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Medicine

The national news publication of the Australian Medical Association

Critical shortage of GPs, specialists looms

Inside

Govt adviser calls for urgent training overhaul, p4

MHS accused of bluffing on Defence contract claims, p5
Irrational vaccination fears could put nation at risk, p7
Health risk from push to expand prescribing rights, p9
Doctors pack more into 15 minutes than ever before, p14
Death on the intensive care front line, p21
The healing power of sweat, p23



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IN THIS ISSUE

NEWS

4-19, 26-30

REGULAR FEATURES

3 VICE PRESIDENTS MESSAGE

20 LETTERS

21 OPINION

22 MEMBERS' FORUM

23 RESEARCH

24 HEALTH ON THE HILL

31 BOOK REVIEW

32 MEMBER SERVICES

Cover: AMA President, Dr Steve Hambleton, and Australian Academy of Science President, Professor Suzanne Cory, hold media conference at launch of *The Science of Immunisation: Questions and Answers*, Sydney, 26 November



Time for a Measured Response?

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Last month I was able to attend a conference co-hosted by the Australian Healthcare and Hospitals Association, the Australian Council on Healthcare Standards (ACHS) and Women's and Children's Healthcare Australia. An excellent meeting it was, too, with some outstanding presentations on the theme, 'Measurement: redefining health's boundaries?'

Afterwards, though, when there was time to reflect on the breadth and burden of measurement and reporting in our health system, it was hard not to wonder if there can be too much of a good thing.

The aims are laudable: to improve the quality of health care, to monitor the performance of individuals, departments, hospitals and health systems, and to assist consumers in making informed choices.

All this requires accurate, validated and useful measures of performance.

Even describing what is meant by 'performance' means different things to different people.

Ideally, it would relate to an integrated measure of patient-centred outcomes and experience of the health system.

This information can be time consuming and expensive to collect routinely.

Collecting a statistically valid sample of important end points is challenging, and more likely to occur as a limited 'one off' audit than as part of routine practice.

The temptation, then, is to make the easily measureable important, without questioning its value as a 'performance' measure, rather than focussing on making a more limited range of validated measures important.

Almost every organisation currently involved in health care has, quite rightly, a safety and quality agenda, but this has resulted in considerable duplication and overlap.

The Australian Commission on Safety and Quality in Healthcare and the National Health Performance Authority (NHPA) have obvious national roles, as do accreditation bodies such as ACHS, with their suite of performance indicators for which there is broad input from the medical colleges and societies.

However, those who fund health care, such as the Independent Hospital Pricing Authority and private health insurers, are also getting into this space.

Then there are State and Territory safety and quality frameworks and reporting requirements, and specialty specific registries against which to benchmark performance for individual hospital departments.

For individuals, the performance frameworks developed by the Royal Australasian College of Physicians and Royal Australasian College of Surgeons are well thought-out to address the spectrum of work undertaken by 21st century physicians and surgeons.

The vast majority of this work is excellent.

But the work of compliance, which seems to be ever increasing, is equally vast.

One of the most pleasing aspects of the conference was the recognition from health administrators that measurement and reporting are not ends in themselves, but need to result in improved quality, effectiveness, or to stimulate innovation.

Just as pleasing was the recognition that some of the most important aspects of a patient's experience of health care delivery are difficult or impossible to measure.

It would be great to see this information from senior health administrators and academics flowing into the safety, quality and measurement sub-industry, so limited resources can be focussed on clinically meaningful service improvement.

Websites such as MyHospitals (www.myhospitals.gov.au), coordinated by the Australian Institute of Health and Welfare under contract to the NHPA, have been designed to put more information on both public and private hospitals into the public domain in an accessible and easy to use format.

As is common with aggregated information, the site suffers from a significant time lag. For example, currently available elective surgery and emergency department waiting time data are for the 12 months to June 2011.

In these days of instant electronic communication many other opportunities exist for people to share their health care experiences, such as through Facebook, Twitter and myriad other websites.

Some, such as www.patientopinion.org.au, are moderated and make it clear that the reports are from individuals recounting their experiences, and are sent to the relevant service providers. But others do not appear to be moderated, and there is a resultant 'free for all' without the discipline of verification.

Nevertheless, it seems many people trust online reviews. A recent Nielsen survey found 71 per cent of Australians trust them.

In the hotel industry there are reports of both 'generated' positive reviews and negative reviews of competitors on websites such as Expedia and TripAdvisor.

I am not aware of any similar examples in health care, but it highlights the need to treat self-reported information with caution.

The bottom line here is that there is a huge amount of information on safety and performance in health care, much of it of high quality.

But there is an opportunity cost in all this measurement, and a review of the many programs, the amount of duplication, and its cost effectiveness seems overdue.

[TO COMMENT CLICK HERE](#)

Severe shortage of GPs and other specialists looms

The country is facing a shortage of general practitioners, obstetricians, psychiatrists and oncologists unless there is urgent action to reform medical training and workforce arrangements, the Government's chief adviser on health workforce planning has warned.

In the most comprehensive assessment ever undertaken of the supply of medical specialists and future demand, Health Workforce Australia (HWA) has forecast that, unless there is reform, the nation faces a critical shortfall of around 450 psychiatrists, 366 radiologists, 142 obstetricians and gynaecologists and 182 ophthalmologists by 2025.

Underlining the nation's heavy reliance on international medical graduates (IMGs) to plug existing gaps in the medical workforce, particularly in general practice, obstetrics, radiology, psychiatry and ophthalmology, HWA projections indicate the country faces a shortage of more than 3800 GPs in 2025 if the current intake of IMGs is halved, as well as a shortfall of almost 800 psychiatrists, more than 500 radiologists, 300 obstetricians and 230 anatomical pathologists.

But, highlighting the unevenness of supply, some specialties are expected to be approaching oversupply by 2025, including cardiology, neurology, gastroenterology and surgical specialties.

HWA found that the supply of medical specialists was increasing, but it was uneven, both by location and by specialty, and the health system was currently heavily reliant on the intake of IMGs to cover significant gaps in access to specialists.

"There are not enough general practitioners and some other specialists, some medical specialties are more popular than others from a career perspective, and there is a growing trend towards specialisation and sub-specialisation, which is resulting in a shortage of generalists," HWA Chief Executive Officer Mark Cormack said.

The AMA and other members of United General Practice Australia (UGPA) seized on the findings to call for urgent action to boost GP training and encourage the more even distribution of practitioners.

At a UGPA meeting last week the nation's general practice leaders – including AMA President Dr Steve Hambleton, Dr Liz Marles of the Royal Australian College of General Practitioners, Dr Arn Sprogis of the Australian Medicare Local Alliance and Dr

Sheilagh Cronin of the Rural Doctors Association of Australia – backed AMA proposals to help address the problem.

Dr Hambleton won UGPA backing for his call for the Practice Incentives Program Teaching Incentive to be substantially increased to boost the capacity of practices to train practitioners.

The UGPA also urged the Federal Government to redirect unspent funds from its troubled GP Super Clinics program to bolster GP infrastructure grants – particularly for training facilities.

"UGPA shares HWA concerns about training capacity to build a GP workforce, in sufficient numbers and with the proper skills, to meet growing community needs," the GP leaders said in a joint statement. "There is an urgent need for Government support for supervisors, training infrastructure, and integrated support services to underpin GP-based training."

They warned that this could not be done on the cheap, and would require "significant new investment".

The HWA's findings, and its calls for reform, were also endorsed by specialist bodies including the Royal Australian and New Zealand College of Psychiatrists, the Royal Australasian College of Physicians, the Australian and New Zealand College of Anaesthetists, and the Internal Medicine Society of Australia and New Zealand.

Mr Cormack said the nation's poorly co-ordinated medical training pathway was contributing to the problems in the uneven supply of specialists.

"[It is] contributing to uneven distribution of numbers between specialties, increasing the length of time to produce specialists, and some level of wastage in training specialists in fields that may not match community needs," he said.

The HWA has suggested that training funding be linked to goals to improve the geographic and specialty spread of doctors, that there be more targeted and effective efforts to attract and retain physicians in rural and regional areas, and strengthen the current system of geographic bonding for entry-level professionals and IMGs.

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MHS accused of bluffing on Defence contract claims



The Australian Defence Force is referring personnel to specialists who have not signed controversial Medibank Health Solutions contracts, as evidence that the private provider is struggling to recruit the doctors it needs continues to mount.

Doctors who have so far refused to sign the MHS contracts, which in many cases demand substantial fee cuts of up to 40 per cent or more, have told the AMA they are continuing to have ADF personnel referred to them for treatment at existing AMA rates.

AMA President Dr Steve Hambleton said the development underlined the view that specialists across the country have “largely rejected” the MHS offer, and renewed his offer to work with Medibank to devise a “more sustainable” system to provide medical services to ADF personnel.

MHS, the health service provider arm of Medibank Private, earlier this year won a four-year contract worth \$1.3 billion to provide health care services to 80,000 Defence personnel.

As part of its new arrangements, MHS has established a centralised database of preferred specialist providers, comprised of doctors who have accepted onerous demands, including fee cuts of up to 50 per cent and the stipulation that all medical reports be completed and lodged within three days.

MHS has claimed that 5000 contracts have been accepted, but an AMA survey has found that fewer than 10 per cent of specialists have so far signed up to the offer, with the practitioner backlash particularly fierce in some areas where major Defence bases are located, such as Darwin.

In a letter to AMA members last month, Dr Hambleton accused Medibank Health Solutions of sending “very misleading” information to doctors regarding the number of specialists who had signed up.

He said that, according to official ADF correspondence, 2329 specialists had been contracted to the new preferred provider network as of 20 November, but in a letter sent to specialists on 2 November, MHS claimed 5000 contracts

had been returned.

“This figure appears to be very misleading,” Dr Hambleton said.

In a letter to *Australian Medicine*, published on p20, an ADF spokesperson claimed that MHS had received a “good response” to its offer from specialists.

The letter asserted that in addition to 2329 specialists, 5536 individual health providers and 118 hospitals have committed to the new arrangements.

“Medibank Health Solutions is contracted to provide a workforce of approximately 800 health practitioners for Australian Defence Force health facilities. Approximately 90.5 per cent of all of these positions have been filled and, importantly, this includes 100 per cent of all critical positions,” the ADF spokesperson wrote.

But Dr Hambleton said the evidence suggested MHS was struggling to secure the services of the specialists it needed.

“We understand that, because MHS has been unable to meet its recruitment targets, a significant proportion of ADF personnel are still being referred to non-contracted medical specialists,” he said. “In these cases, it appears that the lower schedule of fees set by MHS is not being applied.”

Dr Hambleton advised AMA members who had been offered MHS contracts that they should “not feel pressured to sign up to the new arrangements, particularly if you are unhappy with the new, lower fee schedule and associated contract provisions”.

He said those considering signing an MHS contract should seek independent legal advice.

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Asylum seekers need independent health watchdog

The AMA has thrown its support behind legislation to establish an independent panel of experts to monitor the health of asylum seekers.

As concerns about the health of an Iranian hunger striker at the Nauru detention centre mount, and instances of self-harm multiply, the AMA has urged the creation of a panel with the power to thoroughly investigate and report on the health of asylum seekers held in both offshore and onshore facilities.

In a submission to a parliamentary inquiry into the Migration Amendment (Health Care for Asylum Seekers) Bill 2012, the Association said consultations with doctors and frontline services with direct access to children and young people in detention had revealed problems including developmental delays, mood disorders, depression, instances of self-harm, thoughts of suicide and anxiety disorders.

"The weight of evidence and experience clearly establishes the profound risks to health and, in particular, mental health, posed by immigration," the AMA said in its submission. "Indefinite detention poses inherent risks to mental health, however these risks are compounded by poor conditions, overcrowding, and limited access to health screening and appropriate health care."

"A high incidence of self-harm and suicide attempts, insufficient health service staffing, poor screening and clinical governance, and delays in accessing essential specialist and mental health care, were found to be endemic across the immigration detention network."

The AMA warned that the remoteness of the Nauru and Manus Island detention centres posed particular challenges, and underlined the need for the legislation to bestow the expert panel with powers to access all places of detention and interview detainees; be given the necessary financial and material resources; carry appropriate legal immunities; be empowered to examine contracts between the Immigration Department and health and welfare service providers; and the power to report publicly on its monitoring.

In addition, the AMA called for the legislation to be amended to include provisions protecting the privacy of asylum seekers and clauses in the Commonwealth's Memorandum of Understanding with the governments of Nauru and Papua New Guinea giving the panel unfettered access to the Nauru and Manus Island detention centres.

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Going somewhere this summer?

**Planning to go away soon for some much needed R and R?
Or have you been somewhere spectacular recently?**

Whether it be an expedition across the other side of the world or a brief sojourn down the road, here's the chance to share your thoughts and experiences, from the exhilarating and glorious to the tedious and disastrous. It can be anything from travel advice and how-to hints to

hotel and restaurant reviews, and everything in between.

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Please send stories, with your contact details, to: ausmed@ama.com.au

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Irrational vaccination fears could put nation at risk



The AMA has thrown its support behind efforts to counter misinformation and fear mongering regarding the immunisation of children against disease amid fears vaccination rates could decline and expose the nation to potentially deadly disease outbreaks.

AMA President, Dr Steve Hambleton, and Chair of the AMA Council of General Practice, Dr Brian Morton, helped the Australian Academy of Science launch a booklet in Sydney last week aimed at dispelling myths about the dangers of immunisation.

Dr Hambleton said it was “a great concern” that the parents of about 30,000 children had lodged conscientious objections to immunisation on behalf of their offspring.

The AMA President said many parents were being confused by misinformation being spread by a number of individuals and organisations about the dangers of immunisation, and the Academy’s booklet, *The Science of Immunisation: Questions and Answers*, sought to provide a counterbalance by providing clear, scientifically-based information about its benefits and risks.

“There are many irrational fears out there, and there are individuals feeding those irrational fears,” Dr Hambleton said. “It is very hard to fight that, but we need to fight it with actual facts that are simple and clear, that make sense, and [that are]

totally independent of Government, totally independent of pharmaceutical companies.”

The AMA President said vaccination had been one of the great success stories of modern medicine and public health, and it was disturbing that many of the advances that had been made in recent years in getting close to eradicating a range of deadly and debilitating diseases could be put at risk by ill-informed views.

Dr Hambleton said that in the 30 years he had been in medical practice a lot of serious diseases had virtually disappeared in Australia, including measles, mumps, chicken pox, meningococcal meningitis, life-threatening croup, diphtheria and hepatitis A.

But he warned this progress was being endangered by the refusal of a growing number of parents to allow their children to be vaccinated.

Immunisation rates are above 90 per cent for children in the first 18 months of life, but drop to 89 per cent by the time they get to five years of age, and Dr Hambleton warned vaccination rates had to reach up around 95 per cent to ensure society was getting on top of many of these diseases.

“For many conditions it’s not just individual immunity which is very important. It’s herd immunity, so it’s actually getting all of the children vaccinated,” he said. “We only see those outbreaks [of diseases like measles] where the level of herd immunity is falling.”

The AMA President said a disturbing warning sign of falling immunity was the surprise death of a person from diphtheria in Queensland last year.

“These very serious illnesses will be harming our children unless we read the facts, and actually make sure all of our population is appropriately vaccinated,” Dr Hambleton said.

Australian Academy of Science President, Professor Suzanne Cory, said parents who object to vaccines were not only putting the health of their own children at risk, but also that of the broader population.

“If there is a pool developing within Australia of unvaccinated children, they are putting at risk vulnerable people in our society, not only other children, but older people as well,” Professor Cory said.

The Science of Immunisation: Questions and Answers can be downloaded at www.science.org.au/immunisation.html

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Best care comes from doctors and nurses working together



The Federal Government's push for independent nurse practitioners will do nothing to improve health care and could add to the nation's medical bill, according to AMA President, Dr Steve Hambleton.

Dr Hambleton told a meeting of the Australian Gynaecological, Endoscopy and Surgery Society that, while the AMA supported recognition of specialist training for nurses, and welcomed discussion about nursing career paths, it did not believe there was a role for independent nurse practitioners.

"The push for independent nurse practitioners is about governments trying to reduce costs by substituting medical care with care provided by nurses," the AMA President said. "This is a false economy. GPs are very cost effective. Substituting GPs will not improve health care outcomes [and] there is no real evidence that it will reduce costs."

Dr Hambleton said the experience of a new nurse-led walk-in centre based at

Canberra Hospital lent weight to the AMA's concerns.

The centre was conceived of as a way to reduce pressure on the Hospital's emergency department by giving patients a treatment alternative for less critical conditions, while at the same time saving the Government money.

But Dr Hambleton said an evaluation of the centre's operations by the Australian Primary Health Care Research Institute found that it had not worked as intended, with indications it had actually led to an increase in referrals to the emergency department.

The evaluation also found that the average service cost at the centre was \$175 which, while much less than the average \$281 cost of triage 4 or 5 category services at the emergency department, was far more than the average \$45 that GP services cost.

In addition, nurses at the centre expressed a preference to have a doctor available for

consultation, at least over the phone.

Dr Hambleton said the results of the evaluation underlined the AMA's view that the best and most cost-effective care resulted from collaboration between doctors and nurses.

"Nurses do have a role to play, and there is scope for more advanced training and autonomy within the scope of their practice," he said. "But there needs to be someone there to lead the primary care team, [and] all the evidence shows that GPs are the primary health care professional to do this.

"Not only are they the highest-trained general health practitioner but, as it turns out, they are the most cost effective as well."

A survey commissioned by Australian Medicare Local Alliance (AMLA) reflects the increasing role played by nurses within general practice.

The survey found that between 2003 and this year the number of nurses working in general practices more than quadrupled, from 2400 to 10,500, and the proportion of practices employing a nurse jumped from around 40 per cent to 63 per cent.

AMLA Chair Dr Arn Sprogis said the trend to employ more practice nurses was likely to continue, with 16 per cent of practices flagging their intention to hire more nursing staff.

Reflecting the move toward higher qualifications in the profession, the survey found that in 2003 just 9 per cent of practice nurses had immunisation qualifications, compared with 35 per cent this year, while the proportion with women's health qualifications has virtually doubled in the past three years from 9 to 15 per cent.

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Push to expand prescribing rights undermines standards

The AMA has expressed alarm at attempts to expand the range of health professionals able to prescribe medications, warning that the health of patients could potentially be put at risk.

AMA President, Dr Steve Hambleton, said well-intentioned efforts to improve access to health care, including by broadening the pool of practitioners who can prescribe medicines, had to be carefully thought through.

Dr Hambleton told the Australian Gynaecological, Endoscopy and Surgery Society that the AMA supported proposals by Health Workforce Australia to allow non-medical prescribing where the prescriber was under the supervision of an independent prescriber, or who issued prescriptions according to an agreed protocol.

But he said the Association objected to the suggestion that non-medical prescribers be able to operate without supervision, unless they undertook education and training equivalent to that of a medical practitioner.

Dr Hambleton said the idea, while problematic, had helped highlight the lack of rigorous and consistent standards for accreditation of training and education across all 14 registered health professions.

“Currently, there is no consistent approach to accreditation of education and training courses for non-medical prescribing, or any consistency in the way non-medical health professionals may safely and competently prescribe within their recognised scope of practice,” the AMA President said.

Dr Hambleton said courses for non-medical prescribers should meet the same standards set by the Australia Medical Council for medical education and training.

“Some might see this as setting the bar too high,” he said. “But, given the well-documented rates of adverse medication events, we believe this is critical for patient safety.”

The AMA President also took aim at the push by pharmacists to expand the scope of their practice, including a grab at authority to dispense prescription medicines without a valid prescription and to screen customers for mental health problems.

Dr Hambleton said the Continued Dispensing legislation passed by the Commonwealth would effectively allow pharmacists to sell behind-the-counter medicines without a valid prescription, and without consulting a patient's doctor, and was “vigorously” opposed by the AMA.

“We place a high value on the professional role of pharmacists. We work together to improve the medication management of patients,” he said.

“But Continued Dispensing represents a breakdown in this collaborative team-based approach to patient care. Only medical practitioners are trained to make assessments about a patient's

clinical condition.”

Dr Hambleton said it was fortunate that the Commonwealth legislation could not come into effect until the states and territories amended their laws, and so far they had shown little interest in doing so.

The AMA President was scathing of suggestions by the Pharmaceutical Society of Australia that pharmacists could play a role in screening customers for mental health problems.

“The AMA is not aware that pharmacist education and training now covers diagnosis,” Dr Hambleton said. “I can't think of anything more inappropriate than pharmacists initiating conversations with their customers in a public place about their possible mental health care needs.”

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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

AMA, AMSA win victory to block MD cash-cow



Cash-strapped universities have been blocked from enrolling domestic full fee paying students in Doctor of Medicine degrees following warnings by the AMA and the Australian Medical Students' Association the move could undermine efforts to resolve the medical internship crisis.

Tertiary Education Minister, Senator Chris Evans, has set strict conditions on Commonwealth funding for Doctor of Medicine (MD) programs after the AMA and AMSA raised concerns that the plans of several universities to replace undergraduate medical degrees with MD programs could exacerbate the nation's critical shortfall of intern and clinical training places, and compromise equity of access to medical studies, if they included offering full fee paying places to domestic students.

Senator Evans has acted on the warnings from the AMA and AMSA to advise that the Government will only approve the transfer of Commonwealth funded places to MD programs if:

- there is no net increase in the number of medical graduates;
- that no domestic full fee paying students are enrolled in MD programs;
- that the MD programs offered are of appropriate standard; and
- the Government does not incur any extra costs.

Chair of the AMA's Doctors in Training Committee, Dr Will

Milford, said the Minister's instruction to the universities was an "excellent outcome".

Dr Milford said Senator Evans had gone "a long way" to addressing concerns that the shift to MD programs had opened a loophole allowing universities to offer unlimited full fee paying places to domestic students.

He said that without the Government's action there would have been a real risk that the nation's serious shortfall of intern and clinical training places – which has left 64 medical graduates from the class of 2012 in limbo – would become much worse.

"The re-introduction of domestic full fee paying places in such an environment would clearly compound this situation," Dr Milford said.

He said the criteria for MD program funding set out by Senator Evans also went some way to allay concerns that universities might try to simply rebadge their undergraduate medical degrees as Masters programs rather than develop genuine Masters-level courses with a significant research component.

AMSA President, James Churchill, said the Government's move was "a win for equity and access to medical education, and a significant win for the collective efforts of AMSA and the AMA".

Mr Churchill said that, ideally, all domestic full fee paying places would be banned, but Senator Evans's decision was "a big step in the right direction".

The AMSA President said that although the move, by itself, would not solve the internship crisis, it meant that the proliferation of MD courses would not undermine attempts to achieve coordination between the medical education and training pipelines.

In a letter to AMA President, Dr Steve Hambleton, informing him of the decision, the Department of Industry, Innovation, Science, Research and Tertiary Education indicated the internship crisis had been a key consideration in imposing strict conditions on the implementation of MD programs.

"These arrangements have been developed...in the context of an unprecedented increase in domestic medical graduates, which is placing significant demands on existing clinical and intern training systems," the Department's Director of Higher Education Funding Policy, Julie Birmingham, wrote. "They are designed to ensure that the number of domestic medical graduates does not further increase until the medical system has the capacity to cater for the intern and clinical training requirements associated with the recent expansion in medical schools."

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AMA checklist to help practices apply for e-PIP payments

The AMA has issued a comprehensive guide to help practices complete the many, often complex, steps needed to remain eligible for Practice Incentives Program e-health incentive payments.

From today, general practices will have just 39 business days to meet new requirements or lose their access to incentive payments worth up to \$12,500 every three months.

The AMA Federal Council, concerned about the tight deadlines and lack of timely and co-ordinated support and advice from Government, has backed the fast-tracking of the production of a comprehensive checklist to help GPs be better informed about what information they will be required to submit by 1 February, 2013, in order to remain eligible for the so-called e-PIP payments.

AMA President Dr Steve Hambleton said compiling all the information into a single package was something that should have been done by the Government and its agencies.

"We hope our checklist will save time and preserve valuable income for busy general practices around the country," Dr

Hambleton said. "There is a lot of work to be done for practices to meet the new e-PIP requirements."

Even with the AMA checklist, practices are set to encounter obstacles and delays, the AMA President warned.

The Government has just revealed that registration for digital certificates used in secure messaging, which is a mandatory step in applying for e-PIP payments, will not open until 10 December.

"We have also discovered that there is no current mechanism to verify the installation of their software, which is another requirement of eligibility," Dr Hambleton said. "The AMA supports the PCEHR, but we also support fair and orderly processes to allow general practices to properly prepare for its full implementation."

The AMA is currently polling members on whether they expect their practice will have all four e-PIP requirements in place by 1 February next year.

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DECEMBER HEALTH EVENTS

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

Sun	Mon	Tue	Wed	Thur	Fri	Sat
30	31					1 World AIDS Day Red Ribbon Appeal
2	3 International Day of Persons with Disabilities	4	5	6	7	8
9	10 Human Rights Day	11	12	13	14	15
16	17	18 International Migrants Day	19	20	21	22
23	24 Christmas Eve	25 Christmas Day	26 Boxing Day	27	28	29

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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

\$100m drain on patients' super funds, *The Herald Sun*, 25 November 2012

<http://www.heraldsun.com.au/news/national/m-drain-on-patients-super-funds/story-fndo317g-1226523303949>

AMA President, Dr Steve Hambleton, said it should be compulsory for health funds to publish the rebates they pay for each medical procedure, to help patients avoid gaps and make decisions on cover.

Doctors urge parents to immunise kids, *The Australian*, 26 November 2012

<http://www.theaustralian.com.au/news/breaking-news/doctors-urge-parents-to-immunise-kids/story-fn3dxiwe-1226524173894>

Australian Medical Association President, Dr Steve Hambleton, welcomed an immunisation booklet produced by the Australian Academy of Science as a timely counter to widespread misinformation on vaccinations, which was confusing parents.

More bumps in e-health road, *The Australian*, 27 November 2012

<http://www.theaustralian.com.au/australian-it/government/more-bumps-in-e-health-road/story-fn4htb9o-1226524459540>

The Government's troubled electronic health records scheme has hit more problems, with reports that only a small fraction of software providers have met technical standards enabling them to be connected to the system. Australian Medical Association President, Dr Steve Hambleton, said shared health summaries were a key feature of the PCEHR.

Doctors could face mandatory check-ups, *The Sydney Morning Herald*, 29 November 2012

<http://www.smh.com.au/national/doctors-could-face-mandatory-checkups-20121128-2aer6.html>

The Medical Board of Australia is considering options to regularly assess the competence of doctors, but Australian Medical Association President, Dr Steve Hambleton, said he thought the current system worked well.

Radio

Dr Hambleton, 2CC Canberra, 19 November 2012

Private health insurance funds are calling for a 5 per cent increase in their premiums, which could equate to about \$150 a year for some policyholders. AMA President, Dr Steve Hambleton, predicted thousands of Australians would dump their private insurance and flood the public sector because it was becoming increasingly unaffordable.

Dr Hambleton, Triple M, 19 November 2012

The annual cost of treating skin cancer is expected to grow to more than \$700 million within three years. Dr Steve Hambleton, President of the AMA, said excessive sunshine exposure, especially around midday, causes long term skin damage.

Dr Hambleton, 2GB Sydney, 26 November 2012

<https://ama.com.au/audio/dr-hambleton-2gb-sydney-26-november-2012>

AMA President, Dr Steve Hambleton, discussed the importance of immunisation, warning that the number of people

vaccinating their children had dropped to a concerning level.

TV

Dr Hambleton, The Project, 18 November 2012

AMA President, Dr Steve Hambleton, said the health care system is not failing, but some disturbing out-of-pocket expenses were starting to appear. Dr Hambleton said these were mainly for cancer patients and premature babies and, on the whole, people were looked after pretty well.

Dr Hambleton, ABC News 24, 20 November 2012

AMA President, Dr Steve Hambleton, commented on the fact that just 2 per cent of complementary medicines are tested for quality, safety and efficacy. Dr Hambleton said there was a danger inherent in the marketing of products such as vitamins on the basis of claims that they could do things that they cannot.

Dr Hambleton, Channel 10, 26 November 2012

https://www.youtube.com/watch?v=yFv-jIoSCOI&list=UUx5NFeUd5hs3wnViy_LjWrw&index=1&feature=plcp

AMA President, Dr Steve Hambleton, explained that if immunisation levels do not increase, some very serious diseases could return. He said some people are not vaccinating their children because of misinformation being spread by some groups and the misconception that the threat posed by many dangerous infectious diseases no longer existed. The Australian Academy of Science has produced a booklet aimed at dispelling myths and misinformation being peddled regarding the dangers of immunisation.

[TO COMMENT CLICK HERE](#)

AMA in action

AMA President, Dr Steve Hambleton, was thrust into the middle of the media scrum this fortnight when he helped launch the Australian Academy of Science's *The Science of Immunisation: Questions and Answers* booklet. Chair of the AMA Council of General Practice Dr Brian Morton also attended the launch, where he administered a vaccine to one of his younger patients. Dr Hambleton also met with other general practice organisations as part of United General Practice Australia, to discuss their collective response to the third and final volume of Health Workforce Australia's *Health Workforce 2025 Report*, which flagged the need for urgent reform of medical training in order to avert a shortage of GPs and other key specialties in the next 13 years. Dr Hambleton also met with Federal Liberal MP Mal Washer to discuss legal and health issues surrounding illicit drug dependence.

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Dr Hambleton meeting with United General Practice Australia representatives



AMA President Dr Steve Hambleton offers AMA support for *The Science of Immunisation* publication



Dr Hambleton and MP Dr Mal Washer discuss legal and health issues surrounding illicit drug dependence



Chair of the AMA Council of General Practice Dr Brian Morton administering a vaccine to a young patient



Dr Hambleton fronts the media scrum

INFORMATION FOR MEMBERS

Global window on AIDS fight

The 30th anniversary of Australia's first AIDS case has been marked by the opening of an exhibition featuring the work of renowned international photographers.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has, in conjunction with Magnum Photos, launched the Access to Life exhibition at Sydney's Powerhouse Museum, featuring photos of AIDS patients from 10 different countries who are receiving antiretroviral treatment.

Global Fund Board Chair, Simon Bland, said the "incredibly moving" exhibition highlighted how access to treatment was transforming the lives of those living with HIV.

"From a situation of complete despair more than 10 years ago, we are now in the world where a significant volume of funding has turned the tide of the AIDS pandemic," Mr Bland said.

He said the exhibition was a way to show how contributions from the Australian Government through its aid program was making a big difference to the lives of people with AIDS in other countries.

The exhibition, which has already been shown in 10 other countries, will for the first time include photos of AIDS treatment in Papua New Guinea, which is suffering the largest HIV epidemic in the region.

The exhibition, which opened on 27 November, will extend until 9 June, 2012. Admission is \$12 per adult, \$6 per child, \$8 for students and concession car holders, and \$30 for families.

[TO COMMENT CLICK HERE](#)

Doctors pack a lot more into 15 minutes than they used to

If the nation's productivity has faltered in recent years it is not because of doctors, according to a major study of general practice work released last week.

The well-regarded Bettering the Evaluation and Care of Health (BEACH) program has found that general practitioners are fitting much more into their consultations than they were 10 years ago, even though the time spent with each patient has remained virtually unchanged.

People are going to see their GP more often, and are presenting with a wider number of complaints, particularly regarding the management of chronic conditions such as diabetes, hypertension, lipid disorders and depression.

In the 10 years to 2011-12 the number of problems GPs managed leapt from 145 per 100 patient encounters to 154 per 100, the BEACH figures show, suggesting that last financial year doctors collectively treated 48 million more problems than they did a decade earlier.

"We are seeing our GPs more often than we were a decade ago, and the GPs are also fitting more and more into their consultations," BEACH program director, Associate Professor Helena Britt, said. "For example, patients are presenting with more issues, GPs are managing more problems, and doing more tests and procedures – yet the time spent in the average consultation has stayed steady at about 15 minutes."

Associate Professor Britt said this was being achieved despite doctors cutting back on their hours.

BEACH data, drawn from 9802 participating GPs, shows that in the last 10 years the proportion of doctors working between 20 and 40 hours a week has climbed from 42 per cent to 53 per cent, while those working for between 41 and 60 hours a week has dropped from 43 to 32 per cent, and the proportion labouring

for more than 60 hours a week has collapsed, from 4 to 1 per cent.

Associate Professor Britt admitted it was difficult to explain exactly how doctors were fitting more into their consultations, but speculated that improvements in managing chronic conditions and the increasing workload of practice nurses might be part of the answer.

"GPs are managing more chronic conditions overall, but there are perhaps a lot of people for whom they are well-controlled, so consultations do not have to be as long," she said. "Practice nurses are doing an increasing number of procedures, and that is freeing up time."

The BEACH data shows that practice nurses conducted more than a third of all procedures in 2011-12.

The data hint at other areas where doctors may be saving time. In the last decade there has been a marked decline in the number of prescriptions with four or fewer repeats, and a significant increase in the proportion issued with five repeats – which now make up more than a third of all prescriptions issued.

Another potential time saver has been increased use of referrals. Ten years ago a little less than 8 per cent of problems managed by GPs involved referral to another health provider – this jumped to well above 9 per cent last financial year.

The biggest increases in referrals have been to psychologists, podiatrists, dieticians and dentists.

Associate Professor Britt said there was also evidence that GPs were spending less time advising their patients on diet and exercise, but it was not known whether practice nurses were picking up this work instead.

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Wary consumers bypass private hospital cover

Frustrated consumers are increasingly veering away from private hospital cover toward general treatment insurance policies amid rising premiums and surging fund profits.

A report on competition among private health insurers by the industry regulator has warned of a small but growing trend for consumers, particularly younger and healthier people, to insure themselves purely for general health services rather than taking out full hospital cover.

While the proportion of Australians covered by private health insurance has reached its highest point since the introduction of universal health cover almost 40 years ago, analysis by the Premiums and Competition Unit of the Private Health Insurance Administration Council (PHIAC) suggests that many are taking out cheaper insurance that does not include hospital benefits.

“There appears to be a slight increasing trend in the take up of policies that cover general treatment only,” the report said, noting that the proportion with such insurance had risen from 12.6 per cent of the market in mid-2009 to 13.6 per cent two years later, the report said.

Overall, two million people hold general treatment only insurance, and “this number is growing annually”.

In addition, the Council found that an increasing number of policyholders were shopping around in search of a better deal.

Industry figures show there was a spike in number of consumers who switched health insurance providers in the lead-up to the introduction of means testing of the private health insurance rebate in June.

PHIAC said that although policy switching was relatively rare – just 42,000 policies

out of 5.3 million held were transferred to a different provider – where it did occur it was “due to price sensitivity, and this price sensitivity is seen to be strongly linked to regulatory impacts, such as changes to premium rebates and the Medicare Levy Surcharge”.

The Federal Government has seized on PHIAC figures showing a rise in overall private health insurance coverage to ridicule Opposition claims that means testing the 30 per cent Private Health Insurance Rebate would force millions to dump or downgrade their health cover.

In its quarterly update, PHIAC reported an additional 83,128 people took out private hospital insurance in the three months to September, pushing coverage close to 47 per cent of the population.

An extra 104,000 people took out general treatment cover over the same period, pushing that type of coverage to 54.5 per cent of the population.

Health Minister Tanya Plibersek said the results were significant, because they covered the first three months following the introduction of means testing for the rebate.

Ms Plibersek said they showed Opposition Leader Tony Abbott’s prediction that millions would drop their insurance following the change was wrong.

But, while private health insurance coverage is increasing, the PHIAC analysis suggests the type of policies people are taking out is changing – a process that might accelerate as premiums escalate.

Consumers have been warned to brace for health insurance premium increases of up to 5 per cent or more, with the industry complaining that it is struggling to meet rising treatment costs.

The Council said that because government regulations did not allow for much differentiation between funds in the hospital cover they provided, the focus of competition was on general treatment and ‘instant’ benefit products.

“The fastest growing product type tends to be general treatment only policy options, and insurers are increasingly differentiating themselves on the general treatment only-type products,” it said.

PHIAC said the interplay of penalties and incentives in the system encouraged people, especially those younger and healthier, to bypass full hospital coverage.

It found that hospital insurance policies that offered lower premiums in exchange for higher co-payments, excluded treatments and restrictions, were “chosen, but not valued, by price sensitive consumers who hold private health insurance primarily to remove the cost of the Medicare Levy Surcharge”.

Similarly, those older than 30 years taking out insurance for the first time were penalised under the Lifetime Health Cover system if they took out hospital insurance, but not if they took out general treatment only cover.

“General treatment cover policies do not suffer from these confounding disincentives, and are further discounted by the private health insurance rebate,” PHIAC said.

The concern is that consumers with general treatment only insurance will use public hospitals for other care, undermining the push to relieve pressure on the public hospital system, which is one of the key policy goals of government support for the private health insurance industry.

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Cancer drug cut will not compromise treatment: Govt

The Federal Government has rejected claims it is putting the lives of cancer patients at risk by cutting back payments for a key chemotherapy drug.

Health Minister Tanya Plibersek dismissed reports that hospitals would be forced to close and patients hit with massive treatment price hikes as a result of a move to cut the amount the Government paid for Docetaxel under the Pharmaceutical Benefits Scheme.

"Reports that a cut to the subsidy for the chemotherapy drug Docetaxel will mean hospitals will close, and patients will pay more for infusions, are misleading," the Minister said. "Prices paid by cancer patients for PBS medicines are not affected by this price reduction."

The Government has cut the amount it pays for Docetaxel as part of the price disclosure program negotiated with the pharmaceutical industry, under which PBS reimbursements for drugs that have come off-patent are brought into line with market prices.

The Australian Public Hospitals Association has claimed that the move, which came into effect on 1 December, could add \$100 to

the cost of chemotherapy transfusions.

But Ms Plibersek said that under the arrangement, the PBS payment to pharmacists and hospitals matches the price they pay to their suppliers, and they are banned from charging their patients extra.

The Minister said the measure had been introduced amid concerns that the Government was paying up to \$2800 above the market price for Docetaxel, and denied the Government was trying to cut spending on cancer treatments.

"There has been no budget cut to the chemotherapy drugs," she said. "The Government is absolutely committed to providing lifesaving drugs for cancer patients."

The Minister said the savings made through the change would free up funds to be spent on other, newer, cancer treatments.

"By paying less for old, off-patent drugs, we can afford more of the newest, most innovative cancer treatments," Ms Plibersek said.

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Health libraries feeling the squeeze



Librarians have warned that existing archives of health information face an uncertain future unless there is an urgent increase in funding.

Health Libraries Incorporated and the Australian Library and Information Association have joined forces to call for renewed investment in the nation's repositories of health information amid concerns that staff cuts and inadequate budgets are undermining a vital resource for researchers, students and practitioners.

A survey of 250 library users conducted by the groups found that 95 per cent felt library and information services helped them advance their studies or discover new and valuable information, more than 80 per cent said they helped in keeping themselves abreast of the latest clinical

developments and in improving the care of their patients, 76 per cent said they helped them achieve higher exam marks and 65 per cent reported that using a library helped confirm a diagnosis or treatment plan.

The groups said libraries and information services were coming under increasing pressure coping with a significant increase in the number of users and items to catalogue and curate, at the same time as staff levels and floor space declined.

They warned that the delivery of services was suffering as a result.

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Doctors appointed to oversee TGA reform

A group of leading physicians has begun meeting as part of a far-reaching overhaul of the operations of the nation's medicines watchdog.

The Australian Therapeutic Goods Advisory Council, headed by the Chief Medical Officer, Professor Chris Baggoley, has been appointed by the Government to "strategically guide" the Therapeutic Goods Administration as it implements reforms intended to make it more open and transparent.

The appointment of the Council, which is comprised of 14 health and management experts including former Medicare Australia chief Lynelle Briggs, Professor of General Practice Claire Jackson, orthopaedic surgeon Professor Stephen Graves and Professor of Pharmacy Andrew McLachlan, is part of the blueprint to upgrade the TGA's operations.

Parliamentary Secretary for Health and Ageing, Catherine King, said the Administration would report to the Council every six months on progress in implementing its reforms.

"Over the next three years, the Council will give advice to the TGA on communication with the community and stakeholders, new management initiatives, and monitoring the TGA's progress against its broader reform agenda," Ms King said.

The watchdog has recently come under criticism over its regulation of medicines and medical devices.

A Senate inquiry found that it took the TGA 21 months to directly contact surgeons to alert them and their patients about problems with French-made Poly Implant Prothèse breast implants after they were subject to an international recall.

Independent Senator Nick Xenophon condemned the Administration for having an "incredibly lax attitude" toward the safety of PIP implants by approving them for use without requiring evidence that they were medically safe.

Senator Xenophon said two parliamentary inquiries had found there were serious systemic failures within the TGA, and "people are paying for these failures with their own health".

The TGA has also come under criticism for its regulation of joint implants.

Almost three years after an inquiry into the assessment of medical devices, the Therapeutic Goods Administration has re-classified all hip, knee and shoulder joint implants as high-risk, Class III medical devices, effective from 1 July, meaning they will be subject to significantly greater scrutiny before being approved for use in Australia, and to much closer monitoring.

The move comes more than 18 months after the Administration finalised a report recommending reforms to the regulatory framework for medical devices, and comes amid accusations that it has failed to adequately protect patients from dangerous implants.

Senator Xenophon said the National Joint Replacement Registry had very early on flagged serious concerns about the DePuy implants, but it took the TGA a long time to act on the advice.

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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*.

Elderly at heightened risk of brain damage from anaesthetics

Anaesthetics are causing permanent damage to the brains of some elderly patients, according to one of the nation's leading anaesthetists.

Associate Professor David Scott, Director of the Department of Anaesthesia at St Vincent's Hospital, Melbourne, said the preliminary results of research he was undertaking suggested that older patients already suffering mild cognitive impairment were at increased risk of suffering increased cognitive dysfunction following surgery.

Associate Professor Scott told the 13th International Congress of Cardiothoracic and Vascular Anaesthesia in Auckland last month that substances such as alcohol and solvents can cause lasting damage to the brain, and it was wrong to assume that the effects of anaesthetic agents were negligible and completely reversible.

He said there was growing evidence that some patients suffered sustained impairment of their cognitive function following surgery and anaesthesia, at considerable cost to themselves and the community.

"Patients with post-operative cognitive dysfunction may experience a longer stay in hospital, have a reduced quality of life, and even have an increased mortality," Associate Professor Scott said.

He said this was an increasingly critical issue because of the ageing of the population, with more than a third of all anaesthetics administered to those aged 65 years or older.

"This is a serious and urgent issue," Associate Professor Scott said. "We need to be able to identify patients susceptible to post-operative cognitive dysfunction and modify how we treat them."

"It is a huge issue if we don't understand the likelihood of a considerable proportion of these patients suffering some lasting cognitive impairment."

Associate Professor Scott's call for more research on the issue came as the Australian and New Zealand College of Anaesthetists announced that a revised curriculum would be introduced next year.

Under the new curriculum, which has been in development since 2008, trainees will have to have successfully completed a six-month assessment of anaesthetic competence before being eligible to move on to basic training.

Under the revised program, introductory training will take 26 weeks, basic training 78 weeks, advanced training 104 weeks and provisional fellowship training 52 weeks.

To progress to provisional fellowship training, trainees must complete 12 specialised study units.

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INFORMATION FOR MEMBERS

\$10,000 prize on offer for creative clinicians, managers

The nation's most innovative and successful clinicians and practice managers could be in line for a \$10,000 prize under a competition launched by the National Lead Clinicians Group (NLCG).

As part of its efforts to foster clinical best practice and interdisciplinary collaboration, the NLCG has instituted a national Awards for Excellence program.

Clinicians and managers from across the spectrum of health services who have developed creative and cost-effective ways to improve the quality of the care they provide are invited to submit entries for the Awards, which are to be held as part of the National Clinicians Network Forum to be held in June next year.

The Award organisers said that those who had developed innovations that could be applied across disciplines and sectors were particularly encouraged to enter.

Entries will be judged according to several criteria, including innovative approaches to implementing clinical guidelines, demonstrated success in overcoming existing barriers to the use of clinical guidelines, greater efficiency in the use of clinic resources and applicability across disciplines.

Finalists will be sponsored to attend next year's Forum to present their approach to implementing clinical guidelines, with the winner or winners to receive \$10,000 each.

A guide to preparing an application for the Award can be found at <http://leadclinicians.health.gov.au>

Entries close at 5pm on Friday, 16 March, 2013.

[TO COMMENT CLICK HERE](#)

Nation failing the mentally ill

Almost one million Australians with mental illness are missing out on the services they need, condemning them to unnecessarily stunted and troubled lives, the first national report card on mental health has found.

The report, *A Contributing Life*, found that those with severe mental illness were likely to die between 10 and 32 years earlier than the general population, and were more likely to suffer obesity, diabetes and heart-related complaints.

The National Mental Health Commission, which prepared the report, bemoaned the lack of investment and coordinated effort among the nation's governments in addressing mental illness, and took specific aim at practices that put the lives of the mentally ill at risk and undermined their human rights.

Commission Chairman, Professor Alan Fels, said that almost everyone would be profoundly affected by mental ill health at some point in their lives, either their own, or that of a relative, friend or colleague, and it was time for governments to act to

improve the services they provided.

"The statistics related to physical illness and early death among people with a mental health difficulty are appalling," Professor Fels said. "People with a severe mental illness have their life expectancy reduced by 25 years on average, due to the increased likelihood of heart-related conditions, diabetes and obesity."

Apart from urging greater priority to be set on the physical health needs of people with mental illness, the Commission took aim at several practices it believed compromised the health and rights of the mentally ill.

It called for a reduction in the proportion of people involuntarily committed to hospitals for mental health treatment, and an end to the use of seclusion and restraints in treatment.

"Rates of involuntary admission have remained stubbornly around 30 per cent of all mental health hospitalisations. We need to know why," the report said. "The high use of seclusion and restraint

[is] often an early sign of a system under pressure. They can deny people their rights. There is little evidence to support seclusion as an effective and positive clinical intervention."

The Commission also criticised the practice of discharging patients without ensuring they have somewhere to go.

Around one in eight people discharged from a mental health service are left homeless, at the very point when vulnerability to suicide is at its greatest.

The report called for governments to implement existing Council of Australian Government commitments regarding "no exits into homelessness", and ensure there was adequate discharge planning.

The Commission urged governments to make the development and implementation of a nationally-agreed mental health service planning framework a priority, and set goals and targets to improve mental health and reduce suicide.

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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 performance 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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Letters

'Good response' to Medibank contracts: Defence

The report on your website on 19 November 2012 titled *Medibank fails to crack Darwin line in Defence contract battle*, asserted that the number of specialists who have signed up to the new Medibank Health Solutions contract has been minimal.

This is misinformed and factually incorrect.

Medibank Health Solutions has received a good response to join the Defence service provider network and is continuing to engage with their current service provider network, which is growing daily.

To date [20 November] 2329 specialists, 5536 individual allied health providers and 118 hospitals from across the country have committed to the new contract. Australian Defence Force members are continuing to access the full range of off-base services in all locations.

Claims that locums have been engaged through *Charterhouse* to fill gaps caused by poor sign up rates to the new Defence service provider network are baseless. The use of locum agencies to fill short-term vacancies on-base at Australian Defence Force

Health facilities is standard practice and is unrelated to the new contractual arrangement with Medibank Health Solutions.

Medibank Health Solutions is contracted to provide a workforce of approximately 800 health practitioners for Australian Defence Force health facilities. Approximately 90.5 per cent of all of these positions have been filled and, importantly, this includes 100 per cent of all critical positions.

Defence is committed to ensuring our servicemen and women continue receive high quality care and patient confidentiality will not be compromised under the new contract.

The Australian Defence Force collects health information in order to manage an individual's health. Servicemen and women provide consent for this to occur when they join. Defence manages health records in accordance with the *Privacy Act* and the new contract imposes the same strict obligations on Medibank Health Solutions and its subcontractors.

Under the new arrangement with Medicare Health Solutions, all Australian Defence Force personnel will continue to access the highest quality of health care services.

Australian Defence Force spokesperson

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Treat yourself this Christmas

AMA is rewarding 5 lucky members this Christmas

Simply renew your AMA membership with your AMA American Express® Card to be in the draw to win **1 of 5, \$1,000 credit** on your Card. Prizes will be drawn just in time for Christmas.



Promotion Terms and Conditions apply. Salmat Helpdesk 1800 65 33 44. Competition Opens Thursday 25 October at 00:01 AEDT and concludes on 14 December 2012 at 23:59 AEDT. Total prize pool value is \$5,000. Winners drawn at Salmat Digital Pty Limited, Level 2, 116 Miller Street, North Sydney NSW 2060, on Wednesday 19 December 2012 at 14:00 AEDT. Winners notified in writing and published in the Public Notices section of The Australian newspaper on 10 January 2013. NSW: LTPS/12/09697 ACT: TP 12/04414. For full terms and conditions please visit: www.ama.com.au



Reflections on dying from an intensive care physician

BY KENNETH HILLMAN, PROFESSOR OF INTENSIVE CARE, UNIVERSITY OF NEW SOUTH WALES

This article was originally published in The Conversation at <http://theconversation.edu.au/reflections-on-dying-from-an-intensive-care-physician-10082>

As an intensive care physician, I'm increasingly confronted with managing patients who are at the end of their life. Australians need to be aware that the way that they will spend the last few days or weeks of their lives is largely predetermined, not by their own wishes, but by a medical conveyor belt from the community into acute hospitals and from there into intensive care units.

There's no conspiracy behind this, it has just happened this way. The drivers include unreal societal expectations of what modern medicine can and, more importantly, cannot offer, fed by daily reports of the latest miracle cures; a medical profession that's uncomfortable with discussing dying and death; medical specialisation that has resulted in amazing advances but focuses on specific single-organ problems and not the patient's overall health status; and a lack of doctors who can stand back and recognise patients who are at the end of their lives. All this is reinforced by a society reluctant to openly discuss issues around ageing and dying. The perfect storm.

Interestingly, nobody wants it this way. Almost 70 per cent of Australians want to die in their own homes. Yet, almost 70 per cent will die in acute care hospitals.

People who suddenly become ill in their homes or in the community usually have an ambulance called. They are now on the conveyor belt. Ambulance personnel have no discretionary power – they have to take the patient to an acute hospital for further assessment.

Acute illness or trauma is frightening, and most of us have little knowledge of

what is available in the acute hospital. So, the journey starts – and for many, it's appropriate. Medicine can perform some miracles. But for others, the so-called illness state is a normal and expected part of the dying process. Differentiating can be difficult.

The major challenge is to identify a potentially reversible component of a disease. Something that medicine can recognise and reverse – a patient who has fallen and fractured his hip can have it repaired, for instance.

But for many older people, there's often little that's amenable to modern medicine. As people age, they collect chronic health conditions or co-morbidities – this is the medicalisation of the ageing process. These conditions can sometimes be controlled but they're not usually reversible.

Organ function declines markedly with age. Muscles become weaker, bones become more brittle, vital organ function deteriorates, brain function diminishes and wrinkles appear. The rate at which this occurs is encoded at conception and is called apoptosis – the programmed death of cells and tissues.

You can optimise your chances of reaching your apoptotic potential with the help of living healthily and modern medicine. Diabetes can be controlled, for instance, and coronary arteries unblocked. Nevertheless, ageing is unavoidable and dying inevitable.

Eventually, the combination of chronic conditions means that even a small acute problem, such as a simple urinary tract infection, can result in death. This presents the dilemma for medicine and patients – how far do we go to sustain life?

Doctors are programmed to cure. In an age of medical specialisation,

they concentrate on incremental improvements in care of their own organ and refer to colleagues for advice about the other problems. As a result, elderly patients are often taking many medications with little or no benefit in the context of their chronic health status.

Clinical trials showing the efficacy of medicines are conducted in selected patients, not 90-year-olds with many chronic health problems. And when the end is finally near, those at the end of their lives come to hospitals for their last few days or weeks. Many are placed on life support machines and can no longer relate to their relatives and friends. Those who are conscious often plead to be allowed to die.

As an intensive care specialist I often become frustrated with my colleagues' failure to recognise when patients are at the end of life. One of the worst phone calls an intensivist can receive from a colleague goes something like this, "I've had a chat to the relatives and they say they want everything done, can you help?"

This puts people like me in a difficult position. First, there's an inference that what we can do will make the patient better. Then there's the difficult situation of having to explain for the first time that we believe the patient is at the end of her life, and any further active management would be futile.

The speciality of intensive care has a special responsibility to begin a frank and open discussion with our society about the limitations of modern medicine and the inevitability of ageing and dying. Hopefully, this will help people think about how they want to end their life.

Vital Signs: Stories from Intensive Care is published by NewSouth Publishing.

TO COMMENT CLICK HERE



Members' Forum

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

Medibank Health Solutions's controversial take it or leave it offer to specialists treating Australian Defence Force personnel (see Medibank fails to crack Darwin line in Defence contract battle) has confirmed its status as one of the most talked-about stories of the year among *Australian Medicine* readers. Another issue to draw reader comment was the demand from some employers that they be able to sit in on the medical appointments of their staff (see The elephant in the consulting room). While the interest of employers in the health of their workers was generally seen as a good thing, their presence in the consulting room was not.

Readers also added their voices to complaints about delays in the authority prescription phone service (see Govt told to hang up prescription hotline), as well as shortcomings in medical training (see Dozens of grads left in limbo despite intern breakthrough), Medicare Locals and the departure of Dr Bruce Flegg from the Queensland Government ministry.

Defence contracts

MHS contacted us last week to refer a patient even though I had not signed. This was pointed out to them and we were told that if I agree to see the patient they would honour my normal fee. Has anyone else experienced this? Is this a new shift in policy?

Dr David de la Hunty

So far, and only so far, I have asked for 100 per cent of the AMA rebate, and continue to work with the Navy.

Dr William Huang (not verified)

It's not specifically the amount of money on offer. It's the way things were done. There has been no negotiation. The contracts were sent during school

holidays. Many were away and didn't receive them in time. The whole thing is a shambles. I'm more than happy to negotiate a reduction in fees. [But] medical practices have costs. There is a bottom line for all business. You reduce fees 40 percent. I accept but have to sack two staff.

Anonymous

Employers sitting in on consultations

The interest by an employer in the medical status of his employee is to be applauded, but his presence during the consultation is not. In my experience, the employer [or their] representative is usually happy to remain in the waiting room during the consultation, and later come into the consulting room for a discussion of the workplace implications of the illness/injury. During the consultation itself I discuss with the patient what is to be said to the employer and what is not to be revealed.

Dr Beryl Turner

As an occupational physician who deals with workers and injuries as bread and butter, I must agree the scenario of the employer intruding in the consultation is foreign to me. I've never heard of the workplace representative attending the whole history and examination in my practice or that of my colleagues. I find that quite bizarre and concerning that some practitioners might allow that.

Anonymous

Prescription phone line

[I am] frequently prescribing choline esterase inhibitors or increased quantities of psychotropics. When the wait is 5 to 10 minutes, and I have had to do scripts for 6 to 8 patients that day, it can be a long time out of my day. Sometimes the

patients are not present as they have requested a script by phone. So it is non-remunerated time.

Anonymous

The phone up system was working really well, with mostly no undue time wasting, till just the last two months, when it has become almost unworkable. I did question one lady working for the system as to why delays of up to 20 minutes had recently become the norm. Apparently, as people resign, they are not being replaced.

Anonymous

Intern crisis

Why have the governments opened up new medical schools and Australian Medical Council places when there are not enough post-internship jobs in the coming years? The problem doesn't just stop at the 2013 internship shortages. The effect will be escalated every year thereafter.

Anonymous

Medicare Locals

I am receiving a newsletter from our Medicare Local and it does not have much useful information for GPs. It appears to be a public relations newsletter. I wonder who reads it; mine got filed in the round file pretty smartly.

Dr Peter Stephenson

Dr Bruce Flegg

Dr Flegg's actions which led to his fall from grace are an embarrassment to the medical community. Better luck Dr Glasson. A lesson that being in the public eye is not to be taken lightly.

Anonymous

[TO COMMENT CLICK HERE](#)

RESEARCH

Sweat, and heal thyself



Researchers have found that the sweat glands that help our bodies cool down after a trip to the gym or on a warm day also have another important job – they help heal wounds.

Researchers from the University of Michigan found that eccrine sweat glands play a major role in reconstructing the epidermis.

The researchers generated partial thickness wounds on healthy human forearms and studied the repair process at set intervals during the week following the infliction of the wound.

They found that eccrine sweat glands helped promote skin growth.

Previously, wound closure was thought to come from new skin cells originating from hair follicles and from intact skin at the edge of a wound.

But the study found that cells arise from beneath the wound, and suggest that human eccrine sweat glands also store an important reservoir of adult stem cells that can be quickly recruited to aid wound healing.

Lead researcher, Laure Rittie, said skin ulcers and other non-healing wounds remain a tremendous burden on health services and communities around the world.

“By identifying a key process of wound closure, we can examine drug therapies

with a new target in mind: sweat glands, which are very under-researched,” Dr Rittie said.

“We have discovered that humans heal their skin in a very unique way, different from other mammals.

“The regenerative potential of sweat glands has been one of our body’s best kept secrets. Our findings certainly advance our understanding of the normal healing process, and will hopefully pave the way for designing better tested therapies.”

KW

[TO COMMENT CLICK HERE](#)

Brain may change to compensate after traumatic injury: study



Techniques to improve recovery from concussion could be developed following the discovery of changes made by brains to compensate for the damage caused by traumatic injuries.

Researchers from the Albert Einstein College of Medicine at Yeshiva University and the Montefiore Medical Center used as special magnetic resonance imaging (MRI) technique to detect changes in injured brains.

The study involved 17 patients diagnosed with mild traumatic brain injuries. Within two weeks of their injuries, patients underwent diffusion tensor imaging

(DTI), which ‘sees’ the movement of water molecules within and along axons, the nerve fibres that constitute the brain’s white matter. This allows researchers to measure fractional anisotropy (FA) – the uniformity of water movement throughout the brain.

One year after sustaining their injury, patients completed two standard questionnaires to assess their post-concussion symptoms and evaluate their health status and quality of life.

Comparing the DTI data with the patient questionnaires, the researchers found that the presence of abnormally high FA was a good predictor of fewer post-concussion symptoms and better functioning.

Lead researcher Dr Michael Lipton said that areas of low FA indicate axonal injury, while high areas of FA indicate changes in the brain.

“In traumatic brain injury, it’s not one specific area that is affected, but multiple areas of the brain which are interconnected by axons,” Dr Lipton said.

“Abnormally low FA within the white matter has been correlated with cognitive impairment in concussion patients. We believe that high FA is evidence, not of axonal injury, but of brain changes that are occurring in response to the trauma.”

Dr Lipton said following a concussion, some patients experience a brief loss of consciousness. Other symptoms include headache, dizziness, memory loss, attention deficit, depression and anxiety, and some of these conditions may persist for months, or even years, in as many as 30 per cent of patients.

“This finding could lead to strategies for preventing and repairing the damage that accompanies traumatic brain injury,” Dr Lipton said.

KW

[TO COMMENT CLICK HERE](#)

HEALTH ON THE HILL

Stroke patients wait more than 18 months for new drug

The Federal Government has been accused of putting penny pinching ahead of the interests of thousands of stroke patients by holding off on subsidising new blood-thinning medication.

The National Stroke Foundation estimates that up to 100,000 patients who have either survived a stroke or are at risk of one are being denied affordable access to the drug Pradaxa because the Government is yet to add it to the Pharmaceutical Benefits Schedule.

A Government-appointed panel of experts, the Pharmaceutical Benefits Advisory Committee, recommended the listing of Pradaxa – which is widely used in other countries – on the PBS more than 18 months ago.

The medication is seen by many as a significant improvement on Warfarin, the blood thinner currently being used. Unlike Pradaxa, patients taking Warfarin have to have regular blood tests to ensure the drug is working, and National Stroke Foundation Chief Executive Erin Lalor said the older drug was unsuitable for many, including those who could not tolerate it.

Pradaxa is seen to be a particularly valuable treatment for stroke survivors with atrial fibrillation and those at risk of stroke due to an irregular heartbeat.

But estimates suggest that subsidising the drug will cost the Government an extra \$250 million a year, a hefty impost at a time when it is scrabbling to deliver a wafer thin surplus of \$1.1 billion this financial year.

Dr Lalor said many people taking blood thinners regularly simply could not afford treatment unless it was subsidised by the Government through the PBS, and the delay in listing new stroke medications was causing anxiety.

The outbreak of concern regarding Pradaxa came as the Stroke Foundation issued a report suggesting the rehabilitation services being offered to some stroke survivors were inadequate.

A survey conducted by the Foundation found that only half of the 111 hospitals it surveyed routinely provided a discharge plan for patients, and less than 50 per cent of patients leaving hospital were provided with information on how to avoid further strokes.

A spokesman for Health Minister Tanya Plibersek told the *Adelaide Advertiser* the findings of a Government-ordered review of the PBAC's recommendation regarding Pradaxa were imminent, and the Minister would then "consider what further action is required".

AR

[TO COMMENT CLICK HERE](#)

New life breathed into euthanasia bid

A Bill to overturn a 15-year ban on euthanasia laws in the Northern Territory and the Australian Capital Territory has been introduced into federal parliament.

In a move that is likely to stir considerable debate within both the major parties and the broader community, Australian Greens Senator Richard Di Natale last week moved to restore the authority of the NT and ACT assemblies to pass laws legalising euthanasia.

Senator Di Natale said his Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2012 sought to overturn legislation passed in 1997 that prevented the ACT and the NT from passing euthanasia laws.

"This Bill ensures that dying with dignity legislation is back on the national agenda," the Greens Senator said. "This Bill would restore the rights of the territories to make their own laws regarding voluntary euthanasia."

A recent poll conducted by the Australia Institute suggests there is widespread support in the community for euthanasia, with 70.6 per cent of those surveyed supporting the idea that doctors be allowed to end the life of patients suffering "unrelievable and incurable" suffering.

But the prospects for the Bill are uncertain.

Government MPs could be allowed a conscience vote on the issue after a spokeswoman for Prime Minister Julia Gillard confirmed to *The Australian* that the position the PM adopted on the issue in 2010 – when she left open the possibility of a conscience vote – remained current.

But it is unclear whether Coalition MPs would be given the same freedom on the issue by their party leaders.

When contacted by *The Australian*, a spokesman for Opposition leader Tony Abbott refused to speculate on the approach the Coalition would adopt when it came to a vote on the Greens Bill.

The potential for the issue to cause considerable discomfit for both the major parties suggests that neither will want to make it a major issue in the lead-up to the next federal election, due sometime in 2013.

But Senator Di Natale said it was time for the major parties to fall into step with the views of the broader community.

"More than 70 per cent of Australians support voluntary euthanasia, but the fact that the old parties won't touch it shows just how out of touch they are with average Australians," the Greens MP said.

He challenged the Coalition to allow its MPs a conscience vote on the issue, and said any politician who opposed the Bill should "explain why they think the residents of Australia's territories don't deserve the same rights as people in the rest of the country".

HEALTH ON THE HILL

“Party politics need to be taken out of this issue. Fifteen years ago the Parliament had a conscience vote, and it is time we had that opportunity again,” he said.

AR

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Disability Insurance Scheme rules released

Eligibility for help under the National Disability Insurance Scheme will be restricted to those suffering lifelong impairments that have “substantially reduced” their ability to communicate, move, care for themselves and learn, according to draft legislation released by the Federal Government for public comment.

Under criteria set out in the National Disability Insurance Scheme Bill 2012, introduced to Parliament last week, only citizens or visa holders younger than 65 years who suffer substantial impairment that is permanent, or likely to be permanent, will be eligible for assistance.

In a further restriction, the scheme will

not pay for care that a family could reasonably be expected to provide.

The revelations came amid heated debate about how expensive the scheme, which has in-principle bipartisan support, could become.

The Productivity Commission has estimated that by the time it becomes fully functional in 2018 the scheme will cost about \$15 billion a year, though the Centre for Independent Studies (CIS) has released documents from the Australian Government Actuary which it claims shows the actual annual cost will more likely be around \$22 billion.

But National Disability Service Chief Executive, Dr Ken Baker, condemned the CIS claims as “seriously misleading”, arguing that they did not take into account the economic benefits of the NDIS in greater employment and increased efficiency in disability care.

Dr Baker said research had shown that if nothing was done, within 15 years the cost of running the current ad hoc system would exceed that of the NDIS.

The Bill has been referred to a Parliamentary Committee, and is likely to be voted on in early 2013, ahead of trials - costing \$1 billion and involving 20,000 people with a disability - to be held at five sites around the country from the middle of next year.

The legislation puts in place the rules that will govern the scheme, as well as establishing the NDIS Launch Transition Agency, which will oversee the introduction of the scheme.

Minister for Disability Reform, Jenny Macklin, said that although the Bill set out draft rules, the Government would continue to fine-tune its provisions in consultation with participating State and Territory governments, along with people with disabilities and their carers.

Ms Macklin said that the legislation would enshrine a two-year review to ensure the development of the scheme was informed by evidence of what worked.

The draft Bill and other information can be found at www.ndis.gov.au

AR

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

The Toolkit can be downloaded from the AMA website (<http://ama.com.au/>

node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

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

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

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

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

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

[TO COMMENT CLICK HERE](#)

World trade body begins hearings into legality of plain packaging laws



The World Trade Organisation has begun hearing arguments into the challenge being mounted by tobacco-producing countries against Australia's landmark plain packaging laws.

The complainants, led by Honduras, told the WTO's Dispute Settlement Body at a hearing on 19 November that the laws violated international rules on intellectual property rights.

The Honduran delegation, supported by Nicaragua, Zimbabwe, the Dominican Republic and Ukraine, said the Australian legislation, which came into force from 1 November, breached

WTO agreements regarding geographical indications and trademarks, and asked that a dispute panel hear the matter.

But the Australian delegation vetoed the Honduran request and asserted the lawfulness of the plain packaging legislation.

It said the laws were legitimate public health measures that did not violate WTO agreements or go beyond what was necessary to achieve their aims.

The Australian delegation argued that the legislation was non-discriminatory in that it applied to all tobacco products, regardless of point of origin, and was in line with the World Health Organisation's tobacco convention, to which Honduras is also a signatory.

New Zealand, Norway and Uruguay all backed the Australian measure, arguing that it was the sovereign right of nations to regulate to protect public health.

The WTO hearing is the latest action taken by pro-tobacco forces to overturn the plain packaging legislation.

Earlier in the year, the High Court of Australia rejected a joint bid by four major tobacco companies to have the laws declared unconstitutional.

The Australian Government is confident the plain packaging laws will withstand the challenge before the WTO.

AR

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Dr Dolittle, meet Dr Brown

An emerging wave of "terrifying" diseases that are being transmitted from animals to people highlights the urgent need for better cooperation between doctors and veterinarians, according to World Medical Association (WMA) President, Dr Cecil Wilson.

Dr Wilson said 900 of the 1500 identified diseases that infect humans came from animals, including 75 per cent of all new infections.

"About three of every four newly emerging human infectious diseases originated in animals," he said. "This includes terrifying conditions such as Ebola, Lassa Fever and the Nipah, Hendra and Marburg viruses."

Dr Wilson said that this, combined with rising rates of antibiotic resistance, meant a broader approach to health and disease

control was needed.

He said the WMA and the World Veterinary Association had recently signed a Memorandum of Understanding in recognition of the inextricable links between the health of humans, animals and the ecosystem.

Working together, they aim to support cross-species disease surveillance and control efforts and foster collaboration in the responsible use of anti-microbials.

"Given the rise of antibiotic resistance, what is needed is a more holistic approach and a better understanding of resistance related to the use of antibiotic drugs to fight these new contagions," Dr Wilson said.

AR

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Europe cuts back on health



There has been a rare drop in Europe's health bill as cash-strapped governments cut back sharply on their expenditure.

Health spending per capita has declined across the European Union for the first time since 1975, Organisation for Economic Co-operation and Development figures show, shrinking by 0.6 per cent in 2010 after growing at an annual average of 4.6 per cent in the preceding nine years.

In Ireland, health spending per person plunged by 7.9 per cent in 2010, after growing by an average 6.5 per cent a year between

2000 and 2009, while in Estonia it fell back by 7.3 per cent, and in Greece by 6.7 per cent.

There are concerns the cutbacks will have a detrimental effect on health in the region, particularly regarding efforts to head-off expensive and chronic conditions.

"Governments, under pressure to protect funding for acute care, are cutting other expenditures such as public health and prevention programs," the OECD report said, adding that an average of just 3 per cent of health spending was allocated to public health measures such as immunisation, anti-smoking and drinking programs, and efforts to improve diet and boost exercise.

The OECD said more than half of European Union adults were overweight, and 17 per cent obese.

Combined with smoking, this was a major risk factor for heart disease and stroke, which accounted for 36 per cent of deaths in the region in 2010.

The *Health at a Glance: Europe 2012* report also found that there has been a jump in the number of doctors in Europe, up from 2.9 per 1000 people in 2000 to 3.4 per 1000 in 2010, though most of this growth has been among specialists.

The OECD said that in most countries there were now "many more" specialists than general practitioners.

AR

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BMA: Online GP records 'threaten patient care'

The British Government's proposal to give patients online access to their GP records by 2015 has drawn fire from the British Medical Association, which warns that it could harm patients and distort care.

Dr Laurence Buckman, chair of the BMA GP Committee, says that abusive spouses, overbearing parents, insurance companies and employers could put pressure on patients to reveal their confidential records.

GP leaders had warned the Government that GPs had serious concerns about the scheme in January, and again in

November, when the NHS mandate – the goals over the next two years set by the NHS Commissioning Board – was unveiled.

Once patients had their records, Dr Buckman said, they could face pressure from third parties to reveal them, without the traditional gatekeeper protection of GPs holding such information. "I can imagine that there are plenty of parents who would try to get access to their teenaged children's records to find out who's had sex or who is doing drugs or any one of a number of things."

A Health Department spokesman

said that "enabling greater access to health records is one way that we can support people to become partners in decisions about their treatment and better manage their health", though he agreed that this needed to be balanced with "protecting confidentiality and security of information".

A stakeholder group involving the BMA, the RCGP and other colleges, patient groups, the Department and the NHS Commissioning Board is developing plans to manage implementing the proposal.

DN

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Presenteeism – like job insecurity – is a health issue

The impact of job insecurity on mental and other health issues – including the phenomenon known as ‘presenteeism’ – is highlighted in a survey of British employers just conducted by the world’s largest human resources professional body.

According to the regular Simplyhealth Absence Management Survey, by the Chartered Institute of Personnel and Development (CIPD), a third of employers in the UK reported an increase this year in the number of staff coming to work when unwell. The phenomenon occurred most often in organisations expecting to cut jobs in the next six months.

While presenteeism is rising in the UK, absenteeism is falling.

The survey found that average levels of employee absence had fallen, most notably in public sector services.

But, for the first time in its history, it also found that stress had become the number one cause of absenteeism.

Two-fifths of employers reported a rise in stress-related employee absence in the past year, identifying the main causes as workload, organisational change and restructuring and management style – though almost a third of respondents reported that their organisations were not doing anything to reduce it.

In a comment on the survey’s findings, Dr Jill Miller, Research Adviser at CIPD, said that continuing economic uncertainty and fears over job insecurity appeared to be taking its toll on British employees. The sight of employees “struggling into work to demonstrate their commitment” suggested that presenteeism was a sign of anxiety.

It was also a threat to productivity, she said. “Not only can illnesses be passed on to other colleagues, but ill employees are also likely to work less effectively than usual, may be more prone to making costly mistakes and take longer to recover from their illnesses.”

DN

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German organ donation scandal leads to reform

Germany has adopted a tough new regime to govern organ donation following allegations that surgeons were falsifying medical records to move their patients up transplant lists.

Under new measures, at least three medically-qualified people will be responsible for admitting patients on to the country’s transplant waiting list.

The change is the result of an emergency meeting, convened by Health Minister Daniel Bahr, of all the interests involved in overseeing organ donation and distribution in all the 16 German states – physicians, health insurance providers, hospital and medical associations – to devise an efficient, fair and rort-free system.

In addition to the recommendation that at least three qualified people be responsible for adding patients to the transplant list, the meeting called for the abolition of all the major elements in the previous system, which included financial rewards based on

the number of procedures carried out.

In addition, to further guard against aberrations in the system, all specialist transplant clinics in Germany will now be examined through regular, unannounced investigations.

The German Medical Association said that, of about 50,000 transplants carried out over the past few years, only about 30 were found to have violated the rules.

But the controversy has damaged public confidence in the system in Germany, donations having dropped noticeably in a country already well down the list of organ donor rates in the Eurotransplant system.

Germany is one of the only three countries in the 27-member EU that still use the opt-in donation system, a fact regularly cited to explain its low donation rate compared with the countries surrounding it.

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USFDA joins NECC in blame for meningitis outbreak

The US Food and Drug Administration has come under heavy fire from a Congressional committee for its failure to head off the fungal meningitis outbreak reported in *Australian Medicine*.

Committee members accused its Chief Executive Officer, FDA Commissioner Dr Margaret Hamburg, of obfuscation in her evidence to the committee, lack of leadership of the FDA, and failure to ensure that the agency submitted documents on the outbreak requested by the committee.

In a long-winded and vague response, Dr Hamburger had insisted that the Agency's authority over the New England Compounding Center (NECC) – which made the contaminated steroid-based medication blamed for the outbreak – was unclear.

The committee responded that the FDA had all the powers it needed, but that it had failed to use them.

It was also not impressed with the appearance before it of an owner (and chief chemist) of the NECC, who refused to answer questions, invoking his right not to incriminate himself.

A second committee has also become involved in the scandal, asking State pharmacy boards, which regulate compounding

pharmacies, to explain how their oversight machinery works.

The problem is complicated because compounding is legal in the US when it is small scale, making unusual formulations for individual patients with special needs, and so subject to State regulation rather than the stricter federal regimen imposed on major pharmaceutical companies.

But the NECC was actually mass-producing its medication and shipping it to at least 23 states, where at least 14,000 people received it in the form of epidural injections.

The NECC has now been shut down.

But, at time of reporting, nearly 40 people who had received the contaminated medication have died in the outbreak – most of them suffering stroke brought on by the resultant fungal infection – and more than 500 people have developed the disease.

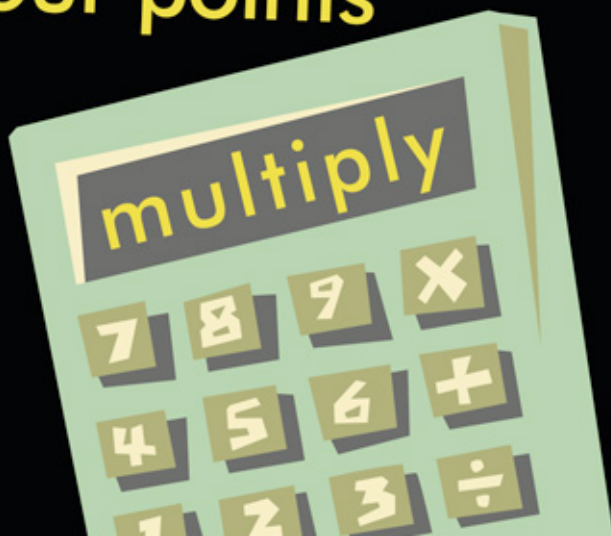
The Centers for Disease Control and Prevention (CDC) said that around 97 per cent of the 14,000 who have received the medication had been contacted for follow-up.

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INFORMATION FOR MEMBERS

Laser and IPL device survey

The nation's nuclear watchdog is looking into the use of lasers and intense pulsed light (IPL) devices amid concerns that they are increasingly being used by beauty studios and other businesses with little or no training.

The Australian Radiation Protection and Nuclear Safety Agency (ARPANSA), in conjunction with the Cosmetic Physicians Society of Australasia (CPSA), is conducting a survey on the use of lasers and IPLs for cosmetic procedures.

The survey aims to gather evidence about the extent of injuries and mistreatments caused by the inappropriate use of lasers and IPLs to help determine the need for national regulations.

CPSA President Dr Gabrielle Caswell said her organisation had

been concerned "for some time" about the use of lasers and IPL devices by people with little or no training, and had been lobbying for a national regulatory framework to set standards for unregistered providers.

If you or your colleagues are working with lasers or IPL devices used for cosmetic purposes, or have treated injuries caused by them, you are encouraged to participate in the survey.

It should take 10 minutes to complete, and can be saved and resumed.

The survey can be found at: <http://surveymonkey.com/s/IPLANDLASERSURVEY>

The survey is open until 12 December, 2012.

[TO COMMENT CLICK HERE](#)

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.

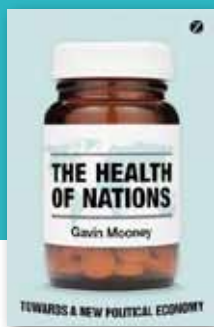
If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

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

Email: careers@ama.com.au

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BOOK REVIEW



The Health of Nations: Towards a new political economy

By Gavin Mooney

Zed Books, RRP\$34.95, pp328, ISBN 9781780320595

Reviewed by Adrian Rollins

In *Team America – World Police*, the rollicking spoof of the War on Terror by the creators of *South Park*, the Tim Robbins character explains the evils of capitalism: “The corporations finance Team America, and then Team America goes out... and the corporations sit there in their... in their corporation buildings, and... and, and see, they’re all corporation-y... and they make money”.

This came to mind while reading *The Health of Nations: Towards a new political economy*, by Gavin Mooney.

In the book Professor Mooney, who has carved out a 40-year career as a health economist, poses important questions about why there is so much sickness and death in the world, and why gaping inequalities in health persist, despite huge advances in medical treatments and technology, and the enormous sums being spent on health care.

But the answer he provides is, just like that from the Tim Robbins character, disappointingly facile.

Professor Mooney lays the blame for the world’s ills on “neoliberalism”, by which he means a political and economic outlook that prizes free markets and trade, strong property rights, individual freedom and minimal government interference.

In health, he argues, this has led to a focus on medicine and individual care rather than the underlying social determinants of health, such as poverty, inequality, housing, education and transport.

From Mooney’s viewpoint doctors are, at best, unwittingly complicit in a system that puts a premium on the health of the rich and damns the rest to benign neglect or worse.

There is nothing subtle about his argument.

The health system is run by, and for, the well-off: pharmaceutical companies shower doctors with money to convince them to prescribe their products, and doctors “willingly connive” with the rich and powerful to devote most health resources to looking after them. As an example of this, he argues, you do not have to look much further than the resources thrown at the battle against obesity compared with that devoted to tackling developing world health problems.

“The power in health care currently rests all too much with the medical profession and the pharmaceutical industry, and all too little with the citizenry,” Mooney writes.

The problem is, there is little in the way of evidence provided to back up his assertions.

In a passage that fairly quakes with indignation, Mooney excoriates the medical profession for being “in the pockets” of Big Pharma.

For him, it is axiomatic that doctors who receive any sort of funding or assistance from pharmaceutical companies will suspend any capacity for independent thought and simply do their bidding.

Mooney adopts a similarly simplistic view of the migration of health workers from places like Africa and Asia to developed countries.

“The West does not care that, with the freeing up of markets under neoliberal globalisation, by ‘stealing’ doctors and nurses from poor countries, they are creating very serious workforce shortages in these countries... This is

an example of the selfishness of the neoliberal West,” he writes.

The solution commonly proposed to this ‘problem’ is to somehow bond doctors and nurses to their home countries.

As development expert Michael Clemens points out, this is a view that essentially treats health workers as objects, rather than intelligent human beings who should have freedom to choose where they work.

Clemens says there is little evidence to suggest that somehow making doctors and nurses from developing countries stay at home does much to improve health care.

For example, a South African study found that many health workers who could not emigrate simply dropped out of the profession altogether.

Mooney’s ‘solution’ to the ills of health care is to convene citizens’ juries to set the principles and priorities for health services, based on information provided by a group of experts.

But who selects the citizen jurors, and the experts who advise them? And what happens if a jury is irrevocably split?

Like other propositions and assertions made by Mooney, the idea seems to be only partially formed and tested.

The Health of Nations appears to be a heart-felt testament to the failures of the current health care system and what needs to be done to improve it.

But its disappointingly thin analysis renders the diagnosis – and the prescribed treatment – far from compelling.

Adrian Rollins is Editor, Australian Medicine

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