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REGULAR FEATURES

The elephant in the consulting room

BY **AMA PRESIDENT DR STEVE HAMBLETON**

I was recently asked to speak at the ACTU Work Health Rights Summit in Melbourne.

It is not often that an AMA President gets to address ACTU gatherings, but the rights of workers when it comes to their health is common ground for the AMA and the ACTU.

My invitation to the Summit followed media reports of employers wanting to accompany their workers to doctor appointments. I was quoted as being against such a move – for the obvious reasons.

Not only would it be a major attack on the doctor-patient relationship, it exhibits a troubling lack of trust between employer and employee.

A few years ago we were having trouble getting businesses to take an interest in the health of their workers and to engage properly in the process.

But now it is likely that the pendulum has swung too far and that, in some cases, businesses are over-involved in the health of their workforce.

Some are almost at the stage of chaperoning their workers when they visit the doctor.

This approach has led to reports of bosses actually wanting to sit through the consultation with their employee and, in some cases, trying to alter their medical certificates to get them back to work sooner. This is not a positive development.

The AMA sees the role of the doctor as being first and foremost to consider the wellbeing of our patients.

Patients entrust themselves to our medical care, often in a vulnerable state of illness or injury.

Good health care will result from a close collaboration between the doctor and the patient.

We are bound to maintain our patients' confidentiality and our role is to act as an advocate for the patient in what is often a complex health system.

Our professional independence is critical to good patient care.

The AMA Code of Ethics also demands that we must safeguard our clinical independence and professional integrity from the increased demands from society, from governments, or from other third parties for the benefit of individual patients.

Our clinical independence is essential when choosing the best treatment for those patients and defending their health needs against all who would deny or restrict access to care.

I have never personally experienced an employer accompanying someone who was 'sick', but have certainly seen on a regular basis patients attending with the safety officer' or the 'workplace rehabilitation coordinator', who have often wanted to enter the consulting room with the patient.

Without the full and informed consent of the patient, the AMA generally sees no role for an employer in our consultation room.

By the very nature of the employer-employee relationship, the power is in the hands of the employer and the situation could be perceived as quite threatening, invasive, and coercive (even if unintended) to the employee (and possibly to the doctor as well).

There is the very real prospect that the employee may be in fear of repercussions from their employer.

From a practical perspective it also poses further real risks to the employees' right to privacy. In a medical consultation, there is every chance that the history will necessarily explore personal information that may be relevant to the consultation, but not relevant to the employer.

In response to this situation, the employee may feel the need to withhold or alter personal information in the presence of their employer in order to maintain their privacy.

This may have adverse health outcomes and could easily undermine the doctor's assessment.

In addition to an appropriate history from the patient as part of the relevant physical examination, the employee may be required to undress to some degree to be appropriately examined.

There is no doubt that if an unrelated third party was present that the behaviour of the doctor or the patient or both would change.

In circumstances such as these, our patients rely on us to advocate for them, and it would be entirely appropriate for the doctor to insist on seeing the injured worker alone to take that additional pressure off the patient.

In most cases with an unrelated third party in the consulting room, there is great potential for harm - with little in the way of potential benefit to justify the risk.

I think it best that we work to promote better trust about health issues in the workplace.

Employers providing transport and support and information can be a good thing, and it can enhance health care - but we definitely don't need that elephant inside the consulting room.

TO COMMENT CLICK HERE

Govts paring back health handouts risk voter wrath

BY AMA SECRETARY GENERAL FRANCIS SULLIVAN

Respected political journalist Laura Tingle set the hares running with a recent Quarterly Essay, *Great Expectations: Government, Entitlement and An Angry Nation*. To paraphrase, she describes a political culture that has set up an almost irrefutable expectation in the community that government can solve all problems, and that interest groups only have to make noise, and a handout - or ongoing subsidy - will shortly follow.

The upshot of this is that governments that preach austerity do so at their peril, as the community will react angrily when told "no".

Taken in its context, this is a very important essay. Already Shadow Treasurer Joe Hockey has called for an end to the "Entitlement Era." Numerous respected economists want a broadening of the GST to help meet the rising social spending budget. And the recent cutbacks from state governments in the health field likewise signal the strain to meet essential services funding.

Last month's Mid Year Economic Forecast Outlook (MYEFO) saw the Federal Government take a knife to what has been termed 'middle class welfare' – subsidies paid to individuals and families on above average incomes.

In the health arena, the most notable example of this largesse has been the 30 per cent rebate for private health insurance.

Long a target of the Department of Finance, the rebate for middle Australia has been steadily shaved away. It is now means tested and has further financial penalties for wealthier people.

This measure exemplifies what Tingle is highlighting. During the Howard Government, private health cover was made more affordable. The subsidy support was expensive, up to $3 billion annually. There was no discrimination on income grounds. Debate swirled around whether the rebate, or the tax penalty for those not taking up a rebate, was the main driver to increasing health fund memberships. Either way, the rebate remained and its price to government grew.

It came as no surprise when first the Rudd Government, and then the Gillard Government, took to cutting back government outlays for private health cover.

So far, the expected rage has not eventuated. Maybe Tingle's thesis may not apply universally.

However, what this does reveal is a bigger issue over future health funding that involves the Commonwealth's actions.

When the Commonwealth decides to target a program that is its sole responsibility, like the health rebate, then savings are both estimated and achieved. It is quite a different exercise when government responsibilities are shared.

The classic example is public hospital funding.

Here, the states and territories are the prime service deliverers for what is a joint agreement on a public entitlement. Free access to public hospitals is an entrenched community expectation.

But the way the system works, most of the financial risk resides with the states and territories. Only in the future is the Commonwealth committed to meeting the growth in funding the system will need.

Given this arrangement, it is unsurprising that the Commonwealth's aspirations for public hospitals outstrip its financial commitment. The inevitable outcome is a reduced entitlement as funds dry up.

We see this playing out in the current design of a new price for hospital services.

For months now, senior Commonwealth and state bureaucrats have jealously guarded the levers that will place a price on hospital services, and which is intended to drive efficiencies in the system.

This may work, but what is even more certain is that, by pricing units of work, governments create an innate incentive for hospitals to focus on the work that either best meets the price or can be done more cheaply. Those services that are too risky, or are prone to cost more than the set price, are at risk of being shifted beyond the public hospital. But where will they go?

Usually, the less predictable services fall in the acute care area. Psychiatric services and services for elderly patients with co-morbidities are prime examples. These services are not easily shifted to private hospitals. They also are not suitably moved into the community. They risk being poorly resourced in public hospitals unless particular attention is paid to the design of their respective prices.

Tingle's essay lays out a challenge for us all. In straitened times, a rationed pool of funding requires serious priority setting. Access to essential health care must be near the top of the list.

Cuts to private cover that are accompanied by a shift in savings towards essential services may be justifiable. But when those savings are removed from the health budget entirely, there may well be grounds for anger.

Determining whether the expectations are too great becomes the political trick.

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Medibank fails to crack Darwin line in Defence contract battle

The AMA has met with senior Medibank Private officials to press home concerns about flawed Defence health care provider contracts as resistance among specialists shows no signs of weakening.

The transfer of Australian Defence Force health care services to Medibank Health Solutions (MHS) has been plunged into crisis, with indications that the provider has so far been unable to secure the services of a single specialist in Darwin, a major Defence hub, and fewer than 10 per cent have signed up nationwide.

At a meeting last week, AMA President Dr Steve Hambleton and Secretary General Francis Sullivan warned MHS it would have to significantly improve the terms of its offer.

An AMA survey has confirmed that MHS is encountering stiff resistance to its plans to force specialists to accept a significant cut in fees and acquiesce to conditions that had the potential to limit patient choice, constrain clinical independence and compromise patient confidentiality, in return for being listed as a preferred provider of services to Defence personnel.

MHS made the offer after winning a four-year contract worth $1.3 billion to provide health care services to 80,000 Defence personnel.

The survey has found that less than 10 per cent of specialists have so far signed up to the MHS offer, with the practitioner backlash particularly fierce in some areas where major Defence bases are located.

Defence Personnel Minister Warren Snowdown, whose parliamentary seat encompasses much of the Northern Territory, is facing an embarrassing backyard revolt, with NT specialists appearing to have unanimously rejected the MHS offer.

None of the Darwin-based specialists so far surveyed by the AMA has signed a MHS contract, and Dr Peter Beaumont, President of AMA Northern Territory, said the private provider was also encountering resistance among general practitioners unhappy with the terms of provider agreements offered to them.

“I am not aware of any specialist who has signed up, and it is not just surgeons and orthopaedic surgeons,” Dr Beaumont said. “I know of three GPs up here who have refused to sign up.”

Shadow Defence Minister David Johnston said he was “deeply concerned” that the MHS dispute would undermine the quality of care provided to ADF personnel.

“I have been warning the Defence Minister [Stephen Smith] the system is flawed because the best doctors in Australia were not going to sign up to what is essentially a cost-cutting measure by the Government,” Mr Johnston said. “The best doctors in the country, who have treated Defence patients for years, have withdrawn en masse, and in some areas not a single doctor has signed up”.

The united front of Darwin specialists against MHS contracts and mounting resistance among GPs has come as a leading medical recruiter has launched a major drive to hire GPs to work at Defence Force barracks and bases around the country.

Charterhouse Medical has called for expressions of interest from locums to work in “defence and military health” at sites including barracks and naval bases.

The call for locums at military barracks and bases around the country has added to perceptions that MHS’s takeover of ADF personnel health care is coming increasingly unstuck.

According to reports in Fairfax newspapers, Defence has delayed the switch to a MHS list of preferred specialist providers by six weeks, in a clear sign that the organisation is struggling to get the practitioners its needs to provide the level of care required.

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Dozens of grads left in limbo despite intern breakthrough

The AMA President Dr Steve Hambleton has warned that the future of 64 medical graduates remains in limbo despite "very encouraging" progress toward ending the stand-off between the Commonwealth and the states over intern places.

Queensland and the Northern Territory have joined Western Australia and the Australian Capital Territory in reaching agreement with the Federal Government over funding additional medical intern places in public and private hospitals next year.

Under the deal, the Commonwealth will fund an extra 84 intern places, while Queensland will pay for an additional 18 positions, WA will pay for an extra 8, the ACT will pay for an additional 5 and the NT will pay for one more.

The breakthrough means that an extra 116 intern places will be funded next year, though 64 medical graduates remain without a place, putting their career prospects under a cloud and denying the health system of the extra doctors it needs – particularly in rural and regional areas.

Dr Hambleton called for the remaining states – including New South Wales and Victoria – to set aside their quibbles and join with the rest of the country in ensuring that all medical graduates get the training they need.

"The bigger states have to enter into the spirit of cooperation shown by the other governments, and do their bit to fund the nation's future medical workforce," the AMA President said. "This is not the time for the blame game of political point scoring – it is time for action and doing the right thing."

The unresolved crisis has highlighted a serious flaw in the nation's medical training system, where rapid growth in medical school places has not been matched by increased investment in post-graduate training.

Dr Hambleton warned that problems in the training system went well beyond a shortfall of internships.

"We are now seeing general shortages of pre-vocational training positions emerging, and Health Workforce Australia has predicted a shortage of 450 first year specialist training places in 2016," he said.

The AMA President said there needed to be a long-term, sustainable plan to ensure that the record number of students graduating from medical schools across the country had the opportunity to complete specialist training and provide the medical services the community would need in the future.

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Radiology crucial to quality care

Properly funded radiology services are essential to ensuring high quality, cost effective health care, according to AMA President, Dr Steve Hambleton.

Dr Hambleton used the International Day of Radiology to highlight the importance of diagnostic imaging services, and urged governments to ensure Medicare rebates were adequate to support their use.

The AMA President said that not only did imaging provide information crucial to diagnosis, it helped in tracking the progress of diseases and treatments and enabled the perofmance of minimally-invasive procedures – helping improve recovery and cutting the length of hospital stays.

"Diagnostic imaging is integral to cost-effective treatment as well as to ongoing patient management," Dr Hambleton said. "Properly funded diagnostic imaging services are critical to the delivery of timely, clinically appropriate and cost effective health care."

Radiologists were important partners for doctors in the treatment of their patients, he said.

"Radiologists supervise support staff such as sonographers, radiographers and nurses, not just to ensure quality and accuracy, but also to provide a pivotal role in guiding clinical care and best outcomes for patients," the AMA President said. "Interpretation of images by radiologists is an integral part of any diagnostic imaging service.

"Radiologists and treating doctors regularly confer on the interpretation of results of diagnostic tests ordered by the treating doctor. This interaction ensures optimal patient care and facilitates quality diagnostic referrals."

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Doctors could get collective bargaining green light

Doctors within a practice will be allowed to collectively set prices and act as a group in striking agreements with public hospitals or Medicare Locals, under a deal being negotiated with the competition watchdog by the AMA.

The AMA is seeking special permission from the Australian Competition and Consumer Commission to allow doctors within a practice – whether AMA members or not – to sidestep tough anti-collusion laws in order to collectively set practice prices, and to negotiate as a group with third parties in certain circumstances.

The AMA stepped in two months ago to seek the authorisation from the ACCC after the Royal Australian College of General Practitioners allowed a similar dispensation to lapse.

In its application, the AMA has sought permission from the competition regulator to allow doctors within a practice to control, set and maintain fees, and to agree on the fees that any locums they engage, either individually or jointly, will charge.

The AMA has also asked that doctors within a practice be able to discuss and agree on the fees that they charge as Visiting Medical Officers to a public hospital, and to bargain collectively regarding the fees they may charge Medicare Locals for medical services, including out of hours care.

In submitting the application, AMA Secretary General, Francis Sullivan, emphasised that all arrangements would be voluntary, and doctors, hospitals and Medicare Locals could not be compelled to enter into collective bargaining arrangements.

"As with any contract, groups of GPs cannot force hospitals, and there is no intention to seek to compel any counterparties, to enter into collective negotiations with GPs," Mr Sullivan wrote. "It is an arrangement which may work in some instances, or may not in others. For the avoidance of doubt, there is no intention that GPs would be authorised to engage in collective boycotts of public hospitals or Medicare Locals."

The original application, which sought to limit the scope of the authorisation to AMA members, was amended following discussions with ACCC officials to apply to any general practice where at least one AMA member was engaged or contracted on a permanent basis.

Mr Sullivan said the change would enhance the public benefits that would flow from the authorisation.

The ACCC is considering the application.

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Govt told to hang up prescription hotline

The AMA is demanding the Federal Government call time on its frustrating and archaic authority prescription system, which has become a massive timewaster for busy doctors and their patients.

AMA President, Dr Steve Hambleton, said doctors were being forced to wait for up to 10 minutes at a time – and occasionally for longer - on calls to Medicare to get approval for prescriptions for medicines that they were prescribing for patients on a daily basis.

Dr Hambleton said the system had become a huge and unnecessary red tape burden for practitioners that did nothing to improve patient care.

Although the scheme was trimmed in 2007 when the list of medicines for which authority prescriptions were required was cut from 450 items to 200, and a system of codes was introduced, the AMA President said it needed to be scrapped.

"Over the past two months, there has been a deluge of complaints from AMA members reporting long delays using the 1800 authority line phone number," Dr Hambleton said. "These delays have usually been between five and 10 minutes. This situation is unacceptable, given that both the medical practitioner and patient are kept waiting during this time."

Experience since the system was streamlined in 2007 showed that it served no useful purpose, he said, with no change in prescribing patterns for medications which had been dropped from authority list.

In its review of the burden of regulations on business in 2009, the Productivity Commission recommended that the system be axed, and Dr Hambleton said it was time for the Government to heed this advice.

The AMA is gathering information from members about how much time they are forced to spend on authority scripts, and the results will be used as part of a concerted campaign to convince the Government that it must scrap the system.

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No need to binge to enjoy Schoolies Week: AMA

As young people from across the country descend on coastal towns and holiday hotspots in search of a party, AMA President Dr Steve Hambleton has urged them to have well-deserved fun without resorting to binge drinking.

Dr Hambleton, who travelled to Byron Bay earlier this month to help launch the Cringe the Binge National Weekend of Action, said the infamous Schoolies Week was a great opportunity for young people to get together and celebrate the end of secondary school and the transition to the next exciting phase of their lives.

But he said such a happy occasion should not be marred by behaviour that put the health of young people and their friends at risk.

"They are travelling to some of the most beautiful holiday spots in the country and they should take the opportunity to relax, share time with their friends, make new friends, and enjoy the beaches and other local attractions," Dr Hambleton said. "Celebrating the end of school and beginning a new stage of life should be about positive experiences and good memories, not accidents or misadventures."

Dr Hambleton said it was important that young people celebrate in a way that did not see them ending up in a hospital emergency department.

"All it takes is common sense – do not binge drink, be alert to drink spiking, avoid drugs, do not drink and drive, avoid balconies if intoxicated, be cautious when texting or tweeting or using other forms of social media, and use sun protection when outdoors," he said. "Misuse of alcohol and drugs can lead to accident, injury, antisocial and embarrassing behaviour, and even violence."

The AMA President warned that young people should be equally careful and cautious about their sexual health.

"Young people can feel pressured to have sex. They should know that it's okay to say 'no'," he said.

Dr Hambleton said there were encouraging signs that celebrating students were heeding the warnings.

"Increasing numbers of schoolies are choosing not to drink or take drugs, and are still having a good time," he said.

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One prominent Qld doctor makes shock public exit as another steps on to the stage

The Queensland Government has suffered its biggest ministerial casualty after Housing and Public Works Minister, Dr Bruce Flegg, resigned amid claims he was moonlighting as a doctor and had undisclosed dealings with his lobbyist son.

Dr Flegg, a former state Liberal leader, quit last week after his former media adviser, Graeme Hallet, publicly damned him as being "unfit" to be a Minister.

Among the allegations he made against Dr Flegg, Mr Hallet claimed the former Minister had lied in his official diary to hide the fact that he was continuing to work as a doctor even after his appointment to the Newman Government ministry.

But the most serious allegation made by the former media adviser was that Dr Flegg had misled Parliament by failing to disclose on his lobbyist register more than 30 contacts he or his office had had with his lobbyist son, Jonathon.

While one prominent Queensland doctor has departed the main public stage, another is seeking to enter it.

Former AMA President Dr Bill Glasson has launched his campaign to unseat former Labor Prime Minister Kevin Rudd at the next federal election.

Flanked by Federal Opposition leader Tony Abbott, who flew to Brisbane to support his candidature, Dr Glasson made government debt the centrepiece of his campaign.

"The finances of this country have been poorly handled," Dr Glasson told the *Courier Mail*. "I don't want my children to have to pay for this; we should have to pay for this."

Earlier, Mr Rudd attacked Dr Glasson, an ophthalmologist, over his support for deep Newman Government cuts to health spending.

"How a former head of the AMA can get out there and defend these slash-and-burn attacks on public health in Queensland and in Brisbane's south side defies my imagination," Mr Rudd said on *ABC* radio. "As a former head of the AMA, I think he's going to find it very difficult to explain the massive cutbacks to health in Queensland by his LNP Newman Government - the cutbacks which he himself has supported."

Mr Rudd held his seat of Griffith by an 8.5 per cent margin at the 2010 election.

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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

Celebrity deaths deter drug use, *The West Australian*, 12 November 2012

http://au.news.yahoo.com/thewest/a/-/breaking/15356069/celebrity-deaths-deter-drug-use/

Australian Medical Association President, Dr Steve Hambleton, said the high-profile deaths of celebrities such as Heath Ledger and Michael Jackson involving the use of powerful tranquilisers like benzodiazepines, while tragic, may have helped save lives.

Family doctors bowing out as multi-doctor medical centres and super-clinics grow, *The Herald Sun*, 11 November 2012

http://www.heraldsun.com.au/news/national/family-doctors-bowing-out-as-multi-doctor-medical-centres-and-super-clinics-grow/story-fndo317g-1226514385964

Australian Medical Association President, Dr Steve Hambleton, said it was clear the days of sole general practitioner practices were numbered, but emphasised the importance for doctors of maintaining a good relationship with patients.

Funds for an additional 15 trainee doctors, *The Canberra Times*, 10 November 2012

http://www.canberratimes.com.au/act-news/funds-for-an-additional-15-trainee-doctors-20121109-293un.html#ixzz2BxOpKtVE

Australian Medical Association President, Dr Steve Hambleton, said a deal struck between the Commonwealth and several states and territories would help to temporarily address the national intern crisis. Dr Hambleton said that, before the deal, there had been a projected shortfall of 180 intern places for 2013.

Funding feud threatens interns' hospital placements, *The Sydney Morning Herald*, 10 November 2012

http://www.smh.com.au/opinion/political-news/funding-feud-threatens-interns-hospital-placements-20121109-2938s.html#ixzz2BxPRDHqy

The President of the Australian Medical Association, Dr Steve Hambleton, said the intern crisis was part of a broader training shortage that would see a shortfall of 450 first-year specialist training places in 2016.

Federal and State health ministers reach agreement on medical intern placement funding, creating extra 58 intern doctor positions in Queensland, *The Herald Sun*, 9 November 2012

http://www.heraldsun.com.au/news/national/federal-and-state-health-ministers-reach-agreement-on-medical-intern-placement-funding-creating-extra-58-intern-doctor-positions-in-queensland/story-fndo45r1-1226513946615

Australian Medical Association President, Dr Steve Hambleton, said that while progress to date in resolving the nation's intern crisis was "very encouraging", the career prospects of 65 full fee-paying international medical graduates remained in limbo, including about two dozen in Queensland.

Fluid in kidney scare, *The Australian Financial Review,* 7 November, 2012

A fluid widely used in resuscitation has been linked to kidney failure and found to be of no clinical benefit, according to *Australian Medicine*, a news publication of the Australian Medical Association

Radio

Dr Hambleton, ABC Illawarra, 1 November 2012

https://ama.com.au/audio/dr-hambleton-abc-illawarra-1-november-2012

AMA President, Dr Steve Hambleton, talks about the Australian National Preventive Health Agency's report calling for a volumetric tax on wine rather than imposing an alcohol floor price.

TV

Dr Hambleton, The Project, Channel 10, 5 November 2012

https://ama.com.au/video/dr-hambleton-project-channel-10-5-november-2012

AMA President, Dr Steve Hambleton, talks about research indicating that inactive lifestyles and poor diets may be to blame for the massive incidence of Alzheimer's disease. Dr Hambleton says that, by 2050, one million Australians will have dementia. He says researchers now think Alzheimer's may be a metabolic disease, like diabetes, and those who do not exercise may develop a type of brain plaque.

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AMA in action

Dr Steve Hambleton travelled to Byron Bay earlier this month to officially launch the 'Cringe the Binge' National Weekend of Action. The Cringe the Binge initiative was developed by the Byron Youth Service to increase awareness of the extent of binge drinking among young people, and the harm it causes. Lending his support to the campaign, which is being run to coincide with Schoolies Week, Dr Hambleton spoke about the importance of young people choosing to binge on life rather than alcohol, and the need to tackle the difficult task of changing Australia's drinking culture. Last week Dr Hambleton also addressed the Work Health Rights Seminar organised by the ACTU, and delivered a speech to the Australian Gynaecological, Endoscopy and Surgery Society.

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The crowd at the Byron Bay Youth Centre

Dr Hambleton speaking to the media

Dr Hambleton with Director of Byron Youth Service Di Mahoney and Chair of Byron Youth Service Committee of Management Richard Heazlewood-Ross

Dr Hambleton launches the Cringe the Binge National Weekend of Action

Mayor of Byron Bay Jan Barham addresses the crowd

Dr Hambleton with dancing man Tommy Franklin

Dr Hambleton with Inspector Greg Jago

HEALTH ON THE HILL

Govt promises GPs: PCEHR software on its way

Doctors should be beginning to receive crucial software needed to link in with the controversial Personally Controlled Electronic Health Record system, according to senior Government officials.

While fewer than 14,000 people have so far registered for a shared electronic health record, Department of Health and Ageing (DoHA) officials assured a Senate committee that the introduction of the system was on track, and promised general practitioners that they would soon have the software they needed to use the system.

Department Deputy Secretary Rosemary Huxtable told the Senate's Community Affairs Legislation Committee on 17 October that software providers were "gradually coming on board…so we will see a gradual upgrading of software into GP practices."

The organisation appointed by the Department to manage and oversee the introduction of the PCEHR, the National E-health Transition Authority, told the hearing two GP software vendors had developed companion tools that were already being used in test sites, and a further seven software vendors – who collectively supply 98 per cent of the nation's GP practices – were expected to have developed desktop products with PCEHR functions by the beginning of this month.

DoHA Secretary Jane Halton told the Committee that developing the GP software was a crucial step in driving the adoption of shared electronic health records.

"When the GP software becomes available, this is when we actually expect to see, and when we indeed expect to drive, registration," Ms Halton said.

She said she had been pleasantly surprised by the fact that more than 13,400 people had so far registered for a PCEHR, and that two practices were using the companion software to prepare electronic health summaries.

"I am delighted we have got 13,000 – we have not gone out and promoted registration to anybody," she said. "What we have here is actually ahead of what we were anticipating.

"It was not our expectation that there would be any summaries available until the GP software actually became available."

Ms Huxtable said that almost 800,000 Medicare documents, including Medicare Benefits Schedule and Pharmaceutical Benefits Schedule claims, organ donor registrations and immunisation records, had been uploaded to the PCEHR system by the end of September.

In its annual report released earlier this month, NEHTA detailed its work program over the next two years, but it will have to mange it with fewer staff, after *eHealthspace.org* revealed the agency had axed 9 per cent of its staff to "align its workforce to meet the needs of its work programme".

The hefty cut has fuelled speculation the agency is beset by low staff morale and will find it even more difficult to achieve its goal "to develop and roll out the national infrastructure and adoption support required for e-health in Australia, as mandated and funded by the Council of Australian Governments".

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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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Medicare Local empire grows

The Federal Government has moved to boost the stature of the Australian Medicare Local Alliance by giving it oversight of a major program to improve the quality of primary health care.

Health Minister Tanya Plibersek told the national Primary Healthcare Conference earlier this month that responsibility for the Australian Primary Care Collaboratives Program, involving more than 1100 general practices around the country, was being transferred to the Alliance as part of its effort to shift the focus of medical care to primary health services.

Ms Plibersek said that giving the Alliance ultimate responsibility for the program was seen as a way to support continuous improvement in the safety, quality and effectiveness of primary health care, which was at the core of its overall strategy.

"We're shifting the centre of gravity in our health system towards primary care," the Minister said. "The evidence is clear. Health systems centred on primary health care have better outcomes."

Ms Plibersek told the conference that international studies had shown that in countries where the health system was organised around primary health care, there were fewer hospital admissions and prescription use was cut by 25 per cent.

But the Minister admitted there was resistance to the move.

"There is still scepticism about the fact that treatment in a primary health care setting can be safer and more effective than treatment in hospital," she said, adding that Medicare Locals and the AML Alliance had a "critical role to play" in helping overcome the wariness of many.

While backing the Government's emphasis on importance and effectiveness of primary health care, the AMA has raised concerns about the approach being taken through Medicare Locals.

AMA President Dr Steve Hambleton said it would be unfortunate if the ability of the Collaboratives Program to foster improvements in primary care was compromised by interference from "a big bureaucracy like the Medicare Local Alliance".

"We would not like to see it bureaucratised and turned into a red tape nightmare," Dr Hambleton said.

The AMA President warned the Government was in danger of making an even bigger mistake in the way it had gone about establishing Medicare Locals and putting them under the control of an overarching bureaucracy – the Alliance.

"Medicare Locals will only succeed with GP leadership and majority GP decision-making," Dr Hambleton said. "The Government is pursuing the wrong model by substituting the role of GP leaders in Medicare Locals and in their decision-making structures. They are not local enough, and they will not be responsive to local health needs unless they are fully engaged with GPs."

But the Government appears so far to be undeterred.

Not only has it given the Alliance responsibility for the Collaboratives Program, it has also pumped $5 million into a new Disease Prevention and Health Promotion in Medicare Locals Program, and is pushing the Alliance to increase its engagement with State governments.

This already appears to be bearing fruit.

Alliance Chair, Arn Sprogis, indicated that Medicare Locals were ready to step in and take over many of Queensland's primary health care programs after the Newman Government signalled its intention to get out of state-funded primary care.

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Nominations for admission to the Roll of Fellows

By-Law 16 enables Federal Council to admit members nominated by a Committee of Fellows to the AMA Roll of Fellows.

Any ordinary member of the AMA may nominate members of the Association who have given outstanding service to the AMA, have had 10 years uninterrupted membership (or shorter period if considered exceptional by Federal Council) and merit special recognition.

Members are reminded that nominations for admission to the Roll of Fellows of the AMA must be accompanied by a written citation setting out the particulars of the services given to the Association by the member, and for which it is considered the member merits admission to the Roll. Nominations should be sent via email to jthomas@ama.com.au, followed by a hard copy to the Secretary General, AMA, PO Box 6090, Kingston ACT 2604, no later than 31 December 2012.

It should be stressed that nominations of Fellows must be treated with extreme confidentiality. Only under exceptional circumstances may the nominated Member be informed and then, only by the President of the appropriate nominating body or, if relevant, the Federal Councillor representing a nominating Craft Group or Special Interest Group.

A Fellowship Committee of Federal Council, appointed by the President, will consider the nominations.

Francis Sullivan
Secretary General
24 October 2012

SPF50 washes up onto Australian shores this summer

Australians will be able to slap on greater sunscreen protection this summer after the medicine watchdog approved the sale of SPF50+ lotions in the country for the first time.

In the biggest shakeup to sunscreen standards since the SPF30+ benchmark was introduced in the late 1990s, the Therapeutic Goods Administration has decided to allow manufacturers to market SPF50+ lotions in Australia.

The change brings the range of sunscreen products available to Australian consumers in line with those already on offer to consumers in the United States, New Zealand and many European countries.

In order to meet the new SPF50+ standard, sunscreens will have to filter out 98 per cent of UVB radiation, compared with 96.7 per cent for SPF30+ lotions, and provide greater protection against cancer-causing UVA rays.

Parliamentary Secretary for Health and Ageing, Catherine King, said new sunscreen products "will be required to have better broad spectrum protection from UVA - the portion of the sun's UV radiation that causes melanomas and other skin cancers".

Chair of Cancer Council Australia's Skin Committee, Terry Slevin, said the introduction of a higher SPF standard was welcome, but warned that using factor 50 sunscreen did not make people invulnerable to potentially deadly skin damage.

"It's not a suit of armour," Mr Slevin said. "[SPF50+] needs to be applied just as generously, reapplied every two hours, and used in conjunction with protective clothing, a broad brimmed hat, sunglasses and shade."

Standards Australia Chief Executive Officer, Colin Blair, said that in a country where sun radiation risks are high, the added level of protection from SPF50+ sunscreens was critical in helping address the prevalence of skin cancers and melanoma.

Ms King said the new standard had been made possible by significant developments in sunscreen technology in recent years that allowed manufacturers to produce and test sunscreens with higher SPF ratings.

While allowing the introduction of SPF50+ labelling, regulators have prohibited manufacturers from making a number of claims for their products, ruling that:

- the term 'waterproof' was misleading and would not be permitted, because sunscreens wash off when immersed in water;
- the term 'sunblock' was misleading and was prohibited; and
- the term 'sweat proof' was misleading and would not be permitted.

Mr Blair said these combined measures meant much better products were now available to consumers.

According to *The Age*, some SPF50+ sunscreens are already on sale, but most brands are not expected to release products with the higher protection labelling before mid-January.

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Call for vaccinations to be backed by no fault compensation

People who suffer adverse effects from immunisation should be protected by a no fault vaccine compensation scheme, according to the Royal Australasian College of Physicians.

The College said it was "entirely just and reasonable" that Government compensate those harmed by vaccinations because immunisations benefited broader society as well as the individual. The recommendation is part of a Position Statement on immunisations released by the College's Paediatrics & Child Health Division last month, in which it urged paediatricians and other physicians to publicly rebut erroneous claims about the dangers of vaccinations.

"Paediatricians have an important role in advocating the benefits of vaccination [and] countering anti-immunisation activism," the Position Statement said, adding that this was particularly so given the advent of the internet.

"Anti-immunisation activists have for years attracted followers [but] alarmist rumour and misinformation is now disseminated more quickly via the media, including internet and social media," the College said. "Exposure to vivid narratives about children being injured by vaccines has the potential to put parents off vaccination, [and] balance in response to this activism is required."

Despite this, the College said it was wrong to withhold treatment from children who had not been immunised.

"It is inappropriate to refuse to treat unvaccinated children, firstly because it represents unethical coercion and, secondly, because the children will be further disadvantaged," the Position Statement said.

The College said only between 2 and 3 per cent of children were not being vaccinated because of active parent refusal.

It said the current vaccination rate among Australian and New Zealand children, which is above 90 per cent, was "acceptable", but warned the high overall figure disguised pockets of low immunisation.

The Position Statement suggested strategies to try and overcome the resistance of many parents to vaccination.

"Recognise that parents who are absolutely opposed to any vaccines are unlikely to change their minds," it said. "[But] some vaccine-refusing parents may still be susceptible to negotiation about selective vaccination. A positive experience with even limited vaccines may increase the chances of further immunisation."

The College said immunisation against infectious diseases had been "more effective in preventing disease and death than any other medical intervention".

It said it "strongly support[ed]" the introduction of a no fault vaccine compensation scheme in Australia similar to that already operating in New Zealand, either as part of a national disability or injury insurance scheme, or as its own entity.

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WIN
a 64GB iPad Mini

Australian Medicine's A Day in the Life of the AMA competition

Win an iPad Mini, with 64GB capacity and full WiFi capability, worth more than $500.

For a chance to win this great prize, simply submit up to five photos of you and/or your colleagues at work.

You can be as candid or creative as you like. We are looking for pictures that capture key moments in your working life.

You can be at your desk, in your rooms, walking the wards, driving between appointments, swotting up for an examination, visiting a patient, talking to colleagues – even taking a break to spend time with your family or indulge in your favourite pastime.

To be in the running for a chance to win the iPad Mini, please send your entry to ausmed@ama.com.au by 31 December, 2012.

Limit of one entry per member.

Please note, the consent of all people identifiable in a picture must be obtained if they would have a reasonable expectation of privacy. Particular care should be taken with photos that include patients and their families.

It is a condition of entry that the AMA will be able to use photos submitted for the competition in future publications. They will not be made available to third parties.

The winning entry will be published in the 14 January, 2013 edition of *Australian Medicine*.

Dangerous diet pill a major health risk

A slimming product being sold online poses a serious risk to health and should not be taken, the medical watchdog has warned.

The Therapeutic Goods Administration has urged people who have bought Majestic Slimming Capsules to immediately stop taking the product and discard it, warning it contains chemicals and other substances that could cause major heart problems and other threats to health.

The TGA said the capsules had not been approved for sale or manufacture in Australia, but investigations had shown that a number of people have bought the product online, putting themselves at risk.

The Administration warned the capsules contained sibutramine, the active ingredient in Reductil, which was withdrawn from the market two years ago after being associated with an increased risk of "major cardiac events".

The Majestic capsules were also found to contain the oral laxative phenolphthalein, which is no longer available in Austrlaia because of serious safety concerns.

"Stop taking Majestic slimming capsules and discard any remaining capsules," the TGA said.

The regulator has also announced that several implants, including Shoulder Modular Replacement L2 Metal Back Glenoid Component, Durom Acetabular Component (for hip replacements) and the Birmingham Hip Modular Head, have been withdrawn from use because data from the National Joint Replacement Registry show they have a higher than expected revision rate.

The TGA has also revealed that a final Administrative Appeals Tribunal hearing on its push to de-register the painkillers Di-Gesic and Doloxene will not be held until 27 February next year.

The stay ordered by the AAT means the drugs are still available, but the regulator has urged practitioners and patients to consider carefully warnings about their use before considering taking them.

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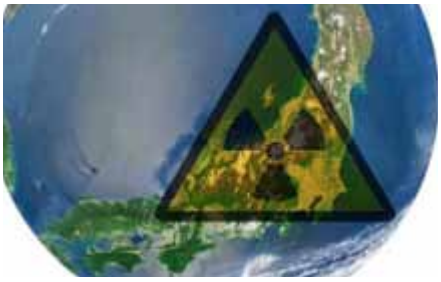
Australia given all clear from Fukushima fallout



Australians have suffered "negligible" fallout from Japan's Fukushima nuclear power plant disaster, according to the nation's radiation watchdog.

Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) officials have told a Senate hearing that goods imported from Japan since last year's calamitous earthquake and tsunami have shown no sign of elevated radioactivity.

ARPANSA Chief Executive Officer, Dr Carl-Magnus Larsson, said tests of more than 500 food samples, as well as cars, ships, ballast water and migratory birds, had detected minimal radiation, while air monitoring stations, including in Darwin, had recorded only "very low levels" of radioactive xenon in the weeks following the accident.

"Back in April 2011 the Darwin monitoring station detected airborne activity, very low amounts," Dr Larsson said. "We have not detected anything since."

His comments came amid reports that Russian customs officials have blocked the import of 300 cars from Japan because of radiation concerns.

In a statement issued in the days following Dr Larsson's testimony, ARPANSA said the levels of radiative xenon detected would have had "no impact on the health of any person living in Australia".

The Agency also found no contamination in Mutton birds, whose migratory pattern takes them up the east coast of Japan before traversing across the top of the Pacific to the North American coast before returning to their Australian breeding grounds.

Dr Larsson sought to reassure the public that food and other goods imported from Japan were not radioactive.

"We have analysed over 500 food samples and found very small levels of radioactivity in most," the ARPANSA CEO said. "[Though] in some of the dried food samples we have found more, like in tea and dried mushrooms."

ARPANSA said it would continue to test food imported from Japan, as well as monitor radiation levels in the atmosphere and ocean.

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Evidence should guide cancer treatment, not wishful thinking

BY **RAY LOWENTHAL, UNIVERSITY OF TASMANIA**

(Originally published in *The Conversation*) http://theconversation.edu.au/

One of the most misleading myths of modern medicine is that conventional cancer doctors reject "natural" therapies in favour of artificial or "unnatural" cancer treatments. This myth has contributed to the popularity of unproven, alternative cancer treatments.

The truth is that oncologists and other trained medical professionals involved in cancer care welcome and support effective cancer treatments in any form, provided there is evidence to show they can work and are safe.

Making assumptions about the benefits and harms of therapies according to whether or not they are natural is high-risk. For example, an extract from apricot kernels, was for years promoted as a natural alternative therapy for cancer; yet it is utterly useless for treating cancer and can cause fatal cyanide poisoning.

The herb comfrey, also recommended as an alternative cancer treatment, actually causes cancer.

So natural does not necessarily equate to harmless. Nor does conventional necessarily equate to unnatural. Plenty of natural products are used in chemotherapy. These include extracts from the yew tree (docetaxel, paclitaxel), the opium and mandrake plants (epipodophyllotoxins) and from natural moulds that produce doxorubicin and related drugs, used effectively to treat breast cancer and lymphoma.

Some natural products used in conventional cancer medicine had for centuries been part of traditional folk remedies and have been adapted for modern use after being rigorously tested.

So the difference between alternative and conventional is not that one is natural and the other is not. It's that conventional cancer treatments must be subjected to rigorous research before they can be recommended for use and prescribed by professional oncologists.

The highest level of research is the randomised control trial, which is only applied to a product after lengthy laboratory studies, preliminary testing and approval by an ethics committee made up of medical experts, ethicists and health care consumers.

A typical trial involves randomly selecting two groups of patients in large enough numbers to control for physical differences between them. One group receives the new treatment and the other group is given a different treatment or a placebo; the results are then compared. A trial is designed to show that any significant difference in patient outcomes can only be the result of the treatment being tested.

Oncologists will only prescribe treatments if they have been tested in this way and are found to be effective and safe.

A good example of this testing process on a natural derivative is the development of the drugs vincristine and vinblastine, extracted from the Madagascan periwinkle. Improved through continual clinical trials over 50 years, these so-called "vinca" alkaloids have been a key part of modern-day successes in curing childhood leukaemia and other cancers that were previously incurable.

Some alternative cancer therapists also promote fad diets, but there is no evidence to support this approach. A healthy diet can prevent cancer and assist people living with cancer. But diet will not cure cancer, which directly attacks the body's cells in a highly destructive and relentless way.

Such a malignant disease can only be cured if the cancer cells are surgically removed before the cancer has spread or if they are destroyed with chemotherapy and/or radiotherapy.

Nor is there any evidence to support mind control in any form as a cancer therapy. Such a belief or expectation in many cases adds to a patient's distress. Can you imagine the terrible trauma of being diagnosed with a potentially fatal cancer and told you can think your way to good health with a positive attitude?

The reality is, we have a limited lifespan; science does not have all the answers to our health needs. But we agree as a society that we should do what we can to increase life expectancy and improve health.

Over the past century, average Australian life expectancy has increased by almost 30 years, largely through a combination of improved infection control, sanitation, diet, immunology and many other advances in medical science.

The changes in medical practice and public policy that have improved our length and quality of life were guided by evidence of what works.

So we must let the evidence – not uninformed perceptions of what is natural – guide continuous improvements in cancer treatment.

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Hope for end to discharge summary lucky dip

BY **DR BRIAN MORTON**

"I look forward to the day that it is accepted practice across the country for GPs to receive a patient's discharge summary prior to their presentation, rather than the lucky dip of today"

Every GP knows the importance of timely, high quality discharge summaries.

For patients being discharged from hospital, they are fundamental to the safe and effective handover of care.

The information provided must be accurate and relevant about the patient's admission, treatment, and ongoing care needs. Poor quality or delayed discharge summaries jeopardise patient care, increase the likelihood of unnecessary diagnostic tests, and heighten the risk of avoidable hospital re-admissions.

For thirty years or more, the creation and provision of this vital information has, by and large, been less than optimal.

This has largely been because hospitals have given them little priority. There has been limited understanding of their importance, or of the information that GPs need, and the situation has not been helped by clinical software systems that have poor or non-existent interoperability.

Until recently, there has been no nationally endorsed standard for the content of discharge summaries. The creation of the National E-Health Transition Authority (NEHTA) eDischarge Summary has changed this.

However, the effectiveness of the eDischarge Summary will depend on the progressive take-up and utilisation of the PCEHR.

Regardless of the potential benefits that the eDischarge Summary will deliver over time, it is not a replacement for direct, point-to-point communication between hospitals and GPs, and it will not absolve hospitals of their responsibilities.

National Safety and Quality Health Service Standards, which from 1 January 2013 will set the accreditation benchmarks for health service organisations, demand that documented and structured clinical handover processes be put in place. This should help to improve the quality of discharge summaries.

Another way to help improve discharge summaries is for junior doctors, who are primarily the ones given the job of completing them, to experience general practice rotations, through programs such as the Prevocational General Practice Placements Program. Such exposure would give junior doctors greater understanding of the information GPs need from a discharge summary.

The use of electronic discharge summaries has been growing, and will certainly continue to do so, as issues of systems interoperability are resolved.

Electronic discharge summaries have not been without their problems, including the interoperability issues identified above and the automatic generation of irrelevant information, but they do have many advantages over paper.

For the GP, they are more legible, more secure, can be quickly received, and easily stored in the patient's electronic record.

I look forward to the day that it is accepted practice across the country for GPs to receive a patient's discharge summary prior to their presentation, rather than the lucky dip of today.

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Where are health reform and health financing going?

BY **DR STEVE HAMBLETON**

The Economics and Workforce Committee was recently told that the nation's health bill was likely to grow massively in the next 20 years, increasing the pressure on funding arrangements that are already struggling to cope.

At its meeting on 27 October, the Committee considered – with the benefit of presentations by two external experts, Professor Andrew Wilson and Professor Elizabeth Savage - trends and growth in health care needs and health financing, including the Medicare Select model developed for the National Health and Hospitals Reform Commission.

Three major factors for growth in health care costs were identified: ageing, population growth and the volume of treatment per case.

On one estimate, these factors will contribute to a 189 per cent increase in health and care costs over the 30 years to 2032-33, requiring close to a trebling of current expenditure.

The biggest factor driving this growth was the increasing volume of treatment per case, having twice the impact of either ageing or population growth.

One way of managing future financing for our health system would broadly involve people accessing their universal Medicare entitlement through a health and hospital plan.

All Australians would automatically belong to a government-funded plan, but could choose to move to a private or not-for-profit plan, with funding for their universal entitlement following them. People could purchase additional cover from private health insurers, just as they do now, for enhanced hospital amenity and access.

Based on the presentations and discussion, the Committee noted that:

- no complex, major reform is able to be implemented in the sorts of timeframes that typically emerge in the political context (where the focus is usually much more short-term);
- it is essential to identify and collect data, to analyse, and to model;
- major new approaches should be tested/piloted/trialled and carefully evaluated; and
- there is a need to understand and document universal (or Medicare) service obligations.

The Committee is also mindful of the current context.

Even a cursory review shows that, despite reforms that have supposedly 'fixed' our health system, many problems remain unresolved.

For example, one State recently required a $325 million emergency rescue package, three other states have announced significant reductions in health expenditure; and the blame game between the Federal and State levels of government is well and truly on again, with claims about withdrawal of funding running prominently in the media.

Despite the provision of ongoing funding under the National Healthcare Agreement, and additional funding through specific improvement partnership agreements, the sentinel measures for the capacity and performance of our hospital system – bed numbers, emergency department and elective surgery – have shown no substantial improvement.

Some states have recently complained of reductions in Commonwealth funding.

This could be either where funding has been tied explicitly to a partnership agreement operating over a fixed period (and now coming to an end), or where a reduction in the amount of increased funding is tied to agreed formula-driven adjustments, such as when the population numbers change.

At this point, health reform has not delivered an agreed approach or a better way of funding our health system; has not achieved sufficient ongoing funding to meet current and projected needs; and has not actually improved performance or increased services at the bedside/in the surgery.

A system with multiple, independent and sometimes hostile funders is always vulnerable to these sorts of problems.

A single funder of the health system still appears to be the best treatment for a health system that is struggling to meet the needs and expectations of the community.

But clearly, moving to a single funder would have to occur in a conducive political and social climate.

In the meantime, the introduction of a national Activity Based Funding (ABF) system may help improve efficiency and the transparency of funding contributions of the Commonwealth, state and territory governments.

In theory, it should also provide a mechanism for managing and funding growth, and overcome the problems of the formula-driven funding of the past – the tail end of which is still delivering political argy bargy.

The AMA continues to hold real concerns around the transition to ABF, including the treatment of critical areas such as safety and quality, teaching and training, and research, and the need to identify and address unintended impacts.

But we have also acknowledged ABF's potential long-term benefits, and the increased transparency measures.

Input from AMA members working on the ground is critical to track any adverse impacts of ABF, and to inform the AMA's approach to preferred health financing arrangements over the longer term.

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The intern crisis: A temporary reprieve?

BY **CHAIR WILL MILFORD**

"We must be wary of short-term fixes that do not address this impending pipeline effect. Solutions will need to be strategic, flexible and responsive to local workforce needs"

On the first Friday in November, 116 careers were changed forever.

One hundred and sixteen additional intern posts were found and funded, allowing 116 medical graduates to continue their medical training in Australia.

After a hard-fought battle, the Federal Health Minister, Tanya Plibersek, deserves credit for her persistence in finally negotiating an agreement with the governments of Western Australia, Queensland, the Australian Capital Territory and the Northern Territory.

This must be seen as a victory for the federal and state branches of the AMA and the Australian Medical Students Association (AMSA).

Both organisations have run dogged, disciplined campaigns in the media - and behind the scenes - that have finally borne results. The medical students who were prepared to put a face to the crisis must also be given credit for the activism that brought a resolution to this crucial issue in medical training.

Attention has to shift to the career prospects of the remaining unplaced graduates. Those states and territories that have participated in this agreement have benefited, with the Commonwealth funding at least two intern posts for every one that was locally funded. Simply put, the states yet to commit to the agreement are passing up an opportunity to gain a three-fold return on their workforce investment. States must move beyond the bitter political point scoring that dominates their agendas on health care.

There are two very large, 'elephants in the room' that have yet to be acknowledged: medical graduate numbers are yet to peak, and internship is only the first year of a medical training pathway spanning many years.

Planning for future medical graduates has been remarkably absent from any discussion currently taking place.

No consideration has been given to next year's graduates. Will we go through the same circus in the second half of next year?

Similarly, internship marks only the beginning of post-graduate training. Next year's interns will need both prevocational and vocational training places in years to come, otherwise we can expect a counter-productive exodus of our trainees overseas.

In an alarming development, we are already seeing hundreds of prevocational doctors 'off-contract' in both Victoria and Queensland.

This is at least partly due to a maldistribution of junior doctors, which has artificially brought forward the vocational training squeeze that is not due to hit until 2016.

We must be wary of short-term fixes that do not address this impending pipeline effect. Solutions will need to be strategic, flexible and responsive to local workforce needs.

There has been some progress. Health Workforce Australia has released the third volume of *Health Workforce 2025*, and the final instalment in its suite of medical workforce predictions looks at medical specialty workforce planning.

Included in the recommendations is a plan for a National Medical Training Advisory Network to develop policies to address these impending crises.

Similarly, the Federal Government's willingness to engage stakeholders on medical training must also be applauded.

But there is a crucial question which remains to be answered: In the post-health reform era, to what extent will the states and territories co-operate, and will junior doctors yet again be the victims in another blame game?

TO COMMENT CLICK HERE

Promising signs of change in rural health

BY **DR DAVID RIVETT**

"Any new system of determining incentives will hopefully continue the current practice of increasing benefits the longer a doctor stays, as well as incorporating an appeal mechanism"

Three government meetings in three consecutive working days is pretty unusual when it comes to rural health and, with more to follow, perhaps changes are in the pipeline at last.

The Small Rural Hospitals Working Group met on 2 November.

Funding seems likely to go ahead with a mix of 'availability' funding and top-up funding, reflecting the costs of higher service volume hospitals. This was generally agreed to be the best funding option.

Disappointingly, similar hospitals will be grouped together and allocated an "efficient cost" payment, and there are no guarantees that the funding individual hospitals currently receive will be maintained.

The Commonwealth will not contribute to capital costs, such as equipment purchases. I assume they will contribute to repairs, so we will see a perverse incentive to keep repairing equipment when it is well past its use by date. More promisingly, clauses will allow rapid changes in funding where circumstances change quickly, such as in booming mining towns.

On 5 November, the Australian Department of Health and Ageing convened the Rural and Regional Roundtable, which brought together the Health Minister, Tanya Pilbersek, senior Department officials, and representatives from many rural health interest groups.

The Minister told the meeting that workforce shortages and a lack of access to medical practitioners was a major concern for Labor MPs, whether their seats are urban, outer metropolitan or rural.

Among the issues discussed were ways to enhance efficiency, reduce rural workforce shortages, guarantee intern places for Australia's medical graduates, details of the recently announced dental care program, the implementation of the Personally Controlled Electronic Health Record system, and the place of Medicare Locals and their funding of GP after hours care.

On 6 November, Melbourne Cup day, the Rural Classification Working Group met in Canberra to review the Australian Standard Geographical Classification and its possible refinement to better reflect rural realities, something the AMA has been advocating for some time now.

Two Monash University researchers, John Humphries and Matthew McGrail, proposed changes to the classification system based on their findings from the ongoing *Medicine in Australia: Balancing Employment and Life* series of surveys.

It was agreed that the status quo was unacceptable and a reformed classification system must be objective and evidence based, easy to interpret, be regularly and independently updated, not be riddled with "discretionary outs", must meaningfully identify small towns, must factor in remoteness, should maximise the effectiveness of limited health budgets and should have built-in monitoring systems.

Any new system of determining incentives will hopefully continue the current practice of increasing benefits the longer a doctor stays, as well as incorporating an appeal mechanism.

So, the New Year looks promising for changes to rural initiatives, but as to how good or bad they will be, we must wait and see.

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Tackling Alcohol in Aboriginal Communities

BY **DR STEVE HAMBLETON**

"... part of the process of empowerment for Aboriginal peoples and Torres Strait Islanders must be for them to recognise the problems they face, take ownership of them, and advance the solutions they see as most viable"

Many would agree that alcohol abuse is a major cause of health problems, violence, family breakdown, and poor early life outcomes for many people right across Australia. These problems and poor outcomes are often magnified in Aboriginal and Torres Strait Islander families and communities.

The incidence of foetal alcohol spectrum disorder (or 'FASD', as it is sometimes known) among Aboriginal and Torres Strait Islander children is a clear indication of the damage that can be caused through alcohol abuse. One study, to be published soon in the *Medical Journal of Australia*, has found that in one area of the Western Kimberleys, half of all babies have been born with intellectual disabilities associated with FASD.

Patterns of alcohol-fuelled community violence and domestic abuse, poor education and work participation, and high rates of cardiovascular and other conditions, continue due to chronic alcohol abuse in many Aboriginal and Torres Strait Islander communities. Often, children and women are the victims, and too often Aboriginal youths end up in prison.

The situation is dire across many Australian jurisdictions, and the solutions are not easy or straightforward.

The Australian Government is now in the process of implementing its Stronger Futures legislation in the Northern Territory and, as part of this, continuing alcohol restrictions in communities and allowing communities to develop and implement alcohol management plans to reduce harms of alcohol abuse.

This legislation, which makes it a crime for alcohol to be brought into communities, has been criticised as discriminatory and as denying the human rights of Aboriginal peoples and Torres Strait Islanders in the Northern Territory.

The AMA, for example, has been vocally opposed to the overbearing and demeaning alcohol and pornography restriction signs outside many Aboriginal communities in the Northern Territory. (In response, the Australian Government has now at least undertaken to ensure that this signage is more culturally respectful.)

Putting aside the difficult issue of individual rights versus community wellbeing, and the issues of discrimination bound up with this, the AMA believes that part of the solution lies in communities being supported to autonomously develop, implement and enforce alcohol management plans that target the specific risks, problems and circumstances that they face.

The AMA has always advocated that part of the process of empowerment for Aboriginal peoples and Torres Strait Islanders must be for them to recognise the problems they face, take ownership of them, and advance the solutions they see as most viable.

Taking responsibility and control through local alcohol management plans requires communities to have the support, advice and resources they need for the long term. The AMA has been invited by the Minister for Indigenous Affairs, Ms Jenny Macklin, to provide advice on what the basic framework should be for the development and implementation of alcohol management plans in Aboriginal communities in the Northern Territory.

The advice that the AMA will provide, through its Taskforce on Indigenous Health, will give pre-eminence to respect, responsibility and the importance of protecting those who are most vulnerable - the same values that the AMA would espouse for any Australian community trying to deal with the vexing problem of alcohol abuse.

TO COMMENT CLICK HERE

Care for the elderly rates as top priority

BY **DR PETER FORD**

A new report shows that half of the nation believes that providing more services to assist elderly Australians to live in their own home for longer should be the top priority for improvements to aged care.

The Menzies Centre for Health Policy and the Nous Group polled 1200 people between July and August this year to ascertain what Australians expect of the health system, and their confidence in, and satisfaction with, the care provided.

For the first time the survey, which has previously been conducted in 2008 and 2010, included questions relating to the nation's views on aged care.

More than 90 per cent of respondents said the Government should make more money available for older people to buy the services they need to stay in their own homes.

Although the survey does not indicate what services respondents thought were necessary, the AMA has repeatedly drawn attention to the crucial importance of domiciliary health services for older people.

This will be an increasingly important issue due to the rapid increase in the proportion of Australians aged 65 years or older. Not only will the demand for quality dementia and palliative care increase, but future generations of older people are likely to expect higher quality domiciliary health services.

Although the AMA acknowledges that there is a time when a very disabled person will receive more appropriate care in a nursing home, even now too many Australians feel the pressure to move into a residential aged care facility to meet their health care needs when these become more complicated.

Given that more than 80 per cent of elderly Australians indicated in the survey that they always saw the same medical practitioner, it is disappointing that more is not being done to help elderly Australians receive medical care from their regular GP into their later years, when they are less able to travel to the GP surgery.

Even when elderly Australians do decide to move into residential aged care, the survey found more than two-thirds of Australians do not think it should come at the expense of the family home.

Under the Federal Government's *Living Longer. Living Better* package, the family home may be counted as an asset when determining a care recipient's ability to pay for their accommodation.

Despite the views of the broader public, aged care reform in Australia has been more about bricks and mortar and not enough about flesh and blood, with the human dimension of aged care being an afterthought for policymakers.

Of all the health care categories measured in the Menzies-Nous survey, aged care was ranked the lowest in terms of satisfaction.

Barely one in every two people were satisfied with the level of service they received in a residential aged care service or nursing home, so it is not surprising that people want to do more to provide services for the elderly at home.

Unfortunately, respondents were not asked what would improve their feeling of satisfaction.

But the AMA has been pushing the need for additional funding to encourage aged care providers to make appropriate facilities available – including adequately equipped clinical treatment areas that afford patient privacy, and information technology to enable access to medical records and improve medication management.

Further, funding is needed to support arrangements between aged care providers and medical practitioners to ensure ongoing access to medical care in residential aged care.

Given that the Menzies-Nous survey shows half of Australia believe it should be the top priority to give elderly Australians more support to live in their homes for longer, greater attention should be dedicated to improving the quality and availability of aged care services.

Despite the advice of the AMA, the Federal Minister for Ageing, Mark Butler, has decided not to convene a clinical advisory group to assist with the implementation of the *Living Longer. Living Better* package.

The Minister's decision demonstrates the Government's attitude that quality advice regarding the clinical care for older Australians is not a priority.

We wonder how the Minister will accommodate the human factor into the implementation of his aged care reforms.

The AMA congratulates the Menzies Centre for Health Policy and Nous Group for making aged care issues an area of priority in their survey.

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HEALTH ON THE HILL

Number crunchers in firing line as Commonwealth, states tussle

The official statistician has been forced into the unusual position of publicly defending its population estimates after a meeting of the nation's health ministers ended acrimoniously earlier this month.

Deputy Australian Statistician, Peter Harper, issued a detailed explanation of why the Australian Bureau of Statistics revised down earlier population growth estimates after health ministers from the major states accused the Commonwealth of misconstruing population data to claw back hundreds of millions of dollars in health funding.

Population statistics have become yet another battleground in the interminable war over health funding between the Commonwealth and the states.

The states claim they are being unfairly dealt with by a Federal Government trying to push more of the health care burden onto them, while the Commonwealth has accused the states - New South Wales, Victoria and Queensland in particular – of provoking the stoush as a smokescreen to hide their own severe cuts to health spending.

The states – all led by Liberal and National governments while Labor is in power federally - have instituted massive cuts to their health spending, including $3 billion slashed from the NSW health budget, $1.6 billion from Queensland's health spending and $616 million cut from Victoria's health outlays.

The latest wrangle has erupted amid mounting concerns about the pressure on stretched public health services, with warnings that hospital waiting lists are set to blow out unless the flow of funds is increased.

The health ministers of New South Wales, Victoria, Queensland and South Australia claim the Federal Government has used an "incorrect" estimate of population growth to justify taking back about $150 million in payments made under the National Health Reform system for 2011-12, including almost $49 million from NSW, around $40 million each from Queensland and Victoria, $31 million from South Australia and $1.6 million from Tasmania.

South Australian Health Minister John Hill told State Parliament last week the Commonwealth had made a "different" interpretation of the data to the states, and said the states also objected to the way the Federal Government had announced the clawback without consultation.

NSW Health Minister Jillian Skinner said the Commonwealth was relying on an estimate that the nation's population only increased by 0.03 per cent in 2011-12 to justify the clawback, whereas it actually grew by 1.5 per cent.

"This incorrect estimate of population growth will see money that NSW has already spent on patient care being stripped from the budget and returned to the Commonwealth coffers," Mrs Skinner said.

Following Mrs Skinner's claim, Mr Harper issued a statement in which he explained that the Australian Bureau of Statistics (ABS) had used results from the 2011 Census to reduce the estimated size of the population as at mid-2011 by 294,400 people.

In pointed remarks at the end of his statement, Mr Harper said the ABS was "an independent statutory authority and is not subject to any Government direction on the methods that it uses to compile its statistics".

Population growth estimates, along with health price inflation readings and calculations about technological development, are used in the National Health Reform formula determining Commonwealth health funding to the states and territories.

Federal Health Minister Tanya Plibersek said all governments had signed up to the funding formula as part of the National Health Reform Agreement, and accused Mrs Skinner and her colleagues of simply trying to find scapegoats for the consequences of their own health spending cuts.

Ms Plibersek said that, despite the clawback of funds, NSW's slice of Commonwealth health funding was set to grow by 23 per cent over the next four years to $5.8 billion, while Victoria's would increase by 26 per cent to $4.5 billion, and Queensland's would jump by 21 per cent to $3.7 billion.

"What we have here are three health ministers who are looking around for someone else to blame for the cuts that they have made to their own health systems," Ms Plibersek said. "It's very unfortunate, and it's not fair to patients when these cuts have been so large in the states and territories."

In a further twist to the spat, Victoria has refused to sign up to an offer from the Federal Government for $100 million for 11 regional health projects.

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Govt under pressure over slow increase in organ donors

The Government has rejected claims it is bungling efforts to boost organ donor rates in Australia.

In a forthright exchange at a Senate estimates hearing last month, Department of Health and Ageing Secretary, Jane Halton, and other senior Health officials, mounted a spirited defence of the Government's handling of the issue and hit back at accusations from Greens Senator Richard Di Natale that other countries were doing far better.

Senator Di Natale accused the Department of making limited progress in implementing the four-year-old, $150 million reform agenda aimed at establishing Australia as a world leader in organ donation.

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HEALTH ON THE HILL

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Australian Organ and Tissue Donation and Transplant Authority Chief Executive Officer, Yael Cass, told the hearing that since 2009 there had been a 36 per cent increase in the number of deceased organ donors, reaching 337 people in 2011, and the organ donation rate had reached 15.1 donors per million people.

Ms Cass said there had been a 25 per cent increase in transplant recipients to 1009 people, and the number of organs transplanted had grown to 1041 – a 22 per cent increase in two years.

She said the goal was to lift the donor rate to 16.2 per million this year, and as at the end of September there had been 256 deceased donors – a 1 per cent increase from the same point last year.

But Senator Di Natale said that, despite the improvement, Australia was still ranked 22nd in the world for rates of organ donation, and the gains were being made too slowly.

"In countries like Portugal and Croatia, where there have been similar reform programs, they have had a much more significant increase over a much shorter period of time," he said.

But Ms Cass rejected Senator Di Natale's critique.

"We very carefully monitor the practices and outcomes that are being pursued internationally," she said. "We particularly look at Croatia, Spain and Portugal…and the rate of growth Australia has achieved in the first two years, which is 1.9 [per cent] average over those two years, is comparable, if not better, than many of those countries."

Senator Di Natale said barely any progress had been made since 1989, when the donor rate was 14 per million.

"The trajectory is not up. In fact, it is flat [and] it appears that we are not even going to meet the target set for this year, [which is] a very modest target," the Greens MP said.

But Ms Halton said the donor rate achieved in 1989 had been a "one-off aberration", and in subsequent years it had slipped down as low as 9 per million, but was now improving.

"We are very familiar with the critique, which clearly you have been briefed on, and we do not agree with it," the Department Secretary said. "This is hard. It requires persistence over a long period. [But] the bottom line is that the numbers are moving inexorably upwards."

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INFORMATION FOR MEMBERS

AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2012 edition of the AMA List of Medical Services and Fees is now available both in hard copy or electronic format.

Members listed as being in private practice or with rights of private practice should have received their hard copy by 31 October 2012. Salaried members who have ordered a hard copy should have received their copy by 31 October 2012.

The AMA Fees List Online (**http://feeslist.ama.com.au/**) has also been updated as at 1 November 2012. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

Electronic versions (PDF and CSV) of the AMA List are also available for free download from the Members Only area of the AMA Website (**www.ama.com.au/feeslist**).

A Fees Indexation Calculator is also available for members to calculate their own fee increase based on their individual cost profile.

To access this part of the website simply enter your username and password in the box on the right hand side of the screen and follow these steps:

1) Once you have entered your login details, from the home page go to **Members Benefits** at the top of the page.
2) Under AMA Member Benefits, select **AMA List of Medical Services and Fees** link.
3) Select first option, **AMA List of Medical Services and Fees - 1 November 2012**.
4) Download either or both the **CSV** (for importing into practice software) and **PDF** (for viewing) versions of the AMA List.
5) For the Fees Indexation Calculator, select option 13. **AMA Fees Indexation Calculator**.

Members who do not currently have a username and password should email their name, address and AMA membership number to **membership@ama.com.au** requesting a username and password

If you do not receive your hard copy of the 1 November 2012 AMA List of Medical Services and Fees or would like one, please contact the AMA on **02 6270 5400.**

TO COMMENT CLICK HERE

Members' Forum

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

Defence contracts

Which corporate clown ever imagined that we would be happy to accept a 50 per cent fee reduction unilaterally, with no negotiation? I've really enjoyed treating ADF personnel over the past five years, and we are a garrison city, but it's not going to carry on! Sad really - enjoy the flights to Brisbane, guys and gals.

Dr Chris Jelliffe (not verified)

There are no specialists that I am aware of who are going to sign the new contract in Darwin, with the huge number of defence personel here. Some female defence members already have been referred to the over-busy public hospital, and I am sure they are not happy.

Jenny Mitchell (not verified)

Although Medibank provides no explanation, to take our fighting forces' health care into the domain of the discounted bulk-billed service, you have decided to put your profit motive ahead of the support from home that these men and women deserve. I feel it significantly degrades your Medibank brand to downgrade the debt we owe these brave men who sacrifice so much on all our behalf, and I am sure the rest of the community will agree.

Mark MacL (not verified)

I have been happy to treat soldiers at a lower rate than I normally charge in the past, because I believe we owe them the best care we can give. They are wonderful people, and I have had an excellent relationship with the Defence Forces. [But] I am not prepared to become a Medicare contractor, and accept a contract drawn up without any consultation.

John O'Donnell (not verified)

Authority Prescription Hotline

I was amazed to hear that 500,000 calls a month are made [to the hotline]. Six million a year. Work out [the] time wasted. Unbelievable. For what?

Dr Chris Mckenzie (not verified)

Internships

The government has an obligation to provide internships for all students holding a Commonwealth-funded university place, but no such obligation should exist for full fee paying students. Otherwise, the government is in effect offering a guaranteed buy back of a proportion of the undergraduate fees collected.

Name withheld

Is this not going to be a recurrent problem every year? Is the federal government planning to recurrently fund their extra 100 intern places that seem to be in excess of the current workforce requirements? This may also result is a dilution of experience for those interns - they may only be asked to job-share or work for only 20 to 30 hours per week. At least they will be compliant with safe-hours directives.

Name withheld

This is not about protecting or advantaging medical graduates or doctors, but simply allowing them the opportunity to begin working and then competing [in the workforce]. Graduates in most other faculties are (I assume) eligible to work once they have their degree, although obviously never guaranteed of anything, just as it is for graduating interns. If you are medically trained then you will know how competitive things become once competition for specialist training begins.

Eyedoc

Fees

Very sadly, the Government seeks to make extremely meagre increases in the MBS schedule of fees at lengthy intervals. What the Government must realise by now is that there are many GPs and specialists carrying out minor, sometimes complicated, surgical procedures for very low fees in their well set up treatment rooms, with nursing staff assistance. All these patients would otherwise end up in the public hospital system, waiting for their operation on the waiting list for a very long time. If the Government was serious about helping the community at large, they would make significant increases to the MBS schedule. The Government will reap so many gains by this process. More and more could be treated as outpatients by GPs and specialists for problems which otherwise would block a bed in hospital.

Dr Gamani Goonetilleka (not verified)

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RESEARCH

Magnets attractive option for depression

Magnetic stimulation could replace electroconvulsive therapy in the treatment of many people suffering chronic depression.

Researchers from Monash University have found that Magnetic Seizure Therapy (MST), which stimulates the brain using magnetic fields, has similar clinical effects to electroconvulsive therapy (ECT), but without unwanted side effects such as memory loss.

The study found that 40 per cent of patients treated with MST showed overall improvement, while 30 per cent showed some improvement, and none complained of cognitive side effects.

Lead researcher, Professor Paul Fitzgerald, said depression was a common and disabling disorder, affecting up to one in five Australians during their lifetime.

"Electroconvulsive therapy is one of the only established interventions for treatment-resistant depression," Professor Fitzgerald said. "But use of ECT is limited due to the presence of memory-related side effects and associated stigma."

"However, in MST, a seizure is induced through the use of magnetic stimulation rather than a direct electrical current, like ECT. Magnetic fields are able to pass freely into the brain, making it possible to more precisely focus stimulation.

"By avoiding the use of direct electrical currents and inducing a more focal stimulation, it is thought that MST will result in an improvement of depressive symptoms without the memory difficulties seen with ECT."

But Professor Fitzgerald said much more work needed to be done to further compare MST and ECT, and to determine when, and under what circumstances, MST could be best applied.

"MST shows antidepressant efficacy without apparent cognitive side effects," the Professor said. "However, substantial research is required to understand the optimal conditions for stimulation and to compare MST to established treatments, including ECT."

The researchers said work involving MST was still at an early stage, and the technology itself was only available in a handful of locations worldwide.

The study was published in *Psychiatry Research: Neuroimaging* and *Depression and Anxiety*.

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Aspirin helps prevent blood clots

The humble aspirin pill has been shown to be a cheap, safe and effective way to prevent potentially deadly blood clots.

A University of Sydney study involving more than 800 people found that low-dose aspirin was effective in preventing a recurrence of serious blood clots or cardiac events in people who had previously suffered from blood clots.

The study involved administering aspirin or a placebo to participants, all of whom had previously suffered a serious blood clot and had completed on average six months of anti-coagulant treatment. The progress of participants was monitored for three years.

The study found that people who had previously suffered from blood clots in the veins of the leg or lungs were less likely to have a recurrence of a serious blood clot or a cardiac event if they took low-dose aspirin.

Lead author Professor John Simes, of the University of Sydney, said the results would change the way patients with blood clots are treated.

"The results of this study suggest the simple, inexpensive treatment of low-dose aspirin could prevent thousands of patients from experiencing recurrent clots each year, and may make substantial health care savings in Australia and worldwide," Professor Simes said.

"These results suggest that aspirin prevents about one third of recurrent blood clot events. For every 1000 patients treated for one year, aspirin can be expected to prevent about 20 to 30 episodes of recurrent major thrombotic events at the cost of about three significant bleeding episodes."

KW

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Hidden killer finding it harder to hide

A new diagnostic test has the potential to save thousands of lives by accurately identifying the point of origin for cancers that have spread throughout the body.

In a major advance in the treatment of Cancers of Unknown Primary (CUP), which are the sixth most common cause of cancer deaths in the country, researchers at Melbourne's Peter MacCallum Cancer Centre have developed a test that correctly identifies the source of cancer in more than 90 per cent of cases.

Professor David Bowtell, Head of the Cancer Genomics Program at Peter MacCallum, announced the breakthrough at the Clinical Oncological Society of Australia's Annual Scientific Meeting last week.

Professor Bowtell said the test profiled the activity of thousands of genomes simultaneously, and matched them to a database of the gene expression patterns of all known tumours, eliminating the need for extensive and potentially debilitating tests which may ultimately prove to be inconclusive.

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RESEARCH

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"CUP is a distressing and frustrating diagnosis for both patients and their doctors," Professor Bowtell said. "In some cases, you can do extensive clinical and pathological tests but still not confirm the site of origin."

"Accurately identifying the primary tumour will allow clinicians to choose the most effective treatment strategy, hopefully leading to better outcomes and quality of life for these patients."

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Hendra vaccination hits the shelf

In a major breakthrough in the fight against the fatal Hendra virus, scientists have developed the world's first commercial vaccine for the illness.

The bat-borne disease was first discovered in Brisbane in 1994. There have been more than 35 outbreaks since that have killed more than 80 horses and claimed the lives of four people.

The drug giant Pfizer, in conjunction with CSIRO, has developed an equine Hendra vaccine that it says will help break the cycle of transmission from horses to humans.

The vaccine is a result of almost two decades of research involving almost 100 researchers and costing millions of dollars. Regulators have fast-tracked the vaccine's release, which will be available even before data on how long it will work to protect horses are gathered.

Lead CSIRO researcher on the project, Dr Deborah Middleton, said she understand the potential impact of the vaccine on the horse industry.

"As a veterinarian, I have seen first hand how Hendra has created difficult working conditions for my colleagues and any Australian who works with horses," Dr Middleton said.

"A horse vaccine is crucial to breaking the cycle of Hendra virus transmission from flying foxes to horses and then to people, as it can prevent the horse developing the disease and passing it on.

"For the first time, we have a Hendra specific tool that provides veterinarians with a greater level of safety when they come into contact with sick horses."

Australian Veterinary Association President, Dr Ben Gardiner, said horses in high-risk areas in Queensland and New South Wales would be the first to be vaccinated.

"From the vets' perspective, this really is a workplace health and safety issue," Dr Gardiner said. "A database will be established of all vaccinated horses."

Dr Gardiner said the development of the vaccine had come as a relief for vets, who have been responding to the disease for some years.

"They've been wearing the very detailed personal protective equipment and, for the moment, they'll need to continue to wear that equipment when confronted with a sick horse, especially in those areas where Hendra is known to exist already," he said.

"We also know that flying foxes carry the antibodies to Hendra in populations of flying foxes right across Australia, so we're saying that it's not going to be a shock if we do find a Hendra case somewhere else outside of the known zone."

Minister for Agriculture, Fisheries and Forestry, Senator Joe Ludwig, and Minister for Science and Research, Senator Chris Evans, applauded the Australian researchers for their involvement in developing the vaccine.

Shadow Agriculture Minister John Cobb also praised the researchers.

The vaccination is available now for use by accredited veterinarians.

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Diabetes treatment given all clear

Experts have given a common diabetes treatment the all clear after finding no evidence to back up claims that users faced an increased risk of developing breast cancer.

The Australian Diabetes Society (ADS) has advised that there is no evidence of a link between using insulin glargine (marketed by Sanofi-Aventis under the name Lantus) and malignancy.

Alarm about the use of Lantus was raised in 2009 when several studies suggested an association between insulin glargine and increased risk of cancer, particularly breast cancer.

But in a statement issued earlier this month, Sanofi-Aventis claimed there had been widespread criticism of this research and its findings, including concerns that unorthodox statistical methods had been employed.

In addition, according to the company, researchers from the University of North Carolina examined more than 12,500 people assigned with insulin glargine or a placebo and found that there was no increased risk of cancer in people with diabetes treated with Lantus compared to those treated with other insulins.

In updated advice, the ADS said that "the current data do not support a relationship between the use of insulin glargine and malignancy".

It advised that patients already taking insulin glargine "do not need to change their insulin therapy".

"Patients with diabetes can be initiated on glargine therapy without concern that insulin glargine will increase the risk of developing a malignancy," the Society said.

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Region tries to slap down malaria superbug

"If we accelerate our efforts, we could save 70,000 lives and prevent around 50 million malaria cases by 2015"

Australia has joined countries across the Asia-Pacific urging decisive international action to tackle the emergence of drug-resistant malaria.

The Federal Government is contributing $5 million to a World Health Organisation project, jointly funded by the Bill and Melinda Gates Foundation, to coordinate an emergency response to the growth of drug (Artemisinin)-resistant malaria in the Greater Mekong delta, encompassing parts of Cambodia, Vietnam, Thailand and Myanmar.

Australia's Ambassador for Malaria, James Gilling, told AAP health authorities were particularly worried that if the drug-resistant strain of malaria made it to Africa, the continent's annual death toll from the disease could jump close to 1 million people.

Announcing the contribution, Health Minister Tanya Plibersek said more than 2 billion people in the Asia-Pacific were at risk of contracting malaria, and emerging Artemisinin-resistance in the Greater Mekong had become a major obstacle to efforts to eradicate the disease.

"National responses to the threat of drug resistance are not sufficient," Ms Plibersek said. "It will take a regional and global response if we are to achieve the goal of reducing malaria deaths in the Asia Pacific by 75 per cent by 2015."

The Minister's comments came as representatives from more than 30 countries in the Asia-Pacific region announced the establishment of the Asia-Pacific Leaders Malaria Alliance to focus efforts on accelerating the fight against malaria, particularly the emergence of drug-resistant strains.

The announcement came at the end of the Malaria 2012 Conference in Sydney, which heard that malaria was endemic in 22 countries in the region, and killed more than 42,000 people a year.

In a communiqué, the region's governments promised to accelerate efforts to achieve a 75 per cent reduction in malaria cases and deaths in the region by 2015, and to eliminate the disease from at least half of the countries where it currently exists by 2025.

But the charity Oxfam has criticised an international scheme to combat malaria and other serious communicable diseases as "risky and dangerous", with no evidence that it has saved vulnerable lives.

The three-year old Affordable Medicines Facility for Malaria (AMFm), operated by the Global Fund to Fight AIDS, TB and Malaria, is an initiative mainly by the World Health Organization, the World Bank and UNAIDS.

It subsidises access to combination therapy for malaria, particularly using private-sector medicine retailers in developing countries. In Phase 1, the scheme is being piloted in nine countries, all but one of which (Cambodia), are in Africa.

According to Oxfam, it is dangerous to "put the lives of sick children in the hands of a shopkeeper with no medical training". There are no cheap options or short cuts in the fight against malaria, the charity said.

The scheme "is a dangerous distraction from genuine solutions like investing in community health workers, who have slashed the number of malarial deaths in countries such as Zambia and Ethiopia".

The Global Fund has rejected Oxfam's claims as "simply untrue". "Some Western aid groups oppose a pragmatic approach that includes any involvement of the private sector," it says. "But the reality of this program is that it is getting lifesaving medicine to people who need it most from the private sector outlets where they already seek treatment . . . An extensive study has shown that AMFm has increased availability and reduced prices for high quality anti-malarial drugs."

Foreign Minister Bob Carr committed Australia to contribute more than $100 million over the next four years to regional efforts to combat the disease.

"If we accelerate our efforts, we could save 70,000 lives and prevent around 50 million malaria cases by 2015," Mr Carr said.

He said the region needed an extra 276 million mosquito nets impregnated with insecticide, 2 billion rapid diagnostic tests and 47 million malaria treatments.

AR and DN

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Go for traffic-light labelling

Major supermarket chains in Britain and Ireland have bowed to government and consumer pressure to introduce traffic-light-labelling on packaged foods high in calories, fat, saturated fats, sugar and salt.

They have not surrendered completely, however.

The British Government has agreed to a hybrid labelling system in which traffic light labels will be placed on the front of products and, on the back, the industry's preferred Guideline Daily Allowance (GDA) labels, which note percentages of daily intakes per portion or per 100g.

Supermarkets in Ireland have agreed to adopt the new British system.

The food industry in both countries has until now resisted the pressure, arguing that their GDA labels were informative enough.

But, according to health campaigners, the GDA labels were confusing and the portion sizes they used were nominated arbitrarily and did not reflect how much people actually ate.

The new labeling regime will come into force in both countries about mid-2013.

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US meningitis toll rises, lawyers hover

More than 30 people have now died in the fungal meningitis outbreak in north eastern United States reported in *Australian Medicine* (November 5 2012).

Nearly 440 have caught the disease, which is thought to have been caused by a steroid-based pharmaceutical suspected to be of sub-standard quality, made by the compounding pharmacy New England Compounding Center (NECC) and still marketed only because of failure over the past eight years by regulators.

In 2004, after it had been established that the NECC had failed to meet accepted standards when making the suspect drug, the Massachusetts Board of Registration in Pharmacy and the NECC reached a consent agreement that proposed a reprimand for the company and a three-year probationary period for its registration and licence.

But the board did not push on with the agreement after the company protested that its terms were unwarranted and could be "fatal to the business". The board's mandate was "to protect the public health safety and welfare," it said, "not punish the licensees". Instead, the board and NECC reached another consent agreement two years later – this time minus any disciplinary action.

The regulators are now scrambling for cover.

A staff report for the House of Representatives Committee on Energy and Commerce has accused the chief pharmacist at the NECC of resisting and occasionally even lying to federal and state regulators who were trying to force changes on the company, whose drug products are now linked to 438 cases of illness and 32 deaths.

The Massachusetts Office of Health and Human Services is investigating the reasons the boards failed to enforce the 2004 agreement and instead agreed to the watered-down 2006 undertaking.

The state administration is taking steps to revoke NECC's licence, while the US Food and Drug Administration is advising doctors that all NECC products should be retained, secured and withheld from use.

NECC itself has voluntarily recalled all its products now in circulation that were compounded at, and distributed from, the facility that produced the alleged offending drug.

And the lawyers are gathering. Media reports note that a Google search of the term "fungal meningitis" brings up thousands of paid ads by law firms urging affected people to "contact us immediately".

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Global anti-TB campaign "fragile": WHO

The World Health Organization's latest global TB report lists some important progress around the world in dealing with TB but insists that "the global fight against the disease remains fragile".

The WHO's *Global tuberculosis report 2012*, based on data from 204 countries and territories, covers all aspects of TB, including multidrug-resistant TB (MDR-TB), TB/HIV, TB R&D and TB funding.

Major findings include:

- a continued decline in the number of people becoming ill with TB - though 8.7 million new cases were reported in 2011, which the WHO says is still imposing "an enormous global burden" on the countries and organisations fighting TB;
- an estimated 1.4 million deaths from TB, including half a million women (highlighting the disease as one of the worst killers of women);
- reduced rates of new disease and deaths in all of the WHO's six regions (though the African and European regions are still not on track to achieve goals to halve 1990 levels of mortality by 2015); and
- persistently slow progress in responding to MDR-TB.

A notable example of progress is in Cambodia, where TB prevalence dropped 45 per cent between 2002 and 2011.

An example of lack of progress, on the other hand, is the finding that finance for research into TB is lacking. It noted that there was already a funding gap per year of about $1.5 billion, and this was expected to reach $3 billion a year between 2013 and 2015. This, the report says, could have severe consequences for TB control.

The WHO is calling for "targeted international donor funding and continued investment by countries themselves to safeguard recent gains and ensure continued progress".

Dr Mario Raviglione, Director of the WHO's Stop TB Department, said that the momentum to break the disease was in real danger. "We are now at a crossroads between TB elimination within our lifetime and millions more TB deaths."

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INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

TO COMMENT CLICK HERE

Maternity errors cost NHS nearly $5 billion

The UK National Health Service has had to pay about $4.8 billion over the past 10 years in damage claims over mistakes by doctors and midwives in managing more than 5000 births in England.

The NHS Litigation Authority, which handles negligence cases against British hospitals, has reported in *Ten Years of Maternity Claims: an analysis of NHS Litigation Authority Data*, that the 5000 cases involved "junior doctors and inexperienced midwives" who were working "without adequate assistance from senior clinicians".

The three most frequent categories of claim related to management of labour (14.05 per cent), caesarean section (13.24 per cent), and cerebral palsy (10.65 per cent). The first and third categories of complaint (along with interpretation of CTG traces), were the most expensive, accounting for 70 per cent of the total value of all claims.

The period analysed was between April 2000 and April 2010.

The NHSLA said that maternity cases represented the highest in value, and the second highest in number, of the clinical negligence claims reported to it.

It also pointed out that in a 10-year period similar to that analysed for the report (between 2000 to 2009), there were 5.5 million births in England. "Thus, less than 0.1 per cent of these births had become the subject of a claim, indicating that the vast majority if births do not result in a clinical negligence claim."

But Dr David Richmond, Vice President for Clinical Quality at the Royal College of Obstetricians and Gynaecologists, still called the report's findings "staggering" and a "serious wake-up call to all with responsibilities in providing maternity care, whether as providers, commissioners or regulators".

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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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Smoking spills: EU's tobacco wars

John Dalli, the Maltese European Health Commissioner, has suddenly resigned, throwing into confusion EC laws proposed by him to force marketing limits on tobacco companies.

The move has also created a climate of suspicion within the EC, given that it has happened during "an onslaught" of lobbying by tobacco companies against the proposed laws, and has been followed by mysterious burglaries at the Brussels offices of anti-tobacco groups.

EC President José Manuel Barroso is reported to have given Mr Dalli 30 minutes to clear his desk after OLAF (the EC's anti-fraud arm) found that a Maltese businessman had tried to get Swedish Match, a leading manufacturer of snus and snuff, to pay him nearly $80 million to influence Mr Dalli and the EC to weaken the laws in favour of its product. OLAF had found no evidence that Mr Dalli was involved in this, but it did consider that he knew about it.

Snus, a powdered product made of tobacco, salt and sodium carbonate, is popular in Sweden. It is consumed by being placed under the top lip and therefore is supposedly safer than tobacco. Snus is illegal in the EU, though not in Sweden, which won exemption for it as part of its joining the EU in 1995.

Mr Dalli's new tobacco laws have now been delayed by his resignation. They proposed to force cigarette manufacturers to put health warnings on most of the surface of their packaging, and contained an option for member countries to mandate plain packaging of cigarettes. They proposed no action against snus.

Mr Dalli has denied that he decided to resign, as the EC had claimed, and maintained that he was given no choice. He has protested his innocence and is taking legal action to clear his name. He has also accused the tobacco lobby of conducting "an onslaught" on the Commission, "meeting all the Commission and their staff over the past months".

To add to the ensuing controversy, within 48 hours of the 30 minutes that Mr Dalli had been given by President Barroso, the Brussels offices of two major anti-tobacco groups had been burgled, with laptops and documents of senior staff stolen. The eight floors of the building occupied by the groups, close by the European Parliament, are used exclusively by many organisations that lobby the EC and monitor EU political developments, but only the anti-tobacco offices were targeted by the break-in.

This has led Dr Florence Bertelletti Kemp,

director of one of the groups, to conclude that the break-in was no coincidence. "What we are witnessing is the biggest tobacco industry interference in public health policy at the European level," she said. "The backdrop to the burglary at our office is the political scene."

EC Vice President Maros Sefkovic has taken over Mr Dalli's portfolio until a new Commissioner of Maltese nationality is appointed, as is mandated by the Treaty on the Functioning of the European Union.

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Stroke: a new European crisis

A report by Action for Stroke Prevention has warned that Europe is at risk of a devastating stroke crisis.

Action for Stroke Prevention (ASP), a global alliance of cardiologists, neurologists, primary care providers, health economists and patient advocates, has issued similar warnings before, but its latest report is backed by the findings of a survey of more than 9200 people aged 40 years and older in 20 countries, mainly in Europe but also in Asia and Latin America, conducted by IPSOS MORI and supported by Bayer Health Care.

The survey found that only 16 per cent of respondents generally knew that the risk of atrial fibrillation-related (AF) stroke could be reduced by anti-coagulant treatment.

The lack of awareness about stroke was especially serious in Europe where, though nearly a third of respondents worried about having a stroke above other serious health conditions, more than half had never heard of AF and, though 65 per cent identified high blood pressure as a risk factor for stroke, only 15 per cent knew that AF was also a risk factor for the condition.

ASP says that though clinical practice guidelines such as the European Society of Cardiology Guidelines on AF are available, adherence to them in Europe is poor, and effective stroke prevention therapies are chronically under-used.

Its report, and supplementary documentation, proposes various ways to deal with the problem, including:

- improving public awareness and understanding of AF and the risk of AF-related stroke;
- implementing effective practice standards and targets for health care professionals (for example, targets for AF screening);
- facilitating multilateral exchange of best practice; and
- developing strategies to support adherence to clinical guidelines and provide equal and adequate administration of treatment for people with AF.

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Massachusetts says no to assisted suicide, yes to medical marijuana

Massachusetts has narrowly rejected a Death with Dignity Bill that would have legalised assisted suicide in the state, in a ballot held in conjunction with the US Presidential election.

The Catholic hierarchy in Massachusetts, where 69 per cent of citizens are Catholic - the highest such concentration in the US – mounted a vigorous campaign against the Bill, which was voted down by 51 per cent of voters.

It proposed to allow doctors to provide life-ending, self-administered medications for terminally ill patients who wished for faster, easier deaths. The process would have been entirely voluntary on the part of all participants, including the patients, their doctors and any other health care provider involved.

The vote means that Oregon and Washington remain the only states in the Union where this form of physician-assisted death is allowed. It is banned elsewhere in the US.

A far larger majority of Massachusetts voters approved a measure – against the advice of the Massachusetts Medical Society – that will allow patients suffering from such conditions as Parkinson's disease, Crohn's disease and cancer to receive certification to possess and use marijuana for pain relief.

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1992 Toyota Cressida Grande: Timeless Toyota

BY **DR CLIVE FRASER**

I recall 20 years ago that doctors at the peak of their professional life were just as likely as ever to buy a car that might reflect their ambition and confidence.

After all, if you've worked hard, why not buy yourself a nice car to get to and from the surgery?

A Toyota Supra with a 3.0 litre double overhead cam 24 valve engine would probably get you to your rooms quickly.

But, by this stage in your career, you've probably acquired some rear seat passengers and your partner's spondylolysthesis from child-bearing might make it difficult to squeeze into a two-door coupe.

Seeing a marketing opportunity, Toyota engineers decided to put the 1986 Mark III Supra's engine in a sedan body and, in 1988, the fourth generation Toyota Cressida was born.

Devoted followers of Doctor Who may remember that Cressida was the name of a character who fell in love with the son of the King of Troy.

The Doctor Who storyline was very loosely based on a Shakespeare play, *Troilus and Cressida.*

You would have to be a very devout fan of Doctor Who to know about Cressida, though, as she appeared alongside the first doctor (William Hartnell) in 1965.

For those of us less versed in Shakespeare and Doctor Who, we will all know that Cressida was a large, rear wheel drive car from Toyota which first appeared in 1976.

Its conventional rear wheel drive train meant that it appealed to conservative buyers.

It was the fourth variant of the model, though, which finally ticked all the boxes.

It had handling to match its abundant power, thanks to the Supra's double wish-bone rear end.

The final Grande version came with an anti-lock braking system, climate controlled air-conditioning, electric leather seats and a CD player.

Sadly, I was never able to afford the $43,990 plus on-road costs that a Cressida Grande cost in 1992, so I was always a little envious of those procedural specialists that had acquired the Toyota limo.

Twenty years on there are a surprising number of Cressidas still on the road, and I even have a colleague who still drives one.

And finally, at $3300 for a 1992 Grande in good working order, it is within my price range.

In a sign of the Toyota's durability after 20 years, all of the buttons still work in my colleague's vehicle – well, almost all of them.

The car still starts and stops, and the only recent breakdown was caused by a loose battery terminal.

The leather seats haven't cracked, and the paintwork would scrub up fairly well if the dirt was hosed off occasionally.

My colleague doesn't wash his cars much and so there isn't any rust at all in his Cressida.

With so many great cars on the market in 2012, it is worth considering which ones will still be on the road in 2032.

I know I won't be!

1992 Toyota Cressida Grande	
For	Twenty years old and still going strong.
Against	No air bags.
This car would suit	Respiratory physicians who like the easy-breathing DOHC.
Specifications	3.0 litre 6 cylinder DOHC 142 kW power @ 5,600 rpm 254 Nm torque @ 4,400 rpm 4 speed automatic with LSD $43,990 + ORC

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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