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In this issue

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PRESIDENT'S MESSAGE

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

> "Health spending has fallen – and fallen significantly – at the very time the Government is claiming it is rising and out of control"

Restore the rebate cut

The AMA was the first to attack the Government's proposed GP co-payment model when it was announced on Budget night back in May.

Since then, the co-payment proposal has dominated the health policy debate in this country.

The Government's co-payment model deserves all the criticism it is getting, but unfortunately it is taking the focus off other Budget decisions that are just as bad, if not worse.

The AMA has been equally opposed to the Government's policy to cut $5 from the Medicare patient rebate.

The Government's stated reasons for this cut are confusing and disingenuous.

On the one hand, it claims that health expenditure is out of control. Wrong.

On the other, it says that it needs to take money from sick people today to pay for medical research sometime in the next 20 years. Illogical and unfair. While the Medical Research Future Fund is a worthy objective, it should not be built on funds that are stripped from vital primary health care today.

The Government's case for the Medicare rebate cut was shot to pieces last week by Australian Institute of Health and Welfare (AIHW) analysis that showed total national spending on health grew by a record low of just 1.5 per cent in real terms in 2012-13.

This was underpinned by a significant 2.4 per cent fall in Federal Government funding.

Health's share of the Commonwealth Budget has fallen over the last seven years from more than 18 per cent to 16.1 per cent.

This is a very important point. Health spending has fallen – and fallen significantly – at the very time the Government is claiming it is rising and out of control.

The AMA has been saying this since Budget day. Health spending is not out of control. There is no health budget emergency. There is no crisis.

So, what should the Government be doing with health spending in this crisis-free environment?

The AMA's advice is to invest in primary care now for the future.

Step one is to restore the $5 that is planned to be cut from the Medicare patient rebate.

Do not make it more expensive for people to see their doctor. Do not take funding out of general practice, the cornerstone of quality primary health care and the best value for every dollar invested in health.

Step two is adopt the AMA's alternative model for a GP co-payment.

Our model is all about valuing general practice and investing in general practice for the long term.

We need to see significant new investment in general practice to benefit patients and communities today and in the immediate future.

The answer to sustainability of our health care system is encouraging people to go and see their GP. The focus must be on prevention and chronic disease management, which is the biggest challenge we face in health in the immediate future.

The Government must forget its unfair and inequitable co-payment plan. The Government must find other means to fund its Medical Research Future Fund.

The priority must be investment in general practice. This means more GPs, more consulting rooms, new equipment, support staff, and resources to meet the growing demand for quality primary health care services.

The evidence is in – health spending is not out of control.

Our advice to the Government on health policy is to invest wisely. Give priority to funding what works.

We present a health policy that will get through the Senate – restore the rebate cut and invest in general practice.

COMMENT

BY AMA SECRETARY GENERAL ANNE TRIMMER

Co-payment fight just one strand of AMA advocacy

The Spring sitting of Parliament started again in late September with no compromise in sight on several Budget proposals, including the introduction of a mandatory co-payment for GP, pathology and diagnostic imaging services and a $5 cut to the Medicare rebate.

As has been reported in the past few editions of *Australian Medicine*, AMA President Associate Professor Brian Owler has had many meetings with politicians in which he has emphasised the need to maintain investment in primary health care. The issue has generated a lot of correspondence from members, who reflect the diversity of views in the community.

When a significant policy issue such as this emerges it often sweeps all before it. But there is a lot of other activity underway within the Federal Secretariat which sometimes is lost to members.

In the primary health care area, the Council of General Practice is looking at how to better target chronic disease management items, which will inform work underway within the Department of Health. In another development, the AMA is working with the Pharmaceutical Society of Australia to model a role for pharmacists in general practice – an area of interest to both professions.

The Medical Practice team is finalising the AMA Fees List, which will be released shortly. The Fees List remains an essential reference tool and this year will also be accessible via doctorportal, the new platform I have written about previously.

The Secretariat, with considerable input from Federal Council, is finalising its submission to the Australian Commission on Safety and Quality in Health Care on National Priorities for Clinical Practice. We are also finalising the draft submission to the review of the National Registration and Accreditation Scheme for health professions.

In other activities, the AMA is working with the Doctors Health Advisory Services to develop a national governance structure for consistent delivery of health services for doctors across Australia, with support from the Medical Board of Australia.

Public health remains a key policy area for the Federal AMA.

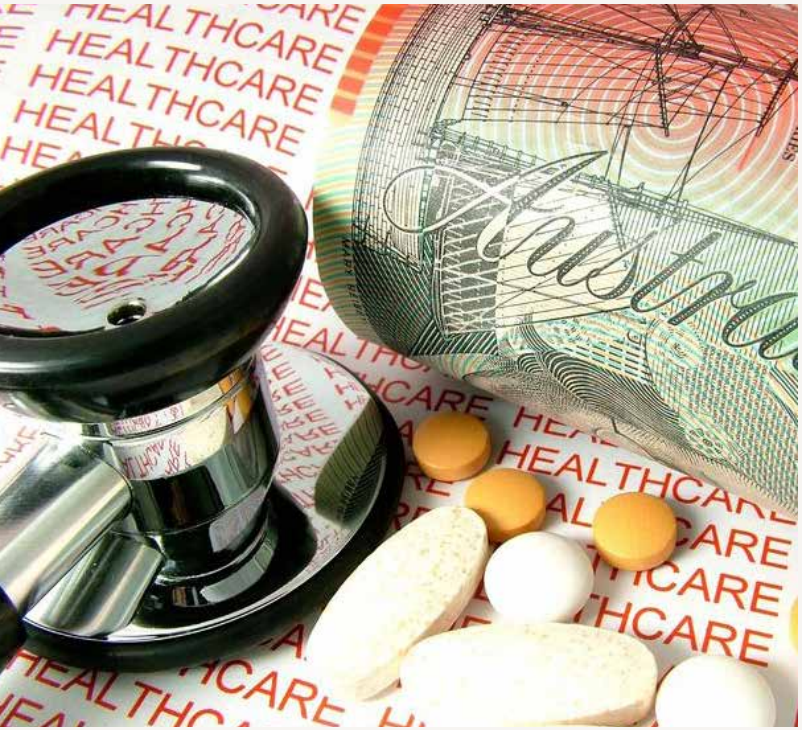
Recently, State and Territory AMA Presidents have been working with the Federal AMA on a unified response to various proposals to trial the medical use of cannabis. While not an issue of high priority, it is one which has attracted a lot of media interest. The AMA position is quite clear. Any therapeutic claim should be tested, like all other therapeutic claims, via the Therapeutic Goods Administration.

“When a significant policy issue such as this emerges it often sweeps all before it. But there is a lot of other activity underway within the Federal Secretariat which sometimes is lost to members”

The National Alcohol Summit is now well-advanced in its planning. The event will be held in Canberra on 28 and 29 October. Another population health issue of interest to the AMA is the growing incidence of obesity. It is an area of activity that we will spend more time on in coming months. To date AMA activity has been centred on food labelling. However, there is also a significant piece of work which could be undertaken in supporting activities to get people moving – making exercise safe and accessible.

COMMENT

Budget emergency? Not on these numbers



Official figures showing Commonwealth health spending has dropped and costs are increasingly being pushed onto patients make a mockery of Abbott Government claims of an out-of-control health budget, AMA President Associate Professor Brian Owler has said.

In a result that dramatically undermines Federal Government claims of unsustainable growth in health spending, the Australian Institute of Health and Welfare (AIHW) has reported total health expenditure grew by just 1.5 per cent in real terms in 2012-13 to $147 billion – the slowest growth on record – dragged lower by a 2.4 per cent slump in Commonwealth Government spending.

A/Professor Owler said the figures fatally undermined the justification used by the Abbott Government for its controversial health cuts, and called on it to immediately abandon its $7 co-payment proposal and planned $5 cut to the Medicare rebate.

"What the report actually shows, very clearly, is the lowest growth in [Government] health care expenditure for the past decade," the AMA President said. "What that does is really make a mockery of the fact that the Government's been claiming that health care expenditure is out of control.

"The Government's used this as a narrative in the lead-up to its Federal Budget, saying that health care expenditure is out of control, and it's used that to justify the introduction of the GP co-payment. Now, there is no justification for a GP co-payment, let alone the $5 [cut] for the patient's Medicare rebate."

A/Professor Owler's comments drew national attention and were cited in the first two questions directed to Prime Minister Tony Abbott by Opposition leader Bill Shorten during Parliamentary Question Time on Tuesday, 23 September.

Challenged on the AIHW findings, Mr Abbott told the House of Representatives that Parliamentary Budgetary Office figures showed Medicare spending was set to grow by 6.1 per cent a year in the next decade, and noted the AMA's in-principle support for a co-payment.

"I am always happy to hear the public comments of the President of the Australian Medical Association, and I certainly note that the Australian Medical Association is quite happy to support a co-payment in principle…as the President made clear in discussions with me some time ago," the Prime Minister said.

The AIHW analysis showed that the pressure on the Commonwealth Budget from health was easing even before the Coalition came to office, and that the nation spent 9.67 per cent of gross domestic product on health in 2012-13 – close to the average among advanced economies.

In fact, the AMA President said Government health spending was failing to keep pace with the growth in demand. On average, $6430 was spent on health per person in 2012-13 – a $17 drop in constant price terms in 12 months.

"These numbers clearly demonstrate that there are simply no grounds for taking even more money out of health," A/Professor Owler said, calling on the Government to scrap its plans for a $5 Medicare rebate cut for GP, pathology and diagnostic imaging services.

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

The AIHW report *Health expenditure Australia 2012-13* shows not only is spending on health (including by government) slowing, but households are shouldering an increasing share of the nation's health bill.

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Institute Chief Executive Officer David Kalisch said the 1.5 per cent increase in total health expenditure in 2012-13 was "the lowest growth the AIHW has recorded since it began the [data] series in the mid-1980s", and was three times lower than the average annual growth rate of 5.1 per cent.

But the burden on individuals to contribute to the cost of their health care is increasing. Their share of total health spending rose from 16.6 to 17.8 per cent in the 10 years to 2012-13. The share of private health funds remained steady at around 8 per cent.

A/Professor Owler said there was a worrying trend toward individuals being left to pick up the tab as the Commonwealth's contribution to the cost of health care shrank.

"The biggest growth in spending as a proportion has actually been for patients, as the cost is being shifted away from the Federal Government," he said. "If we see the introduction of the co-payment and the other plans that the Government has had, we are actually going to see a much greater growth in terms of out-of-pocket expenditure for patients, and I think that is a bad thing for the health care of Australia."

Significantly, the AIHW found only modest growth in spending on GP services, which has been targeted by the Federal Government in its proposed $5 Medicare rebate cut.

For the first time, the Institute has reported separately on non-referred medical services, showing that spending in this area of care grew by just 6.1 per cent in 2012-13, following 4.4 per cent growth the previous year.

To put this increase in context, there are more people seeking treatment (the nation's population is growing an average 1.5 per cent a year), the number of GP services they require is increasing by almost 1 per cent a year and there are more doctors (the GP workforce has expended by 3.5 per cent since 2007-08).

The record slow growth in total health spending was underpinned by the biggest drop in government expenditure on health in a decade – a 1.6 percentage point plunge in 2012-13.

The result shows that the Commonwealth's health bill was coming down even before the Abbott Government took office, meaning the cuts it has made or plans to implement come from an already shrinking plate.

The previous Labor Government's price disclosure reforms to the Pharmaceutical Benefits Scheme delivered significant savings, but the slowdown in Commonwealth spending was also due to funding cuts to public health, dental and e-health programs.

On the surface, the Federal Government's claims of unsustainable growth in health spending appeared to be backed by the crucial measure of health expenditure as a proportion of tax revenues.

Before the global financial crisis, both were growing roughly in step. But when the crisis hit, health spending continued to grow while the Commonwealth's tax take plummeted. As a result, the health-tax ratio surged as high as 29 per cent in 2009-10.

But Institute figures show it has fallen back steadily since then, and dropped to 25 per cent in 2012-13.

Even with a strong 7.2 per cent increase in non-government health spending, the amount expended on health per capita actually shrank by $17 in 2012-13 to $6430 – a 0.3 per cent drop after inflation.

Australia's overall health spending remains close to the average among developed nations. As a proportion of GDP, in 2012 it was at 9.4 per cent, 0.2 of a percentage point above the OECD average and similar to that in the UK and Norway, and far below 16.9 per cent in the United States.

The Commonwealth is not only unloading its health care burden onto individuals, but also the states, which A/Professor Owler warned could lead to severe problems in the public hospital system, particularly in South Australia and Tasmania.

The AIHW found that, in the 10 years to 2012-13, the Commonwealth's share of health funding slid from 43.6 to 41.4 per cent, with some of the slack picked up by the states and territories, whose share grew from 24.3 to 26.9 per cent.

"The problem for State governments has been the fact that their revenue base has fallen," he said. "So, particularly for smaller economies such as South Australia and Tasmania, they are going to have a very difficult time in funding our public hospitals, as the Government shifts cost away from itself, shifts cost back towards State governments, and back to the patients."

Adrian Rollins

COMMENT

Millions at risk unless Ebola outbreak brought under control

Infectious disease experts have warned almost 1.5 million may be infected with Ebola by early next year unless the international community immediately ramps up its effort to help bring the world's worst ever outbreak of the deadly disease under control.

As AMA President Associate Professor Brian Owler called on the Federal Government to work with other nations to make arrangements to evacuate Australian doctors and other health workers who may contract Ebola while helping to treat people in West Africa, the US Centers for Disease Control and Prevention released estimates that there could be as many as 21,000 cases by the end of September, and up to 1.4 million in Liberia and Sierra Leone alone by the end of January 2015.

"If conditions remain unchanged, the situation will rapidly become much worse," the CDC said. "Cases in Liberia are currently doubling every 15 to 20 days, and those in Sierra Leone and Guinea are doubling every 30 to 40 days."

The World Health Organisation has described the worsening crisis as "unparalleled in modern times", and warned Ebola could become endemic to the region.

Global attention is finally swinging on to the epidemic.

The UN Security Council has passed a resolution declaring the outbreak to be a threat to international peace and security – only the second such declaration it has made about a health issue.

The CDC reported that, as of 25 September, there had been 6263 cases – 3487 of which had been laboratory-confirmed – resulting in 2917 deaths.

Alarmingly, both the WHO and the CDC believe the extent of the outbreak is being under-reported, and the CDC has estimated there could be as many as 21,000 cases by the end of September.

In its response, the US has despatched 3000 troops to Liberia to build 17 Ebola treatment units, provide logistical and engineering support for health teams, and to establish facilities to train up to 500 health workers a week to combat the disease. It has so far committed $US175 million to the effort.

The British Government has pledged support for 700 treatment beds in Sierra Leone, while the EU is providing 150 million Euros and mobile laboratories and the World Bank has committed $US105 million. In addition, Cuba has deployed 165 health workers to the affected region, and China has sent 174 medical personnel.

So far, Australia has committed $8 million, including $2.5 million to each of the WHO and Medicins Sans Frontieres.

But A/Professor Owler said much more was needed, both from Australia and the international community.

"What we're witnessing is an evolving humanitarian tragedy of unprecedented proportions," he told ABC News Radio. "This is the sort of thing of Rwandan proportions - different reason, obviously, but you can see this evolving."

The AMA President said the Government had demonstrated through its actions in northern Iraq its ability and willingness to provide and deploy resources far away from Australia, and a similar effort needed to be made to help the crisis in West Africa.

"What we need to see is the same sort of commitment from the international community, including Australia, to actually make sure that we provide humanitarian assistance, not just to people in Iraq, but to people in West Africa as well," A/Professor Owler said. "Their lives are just as important.

"While it might be okay to send arms to Iraq, we need to make sure we send arms and legs to actually provide treatment for the people of West Africa."

He said Australia needed to provide, equip and staff mobile hospitals and treatment centres, as well as support the work of other organisation on the ground, such as the Red Cross and MSF.

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Millions at risk unless Ebola outbreak brought under control

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A/Professor Owler said Australian doctors and nurses were already on the ground in the affected countries, and more were willing to volunteer to help combat the outbreak, but the country needed to provide them with the resources and support they needed, including devising arrangements for their evacuation in case of infection with the deadly virus.

Evacuation direct to Australia is considered nigh on impossible, given the 30-hour flight time involved and the complexity of arrangements that would be required to bring it about, and Foreign Minister Julie Bishop has warned any health workers travelling to the region that the Government did not have the capacity to evacuate them in case of infection.

But A/Professor Owler said the Government should negotiate evacuation arrangements with other countries that are also sending health workers.

"What we would like to see is the Government coming to some arrangement with its so-called allies that it's working with in other forums, such as the UK and the US and France, to actually have a way of treating those health care workers if the worst should happen and they became infected," he said.

Adrian Rollins

COMMENT

Criminal history checks

Members will know that when they renew their medical registration in September each year they have to make a declaration about their criminal history. At the same time, they are authorising the Medical Board to obtain a written report on their criminal history (e.g. a CrimTrac agency report).

Different jurisdictions have different laws prescribing what constitutes a criminal offence. Members may have had their renewal delayed if they have not declared an offence that is minor but which nevertheless constitutes a criminal offence in their State.

Criminal history checks are an integral part of the assessment of a medical practitioner's suitability to practice medicine in Australia.

A criminal history includes:

- every criminal charge made against a person for an offence;
- every conviction (including spent convictions); and
- any plea of guilty or finding of guilt by a criminal court, whether or not a conviction is recorded for the offence. Any criminal matter that goes before the courts, no matter how minor (even a challenge to a traffic infringement), is relevant to a criminal history declaration and will show up on a CrimTrac agency report.

Civil matters such as contract disputes or debt matters do not form part of your criminal history.

When you apply to renew your registration, you are only required to declare any change to your criminal history during the preceding year of registration.

If your criminal history has changed in any way over the preceding year, you must tick 'Yes' on the renewal form, and provide details of the offence.

When the Australian Health Practitioners Regulation Agency (AHPRA) processes your renewal application, a 'Yes' response will prompt them to obtain a report from CrimTrac to verify the details of your criminal history. AHPRA will then conduct an assessment of the information, and a decision will be made about whether the offence is relevant to your practise.

The factors the Board will consider in deciding whether a health practitioner's criminal history is relevant to the practise of their profession are set out in the Criminal History Registration Standard, which is available on the Medical Board of Australia website.

To reconcile the variation between jurisdictions about what constitutes a criminal offence, the Medical Board recently authorised AHPRA to make direct assessments when a criminal history shows a minor offence and there is no demonstrable connection with the profession. Minor offences include (but are not limited to) low level speeding, failure to wear a seatbelt, driving while unlicensed, driving an unlicensed or unregistered vehicle, parking offences, public nuisance, trespass and fishing offences.

The risk of failing to declare your criminal history is that it will subsequently show up on a CrimTrac report during one of AHPRA's regular audits, triggering an investigation into a false declaration.

Medical practitioners who have been found to have made false declarations will be asked to submit a written explanation to the Medical Board. The Board will then decide how to deal with the practitioner, including the relevance of the criminal history to the practice of medicine.

We remind members it is important to declare your criminal history on the registration form, no matter how minor the offence.

You will not normally incur any delays to your registration renewal, as you will continue to be registered while AHPRA makes an assessment, and you will also be protected from inadvertently making a false declaration.

Put medicinal cannabis to the test: AMA

The AMA has called for a co-ordinated national approach to the medicinal use of cannabis as New South Wales begins preparations for clinical trials.

AMA President Associate Professor Brian Owler said that although more clinical trials of the drug were welcome, the move toward legalising its medicinal use should be conducted as a national strategy rather than being undertaken on an ad hoc State-by-State basis.

"I think we need a much more consistent approach across the country and some coordination … about regulating marijuana or cannabis as a medicine rather than as a drug," A/Professor Olwer told ABC News Radio.

His comments came as New South Wales Premier Mike Baird announced the formation of a working group to investigate how to establish a clinical trial for the use of cannabis to help the terminally ill, and Prime Minister Tony Abbott threw his support behind medicinal cannabis.

"I have no problem with the medical use of cannabis, just as I have no problem with the medical use of opiates," the Prime Minister wrote in a letter to radio announcer Alan Jones. "If a drug is needed for a valid medicinal purpose… and is being administered safely, there should be no question of its legality."

Considerable momentum has built up around legalising the use of cannabis to treat medical conditions, with claims the drug has been an effective treatment for a wide range of illnesses and conditions.

But A/Professor Owler said there needed to be a careful, considered and evidence-based approach to its use.

"There are some areas where we know that cannabinoids as a pharmaceutical preparation have already been approved, but there are other areas, such as epilepsy, where there are large clinical trials underway in the United States, and so we probably need to wait for some of those trials to come through," he said. "While I think proponents of the move to decriminalise marijuana point to various trials, I think the validity of some of those trials varies."

He said the efficacy of medicinal cannabis for treating symptoms of multiple sclerosis had already been well established, but other applications should be subject to the same rigorous assessment process as applied to other medicines.

"The way that we regulate medicines in this country for clinical indications is through the TGA, and I think we need to keep using those mechanisms…to regulate the availability of cannabis - not crude cannabis that can be grown at home, but the pharmaceutical preparations that are actually already available, and even looking at putting those on the PBS for particular indications," the AMA President said.

He said the introduction and use of cannabis for medicinal purposes was akin to the regulation and use of morphine.

A/Professor Owler said that, while morphine was used in medical application every day, it remained a controlled substance.

"We wouldn't dream of being without it. But we, of course, don't let it out on the street," he said. "We don't have people using it in an unregulated fashion, and I think we have to take some of the emotion out of this debate and look at marijuana or cannabis in exactly the same way."

Adrian Rollins

COMMENT

Mandatory reporting laws backfire

Laws that compel medical practitioners to report doctor-patients who may pose a public risk are counter-productive and should be changed, according to medico-legal experts.

As a review of national medical registration and accreditation standards led by former WA health bureaucrat Kim Snowball moves into high gear, a study of the mandatory reporting regime for health practitioners has concluded it is deterring doctors who need help from seeking care, and potentially compromising patient safety.

Under the National Law, doctors in all states and territories except Western Australia are required by law to notify the Australian Health Practitioner Regulation Agency (AHPRA) if they believe a health practitioner they are treating has practised while drunk or on drugs, has engaged in sexual misconduct, has provided care in a way significantly at odds with accepted professional standards, or has an impairment that could put patient safety at risk.

In WA, there is an exemption from reporting doctor-patients with an impairment.

The mandatory reporting obligation was introduced late last decade following several high-profile cases in both Australia and overseas where doctors had harmed or endangered their patients, including Dr Jayant Patel in Bundaberg, Dr Graeme Reeves in Bega and Dr Abdalla Khalafalla in Mackay.

Associate Professor Louise Nash, of Sydney University's Brain and Mind Research Institute, said that although mandatory reporting laws had been introduced with the aim of protecting the public, it was likely that they were having the opposite effect.

A/Professor Nash said the fact that mandatory reporting had been implemented as part of major changes to the regulation of the medical profession, including the introduction of a national registration system, meant it was very difficult to disentangle its specific impact.

But she told *Australian Medicine* that a recent *beyondblue* report had highlighted the danger that mandatory reporting laws would make it less likely that medical practitioners with problems would seek treatment, keeping their problems hidden and increasing the risk of patient harm.

In its report on mental health in the medical profession, *beyondblue* found more than a third of 12,252 doctors surveyed would be reluctant to seek help for mental health problems because of concerns it could have implications for their registration and right to practise, while more than a quarter expressed concern it might impair their career prospects.

A/Professor Nash said this was a striking finding that showed fears mandatory reporting laws were deterring doctors from seeking help were well founded.

It is this concern that has underpinned the AMA's long-standing objection to the inclusion of treating medical practitioners in mandatory reporting requirements.

"It is critical that health practitioners are not deterred, for any reason, from seeking early treatment for health conditions," the Association said.

Not only may mandatory reporting laws be counter-productive, they are also unnecessary, according to critics.

Both A/Professor Nash and the AMA said the evidence showed that the vast majority of doctors who posed a risk to patient safety were identified other than through

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Mandatory reporting laws backfire

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mandatory reporting, and that the exemption provided for practitioners in WA had not compromised the protection of patients.

In her study, co-authored with WA MP Nick Goiran, University of Queensland general practice academic Margaret Kay and Avant Head of Advocacy Georgie Haysom, A/Professor Nash cited figures from AHPRA's 2012-13 annual report showing that, of 4709 notifications received about medical practitioners, only 299 were mandatory reports, and just 10 came from a treating practitioner.

The AMA said a consultation paper prepared as part of the Snowball review found no evidence that the WA exemption for treating practitioners had impaired the ability of the Medical Board to protect patients, as had a study published in the *Medical Journal of Australia* which found 92 per cent of notifications were made by a practitioner's colleagues or employer.

"The case has not been made that the mandatory reporting requirement on treating practitioners outweighs the need to ensure health practitioners seek early treatment for their health conditions," the Association said.

A/Professor Nash said the Snowball review should consider bringing mandatory reporting laws in other states and territories into line with those in WA.

"Doctors who are unwell need to feel they can attend their treating doctor without the stumbling block of mandatory reporting," she and her co-authors wrote. "Doctors have a right to a therapeutic relationship through which care will be provided. They have a right to confidential care without being concerned that they will be reported."

A/Professor Nash said it was unfair that doctors in the rest of Australia were treated differently to those in WA.

"The continuing refusal by other jurisdictions to provide health professionals with the same authentic access to care for their own health is unjust," her report said. "While it may be politically uncomfortable for other jurisdictions to revisit this, delay benefits no sector of society [and] it potentially compromises patient safety."

Adrian Rollins

COMMENT

Major e-health record re-think underway

A major re-think of the use of e-health is underway that would see a shift away from a single, national electronic health record scheme to a network of smaller systems through which vital clinical information can be shared.

University of Western Sydney computing expert, Adjunct Associate Professor George Margelis, is among those urging a new approach that seeks to harness existing e-health systems, which are often organised around a hospital, geographic region or specialty, by developing ways that can communicate with other and allow for clinical information to be shared nationwide.

The ability to securely deliver reliable clinical information was "the ultimate end point," A/Professor Margelis said, "but we need to get there by evolution rather than revolution".

The UWS academic will be among a number of speakers to address the *e-health Interoperability Conference* to be held in Sydney in late October, at which ideas on how to link existing e-health systems to create a virtual national network through which patient and clinical information can be shared.

The new direction in thought is being developed as the Abbott Government ponders how to proceed following the damning findings of a review it commissioned into the previous Government's $1 billion Personally Controlled Electronic Health Record (PCEHR) scheme.

The design of the Scheme has been heavily criticised by clinicians worried that the ability of patients to delete or modify information without notification seriously compromised the reliability and clinical usefulness of the record. Very few medical practices have signed up to the scheme.

The review panel, which included former AMA President Dr Steve Hambleton, recommended that the PCEHR be turned into an opt-out scheme, be re-named MyHR, and include arrangements to make it clear when patients changed or withheld information.

It also recommended that the National E-Health Transition Authority (NeHTA) be dissolved and replaced by the Australian Commission for Electronic Health, which would be advised by committees that included clinicians.

A/Professor Margelis said there were many e-health systems already up and running around the country, though mostly they were small and self-contained.

He cited as an example the system set up by St Vincent's & Mater Health Sydney that enabled patient electronic records to be shared between St Vincent's Hospital, St Vincent's Private Hospital, St Vincent's Clinic and local GPs and specialists.

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Major e-health record re-think underway

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A/Professor Margelis said such systems were often well-suited to the particular characteristics of the area, including the needs of patients, but it meant the e-health landscape was “very fragmented”.

He said it made more sense to develop ways to enable these systems to securely communicate with each other rather than to impose an overarching national system.

“The system that works well in inner-metro Sydney is not necessarily the system that will work well in rural WA,” A/Professor Margelis said. “We need to remember that most health is local.”

He likened the idea of creating a national electronic health record system from scratch to “going from nought to 100 overnight”, and a better way was to help connections and networks to evolve with the active involvement of clinicians.

A/Professor Margelis said input from clinicians was critical in order to ensure e-health records developed in ways that were clinically useful and appropriate.

For this reason he thought the appointment of Dr Hambleton to head NeHTA was “exciting” because “he understands the need for clinical engagement at the grass roots”.

He said e-health needed to be part of the medical school curriculum so that doctors we familiar enough with the concepts to be able to convey their needs to those designing e-health systems.

The *e-health Interoperability Conference* is being held at the Parkroyal Darling Harbour, Sydney, on 28 and 29 October.

Adrian Rollins

COMMENT

Work needed to make sure this Apple not poison

IT giant Apple has been warned it needs to consult closely with the medical profession over plans to roll out a system that monitors and reports on the health of customers.

Apple has launched a system called HealthKit and an associated Health app designed to gather almost 70 different health and fitness measurements including diet, blood pressure and glucose levels, activity, heart rate, potassium levels, sleep and body temperature, and to send an alert to treating doctors when potential problems are detected.

The system is already in use in the United States, where researchers are trialling its usefulness in tracking the health of patients with diabetes, heart disease and cancer.

But AMA Council of General Practice Chair Dr Brian Morton said there were many issues to be resolved in order to convince doctors it was clinically reliable enough to be useful.

Dr Morton told *The Australian* potential issues included false alarms or the failure of the app to identify when a real medical emergency was underway.

He said there was “a long way to go” before such systems could be relied upon by medical practitioners, and called on Apple to engage with the medical profession and consumers to discuss how the HealthKit system would work and to address safety concerns.

Adrian Rollins

COMMENT

Coroner calls for hospital admission overhaul following deaths

BY JOHN ALATI, AMA SENIOR INDUSTRIAL AND LEGAL ADVISOR

The admission practices of small private hospitals and the referral of at-risk patients to inadequately resourced facilities have been put under the spotlight following the findings of an inquest into the deaths of two patients in South Australia.

In a case seen to have national implications, the SA Deputy State Coroner Anthony Schapel found that the deaths of two morbidly obese patients – John William Ryan, 54, and Patricia Dawn Walton, 66 – following orthopaedic surgery at a small private hospital in Adelaide highlighted systemic failings in the quality of care they were provided with.

Though the deaths occurred two years apart – Mr Ryan in 2008 and Mrs Walton in 2010 – Mr Schapel said both involved similar circumstances and issues around the admission practices of small private hospitals for higher risk surgical patients.

Both Mr Ryan and Mrs Walton underwent orthopaedic procedures at SportsMed Hospital SA, a small private hospital which did not have medical practitioners in attendance overnight.

Mr Schapel found Mr Ryan's condition deteriorated during the night immediately following his surgery, while Mrs Walton's health deteriorated during the fifth night after her operation.

Both were given opioid analgesia, which the Coroner said played a role in their deterioration.

In both cases, the degree of obesity complicated the post-operative management of the patients, as well as hampering resuscitation efforts following their collapse.

In his judgement, Mr Schapel found that both of the deceased posed predictable and continuing risks during the post-operative phase that required a higher level of care than was provided by the hospital concerned.

The Coroner noted that despite the increasing prevalence of obesity in the community, the link between opioid medication and respiratory depression in this type of post-operative patient appeared to be poorly understood by nursing staff and some medical practitioners.

Based on the evidence presented to the inquest, Mr Schapel concluded that Mr Ryan's death could have been avoided if more frequent and adequate monitoring had taken place during the night following his surgery.

It was found that he suffered acute respiratory failure, secondary to a combination of the opiate medication received post-operatively, in the context of his morbid obesity. Had his deterioration been detected in a timely manner, the anaesthetist could have been contacted to formulate a plan which may have involved intravenous administration of naloxone to reverse the effects of the opioid medication.

Additionally, there is a question as to whether Mr Ryan suffered from undiagnosed sleep apnoea, and how this might have contributed to his respiratory failure.

In the case of Mrs Walton, who had suffered severe hip pain for some years and had become opioid tolerant, post-operative pain management was always going to be a challenge. She also had hypertension and sleep apnoea, which required a continuous pressure device overnight.

Throughout the post-operative period her pain and high blood pressure proved difficult to manage. When early signs of cardiac ischaemia emerged during an overnight shift, it was attributed to asthma because the deceased had suffered from the condition in the past. There was no medical officer on site to confirm the diagnosis or to investigate the matter.

The Coroner found that, notwithstanding the unknown cardiac disease, her known medical challenges were such that she should have had her surgery in a hospital which had the medical and nursing resources to handle her complex pain requirements and hypertension.

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Coroner calls for hospital admission overhaul following deaths

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Further, this important issue was not appropriately addressed pre-operatively.

Mr Schapel found that to maximise her safety, Mrs Walton should have had her hip surgery in a facility with Intensive Care Unit backup and medical emergency team capability, for early intervention in the event of deterioration. The Coroner found that had she been managed in such an environment, her death may have been prevented.

Neither patient had the benefit of a pre-anaesthetic consult. As a consequence, the anaesthetists had to deal with the situation under pressure, moments before surgery.

In both cases, the surgery was completed without incident, but the problems arose in the post-operative phase.

Both patients were evacuated to Royal Adelaide Hospital by ambulance when they collapsed, but passed away in the ICU once testing confirmed that irreversible hypoxic cerebral damage had occurred.

In delivering his findings, Mr Schapel made a number of detailed recommendations aimed at reducing the likelihood of more deaths in circumstances similar to those that claimed the lives of Mr Ryan and Mrs Walton.

His recommendations, which have been directed to a range of health related bodies, including the AMA, included:

- that small private hospitals develop robust pre-admission processes in which higher risk patients are screened to ensure that they are not accepted for overnight admission unless they have been assessed as suitable for that facility by a medical specialist or anaesthetist, well in advance of the planned admission date;
- heightened awareness amongst medical practitioners and nurses about the inherent risks of post-operative respiratory depression occurring in obese patients who may or may not have a diagnosis of sleep apnoea and who are receiving or have received opioid analgesia;
- that the Medical Board of Australia consider formulating a code of conduct which stipulates that medical practitioners who practice preferentially in a facility in which they have a financial interest, should disclose that fact to the patient appropriately and specifically raise the issue concerning suitability of that facility with other specialists to whom they refer the patient for pre-admission assessment;
- that the process by which higher risk patients are referred for pre-anaesthetic assessment be streamlined; and
- that last minute changes to operating lists which would result in a different anaesthetist taking over immediately before surgery be avoided.

The full decision can be found on the South Australian Coroner's website at http://www.courts.sa.gov.au/CoronersFindings/Pages/Findings-for-2014.aspx

COMMENT

Qantas Club – AMA member rates – fee rise

Qantas has increased its Qantas Club membership fees for AMA members.

The new rates are listed below.

AMA Member Rates (GST inclusive)

- Joining Fee: $240 - save $140
- 1 Year Membership: $390.60 - save $119.30
- 2 Year Membership: $697.50 - save $227.50

Partner Rates(GST inclusive)

- Partner Joining Fee: $200
- Partner 1 Year Membership Fee: $340
- Partner 2 Year Membership Fee: $600

These are special rates provided for AMA members and their partners.

If you have any questions about this offer, please do not hesitate to contact AMA Member Services at memberservice@ama.com.au or phone 1300 133 655.

College warned off push to make trainees work long hours

Suggestions that surgical trainees work extra hours without overtime to accumulate necessary clinical experience have been firmly rebuffed by hospital doctors.

The Australian Salaried Medical Officers' Federation (ASMOF) has issued a stern warning to the Royal Australasian College of Surgeons (RACS) that proposals to remove award protection for surgical trainees and make them work extended hours would be fiercely resisted by its members.

Earlier this year the RACS raised concerns that existing industrial arrangements were preventing surgical trainees from accumulating clinical experience the College deemed necessary, and suggested that they be 'carved out' of industrial agreements so they could work extended hours without overtime pay.

The RACS subsequently indicated it had dropped the idea when it was met with vigorous objections from the AMA.

But ASMOF President Dr Tony Sara has raised concerns that, despite this assurance, College officials in Queensland are continuing to pursue the proposal in discussions with Queensland Health ahead of the negotiation of a collective agreement for junior medical officers in the State, and that College staff have made similar approaches to Western Australian health authorities.

"ASMOF does not perceive that it is in the interests of patients, its members, or of the profession, that the proposal proceeds," Dr Sara said in a letter to RACS President Professor Michael Grigg last month. "Similarly, ASMOF is firmly of the view that the overwhelming majority of doctors in training would not support it either."

Dr Sara said his organisation objected to the idea both on safety and equity grounds.

"ASMOF bases its objections…on the increased patient risk arising from fatigue and the increased risk for harm to medical practitioners working unsafe hours, including a reduced ability to learn when fatigued," he wrote.

He said ASMOF would resist "any move to establish payment for work performed outside of established industrial penalty rates, both from the perspective of equity with other employees, and from the realistic risk of employers imposing excessive, and thus unrealistic, workloads through inadequate staffing levels".

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Vaccine safety seminar

Ideas to improve the surveillance of patients following the administration of vaccines will be the focus of a seminar bringing together national and international experts.

Health workers, researchers, immunisations providers and public health staff interested in the active surveillance for adverse events following immunisation are invited to attend the Vaccine Safety Seminar, to be held at the Harbour View Hotel in North Sydnye on 29 October.

The seminar has been organised by the National Centre for Immunisation Research and Surveillance, and speakers include Dr Jennifer Nelson of the University of Washington's Group Health Research Institute, Associate Professor Michael Gold, a member of the WHO's Global Advisory Committee on Vaccine Safety and Dr Bronwyn Harvey of the Therapeutic Goods Administration.

Topics to be covered include methods of active and enhanced surveillance such as solicited feedback via SMS, hospital-based surveillance, and the use of large health care databases.

For more information, visit: http://ncirs.edu.au/news/index.php#Seminar

Patients left in limbo by listing stand-off

The Federal Government's top medicines advisor has lashed out at a major pharmaceutical company as a row over the subsidised supply of a life-saving but very expensive treatment for a rare illness deepened last week.

Associate Professor Suzanne Hill, who chairs the powerful Pharmaceutical Benefits Advisory Committee (PBAC), has accused drugs supplier Alexion of unnecessarily alarming people with the rare and potentially fatal disorder atypical Haemolytic Uraemic Syndrome (aHUS) over its claims about conditions laid down by her committee for the subsidised supply of the treatment Soliris.

Federal Cabinet has set aside $63 million over the next four years to subsidise access to Soliris, which has been formulated to treat aHUS – which can cause blood clots to form in small blood vessels throughout the body, potentially leading to stroke, heart attack, kidney failure and death.

About 35 people, including children, are diagnosed with the disease every year, and Soliris has been hailed as a breakthrough treatment that not only can control symptoms and the severity of attacks, but can restore critical organ function and lead to remission in some patients.

But so far, the treatment's prohibitively high cost - more than $500,000 to treat a single patient for a year – has put it out of the reach of most sufferers.

In approving the listing of Soliris on the PBS, Cabinet followed the advice of the PBAC that although Soliris demonstrated significant clinical benefits in the short-term, there was little evidence to support its sustained use in patients who had experienced remission.

Following a meeting in late August, the PBAC recommended that Soliris be supplied through the PBS, but that therapy be discontinued for patients in remission at 12 months – subject to ongoing monitoring and an immediate resumption of treatment at any sign of a relapse.

"In reaching this conclusion the PBAC noted, among other matters, that the vast majority of the benefit observed in patients receiving [Soliris] occurs in the first six months of treatment," the Committee said in a statement.

Health Minister Peter Dutton said the criteria set by the PBAC for commencing treatment with Soliris, its termination and possible recommencement, reflected "principles of good medical practise".

But the drug firm Alexion, which makes Soliris, objects strongly to supplying the drug on the terms set by the Government.

Managing Director of Alexion's Australian subsidiary, David Kwasha, told *PharmaDispatch* the company could not accept what it considered to be "inhumane treatment conditions".

"It's dangerous, clinically inappropriate, and goes against dose administration guidelines," Mr Kwasha said. "We all agree that this needs to be resolved quickly, we have this one issue, but we just can't agree to the experiment being proposed by the PBAC."

He said the nature of the condition meant that, even though the PBAC criteria allowed for the reintroduction of therapy where there is a relapse, "for some patients it could be too late".

"We remain hopeful for a change in the criteria, at least so that those patients at highest risk can continue on treatment beyond 12 months," Mr Kwasha said.

But A/Professor Hill reacted vehemently to what she considered to be Alexion's gross misrepresentation of the PBAC's recommendation, which she believed had unduly alarmed patients and delayed listing of the drug.

"Let me be clear about what the PBAC recommended," she told *Medical Observer*. "We have not recommended that all patients must stop receiving treatment after 12 months."

Mr Dutton sought to put the onus for any delay in the supply of Soliris on to Alexion.

"The Government has acted upon the PBAC's expert advice and, as a result, aHUS patients should be aware that the Government is ready to make this treatment available to them and is awaiting the response of the drug sponsor Alexion to the independent PBAC's recommendation for the listing of Soliris," the Minister said.

Adrian Rollins

COMMENT

Superbugs spreading into the community

Antibiotics prescribed by family doctors are increasingly failing to eliminate infections in a worrying sign that the problem of antibiotic resistance is spreading well beyond hospitals.

A large British study has found that more than one in every 10 antibiotics prescribed in the primary care setting are failing, and that the failure rate has increased in the past 20 years.

The research, involving data gleaned from 14 million patients who received 11 million antibiotic prescriptions between 1991 and 2012, found that pneumonia, bronchitis and other lower respiratory tract infections were becoming the most intractable to treat – the failure rates for antibiotics prescribed for these infections jumped 35 per cent in the period covered by the study.

The Cardiff University study adds to evidence that the effectiveness of antibiotics is waning.

The World Health Organisation has warned that rising antimicrobial resistance threatened the effective prevention and treatment of an ever-increasing range of infections, and posed an "increasingly serious threat to global public health".

In Australia, highly drug resistant infections such as methicillin-resistant *Staphylococcus aureus* (MRSA) and multidrug-resistant Gram-negative bacteria are becoming increasingly common in hospitals, and cases of multidrug- and cephalosporin-resistant gonorrhoea have emerged.

In a report prepared for the Federal Health Department, a team of Adelaide University researchers led by Professor John Turnidge confirmed the prevalence of antibiotic-resistant strains of disease-causing bacteria such as E.coli was steadily rising.

"The research has shown that we're having steadily increasing resistance now, to the point where we're seeing more than 5 per cent of strains being resistant to multiple antibiotics," Professor Turnidge told the ABC. "Previously people think of the resistance as being in hospital. We now know it's very much a community problem as well."

The Adelaide University team found general community resistance to three types of antibiotics in more than 7 per cent of E.coli samples taken from 29 health centres, compared with 4.5 per cent four years earlier.

Professor Turnidge said a culture of entitlement around the prescription of antibiotics was fuelling the problem – a point underlined by the Cardiff University study.

"There is a strong link between the rise in antibiotic treatment failure and an increase in prescriptions," Cadiff University School of Medicine researcher Professor Craig Currie said. "Between 2000 and 2012 the proportion of infections being treated with antibiotics rose from 60 to 65 per cent, which is the period in which we see the biggest increase in antibiotic failure rates."

Professor Currie said failure was most marked where the antibiotic prescribed was not considered a first-choice treatment for infection involved.

"We need to ensure that patients receive the appropriate medication for their condition, and minimise any unnecessary or inappropriate treatment which could be fuelling microbial resistance to antibiotics, prolonging illness and, in some cases, killing people," he said.

For the Cardiff University study, an antibiotic treatment was considered to have failed if, within 30 days, a different drug was prescribed, a patient was hospitalised because of an infection-related diagnosis, a patient was referred to in infection-related specialist, of a patient died with an infection-related diagnosis.

Professor Currie said his research emphasised that superbugs were not just a problem in hospitals, but also in the broader community.

"There is a mistaken perception that antibiotic resistance is only a danger for hospitalised patients, but recent antibiotic use in primary care is the single most important risk factor for an infection with a resistant organism," he said. "Furthermore, what happens in primary care impacts on hospital care, and vice versa."

The study was funded by Abbott Healthcare Products and has been published in the *British Medical Journal*.

Adrian Rollins

COMMENT

OCTOBER HEALTH EVENTS

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

Sun	Mon	Tue	Wed	Thur	Fri	Sat
28	29	30	**1** NSW Mental Health Month QLD Breast Cancer Awareness Month National Dwarfism Awareness Month National Shocktober Month National Polio Awareness Month World Cerebral Palsy Day National Australian Borderline Personality Disorder Awareness Week Ocsober - Alcohol absinence	**2** International Day of Non-Violence	**3** World MSA Awareness Day	**4** National Amputee Awareness Week
5 National Mental Health Week	**6** National R U OK? Day	**7**	**8**	**9**	**10** World Mental Health Day National Hat Day TAS Road to Recovery Day	**11** World Sight Day
12 World Arthritis Day National Nutrition Week National Haemophilia Awareness Week & Red Cake Day	**13** National Be Medicinewise Week National Veterans Health Week	**14** National Carers Week	**15** World Pregnancy and Infant Loss Awareness Day World Hand washing Day	**16** National Drug Safety Day	**17** National Sock it to Suicide Week	**18**
19 National Loud Shirt Day National Bloody Long Walk Day	**20** National Herpes Day National Week of Deaf people National Children's Week World Osteoporosis Day World Year Against Neuropathic Pain	**21**	**22**	**23** NSW Great Strides Walk	**24** World Polio Day National Occupational Therapy Week	**25** National Baby's Day Out
26 National Walk for Prems Day World Brain Tumour Awareness Week	**27** National Blue Knot Day National Pink Ribbon day	**28**	**29**	**30**	**31** National Bandanna Day	1

AMA IN THE NEWS

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

Print/Online

Nurses fear frail may be bullied, *Weekend West*, 13 September 2014

Nurses have warned vulnerable terminally ill patients could be bullied by family members into undergoing euthanasia under a proposal for national right-to-die laws. The AMA has rejected the proposal, saying it is at odds with ethical practices of medicine.

The doctor's not for rushing, *Australian Financial Review*, 13 September 2014

AMA President A/Professor Brian Owler is a neurosurgeon who now finds himself crossing swords with politicians on the future of our health system.

Send us doctors not cash, *Courier Mail*, 18 September 2014

The Federal Government has been embarrassed over its $7 million response the Ebola virus with an international medical group rejecting the money and demanding Australian doctors be sent to Africa instead. The AMA has been calling for Australia to send its own troops and Australian medical assistance teams to the region.

US leading the world on two vital fronts, *Courier Mail*, 18 September 2014

US President Barack Obama announced his nation will send troops to help the Ebola outbreak in West Africa. AMA President A/Professor Owler pointed out that Australia has medical assistance teams comprised of doctors, nurses, paramedics, firefighters, and allied health staff who are trained and ready to rapidly respond and provide lifesaving treatment.

Ebola may cost world economy many billions, says bank chief, *Sydney Morning Herald*, 20 September 2014

Aid group Medecins Sans Frontieres has called for Australia to go beyond just pledging money and deploy specialised civil and military personnel to countries affected by the Ebola outbreak. AMA President A/Professor Brian Owler backed the call.

AMA to scrutinise Apple's HealthKit, *The Australian*, 23 September 2014

Apple's new HealthKit system for patient care may have benefits but there are also big issues involving privacy and the accuracy of data, AMA Chair of General Practice Dr Brian Morton said. Dr Morton said any discussions between doctors and Apple about adapting its HealthKit technology in Australia for patient care would be approach with good will.

Spending indicates new GP fee not needed, *Courier Mail*, 23 September 2014

The Government's own AIHW reports that Federal Government spending on health fell by 2.4 per cent in 2012-13. AMA President A/Professor Brian Owler said the latest figures showed the Government's claims that health spending was out of control were completely wrong.

Medical bills starting to hit home as government tightens belt, *Sydney Morning Herald*, 24 September 2014

Australians' out-of-pocket health care costs are the highest they have been in a decade while growth in spending from State and Federal governments is at a record low. AMA President A/Professor Brian Owler said the figures showed there was no justification for the Government's plan to cut the Medicare rebate for doctors and introduce a co-payment.

Radio

A/Professor Brian Owler, 5AA Adelaide, 17 September 2014

AMA President A/Professor Brian Owler talked about the AMA's call for the Federal Government to contribute to the efforts made by the US to stop the Ebola epidemic from worsening. A/Professor Owler referred to warnings the number of cases could double every three weeks.

Dr Brian Morton, ABC Darwin, 17 September 2014

AMA Chair of General Practice Dr Brian Morton discussed the cyber-chondria phenomenon and internet self-diagnosis. Dr Morton said it is important to ensure that any information found online is confirmed by someone with professional knowledge.

A/Professor Brian Owler, 2SM Sydney, 23 September 2014

AMA President A/Prof Brian Owler talked about an AIHW report showing health spending has decreased in 2012-13. A/Professor Owler said there was no justification for cutting the Medicare rebate and introducing a co-payment.

A/Professor Brian Owler, 4BC Brisbane, 23 September 2014

AMA President A/Professor Brian Owler talks about the Federal Government's health funding, GP co-payment, and $5 cut to Medicare rebate. A/Prof Owler said medical spending in Australia is not out of control.

MORE P23

AMA IN THE NEWS

... FROM P22

Television

A/Professor Brian Owler, ABC News 24, 17 September 2014

AMA President A/Professor Brian Owler calls on the Australian Government to increase its efforts to fight the worst ever Ebola crisis.

A/Professor Brian Owler, SKY News, 17 September

AMA President A/Professor Brian Owler talks about the worst ever Ebola crisis in West Africa, medical use of cannabis, and the GP co-payment.

A/Professor Brian Owler, ABC News 24, 23 September 2014

AMA President A/Professor Brian Owler discussed an AIHW report showing a drop in the Government's health spending. A/Professor Owler believes there is no justification for introducing a GP co-payment or make any cuts to the Medicare rebate.

A/Professor Brian Owler, Channel 9 Sydney, 24 September 2014

AMA President A/Professor Brian Owler reveals his true colours as a Canterbury Bulldogs fan ahead of the 2014 NRL semi-finals.

COMMENT

INFORMATION FOR MEMBERS

Palliative Care

Palliative Care Australia is seeking feedback on its latest draft of industry standards.

PCA President Professor Patsy Yates said the process had been driven by the palliative care sector, which was calling for the standards to be updated to "clearly articulate and promote a vision for compassionate and appropriate end of life care across all settings".

Australia's ageing population will place increasingly heavy demand on the palliative care sector in the coming years. The industry body is aiming to ensure the standards reflect current practice while remaining relevant in the future.

Individuals and groups can offer their contributions on National Palliative Care Australia website until 26 September 2014.

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

PUBLIC HEALTH OPINION

Coming to terms with Ebola

BY PROFESSOR STEPHEN LEEDER AND SHAUNA DOWNS

The UN Security Council and its Secretary General, Ban Ki-moon, have declared the outbreak of the Ebola virus in West Africa a "threat to international peace and security," according to the BBC (http://www.bbc.com/news/world-africa-29262968).

> "Ebola continues to trouble not only the five African countries where an epidemic has led to nearly 3000 deaths since February this year, but the World Health Organisation is deeply worried on behalf of its 194 member states"

Ebola continues to trouble not only the five African countries where an epidemic has led to nearly 3000 deaths since February this year, but the World Health Organisation is deeply worried on behalf of its 194 member states.

After a puzzling five-month delay following the alarm raised by Médecins Sans Frontières, WHO declared Ebola to be an international public health emergency in early August, a category not used lightly.

Today's travel means that the Ebola incubation period of two to 21 days can easily coincide with the movement of infected persons from afflicted countries. Their illness would declare itself only after arrival at their destination country. Fortunately, Ebola sufferers are not infectious during the symptom-free incubation period.

The Ebola epidemic began in February in Guinea, when 75 people were infected and 41 died. According to the WHO, from there it spread to Liberia and Sierra Leone, then to Nigeria and, most recently, to Senegal. WHO reports that "as of September 6, 4293 people had contracted Ebola in the West African outbreak, resulting in 2296 deaths, a mortality rate greater than 50 per cent".

Are we safe?

The threat posed by Ebola to affluent western nations is low. Ebola is not spread by airborne fomites – blood and vomitus can transmit it, but the potential patient must have direct contact with body fluids or parts. In countries with scant resources, such as in the five affected West African states, decontamination is too costly for fully effective implementation for all patients and contacts.

As a young Sierra Leone health student visiting Sydney recently told me, the cost of disposable cups for patients requiring oral rehydration fluids was prohibitive. This unimaginable destitution is why Ebola takes hold. It also explains – because we are so affluent with massive health resources – why it is a low risk for us. Public campaigns in the Ebola area are distributing soap.

When considering the risk of a global pandemic, we need to know how lethal the biological agent is and how readily it is transmitted. A highly lethal agent such as the Spanish H1N1 influenza strain that caused between 20 and 40 million deaths at the end of World War One was transmitted easily by airborne droplets. It was especially lethal among people aged between 20 and 40 years. In an account of the outbreak, Stanford University researchers noted that "of the US soldiers who died in Europe, half of them fell to the influenza virus, and not to the enemy" (https://virus.stanford.edu/uda/).

Ebola mortality is about 50 per cent, but varies by place. There is now an urgent pursuit and trial of antiviral agents that might be used against it. Vaccines are also being tested.

MORE P25

Coming to terms with Ebola

... FROM P24

Because Ebola is so rare on the world stage, the commercial possibilities of a new drug are few, certainly compared with the profits that would accrue from a drug effective against obesity.

Controversy swirls around who has a moral obligation – government or private enterprise – to support the development of new drugs and vaccines for conditions like Ebola.

If the countries in which it is rife cannot afford disposable cups they will never meet the cost of new drugs.

International aid may be part of the solution, perhaps through a rejuvenated Global Fund to Fight AIDS, Tuberculosis and Malaria that "mobilizes and invests nearly US$4 billion a year to support programs run by local experts in more than 140 countries" (http://www.theglobalfund.org/en).

What can we do? President Obama has, according to the ABC, promised 3000 troops, including engineers and medical personnel, to build 17 treatment centres with 100 beds each, train thousands of health care workers and establish a military control centre for coordination of the relief effort, including a major deployment in Liberia, the country where the epidemic is spiralling fastest out of control.

The Federal Government has announced it will provide a further $7 million to support the international response. The funds include $2.5 million to support the WHO's response, $2.5 million to Médecins Sans Frontières, and an additional $2 million to support the UK's delivery of front-line medical services in Sierra Leone. The commitment brings the Australian total contribution to $8 million.

Current estimates from the WHO suggest that it will cost $1 billion to bring Ebola under control. This may be a vast underestimate.

If poverty is an important factor in its spread, then only substantial economic development will be the cure.

We can applaud Australia's contribution to this fight, advocate for more and make personal contributions through agencies such as International Red Cross Ebola Outbreak 2014 Appeal. http://www.redcross.org.au/ebola-outbreak-2014-appeal.aspx

COMMENT

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

SALARIED DOCTORS

Verbal, physical assaults have no place at work

BY DR BARBARA BAUERT

I'm pleased to take over, at least for the moment, as Chair of the AMA Council of Salaried Doctors from Dr Stephen Parnis, who continues to advocate tirelessly for doctors as Vice President of the Australian Medical Association. I congratulate him on his appointment.

It is great to have a committed salaried doctor in the Vice President's position, and we should all be proud and pleased with his appointment.

The AMACSD has a busy agenda every year and does great work. We need to ensure that our voice is heard within the AMA, and the profession as a whole.

The CSD will be meeting in October to discuss a range of issues vital for salaried doctors.

Among the topics for discussion will be the personal safety and privacy of doctors.

The AMA is working on a review of its *Position Statement Personal Safety and Privacy for Doctors – 2005*. It has already been reviewed by the CSD and the AMA Council of Doctors in Training and, based on the comments of those committees, it is being considered by the Federal AMA for further review. It is a vital issue which deserves our attention and input given that salaried doctors are facing an increase in issues around safety and privacy.

We have all been in situations where our security has been compromised in some way. We know that prevention is better than cure, and having sound, workable policies in place helps to mitigate risks. In developing a revised Position Statement, we aim to go further and cover such issues as managing risk, personal protection, the role of security staff, protecting personal privacy, education and training and bullying.

Bullying is an area that is particularly topical at the moment. Most of you will be aware that from 1 January this year, changes to the Fair Work Act were implemented providing protection for workers who reasonably believe they have been bullied at work. These new laws are relevant to national system employees only, and apply to those working in hospitals in Victoria, the Northern Territory and the ACT.

However, even where these laws do not apply, hospitals have policies in place to address bullying and harassment, and workplace awards and agreements may also address bullying. Occupational health and safety and anti-discrimination legislation may also apply where bullying involves harassment or discrimination based on a personal characteristic such as race, sex, pregnancy, marital status, religious beliefs, disability or age.

> "... hospitals have policies in place to address bullying and harassment, and workplace awards and agreements may also address bullying"

Apart from this, the Victorian Government has amended its Crimes Act to address the issue of serious bullying. Under the changes, employers must ensure that employees can work in a safe environment that is free from risk, including bullying. It is a complicated area, and one which merits our attention.

I'm very pleased to be working with you all and look forward to discussing the issues important to salaried doctors in the months to come.

Review of medical intern training: improving quality and co-ordination

BY DR JAMES CHURCHILL

> "... in the wake of increasing numbers of medical graduates now is the time to examine opportunities for training in expanded settings"

The medical internship is a cornerstone of Australia's system of high-quality, generalist medical education and is a longstanding practice in medical education systems worldwide.

In the past five years the internship has come under significant professional, educational and political attention with the creation of registration standards, national accreditation frameworks, consistent assessment processes and outcome statements. As a consequence, what constitutes the essential internship experience is much better defined now than in the past.

However, a hallmark of a healthy medical education system is one that looks continually to improve quality of its graduates, and is responsive and accountable to the needs of the profession and the community.

At the Standing Council on Health meeting in April, the nation's Health Ministers ordered a review of medical intern training to examine the current model and consider potential reforms. This is a significant opportunity for recommendations to improve the quality and coordination of medical training in Australia.

First, in the wake of increasing numbers of medical graduates and a desire for these graduates to embark upon generalist careers, now is the time to examine opportunities for, and barriers to, training in expanded settings.

In recent years there has been much progress in achieving a better balance of training interns inside and outside of the clinical departments of the various Royals and Saints. Interns currently have the opportunity to complement their essential medical, surgical and emergency medicine terms with general practice and, in some pioneering centres, system improvement and academic terms.

The loss of the Prevocational General Practice Placements Program (PGPPP), abolished in the May budget, is a significant setback to this progress. Promisingly, some State governments have committed funding to maintain placements supported by PGPPP funding.

While there are limits to the experiences that can be delivered outside of the inpatient teaching hospital setting – medical and surgical inpatient terms are very difficult to deliver in a manner that provides the experiences required for the development and consolidation of safe and comprehensive medical knowledge – there is clearly benefit in delivering training to as many interns as possible in community, academic, system improvement and other non-traditional settings.

The second target for the review should be the coordination and governance of the medical training system – specifically, the interaction between medical school, internship and further training.

The rapid growth in medical school intakes and the subsequent challenge to place increasing numbers of interns and prevocational and vocational trainees in quality positions, clearly illustrates the need to better coordinate each stage of training. The consequences of failing to train sufficient graduates to meet the future needs of our health system are significant and well documented.

Concentrating on the 'intern crisis', a dangerously simplistic answer would be to 'solve' the problem by abolishing internships and moving to a US-style system of progression from medical school directly to vocational training.

While perhaps attractive to advocates of shortened training pathways, the inevitable negative effects on generalist skills and the fragmentation of patient care significantly outweigh any benefits.

The review needs to examine governance of the training pipeline and recommend reforms that give teeth to policies that are based on the best available national workforce planning data. The long-awaited National Training Plans are essential for the effective coordination of our medical training system.

In the meantime, accepting that government and non-government bodies across multiple jurisdictions each manage various parts of the medical training system, data collection and the allocation of trainees must be improved through nationally coordinated systems for application, offer and acceptance of prevocational positions.

Phase one of the review was due to start in the second half of this year. The AMA Council of Doctors-in-Training will be active in advocating for it to make the most of its opportunity to improve the quality of Australian medical training.

GENERAL PRACTICE

Time for action on chronic disease management

BY DR BRIAN MORTON

With GP co-payments dominating media and advocacy priorities since early 2014, previous discussions around reforming chronic disease management (CDM) items in the Medicare Benefit Schedule (MBS) have not progressed. It is time for this conversation to be kick-started and reach a successful and appropriate conclusion.

Evidence shows that a comprehensive, coordinated and longitudinal approach to the management of chronic and complex disease delivers good outcomes for patients, improving their health and wellbeing. It can also help reduce health system costs that arise from poor health outcomes and avoidable hospital admissions.

Instead of focussing on how it can further strip funding from frontline care, it is time for the Government to turn its attention to how it can make better use of available health funding. Investing in primary health care to support quality general practice is the answer.

To help reduce the burden of chronic disease on health expenditure, GPs need to be supported to provide preventive care and proactive management of chronic disease. It is important that funding for this essential work be well targeted and directed towards high quality care.

> “To help reduce the burden of chronic disease on health expenditure, GPs need to be supported to provide preventive care and proactive management of chronic disease”

We know that the Department of Health thinks that the claiming data on current CDM items indicates that they are not being utilised as intended. They point to the fact almost every GP Management Plan results in a Team Care Arrangement, with few reviews being undertaken.

This presents an opportunity for the profession to take a proactive approach to the reform of existing items, particularly if we want to avoid the sort of blunt cuts we saw applied to the GP Mental Health items a few years ago.

There is also the opportunity to push for cuts to red tape as part of sensible reform. There is too much focus in the existing items on paperwork and compliance, when what we need is time to have a real conversation with patients about their care needs, and to develop a structured approach to their care. Streamlined referral processes to allied health for patients who need this is essential.

The AMA has consistently stated its willingness to help make chronic disease items work better for patients and GPs alike. We want to see investment in quality, longitudinal care, built around the central role of the usual GP. The items need to reflect modern GP practice so that we can focus on delivering care for patients.

Making the CDM items work better will necessitate revisiting the regulatory requirements of the CDM items and making appropriate changes. Given some of the poor templates for management plans and team care arrangements I’ve seen residing in desktop software, they too will need a revamp.

There is some light at the end of the tunnel.

After pressure from the AMA, the Health Department is now looking again at how it can work with the profession to get the CDM items right. This is a discussion we have to have. Policy cannot be driven by the limited examples of poor practice that the Department sees taking place, but instead should focus on how we can better support the vast majority of GPs who are doing great work in this area.

The AMA’s role in this debate will be to ensure that vital funding is protected and directed to supporting high quality GP care and improved health outcomes for patients.

Health on the hill

Political news from the nation's capital

Pharmacist closed shop must end: Govt adviser

A high-powered Federal Government review has declared that closed-shop restrictions on the placement and ownership of pharmacies do not benefit consumers and should be scrapped, intensifying the pressure on the embattled pharmacy sector.

In a blow to the Pharmacy Guild of Australia in its efforts to shield its members from increased competition, the Competition Policy Review ordered by the Government has recommended that rules dictating the location of pharmacies be abolished in the next Community Pharmacy Agreement due to come into effect on 1 July next year.

And the Review, led by economist Professor Ian Harper, has advised that laws prohibiting anyone but pharmacists from owning a pharmacy should also be abandoned.

"The current regulations preventing pharmacies from choosing their own locations, and limiting ownership to pharmacists and friendly societies only, are more restrictive than those in other health sectors (such as general practice) and many comparable countries," the Review said in its draft report. "[They] impose costs on consumers; yet it is unclear how restricting the location of pharmacies or requiring that only pharmacists can own a pharmacy ensures the quality of advice to consumers."

Launching the draft report, Professor Harper said it was time that pharmacists fell into line with doctors when it came to the extent of deregulation of their industry.

"Isn't it a bit strange that those same rules that have no impact on the health and safety of the public in respect to general practitioners are suddenly supposed to have [an] impact in the case of pharmacists?" he told *The Age*. "It's just irrelevant. All it's doing is serving the interests of incumbent pharmacists."

The Review said the restrictions limited the ability of consumers to choose where to shop for pharmacy products and services.

The Pharmacy Guild is fighting a rearguard action to hold on to privileges that shield its members from competition while simultaneously trying to expand pharmacist scope of practise to include health checks and vaccinations. Executive Director David Quilty said community pharmacies were "struggling" and "need certainty and stability – not a constant push to abolish a system that's working, and replace it with an economic theory".

But AMA President Associate Professor Brian Owler has accused the Guild of using the idea of pharmacist health checks as a bargaining ploy as it prepares for negotiations with the Federal Government over the next five-year Community Pharmacy Agreement.

Health Minister Peter Dutton insisted in early September that the Government had no interest in stripping pharmacists of current protections.

"The Coalition has long held the belief that we shouldn't have that corporate ownership model, that we believe very strongly in a pharmacy that is owned at a community level," Mr Dutton told *The Australian Financial Review*. "Nobody's convinced us of the need for Coles and Woolies to run a pharmacy, and we've said very specifically…that we want to make sure that pharmacy – the pharmacy location rules and the pharmacy ownership rules don't change."

But the Review's report, coming on top of similar Commission of Audit recommendations earlier this year, will heighten the pressure for a re-think.

The Review said that it accepted the need for some regulation of pharmacies given the pivotal role they play in primary health care.

But it said developments since the turn of the century had made justifications for the existing restrictive regime increasingly tenuous.

It said the rise of discount pharmacy groups, the proliferation of online prescriptions, and accumulated evidence about the effects of deregulation in other areas of the health sector all strengthened the case for change.

"Since 2000, there is a better understanding of how well other primary health care sectors operate without such anti-competitive restrictions," the draft report said. "For example, ownership of medical practices is not limited to GPs, and nor are GP practices prevented from opening in close proximity to one another."

The draft report is open for public comment until 17 November and the Review is due to present its final report to the Government in March 2015.

It can be viewed at: http://competitionpolicyreview.gov.au/draft-report/

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

PM launches extraordinary attack on watchdog

Prime Minister Tony Abbott has called for drugs approved in other countries to be automatically allowed onto the Australian market, bypassing the medicines watchdog.

In an extraordinary attack on the nation's system of medicines regulation, Mr Abbott condemned it as "a thicket of complexity, bureaucracy and corporate and institutional self-interest".

"If a drug is needed for a valid medicinal purpose and is being administered safely, there should be no question of its legality," the Prime Minister said. "And if a drug that is proven to be safe abroad is needed here, it should be available."

Mr Abbott was speaking in the context of the debate over the legalisation of cannabis use for medicinal purposes, but his comments have sparked fears the Government is looking more broadly at watering down the current system of medicines regulation, including the pivotal role played by the Therapeutic Goods Administration.

Criticism of the nation's system of medicines regulation are nothing new – the TGA and the Pharmaceutical Benefits Advisory Committee are often accused of denying patients access to treatments available overseas.

But it is rare for the Prime Minister of the day to launch such a forthright attack, and his comments appear to call current levels of oversight of the drugs market into question.

Under current arrangements, it is illegal to supply or sell products with claimed therapeutic properties unless it is listed on the Register of Therapeutic Goods administered by the TGA.

Approving a drug for listing on the register can be a lengthy process because the TGA, like counterparts overseas such as the US's Food and Drug Administration, requires detailed information about what it contains as well as evidence from clinical trials regarding its safety and efficacy.

AMA President Associate Professor Brian Owler said it was an important process that protected the public from useless or harmful concoctions.

"The way that we regulate medicines in this country for clinical indications is through the TGA, and I think we need to keep using those mechanisms, having experts look at the evidence that exists, whether there's a gap, conduct a clinical trial," A/Professor Owler said.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

OPINION

Tackling obesity will help reduce Budget fat

BY DR LESLEY RUSSELL, ADJUNCT ASSOCIATE PROFESSOR, MENZIES CENTRE FOR HEALTH POLICY, UNIVERSITY OF SYDNEY

This story was first published in The Canberra Times on 10 September, 2014

The current level of obesity in Australia is properly called an epidemic, and the associated costs of around $60 billion a year are a growing drain on the health care budget and the economy as a whole. Under such circumstances, it makes no sense to invoke the idea that obesity is the result of individual irresponsibility and lack of resolve in making choices about diet, lifestyle, and even par-enting.

"The only person responsible for what goes into my mouth is me," says the Prime Minister [Tony Abbott] "and the only people who are responsible for what goes into kids' mouths are the parents". It wasn't always thus. In 2006, as Minister for Health, Mr Abbott said, "If we want to keep living longer, better lives then we have to tackle the obesity crisis," and went so far as to lash Coca Cola for its role in driving childhood obesity. Back then about 22 per cent of adults were obese.

Today the adult obesity rate is 29 per cent and growing faster than anywhere else in the world. But the Abbott Government has dismantled the Australian National Preventive Health Agency and scrapped the National Partnership Agreement on Preventive Health, ripping $377 million from the major federal programs that were addressing alcohol, tobacco and obesity.

There have been implicit and explicit criticisms of Government initiatives in obesity as 'nanny state' or 'paternalistic'. The basis of these arguments is that individuals are the best judges of their own interests and people have the right to make their own choices, including bad choices. These arguments ignore the fact that many choices are made on the basis of inadequate knowledge or poor reasoning, or even that choice may be removed by circumstances such as poverty or access.

Those who invoke warnings of a nanny state generally have some vested interest in problem prod-ucts such as junk food and sugary drinks. And concerns about paternalism and the right to choose are usually more about 'when' rather than 'whether', as seen by this government's push for welfare reforms.

By resorting to the personal responsibility argument, the debate about obesity is reduced to a sim-plistic equation about controlling consumption and promoting physical activity. It also means ac-cepting that Australia has doubled its obesity levels over the past two decades due to a lack of re-sponsibility. This denies the complex reasons involved and, in particular, ignores the impact of ma-nipulative marketing, which is offset by minuscule efforts and resources.

We all pay the price - directly and indirectly - for the Government's lack of leadership in this area.

In 2005, it was estimated that overweight and obese Australian adults cost the Australian economy $21 billion in direct health care and non-health care costs, plus an additional $35.6 billion in Gov-ernment subsidies.

It's shocking that we don't have a more up-to-date estimate. But if there are concerns about unsus-tainable health budgets, growing waiting lists for surgery and access to crowded emergency de-partments, one obvious solution lies in tackling obesity.

Canberra Hospital has its own budget story in this regard. In recent times, to facilitate the provision of safe care to the two-thirds of Canberrans who are overweight or obese, the hospital has had to replace toilets, provide bigger beds, widen doorways, install lifting equipment and purchase new ambulances. Some rooms have now been refurbished to cope with patients weighing up to 500 kil-ograms.

Australia is now up there with the United States in the obesity stakes. However, as the annual *State of Obesity* report from Trust for America's Health and the Robert Wood Johnson Foundation shows, the US now has some optimistic news.

While obesity rates are above 30 per cent in 20 states, and not below 21 per cent in any, adult obesi-ty rates seem to have stabilised over the past two years and childhood obesity rates have not just levelled off but begun to decline in some places. Importantly, there's a downward trend in obesity rates among young children in low-income families.

It's easy to read this report and see only the continuing bad news, but increasingly the US is doing what Australia is not - successfully tackling obesity. It's an effort led by the Federal Government across a range of departments and involves partnerships with state and local governments, commu-nity groups, schools and churches and business. These efforts are backed by detailed annual reports that highlight both the shameful statistics and the progress.

Meanwhile, obesity rates in Australia continue to climb, and the consequence is that health care costs and productivity losses will continue to grow along with Australians' waistlines.

COMMENT

Research

No need to be wary of dairy, study finds

A small daily serve of milk or cheese can reduce the risk of heart disease and stroke even among people who have not traditionally eaten dairy products, a long-term study has found.

In a result that undermines fears in some Asian countries that adding milk and cheese to traditional diets is contributing to a jump in heart attacks, strokes and cancer, Monash University researchers found that eating a little dairy most days actually improved health.

"In a dominantly Chinese food culture, unaccustomed to dairy foods, consuming them up to seven times a week does not increase mortality and may have favourable effects on stroke," lead author Emeritus Professor Mark Wahlqvist said. "We observed that increased dairy consumption meant lower risks of mortality from cardiovascular disease, especially stroke, but found no significant association with the risk of cancer."

Lactose intolerance is particularly common in Asia – in some countries it can be as high as 90 per cent – helping fuel resistance to including dairy products in the diet.

But the study, which began in 1993 and has involved tracking the eating habits and health of 4000 Taiwanese, found that consuming even small amounts of milk, cheese or yoghurt could improve health.

Professor Wahlqvist said those who ate no dairy products actually had higher blood pressure, body fat and body mass indices than those who did.

"Taiwanese who included dairy food in their diet only three to seven times a week were more likely to survive than those who ate none," he said, adding that people only needed to eat small amounts to gain a benefit.

The key is daily consumption of dairy foods, at the rate of about five servings (the equivalent of about five cups of milk or 225 grams of cheese) spread over a week, the study found.

Such quantities rarely cause problems, even for people considered to be lactose intolerant, Professor Wahlqvist said.

The study, which also involved researchers from the National Health Research Institutes and National Defence Medical Centre in Taiwan, was published in the *Journal of the American College of Nutrition.*

Adrian Rollins

COMMENT

Doubts about e-cigarette health benefits deepen

Claims that electronic cigarettes can help people quit tobacco have been undermined by the findings of a US study into the smoking habits of cancer patients.

The study of 1074 New York cancer patients who smoked found those using e-cigarettes were just as likely to be smoking after a year as those who did not use them, and that seven-day abstinence rates were virtually the same for both groups.

Health authorities and experts are still grappling with the issue of whether e-cigarettes pose a threat or are a benefit in the fight to cut down rates of smoking.

Concern about the technology - which uses battery power to vaporise a solution that typically includes nicotine, which users then inhale – is mounting as its use spreads at a massive rate.

Recent US research identified more than 500 brands offering more than 7760 flavours, with an extra 10 brands being added every month, and e-cigarette use among the New York cancer patients involved in the latest study tripled between 2012 and 2013.

In June, public health experts worldwide made a joint appeal to the World Health Organisation to ignore tobacco industry claims about e-cigarettes and instead focus on the evidence in assessing their health implications.

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Research

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

Their call has come amid mounting international concern about the rapid, and largely unregulated, growth in e-cigarettes, which are often being spruiked as a safe alternative to tobacco products and an aid in kicking the smoking habit.

But those claims have been dented by the New York study.

Lead author Dr Jamie Ostroff, of the Memorial Sloan Kettering Cancer Center, said all cancer patients were counselled to quit smoking, and her study looked at the efficacy of e-cigarettes in supporting that.

The rising use of e-cigarettes has raised many questions among patients and the health care providers. Including whether e-cigarette use helps or hinders quitting efforts, Dr Ostroff said.

She admitted that the small and limited nature of her study meant the findings were far from conclusive.

"Controlled research I needed to evaluate the potential harms and benefits of e-cigarettes as a potential cessation approach for cancer patients," Dr Ostroff said, and advised that in the meantime all smokers should be advised to quit and informed about the "potential risks and lack of known benefits" of long-term e-cigarette use.

The WHO has said it is reviewing evidence around the use of e-cigarettes, and is working with national regulatory bodies to look at regulatory options, as well as with toxicology experts to understand more about the impact they may have on health.

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

Adrian Rollins

COMMENT

Most effort goes on treating cancer rather than preventing it

Support for research into cancer prevention has stagnated despite evidence that half of all cases of the deadly disease could have been avoided.

Of more than $1 billion pumped into cancer research between 2006 and 2011, just $20 million went on work to help prevent the disease, a national audit of cancer research funding has found.

The report, prepared by Cancer Australia, found that in the past decade cancer research funding has substantially outpaced inflation, boosting the nation's research effort.

Less than $300 million was committed to cancer research project in the three years to 2005, but in the three years to 2011 this had swelled to almost $600 million.

Research into the biology of cancer claimed the biggest slice of research funding, accounting for more than third of all spending between 2006 and 2011, while inquiries into treatment attracted a quarter of total funding, and work on the early detection, diagnosis and prognosis of cancer received around 15 per cent of funds. By comparison, research into prevention received just 2 per cent.

Cancer Australia said relative lack of funding for cancer prevention research could be explained in part by the fact cancer shared a number of risk factors in common with other conditions such as cardiovascular diseases and diabetes, so research into mitigating these may not have been captured by the audit.

It added that some inquiries into cancer vaccines may have been classified as research into treatment.

Nonetheless, the Council said there were strong reasons to boost prevention research.

"It is estimated that, worldwide, more than 50 per cent of cancer can be prevented, and many preventable risk factors for cancer are common with other chronic diseases such as cardiovascular disease and diabetes," it said. "Development of international initiatives to fund cancer prevention research, and initiatives which bring together funders of chronic diseases to co-fund prevention research, could help to reduce the burden of disease of cancers and other chronic diseases."

Among cancer types, breast cancer claimed the largest share of research funding, accounting for almost a third of funds in the early 200s before easing down to a quarter by early this decade.

MORE P34

Research

... FROM P33

Investigations into cancers of the blood attracted the next highest level of support (17 per cent of total cancer research funding), followed by colorectal cancers (14 per cent), genito-urinary cancers (13 per cent), skin cancer (10 per cent) and lung cancer (5 per cent).

Chair of Cancer Australia's Advisory Council, Professor Jim Bishop, said the information provided by the audit would help identify ways to optimise investment in cancer research, including through targeting funding and fostering national and international research collaborations.

While charitable foundations engage in high-profile campaigns to encourage individual donations for cancer research, the audit found that the Federal Government was by far the most important source of funds.

The National Health and Medical Research Council allocated $568 million (56 per cent of total funding) to cancer research projects between 2003 and 2011, and other Federal Government sources provided a further $97 million.

The next biggest contribution came from Cancer Councils ($96 million, 9 per cent); followed by State and Territory governments ($75 million, 8 per cent); and charitable Cancer Foundations such as the National Breast Cancer Foundation and the Leukaemia Foundation ($74 million, 7 per cent). Direct donations from philanthropists (as opposed to those funnelled through charities) amounted to just $2.6 million over the eight-year period.

Cancer Council Australia Chief Executive Officer Professor Ian Olver said a three-fold increase funding for in tumour-specific research projects was promising, but needed to continue.

"The trend towards a relative increase in funding for research into cancers that are particularly difficult to treat, such as lung cancer, is encouraging," he said. "We need to continue and accelerate that trend, even though difficult-to-treat cancers pose the greatest challenges to researchers."

Professor Olver said the relative stagnation of funding for research into prevention highlighted the importance of supporting non-government and not-for-profit organisations that were leading work in areas such as skin cancer prevention.

"A lot of prevention science and research in areas such as survivorship and patient support has no commercial application, so it is important to have a strong not-for-profit sector driving that research," he said.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Doctor Portal: the doctor's complete online resource

All the resources and information a busy practitioner needs is now just a click away following the launch of the AMA's Doctor Portal website.

Doctor Portal brings together all the tools and resources doctors look for on a daily basis – the GP Desktop Toolkit, the Find a Doctor feature, the CPD tracker, the Fees List, policy guidelines, position statements, practice advice and support – as well as access to AMA publications including the *Medical Journal of Australia* and *Australian Medicine*, all in one convenient location.

No more wasted time digging around through the entrails of the web to find the information you need – Doctor Portal is your one-stop information hub.

Not only does Doctor Portal give you ready access to the information and resources you need, it gives you a way to connect with colleagues near and far through public and private forums.

Click on the Doctor Portal link to check out these and other features:

- Content sharing – Doctor Portal allows you to securely share information and ideas with colleagues, providing public and private forums that only other registered medical professionals can access and participate in;
- Find a Doctor – locate practitioners using the Find a Doctor feature, which gives you access to Medical Directory of Australia information, including current practice contact details and a scalable map – perfect for when you are referring patients;
- All in one convenience: Doctor Portal features a refreshed MJA Bookshop, careers and jobs resources and the GP Desktop Toolkit, all at one site;
- Free access: Doctor Portal is a free service, and includes features exclusive to AMA members.

Doctor Portal is continually updated, ensuring that all information is current and you are never left out-of-date.

To explore all that Doctor Portal has to offer, visit: http://www.doctorportal.com.au/

Social media sting

Complaints against doctors have surged in Britain because of the spread of social media rather than a lapse in professional standards, an investigation has found.

Amid mounting concerns that doctor rating sites and other online tools leave practitioners vulnerable to unfounded and malicious slurs on their reputation, a Plymouth University study has found that social media has contributed to an increased tendency of patients to complain.

The UK's General Medical Council commissioned the research after complaints it received about doctors virtually doubled in five years, to 10,347 in 2012.

The investigators could not identify a single cause for the increase, but noted a number of trends that made it more likely for patients to make a complaint.

These included improvements in practice that made patients better informed, higher expectations regarding the quality of treatment and less deference felt toward doctors.

But the researchers said the rise of social media had also contributed to the increase by making it easier for patients to share their experiences with a wider audience.

They speculated that high-profile reports of medical malpractice and other unfavourable media coverage was gradually undermining the medical profession's reputation, encouraging more patients to make "me too" complaints.

Lead author Dr Julian Archer, of the University's Peninsula Schools of Dentistry and Medicine, told the BBC there was no simple explanation for the increase in complaints.

"[The findings] show that the forces behind a rise in complaints against doctors are hugely complex and reflect a combination of increased public awareness, media influence, the role of social media technology and wider changes in society," Dr Archer said.

GMC Chief Executive Niall Dickson said the increase in complaints appeared to be due to an increased preparedness of patients to voice dissatisfaction rather than a poorer medical practice.

"We have no evidence that the rise in complaints against doctors reflects falling standards," he told the BBC.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Chronic disease management seminar

Adjunct Associate Professor and Principal Consultant Gerontologist, Drew Dwyer is presenting a series of seminars organised by the Australasian College of Care Leadership & Management.

The one-day workshop, *Chronic Disease Management: Aged Care in General Practice*, is designed to inform general practitioners about the latest developments with Medicare chronic disease items.

The information presented will be clinically-based and aimed at GPs and the clinical team, including practice managers and nurses. Topics covered include Medicare item allocations, clinical care management, assessment and management of frailty, dementia and chronic disease management.

The workshop, which has been approved by the RACGP's Q&CPD Program, is being conducted in Melbourne on 25 October, Brisbane (22 November) and Sydney (6 December). It provides 40 Category 1 points for the 2014-2016 Triennium (Activity Number pending from RACGP).

Bookings can be made online at http://www.acclm.edu.au/racgp or by phoning (07) 5440 5188. Early Bird discounts are available for a limited time.

If Queen Elizabeth was a wine, she would be a Chardonnay

BY **DR MICHAEL RYAN**

If Cabernet is King, Chardonnay is definitely the Queen of the viticultural landscape.

It is widely known and grown, and though its spiritual home may be in Burgundy, it is found in most parts of the viticulture world – old and new.

It can be a workhorse variety produced in vast quantities, or it can be tamed and coaxed out of its shell to become some of the most sought-after wines in the world, such as the Premier Cru Burgundy. If raised in an austere climate, tighter acidity with green apple and pear aromas develop. Warmer climes bring out tropical and peach characteristics; even fig and melon notes.

Some unwooded Chardonnay exists, but its marriage with oak raises it to another level. Toasty, buttery characteristics develop, depending on age and type of French oak used. It can undergo malo-lactic fermentation which softens the acidity, and it can have lees contact to add nutty, meaty characteristics.

It can be blended with other whites, such as Semillon or Colom bard. It is a principal grape in Champagne, supplying the rich back palate structure and flavours, surpassing the Pinot Meniere and Pinot Noir contributions. The occasional dessert wine has been made from the botrytis effect in cooler climates.

DNA analysis proves a relatively pure hereditary line. It comes from a Pinot and Gouais Blanc cross. Romans brought Gouais Blanc to France, and French experimentation led to the cross-bred variety.

The cross-breeding has resulted in vigorous growth characteristics and relative hardiness. More than 30 clones have been developed by the University of Dijon, allowing growth diversity. Chardonnay has been crossed with other species as well.

Chardonnay was brought to Australia in 1832 by pioneer James Busby. It flourished in the Hunter Valley and is in most wine geographes in Australia.

Terroir and winemaking techniques have resulted three distinct styles.

The new Australian style, which mimics the mineral steely Chablis, involves cool climate Chardonnay picked early, with minimal malolactic fermentation, older oak and no lees contact.

More ripened fruit with new French oak, Lees contact, full malolactic ferment have resulted in the 80s style , often described as voluptuous and buttery Chardonnay. Jacobs Creek Chardonnay put Australian winemaking on the map with phenomenal success in England. The popularity was such that during the decade there was actually a Chardonnay shortage. But then the relatively heavy style fell out of favor, and across the country Chadonnay vines were pulled.

The third style is somewhere in the middle, and to me represents a more Burgundian, palatable but very classy style. Yarra Valley, Mornington Peninsula, Margaret River and Adelaide Hills shine as producers.

So I think that the royal analogy for Chardonnay is apt. It is a variety that is aristocratic, well presented, with a pure lineage. It can be powerful and assertive, yet is often diplomatic, and it has re-emerged in popularity, just like the royal family.

COMMENT

RECOMMENDED WINES

1. **2012 Kooyong Clonale Chardonnay Yarra Valley** - light green, almost yellow in colour, with a nose of nectarines, figs and lemons, and hint of mild funk with lees contact. On the palate there is surging quality fruit with good acidity and mouth feel. One to three years cellaring. Have with firm sheep's cheese.

2. **2013 David Franz Brother's IIk Adelaide Hills Chardonnay** - medium yellow, with vibrant white peach, and mild floral aromas, and a hint of cashews and funky yeast. Generous fruit – with mid-palate citrus-like acidity, and a lingering taste supported by a creamy mouth feel. Excellent drink now or cellar for five or more years. I had with spaghetti carbornara.

3. **2013 Holm Oak Chardonnay Tamar Valley Tasmania** - elegant pale green/yellow in appearance. Aromas of white peach, apricots, hints of grass, lemon notes. A new age style of wine with cool climate origins, austere but rewarding balanced flavors and acidity. Drink in the next three years. Excellent with Pacific oysters - yum!

4. **2011 Mountadam Eden Valley Chardonnay** - a deeper yellow wine, with aromas of peaches, figs and spicy oak notes. Hints of citrus (grapefruit), with creamy cashew aromas. Well balanced fruit with a mineral like feel and acidity. A complex long-lasting wine. I had with smoked ocean trout.