, irrespective of treatment delay, age, or stroke severity. But, overall, it was found that death at 90 days after a stroke was 608 (17.9 per cent) in the alteplase group versus 556 (16.5 per cent) in the control group.

The authors found that, despite an average absolute

increased risk of early death from brain haemorrhage of about 2 per cent by about three to six months among alteplase patients, this risk was offset by an average absolute increase in disability-free survival of about 10 per cent for patients treated within three hours and five per cent for patients treated after three hours but before 4.5 hours.

"This treatment is not without its risks. However, the risks are worth the benefits, given that stroke is so disabling," Professor Lindley said.

Professor Lindley said the study built on earlier research published in *The Lancet* which found that alteplase was just as effective in older stroke patients as it was in younger patients.

Stroke is Australia's second biggest killer after coronary heart disease, with one stroke occurring every 10 minutes, and is a leading cause of disability. One in six Australians will have a stroke in their lifetime and 65 per cent of stroke survivors suffer a disability that impedes their ability to carry out daily living activities unassisted.

An abstract of the study, *Effect of treatment delay, age, and stroke severity on the effects of intravenous thrombolysis with alteplase for acute ischaemic stroke: a meta-analysis of individual patient data from randomised trials*, can be viewed at: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60584-5/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60584-5/abstract)

Debra Vermeer



INFORMATION FOR MEMBERS

International Indigenous Health Conference 2014

Indigenous health agencies, groups and individuals from around the world are set to converge on northern Australia late this year for the inaugural 2014 International Indigenous Health Conference.

The Conference, which had its genesis in last year's Australian National Indigenous Health Conference, aims to bring together more than 300 First Nations speakers and participants from across the globe to share experiences and ideas about how to close the health gap between Indigenous peoples and the wider community.

For the event's organisers, for any such action to be successful it must involve a holistic approach embracing a person's mind, body, soul and culture.

"This gathering will highlight some of the existing Indigenous health programs currently implemented in Aboriginal communities all over the world and provide a unique opportunity for delegates and speakers to see the power of people networking in one place, at one time, with similar goals," the organisers said.

Community-based health programs will be a particular focus, with presentations from community groups to account for at least half of the conference's proceedings.

The conference will be held at the Pullman Cairns International hotel, Cairns, from 15 to 17 December.

For further details, visit: <http://www.indigenoushealth.net/submitpaper.htm>

Borders shut as WHO admits Ebola outbreak ‘vastly underestimated’



Kenya is the latest country to join an expanding list of airlines and nations banning travellers from west African countries at the centre of the worst Ebola virus outbreak on record.

While the World Health Organisation has admitted that it had “vastly underestimated” the scale of the outbreak, which has so

far claimed at least 1145 lives out of 2127 confirmed and suspected cases, the multilateral agency urged against blanket travel and trade bans with affected areas.

But on the weekend Kenya joined Cameroon in banning people travelling from Guinea, Sierra Leone and Liberia from entering the country, while several airlines including British Airways, Emirates and Korean Air from suspending flights to and from the countries, which are at the epicentre of the outbreak.

Already, the Liberian Government has announced a 90-day state of emergency and closed the majority of its borders, while Sierra Leone has declared a 60 to 90-day state of emergency, and Nigeria has announced a National Emergency following the death of two people from the disease, with a further five people suspected of being infected in quarantine.

Fears about the Ebola threat have been heightened following the WHO’s admission

that earlier estimates about the scale of the outbreak had been seriously off-target.

“Staff at the outbreak sites see evidence that the numbers of reported cases and deaths vastly underestimate the magnitude of the outbreak,” it said last week.

The WHO had already upgraded its response to the outbreak. At a meeting on 6 and 7 August, its Emergency Committee declared it to be a Public Health Emergency of International Concern.

The upgraded status of the outbreak has ushered in a range of more stringent measures and greater resources aimed at taking the disease’s spread.

“WHO is coordinating a massive scaling up of the international response, marshalling support from individual countries, disease control agencies, agencies within the UN system, and others,” the agency said.

WHO Director General Dr Margaret Chan told a meeting of Member States last week that around one million people in areas affected by the outbreak were in need of urgent support, including supplies of food and medicine. The United Nations has appointed Dr David Nabarro to coordinate its overall response to the crisis.

In an extraordinary move, a panel of medical ethicists convened by the WHO gave approval for the use of experimental drugs on people infected with Ebola, though

the decision to use them on a case-by-case has been left to the treating clinicians.

Despite mounting international concern, Australia’s Chief Medical Officer Professor Chris Baggeley said there was a “very low” risk of the infection entering the country.

Professor Baggeley said authorities were closely monitoring the outbreak and comprehensive plans and arrangements were in place in the unlikely event that an infected person arrived in the country.

The Department of Health said all boarder agencies were aware of the outbreak and had been advised on how to detect and quarantine any travellers displaying symptoms of Ebola infection.

Professor Baggeley said that, while Ebola was a very serious disease with no vaccine or treatment, it did not pose a pandemic threat.

He said it was not highly contagious and that, unlike the flu, it was not transmitted by coughing or sneezing.

He advised that the risk of infection was “extremely low” unless a person had direct contact with the bodily fluids of an infected person or animal.

There have not been any reported cases in Australia.

Adrian Rollins





BY DR CLIVE FRASER

"Big Brother" - GPS Log Book



Most of us would agree that cars have never been safer.

Anti-lock brakes, stability control, air bags and crumple zones are saving lives every day of the year.

They are pieces of technology that don't require driver intervention, and that's what makes them an essential piece of kit.

While I've always been a fan of gadgets, I'm increasingly concerned about the distraction that some of them pose when people are driving, with mobile phones being at the very top of my list.

I've lost count of the number of people I've seen driving towards me

who aren't looking ahead at where they are going.

They all seem to be staring at their laps, and I'd wager that somewhere within view there is a smartphone involved.

Even more perturbing is the scene when I glance up in my rear-view mirror to see a driver staring down at their crotch.

I've lost count of the number of people I've seen who've been injured when struck from behind by a driver distracted by their phone.

I know that the police routinely check the driver's mobile call history whenever they investigate any

serious crash.

But there are great bits of technology that go about their work in the background and will never distract the driver.

One that I'm very impressed with is the GPS log book device.

It simply plugs into the cigarette lighter socket and uses global positioning to record a database of all the information related to where the vehicle has gone.

Within that data is the maximum speed of the vehicle on the trip, which might be handy for transport companies who don't want their drivers to exceed any speed limits.

It also is a useful way for learner drivers to keep their log book.

Stalkers will probably have a field day with this device, and it might be useful for spousal surveillance or keeping an eye on the movements of teenagers.

But the most likely use of this technology is for producing an Australian Taxation Office-compliant log book of business-related travel.

The GPS device keeps track of where every trip started and stopped and, via Google maps, will also show which route was taken.

Once the data is downloaded via USB to a computer, each journey can be coded as either personal (such as to or from work) or business-related (like travel between surgeries, home visits, on-call and so on).

At the end of three months the software compiles the business travel percentage as a function of the total distance travelled.

A colleague has extensively evaluated the device, and so far the only glitch has been that it may not record the exact start location for a minute, as it takes the device a short time to sync with enough satellites to work out where it is once the ignition is turned on.

This did mean that in his log book his trips sometimes started from an address just down the road from where he lives.

Overall, I think that the GPS log book will save doctors a lot of time and effort compared with the paper-based approach, and at \$149, plus postage, it's a tax-deductible bargain.

Anyone interested can check it out at www.gpslogbook.com.au.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com