AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

States leave interns in the lurch

Graduates snubbed as states refuse Commonwealth deal, p5

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ISSUE 24.19 - OCTOBER 15 2012

AUSTRALIAN
Medicine

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Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

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Cover: AMA Executive (L to R) Dr Iain Dunlop, Dr Rod McRae, Prof Geoffrey Dobb, Dr Liz Feeney, Dr Steve Hambleton and Dr Peter Ford

Short term cuts, long term pain

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Fiscal restraint is the catchcry from governments around Australia.

Risking all for a budget surplus, or a plan to get back to it, seems to be the main game.

Of course, this doesn't stop new promises, but these are increasingly pushed into the future for (possible) implementation, so the costs recede into the distant end of budget estimates.

I'm not an economist, but I can see the pain in the European countries with large debts. Among the first casualties in their attempts to rein in expenditure have been pensions and health services.

Their population ageing profile is ahead of Australia's. The paradigm where the taxpayers of today pay for the pensions and health needs of the workers of yesterday had become unsustainable, and projections suggest it is only a matter of time before it becomes unsustainable in Australia too.

Australia has mitigated its risk for pensions through compulsory superannuation and a taxation environment that favours saving for retirement through superannuation.

Meanwhile, health is largely funded from current taxation, current health insurance premiums and current co-payments by patients. This makes health very sensitive to the vagaries of the economic cycle, especially when governments act responsibly by reducing or eliminating debt funding for recurrent expenditure.

During economic growth, restrictions on the availability of healthcare professionals tend to limit growth in frontline services. Instead, during the growth phase, it is all too easy for the growth to be directed into IT projects destined for failure, increased regulation, reorganisation and changes or 'reform' that bring decreased efficiency.

Increased productivity may come from investment in new equipment and technologies, but bring a future burden when equipment needs to be replaced as it reaches the end of its useful life.

When the inevitable economic downturn finally comes, or realisation dawns that recurrent expenditure cannot be paid for from ever-increasing debt, cuts to health budgets follow.

The Commonwealth Government and many states are entering this phase.

But instead of seeing it coming and making planned changes based on an evaluation of cost effectiveness, the aim all too often is a quick fix to the budget bottom line, tempered by what is politically palatable.

In practice, the solutions include freezes on new employment and slashing cuts to soft targets such as preventative health and rehabilitation programs, services at the interface between hospital and community care, staff education and development, clinical support services and so on.

The rhetoric is always that front line services will not be affected. Those working at the front line of medicine know that cuts such as these will ultimately increase the burden of disease, increase the likelihood of hospitalisation or re-hospitalisation, or distract those who should be providing direct patient care with tasks that can and should be performed more cheaply and effectively by other staff.

The result: frontline services are inevitably affected, though covertly rather than overtly. Add to this the workforce-distorting effects of staff freezes, which disproportionately affect areas of high staff turnover, and the stage is set for even greater inefficiency.

Then add again the delayed consequences of cuts to public health that, for example, risk the spread of multi-drug resistant tuberculosis. Any short term gain is then certain to be offset by longer term pain.

The Federal and State AMAs are out there at every opportunity, advocating a greater proportion of public expenditure to be directed to health. But when Treasury and Finance hold sway over Cabinets, that message becomes muffled.

Health bureaucracies can be smarter and not sacrifice long-term efficiency for the sake of meeting this year's budget target.

This means minimising red tape and regulation, applying lean principles to administrative processes and taking a blank sheet approach to the minimum administrative structure needed to support doctors, nurses and other health professionals in doing their work while maintaining accountability for patient outcomes, activity and expenditure.

In health it's the 10 year impact of budget cuts, not the one year impact, that really matters.

It also means being honest with Australians about what they can reasonably expect. Already Medicare Benefits Schedule increases lag behind inflation, and the failure to list many new medicines on the Pharmaceutical Benefits Schedule, mean that the out-of-pocket health costs for Australians are amongst the highest in the developed world.

These are costs that affect the sick at their time of need and, with current policy settings, these costs will only grow.

The funding of Australian health care is a major topic for the next meeting of the AMA's Economics and Workforce Committee. All members are invited to provide their comments for consideration.

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Doctors could pick up the tab of extra care

The AMA has expressed disbelief that a Commonwealth strategy to shift an increasing share of the burden of care on to general practice is not backed by a single extra dollar of funding.

AMA Vice President Professor Geoffrey Dobb said that while the AMA supported "many aspects" of the Government's draft National Primary Health Care Strategic Framework, it was astounding that it did not include any extra funding to support primary care in the next three years.

"AMA President Dr Steve Hambleton warned that although an increased focus on primary health care would deliver exponential benefits in reducing pressure on hospitals and stretched health budgets downstream, this could not be achieved without some initial additional investment"

"It does not make any sense for the Framework to state that the centre of gravity in health care is going to shift to primary care to take pressure off the hospital sector, and expect that this can be done within existing resources in primary health care," Professor Dobb said. "We support the recognition that general practice is the foundation of good primary health care in Australia and the admission that a strong GP-led primary health care system keeps people well and saves lives.

"The GP-patient relationship is one of the strongest features of the Australian primary health system, and it must be supported and encouraged, but it cannot survive on goodwill alone.

"The primary care sector, general practice particularly, must be properly funded to meet future demand and to maintain the high quality that makes the Australian health system one of the best in the world," Professor Dobb said.

The draft Framework is intended to build on the key priority areas identified in the Commonwealth's National Primary Health Care Strategy released in 2010.

In a submission to the Government on the draft, AMA President Dr Steve Hambleton warned that although an increased focus on primary health care would deliver exponential benefits in reducing pressure on hospitals and stretched health budgets downstream, this could not be achieved without some initial additional investment.

"The AMA supports the view that investment in primary health care has exponential benefits in reducing pressure in the hospital sector – that is, what is spent in primary care will lead to much bigger savings downstream in the health system," Dr Hambleton wrote. "However, this does require some investment – downstream savings cannot be realised without proper investment at the front end."

The AMA President said GPs provide all the care needed for 90 per cent of the problems they encounter while accounting for less than 10 per cent of per capita health spending, meaning they provided very good value for money and were an extremely efficient way to spend scarce health dollars.

The submission also addressed a number of other concerns.

On e-health, Dr Hambleton said the Framework needed to include details of how GPs and practices would be encouraged to support Personally Controlled Electronic Health records and other e-health initiatives.

The AMA President also said the Government needed to overhaul its approach to tackling chronic disease by changing GP items on the Medicare Benefits Schedule to encourage longer consultations, which would allow doctors to provide preventive health care services, and give them the time they need to communicate with other parts of the health system.

Professor Dobb warned that the draft Framework also raised a number of contentious issues with no consultation and little detail.

These included blended payment systems, pre-payments and payment for performance with salaried arrangements, and the development of performance indicators to identify circumstance sin which patients may not be receiving the most appropriate care.

"These issues require extensive discussion and consultation with the AMA and other groups before the Framework is finalised," Professor Dobb warned.

The AMA submission can be viewed at: http://ama.com.au/ama-response-consultation-draft-nationalprimary-health-care-strategic-framework

The AMA's *Chronic Disease Plan: Improving Care for Patients with Chronic and Complex Care Needs – Revised 2012*, which builds on existing MBS items with streamlined access to allied health and other services across levels of care relevant to the complexity of the patients' needs, can be viewed at: http://ama.com.au/node/5519

The Plan provides for enhanced access to a broader range of services, including the services of a care coordinator for those patients with chronic and complex disease that need greater support and are at risk of a preventable hospital admission.

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States fail doctors and communities: AMA

The career prospects of almost 100 medical graduates have been thrown into doubt by the refusal of State and Territory governments to help make up a critical shortfall in intern places.

The Commonwealth has committed to provide a one-off injection of funding for an extra 100 medical intern places for 2013 after it was confirmed there was a national shortage of 182 internships for graduates.

But the nation's State and Territory governments have refused to pay for the training of the remaining 82 graduates, drawing condemnation from AMA President Dr Steve Hambleton.

"No intern place, no medical career – it's as simple as that," the AMA President said.

"It is disgraceful that a funding blame game could threaten the careers of these young doctors and deny needy people the quality health care they deserve," Dr Hambleton said. "At a time when many communities are crying out for locally-trained doctors, it is unbelievable that a number of our State and Territory governments are refusing to contribute to the full training of the next generation of Australian doctors."

There have been long-standing warnings that medical internship places were failing to keep pace with the recent rapid expansion in medical student numbers.

Medical training is a shared responsibility of the Federal, State and Territory governments, and when it became clear last month that almost 200 graduates were set to miss out on a vital internship place, the Commonwealth stepped in with an offer to pay for an additional 100 places, and called on the next tier of government to fund the remaining 82 places.

"The Commonwealth has acted in good faith to find funding for 100 of the remaining 182 places needed to ensure all our graduates can complete their training," Dr Hambleton said. "It is now up to the states to come good on their side of the bargain.

"We are talking about a few million dollars per State – a small price to pay for a huge dividend to people in need of quality medical services.

"The states must do the right thing – chip in and finalise the agreement with the Commonwealth immediately."

The AMA President said the failure to provide adequate internship places, which are needed to complete the training of future doctors, potentially wasted the large investment already made by taxpayers in educating medical graduates, and denied Australia the locally-trained doctors it urgently needed.

"If allowed to complete their training, these doctors will work in public hospitals or private practice in communities in all states and territories, some in areas of high need," Dr Hambleton said, urging governments at all levels to agree on a solution to the problem, which is only likely to get worse in 2014 and beyond.

"We would like to see a long-term national solution so we can get as many of these Australian-trained doctors into the system as possible," he said.

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Mental health concerns grow

The AMA has backed efforts to raise awareness of depression and other mental illnesses as part of World Mental Health Day.

AMA Vice President Professor Geoffrey Dobb said growing numbers of people are being affected by mental illnesses, and governments needed to do more to inform people about these conditions, and provide treatment for them.

"The number of people around the world, including Australia, experiencing mental illness is increasing," Professor Dobb said. "People need information and education to recognise the signs of mental health problems and where to go for help."

The AMA Vice President said general practitioners were at the front line in providing mental health information and care.

"GPs are trusted providers of mental health care and advice at the local level," he said. "In 2008-09, more than 13.2 million GP-patient encounters involved management of a mental health issue."

The AMA has voiced strong objections to the Federal Government's decision to axe the Better Access program, which was shown to have been very effective in providing mental health care to millions of Australians.

Figures show that about one in three Australians experience mental illness at some stage in their life, and it accounts for about 13 per cent of the total burden of disease in the community.

Despite significant gains in primary health care more broadly, information shows that too many suffering mental illness are still not seeking or receiving treatment, with estimates that just 46 per cent are receiving care, compared with more than 80 per cent for comparably disabling physical ailments.

Professor Dobb said doctors played a vital role in helping identify and treat mental illness.

"GPs provide continuity of care over time, and it is not uncommon for general practitioners to treat families across generations," he said. "They offer early intervention and timely responses in mental health detection, diagnosis and referral, as well as ongoing management.

"It is important that GPs are supported in the key role they play in proving people with easy local access to mental health services."

Professor Dobb said the AMA had been active in advocating for improved mental health services, particularly for the disadvantaged.

In August, the AMA called for improved mental health care for prisoners as part of its *Position Statement on Health and the Criminal Justice System 2012*, which can be viewed at: http://ama.com.au/position-statement/health-and-criminal-justice-system-2012

Earlier the same month, the AMA urged the Australian Parliament to establish an independent medical panel to oversee and report on the health services, including those for mental health, provided to asylum seekers held in detention both in Australia and offshore. For more information, see: http://ama.com.au/ama-calls-independent-mendical-panel-oversee-health-asylum-seekers

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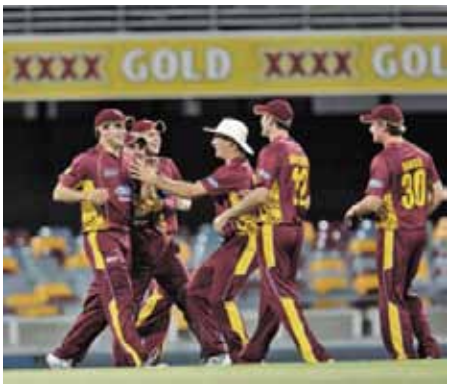
Bathurst V8s drive drink message home to the young



The AMA has called for the closure of a loophole in advertising standards that allows for the promotion of alcohol in broadcast coverage of major sporting events including football grand finals and Bathurst 1000 V8 Supercar race.

AMA Vice President Professor Geoffrey Dobb and the National Alliance for Action on Alcohol (NAAA) have warned that prominent alcohol marketing and sponsorship at the hugely popular events exposed children and adolescents to harmful messages glamourising the consumption of alcohol.

"We saw it with the AFL and NRL Grand Finals, and we see it again with the Bathurst 1000," Professor Dobb said.

"These are traditional iconic family events on the Australian sporting calendar, and alcohol companies are getting easy access to millions of people, including children, to promote and market their products."

The AMA Vice President said the situation highlighted a significant loophole in the Commercial Television Industry Code of Practice which must be closed.

"The alcohol industry is being allowed to reach vulnerable young people and send them messages that alcohol is associated with all that is best in sport, and that alcohol is closely linked to driving fast cars," Professor Dobb said. "This marketing fuels pro-drinking attitudes in children and young people. It persuades them that alcohol products and brands are attractive, glamorous and risk-free. It perpetuates the dangerous myth that motor sports and alcohol go together."

Professor Mike Daube, Co-Chair of NAAA and Director of the McCusker Centre for Action on Alcohol and Youth, called on the organisers of the Bathurst 1000 race, which is broadcast to a huge national and international audience, to review their sponsorship arrangements.

"The event has become a strong vehicle for alcohol and alcohol-branded promotional gear," Professor Daube said. "Alcohol is being promoted to children in a glorified way – fun, outdoors, sporty.

"There is also the very dangerous association of fast cars and drinking alcohol. The event includes two Jack Daniels Racing cars, two Jim Beam Racing cars and one Bottle-O Racing Team car.

"And it is especially disturbing that the V8 website promotes Jim Beam Racing clothing in kids' sizes."

The AMA last month hosted a National Summit on Alcohol Marketing to Young People, and issued a report highlighting the extensive use alcohol companies are making of social media, video games, mobile phones and other non-traditional marketing avenues to promote their products to young people.

A communiqué issued by the summit said industry self-regulation of alcohol advertising and marketing had failed, and called for the establishment of an independent regulator to control the promotion of alcohol.

The communiqué can be viewed at: http://ama.com.au/media/communique-national-summit-alcohol-marketing-young-people

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Plan to protect doctors, hospitals in Syria

The AMA has backed efforts by the Federal Government to protect doctors and medical facilities in war-torn Syria as the death toll among civilians and combatants soars.

Foreign Minister Bob Carr announced late last month that the Australian Government was seeking international support for a plan to ensure all victims of the conflict, which has so far claimed the lives of more than 30,000 people, had unfettered access to treatment.

Senator Carr said the plan called for a commitment from all combatants that they would not target medical personnel, not attack medical facilities and not block access to doctors, hospitals and emergency care.

"This would not be a military or political intervention in Syrian affairs," the Minister said. "It would simply be designed to protect the lives of ordinary Syrian caught in conflict zones."

AMA President Dr Steve Hambleton welcomed what he said was an important initiative to make care for the sick and injured the top priority.

"It is important that people affected by war, conflict and unrest in any part of the world have access to medical care and treatment, and that all medical and health professionals be allowed to carry out their work," Dr Hambleton said.

"For doctors, the health of patients is the first priority. Individual doctors must have the freedom to exercise their professional judgement in the care and treatment of their patients without undue influence by outside parties or individuals."

As a member of the World Medical Association, the AMA strongly urges governments, armed forces and others in positions of power to comply with the Geneva Conventions, under which doctors and other health workers receive the protection they need to provide care to all harmed by conflict, regardless of political affiliation, ethnic origin, nationality or creed.

Under the Australian Government's plan, a neutral third party such as a non-government organisation,would be appointed to ensure all combatants adhered to their commitments.

Senator Carr said that to make his plan work, he needed support from countries in the Middle East, Europe and Russia.

Regardless of the outcome, the Government has boosted its support for humanitarian relief for those caught up in the Syrian conflict, committing an extra $4 million to help deliver medical supplies and emergency food aid within Syria, as well as contributing to international efforts to provide food, shelter and health care to the 2.5 million people displaced by the conflict.

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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

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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

Ban alcohol until 21, *The Adelaide Advertiser*, 2 October 2012

AMA President Dr Steve Hambleton said more people were acknowledging the problems caused by alcohol.

States slammed over medical intern funds, *The Canberra Times*, 3 October 2012

AMA President Dr Steve Hambleton said it was disgraceful that a funding blame game could threaten the careers of young doctors and deny people the quality of health care they deserved.

Soldiers say privacy is at stake, *The Sunday Telegraph*, 7 October 2012

AMA President Dr Steve Hambleton said he was concerned over a confidentiality clause in Defence's contract for outsourced health services.

Radio

Dr Hambleton, ABC NewsRadio Sydney, 2 October 2012

Dr Steve Hambleton, President of the Australian Medical Association, commented on a report by the Australian Institute of Health and Welfare showing Australians have piled on weight in the past decade. Dr Hambleton said rates of obesity and overweight have increased in the last 20 years, rising from 56 per cent to 61 per cent.

Dr Hambleton, 6PR Perth, 2 October 2012

AMA President, Dr Steve Hambleton, calls to lift the legal drinking age to 21 years. He said such a change would make a difference to attitudes, which seemed to be more accepting of public drunkenness than they used to be. Dr Hambleton said the debate about the legal drinking age was "very useful" in getting people to assess what they want in the Australian culture.

Dr Hambleton, Radio Adelaide, 3 October 2012

Australia may be facing a doctor shortage, with the future of 180 international medical students in question after the states and territories were unable to reach an agreement about addressing a shortage of intern places. Dr Steve Hambleton, President of Australian Medical Association, said this was an area that needed to be addressed by both the Federal and State governments.

TV

Dr Hambleton,ABC 24, Sydney, 28 September 2012

AMA President, Dr Steve Hambleton, commented on the possibility of new pain relief drugs with no addiction side effects after Australian researchers identified a mechanism in the immune system responsible for addiction. He said the discovery was likely to change the way pain and addiction are treated.

TO COMMENT CLICK HERE

AMA in action

AMA President Dr Steve Hambleton has been busy this fortnight planning with the AMA Executive and speaking at the RACGP/AMA/Medicare Locals Chair and Executive Dinner.

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The AMA Executive hard at work

AMA President Dr Steve Hambleton with Prof Di O'Halloran (left), Dr Liz Marles, Dr Brian Morton and Dr Brian Owler

Dr Hambleton addresses the RACGP/AMA/Medicare Locals Chair and Executive Dinner

US-style managed care concerns revived by insurer's grand plan

The AMA has voiced alarm at a push by the nation's largest health insurer to become a major health services provider, reviving concerns about the imposition of US-style managed care arrangements.

Medibank Private has confirmed that it is undergoing a radical transformation from being primarily an insurance company to one directly involved in providing health care.

In its annual report released late last month, the insurer's Managing Director George Savvides said that in the past three years the business had been "quietly but substantially reshaped from that of a conventional private health insurer to more of an integrated health insurance and health services company".

One of the planks of the transformation has been Medibank Health Solutions, a fully-owned entity that provides a range of telephone-based health advice services, after-hours GP services and workplace-based medical services.

In June it won a $1.3 billion, four-year contract to provide health services for the Australian Defence Force, and is expected to double in size by mid-2014.

Medibank Private chairman Paul McClintock told *The Australian* the contract meant the insurer would have oversight of the care provided at 100 barracks supporting 80,000 defence personnel, meaning that "we will in fact be operating a purpose-built health system".

Mr McClintock said the "exciting" transformation of the company offered the chance to increase revenue from sources outside the health insurance sector.

"[It is] time to start thinking of Medibank as a health care company that offers really great health insurance," he said.

In the past three years the company has steadily acquired a portfolio of health providers, and Mr Savvides said this had unveiled many other opportunities to expand its health care services – though he hastened to add this did not include the operation of hospitals.

"We are not going to run hospitals – we are talking about the primary care environment, where our nurses and GPs are doing the work that either treats or prevents the more expensive hospitalisation episodes, and means people can avoid the more expensive acute care," Mr Savvides told *The Australian*.

As of last year the company directly employed 1500 doctors, nurses, physiotherapists and other health professionals.

The move by Medibank revives concerns raised in the late 1990s about a shift towards US-style managed care arrangements, in which insurance companies could seek to dictate the type of care doctors could provide for their patients.

AMA President Dr Steve Hambleton said Medibank Private's move into the direct provision of care was a concern.

"Where [health care] companies make decisions that are in the interest of the bottom line, you start to worry," Dr Hambleton said. "When funders become providers, the only loser is the patient. "Healthcare is all about the best interests of the patient. If economic issues squeeze them out of being the number one concern, there would be a problem."

But Mr Savvides sought to allay such concerns, arguing that the company's focus was on providing after-hours care, and should be seen as a partner rather than competitor.

For more, see also **Specialists fear care the casualty as Medibank takes charge of Defence health**, p12.

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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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Specialists fear care the casualty as Medibank takes charge of Defence health

Giant health insurer Medibank Private is facing a backlash from medical specialists over cost-cutting changes it is trying to make to the treatment of defence force personnel.

The Australian Society of Anaesthetists (ASA) is reported to be among a number of individuals and organisations preparing to lodge complaints with Medibank Private offshoot Medibank Health Solutions over plans to slash fees and centralise patient referrals.

The company earlier this year won a $1.3 billion, four-year contract to provide health services for the Australian Defence Force, and has notified specialists that the new arrangements will come into effect from 28 October.

But practitioners are concerned that they will undermine the continuity and quality of care provided to their military patients.

Under the new arrangements, which will apply to 100 barracks and bases serving 80,000 personnel, military doctors will no longer be able to refer patients to a specialist of their choosing.

Instead, Medibank will select a practitioner from a centralised database of preferred specialists providers, according to a report in *The Age*.

Specialists who sign up to the new scheme face onerous demands, including a cut in fees and a stipulation that all medical reports be completed and lodged within three days.

Chair of the ASA's Economics Advisory Committee, Dr Mark Sinclair, advised members that they faced a cut of up to 50 per cent in their fees under the new arrangements.

"The proposed fees for anaesthetists' services are significantly less (up to almost 50 per cent less) than under the current arrangements, where fees are calculated according to the Relative Value Guide (RVG), and paid at the AMA rate of $73 per unit," Dr Sinclair said.

"This system has been in place for many years and has been most successful for all concerned, ensuring high quality treatment without delay for Australian Defence Force personnel."

Dr Sinclair said that not only were specialists being offered less, but the proposed new fee schedule was "extremely complex", with each subgroup of the RVG having a different fee.

"This results in a situation where the fees for different services of the same relative value will vary significantly. This is completely at variance with the basic philosophy of the RVG.

"All other rebate schedules, including those of Medicare, private insurers and other third party payers, are funded via a single unit value across the whole RVG."

The ASA has made representations to the Government urging changes to the proposed arrangements, and has advised its members that they are under no obligation to provide treatment for elective services in private hospitals if they are not happy with any aspect of the arrangement.

According to *The Age*, many specialists have so far resisted signing up to the new scheme, though Medibank said it was "very happy" with the response from practitioners.

Defence decided to outsource its health care, ultimately awarding the contract to Medibank Health Solutions, after an investigation by the Auditor General found its health care costs were about double those of the wider community.

For more, see also **US-style managed care concerns revived by insurer's grand plan**, p11.

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Views sought on drug company payments to doctors

AMA President Dr Steve Hambleton is seeking the views of doctors on the relationship between health professionals and the pharmaceutical industry.

Dr Hambleton has sent AMA members a short questionnaire inviting contributions on how, and to what extent, the disclosure of such relationships should be managed.

"The AMA supports transparency of these relationships," Dr Hambleton said. "However, there are different views about the way this should happen."

The AMA President said that in the United States pharmaceutical companies are legally required to publicly name individual health professionals to whom they provide payments or benefits, and to report the total value of these outlays.

"Some commentators argue that this requirement should be introduced in Australia," Dr Hambleton said, adding that currently companies only have to report aggregate payments without naming individual practitioners.

The questionnaire can be accessed at: http://ama.com.au/survey/pharmaceutical-transparency-survey

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Bosses warned that doctor-patient confidentiality is sacrosanct

The industrial relations watchdog has joined the AMA in objecting to attempts by employers or their representatives to sit in on appointments between workers and their doctors.

The Fair Work Ombudsman said it was "concerned" by reports that bosses were attempting to attend the medical appointments of their staff, and warned that such behaviour would put them in breach of the Fair Work Act.

"The Fair Work Ombudsman does not condone or support this behaviour, and sees no reason why an employer should seek to attend a private and confidential appointment with an employee, unless specifically requested to do so by the employee," the Ombudsman said.

The Ombudsman's comments followed a warning from AMA President Dr Steve Hambleton that such behaviour was "unacceptable".

Dr Hambleton told *The Sydney Morning Herald* that "companies need to know that intruding on patients' privacy is not acceptable."

As reported in the *Herald*, union officials have raised concerns that some employers have demanded the right to sit in on visits between doctors and their staff, as well as instances where doctors have come under pressure to alter medical reports and certificates.

Dr Hambleton said doctors should also be aware of the phenomenon and act appropriately.

"We'd be very unhappy if medical certificates were not being respected," he said. "Altering information is a very serious charge … All doctors should know that the prime responsibility is their patient."

The Ombudsman said the laws around sick leave were "quite simple", and while an employers could require evidence of incapacity such as a doctor's certificate or a statutory declaration, they had no right to intrude in the relationship between a patient and his or her doctor.

"The Fair Work Ombudsman has great respect for the medical profession and there are well established processes within the profession for dealing with practitioners who issue fraudulent or unjustified certificates," the Ombudsman said. "It is not the role of the employer to attend the appointment in order to determine a certificate's validity."

It highlighted the importance of trusting relationships between bosses and their workers in creating a "positive and productive" workplace.

"It is important for employers to respect their employee's privacy, and to only obtain evidence that is relevant to substantiate [their] absence," the Ombudsman said. "[Information about] the cause and nature of their absence is not necessary, except in unusual or exceptional circumstances."

To read more on this story, **click here**.

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Emergency care speeds up, but still off target

Emergency department waiting times are coming down, but more than a third of patients have to wait longer for treatment than the agreed four-hour standard due to come into effect in 2016.

Official figures show that the median waiting time for treatment dropped to 21 minutes in 2011-12, down from 23 minutes the previous year and 24 minutes in 2007-08.

Patients in South Australia had the quickest turnaround (15 minutes), followed by those in New South Wales (19 minutes), while those in the Northern Territory had to wait the longest (39 minutes).

Overall, the Australian Institute of Health and Welfare (AIHW) figures show emergency departments have managed to provide treatment for the vast majority of patients within two hours, despite accelerating growth in the number of cases.

According to the Institute, in 2011-12 there were more than 6.54 million emergency department presentations, a 5.4 per cent jump from the previous year, of which 90 per cent were seen within two hours of arrival.

The figures show that emergency departments were particularly effective in dealing with critical cases, with 100 per cent of resuscitation patients treated within the time specified by their triage category, as were 80 per cent of emergency cases, 66 per cent of urgent cases, 70 per cent of non-urgent cases and 89 per cent of non-urgent cases.

But the data suggests public hospitals are struggling to meet the four-hour rule agreed upon by the Federal, State and Territory governments as the benchmark for performance by which they will be judged form 2016.

Under the National Emergency Access Target agreed to as part of the National Health Reform Agreement, by 31 December 2015 90 per cent of emergency department patients will, within four hours, have to be either admitted to hospital, be referred to another hospital, or be discharged.

Data compiled by the Institute show that in 2011-12 just 64 per cent of emergency department patients had their visit completed within the specified time.

Only Western Australian hospitals (79 per cent) came close to the target, though their relatively strong performance is not surprising because they have been operating under this system since 2009.

There are concerns that the performance of hospitals may be even worse than the figures suggest – fears exacerbated by the revelation of significant data manipulation at Canberra Hospital.

A senior Canberra Hospital official resigned earlier this year after admitting to doctoring records for thousands of hospital visits and treatments.

There have also been anecdotal claims and reports of patients being given painkillers and discharged prematurely in order to massage treatment data.

But AIHW Chair Dr Andrew Refshauge has sought to assure governments and the public of the veracity of the figures being collected by his organisation.

Dr Refshauge said the Validata system being used meant that data could be validated much more quickly and easily than in the past, and eliminated inconsistent manual checking processes.

He said this was important not only for evaluating the performance of hospitals against national benchmarks, but also gave individual institutions timely access to critical information.

"During the trial of this system, hospital Golden Staph infection rates were available on the My Hospitals website within four months, whereas previously the data wasn't available until the end of the financial year," Dr Refshauge said. "This doesn't just allow for accurate reporting, it allows hospitals to see and react to data just a few months after it's collected, rather than trying to respond down the track."

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INFORMATION FOR MEMBERS

Upcoming 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

Silent Witnesses: The place of the coronial system in a civilised society

The deaths of asylum seekers in custody will be a focus of the Asia Pacific Coroners' Society's annual conference at the Amora Jamison Hotel, Sydney. Former High Court judge Mary Gaudron will speak on the role of the coroner and the rule of law in a keynote address to the conference on 21 November, while coroners from New South Wales and Western Australia will lead a discussion on asylum seeker deaths on 22 November. The conference will also hear speakers on forensic psychiatry, eyewitness memory, the future of autopsy and preventing deaths in custody.

For more information, visit: www.dcconferences.com.au/apcsc

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GP Super Clinics: Evaluation

BY **DR BRIAN MORTON**

"Clinicians working in GP Super Clinics, as well as the directors, reported that they provided internally integrated multi-disciplinary care, and that this was benefiting patients"

An initial evaluation of the GP Super Clinics program has not delivered the glowing report card that the Government would have been hoping for.

The evaluation, for 2007-08, focused on three aspects of the program: its implementation and administration by the Department of Health and Ageing the planning and construction of 36 GP Super Clinics; and services delivered by seven clinics which had been operational for at least 6 months.

Key stakeholders including the AMA were not consulted as part of the assessment, which instead drew on the experiences of departmental staff, the clinics themselves and their patients.

The limited period covered by the evaluation, and the small number of operational GP Super Clinics involved, did not lend itself to a comprehensive evaluation of the benefits and cost effectiveness of the program.

Indeed, many of the 32 recommendations focused on administrative processes, rather than the delivery of health care.

The AMA was keen to see the evaluation look at the cost effectiveness of the Government's investment in GP Super Clinics in terms of its delivery of good health outcomes for patients.

Instead, what we got was an assessment of cost effectiveness based on construction costs per square metre. This measure has nothing to do with the health care needs of local communities.

In relation to the cost effective measure applied in the evaluation, one third of the 18 clinics that were assessed were shown not to be good value for money.

One good measure of cost effectiveness from my perspective is how many more GPs are working in the local communities as direct result of the operation of a GP Super Clinics. In this regard the evaluation stated that the seven operational clinics claim to have experienced a net increase of 19 GPs (headcount) overall.

The 2007-08 Federal Budget set aside $280 million to fund 36 GP Super Clinics – an average of more than $7.5 million per clinic.

While we don't know how much funding the seven clinics highlighted in the evaluation received, a net increase of 19 GPs looks like fairly poor value for money.

The evaluation also showed that the GP Super Clinics had been plagued by delays during the evaluation period, with 181 reported instances. It is hardly surprising, therefore, that only 29 of the 36 clinics announced in 2007-08 have been delivered to date.

Patients were positive about their experience of the seven clinics whose operations were evaluated, particularly in relation to access, quality of care and cost.

Nevertheless, while engagement with the community about needs was required in the application process, few of the clinics had a plan or process for ongoing community engagement.

Clinicians working in GP Super Clinics, as well as the directors, reported that they provided internally integrated multi-disciplinary care, and that this was benefiting patients.

That said, there was some concern that the "price and volume" approach employed by these practices to ensure their financial viability required GPs to largely focus on medical assessment and clinical treatment advice, with the other disciplines left to handle other aspects of patient management.

From my reading of the evaluation, there also seemed to be an unhealthy focus on throughput in order to underpin the viability of the clinics – it is unclear what this means for the quality of patient care, as we all know the importance of spending more time with patients, particularly those with complex and chronic illnesses.

The Australian National Audit Office (ANAO) is currently conducting an audit of the GP Super Clinics Program.

I am confident the ANAO will deliver a much more robust and useful evaluation.

It has consulted extensively with the AMA and has a strong reputation for delivering high quality assessments of government programs – which the GP Super Clinics program is clearly in need of.

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Search for sense in rural hospital funding

BY **DR DAVID RIVETT**

"Is there sound science for these decisions, when there is so little data on small rural hospital funding, or are these key decisions based on guesstimates?"

The AMA Rural Medical Committee next convenes on 20 October in Canberra for what will be something of a watershed meeting, in that it will be the first time we will meet jointly with the AMA Council of Doctors in Training.

Topics for discussion on this joint agenda include the barriers and disincentives to rural practice (and possible solutions), as well as bonded medical places and the issue of "Generalism".

Although our committee includes a Council of Doctors in Training member, it will be great to get broader input on ways forward from a concerned group of young medico-political dynamos. In particular, I am busting to learn just what they see as solutions to the rural workforce crisis.

Perceptions of rural practice as being backbreaking work conducted in isolation from professional support and short on fun must be ended. With modern technology, rural practitioners are less isolated than ever before, and a country lifestyle has heaps to commend it. Furthermore, steadily improving locum backup and Commonwealth funding for training is giving increased opportunities for city recreation and study breaks.

I am the AMA's representative on the Independent Hospital Pricing Authority's Small Rural Hospitals Working Group.

One voice on a committee bigger than Ben Hur does not give us a lot of clout, but I will nonetheless try to ensure the concerns of rural practitioners are aired, and that reasons are given for the Independent Hospital Pricing Authority's rulings affecting rural hospitals.

There are many questions which need answering, including: how the threshold above which Activity Based Funding rather than block funding will apply to small rural hospitals was set; why outer regional hospitals got an 8.7 per cent loading while inner regional hospitals got nil; and why the Indigenous loading was set at 5 per cent.

Is there sound science for these decisions, when there is so little data on small rural hospital funding, or are these key decisions based on guesstimates?

Coming from a 30-bed hospital 300 kilometres south of Sydney, which has been determined to be too busy to receive block funding, I cannot be less than seriously alarmed about the templates being applied to decision making.

Small hospitals cannot maintain steady bed occupancy. One day you can have every bed full and bed-locked patients stuck on trolleys in emergency. On another you can have the wards half empty. Such is the nature of small rural hospitals. This must be recognised.

The application of "efficient funding" formulae derived from urban centres is madness and will only bring distress to many excellent rural hospitals.

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Neglect of prisoner mental health costs us all

BY **PROFESSOR GEOFFREY DOBB**

During this year's Mental Health Week the AMA issued a timely reminder to consider the links between mental health and the criminal justice system.

The extent of mental illness in Australia's prisons, juvenile detention centres and police cells is a legacy of years of policy failure and neglect.

In recent decades, prisoner numbers have swelled, growing at a rate that outstrips population growth.

At the same time, the proportion of those in custody with a mental illness has also risen. A third of people entering prison report being previously diagnosed with a mental disorder, and the prevalence of some mental disorders is almost ten times greater among prisoners than in the general community. As a group, prisoners with a mental illness experience poorer health, experience greater socio-economic disadvantage, and higher rates of recidivism compared with prisoners without a mental health disorder.

One area of particular concern is the growing incidence of mental illness among children and young people in juvenile detention.

In the most recent NSW *Young People in Custody Health Survey*, 87 per cent were found to have had a psychological disorder of some description.

Despite this bleak picture of mental health in Australia's prisons and juvenile detention facilities, there has not been a systematic and sustained policy response.

Unfortunately for those who wind up in prison, appropriate treatment for mental health problems is often unavailable. Even where services and supports are provided while in custody, the failure in many instances to provide ongoing care upon release means the mental health and wellbeing of ex-prisoners is at risk.

From a criminal justice perspective, this lack of mental health services makes little sense, as comprehensive treatment and support can delay or prevent recidivism in mentally ill offenders.

Ultimately, the lack of effective treatment options both within and beyond prison walls contributes to a revolving door between prisons and the community.

So, what can be done?

Firstly, children and young people at risk of falling foul of the law should be the target of early intervention efforts. Although crime rates in general have not increased, the numbers of juveniles in detention have grown substantially, and all too often their mental health needs are not being adequately identified and treated in the community.

For adult offenders with a mental illness, there is growing evidence that timely and appropriate treatment reduces rates of re-offending and incarceration.

There is an opportunity, while people are in the criminal justice system, to screen for mental health problems and provide appropriate evidence-based treatment. Additionally, expanded mental health services, court diversion programs, and well-resourced inpatient forensic mental health services are needed.

We know, however, that improving the health of prisoners is not a vote winner.

Prisoners with a mental illness are typically out of sight, out of mind, or are considered unworthy of attention or better health care.

But if we continue to use prisons as de facto mental institutions, then we will have to be prepared to bear the substantial costs. In 2010-2011 alone, nearly $3 billion was spent building and running prisons, with each prisoner costing taxpayers an average $289 a day to keep behind bars.

In terms of the health and social costs, the impact of incarceration extends beyond individual prisoners and reaches into families and communities. Almost all of those who are placed in custody come out again, with more than 50,000 adults released from prison into the community each year.

Addressing the mental health needs of prisoners can reduce the likelihood of re-offending, meaning fewer will end up back behind bars, ultimately curbing the drain on public finances from running prisons.

In August the AMA released its updated Position Statement on *Health and the criminal justice system*, reaffirming its commitment to policies and programs that improve the health and wellbeing of people who come into contact with the criminal justice system.

Addressing the mental health needs of this vulnerable population is critical, and the AMA has issued a challenge to governments at all levels to address the growing disparities in the health and wellbeing of prisoners and juveniles in detention compared with the rest of the population.

It remains to be seen whether governments will meet this challenge and overcome the policy neglect and failure that has characterised the approach to mental illness in the criminal justice system.

But without remedies the social, health and financial costs will continue to grow for individual offenders, their families and for the wider community.

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More Than Just A Union – a history of the AMA

In the sixth 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 Rosanna Capolingua and Dr Andrew Pesce, who led the organisation from 2007 to 2011, a period electrified by the election of the Rudd Government, which embarked on a flurry of reform.

During her tenure – which straddled the final months of the Howard Government and the election of Federal Labor, Dr Capolingua found herself fighting against an expanding array of health professions encroaching on the domain of medical practice, while also seeking to blunt the worst aspects of the GP Super Clinic program and a push for home births.

Dr Pesce sought to bring the AMA's voice to the table to help steer the Rudd Government's enthusiasm for health reform in constructive directions. While many of these initiatives are a work in progress, the former President played a prominent role in guiding the development of the National Disability Insurance Scheme.

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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Standing up for the profession

BY **DR ROSANNA CAPOLINGUA, AMA PRESIDENT 2007-09**

Becoming Federal President of the AMA was never a specific goal in my life, but rather an evolution of passion and commitment.

As leader of the AMA, you are able to serve your profession and patients across the spectrum.

It is a role that should always be observed with humility. It is a role that represents the entire profession and must not be affected by vested interests. It is a role that should be underpinned by patient care as a priority, utilising tax dollars efficiently and effectively for health care delivery.

My Presidency commenced in 2007 with the Secretary General's position vacant and a Federal election five months away. It was like being Chair of the Board of a major company facing a critical time in business, with no CEO.

The AMA relies on the intellect, ability and hard work of good staff, and the overwhelming voluntary contribution of colleagues. On these shoulders we were able to continue to do business, but it was an additional challenge.

During the lead-up to the federal election the AMA made health a pivotal issue, and it was a hot contest between a Government facing loss and an Opposition striving for power. That election and the change of Government was an exciting time to be Federal President. Many issues current today are a legacy of policy proposals debated then, and the AMA's ability to influence them is essential for better outcomes.

A good example is *The Australian* headline on 5 March this year, with the new Health Minister allowing up to 10 'health professionals' prescribing rights under the Australian Health Practitioners Regulation Agency (AHPRA) workforce improvements. This ongoing deregulation of quality health care for Australians was borne out of the concept of National Registration.

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Initiated in the Howard Government, this legacy is based on lowest common denominator ideologies rather than recognition of the requirement for training, standards, and complexity of skills to deliver optimal care based on expertise. We continue to suffer the afflictions of AHPRA on medical practice and care.

During my term as President we finally enlightened Health Minister Tony Abbott and, subsequently, the Prime Minister, that the National Registration model was convoluted, bureaucratic and expensive. The AMA was instrumental in stopping John Howard from signing the intergovernmental agreement.

There was an interval pause for some sense to be applied but, with a change in Government, Kevin Rudd hurriedly went ahead. Many have experienced the inefficiencies and costs of this system of registration, and the ongoing repercussions for the medical profession.

At election time the AMA had to hold the parties accountable with regards to bed shortages, emergency department overload, hospital occupancy, cost shifting, health funding, General Practice infrastructure, rural health services, Medicare, training, public–private split and, of course, party ideology.

Misdirected drivers to pork barrel electorates with Super Clinics; babies put at risk with a push for home births that made mothers feel inadequate if they chose a hospital; the 'buck stops with me' and Health Minister Nicola Roxon's 2008 Ben Chifley Memorial Light on the Hill speech - these were all at play during my Presidency.

In the 2012 Labor leadership battle, Ms Roxon's references to Kevin Rudd which – according to *The Australian* – "revealed the depth of this shambolic policy making" in health, were an insight into those times.

We have an AMA for a reason. We must never assume that Government policy should not be questioned, challenged, and informed by service providers at the coalface who understand what is needed, and what can be responsibly and sensibly provided.

So, in my Presidency, to be constantly analysing and questioning; to be putting forward alternative, more effective and efficient solutions, and to be pushing hard against the juggernaut of a confident new Government bureaucracy was energising.

Bringing together our colleagues across Colleges and Craft groups was important. We achieved this across the medical profession, and even across the allied health providers on the issue of the AHPRA model.

Federal Presidency is a learning curve across all issues. The big picture is as important as attention to detail. You need to be able to stand in the face of attack, and stand on principle for the profession, not for yourself. The reward is the experience and the privilege.

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Reforming health care

BY **DR ANDREW PESCE, AMA PRESIDENT 2009-11**

It is indeed a great honour for all AMA Presidents to represent our profession and, in a sense, be seen as the public face of the medical profession.

Without doubt, the defining issue for the AMA and my Presidency was the Health Reform agenda of the Rudd Labor Government.

Prime Minister Kevin Rudd had correctly identified the widespread dissatisfaction among patients and health professionals with the increasing failure of the health system to cope with the community's health care needs.

Identifying that a problem exists is one thing, fixing it is another.

The AMA did its best to help steer the reform process in a direction that would allow doctors to deliver the best care that they could for their patients, while not themselves having to pay the price of health reform.

It was important that the AMA was seen to be part of health reform, rather than an obstacle to necessary reform.

History will judge the success or failure of the Health Reform initiatives. At present, it appears that the only significant outcomes of the process were to introduce activity-based funding in those states where it had not previously been used, and the move to increase local decision making via the appointment of Local Governing Councils to oversee local management of health district hospitals. Medicare Locals provide an opportunity for sensible structured assistance to our long suffering GPs, but also for difficulties if they are not properly run.

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It was inspiring to me to see the passion and dedication of doctors at all levels and our AMA Secretariat work to improve the health system.

I was proud of how they rose to the challenge of working with sometimes-unsympathetic political and bureaucratic systems to provide constructive solutions to problems not of their own making. For example, the AMA's consensus document on training of the future medical workforce remains the single concise template for an effective training system from medical school intake to vocational specialist training, which will provide the doctors that our communities need.

The opportunity to promote and advance the cause of a National Disability Insurance Scheme was a personal highlight. A journey that for me had begun a decade earlier as a struggle to address the unaffordability of the medical indemnity insurance system now took on more widespread significance as the AMA championed support for disability based on need rather than blame.

The Productivity Commission delivered visionary and aspirational recommendations recognising that the political realities of a federated system should not forever condemn Australians with disabilities to fragmented and inadequate support. A once-in-a-generation opportunity now exists to advance solutions to a problem that has remained in the too-hard basket for too long.

Should a National Disability Insurance Scheme proceed, I believe all AMA members can be proud that the AMA played its part in assisting our most vulnerable patients.

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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 produced 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 sometime 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.

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RESEARCH

Eight hours of sleep for heart health

Teenagers who don't get a minimum of eight hours of sleep a night are more likely to develop heart disease later in life, a study has found.

Canadian researchers investigated the association between sleep quality and duration with cardiovascular risk factors such as cholesterol, hypertension, body mass index and dietary factors in adolescents.

The researchers found, that of the 4100 teenagers who participated in the study, nearly 20 per cent reported poor quality of sleep during the week and 10 per cent reported poor sleep on the weekends. On average, the participants slept 7.9 hours per night on weeknights and 9.4 hours per night on weekends.

Poor sleep quality included difficulty falling asleep, restlessness, frequently waking during the night and waking early. Participants who had poor sleep quality were identified to exercise less, spend more time in front of the TV and eat a poorer diet than those who had adequate sleep.

Participants who had poor sleep quality were also found to have higher cholesterol levels, higher blood pressure, a higher body mass index and a larger waist – all potential risk factors for heart disease.

Researchers took these factors into consideration and found that those who had poor sleep were linked to a higher rate of potential heart risks despite their lifestyle choices.

Participants with the worst sleep quality were found to be 43 per cent more likely to have heart risk factors.

Lead researcher Dr Indra Narag, Director of Sleep Medicine at the Hospital for Sick Children in Toronto, said the importance of sleep hygiene could not be over-emphasised.

"In general, we recommend teenagers get between eight and nine hours of sleep each night," Dr Narag said. "But, in reality, the study indicates that half of the teenagers examined got fewer than seven hours of sleep on weeknights.

"Weekends are a different story, since kids often take the chance to sleep in. But that doesn't make up for late nights during the week".

Dr Narag said parents should encourage their children to keep a consistent sleep schedule by removing stimulants such as TVs, computers and mobile phones from their bedrooms.

She also indicated that energy drinks are a major culprit in affecting the quality of sleep among teenagers.

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Bisphenol A linked with obesity

A New York University study of bisphenol A (BPA) levels in the urine of nearly 3000 young Americans aged between six and 19 years suggests an association between urinary BPA concentration and obesity.

Using as subjects children and teenagers drawn at random from the 2003-2008 US National Health and Nutrition Examination Surveys, the study was controlled for race/ethnicity, age, caregiver education, poverty-to-income ratio, sex, serum cotinine level, caloric intake, television-viewing habits and urinary creatinine level.

Rates of obesity among those with the highest BPA were 2.6 times higher than those with the lowest: among those with the highest, 22.3 per cent were obese compared with 10.3 per cent with the lowest.

The report – published in the *Journal of the American Medical Association* – emphasises that "explanation of the association cannot rule out the possibility that obese children ingest food with higher BPA content or have greater adipose stores of BPA".

The European Union and the US Food and Drug Administration have banned the use of BPA in polycarbonate feeding bottles, though pre-ban bottles are thought to be still in use, and the insides of aluminium drink cans (at least in the US) are coated with BPA.

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Falls send many to hospital

Accidental falls are the leading cause of injury hospitalisations in Australia, according to a report by the Australian Institute of Health and Welfare.

In 2008-09 almost 40 per cent of the 413,000 injury cases requiring hospitalisation were as a result of accidental falls.

The Institute's spokesperson, Professor James Harrison, said accidental falls are most common in young children and the elderly.

"They [accidental falls] are common among children coming off playground equipment, or bicycles or so on, but they are also very common, and in many ways more severe for older people, who may fall and fracture a hip, which can be a quite serious event that can lead to people losing their independence and even dying," Professor Harrison said.

The report found that women were more likely to be hospitalised as a result of an accident than men, with rates highest among older Australians.

Young children aged up to four years were most likely to be hospitalised due to accidental falls (40 per cent) followed by smoke, fire, heat and hot substance injuries (8 per cent) and poisoning by drugs (7 per cent).

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For people over the age of 65 years, accidental falls accounted for 51 per cent of hospitalisations, followed by poisoning by drugs (15 per cent).

The second most common cause of hospitalisation injury for Australians was transport accidents, which accounted for 14 per cent of all injuries. Men were found to have a higher hospital admittance rate than women.

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TB: A cheap, off-patent drug?

Researchers at Weill Cornell Medical College in New York have made the "completely surprising" discovery, after laboratory-only tests on thousands of approved drugs, that the cheap, off-patent drug oxyphenbutazone appears to kill replicating and non-replicating drug-resistant TB.

Their discovery is reported in the journal *PNAS*.

Oxyphenbutazone first went on the US market as a patented drug for arthritis-like pain relief 50 years ago, but it lost its patent – and its market dominance – by the 1970s.

Taking the discovery further will not be easy.

First, it is difficult to conduct clinical trials of a drug so outdated and confined in the US these days to veterinary medicine. Second, the Cornell researchers could not use animal trials to test oxyphenbutazone against experimental TB because animals metabolise it to an inactive form far more quickly than humans do.

Because the US Food and Drug Administration requires pre-clinical animal testing studies for safety and efficacy, "testing the drug for TB use in humans is thus problematic," lead researcher Dr Carl Nathan says.

Third, "no drug firm will pay for clinical trials if they don't expect to make a profit on the agent," he says.

The study admits that oxyphenbutazone has some established toxicities but points out that they seem to be less frequent than the major side effects of the drug regimes used currently in the US to treat TB.

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Australian UV radiation levels steadily rising

A study of UV radiation in three regions in Australia between 1959 and 2009 just reported in the *International Journal of Biometeorology* has detected an increase in UV levels of 2 to 6 per cent a year over the past 20 years.

The study was conducted by Dr Lilia Lemus-Deschamps of the Bureau of Meteorology and Ms Jen Makin of Cancer Council Victoria's Centre for Behavioural Research in Cancer.

It found that, during the 1970s and early 1980s, clear-sky UV index levels for Northern, Central and Southern Australia were fairly stable. Over the past 20 years, however, "deviations from 1970–1980 levels show that clear-sky UV is on the rise. After the 1990s, an overall annual increase from 2 to 6 per cent above the 1970–1980 levels was observed at all latitudes.

"Examining the summer and winter deviations from 1970–1980 showed that the winter signal dominated the annual changes, with winter increases almost twice those in summer."

The study used two long-term ozone datasets derived from surface and satellite measurements, a radiation code and atmospheric meteorological fields to calculate clear-sky UV radiation over the 50 years.

"If all other atmospheric factors are equal, stratospheric ozone decreases result in UV increases," the report says. "Given that Australia still has the highest skin cancer rates in the world, it is important to monitor Australia's stratospheric ozone and UV radiation levels over time because of the effects that cumulative exposure can have on humans.

"With ozone levels not expected to recover to pre-depletion levels until the middle of this century, UV levels are expected to continue to rise.

"Combined with Australians favoring an outdoor lifestyle, when temperatures are warmer, under high levels of UV, the associated risk of skin cancer will increase."

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Cardiac study: twins needed

St Vincent's in Sydney and the Victor Chang Cardiac Research Unit are looking for twins to take part in a study into the relationship between genes and heart electrical activity.

The twins can come in all varieties: identical, non-identical, same sex, different sex. But they have to be aged between 18 and 35, be non-smokers, have no major health problems and taking no regular medication. They also need to be happy about wearing an ECG (Holter) monitor for 24 hours.

The reason for the study is to assess the relationship between heart tracing appearance on a Holter monitor and differences in DNA between different people.

In normal, healthy people, while some variations in ECG characteristics (thought to be caused by differences in how an individual's DNA is used by the body) may protect against abnormal heart beat, others may increase the risk. With the Holter monitoring, the twins can help

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discover how the gene-heart activity interaction works because they share genetic code - 100 per cent in the case of identical twins, 50 per cent in non-identical twins.

Contacts for more information are principal investigator Professor Jamie Vandenberg at j.vanderberg@victorchang.edu.au or research assistant Dr Emily Hodkinson at e.hodkinson@victorchang.edu.au or (02) 9295 8600.

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Energy drinks cause hearts to flutter

Young Australians are unwittingly putting their heart heath at risk by mixing energy drinks with alcohol, an Australian-first study has found.

Researchers from the Turning Point Alcohol and Drug Centre and Monash University examined consumption patterns and associated harms of mixing energy drinks with alcohol among Victorians aged between 18 and 35 years over a six-month period.

The study found that some participants were consuming in excess of eight energy drinks mixed with alcohol in a session, unaware of recommended consumption guidelines suggesting only two energy drinks should be consumed a day, or the associated health risks, which can include heart palpitations, blackouts and sleep disturbance.

Lead researcher, Dr Amy Pennay, said mixing energy drinks with alcohol as a party beverage is now considered normal by young Australians, who are putting their health at risk by consuming amounts beyond what is deemed safe.

"Energy drinks are concentrated with stimulants like caffeine, ginseng and taurine, while alcohol is a depressant," Dr Pennay said. "By mixing the two it confuses the nervous system, which can often trigger cardiac problems."

Dr Pennay said young people having a big night out often combined energy drinks with vodka, Jagermeister and Cointreau, and sometimes with illicit stimulants.

"When people drink alcohol and energy drinks in excess, they're also at high risk of symptoms of over-stimulation, including difficulty sleeping, severe hangovers, aggression, violence, heart palpitations, blackouts, vomiting and tremors," she said.

AMA President Dr Steve Hambleton said there is hard evidence that mixing energy drinks with alcohol is harmful to health, and the Government needs to do more to regulate the industry.

"Energy drink regulations need to be overhauled to prevent further harmful health problems," Dr Hambleton said

"In addition to the Australian findings, international findings have found that mixing alcohol and energy drinks increases the risk of getting into a car driven by an intoxicated individual, being sexually assaulted, and sexually assaulting."

In 2011, a Ministerial Council agreed to a comprehensive review of the 2003 Policy Guideline on the Addition of Caffeine to Foods, after the AMA cited new research showing that young people chose alcoholic energy drinks because they allowed them to keep drinking for longer.

The review has not yet been completed.

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Use of beta-blockers questioned – study

The benefits of using beta-blockers for treating heart disease have been called into question by an American study.

Beta-blockers have been used since the 1970s to slow the heart rate, treat heart failure and other heart disease symptoms, but US researchers have found that the drugs might be more of a detriment than a benefit for patients.

Researchers from the New York University School of Medicine found people with stable heart disease who are prescribed beta-blockers are just as likely to suffer a heart attack or stroke than patients not on the medicine.

The researchers assessed data from more than 45,000 people with established coronary artery disease or risk factors for heart disease to determine the effectiveness of beta-blockers.

The data was divided according to whether people had suffered a heart attack, had coronary artery disease but had not had a heart attack, or just had risk factors such as diabetes and high blood pressure.

The researchers monitored the participants for 44 months and found that people on beta-blockers fared no better than others in each of the three categories.

There was no difference in outcomes overall among people who suffered from a heart attack who did or did not use beta-blockers. However, participants who had suffered a heart attack within the past year and took beta-blockers were less likely to end up in hospital due to their condition.

Participants who had risk factors for heart disease who took beta-blockers were 14.2 per cent likely to end up in hospital compared with 12 per cent not on the drugs and 12.9 per cent of people with coronary artery disease who took beta-blockers had a heart attack or stroke or died, compared with 13.6 per cent who did not.

The researchers said the slight variations between non beta-blocker patients and beta-blocker patients could easily be due to chance.

The research was published in the *Journal of the American Medical Association.*

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HEALTH ON THE HILL

New Australian Ambassador for HIV/AIDS, TB and Malaria

James Gilling, a senior officer in AusAID, is to be Australia's Ambassador for HIV/AIDS, Tuberculosis and Malaria, succeeding Murray Proctor, who has been Ambassador for HIV/AIDS since 2007.

Announcing the appointment, Foreign Minister Bob Carr said that the role had been expanded to cover TB and Malaria "to reflect the major health challenges facing Australia's region".

"Millions of people continue to be affected by these threatening diseases which in 2010 alone claimed more than 3.5 million lives," he said. "In the Asia Pacific region in 2010 there were 30 million cases and 43,000 deaths as a result of malaria alone, so Australia's support is vital."

Mr Gilling is the First Assistant Director General in AusAID's Policy and Sector Division, where he is responsible for policy coordination on HIV/AIDS, malaria and TB issues.

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Medicare rebates for specialist supervisors

Changes to rebates for specialists supervising procedures by trainees are set to be approved.

Regulations made under the *Health Insurance Act* last year to change the way that procedures by trainee specialists attract Medicare rebates for the supervising specialists are to be confirmed in legislation now before the Parliament.

Health Minister Tanya Plibersek said when introducing the change that, before July last year, only trainee surgeons with the Royal Australasian College of Surgeons could conduct a procedure under the direct supervision of a specialist in a private setting and have that service attract a Medicare rebate for the supervising surgeon.

In July, the regulations were changed to make it possible for trainees of other approved professional colleges to also provide certain procedures under the direct supervision of a specialist - including trainees in orthopaedic surgery, ophthalmology, obstetrics and gynaecology, internal medicine and anaesthetics – and have those procedures attract a Medicare rebate for the supervisor.

The change was made as a way to expand the nation's capacity to train specialists without significant additional cost to the Government.

Ms Plibersek said the change had been successful, and the Government considered that it should now be recognised at the level of primary legislation.

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Doctors on the front line in monitoring dodgy devices

Doctors could face sanctions if they fail to notify the medical watchdog of problems with medical devices, under proposals being considered by the Federal Government.

A Senate committee inquiring into the regulation of medical devices has recommended that mandatory reporting requirements be introduced to compel health practitioners to inform the Therapeutic Goods Administration of problems with prostheses, implants and other devices.

The inquiry, set up amid concern about the regulation of medical devices following the worldwide recall of Poly Implant Prosthese breast implants, suggested compulsory reporting of device problems and failures as part of stringent measures to protect patients.

"The [Community Affairs References] Committee recommends that the Therapeutic Goods Administration put in place mechanisms to educate and encourage doctors to report adverse incidents associated with the use of medical devices," the inquiry said. "The committee further recommends that the Department of Health and Ageing introduce mandatory reporting for health practitioners to the TGA on relevant issues, in certain circumstances, including problems with medical devices."

In its response, the Government said it would consider the recommendation and discuss it with regulators and State and Territory governments.

"The Government agrees that adverse event reporting by medical practitioners is a vital component of a comprehensive system of post-market surveillance," Government leader in the Senate, Senator Penny Wong, told the Senate last month. "The Government undertakes to raise this matter with the Medical Board of Australia." But the Government appears lukewarm about introducing mandatory reporting requirements before efforts to establish a successful voluntary notification system are fully exhausted.

An online data base to report, catalogue and notify of adverse events involving medical devices was set up by the TGA earlier this year, and Senator Wong said efforts to publicise the resource to practitioners and the public would be intensified.

"Further work is required to encourage greater reporting of adverse events from therapeutic goods," the Senator said. "The Government has agreed to implement recommendations to more effectively facilitate the recognition and reporting of adverse events by health practitioners and consumers, and promote the adverse event reporting system."

She said this would include making the Adverse Events Database available to, and searchable by, the public "in a manner that promotes the quality use of therapeutic goods".

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HEALTH ON THE HILL

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"In this context, the TGA will investigate ways to upgrade the value of individual clinician input and subsequent information exchange," Senator Wong added.

But the Government has so far baulked at calls for more stringent assessment of Class III medical devices, which include coronary artery probes, intrauterine contraceptives and, since July this year, hip, knee and shoulder joint replacements, except as part of a concerted international effort.

"The Government recognises that greater regulatory rigour for high risk, Class III medical devices would allow further evidential review prior to market entry, [but] believes that any increase to the level of assessment of Class III devices will be best achieved in harmony with international counterpart regulators," Senator Wong said.

In its response, the Government also played down concerns that the importation of medical devices bought via the internet was inadequate, and rebuffed suggestions that laws be put in place to govern the conduct of drug companies and medical device manufacturers.

"A legislative framework for ethical conduct of industry in the promotion of therapeutic goods to health care professionals is not warranted in the Australian context at this time," Senator Wong said.

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Dental scheme: Government's version prevails

The Government narrowly held off an attempt by the Opposition to block its move to shut down the Howard Government's Chronic Disease Dental Scheme and replace it with a program of its own.

Government legislation giving effect to the 2012 Budget decision to end the Chronic Disease program and replace it with a $4 billion initiative to provide dental care to more than 3.4 million children and 1.5 million pensioners and low income earners in the next six years was narrowly passed by the House of Representatives.

Health Minister Tanya Plibersek denied Opposition claims the new scheme would not be in full operation until July 2014. The $345 million allocated in the Budget to the new scheme would be available to the states and territories from January next year, the Minister said, one month after the old scheme had been closed down.

The Government prevailed over the Opposition move against the new scheme by only two votes, with Australian Greens MP Adam Bandt and independents Rob Oakeshott, Andrew Wilkie and Tony Windsor voting with the Government.

It is not clear at time of writing if the Opposition intends to carry on the struggle in the Senate, where the Greens – who have decided that the old scheme should be wound up and made welcoming noises about the new scheme – would be expected to support the Government's position.

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Sterilisation of people with disabilities: Senate inquires

The Senate has agreed with a proposal by the Australian Greens to inquire into the involuntary or coerced sterilisation of people with disabilities in Australia.

Senator Rachel Siewert moved the motion supporting the proposal but did not explain the reason for it. The Senate agreed without debate.

The investigation will be conducted by the Community Affairs Reference Committee.

It will cover seven broad areas:

- the types of sterilisation practices used,
- their prevalence and how they are recorded in the various jurisdictions,
- the various Commonwealth and State legal regimes, plus any action to date to harmonise these regimes,
- whether or not the various regimes adequately protect people's interests,
- the impacts of sterilisation on people with disabilities,
- Australia's compliance with international obligations on the issue, and
- the factors leading to sterilisation being sought by others than people with disabilities, including "medical practitioners, guardians and carers' knowledge of and access to services and programs to support people with disabilities in managing their reproductive and sexual health needs".

The Committee is to report back by 24 April next year.

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British and Dutch GPs lose income

Income from general practice in the UK and The Netherlands – both countries having undergone profound health reforms – is deteriorating, even though demand for GP services in both countries has remained high or even increased.

In the UK, the National Health Service's Health and Social Care Information Centre has disclosed that the average pre-tax income for doctors operating in the new GP contracting system began falling in 2010, when the Cameron Government began introducing its health reforms. The average level is now at its lowest point since 2005-06.

In The Netherlands, the Dutch Healthcare Authority (NZa) has reported that, though consults have grown roughly 20 per cent since 2005, the income of GPs over this period has fallen two per cent.

Like the UK, The Netherlands has undergone health system reforms that the NZa says were "designed to foster demand-based competitive provision of services to the benefit of consumers within a framework of basic public interest guarantees".

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Obamacare: yet another challenge fails

The latest result in a string of legal challenges to Obamacare by Republican and other opponents is a victory for the White House.

The case – brought before a Federal District Court in Missouri by a St Louis employer – challenged a section of President Obama's Patient Protection and Affordable Care Act requiring that the health insurance offered by businesses to their employees should cover contraceptives. The employer had claimed that this violated his Catholic beliefs, the philosophy with which he ran his business and also, therefore, the First Amendment of the US Constitution.

The judge ruled that the Act did not prevent the employer "from keeping the Sabbath, from providing a religious upbringing for his children or from participating in a religious ritual such as communion".

Instead, he remained free to exercise his religion, "by not using contraceptives and by discouraging employees from using contraceptives.

"This court rejects the proposition that requiring indirect financial support of a practice, from which plaintiff himself abstains according to his religious principles, constitutes a substantial burden on plaintiff's religious exercise."

The judgment is expected to be appealed. There are more than 30 other lawsuits against the health legislation wending their slow way through the US legal system.

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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.

To register for the product, please sign up here.

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Record complaints against UK doctors

Complaints about doctors in the UK have reached record levels, according to a report by the UK General Medical Council (GMC).

Almost 9000 complaints about doctors were lodged with the Council last year, a 23 per cent jump from 2010, and the number of complaints has been steadily rising since 2007.

In its report, the GMC noted a "significant" rise in concerns about how doctors interacted with their patients; allegations about communication increased by 69 per cent and "lack of respect" by 45 per cent.

"The GMC trends are in keeping with rising complaints across the National Health Service and, in particular, complaints about doctors," the report said, though "there is no evidence that this points to falling standards of practice.

"Initial analysis suggests that greater expectations, an increased willingness to complain, less tolerance of poor practice within the profession, as well as media attention for high profile cases may be behind the increase," it said. "The number of doctors falling seriously below the standards expected of them remains relatively small."

The GMC had taken action in more than 500 cases, and it "gave advice" for a further 700. The names of 65 doctors were erased last year from the medical register (in effect removing their right to practice medicine in the UK), and another 95 were suspended.

GMC Chief Executive and Registrar Niall Dickson commented that the GMC planned to introduce its revalidation policy from the end of this year. Revalidation is a new system of regular checks for all doctors in the UK. British Medical Association Chair of Council Dr Mark Porter has warned that revalidation must protect patients while being fair to doctors.

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2012 Nobel goes to cloning and stem cell pioneers

Two biologists specialising in cloning and stem cell research - one Japanese and the other British – share this year's Nobel Prize in Physiology or Medicine.

Professor Shinya Yamanaka, of Kyoto University, demonstrated in 2006 that it was possible to clone animals from skin cells genetically engineered with just four additional genes.

Sir John Gurdon, of Cambridge University, was the first person to clone an animal from a single cell, pioneering the development of stem cell technology.

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Swiss reject smoking bans

Voters in Switzerland have rejected a total ban on smoking in enclosed public places in a referendum initiated by the Swiss Pulmonary League.

The newspaper *La Tribune de Geneve* reports that, in some of Switzerland's 26 cantons, more than 70 per cent of voters rejected the ban, though voters in Geneva supported it 52 per cent to 48 percent.

Geneva and seven other cantons have already imposed their own comprehensive bans on indoor smoking in places of employment.

But restrictions introduced nationally two years ago have been watered down after lobbying from the catering trade and tobacco firms.

The remaining, smaller cantons have been less restrictive.

Before the referendum result was known, Dr Jean-Charles Rielle, a Pulmonary League office-holder, said that there was a need to clear up confusion created by these differences, pointing out that "in the cantons where these laws [banning smoking rooms] are already in effect, we saw immediately ... a 20 per cent drop in hospitalisation due to cardiovascular incidents, heart attacks and these kinds of problems".

The outcome of the referendum was welcomed, as expected, by the Swiss Business Federation, which described the result as "heartening".

"The initiative would have imposed more costs on restaurateurs who have already made considerable investments to protect non-smokers," it said.

But it was deplored by the Swiss Socialist Party, which said that better protection against passive smoking would have "incontestably been a major step in the improvement of (workers') conditions".

La Tribune de Geneve said that the result suggested that voters rejected a full ban because they did not want to force the smaller cantons into changing their local laws, plus resentment at perceived interference by the state in people's lives.

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Bariatric surgery: Canadian doctors warned

After 27 medico-legal cases involving bariatric surgery have ended up in Canadian courts in the past five years, the Canadian Medical Protective Association (CMPA) has issued new risk management guidelines for its members.

A CMPA review of the cases found that the most common procedures involved were gastric banding, laparoscopic Roux-en-Y gastric bypass and open biliopancreatic bypass. The only CMPA members involved were general surgeons. All but six of the 26 cases were settled.

The review reported that no concerns were expressed about whether or not each procedure was appropriate. Instead, the main allegations made by patients were that consent discussions were lacking and that histories were inadequate.

The new, six-point risk management guidelines for bariatric surgery offered by the CMPA - "based on the opinions of the surgical experts who examined the clinical care in the [27] cases" – cover pre-operative, inter-operative and post-operative management.

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With earthquakes in mind, NZMA redevelops HQ

NZMA House, headquarters of the New Zealand Medical Association on The Terrace in the prestigious parliamentary precinct of Wellington, is the first commercial property to be rebuilt in the capital so as to comply with new post-Christchurch earthquake building standards.

Demolition has just begun on the existing building, which was built in 1938 but which was found by an engineer's report on earthquake strength to meet only 10 to 15 per cent of the post-earthquake standards.

The redevelopment of NZMA House will add three floors to its existing three – the NZMA planning to occupy two of them - and is expected to be completed by the end of next year.

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Rate quickens in reducing world under-five mortality

UN agencies have reported that success in reducing child deaths has accelerated sharply since 2000.

The annual report of the UN inter-agency Group for Child Mortality Estimation (UN-IGME) noted that an estimated 6.9 million children around the world died before their fifth birthday in 2011, compared with about 12 million in 1990.

It said that the annual rate of reduction jumped to 3.2 per cent between 2000 and 2011, against 1.8 per cent in the 10 years to 2000.

But, despite the increasingly rapid pace of improvement, the gains will not be enough to achieve the UN Millenium Development Goal of reducing global under-five mortality by two thirds by 2015. Only six of the 10 regions are on track to achieve this.

The leading causes of deaths of children under five are pneumonia (18 per cent of all under-five deaths), pre-term birth complications (14 per cent), diarrhoea (11 per cent), complications during birth (nine per cent) and malaria (seven per cent).

Half of all under-five deaths occurred in only five countries: India (24 per cent), Nigeria (11 per cent), Democratic Republic of the Congo (seven per cent), Pakistan (five per cent) and China (four per cent).

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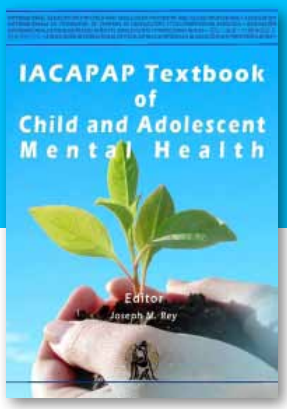
BOOK REVIEW



IACAPAP Textbook of Child and Adolescent Mental Health

Health, International Association for Child and Adolescent Psychiatry and Allied Professions

Edited By Professor Joseph M Rey

Reviewed by Dr Martin Beckmann

Practitioners, young people and their parents have free access to up-to-date and authoritative advice on the diagnosis and treatment of mental illness in children and adolescents following a breakthrough initiative of the Geneva-based International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP).

Published as an open access online publication, the *IACAPAP Textbook of Child and Adolescent Mental Health* is a comprehensive guide that draws on the latest research and evidence to help in the diagnosis, treatment and prevention of mental health disorders and illnesses.

It is edited by University of Sydney Medical School Honorary Professor Joseph Rey, who has brought together contributions from around 90 international experts.

Published under the Creative Commons Attribution Non-commercial License, the textbook – which can be downloaded instantly for free - is divided into 10 sections covering everything from perinatal and early childhood risk factors to mood, anxiety and externalising disorders.

The book begins with three citations which set the tone. The first, initially published in *The Lancet* in 2006, reads that "knowledge is the enemy of disease... Applying what we know already will have a bigger impact on health and disease than any drug or technology likely to be introduced in the next decade". The second, taken from Healthcare Information for All 2015, notes that "mental illnesses are different to most other illnesses. The overwhelming burden of mental illnesses falls upon the young". The final citation, from the World Health Organisation, observes that "supporting the mental health of children and adolescents should be seen as a strategic investment that creates many long term benefits for individuals, societies and health systems."

It is an interactive, consumer and professional-friendly electronic resource, but it is no Wikipedia.

It is divided into Sections A to J, which are further divided into chapters.

While all of the most important topics within child and adolescent mental health are addressed, a few areas are missing, and the editor is looking for volunteer authors to come forward to address these gaps.

Furthermore, readers are invited to provide feedback, including on such issues cultural and ethnic variations and interpretations.

The text is well referenced and enriched with hyperlinks to key research articles.

There are also links to video interviews with patients and professionals.

Some video clips underline particular issues. For example, the chapter on substances of abuse has a link to a 15 minute YouTube clip from the Australian film *Samson and Delilah* which shows the horrifying effects of solvent abuse on young Aboriginal people.

Moreover, there is access to access to the most recent and authoritative practice guidelines, as well as day-to-day practice-orientated clips for use in the clinic.

The textbook also includes access to tools like rating scales and questionnaires that are not covered by copyright and can be freely downloaded.

This online publication is a great resource for clinicians, their patients, academics and researchers from all points of the globe. All that is needed to view and download it is electricity and a computer with internet access. An interpreting tool on the IACAPAP website means it can be readily translated into other languages.

I am intrigued by the possibility that many more young people and parents than ever before will have access to evidence-based child and adolescent mental health information.

An updated edition is already being planned for released next year, and at this pace, and with this easy access, I believe that the IACAPAP textbook is going to be the most up-to-date, and also the most popular, child and adolescent mental health textbook going.

The textbook can be viewed and downloaded at: http://iacapap.org/iacapap-textbook-of-child-and-adolescent-mental-health

Dr K.M. Beckmann is a psychiatrist at Evolve Therapeutic Services, Metro South, Queensland, and is a Senior Lecturer at the Griffith University School of Medicine, Logan Campus.

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Toyota 86 - Worth its weight?

BY **DR CLIVE FRASER**

Readers of last month's column will recall the great return on your investment for those who manage to hang on to their Ford GTHO Phase 3 for 40 years or more.

My calculator came up with an annual compound return of 10 per cent.

Not bad I thought, particularly when shares, property and fixed interest investments at the moment are scratching to even stay in positive territory.

So for the second month running I'm going to suggest that buying a new car may be the best investment you can make right now!

How does a return of 20 per cent sound?

And that's over only three months, and not a whole year.

The suggestion of buying a new car did not of course come from my financial planner but, as you might expect, from my local car dealer.

A Toyota dealer, no less.

It all began when I started spruiking for a discount on Toyota's latest model, the Toyota 86.

"No way", he said and then he proudly Googled up the second-hand prices, which seemed to suggest anything up to an eight grand mark-up over the new car price for a three month old vehicle with about five thousand kilometres on the clock.

You see, it's all about the law of supply and demand.

If you want a Toyota 86 so badly and can't wait till Christmas, you might just have to shell out something extra for one.

Toyota are supplying 150 Toyota 86's each month and buyers are queuing up to drive off in one.

Subaru sell a virtually identical vehicle called the BRZ, but they are in even scarcer supply.

The Toyota dealer proudly proclaimed that the 86 was "about 80 per cent Toyota!"

But, lifting up the bonnet, Subaru is stamped all over the body panels and a "Made by Fuji Heavy Industries" (ie Subaru) sticker is mounted on the B-Pillar.

The motor is a familiar Subaru flat four, but the dealer assured me that there were plenty of other Toyota bits on the Toyota 86.

In the flesh, the 86 is surprisingly small, and that's where the low weight equation comes in.

With 147 kilowatts of power to drive 1257 kilograms of weight, there is a very favourable power-to-weight ratio - better than the Golf GTi and Mazda's MX5 and RX8.

Despite this, acceleration from zero to 100 kilometres per hour takes a leisurely 7.6 seconds - though this is due to gearing that favours twisting roads rather than drag strips.

But the handling and fun-to-drive factors more than make up for any deficiencies in straight-line performance.

The seating position is very, very low, and while there are two seats in the back, they were probably only ever intended for nephews and nieces.

The boot is a real surprise, though.

I was pleased to see that it accommodated a full-sized spare wheel with a neat dish-shaped space for all those little items that roll around - although this meant there was only enough room left for a small doctor's bag.

So what sort of doctors will buy a Toyota 86?

Anyone whose spouse won't let you indulge your passion for a really sporty set of wheels, but who likes the idea of buying a depreciating asset that appreciates in value, even if that's only for a very short term.

Toyota 86 GT	
For	At $29,990 plus on-road costs, it's a steal.
Against	Not quick off the mark.
This car would suit	Young registrars without kids.
Specifications	2.0 litre 4 cylinder boxer 147 kW power @ 7,700 rpm 205 Nm torque @ 6,600 rpm 6 speed manual 7.6 seconds 0-100 km/h 7.8 l/100 km combined $29,990 plus on-road costs

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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