AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

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Don't forget the 'Gap'!

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

The election is over and a new Government has taken the reins in Canberra.

It's interesting to reflect that although health was in the top two or three issues for electors, it hardly rated in the daily media cycles that dominated the theatre of the electioneering.

Even less visible were the issues relating to Indigenous Affairs. Clearly no Party sees too many votes in an area that has challenged successive Australian Governments. That isn't to say this was a policy-free zone. Varying amounts of material have been available on the Party websites.

One in five of the patients I see are Aboriginal. The hospital that I work in is only surpassed by Royal Darwin and Alice Springs hospitals in terms of the number of Aboriginal patients treated. I see the 'Gap' every day.

So what can be gleaned from the Party websites to provide a guide to the approach and interest of the new Parliament?

It's probably not a surprise that the micro-Parties do not reveal a lot. From the other Parties that will participate in our national government, I looked for policies that might influence the social determinants of health or specific Indigenous health policy.

The Palmer United Party refers to '… equality of opportunity with all Australians having the opportunity to reach their full potential in a tolerant national community.'

They also recognise that the Europeans who came to Australia over 200 years ago did not come to an empty land and that the contribution of Aboriginal and Torres Strait Islander peoples '… to Australia's identity has been and will continue to be a vital and enriching one'.

The Greens' policy on First Australians concentrates on two issues: providing essential services, and caring for country and community building.

Specific health policies are to close the gap in hearing health, targeting services to stop blindness for ATSI people, and boosting funding for community-based mental health services in rural and regional Australia.

'Labor is for First Australians' headlines their website policy. The policy statement recognises that Labor's approaches to end disadvantage haven't worked but records their 'unprecedented effort and record investment'.

The 'Closing the Gap' targets remain at the heart of the policy. One of these is to halve the difference in unemployment rates between Indigenous and non-Indigenous Australians by 2018. They also agree with the Expert Panel on Constitutional Recognition of Aboriginal and Torres Strait Islander Peoples that a referendum should be held – at a time when it has the greatest chance of success – to change the Australian Constitution to recognise their place in our society and culture.

The Coalition – now in Government – went into more detail in their policy statements with a Policy on Indigenous employment in addition to the overall policy on Indigenous Affairs.

The policy on Indigenous employment addresses one of the key social determinants of health.

The main points include a review of Indigenous training and employment to be commissioned within one month of the election, headed by Andrew Forrest, to report to the Prime Minister within six months, and increased support for training of up to $45 million.

The Coalition's overall policy on Indigenous Affairs appeared late in the campaign. It addresses education, employment, health, housing and recognition.

On health, the Coalition committed to maintain the funding in the Budget allocated to Closing the Gap in Health as well as the support to address the social determinants of health.

They also commit to establishing a Prime Minister's Indigenous Advisory Council, headed by Warren Mundine, transferring responsibility for Indigenous programs to the Department of Prime Minister and Cabinet, and to progress Constitutional recognition.

Interestingly, the Coalition also commits to providing $5 million to design a five-year trial of Jawun's Empowered Communities initiative.

Despite the lack of mainstream media attention during the election campaign, the Coalition clearly have policy initiatives that suggest the 'Gap' will not be forgotten in Government.

They should be heartened by the policies of other Parties in Parliament who should support continuation of 'Closing the Gap' initiatives, actions to address the social determinants of health, and Constitutional recognition.

Those who remember the Prime Minister's interest in Indigenous health during his time as Health Minister will recognise his genuine personal interest in this area. This should mean the 'Gap' is far from forgotten.

The AMA will look forward to significant progress over the next three years.

TO COMMENT CLICK HERE

New health team unveiled

Peter Dutton, Minister for Health

Senator Fiona Nash
Assistant Minister for Health

Kevin Andrews
Minister for Social Services

Senator Nigel Scullion
Minister for Indigenous Affairs

Senator Michael Ronaldson
Minister for Veterans' Affairs

Senator Marise Payne
Minister for Human Services

Senator Mitch Fifield
Assistant Minister for Social Services

The AMA has welcomed the appointment of Peter Dutton as Minister for Health, with AMA Vice President Professor Geoffrey Dobb saying the AMA is keen to get to work with all the Ministers and Assistant Ministers with responsibilities across the health sector.

Professor Dobb said that the AMA enjoyed a constructive working relationship with Mr Dutton when he was Shadow Minister and will build on that relationship to help deliver better health services for all Australians.

"The new Government has been very clear about its focus on primary health care and the leadership role of general practice," Professor Dobb said.

"We welcome the commitment to get rid of waste and bureaucracy and cut red tape in the health system, and we look forward to working with the Government on its review of Medicare Locals with a view to providing greater direct support to frontline services.

"It is appropriate that Mr Dutton has carriage of mental health at Cabinet level, and there are positives in having the Health Minister also the Minister for Sport."

Professor Dobb said the AMA is encouraged by the appointment of experienced people as Ministers with responsibilities in other areas of the health system.

"Minister for Social Services, Kevin Andrews, will be in charge of the administration of aged care, Senator Nigel Scullion is the Minister for Indigenous Affairs, Senator Michael Ronaldson is Minister for Veterans' Affairs, Senator Marise Payne is the Minister for Human Services, and the Assistant Minister for Social Services, Senator Mitch Fifield, has responsibility for the National Disability Insurance Scheme.

"The Assistant Minister for Health, Senator Fiona Nash, is the Deputy Leader of the Nationals in the Senate and has a strong personal interest in rural health.

"The AMA will meet with all members of the Government's health team at the earliest opportunity," Professor Dobb said.

John Flannery

TO COMMENT CLICK HERE

Lorenzo's foiled

The abandonment and cost blowouts of *Lorenzo* – the UK National Health Service (NHS) electronic patient record system for hospitals – sends strong messages to the new Australian Government as it inherits the troubled implementation of the Personally Controlled Electronic Health Record (PCEHR).

The Guardian last week reported that the failed system has so far cost the British taxpayer nearly 10 billion pounds, with the final bill expected to be several hundreds of millions of pounds higher.

Successive Ministers and civil servants have been blamed for the failure of the NHS project, which has been described as 'the biggest IT failure ever seen'.

The project was launched in 2002 but was beset by changing specifications, technical challenges and disputes with suppliers, which left it years behind schedule and over budget.

In September 2011, dismantling of the program was announced but, in an effort to salvage something from the failure, Ministers said they would keep the component parts in place with separate management and accountability structures.

A Parliamentary report found that, after 10 years, the software had not been delivered and "not a single hospital trust has a fully functioning *Lorenzo* care records system".

Australian doctors familiar with the UK debacle say that one of the major contributing factors to the failure was a lack of clinical input to decision making, which is a common criticism of the PCEHR implementation.

This could be food for thought for the new Australian Government as it gets down to business implementing its policy agenda.

John Flannery

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Assist at Gallipoli – ANZAC Day 2014

Volunteers with medical expertise, such as nurses and paramedics, are sought to assist with the Visitor Services at Anzac Day commemorations at Gallipoli in 2014.

Conservation Volunteers, under the supervision of the Department of Veterans' Affairs and Veterans' Affairs New Zealand, manages the Gallipoli Volunteer Visitor Services team at the commemorative services.

Volunteers undertake a range of responsibilities including the care of 'Assisted Mobility' visitors. Volunteers with a medical background offer valuable skills for this very important task.

Join this 13-day experience as we assist with vital duties in caring for visitors at the Gallipoli commemorative services as well as tour the battlefields and the vibrant city of Istanbul.

For more information and to apply for this volunteer opportunity, go to www.gallipolivolunteer.org.au

Applications close on 15 November 2013.

Sanja Novakovic

TO COMMENT CLICK HERE

Organ donation – not so rare Welsh bits

People in Wales who fail to make a decision before they die about donating their organs will be deemed to have given consent for donation under a new law passed by the National Assembly.

Wales will become the first nation in the United Kingdom to introduce a soft opt-out system of organ donation when the new law is brought fully into effect on 1 December 2015.

The new law means that unless a person makes a decision to be a donor (opts in), or not to be a donor (opts out), their consent to donation will be deemed to have been given.

The Human Transplantation (Wales) Act 2013 completed its passage through the National Assembly for Wales on 2 July, and received Royal Assent on 10 September.

The First Minister of Wales, Carwyn Jones, said in a statement that the Act was arguably the most significant piece of legislation passed by the National Assembly for Wales since it acquired full lawmaking powers in 2011.

"Many people will wait years for a transplant, but sadly many die waiting on the list," Mr Jones said. "The shortage of human organs continues to cause otherwise preventable deaths and suffering.

"This law will not only help reduce the waiting list, but will also help save lives by reducing the number of people who needlessly die waiting for an organ transplant."

At any one time, there are about 220 Welsh residents on the active waiting list for a transplant. Last year, around one person a week died in Wales while waiting for an organ donation.

"This law will not only help reduce the waiting list, but will also help save lives by reducing the number of people who needlessly die waiting for an organ transplant"

Wales' Health Minister Mark Drakeford said the passage of the legislation was a momentous day in the history of the Welsh Government.

"Although we celebrate the commencement of the Act today, it is important to remember the new system will not come into force until 1 December 2015, following a two-year public information campaign," Mr Drakeford said.

"During this two-year campaign, people will be given plenty of information on how the new system works and what their choices are. Even today, though, people can help others by ensuring their loved ones know their wishes about organ donation, and I would encourage everyone to have that conversation."

The new law has received a mixed response from community groups.

Ed Owen, the CEO of The Cystic Fibrosis (CF) Trust, said the Trust was delighted to have had an ongoing engagement during the law-making process and hopes it will improve the rate of transplantation for people with CF.

Currently, one in three people with CF will die before they can receive a lung transplant.

"This is good news for those people with cystic fibrosis, whose only option to significantly improve their lives is transplantation," Mr Owen said.

"We have supported the move towards an opt-out system as a way of increasing usable lungs and other organs and to raise the debate to get families to support organ donation. It is a testament to the hard work and dedication of all those involved that the Bill has now become law in Wales, and we hope other countries across the UK follow suit."

However, faith leaders and some community groups in Wales voiced strong opposition throughout the debate to any weakening of the principle that the donation of organs should be free and voluntary.

In a letter written ahead of the final vote in the Welsh Assembly, leaders from the Catholic Church, the Church of England, the Muslim Council for Wales, the Jewish Representative Council, the Wales Orthodox Mission, Patient Concern and Care, among others, outlined their opposition to presumed consent.

"We … regard the concept of 'deemed consent' as a contradiction in terms and a misleading fiction, and remain unconvinced that a change in the law to accommodate this fiction will in itself lead to any increase in organ transplantation in Wales," they wrote.

Debra Vermeer

TO COMMENT CLICK HERE

NHS efficiency savings affecting care

A survey of National Health Service (NHS) bosses in the UK has revealed that the NHS is facing deepening financial problems, growing numbers of patients are waiting longer than they should in accident and emergency (A&E), and there are worsening bed shortages.

The Guardian reports that many hospital trusts and other NHS organisations are struggling to meet their share of 20 billion dollars of efficiency savings ordered by NHS England chief executive Sir David Nicholson.

Professor John Appleby, chief economist at the King's Fund health think tank, said that the reality for hospitals is that they face an uncomfortable choice between whether to prioritise the quality of services to patients or allow performance in some areas to slip in order to balance the books.

The Department of Health said that bold steps were being taken to relieve pressure on the NHS, including a named GP being in charge of every elderly patient's care, the integration of health and social care, and better use of electronic health records and care plans.

John Flannery

TO COMMENT CLICK HERE

WHO slams tobacco industry

According to online news service, *News Reporter*, World Health Organisation (WHO) Director General Margaret Chan has slammed the tobacco industry for "sabotaging" the vote on a strong European law on tobacco.

"Unfortunately, many countries give more importance to tobacco as an issue for trade and commerce than as a severe threat to health," Chan said, while addressing a gathering at the recent International Conference on Public Health Priorities in the 21st Century in New Delhi.

The WHO chief said the tobacco industry ruthlessly exploits this appeal to commercial interests.

"The most recent example concerns efforts on the part of Philip Morris to sabotage the vote on a stronger European directive on tobacco," she said.

The law calls for having larger pictorial warnings on the cigarette packets and banning all tobacco products with flavours like menthol, among others.

She said lobbyists have been deployed to delay or block passage of the new directive until the European Council presidency moves to Greece, where the company has opened a huge hub for the production and distribution of cigarettes throughout Europe.

The vote on the stringent tobacco law in Europe has been put off till 8 October.

Putting off the crucial vote is being seen as a victory to the tobacco industry.

John Flannery

TO COMMENT CLICK HERE

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

Global child deaths down by almost half since 1990

In 2012, approximately 6.6 million children worldwide – 18 000 children per day – died before reaching their fifth birthday, according to a new report released this month by UNICEF, WHO, the World Bank Group and the United Nations Department of Economic and Social Affairs/Population Division.

This is roughly half the number of under-fives who died in 1990, when more than 12 million children died.

"This trend is a positive one. Millions of lives have been saved," said Anthony Lake, UNICEF Executive Director.

"And we can do still better. Most of these deaths can be prevented, using simple steps that many countries have already put in place – what we need is a greater sense of urgency."

The leading causes of death among children aged less than five years include pneumonia, prematurity, birth asphyxia, diarrhoea, and malaria. Globally, about 45 per cent of under-five deaths are linked to undernutrition.

About half of under-five deaths occur in only five countries: China, Democratic Republic of the Congo, India, Nigeria, and Pakistan. India (22 per cent) and Nigeria (13 per cent) together account for more than one-third of all deaths of children under the age of five.

Newborn children are at particularly high risk

"Care for mother and baby in the first 24 hours of any child's life is critical for the health and wellbeing of both," says Dr Margaret Chan, Director-General at WHO.

"Up to half of all newborn deaths occur within the first day."

The lives of most of these babies could be saved if they had access to some basic health-care services. These include skilled care during and after childbirth; inexpensive medicines such as antibiotics; and practices such as skin-to-skin contact between mothers and their newborn babies, and exclusive breastfeeding for the first six months of life.

Progress, challenges

While the global average annual rate of reduction in under-five mortality accelerated from 1.2 per cent a year for the period 1990–1995 to 3.9 per cent for 2005–2012, it remains insufficient to reach Millennium Development Goal 4, which aims to reduce the under-five mortality rate by two-thirds between 1990 and 2015.

"Continued investments by countries to strengthen health systems are essential to ensure that all mothers and children can get the affordable, quality care they need to live healthy, productive lives," said Keith Hansen, Acting Vice President of Human Development at the World Bank Group.

Sub-Saharan Africa, in particular, faces significant challenges as the region with the highest child mortality rates in the world. With a rate of 98 deaths per 1000 live births, a child born in sub-Saharan Africa faces more than 16 times the risk of dying before his or her fifth birthday than a child born in a high-income country.

However, sub-Saharan Africa has shown remarkable acceleration in its progress, with the annual rate of reduction in deaths increasing from 0.8 per cent in 1990–1995 to 4.1 per cent in 2005–2012.

This is the result of sound government policies, prioritised investments and actions to address the key causes of child mortality and reach even the most difficult to reach populations.

Global and national action to improve child health

Both globally and in countries, a series of initiatives are in place aimed at improving access to maternal and child health care, inspired by the United Nations Secretary-General's widely endorsed Global Strategy for Women's and Children's Health, which aims to save 16 million lives by 2015 through a "continuum of care" approach.

As part of this strategy, focus on specific areas is given through:

- A Global Vaccine Action Plan that is working towards universal access to immunisation by 2020. Vaccination against preventable diseases is one of most effective country-driven and globally-supported actions, as it currently averts an estimated two to three million deaths every year in all age groups from diphtheria, tetanus, pertussis (whooping cough), and measles. In 2012, an estimated 83 per

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Global child deaths down by almost half since 1990

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cent (111 million) of infants worldwide were vaccinated with three doses of diphtheria-tetanus-pertussis (DTP3) vaccine.

- Some 176 countries have signed on to A Promise Renewed – the call to action spearheaded by the Governments of Ethiopia, India and the United States, together with UNICEF in a global effort to stop children from dying of causes that are easily prevented.
- The United Nations Commission on Life-Saving Commodities for Women and Children is helping countries improve access to priority medicines such as basic antibiotics and oral rehydration salts.
- Earlier this year, WHO and UNICEF joined other partners in establishing a new Global Action Plan for Pneumonia and Diarrhoea, which aims to end preventable child deaths from these two major killers of under-fives by 2025. The plan promotes practices known to protect children from disease, such as creating a healthy home environment, and measures to ensure that every child has access to proven and appropriate preventive and treatment measures.
- Similarly, partners are working on Every Newborn: a global action plan to end preventable deaths. The aim is to launch this global newborn action plan in May 2014 and provide strategic directions to prevent and manage the most common causes of newborn mortality, which account for around 44 per cent of all under-five mortality.
- UNICEF, WHO and the World Bank Group all support the Scaling Up Nutrition (SUN) global movement in its efforts to collaborate with countries to implement programs to address poor nutrition at scale with a core focus on empowering women.

"Global partnerships to further accelerate the reduction of under-five mortality globally and in sub-Saharan Africa are essential," said Wu Hongbo, Under-Secretary-General for Economic and Social Affairs at the United Nations.

"In this regard, it is critical that national governments and development partners redouble efforts through to the end of 2015 and beyond."

John Flannery

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Understanding the Military Experience

The Department of Veterans' Affairs (DVA) has developed a new, free online training program to help mental health professionals better understand the impact of military experience on the mental health of veterans.

Understanding the Military Experience is a two-hour program to help providers understand Australia's involvement in wars and peace operations and the long-term effects that military service can have on veterans of all ages.

It seeks to increase providers' awareness and understanding of the military experience by providing an insight into a range of veteran experiences and their potential impact on mental health and wellbeing.

Understanding the Military Experience makes clear that not only does trauma have the potential to affect veterans, but that military training and culture may shape veterans' behaviour long after they have left the military.

The aim of the training is to assist providers to offer more relevant and effective care for their veteran patients.

The training will also help providers understand the changing DVA client profile and their health needs.

Understanding the Military Experience can be accessed via the new *At Ease Professional* portal.

For more information please contact the team at at-ease@dva.gov.au.

John Flannery

TO COMMENT CLICK HERE

Doctors volunteer to work in Syria

Both the World Medical Association (WMA) and the AMA have been vocal about the need to ensure the safety of doctors in world trouble spots, and have made calls on governments to provide protections for doctors, hospitals, and other health workers and facilities to allow them to help people who have been injured during civil conflicts.

Doctors from around the world have been volunteering to work in conflict zones, most notably in Syria in recent times.

The '*Nightline*' program on the American *abc news* network last week ran a special program on doctors volunteering in Syria. Here is an edited extract of that story …

At a hospital in Amman, Jordan, 2-year-old Raged put on a brave face as doctors examined an oozing shrapnel wound on the left side of her stomach. Her wound was so infected it wouldn't heal. The toddler was in constant agony, unable to sit or stand.

Raged was one of the two million Syrian refugees that have flooded into Jordan to escape the war in their homeland. Many of the refugees and the wounded are children. Their families are left to nurse them without assistance through injuries unimaginable to most parents.

Raged was born into the war in a town called Daraa, Syria, about an hour drive away from Amman. But for her entire life, the town has been the scene of fierce warfare between the rebels and the Syrian government.

Her mother, pregnant, left her home, her husband and her entire extended family in a desperate search for help after Raged was hit. Hospitals in Syria, crowded with injuries even worse than Raged's, patched up her wound and asked her family to move on. So they kept moving, and made it to Jordan.

"She was playing on the veranda of their home and there was rocket fire," said Dr Abier Abdelnaby, one of the doctors at the Amman hospital.

"Shrapnel, rocket fire and so forth struck her in, basically, her left side and blew out all of her intestinal and abdominal contents."

As world leaders waver on whether or not to intervene in the civil war that shattered half of Raged's little body, Abdelnaby will try to give the toddler back the ability to walk, play and be a child.

...CONTINUED ON PAGE 11

Doctors volunteer to work in Syria

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"It's heartbreaking, it's absolutely heartbreaking," Abdelnaby said.

"This is a little baby. She should be out playing and running. She should not have her sides blown out and her intestines hanging out of her."

Abdelnaby, an Arab-American, was part of a group of 30 other medical professionals from all over the world who travelled to Jordan in order to help treat Syrian refugees.

The group was led by Dr. Human Akbik, a Harvard-educated surgeon who practises at Mercy Health in Cincinnati, and a Syrian-born American who has led six week-long trips to Jordan to help care for dislocated Syrians.

During their short time there, Akbik and his team travelled around the country in packed vans and cars. The cases they saw ranged from asthma to gunshot and shrapnel wounds.

They established the group's first optometry clinic and even set up mobile pharmacies.

"We have 750 pounds-worth of medication right now," Akbik said as he landed in Amman with 10 pieces of luggage, each packed with medicine.

Eighty per cent of their patients were women and children.

While Raged waited for further treatment, her new roommate arrived - another girl, 14-year-old Khetan, with a similar injury.

Last month, Khetan was fleeing her home with her family when a sniper's bullet tore through the door of their moving car and passed straight through her body.

Two emergency surgeries kept her alive, but she lost 30 pounds. Her insides were shredded and she needed another surgery to have her intestines sewn back together - a procedure she couldn't get in the refugee camp where she lives.

She and her family travelled to the Amman hospital - a journey that left them almost penniless, their clothes carried to the hospital in two trash bags - where she was examined by Dr Abdelnaby. She was to spend the next two days trying to rebuild Khetan's decimated stomach and trying to relieve Raged's agony.

The parents of both girls waited anxiously to find out if their daughters would survive their next round of surgeries, as doctors rushed to treat Raged, Khetan and the dozens of other Syrian refugees who make the dangerous journey to the hospital.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

HEALTH PROFESSIONALS' CONFERENCE
(formerly known as the Doctors' Health Conference)

DATE: 3rd - 5th October 2013

VENUE: Sofitel Brisbane

The Health Professionals' Health Conference will be held at the Sofitel Hotel in Brisbane from 3rd to 5th October 2013.

The conference recognises the enormous benefits for doctors, nurses, dentists, physiotherapists, pharmacists and other allied health professionals who engage collaboratively in the creation of a healthier workforce.

International speakers from Ireland and Canada and UK will provide insights into how health professionals manage their health across the globe.

There will be preconference workshops on bullying, compassion fatigue and burnout, as well as a session to teach doctors to treat the doctor-patient.

Engage in an interactive inter-professional forum on Mandatory Reporting in Australia with legal and medical experts.

There will also be an interactive session, the Carefactor Workshop for students, with a special student rate available.

beyondblue will also present the results of their mental health survey of doctors and medical student– the latest Australian research on doctors' health.

For more information visit http://www.hphc2013.com.au/

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

Since the Service was launched in September, 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

INFORMATION FOR MEMBERS

Last days to renew AHPRA registration by 30 September 2013

The AMA reminds all members to renew their medical registration by 30 September 2013.

You can renew your registration online at www.ahpra.gov.au. To do this you will need to know your User ID and your password. If you have misplaced your User ID and password, contact AHPRA on 1300 419 495. Please note that your User ID is different to your registration number that appears on the National Register.

If you have not yet renewed your registration, you would have received electronic or hardcopy reminders from AHPRA. If you have not received any reminders to renew or are unsure, please check the National Register to make sure your details are up to date or contact AHPRA on **1300 419 495.**

Leaving renewal to the last minute may have serious consequences for your practice.

- Should you fail to lodge your application to renew by 30 September, there is a late payment period during the month of October.
- If you lodge your application to renew during the late payment period ending 31 October, you will pay a late fee of $174 in addition to the renewal fee of $695.
- If you fail to lodge your application to renew your registration during the late payment period, your registration will automatically lapse from 1 November.
- Once your registration has lapsed, you will have until 30 November to apply to AHPRA for a fast-track application for re-registration at the cost of $348, in addition to the registration fee of $695.
- If you fail to re-register through the fast-track process by 30 November you will have to apply for new registration and only pay the registration fee of $695. AHPRA will process your application as a new registrant within the usual timeframe of up to 90 days.
- Should your registration lapse, you will not be able to practice until your registration application has been granted.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Can I prescribe ...?

Most doctors know what the rules are for prescribing medicines in Australia. Or do they?

AMA members frequently ask whether they are able to prescribe in certain circumstances. The most common questions are:

- Can I prescribe for myself?
- Can I prescribe for my family?
- Can I prescribe for someone who isn't directly my patient (a third party)?
- Can I backdate prescriptions?

It is understandable that doctors are uncertain, because there is no simple answer.

Prescribing in Australia is regulated by a range of laws.

For a medicine to be prescribed in Australia, the Therapeutic Goods Administration (TGA) must approve it for sale.

However, each State and Territory has its own laws regulating the prescription of medicines.

These laws determine who can prescribe, which medicines, in what circumstances, in what manner and for what purpose. In addition, specific conditions must be met to prescribe certain classes of medicines, such as some with Schedule 4 and Schedule 8 classifications.

These laws vary in each jurisdiction, so doctors must be careful they understand and comply with the laws in force where they practise.

A further layer of compliance is added for patients to receive a government subsidy under the Pharmaceutical Benefits Scheme (PBS) when they purchase prescribed medicines. Doctors must comply with requirements and restrictions under Commonwealth laws in order to prescribe under the PBS.

Finally, all doctors are bound by the Medical Board of Australia's code of practice – *Good Medical Practice* – as a condition of their registration to practise in Australia.

So can doctors self-prescribe, prescribe for family or for a third party?

Here's what the different laws say:

- Commonwealth, NSW, Queensland, Tasmanian and South Australian laws do not appear to prohibit self-prescribing, prescribing for family or for a third party.
- Doctors practising in Victoria cannot prescribe any S4 or S8 medicines for themselves or for a third party.
- In the Northern Territory, it is slightly more complicated. Doctors cannot self-prescribe S8 medicines or certain restricted S4 medicines, and cannot prescribe for a third party unless the third party is the partner of a patient being treated for Chlamydia who is also likely to have Chlamydia.
- In the ACT, doctors are only prohibited from prescribing for themselves if they are still an intern, or the medicine is a restricted medicine.
- WA law simply prohibits prescribing for the purpose of self-administration.

Good Medical Practice cautions against prescribing for self, family, friends or "those you work with".

It recommends "seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment".

It also advises doctors to "avoid providing medical care to anyone with whom you have a close personal relationship … because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient".

No State or Territory law appears to specifically prohibit backdating of prescriptions. Interestingly, neither does Commonwealth law. While the PBS website states that prescriptions must be not backdated, in fact neither the *National Health Act* nor the *National Health (Pharmaceutical Benefits) Regulations* provide any power to enforce this.

However, all prescribing-related laws require that the prescriber signs and dates prescriptions. It is likely that the intention, while not enforceable, is that the date is contemporary with the signature.

In summary, it is important that you understand the laws in force in the State or Territory in which you practise. Don't rely on hearsay (or this article), because laws change or can be misinterpreted without legal expertise.

If in doubt, check with the drugs and poisons unit in your State/Territory. The TGA maintains up-to-date contact details on its website at: www.tga.gov.au/industry/scheduling-st-contacts.htm.

Information about PBS prescribing rules is available at www.pbs.gov.au.

Good Medical Practice is available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

The AMA's website also maintains a summary of prescribing rules information and links to other sources at https://ama.com.au/node/12303 or you can go to the 'resources' tab on our homepage and look under 'FAQs'.

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Richard Kidd	QLD Area nominee	Health Sector Group advising on key health infrustration resilience	6/8/2013
		Home Medicines Review research project advisory panel	2/9/2013
Dr Lawrie Bott	AMA member	PCEHR Pathology Stakeholder Workshop	13/8/2013
Dr Ashish Jiwane	AMA member	MSAC Review Consultation Committee for Paediatric Surgery	23/8/2013
Dr Chris Moy	AMA member	NeHTA Clinical Usability Program Clinical Consultation (working group)	27/8/2013
		NeHTA Clinical Usability Program Steering Group	3/9/2013
Dr Suzanne Davey	AMA member	PBAC Asthma medication in children review expert advisory group	28/8/2013
Dr Brian Morton	AMA Chairman of General Practice	DVA Local Medical Officer Advisory Committee meeting	28/8/2013
		Presentation to Medical Indemnity Insurance Association of Australia 2013 Forum on PCEHR	12/9/2013
Dr Steve Hambleton	AMA President	Meeting with CEO, Therapeutic Goods Administration	29/8/2013
Dr Cathy Hutton	AMA member	Communicable Diseases Network Australia and National Immunisation Committee	29-30/8/2013
Dr Anne Wilson	AMA member	Mental Health Nurse Incentive Program (MHNIP) Expert Working Group teleconference	10/9/2013
Dr Iain Dunlop	Chairman of Council	Speech to Medical Indemnity Insurance Association of Australia 2103 Forum on AMA advice to Government	12/9/2013
Prof Stephen Lee	Dermatologist Craft Group nominee	MSAC Review Consultation Committee for Skin Services	13/09/2013

TO COMMENT CLICK HERE

Election should result in greater support for General Practice

BY **DR BRIAN MORTON**

"This cap is bad for education, productivity, and the economy, as well as the safety and quality of our health services. The AMA will keep working to see that it is scrapped once and for all"

The Coalition's win in the recent Federal election will provide more support for general practice.

Primarily, this comes in the form of the Coalition's pre-election promises to strengthen primary care by providing $52.5 million for general practice infrastructure grants, $119 million to double the practice incentive payment for teaching medical students, and $40 million for up to 100 additional intern places per year.

The promised review of Medicare Locals is also welcome. From the outset, the AMA has been concerned about the structure of Medicare Locals and their potential to absorb funding that could be better spent on frontline services or diminish the role played by GPs.

The election outcome has not only buoyed the stock market, it has also buoyed my hopes our role in the health system will be given greater practical recognition. While the previous Government was strong on words, its delivery did not match its promise. This gives me cause for hope.

While the AMA welcomes the Coalition's pledges and looks forward to working with the new Government to provide better health services for all patients, there is still more work to be done. A quick review of the *AMA's Key Health Issues for the Federal Election 2013* highlights where further advocacy is required.

The funding for the GP infrastructure grants, which will assist existing practices to expand their facilities for teaching and supervision, while a promising start, is a fraction of what was called for and what has been spent on GP Super Clinics.

One of the most pressing issues prior to the election was scrapping of the cap on the tax deductibility of work-related self-education expenses. This cap is bad for education, productivity, and the economy, as well as the safety and quality of our health services. The AMA will keep working to see that it is scrapped once and for all.

To ensure there is a GP workforce to meet future community need, we will continue to press for additional funding for 1500 places per annum for both the Prevocational GP Placements Program and the GP training program.

In reviewing Medicare Locals, the new Government has to assess whether Medicare Locals are contributing to the provision of quality primary care in Australia. Have they met their objectives to improve coordination of GP services and fill gaps in service delivery?

The AMA will be encouraging the new Minister for Health to establish an Advisory Group with AMA representation to oversee the evaluation and implementation of any review recommendations.

The AMA is also seeking a re-establishment of the After Hours Technical Working Group in the face of ongoing issues with Medicare Locals in taking on responsibility for distribution of after hours funding.

Other issues of particular interest to GPs are those that impact on patient access and affordability of medical care.

Appropriate MBS indexation will remain a prominent goal.

The AMA Council of General Practice will be considering the outcomes from the election, and the policy priorities for general practice going forward and how they can be achieved at its meeting later this month.

What do you think should be our policy priorities for 2014? Email me at gpnn@ama.com.au.

TO COMMENT CLICK HERE

College transgressions

BY **CHAIR DR WILL MILFORD**

"In the face of fee increases, trainees often feel disenfranchised and 'ripped off', perhaps perceiving that they are subsidising other College activities or fees for other College members"

Medical Colleges form the foundation of post-graduate medical education in Australia and deliver high quality training to those enrolled in their training programs. Highly variable in their form and function, the Colleges are universally held to account by the Australian Medical Council (AMC) specialist training program accreditation process.

Yet no other component of medical training draws the same degree of anger, complaint and dissatisfaction from trainees as the Colleges do. The majority of the complaints seem to relate to College fees and College processes, particularly unheralded changes that are characteristically poorly considered and opaque, often with substantial impact upon trainees. This is by no means universal, as some Colleges perform well in this regard and consult effectively with trainees, giving notice of changes and protecting existing trainees.

For this, the Colleges are very much to blame, not so much for making changes, but often in their inability or reluctance to effectively communicate the rationale for such changes to trainees with clarity and transparency. When this happens, they are their own worst enemies and perceived as operating with an apparent disregard for the rights, opinions and views of their future - the trainees, the next generation of Fellows.

There are many examples of such activity but one recent complaint stemming from one of the larger Colleges provides an excellent illustration of these points.

The College ended a long-running agreement to provide trainees from another, newly established College with dual Fellowships. While this always seemed a natural part of the evolution of the newer specialty and, in itself, appeared a logical decision, it was the manner in which this was done and the way it was communicated that was problem. The large College in question applied this change *retrospectively*, informing a large number of trainees already enrolled in the programs, some with less than six months training remaining, that they would now be ineligible to apply for a Fellowship from the larger College.

This change showed flagrant disregard for the basic premise that training program changes should not disadvantage trainees already enrolled in the program, enshrined by the AMC's standards for specialist medical education programs.

With mediation from the AMC and persistent advocacy from the AMA, these changes were ameliorated to the satisfaction of the AMC, the Colleges in question and the trainees, although in a touch of pique, the College is now charging the affected trainees exorbitant fees for the recognition of the training leading to Fellowship.

In many cases, the actual actions of the Colleges cannot be questioned – change is generally necessary and justifiable. It is the way in which the changes are implemented that causes the trouble. If, in the above example, the change to Fellowship rules had been changed prospectively, the volume of trainee outcry would not nearly have been so loud.

The other constant source of complaints from trainees relates to fees. The right of Colleges to set their own training fees cannot be argued. In the face of fee increases, trainees often feel disenfranchised and 'ripped off', perhaps perceiving that they are subsidising other College activities or fees for other College members.

While increasing training fees intermittently is necessary to continue the financial viability of the Colleges, justification and explanation to trainees is essential. If Colleges published a breakdown demonstrating how trainee fees fund training, and illustrating the rationale for fee increases, far fewer trainees would express their dissatisfaction.

The medical education system in Australia is approaching an era where viable competitors for Colleges will start to exist. Already, for a number of Colleges, ongoing subscription is unnecessary once Fellowship is achieved as other organisations are offering services once provided solely by Colleges.

In this era of increasing competition, can Colleges really afford to continue producing disaffected trainees who, by the end of their training, want nothing more than ending their association with their College?

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

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Right of Private Practice

BY **DR STEPHEN PARNIS**

Late last year, the issue of doctors' Right of Private Practice (RoPP) in public hospitals came into the media, as the Queensland Auditor-General undertook a performance audit of RoPP arrangements in the Queensland public health system.

This was in response to a report from a major accounting firm, which was tabled in the Queensland Parliament. The report was not entirely specific, but was apparently sufficient to spark a response from the Queensland government.

The objectives of the audit were, broadly, to check that the intended health and financial benefits of the scheme are being realised, that the scheme was being administered efficiently, and that practitioners are acting with propriety and in compliance with their contractual obligations.

There are many different arrangements in different States and Territories regarding RoPP.

They are broadly similar, but a diversity of detail on things such as indemnity for doctors can make this a very challenging area for practitioners, hospitals, and groups that support them. There are also implications for taxation and other issues.

We believe that doctors and hospitals doing the right thing can have a productive relationship within the ROPP setup. It should be remembered that private practice privileges can form part of the overall employment arrangement for medical staff. It is designed to attract and retain staff. However, the practice is not without risks for the doctor.

In Queensland, the Auditor General is proposing to release further details on allegations of 'rorting' by some individuals. Of course, doctors who deliberately do the wrong thing should be called to account for their actions. However, our experience is that often hospitals are behind the push for doctors to treat patients on the public waiting lists as 'private patients'. This push is to maintain services, prop up hospital budgets, or to provide support for important Departmental activities such as research and care.

We firmly believe in an honest and ethical approach in financial dealings, consistent with a doctor's broader ethical duties. In this instance, the sheer complexity and diversity of private practice arrangements can leave many doctors confused and bewildered as to their obligations. That is why their obligations and rights should be spelled out clearly by their hospital when they are granted these privileges.

Their hospital must also be supportive in providing good processes for patient election (to be treated privately) along with an accounting and reporting system that ensures patients are billed correctly. Monthly 'billing' reports should be provided to doctors, identifying the amount of invoicing, so that appropriate oversight can occur and tax obligations fulfilled.

Billing and collection arrangements need to be clear and transparent. The use of 'special purpose funds' needs to be appropriate and transparent. Hospitals holding these funds need to ensure they are directed consistent with the agreement of medical staff.

We are currently considering this issue from a national perspective.

Identifying the different modes of RoPP is challenging but the clinical advantages may be the common thread in a myriad of arrangements. There is little doubt that patients can and do benefit from the system. Around the country, it seems that generally the number of private patients treated in public hospitals has increased in recent years.

It should be remembered that RoPP have been granted to accredited medical practitioners in public hospitals over many decades. By way of example, the report to the Victorian Hospitals and Charities Commission on *Salaries terms and conditions of service of medical officers employed in public hospitals*, made recommendations in relation to RoPP. This report was tabled in 1959!!. That report identifies valid reasons for RoPP, including access to specialised skills, availability of modern and complex equipment, and to broaden the experience of the doctor.

On the whole, they have worked well. Like any complex arrangement, there has been some confusion, which should be addressed by administrators.

Doctors working in public hospitals are working to full capacity meeting their patient care obligations. The vast majority want to do the right thing. Hospitals have a responsibility to ensure that doctors are readily able to comply with their obligations and exercise private practice privileges lawfully, without the constant fear of accusations, and with patient care uppermost among their priorities. This means a commitment from hospitals and the governments that fund them to giving them the support that they need.

TO COMMENT CLICK HERE

Aboriginal health in the NT – small gains but a long way to go

BY CHIPS MACKINOLTY

"But nevertheless it was a town, at that age, in which I "grew up". Whatever I thought I had learnt on the streets of inner city Sydney were, frankly, SFA when it came to the Territory"

Four or five years ago I made the decision to pretty much stop going to funerals. Of course since then I have been to many—too many. There came a time when it had got too much, with the vast majority of funerals for Aboriginal people. And the people were dying younger.

It was a difficult decision, for many were from the Katherine region. It might sound peculiar to readers, but Katherine was where I "grew up". I got there in the early '80s in my late 20s. An evening of fireworks for the third celebration of Self Government in Darwin then, bizarrely a day or so later for the final shoot in Mataranka of *We of the never never* with Aboriginal artists I then spent the next four years with.

But nevertheless it was a town, at that age, in which I "grew up". Whatever I thought I had learnt on the streets of inner city Sydney were, frankly, SFA when it came to the Territory.

Most of that learning was with Aboriginal people across an area greater than Victoria: from Borroloola to Elliot; to Lajamanu and Kalkarindji and west to the Kimberley: Halls Creek, Kununurra and Wyndham. And then across via Timber Creek to Bulman, Numbulwar and Angurugu, south through Numbulwar to Ngukurr and back up through Jilkminggan, Barunga, Manyallaluk and Wugularr.

It was an astonishing education in land, language and law. But it was a period I spent far too much time learning about death: the death of the artists I worked with, their families, and their children.

But I also learnt from whitefellas in Katherine: from the legendary Judy King and John Fletcher; from Francesca Merlan, Paul Josif, Mick Dodson and Toni Bauman, to Anne and John Shepherd and John O'Brien.

In different ways they, and many others, all taught me about living in the Territory.

In the late 1990s the CEO of the Jawoyn Association, the late Bangardi Lee, recruited me, Jawoyn woman Irene Fisher and Dr Ben Bartlett to put together a seemingly endless series of submissions that resulted—some years later—in the establishment of the Sunrise Health Service: an Aboriginal community-controlled comprehensive primary health care service.

An Aboriginal community-controlled comprehensive primary health care service? A bloody mouthful of a description, but nonetheless a symbol and practical evidence of what Aboriginal people and their supporters have achieved -and continue to achieve.

Across the NT, from remote clinics such as that run by the Pintupi Homelands Health Service to Danila Dilba in Darwin, the Aboriginal community controlled primary health sector serves roughly half our Aboriginal population, the rest through NT Government health services.

Over time, the process of privatising into the community-controlled health sector will increase as services are devolved from government. It's not been an easy process—and slower than many of us want. Nevertheless, it has had bipartisan support federally and locally for more than a decade. Famously, former CLP health minister Steve Dunham "rescued" the Sunrise Health Service in its early development stage when it met resistance from some health bureaucrats. His intervention saved what is now one of the NT's great success stories.

The evidence, internationally, nationally and locally is that community-controlled primary health care is more efficient and effective in delivering the goods.

According to recent data produced by COAG, the Northern Territory is the only jurisdiction in Australia on track to meet the Closing the Gap target of reducing the difference in life expectancy between Aboriginal and non-Aboriginal people. This is a good news story that has been barely reported in the NT outside the pages of the *NT News*.

There are a number of reasons for this success. The last decade has seen a dramatic rise in hospital spending; more importantly greater resources have been distributed more equitably to the bush. The increased resources to primary health care through the Intervention, now known as Stronger Futures, has been a prime reason this has been possible.

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Aboriginal health in the NT – small gains but a long way to go

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But we are also doing it better—and in many instances better than anywhere else in the nation. For example, childhood immunisation rates in the community-controlled sector are better than in many affluent suburbs down South.

And we are doing it smarter: led by the Aboriginal community-controlled health sector, there has been an increased use of electronic data collection and analysis. Clinical Information Systems are used at the individual patient level to keep up-to-date, easily accessible health histories, as well as to alert clinicians to possible allergies, and efficiently prompt clinics to recall patients for regular checks as well as follow ups.

The data analysed can be tailored by individual health services, but all clinics in the NT now contribute the to Northern Territory Aboriginal Health Key Performance Indicators, which have a commonly shared set of clinical measures. Access to this data is strongly protected through privacy protocols.

The big picture of this is the capacity for these systems to allow for public health data to be analysed at a community and regional level, and for subsequent follow up. For example, a regular system of patient interaction through Child and Adult Health Checks has the capacity to identify "spikes" in particular conditions such as childhood and maternal anemia or otitis media in children.

This not only keeps an individual clinic alert to changes in local health, but also in ways to respond. This is achieved through a process called Continuous Quality Improvement [CQI], and is carried out by all clinicians at a service and the data collected is a key part of this process. For example, with otitis media it will guide individual treatment (are we always checking following the national guidelines? what evidence-based treatments are we giving? are we referring the patients to specialist diagnosis and care?), but also to the community as a whole (are we working with the council, school and families? what sort of other public health campaigns might we undertake?)

At regional level this data can be very powerful. As well as the regional Aboriginal Community-Controlled Health Services we already have, such as Katherine West Health Board and the Sunrise Health Service, other regions are now working together through Clinical and Public Health Advisory Groups [CPHAGs]. The CPAHGS meet regularly and work cooperatively to share experiences and data, and ways to do things better. Some have identified particular regional health problems that would otherwise might be "lost" in large scale data bases.

The Northern Territory is the first jurisdiction in Australia in which all remote clinics now have electronic health records for their patients.

Further to this, our sector, along with government clinics, has pioneered the idea of a "shared electronic health record". Over half the Aboriginal people in the NT have signed up to such a record, and we are in the process of readying the system so as to be part of a national network. This allows, with full permission from the patient or carer at every consultation to update their health record to a database that can then be accessed by other clinics and hospitals. For example, a patient at Ngukurr may fall ill at another community, and get the appropriate treatment through their shared electronic health record.

A hospitalisation will allow the clinicians to see someone's record, know what medications they are on, and past conditions. After discharge from hospital, the health records are updated, and an electronic discharge summary is available to the home clinic.

> "The evidence, internationally, nationally and locally is that community-controlled primary health care is more efficient and effective in delivering the goods"

These and many other innovations are behind the improved statistics—but there is a long way to go. It's a welcome trend—but the good results will flatten out and perhaps reverse if we do not tackle the other social determinants of health. These include housing, education, early childhood development, substance abuse, food security, incarceration rates and social exclusion. It is reckoned that health services alone will only be able to deal with about 25 per cent of "the gap": the rest is down to the other social determinants.

And that's where governments of all stripes come in, and where the need for truly bipartisan approaches must prevail. Aboriginal health remains the Territory's major challenge. Aboriginal children yet to be born will benefit if only our politicians are working, in the words of the AMSANT slogan, "together for our health".

Artist and journalist Chips Mackinolty has lived and worked in the Northern Territory for more than 30 years, the last four with Aboriginal Medical Services Alliance Northern Territory (AMSANT). This article has previously appeared in the NT News and Croakey.

TO COMMENT CLICK HERE

Mid Staffordshire – Lessons for Australian Physicians

BY **PROFESSOR STEPHEN LEEDER**

"Shared experience may prove valuable here, trumping the lament that might otherwise be heard – 'with the benefit of hindsight'"

The inquiry into the failure of the Mid Staffordshire Hospital in the UK to maintain adequate quality of care has achieved notoriety. Hundreds of patients died. Robert Francis QC produced a report of 1800 pages (www.midstaffspublicinquiry.com/report).

If only the board and the management had visited the wards, they would have smelt urine. There was, it seems, massive disconnection among those responsible. Clinicians felt disempowered, managers feared reprisals and the board was concerned to maintain a credit rating for the institution that had little to do with clinical care but much to do with economy, throughput and activity.

My friend and colleague, physician Jim Lawrence, gave me copies of three pages of editorial wisdom drawn from the Journal of the Royal College of Physicians of Edinburgh (2013; 43:3–6) responding to the Francis inquiry. It makes salutary reading.

Lest we think that a new and riveting set of insights is required for remedy, Francis drew attention to the use of the term 'benefit of hindsight' 378 times in the transcripts of the oral hearings'.

Francis made 290 recommendations. The Royal College of Physicians of Edinburgh (RCPEd) homes in on several.

First, they argue for universal nomination of a senior 'clinical lead' for all patients. This may require 'a consultant presence seven days per week'. This, they hope, will be achieved through a mixture of rekindled commitment among consultants and a payment structure that makes it more than a matter of charity.

Second, they see it as critical that clinicians become re-engaged with the management of clinical services.

Third, they would like to see colleges involved in 'developing procedures, metrics or guidance to assist compliance with fundamental standards'. This is brave. In other words, the college might drop in on your ward.

But to develop quality standards, the RCPEd has fostered much closer working relations with health authorities, including in the formation of health policy, than we have in Australia. The RCPEd makes a special plea for greater cooperative involvement in the development of workforce policies.

Fourth – and it is in service provision and training that the editorial has the most powerful things to say – they recognise 'the interconnected problems in the acute medical specialties, which impact upon training and the quality of patient care'.

They make five substantial recommendations:

1. Establish all-age generalist expertise in hospital medicine.
2. Address the status and working patterns for general physicians and trainees, with special concern for staffing acute medical services.
3. Ensure continuity of care through the 'development of a cadre of general physicians carrying lead responsibility for patients throughout their hospital stay'.
4. Acute medical specialties should require trainees to dual accredit in general medicine to enable them to participate in acute medical receiving.
5. Expand the availability of consultants to seven days a week and to extended hours through 'fully trained clinical practitioners in general medicine'.

It seems that some of the challenges facing our colleagues in Scotland may be ours, too. Shared experience may prove valuable here, trumping the lament that might otherwise be heard – 'with the benefit of hindsight'.

This article was first published in The Royal Australasian College of Physicians (RACP) publication, RACP Fellowship News

TO COMMENT CLICK HERE

Research

Tasmania failing to win hearts

Tasmania, long admired for its pristine, healthy, active environment, has received a shock diagnosis of being a heart disease hot spot, with residents at higher risk of heart, stroke and cardiovascular disease than those living elsewhere in Australia.

A study, partially funded by the National Heart Foundation, has ranked Tasmania as the worst performing state or territory when it comes to the number of people with key risk factors for heart disease and stroke, including high cholesterol, high blood pressure, sedentary lifestyles, and smoking.

The ACT took out the top prize for healthiest state or territory on the same measures.

The research found that close to 40 per cent of Tasmanians have high cholesterol, the highest rate in the country and higher than the national average of 33 per cent.

It also found that 30 per cent of Tasmanians have high blood pressure, higher than the national average of 21.5 per cent.

And despite the lure of its great outdoors, Tasmanians were ranked the least physically active, with 69.4 per cent of adults surveyed admitting to high levels of sedentary activity, compared to the national average of 67.5 per cent.

Alarmingly, the research found that only a small percentage of those surveyed listed conditions such as high blood pressure and high cholesterol as being a risk factor for heart disease.

Heart Foundation CEO Dr Lyn Roberts said the study highlighted an urgent need for more Australians to have routine heart health checks with their GP to help identify people at high risk of heart attacks, strokes, and chronic disease.

"High cholesterol and blood pressure are major risk factors for heart attack, stroke and cardiovascular disease, and having multiple risk factors, places you at higher risk," she said.

"We live in one of the best places on earth when it comes to the great outdoors, but we need to be doing more to encourage and make it easier for Aussie adults to adopt healthier lifestyles."

Dr Roberts said heart disease is the single biggest killer of Australian men and women, claiming one life every 24 minutes, and costing the health system $8 billion.

"Looking to the future, we can expect one in three Tasmanians will be affected by the disease by 2051 and we're very concerned that today's children look set to be the first generation in history to die at a younger age than their parents," she said.

"These findings show the need for ongoing research to better understand the challenges we face in combating all cardiovascular conditions."

The study also highlighted the widespread problem of obesity in Australia, with four states, led by South Australia and Western Australia, exceeding the national average for the number of overweight or obese adults.

Debra Vermeer

TO COMMENT CLICK HERE

Weighty research questions diets

People who go on a diet after years of consuming high fat food eventually put their weight back on, because the stomach has become desensitised to the message that it is full, new research shows.

The study, from The University of Adelaide, shows that the mechanism by which the stomach detects and tells our brain how full we are becomes damaged in obese people but does not return to normal once they lose weight.

PhD student Stephen Kentish investigated the impact of a high-fat diet on the gut's ability to signal fullness, and whether those changes revert back to normal by losing weight.

The research was carried out on mice in the laboratory.

The results, published in the International Journal of Obesity, show that the stomach nerves that signal fullness to the brain appear to be desensitised after long-term consumption of a high-fat diet.

"The stomach's nerve response does not return to normal upon return to a normal diet," said study leader, Associate Professor Amanda Page from the University's Nerve-Gut Research Laboratory.

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Research

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"This means you would need to eat more food before you felt the same degree of fullness as a healthy individual.

"A hormone in the body, leptin, known to regulate food intake, can also change the sensitivity of the nerves in the stomach that signal fullness. In normal conditions, leptin acts to stop food intake. However, in the stomach in high-fat induced obesity, leptin further desensitises the nerves that detect fullness.

"These two mechanisms combined mean that obese people need to eat more to feel full, which in turn continues their cycle of obesity."

Associate Professor Page said the results had strong implications for obese people, those trying to lose weight, and those who are trying to maintain their weight loss.

"Unfortunately, our results show that the nerves in the stomach remain desensitised to fullness after weight loss has been achieved," she said.

Prof Page said the team is not yet sure whether this effect is permanent or just long-lasting.

"We know that only about five per cent of people on diets are able to maintain their weight loss, and that most people who've been on a diet put all of that weight back on within two years," she said.

"More research is needed to determine how long the effect lasts, and whether there is any way – chemical or otherwise – to trick the stomach into resetting itself to normal."

The study was funded by the National Health and Medical Research Council.

Debra Vermeer

TO COMMENT CLICK HERE

Antibiotics for drug-resistant bacteria - breakthrough

Biologists in the US have developed a way to perform an autopsy on bacterial cells, opening up a revolutionary new method of identifying and characterising antibiotics, and perhaps paving the way to discovering new drugs to treat antibiotic-resistant bacteria.

The research, by biologists at the University of California, San Diego, came as the US Centres for Disease Control and Prevention released new figures showing that in the United States an estimated two million people are infected each year with drug-resistant bacteria and 23,000 die.

The new breakthrough, published in the online edition of the journal, *Proceedings of the National Academy of Sciences*, could help find new antibiotics to overcome the resistance problem.

"This will provide a powerful new tool for identifying compounds that kill bacteria and determining how they work," said Joseph Pogliano, a professor of Biology at UC San Diego, who headed the research team.

"Some bacteria have evolved resistance to every known class of antibiotic and, when these multi-drug resistant bacteria cause an infection, they are nearly impossible to treat. There is an urgent need for new antibiotics capable of treating infections caused by antibiotic-resistant bacteria."

The antibiotic penicillin was first discovered in the late 1920s, and received widespread clinical use in the 1940s. However, bacteria quickly evolved resistance to penicillin, so new and better versions were developed. Since that time, a continuous race has been fought to identify new antibiotics in order to stay one step ahead of the evolving resistance.

Kit Pogliano, a professor of biology and a co-author of the paper, said one of the main problems in identifying new antibiotics and bringing them to market is a lack of understanding of how the molecules work.

"It's easy to identify thousands of molecules capable of killing bacteria," he said. "The hard part is picking out the winners from the losers, and choosing molecules that are the best candidates for drug development.

"One key piece of information needed for this choice, is knowledge of how the drug works, but this is traditionally difficult information to obtain, usually requiring months of intensive work.

"We've applied 21st century methods that within just two hours provide this information, allowing more rapid prioritisation of new molecules. This will open up the discovery pipeline, allowing us to more rapidly identify new molecules with potential to enter the clinic for treatment of multi-drug-resistant pathogens."

The researchers say their new method, discovered by developing a way to perform the equivalent of an autopsy on bacterial cells, promises to revolutionise how drug discovery teams guide their studies.

With previous methods, understanding how an antibiotic works required many different biochemical assays to be performed, which took a lot of time and required relatively large quantities of the compound, which is almost always in short supply when it is first discovered.

"Our new method represents the first time that a single test can be performed and identify the likely mechanism of action for a new compound," said Joseph Pogliano.

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Research

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"It is also faster and can be easily adapted for high-throughput drug discovery efforts. This method will allow us to more quickly identify chemicals that kill bacteria, which will accelerate the development of new medicines. Understanding how antibiotics work is key to understanding how they evolve resistance."

Debra Vermeer

TO COMMENT CLICK HERE

Home is where the mesothelioma is - study

Home renovators are failing to take protective measures when working with asbestos, opening them up to the risk of contracting the deadly cancer mesothelioma, a new study has found.

The study, published in the *Medical Journal of Australia (MJA)*, was based on a questionnaire sent to 10,000 randomly selected adults in New South Wales, with a 37.5 per cent response rate.

It found that, among those who took part in the study, six in 10 renovators had been exposed to asbestos and fewer than 15 per cent said they used the proper protection.

"This preventable exposure could place adults and children at risk of malignant mesothelioma (MM) many years into the future," the report authors, led by Associate Professor Deborah Yates from St Vincent's Hospital in Sydney, wrote.

The report said that asbestos inhalation has been established "beyond doubt" as the cause of the fatal cancer, MM.

"Recently, there has been an epidemic of asbestos-related diseases in several westernised nations, resulting from past occupational exposure. Although estimates suggest that more than 125 million people are exposed to asbestos in occupational settings, the number of people non-occupationally exposed is not known."

The questionnaire used for the study was designed to measure renovation activity, tasks undertaken, and family members exposed to asbestos.

Of the 1597 respondents who reported having home renovations, 858 people were Do-It-Yourself (DIY) renovators and 739 were non-DIY renovators.

Most of the DIY renovators (61 per cent) reported having had asbestos exposure, and 20 respondents (2.7 per cent) in the non-DIY group also reported having exposure.

As would be expected, women were less likely to report DIY asbestos exposure than men.

However, during home renovations, 22.8 per cent reported their partner and children had also been exposed to asbestos. Only 12 per cent of the DIY renovators reported using respiratory protection regularly, while 28.4 per cent used this occasionally.

"This study documents significant potential exposure to asbestos during DIY home renovation in NSW," the authors say in the MJA report.

"Self-reported asbestos exposure during DIY renovations is common, as is reported exposure of family members, and even basic precautions regarding protection against asbestos inhalation are not used in many DIY renovations.

"Although recommendations have been made for asbestos removal in the commercial sector, active steps need to be taken to prevent future possible disease in the residential sector as well.

"Whether exposure during home renovation will result in disease in the future remains to be seen; however, this entirely preventable exposure needs to be addressed."

The article says Australia has the highest per capita rate of asbestos diseases in the world, and rates of MM continue to climb.

The Federal Government recently approved a national strategic plan to improve asbestos identification and management and remove all asbestos-containing materials from government and commercial buildings by 2030.

The plan will also include examining the feasibility of removing asbestos from homes. More than 820,000 dwellings in Australia (about 15 per cent of homes built before 1987) are reported to have asbestos-containing materials or fibro as a main construction material, but the exact number of homes containing asbestos products is not known.

Debra Vermeer

TO COMMENT CLICK HERE

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Research

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High blood pressure risk in childhood obesity

According to a new study, childhood obesity could quadruple the risk of developing high blood pressure in adulthood, while the risk is doubled if a child is simply overweight.

Researchers from the Indiana University School of Medicine found that 18 per cent of adults with high blood pressure had at least one high blood pressure reading as a child, and just below nine per cent of adults did not have any experience of high blood pressure as a child.

The data came from a study that began in 1986. It followed growth and blood pressure in over 1,000 Indianapolis children and adolescents for 27 years.

Sixty eight per cent of children were of normal weight, 16 per cent were overweight, and 16 percent were obese. Researchers at the American Heart Association reported that, as adults, 10 per cent of all the participants were diagnosed with high blood pressure.

In further detail, six per cent of normal weight children, 14 per cent of overweight children, and 26 per cent of obese children developed high blood pressure as adults.

Study author and paediatrician at the Indianapolis Riley Hospital for Children, Dr Sara E Watson, said the findings contribute to a growing body of evidence suggesting that heart disease may begin in childhood.

"A healthy diet, including reducing salt intake and participating in exercise, may help reduce the risk of developing high blood pressure," Dr Watson said.

"A slight increase in a child's blood pressure does not need treatment, but it does justify monitoring children more closely."

Sanja Novakovic

TO COMMENT CLICK HERE

Smoking increases risk of joint disease

Australia's expert group on bone and joint disease, the Australian Rheumatology Association (ARA), is warning Australians that smoking can cause an increased risk of experiencing extreme pain and contracting the serious joint disease, rheumatoid arthritis.

A study of 6000 women smokers aged over 18 found that they were significantly more likely to experience long term and difficult-to-treat pain than non-smokers.

An American study of 5,000 people found that smokers

experience worse back pain than non-smokers, and those who quit smoking experienced pain reductions.

And a recent Swedish study of 34,000 women found that smoking between one and seven cigarettes a day doubled the risk of joint disease.

Rheumatologist, Associate Professor Michelle Leech, says the ARA wants to raise awareness about the serious effects of smoking.

"Everyone knows that smoking causes heart disease, stroke and lung cancer, and increases the risk of dementia," she said.

"Many people know that smoking shortens your life by up to 19 years if you smoke a pack a day from your teens and don't quit.

"But what's not well known is how miserable life can be when you're a smoker.

"There is growing evidence that smoking increases pain when you have problems with your bones, joints, and muscles.

"Smoking increases the risk of rheumatoid arthritis, which is a very destructive and life-long joint disease.

"Rheumatoid arthritis is a painful swelling of the joints, thought to be caused by the body's own immune system attacking itself.

"It often begins to affect people between the ages of 40 and 60, and is three times more common in women than in men.

"If you smoke and are suffering from pain or rheumatoid arthritis, one of the best things you can do for your health is to stop smoking.

"If you quit smoking, it will decrease the pain, decrease the activity of rheumatoid arthritis, and increase the chances of responding to medication," A/Prof Leech said.

Sanja Novakovic

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Members' Forum

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

We have a new Coalition Government after a convincing election win on Saturday, but what will this mean for health? Our AMA members share their opinion.

My apologies but this article is more like a Liberal Party press release than a true analysis of what is to come from the new Government. Among many of the accolades, you mention, "He also put in place measures to dramatically increase medical student numbers." Yes, just ask any unemployed intern or many of the junior HMOs stuck for years in the washing machine without a training position how well the increase in medical students worked out. It was the equivalent of buying a million cars for a small town with a single lane road each way. Forgive me if I don't share the same optimism and enthusiasm as you...I guess time will tell.

Submitted by Jay (not verified)

I agree. We are over-training and need to cut back numbers now. The result of any change in students is about 12 years. With such a long lag time, it is really difficult to see the road forward. We need to stop importing overseas graduates and save places for our young graduates. They are in the system and will be coming into the workforce very soon.

Submitted by Wilson Lim (not verified)

As a financial conservative at heart, I must admit I have given the benefits to health only secondary consideration in this election. I do hope we shall see a reduction in health bureaucracy and red tape allowing more flexibility and more resources on the front line. However, I fear the Liberal government will only delay the march of the bureaucracy towards a UK style NHS when GPs will become fund holding, and expense rationing, contractors to the system. Fortunately, for me as a specialist, I shall be spared a little longer.

Submitted by Dr Raymond Taylor

I agree with the previous comment. When the Queensland Government Health Department announced closure of the Queensland Tuberculosis Control Centre in 2012, a former president of the AMA was cited as announcing that there were no cuts to front line services in Queensland Health (hopefully the comments were misquoted). It is important that the medical profession hold all governments to account for delivery of health services and not too quickly endorse the health policies of a new government. Hopefully there will not be cuts to important public health programs and with appropriate advice (including advice from the AMA) the new Government will not confuse important public health programs with unnecessary bureaucracy. However it is important that we sit back and give accurate reports on progress (both positive and negative feedback) rather than provide too rapid an endorsement before we have seen any outcomes.

Submitted by Tasos Konstantinos (not verified)

The failure to ensure adequate Medicare rebates - services not able to be insured in the private sector - and not even a hint of indexation - is a glaring policy failure (as it was for Labor). Working in a low socio-economic area, where waiting lists are up to 450 weeks at Logan hospital, these issues listed are irrelevant and trivial compared to the crucial issue of Medicare rebates. When many specialists are charging $350 plus for an initial consultation, with Medicare rebating less than a quarter, and gap fees for those with top insurance, of $7000 for neurosurgery etc. I am disgusted that this statement is so out of touch with the coalface.

Submitted by Maureen Fitzsimon (not verified)

The Nationals have announced a raft of policies which, if they can muscle them through an elected Coalition, will have a huge impact on rural health provision. One member shares what The Nationals should do if they are serious about building rural health.

If The Nationals are truly serious about building rural health, they will drop their support of Turnbull's second rate NBN proposal, and support a proper network capable of fast large data transfers (e.g. MRI files, HD patient contact) and the opportunities for rural health that provides. They are selling out rural Australia's future through their support of second-rate infrastructure in rural areas.

Submitted by Jon W (not verified)

AMA Chair of General Practice Dr Brian Morton said nothing frustrates him more as a GP than seeing his patients inconvenienced unnecessarily because of the rigidities of the heath system. A case in point is Medicare-funded GP MRI referrals, nearly a decade-long issue. AMA members agree with Dr Morton and give their suggestions.

It is indeed insidious that the Government and $$ have inserted themselves into the consulting room and between Dr-patient care. I find this "influence" as ethically objectionable as the caricature of "evil big Pharma" and its influence. However Government is less obvious. I like to call it the Galileo issue. It's not good Science.

Submitted by Karen Price (not verified)

Entrenched bureaucracies spread like a cancer pursuing their own interests rather than those of whom they purport to serve. The process is insidious, incessant and ubiquitous. The AMA should request the Auditor-General to report on the total cost of preventing GPs from using MRI to investigate patients in terms of increased costs due to treatment delayed and the total cost of administration (including the "hidden costs" of providing accommodation, utilities, insurance, etc for the staff performing and supervising the "work" as well as their salaries including provision for superannuation, long service leave etc.) A true balance sheet of benefits vs costs would then show whether costs are increasing needlessly, what benefit has

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Members' Forum

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

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been gained and whether the process is on track (NOT in terms of bureaucratic benefits) in benefiting the patients individually and in toto.

Submitted by Bill McCubbery (not verified)

I am a female with a very painful spine, which my physiologist is trying to work through with me. I have anti-inflammatory injections into the areas which cause the most concern, but without an MRI my physiologist is running blind, having to go and see a specialist, who incidentally, knows nothing about my history, just to get a referral for an x-ray, and which will cost me in excess of $180 is ridiculous. Is this a 3rd world country? Or do we just like drowning in red tape and protocol. Perhaps a way around this hiccup is to say that if a patient has an MRI, but an old one, say 4 years old, and needs an update of the existing condition, there should be no problem getting a follow- through scan.

Submitted by Caroline (not verified)

A Melbourne health economist claims that pharmacies are pocketing an average of $340,000 each in overpayments for generic medicines. One member disagrees and discusses pharmacists going through tough times.

A medical Professor, sitting on a salary of $500k, is not in a position to make a comment about other professions. It would be appreciated to start with yourself, understand it is so sickening to know how much an average medical professor makes out of an average poor patient. Regulate your profession; improve your public image first, then maybe you can start criticising other professions. Pharmacy is going through very tough times. We are always open to listen and help people regardless of their background, We go down to spend time as much as it takes to help patients and that's all for free. We have people's trust and we are part of the community, rich or poor.

Submitted by Daniel Hews (not verified)

What did the Coalition promise on health policy? One AMA reader voices his opinion on middle class welfare.

Abolishing the means test is retrograde and will cost billions dollars. It means the poor will once again subsidise the rich, which is outrageous and that's why it was stopped, means tested, very generously, by the former government. Middle class welfare is back and increased with the unfair, huge, parental leave scheme, the cost of which will be passed on to the public by the large companies that will fund it. Middle class welfare is alive and well again, outrageous.

Submitted byAndrew McLaughlin (not verified)

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

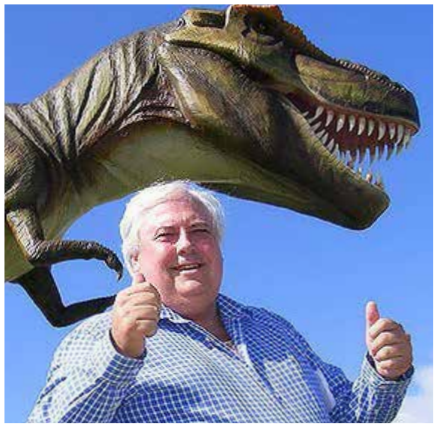
The Tracker has been developed taking full account of the requirements set out in the Medical Board's Continuing Professional Development Registration Standard.

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

To register for the product, please sign up here.

How to vote - "Just call me Clive!"

BY **DR CLIVE FRASER**



Never one to listen to gossip, I was surprised recently to hear a rumour that's doing the rounds about me at the moment at my local hospital.

That rumour is that Clive Palmer and myself are the same person.

It seems that those colleagues who believe the rumour have pointed out that as well as sharing the same name, we both have a BMI over 25 and we both have university qualifications (Clive Palmer is an adjunct professor at Deakin University).

We both love cars. He has 50 vintage cars in his museum at The Palmer Coolum Resort. I own an almost vintage 1997 Volvo V70.

We both aren't billionaires. Clive Palmer is only worth $795 million, which doesn't even make him a billionaire in New Zealand.

We live in the same electorate, my abode being slightly more humble than his.

But the strongest evidence of all that I might be Clive Palmer is the fact that we have never been seen in the same room at the same time.

Previous rumours that I was Santa were only dispelled forever once I produced a photo of myself next to the man in the red suit.

As this column is being written, Clive Palmer is just three votes ahead of his LNP rival in the Fairfax electorate.

His political future is in the hands of a tiny number of postal votes that will trickle in over the next two days and there will almost certainly be calls for a re-count.

Regardless of who you voted for in 2013, the result in Fairfax exemplifies that democracy is at work in Australia.

So it was with no surprise on voting day that I was confronted in the polling booth by a ballot paper for the Senate with 82 names on it.

But I was surprised to find a party on the ballot paper that I'd never heard of. It was the Australian Motoring Enthusiast Party (AMEP).

We've had major parties, minor parties and a now we have a new genre called micro-parties.

I was expecting the Greens and Family First to be on the ballot paper, and I wasn't surprised to see Stop the Greens and the Sex Party on there too.

But from where did the AMEP come from and what do they stand for?

Well their health policy states that, "*We believe that every Australian should have access to a fair and equitable decentralised health system. We advocate the establishment of Regional Health Boards and decentralisation of health services to ensure local participation in service delivery*".

That sounds great to me, so they might just get my vote.

But what about their other policies?

Whilst the AMEP does have a policy on vehicle maintenance and off-road vehicle use, they don't seem to have a policy on paid maternity leave or asylum seekers!

Multiple small parties proliferate in the Senate according to Duverger's law - because of proportional representation; the number of votes received determines the number of seats won.

Forget about factionalism spoiling our democracy; the real area of concern is preference deals, most of which fly under the radar once you vote above the line for the Senate.

The AMEP preference strategy was to put the major parties last and cross preference with like-minded micro-parties.

With multiple group voting tickets and an equal split between Labor and Liberal they have managed to elect Ricky Muir as a Senator in Victoria with only 13,736 first preference votes.

The Senate voting system re-distributed the preferences 37 times to lift Mr Muir's vote from 0.50 per cent (first count) to 14.70 per cent (38th count).

Mr Muir's first preference vote was only about one quarter of that gained by the Sex Party who couldn't get up (no pun intended).

Mr Ricky Muir does have some four-wheel drive experience and he has come close to nature as evidenced by his particular affinity for kangaroo poo.

But does he know how to steer Australia in the right direction?

And getting back to the Sex Party for a moment - I would have loved to have seen what they could have achieved if they had held the balance of power in a 'hung' Parliament.

The 2013 election has come and gone.

Now let's get back on the road.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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