BUMPER Summer Edition!

AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Defence contract fight spreads

More professions join specialists in the trenches, p4

Inside

AMA

ISSUE 24.23 - DECEMBER 17 2012

Win a 64GB iPad Mini with Wireless

Competition details, p 17

AUSTRALIAN
Medicine

Managing Editor: John Flannery
Contributing Editor: Dominic Nagle
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford

Graphic Design:
Streamline Creative, Canberra

Advertising enquiries
Streamline Creative
Tel: (02) 6260 5100 Fax: (02) 6260 5200

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

42 Macquarie St, Barton ACT 2600

Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499

Web: www.ama.com.au
Email: ausmed@ama.com.au

IN THIS ISSUE

NEWS

SPECIAL FEATURE

REGULAR FEATURES

The team at *Australian Medicine* wishes all our readers a happy and safe Christmas and New Year. May your mobiles ring only for good reasons. After a short break, the first edition of *Australian Medicine* for 2013 will be published on 14 January. Merry Christmas!

Fighting the good fight

BY **AMA PRESIDENT DR STEVE HAMBLETON**

"We are the only organisation that can provide rapid, evidence-based responses to the health and medical issues of the day – day in, day out. We cut through"

In a year of Federal politics that will perhaps be best remembered for the negativity and bitter personal attacks among our elected officials on Capital Hill, your AMA has been busy ducking and weaving to chalk up quite a few successes in 2012.

It has been the first year in quite a while where – other than the late-year descent to the good old days of the 'blame game' over public hospital funding – health has not been one of the top political battlegrounds in Canberra politics.

We are well and truly past the Kevin Rudd 'big ticket' reform era. It is now a matter of the Government bedding down that which is left of the busy and optimistic health reform surge of a couple of years ago.

The AMA has remained vigilant and active to ensure that any reform implementation progresses with the best possible outcomes for doctors and patients, the broader community, and the Budget bottom line. We have to ensure that every precious health dollar makes its way to frontline services, not wasted on unnecessary bureaucracy or burdensome red tape.

A good example of our advocacy was getting the Australian National Audit Office to conduct an audit of GP Super Clinics. There has been so much waste in this program, with no tangible evidence of significant improvement in primary health care service delivery.

The AMA identified much more successful Government investment in GP infrastructure grants. This program is building on successful general practice, and there is clear evidence that the grants are helping GPs provide even better services to their communities.

We want to see uncommitted GP Super Clinic funding shifted to GP infrastructure grants. That would be a vote winning initiative in 2013, an election year.

Another significant lobbying success for the AMA was gaining an extension for general practices to be able to remain eligible for the new PIP e-health incentive requirements. This was done in tandem with our ongoing work with the Government to ensure that the PCEHR is the right electronic health record for patients and doctors, and that it is up and ready for use at the best time for all concerned.

We are also gaining acceptance from the Government that GPs must have a strong leadership role in the decision-making of Medicare Locals.

And just last week the ACCC announced it is proposing to authorise the AMA application to permit GPs working in the same practice to agree on fees. This is a big step forward.

In public health, the AMA played a major role in promoting public awareness about the benefits of immunisation, and we led the way in calling for action on the way that alcohol is marketed to young people.

My early morning radio interviews this year have covered everything from the health risks of Brussels sprouts and grapefruit juice, the harmful effects of caffeine energy drinks, breast implants, whooping cough, hospital funding, Medicare cuts, the Pill for men, the health of asylum seekers, climate change, fluoride in water, the Duchess of Cambridge's morning sickness, and on it goes.

The AMA view is always in demand from the media, the public, the profession, and our politicians.

We are the only organisation that can provide rapid, evidence-based responses to the health and medical issues of the day – day in, day out. We cut through.

I have to say that we have enjoyed a productive relationship with Health Minister Tanya Plibersek this year. It has been open and honest, and we tell each other how things are going – the good and the bad. The same can be said for Shadow Health Minister Peter Dutton. This puts the AMA is very good shape going into the election year.

In closing for this year, I pay tribute to the outgoing AMA Secretary General Francis Sullivan. He has been an outstanding advocate for the AMA and the profession. We wish him well for the future in his work for the Catholic Church.

May you all have a safe, relaxing and rewarding holiday season.

TO COMMENT CLICK HERE

Defence contract fight spreads

Dentists and physiotherapists are joining specialists in resisting pressure from Medibank Health Solutions to sign up to controversial contracts in order to provide medical services to Australian Defence Force personnel.

In a strongly worded statement, the Australian Physiotherapy Association (APA) has urged its members to reject the MHS offer, and the Australian Dental Association (ADA) has recommended that dentists not sign the contract "until you have heard further from the ADA on this matter".

The warnings follow evidence of a widespread backlash against the MHS among specialists over the terms of the contract, which requires practitioners to accept fee reductions of up to 50 per cent and onerous reporting conditions in return for being registered as a preferred provider for Defence personnel care.

Earlier this year, MHS won a $1.3 billion, four-year contract to provide health services to 80,000 ADF personnel and their families.

It then wrote to specialists, many of whom have cared for Defence personnel for many years, with a take-it-or-leave-it offer to accept the terms of its preferred provider agreements or be blocked from providing further services to the ADF.

But the organisation, an offshoot of Medibank Private, has encountered widespread resistance to its plans.

An AMA survey has found that fewer than 10 per cent of specialists nationwide have so far signed up to the MHS offer, and the organisation has not been able to recruit a single specialist in Darwin, which is a major defence hub.

The Defence Force has rejected these figures, claiming that there has been a "good response" to the MHS offer, with 2329 specialists, 5536 individual health providers and 11 hospitals committing to the new arrangements.

But AMA President, Dr Steve Hambleton, accused MHS of presenting some "very misleading" information to doctors

regarding the number of specialists who had accepted its arrangements, and urged any contemplating signing the contract to seek independent legal advice.

APA President Melissa Locke was even more forthright in her advice to physiotherapists.

Ms Locke told her members that the fee schedule offered by MHS was "well below" market value, and failed to take into account business costs or acknowledge the skills and experience of practitioners.

The APA said it was unacceptable that senior, experienced physiotherapists should be required to discount their fees to below market rates.

"Members of the physiotherapy profession are rightly concerned about the restrictive nature of these contracts," Ms Locke said. "We believe defence personnel and their families deserve the right to access the most appropriate clinician to manage their health needs. The APA has advised all members to reject the contract."

In a notice to dentists, ADA Chief Executive Officer Robert Boyd-Boland said MHS's scheme had been developed without consultation with the profession, and had several features that were of serious concern.

Mr Boyd-Boland said the fees offered were low by comparison with current rates, and in some instances "very low".

He also warned members that there was no mechanism for fee review, the invoicing and payment arrangements were concerning, and there was a requirement to disclose patient information to MHS.

He advised Association members to "take no action until you have heard further from the ADA on this matter".

In a briefing to members, Avant, one of the nation's largest medical defence organisations, warned that a provision in the MHS requiring the disclosure of patient information without necessarily obtaining prior patient consent could be illegal.

"Providing private health information to MHS in accordance with the agreement may be in breach of Commonwealth and State privacy legislation, and a practitioner's duty of confidentiality to the patient, if it is done without the consent of the patient," Avant warned. "Members should ensure that they have the patient's consent before releasing health information to MHS in accordance with the agreement."

AR

TO COMMENT CLICK HERE

Hyped-up drinks need tougher controls

Food regulators are being urged to crack down on the marketing of heavily caffeinated energy drinks to children amid concerns they are putting the health and safety of young people at risk.

AMA President, Dr Steve Hambleton, has called for Food Standards Australia to step in and subject energy drinks to the same restrictions regarding caffeine content as soft drinks.

"I don't know why the heck Food Standards Australia are letting these products go onto the market," Dr Hambleton told *news.com.* "I'm just amazed and appalled by the amount of caffeine that is legal to be sold."

The AMA President's comments followed the release of a 1.2 litre bottle of V energy drink containing 320 milligrams of caffeine per litre – equivalent to about six cups of coffee – and well above the maximum permissible caffeine dose in cola drinks of 145 milligrams per litre.

Dr Hambleton said it was particularly concerning that energy drinks were being marketed to children and young people like soft drinks.

"Here is a product with enormous amounts of caffeine, and now we have got a super-sized product as well," Dr Hambleton said on Channel Nine's *Today* show. "They are being marketed like soft drinks, so why aren't we regulating them like soft drinks and get the caffeine level down?"

The general practitioner said the side effects of caffeine included agitation and tremors, and could affect heart and neurological functions.

Dr Hambleton said these effects were amplified and multiplied if energy drinks were mixed with alcohol, as has become fashionable among many young people.

"Mixing with alcohol multiplies the problem," he said. "We know from international studies that people are likely to get into more trouble if they have energy drinks and alcohol."

The regulation of energy drinks has been under review by the Legislative and Governance Forum on Food Regulation (the former Australia New Zealand Food Regulation Ministerial Council) since May last year, and it is yet to refer the matter to Food Standards Australia New Zealand.

At its 7 December meeting, the Forum noted "progress" in the review, and said public consultations were likely to be held from March next year.

A separate Intergovernmental Committee on Drugs is examining the issue of mixing alcohol with energy drinks.

But Dr Hambleton has called for urgent action.

"I think regulators have to ask where are they [energy drink manufacturers] targeting their marketing. If it's a soft drink, regulate it like soft drink, and the problem is solved," he said.

AR

TO COMMENT CLICK HERE

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.

Australian Medicine invites readers to write and submit travel stories of up to 550 words, with two bottles of fine wine sent to the author of each article published. Pictures welcome.

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

TO COMMENT CLICK HERE

Bring back the generals, says AMA

The days of the all-round physician who could run a general practice, deliver babies and perform surgery could be numbered unless urgent action is taken to improve remuneration, training and support for generalist doctors, the AMA has warned.

The Association said the intensifying trend toward specialisation in medical practice was coming at the expense of a breadth of knowledge and ability as a shrinking proportion of medical graduates opt for generalist careers.

Research indicates that just 20 per cent of general (non primary care) specialists practice some form of generalist medicine in Australia, which is a far lower rate than in the United States, where it is 50 per cent, or New Zealand (40 per cent).

AMA President, Dr Steve Hambleton, said this was a worrying trend because generalists played "a vital role" in health care.

"Many Australian families, especially in rural Australia, have been cared for by the local family doctor who ran the general practice, delivered babies and performed minor operations," Dr Hambleton said. "But, over the last decade, the medical workforce has become increasingly specialised [and], at the same time, many generalists are retiring or moving to other locations, and there is nobody with the skill set to replace them. The allure of generalist medical practice is in decline."

To arrest the slide and revive interest in an increasingly neglected skills set, the AMA has released a *Position Statement on Fostering Generalism in the Medical Workforce 2012,* in which it recommends boosting remuneration, improving training and increasing recognition and support.

"Medical practitioners are usually better remunerated in sub-specialty disciplines (particularly for procedural work), and for these reasons it is not unusual for generalist medical practitioners to drift out of the generalist area as they build up practice in sub-specialty areas," the Position Statement said. "Remuneration and support for generalist medical practitioners in both public and private practice must be improved to reduce the financial disincentives."

AR

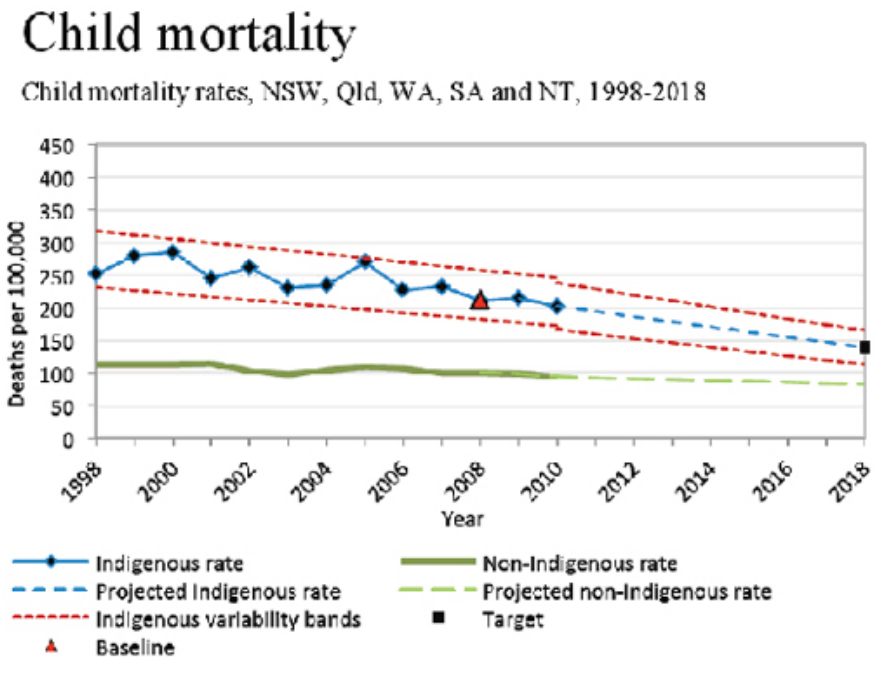
TO COMMENT CLICK HERE

Early childhood key to closing health gap: AMA

Robust and properly targeted investment in the health and development of Indigenous children in their early years is "one of the keys" to breaking the cycle of ill-health and premature death afflicting Aboriginal and Torres Strait Islander peoples, according to AMA President, Dr Steve Hambleton.

Dr Hambleton told the 2012 National Indigenous Health Conference that improving early childhood health should be a priority in efforts to close the gap in life expectancy and well being between Indigenous people and the rest of the community.

In his speech, the AMA President paid tribute to pioneering Indigenous health leader Puggy Hunter and his work to promote partnerships and information sharing in primary health care.



...CONTINUED ON PAGE 8

Fewer doctors visiting the elderly

Nursing home residents will find it increasingly difficult to get seen by a doctor as the number of practitioners willing to visit residential aged care centres drops.

A survey by the AMA has found that more than 15 per cent of the doctors currently conducting consultations in nursing homes plan to cut back on their visits in the next two years, and fewer younger practitioners are looking to provide the same service.

AMA President, Dr Steve Hambleton, said the results underlined concerns that the aged care sector was in urgent need of support and long-term vision.

Dr Hambleton said the Government's *Living Longer. Living Better* aged care reform package had been a major disappointment because it had "provided no focus at all on the medical needs of older Australians once they enter residential aged care".

"For many years, the AMA has highlighted that access to medical care for older Australians has been a policy free zone," Dr Hambleton said. "It is time for the Government to take a serious look at measures to ensure older Australians continue to have access to medical care."

The survey of 731 GPs, consultant physicians, geriatricians, emergency physicians, psychiatrists and palliative care specialists showed nursing home visits by doctors are becoming increasingly rare.

It found that, on average, residential aged care facilities were visited by doctors 6.3 times a month this year, compared with 8.3 times a month in 2008 – though the time spent with each patient jumped over the period, from around 13 minutes to more than 16 minutes.

In a sign that demand for medical services is rising, the average number of patients seen by practitioners per visit has increased in the past four years from 4.8 people to 5.8.

But while the need for medical care is increasing, the survey found that an ever-shrinking pool of practitioners is providing it.

It found that average age of doctors visiting nursing homes was 52.5 years, around 90 per cent were older than 40 years and 75 per cent were male.

It is a demographic that appears increasingly out of step with that of the broader profession, two-fifths of which is female and a third of which is younger than 45 years.

Dr Hambleton said the results underlined the urgent need for action.

"Medicare rebates for medical services provided in residential aged care facilities must be increased to reflect the complexity of care and the significant amount of additional – but clinically relevant – non face-to-face time with the patient that goes into overseeing their care," he said.

The AMA President said there should also be Medicare rebates for GP video consultations.

AR

TO COMMENT CLICK HERE

Early childhood key to closing health gap: AMA

...CONTINUED FROM PAGE 6

In this spirit, Dr Hambleton said there was already good evidence about what would work to boost the health of Aboriginal and Torres Strait Island children in their crucial formative years, and what was needed was the political will to make a "substantial funding commitment" to these measures.

"We know that robust and properly targeted and sustained investment in healthy early childhood development is one of the keys to breaking the cycle of ill-health and premature death," Dr Hambleton told the conference.

He said that to be effective, efforts to improve child health had to encompass the conditions in which they live and develop, including the family environment, living conditions, access to culturally appropriate health care and opportunities for education and work.

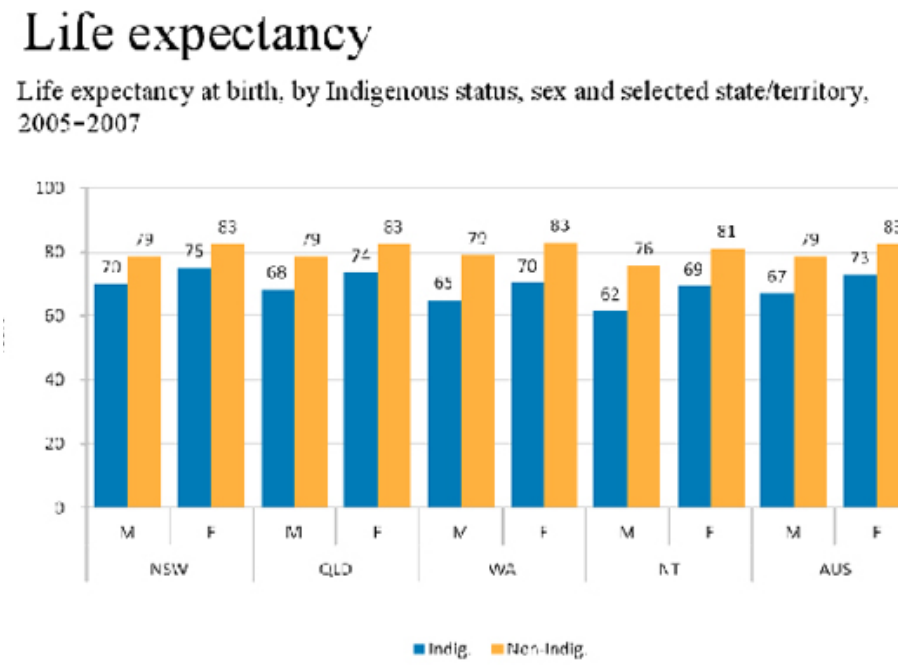
"The timing for this investment is crucial. It needs to be in the early years, where a healthy childhood can lay the foundation for resilience [later in life]," the AMA President said.

Dr Hambleton said health at infancy was a "strong indicator" of how people would fare in later life, pointing out that the life of an Indigenous person born in the middle of the last decade was likely to be up to 11 and a half years shorter than that of a non-Indigenous person born at the same time.

He said Indigenous babies were twice as likely to die as those in the rest of the population, most commonly from complications during pregnancy or birth, as well as respiratory and cardiovascular disorders suffered just before or after delivery.

The AMA President told the conference that a number of factors contributed to these problems, including smoking, drinking and poor diet among pregnant women.

But Dr Hambleton said improving early Indigenous childhood health also involved addressing social problems that undermined well being, including family poverty, poor housing, low educational attainment and emotional stress.



He said there was "decades of evidence" that a number of early childhood programs were effective in helping protect the health of infants, particularly Nurse Home Visiting maternal health and Abecedarian programs.

For every dollar spent on regular home visits to mothers by registered nurses, $5.70 was saving in future health and social costs, Dr Hambleton said, while Abecedarian programs had been shown to be effective in helping disadvantaged children attain higher levels of education and lower instances of risky behaviour.

"It is true that neither of these successful long-term interventions is cheap," he said. "They are quite costly to implement where they would be needed in Indigenous communities. [But], their success is manifest, and they will bring about health benefits and savings that far exceed their cost."

Dr Hambleton said that although some progress had been made in improving Indigenous health, outcomes still remained very poor compared with the broader community, and warned that the current $1.6 billion Council of Australian Governments National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes was due to expire next year.

"There is a need to renew [it] with comparable funding, and build on the groundwork that has been established," he said.

To help maintain the momentum of effort, the AMA plans to release a major report on early Indigenous childhood health and development next year.

Dr Hambleton said the AMA's 2013 Aboriginal and Torres Strait Islander Health report card will "highlight the importance of healthy early development, and the role that tried and true interventions can play, [including] recommendations about how governments ought to be supporting these interventions more".

AR

TO COMMENT CLICK HERE

Doctors win (provisional) right to set practice fees

The competition watchdog has given doctors provisional permission to set practice-wide charges and collectively bargain with hospitals and Medicare Locals on fees.

In a major win for the AMA on behalf of doctors, the Australian Competition and Consumer Commission (ACCC) has issued a draft decision to allow GPs in a single practice to set practice prices and collectively bargain.

"In response to an application lodged by the Australian Medical Association, the ACCC proposes to allow doctors within single practices to collectively set prices and bargain over visiting medical officer services, and with Medicare Locals," ACCC Chairman, Rod Sims, said.

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

AMA President, Dr Steve Hambleton, said the Association took a leadership role on the issue in order to protect GPs who otherwise might inadvertently fall foul of competition laws.

"We want to ensure that GPs who engage in this type of conduct are not exposed to action under competition laws," Dr Hambleton said. "The draft decision is the first step to removing this uncertainty."

Mr Sims said the proposed authorisation was similar to that previously granted to the RACGP, and which lapsed on 14 June this year.

"The ACCC proposes to grant authorisation for five years, as sought by the AMA. Authorisation will extend to all GPs, not just AMA members," the ACCC head said.

A final determination on the authorisation is expected in February next year.

AR

TO COMMENT CLICK HERE

Look beyond public hospitals to solve training crisis: AMA

Training opportunities in private hospitals and other settings must be boosted to ease the pressure on traditional public teaching hospitals, according to the AMA.

In a major statement, the AMA said that although public teaching hospitals, complemented by general practices, would remain the cornerstone of medical training, the crisis in internships had highlighted the urgent need to expand the range of places that can provide prevocational and vocational training.

"The increasing numbers of medical graduates mean we have to make better use of other training environments to build a quality workforce in sufficient numbers to meet the growing health needs of the community," AMA President, Dr Steve Hambleton, said.

More than 60 medical graduates were left in limbo this year after a last-minute scramble by Federal, State and Territory governments only partly filled a national shortfall in intern training places for 2013.

There are fears the shortage of training places will get worse in coming years without significant investment in training by governments, exacerbating concerns that the size of the nation's medical workforce will become increasingly inadequate to meet future health needs.

Recent projections by Health Workforce Australia indicate that, without reform, the country faces a shortage of up to 450 psychiatrists, 366 radiologists and 142 obstetricians by 2025.

The Authority warned of an even deeper shortfall of up to 3800 GPs, 800 psychiatrists, 500 radiologists and 300 obstetricians if the nation's intake of international medical graduates was halved.

Dr Hambleton said better use had to be made of opportunities to provide training outside traditional settings.

"The private hospital and community sectors have emerged as excellent training environments to complement the teaching and training that occurs in public hospitals," he said. "It is widely acknowledged that the private sector can provide access to clinical experiences that may no longer be accessible in the public hospital system."

The Federal Government has provided support for vocational training in expanded settings through the Specialist Training Program, but Dr Hambleton said that more could be done.

He said the recent agreement by the Commonwealth and some State governments to support a modest number of extra intern places in 2013 was "a good start", but ongoing funding increases were needed as medical graduate numbers grew.

"The AMA is calling on all governments to better resource expanded settings to provide medical training, including professional support and access to educational resources for supervisors and trainees," the AMA President said, adding that expanded training settings had to be accredited by relevant authorities to ensure quality was maintained.

AR

TO COMMENT CLICK HERE

Help at hand for stressed-out managers, workers

The apparent suicide of a man soon after losing his job has prompted a focus on workplace stress and the emotional well being of both employers and staff.

In the first move of its kind, the Fair Work Ombudsman is preparing information and a list of helpful resources for company executives faced with the difficult – and often very stressful – task of sacking staff or providing poor performance appraisals, according to news website *news.com.*

The website reported that the Ombudsman was gathering information and help group contacts that would assist both employers and their workers "in better managing these often complex issues".

Since the global financial crisis, thousands of workers have been thrown out of their jobs by a rash of business collapses and workplace closures, many involving well-known manufacturers and retail outlets.

AMA President, Dr Steve Hambleton, told *news.com* that such periods of economic upheaval could be enormously stressful for both workers who feared losing their jobs, and for managers who had to carry out retrenchments.

Dr Hambleton cited as an example the widespread distress that had been fuelled by job insecurity following recent savage cutbacks in public service numbers in Queensland that had fuelled job insecurity.

"People are not confident about whether their job still exists," Dr Hambleton told *news.com.* "I've even got family members who think their [relative's] whole section is going to be lost. It just leads to that huge uncertainty."

The AMA President said even conducting performance appraisals could be quite stressful for all involved, including managers.

"It does take its toll on people doing [reviews]," he said. "They might have to sit down with someone and say, 'my job is to tell you, you are not doing your job'."

AR

TO COMMENT CLICK HERE

AMA Secretary General departs

AMA Secretary General, Francis Sullivan, is leaving the organisation to take up a key role in leading the Catholic Church's response to issues raised by the forthcoming Royal Commission into Child Abuse.

Mr Sullivan is departing the AMA, after having completed his five-year contract, to become Chief Executive Officer of the newly-created Truth, Justice and Healing Council within the Catholic Church, which will manage the issues and ramifications thrown up by the Royal Commission.

On his departure, Mr Sullivan received warm praise from AMA President, Dr Steve Hambleton, for his work in steering the organisation through a challenging period.

"It is with much regret that the AMA is losing such a strong and well-connected colleague, but he is taking on a role for which he is uniquely equipped and very passionate about," Dr Hambleton said. "Francis has been a diligent and hard-working leader and manager for the AMA. He has not only been a trusted chief executive officer, and adviser to the AMA leadership, he has been a fiend and confidant."

During his term, Mr Sullivan helped the AMA navigate the Rudd Government's health reforms, engineered its response to the National Health and Hospitals Reform Commission recommendations, and "drove the AMA's advocacy through the very tight 2010 Federal election," the AMA President said.

"Highly regarded by both sides of politics, Francis ensured that the AMA always had access and impact at the highest levels in Parliament House," Dr Hambleton said. "[He] leaves the AMA with a significant legacy of achievement."

Mr Sullivan joined the AMA after 14 years as Chief Executive Officer of Catholic Health Australia, prior to which he served as a senior adviser to former Western Australian Health Minister, Keith Wilson.

Mr Sullivan has a Master's degree in Theology from Loyola University, Chicago.

AR

TO COMMENT CLICK HERE

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

Being exposed to patients and the work of medical practitioners generates enthusiasm, *The Australian*, 4 December 2012

http://www.theaustralian.com.au/higher-education/opinion/being-exposed-to-patients-and-the-work-of-medical-practitioners-generated-enthusiasm/story-e6frgcko-1226530004844

AMA President, Dr Steve Hambleton, reflected on his time as a medical student, saying "in medicine, no matter what specialty you're in, it's ongoing learning. If you don't learn that at university, you soon learn it when you come out".

Family rues call on whooping cough booster ban, *The Australian*, 10 December 2012

http://www.theaustralian.com.au/news/health-science/family-rues-call-on-whooping-cough-booster-ban/story-e6frg8y6-1226533226786

Australian Medical Association President, Dr Steve Hambleton, said State and Territory governments should have erred on the side of caution before deciding to axe free whooping cough booster programs.

Older medical workforce providing services to older Aussies, *The Sunshine Coast Daily*, 12 December 2012

http://www.sunshinecoastdaily.com.au/news/older-medical-workforce-providing-services-older-a/1655652/

An AMA report warned that residential aged care patients would find it increasingly difficult to see a doctor because the medical workforce serving them was ageing. AMA President, Dr Steve Hambleton, called for a high-level forum to be convened to address the medical issues around aged care.

Radio

Dr Hambleton, 3AW Melbourne, 4 December 2012

AMA President, Dr Steve Hambleton, said patients often went to their GP with a list of complaints, making it hard to address all concerns within a standard 15-minute consultation.

Dr Hambleton, 2GB Sydney, 9 December 2012

AMA President, Dr Steve Hambleton, discussed the growing trend among health funds to arrange for patients who have undergone surgery to be discharged from hospital earlier than in the past in order to speed recovery and save money.

TV

Dr Hambleton, The Today Show, Channel 9, 5 December 2012

https://www.youtube.com/watch?v=T5n5jL40sh8&list=UUx5NFeUd5hs3wnViy_LjWrw&index=1

AMA President, Dr Steve Hambleton, called for a crackdown on the caffeine content of energy drinks following the launch of a new 1.2 litre bottle of the energy drink *V*. Dr Hambleton said energy drinks could have as much as 320 milligrams of caffeine per litre, which was more than double the maximum amount allowed in cola soft drinks. He said that energy drinks were being marketed like soft drinks, and should come under the same set of regulations.

TO COMMENT CLICK HERE

Book Reviewers

If you devour books and want to share your knowledge, passion, likes and dislikes with your colleagues, *Australian Medicine* invites you to become a book reviewer.

You can review books on any medical or health topic you like, and can be as complimentary or scathing as you think is warranted (as long as it is not libellous). Just keep it under 650 words.

Australian Medicine will supply the book, which you get to keep after the review.

Interested? Just email the editor at ausmed@ama.com.au, including the book subjects you would be interested in reviewing and a current postal address.

TO COMMENT CLICK HERE

AMA in action

For devotees of political scandals, triumphs and muckraking, it is hard to go past 2012. While Americans re-elected Barack Obama and the British wallowed in the sleaze and corruption of the phone hacking scandal, in Australia Federal politics become mired in mud slinging. There were tragic deaths and heinous crimes, sporting breakthroughs such as Bradley Wiggins' Tour de France victory and Sally Pearson's Olympic hurdles triumph.

Closer to home, it was a busy year for the AMA, and, in the last edition for the year, AMA in Action reflects on the achievements of AMA President, Dr Steve Hambleton, and his colleagues during 2012.

In January Dr Hambleton met with newly appointed Health Minister Tanya Plibersek after Nicola Roxon moved to the Attorney General portfolio. In February he met with Mark Butler the Minister for Mental Health and Ageing and held a meeting with fellow GPs on the Council of General Practice to discuss the future of AMA policy. In March he launched the AMA Bullying brochure with School Education Minister Peter Garrett and held a press conference to discuss the legalities of a medical certificate.

Dr Hambleton fronted the media in April and voiced the AMA's opinion about Budget changes in May. In the same month, Dr Hambleton was re-elected by AMA members to his position, as were Vice President Professor Geoffrey Dobb, Treasurer Dr Peter Ford and Chairman Dr Rod McRae. At the end of the month, Dr Hambleton awarded Big Tobacco the Global Coffin Nail Award for its desperate, devious and dishonest tactics in opposing the introduction of plain packaging.

In June, Dr Hambleton met with Paul McClintock, Chairman of the COAG Reform Council, and in July he addressed the National Press Club. Shadow Health Minister Peter Dutton met with Dr Hambleton in August and in the same month Dr Hambleton hosted Prime Minister Julia Gillard, Ms Plibersek, Mr Dutton and other political leaders at the AMA's annual Parliamentary Dinner.

The following month Dr Hambleton released an AMA report highlighting the importance of restricting alcohol marketing to young people, and in October he met with Dr Dianne Watson, CEO for the National Hospital Pricing Authority. In November, Dr Hambleton went on the *Today* show to discuss what is becoming a very prominent public health issue – the side effects of energy drinks, particularly when consumed with alcohol. He also helped the Australian Academy of Science launch its *The Science of Immunisation* publication aimed at combating myths about the safety of vaccination, and officially opened the Cringe the Binge campaign in Byron Bay at the start of Schoolies Week.

The AMA has had a busy year making sure the interests of doctors and their patients are heard at the highest political levels, and we are planning for what promises to be an exciting and eventful Federal election year in 2013.

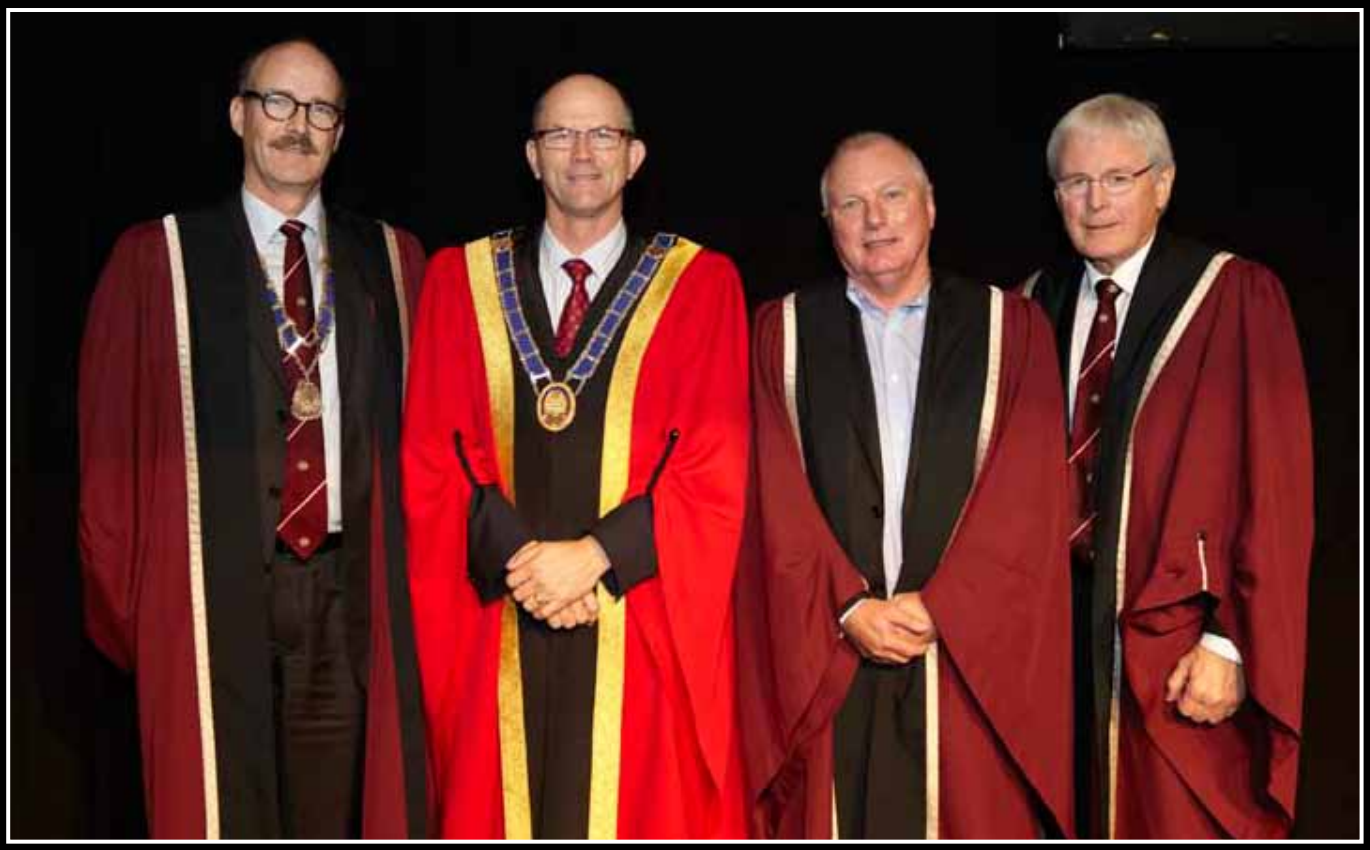
TO COMMENT CLICK HERE

Dr Hambleton and Prime Minister Julia Gillard at the AMA Parliamentary Dinner

Dr Hambleton fronts the media about the AMA National Summit on Alcohol Marketing to Young People

Dr Hambleton and the Minister for Yout Peter Garett launch the AMA brochure on Bullying

AMA in action



AMA President Dr Steve Hambleton re-elected with AMA Vice President Professor Geoffrey Dobb, Chairman Dr Rob McRae and Treasurer Dr Peter Ford

AMA President Dr Steve Hambleton with Paul McClintock Chairman of the COAG Reform Council

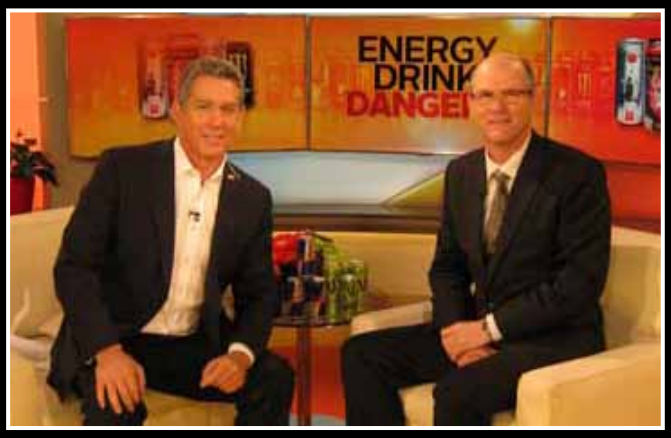
Dr Hambleton meets with Shadow Minister for Health Peter Dutton

Dr Hambleton launches the Cringe the Binge National Weekend of Action in Byron Bay

AMA in action

The AMA Council of General Practice meet to discuss future AMA policy

Dr Hambleton holds a press conference on medical certificates



Dr Hambleton spoke on the *Today* show about energy drinks

Dr Hambleton talks to the media about the health of fly in fly out workers

Dr Hambleton with Health Minister Tanya Plibersek

AMA in action

Dr Hambleton meets with Minister for Mental Health and Ageing Mark Butler

Dr Steve Hambleton address Naitonal Press Club

Dr Hambleton fronts the media scrum at the launch of the Australian Academy of Science's the Sciene of Immunisation publication

Dr Hambleton with Dr Dianne Watson CEO for the National Hospital Pricing Authority

DR Hambleton presents Big Tobacco with the Global Nail in the Coffin award

Dr Hambleton voices the AMA opinion about the Budget

Doctors prime targets for hacker extortion scams

Medical practices have been warned to ensure the security of their databases after computer hackers targeted a Gold Coast medical centre in an extortion bid.

Criminals hacked into the database of the Miami Family Medical Centre overnight on 30 November-1 December and encrypted its patient records, leaving a ransom demand of $4000 to decrypt the information.

Co-owner of the Centre, David Wood, told *Australian Medicine* the criminals "knew exactly what they are doing, and what they are looking for".

Mr Wood said that, in addition to attacking the database, the criminals also partially disabled the clinic's back-up systems.

"If you want to know what it felt like, go to your server and pull the plug out of the wall," he said.

Mr Wood said that, until the attack, the practice thought it had appropriate security precautions in place, but the incident had shown just how vulnerable its systems were.

He assured patients that none of their information was stolen in the incident, but said the attack should serve as a warning to other practices to thoroughly review and, if necessary, upgrade their IT systems.

The AMA's Chief Information Officer, Michael Manning, advised practices to check their firewall settings.

Mr Manning said practice firewalls should be configured to prevent any connections being initiated from outside the network.

Mr Wood said the Centre had not paid the ransom, and instead had undertaken the laborious task of restoring its records.

He said data from seven of the past eight years had been retrieved from back-up discs, and was being added to by patient information that had been contained in referrals to specialists, pathology labs and other health services, as well as in printed copies of health care plans that had been given to patients themselves.

"The actual true loss will be very small over time, there is a ton of information that is retrievable," Mr Wood said.

He said that going public with news of the attack had been the right decision, both to serve as a warning to other practices and because the Centre had been deluged with information and offers of assistance.

"The patients have been wonderful and very considerate, and the medical fraternity has been very supportive and helpful. Even Medicare has been great, manually processing things for us."

He lamented that although the clinic had been able to continue operating following the attack by reverting to paper-based systems, it had been a "very tough" experience, not least because it had felt it was on its own in working out how to respond.

"There is just nowhere to go," Mr Wood said. "We had to make it up as we went along."

He said his hard-won experience underlined the need for practices to make sure their data base security systems were thoroughly checked, that back up systems were not connected to the server and were regularly tested, and that databases were not connected to the internet.

He recommended that practices hire outside IT experts to test the security of their IT systems.

Mr Wood lamented a lack of specific information for practices on how to set up and operate secure databases.

"Everyone has to re-invent the wheel," he said. "How much money does every practice spend trying to work out and solve exactly the same problem? I know we are not the first [clinic to be hacked], and we will not be the last."

Computer security experts warned that businesses that store valuable information, such as medical clinics, were a prime target for small to medium hacking operations, with reports of a rash of such incidents across the country.

AR

TO COMMENT CLICK HERE

Guide for child medicine doses on its way

Doctors will soon be able to prescribe medicines for children with much greater confidence, with work underway on a paediatric dosing guide.

The Federal Government has commissioned Adelaide-based Australian Medicines Handbook to develop and maintain the National Children's Medicines Dosing Resource, the nation's first comprehensive guide to paediatric doses of many of the most common drugs prescribed for young people.

The guide, to be available from mid-2013, will provide an "essential reference with specific Australian information, fulfilling [sic] a need which has been identified by paediatricians, general practitioners and health care facilities," according to Gary Adams, an assistant director in the Department of Health and Ageing.

Mr Adams said that, in its first edition, the guide would provide "practical information on the safe and effective use of approximately 240 prescription and over-the-counter medicines," with more drugs added in later editions.

He said that, for each medicine, the resource would provide dosing information for various age groups, as well as more general advice on the use of medicine for children.

"The resource will be for use by all health professionals prescribing, dispensing and administering medicine to children, and will be a primary resource for treating children in community and acute care settings," Mr Adams said.

It will be published in online format suitable for computers and smartphones every six months, while a printed handbook – to be updated at least once a year – will be available for purchase.

AR

TO COMMENT CLICK HERE

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*.

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

Obstetricians debate change of position on breach birth

The automatic resort to caesarean procedures to deliver breech birth babies is coming under intense scrutiny within the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

While the College is yet to formally update its clinical guidelines regarding breech birth, the issue has sparked vigorous debate among obstetricians amid concerns that if vaginal breech birth is not offered as an option, some women will instead opt for home birth, which can carry increased risk.

Most breech babies have been delivered by caesareans following a study in *Lancet* in 2000 (known as the Term Breech Trial or TBT) which found that the perinatal mortality and morbidity rate among breech babies delivered by planned caesarean section was, at 1.6 per cent, far lower than among those delivered through planned vaginal birth (5 per cent).

In its current Position Statement on the issue, the College noted that "a subsequent increase in the use of planned caesarean section for breech presentation…has been associated with substantial improvements in perinatal outcome, with a halving of mortality and even greater reductions in the incidence of birth trauma".

Caesarean deliveries have become increasingly common. In 1997 one in every five births was by caesarean section, rising to almost one in every three (31.5 per cent) in 2009, and the rise has been attributed in part to increasing resort to caesareans for breech birth deliveries.

But the *Lancet* study and its conclusions have come under increasing scrutiny, stirring considerable controversy within the profession.

Writing in *O&G Magazine* earlier this year, obstetrician Dr Henry Murray complained that many of those who questioned the conduct and findings of the study were "subjected to vehement, and at times intensely personal, abuse".

While admitting that breech delivery does carry risk, Dr Murray warned "the art of delivery has in some places been lost through the headlong dash of many obstetricians to the comfort of caesarean delivery and the exhortations of the vociferous randomised controlled trial lobby".

"Complex clinical issues like breech do not lend themselves to controlled trials," he wrote. "The TBT did not show any benefit for the fetus delivered by a planned caesarean section. Rather, it showed that caesarean section increased maternal morbidity. Planned vaginal delivery must become part of the armamentarium of the competent obstetrici an."

A number of obstetricians, including College Vice President, Associate Professor Stephen Robson, believe that, under the right conditions, vaginal breech birth remains a valid option.

"There is intense interest at the College in this issue," Associate Professor Robson said. "There is a lot of discussion about the issue of vaginal breech delivery, and people should not assume that we are against it."

Associate Professor Robson, who runs a course on vaginal breech delivery with several of his colleagues, said he was "extremely aware" of public interest in the issue.

Of speculation that the College may change its advice on breech births, he said "there is always a lot of discussion about position statements, and all are regularly reviewed."

AR

TO COMMENT CLICK HERE

Vitamin D mania puts pathology budget under pressure

The Federal Government has slashed its rebate for vitamin D tests after massive growth in the procedure helped drive a hefty blow out in Medicare's budget for pathology services.

The Government and pathology companies have agreed on a $3.50 cut in the Medicare rebate for vitamin D tests and an across-the-board 0.67 per cent reduction in all pathology rebates as part of efforts to claw back an over-spend of $72 million on all pathology services in 2011-12.

Under the terms of the Pathology Funding Agreement struck between the Government and pathology firms in 2011, any blow out in the budgeted Medicare pathology rebate is to be recovered from future spending.

The agreement allowed for spending of almost $2.17 billion in 2011-12, rising by 4.9 per cent this financial year to $2.27 billion, and reaching $2.38 billion in 2013-14. Annual Medicare pathology rebate spending is expected to reach $2.63 billion in 2015-16, the fifth and final year of the deal.

But the surge in vitamin D testing is helping put these budget targets under pressure.

An analysis of vitamin D testing published in the *Medical Journal of Australia* earlier this year found that the number of such procedures grew by an average of 59 per cent a year last decade.

Underlining the impact on health spending, the study by Kelie Bilinski and Steven Boyages showed that Medicare Benefits Schedule payments for the test swelled from a little more than $1 million in 2000 to $96.7 million in 2010.

According to Catholic Health Australia, spending on vitamin D testing reached almost $130 million last year, a jump of almost 20 per cent in 12 months, vastly outstripping an average annual gain of 6 per cent across all pathology services.

The huge growth in vitamin D testing has come despite a lack of evidence regarding its efficacy for more than a small proportion of the population.

Vitamin D deficiency has been linked with a strong of conditions and diseases but, in a study published in the journal Clinical Biochemistry earlier this year, one of Australia's leading vitamin D experts, Royal Perth Hospital endocrinologist Dr Paul Glendenning, pointed out that in most cases these associations were yet to substantiated.

"Many diseases are associated with vitamin D deficiency, but randomised clinical trial data demonstrating the benefit of un-activated sterol supplementation only exists for the prevention of falls and fractures," Dr Glendenning and his co-author, Dr C.A. Inderjeeth, wrote.

"Consequently, 25 hydroxyvitman D (OHD) measurement should be restricted to high falls or fracture risk patients."

Dr Glendenning and his colleague advised that, until there was consensus on the test as a target of therapy, "widespread adoption of screening programs and measurement of 25OHD in patients at risk of non-musculoskeletal disease is premature, costly and not supported by evidence".

Catholic Health Australia sits on the committee that advises on the Pathology Agreement, and its Director of Policy, Patrick Tobin, said that, with the likelihood of further fee reductions across the pathology sector in future, growth in vitamin D testing "certainly deserves close scrutiny".

AR

TO COMMENT CLICK HERE

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

Hospitals well short of treatment target

Patients seeking emergency care are facing lengthy delays because of inadequate funding for public hospitals rather than any shortcomings in the operation of emergency departments, the AMA said.

In a stark assessment of the scale of the problem confronting governments in their efforts to bring down treatment times, the National Health Performance Authority (NHPA) found that most patients are waiting in emergency departments for up to 17 hours for care.

The nation's governments have jointly committed to a goal that by 2015, 90 per cent of emergency department (ED) patients will be seen and discharged or admitted within four hours of arrival.

But the first nationwide assessment of emergency ward performance has found that just 54 per cent of patients at major metropolitan hospitals left the emergency department within four hours, while an average of 63 per cent were seen in the same time at major regional hospitals.

The nation's worst performing major hospital was Queensland's Princess Alexandra, where just 33 per cent of ED patients departed within four hours, followed by three hospitals in New South Wales (Liverpool, 36 per cent; Blacktown, 37 per cent; Westmead, 39 per cent), and one in Victoria – Western – where just 41 per cent of ED patients left in four hours.

The report, based on data from 134 public hospitals for the 12 months to June this year, showed that larger institutions struggled the most to achieve the patient turnaround target.

At the nation's best performing major metropolitan hospital, Western Australia's Fremantle, 74 per cent of ED patients departed within four hours. This compared with a best performance among major regional hospitals of 79 per cent, large metropolitan hospitals (83 per cent), large regional hospitals (92 per cent) and medium hospitals (93 per cent).

AMA President, Dr Steve Hambleton, said the results reflected problems afflicting hospitals more generally, rather than just emergency departments, and showed that they simply did not have the capacity to meet demand.

The AMA President called for governments to take joint responsibility to work on solutions.

"It is time for cooperation, not blame," Dr Hambleton said. "There are many reasons for the variance in performance across the states and territories, but a united focus on a small number of key priority areas will help lift hospital performance across the board."

The AMA President said, "whole-of-hospital reform is needed, not just emergency departments".

Dr Hambleton said this should include increasing the involvement of frontline doctors in hospital decision-making, boosting overall hospital capacity and installing more beds.

"These are themes that the AMA has been promoting for many years," he said. "The NHPA report confirms and highlights where the problems are. It is time for our governments to work together on the solutions."

AR

TO COMMENT CLICK HERE

More getting cancer, but survival odds improve

The incidence of cancer has soared in the past 20 years, but the odds of survival are now better than even, a comprehensive national survey has found.

An Australian Institute of Health and Welfare report shows that the number of new cancer cases diagnosed each year surged from 66,000 in 1991 to 114,000 in 2009, with around 121,000 likely to be diagnosed this year. Overall, the incidence of all cancers, standardised for age, jumped 12 per cent during the period covered by the report.

According to the Institute, part of the rise is due to the increasing size and age of the population, as well as improved testing and screening.

The most commonly identified cancer this year is prostate cancer, followed by bowel cancer, breast cancer, melanoma and lung cancer.

But the report found variations in the incidence of cancer by age and gender. Between the ages of 30 and 54 years, women were more likely to be diagnosed with cancer than men, but among those 55 years and older, the disease was more prevalent among men.

There were also differences between the genders in the types of cancers they were most likely to get.

Among men, prostate cancer and melanoma were on the rise, while lung and bowel cancer rates were falling, while women were more likely to succumb to lung cancer or melanoma, and less likely to get cervical and ovarian cancers.

Reflecting these shifts, the Institute found that the odds of beating cancer were improving, with the five-year survival rate rising from 47 per cent in 1982-87 to 66 per cent in 2006-10.

Despite this, cancer still accounted for three deaths out of every 10 recorded in 2010, the second most common cause of death behind cardiovascular disease, and around half the population would be diagnosed with the disease in their lifetime.

AR

TO COMMENT CLICK HERE

Cigarette smuggling scheme floored

Customs officials seized an illegal shipment of more than 10 million cigarettes just days before Australia's world-leading plain tobacco laws came into force.

Customs and Border Protection officers found the cigarettes concealed in what was meant to be a shipment of ceramic tiles.

Officials uncovered the unsophisticated smuggling attempt after noting "anomalies" in x-rays of a shipping container supposedly carrying the tiles.

"When officers x-rayed the container, it was immediately apparent that the goods had been intentionally mislabelled, in a poor attempt to void paying duty," said Kingsley Woodford-Smith, National Manager, Investigations, for the Customs and Border Protection Service.

The Service did not disclose where the container was shipped from, but said it was bound for an address in Sydney when seized on 28 November.

Mr Woodford-Smith said the criminals involved had attempted to evade almost $4 million in customs duty and, if caught, could face up to 10 years imprisonment.

Major tobacco companies have warned of an increased trade in illegal cigarettes as a result of the nation's plain packaging laws, which are being challenged at the World Trade Organisation by several tobacco-producing countries.

The laws, which require tobacco to be sold in drab olive-brown packages with limited branding and prominent health warnings, came into effect on 1 December.

AR

TO COMMENT CLICK HERE

Demands on psychiatrists increasing

Patients are coming to psychiatrists with increasingly severe and complex problems, exacerbated in many cases by significant physical disorders, a national survey has found.

In a sign that many psychiatrists are encountering increasingly challenging cases in their daily practice, a third who took part in the *Psychiatrists' Workload Survey 2012* reported that the severity or complexity of conditions suffered by patients at first referral had increased in the past five years.

The survey, conducted by the Private Mental Health Alliance, found that psychiatrists are treating the full gamut of mental disorders, including schizophrenia and schizo-affective disorder, though the most common complaints seen are major depression, anxiety, bipolar disorder and post-traumatic stress disorder.

In addition to mental ailments, the 155 psychiatrists surveyed reported that a "substantial number" of their patients also suffered physical illnesses, most commonly arthritis, cardiovascular and renal disease, diabetes and respiratory disease.

On average, psychiatrists saw 37 patients a week – mostly in private consulting rooms – and worked 46 hours a week.

Direct patient care consumed 62 per cent of total work time, though about two-thirds of psychiatrists complained that their administrative workload had increased in the past five years.

"They work long hours and consider their administrative tasks to have substantially increased in the last five years, making it difficult to find opportunities to reflect on their professional experience," the survey report said. "At the same time, they feel the myriad of tasks associated with providing good care which is additional to face-to-face care, is poorly remunerated."

Underlining concerns that the nation's psychiatrist workforce is ageing and there may soon be a shortage of practitioners, the survey found that the average age of psychiatrists – two-thirds of whom are men - was 54 years.

The Alliance said the survey results provided important information for the development of policies to help attract and retain people in psychiatry.

AR

TO COMMENT CLICK HERE

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

Snaking the tub drain versus aged care

BY **DR EDWIN KRUYS***

"The AMA report mentioned that the Government and the aged care sector are "struggling to produce incentives for female and younger doctors". That's the understatement of the year. "

Today I am going to talk about what doctors earn. This is regarded by many as a no-go zone. I am taking a bit of a risk here, please don't take it out on me. Here we go.

First, I would like to share this conversation with you that I found on answers.yahoo.com:

> "My mother just had a plumber come snake the tub drain in the bathroom. He got the job done in literally 5 min, pulled out the hair that was clogging the drain and was done. He charged her $120.00 for the job and I think that's outrageous being that my moms been going to him for years for everything. What ya think? Too much or am I just cheap? Lol."
>
> "Sounds about right. 1 hour travel time, having the equipment, and knowing how to use it all are part of the service charge."
>
> "That's about the going rate. Most skilled tradesmen charge a minimum of $75 just to show up and then about $50 per half hour or less for the job. I've paid from $90 to $150 over the years for clogs I was not able to snake out myself. It's nasty work and I am happy to pay somebody else to do it."

[Last week] the Australian Medical Association published a concerning report about aged care. The report didn't get much media attention because, just like doctor's wages, not many people are concerned about aged care.

However, the conclusion of the report, that aged care residents will miss out on medical care because doctors are moving away from nursing home care, is a big worry.

Who is going to look after our parents? Who is going to look after us?

The AMA report mentioned that the Government and the aged care sector are "struggling to produce incentives for female and younger doctors". That's the understatement of the year.

The opposite is true. Medicare has put clear disincentives in place to see more than one patient. Have a look at the table.

LEVEL B - ITEM 35		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PATIENT)
ONE	82.10	82.10
TWO	59.20	59.20
THREE	51.55	51.55
FOUR	47.75	47.75
FIVE	45.45	45.45
SIX	43.95	43.95
SEVEN	39.55	39.55

Medicare fees for GP attendances at a residential aged care facility. Source: Medicare.

As you can see, Medicare is paying doctors less, the more patients they treat.

The fees drop from $82.10 to $39.55 per consultation if seven or more patients are seen at an aged care facility. In other words, doctors with an interest in aged care are penalised for driving to a nursing home and treating a few patients in a row.

We pay $120 to have a clog in the bathroom tub drain snaked out. Medicare is prepared to pay $39.55 for a doctor's consultation at a nursing home.

I'm out there every week and I bulk bill the residents from a compassion point of view.

It's not sustainable anymore.

I love aged care but it is time-consuming and involves much paperwork and travel time. It's clear to me why doctors are turning their backs on aged care. You get what you pay for.

**Dr Edwin Kruys is a rural doctor in Western Australia. His blog can be viewed at: http://www.panaceum.com.au/author/edwinkruys*

TO COMMENT CLICK HERE

An (almost) perfect summer

As anyone in the medical profession knows, time off is a rare and all-too-precious commodity that should not be squandered. *Australian Medicine* asked a number of prominent doctors who have very busy schedules combining leadership roles within the AMA with their clinical work, what makes for a good holiday, how they plan to spend the Christmas-New Year period, and how important it is for them to have a break.

AMA President – Dr Steve Hambleton:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   Not this year but I have been lucky enough to wash elephants in northern Thailand this year and walk through the botanical gardens in Singapore, so I can't complain.

2. **If so, what do you plan to do?**

   No big break but definitely a swim at the beach (surf) and catch up with family.

3. **If not, do you intend to take time off during 2013?**

   Again, this will be a busy year. The World Medical Association meeting is in Brazil, so a few extra days there would be a great bonus.

4. **How difficult is it for you to get time off work?**

   Very difficult right now to get away. Every day a new challenge. Great time to be AMA President.

5. **How important do you think it is to take a break?**

   Very important. We need to smell the roses on a regular basis and recharge those batteries. Some of us get a buzz out of being busy, so we need to be particularly careful.

6. **What is your idea of the perfect holiday?**

   Fraser Island before the phone repeaters arrived. Maybe Lord Howe Island for the same reason. No mobile phone access!

7. **What is the one place/activity on your must do list?**

   Lord Howe Island.

8. **What is on your holiday reading list?**

   Tony Abbott's book, *A Strong Australia* - he was kind enough to send it to me with his Christmas card. Prime Minister Gillard sent me a card too. Cool!

...CONTINUED ON PAGE 25

An (almost) perfect summer

...CONTINUED FROM PAGE 24

Chair of the AMA Council of General Practice, Dr Brian Morton:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   Just some of the days between Christmas and New Year. I'll work one day during that period.

2. **What do you plan to do?**

   See the extended family – lunches and the like; a golf game or two

3. **Do you intend to take time off during 2013?**

   Yes, hopefully skiing in Niseko, Japan in February. We have grown up children we won't go away during the school holidays – others in the practice need that time.

4. **How difficult is it for you to get time off work?**

   It is a matter of negotiating with others in the practice so that we are all not off at once. It's not difficult. That's the advantage of a group practice.

5. **How important do you think it is to take a break?**

   It's important to look after one's own body and psyche to achieve a work life balance that matches the advice we give to patients.

6. **What is your idea of the perfect holiday?**

   A mix of relaxation, sightseeing and a sporting activity like golf or skiing.

7. **What is the one place/activity on your must do list?**

   Machu Picchu, Peru.

8. **What is on your holiday reading list?**

   Any crime thriller recommended by my wife.

AMA Vice President, Professor Geoffrey Dobb:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   I'll be working Christmas Day and Boxing Day in the Intensive Care Unit at Royal Perth Hospital. I'm also working New Year's Eve and New Year's Day. Clearly I need to speak to the person who prepares the roster before next year. However, I'll be off the weekend between Christmas and New Year.

2. **What do you plan to do?**

   I hope to be able to spend the evening of Christmas day with family enjoying a traditional Christmas meal. I'll be spending the weekend at the family beach house on the coast in Dunsborough in the south west – one of the most beautiful places I know.

3. **Do you intend to take time off during 2013?**

   In addition to the short break after Christmas I'll be taking a week off in Dunsborough during January and more time off at the end of March to coincide with my daughter's wedding with family coming to Perth from around the world.

4. **How difficult is it for you to get time off work?**

   Not that easy – we have an annual leave planner to help ensure there are always enough of the group available to meet clinical service needs and we are short on consultant staff at present. Those with school age children get priority for the school holidays.

...CONTINUED ON PAGE 26

An (almost) perfect summer

...CONTINUED FROM PAGE 25

5. **How important do you think it is to take a break?**

   Really important, and for everyone. Working in intensive care can be stressful and sometimes it's only after a few days break that you realise how much better you are feeling and how much you needed the break.

6. **What is your idea of the perfect holiday?**

   One that is active with new places to see every day – bush walking and sailing both fit the bill and take me out of mobile phone and mobile reach.

7. **What is the one place/activity on your must do list?**

   I've been lucky to have the opportunity to travel to many places, but not the Greek islands and Crete: they definitely on my 'must do' list.

8. **What is on your holiday reading list?**

   Cricket and all that by Henry Blofeld. I'm told it's an interesting read and a great source of cricket trivia to mix with the Boxing Day test match.

AMA Treasurer, Dr Peter Ford:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   I am taking a week off over Christmas, and another in mid-January.

2. **What do you plan to do?**

   At Christmas my wife, and my daughter and her family who live in Adelaide, are spending a week with my other daughter and her family in Perth. In January, we are all going the Bay of Islands in New Zealand, where I have hired a yacht for a week.

3. **Do you intend to take time off during 2013?**

   I hope to be able to have three to four weeks off around September 2013.

4. **How difficult is it for you to get time off work?**

   In a practice of seven, some of whom are part-time, there is always someone away, and it can be a stretch to cover the work. However, we are a very obliging group and somehow our Practice Manager seems to make it work. It does help that we have most of our nursing home medication charts on computer at the rooms, and generally whoever is absent ensures their charts are current - that does apply some pressure before and after the holiday.

5. **How important do you think it is to take a break?**

   I think it is important to have interests outside the practice, and to take leave. It helps to prevent burnout and irritability, and improves perspective.

6. **What is your idea of the perfect holiday?**

   The perfect holiday it one where you do something like sailing, or something different, outside the usual routine. I suppose it is about taking time out. Travel is good, but I prefer to not be entirely a spectator.

7. **What is the one place/activity on your must do list?**

   A place on my to do list is sailing in the Adriatic.

8. **What is on your holiday reading list?**

   I like reading biographies, but also some fiction. Regrettably, I am mainly only a holiday reader.

...CONTINUED ON PAGE 27

An (almost) perfect summer

...CONTINUED FROM PAGE 26

AMA Northern Territory President, Dr Peter Beaumont:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   Yes.

2. **What do you plan to do?**

   Visit Hanoi and Ha Long Bay, Vietnam.

3. **Do you intend to take time off during 2013?**

   I will also be taking a reasonable amount of leave during 2013, mainly during the build up and wet.

4. **How difficult is it for you to get time off work?**

   Not difficult at all. I have arranged my work commitments so that I can easily take time off.

5. **How important do you think it is to take a break?**

   Very. It is wise to consider work as the time between breaks.

6. **What is your idea of the perfect holiday?**

   Bareboat sailing in Turkey with my wife, Julie and a small number of close friends.

7. **What is the one place/activity on your must do list?**

   My to do list is not very grandiose, but almost bottomless. There is no bucket list as such.

8. **What is on your holiday reading list?**

   Medical Journal of Australia Christmas edition, sailing and Apple computer magazines and books.

AMA Emergency Physician representative, Dr David Mountain:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   Yes.

2. **What do you plan to do?**

   A family skiing trip to Japan for two weeks.

3. **Do you intend to take time off during 2013?**

   Will take some other holidays during year.

4. **How difficult is it for you to get time off work?**

   It can be difficult at times but generally it is ok. We have a large department, and we like our staff to be able to take leave.

5. **How important do you think it is to take a break?**

   Very.

6. **What is your idea of the perfect holiday?**

   Activity based, somewhere exotic, new and with limited phone and email access.

7. **What is the one place/activity on your must do list?**

   Latin America, including an Amazonian wildlife trip.

8. **What is on your holiday reading list?**

   Anything, as long as I get to finish it.

...CONTINUED ON PAGE 28

An (almost) perfect summer

...CONTINUED FROM PAGE 27

AMA Queensland President, Dr Alex Marwell:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   I don't have any holidays planned over the holiday period, but am looking forward to a bit of down time.

2. **What do you plan to do?**

   Spend the time I have at home with family and friends.

3. **Do you intend to take time off during 2013?**

   My husband has a holiday planned for us at the end of my Presidential term. Currently the destination is a "surprise".

4. **How difficult is it for you to get time off work?**

   Work has been very supportive and flexible to enable me to undertake my many and varied activities. Even when not officially taking holidays, the rosters are done thoughtfully to try and maximise runs of days off!

5. **How important do you think it is to take a break?**

   Essential! My wise uncle (a retired GP) told me that you should always have your next holiday planned before the current one finishes! As busy people, I think we often overlook the necessity for recharging and relaxation. Even more so, considering the type of work we undertake...

6. **What is your idea of the perfect holiday?**

   A week or two with my family and friends where there are outdoor activities, good food and an opportunity to nap in the sun...

7. **What is the one place/activity on your must do list?**

   Italy.

8. **What is on your holiday reading list?**

   Anything by Alexander McCall Smith.

Outgoing Australian Medical Students' Association President, James Churchill:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   Following my graduation ceremony in early December, I'm travelling through South America for four weeks, spending most of that time in Patagonia and Peru. I'm very much looking forward to travelling through the deep south of South America, all the way down to Cape Horn and Tierra del Fuego.

2. **How difficult is it for you to get time off work?**

   Thankfully, universities publish their holiday schedules quite a while in advance, so it has not been a problem during medical school, although medical teaching periods are much longer than other courses. As an intern at Austin Health next year, my five weeks of leave is scheduled into my rotations for the year, so it's pretty easy to plan ahead.

3. **How important do you think it is to take a break?**

   Taking regular breaks is really important to recharge and maintain mental wellbeing. Too often we work too hard for too long, to the detriment of ourselves and, therefore, the work that we do.

...CONTINUED ON PAGE 29

An (almost) perfect summer

...CONTINUED FROM PAGE 28

4. **What is your idea of the perfect holiday?**

   Going somewhere with tall mountains (though not too cold all the time), few people (but good company) and no mobile phone reception.

5. **What is the one place/activity on your must do list?**

   I'd very much like to travel through the North-West of India. Having travelled briefly through the north a couple of years ago, I found India to be a fascinating place and definitely need to see more.

6. **What is on your holiday reading list?**

   The Innovator's Prescription, by Clayton Christiansen.

AMA Federal Councillor – Radiologists, Professor Mark Khangure:

1. **Are you planning to take a break during the Christmas/New Year holiday period?**

   Yes, I will be taking a break from December 21 to January 3.

2. **What do you plan to do?**

   My wife and I have property in the Margaret River region of south-west Western Australia, and we will spend a relaxing few days with visits to the beach, wineries and galleries in the region. Some family members and friends will probably join us.

3. **Do you intend to take time off during 2013?**

   I will take additional time off during 2013.

4. **How difficult is it for you to get time off work?**

   I have a "casual contract" arrangement, which means I can take leave with four weeks notice, but the leave is always unpaid.

5. **How important do you think it is to take a break?**

   I have no doubt that breaks are essential for efficient work output. I have always had at least six weeks leave [a year] since becoming a consultant in 1982.

6. **What is your idea of the perfect holiday?**

   A perfect holiday is a combination of culture, history and food and wine of countries we visit, along with interesting scenery of the countries.

7. **What is the one place/activity on your must do list?**

   To walk the entire St. James's Walk from France to Spain as an activity. An upper Amazon cruise as a location.

8. **What is on your holiday reading list?**

   The Emperor series on the life of Julius Caesar, by Conn Iggulden.

...CONTINUED ON PAGE 30

An (almost) perfect summer

...CONTINUED FROM PAGE 29

AMA Federal Councillor – Western Australian branch nominee, Dr Michael Gannon:

1. Are you planning to take a break during the Christmas/New Year holiday period?

I am not taking much of a break at Christmas this year. Every month I need to find time for about 250 antenatal appointments, and patients need to be seen at least every six to 10 days late in pregnancy. I'll get about 4 days off work.

2. What do you plan to do?

I am looking forward to the joy on my children's faces on Christmas morning. Hiding from the scorching Perth sun, watching some cricket, enjoying the company of family and friends. My parents and my brothers will all be in Perth this year, so a long lunch is in store on Christmas Day. The phone will be off, but it's my turn to work on Boxing Day.

3. Do you intend to take time off during 2013?

I am planning a holiday in July. My wife is overdue to see family in Ireland. I need little in the way of an excuse to include France or Italy in the itinerary. I'm hoping to spend a few days at the test match at Lords.

4. How difficult is it for you to get time off work?

I always plan my holidays eight to nine months in advance and accept no new obstetric patients. I am very grateful for the support of my colleagues who I also share a weekend roster with. These arrangements between private obstetricians are still relatively new in many places. They make for safer patient care, and less grumpy obstetricians.

5. How important do you think it is to take a break?

It is essential to recharge the batteries. Most areas of medicine are demanding, whether it be physically, mentally, intellectually. Gynaecology and obstetrics is also very emotionally taxing. Miscarriage, infertility, stillbirth, foetal anomalies - these are difficult issues that are part and parcel of our work, week in, week out. And, theoretically, having to be in the hospital at 30 minutes notice close to 24 hours a day, seven days a week. I would take more holidays if I could.

6. What is your idea of the perfect holiday?

Turning my phone off, not paying for data roaming so I get no emails, and then devouring everything that a foreign land has to offer. Walking all day, and finding the things you won't read about in a travel guide. People watching, trying to come to an understanding of the history, drinking the local beer, savouring the local cuisine. And more often than not coming to the conclusion that Australia does things better.

7. What is the one place/activity on your must do list?

I have never been to the Holy Land. If some form of sustained peace can be achieved, I would love to visit Egypt and Israel.

8. What is on your holiday reading list?

I have been working my way through Malcolm Knox's book *The Greatest*, about Australian cricket 1993-2008 for nearly two years now. I don't get much time to read.

...CONTINUED ON PAGE 31

An (almost) perfect summer

...CONTINUED FROM PAGE 30

AMA Victoria President, Dr Steve Parnis:

1. Are you planning to take a break during the Christmas/New Year holiday period?

I certainly am, though it's quite a novelty, because emergency medicine doesn't have the luxury of any "low activity periods". This year will be my second break around the New Year since I graduated 20 years ago. I am really looking forward to it.

2. What do you plan to do?

My wife and the kids are going to south-west Victoria to spend a few days with my mother and father-in-law, and then to a beachside suburb of Adelaide for more time with friends and family. I am relishing the prospect of time that is not filled with appointments, meetings, and the pressures of my clinical work. Hopefully, in that time, I'll read a good book or two, taste some nice wine, and have a few adventures with my family.

3. Do you intend to take time off during 2013?

I plan to arrange some brief breaks during 2013 as well, given the intensity of my schedule these days. I think it's absolutely essential for my work-life balance.

4. How difficult is it for you to get time off work?

As a salaried doctor, and on emergency roster that requires 24/7 cover, it can be a little difficult getting swaps or time off at short notice. Having said that, it helps to be organised, and I'm very fortunate to work with two wonderful teams of supportive colleagues at St Vincent's and John Fawkner Hospitals. It always helps being on good terms with the roster people!

5. How important do you think it is to take a break?

I can't overestimate its importance to me. I'm actually finding that half the joy of a good holiday is in the planning and anticipation.

6. What is your idea of the perfect holiday?

I would probably sum it up as spending uninterrupted time with the people I love. Beautiful places such as Cradle Mountain in Tassie, and the island of Malta are places where I have felt this way.

7. What is the one place/activity on your must do list?

That's an easy one. I would love to see the Socceroos play in a World Cup. Maybe in Brazil in 2014???

8. What is on your holiday reading list?

I am deliberately going to stay away from all things professional these holidays. *The Island House* by Posie Graeme-Evans, *Thomas Jefferson* by Alf Mapp, and probably a couple of form guides.

...CONTINUED ON PAGE 32

An (almost) perfect summer

...CONTINUED FROM PAGE 31

Chair of the AMA Council of Doctors in Training, Will Milford:

1. Are you planning to take a break during the Christmas/New Year holiday period? And, 2. What do you plan to do?

Yes, I am planning to take some time off. My brother is a chef and is currently working in a chalet in the French Alps. My fiancé and I plan on travelling to Europe, spend a week over Christmas with him, skiing and then travelling, touring Switzerland and then visiting Ljubljana in Slovenia, and spending New Years Eve in Budapest, before heading back to Australia in early January. Hopefully it'll be relaxing, with plenty of good food, skiing and sightseeing.

3. Do you intend to take time off during 2013?

Yes, hopefully we'll head overseas again next year. We'd really like to spend some in the US and visit New York. I've got leave pencilled in for August next year, but I'll have to see how things go prior to making any concrete plans.

4. How difficult is it for you to get time off work?

Being a trainee, getting time off is relatively straight forward - it's the representative duties which are hard to escape! Most jobs will ask for leave requests at the beginning of the year and, once they are pencilled in, they generally happen. Obviously, the industrial agreements mandate annual leave provisions, and working in public means that there is no private practice to worry about while I'm gone, including a continuing income stream.

5. How important do you think it is to take a break?

I think it's crucial to take a break. I notice that I become progressively more jaded and cynical, the longer I go without a break. A holiday allows me to take my mind off work and truly relax, spending time with my fiancé. I find that I return to work refreshed and rejuvenated. It's very easy to get burnt out. Some people feel like they can't go on leave as they let their workplace down, but I think having time away from work improves people's productivity and quality of work.

6. What is your idea of the perfect holiday?

The perfect holiday? Not lying on a beach! I enjoy being active and keeping busy on holidays, with plenty of sightseeing and activity. For longer holidays, things like hiking or trekking, sailing, skiing, would all come close to the top of the list. Being able to spend time with my fiancé, family and friends is a priority, as is the ability to get away from my phone and email. For shorter breaks, getting some downtime to relax and read is also important to me.

7. What is the one place/activity on your must do list?

A must do? I've got so many! Visit New York. Hike the Larapinta trail in Central Australia. Travel overland from St Petersberg to Shang-Hai. Sail northern Australia. Where do I stop!

8. What is on your holiday reading list?

The reading list is getting longer given my busy-ness over the last couple of months. A good mix of non-fiction and fiction. Here's the short list:

- *American stories* by Michael Brissenden
- *Reconstructing Medical Practice* by Christine Jorm
- *Alif the Unseen* by G Willow Wilson
- *Absolution* by Patrick Flanery
- *The Fractal Prince* by Hannu Rajaniemi
- *The Atrocity Archives* by Charles Stross

TO COMMENT CLICK HERE

Big challenges loom for GPs in 2013

BY **DR BRIAN MORTON**

As another year comes to an end, it is time to reflect on what the AMA, with advice from the AMA Council of General Practice, has achieved on behalf of GPs during the year, and what lies ahead.

The big issue coming our way in 2013 is the introduction of the Personally Controlled Electronic Health Record (PCEHR) and new Practice Incentives Program (PIP) e-health requirements.

The AMA has always supported the benefits an electronic health record would bring to patient care. Nevertheless, the AMA has not shied away from advising the government about the potential problems with the design and implementation of the PCEHR, and what is required for its true potential to be realised.

After extensive lobbying by the AMA, in August the Health Minister, Tanya Plibersek, gave much welcomed clarity about the PCEHR. Ms Plibersek made it clear that the time spent by a GP on a shared health summary, or an event summary, during a consultation would count toward the total consultation time, and could be billed accordingly.

The AMA was also able to secure a delay in the implementation of PCEHR e-health practice incentive payment (ePIP) capacity requirements until May 2013. While this was some good news, the expectations on general practice to meet the other requirements of the incentive remain very demanding - and confusing.

The AMA has produced a consolidated checklist to help GPs and their practices get ready for the ePIP and the PCEHR. This was work that should have been done by the government, but the AMA has stepped in to meet the need.

Medicare Locals are now operating across Australia. While the AMA still has concerns about their governance and consultation processes, we recognise that they will be here for some time, and we have kept up the pressure to ensure GPs are represented on Medicare Locals Boards and governance committees.

In response to the lack of clarity from Medicare Locals, and concerns about GP engagement on after hours arrangements - particularly in rural areas - I recently wrote to all rural Medicare Locals across Australia to reinforce the proposition that funding for existing practices providing quality after hours services should be maintained, and that consultation with existing after hours service providers is an essential component in the development of the Medicare Locals' Stage 2 plans.

The AMA has long championed the cause of reducing red tape in general practice. In 2012 we worked with Centrelink to improve and streamline the Disability Support Pension Medical Report and the Medical Certificate, enabling on-line completion, submission and retention. Thanks to AMA advocacy, Centrelink forms now make it clear that the time taken to complete these reports counts towards the length of the consultation claimed.

Some other areas where the AMA has been working to reduce administrative burden and make life easier for GPs is the development and release of:

- the Continuing Professional Development (CPD) tracking tool - an online tool to help doctors keep track of the information they need to meet the Medical Board of Australia's annual continuing professional development requirements (https://cpd.ama.com.au);
- the GP landing page on the AMA website - for GP relevant information and resources, and for news about how the AMA is advocating for GPs across the country (https://ama.com.au/generalpractice); and
- the GP Desktop Practice Support Toolkit - a one-stop shop for commonly used practice support tools, forms and resource documents used by GPs (https://ama.com.au/node7733).

Following AMA concerns about the implementation and administration of the GP Super Clinic program, and a call for a proper review, the Australian National Audit Office commenced an audit of the program that should be published shortly. Another ANAO report this year vindicated the AMA's view that Primary Care Infrastructure Grants provide good value for money, and are delivering important new practical resources faster, cheaper, and more efficiently than the GP Super Clinics program.

During Family Doctor Week in July, we released the AMA Chronic Disease Plan. The number of our patients with chronic diseases is increasing, and the current system does not provide sufficient support and care to meet their needs – and it has too much red tape! The AMA's Chronic Disease Plan offers a better way, and we will keep the pressure up in 2013 for it to be adopted.

I wish you and your family a relaxing and enjoyable festive season. My AMACGP colleagues and I look forward to representing you, and all GPs, in 2013.

TO COMMENT CLICK HERE

Critical time for training crisis as election looms

BY **JAMES CHURCHILL**

"It's been a pleasure leading AMSA in 2012. Many thanks must go to the hard-working National Executive team and all of AMSA's volunteers. Thanks also to the AMA's office bearers and staff, who have been working hard alongside AMSA on these issues of shared interest."

There's no doubt that 2012 has been a year full of excitement and challenges for AMSA and for Australia's medical students. As we look back upon this past year, activity on the essential 'Big Issues' has been unrelenting, as today's medical students find themselves subject to a looming and real medical training crisis.

It had long been anticipated that 2012 would be a crunch time for internships. Health systems which had already been struggling to keep pace with the growth in medical graduates in recent years were facing forecasts of an extra 486 graduates – a rise of 16 per cent. Though breakthroughs were achieved late in the piece to avert a full-blown crisis, with an additional 116 new internships announced in November, solutions to date are not complete and provide nothing for future years.

While this year has seen unprecedented data collection processes, for the first time allowing us to understand internship applicant patterns and better predict shortages of doctors and training posts, many of these data sets are not yet being used to their full potential to plan for future challenges at all stages of training.

Notably absent are data-collection systems for pre-vocational jobs beyond internship.

A major issue remains the mechanism to achieve greater horizontal and vertical coordination, even if and when accurate data are available. The Australian Medical Students Association, like many, has high hopes for the ability of Health Workforce Australia's new National Medical Training Advisory Network to bridge the divides and overcome these significant barriers.

Following the one-off Federal government funding of internships this year, the focus in 2013 must be on long-term solutions involving the demonstrated capacity for pre-vocational training in private and community settings, not just in general practice through the Prevocational General Practice Placements Program.

Many private providers have expressed a desire to be involved in intern training; now is the time for long-term Federal programs to establish a base capacity in these private settings and build for the future. To fail to act now, while conditions are relatively welcoming, would be a loss to the Australian health care system.

Simultaneously, the states must maintain their leadership in the medical training space, ensuring that the pressure on state budgets is not allowed to compromise the quantity or quality of training for tomorrow's GPs, specialists and hospital doctors.

There is no doubt the current political and fiscal climates have affected progress on resolution of this crisis, so the 2013 Federal election is likely to be a critical juncture.

The future would seem to point not only to a move to better coordinate medical training, but to a simultaneous battle over funding of medical training, both at university and health system level.

Funding of universities has been flagged as a likely point of contentious debate at next year's federal election, and the introduction of activity-based funding for teaching and training will fundamentally alter the structures for postgraduate medical education.

I'm sure these issues alone will keep AMSA, and medical students, active in 2013.

It's been a pleasure leading AMSA in 2012. Many thanks must go to the hard-working National Executive team and all of AMSA's volunteers. Thanks also to the AMA's office bearers and staff, who have been working hard alongside AMSA on these issues of shared interest.

With a Sydney-based National Executive team taking office in 2013, led by Mr Ben Veness, I'm sure that AMSA is in safe hands.

TO COMMENT CLICK HERE

Christmas wish: an end to the bickering

BY **DR DAVID RIVETT**

"Any sound solutions for future healthcare provision are constantly undermined by this unholy mantra of each provider, be they State or Federal, seeking to ensure the other pays as much as possible, and they as little as possible, and patient outcomes be damned"

Almost 12 months ago I began the process of applying for 'Area of Need' status, having failed to recruit any Australian doctors to Batemans Bay to replace doctors leaving the area. In July I was granted 'Area of Need' status and, once registered for such, the avalanche of e-mails from Overseas Trained Doctors (OTDs) seeking to migrate to Australia began.

Most days I get around three or four emails from the Middle East and the subcontinent, from doctors keen to begin life anew in Australia. Thankfully, some applicants are already in Australia, often working as hospital Career Medical Officers (CMOs), and can be easily interviewed.

However, 'Area of Need' is sadly applicable to only a single practitioner, ruling out husband and wife practitioners who would be much more likely to provide long-term rural workforce provision.

Once selected, another round of prolonged red tape then ensues, with submissions of detailed work and supervision programmes, plus an assessment of the candidate via a Pre-Employment Structured Clinical Interview (PESCI), where the candidate is assessed by a panel as to their ability, suitability and the degree of supervision likely to be required. None of this happens quickly.

At present, I am at the PESCI stage, and awaiting its outcome for my chosen candidate.

However, it would make more sense if doctors qualifying to work in Areas of Need could sit their PESCI prior to applying for and securing a position rather than after, as it would enable an employing practice to factor in its results in assessing applicants.

The staggering numbers of OTDs coming into Australia and being employed by State governments as CMOs underlines the sheer stupidity of the claimed shortage of intern places for Australian medical graduates.

To see Federal and State bureaucracies have no clear, agreed plans for providing adequate numbers of quality training places for these doctors, despite having years of notice of their increased numbers, is shameful, and even more so when we have a workforce crisis. It underlines very starkly the buck-passing and cost-shifting between Federal and State governments, which bedevils quality healthcare planning in our nation.

Any sound solutions for future healthcare provision are constantly undermined by this unholy mantra of each provider, be they State or Federal, seeking to ensure the other pays as much as possible, and they as little as possible, and patient outcomes be damned.

In the New Year we will see the unveiling of future solutions to meet health care workforce needs from Health Workforce Australia. Without bipartisan support from State and Federal bureaucracies, such solutions will not be worth the paper they are written on.

However, I fervently hope we will see a spirit of State-Federal health department togetherness in the year ahead, and my cynicism be proven unfounded.

Then again, pigs might fly.

TO COMMENT CLICK HERE

The perils of putting your genes to the test

BY **DR LIZ FEENEY**

Of his identification of DNA in 1953, along with Francis Crick, co-discoverer James Watson said: "We used to believe our destiny was in the stars; now we know it is in our genes".

While overstating the role of genetic determinism, Watson nonetheless highlighted what is an attractive proposition - individual empowerment through knowledge of personal genetic information.

One of the avenues opened up by the discovery of DNA – personalised medicine – is now a reality.

The ability to determine one's genotype, combined with increasing understanding of genetic disease risk factors, has fuelled interest in the ability to assess a person's susceptibility to disease.

Under Australian regulations, direct-to-consumer genetic testing (DTCGT) is not allowed, and local laboratories can only conduct genetic tests upon direction from a health practitioner.

But, as with so many other aspects of life, the Internet has changed the reality of the situation.

Recognising the commercial opportunity, private companies are now using the Internet to bypass medical professionals and directly approach consumers online to offer genetic tests.

The rise of DTCGT presents clinical, ethical, legal and social challenges for patients, policy makers and medical practitioners, in Australia and internationally.

In recognition of the global nature of the issue, the United Kingdom's Human Genetics Commission recently decided to develop a high-level set of principles, A Common Framework of Principles for direct-to-consumer genetic testing services, that could be applicable across all jurisdictions.

Under the framework, the results of DTCGT must be interpreted by qualified professionals.

The question is, where does this place the local practitioner who is asked to interpret such results?

While these are relatively early days, evidence to date indicates that DTCGT results can be inaccurate and unclear, analysis of results can be misleading, and the utility of some tests is unproven.

Despite these issues, DTCGT is attractive to many, and is frequently viewed as a person's right.

However, it is often undertaken to satisfy curiosity, or for fun, with no understanding of either the health, insurance or employment implications for the individual or for those with whom they share genetic material.

Disturbingly, it may also be performed surreptitiously on third parties.

Interpretation of medical genetic testing has been recognized as being a complex undertaking that frequently requires expert input, not only in understanding and interpreting results, but in counseling those tested and even in answering the very threshold question of whether to test or not.

Those undertaking DTCGT as a way to predict their future health outcomes may not appreciate that the genetic variation being tested for may have only a small influence on the risk of developing a particular disease.

Attaching too much predictive certainty to such testing has the potential to add to the imposts on individuals and the health care system through heightened anxiety and unnecessary requests for further testing.

Conversely, negative results may impart a false sense of security, and deter people from taking preventative measures to protect or improve their health, including appropriate screening.

The growth of direct consumer access to genetic testing not only increases the pressure on medical genetic services, but also adds to the burden on the medical profession more broadly, particularly general practitioners, who not only have to learn about genetic testing, but be able to effectively communicate the limitations as well as the risks and benefits of DTCGT to their patients, both before and after testing.

Risk is probably the most significant issue surrounding DTCGT, but it is notoriously difficult to convey in way that can be easily comprehended.

GPs will also have to grapple with expectations for a level of knowledge about the validity of individual tests and products in a rapidly changing field where not all tests have undergone clinical evaluation before being made available online.

Will there be an obligation, perceived or real, for the referral of patients for assessment by a geneticist? Or for repeat or further testing, followed by genetic counseling, adding to health care system costs.

Could this impost be avoided if it is determined before testing that there is no intention on the part of the patient to make lifestyle changes, or that proposed changes were already known healthy lifestyle factors, or that the tests themselves were of low predictive value?

In the Australian context, the DTCGT market is unregulated, and there is consequently no protection for individuals or the medical profession, and nothing to shield the health care system from rising costs.

Perhaps it will ultimately become more effective to have this testing made available locally, bringing the market under jurisdiction of the Therapeutics Goods Administration, the Trade Practice Act and relevant privacy legislation, providing protection, meaningful results and appropriate interpretation that may confer not only individual, but public, health benefits.

TO COMMENT CLICK HERE

The Importance of Generalism in Australia's medical workforce

BY **DR STEPHEN PARNIS**

There has been a significant trend in Australia over the last few decades toward increasing sub-specialisation among doctors.

A number of factors have contributed to this, including changes in the health system and levels of remuneration. These factors continue to bear disproportionately on the choices made by trainee doctors.

Sub-specialists are a vital part of our world-class health system. But the number of medical graduates choosing a pathway with more generalist skills has decreased.

The feedback I have received from doctors in training across the nation has given me the sense that there is a fairly widespread preference for specialisation and special interests. The very word 'specialist' seems to carry a great deal more kudos.

The irony is that Australia's future health care provision depends on training more doctors with generalist skills than has been the case for many years.

The data provided in Health Workforce Australia's latest report makes a compelling case for this, and I urge you to take a look (click here).

As Australia's population ages and medical issues become more complex and chronic, the need for generalists is becoming even more apparent. Whether it be an elderly person who presents with confusion, an infant who is failing to thrive, or a young adult with mental illness and associated drug abuse or dependency, there is a clear and growing need for doctors with highly developed skills in the assessment and management of issues that are not confined to a single system or part of the body.

It is something of a myth that generalists only have a role once you live more than 50 kilometres from a capital city. Nothing could be further from the truth. The fact is that the breadth of skills required to treat complex and undifferentiated patients is needed in our tertiary hospitals as much as it is required in rural and regional or community based care.

The term 'generalist medical practitioner' refers to general practitioners (GPs), rural generalists with multiple advanced skill sets, and general specialists, such as general surgeons and physicians who retain a broad scope of practice.

The broad ranging care that can be offered by a competent generalist improves health outcomes, and is a practical and cost-effective method of sustaining medical services, as well as obtaining better outcomes for our patients.

But so often the generalist pathway may be difficult to pursue. Issues such as obscure and dysfunctional training pipelines, a lack of funding, poor remuneration prospects and dubious status in the medical and wider community are but a few of the challenges the aspiring generalist faces.

Of course, we'll always need specialists, whose unique training and expertise is a vital cog in the provision of quality health care in Australia. But those who choose a greater degree of generalism as their path need to know that their career choice is a sound, long term choice that will provide them with the training, rewards, support and remuneration they deserve.

I am delighted that the AMA has recently adopted a policy on the value of generalism in Australia's medical workforce, which provides a sound, evidence- based platform for our advocacy in this area.

We need to provide trainees with more exposure to a quality generalist model that continues from the undergraduate years through to vocational training. There also needs to be greater support and recognition for those who supervise and train generalists.

Support for generalists in training, and at senior levels, needs to be provided regardless of locality, with particular emphasis on regional and isolated areas, which are the areas of greatest medical need. Governments at both state and federal levels have shared responsibility to ensure support, training and the continued viability of generalism as a valued career. Should these measures be promoted to the extent we regard as necessary, I belive we will see more comprehensive care, provided more efficiently.

As this is my last column for the year, I take this opportunity to wish you all a safe and peaceful Christmas. I also pay tribute to our colleagues who will be working over the holidays, and note the sacrifices that they and their families make in caring for their communities.

See you in 2013.

TO COMMENT CLICK HERE

RESEARCH

Advances in mother, infant health

Gestational diabetes

Expecting mothers with gestational diabetes can lower the risk of birth complications through diet, exercise and monitoring their blood glucose levels, according to an Australian study.

Researchers at the University of Sydney have found that mothers who carefully control their gestational diabetes mellitus (GDM) can give birth to babies with normal levels of body fat, reducing their obesity and diabetes risks.

During a normal pregnancy the hormone insulin becomes less effective in transferring glucose from the bloodstream to the mother's tissues, in order to make sure the baby gets sufficient nutrients from her blood.

GDM occurs when the mother is unable to secrete enough insulin, resulting in high concentrations of glucose in her blood stream. Often this results in an excessive transfer of nutrients to the baby, causing increased weight and body fat, which can lead to complications for the child both at delivery and later in life.

The study examined 532 babies born to mothers without GDM and 67 babies born to mothers with GDM. The majority of GDM mothers were treated at a dedicated GDM clinic where treatment consisted of diet, exercise, and self-monitoring of glucose four times a day if needed, resulting in good control of blood glucose levels for the majority of mothers.

Lead author, Dr Cheryl Au from the Sydney Medical School, said the study demonstrated to mothers with gestational diabetes that if it is well managed their child can be born with minimal complications.

"To our knowledge this is the first study to show that mums with carefully controlled GDM can give birth to babies with normal levels of body fat," said Dr Au.

"This is very important for those babies' immediate and future health. An overweight baby with a high percentage of body fat is at higher risk of complications during labour such as fractures due to difficult delivery and caesarean sections.

"After birth, they are at increased risk of obesity and diabetes. If the baby is a girl she is more likely to develop GDM if she gets pregnant.

"We were surprised and delighted to find there were no differences in body fat percentage between the GDM and non-GDM babies. This is in contrast to previous studies, which showed that, even if birth weight can be normalised with good glucose control, body fat is still increased in these infants, with all the accompanying health risks."

The researchers will continue to follow the babies' progress to assess their long-term health.

Genetics link to pre-eclampsia

Women can lower the risk of developing a serious pregnancy disorder linked to genetic mutation by controlling their weight, a study has found.

University of Adelaide researchers have discovered that the condition pre-eclampsia – which affects around 7 per cent of women and causes high blood pressure and fluid retention that can result in damage to the kidneys and liver – is connected to genetic disorders in both expectant mothers and their male partners.

But, in a promising development, the research team has found that mothers can lower their risk of developing the condition by maintaining normal weight during pregnancy.

Lead researcher, Professor Claire Roberts, said her team discovered that a variant of the gene AGT2R predisposed women to pre-eclampsia during pregnancy. However, they found the genetic variant was only associated with pre-eclampsia when the pregnant mother was overweight.

"Being able to predict which women are at risk of pre-eclampsia is a very important goal in obstetrics," Professor Roberts said.

Professor Roberts, from the Robinson Institute, studied data from the SCOPE study – which involved more than 2000 women and their partners - and found that females who developed pre-eclampsia were also overweight and were twice as likely to carry the ADT2R gene variant, and their partners were also twice as likely to carry the gene.

The researches said the genetic variant had only a subtle effect in women of normal weight, but in overweight and obese women it appeared to independently contribute to the risk of pre-eclampsia.

Professor Roberts said understanding this association could help predict which women were likely to develop pre-eclampsia, and it reinforced the importance of maintaining normal weight prior to pregnancy in order reduce the risk of serious complications.

...CONTINUED ON PAGE 39

RESEARCH

...CONTINUED FROM PAGE 38

Preterm babies

Babies born prematurely are more likely to develop learning difficulties during their teens, according to a study by the University of Adelaide.

Lead researcher, Dr Julia Pitcher, found that teenagers who were born preterm (at or before 37 weeks gestation) showed reduced plasticity in their brains.

The researchers compared preterm adolescents with those born at term, and with term-born adults. They used a non-invasive magnetic brain stimulation technique, including responses from the brain, to obtain a measure of its plasticity.

The researchers also measured the levels of cortisol, normally produced in response to stress, to better understand the chemical and hormonal differences between the groups.

Dr Pitcher said a brain's plasticity was vital for leaning and memory.

"It enables the brain to reorganise itself, responding to changes in environment, behaviour and stimuli by modifying the number or strength of connections between neurons and different brain areas," Dr Pitcher said.

"Teenagers born preterm clearly showed reduced neuroplasticity in response to brain stimulation.

"Surprisingly, even very modest preterm birth was associated with a reduced brain response.

"Preterm teens also had low levels of cortisol in their saliva, which was highly predictive of this reduced brain responsiveness.

"People often associate increased cortisol with stress, but cortisol fluctuates up and down normally over each 24-hour period, and this plays a critical role in learning, the consolidation of new knowledge into memory, and the later revival of those memories."

The researchers said the cortisol link could hold the key to possible therapies to overcome the neuroplasticity problem.

KW

TO COMMENT CLICK HERE

Turbo-charging vaccines

The potency of vaccines for a range of life-threatening infections including hepatitis, influenza, diphtheria and pertussis could be enhanced by an agent being developed by Australian researchers.

A University of Melbourne team has joined forces with Indonesian vaccine manufacturer Bio Farma to advance the production of a prototype adjuvant shown to boost the effectiveness of a number of vaccines.

The team led by Professor David Jackson of the University's Microbiology and Immunology Department, has found that a synthetic Toll-like receptor 2 agonist-based adjuvant can enhance immunity and protect animals from viral and bacterial infections.

The University has entered into collaboration with Bio Farma to fund the further evaluation and development of the concept.

Dean of the University's Faculty of Medicine, Professor James Angus, said that under the deal, researchers from both organisations would work together to develop what would be a "novel vaccine platform [that] could lead to better and more efficacious vaccines against infectious diseases".

"This agreement reflects the desire for research at the University of Melbourne to be translated into impact, and recognises the importance of collaboration with leading vaccine companies to achieve this," Professor Angus said.

Bio Farma, established in 1890, is a state-owned enterprise, and is Indonesia's only world-standard producer of vaccines for diseases including polio, diphtheria, tetanus, pertussis, hepatitis B and measles.

AR

TO COMMENT CLICK HERE

Gene therapy used to restore heart function

Researchers have used gene-based therapy to restore heart function to members of a family who suffered from a dangerous cardiac disease.

Rather than using conventional heart failure medicine, researchers from the Victor Chang Cardiac Research Institute in Sydney identified and treated the gene mutation that causes dilated cardiomyopathy (DCM), a disease that causes heart rhythm disorders.

The researchers screened 42 members of a family with a history of DCM.

The genetic screening revealed a rare gene variant in the cardiac sodium channel that was present in all affected family members. The family members were also found to have a very unusual set of extra or ectopic ventricular heartbeats.

Laboratory studies of the genetic mutation revealed that it caused increased activity of the cardiac sodium channel. In particular, it increased activity in special fibres that are part of the conduction system of the ventricle – Purkinje fibres.

Researchers recommended that family members be treated with a sodium channel blocker to potentially combat the ectopic beats. Sodium channel blockers are not usually recommended for patients with heart failure because of the potential for adverse side effects.

Within six months of commencing treatment, patients who had suffered substantial ventricular ectopic heartbeats showed almost normal electrocardiograms, and their heart function significantly improved.

Lead author of the study, Associate Professor Dianne Fatkin, said usually ectopic beats are thought of as a consequence of dilated cardiomyopathy, and not the other way round.

"Patients are treated with diuretics, beta blockers and regular drugs you get for heart failure. But we found these patients

...CONTINUED ON PAGE 40

RESEARCH

...CONTINUED FROM PAGE 39

weren't getting any better – in fact they were getting worse," Professor Fatkin said.

Professor Fatkin said the results were outstanding, with many patients with severe disease returning to full health within six months.

"This is game-changing research. While we can only claim to have treated one particular mutation that causes cardiac dysfunction, and there is still much more to do to find the genetic causes of heart disease in every family, this is huge step in the right direction," Professor Fatkin said.

Co-author on the paper, Associate Professor Rajesh Subbiah from St Vincent's Hospital in Sydney, said this was an example of integrated medicine and research at the cutting edge.

"We still have a long way to go for many families, but this research is an example of what can be achieved if we know the what, where and why about the underlying gene mutation.

"It's also a perfect example of research that extends from the bedside, to the bench, and back to the bedside – and how molecular research and clinical medicine can come together to unravel the cellular mechanisms of cardiac arrhythmias and cardiomyopathies." Associate Professor Subbiah said.

KW TO COMMENT CLICK HERE

Duffy comes to the rescue

Platelets, known for preventing bleeding by forming a plug in the vessel wall, have been found to target and kill the parasite that causes malaria.

Researchers found that a molecule on red blood cells called Duffy, is essential for platelet-mediated killing of the plasmodium falciparum malaria parasite.

Lead researcher, Professor Brendan McMorran from Macquarie University, said that although it was known that platelets defended infected people by attacking the malaria parasites that infected blood cells, until now it was not known how platelets did this.

"What we found was that platelets release a molecule called PF4 that kills the [malaria] parasite," Professor McMorran said. "But, what was really interesting is that PF4 needs to bind to the red cell Duffy molecule for this to occur".

Professor McMorran said the research was significant because most people in Africa lack Duffy, and this could provide a new explanation for why malaria is more common and more lethal there than anywhere else in the world.

Other studies have estimated that between 98 and 100 per cent of people living in the equatorial regions of Africa are Duffy-negative.

Professor McMorran said the lack of Duffy on the red cell occurs through a genetic change and is known as Duffy negativity.

"We know that Duffy-negativity gives them resilience against another malarial parasite, P. vivas but, as a consequence, this has produced a chink in the protective armour in these people and suggests another reason why falciparum malaria is a major problem in Africa," Professor McMorran said.

Professor McMorran ruled out the prospect of being able to re-establish the Duffy antigen receptor in populations that no longer have it, and said that thousands of years ago being Duffy-negative might have been an advantage.

It is estimated that P. falciparum is responsible for the majority of the 655,000 deaths from malaria each year – mostly in the sub-Saharan Africa.

KW TO COMMENT CLICK HERE

This Christmas, kiss the mistletoe

The Northern European tradition of a kiss under the mistletoe at Christmas time may have more going for it than just a quirky old custom.

Cancer patients may have reason to get even more intimate with the plant after a University of Adelaide scientist found it was highly effective against colon cancer cells.

The researcher, Zahra Lotfollahi, compared the effectiveness of three different types of mistletoe extract and chemotherapy on colon cancer cells and healthy intestinal cells. She found that mistletoe was highly effective and gentler on healthy intestinal cells compared with chemotherapy.

Ms Lotdollahi said that, overall, the Fraxini mistletoe extract grown on ash trees was the most potent extract against the cancer cells, and also enhanced the effectiveness of the chemotherapy drug.

"Our laboratory studies have shown Fraxini mistletoe extract by itself to be highly effective at reducing the viability of colon cancer cells. At certain concentrations, Fraxini also increased the potency of chemotherapy against the cancer cells," Ms Lotdollahi said.

"Of the three extracts tested, and compared with chemotherapy, Fraxini was the only one that showed a reduced impact on healthy intestinal cells. This might mean that Fraxini is a potential candidate for increased toxicity against cancer, while also reducing potential side effects.

"This is an important result, because we know that chemotherapy is effective at killing healthy cells as well as cancer cells. This can result in severe side effects for the patient, such as oral mucositis (ulcers in the mouth) and hair loss."

Professor Gordon Howarth, who supervised the study, said mistletoe extract has been considered a viable alternative therapy overseas for many years, but it was important to develop a scientific understanding as to why.

"Although mistletoe grown on the ash tree was the most effective of the three extracts tested, there is a possibility that mistletoe grown on other, as yet untested, trees or plants could be even more effective," Professor Howarth said.

"This is just the first step in what we hope will lead to further research, and eventually clinical trials, of mistletoe extract in Australia."

KW TO COMMENT CLICK HERE

Members' Forum

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

Issues of death and dying stirred much debate among *Australian Medicine* readers following Professor Kenneth Hillman's powerful piece on the dilemma confronting many in the medical profession in treating patients who may be approaching the end of their lives (see Reflections on dying, from an intensive care physician). Predictions the nation will face a severe shortage of GPs and specialists in the next 13 years (see Severe shortage of GPs and other specialists looms) also drew much comment. Several readers argued authorities were only making the situation worse by preventing many older doctors from continuing to practice.

Medibank Health Solutions' attempts to sign up specialists to its Defence health contracts continued to draw the ire of many, as did lengthy delays on the authority prescription service.

Reflections on dying

Most of the time there is no dispute between ICU specialists and non-ICU specialists about who can and can't survive but, after 40 years in the game, I now find that many ICU specialists want to turn off post-op patients that the surgeons think deserve better support. ICU's need to be very careful not to become sites of engineered euthanasia. ICU specialists need to stay within their area of expertise and respect the specialisation of their colleagues.

Anonymous

As an anaesthetic registrar who has worked in ICU recently, this issue is frequently vexing. We should have advanced care directives routinely on high-risk patients. We continue to do surgery of increasing complexity and challenge in ever-older patients. Some surgeons are realistic about what is achievable; others seem less so and appear to believe that just because something is technically fixable, it should automatically be fixed, without considering the health context.

Anonymous

Euthanasia

I have just finished a seven-month journey caring for my mother who had brain cancer. She died two weeks ago. Her end was not peaceful or dignified and she had pleaded with her palliative care doctor, her GP, her partner and my sisters and I to end her suffering - none of us could. She reached this point just two weeks before she died. Her last two weeks were a nightmare, for her and for her loving family. Surely she should have had the right to end her life before the suffering became unbearable. We have to change the law...and soon.

Anonymous

Doctor shortage

On 1 July 2010 the Australian Health Practitioners Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) disenfranchised hundreds of senior doctors who could contribute to the medical work force in a small but significant way. Currently it is proposed by AHPRA/MBA to further cut this contribution by terminating the Limited Registration Public Interest Occasional Practice (LRPIOP) registration category after 30 September, 2013.

AHPRA's estimate has been that about 1800 doctors currently on LRPIOP registration will be affected.

Dr Frank Johnson (not verified)

I wholeheartedly agree with Dr Frank Johnson. Medicine is one of those professions in which the number years of clinical experience can exponentially expand the ability to solve a patient's problems, encourage, educate and mentor colleagues, give community advice and direction, and make sense of new therapies. The actions taken by APHRA to throw the years of service and accumulated knowledge of some of our best doctors into the abyss of regulatory administration is wasteful and deplorable.

Robert Goldsmith (not verified)

Prescription phone line

I think the authority system is useful as a break on wholesale overuse of medications. It makes one think about the appropriate and evidence-based use of each one. Expensive antibiotics, with potential for increasing resistance, and narcotics would likely be even more over-used if not for authority restrictions.

Ian Turner

The authority system is a joke. The clerks manning the lines don't know what the authorised conditions mean anyway, so I merely parrot the authorised conditions as exactly as possible to speed up the whole process.

June Choo

E-PIP

GP workload, fluency with technology, and level of disinterest have been underestimated. We can't get many or timely discharge summaries from the tertiary sector, let alone with use of secure messaging. Big cost for only partial efficacy.

Megan Elliott-Rudder (not verified)

...CONTINUED ON PAGE 42

Members' Forum

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

...CONTINUED FROM PAGE 41

This is a dog's breakfast area at present

Peter Winterton

Health of Nations book review

Adrian [Rollins] is absolutely correct. [Gavin]Mooney turns a blind eye to why doctors in developing countries make the heart-breaking, life-altering decision to leave home and hearth, family and friends, culture and career, for a foreign land where they will often have to work in a foreign language. The reasons are legion, varying by country and over time, and are discussed fully in my book, A Unique Migration: South African Doctors Fleeing to Australia.

Peter Arnold

I am grateful for the review. I had hoped that my ideas might provoke debate and where there is agreement (as in Dr Rollins' case) that we are failing on health globally, others who disagree with my analysis might put forward alternative explanations for why we are failing. I believe that debate needs to happen. Also, regarding citizens' juries, the book does explain clearly how these are chosen, but Dr Rollins clearly missed that or didn't read that chapter.

Gavin Mooney (not verified)

Defence contracts

I signed their contract, sent it, heard nothing, then the ADF contacted me asking why I wouldn't sign the contract. I've sent it three times more, each time Medibank say thanks for sending the contract.....then I haven't gone on the preferred provider list. Medibank still refer patients to me, then they don't notify the patient or the ADF, and I get no shows. This organization is incompetent.

Anonymous

I offered to take the 50 per cent cut in rates for anaesthesia if everyone at MHS also took a 50 per cent pay-cut. Because they did not accept my offer, I am continuing to treat Defence patients at AMA supported rates. If Defence does not continue to pay my usual fee, then I will cease treating Defence personnel.

Alec Harris (not verified)

TO COMMENT CLICK HERE

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 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

HEALTH ON THE HILL

Govt told to back obesity claims

The Federal Government has been told to provide more evidence for claims made in its *Swap It, Don't Stop It* anti-obesity campaign.

In a report released earlier this month, the Australian National Audit Office said that although assessments of the effectiveness of the campaign were "encouraging", greater effort needed to be made in ensuring the claims and suggestions it presented were backed by evidence.

"Campaign materials should enable the recipients of the information to distinguish between facts, comment, opinion and analysis," the Audit Office said. "*The Swap It, Don't Stop It* campaign provides 'suggestions' for better health. Nonetheless, these should be evidence-based."

Suggestions made in the campaign, being run by the Australian National Preventive Health Agency (ANPHA), include swapping large meals for smaller serves, drinking water instead of soft drink, going for a walk instead of watching television and substituting take-away food with home cooked meals.

The campaign is being run as part of the Commonwealth's $932 million contribution to a national preventive health agreement involving all the states and territories which aims to prevent any rise in rates of obesity among adults and children between 2009 and 2018, as will as increase the amount of daily exercise people perform and cut the amount of smoking.

A recent Australian Institute of Health highlighted the dimensions of the problem, showing that a quarter of all children aged between 5 and 17 years were overweight or obese in 200708, as were 61 per cent of adults.

A survey of attitudes among teenagers by Mission Australia showed that weight and appearance was a major concern among the young, with 40 per cent of girls reporting they were very conscious of their looks, including 18 per cent who were "extremely concerned" about their appearance.

The Audit Office said that, overall, the Commonwealth – through the Department of Health and Ageing and ANPHA – had made "a good start" in implementing the National Partnership Agreement on Preventive Health.

AR

TO COMMENT CLICK HERE

Govt rejects round the clock care for detainees

The Federal Government has rejected proposals for asylum seekers held in detention centres outside metropolitan areas to have round the clock access to medical staff.

And a Bill that picked up on the AMA's call for the appointment of an independent panel of medical experts to monitor the health of detainees appears headed for defeat.

Responding to the recommendations of a parliamentary committee report on immigrant detention, the Government said it accepted the need for medical staff at metropolitan detention centres to be on a 24 hour a day roster, but did not support similar arrangements for detainees held in facilities outside cities.

In a separate report, the Legal and Constitutional Affairs Legislation Committee recommended that the Senate vote down a Bill proposed by the Greens to establish an independent panel of medical experts to monitor the health of asylum seekers – an idea for which the AMA has advocated strongly.

In explaining its decision, the Committee instead recommended beefing up the role of the existing Immigration Health Advisory Group to give it the power to meet detainees in offshore centres and require it to report to the Government every six months.

AMA President, Dr Steve Hambleton, said the decision was disappointing.

The focus on conditions in offshore detention centres has intensified following a damning report by Amnesty International and a growing catalogue of instances of injury, psychological distress and self-harm among detainees.

On the last sitting day of Parliament for the year, the Government tabled its response to the recommendations of the Joint Select Committee on Australia's Immigration Detention Network, which reported on 30 March.

In the report, the Committee proposed that International Health and Medical Services (IHMS), which has been contracted by the Government to provide health services to detainees, establish 24 hour a day staff rosters at non-metropolitan centres.

While rejecting this recommendation, the Government said it accepted "in principle" a separate suggestion that IHMS pilot mental health outreach services in detention centres.

But the Government rejected outright recommendations from Greens Senator Sarah Hanson-Young, who sat on the committee, regarding children in detention.

Among her suggestions, Senator Hanson-Young proposed that the Migration Act be changed to preclude mandatory detention of children, and to enshrine the principle that the best interests of the child be paramount in decisions regarding accommodation.

In a submission to a separate parliamentary inquiry being conducted into the Migration Amendment (Health Care for Asylum Seekers) Bill 2012, the AMA highlighted concerns that children in detention developed a range of problems including developmental delays, mood disorders, depression, instances of self-harm, thoughts of suicide and anxiety disorders.

...CONTINUED ON PAGE 44

HEALTH ON THE HILL

...CONTINUED FROM PAGE 43

"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 appointment of an independent expert panel to monitor the health of asylum seekers.

Concerns regarding the mental wellbeing of detainees, particularly in offshore detention centres, have been heightened by doubts about the ability of IHMS to provide the level of care required.

The Detention Health Advisory Group, which provides the Department of Immigration with independent expert advice on detention health care policy, last year raised "persistent and serious concerns about the ability of IHMS to provide adequate services to detainees within the bounds of [its] contract," according to the parliamentary inquiry into immigration detention.

Group chair, Professor Louise Newman said the very terms of its contract called into question the ability of IHMS to provide adequate health services to people who continue to be detained against professional advice.

AR

TO COMMENT CLICK HERE

Food makers have to put up or shut up

Food manufacturers will have to back up health claims with evidence under changes approved by a meeting of Australian and New Zealand ministers responsible for food regulation.

In a move welcomed by health groups as an important step in helping consumers make better food choices, the Legislative and Governance Forum on Food Regulation has directed that "all health claims will be required to be supported by scientific evidence, and will only be permitted on foods that meet specific criteria, including nutrition criteria".

In a joint communiqué issued following their 7 December meeting in Brisbane, the ministers said that general level health claims such as calcium is good for strong bones can be supported by either "pre-approved or industry self-substantiated food health relationships".

But they warned that so-called high level claims (such as calcium reduces the risk of osteoporosis) would require pre-approval by Food Standards Australia and New Zealand.

Cancer Council Australia said the change was an important one in helping inform consumers when purchasing food.

The Council's nutrition spokesperson, Clare Hughes, said it meant that health claims could only be made for food that met minimum nutrition standards.

"For example, a claim like 'reduced fat for heart health' could not apply on a product that is high in sugar and, therefore, not a healthy food choice," Ms Hughes said.

Governments in Australia and New Zealand have agreed to introduce the new laws early next year, and have given manufacturers three years to comply.

The ministerial meeting also reported that "good progress" was being made in developing front-of-pack labelling standards to make it easier and quicker for consumers to assess the nutritional content of food.

The Forum said the system was being developed with a view to introducing it by mid-June, 2013.

The developments in food labelling came as AMA President Dr Steve Hambleton joined a number of health experts in calling on the giant weight loss business Weight Watchers to provide evidence to support its push to have its services added to the Medicare Benefits Schedule.

The company claimed that, for a subsidy of just $202 per person, it could help around 200,000 Australia shed up to 15 kilograms each.

It estimated that the total programs would cost taxpayers about $39 million, but could save up to $1.3 billion a year in health spending.

But Dr Hambleton told the *Herald Sun* Weight Watchers should provide much more evidence before its service is considered to eligible for Medicare subsidy.

AR

TO COMMENT CLICK HERE

Former Qld Premier joins Medibank Board amid doctor stoush

Former Queensland Premier, Anna Bligh, has been appointed to the Board of Medibank Private.

Announcing the appointment, Finance Minister Penny Wong said that Ms Bligh – who was swept out of office when Labor was annihilated in the March state election – would bring with her "expertise across a wide range of public policy areas".

As a non-executive director, Ms Bligh is set to receive up to almost $90,000 a year in cash, superannuation and benefits, according to *The Australian*.

Her appointment comes as Medibank Private offshoot, Medibank Health

...CONTINUED ON PAGE 45

HEALTH ON THE HILL

...CONTINUED FROM PAGE 44

Solutions, is struggling to sign up the specialists its needs to fulfil its $1.3 billion, four-year contract to provide health services to Australian Defence Force personnel.

A survey of member conducted by the AMA has found that less than 10 per cent of specialists have signed up to MHS contracts, which involve cuts to fees of up to 50 per cent for medical services, as well as onerous reporting requirements.

Ms Bligh will take up her three-year appointment from

21 December, replacing Philip Twyman, who joined the Board at the end of 2007.

While Mr Twyman is departing, existing Board member Dr Cherrell Hirst has been re-appointed to a second three-year term.

Senator Wong said Dr Hirst, who is also Chair of Medibank's Health and Business Innovation Committee, had "extensive board experience, particularly in the clinical health field".

The appointments mean that there are now five women on the eight-member Board, which is chaired by Thales Australia Chairman, Paul McClintock.

While Ms Bligh is establishing her career post-politics, former Newman Government Minister Bruce Flegg – who was forced to resign from the ministry last month amid allegations of misconduct - has launched legal action against a former staffer he accuses of causing his political downfall.

Mr Flegg launched the action after the staffer, Graeme Hallett, publicly accused him of being unfit to hold office amid claims of undisclosed dealings with his lobbyist son, and is reported to be seeking damages worth up to $1 million.

Meanwhile, Federal Health Minister, Tanya Plibersek, has acted to provide certainty to the recently-established Independent Hospital Pricing Authority, confirming acting Chief Executive Officer, Dr Tony Sherbon, in his job as a permanent appointment.

Dr Sherbon, who has been acting in the position since IHPA's creation a year ago, has proven himself to be the leading candidate through his work in establishing the Authority, Ms Plibersek said.

"Dr Sherbon has done an excellent job in establishing the IHPA and working with all jurisdictions to determine Australia's first National Efficient Price for hospital services," the Minister said.

His appointment is for five years, effective from 13 December.

AR

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

AMA LIST OF MEDICAL SERVICES AND FEES

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

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

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

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

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

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

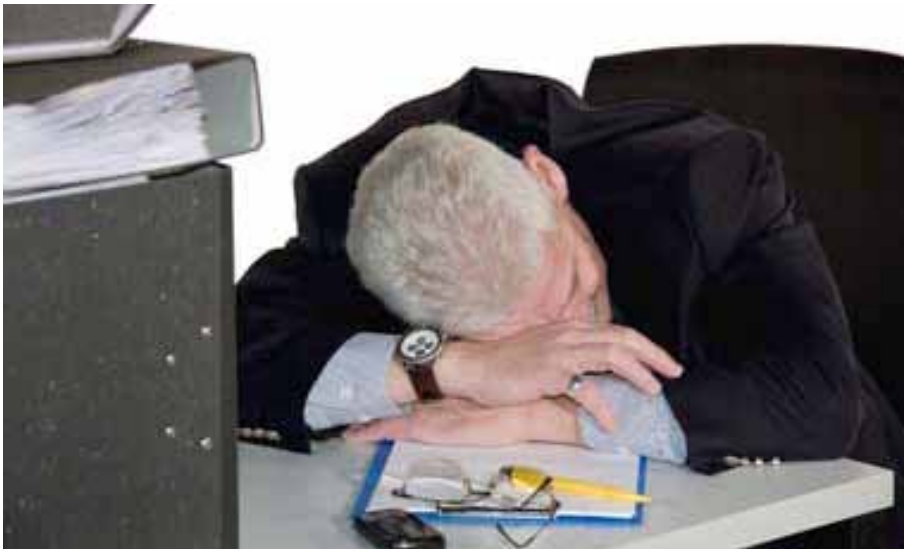
1) Once you have entered your login details, from the home page go to **Members Benefits** at the top of the page.
2) Under AMA Member Benefits, select **AMA List of Medical Services and Fees** link.
3) Select first option, **AMA List of Medical Services and Fees - 1 November 2012**.
4) Download either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

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

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

TO COMMENT CLICK HERE

Power naps help on-call DITs fight fatigue



Power naps could help doctors in training stave off fatigue and the physiological and behavioural effects of sleep deprivation caused by long hospital shifts, a study by a team of American researchers has found.

The study, conducted by researchers at the University of Pennsylvania, compared the sleep patterns and alertness of trainees working a standard 30 hour overnight shift with those who had a protected sleep period between 12.30am and 5.30 am.

It concluded that protected sleep periods during prolonged duty were "feasible, likely to increase the amount of uninterrupted sleep interns obtain during extended duty overnight shifts, reduce the number of 24-hour periods awake and improve behavioural alertness in the morning following on-call nights". But it found no association between less fatigue and improved patient outcomes.

The study was conducted to test the findings of a report by the Institutes of Medicine, which recommended protected sleep periods for trainees on extended overnight shifts. The viability of the recommendation, which has since been adopted by the Accreditation Council for Graduate Medical Education, has questioned by some health authorities in the US.

The study has been reported in The *Journal of the American Medical Association*.

DN

TO COMMENT CLICK HERE

All-rounder wins NZMA's highest award

An innovative University of Queensland skin specialist who developed a ground-breaking grafting technique, writes novels and finances local literacy programs has won New Zealand Medical Association's highest honour, the Chair Award.

Dr Sharad Paul – whose achievements were described by NZMA Chair Dr Paul Ockelford as "remarkable, and remarkably varied" – is an all-rounder.

The surgeon, who gained international recognition for developing a new skin grafting procedure, is director of the skin surgery clinic in Auckland, where he specializes in treating skin cancer and wound repair.

In addition to his clinical work, Dr Paul is a senior lecturer in surgical skills and skin cancer at Auckland University and the University of Queensland.

But his interests spread well beyond the medical world. He is proprietor of a popular Auckland café and bookstore that funds literacy programs in schools in disadvantaged areas of Auckland schools, and he is the author of two novels - *4th Estate* and *To Kill a Snow Dragonfly*.

The annual Chair's Award is for an individual or organisation having made a substantial contribution to the health of New Zealanders.

DN

TO COMMENT CLICK HERE

Canadian Govt overrides protests to approve addictive painkiller

Canadian Health Minister Leona Aglukkaq has refused requests from provincial Canadian governments and First Nation communities to delay approving generic OxyContin until regulators can examine widespread abuse of the drug.

The patent on brand-name OxyContin expired at the end of November. Ms Aglukkaq announced the very next day that the federal government would allow six manufacturers to make the generic version, though she also agreed, in response to criticisms of the move, that manufacturers and pharmacists would have to report unusual changes in sales and distribution patterns of the drug.

The request for delay had been prompted by concerns about the highly-addictive effects of the drug.

After the United States, Canada is the world's largest consumer of oxycodone-based products. In Ontario in particular, more than half the adult population in some First Nation reservations are already addicted to prescription drugs. The Ontario government, reporting that OxyContin-related deaths had increased fivefold, wanted it banned altogether.

Deputy Grand Chief Alvin Fiddler, of the Nishnawbe Aski Nation (NAN), said that the move was another blow to the northern remote First Nations who were "combating an addiction epidemic". He appreciated the Government's distinction between science and politics, he said, but "NAN First Nations are experiencing extreme levels of addiction, and require extreme solutions".

Ms Aglukkaq, herself an Inuk, said that she was prevented by federal law from banning a drug because it was abused by some people. The provinces could prevent OxyContin and other opiates from being abused, she said. The federal government could only take action if the provinces could prove that pharmacists or doctors were enabling abuse.

DN

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

TO COMMENT CLICK HERE

Weekend work for seven-day health care

More British GPs should be available to work at weekends if the National Health Service is to offer high-quality care seven days a week, according to a report by the Academy of Medical Colleges.

The Academy, composed of 20 medical colleges and faculties in the UK, said that patient care should not be delayed because hospital or community services were not available on certain days of the week.

But a current lack of available community care services was a major reason why hospitals were unable to discharge patients at weekends.

Patients should expect to receive the same standard of care regardless of when they needed it, the report, Seven Day Consultant Present Care, said.

More "consultant-to-GP" handovers were therefore needed at weekends so that hospitals could discharge patients on any day in the week into community care.

"Given that GPs provide the equivalent of 'consultant-present care' for patients in the community, the provision of direct 'consultant-to-GP' handover for selected patients at weekends would help to ensure that they remain on the appropriate care pathway after discharge from hospital," the report said.

Dr Paul Flynn, chair of the British Medical Association's Consultants' Committee, responded that the report – and "mounting evidence that patients are more likely to die if admitted as emergencies in the evening and at the weekend" – posed a "huge challenge" for consultants and hospital managers.

"What works for one specialty may not be appropriate for another, and it will be for senior doctors to discuss with their clinical teams what works best for their patients," he said.

"Patients should receive high-quality care no matter when they are in hospital and we need to work together to explore how best to meet this challenge."

DN

TO COMMENT CLICK HERE

Meningitis vaccine reaches 100 million Africans

The revolutionary MenAfriVac meningitis vaccine has reached its 100 millionth recipient in Africa – in northern Nigeria, a region plagued by various epidemics for more than a century and known as the "meningitis belt".

The low-cost vaccine was developed by the World Health Organisation and PATH (Program for Appropriate Technology in Health), a global non-profit funded by governments, NGOs and multilateral agencies that helps develop and deliver high-impact, low-cost medicines and health devices for use in developing countries.

The MenAfriVac program is a product of the GAVI Alliance, a public-private partnership to fund vaccination programs involving the WHO, the World Bank, developing and donor governments, the Bill and Melinda Gates Foundation and vaccine producers.

It has been operating since 2010, starting in Burkina Faso before spreading into nine other sub-Saharan countries in the meningitis belt via programs to protect people aged between one and 29 year from meningitis A.

The meningitis belt encompasses 450 million people in 26 countries from Gambia in the west of sub-Saharan Africa to Eritrea in the west. In 1996-97, meningitis A infected 250,000 people, killing 25,000.

DN

TO COMMENT CLICK HERE

Deadly new virus claims five lives, and counting

The World Health Organisation has confirmed that a novel coronavirus that has so far killed five people has spread to the third county in the Middle East.

The disease, like SARS, infects the upper respiratory system, causing symptoms including coughing, congestion and difficulty breathing.

But, unlike SARS, so far it coronavirus "does not appear to transmit easily between people", the WHO said, though it warned that two clusters in Saudi Arabia and Jordan "raise the possibility either of limited human-to-human transmission or that the victims could have been exposed to the same source".

At time of reporting, five cases (including three deaths) have been identified in Saudi Arabia, two cases (both fatal) in Jordan and two cases in Qatar.

The WHO's Eastern Mediterranean Regional Office has set up office in Jordan to help in sentinel and epidemiological surveillance systems for the outbreak.

The world body is still trying to identify the source (or sources) of the infection, for with there is no vaccine or specific treatment available.

DN

TO COMMENT CLICK HERE

HIV scourge returns amid ignorance and fear

A HIV epidemic has re-emerged in America's deeply conservative South amid concerns repressive attitudes are hampering efforts to encourage safe sexual practices.

Medical experts have identified an upsurge in HIV infections in states including Florida, Alabama and Louisiana, igniting concerns that the disease, once thought to be contained, is spiralling out of control.

According to the Centers for Disease Control and Prevention (CDC), the rate of new HIV diagnoses has reached 33 cases per 100,000 people in Florida – virtually double to national average of 17.4 cases – while in Louisiana it has reached 28.8 cases.

A report by the Southern AIDS Coalition, cited by *American Medical News*, estimated that the South accounted for almost half of all new AIDS cases in the US each year, despite having little more than a third of the nation's population.

Just as concerning, the CDC said that about one-fifth of the 1.2 million Americans 13 years or older living with HIV were not aware they were infected.

The situation has local doctors, such as Laurie Dill of the Medical AIDS Outreach of Alabama, worried.

"People thought we have HIV/AIDS taken care of," Dr Dill told *American Medical News*. "But when they looked at the numbers, they saw that's not true."

Efforts to combat the spread of the disease are being hampered by ignorance and stigma. Health workers report concerns among some that the condition can be transmitted by mosquito bite, while prejudice against those with the disease discourages many at risk from being tested – and consequently receiving early treatment.

Kathie Hiers, Chief Executive Officer of the organisation AIDS Alabama, said that although some innovative health services and education programs were springing up, there was a lot of ignorance and misinformation regarding the disease that was hampering efforts to bring it under control.

"It's going to take a lot of different tools to get to the end of the AIDS epidemic," Ms Hiers told *American Medical News*. "Until we move from [viewing HIV/AIDS as a] moral issue to a medical one, we're going to continue to have challenges."

AR

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

TO COMMENT CLICK HERE

2013: the year for politicians to start listening

BY **PROFESSOR STEPHEN LEEDER**

"So, while clinicians and scientists may feel put out that their ideas do not achieve prominence, there is a bigger problem. Australia at present exhibits a deeper malaise on the policy front."

The biggest mistake clinicians and scientists make in relation to health policy is to believe that, if all the facts and figures and randomised trials can be collected into one supersized policy document, it will change the world.

Well, no, actually it won't – and shouldn't. We live in a democracy, not a scientific or professional-dominated plutocracy, and our ideas need to be debated and tested against the perspectives of society – conservative and radical, publicly-supported and free enterprise.

And because science-based policy statements get roughed up so frequently, many players limp away nursing a bruised limb or with a black eye, never to be seen on the field again. They shouldn't. The policy game is too important to abandon. Policy takes time, patience and pragmatism to develop.

Packing up the bat and ball and walking off simply leaves the policy arena to others, many of whom have no interest in policy and only in beating others up and coming out on top. 2013 will be an election in Australia and poor old policy – of any form, scientific or not – will not receive a good hearing.

We will all behave next year essentially as we did this year, and so we are in for energetic trade of personal insults, accusations, rhetoric and promises. It is easy to imagine that there will be no contest over policy.

Without contested policy there will be no vision of where Australia's health system might go in the next five years. Instead, we will hear how diluting Medicare with a fistful of private health insurers offering Dutch and Israeli-style health insurance will save us, more muddling over electronic records, nothing about how to bring IT into every crevice of the system - as is essential to achieve coordinated care - and nothing further about moving to a single payer for publicly funded health care - another change essential to achieve the allocative efficiency demanded of us because of unsustainable rising costs. In short, don't hold your breath that 2013 will bring a vintage harvest of thought-provoking policy options.

Labour has exhausted itself over health care reform in the past five years, and the Coalition has had nothing to say by way of coherent policy – just criticism and threats of dismantling and occasional responses to the lobbyists pushing their private schemes in Canberra.

So, while clinicians and scientists may feel put out that their ideas do not achieve prominence, there is a bigger problem. Australia at present exhibits a deeper malaise on the policy front.

Public policy – science-based or not – has been run over in an anti-intellectual brawl, and what we are left with is blood on the floor and shouting. Not very good for the health of the nation. Our mineral wealth allows us to obscure deep social and political poverty because the money keeps rolling in, so no need to worry about anything, right?

Need it be this way? Of course not. Over Christmas and the holiday season, it would be wonderful if our politicians were to stop shouting at one another, searching in their pockets for another negative epithet to hurl at their opponents, and thought again about the purpose of our politics beyond establishing themselves in power. What do we want for our health system? How can we get it? How can we respond to an ageing population? When will we start to look after people in nursing homes properly? What do we want on the final journey towards death from palliation, advance care orders, euthanasia? What are the people saying? What could politicians hear if they would stop shouting for a while?

Good policy is policy developed by listening. To everyone, including clinicians and scientists, how wonderful it would be if 2013 was the Year of Rejuvenated Policy in Australia! We could do it. We should do it. Happy New Year.

TO COMMENT CLICK HERE

BOOK REVIEW

The Great Pain Jack: A self-help mapping tool to assist you and your physician in making an accurate diagnosis and appropriate treatment plan of your chronic or acute pain condition

By J.F. Petraglia

AuthorHouse, RRP $20, pp153, ISBN 978-1-46856-871-4

Reviewed by Julie Chan

For some people, pain is so much more than just a symptom.

The consequences of pain may prove to be both devastating and long lasting for those who suffer from it.

Access to adequate pain management is considered to be such an important public health issue that it has been described as a fundamental human right.

One of the essential components to the management of pain is providing education to patients on the nature and course of their condition, as well as the treatment options that are available to them. *The Great Pain Jack* is a guidebook that was written in an attempt to address this need.

Written by Dr John F. Petraglia, an anaesthesiologist and pain management specialist working in California, *The Great Pain Jack* is aimed at individuals who may be suffering from acute or chronic pain conditions.

The "Jack" in the title refers to people from non-medical backgrounds who have succumbed to self-treatment of their painful condition, as well as to those whose brains have been "hijacked" due to the inappropriate use of pain medications.

The Great Pain Jack is both easy to read and well organised.

Dr Petraglia begins the book by presenting a brief historical perspective of the management of pain, followed by a series of definitions and classifications of pain.

He describes a typical day in his job as a pain management specialist, providing his readers with an insight into how a pain doctor thinks, and some of the daily issues they are faced with.

This is followed by a series of chapters, organised into regions of the body, describing a range of painful conditions.

The chapters contain an accessible amount of information on symptoms, signs, and treatment options available. Each includes an illustrated pain mapping tool and a pain questionnaire for readers to complete and present to their doctor, as an aid in the diagnosis and management of their painful condition.

In addition, interspersed throughout the book, are a series of case studies that Dr Petraglia has encountered throughout his career that highlight some of the many complexities associated with the diagnosis and treatment of pain.

At 153 pages, *The Great Pain Jack* is not all-inclusive. For example, although there are chapters dedicated to knee and shoulder pain, there is no discussion of hip or elbow pain. Dr Petraglia does, however, refer readers to his website, www.thegreatPainJack.com, throughout his book for those who may be seeking further information.

Although *The Great Pain Jack* is not a substitute for appropriate medical assessment and management, it is an honest and informative self-help text.

No doubt it will prove to be a useful starting point for individuals suffering with acute or chronic pain conditions.

Julie Chan, is an anaesthetics registrar at The Alfred, Melbourne.

TO COMMENT CLICK HERE

Champagne Charlie rides again

BY **DR MICHAEL RYAN**

Charles Heidsieck

It's funny how those who once basked in popularity somehow drop off the stage of fashionable desirability.

Of the three current Heidsieck labels, which include the giant Piper Heidsieck, Heidsieck & Co Monopole and Charles Heidsieck, the latter was once revered, and oozed a must-have sense of desirability.

At one time it was said that, when ordering Champagne, a call to the waiter for a bottle of "Charlie" was in order.

Charles "Champagne Charlie" Heidsieck was well known in France, and his fame spread to the United States, when he became the first Champagne merchant to travel there in 1852.

His flamboyance and social affluence elevated his standing as a genuine ambassador for Champagne. His bold step at the age of 29 saw him set up his own house and develop a style of wine that reflected his personality.

He forged his own marque, breaking from the Heidsieck clan that had founded Maison Heidsieck et Cie in 1775.

For 125 years, Charles Heidsieck Champagne was family owned and run.

It was taken over by the Heriard-Dubreuil family (of Cointreau fame) in the 1980s before being acquired by the Descours family in 2011.

The new owners aim to re-establish the brand as a leading quality producer, after slipping off the radar of many outside Champagne's elite circles in recent years. For example, it is little known that Heidsieck has been crowned sparkling winemaker of the year 15 times in the last 18 years.

Heidesieck sets the foundation for quality in its use of reserve base wines, which comprise 40 per cent of each sparkling. Each reserve wine is aged for between 10 and 15 years, and add layers of complexity. Even non-vintage wines are aged for three years before release; double the standard appellation time. The wines are aged in Second Century limestone caves dug out by the Romans, which keep a constant 10 degrees Celsius.

Heidesieck's non-vintage Cuvees and Roses have been given a makeover in bottle shape and labelling but, most importantly, their style has been lifted and they have become livelier, and with greater complexity.

I recently had the pleasure of trying the entire range, including vintage and non-vintage styles. They are a little more costly than the average, but not outrageous. The value is there and the quality exemplary. With the festive season upon us I will be making it a Charles Heidsieck moment every step of the way.

Wines Tasted

Charles Heidsieck Brut Reserve

A dreamy light gold colour with a fine bead of bubbles. The nose is a tantalising fusion of racy tropical fruits and apricots with complex notes of sweet yeasty bread. A supple palate that exudes class for a house style, it is perfect with just about anything.

Charles Heidsieck Millesime 2000 Brut Grand Cuvee

The colour is a deep gold with lively effervescing bubbles that ascend as though on fine silk. The bouquet reflects its 58 per cent Pinot Noir and 42 per cent Chardonnay blend, with the Pinot Noir giving up spicy savoury notes and the Chardonnay chipping in with floral notes and complex white fruits. The ageing of the wine results in multi-layered yeast and mushroom nuances. The palate is plush, with guided power that coats the tongue and dances seamlessly. Goat's cheese soufflé would match.

Charles Heidsieck Millesime 1999 Rose

A beguiling soft coral hue is complemented by its fine bead. Aromatic complexity abounds, with compote of strawberries and hints of spicy fig. Woody, peppery notes provide a second tier of aromas, and is complemented by 7 per cent Pinot Noir in the mix. This is a silky, sexy wine that has subdued sweet notes harmonising with bridging tannins. A most excellent wine that needs some foie gras and venison.

Charles Heidsieck Blanc Des Millenaires Millesime 1995

AThe deep golden hue is enhanced by a slow caravan of bubbles nearly 20 years old. This is a cornucopia of aromatics that begin with the aged, slightly cooked effect of peaches, continue with the nutty aroma of almonds, and are enhanced by complex aged yeasty notes. The 100 per cent Chardonnay fruit oozes over the palate in a wave of sensory delights that evokes pleasure and sensuality. While Mr Gray may have toyed with this, Mr Bond would do it justice. No match, just enjoy!

TO COMMENT CLICK HERE

General Enquiries:
1300 133 655
Web:
www.ama.com.au/amex

General Enquiries:
1300 245 578
Web: www.ama.com.au/memberservices

General Enquiries:
1800 658 679
Web:
www.ama.com.au/onepath

General Enquiries:
1300 360 525
Web: www.ama.com.au/memberservices

Bookings:
13 30 39
Web: www.ama.com.au/memberservices-hertz

General Enquiries:
1300 133 655
Web: www.ama.com.au/powerbuy

General Enquiries:
1300 133 655
Web: www.ama.com.au/memberservices-qantas

General Enquiries:
300 133 655
Web: http://www.ama.com.au/memberservices-vw

General Enquiries:
1300 133 655
Web: http://www.ama.com.au/node/5292

GREAT MEMBER DEALS

Discounts off new Volkswagen and Skoda vehicles for AMA Members*

AMA members can access substantial discounts off the list price of new Volkswagen and Skoda vehicles. **A deal that could save you thousands!**

The discount is model dependant and does not include options and accessories. Please see your local VW dealership for further details on the discount structure.

To access this exclusive offer simply contact AMA Member Services on 1300 133 655 or email memberservices@ama.com.au.

*Please Note: Must be an AMA Member for minimum 3 months prior to vehicle delivery. Cannot be used in conjunction with any other offer.

Great Qantas Club Rates for AMA Members

Joining Fee: $230.00
One Year Membership: $300.00
Two Year Membership: $530.00

As a Qantas Club member you also receive complementary Qantas Frequent Flyer membership and access to dedicated Qantas Club check-in counters.

Call AMA Member Services on 1300 133 655, email memberservices@ama.com.au or login to the AMA website http://ama.com.au/memberservices-qantas to obtain an application form.

powerbuy

PowerBuy and the AMA have partnered to give Members savings on popular IT products and services. PowerBuy offers discounted deals on brands including Dell, Lenovo, HP, Fuji Xerox and NETGEAR.

For further details and to access PowerBuy's special offers for AMA Members, simply visit **www.ama.com.au/powerbuy** or phone AMA Member Services on **1300 133 655.**