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Cover: AMA President Dr Steve Hambleton met with Health Minister Tanya Plibersek in her Sydney office on Thursday 6 September to discuss Primary Care Issues.

Is the health reform landscape a barren plain?

BY AMA PRESIDENT DR STEVE HAMBLETON

From the AMA perspective, the dream of the Kevin Rudd-led attempt at 'big bang' health reform that began in 2007 has not been realised. Where has the dream gone, and what is left? What should health reform deliver?

Real health reform for doctors, patients, nurses, and allied health professionals should deliver more resources at the hospital bedsides, in the surgeries, and in community health services, and it should connect them all up and we should end the blame game.

But what did we get instead?

We have a COAG Agreement between the Commonwealth and the States for refinancing and restructuring, but the blame game is alive and well. This Agreement will continue to come under immense pressure as the new State Governments attempt to flex their muscles.

Meanwhile, we have to come to grips with and hopefully have some say in the running and output of some new health organisations.

First we have the Australian National Health Prevention Agency dedicated to prevention. We welcome this Agency. It has important work to do.

It is currently targeting obesity, harmful alcohol consumption and tobacco. Figures released say we are not doing too well with obesity rates continuing to rise, and no respite from harmful alcohol consumption. We are making progress, though, on tobacco consumption.

Australians are cutting down on the smokes, but we are finding it harder to knock back a burger or cut down on the grog, even if we are pregnant.

More work needs to be done to get people eating more healthily and drinking more responsibly. This new Agency cannot solve these problems alone. It is up to the whole community working together to improve public health.

The Government has also established new organisations to:

- monitor and report on health performance (National Health Performance Authority - NHPA),
- manage and report on the activity-based pricing framework for hospitals (Independent Hospital Pricing Authority - IHPA), and
- administer the funding pool (National Health Funding Body).

Individually, these new bodies and processes being rolled out under the National Health Reform Agreement have potential to make improvements in their specific areas.

While it is early days, there are some significant risks.

What we can be certain of is that the new public hospital pricing arrangements will bring a much sharper focus on costs and cost accounting in the public system. But it is yet to be seen exactly how the new arrangements will play out and what 'new behaviours' might develop as a result of their introduction.

The AMA has argued strongly in submissions to both IHPA and NHPA for an active program of monitoring and evaluation to track these trends as they develop, and to make adjustments to address any adverse effects.

This includes potential adverse impacts on the number and mix of services provided from the introduction of the new pricing arrangements and, indeed, the impact of the actual collection of the data.

I have heard it said that they already collect much of the data – it's sharing this that might be their problem.

While the individual reforms and new organisations are worthwhile in their specific areas, there are significant broader issues.

The AMA has argued that the reforms are overly focused on backroom issues, such as issues about how governments split funding responsibilities, how they measure performance in the abstract, and how they create new organisations but don't invest in the system's overall capacity for service delivery.

The reforms and new funding arrangements themselves fall short of being able to improve service delivery – clearly illustrated by the Federal Government's decision to provide a $325 million emergency rescue package for Tasmania's health system, targeted to direct health care delivery.

There is no clear picture of the overall performance of the system, and the impacts of the new bodies and processes are not fully predictable.

These issues are clear in terms of the performance of our public hospitals system.

The Government's published hospital statistics show no evidence of progress towards achievement of any of the national targets agreed by the Council of Australian Governments (COAG) as part of health reform.

...CONTINUED ON PAGE 5

Health Panel for Asylum Seekers

The AMA last week welcomed the Australian Greens' announcement to introduce a Bill to establish an independent Expert Health Care Panel to oversee the health of asylum seekers and refugees in immigration detention.

AMA President Dr Steve Hambleton called for an Expert Panel at the AMA Parliamentary Dinner in Canberra last month, saying the Panel would "*add some humanity to an otherwise inhumane policy*".

Dr Hambleton urged all Parliamentarians to support the Greens' Bill.

"Indefinite detention has a serious mental health impact on detainees," Dr Hambleton said.

"The remoteness of Nauru and Manus Island for offshore processing will make effective health care delivery more difficult.

"Asylum seekers and refugees are at particular risk from a range of health conditions including psychological disorders such as post-traumatic stress disorder, anxiety depression, and the physical effects of persecution and torture.

"They also suffer poor dental hygiene, poor nutrition and diet, infectious diseases, and health problems associated with the general living conditions in detention facilities.

"Children especially are more vulnerable. Detention can cause serious harm to a child's development, particularly when there is ongoing exposure to traumatised adults.

"It is important that independent medical experts be allowed to inspect the health services and conditions in detention facilities and report back to the Parliament.

"The Bill being introduced by the Australian Greens must be supported by the Parliament to show the world that we are a compassionate society.

"The AMA would like to see the Expert Panel's responsibilities extend to inspecting and reporting on health services and conditions in onshore facilities as well," Dr Hambleton said.

The AMA believes that people who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay. Like all seeking health care, asylum seekers and refuges in Australia should be treated with compassion, respect, and dignity.

The AMA Position Statement on the Health Care of Asylum Seekers and Refugees is at http://ama.com.au/asylum-seekers

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GPs in Emergencies and Disasters

The AMA last week released two new Position Statements outlining the role of GPs in emergencies and natural disasters and how best to support GPs in these situations.

The ***AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012*** has been developed to help policymakers at all levels of government and medical practitioners across Australia be more aware of the issues involved in natural disaster planning and emergency management, and the role of GPs in these situations.

The ***AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012*** is aimed at helping those involved in planning the immediate recovery from a natural disaster or emergency to focus on the needs of general practices in the immediate aftermath of such events.

AMA President Dr Steve Hambleton said that GPs were at the forefront of providing care in a crisis.

"When a crisis hits and there are injuries, GPs and other doctors make themselves available to see their patients, patients not able to see their own doctors, backfill positions in hospitals, provide on-the-ground assistance in emergency locations and in emergency accommodation, and they treat the walking wounded – both the rescued and the rescuers," he said.

"We saw this recently in the Queensland floods and the Victorian bushfires.

"Despite this strong record of volunteerism, the role of GPs in emergency response situations is not well understood by governments, and GPs have not had enough input into disaster planning.

"The AMA would like to see a more formal process of involving GPs in planning for emergency or disaster situations.

"We also want to see coordinated planning to ensure that primary health care services remain active in the aftermath of disasters, including when GPs, their families, and their general practices are victims of natural disasters," Dr Hambleton said.

The ***AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012*** is at http://ama.com.au/node/8162

The ***AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012*** is at http://ama.com.au/node/8167

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

TO COMMENT CLICK HERE

Is the health reform landscape a barren plain?

...CONTINUED FROM PAGE 3

In relation to our public hospitals, the 2007 dream of health reform remains just that – a dream.

Despite an almost 10 per cent increase in recurrent expenditure on public hospitals, there has been no real change in the key performance measures for public hospitals. Bed numbers, waiting times in emergency departments and waiting times for elective surgery are basically unchanged and still a long way short of the COAG targets.

With insufficient inpatient bed capacity, these two targets work against each other. The broader public is beginning to understand this.

In the quarter ended June 2012, a record 132,366 people took out private hospital insurance (PHI), the largest quarterly increase since 2007.

While the full effect of the PHI changes may take longer to play out, this significant increase is a strong sign that many people see PHI as a value proposition. It also suggests a corresponding lack of confidence in the public hospital system.

We know that there is significant scope to improve patient care by strengthening the links between private hospitals and GPs.

In my discussions with private health insurers, it is clear that they all recognise this and, in order to decrease their fiscal risks, they are likely to try to influence this.

Discharge summaries play a critical role in ensuring safe and effective continuity of care for patients being discharged from hospital and have been shown to decrease readmission rates.

Discharge summaries need to be more timely (ie, sent to the patient's GP on the date of discharge) to ensure effective continuity of care; be of a standardised format and be interoperable; and include accurate and relevant information regarding the patient's admission, treatment and post-discharge care requirements.

The nature and pace of health reform has changed significantly since the 2010 election.

Having a minority Government has made a huge and understandable difference.

The growing number of State and Territory Coalition Governments has made COAG a very different – and far less tame – beast. COAG fights will become more frequent and more fierce.

Despite all the differences, all jurisdictions must realise that things cannot stay the same in health.

It won't be long before there is another round of major health reform, hopefully meaningful health reform. We need to be ready to influence any changes.

This is an edited extract from a speech Dr Hambleton gave at the Ramsay Health Care Conference on the Gold Coast on Wednesday 12 September 2012. The full text is available at http://ama.com.au/media/dr-hambleton-speech-ramsay-health-care-conference-12-september-2012

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AMA Interns Plan

The AMA has released its *Position Statement on National Intern Allocation.*

The AMA has been lobbying all Australian governments to address the intern shortage as a matter of urgency.

In 2013, there will be 3326 graduates of Australian medical schools competing for only 3091 currently available positions.

Following a recent meeting with Health Minister Tanya Plibersek, AMA President Dr Steve Hambleton said that the Federal Government had made intern places a priority issue to be sorted out with the States and Territories.

"The Minister assured me that the Federal Government is determined to resolve this issue," Dr Hambleton said.

"We are keen to help the Government achieve a favourable outcome, which will require the full cooperation of the States and Territories.

"We need a quick solution so that medical graduates have some certainty regarding their future and so we can continue to train the appropriate number of highly trained doctors to serve community needs.

"The AMA Position Statement sets out a way to improve the efficiency of intern allocation processes so that medical school graduates do not have to apply to multiple States or Territories for an intern place.

"Not only will this simplify the process for graduates, it will help address many of the weaknesses in the current system that result in duplication and delay the allocation of places.

"Our policy would provide greater certainty in the allocation of intern places, but it will not solve the expected shortage of intern training positions.

"The quick solution is to immediately expand the number of available intern places.

"If things do not change, many medical graduates will next year be unable to enter the medical workforce."

The *AMA Position Statement on National Intern Allocation* is at http://ama.com.au/node/7384

The Commonwealth has recognised the need for more doctors and, since 2004, medical student numbers have expanded dramatically. By 2016, there will be around 3970 medical graduates finishing medical school each year.

Unfortunately, no plan has been developed to ensure that there are enough prevocational and vocational training positions for these graduates once they leave medical school.

Health Workforce Australia predicts that, without changes, there will be a shortage of 451 specialist training positions in 2016.

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AMA offers career advice

The AMA has launched a new AMA Careers Advisory Service to assist young doctors as they set off on their medical careers, and to advise older doctors when they are changing their career direction or the location where they practise.

Stage 1 of the Service, launched last week, will be of particular benefit to medical students who are about to graduate, doctors in training, and international medical graduates working or hoping to work in Australia.

The Service provides practical assistance in producing a professional resumé, completing job applications, and preparing for job interviews.

Stage 2 of the Service, to be developed over the next six months, will concentrate on helping experienced medical practitioners take on new career challenges or move to new locations.

There is also a dedicated AMA Careers Advisory Website, which will be constantly modified and updated to meet the needs of doctors as they progress in their medical careers.

The AMA Careers Advisory Service provides information on:

- Medical institutions including medical schools, medical societies, and vocational colleges;
- Domestic and international medical graduate information on registration, employment, and immigration requirements;
- Resumés, job applications and cover letters, and interview skills assistance;
- Education and training information with links to medical colleges and State/Territory training institutes
- Doctors' health support services; and
- Career change opportunities.

The Service is available nationally and will be coordinated out of the offices of the AMA (ACT) in Canberra.

Further information is available from Kathryn Morgan, Careers Consultant, 02 6270 5410 or careers@ama.com.au

The AMA Careers Advisory Service website is at http://careers.ama.com.au

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INFORMATION FOR MEMBERS

Upcoming conferences

Suicide Prevention Conference

A key adviser to the United States military on suicide will be among the keynote speakers to address the annual Suicide Prevention Conference in October.

Dr Thomas Joiner, who is Director of the US Military Suicide Research Consortium and Professor in Psychology at Florida State University, headlines a group of speakers that includes Dr Jerry Read, Director of the National Suicide Prevention Centre in the United States, Edinburgh University Professor of Health Policy Stephen Platt and Jonathan Nicholas, chief executive of the Inspire Foundation.

The conference, organised by Suicide Prevention Australia, is being held at the Crowne Plaza Hotel, Coogee Beach, New South Wales, on 10-11 October.

For registration and further details, visit: www.suicidepreventionaust.org/conferences

Breast Cancer Congress

Australian healthcare professionals are invited to attend the Sydney International Breast Cancer Congress (SIBCC), the multidisciplinary Congress for breast cancer health, research, treatment and care in Australia.

This multidisciplinary congress hosts opportunity for Australian healthcare professionals to have the chance to learn and network with leading international cancer screening specialists and key collaborators. The conference is designed to offer comprehensive clinical sessions to address current issues across a variety of disciplines including surgery, radiation oncology, medical oncology, pathology, radiology, radiography and breast care nursing.

The conference is being held at the Sydney Convention and Exhibition Centre on 23-26 October 2012

For more information or to register, go to www.sydneybreastcancer2012.com

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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

Let kids have rough and tumble childhood: MPs, *Courier Mail*, 8 September 2012

Australian Medical Association President Dr Steve Hambleton said parents with clumsy kids need not fear being dobbed into welfare authorities

Be smart with diabetes, *The Daily Telegraph*, 8 September 2012

AMA President Dr Steve Hambleton said the blood glucose meter that hooks straight into an iPhone to record and manage a person's diabetes is the start of things to come.

Position shortage fix urged, *The Adelaide Advertiser,* 11 September 2012

The Australian Medical Association warned that next year there will be 3326 medical graduates competing for only 3091 intern positions.

Radio

Dr Hambleton, 2GB, Sydney, 3 September 2012

Sick leave costs have risen to $1b p.a. but experts say it would be worse if public servants turned up with the flu to work. AMA President Dr Steve Hambleton said those genuinely sick should stay home.

Dr Hambleton, 2GB, Sydney, 10 September 2012

AMA President Dr Steve Hambleton talks about a shortfall of doctors because there aren't enough internships available for them to train on the job. He met with Federal Health Minister Tanya Plibersek to talk about it and was assured that the Federal Government is determined to resolve the issue.

Dr Hambleton, MIX FM, Sydney, 11 September 2012

Research from the Australian Institute of Health and Welfare shows Australians are smoking less, but getting fatter and that most adults and children don't eat enough vegetables. Australian Medical Association President Dr Steve Hambleton says a lot of people will end up sick if they don't change their ways.

TV

Dr Hambleton, Channel 10, Brisbane 6 September 2012

AMA President Dr Steve Hambleton comments on new research that around 80 per cent of DNA once considered 'junk' is actually vital in keeping life going and controlling health.

AMSA

AMSA outraged by Coalition suggestion of increased student fees 6 September 2012

The Australian Medical Students' Association is deeply concerned by indications of Coalition support for university fee deregulation and Christopher Pyne's public statements affirming the Coalition's commitment to reintroduce Domestic Undergraduate Full Fee places if elected.

Time running out for internships: AMSA 12 September 2012

The Australian Medical Students' Association is calling for urgent action to create and fund additional internship places before time runs out.

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Indigenous medical student numbers grow

The number of Aboriginal and Torres Strait Islander people studying medicine has soared to a record high, in a sign of progress in efforts to boost the size of the Indigenous health workforce.

Figures released by the Medical Deans of Australia and New Zealand show that the proportion of first-year medical students who are of Aboriginal and Torres Strait Islander descent has swollen from 0.8 per cent in 2004 to 2.5 per cent this year – a level that matches their overall representation in the nation's population.

The AMA has long campaigned for a lift in the number of Aboriginal and Torres Strait Islanders studying and practicing medicine as an important part of measures to increase health services for Indigenous communities.

Almost a decade ago the Association began pushing for additional training places for Indigenous doctors, nurses and health workers, and in 2007 it called on governments to ensure that, by 2012, 2.4 per cent of all health professionals would be of Aboriginal or Torres Strait Islander background.

Reaching this goal seems a way off yet, despite the recent increase in the number of Indigenous students medicine.

Australian Indigenous Doctors' Association Chief Executive Officer Romlie Mokak said that, as at 2009, just 0.2 per cent of all medical practitioners were of Aboriginal or Torres Strait Islander descent.

Mr Mokak said that, in order to come close to population parity, there would need to be an immediate injection of 1200 Indigenous doctors into the health system.

While the increase in the number of Indigenous medical students is promising, educators warned that much work was needed to ensure as many as possible complete their studies and qualify as doctors.

To improve retention, the Indigenous Doctors' Association and the Medical Deans have entered into an agreement to ensure medical schools provide support for Aboriginal and Torres Strait Islander students.

"The rise in the number of Aboriginal and Torres Strait Islander medical students is a great way we can build the numbers of Aboriginal and Torres Strait Islander doctors," Indigenous Doctors' Association Student Director Dana Slape said. "It's important to ensure that these students can access appropriate cultural and academic support to graduate."

In a joint statement, the Association and Medical Deans said there needs to be "sustained and accelerated support from governments, education and health sectors to increase the recruitment, retention and completion rates of students, as well as work environments that encourage medical graduates to practice and specialise in their chosen field".

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New cholesterol targets for heart attack survivors

The Heart Foundation has set more aggressive LDL cholesterol targets that will affect treatment plans for heart attack patients, lowering the previous LDL target of 2.0mmol/L to 1.8mmol/L.

The Foundation's Clinical Director Dr Robert Grenfell warned that doctors would need to check whether or not patients' anti-cholesterol pills would have to be increased to meet the new targets.

"These new targets are not for healthy Australians," he said. "They are specifically for people who have already suffered a heart attack and are at high risk of a secondary event.

"The new cholesterol targets will impact on the way doctors treat the hundreds of thousands of Australians who have had a heart attack."

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Gen Ys flock to careers in general practice

Generation Ys are driven towards a career in general practice because of the work flexibility and work/life balance it offers, according to research commissioned by General Practice Registrars Australia.

The research examined how Gen Y medical students and recent graduates accessed medical information and how the information influenced their speciality choice. It found that almost one in five participants intended to pursue a career in general practice, most of them making the decision within the first three years of study.

Most participants saw a large number of advantages in choosing general practice as a specialty, including the flexibility, lifestyle, and sense of community it offered. The opportunity to undertake preventive medicine, managing whole-patient care, holistic medicine and the opportunity to get into global health also attracted Gen Y to the career path.

Although participants were attracted to a career as GPs, many expressed concern over the negative perceptions associated with the speciality, including general practice being a 'lesser' speciality and perceived as not as challenging as other specialties.

For the majority, a career as a rural GP overcame many of the negative perceptions, as the role was considered to be challenging and anyone working in this area was considered of high value to the medical community.

Gen Ys listed career and lifestyle as more important than money when it came to a choice in speciality, and most participants based their career decisions on their own or others' personal experience.

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INFORMATION FOR MEMBERS

Pathology and diagnostic imaging request form changes

New laws affecting information that must be provided to patients on pathology and diagnostic imaging request forms have come into effect.

All branded request forms must include a patient advisory statement, which informs patients that they are free to take their referral to a provider of their choice.

The information required is different depending on whether the request form is for a pathology service or a diagnostic imaging service.

Diagnostic imaging request forms

- All branded diagnostic imaging request forms produced and distributed must include a statement advising patients that they are free to take their referral to a diagnostic imaging provider of their choice.
- The wording, formatting and positioning of the statement will be at the discretion of the provider but must be obviously positioned to ensure the patient has a reasonable likelihood of noticing and being able to read the advice.

Pathology request forms

- All branded pathology request forms must include the following mandatory statement: *Your doctor has recommended that you use [insert name of pathology provider]. You are free to choose your own pathology provider. However if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.*
- An alternative statement may be used that is the same as above but where the word 'doctor' is replaced with 'treating practitioner'.

In all cases, it will be an offence for pathology and diagnostic imaging providers to produce or distribute branded request forms that do not contain a patient advisory statement.

However, patients who present branded request forms without the patient advisory statement will still be eligible for a Medicare rebate. This recognises that old forms may remain in the system for some time and providers can only control the distribution of new forms.

It is important that pathology and diagnostic imaging service providers ensure they have up-to-date business and after hours contact details for medical practitioners in their region, not just those in their usual catchment area, in case critical results need to be communicated urgently.

TO COMMENT CLICK HERE

Doctors more likely to be deregistered for character flaws

Doctors are more likely to be banned from practice for having a sexual relationship with a patient than for misdiagnosing, breaching patient confidentiality or performing a wrong operation, according to a study by researchers at The University of Melbourne.

They have found that Australian and New Zealand medical tribunals tend to deregister or remove doctors for character flaws and lack of insight rather than for errors in care or poor clinical knowledge.

They analysed 485 population misconduct cases over 10 years in Australia and New Zealand in which doctors were found guilty. Of the 79 cases in which doctors were guilty of a sexual relationship with a patient, 64 were removed from practice.

While the study found that it was more common for doctors to be found guilty for inappropriate or inadequate treatment, those doctors were less likely to be removed from practice.

The researchers suggested that this might be the case as "dysfunctional behaviours and clear signs of bad character may be perceived as relatively untreatable", while a lack of knowledge or problems in the work environment might seem easier to correct.

The researchers said that tribunals tended to dismiss the idea that patient consent had any weight, given the doctor/patient power imbalance.

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Adverse reactions to medicines now available at a click of the finger

Information on adverse drug reactions will now be more accessible to both consumers and health professionals through the aid of an online database organised by the Therapeutic Goods Administration.

The TGA has unveiled an online database containing information on the adverse drug reactions reported to it since 1971.

The database includes adverse event reports about prescription medicines, over-the-counter medicines sold in pharmacies and supermarkets, as well as complementary medicines such as vitamins and herbal remedies.

Users are able to search the database by the name of a medicine to find out commonly reported adverse events to a particular medicine and de-identified reports about affected patient, including information on other medicines they were taking and the reaction/s they experienced.

The Consumers Health Forum of Australia praised the move, saying that consumers would benefit from the increased transparency and earlier access to information of adverse drug reactions.

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Medical Officers / GP's

(Remote Area)

NGANAMPA HEALTH COUNCIL

Are you a **General Medical Practitioner** or **Medical Officer** looking for a new challenge in a stunning Australian outback location? Full time roles available or Locum if desired!

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In addition, you will receive a **highly attractive salary package of $320,000 ($280,000 cash benefits, $40,000 other benefits)**, negotiable with experience and qualifications including super and **flexible salary packaging arrangements** and a range of further benefits, including:

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* **2 weeks study leave** in order to plan and develop your career;
* **Full support** from the health team; and
* **Relocation costs assisted.**

www.nganampahealth.applynow.net.au

If you have any further questions phone 1300 366 573.

The basics of Twitter

What is Twitter?

Twitter is a real-time information network that connects you to the latest stories, ideas, opinions and news that you find interesting. Follow accounts that you find the most compelling and monitor the conversations.

Tweets

Twitter displays small bursts of information via Tweets. Each Tweet is 140 characters long so you need to be creative with what information you share. You can share and see photos, videos and conversations in Tweets or get the low down on a whole story with a glance.

How to sign up to Twitter

1. Go to http://twitter.com and click on the sign up box, or go directly to https://twitter.com/signup.
2. Enter your full name, email address, and a password.
3. Click Sign up for Twitter.
4. On the next page, you can select a username (usernames are unique identifiers on Twitter) — type your own or choose one Twitter suggests. Twitter will let you know if your username is already in use.
5. Double-check your name, email address, password, and username.
6. Click Create my account.
7. Twitter will send a confirmation email to the address you entered on sign up, click the link in that email to confirm your email address and account.

Tips for picking a username:

- Your username is the name your followers use when sending @replies, mentions, and direct messages.
- It will also form the URL of your Twitter profile page.
- Please note: You can change your username in your account settings at any time, as long as the new username is not already in use.
- Usernames must be fewer than 15 characters in length and cannot contain "admin" or "Twitter", in order to avoid brand confusion.

First steps after you've created your account:

1. After signing up, follow a handful of accounts to create a customised stream of information on your homepage. Following means you'll get that user's Tweets on your Twitter homepage. You can unfollow anyone at any time. Find out how to follow news sources, friends, and more at https://support.twitter.com/articles/15355-how-to-unfollow-users-on-twitter
2. Read the Twitter 101 article. It explains lots of handy tips and tricks to help you get started. https://support.twitter.com/articles/215585-twitter-101-how-should-i-get-started-using-twitter
3. Take the Twitter Tour https://support.twitter.com/groups/40-twitter-tour/topics/181-twitter-tutorial/articles/20169519-twitter-tour-let-us-show-you-around# to find out where things are on the website. Or, learn about using Twitter on your mobile phone https://support.twitter.com/groups/34-apps-sms-and-mobile#

Twitter Glossary

Twitter users use symbols and abbreviations to talk to each other. Listed below is some of the most commonly used Twitter language.

1. **@Replies**
   If a message begins with @username, meaning it was directed to another user, it is an @reply. Click the Reply button on another person's Tweet to reply to it. Please note that if your Tweets are protected, users who are not following you will not see your @ replies or mentions.
2. **Direct messages**
   Direct messages are personal messages sent from one Twitter account to another; they do not appear in public for anyone else to read. You can only send a direct message to a person who follows you.
3. **Retweet (RT)**
   A retweet is a re-posting of someone else's Tweet. Twitter's retweet feature helps you and others quickly share that Tweet with all of your followers. Sometimes people type RT at the beginning of a Tweet to indicate that they are re-posting someone else's content. This isn't an official Twitter command or feature, but signifies that they are quoting another user's Tweet and also allows the user to comment on the Tweet.
4. **Hashtags ("#" Symbols)**
   The # symbol, called a hashtag, is used to mark keywords or topics in a Tweet. Twitter users originally created it as a way to categorise messages.

- People use the hashtag symbol # before a relevant keyword or phrase (no spaces) in their Tweet to categorise those Tweets and help them show more easily in Twitter Search.
- Clicking on a hashtagged word in any message shows you all other Tweets marked with that keyword..
- Hashtags can occur anywhere in the Tweet – at the beginning, middle, or end.
- Hashtagged words that become very popular are often Trending Topics.

For more Twitter terms go to https://support.twitter.com/groups/31-twitter-basics/topics/104-welcome-to-twitter-support/articles/166337-the-twitter-glossary#

Don't forget to follow the AMA on your Twitter account to keep up to date with the latest policy and AMA news.

Follow the AMA President on Twitter @ http://twitter.com/amapresident

Follow the AMA on Twitter @ http://twitter.com/ama_media

Follow *Australian Medicine* on Twitter @ https://twitter.com/amaausmed

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NOTICE TO MEMBERS

Reminder to renew AHPRA registration by 30 September 2012

The AMA reminds all members to renew their medical registration by 30 September 2012.

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

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

There are four things you can do to prepare for your renewal:

- **CHECK YOUR REGISTRATION EXPIRY DATE:** You can check the online National Register at www.medicalboard.gov.au to confirm when your registration is due to expire and check your details.
- **UPDATE AHPRA WITH YOUR EMAIL ADDRESS YOUR CONTACT DETAILS:** Make sure your contact details, including your email address, are correct and current. This will allow AHPRA to send you email renewal reminders and to contact you if necessary. If you have your User ID, go online at www.ahpra.gov.au, click online services and follow the prompts to update your contact details. If you do not have your User ID, complete an online enquiry form, selecting 'User ID' as the category of enquiry or by calling 1300 419 495.
- **WATCH FOR THE REMINDER TO RENEW:** A reminder to renew registration will be sent to each practitioner up to eight weeks before registration expires. Set your email account to receive communications from AHPRA and the Medical Board to avoid misdirection to an account junk box.
- **RENEW ONLINE, ON TIME:** The quickest and easiest way to renew your registration is online. Make sure you renew on time because under the National Law there is no option for AHPRA or the Medical Board to renew your registration after it has lapsed without a new application.

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

- Should you fail to lodge your application to renew by 30 September, there is a late payment period during the month of October.
- If you lodge your application to renew during the late payment period ending 31 October, you will pay a late fee of $170 in addition to the renewal fee of $680.
- If you fail to lodge your application to renew your registration during the late payment period, your registration will automatically lapse from 1 November.
- Once your registration has lapsed, you will have until 30 November to apply to AHPRA for a fast-track application for re-registration at the cost of $340, in addition to the registration fee of $680. If you apply through the fast-track process AHPRA processes, most applications within 48 hours of receiving a completed application. Applications that include adverse declarations can take longer.
- If you fail to re-register through the fast-track process by 30 November, you will have to apply for new registration and only pay the registration fee of $680. AHPRA will process your application as a new registrant within the usual timeframe of up to 90 days.
- Should your registration lapse, you will not be able to practice until your registration application has been granted.

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Medicare Locals and After Hours – a Field of Dreams?

BY **DR BRIAN MORTON**

"The superficial way in which some concerns have been addressed suggested that some elements of the new funding arrangements for after hours care were based more on hope than evidence, concrete commitments and plans"

The last meeting of the After Hours Technical Working Group (AHTWG) was held recently and it was a disheartening and frustrating occasion. The stakeholder representatives, such as the AMA, have been able to ensure appropriate instructions and guiding principles for Medicare Locals to follow in taking over responsibility for coordinating access to after-hours GP care, but concerns remain about the future of after hours care.

The superficial way in which some concerns have been addressed suggested that some elements of the new funding arrangements for after-hours care were based more on hope than evidence, concrete commitments and plans. The "if you build it, they will come" approach from the movie Field of Dreams seems to apply - driven to some extent by the political imperative to deliver something, anything, regardless of its quality.

One of the biggest concerns for general practices is whether or not they will continue to be supported to provide access to after-hours services. The AMA has stressed the need to preserve and support services that are working effectively.

GPs need to know what their Medicare Local intends to do to support them to maintain existing services to ensure that the after-hours needs of the community are met. Medicare Locals need to be talking to GPs right now to ensure that arrangements are in place on 1 July 2013 when the PIP funding for after hours ceases. From this point on, Medicare Locals will take over the administration of after-hours funding and general practices need urgent clarity about what they can expect. They need to know if the funding will be there to help them continue to provide after-hours care.

For some Medicare Locals, the time frame between now and 1 July next year will be daunting considering that 24 of them were not even established until 1 July this year. Will they have the capacity to make the necessary preparations in time? The risk for all Medicare Locals is that practices may decide that after-hours services are no longer sustainable. It is a prospect that is all too likely if Medicare Locals don't take steps now to work with practices on the way ahead and to inform them of their funding intentions.

The After Hours Primary Care Program will of course be evaluated, although it will be some time before the evaluation is completed and the findings known. The AMA expects to be consulted as part of this process.

With the guidelines for funding and implementing after-hours arrangements having now been finalised, the ball is now clearly in the Medicare Locals court. From my discussions with GPs to date, most have heard nothing on this topic from their Medical Local and most feel completely in the dark.

If your Medicare Local has not contacted you yet regarding after-hours service provision, initiate a conversation. Let us know at generalpractice@ama.com.au how you found the experience. Did they understand the issues, outline their intentions and indicate what support would be available?

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Plaudits and apologies

BY **DR DAVID RIVETT**

"This was a foolish scheme from its inception and the AMA told the government of the day so. Hopefully, the proposed new scheme will direct taxpayer dollars where they are most needed. Our nation's dental health deserves better accessibility to and affordability of care"

Firstly a loud Hooray for the termination of the current MBS Dental Benefits Scheme. Its demise cannot come swiftly enough. This program has been a real burden for GPs, with patients often supported by family members, aggressively demanding dental funding and bullying GPs to acquiesce. Some standouts were:

1. A young lady referred by a Centrelink official allegedly suffering depression and directed to tell me that 'whitening' her teeth would dramatically cure her depression. When I said "no way does this meet the criteria", I had an irate patient and later an abusive Centrelink worker on the phone.
2. An elderly diabetic referred for dental care under the scheme to improve her nutrition coming back two weeks later with receipts for the full $4,000-plus of care for a couple of fillings and some descaling work.

This was a foolish scheme from its inception and the AMA told the Government of the day so. Hopefully, the proposed new scheme will direct taxpayer dollars where they are most needed. Our nation's dental health deserves better accessibility to and affordability of care.

Secondly, it is pleasing to see some solid and sound recommendations from the Senate Report *Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas*; in particular, that ASGC-RA must be replaced, the acceptance that rural generalist training is a lynchpin for any future workforce solutions, and that IMG registration and accreditation must be simplified. Hopefully, government will now act swiftly to address these issues.

I am in the process of employing an "area of need" doctor, having failed to attract applications to work in beautiful Batemans Bay from our own workforce. The whole process is way too slow and user unfriendly, with loads of red tape. The limitation restricting practices to the employment of a single doctor immediately rules out those multiple husband-and-wife teams of medicos applying, which is extremely dumb as both spousal satisfaction and employment, are always at the top of the list of factors impacting on retention of rural doctors.

I was contacted by the RDA NSW following my comments in the last edition of *Australian Medicine*. After discussing the issues with Dr Paul Mara, I realise I was a bit hasty in my comments about the negotiations around the RDA NSW Settlement Package. I am happy to withdraw my comments, as I understand the work that has gone into the negotiation of the new arrangements and the efforts RDA NSW are putting in to dealing with any outlying items for specialists or GPs.

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Removing the barriers to Indigenous health - strategies to improve access

BY **DR STEVE HAMBLETON**

"Appropriate access to primary health care can narrow the life expectancy gap, and may also offset some of the harmful health effects of socio-economic disadvantage and inequality"

A major cause of the high rates of illness and premature death among Aboriginal peoples and Torres Strait Islanders is the fact that they do not access primary health care at a rate appropriate to their needs. The AMA is working to address this issue in its advisory role to the Commonwealth Government's development of a National Health Equality Plan for Aboriginal people and Torres Strait Islanders.

There are many respects in which access does not match need. For example, the use of Medicare and subsidised medicines through the PBS is markedly lower for Aboriginal peoples and Torres Strait Islanders, with total expenditure being approximately 35 per cent less and 56 per cent less per capita respectively, than for other Australians. The use of MBS Aboriginal and Torres Strait Islander Health Assessment items is also low, despite the opportunities for health improvements that they offer. It has been estimated that fewer than 12 per cent of eligible Aboriginal people and Torres Strait Islanders receive these assessments. There are also low rates of access to specialist follow-up medical care when it is needed.

Appropriate access to primary health care can narrow the life expectancy gap, and may also offset some of the harmful health effects of socio-economic disadvantage and inequality. There are many barriers to these benefits, however, including the limited geographical availability of primary care services in many areas, problems in ensuring their cultural acceptability and, sometimes, the affordability of services.

To overcome these barriers, the AMA is making the following case to the Government.

High quality culturally safe care is important for increased rates of access. This can be enhanced through:

- reviewing the funding arrangements for Aboriginal community-controlled health services (ACCHSs) to allow them to provide a core set of primary care services to patients, including providing outreach services and community visiting in both urban and rural/remote areas, and provision of patient transport where necessary, and
- funding existing or proposed non-community-controlled Indigenous specific health centres to enable provision of a core set of primary care services, outreach services, and provision of patient transport where necessary.

Linking and coordinating services are important to maintaining quality and continuity of care, including:

- supporting regionalised models of service delivery (particularly in regional and remote locations), where a large service in a regional centre can support and coordinate services in surrounding communities (community-controlled and mainstream), and
- linking private general practices and mainstream health centres that provide significant level of services to Aboriginal people to Aboriginal community-controlled services. This can be sponsored through funding arrangements between DoHA and Medicare Locals that facilitate systematic engagement between ACCHSs and mainstream services in Medicare Local regions (where the former can provide guidance where necessary).

With these strategies in place, and fully funded for the long term, we can expect changes in health access and outcomes for Aboriginal peoples and Torres Strait Islanders.

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AMA Aged Care Survey

BY **DR PETER FORD**

Obligation, rather than enjoyment or remuneration, is keeping AMA members in aged care services, the *AMA Aged Care Survey* has discovered.

Using a confidential online survey in July 2012, the AMA consulted members on their experiences in providing medical care to older Australians. The survey, repeating a survey undertaken in 2008, will inform AMA policy and lobbying for medical services for older Australians.

Check box questions and free text sections were included in the survey. The result is a clear picture of members' major concerns enriched by comments about their frustrations and challenges experienced.

Very little has changed in the demographic profile over the last four years. Members who attend residential aged care facilities (RACFs) tend to be older (91 per cent over 40, compared to 94 per cent in 2008) and are more likely to be male (74 per cent; 72 per cent in 2008 - only 59 per cent of GPs are male nationwide). Nearly three in four men stated that they attended RACFs, while just over half of women stated the same. A surprising result was that there was a link between retention and gender. More than a quarter of women who currently attended RACFs were likely to reduce or stop attending in the next two years (compared to fewer than a fifth for men). These results provide an opportunity to discover what might improve the retention rate of female doctors working in RACFs.

Women who attended RAFCs in the past but no longer do were very consistent in their reasons for why: a change in the scope of their practice. Despite this, the written responses portray a range of frustrations:

- 'I am over wrecking my life trying to be all things to all people',
- 'I became increasingly frustrated when agency staff were in charge, with no knowledge of my patients, or why I had been called,' and
- 'I am a mum and work school hours'.

Men who stopped attending were less consistent in their reasons, but quite a number noted the increasing red tape and paperwork:

- 'in the latter years I started to spend more time filling in forms and very trivial incident reports and less time seeing patients', and
- 'increased red tape, phone calls and irrelevant paper work to cover the nursing homes' insurance premiums'.

Meanwhile, those who did attend were mostly doing so out of a sense of obligation. Where 84 per cent of people who increased the amount of visits to RACFs were motivated by obligation, only 53 per cent increased their visits because of enjoyment.

The most cited reasons for a reduction in visits to RACFs was an increase in the amount of unpaid non face-to-face time (83 per cent) and the inadequate patient rebates to cover the lost time in surgery (79 per cent). Respondents estimated that, on average per visit, more than an hour and a half was lost in surgery time to visit RACFs.

Across the range of responses, many highlighted frustrations and poor perception of aged care work, while others reported positive experiences and the emotional aspect of the work:

- 'financial remuneration is only part of it. Job satisfaction is more important',
- 'I look after my old patients who go to Aged Care Facilties because I know them already',
- 'I feel obliged to support RACF as a medical practitioner. We have to give some incentive for others to do so, especially younger GPs',
- 'aged care work has low status and poor perceptions in the profession' and
- 'I lost a 91 year old nursing home resident this early morning ... a big, emotional loss as we had built a good rapport since she moved into the nursing home seven years ago'.

The survey also sought feedback on what should be improved and the responses were consistent for both those who attended RACFs and those who did not. The number one issue was increasing the MBS rebate to properly compensate doctors for time away from the surgery. Both groups also stressed the importance of medical practitioners being able to authorise access for their patients to government-subsidised respite care in emergency circumstances.

The results support findings from other surveys. In December 2011, the AMA Red Tape Survey found that 62 per cent of GPs agreed that completing duplicate scripts for residents in residential aged care facilities was creating too much red tape. The results also align with the earlier Catholic Health Australia April 2010 *Survey of Access to General Practice Services in Residential Aged Care*. CHA's survey also revealed some of the consequences of being unable to attract and retain GPs to RACFs: increased referrals to emergency wards, and increased disruption to continuity of care.

The AMA thanks members who contributed their time to complete the survey.

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Volunteering for our education

BY **DEPUTY CHAIR ROSS ROBERTS-THOMSON**

"We need to be prepared for the future, and volunteering in poor communities both in Australia and overseas can give trainees crucial experience to help them in their future practice"

For years, one of the highlights of medical school has been the elective term. Travelling to developing countries, students get a taste of a different health care landscape and, as a consequence, wish to pursue this interest as junior doctors. Further, diseases are becoming increasingly less confined by geographical boundary, as demonstrated by 'airport malaria'. Given this, clinical exposure to infectious diseases previously rare in western countries can only be beneficial in the 21st Century. Beyond medical school, options for vocational training in the developing world are severely limited and many argue that this should be improved to provide trainees with exposure to a broader range of pathology to equip them for the future.

The AMA Council of Doctors in Training has long been pushing for colleges to accredit advanced trainees undertaking training in developing countries. The caveat is that sufficient support is provided and that the placement benefits the local community. RANZCOG has been one such college considering facilitating this, and others are looking to follow.

Outside of medicine, AusAid runs the Australian Youth Ambassador for Development (AYAD) program, supporting skilled young Australians to volunteer in the Asia-Pacific region to work in developing countries for between three and twelve months. Various health disciplines are included but, unfortunately, placements in clinical medicine are non-existent at present. Junior doctors keen for this exposure have been undertaking health promotion placements. In one such example, one junior doctor recently returned from Cambodia after running an HIV education program. Apart from the clear issues with interruption of training, many other junior doctors perceive significant barriers to volunteering in both Australian and overseas settings, despite their eagerness to do so.

Future Health Leaders (FHL) is a recently established organisation that helps to link students and early-career health professionals with existing volunteer programs and initiatives in Australia and overseas. CDT has become part of the FHL stakeholder forums, which include student and early-career representative organisations across health science disciplines. This is also a great advocacy avenue for the AMA to push training issues as well as broader public health advocacy.

The FHL Conference held recently in Adelaide illustrated many of the important health changes that we will likely see in the future. These include the rise in chronic disease, change in infectious disease patterns and resistance, as well as the increasingly migratory health workforce. We need to be prepared for the future, and volunteering in poor communities both in Australia and overseas can give trainees crucial experience to help them in their future practice.

Vocational medical education needs to change. To confine doctors to restricted geographical areas for the vast majority of their vocational training is to limit their opportunities and experience, and not in their best interests or that of their future patients.

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HEALTH ON THE HILL

Asbestos control push hits snag

The Federal Government could face a battle in its push to establish a national agency to oversee the removal of deadly asbestos material from government and commercial buildings by 2030.

The Coalition has pledged bipartisan support for the development of a national plan for the management and removal of asbestos, but has baulked at committing itself to the Government's goal to set up a Commonwealth body to oversee the work.

The establishment of a national agency with responsibility to implement, refine and review a National Strategic Plan for Asbestos Awareness and Management was the key recommendation of the Government's Asbestos Management Review.

The 18-month Review, which was supported by an expert advisory group, warned that although the use of asbestos had been banned since 2003 the material was nonetheless prevalent in houses, factories and office buildings throughout the country, posing a potentially lethal threat to tradesmen, renovators and construction workers.

"Dealing with Australia's asbestos legacy requires a national and systematic approach," the Review said.

It called for governments at all levels to agree on the development of a National Strategic Plan to coordinate the identification and removal of asbestos in government and commercial buildings by 2030, as well as establish a national system to determine and disclose the existence of asbestos in houses to workers, potential purchasers and tenants.

In order to administer the Plan, the Review recommended that "the Australian Government support and legislate for the establishment of a new national agency to have responsibility for the implementation, review, refinement and further development" of it.

Workplace Relations Minister Bill Shorten has thrown his support behind the Review's findings, describing asbestos as an "implacable grim reaper".

In a statement to Parliament last month, Mr Shorten said Australia had the highest reported per capita instance of asbestos-related disease in the world.

The Minister said 642 people died from mesothelioma in 2010, and it was estimated that between 30,000 and 40,000 would be diagnosed with asbestos-related disease in the next 20 years, including adults who had been exposed to asbestos dust as children, home renovators, construction workers and mechanics.

"Due to extensive asbestos use throughout the country, and incubation periods of up to 50 years or more, the sad reality is that Australians will continue to contract and die from asbestos-related diseases for many years to come," Mr Shorten said. "There are huge amounts of asbestos in the built environment, and the greatest risk to Australians is the risk of exposure to home renovators, tradespeople and demolition workers."

He added: "more than 650 Australians are diagnosed with mesothelioma every year and experts predicts that this rate will not taper off until 2022."

Shadow Workplace Relations Minister, Senator Eric Abetz, told ABC Radio that, while the Opposition supported the development of the National Strategic Plan, it was wary about the creation of national agency to oversee the process.

"In relation to a new bureaucracy, we do [already] have Safe Work Australia, we do have established bureaucracies, so I'm somewhat agnostic about establishing a new bureaucracy, which could potentially cost more money," he told ABC Radio.

Earlier, Senator Abetz had told Parliament the Opposition would support Government action to reduce the asbestos threat.

"The Coalition is looking at the recommendations carefully, [and] I wrote to Mr Shorten on 16 August indicating that it is the Coalition's view that the issues raised in the review should be dealt with in a bipartisan manner," the Senator said.

"Now that we are fully aware of all the dangers of asbestos, and the effects that it has on people exposed to it, it makes good sense for all sides of politics, for unions and employers, to join together to try to overcome the legacy issues that are clearly out there.

"As a country, we should try to ensure that no new cases or new exposures occur, [and] commit the Coalition to a bipartisan approach on this important issue."

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More Than Just A Union – a history of the AMA

In the fourth instalment of our series of excerpts from a history of the AMA, *More Than Just A Union: A History of the AMA*, we feature former Presidents Dr David Brand and Professor Kerryn Phelps, who led the organisation from 1998 through to 2003 – a period of aggressive politics, both internally and externally.

It was an era that saw the introduction of the Private Health Insurance Rebate, the Relative Value Study (RVS), the medical indemnity crisis, and a broader public health agenda for the AMA.

AMA President Dr Steve Hambleton launched the history during a nationally televised speech to the National Press Club on 18 July.

The publication, which can be viewed at http://ama.com.au/a-history-of-the-ama, is considered by the AMA to be very much a work in progress, and invites contributions from members past and present.

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Engaging with Government

BY **DR DAVID BRAND, AMA PRESIDENT 1998-2000**

While my Presidency lasted from 1998 to 2000, my active involvement with the AMA began in 1990. It was 10 turbulent years.

For General Practice, it saw the introduction of the Vocational Registrar (an important step in the formal recognition of General Practice as a specialty), the Practice Incentive Program (the first non-fee-for-service Government remuneration for General Practices), financial incentives for performing and recording vaccinations (a highly successful public health program) and the formation of Divisions of General Practice (later GP Networks and now Medicare Locals).

Private health insurance and concerns about US-style managed care were major issues for privately practising specialists. The term of my Presidency saw the introduction of the Private Health Insurance Rebate - hard fought for, and no certainty to succeed in a Senate where the Liberal Government did not have the balance of power. No-gap private health insurance products were also introduced, under which the majority of private hospital services are now provided.

And ticking away in the background was the probably always ill-fated Relative Value Study. This was a process that involved countless hours from doctors and consultants, the political management of which was like trying to keep chunks of fissile material apart before they came together in a supercritical mass to blow the profession apart.

These were interesting times indeed.

Not all of these changes were supported by the AMA, but many were. Some of those we opposed were introduced anyway with the support of other medical groups.

As the Government moved ahead, I believed the AMA was faced with a clear choice. Either get on the playing field and engage the Government and try to slow or redirect some of these changes, or remain a noisy spectator shouting insults at the referee but not changing the course of the game.

Not all AMA members agreed with that course of action. Despite widespread consultations, sections of the profession continued to oppose engagement and change.

In addressing that discontent, it is important to understand there was a clear mandate.

I did not become President by accident or subterfuge. My view on how we should proceed was put at Federal Councils and National Conferences and was my consistent platform. Every time I stood for an elected position in the AMA it was contested, giving those who voted a clear choice between my approach and that of the opposition. That culminated in 1998 when I became Federal President, defeating the incumbent. That win stemmed at least in part from a desire by

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National Conference to engage the Government.

That engagement was always underpinned by the AMA's basic principles – the professional freedom to always provide care in the best interests of our patients, and the right to charge a fair and reasonable fee independent of any government or private health insurer's interference.

Despite the consultation and re-election of the Executive at National Conference, the opposition continued. After being challenged to put up or shut up, those opposed to our approach sought to remove the entire executive at an Extraordinary General Meeting (EGM) of AMA members. Two EGMs later the Executive, already elected by National Conference, was endorsed by the full membership.

They were turbulent times and I could not have survived without the support of my Executive, Federal Council and, perhaps importantly for my sanity, the unwavering support of my family.

Perhaps time has dulled my memory but, despite the upheavals and the near total destruction of my solo general practice caused by constant absences, it was a great time to lead a great organisation.

In 1993, the then Prime Minister, Paul Keating, described the AMA as "The greedy doctors who are represented by the most rapacious union boss in the country". In 2006, in the last survey of Federal politicians' lobbying preferences, the politicians voted the AMA the top Canberra-based lobby group.

If I was part of leading the AMA from where it was in 1993 to the respect it enjoyed in 2006, and I believe it enjoys still, then all the elections and all the EGMs were worth it.

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Informing the public

BY **PROFESSOR KERRYN PHELPS, AMA PRESIDENT 2000-2003**

I came to the AMA Presidency at the turn of the century - 2000 was a fortuitous time in Australian medical politics. The medico-political landscape was tough, divided and complex.

The big issue of the time was the medical indemnity crisis. We were at risk of losing entire specialties like obstetrics and neurosurgery. Procedural specialties would have become uninsurable and unaffordable. Major indemnity providers were at risk of imminent bankruptcy.

Yet we were faced with a Health Minister who did not want to know about it.

Blocked by the Minister, Michael Wooldridge, we had to find a way to get the government's attention. The public picture was one of a bitter feud, but in fact I just needed to get the government's attention focused on this issue.

We engaged every member of both houses of parliament, until the Prime Minister John Howard eventually became convinced that this was an issue of national importance. Working directly with his office, and through a taskforce involving every state and territory government, we forged a long term solution through scaffolding of the existing system and tort law reform to reduce the level of litigation that was plaguing the effective delivery of medical services.

The national momentum for reform commenced with an AMA survey of obstetricians and gynaecologists in February 2001 that revealed that at least a quarter of trainees would not continue obstetrics because of the fear and cost of litigation.

This gave the AMA some palpable political capital that was used in a letter writing campaign to all Federal politicians from the Prime Minister down, accompanied by a broad grassroots media campaign aimed at every electorate.

The campaign grew and grew throughout the year, building public support and political concern, until the Prime Minister announced a national summit to take place in April 2002.

The AMA convinced the Government to put in place a $35 million guarantee to keep key medical insurer, UMP, viable.

In October 2002, the Prime Minister announced a medical indemnity rescue package with guarantees extended a further 12 months.

Work began on tort law reform and a solution to the unfunded incurred but not reported (IBNR) claims – otherwise known as 'the tail' – was nutted out.

The concept of a long term care scheme for the severely injured – the precursor to today's National Disability Insurance Scheme (NDIS) – also came out of this period of frenetic activity.

In May 2003 at the end of term as President, I awarded my AMA President's Award to the members of the AMA Medical Professional Indemnity Taskforce for the support they gave me in achieving such a significant victory for AMA members and the profession.

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A HISTORY OF THE AMA

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My successor, Dr Bill Glasson, a member of the Taskforce, carried on the good work to ensure that all the Government promises and commitments were in legislation by the end of 2003.

I had worked on medical indemnity at various levels at both the AMA NSW and Federal AMA for the best part of eight years.

Medical indemnity was a big part of my Presidency, but not all.

One of the things I sought to do as AMA President was to inform the Australian people about their health system…how it worked, where it was successful, where it fell short of reasonable expectations.

The Australian public became, through the media and directly through their doctors, a far more informed participant in the Medicare debate than they had ever been.

What resulted was a more sophisticated understanding of how health funding and bulk-billing work, who ultimately pays and why doctors were so concerned about the level of funding failing to keep up with a growing aging population.

No longer could governments of any persuasion get away with the old "greedy doctor" argument.

When I became AMA president, we were being told there was an oversupply of doctors, yet this was at odds with our information from our members and from the public. We commissioned our own modeling and were able to demonstrate that the workforce figures were wrong.

In fact there was an undersupply in critical specialties like general practice. We were able to convince the government to change the way they assessed the medical workforce to plan more appropriately for the needs of the future.

The government could no longer use a mythical "oversupply" as an excuse for draconian or inappropriate workforce policies.

We took the message beyond the major centres to rural and remote parts of Australia.

We were also perennially frustrated with the cost-shifting games being played by successive State and Federal governments, so I coined the term "blame-shifting" to focus attention on the way different levels of government attempted to foist responsibility for health funding shortfalls onto the other level of government. That is still unresolved.

Along with the battles about health funding, workforce supply and tort law reform, I was determined to pursue a parallel public health agenda.

The Australian medical profession has a long and proud history of advocacy for public health, and the AMA was ideally positioned to contribute. During my Presidency, the AMA team:

- developed a position statement on Climate Change and Human health
- developed a position statement on complementary medicine
- addressed the issue of preparedness for bioterrorism
- created the indigenous health report card
- developed a position statement on sexual diversity and gender identity
- worked to improve the occupational health and safety of young doctors with the Safe Hours Project.

While we worked closely with government on a raft of major issues, we also kept up the pressure with a unified message and a sophisticated media campaign of constructive commentary, positioning the AMA as the powerful independent voice of the medical profession that the AMA must be.

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RESEARCH

Breakthrough stem cell treatment has restored feeling to paralysed patients

Two clinical trial patients paralysed with a spinal cord injury have regained some sensation after undergoing breakthrough stem cell treatment in a trial conducted by researchers at the University of Zurich.

Three patients were involved in the trial. All participants suffered injury to their thoracic spinal cord, which left them with no function or feeling below the injury.

The researchers injected the three patients with neural stem cells. After six months of treatment, two of the participants regained some sensation in their chest and abdomen. The treatment was conducted four to nine months after the participants' injuries.

The two participants who regained feeling can feel heat and electrical and touch stimuli. The reappearance of sensation was deemed "rather unexpected" by lead researcher Dr Armin Curt.

"We are very intrigued to see that two of the three patients have gained considerable sensory function," Dr Curt said.

"The gains in sensation have evolved in a progressive pattern below the level of injury and are unanticipated in spinal cord injury patients with this severity of injury, suggesting that the neural stem cells are having a beneficial clinical effect."

The study was met with enthusiasm at a meeting of the International Spinal Cord Society in London, though one scientist warned that three per cent of spinal patients can show spontaneous improvement in the months following injury and said that the study should extend to patients who had been injured for a longer period prior to treatment to achieve accurate results.

The three patients are the first of a dozen scheduled for the treatment.

The stem cells used in the trial were harvested from donated fatal brain tissue.

KW

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Workers shun compensation for psychological harm

Australians are much less likely to claim workers' compensation for treatment of psychological illnesses than for physical injuries, a study of general practitioner consultations shows.

A review of more than 486,000 GP visits found that 22 per cent of workers refused to make compensation claims even though their GP had determined that their psychological illness was work-related, and these cases accounted for almost half of all instances where workers declined to use the compensation system for injuries suffered in the course of their employment.

According to the study, treatment for work-related psychological problems was more than three times as likely to be unclaimed as claimed.

"Differences between claimed and unclaimed encounters may relate to the type of problem managed, in addition to severity," the report said. "Specifically, GP encounters claimed through workers' compensation are more likely to involve physically evident conditions such as musculoskeletal injury, and less likely to involve non-physical conditions such as psychological and social problems."

The report's lead author, Institute for Safety, Compensation and Recovery Research Chief Research Officer Dr Alex Collie, attributed much of this reluctance to concern among patients about how they would be treated at work if their psychological problems were revealed.

"It could be that workers are less willing to claim for psychological conditions compared with physical conditions because of potential for stigma in the workplace," Dr Collie said.

The report found that the most common psychological illness for which workers' compensation was claimed was depression, and suggested that failure to claim for compensation might also be due to difficulty in establishing a causal relationship between work and the ailment, as well as ignorance that compensation might be available.

"Workers and treating medical practitioners may be less aware of their ability to claim workers' compensation benefits for psychological and social conditions than for physical conditions such as back injury," the study, published in the *International Journal of Social Security and Workers Compensation*, said.

"Finally, workers may be less able to claim benefits for psychological and social conditions than for physical conditions, as some Australian jurisdictions exclude or limit the availability of workers' compensation benefits for psychological injury.

"For example, a worker experiencing depression may continue to work with that condition and thus not meet the regulatory criteria for acceptance of a workers' compensation claim.

"It may also be more difficult to demonstrate that work is the cause of a psychological or social condition than it is of a physical condition."

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RESEARCH

Blood sugar levels: time to re-evaluate "normal"

An ANU study suggests that people whose blood sugar is in the high end of the normal range may be at risk of the brain shrinkage that comes with ageing and diseases such as dementia.

It was conducted by a team led by Dr Nicholas Cherbuin of the ANU College of Medicine, Biology and Environment and supported by the NHMRC. The study involved brain scans of 249 people aged 60 to 64 with blood sugar in the normal range (as defined by the WHO) at its start and again, on average, four years later.

The researchers have reported finding, after controlling for such factors as age, HBP, smoking and alcohol use, that blood sugar at the high end of the range accounted for six to 10 per cent of the brain shrinkage.

Dr Cherbuin says that the findings suggest that, even for people who do not have diabetes, higher blood sugar levels could have an impact on brain health.

Though more research is needed, he says, the study results may lead to a re-evaluation of the concept of normal blood sugar levels and the definition of diabetes.

The study is reported in *Neurology.*

DN

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Children eat too much salt

Australian children are eating four times the daily-recommended amount of salt, which could lead to higher blood pressure and heart disease later in life, according to a Deakin University study.

Researchers found that seven out of 10 children aged between five to 13 exceeded the recommended daily limit for salt. Prof Caryl Nowson says that on average kids are eating a level teaspoon of salt a day, which is the recommended daily amount for adults. Daily salt intake in Australian children could be cut by up to 20 per cent by applying internationally recognised salt targets to Australian foods, she said.

"Sodium targets have been established in Australia for only six food categories so far. This falls short of other countries such as the United Kingdom, America and Canada, where targets have been set for more than 80 food types.

"A hot dog alone provides 65 per cent of an eight year old's maximum daily salt limit and a take-away cheeseburger contributes around half the upper limit of salt."

Prof Nowson said that high salt intake might also contribute to obesity risk, as salty foods increase thirst and drive intake of calorie-rich sugary drinks.

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Junk DNA rebranded as crucial

Researchers for the international collaboration Encyclopaedia of DNA Elements (ENCODE) have uncovered a vital clue to understand better the mysteries of the human genetic code.

They have found that what was once dismissed as 'junk' DNA is actually a complex system of more than four million gene switches that play a critical role in controlling how cells, organs and other tissues behave. The discovery is considered a major scientific and medical breakthrough for human health because complex diseases, such as diabetes, high blood pressure and psychiatric disorders appear to be caused by tiny changes in hundreds of gene switches.

The first sketch of the human genome described DNA as a string that contained genes in isolated sections that made up three per cent of its length. The space in between was dubbed 'junk' DNA, and many researchers did not believe it served a function. Attention was focussed on the 'coding' genes that carried instructions for making the proteins that carried out basic biological functions.

The ENCODE collaboration combined the efforts of 442 scientists from 32 labs across the world. Studying the 97 per cent of the human genome or 'junk' DNA (parts of the DNA that are not actual genes and which contain instructions for proteins), it discovered that the bulk of it is actually a complex system of switches that determine how genes work, essentially acting as a massive control panel.

It is thought that this finding will have immediate applications for understanding how changes in the non-gene parts of DNA contribute to human diseases, which may lead to new medications.

Dr Ewan Birney, a lead ENCODE researcher from the European Bioinformatics Institute, said that the genome was simply alive with switches: millions of places that determined whether a gene is switched on or off. "We found that a much bigger part of the genome – a surprising amount, in fact – is involved in controlling when and where proteins are produced, than in simple manufacturing the building blocks."

ENCODE has enabled scientists to assign specific biological functions for 80 per cent of the human genome and has helped to explain how genetic variants affect a person's susceptibility to disease.

Dr Michael Snyder, a Stanford University researcher working in ENCODE, said that most of the changes that affected disease did not lie in the genes themselves but in the switches. This knowledge would be particularly useful in interpreting genome-wide association studies, a key tool in developing personalised medicine.

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RESEARCH

Angioplasty: intercepting heart damage

Researchers at The Heart Research Institute and the RPA and Concord Hospitals in Sydney have reported finding a way to identify the one in every three patients who is at risk of heart damage after undergoing angioplasty.

It has been hard (if not impossible) to predict until now the patients who may be at risk of heart damage from angioplasty, though it has been estimated that up to a third of patients incur it as the stents used in the procedure dislodge the plaque in arteries and push it downstream where it can block microcirculation vessels.

Work by a collaboration between researchers at the Heart Research Institute and Sydney Local Health District in Australia and Stanford University in the US indicates that there is a strong possibility that measuring the health of heart capillaries of patients before they undergo angioplasty can help predict those who may be at risk.

Lead researcher Dr Martin Ng of the HRI suggests that patients shown to be at risk could be given preventive treatment: strong intravenous blood thinners before the procedure or the use of small filters that can be used to capture the plaque dislodged by angioplasty, preventing it from lodging downstream.

The study is reported in *Circulation: Cardiovascular Interventions*.

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Chocolate: the good news continues

According to a study involving more than 37,000 Swedish men aged between 49 and 75, men who eat an average 63 grams of chocolate a week (ie, a standard bar) have a lower risk of stroke in later life than men who eat none. The correlation does not seem to differ between different types of stroke.

Previous studies have found links between eating moderate amounts of chocolate and protection against CV diseases but the Swedish study, by researchers at the Karolinska Institute, is thought to be the first to search for links between chocolate and development of stroke risk.

It involved the participants detailing the frequency with which they ate chocolate over the previous decade and this information being checked with hospital records. It found that the risk of stroke for the study participants in the highest category of consumption was 19 per cent lower than those who had not eaten chocolate. Every increase in consumption of 50g a week reduced the risk of stroke by about 14 per cent.

Lead author Dr Susanna Larsson says that its findings have been corroborated via a meta-analysis of five other studies involving more than 4,000 cases of stroke in Europe and the United States.

The researchers hypothesise that the beneficial effects of chocolate could be caused by the cocoa flavenoids in it that play a role in preventing clot formation - in particular epicatechins, catechins (also found in tea) and procyanidins (also found in such foods as grapes, blackberries, apples and wine).

Dr Larsson admits that more studies are needed to confirm the Karolinska findings before any recommendation could be made about chocolate consumption, and that chocolate, which is high in sugar, saturated fat and calories, should be eaten in moderation.

The study has been reported in *Neurology*.

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

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RESEARCH

Diabetes: even normal urinary protein excretion has its risks

An Italian study suggests that, in people with type 2 diabetes, any degree of measurable urinary protein excretion – even in what is considered the normal range – increases their risk of experiencing cardiac health problems.

It is known that type 2 diabetes patients suffering albuminaria have a considerably higher risk of developing heart problems than other diabetics and people in the general population (normoalbuminuric) with urinary albumin excretion levels of less than 20 µg/min. Since normoalbuminuria patients account for such a high proportion of all diabetics, health researchers have long wondered if any level of excretion might increase risk of heart problems.

A group of researchers at the Mario Negri Institute for Pharmacological Research and the Ospedale Riunti in Bergamo set out to evaluate the relationship between albumin excretion levels and heart problems by following about 1,200 normoalbuminuric patients with type 2 diabetes over an average of 9.2 years.

They found that any degree of measurable albumin excretion bore significant risk of heart problems. There was a progressive incremental risk of heart problems during follow-up for each 1 µg/min in albumin excretion at the start of the study. Even albuminaria of 1-2 µg/min, compared with <1 µg/min, was significantly associated with increased risk.

When they investigated only the subgroup of patients in the study who were taking ACE inhibitors from the start to the end of the study, they found no link between excretion levels and heart risks, suggesting that ACE inhibitors have heart-protective properties that may benefit both albuminuric and normoalbuminuric patients.

They say that more clinical trials are needed to identify levels of albumin excretion above which this cardio-protective therapy would be beneficial.

Their study has been accepted for publication in the *Journal of the American Society of Nephrology*.

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Cardiac arrest: the longer resuscitation the better

A large American study, reported in *The Lancet*, has challenged the common view that extending the duration of resuscitation of hospital patients who go into cardiac arrest is often futile.

This finding is the result of a collaboration, financed by the American Heart Association (AHA), conducted by researchers at Michigan, Pennsylvania and Yale Universities and the Mid-America Heart Institute by analysing data from the AHA's Get with the Guidelines-Resuscitation Registry – said to be the largest registry of in-hospital cardiac arrest in the world, identifying nearly 65,500 patients who went into cardiac arrest at 435 US hospitals between 2000 and 2008.

The researchers sought to work out whether patients in hospitals that tried CPR for longer had higher rates of survival than those in hospitals that followed the common, shorter practice.

They did so by calculating the median duration of resuscitation on non-survivors in each hospital before efforts were ended. They found that those in the hospitals using the longest median efforts had a higher likelihood of spontaneous circulation and survival to discharge. Neurological function was similar, regardless of the duration of CPR.

"Although we cannot define an optimum duration for resuscitation attempts on the basis of these observational data," the researchers report, "our findings suggest that efforts to systematically increase the duration of resuscitation could improve survival in this high-risk population."

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INFORMATION FOR MEMBERS

Expert witness training

Doctors and other health professionals are invited to attend a two-day training session on providing expert testimony in court.

The course, to be run by the Australasian College of Legal Medicine, provides instruction on how to be an expert witness, and what will be expected when attending court.

As part of the training, attendees will be required to submit a report (from which identifying details have been deleted) a month prior to the course. During the training they will be led and cross-examined on the contents of the report.

When: 24-25 November, 2012

Where: Royal College of Surgeons, 250-290 Spring Street, East Melbourne

Registration: Forms available at www.legalmedicine.com.au

More information: Australasian College of Medicine, 02 4573 0775

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Doctors tell governments to butt out

American doctors are fighting back against state intrusion into the physician-patient relationship following the passage of laws stipulating how and when they should provide advice to women considering abortions.

The American College of Physicians has drafted a set of principles asserting the sanctity of physician-patient communications and rejecting attempts by lawmakers to direct the sort of treatment that can be provided.

Doctors in the US have become increasingly concerned about laws in several states they believe have stepped over the boundary and interfered in how they care for their patients.

Among the legislation in their sights is a law that recently came into effect in Wisconsin regarding abortions.

Under the law, doctors prescribing a drug-induced abortion are required to ensure their patient is seeking the termination free of coercion by ensuring consultations are conducted with the woman alone, and providing her with private access to a telephone.

"The physician must determine if the woman's consent is voluntary by speaking to her in person, out of the presence of anyone other than a person working for or with the physician," the law said. "If the physician has reason to suspect that the woman is in danger of being physically harmed by anyone who is coercing the woman to consent to an abortion against her will, the physician must inform the woman of services for victims or individuals at risk of domestic abuse, and provide her with private access to a telephone."

Wisconsin Medical Society President Dr Tosha Wetterneck said the law was objectionable because it stipulated how physicians should treat their patients.

"There are a lot of things in the law that interfere with the physician-patient relationship," Dr Wetterneck told *American Medical News*. "Things that must happen that are not adding to quality care."

Doctors have also fought back against laws in Connecticut regarding the administration of mammograms.

The legislation, which came into effect in 2009, required doctors to notify women if they had high breast density and offer them additional screening opportunities.

But the law created problems for physicians because health insurers refused to cover certain screenings based on a diagnosis of dense breasts.

Former President of the Connecticut State Medical Society, Dr Kathleen LaVorgna, said the law placed doctors in an invidious position, with woman blaming them for not having access to screening covered by insurance.

Dr LaVorgna said legislators had failed to foresee the consequences of the new law, and subsequently had to amend it to require that insurers pay for additional screening.

The statement of principles drawn up by the American College of Physicians opposes laws that override doctor orders, mandate provision of certain health services and limit the topics that practitioners can discuss with their patients.

College President Dr David Bronson said several states had, or were considering, laws that "go after" conversations between doctors and patients, and which must be opposed because "that is protected territory".

The statement includes a list of issues politicians should consider when devising health policy.

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Plain packaging: WMA supports Australia

The World Medical Association is encouraging all governments to go ahead and follow Australia's example in mandating plain cigarette packaging now that the enabling legislating has been confirmed by the High Court.

WMA Chair (and former Federal AMA President) Dr Mukesh Haikerwal said that the world body believed that the legislation would save lives "by reducing the terrible health-related deaths, long-term illnesses and disability caused by smoking".

The WMA General Assembly, when it met in Thailand next month, would discuss further steps to strengthen its anti-tobacco policy "against the aggressive promotion by the tobacco industry to make their products more appealing to young people", Dr Haikerwal said.

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India's generic drug laws under attack again

Big Pharma – like Big Tobacco – never give up.

The campaigns over years by Novartis of Switzerland and Bayer of Germany against India's health-friendly medicine patent laws are now in separate Indian courts where, according to Médecins Sans Frontières, success by the companies will devastate the supply of cheaper but essential medicines throughout the developing world.

Protected by these laws, India is the world's leading producer of the generic (and much more affordable) drugs used by MSF and similar NGOs in public health campaigns in scores of developing countries.

The Novartis action, in the Indian Supreme Court, challenges that part of Indian patent law (Sec.3d) that provides that a new form of medicine can only be patented if it shows significantly improved therapeutic efficacy over existing compounds. This helps prevent drug manufacturers from following the practice known as "evergreening"; that is, extending patent monopolies via additional patents on essentially the same medicines.

Novartis unsuccessfully challenged the law as a whole as being unconstitutional in the Indian High Court in 2006. It is now challenging the interpretation of Sec.3d in particular, the effect being (if the challenge is successful) that the law as a whole would lack substance.

Bayer is mounting an appeal in the Indian Intellectual Property Appellate Board to a decision in March by the Indian Patent Controller in favour of a licence to allow production of a generic version of its cancer drug sorafenib tosylate.

The effect of the decision has been that the cost of the generic is now about $170 a month, compared to the $5,500 a month charged formerly for the Bayer version. The generic is produced by the Indian generic manufacturer Natco, which pays Bayer a six percent royalty on sales.

MSF says that Bayer's "predictable" appeal is part of its strategy to use litigation to protect price, rather than deal with the reality that its price is too high. It is not the use of a licence that should be challenged, MSF says, "but the continued pursuit of excessively high profits over public health needs".

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Health in the UK: another front in the class divide

According to the King's Fund in the UK, the good news is that the number of people in England who risk their health through "multiple lifestyle behaviours" is falling.

The bad news is that they are the better-off people.

Those down the SES scale, are still stuck in a cycle of risky behaviour that increases their chances of developing ill health and so adding more cost pressure on a health system that is being battered by the Cameron Government's budget-cut policies.

Among its other unfortunate effects, this contradicts the pledge by the previous and just-demoted Health Secretary Andrew Lansley that he would improve "the health of the poorest fastest".

The King's Fund is a charity that finances arguably the UK's most influential health research. Its study of health trends was led by Dr David Buck, now a senior fellow at the Fund but until 2010 head of health inequalities at the UK Department of Health.

His study covered the period from 2003 to 2008. It analysed data from the National Health Service health survey covering four kinds of behaviour in England that are closely linked to disease and early death: smoking, excessive drinking, poor diet and sedentary lifestyle.

It found that people with little education were more than five times more likely as those with tertiary qualification to engage in the four misbehaviours. In 2003, the gap was bad enough but still only three times. The richest English citizen lived seven years longer on average than the poorest.

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IDF supping with the devil?

The International Diabetes Federation (IDF) has come under fire from leading health experts because of its decision to "partner" with Nestlé, "the long-term effect of which will be contrary to IDF's mission and bad for public health".

The 16 experts include Prod Boyd Swinburn of Deakin University and colleagues from seven other countries, and their criticism has been published in *The Lancet*.

The IDF is the peak international group of more than 200 national diabetes organisations, including Diabetes Australia. Its mission is to "promote diabetes care, prevention and a cure worldwide".

"The partnership is undoubtedly excellent publicity for Nestlé, adding to its claim of genuine concern for population health after being vilified in the past, not least for its unethical promotion of infant formula in developing countries," the experts said.

"The tobacco industry has used similar tactics in an attempt to rehabilitate itself and maintain its profits. But when Nestlé remains so obviously wedded to the intense marketing of energy-dense confectionery and sugar-sweetened beverages, this is analogous to the tobacco industry showing its commitment to health through the production of low-tar cigarettes."

IDF's partnering with Nestlé was retrograde, they said, and put at risk the credibility of the global health peak body NCD Alliance, of which the IDF is a leader. Ultimately, it was promoting Nestlé's commercial interests in return for little more than cosmetic changes.

"This approach is a recipe for more business as usual, more obesity and more diabetes."

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European court rejects Italian limits on IVF

An Italian law dealing with assisted reproduction has been overturned in the European Court of Human Rights.

Among other things, the law permits assisted reproduction only to heterosexual couples who are infertile and prohibits pre-implantation diagnosis of embryos for couples wanting to have children via in vitro fertilisation.

It had been challenged in the court by a couple who, having had one child born with cystic fibrosis, wanted to ensure through preimplantation diagnosis that a second child would not have the same condition.

The court had noted inconsistencies in the law that prevented them from implanting healthy embryos but at the same time allowed them to start a pregnancy and then to abort the foetus if it showed signs of having cystic fibrosis. This caused the couple anxiety and suffering, the court said, and was disproportionate interference with their right to respect for their private and family life.

The law had also been strongly criticised by Italian and other European doctors in the field on the grounds that decisions about pre-implantation genetic diagnosis should be informed by medical need, not determined by government edict.

Italian Health Minister Prof Renato Balduzzi is considering whether or not to appeal the court's decision.

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India joins the anti-obesity campaign

India has joined the struggle to stem the tide of obesity, which has seemed until now to have been more of a concern in the Western world.

The government there has decided that school children from the age of nine will have to undergo biannual fitness tests as part of its strategy (the National Physical Fitness Program) to encourage young Indians to exercise more.

The decision follows publication of a report of a study by the Amrita Institute of Medical Sciences and Research Centre of 20,000 pupils aged between five and 16 that found that more than 6.5 per cent of them were overweight in 2005, compared with a little over five per cent only two years earlier.

The results of the pupils' physical tests will be combined with those of their academic performance for their annual school assessments.

The Indian Government tried something similar nearly 50 years ago, but the plan was dropped after the tests at the time were criticised as being inaccurate.

The latest decision is open for public comment but Prof Manu Raj, the paediatric cardiologist who led the Amrita study, has already questioned how, apart from the "serious academic consequences", children with medical issues would be tested accurately. "Fitness assessment in children is prone to high measurement error," he said. "This is an idea with a good intention, but destined to fail."

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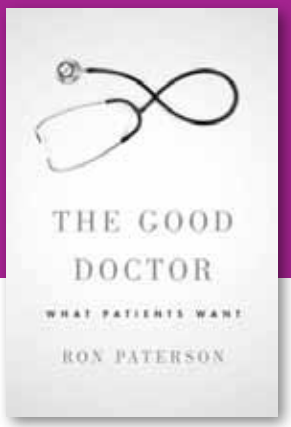
BOOK REVIEW



The Good Doctor

What Patients Want

By Ron Patterson

Auckland University Press, $29.99. ISBN 1869405927

It has never been easier to become, or remain a good doctor in Australasia than at this time. Rigorous selection into medical school, demanding examinations, searching registration requirements, post-graduate CME and CPD commitments, and learned College oversight are part of a larger list designed to ensure the best people end up practising medicine. It has been (more or less) ever thus.

Conversely, it has never been harder to remain a good doctor. The source of this paradox lies in the broad definition of "good" but more importantly, who applies it. "Good" is a nebulous word, (like "nice"), with *The Shorter Oxford English Dictionary* devoting one full A4-sized page to its many definitions.

Modern medicine is populated by a diverse group of "stakeholders" with each applying its own standards, rules, regulations, codes of conduct and legal framework. The penalties can be severe if the doctor breaches any of them. And here lies the heart of the paradox. How can one serve so many, to the full satisfaction of all? It is not easy to remain good.

Ron Paterson, a former Commissioner for Health and Disability in New Zealand, refers to this wider medical environment to help make his points, but sensibly focuses on the relationship that from time immemorial has defined medicine: the doctor-patient relationship. Appropriately, the subtitle of the book is "What Patients Want".

He brings a lawyer's perspective to the problem and, not unexpectedly, finds that medical self-regulation, a freedom long embraced by the profession, has been largely unsuccessful. He argues that professionalism - itself a concept under challenge - and self-regulation must be balanced with external oversight, and that the balance has not yet been met. At the moment, there is too much reliance on medical trust without verification, when accountability should be emphasised.

The book is divided into four parts; the first explores the ideal good doctor. The author acknowledges the difficulty, if not impossibility, of achieving and maintaining this lofty state, as the bar is high. He notes practitioners occupy the bell shape curve for competence and, consequently, there will be outliers. The gifted are at one end and the problem doctors the other. He calls the vast majority within the curve the "good-enough doctor", one who can satisfy an assessment against standards of good medical practice. The name might be considered pejorative, but his reasoning is sound even if the terminology sounds offensive at first reading.

The second part of the book develops the theme that problem doctors are real. A sobering case study begins the chapter, before the author leads into detailed discussion of certain medical scandals in a number of countries, and some well-known cases of medical criminality. These all resulted in inquiries that led to major reforms. Despite these, and initiatives such as informed consent and the newer capacity for patients to research medical practitioners on the internet, the author states there is still an "information abyss" for patients, particularly in the Antipodes.

Part three explores the barriers to change; why do the new systems and initiatives allow problem doctors to still exist? The final part tries to answer this with a series of practical and achievable suggestions to ensure "good doctors, safer patients". Yet the author acknowledges change management is not easy and can be unexpectedly complicated and even painful.

This book is well researched, timely and thought provoking, written without recourse to lawyerly circumlocution. All doctors who care for their profession should read it.

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Falcon XR6 Turbo - "Who needs a V8?"

BY **DR CLIVE FRASER**

In early October, an army of motoring enthusiasts will once again make a pilgrimage to the sleepy hamlet of Bathurst for another round in the Holden Vs Falcon V8 Supercar series.

You see, while Australia can rightly claim to be a secular society, we still do have some religious rituals. The Australia Day long weekend, Anzac Day, Show Day, AFL/NRL Grand Final football and, of course, Melbourne Cup Day are in every Australian's calendar, even those of the non-believers.

But if Australian motorists have a Mecca, it would be at Bathurst.

Since 1963 this was the place that ordinary Australian cars raced on ordinary Australian roads, Logically, a rivalry would eventually develop between the two main tribes (ie, Holden vs Falcon).

In the early years, the rules stipulated that the cars had to be identical to vehicles that were sold to the public. With this in mind, the Ford Cortina dominated the first three years, then the Mini Cooper in 1966.

But, when the rules changed in 1967 allowing pit-stops, muscle cars (viz, V8s) took over the lead and the advantage of going fast in a straight line was the key to success at Bathurst for ever more.

In 1969, a young 24-year old driver named Peter Brock raced for the first time at Bathurst and he would go on to be named the 'King of the Mountain', winning the Bathurst race nine times.

His legacy still lives on as the winner's trophy carries his name.

A little known fact about Peter Brock was that he was conscripted into the Australian Army in 1964 and, un-be-known to him, another private named Dick Johnson was also stationed at the same Wagga Army Base. They would of course go on to be heroic rivals in the gladiatorial battles at Bathurst.

But, for the purposes of this article, Peter Brock was racing for the wrong side, the 'Holden Dealer Team' and I'm reviewing a Ford in this column, a Falcon XR6 Turbo no less. Instead of taking the Ford XR6 Turbo up 'The Mountain', my road test would take me around the Adelaide Hills.

Bolting on the Turbo option does add $8,000 to the price of a naturally-aspirated XR6, but for the extra money you do end up with an off-the-shelf car which easily out-performs the 1971 GTHO Phase III (see below).

Performance is outstanding and so is fuel economy (on the highway).

I had no trouble achieving the stated 9.0 l/100km quoted in the specs on the open road.

I even made a pit-stop after 500 kilometres as I thought the fuel gauge wasn't working properly, but all was in order and the trip computer was completely accurate after all.

If you are spending most of your time around town you might still take a look at Ford's EcoBoost 2.0 litre motor which returns fuel economy, which is about 30% better over-all.

At the moment Ford is offering a Limited Edition XR6 model with leather seats, 19-inch wheels and a reversing camera for a cost saving of $3,824.

And, as Ford sales are in a slump, I'd say that pricing would be very negotiable.

On a final note the 50th anniversary of racing at Bathurst in 2013 will see the entrance of a third player, as Nissan will enter the V8 Altima.

Ford Falcon XR6 Turbo Vs (GTHO Phase III)	
For	Great performance, great value.
Against	Will it still be around after 2016?
This car would suit	Dermatologists because they have speedy consultations.
Specifications	4.0 litre in-line 6 cylinder turbo (351 cu in V8) 270 kW power @ 5,250 rpm (291 kW @ 5400 rpm) 533 Nm torque @ 2,000 rpm (520 Nm @ 3400 rpm) 6 speed manual (4 speed manual) 6.0 seconds (6.6 seconds) 0-100 km/h 12.0 l/100 km combined $45,990 + ORC ($5,302 + ORC in 1971).

PS. A 1971 XY Falcon GTHO Phase III in good condition is now worth $271,000, which is a compounded interest rate greater than 10% per annum over 41 years. In 2007, an un-restored GTHO Phase III sold for $683,650! Who said that cars are a bad investment?

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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1 The monthly amount payable for the Total Disability Benefit is the lesser of (1) the monthly benefit that you choose to insure (to a maximum of $20,000) and (2) 75% of the first $20,000 per month of your pre-claim earnings plus 50% of the next $10,000 per month of your 'pre-claim earnings' less 'other payments'. Please refer to the Glossary in the PDS for further information on 'pre-claim earnings' and 'other payments'. It is in your interest to not insure more than the maximum you can be paid. The monthly amount payable excludes business expenses.

AMP

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- Investigated whether or not you're able to split your loan between a Fixed and Variable rate?

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