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Honesty and alcohol

BY AMA PRESIDENT DR STEVE HAMBLETON

"Part of the problem is Australia's national drinking culture, which is pervasive and almost universal – it is with us from cradle to grave"

Recent research from the Centre for Alcohol Policy Research (CAPR) shows that 95 per cent of people are unable to correctly identify safe alcohol drinking levels.

This suggests that just a very small minority of Australians is actually aware of, or concerned about, the short- and long-term harms associated with excessive and prolonged drinking.

This is a startling statistic.

Not only are most people ignorant of the risks, they are reluctant to be honest about how much they drink – with themselves, their family and friends, and with their doctor.

Many Australians are not aware they have a drinking problem or refuse to accept that they have a drinking problem, which means they remain ignorant of the very severe health risks that come with heavy and consistent alcohol consumption.

Alcohol affects every part of the body and causes many health problems.

These include poor nutrition, memory disorders, difficulty with balance and walking, liver disease, high blood pressure, muscle weakness, heart rhythm disturbances, anaemia, clotting disorders, decreased immunity to infections, gastrointestinal inflammation and irritation, acute and chronic problems with the pancreas, low blood sugar, high blood fat content, interference with reproductive fertility, increased risk of cancer of the liver and oesophagus, weakened bones, sleep disturbances, anxiety, and depression. And that's just a start.

Urgent reform is needed to address the estimated $36 billion in social and excess health costs that excessive alcohol consumption causes each year.

Part of the problem is Australia's national drinking culture, which is pervasive and almost universal – it is with us from cradle to grave.

When a baby is born we feel the need to 'wet the baby's head'.

When a baby has his or her first birthday, it's 'drinks all round'.

It's 'beer o'clock' whenever it's 'beer o'clock'.

Our children are exposed to alcohol sponsorship of sport and leisure activities, both directly and indirectly, and it definitely influences their decisions.

Alcohol is sold in supermarkets commonly in places much more prominent than the milk or the bread – desensitising us to its dangers when compared to tobacco. Tobacco is available in the same supermarket but now, thankfully, out of sight and covered in gruesome health warnings.

No motor race is complete without a bottle of champagne being fizzed over the participants and the crowd before being guzzled by the winners.

Alcohol is with us somehow, somewhere in every aspect of our lives, but it doesn't carry prominent health information or warnings. Nor are their sufficiently strong controls on alcohol advertising and marketing.

In 2007,one third of 12-15 year olds and nearly 80 per cent of 16-17 year olds had drunk a full serve of alcohol. For our boys, socialisation into traditional gender roles, often driven by media advertising, puts them at greater risk of unsafe alcohol consumption.

Indeed, 20 per cent of Australians put their health at risk in the short term by their drinking habits. The new paradigm of preloading with cheaper alcoholic drinks at home before going out on the town fuels the violence that out cities are exposed to every weekend and contributes to the 60 Australians who die each week and the 1500 who are hospitalised each week due to alcohol.

It is well known that there is under-reporting of alcohol consumption to both researchers and medical practitioners. The answers given depend on the questions asked.

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AMA acts to prevent bullying

In recognition of the National Day of Action Against Bullying and Violence, the AMA last week released two new practical tools to help raise awareness of child and adolescent bullying and its health effects and to provide sound advice about who people can turn to for help.

The Minister for School Education, Early Childhood and Youth, The Hon Peter Garrett MP, and AMA President Dr Steve Hambleton launched the two new AMA brochures at Mascot Public School in Sydney.

A brochure for older children and adolescents, *Bullying: What you need to know*, explains what bullying is, provides specific information on cyber bullying, and gives advice about how to deal with being bullied and how to identify bullying behaviours.

A second brochure, *AMA Guidance for Doctors on Childhood Bullying*, contains a childhood bullying fact sheet for use by medical professionals who are interested to know more about childhood bullying and its health impacts.

Minister Garrett said that all school students need information and encouragement to work collectively towards reducing the incidence of bullying in Australian schools.

"It's been estimated that one in four school students are bullied every few weeks or more," the Minister said.

"Schools have an important role to play in the prevention of bullying and many schools are making concerted efforts to prevent and address the problem.

"There can never be too much information to help prevent bullying and I am sure that schools and families will welcome the contribution of the AMA in the ongoing campaign to stamp out bullying and its harmful effects," the Minister said.

Dr Hambleton said that young people might be reluctant to disclose that they are being affected by bullying, especially online or through social networking sites, and that is why the AMA is promoting doctors as a source of safe and reliable information and advice about bullying.

"Doctors are a trusted and confidential source of information in the community," Dr Hambleton said.

"We want young people to know that they can talk about bullying with their family doctor, and we want to make sure that doctors are equipped with comprehensive information and advice to help their young patients.

"The physical and mental health consequences for people who are bullied are serious.

"Victims of bullying can become traumatised, anxious and seriously depressed, and sometimes these problems can continue through to adulthood.

"The AMA congratulates the Government and the Minister for taking a strong stand against bullying," Dr Hambleton said.

Background:

- Research from the Murdoch Children's Research Institute found students who were bullied had almost a two-fold increase in the likelihood of depressive symptoms the following year;
- While schools can work towards the prevention of face to face bullying, cyber bullying that happens outside the school setting is an increasing problem;
- Cyber bullying can take a number of forms including sending threatening text messages or emails; circulating untrue, embarrassing or hurtful information by sms, email or social networking sites; emailing or posting altered images; sending a virus or spy ware or taking on someone's identity online and damaging their reputation;
- Cyber bullying can involve a wide audience, the person being bullied may have little or no respite from online bullying, and the person or people doing the bullying may have some element of anonymity;
- According to a January 2012 study by the Ipsos Social Research Institute, of the 24 countries surveyed Australia was the worst place for bullying over social networks, and the fifth for bullying online (this means that Australians were more likely to bully on social network sites like Facebook and Twitter than in chat rooms or on mobile phones);
- A survey conducted by BoysTown found that the most prevalent forms of cyber bullying were name calling (80 per cent), abusive comments (67 per cent), and spreading rumours (66 per cent);
- Recent research suggests that 10 to 15 per cent of students have experienced cyber bullying more than once (experience from the US and the UK suggests that this could increase to 30 to 40 per cent);
- In a survey conducted for the recent Government Inquiry into Cyber Safety, 8.8 per cent of survey participants (15,592) admitted that they had cyber bullied someone else. Of those, 66 per cent reported that they had also been the victim of cyber bullying;
- Research commissioned by Microsoft in 2008 found that 83 per cent of parents did not know what to do if a child was being cyber bullied, and two out of three were unsure of the best ways to help their children; and
- Facebook has introduced tools that aim to reduce cyber bullying (and identify those people who may be at risk of suicide).

Bullying: What you need to know is available at http://ama.com.au/youthhealth/bullying

AMA Guidance for Doctors on Childhood Bullying is available at http://ama.com.au/youthhealth/bullying-guidance-for-doctors

TO COMMENT CLICK HERE

MBS interpretation service welcomed

The AMA has welcomed the decision of the Department of Human Services to introduce a Medicare Benefits Schedule (MBS) item enquiry email service to assist doctors with complex interpretations in the use of MBS item numbers.

AMA President Dr Steve Hambleton said that the service is something that the AMA has been pursuing for some time.

"There are situations when doctors in a busy practice require informed assistance about the interpretation and application of specific item numbers for specific treatments or patient conditions," Dr Hambleton said.

"Doctors can now send queries to a dedicated email address and receive a rapid written response to specific questions about the correct MBS item for a particular medical service.

"The MBS is very complex and there are many grey areas.

"If questions are raised about interpretations of MBS items, doctors can now refer to the written advice they have received from the Department and ask for it to be considered should there be any investigations.

"The AMA congratulates the Department of Human Services for recognising and responding to the need for a mechanism to help doctors navigate the complexities of the MBS so that their patients can access the Medicare rebates they are entitled to.

"We are pleased that enquiries sent to this email address will be handled by a centralised specialist team, who are trained to respond to these often complex MBS interpretation questions.

"This will ensure there is consistency in the advice given to medical practitioners around the country," Dr Hambleton said.

Doctors or practice managers can either:

- email MBS item questions directly to askMBS@humanservices.gov.au; or
- use the online enquiry form available at Contacts for providers.

JF

TO COMMENT CLICK HERE

Honesty and alcohol

CONTINUED FROM PAGE 3

Individuals commonly leave out binge drinking episodes when asked about regular use of alcohol. This is further complicated by the lack of knowledge by many about the number of standard drinks that are contained in different alcoholic beverages.

The 2009 Australian Alcohol Guidelines advise that healthy adults should consume no more than two standard drinks on any day. So, the 'safe' level of consumption for both men and women – if there is such a thing as a safe level - is two standard drinks in any one day. When given this advice, most choose to ignore it.

The lack of knowledge about safe levels of drinking is almost universal but most people can recite the jingles for most beer adds.

The more our adolescents are exposed to advertising, the more of them will choose to drink. If they are already drinking, they will drink more.

There is even greater difficulty discussing alcohol consumption with minors because the young people are usually accompanied by their parents. Parents will often offer alcohol to their children at home in the hope that it will encourage responsible use of alcohol later in life. In fact, parent disapproval of alcohol use is protective for both boys and girls.

The issue for doctors is that if we do not know the extent of our patients' alcohol use and abuse, it is harder for us to provide the appropriate advice, care and treatment for each patient, based on their individual circumstances.

If we can't measure it, we can't help manage it.

We need to increase the number of times that doctors have the conversation with their patients about alcohol consumption.

We need to ask the right questions to improve the reliability of the answers we get.

Above all, we need people to be honest with us about how much they drink.

Only then can we can increase the opportunities for 'brief alcohol interventions' in primary care and put people on the paths to better health.

This is an edited version of an article that first appeared on *The Punch* website.

TO COMMENT CLICK HERE

Medical Trainee Forum

The AMA recently brought together trainee doctors from across Australia for a Forum on training pathways for the future, with a strong emphasis on improving access to a well-trained medical workforce for all Australians, no matter where they live.

Forum delegates represented major medical trainee organisations across most specialties including general practice, surgery, medicine, emergency medicine, psychiatry, pathology, radiology, and obstetrics.

The trainees discussed the growing pressures on the health system, including the need for more support and resources to ensure that the increasing number of medical graduates can access high quality training positions into the future.

Medical students numbers have more than doubled. By 2014, there will be more than 3700 students graduating from medical schools across the country.

These graduates still need to be able to progress through prevocational and specialist training, and this will require more training places in our public hospitals and other clinical settings than are currently available.

The Forum trainees unanimously agreed that there was an urgent need for the development of key performance indicators to measure the performance of the health system in supporting the delivery of high quality medical training.

They will request the Medical Training Review Panel to prioritise this as a critical area of policy development.

The Forum participants want the Council of Australian Governments (COAG) to recognise the potential for access to medical care to be greatly improved as a result of the significant increase in the number of medical graduates since 2004.

Trainees want COAG to take meaningful action to ensure that these graduates can access high quality prevocational and vocational training places, taking into account the analysis and findings of the soon to be released workforce planning undertaken by Health Workforce Australia.

Another Forum recommendation was for the promotion and support of clinical academia as a career pathway, recognising the crucial role of academic medical practitioners in training the next generation of doctors.

AMA President Dr Steve Hambleton welcomed the outcomes of the Forum, which represent a strong endorsement of the AMA's policy on medical training, and congratulated the trainees on the quality of their deliberations.

Dr Hambleton said that the feedback from the medical trainees on the ground confirms that governments have a lot more work to do provide access to prevocational and vocational training positions and deliver on their commitment to improve access to medical care.

JF

Sir Keith Jones 1911 – 2012

FEDERAL AMA PRESIDENT 1973-76

Surgeon's steady hand helped ease in Medibank

One of most gratifying moments in Sir Keith Jones's eventful life was when, aged 98, he received news that the wreck of the Centaur, the hospital ship sunk by the Japanese in 1943, had been found, and with it the final resting place of his younger brother, Gordon. Jones and Gordon, both medical graduates, had signed up for war service, and Jones had been offered a cabin on the Centaur, to spend a few days with his brother, but had turned it down.

"I did not think it appropriate that two brothers should be together," he said. "And, I got dreadfully seasick."

Jones went on to serve as the deputy assistant director of medical services in the Lae campaign in New Guinea.

But if he had been on that ship on May 14, 1943, the tortuous introduction of government-funded medical insurance in Australia - which was to change the administration of medicine in this country forever - would have been much more difficult.

Keith Stephen Jones was born at Narrandera on July 7, 1911, son of Stephen Jones, an engineer who was then engaged in constructing the first irrigation ditches in the Riverina, and wife Muriel (nee Rickard).

The family moved to Newcastle and the young Jones was woken on the night of November 11, 1918, to hear the city bells ringing to signal the end of World War I.

He won a scholarship to Newington College in Sydney, where he displayed enormous athletic skill, establishing junior NSW and Australian 440 yards and 880 yards running records.

He was dux of the school, and enrolled in medicine at the University of Sydney.

But running remained a passion and competing in the 1932 Australian Athletics Championships, he was in the team that set Australian records in the 4x440 and 4x880 yards relays.

He would have been a candidate for the 1934 Empire Games and even the 1936 Olympics but the medical profession was too demanding and he decided to retire from running.

His internships were at the Royal Prince Alfred and Western Suburbs Hospitals until his father bought him a practice at Pambula on the south coast.

In 1936 he married an artist, Kathleen Abbott.

When war was declared, Jones signed up and served in NSW, Queensland and New Guinea.

He was demobilised in 1944 after Kathleen suffered a serious accident, to look after her and their three sons: Stephen, born in 1937, Richard (1941) and Robert (1945).

The family moved from Pambula to Sydney where the sons could be educated and Jones started general practice in Manly. He became an honorary surgeon at Manly Hospital, and chief medical officer for the NSW State Emergency Service. In 1949, he became a fellow of The Royal College of Surgeons of Edinburghand in 1955, Jones took rooms in Macquarie Street as a general surgeon.

He tutored in surgery at the University of Sydney and in 1957 he became a Fellow of the Royal Australasian College of Surgeons.

Many appointments were to follow, to bodies such as the NSW Medical Board, the postgraduate medical committee of the University of Sydney and the Australian Council of Professions.

Jones became involved in the politics and administration of medicine, helping found the Medical Benefits Fund and forming the Australian Medical Association in 1962. He became the association's NSW president and one of the NSW representatives on the association's federal council. He was also elected to the council's economic advisory committee.

When the Gorton government introduced the national health scheme in 1969, Jones joined a working party to go to Canberra on behalf of the AMA to produce a list of fees on which government benefits would be based.

But on July 1, 1970, when that list was finalised, most general practitioners were outraged.

Following an extraordinary general meeting of the NSW branch of the AMA and a vote of no confidence, Jones and Dr Munro Alexander, who was also a representative for NSW on the association's council, tendered their resignations, which the NSW branch refused to accept.

"I think they realised they were going to lose their two most experienced men on council," Jones said.

At the next general meeting of the branch, Alexander lost his position and Jones retained his seat by about five votes. On June 6, 1973, Jones was elected president. The Herald's medical correspondent, Shaun McIlwraith, wrote at that time that Jones was "one of the more stylish of Australia's medical leaders … A veteran of medico-legal politics, Dr Jones has come across well on television and has dared to express a private opinion on controversial matters."

Twelve months later, Jones was seconded to take up a position as executive officer with the federal branch of the AMA, a period that involved the introduction of Medibank by the Whitlam government.

"The AMA decided it would not fight the introduction of Medibank," Jones said.

"It has had its ups and downs ever since. There will always be problems when money is involved. But it is here for good, and if we had not had it we might now have a form of capitation [standard payments per patient in care] or salaries, as in Britain."

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AMA in action

AMA President Dr Steve Hambleton has chalked up plenty of kilometres in recent weeks, including a visit to the Northern Territory for a range of meetings and a trip to Sydney to launch the AMA's new anti-bullying brochures.

While in Darwin, Dr Hambleton attended the AMA NT Council meeting, hosted a get-together for local doctors, had discussions with refugee advocate groups, met with the Department of Immigration's NT Detention Centre Manager, and called on senior officials from the NT Health Department … and dropped by the local ABC Radio studios.

One of the key topics of discussion in Darwin was the health and suitability of accommodation for children in immigration detention.

In Sydney, he visited Mascot Public School with Minister for School Education, Early Childhood and Youth, Peter Garrett, for the launch of new resource to combat bullying in our schools.

Dr Hambleton's travels are chronicled here …

Minister Peter Garrett and Dr Hambleton talking to Mascot school children about bullying

Dr Richard Kidd (AMAQ), Dr Hambleton, Dr Eleanor Chew (RACGP), Dr Mukesh Haikerwal (NEHTA), at the RACGP Primary Care Conference, Brisbane

Dr Hambleton outside the Northern Immigration Detention Facility

Dr Hambleton with ABC Darwin radio presenter Kate O'Toole

Dr Hambleton with Luca, school captain at Mascot Public School

Dr Hambleton with members of the AMA NT Council

Dr Hambleton with NT Health Department officials

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.

Radio

Dr Hambleton, *ABC 774* Melbourne, 14 March 2012

Dr Hambleton discusses the Australian National Health and Medical Research Council's investigation into homoeopathy.

Dr Hambleton, *2UE* Sydney, 5 March 2011

Dr Hambleton says the Government's plan to allow psychologists and pharmacists to dispense the contraceptive pill and cholesterol-lowering drugs to patients without a current prescription from their GP is the wrong approach. He says GPs have the option of writing a long-term prescription if they feel the person will need it for an extended amount of time.

Dr Hambleton, *ABC 702* Sydney, 1 March 2012

Dr Hambleton says people taking cholesterol-lowering drugs should not be concerned after US researchers found cholesterol-lowering drugs can have serious side effects. Dr Hambleton says the benefits of the drugs far outweigh the risks and if patients are concerned they should speak to their doctor.

The latest from AMSA

AMSA National Council meets to tackle crisis in medical education

The Australian Medical Students' Association (AMSA) brought together over 100 student leaders from each of Australia's 20 medical schools to the AMSA National Council meeting in Melbourne to discuss critical issues affecting medical students.

Recent news from the *MJA*

Antibiotic resistance risk in nursing homes

Residential aged care homes could become a 'reservoir' of drug-resistant bacteria because of incorrect use of antibiotics.

First case of potentially lethal tick-borne infection hits Australian shores

Doctors have reported what they believe to be the first Australian case of human babesiosis, an emerging tick-borne infection.

Diet and exercise alone could slash cancer cases

Almost 43,000 cancers could be prevented by 2025 through dietary improvements and increases in physical activity.

Heavy rain implicated in potentially deadly melioidosis

Researchers have identified the above average rainfall in Darwin in 2009-2010 as the likely cause of a recent spike in the number of cases of the disease melioidosis in the Northern Territory.

Urgent call for Australian Centre for Disease Control

Infectious diseases experts have issued a united call for the establishment of an Australian Centre for Disease Control.

Antibiotic use in farming: are humans at risk?

The use of antibiotics in Australian farmed animals should be better regulated and the use of critically important antibiotics stopped altogether.

TO COMMENT CLICK HERE

Sir Keith Jones 1911 – 2012

CONTINUED FROM PAGE 8

Jones retired from Macquarie Street and the AMA in 1976 but was immediately drawn into a project by Manly Hospital, to plan, build and administer a new modern medical and emergency centre, which he then went on to direct for seven years.

He was awarded the Gold Medal, which was the highest honour of the AMA. In 1979, he was awarded a Knight Bachelor for his services to medicine and health administration.

Retiring from clinical medicine in 1981, Jones undertook consulting work in the medico-legal field. He served on the council of Newington College for 18 years. Kathleen died in 2003 and Jones moved into a retirement home at Bayview Gardens, his sharp brain unaffected by the progressing years.

Jones died on March 2. His funeral was at St Matthews Anglican Church, Manly, on March 8. He is survived by his sons, eight grandchildren and 11 great-grandchildren.

Malcolm Brown

TO COMMENT CLICK HERE

Bureaucratic and regulatory madness

BY **DR DAVID RIVETT**

"Why such medieval protectionism of existing businesses occurs in this day and age is difficult to rationalise. The ACCC seems unprepared to rock the boat of vested interests for the public good"

Outdated and discriminatory rules and regulations are denying patients access to care in many rural locations and, I am sure, even more urban settings.

Archaic protectionism limiting fair competition between healthcare providers is all too rife, and should have been put to the sword many decades ago.

I give you some examples close to my own heart and geographic location.

I cannot place a dispensing pharmacist in the medical centre where I work because I am within 1.5 km of an existing pharmacy as the crow flies. This prevents provision of one-stop integrated medical care boosted in safety and rigour by the inclusion of an in-house consultative pharmacist. The losers are the patients. They must forgo any such intellectual input benefit and travel to a second location to get their medications.

Interestingly, the Government has recently moved to drop these regulatory restrictions if a clinic is open 70 hours a week and has, I think, seven medical practitioners. However, this change was initiated purely for politically self interested reasons, namely to try and let the disasters known as 'Super Clinics' live up to the hype they were marketed with.

Surely if regulatory freedom and change is good for 'Super Clinic' patients it is good for all. This change should not have been so perniciously enacted, nor targeted in this way.

A new radiology centre cannot be set up in Batemans Bay despite our population of nearly 17,500 as there is an existing centre in a population centre of 7,500 26 km to our south. This forces a population that is both older and poorer than average to have to travel to access care. Public transport is minimal, and many as a result simply do not access imaging.

Why such medieval protectionism of existing businesses occurs in this day and age is difficult to rationalise. The ACCC seems unprepared to rock the boat of vested interests for the public good.

More plain absurdities spring up from the Department of Health. A conscientious College recently sent off 110 signed Medicare vouchers for bulk-billed nursing home visits, only to have the lot returned.

The attached note advised that the Department was only able to process a maximum of 99 vouchers in any one batch. Do such rules exist for the public good? I really doubt it.

One can only imagine that they were instituted by a public official with too little to do and who was trying to ensure his workmates enjoyed the same ability to minimise their outputs.

TO COMMENT CLICK HERE

GP groups send strong signal on PCEHR and 'continued dispensing'

BY **DR BRIAN MORTON**

"GPs cannot be expected to undertake this work without fair remuneration. Nor, can practices be expected to self fund the processes and tools to facilitate uptake and usage of the PCEHR"

United General Practice Australia (UGPA) met recently in Canberra to discuss a range of issues including the Personally Controlled Electronic Health Record (PCEHR) and non-medical prescribing.

UGPA comprises the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association (AMA), the Australian General Practice Network (AGPN), General Practice Registrars Australia (GPRA), the Australian College of Rural and Remote Medicine (ACRRM), and the Rural Doctors Association of Australia (RDAA).

UGPA is concerned that unless the Government properly funds and supports individual general practices and individual GPs in implementing the PCEHR that the potential it offers may never be realised. GPs are united on this score.

As an electronic health record the PCEHR has the potential to reduce adverse medical events and unnecessary diagnostics or treatment. It would be a shame and a waste of resources if this potential is lost or impaired due to a failure to properly support general practice. There is no doubt in my mind that much of the effort to make the PCEHR work will be expended in general practice.

Preparing the Shared Health Summary (SHS) is a clinical service and it will require the nominated healthcare provider to undertake additional clinical work that is not currently a feature of clinical practice. It will involve reviewing the patient's file to determine relevant and useful information for sharing; direct negotiation with the patient in relation to content to be shared; and possibly some physical assessment of the patient at the time the SHS is prepared to ensure information is up to date and accurate and acceptable to both the nominated provider and the patient.

GPs cannot be expected to undertake this work without fair remuneration. Nor, can practices be expected to self fund the processes and tools to facilitate uptake and usage of the PCEHR.

Like the AMA, UGPA is also concerned at the passage of the National Health Amendment (*Fifth Community Pharmacy Agreement Initiatives*) Bill through Parliament that allows a practice known as 'continued dispensing'. Pharmacists will now be able to dispense prescription medication without a valid prescription and without consulting a patient's medical practitioner. The Government has said that it will allow continued dispensing of the contraceptive pill and cholesterol-lowering medications (statins).

Naturally, GPs are concerned that statins and the oral contraceptive pill can be continued without reference to the prescriber. The AMA strongly opposes continued dispensing not only because of the risks it creates for patient safety but because the measure will breakdown the collaborative working arrangements doctors have with pharmacists. The AMA is also concerned at the fundamental conflict of interest continued dispensing will create with pharmacists for a period now effectively becoming the prescriber and dispenser of medication.

In my view, there is no need for this measure, as the vast majority of GP have arrangements in place to ensure patients, where appropriate, are able to renew their prescriptions.

TO COMMENT CLICK HERE

Improving aged care

BY **DR PETER FORD**

"For several years, the AMA has lobbied for improvements to a number of aspects of aged care, with a particular focus on improving access to medical care"

At its first meeting for 2012, the Committee for Healthy Ageing focused on setting out its priorities and strategies for the year ahead. The Committee reflected on the difficulty in getting traction on aged care issues in the current period of hiatus between release of the Productivity Commission's report on *Caring for Older Australians* and release of the Government's formal response to the Commission's recommendations. The Government continues to give no indication of when it will deliver its response to this important report, or when it will focus its efforts on much-needed aged care reform.

For several years, the AMA has lobbied for improvements to a number of aspects of aged care, with a particular focus on improving access to medical care. At the recent Committee for Healthy Ageing meeting, members concluded it would be useful to prioritise and pursue a few of the most important issues for the AMA in the aged care sector. The Committee agreed current areas of focus should be on the implementation of more sub-acute beds as already committed by the Government; extension of MBS video consultation items to general practitioners in residential aged care facilities; and enabling medical practitioners to authorise access to subsidised respite care in emergency circumstances.

Under the *National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services*, the Government agreed to provide $1.6 billion in capital and recurrent funding from 2010-11 to 2013-14 to States and Territories to deliver and operate over 1,300 new sub-acute care beds nationally, in hospital and community settings, by the end of this period. The AMA will monitor implementation of this vital measure across all States and Territories. Having efficient sub-acute care beds available enables older Australians to access an appropriate treatment environment that allows a full recovery without forcing a premature decision to enter the residential aged care sector or inappropriate admission to the acute care sector.

Future work for the Committee in 2012 includes developing a position statement on community aged care services, and a position statement on new and emerging roles for residential aged care. The Committee is currently formalising its policy positions on medical care for older Australians in a position statement titled *Access to Medical Care for Older Australians – 2012*. Once finalised, the position statement will be available on the AMA website.

TO COMMENT CLICK HERE

Training pathways for the future

BY **DR ROB MITCHELL**

"The Forum resolved that the Council of Australian Governments (COAG) needed to take meaningful action to ensure that medical graduates continued to have access to high quality prevocational and vocational training places"

The 2012 annual AMA Trainee Forum was recently held in Sydney. With a theme of 'Training pathways for the future', the event provided an opportunity for vocational trainees from across the country to discuss current and emerging issues in specialty education. More than 40 doctors-in-training attended, including representatives from most college trainee committees. It was a very successful meeting.

With a revitalised format, the 2012 Forum featured a keynote address and four interactive policy sessions. Each of these included presentations from senior doctors, academics and vocational trainees who are recognised for their particular expertise in their relevant area.

Former Chief Medical Officer Professor John Horvath opened the program with an historical perspective on the extent of Commonwealth Government engagement in postgraduate medical education. He stressed the ongoing importance of the Australian Medical Council's accreditation framework for specialty education as well as the role of the Medical Training Review Panel (MTRP) in monitoring training numbers. Questions focused on the need to look at international models for funding quality clinical training, and the potential role of new national agencies in measuring performance in teaching and research.

After a period of useful discussion, the Forum resolved that there was a need to develop key performance indicators for medical training, and called on the MTRP to undertake this work as a matter of urgency. This is very much in keeping with existing AMA policy.

The first policy session of the day focused on building training capacity, a topic close to the hearts of many trainees. Professor Simon Willcock (Chair of General Practice Education and Training) and Dr Ruth Kearon (Clinical Advisor, Health Workforce Australia) presented perspectives on the challenges and opportunities brought about by the rapid expansion in undergraduate and prevocational training numbers.

Discussion focused on the need to build supervisory capacity, the potential to use innovation and structural reform within health services to create additional training places, the case for greater training and workplace flexibility, and the need to develop an implementation plan for HWA's Health Workforce 2025 report (which is yet to be publicly released).

The Forum resolved that the Council of Australian Governments (COAG) needed to take meaningful action to ensure that medical graduates continued to have access to high quality prevocational and vocational training places. There was agreement that COAG's decision-making needed to be informed by the analysis and findings of Health Workforce 2025.

In the next session, Professor Richard Doherty (Dean of Education at the Royal Australasian College of Physicians) and Dr Richard Hanney (General Surgeon) presented eloquently on issues and initiatives in academic medicine and surgery respectively.

Dr Hambleton, Professor Dobb, NSW Health Minister Jillian Skinner and AMACDT members at the AMA NSW Black & White Ball.

Subsequent discussion focused on the need for a defined training pathway to clinical academia, and potential solutions to overcoming barriers to undertaking education and research projects. Time and funding were nominated as particular issues. After discussion, the Trainee Forum requested that AMACDT develop a position statement around trainee involvement in academic activities, including the case for a defined clinical academic training pathway.

In a change of direction, the third session took an in-depth look at training in overseas settings. Dr John Kennedy (Emergency Physician) presented a model of remote supervision for emergency medicine trainees in Papua New Guinea, and Associate Professor Rosemary Aldrich (Public Health Physician) spoke about the Australasian Faculty of Public Health Medicine's new curriculum for global health practice.

Discussion focused on the fact that most placement arrangements were ad hoc, and that there was a need for robust personal and professional support structures, including pre-departure training.

The Forum resolved that all vocational training colleges should work cooperatively to develop models for overseas rotations that are appropriately supervised and supported. All agreed that placements should adhere to relevant ethical and training guidelines.

Dr Steve Hambleton closed the Forum by acknowledging the contributions of the assembled trainees and speakers to the meeting, and reaffirmed that medical training issues were central to the AMA's advocacy agenda.

At the end of the day, members of AMACDT attended the AMA NSW Doctors-in-Training Black and White Ball. It was an outstanding event, and provided an opportunity to acknowledge many of the junior doctors who do outstanding things in their workplaces and communities.

Thanks go to all those trainees and Secretariat members who helped ensure the Trainee Forum was a successful event. It has certainly helped inform CDT's advocacy priorities for the year. For those with an interest in vocational training, a summary of discussions and outcomes is available on the AMA website at http://ama.com.au/node/7515

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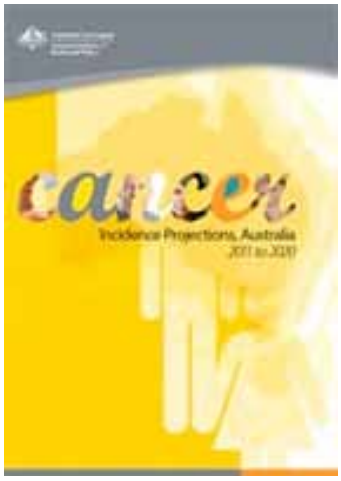
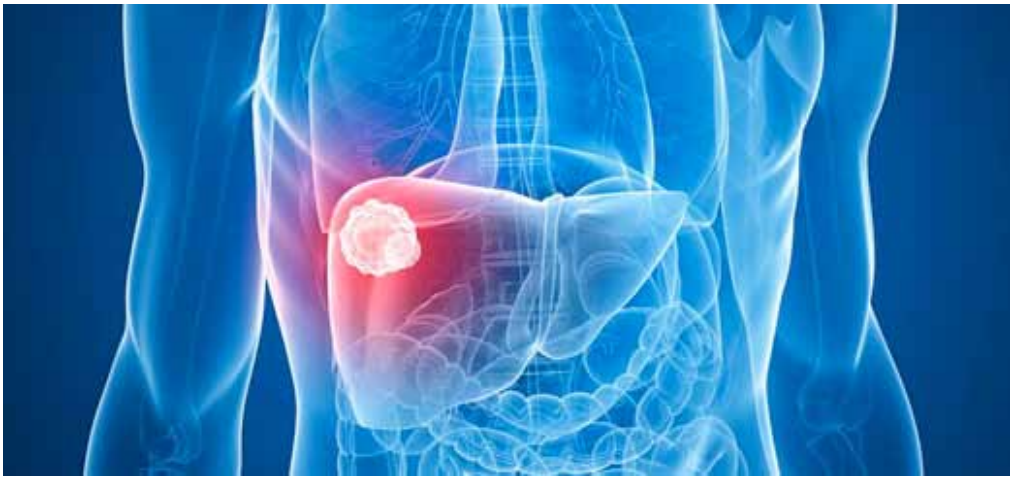
Number of new cancer cases to rise





The number of new cancer cases diagnosed in Australia each year is predicted to jump by almost 40 per cent by 2020, mainly due to the growing and ageing population, new forecasts show.

And prostate cancer and breast cancer are expected to retain their positions as the most common cancers diagnosed in men and women respectively.

The Australian Institute of Health and Welfare report says the total number of new cancer cases diagnosed each year is projected to rise from an expected 118,000 in 2011 to about 150,000 in 2020.

"This increase is expected to be most evident in older people as the Australian population ages and increases," AIHW spokesperson Chris Sturrock said.

However, the report contains some good news for men, because while the total number of cancer cases is predicted to rise for men, their cancer incidence rate (that is new cases per 100,000 population per year) is predicted to fall.

"Among males, cancer incidence is highly influenced by prostate cancer, which accounts for about 30 per cent of all cases," Ms Sturrock said.

"Early detection of prostate cancer and changes in diagnostic procedures have contributed to the sharp increases in the incidence rate of prostate cancer in recent decades.

"We expect that prostate cancer incidence will stabilise in the future, leading to an overall fall in cancer incidence rates in males from 595 to 568 cases per 100,000 between 2007 and 2020.

"Prostate cancer is expected to remain the most common cancer diagnosed in males in 2020, followed by bowel cancer, melanoma of the skin and lung cancer."

The report showed that increases are expected in rates of melanoma as well as liver, thyroid and testicular cancer, while rates of lung, stomach and pancreatic cancer for males are projected to fall.

For women, breast cancer will continue to be the most common cancer diagnosed in 2020, followed by bowel cancer, melanoma and lung cancer.

Among females, the overall cancer incidence rate is projected to rise from 394 to about 408 cases per 100,000 between 2007 and 2020.

Increases are expected in rates of melanoma, lung, liver and thyroid cancer for females, while rates of stomach cancer are expected to fall.

The cancers most on the rise up to 2020 will be liver and thyroid cancer, especially for women. Age-standardised rates for liver cancer are projected to increase by 38 per cent from 2007 to 2020 in men and by 78 per cent in women. Thyroid cancer rates are projected to increase by 33 per cent in males and 62 per cent in women.

Ms Sturrock said the report, *Cancer incidence projections, Australia 2011 to 2020*, provides a useful insight into what might reasonably be expected in the future and is of particular value in planning for health services.

She said it is important to note that projections are not exact forecasts, but give an indication of what might be expected and are dependent on current assumptions remaining valid into the future.

To see the full report, visit www.aihw.gov.au.

DV

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Weight loss and stigma

People who achieve a healthy weight loss through surgical methods, such as gastric bypass, encounter far more social stigma than those who lose weight through exercise and diet, because surgery is perceived by many to be the lazy option, a new study shows.

In a paper published in the International Journal of Obesity, researchers from the University of New South Wales School of Psychology – led by phD student Jasmine Fardouly and supervised by Dr Lenny Vartanian – set out to study what impact weight loss has on social bias against obese people.

"It's well-known that, as well as suffering adverse health, overweight and obese people are often stereotyped as lazy, incompetent and lacking self-control," Dr Vartanian said.

"Many obese people are motivated to lose weight to reduce that bias, but few studies have actually looked to see whether success in losing weight also succeeds in changing attitudes."

Ms Fardouly said they found that those negative attitudes could indeed swing markedly the other way.

"People tend to see an obese person who sheds a lot of weight as someone who eats more healthily, exercises more and is more competent and less sloppy," she said.

"But that may be because people assume the weight loss was a result of better diet and more exercise. If they are told it was the result of surgery, our findings suggest they will view a previously obese person in some of the same ways as they did before – as someone who is lazy, lacks willpower and does not exercise enough."

The study involved 73 psychology students being shown a photograph of an obese woman named Susan (not her real name), who had a body-mass index of almost 40 (much higher than a healthy BMI which is between 20 and 25). They were given Susan's basic biographical information, asked to answer a series of questions about her lifestyle, and to rate her personality and behavioural traits.

Then they were then shown a more recent photograph - similar in clothes, facial expression and pose - after Susan had undergone a dramatic weight loss, down to a BMI of just 22. Some were told that she had used either surgery or diet and exercise, while others were given no explanation.

Regardless of the explanation given, the students generally rated Susan far more favourably for having lost weight. Even those given no explanation believed she was now eating more healthily and exercising more, and was more competent than before. But those who were told that the weight loss had been achieved through surgery judged her more negatively.

Dr Vartanian said people mistakenly believe that losing weight through surgery does not require the effort and discipline that losing weight through exercise and dieting does.

"Thus, despite choosing to undergo weight-loss surgery to better their health and reduce weight stigma, obese individuals may continue to be viewed as conforming to the obesity stereotype, and hence be considered lazy and lacking willpower," he said.

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Breast implant MRI scans

The Government has announced that women with PIP breast implants are now entitled to Medicare rebates for MRI scans to check whether their implants are faulty.

The rebate will also be available in cases where a woman's doctor strongly suspects she has PIP-made implants.

The French manufacturer PIP has been prosecuted for using industrial grade silicone, instead of medical grade silicone, in its breast implants.

The French and German Governments have instructed women to have the implants removed after they were linked to higher rupture rates and a rare form of cancer.

"Medical advice from the Chief Medical Officer and an expert committee is that removal of PIP breast implants in the absence of evidence of rupture is not routinely required," Health Minister Tanya Plibersek said.

"We want women to get the best clinical care including access to a subsidised MRI scan if they choose."

The rebate will be available for one year.

The latest figures on the TGA website indicate there have been 171 confirmed cases in Australia of the implants rupturing and 26 unconfirmed reports.

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Hospitals failing on hand hygiene benchmarks

New data show that nearly one in five public hospitals are failing to meet benchmarks for hand hygiene standards.

The data, released on the MyHospital website, reveal how often staff at 233 public hospitals cleaned their hands to reduce the risk of hospital infections, including golden staph.

The data ranked Logan Hospital in Queensland as the worst major hospital performer for hand washing with an average of 44.4 per cent of staff meeting hand washing benchmarks.

Royal Darwin Hospital (55.8 per cent), Queen Elizabeth II Jubilee Hospital in Queensland (58.2 per cent), Gosford Hospital in New South Wales (58.3 per cent), and Flinders Medical Centre in South Australia (61 per cent) joined Logan Hospital in the top five worst major hospitals for hand hygiene in Australia.

The Australian Commission on Safety and Quality in Health Care has set a hand washing benchmark that requires doctors

and nurses to clean their hands with soap and water or alcohol rub on 70 per cent of the occasions a patient is touched.

AMA President Dr Steve Hambleton said that hospital doctors need to clean up their act in the wake of these findings.

"Lack of hand hygiene is associated with the spread of sometimes lethal infections in hospitals, and the latest figures show that, despite a national hand hygiene campaign last year, more needs to be done," Dr Hambleton said.

"It is time for us to pick up our game and I think we will now certainly do that."

Health Minister Tanya Plibersek said that the data should trigger hospitals rated below the national benchmark to look at how other hospitals are doing better, and focus on how they can improve their own policies and practices.

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TGA quarantines blood products

The Therapeutic Goods Administration (TGA) quarantined CSL human albumin solutions from further use earlier this month, after CSL Biotherapies notified the TGA that some of its solutions were contaminated with ethylene glycol after manufacturing equipment failed.

The company found a hairline fracture in one of the tanks used to process the human albumin resulting in ethylene glycol, used in the casing of the tank to control temperature, leaking into the protein.

The problem affects batches made before 25 January 2012.

The TGA advised that the levels of contamination detected were very low, and that adverse clinical effects were unlikely to occur.

CSL said that as far as it knew, patient safety had not been compromised.

The TGA said that supplies of human albumin are likely to be low while products are recalled.

It said that the blood service would advise hospitals and laboratories about the resupply of CSL human albumin products.

For more information on ethylene glycol toxicity, visit http://www.tga.gov.au/safety/alerts-medicine-ethylene-glycol-120308.htm

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Another one bites the dust

BY **DR CLIVE FRASER**

Holden VN Commodore

In 1990, Holden's VN Commodore was Australia's most popular new car.

Though it was powered by an old Buick V6 from a front-wheel drive US model, it still managed to be awarded the Wheel's Car Of The Year award against an inferior EA Falcon rival.

For $19,990 plus on road costs, it was great value and in the second-hand market the VN became the preferred chariot for boy-racers who worshipped Peter Brock's three previous Commodore Bathurst wins in 1980,1982 and 1984.

Unimpressed by street-racers, in 1990 my father traded in his much-loved Holden Camira on a VN Commodore and in the past 22 years he has covered only 70,000 kilometres in what has been a mostly reliable, simple to fix, and cheap to run vehicle.

There were some features of the VN Commodore that you learn to love, like the coarseness of the V6 motor, which redeems itself by taking off from the lights like a V8.

There was 125 kW from a theoretical 4,800 rpm, but the harshness of the engine wouldn't let you test those revs.

The engine's strong point was the whopping 288 Nm of torque peaking at 3,200 rpm.

In the past 14 years, Commodore sales in Australia have dropped by 60 per cent from a very healthy 94,000 in 1998 to only 40,000 last year and our most popular new car now is the much-lauded Mazda 3.

At $23,690 drive-away for a 5 speed auto Mazda 3, it's easy to see why they sell so well and I doubt that my father will buy another full-size car such as the current model VE Commodore.

But his old VN's wiring is 22 years old and unfortunately the car has stopped twice unexpectedly in traffic with electrical problems.

Those breakdowns have been fixed, but no amount of reassurance about the repairs will restore my father's confidence in the car and it's time to trade it in and move on.

If you allow for inflation, the VN Commodore would cost about $39,000 in today's dollars, significantly more than Holden's current model VE Series 2.

Holden have been selling 2011 plated VEs with a limited edition Equipe package for $34,990 drive-away.

Back in 1990, the VN made do with 14 inch steel wheels and air conditioning was an option. In 2011, the VE Equipe has 18 inch alloys and dual climate control.

Leather seats, a reversing camera and a six speed automatic transmission are but a few of the pieces of fruit in today's car.

And while the VE Series 2 Equipe's pricing seemed very keen when first advertised, GM are now offering another $750 bonus on genuine accessories.

But I'm thinking that my father doesn't really need another large car and that he'll save about $11,000 and buy a Mazda 3, just like almost everyone else.

1990 VN Commodore Executive vs 2011 VE Commodore Equipe

Specifications:

	1990 VN Commodore	2011 VE Commodore
Body	Executive Sedan	Equipe Sedan
Engine	3.8 litre V6	3.0 litre V6 DOHC VVT
Power	125 kW @ 4,800 rpm	190 kW @ 6,700 rpm
Compression ratio	8.5:1	11.7:1
Torque	288 Nm @ 3,200 rpm	290 Nm @ 2,400 rpm
Transmission	4 speed auto	6 speed auto
Kerb weight	1335 kg	1648 kg
Length	4850 mm	4903 mm
Economy	9.7 l/100 km	9.1 l/100 km
Air conditioning	Optional	STD climate-controlled
Airbags	Nil	Six
Price	$19,990 + ORC	$34,990 drive-away

Safe motoring,
Doctor Clive Fraser
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