AUSTRALIAN
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Hands off prescribing!

AMA takes strong stand on non-medical prescribing - Page 3

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Hands off prescribing

BY AMA PRESIDENT DR STEVE HAMBLETON

"It is a responsibility we take very seriously, and it is a responsibility that should not be handed over unsupervised to other health professionals who do not have the same levels of training and experience"

In response to a growing trend to grant prescribing rights to more non-medical health professionals, the AMA has adopted a formal position rejecting all forms of non-medical practitioner prescribing, with the exception of dentists.

At its March meeting in Canberra, the AMA Federal Council unanimously carried the following motion:

That Federal Council rejects all forms of non-medical practitioner (exclusive of dentists) prescribing outside of a consistent and sustainable medically delegated environment in the interests of patient safety.

The motion comes at a time when there is a concerted push by governments to expand the range of healthcare practitioners who can prescribe medicines.

We believe there is a very real risk to patient safety when expanding the roles of health practitioners beyond roles for which they are properly trained.

The risk of adverse events increases when more than one medication is taken, or used, at one time.

Only medical practitioners are trained to take a comprehensive history, examine the whole person when making a diagnosis, and initiate investigation, management and treatment.

Only medical practitioners are trained to know the full range of clinically appropriate treatments for given conditions.

In the interests of patient safety, any prescribing by non-medical practitioners should only be carried out within strict co-management regimes, with the relevant medical professional groups working with the relevant non-medical groups.

It is the AMA's view that there must be consistent and sustainable medically delegated environments that ensure:

- practitioners are prescribing within their scope of practice;
- practitioners are competent in using their knowledge and making judgements about when not to prescribe;
- patients are referred to another health professional when the patient's clinical condition is outside the scope of practice of the treating practitioner; and
- patients are referred to a medical practitioner if they fail to improve within a specified period of time.

It is important that prescribers fully understand the interactions between various medications.

Medical practitioners have extensive training in medication management and medical practitioners know and recognise the risks of adverse events from taking medications - and they know how to respond to those events.

It is a responsibility we take very seriously, and it is a responsibility that should not be handed over unsupervised to other health professionals who do not have the same levels of training and experience.

Health Workforce Australia is currently considering the safest approach to non-medical prescribing, the quality use of medicines, and the most effective use of healthcare services.

In the interests of patient safety, governments should not take any further action to expand health practitioner prescribing rights until this important work is completed.

I add that the AMA supports prescribing by dentists. Dentists are trained to prescribe medicines for dental conditions, and they prescribe within their scope of practice.

The AMA will speak out and oppose moves to grant prescribing rights to non-medical health professionals in situations outside those covered by our guidelines.

TO COMMENT CLICK HERE

Keeping the faith in politics

BY AMA SECRETARY GENERAL FRANCIS SULLIVAN

The Queensland election result amplifies the message that was so clearly sent to the Labor Government in last year's NSW poll - responding to community concerns and keeping faith with commitments is gold in politics.

Governments lose community support when they fail to convince the electorate that they have their interests at heart. Promulgating 'tough decisions' and 'hard choices' is one thing, but failing to demonstrate – or explain clearly – how these 'difficult' policies will actually improve the lot of ordinary citizens is terminal.

That said, there is no doubt that governing these days is very difficult.

What flies below the surface in public opinion polling are the everyday concerns of people and communities. The newspapers are keen to highlight topical issues and dramatic events - carbon and mining taxes, the beauty contest between leaders, or the value of a one per cent drop in the company tax. They even suggest that these factors shape the bi-weekly snapshot of the community's political preferences.

Maybe they do, but it is also common sense to note that the issues that make up the regular negotiation of life are those that matter most. It is usually the immediate concerns, the 'top of mind' worries, that consume the waking hours of people, rather than issues that are too far removed from their daily lives.

Consequently, when pollsters publish the ranking of community concerns as opposed to political preferences, health, education, housing, employment and interest rates always remain at the forefront.

Of course, this is the dilemma for political parties – remaining relevant between elections.

As is so often commented, the pervasive degree of disengagement in the community with the 'business of politics' is only matched by the enthusiasm with which television shows like *My Kitchen Rules* dominate household life over the course of the year.

Partisan politics aside, people expect their governments to soberly keep things in order and to give everyone a fair go. They expect sensible decisions that don't waste money and which favour the majority. They shy away from extremists and put their lot with those of practical experience and demonstrated prudence. Change is only embraced when it seems inevitable, and hubris and flamboyance always send warning signals. There is nothing so successful as an ordinary politician known for hard work, caution, and pragmatic decisions.

This rather colourless scenario suits an ageing demographic. One that has seen it all and outlived the lot! But not only the elderly. People on average incomes and families with little to no savings are looking to governments for economic and social security.

They can ill afford uncertain swings in their prosperity, even their prospects. Proper safety nets and affordable essential services are the bedrock for most Australians and the trust a government engenders is proportional to the degree to which they deliver these across the community.

Labor's time in office federally has been marked by its push for health reform. The AMA was initially enthusiastic about the prospects for reform - less bureaucracy, either in structures or red tape; more resources at the hospital bedside, surgery or clinic.

Sadly and disappointingly, not all this has transpired. Even though more funding has been injected into public hospitals, results on the ground are contestable. Despite favourable noises that GPs would be freed of red tape, precious real change has occurred.

Even in the face of massive infrastructure depletion in the general practice sector, the Government has persisted with building Super Clinics and mounting a relatively limited capital support programs for existing practices.

In many instances, the Government seemed to want to innovate in the face of more pragmatic alternatives.

On a positive note, medical training requirements have remained centre stage, but the cost implications and quality of the training continue to be points of tension between the Commonwealth and the other governments. That said, the system still relies heavily on the goodwill of the profession and the availability of senior doctors to spare the time to become the teachers so sorely needed.

Nobody has ever said that meeting the demands of a sophisticated health system is an easy task. However, it can be said that the political debate that surrounds health care is too often characterised by political parties promising big and delivering far less. As commentators have remarked about politics in general these days, spin prevails over substance.

CONTINUED ON PAGE 6

PCEHR - more unpaid work for GPs?

Last week's announcement from the Health Minister about Medicare rebates for preparing shared health summaries for the personally controlled electronic health record (PCEHR) raised more questions than answers.

AMA President Dr Steve Hambleton said it is still unclear whether Medicare rebates will be available for this new clinical service that GPs are being asked to provide for their patients.

"The Government has acknowledged that preparing shared health summaries with patients will require considerable extra work for GPs, but there is no clarity that the longer consultation items will apply to cover this extra work," Dr Hambleton said.

"We have been told by officials that there is no new money to cover this work. It all has to be covered under the existing MBS items.

"And we understand that there will be no changes to the item descriptors.

"So the only clarity we have about this announcement is that GPs can use existing items but do more work in the allotted time to prepare shared health summaries and take a detailed medical history.

"This simply raises more questions.

"For example, if preparing a shared health summary as part of a standard 20 minute (Level B) consultation stretches it out to 30 minutes, will the longer Level C item apply?

"Similarly, if the more complex Level C consultation stretches out to more than 40 minutes, will the Level D item apply?

"We believe the Government should create specific new items for PCEHR work and we will be having more to say on this soon.

"For now, there is no evidence that GPs will be properly funded and supported by the Government to assist patients obtain the benefits promised by the PCEHR.

"The AMA supports the PCEHR and wants to help make it work, but GPs must be supported for the extra clinical service they will be providing their patients."

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Keeping the faith in politics

CONTINUED FROM PAGE 4

Health is one of the areas where frustration in the community does translate into political perceptions.

The next federal election is already being framed within the context of trust and reliability. Being transparent with the community about what is achievable and affordable will be vital to winning that trust.

Our entitlement systems are straining and the use of market forces is not always to the benefit of all. Our workforce is ageing and access to services is suffering. With prosperity and technology come increased demand pressures and our health system still functions as if we were in the 1980s. New drugs and procedures may make for better life prospects, but they also raise the bar on affordability.

Urgent needs like dental care, proper disability support, and mental health services remain sadly underdone.

Change is essential, but so too is the explanatory story. Juggling the financial challenges of a health system so forcefully driven from both demand and supply side influences is proving to be politically unmanageable. We do need to reconfigure our system and better serve the battler as well as the entrepreneur. We do need to keep pace with improved ways to deliver services, promote wellbeing and distribute the financial burden more equitably. We do have to recognise that rationing of scarce resources is a community responsibility and not a myth.

So what is the upshot? On one side, you have well-intentioned and intelligent public servants charged with prudent use of public funds to finance health services. On the other, you have highly committed and intelligent doctors, health professionals, carers, and consumers negotiating the daily task of meeting the needs of the sick, frail, and suffering within limited resources.

It may have always been thus but unless this dynamic can be conducted within a community consensus of what is possible and what is not, the grounds for partisan political posturing and myth making will be fertile indeed.

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Better support for IMGs

The AMA has welcomed the release of the House of Representatives Standing Committee on Health and Ageing's '*Lost in the Labyrinth*' report into registration processes and support for international medical graduates (IMGs).

AMA President Dr Steve Hambleton said that the AMA values the immense contribution that IMGs make to the Australian health system.

"We are pleased that the Committee consulted extensively, including with the AMA, in its examination of how IMGs enter the system, how they are treated in it, and what can be done to improve their conditions and maximise their contribution to Australian communities," Dr Hambleton said.

"The AMA supports many of the Committee's recommendations and we stand ready to help the Government implement them, particularly those that provide improved support, greater transparency, and streamlining of processes that do not undermine standards.

"The Committee has correctly identified that Australia is too reliant on the 10 year moratorium to force overseas doctors to work in rural and remote areas and raised questions about the need for this policy into the future.

"The AMA has called for the abolition of the 10 year moratorium, because it has failed to establish a stable long-term medical workforce in areas of need, especially in rural, regional and remote communities.

"We need better, more clever solutions based on local knowledge and the Committee's report will help us achieve that goal," Dr Hambleton said.

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Taking care with medicines

The AMA last week supported *NPS Be Medicinewise Week 2012* by urging all Australians who are taking medicines, be they prescription or over the counter, to take the time to learn about their medications and to use them safely according to the prescription or the instructions.

People should carefully follow the medicines advice provided by their family GP and always consult their GP with any doubts or questions about their medication.

When a doctor prescribes medication for a patient, it is important that the patient knows what the medicine is for and why it is important for it to be taken as directed.

Doctors can inform patients about the things to look out for to know that the medication is doing its job and, importantly, they can also tell people about the tell-tale things to look out for if the medication is having the wrong effect.

It is important for people to make note of when their doctor wants to review their condition to ensure that the medication is having the intended effect.

The doctor will write a prescription for a certain period of time to make sure that the medication is the right one for the patient, and that the dose is correct.

The review is a vital part of patient care - it is crucial that people make a note in their diary and make an appointment to be reviewed by the doctor before the prescription runs out.

The pharmacist will advise when the last repeat of a prescription

has been dispensed, and this is a good time to make an advance appointment with the doctor for review. Doctors will advise patients if they do not need a further appointment when they finish their course of medication.

If people take responsibility for managing their medicines, in partnership with their doctor and pharmacist, they will get the greatest benefit from their medicines and minimise any adverse events.

More information on how to be responsible with medicines is available at www.nps.org.au/bemedicinewise

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APRIL HEALTH EVENTS

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

Sun	Mon	Tue	Wed	Thur	Fri	Sat
1 Daylight Saving ends in NSW, SA, Vic, Tas, and ACT April Fools Day	**2** World Autism Awareness Day April Falls Day	**3**	**4** Orange Hope Day	**5**	**6** Good Friday	**7** World Health Day
8 Easter Sunday	**9**	**10**	**11** World Parkinson's Day	**12**	**13** National Youth Week	**14**
15	**16**	**17** World Haemophilia Day	**18**	**19**	**20**	**21**
22 Earth Day	**23** Immunisation Week commences	**24**	**25** Anzac Day	**26**	**27**	**28**
29	**30**					

Standing up for medical certificates

The AMA was recently called upon to defend the integrity of medical certificates in the middle of a political brouhaha over the health of Federal Labor MP, Craig Thomson.

With the Federal Parliament delicately poised due to the minority Government, things have got tougher for the major parties when one of their MPs is absent from the Chamber for votes on legislation. The time-honoured tradition of 'pairing' – whereby one side of politics will take one of their people out of a vote if a member from the other side is absent from the Chamber for official business, illness, or other significant events – has become much tougher these days.

There was speculation that the Opposition would deny the Government a 'pair' for Mr Thomson over doubts of the veracity of Mr Thomson's medical certificate, which advised he be off work for a week.

This created a media debate about the integrity and trust around medical certificates. The AMA stood up for doctors and medical certificates.

At a well-attended media doorstop at Parliament House in Canberra, AMA President Dr Steve Hambleton reminded journalists that a medical certificate is a legal document.

"It's not something that's issued lightly by a doctor," Dr Hambleton said.

"In fact, it doesn't have to contain a diagnosis. All it has to say is that the doctor has certified that someone is unwell.

"Some employers want further information but that information can only be supplied with permission of the patient.

"The patient's confidentiality is sacrosanct in this country. The veracity and the high worth of medical certificates are sacrosanct as well. Employers are entitled to rely on those certificates and rely on the opinion of the doctor.

"If the doctor makes a certificate knowingly that misleads an employer, or is false, they can be subject to quite serious sanctions and they can actually be subject to both civil and criminal penalties.

"All Australians are entitled to their privacy. All Australians are entitled to keep their medical conditions confidential. I think that the doctor-patient relationship and confidentiality are very important," Dr Hambleton said.

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AMA in action

Another busy week for the Federal AMA. The President and Vice President were out and about meeting and greeting and making sure that the AMA brand was prominent in the world of politics and health. There was AMA Federal Council, the Close the Gap Parliamentary Breakfast, a visit to the Red Hill Special School in Brisbane for the AMAQ Charitable Foundation, the GPRA Conference at Parliament House, and the AMA Trainee Forum ... and that is just a selection.

Dr Hambleton speaking at the Breathing New Life into General Practice Conference in Canberra

Heads down at Federal Council

Dr Hambleton with Minister for Indigenous, Rural and Regional Health Warren Snowdon and Brad Murphy at the Close the Gap Parliamentary Breakfast

Dr Hambleton at Red Hill Special School in Brisbane for AMAQ Charitable Foundation

Vice President Professor Geoffrey Dobb at the AMA Trainee Forum

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AMA IN THE NEWS

Your AMA has been active on policy and in the media on a range of issues crucial to making our health system better. Below is a snapshot of recent media coverage.

Print

Australian Medical Association puts bosses on notice over sick leave

The Herald Sun, 20 March 2012

Australian Medical Association President Dr Steve Hambleton said he feared employers might start doubting doctors' notes after the Opposition questioned the absence of embattled Labor MP Craig Thomson from Federal Parliament.

Thomson absence causes a bellyache

The Sydney Morning Herald, 20 March 2012

The Opposition came under fire from the Australian Medical Association when it cast doubt on a certificate provided by a doctor saying Mr Thomson was unfit for work.

Patients will have to pay for e-health

The Australian, 20 March 2012

Dr Hambleton warned that, three months before the scheme was due to start, doctors did not have the computer software to upload the patient records so they could be shared.

Big Pharma to derail gravy train

The Australian, 19 March 2012

Dr Hambleton said the AMA would not oppose greater disclosure about pharmaceutical company sponsorship of medical conferences, saying he thought it would put the profession in a healthier position

Radio

Dr Hambleton, *ABC 666*, 19 March 2012

Dr Hambleton says medical certificates are legal documents, and that the doctor who wrote the certificate for Labor MP Craig Thomson should be respected, after the Opposition said his medical certificate was too vague.

Television

Dr Hambleton, *ABC 1*, Sydney, 19 March 2012

Dr Hambleton discusses the validity of medical certificates and says that all Australians are entitled to keep their medical conditions confidential.

The latest from AMSA

AMSA calls for more Indigenous doctors

The Australian Medical Students' Association (AMSA) is calling for new strategies in medical education to help close the gap in the health status and life expectancy between Indigenous and non-Indigenous Australians.

AMSA reaffirms stance against Curtin Medical School proposal

AMSA is reaffirming its call for a ban on new medical schools, including Curtin University's proposal, until all students currently in the system can be guaranteed high quality clinical training and internships.

Recent news from the *MJA*

People in pain wait five months for services

People with persistent pain are forced to suffer for months on waiting lists for pain management services.

Treating drug addiction in general practice – what really happens in the waiting room?

Patients are more likely to change practices because of waiting time then of concerns about sharing a waiting room with drug addicts.

The PBAC should set the agenda for drug subsidy decisions

The government body tasked with deciding which drugs attract subsidies is overlooking cheap and effective medicines.

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Four pitfalls of bulk billing

BY **DR BRIAN MORTON**

"As a GP, I understand the strong commitment that GPs have to their patients, particularly around bulk billing their disadvantaged patients wherever possible"

In a recent Forum article, Medicare Australia reminded doctors that when a professional service is being bulk billed, the doctor is prohibited from charging any co-payment (i.e. any other charge) for the service being provided, except for certain vaccines.

In agreeing to bulk bill the patient, the doctor has agreed to accept the Medicare rebate for that professional service as full payment for the service. Raising a separate charge, for example for dressings used in treating a patient's wound during a consultation, would contravene the Section 20A of Health Insurance Act 1973.

The AMA encourages doctors to set their fees based on their practice cost experience. Explanatory Note G.1.3 in the Medicare Benefits Schedule states that medical practitioners are free to set their fees for their professional service. Practice costs, such as employing staff, and operating expenses, such as rent, electricity, computers, continuing professional development, accreditation and professional and business insurance must all be met from the single fee charged by the medical practitioner.

The first pitfall of bulk billing is that you may not be covering these costs, or be appropriately remunerated for your service.

The second pitfall is this may threaten the sustainability of your practice.

As a GP, I understand the strong commitment that GPs have to their patients, particularly around bulk billing their disadvantaged patients wherever possible. Herein lies the second of the pitfalls of bulk billing. I suspect this recent warning from Medicare is the likely result of some practices trying to maintain their commitment to bulk billing while trying to recoup some of the increasing costs of providing medical care.

Practices can recoup the costs of providing care in a variety of ways. The efficiency gains that larger practices realise is one way. Subsidising bulk billed patients with the fees billed to other patients is another. Full patient billing is yet another. Contravening the Act, and facing possible recovery action and/or prosecution, is not a recommended option.

The third pitfall of bulk billing and raising separate charges is that it hides the true cost of providing a medical service from Government.

The fourth pitfall of bulk billing is that it excludes the out of pocket payment counting towards the patient's Safety Net thresholds. The original and extended Medicare Safety Nets are there to assist patients who have high out of pocket expenses for out of hospital MBS services.

It is important for you to review your fees on a regular basis. If you find your fees do not reflect the true costs as well as the value of the services you provide, the AMA has on its website several resources, developed by the AMA Council of General Practice, to assist you to move to patient billing.

TO COMMENT CLICK HERE

Sickness Certificates

BY **DR LIZ FEENEY**

"Often, the mistrust in the doctor simply reflects a lack of understanding of the ethical and legal requirements doctors must adhere to when providing sickness certificates"

The AMA has spoken out strongly regarding the integrity of the medical profession in relation to the provision of sickness certificates. In the media recently, Labor MP Craig Thomson sought an absence from Parliament due to a stomach complaint. Members of the Opposition questioned the sickness certificate, describing it as 'vague' and requested a second opinion be provided. The AMA President spoke out on behalf of the medical profession, clarifying that certificates do not normally require a diagnosis due to the importance of protecting patient confidentiality.

While the public nature of this incident is unfortunate, it reflects an issue faced by many doctors – a lack of trust from employers (and other relevant third parties) in the doctor's professional judgment and/or integrity in the provision of sickness certificates.

Employers have a legitimate interest in ensuring that their employee's absence from work is based on valid medical reasons.

In most cases, employers accept the certificates without issue; however, in some cases, an employer may not believe their employee is legitimately unfit for work and seeks further explanation from the doctor. When the doctor refuses to elaborate on the patient's condition, the employer may turn their frustration on the doctor. And while we would like to think that citing patient confidentiality would be enough to assuage an irate employer, it often isn't. What starts out as the employer's mistrust of the employee may end up as mistrust of the doctor.

Often, the mistrust in the doctor simply reflects a lack of understanding of the ethical and legal requirements doctors must adhere to when providing sickness certificates. At the Federal AMA, we often receive queries from the public, including employers and patients, regarding sickness certificates. We refer them to the AMA's *Guidelines for Medical Practitioners on Certificates Certifying Illness 2011* (available on the AMA's website) that clearly outline the ethical and legal responsibilities of doctors along with the responsibilities of employers and patients. The Guidelines can assist members of the public to become better informed as to what doctors can, and cannot do, relevant to providing a sickness certificate.

Further, the Guidelines emphasise the legal nature of sickness certificates, where doctors who deliberately issue a false, misleading or inaccurate certificate may face disciplinary, civil, or criminal action. When better informed, members of the public realise that doctors don't just hand out certificates lightly.

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Clinical Governance, the law and policy

BY **DR STEPHEN PARNIS**

We are all familiar with the term 'clinical governance' and its implications in our particular area and jurisdiction. Most of us would agree that a systematic approach to maintaining and improving patient care within our system is a worthwhile objective.

Of course, it requires practitioners and administrators to work together in a cooperative manner towards a common objective, and accept joint responsibility for matters that arise.

Effective clinical governance has the potential to improve patient care and provide better outcomes for staff, patients and administrators. However, it has been noted that in jurisdictions such as New South Wales, very little in the way of new policy direction is being provided to assist in this area.

Particularly in the area of risk management and incident reporting, our members are reporting that administration has become onerous, with very little corresponding benefit.

In NSW, the Department of Health and Health Administration Regulation 2005 has defined 'reportable incident' as an incident with 'serious' or 'major' clinical consequences.

Serious clinical incidents (SAC1) are reported to the Department of Health. Under the *Health Administration Act* a Root Cause Analysis (RCA) is required once an incident has been reported. Less serious incidents are investigated at the local level and aggregated data is used to identify key issues.

We are seeing an increase in the amount of documentation, policies and procedures and a corresponding increase in the number of minor incident reports. This has had an impact on service managers, with a sense that the expected standard is perfection. This may have implications for practitioners across a range of legal areas, including duty of care, employment, and possibly even criminal law. The issue of privilege relating to the information is not settled in most jurisdictions and is of some concern.

It has to be remembered, from a duty of care point of view, the standard required of practitioners is not 'perfection'. The exact definition varies among jurisdictions, but generally it is that of the 'reasonable professional'. For example, in NSW it is defined as acting in a manner widely accepted in Australia by peer professional opinion as competent professional practice.

The RCA process is often producing recommendations that are neither feasible nor likely to be effective in implementation. Departmental policies directed at risk management should reflect the general law and take from it the principles that best protect patient and doctor interests. There is no value in attempting to supplant it. This is of no help to practitioners or patients and ultimately leads to unreasonable expectations.

While we recognise that an efficient and fair event reporting system can optimise outcomes and improve quality, it should not be an undue burden, particularly at the less serious level, nor should it expose doctors to legal or disciplinary action when such action is unwarranted.

It should ideally be privileged so its aim as a tool to improve service and outcomes is optimised and to facilitate a privileged investigation designed to assist in improving services. All practitioners need to respond quickly and openly to adverse events and cooperate in their investigation but should be cautious, particularly in more serious situations.

Doctors who have concerns should seek professional advice from the Association and /or their MDO.

However, in order to make the system fairer for all users, policy needs to be updated with clearer definitions and a workable system put in place, which does not unduly burden practitioners and administrators.

TO COMMENT CLICK HERE

Funding: what's filling the gap?

BY **JAMES CHURCHILL**

"With a doubling of medical student numbers since 2001, universities and hospitals are being pushed to educate more and more students while funding remains inadequate"

In the wake of the Higher Education Base Funding Review, and with the Federal Budget 2012-13 around the corner, the Federal Government must be held accountable to rectify the chronic underfunding that threatens the quality of Australia's medical education.

The final report of the 2011 Review, commissioned as part of the Federal Government's plans to 'transform' Australia's Higher Education sector, was released in December. The authors highlighted that medicine is significantly underfunded and recommended urgent Federal Government action to increase funding to the medical education system.

With a doubling of medical student numbers since 2001, universities and hospitals are being pushed to educate more and more students while funding remains inadequate.

The total 'base funding' provided in 2011 to universities for each Commonwealth-supported medical student was $28,622, with only small additional amounts provided in the form of medical loadings. The cost of medical education is estimated to be around $50,000 per student per year.

The question must be asked - what's filling the gap? The answer is twofold.

Universities have, for some time, been increasing numbers of international full-fee students to make up the deficiency in funding for Commonwealth-supported students. Universities that offer 'MD' postgraduate degrees are also now able to circumvent the usual quotas of university places and the ban on Domestic Undergraduate Full-Fee places, and are free to enrol as many Postgraduate Full-Fee students as they wish.

Secondly, universities may be forced to cross-subsidise their medical programs using funding provided for other areas of university activity. Whether or not these practices are sustainable is a crucial question for universities, medical schools and the Federal Government.

As a result of the compounded burden resulting from chronic underfunding and increasing numbers, students are concerned that the quality of Australian medical education is under threat. While increasing the number of full-fee students may fill the gap' with respect to funding, such unregulated increases exacerbate the problems associated with increased student numbers and pose challenges for workforce planners who are already playing catch-up.

However, regulation of student numbers without correction of underfunding is unlikely to solve the issue, and may worsen funding pressures in the short term. What is needed is action on the core issue and for funding of medical education to be provided such that our medical schools are sustainable, without resorting to unregulated expansion or cross-subsidisation.

As recommended by the Base Funding Review, the Federal Government must make it a priority to urgently address issues of underfunding in the Australian medical education system to ensure that the quality of Australian medical education is maintained.

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Eliminating medication errors

One in two Australians have made a mistake with their medicines in the past year, according to research from the NPS.

In a survey of 1205 people, NPS found 57 per cent had made a mistake in the last 12 months; 44 per cent had forgotten to take a dose, while 25 per cent took a medication without food, despite differing instructions.

Other mistakes included taking a higher or lower dose than prescribed or accidentally taking the wrong medication.

In an additional survey, NPS found one in five people reported having taking an expired medicine.

AMA President Dr Steve Hambleton said that, from time to time, we all make mistakes with our medication, and while most of the time mistakes are relatively harmless, sometimes the consequences can be serious.

"When a doctor prescribes medication for a patient, it is important that the patient knows what the medicine is for and why it is important for it to be taken as directed," Dr Hambleton said.

The NPS said that patients should follow the following steps to minimise mistakes from occurring:

- Know it's a medicine – if you are expecting it to affect your body or your health, it is likely a medicine.
- Know the active ingredient of your medicine – the active ingredient of your medication may interact with other medications, including complementary medicines such as herbs and vitamins, so it is important to know what the active ingredient is.
- Always follow instructions from your doctor or pharmacist on how to use the medication.
- Ask your doctor or pharmacist questions about your medication.

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Medical workforce grows

The number of employed doctors in Australia increased by 13 per cent between 2006 and 2010, according to the Australian Institute of Health and Welfare (AIHW) *Medical Workforce 2010* report, which was released last week.

The proportion of women in the medical practitioner workforce continued to grow, from 34 per cent of employed practitioners in 2006 to 37 per cent in 2010, while the average age of all practitioners remained stable at 46 years.

Across Australia (excluding Queensland and WA), over 90 per cent of all medical practitioners worked as clinicians, of whom 36 per cent were specialists and 35 per cent were GPs.

The average weekly hours worked by employed medical practitioners decreased slightly from 43.5 hours in 2006 to 43.3 hours in 2010. Over the same period, average hours worked by men decreased slightly, while hours worked by women increased.

The supply of medical practitioners varied across areas of remoteness, ranging from 400 full-time equivalent (FTE) medical practitioners per 100,000 people in *Major cities* to 185 per 100,000 people in *Outer regional* areas.

The AIHW says that the larger supply of medical practitioners in *Major cities* reflects the much higher numbers of specialists and specialists-in-training working in *Major cities.*

When looking only at the supply of general practitioners (GPs), the numbers are quite similar—105 FTEs per 100,000 people in *Major cities* and 103 FTEs per 100,000 people in *Outer regional* areas.

Between 2006 and 2010, the number of employed medical practitioners in *Major cities* increased by 10.0 per cent and, in *Outer regional* areas, by 11.9 per cent, which was more than the population growth in these areas.

Medical practitioners in *Outer regional* areas in 2010 worked, on average, 2 hours per week more than the national average (45.3 compared with 43.3). GPs in *Outer regional* areas worked an average 44.5 hours a week compared with the national average for GPs of 39.2 hours.

The full report is on the AIHW website at www.aihw.gov.au

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‘We treat them as humans’

BY AMA SECRETARY GENERAL FRANCIS SULLIVAN

“Just imagine how long any of us would cope with a life drained of purpose, hounded by the guards, surrounded by strangers, and abandoned by the wider society”

“We treat them as humans”, the immigration official said as we sipped coffees in one of Darwin’s better cafes. Clearly there was another option.

The fact that we were even needing to discuss the everyday treatment of asylum seekers, their detention and despair, spoke volumes about the turbo-charged atmosphere created by activists and others of goodwill appalled with the human decay that passes daily as Australia’s humanitarian response to illegal boat arrivals.

The statistics are mounting and you have the sense that the ‘official line’ is tired, unimaginative and delivered in a tone that speaks of a plea bargain - desperate for acceptance yet all too aware the justification was wafer thin. Sure, the situation was complex and the predicament made all the worse with the fires of racism regularly fuelled by radio shock jocks and opportunists.

Undoubtedly, the ‘real story’ couldn’t be told because political sensitivities muzzled officials and jeopardised marginal seats. But the horror of the ‘real stories’ - the self harm and suicides, the violence and fear, reactions to the sinister, grinding regimen that does make people feel less than human - struggles to be heard within the layers of political spin, correctness, and ‘arse covering’.

The facts are compelling. Every week, Darwin’s hospital could deal with up to 10 cases ranging from attempted suicides to numerous self-harm injuries and associated acts of violence. Every day, volunteers try to instill a personal lifeline to people mired in a hopeless fug of bureaucratic processing and time wasting.

There are medical services, and detainees are permitted to attend schools, churches and recreational activities. But real life remains behind electrified fences with the nightly terrors and the ever-present fear. A fear you can taste and smell. It reeks of insecurity in one of the most guarded places you can find. And this is a place that unaccompanied minors now call ‘home’. The beds are foreign, and so too are the carers. Any comfort comes clothed in suspicion and dread. What future for a six year old whose brother can’t share her room because officials can’t verify if he is her brother at all. So a stranger must do!

Just imagine how long any of us would cope with a life drained of purpose, hounded by the guards, surrounded by strangers, and abandoned by the wider society. What price liberty?

This only makes sense if you accept that the life left behind was worse. The only sanity in this hellhole is the promise of freedom, of opportunity and new life.

Officialdom has begun to soften. The processing of families appears to have accelerated, but children still remain behind barbed fences. Community detention, a cute halfway house, is now more commonplace. So too are bridging visas where people are free to seek work, rely on Medicare, and begin to make a life. But, in all, everything is so slow, so bureaucratic, so grindingly process driven.

Access to basic health care is widely considered to be a human right. Denying this access should be regarded as a scandal. Legal rights may be nuanced depending on a person’s official status, but this does not hold for health care. Our moral duty to provide health care to others knows no legal limitation.

But the provision of health care cannot be tokenistic. Real health care means tailoring resources to meet individual needs. Take the children, for example. Specialist paediatric opinion warns that, after a week, children placed in environments like detention facilities, even just locked up accommodation, are at risk of psychological harm. The combination of anxiety and terror is a toxic cocktail. But there are no regular paediatric assessments, evaluations, and ongoing supervision for children behind bars. This, despite the fact that it is generally recognised that they, at least, are the defenceless victims in the system.

The Government has begun accelerating children out of fenced facilities. But still close to 40 per cent of asylum seeker children have not been placed in community detention. Usually they will be in the curiously named ‘alternative places of detention’ where they are locked up in secure facilities, with fences and guards, and only able to leave under supervision.

Reports from these facilities in South Australia, Western Australia, the Northern Territory and Christmas Island indicate that these are not appropriate settings for children. Places such as Leonora, in WA, are in remote and harsh locations, isolated from services and ill-equipped to deal with the array of health and other needs of asylum seeker children and their families. Leonora’s remoteness makes a mockery of the need for a fence!

Public pressure has forced the authorities to make improvements to facilities and even move people from one to the other.

CONTINUED ON PAGE 17

New Alcohol Advertising Review Board

AMA Vice President Professor Geoffrey Dobb last month assisted in launching a new national body to review alcohol advertising in Australia.

The new Alcohol Advertising Review Board hopes to counter out of control advertising and marketing of alcohol, which is contributing to increased levels of alcohol-related harm.

It will act on complaints from the community about alcohol advertising and name and shame companies with campaigns in breach of international alcohol regulations.

However, it will not have the power to penalise or order certain advertising to be stopped.

Professor Dobb said that currently there are no serious constraints on alcohol promotion.

"The alcohol industry's self-regulation has failed demonstrably, and there is not the faintest chance that their system will ever work effectively," Prof Dobb said.

"This Board will highlight the fact that more action is needed to pull the alcohol industry into line.

"We believe that it is time for the Government to act and apply regulations to the promotion and marketing of alcohol where the industry itself has failed."

The AMA urged the Government to tighten restrictions on alcohol marketing earlier this year.

Young people are exposed to multiple forms of alcohol marketing on a regular basis and studies have shown that exposure to alcohol marketing increases the likelihood of harmful drinking patterns.

Former Australian of the Year Professor Fiona Stanley will chair the Board.

The public can direct complaints about alcohol advertising and promotion to www.alcoholadreview.com.au

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'We treat them as humans'

CONTINUED FROM PAGE 16

Ultimately for the children this is but a 'band aid' solution. Incarceration in detention - even in more pleasant surroundings - is antithetical to good mental health and child development. Evidence shows that even when the children have been shifted from the high-security facilities to other guarded environments, they are still presenting with similar health issues - attempted suicide, self-harming, anxiety disorders, depression and post-traumatic disorder.

The change that is occurring is far too slow. It will be justified, but it can never be accepted. It is sobering to bear in mind that close to most of all asylum seekers end up as Australian citizens. This must not be the price of entry.

AMA President Dr Steve Hambleton and Secretary General Francis Sullivan visited the Northern Territory in March and met with doctors, activists, and health and immigration officials and were granted a tour of a detention facility.

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Another legacy for former AMA President

Former AMA President Bryce Phillips has been elected as President of Melbourne Legacy.

Melbourne Legacy provides welfare support to families of the Australian Defence Force who lose their lives as a result of their service. Legacy cares for 18,500 widows and 350 children and dependants with a disability.

TO COMMENT CLICK HERE

New national elective surgery urgency categories

The Australian Institute of Health and Welfare (AIHW) is calling for public submissions to assist with the development of new national elective surgery urgency categories.

The new categories, to be used in all Australian public hospitals, will be designed to enable more consistent, comparable, transparent and meaningful reporting of waiting times data, both within and across States and Territories.

Enhanced waiting times data, when applied to elective surgery waiting list management, will benefit patients and their families, clinicians, policy makers and service managers.

The AIHW will work with the Royal Australasian College of Surgeons to ensure an appropriate balance between standardisation of practice and clinical decision-making when assigning urgency categories.

The two organisations will consult with Commonwealth and State and Territory health authorities, and surgical and other clinical groups, but are also seeking

submissions from other interested organisations and the public.

Written submissions can be made by either post or email to:

Australian Institute of Health and Welfare
GPO Box 570
Canberra, ACT 2601, Australia
or submissions@aihw.gov.au.

Submissions should be marked 'National Definitions for Elective Surgery Urgency Categories'.

Submissions close at 5pm on Friday, 27 April 2012.

All submissions will be published on the AIHW website, unless confidentiality is requested.

For further information about the submission process or the development process for new national definitions for elective surgery urgency categories please visit www.aihw.gov.au/submissons/esucdefinitions/

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Ethics study seeking volunteers

John Neil, a PhD candidate from the University of New South Wales, is conducting a study exploring the emotional dimensions of people's experiences of ethically challenging situations in organisations.

John is particularly keen to discuss these issues with people who are dealing with such a dilemma at the moment to establish how they deal with the situation as it unfolds or develops over time.

He would like to interview people to explore the ethical challenge they are facing, the emotional dimensions of their experience and how the organisation they work in responds to the issue.

The University's ethics committee has approved this project. All the information provided will remain confidential and will be de-identified in any reports of the research.

If you are interested in participating, please go to John's website or Facebook to find out more about this research. His contacts are listed below.

Email: john.neil@uts.edu.au
Email: john@affectiveethics.com
Facebook: http://www.facebook.com/ethicsstudy
Website: http://www.affectiveethics.com

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Matters of life and death

BY **PROFESSOR STEPHEN LEEDER**

When in 1968 I worked in Papua New Guinea, my credibility fell sharply when it became obvious several weeks after my arrival that my interest in epidemiology did not mean that I had the skill to diagnose and treat rare rashes and perplexing pimples.

Epidemiologists, famed neither for their sense of humour nor their warmth, have been defined variously as voyeurs who study populations broken down by age and sex, or (rather more engagingly) as magicians who convert death certificates into airline tickets.

In which case, have some sympathy for them. Death certificates are not as plentiful as you may think. A recent document from the World Health Organisation concerning ways forward in combating the universal scourge of chronic disease contains the following surprising information.

> *Only a third of the global population lives in an area where more than 90 per cent of births and deaths are registered.*
>
> *Currently, only 38 countries have high quality cause of death data, 81 countries have lower quality cause of death data, and 74 countries lack such data altogether.*
>
> *There are some encouraging signs of increased awareness of the need for better vital statistics among decision-makers, and use of information technology holds the promise of overcoming some persistent obstacles…National initiatives to strengthen vital registration systems, and cause-specific mortality statistics, are a key priority.*

Now I fully accept that there is much more to good medical care than the information we record. The exceptional durability of the tatty paper-based hospital record alongside high-quality patient management is fair testimony: people get better and deaths are prevented yet we write down the scratchiest of detail – and we are one of the 38 countries deemed by WHO to have good statistics! Spare a thought for the others!

We may not do well with the quality of our medical records in Australia, but we do have a fine system for recording vital statistics, thanks to the Australian Bureau of Statistics, and we are in the top league. But reflect on what the state of the world's vital statistics means for managing rationally the resources available to us to preserve and promote global health.

Although anti retroviral drug treatment for HIV now has a substantial evidence base, in the early days of its application in Africa it was not possible to examine trends in HIV-associated deaths to see what it was doing. This is the problem: what to do and how to know how well we are doing in the absence of dependable evidence.

While the 'vital' in 'vital statistics' does not mean 'can't live without them' but refers to the life (and death) of the individuals recorded in them, nevertheless global health progress is limited when we cannot get a clear picture of what needs to be done nationally and internationally, and we cannot discern accurately how well we are doing. The most basic of that information is the cause of death. We all know, and studies have confirmed, major inaccuracies occur even in this measure. Certificates that are completed ignorantly or incompletely cloud the picture. But not all is gloom.

First, in several less economically advanced countries, verbal autopsies, whereby relatives provide detailed answers about events surrounding the death of a decedent, have been used effectively to gain insight into causes of death, events surrounding the death (defective care, hazardous environment etc), and as a way of evaluating the effectiveness of interventions.

Second, the WHO points to the role of information technology in remedying this state of ignorance. In India, where information technology capability is high, we are seeing interesting developments. India has fine capabilities in demography and associated statistics. These are now being supplemented by the development of a universal electronic identification system, as I commented last month. This could have profound implications for health intelligence.

Although privacy concerns are real, there are many circumstances where accurate medical data – even about causes of death – are an even greater necessity for effective planning of our health care future as a world community.

Maybe the branch of epidemiology that studies death certificates still has life!

TO COMMENT CLICK HERE

The Love Chack

BY **DR MICHAEL RYAN**

There are no successful glorious works of art or endeavours that aren't fuelled by love and commitment, and this is evident in the Eden Valley winery, Brochenchack.

The passion and love stems from proprietors Marilyn and Trevor Harch's connection with their wonderful four grandchildren whose combined names make up the winery's name; **BRO**nte, ma**CKEN**zie, **CH**arli and j**ACK**.

Throw in the skill of a sixth generation master winemaker in the form of Shawn Kalleske, whose own label, 'Laughing Jack', finds its way on to wine lists at the top end of the market, and you have a team whose end product will always represent quality over commerce.

The Brochenchack vineyard is on Pub Road and, in its day, must have been a charismatic area with a pub and horse watering stables down the road and a butchery and a brothel on the vineyard site. The latter buildings have been renovated and act as Tasting Room and Guest House. Great wine begins in the vineyard and the vinous pedigree of these 100 plus year old vines is evident as the Shiraz fruit has been going into Yalumba's premium Octavius Shiraz for years. The Riesling vines are from 1896 and believed to be the oldest in Eden Valley.

Trevor and Marilyn, also owners of the Purple Palate wine shops, are both commuting Queenslanders who feel a real connection to the vineyard. Trevor's main vocation has been in building and development but he has been unable to quash the Lutheran Germanic stirrings entrenched in his Barossa ancestors. Hence his natural attraction to the Adelaide surrounds.

The first 66 acre block was purchased in 2007 and they have an additional 40 acres acquired in 2010. At present, about 23 acres are producing a mix of Shiraz and Riesling. More Shiraz has been planted along with Chardonnay, Cabernet Sauvignon, Pinot Gris and Pinot Noir.

Shawn and Trevor see the intricate challenge of growing a thorny grape like Pinot Noir as a personal challenge. At 450 plus metres above sea level and the choice of the right clones, they may be closer to success than what is realised.

The grandchildren adore their holidays at Brockenchack and, at ages between 8 and 11, they see a future here forb themselves. The two boys have a convivial familial rivalry as indicated by Mackenzie saying to Jack, "how about you make the wine and I travel the world and sell the wine."

Trevor and Marilyn have an innate sense of the legacy that is forming. They strongly believe that while the immediate gratification of producing award winning wine from their earthly retreat is soulful contentment, it pales into insignificance when compared to the substance of a palpable bequest that will live on in the hearts of four spirited grandchildren.

The Wines

2011 Brockenchack Mackenzie William 1896 Riesling ($15)

Named after the eldest grandson, Mackenzie. One of only two gold medal Riesling winners in the 2011 Barossa Show. Also listed in the Adelaide Review Hot 100 Wines for 2011 (out of over 1,200 entrants). Enticing pale yellow colour, lime citrus nose with hints of fresh grass and ginger. The palate is moderately lush with loads of acid that zings on the palate like a lemon curd. Have with Thai grilled scallops.

2011 Brockenchack Tru-Su Rosé ($12)

Named after Trevor & Marilyn's two daughters, Trudi & Susan. Silver medal winning wine made after only hours of skin contact from premium Shiraz grapes. Pale ruby colour with strawberry nose and hint of spice. Luscious moderately sweet anterior palate with a hint of pepper. Serve chilled with an artisan pepperoni pizza.

2010 Brockenchack Zip Line Shiraz ($19)

Bronze medal winning wine. Deep ruby to purple colour. A nose full of aromatic plums that open up in the glass to more Christmas cake aromas. Full palate with dark fruit and mid palate tannins balanced by French and American oak. Try with Maggie Beer's Quince and Thyme Spatchcock.

2009 Brockenchack Jack Harrison Shiraz ($57)

Release date May 9th 2012. Named after second grandson, Jack. Serious wine from handpicked fruit. All the classic aromas of plum, blackberries, and hints of tarragon and pepper. Full palate and loads of balanced sweetness. Cellar 20 years easily. Scored 93 points from James Halliday. Try with Boeuf Wellington, a classic!

Website recently launched www.brockenchack.com.au

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Web:
www.ama.com.au/amex

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