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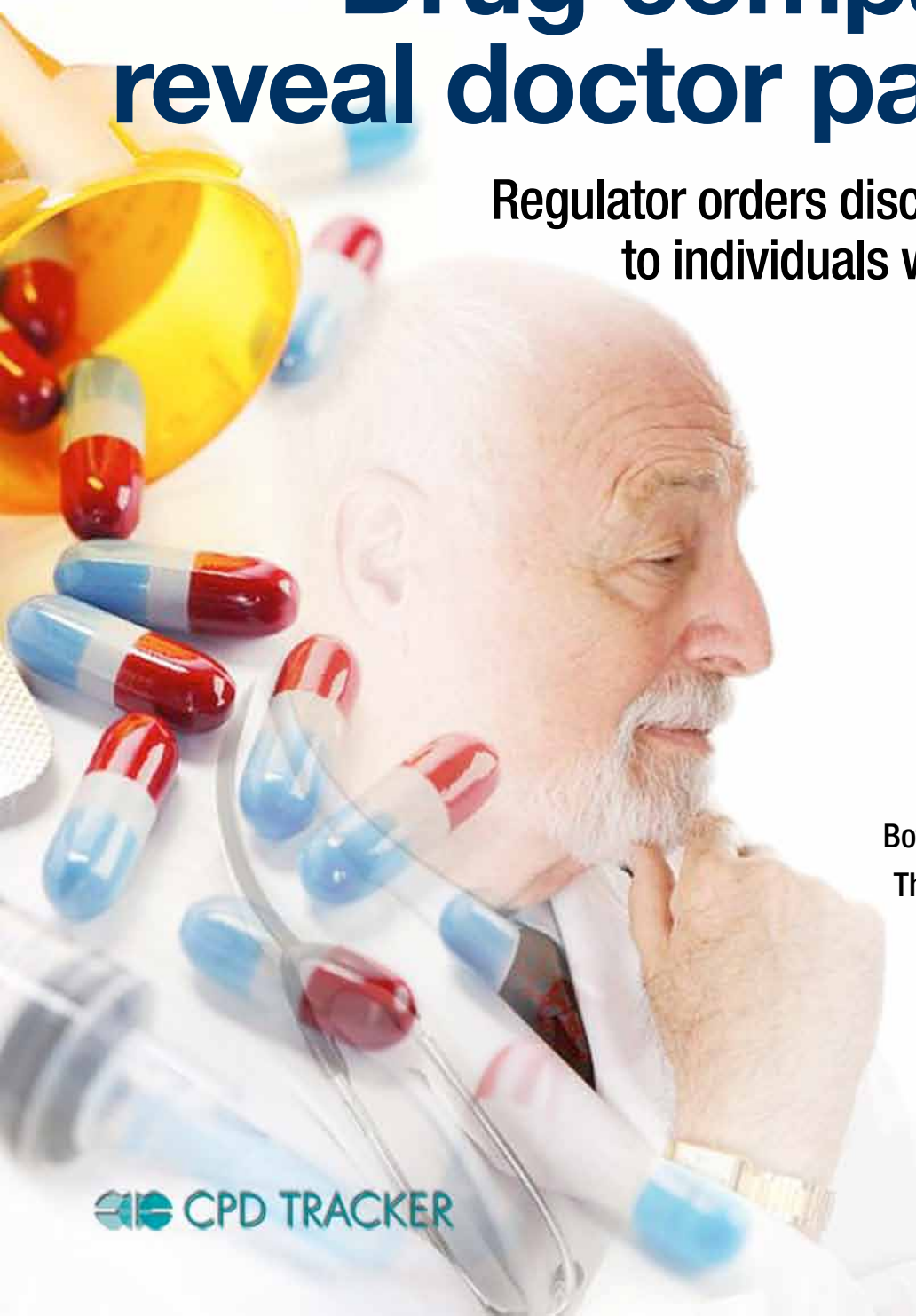
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Revalidation: Burden or Benefit?

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Revalidation seems destined to become one of the buzz words of 2013, even though the year has just started. The International Association of Medical Regulatory Authorities defines it as "... the process by which doctors have to regularly show that they are up to date, and fit to practise medicine. This will mean that they are able to keep their licence to practise."

The Medical Board of Australia have advised that they are considering the introduction of cyclical revalidation for those who wish to continue to practise medicine in Australia.

The justification they provide is that revalidation has been introduced in other "jurisdictions around the world". However, many of these have very different systems for medical education and training, and the credentialing and maintenance of medical registration.

Importantly, in our context, what might be the cost and the benefit to Australian health consumers?

As an indication of what might be envisaged, it is instructive to look at the revalidation process that came into operation in the United Kingdom from 3 December 2012.

There, revalidation will run over a five-year cycle that involves an appraisal process and the collection of a portfolio of evidence to demonstrate that the necessary standards are met.

Each medical practitioner has a 'responsible officer' who assesses the portfolio and reports to the General Medical Council (GMC) on the doctor's fitness to practice.

Responsible officers and other medical leaders are the first to go through the revalidation process, and are expected to complete it by March.

Under the new system, revalidating doctors will need to provide the following information when they present for appraisal: evidence of continuing professional development, quality improvement activity, significant events, feedback from colleagues, feedback from patients, and a review of complaints and compliments.

The GMC's *Good Medical Practice Framework* sets out the areas that should be covered in the medical appraisal, all twelve of them. They are all very worthy attributes, there is no question about that. But compliance will have a cost.

The British Royal Colleges have estimated that for full-time doctors employed by the National Health Service, this will equate to 15 per cent of their time, not including study leave, and will need to be included in job plans.

To this must be added the time taken by the responsible officers in preparing for the appraisals, undertaking interviews and preparing reports.

The interview to be conducted as part of the appraisal is unlikely to be brief, with the GMC indicating, "...your appraiser will be interested in what you did with the information and your reflections on that information, not simply that you collected it and maintained it in a portfolio. Your appraiser will want to know what you think the supporting information says about your practice, and how you intend to develop or modify your practice as a result of that reflection."

Again, a worthy objective, but teasing out these reflections will add time and complexity to the appraisal. The appraisers will need training to perform their role consistently and ensure the objectives of appraisal are met - at a further cost.

To this needs to be added the cost of the bureaucracy needed to track and record the appraisals, and a process for those whose appraisal is deemed unsatisfactory.

Quite a burden, so there should be a corresponding demonstrated benefit to patient health.

However, my literature search on 'revalidation' failed to come up with any trial to demonstrate such a benefit.

The Australian system already has multiple safeguards to ensure that medical practitioners are safe to practise: Australian Medical Council (AMC) accreditation of undergraduate medical courses; a structured and supervised intern year; AMC-accredited College vocational training programs; rigorous examinations; ongoing registration that is dependent on continuing professional development and recency of practise (with these being subject to audit); in-training assessments for doctors in training; regular appraisals for specialists working in the public hospital system; credentialing and re-credentialing for specialists working from private hospitals; and so it goes on.

The Medical Board of Australia has said it is time to begin a conversation on revalidation.

Sceptics define a 'conversation' as a pseudo-consultation process conducted by Government and quasi-Government bodies to justify a predetermined outcome.

Let's hope that isn't the intention in this instance.

The Board also indicate that their approach will be evidence-based.

The first piece of evidence needed from the many jurisdictions that have adopted revalidation is that of improvement in patient-centred outcomes.

...CONTINUED ON PAGE 9

Full disclosure of drug company payments in two years



Pharmaceutical companies have been given two years to begin revealing details of payments made to individual doctors and other health professionals, following a ruling by the consumer watchdog.

In a rebuff to the medicines industry, the Australian Competition and Consumer Commission (ACCC) has given drug companies just two years – rather than the five they had been seeking – to comply with a more stringent set of rules regarding the transparency of payments and sponsorships providing to doctors.

Responding to the announcement, AMA President, Dr Steve Hambleton said that the organisation supported moves toward greater transparency and disclosure.

“The AMA is clearly moving towards disclosure rather than away from disclosure,” Dr Hambleton said. “The priority for the AMA is to maintain the confidence of the patient that their doctor is making decisions in their best interest.”

But the AMA President warned that the two years allowed by the ACCC may not

be long enough to get a fair and robust system of disclosure in place.

The pharmaceutical industry, with the backing of the AMA, has already begun to disclose how much in aggregate it spends on sponsorships, stipends and other payments to health professionals.

The new rules, which came into effect on 11 January, are expected to show drug companies made payments of almost \$70 million a year.

But in coming to its decision, the ACCC wants to push the bounds of disclosure much further.

Laws in place in the United States call for pharmaceutical companies to publish details of payments made to individual practitioners, and the consumer watchdog wants a similar regime in place here by early 2015.

“Improving transparency around payments to individual doctors will play an important role in promoting community confidence in the integrity of these payments to health care professionals,” ACCC Commissioner Sarah Court said.

But Dr Hambleton said the fact that there was yet to be a single disclosure in the US, despite the law, showed how difficult and complex it was to establish arrangements that provided full disclosure in a way that was fair to all and did not lead to misconceptions.

Peak industry group Medicines Australia (MA) sought to put the best possible spin on the ACCC’s announcement, declaring it heralded a “new era” of greater transparency and disclosure.

MA chief executive, Dr Brendan Shaw, said his members were “firmly committed” to increased transparency regarding their relationships with doctors.

“Transparency is important because it builds public trust and confidence in those relationships,” Dr Shaw said. “Engagement with doctors is important and legitimate because patients want to be sure that their doctors know how to use the medicines they’re being prescribed. Now the nature of that engagement will be much more transparent.”

The AMA has supported moves to increase transparency, including reporting of aggregate payments made by drug companies to sponsor health professionals to attend and speak at conferences, as well as to compensate doctors who provide advisory or consulting services.

In a submission to the ACCC last year the AMA said there was public benefit in reporting the total amount of drug company sponsorships and payments, just as the public derived benefit from ethical relationships between doctors and the pharmaceutical industry.

In its submission the AMA said advice from doctors was important in developing medicines that were effective, and they were often best placed to inform colleagues of how they could be best used.

While supporting the disclosure of payments made by drug companies at the aggregate level, the AMA is more cautious about moves to disclose payments made to individual practitioners, citing concerns about the potential for misinformation and reputational harm.

In its submission to the ACCC, the AMA warned that “members of the public may make incorrect judgments about the independence of a medical practitioner merely because he or she has been individually named.

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MHS begins to shift in the face of stiff resistance from doctors

“Hardworking doctors who have been looking after Defence personnel for years are being asked to do more for less, and soldiers may end up with poorer access to the quality health care they deserve”

There are signs private provider Medibank Health Solutions is beginning to give ground on the terms of its controversial Defence health contracts in the face of fierce resistance from doctors.

Australian Defence Force personnel face a potential crisis in access to specialist medical care, with evidence that doctors have overwhelmingly rejected new arrangements being introduced by Medibank Health Solutions.

Just 8.4 per cent of specialists surveyed by the AMA survey said they had accepted an offer to be part of a preferred provider network being established by MHS, which last year won a \$1.3 billion, four-year contract to provide health services to 80,000 ADF personnel and their families.

Of 835 specialists who took part in the online survey, conducted between 30 October and 7 November, 72.55 per cent had previously provided medical services to ADF personnel.

Of these, 30 per cent reported they had rejected the MHS offer outright, and of the 61 per cent who were yet to respond to MHS, more than 95 per cent said they were unlikely to sign up.

The results bear out claims of a widespread backlash among doctors over the terms being offered by MHS, including fee reductions of up to 50 per cent and onerous reporting requirements.

The AMA has raised concerns that MHS's bungling could leave soldiers and other

Defence personnel without the health care they deserve.

“Hardworking doctors who have been looking after Defence personnel for years are being asked to do more for less, and soldiers may end up with poorer access to the quality health care they deserve,” AMA President, Dr Steve Hambleton, said.

“It is of particular concern that the MHS arrangements appear to be demeaning and disenfranchising for many specialists who have been dedicated providers of care to ADF personnel.”

Dr Hambleton was sharply critical of a lack of consultation by MHS and the ADF before implementing the new arrangements, and said the contracts on offer were “one-sided, and have an impact on privacy and clinical independence”.

“The net result is that ADF personnel may have less choice, poorer access to specialist care, and there will be a significant loss of specialists who have a strong understanding of the health needs of ADF members,” he said.

Other medical groups and allied health organisations including the Australian Society of Anaesthetists (ASA), the Australian Dental Association, the Australian Physiotherapy Association and medical defence organisation Avant, have also raised strong concerns about the MHS proposal.

Despite this, the ADF insists the transition

to MHS-provided medical services is proceeding well, saying there had been a good response to the MHS offer.

And earlier this month, Aspen Medical announced that a deal for it to provide GPs, specialists and allied health professionals at military bases “as part of the MHS contract with Defence” had been approved by the ADF.

But there are signs that resistance from doctors is forcing MHS to begin giving ground on some of its conditions.

At a meeting with ASA officials last month, the provider scrapped plans to fund subgroups within the anaesthesia Relative Value Guide (RVG) at different rates, and instead offered to apply a single unit value of \$55 across the entire anaesthesia RVG.

Despite the concession, the ASA said the MHS offer remained unacceptable, not least because the proposed fee was 27 per cent below current rates.

In a letter to MHS, ASA President, Dr Richard Grutzner, warned the agreement was “still weighted to the advantage of MHS rather than the provider or patient” and “will result in a significant number of anaesthetists simply refusing to provide elective services”.

The AMA has urged doctors to consider their situation carefully before accepting the MHS offer, including seeking independent legal advice.

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2013 – a year of scarcity?

“We have to see a systematised approach to the expansion of junior doctor training positions across Australia in 2013 ... Failure to achieve this would be nothing short of scandalous.”

Better use of scarce health dollars to support GPs, improve electronic health records, upgrade palliative care, and an end to the medical training crisis top the wish lists of medical leaders as the nation's heads into a politically-fraught federal election year.

Recognising that neither of the major parties are likely to commit to significant increases in health funding, senior AMA members including President Dr Steve Hambleton are instead urging politicians to reconsider spending priorities and direct funds to areas where they will deliver the greatest health benefit.

Dr Hambleton said the Association wanted to see “clear, properly funded policies from the major parties that support the key role of doctors in primary care”.

The AMA President said one simple change would be to redirect unspent funds from the troubled GP Super Clinics program - the Government withdrew \$44 million from the \$650 million program last year – and put it towards the successful GP Infrastructure Grants program.

Dr Hambleton said there also needed to be measures to give GPs leadership roles in Medicare Locals, greater incentives for doctors to offer aged care and after hours services, and support for longer consultations to improve management of patients with chronic health problems and mental illness.

AMA Vice President, Professor Geoffrey Dobb, said efforts should be made this year to strengthen links between Medicare Locals and Local Health Networks.

“Both are likely to find that a symbiotic relationship is needed to help them meet

their goals,” Professor Dobb said, though adding “this mustn't undermine the core values of the health system, including patient choice of provider and access to quality services”.

According to AMA Northern Territory President, Dr Peter Beaumont, 2013 could be a disastrous year for Medicare Locals unless they demonstrate solid results.

“If Medicare Locals chew up funds and do not deliver meaningful improvement to the health of Australians through existing general practice, the resulting storm that develops could be fatal,” Dr Beaumont warned.

Outgoing Australian Medical Students Association President, James Churchill, expressed hope for a boost in medical training places to prevent a repeat of last year's debacle, in which only a last-minute deal between the Commonwealth and several State and Territory governments ensured more than 100 medical graduates were not left stranded without an internship – though 46 were not so lucky.

“[I am] hoping for a long-term plan for medical training that creates sustainable models of training, with sufficient training places for Australian-trained students and doctors,” Mr Churchill said.

AMA Victoria President, Dr Steve Parnis, said politicians from all sides of politics must work together to resolve the issue this year, or stand condemned.

“We have to see a systematised approach to the expansion of junior doctor training positions across Australia in 2013,” Dr Parnis said. “Failure to achieve this would be nothing short of scandalous.”

But Will Milford, chair of the AMA

Council of Doctors in Training, was not optimistic, however urgent the problem.

“I expect to see a repeat of this year's intern crisis,” Dr Milford said. “I wish I could say otherwise, but all signs point to a repeat performance. Nothing we've seen so far points to any long term solution to this problem.”

“Graduate numbers are expected to rise again next year and no government has given any indication of how this will be managed.”

“We've tried to put this on the agenda but the political short sightedness has persisted.”

But Dr Milford expressed some hope that the pressure of a federal election might force the nation's politicians into action on the issue, raising the prospect of some resolution in the future.

“With a federal election on the horizon, hopefully health care will be on the agenda and we can advocate for concrete policy to look after Australia's health and our junior doctors,” he said. “The two are linked, and the sooner the Government realises this the better.”

The Gillard Government is likely to make great play of the introduction of the National Disability Insurance Scheme in the lead up to the election – which some tip will be held in September or October.

But Western Australian branch nominee on the AMA Federal Council, Michael Gannon, thinks that, as currently conceived, the scheme is seriously flawed – as is the Government's approach to midwife regulation.

“My first view of the NDIS suggests that obstetric indemnity premiums will need to rise significantly to cover the big

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Slapping on factor 50 not enough

Medical experts have warned that people should not to be drawn into complacency about the dangers of sunburn by the release of sunscreens offering a sun protective factor of up to 50.

For the first time, shelves are being stocked with SPF 50+ sunscreens following approval by the medicines watchdog, but AMA President, Dr Steve Hambleton, said people should not rely on stronger sunscreens alone to help protect them from the sun.

“These products offer more protection, but people shouldn’t become careless about comprehensive sun safety for themselves and their families,” Dr Hambleton said. “People should limit their time in the sun, especially during the middle of the day when they should seek out shade.”

Sunburn is a risk factor for all types of skin cancer, which claims around 2000 lives a year, and is diagnosed in more than 430,000 people each year.

Dr Hambleton said skin cancer accounts for around 80 per cent of all newly diagnosed cancers, and between 95 and 99 per cent of skin cancers are caused by exposure to the sun.

He said that sunscreen should be used in conjunction with other sun smart practices, including wearing sunglasses and wide-brimmed hats, protective clothing and using shade where



possible.

Each year about 1 million patients consult their GP to check for skin cancer, and a study recently published in the *Medical Journal of Australia* reported that non-melanoma skin cancer was the most common and expensive cancer in the country, involving more than 767,000 treatments in 2010 at a cost of \$93.5 million.

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2013 – a year of scarcity?

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cerebral palsy claims,” Dr Gannon said. “One informed opinion has them doubling. They’ve got this horribly wrong.

“At the same time, they are breathlessly promoting midwife-led care, but not requiring private midwives to get insurance in the marketplace.”

AMA Federal Councillor – Radiologists, Professor Mark Khangure, hopes 2013 will see many of the issues surrounding the use of electronic health records sorted out and a viable system get up and running.

“As a radiologist I look forward to being able to deliver the imaging studies of a patient linked to the clinical history and lab test results, and so on,” he said.

AMA Queensland President, Dr Alex Markwell, said she hoped the year ahead would see better use made of apps and programs to help with clinical decision-making, while AMA Emergency

Physician representative, Dr David Mountain, thought it time there was “real” policy and funding to support the making of end of life decisions and care.

But AMA Treasurer Dr Peter Ford thought 2013 was likely to see increased demands made of patients to increase their contribution to the cost of their care, while cost concerns would drive Government to increasingly interfere in decisions regarding the subsidisation of medicines.

“[One of the] major developments in health and medical practice will be the realisation that the public and private funders will not entirely cover costs, and there will inevitably be more means-testing and a patient contribution,” Dr Ford said. “Despite the political claims, we are seeing limitations imposed, with Government overriding the Pharmaceutical Benefits Advisory Committee.”

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Alcohol and energy drinks a toxic mix



The dangers of mixing alcohol with energy drinks and playing in and around water while intoxicated have been highlighted by the AMA in an effort to ensure people have fun safely this summer.

AMA President, Dr Steve Hambleton, said that summer was a great time for people to relax with their family and friends, and potentially harmful or tragic incidents could be avoided by exercising just a little care in how alcohol was used.

The AMA President cautioned the thousands of young people flocking to the beach, outdoor concerts and parties, to resist the temptation or pressure to mix alcohol with highly caffeinated energy drinks in an effort to keep partying.

Dr Hambleton said mixing such drinks had become a popular but dangerous habit that was not only harmful, but potentially deadly.

“The combination reduces the perception of intoxication and allows people to drink for longer,” he said. “It can lead people to consume excessive amounts of alcohol and caffeine, both of which can be harmful on their own, but potentially lethal when consumed together.”

More than 15 per cent of calls to the New South Wales Poisons Information

Line have been triggered by the consumption of energy drinks with alcohol, and the United States’ Food and Drug Administration has launched an investigation into the health effects of energy drinks amid reports that they have caused 18 deaths and harmed more than 150 people in the last five years.

Dr Hambleton said people needed to take the risk of combining energy drinks and alcohol seriously, warning it could lead to dehydration, particularly in warm weather, while impairing judgement and encouraging greater alcohol consumption as well as sending mixed signals to the nervous system that could trigger heart and sleeping problems.

Last year the AMA launched a major report highlighting the ways alcohol companies were targeting the marketing of their products to young people, and Dr Hambleton said there was a concern that energy drink companies were following a similar strategy.

The AMA President also urged holidaymakers to exercise care in and around water, particularly where alcohol was involved.

Dr Hambleton said there was “always an element of danger” involved in water activities such as swimming, surfing, diving, boating and jet skiing, and risks were amplified when people had been drinking.

He said alcohol severely impaired judgement and led to poor decision-making, often with tragic consequences.

“Every summer there are tragic instances where people are seriously injured, and even killed, in situations involving water and alcohol consumption,” the AMA President said. “Games that involve holding your breath underwater for long periods might seem fun, but can actually lead to drowning. There was a tragic example of this during Schoolies Week.”

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Full disclosure of drug company payments in two years

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“Public reporting does not allow medical practitioners to explain the nature of the relationship as they can on a one-to-one basis with a patient.

“Any public reporting mechanism would have to ensure patients are fully informed about the nature of the payment.”

The AMA is part of a Transparency Working Group set up by Medicines Australia to examine how public reporting of payments made by pharmaceutical companies to individual practitioners should be best managed to address these concerns, warning that if it was not handled correctly it could discourage doctors from undertaking work with drug companies that was in the public benefit.

“If not done correctly, public reporting has the potential to misinform the public, and could unduly affect a medical practitioner’s reputation,” the AMA said. “Further, the sensitivity and impact of publicly reporting elements of individual health professions’ personal incomes needs careful consideration. Significant work would need to be done to develop the right reporting framework and mechanisms for correcting errors.”

While acknowledging these concerns, the ACCC did not consider them to be grounds for substantial delay.

In announcing its decision for the introduction of a more comprehensive disclosure regime, the Commission said it believed issues regarding disclosure of individual payments “can be substantially addressed in the next 12 to 18 months, and an amended Code completed by early 2015”.

Dr Shaw said the two-year time frame was “reasonable”.

“We anticipate getting our Transparency Working Group process completed within that two-year timeframe”.

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Claims that measles is ‘marvellous’ rubbished



A book claiming that contracting measles can be a “good thing” for children has been strongly condemned by AMA President, Dr Steve Hambleton.

The book, *Melanie’s Marvellous Measles*, written by Brisbane-based anti-vaccination campaigner Stephanie Messenger, is aimed at “educating children on the benefits of having measles, and how you can heal from them [sic] naturally and successfully”.

According to Ms Messenger, who claims one of her children died as a result of a vaccination, the book takes “children on a journey to learn about the ineffectiveness of vaccinations and to know that they don’t have to be scared of childhood illnesses like measles and chicken pox”.

The front cover of the book, self-published through Trafford, depicts a happy girl in a garden with a rash on her stomach.

Dr Hambleton told *news.com* the publishers of the book “should be ashamed of themselves”.

“Last time I saw a kid with measles with a rash, they were carried into the surgery and the child looked like a rag doll. The mother was terrified,” he said.

Dr Hambleton said measles could lead to potentially fatal complications such as encephalitis, and could not be cured – as the book suggests – by carrot juice and melon.

“Any publication that suggests getting the illness is safer than getting the vaccination is patently wrong and misleading, and the publishers should be ashamed on themselves for the picture they’ve allowed to be put on the front cover,” he said.

The medical and scientific communities have recently intensified their efforts to provide accurate information about the benefits

and risks of immunisation in the face of a rash of misleading and alarmist claims about the dangers of vaccination.

In November the AMA endorsed publication of the booklet *The Science of Immunisation: Questions and Answers*, which was produced by the Australian Academy of Science to dispel myths and misinformation about the dangers of vaccination.

In a recent article at *The Punch* (to view, click here), world-renowned Australian research biologist Sir Gustav Nossal condemned the arguments of anti-vaccination activists as “fatally flawed”, and last month the New South Wales Office of Fair Trading gave the anti-vaccination lobby group the Australian Vaccination Network two months to change its name, judging it to be “misleading and a detriment to the community”.

Copies of *The Science of Immunisation: Questions and Answers* booklet can be obtained by contacting the AMA, either by email at:

media@ama.com.au, or by writing to:

AMA Public Affairs
AMA House
42 Macquarie Street
Barton, ACT
2600

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Revalidation: Burden or Benefit?

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Without such evidence, revalidation will be a burden without benefit.

The momentum behind revalidation may be irresistible, but if there is no evidence of patient benefit, let’s be clear that introduction of Medical Board-based revalidation has no more justification than any other fashion.

Application of revalidation across all health professions covered by the Australian Health Practitioner Regulation Agency - there appears no justification for limiting it to just medical practitioners - is an overhead cost our health system doesn’t need without clear evidence of benefit, particularly when every dollar is needed for direct patient services.

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GPs told to ration mental health care as system struggles

“Dr Hambleton said that, before it was cut, the Better Access program had been very successful, providing services to more than one million people, including 150,000 from disadvantaged areas”

Moves by a Queensland Medicare Local to ration GP referrals to psychological services has borne out AMA fears that Government cuts to the Better Access program would undermine mental health care.

Australian Doctor has obtained a letter from John Torpy, acting Chief Executive Officer of Greater Metro South Brisbane Medicare Local, in which he advises GPs they will be limited to just three referrals each to the Access to Allied Psychological Services (ATAPS) program in a six-month period.

In the letter, sent to GPs on 17 December, Mr Torpy said that since the establishment of the Medicare Local, the number of referrals to the ATAPS program in the area had trebled.

“To ensure that the program achieves equitable service availability for both clients and providers, a decision has been made to limit the number of Tier 1 (General) ATAPS referrals to three referrals per GP,” he wrote. “Inappropriate referrals or requests for further sessions cannot be accepted.”

The decision bears out warnings made by the AMA almost 18 months ago that the decision by the Government to slash funding for the Better Access program would result in reduced care for the mentally ill.

In the 2011-12 Budget the Government cut more than \$580 million from Medicare

rebates for patients receiving mental health care from their GP, with the money freed up used to fund other parts of its mental health package.

At the time, the Government argued that the shift would result in better mental health services for people in disadvantaged areas.

But, in a submission to a Senate inquiry following the decision, AMA President, Dr Steve Hambleton, warned the cuts would “impact heavily on vulnerable patients and reduce access to vital GP mental health services by making them less affordable”.

A survey of 404 GPs conducted by the AMA last year following the cuts to the Better Access program lent weight to these concerns.

It showed that the proportion of GPs who were bulk-billing patients for providing them with mental health treatment plans had dropped from almost 80 per cent before the cuts to less than 39 per cent, while over the same period the proportion charging a co-payment of \$31 or more for mental health treatment plans had climbed from less than 30 per cent to 40 per cent.

Dr Hambleton said that, before it was cut, the Better Access program had been very successful, providing services to more than one million people, including 150,000 from disadvantaged areas.

Analysis by the AMA showed that the cuts would virtually halve rebates for GP mental health services.

“They will impact heavily on vulnerable patients and reduce access to vital GP mental health services by making them less affordable,” Dr Hambleton warned in his submission. “People with mental illness will have to pay more to see their GP for vital mental health care, advice and referrals.”

The ATAPS program was established in the 2001-02 Budget to address chronically poor access to mental health care for traditionally ‘hard to reach’ groups, including those in Indigenous communities, young people and the homeless.

But Dr Hambleton said the decision by the Greater Metro South Brisbane Medicare Local to ration access to ATAPS undermined its ability to reach such groups, casting into doubt the Government’s stated rationale for cutting back the Better Access program, which was that ATAPS would be more effective in delivering mental health care to the disadvantaged.

“The 2001-12 Budget cuts were clearly all about the Budget bottom line, and nothing to do with improved outcomes for mental health patients,” the AMA President said.

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Jabs in pharmacies wrong: AMA



The AMA has objected to proposals to allow pharmacists to administer injections without big improvements in training and the imposition of strict conditions and controls.

Responding to *Draft Practice Guidelines for the Provision of Immunisation Services in Pharmacy* by the Pharmaceutical Society of Australia (PSA), the AMA said it could not support legislative changes to allow pharmacists to administer injections until such procedures were included in core pharmacist training, and were not just an adjunct.

The AMA clashed with pharmacists late last year on this issue when a national pharmacy chain offered patients discounted seasonal flu vaccines administered in the store by a qualified nurse.

AMA President Dr Steve Hambleton said at the time that vaccinations, including the annual flu jab, should only be administered by a GP and not performed in a local chemist.

“The AMA has a lot of concerns with pharmacies offering vaccinations,” said Dr Hambleton. “There is no privacy. Patients

need to be made aware of possible side effects and discuss their medical history. What private room can a pharmacy offer a patient?”

Dr Hambleton said any nurse who administered a vaccination must be able to diagnose anaphylaxis.

“I want to know who will deliver the needles, they need specific training. What questions are asked before the vaccine is administered? And where will they record the information?”

“This fragments the health record, because then we have patients coming into the GP to say they had some kind of needle at a chemist.”

The AMA said the PSA’s draft guidelines aligned with the principles promoted in the AMA Position Statement – *Vaccinations Outside of General Practice – 2011*, but could be further improved by:

- ensuring appropriately qualified and authorised registered nurses also held a statement of proficiency in CPR;
- pharmacies were able to demonstrate adherence to vaccine management policies and protocols; and
- ensuring consumers were asked if they had a regular GP and, if so, if they would consent to that GP being provided with a copy of their vaccination statement.

Dr Hambleton said vaccinations provided outside of general practices should be subject to the same proficiency and safety and quality requirements as those provided within a general practice.

KW

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Going somewhere this summer?

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

Whether it be an expedition across the other side of the world or a brief sojourn down the road, here’s the chance to share your thoughts and experiences, from the exhilarating and glorious to the tedious and disastrous.

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

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

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AMA IN THE NEWS

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

Print/Online

Alcohol, water don't mix, *The Hobart Mercury*, 8 January 2013

http://www.themercury.com.au/article/2013/01/08/369944_tasmania-news.html

AMA President, Dr Steve Hambleton, warned holidaymakers to be careful playing in and around water, and advised against such activities while drinking alcohol.

Turning off airconditioners to save money 'may prove fatal', *The Daily Telegraph*, 7 January 2013

<http://www.dailytelegraph.com.au/news/turning-off-airconditioners-to-save-money-may-prove-fatal/story-e6freuy9-1226548518534>

AMA President, Dr Steve Hambleton, said soaring electricity prices could have killer consequences on hot days if people at risk of heat stroke turned off their air conditioners to save money.

Free covers to filter cigarette pack warnings may be illegal, *The Age*, 4 January 2013

<http://www.theage.com.au/national/health/free-covers-to-filter-cigarette-pack-warnings-may-be-illegal-20130103-2c797.html-ixzz2HL3HZzOM>

President of the Australian Medical Association, Dr Steve Hambleton, condemned a decision by tobacco franchiser, the Tobacco Station Group, to offer free cigarette packet covers to smokers to hide new plain tobacco packs, which carry graphic health warnings.

In the line of fire, nation set for soaring 40s, *The Australian*, 3 January 2013

<http://www.theaustralian.com.au/news/health-science/in-the-line-of-fire-nation-set-for-soaring-40s/story-e6frg8y6-1226546818081>

The Australian Medical Association warned people of the dangers posed by a heatwave that baked the nation in early January. AMA President, Dr Steve Hambleton, said there were particular concerns for the health of young children and the elderly.

Longer wait, further travel for health services, *The Age*, 3 January 2013

<http://www.theage.com.au/victoria/longer-wait-further-travel-for-health-services-20130102-2c5n1.html>

AMA President, Dr Steve Hambleton, said changes to the Medicare rebate for telehealth services would force some patients to revert to travelling long distances for care. He said doctors had protested against the Medicare Benefits Schedule rebate cuts, which would interrupt the care many patients had received in the past year.

Radio

Dr Hambleton, 774 ABC Melbourne, 10 January 2013

AMA President, Dr Steve Hambleton, condemned the publication of a children's book claiming it was safer for children to contract measles to be vaccinated.

Dr Hambleton, 2GB Sydney, 8 January 2013

AMA President, Dr Steve Hambleton, advised people to sit under a fan and stay out of the direct heat during a day when the temperature in many areas topped 40 degrees Celsius.

Dr Hambleton, ABC 666 Canberra, 7 January 2013

AMA President, Dr Steve Hambleton, talked about the risks of drinking alcohol in less developed countries following the death of a Perth teenager who consumed a drink spiked with methanol while holidaying on the Indonesian island of Lombok.

TV

Dr Hambleton, *A Current Affair*, 9 January 2013

Dr Steve Hambleton, President, Australian Medical Association, said it was dangerous not to vaccinate children, especially against diseases such as measles and diphtheria.

Dr Hambleton, *The Project*, 7 January 2013

AMA President, Dr Steve Hambleton, discussed online DNA testing kits, expressing concern about a lack of regulation of such products.

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AMA in action

AMA President Dr Steve Hambleton started the year off with a jib jib job by attending the 23rd Australian Scout Jamboree in Maryborough. He volunteered to lend a helping hand as did many other fellow doctors if any medical emergencies arose.

Dr Hambleton was also busy talking to the media. He spoke the Channel 10's *The Project* about online DNA testing.

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AMA President Dr Steve Hambleton preparing for an interview on *The Project*



Dr Hambleton being interviewed on *The Project*



Dr Hambleton standing outside the entrance to the 23rd Australian Scout Jamboree



Dr Hambleton with fellow doctors at the Scout Jamboree

Aspiring doctors losing ground on pay rates

Starting salaries for medical graduates are growing more slowly than for many of their peers as governments clamp down on health spending.

Figures compiled by Graduate Careers Australia show that the median starting salary for medical graduates rose by just 2.5 per cent last year, compared with an average gain among all graduates of 4 per cent.

While medical graduates remain among the best remunerated in the country – with a median starting salary of \$60,000, compared with the national average of \$52,000 - data show their advantage over graduates from other fields is slowly being eroded.

Dentistry graduates remain the best rewarded, with a median starting salary of \$80,000, rising to almost \$97,000 for those in private practice, closely followed by optometry graduates, whose median annual salary jumped almost 13 per cent to reach \$79,000 last year.

Graduates in the earth sciences enjoyed a similar surge in earnings to reach a median starting salary of \$73,000 – putting them third in the ranking of graduates earnings, well ahead of fourth-placed engineers (\$63,000) and fifth-placed medical graduates.

While medical graduates are not the best paid, traditionally they have enjoyed the best employment prospects, and this continued to be the case last year.

The Graduate Careers Australia study showed that more than 98 per cent were in full-time work within four months of completing their undergraduate degrees.

By contrast, just 54 per cent of graduates with visual or performing arts degrees found full-time jobs in the same period.

But the virtual guarantee of work for medical graduates is

threatened by the failure of governments to provide enough pre-vocational internships to match the growth in medical school places in recent years.

In November last year a shortfall of 162 internship places was only partially averted by a hastily arranged deal between the Commonwealth and several State and Territory governments to provide an extra 116 positions, leaving 46 graduates in limbo.

With the number of graduates set to swell even further this year, there are fears that without a permanent solution negotiated between the Commonwealth, State and Territory governments, hundreds of aspiring doctors may be denied the opportunity to complete their education, a great cost both to themselves and the community.

Top 10 median graduate starting salaries

Discipline	Median starting salary (\$)
Dentistry	80,000
Optometry	79,000
Earth sciences	73,000
Engineering	63,000
Medicine	60,000
Mathematics	57,000
Education	56,000
Physical sciences	55,000
Law	53,000
Computer science	52,500

Source: Graduate Careers Australia

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Don't let her drink dirty water

malaria, typhoid, dysentery, cholera, diarrhoea, intestinal worm infection, ... dirty water can kill.

6,000 children are dying every day – and it's because they don't have clean water. So they're forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

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INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

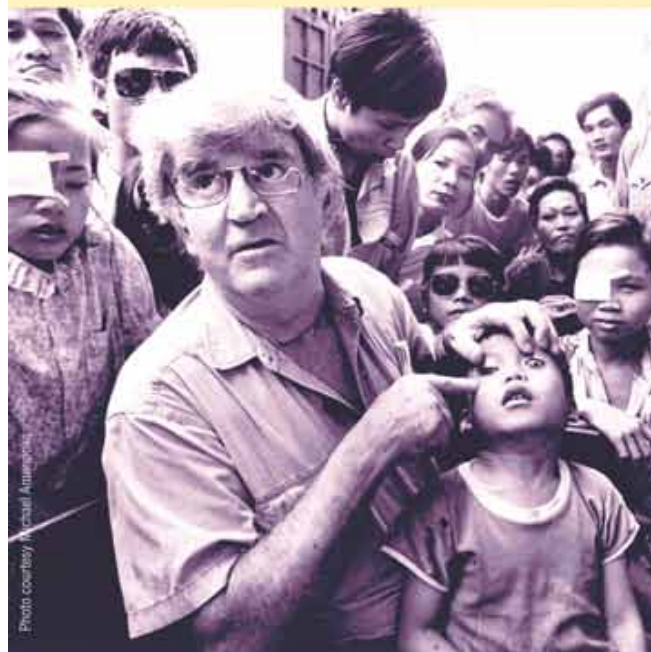
If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

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

Email: careers@ama.com.au

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The Fred Hollows Foundation

Fault could leave asthmatics breathless

Asthmatics reaching for their inhaler have been warned they may need to take an extra puff or two in order to get relief following the discovery of a fault affecting thousands of common asthma treatments.

Up to 50,000 Ventolin and Asmol inhalers are being urgently recalled because a problem in the delivery mechanism means that users get less than the full dose of the medicine.

The recall was announced on Christmas Eve, and the Therapeutic Goods Administration said asthmatics needed to be aware of the problem, and the possible need to take extra puffs from their inhalers in order to get relief.

"It is important that consumers are not alarmed by this recall but, at the same time, they need to be aware that there is a possibility that their asthma relievers may not be supplying the correct dosage in each puff," a spokeswoman for the Administration said.

Pharmaceutical companies GlaxoSmithKline and Alphapharm have commenced a voluntary recall of all affected batches of the medicine, though the TGA said the problem did not totally compromise the effectiveness of the treatment.

"If you have an inhaler from an affected puffer within an affected batch, the dose delivered may still treat your asthma symptoms," the medicines watchdog said. "[But] you may need to take one to two extra puffs to get the expected effect from your usual dose."

The TGA has advised doctors to be alert to the possibility that patients suffering deterioration in their respiratory symptoms may be using faulty inhalers.

"Patients presenting with worsening respiratory symptoms, and who are using the affected inhalers, may have symptoms attributed to this recall," the Authority said. "Alternatively, the symptoms may be due to underlying worsening of the patient's airway disease."

The batch numbers of the medicines being recalled are:

- Ventolin – KN7170, KN7173, KN7178 and KN7179;
- Asmol – KL6790, KL6795, KL6796, KL6797, KL6798 and KL6799.

The batch number is located at the bottom of the canister label, and all affected inhalers can be returned to pharmacies for replacement.

Manufacturers estimate that between 25,000 and 50,000 inhalers are affected by the fault, out of around 900,000 distributed each month.

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

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

To be in the running for a chance to win the iPad Mini, please send your entry to ausmed@ama.com.au by 28 February, 2013.

Limit of one entry per member.

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

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

The winning entry will be published in the 11 March, 2013 edition of *Australian Medicine*.

Push to subsidise rapid HIV test

Sexual health experts have urged the Government to subsidise access to a rapid screening test for HIV, following its approval by the medicines watchdog.

In a development hailed by public health advocates as an important advance in combating the spread of HIV, the Therapeutic Goods Administration last month registered the Alere Determine HIV Combo test, which produces a preliminary result within 30 minutes.

The convenience and rapid results of the test are seen as important improvements in encouraging people to be screened for the potentially deadly disease more often, improving infection control and treatment.

“Rapid testing will increase the likelihood that people at risk will come forward for HIV testing, and be tested frequently,” Australasian Society for HIV Medicine Vic President, Philip Cunningham, said. “Diagnosing HIV early is a priority, as this is when the infection is most contagious, and making testing easier also facilitates the identification of HIV at this crucial stage.”

Approval of the test has come amid alarm at an apparent increase in HIV infection rates.

More than 1130 people – mostly men – were infected with HIV in

2011, according to figures compiled by The Kirby Institute, up 8 per cent from the previous year, significantly above the average annual rate of increase of 5 per cent – though some of this jump may be attributed to increased immigration from sub-Saharan Africa, where rates of infection are much higher.

According to The Kirby Institute, almost 25,000 people were diagnosed with HIV by the end of 2011, though health workers believe there may be a further 8000 people who are infected but have not been diagnosed.

The Royal Australian College of Physicians said approval of the testing kits was a “welcome” initiative, but needed to be backed up by Government subsidies.

The College said the next step was to make access to the test equitable by funding it through Medicare.

“Making the test for HIV more accessible, and producing near immediate results, has the potential to increase rates of those getting tested,” said sexual health medicine expert, Associate Professor Richard Hillman. “Providing this important test across Australia will enable more people to get tested quickly, potentially encouraging a reduction in transmission figures.”

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Health alert on dieting supplement

Bodybuilders, dieters and other users have been warned that a supplement being bought online to shed weight contains dangerous substances and poses a “serious risk” to health.

In the latest such incident highlighting the dangers of buying health supplements online, the Therapeutic Goods Administration has issued a safety alert regarding Albuterex Xtreme Formula, which has been found to contain several restricted and prohibited ingredients and “very high” levels of caffeine.

The Administration said tests had shown the product contained several undisclosed substances including yohimbine, a prohibited import;

theophylline, the active ingredient in several prescription-only treatments for bronchospasm relief; and very high concentrations of caffeine.

“The combined stimulant effect of caffeine, yohimbine and theophylline may pose [a] serious health risk to people consuming this product,” the TGA warned, adding that its supply in Australia was illegal.

“Albuterex Xtreme Formula has not been assessed by the TGA for quality, safety and efficacy as required under Australian legislation, and the place of manufacture is not approved by the TGA,” the watchdog said.

Despite this, the TGA said investigations

had shown that “a number of people” in Australia have bought the product online.

It advised anyone with the supplement to stop using it immediately, and take it to a pharmacy for safe disposal.

It said it was working with Customs to help prevent future shipments, and any capsules found at the border would be seized and destroyed.

Last year the TGA banned the stimulant DMAA, which was a common ingredient in many dietary supplements for body builders, because of potentially lethal side-effects including high blood pressure, headaches, vomiting and stroke.

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Medical community remembers leading health academic



Gavin Mooney and Delys Weston

Renowned health economist Gavin Mooney who, with his partner Delys Weston, was murdered in shocking and tragic circumstances at their Tasmanian home just before Christmas, was often a harsh critic of the medical profession in general, and the Australian Medical Association in particular.

In his most recent book *The Health of Nations* (reviewed in the 3 December 2012 edition of *Australian Medicine* – to view, click here), Professor Mooney accused doctors of conniving with pharmaceutical companies to prioritise the health of the wealthy above that of all others.

But AMA President, Dr Steve Hambleton, said that although the 69-year-old health economist was frequently critical of the medical profession and the AMA, this was driven by concern about inequities in health rather than animosity, and should not overshadow the important contribution he made to the field of health economics.

Dr Hambleton, who met Professor Mooney during a recent visit to Tasmania – where he and Dr Weston had moved after spending more than a decade as director of Curtin University's Social and Public Health Economics Research Group – said the academic did much to develop understanding of the economics of health and strove to improve equity in access to care.

“He was a charismatic speaker who had a great talent for making complex financial concepts clear to whoever he was speaking to,” Dr Hambleton said.

The AMA President paid tribute to the work Professor Mooney did during his 40-year career, particularly in helping carve out health economics as a distinct area of study.

Dr Hambleton said that, thanks to the academic and his colleagues, much more was now known about the real costs of health care, as well as disparities in health outcomes and access to care.

As an adjunct to his academic research, Professor Mooney publicly campaigned for the need to involve the community directly in decisions affecting their health care, particularly Indigenous Australians.

In *The Health of Nations*, he argued the case for citizen juries to set the principles and priorities for health services, and Justin Mohamed, chair of the National Aboriginal Community Controlled Health Organisation, said the health economist had an “enduring commitment” to improving Aboriginal health, a view shared by Dr Hambleton.

“He was a strong advocate for community consultation, including Aboriginal community consultation, and helped deliver that in Australia,” he said.

It was not just inequities in Indigenous health that drew his ire.

In a tribute published in *The Age*, close colleague Alan Shiell also recalled Professor Mooney’s “disgust” at what he saw as AMA plans to offer inducements to lure doctors from developing countries to practise in Australia – an issue he revisited in *The Health of Nations* when he accused the West of “stealing” doctors and nurses from poor nations.

There was sharp criticism of this

proposition in the *Australian Medicine* review, to which Professor Mooney generously responded (to view, click here) that he was “grateful for the review. I had hoped that my ideas might provoke debate, and where there is agreement that we are failing on health globally, others who disagree with my analysis might put forward alternative explanations for why we are failing. I believe that debate needs to happen.”

It is a measure of the breadth of impact that the Glasgow-born and raised academic had, that his passing has drawn tributes from a wide range of politicians, academics, public servants, health groups and health workers.

Federal Health Minister Tanya Plibersek said Professor Mooney was a “fearless advocate for social justice [and] a rare breed of academic”, while Greens Senator Richard Di Natale praised him as a “powerful voice” on the social determinants of health, while Associate Professor David Thomas of the Lowitja Institute said he had made a “significant contribution” to understanding inequity in Aboriginal health.

Dr Weston, 62, had recently completed a doctorate on the political economy of global warming.

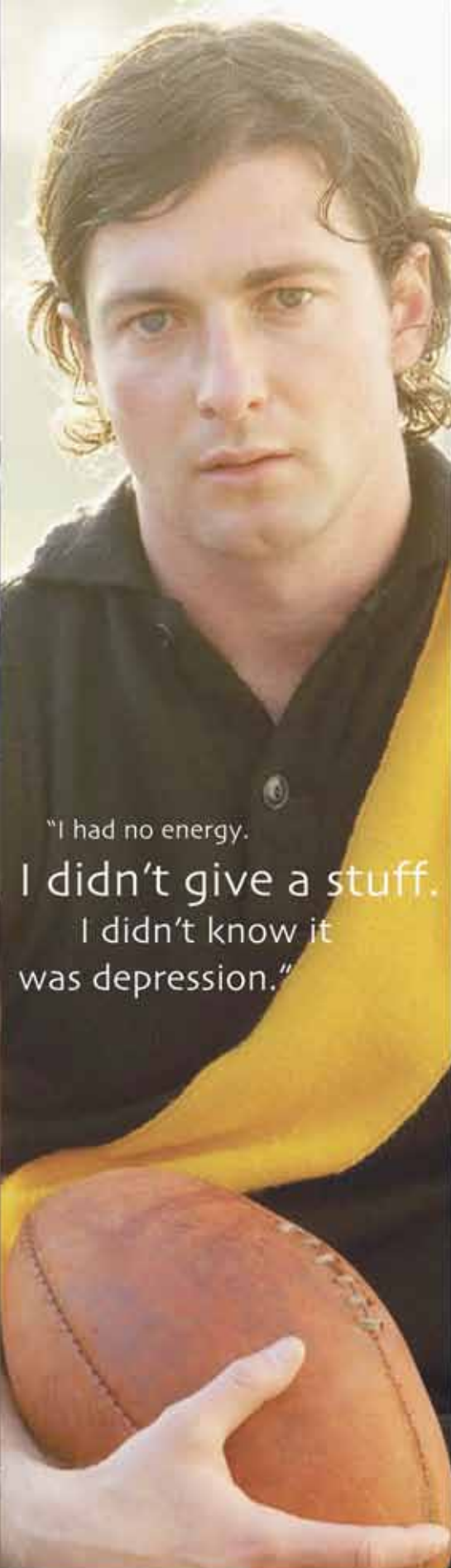
The couple moved to a small farm in the remote hamlet Mountain River, south of Hobart, in 2011, and – despite being in semi-retirement – were very active in health and social justice networks in the state.

Their bodies were found in a house at the property on 19 December, and police have charged Dr Weston’s 27-year-old son, Nicholau Francisco Soares, with their murder.

The couple were buried following a service in Perth on 3 January.

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"I didn't want people
to think I was weak."

I'm a man

and men don't get
depression."

"I had no energy.
I didn't give a stuff.
I didn't know it
was depression."

"When you're growing up
you're told you have to
be the strong one.
But depression
doesn't care."

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Painful times as morphine supplies tighten



Health authorities have fast-tracked approval of a drug to avert a national shortage of morphine amid serious disruption to supplies of the painkiller.

Indian-based pharmaceutical company Wockhardt will begin shipping consignments of its morphine sulphate injection 10 milligrams per millilitre to Australia from the middle of the month to help fill a supply gap caused by a breakdown in the manufacture of morphine sulfate injections under the DBL brand name, which until now has been Australia's sole registered supplier.

But health workers have been warned to exercise great care in the use of the Wockhardt product because, unlike the DBL drug, it contains a preservative,

which means it cannot be administered through epidural or intrathecal routes.

The Therapeutic Goods Administration approved the use of the Wockhardt-made morphine after Hospira, which makes the DBL product, ran into difficulties upgrading its European manufacturing and packaging facility.

The TGA said as a result of the problem, all DBL Morphine Sulfate Injection products, from 5 to 30 milligrams per millilitre, would be in limited supply for at least the first half of the year.

It said it had worked with Hospira to secure an alternative supply of 10 milligrams per millilitre morphine sulphate injections from Wockhardt, though it was not a perfect substitute

for the DBL product, and supplies of the 5, 15 and 30 milligrams per millilitre concentrations would remain "tight".

The TGA said the Wockhardt product had "gone through a regulatory approval process" in the United Kingdom, and would be available in Australia from the middle of January.

"[But] there are critical formulation differences between DBL Morphine Sulfate Injection and Wockhardt Morphine Sulphate Injection products which have potential patient safety implications," the Authority warned.

The medicine watchdog said it was aware that on occasion there was a "certain amount of off-label use" of DBL morphine being administered through epidural and intrathecal routes, even though approval was only given for intravenous, intramuscular and subcutaneous modes.

It said that a similar circumvention of the rules regarding the Wockhardt morphine product would be unacceptable because the preservatives it contained made it dangerous to administer it any other way than by the intravenous, intramuscular or subcutaneous routes.

The TGA has warned hospitals, clinics and other places where morphine is used to ensure that the Wockhardt product is only administered as approved.

It has also advised those who use morphine in concentrations other than 10 milligrams per millilitre to carefully manage their existing stocks "so that they can continue to administer morphine by the epidural and intrathecal route whilst the shortage exists".

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HEALTH ON THE HILL

Beds close, jobs cut, as Victorian health row intensifies

Victorian health authorities have begun closing beds and drawing up plans to axe hundreds of jobs as the Federal and State governments trade accusations over responsibility for a downgrade in health funding.

The Baillieu Government has sought to sheet home to the Commonwealth responsibility for cuts that could see elective surgery waiting lists blow out and about 200 health workers lose their jobs.

But the Federal Government has accused the Victorian Government of trying to use a downgrade in planned Commonwealth spending as a smokescreen to hide the impact of significant cuts made by the State to its own health budget.

Last year the Federal Government revealed that its contribution to Victoria's health budget would be \$106.7 million less than earlier planned, based on revised official population figures following last year's census, and would amount to \$3.15 billion this financial year.

But the Victorian Government has disputed the formula applied to the population figures by the Commonwealth to justify its spending adjustment, accusing it of putting its own budget priorities ahead of the health of Victorians.

Victorian Health Minister, David Davis, said Federal health funding cuts would force almost 29,000 people to wait longer for elective surgery, and the *Herald Sun* reported the state could also be at risk of foregoing a further \$12 million in Commonwealth funding this year if it misses surgery waiting list performance targets.

"Victoria signed up to be part of national health reforms, on the basis that there would be a transparent and cooperative sharing of health costs to benefit patients, particularly as hospital demand grew," Mr Davis said. "However, what we have experienced since then is national health – not national health – and Victoria's

hospital patients are losing out."

But the Federal Government said it had increased health funding for Victoria in the next four years, and State Opposition health spokesman, Gavin Jennings, said the funding problems being experienced by the health system stemmed from the State Government's own decision to cut its health budget by \$616 million.

"David Davis is using the blame game between Canberra and Spring Street to avoid answering hard questions about his mismanagement of Victoria's health system," Mr Jennings told the Herald Sun. "Now the double whammy is set to hit hard, with the State's failure to reach targets resulting in our hospitals missing out on reward funding, which will choke the system even further."

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Experts reverse advice on anti-coagulants

The Federal Government's chief drug advisor has reversed its recommendation regarding the listing of dabigatran and other new oral anti-coagulants following concerns about the cost-effectiveness of the treatment.

A report, commissioned by former Health Minister Nicola Roxon, has found that "more work" needs to be done before the drug and other oral anticoagulants can be considered for listing on the Pharmaceutical Benefits Schedule.

In March 2011, the Pharmaceutical Benefits Advisory Committee (PBAC) recommended that dabigatran be listed on the PBS, and six months later Ms Roxon commissioned former PBAC chair, Emeritus Professor Lloyd Sansom, to review anti-coagulation therapies for atrial fibrillation.

The review found that "the net benefit of New Oral Anti-Coagulants (NOACs) is clinical practice, and the subsequent impact on cost-effectiveness, is uncertain at this stage, and PBAC should review its March 2011 advice to list dabigatran on

the Pharmaceutical Benefits Schedule".

Releasing the report, current Health Minister Tanya Plibersek said its findings had caused a re-think by the PBAC.

"The Committee has advised me that, based on the new information that has arisen about this drug's use in clinical practice, it is now concerned about whether dabigatran represents value for money at the price offered by the company," Ms Plibersek said. "Because of this, the PBAC has now advised me that it is of a mind to rescind its March 2011 recommendation for dabigatran."

The Minister said that although the PBAC felt there was a place for newer anti-coagulant medicines in clinical treatment, it wanted to see further economic modelling demonstrating the value of such treatments.

The listing of new medicines on the PBS has become an acutely sensitive political issue following accusations the Federal Government had been purposefully delaying the approval of drugs recommended by the PBAC in order to save money.

In early 2011 the Government announced all drug listing recommendations by the PBAC would have to be approved by Cabinet. But, following a public outcry, it shelved the idea.

Ms Plibersek said the fact that the Therapeutic Goods Administration had twice had to issue safety alerts about dabigatran since the original PBAC recommendation to list highlighted the need for caution in prescribing the drug some patients, particularly the elderly.

"All drugs have both risks and benefits associated with their use," the Minister said. "Dabigatran and other, newer anti-coagulants are no different and, as relatively new drugs, it's important to stay on top of the evidence as it emerges, to ensure patient safety."

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Hate blood but want a career in medicine? Don't worry, there's a job for you

BY PROFESSOR IAN WILSON, UNIVERSITY OF WOLLONGONG

*This story originally appeared in The Conversation, and can be viewed at: <http://theconversation.edu.au/hate-blood-but-want-a-career-in-medicine-dont-worry-theres-a-job-for-you-10132>

Just before I finished high school, my local general practitioner suggested I consider medicine. But the thought of blood made me feel squeamish, so I went to university to do maths and physics, and to try the new field of computer science. Needing a fourth subject, I opted for biology so that my friend who also did biology could give me a lift to campus.

I ended up becoming fascinated with biology, so much so that I wanted to study neuroscience, and I felt the best way into a research career was through medicine. Luckily, I was successful. As an undergraduate I discovered patients and shifted my focus to a career as a psychiatrist.

I was called up for National Service and ended up on a Defence Force Scholarship. During this time I became interested in trauma surgery and after discharge joined the surgical training scheme. After six months of surgery, I was bored with the technical side but still enjoyed the patient contact and interaction. Being married with one child and another on the way, I opted for general practice with a mental health and procedural focus.

I tell this story in some detail to highlight the meanderings that many students undertake in their career decision-making. Some students come into medicine with a fixed idea of what they want to do and spend their time achieving that goal.

But the majority are more like me and develop multiple interests. Where they end up generally depends on a number of factors such as available training posts,

skill levels, controllability of lifestyle and to a very small extent, salary. The Medical Schools Outcome Database and Longitudinal Tracking Project (MSOD) asks students about their career intentions on entry to and exit from medical school, and as interns (their first year working in a hospital) and residents (their second year of work). On entry to medical school in 2011, 25 per cent of medical students had a first preference for surgery, with paediatrics and general practice the next most frequent.

The preferences of those exiting medical school in 2011 were a little different: internal medicine and surgery were the most common career choices (18 per cent each), followed by general practice and then paediatrics.

Towards the end of the internship, the preferences changed again, with internal medicine the most frequently chosen (19 per cent) followed by general practice and then surgery.

The least preferable career options tend to be rehabilitation, public health and palliative care – most students come into medicine to save lives, making these specialities less appealing.

With the growing number of medical graduates and the relative shortage of intern and specialist training positions, we have noticed a change in student behaviour.

Increasingly, students are attempting to ensure their undergraduate experiences provide them with the best advantage for their career selection process. Honours degrees or the publication of papers will add a few extra points in some speciality selection processes, and students are working hard to achieve these goals.

Hospital choice is also seen as important, as there is a perception among medical students that undertaking an internship in

a specific hospital increases their chances of being selected into a specific specialist training program. But these beliefs aren't necessarily based on facts.

Some experts have suggested using career counselling to increase the number of students entering careers that are less appealing, or where there are significant shortages. But there's no evidence to show career counselling works in this way.

The best way to deal with this issue is around student selection and undergraduate experiences.

Choosing students who are more likely to enter a given profession, and providing them with experiences that are positive, will work much more effectively in promoting careers in the generalist professions (medicine, surgery and rural general practice).

But often the impact of changes does not stop at the school level. Many professionals, including doctors, invest so much of their time and energy into their careers, they are surprised that their practice takes on a sameness.

Once you have delivered 200 babies or conducted 100 gall bladder operations the procedures lose their excitement.

This is the point at which many doctors start looking for something new and engage in medical politics, education, research, business ventures or artistic endeavours.

Some, like me, become dissatisfied with individual care and want to have a bigger impact on the world.

Moving into academia to train the next cohorts of doctors seemed a logical step. In light of my original interest in research, this was a hugely positive for me.

[TO COMMENT CLICK HERE](#)



Fresh eyes needed

BY DR BRIAN MORTON

“The AMA will be at the forefront of any such debate, recognising the need to better support the comprehensive, coordinated, longitudinal care of those patients at risk, hard to reach, or with high health care needs ”

The new year is the time for reviewing current situations, taking stock and making resolutions to improve things where required.

As GPs, we need to consider the healthcare needs of our patients, how they can best be delivered, and make the changes necessary to ensure their access to quality care.

For many GP practices, the early part of the year will see them putting in place the requirements of the Practice Incentives Program (PIP) e-Health Incentive, and making themselves ready to use and interact with the Personally Controlled Electronic Health Record (PCEHR). The AMA checklist prepared late last year should save you time finding the right documents in this regard.

But e-health is not just about the PCEHR.

It is also about telehealth – email, online appointment systems, e-discharge summaries, video consultations, electronic prescriptions, and so on. This technology promises efficiencies in practice and GP management of patient care, with the additional bonus of improving patient access to their GP.

Given the potential it offers to improve patient outcomes, the Department of Veterans Affairs is currently trialling an in home telemonitoring service for veterans with selected chronic conditions, enabling GPs to remotely monitor patients' vital signs and promptly intervene if any irregularities occur.

With the growth in online shopping, it will follow that there will be demand from patients for e-access to their GP. There are already medical practitioners providing this service to patients.

There are plenty of formal guidance materials available to inform you how you might implement such services, and the AMA Council of General Practice will explore avenues for greater integration of these type of services into overall practice over the coming year.

How to better fund the provision of quality care is another issue that will be further explored by the Council in the coming year.

Medicare rebates do not adequately reflect the true cost of being able to open our doors and provide quality care, something many other specialties came to realise years ago.

The AMA encourages GPs to set their own fees in line with their cost experience – recognising the value of your services and the significant skills GPs apply. Not doing so, only ensures the status quo.

Worldwide there is evidence that models of care that embrace the concept of a medical home are providing health savings and better health outcomes, and the recent Draft Primary Healthcare Strategic Framework has signalled the Federal Government's intent to look more closely at this concept and how it might be applied in the Australian context.

The AMA will be at the forefront of any such debate, recognising the need to better support the comprehensive, coordinated, longitudinal care of those patients at risk, hard to reach, or with high health care needs.

The challenge for every GP, and for the AMA, in the year ahead, will be to look with fresh eyes at what is needed to better support the viable provision of quality GP care.

[TO COMMENT CLICK HERE](#)



Involve doctors to boost hospital performance

BY DR STEVE HAMBLETON

“The AMA has strongly argued that hospital performance can be improved when doctors are involved in hospital and primary care governance”

The country has got its first glimpse into how public hospitals stack up against nationally agreed performance targets.

The National Health Performance Authority (NHPA) last month released its inaugural report on the extent to which patients depart public hospital emergency departments within four hours of arrival – the benchmark set under the National Emergency Access Target.

The report, which grouped hospitals by size to allow comparative analysis and peer-based performance improvement, highlighted where the problems are.

It found large variations in the proportion of patients seen within four hours, both between groups of hospitals by size and location, and also by individual hospitals within the same groups.

It also found that the type of hospital influences performance more than the type of emergency department. This, of course, is something AMA members know from working in hospitals.

In 2010, the Economics and Workforce Committee (EWC) developed an AMA Position Statement on time-based national access targets. The Committee identified key issues in this area, and predicted the sort of mixed performance by hospitals we now see reported.

The Position Statement set out the principles the AMA considers should underpin time-based targets for public hospital emergency departments (EDs) in order that patient safety and outcomes, quality of care, and the training of doctors, are not compromised.

Importantly, EWC identified that the purpose of time-based targets should be to drive improvements in whole-of-system service delivery. Clearly, hospitals must have sufficient resources and capacity to meet the targets.

As EWC found two years ago, the reasons for

delays in emergency departments extend into other areas of the hospital. The NPHA report is more a reflection on overall hospital capacity rather than the actual performance of the emergency department in isolation.

Reasons for variations in performance across individual hospitals and states and territories are likely to include:

- public hospitals do not have the capacity to meet existing demand;
- more funding is required to provide the necessary infrastructure and capacity - more beds and more medical and nursing staff to provide care;
- emergency departments will continue to struggle if the hospital wards are already full and there is no bed to admit a patient from the emergency department;
- whole-of-hospital reform is needed, not just emergency departments; and
- frontline doctors must be more involved in hospital decision-making.

The AMA has strongly argued that hospital performance can be improved when doctors are involved in hospital and primary care governance.

Evidence shows that where doctors run the management of hospitals, results improve and morale is better.

Doctors have the knowledge and the experience to make the system work better – better for patients, better for the doctors and nurses, and better for governments.

The NHPA report should act as a catalyst and a tool for governments to work cooperatively to improve public hospital performance in all states and territories.

[TO COMMENT CLICK HERE](#)

RESEARCH

Researchers turn off immune 'kill switch' to speed patient recovery

Survival prospects for patients with severe infections or undergoing chemotherapy have improved sharply after Melbourne scientists found a way to speed recovery by blocking signals from an immune receptor that destroys blood stem cells when the body is under severe stress.

Scientists from the Walter and Eliza Hall Institute found that immune cell receptor NLRP1 acts as a 'kill switch', set off when signals from immune cells – normally functioning to help protect the body from infection – go haywire.

Lead researcher, Dr Seth Masters, said NLRP1 was part of a family of immune receptors that act as a protective mechanism, instructing immune and blood stem cells to die when they sense infection or severe stress-related damage. However, the protective mechanism can go too far, and cause damage.

"One theory is that when stem cells are infected with a bacteria or virus, they can effectively pass the infection on to all their blood cell offspring, helping to spread the pathogen throughout the body," Dr Masters said.

"So the body has evolved [a] pathway to kill the infected stem cell, reducing the risk of infection.

"However, in the case of sepsis, or in a cancer patient who contracts an infection, the NLRP1 receptor inappropriately instructs blood stem cells to die, and too many are killed, until patients can't recover their immune cells, leaving them at much higher risk of death."

The researchers were able to block NLRP1, which stopped blood stem cells from self-destructing, preventing death after chemotherapy and boosting recovery from infection.

The research team is involved in testing

inhibitors to treat severe infections, and have high hopes for use of the technique.

Dr Masters admitted it was "early days, but we are optimistic that this is a pathway that could help to prevent blood cell death and treat severe cases of sepsis, as well as other conditions where blood stem cells are critically depleted, such as during chemotherapy."

The research was published in the journal *Immunity*.

KW

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Botox aiding long-term stroke recovery

The commonly used cosmetic treatment botox has been found to help stroke survivors in their long-term recovery.

Researchers from Neuroscience Research Australia monitored nerve activity in the arms and brains of stroke survivors before and after botox was injected into rigid and stiff arm muscles.

They found that botox not only improved the functioning of arm muscles, but also altered brain activity in the cortex.

Lead author of the study, Dr William Huynh of Neuroscience Research Australia, said injecting botox can result in electrical and functional changes within the brain itself, making it useful in treating a range of muscular and neurological conditions.

"This effect of botox on the brain may arise because the toxin travels to the central nervous system directly, or because muscles treated with botox are sending different signals back to the brain," Dr Huynh said.

"Either way, we found that botox treatment in affected muscles not only improves muscle disorders in stroke patients, but also normalises electrical activity in the brain, particularly in the half of the brain not damaged by stroke.

"Restoring normal activity in the

unaffected side of the brain is particularly important, because we suspect that abnormal information sent from affected muscles to the brain may be disrupting a patient's long-term recovery."

The study was published in *Muscle and Nerve*.

KW

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New treatments for renal failure on the horizon

Greater understanding of the role white blood cells play in kidney inflammation has opened the way for the development of a whole new range of treatments for renal failure that do not leave patients so vulnerable to infection or cause debilitating side effects.

Researchers from Monash University, using advanced microscopy techniques, have tracked the movements of white blood cells, or leukocytes, through both healthy and diseased kidneys.

Lead researcher, Associate Professor Michael Hickey, said that "in order to manipulate a system you must understand it, and now we have a really clear understanding of the disease process, and the molecules involved in the key steps".

"Contrary to conventional medical and scientific opinion, we found that leukocytes are constantly circulating through and patrolling the blood vessels within healthy kidneys. It was previously believed that they only arrived in the kidney during the development of disease," Associate Professor Hickey said. "However, during disease they linger in the kidney during the course of their normal journey, become agitated and cause inflammation and kidney damage."

Leukocytes play an important role in the body's immune system but can also cause inflammation.

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RESEARCH

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Glomerulonephritis is an inflammatory disease of the kidney that can leave those afflicted in need of regular dialysis, or even a kidney transplant. Glomerulonephritis causes more than 20 per cent of cases of end-stage renal failure.

Renal physician and co-investigator, Professor Richard Kitching, said therapies to effectively target glomerulonephritis were needed before end-stage renal failure was reached.

“Currently, we have to suppress the immune system to combat inflammation, and this immunosuppression leaves the body more prone to infections,” Professor Kitching said. “Additionally, some of the drugs have metabolic side effects, such as weight gain and bone thinning.

“Now that we have a better understanding of how the disease develops, we can identify targets for more specific drugs with fewer side effects.”

The research was published in the journal *Nature Medicine*.

KW

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Sunscreens may soon reduce DNA damage, wrinkles

Australian researchers have developed a synthetic compound that reduces DNA and skin damage caused by sun exposure, potentially cutting skin cancer rates.

The vitamin D-like compound, which can be put into sunscreen and after-sun lotion, not only reduces DNA damage but also fights other effects of sustained sun exposure such as wrinkles and dark spots.

The compound could be on the shelves within in two years.

Lead researcher Professor Rebecca Mason, from the Bosch Institute for Medical Research, told the *Sun Herald* that studies have found the Vitamin-D like compound can reduce DNA skin damage by at least 50 per cent, and

possibly by as much as 80 per cent.

“It will enhance the body’s defences against sun damage,” Professor Mason said.

She said the findings came amid concerns many Australians were not getting enough sun exposure to produce adequate levels of Vitamin D – potentially making them sick.

AMA President, Dr Steve Hambleton, said doctors were very aware of the need to focus on Vitamin D and the role it plays in good health.

“Vitamin D deficiency is linked to poor bone health,” Dr Hambleton said.

“If you’ve got low Vitamin D you don’t absorb calcium from the gut and you start taking it from the bones.

“We need to find a happy medium between protecting ourselves from the sun, but also getting enough Vitamin D into our systems.”

KW

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INFORMATION FOR MEMBERS

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

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

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

Clinicians and managers from across the spectrum of health services who have developed creative and cost-effective ways to improve the quality of the care

they provide are invited to submit entries for the Awards, which are to held as part of the National Clinicians Network Forum to be held in June next year.

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

Entries will be judged according to several criteria, including innovative approaches to implementing clinical guidelines, demonstrated success in overcoming existing barriers to the use

of clinical guidelines, greater efficiency in the use of clinic resources and applicability across disciplines.

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

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

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

[TO COMMENT CLICK HERE](#)



Members' Forum

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

The attack by hackers on a Gold Coast surgery (see Doctors prime targets for hacker extortion scams) prompted *Australian Medicine* readers to wonder whether personally controlled electronic health records will be any more secure. Several saw the focus on hospital treatment targets (see Hospitals well short of treatment target) as evidence that health reform has lost its way, and some lamented the increasingly difficult lot of GPs (see Snaking the tub drain versus aged care and Big challenges loom for GPs in 2013). But one reader took heart from signs the trend against vaginal breech births may be reversing (Obstetricians debate change of position on breech birth) and another backed criticisms of Vitamin D testing (Vitamin D mania puts pathology budget under pressure).

Hacker attacks

This incident highlights the insecurity of electronic medical records under current circumstances. The problem of record hacking and privacy intrusions for the PCEHR is also immense.

Anonymous

As a Practice Manager, this event is one of our nightmares: fire, water and hacking. It is my belief that the e-health system will prove to be an easy target for troublemakers from inside organisations and outside. The hackers are smarter than the IT staff that most medical centers and government health organisations use to assist with technical problems. If we can't solve a computerized payroll system, why do we imagine for one minute that patient records will be safe?

Bev

Hospitals fall short

It is so sad that the opportunity for health system/funding reform that looked so promising under Rudd and Roxon has lost its way. Our current situation is no better because the reform that has happened is only a rearrangement of the deck - chairs on the sinking Titanic, maybe with the rate of the sinking slowed a bit and evened up so that it doesn't sink nose first quite so fast. Thanks for keeping up the fight, Steve [Hambleton].

Dr Kim B (not verified)

If an ED department can draw a line down one side with a curtain and call this area the "long stay unit" and, therefore, be officially meeting the four-hour rule when a patient is "admitted" by being moved five metres, then that's wonderful. The issue has been and always will be bed block. Whether a patient is waiting for a bed in the "long stay" unit (meets the four hour rule) or ED (doesn't meet the four hour rule) is irrelevant. It has more to do with the acuity of the patients rather than the processes in the hospital.

Anonymous

GPs under pressure

GP services are indeed being relentlessly devalued, and not just financially. I presume it no longer happens, but in the old days there were undoubtedly lovable rogues who would pop in to do a "ward round" every day on their way home from the rooms. The ethical have paid a price for this, and bulk billing simply facilitates it. Medicine is not "free", it should not be perceived as such.

Patrick Hanrahan

The introduction of e-health is very demanding, let alone being confusing and time-consuming on GP practices. It is most welcoming to see some solid support forthcoming from AMA leadership. Unannounced incentives, such as the After Hours Service Incentives now managed by Medicare Locals may not be worth the effort, with exploitative GP Medicare rebates dwindling to unviable level over the past twenty years or more. I am sure many GPs like myself are finding it extremely challenging, to the point of either leaving, or battling on for the crumbs from the fat cats' table.

Dr Andrew Kwong

Vaginal breech birth

It is unfortunate that routine caesarean for breech babies had become common practice, which led to many practitioners becoming de-skilled when dealing with vaginal breech birth. Breech presentation may not be diagnosed until the presenting part emerges, so vaginal breech births do occur regardless of a facility's policy or obstetrician's experience level, therefore skilled practitioners are essential to minimise risk to mother and baby.

Bonita

Vitamin D testing

D25 tests without PTH and D1,25 are a waste of money. For the proportion of the population who need D25 tests, these should be done as a panel with PTH and D1,25 otherwise the big picture regarding the patient cannot be seen. D is not a vitamin but a secosteroid. Save the money on D25 tests and spend it re-naming D correctly.

Anonymous

[TO COMMENT CLICK HERE](#)

Polio immunisation resumes in Pakistan despite killings

Pakistani health workers have defied death threats and a wave of violence in which more than a dozen of their colleagues have been killed to resume a polio vaccination program in the country's troubled north-west region.

Police are providing security for 82 vaccination teams working in the Charsadda district of the north-western Khyber Pakhtunkhwa Province, which is considered to be a high risk area for the debilitating disease.

The UN suspended its polio vaccination programs in the country last month after a spate of attacks in which gunmen shot dead nine health workers – several of them teenage girls – amid claims the immunisation program was part of a plot by American intelligence agencies.

These attacks were followed by a brutal assault in the north-west Swabi region early this month in which six aid workers and a doctor were killed after their van was sprayed with bullets.

No-one has yet claimed responsibility for the attacks, though the Taliban has

repeatedly denounced polio vaccination programs as harmful and a plot by spies working for the US, with many linking the killings to the revelation that US intelligence agents used an immunisation program as a ruse to obtain evidence about the whereabouts of Osama bin Laden.

But several commentators believe the attacks are due more to widespread ignorance about polio and its prevention, and intolerance about the role women should be allowed to play in public life.

While Pakistan is just one of three countries where the debilitating disease polio remains endemic (the others are Afghanistan and Nigeria), a World Health Organization study conducted late last year found that almost half of Pakistanis had never heard of the disease.

Such ignorance has meant people are susceptible to myths and rumours about polio vaccination programs including, according to the American network NBC, that they were actually intended to sterilize men.

Pakistani researcher and feminist Afiya Shehrbano Zia said the attacks on health workers, many of whom were women, were also part of a campaign by Muslim hardliners to drive women from public life.

Ms Zia cited a study by the *British Medical Journal* which found that religious leaders in the conservative Swat region used FM radio to condemn women working as community health workers.

She said that in the broadcasts religious edicts were issued against these health workers, who were condemned on the grounds that it was illegal for Muslim women to work for wages, and that they were subverting the social order by travelling and visiting houses unaccompanied by men.

Listeners were urged to kidnap women health workers, forcibly marry them or even rape and kill them as “spoils of war”.

According to the WHO, there were 198 polio cases in Pakistan last year, the highest number for more than a decade.

AR

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Italian cardiologists “used experimental treatment on patients”

The Italian police have yet to release more information about nine cardiologists arrested late last year for a number of alleged crimes including “unauthorised experimental treatments” on patients in the Policlinico Hospital in Modena.

They were arrested after the police followed up complaints from a patients' group called Friends of the Heart that had received anonymous information about the deaths of two patients and allegations

of financial irregularities.

One of the nine has been jailed; the others are under house arrest. The investigations also involve 12 medical device companies, which have already been officially barred from ever again working with Italy's national health system.

A police spokesman said that the doctors had been accused of corruption, criminal association, embezzlement, defrauding

the Italian health system and performing unauthorised medical experiments on patients using unapproved and defective devices.

These accusations have yet to be tested by the judiciary, but Health Minister Prof Renato Balduzzi has said that, if they are confirmed, they showed that “a number of professionals are sadly not playing by the rules”.

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First new TB drug in 50 years a potential 'game changer'

The first tuberculosis medicine to be developed in the last 50 years has been approved by the US Food and Drug Administration, providing a new weapon to combat drug-resistant strains of the disease.

In a development hailed as an "immense milestone" by aid group Medicins Sans Frontieres, the FDA has given the go-ahead for the drug bedaquiline, developed by pharmaceutical company Janssen, which has been found to be active against drug-resistant forms of the disease.

MSF, which is at the forefront of worldwide efforts to treat TB, said the new medicine, and a similar drug

delamanid undergoing registration by the European Medicines Agency, was a major advance in efforts to combat the infection.

Dr Manica Balasegaram, executive director of MSF's Access Campaign, said that currently treatment for drug-resistant TB involved a two-year course of up to 20 different pills per day and eight months of daily injections – a regime frequently associated with debilitating and painful side-effects including permanent deafness, persistent nausea and psychosis.

Globally, the cure rate is less than 50 per cent.

Dr Balasegaram said the development of

bedaquiline was a "potential game changer" in global efforts to combat the disease.

The scale of the problem is enormous, with 310,000 new cases notified in 2011, though fewer than 20 per cent of those thought to be infected received treatment.

MSF said the development of the two new drugs was a great opportunity to improve treatment for drug-resistant TB, and there was an urgent need to ensure the drugs were combined and introduced in the most effective manner possible.

AR

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Anti-smoking laws on the way in Europe

The European Commission has drawn up legislation for the 27 member states of the European Union that will mandate bigger health warnings on cigarettes and ban strong aromas from cigarettes such as menthol and vanilla that are thought to make tobacco more attractive to young people.

The legislation – two years in the making – proposes that 75 per cent of the front and back of packets containing cigarettes and roll-your-own tobacco must comprise pictorial and textual health warnings.

Current information about tar and nicotine content – considered misleading by the Commission – will have to give way to a statement that tobacco contains 70 different cancer-causing substances.

The legislation proposes to ban the oral tobacco known as snus, which is legal and particularly popular in Sweden. It would allow individual European member states to require cigarettes to be sold in plain packs, as in Australia, in addition to the warnings.

As expected, Big Tobacco – faced with declining sales as the result of ever clearer information about the health dangers of smoking – has energetically opposed the legislation.

British-American, the world's second-largest listed tobacco group by revenue after Philip Morris, called it "not proportionate" and said that it could breach European law.

Peer Imperial Tobacco Group PLC complained that many of the bloc's proposals were "disproportionate and unreasonable", and insisted that "increased pictorial health warnings do not give the consumer any additional information about the health of risks of smoking."

The Commission's move is also unpopular in Sweden, a country with a billion-dollar snus industry, and consequently a big snus problem.

Swedish officials had been trying to get the Commission to exempt snus from its

labelling proposals, arguing that it should be classified as less harmful than other types of tobacco.

But the new EU Health Commissioner Dr Tonio Borg said that the statistics spoke for themselves.

"Tobacco kills half of its users and is highly addictive. Consumers must not be cheated: tobacco products should look and taste like tobacco products and this proposal ensures that attractive packaging and flavourings are not used as a marketing strategy."

The legislation must be approved by the European Parliament and the European Council of Ministers if it is to become law throughout the European Union.

The Parliament will organise public hearings on the draft next month. Member governments will consider it during 2013 and 2014. If it passes all these stages, the legislation will come into effect in 2015.

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UK Government losing doctor friends



Relations between the British Medical Association and the British Government have grown decidedly frostier over the Government's intention to use funding to dictate how 36,000 GPs in England and Wales are to look after their patients.

The Government's move will come about through changes to what is called the 'GP contract'.

These changes include that, from next April, practices will no longer receive the annual Quality and Outcomes Framework (QOF) payment for administrative tasks such as medical record-keeping unless they boost services for people with dementia and frail elderly patients, use technology to monitor patients' long-term health problems and improve online access to Government programs.

The Government says that the changes will mean that GPs will be rewarded for earlier diagnosis and better care of dementia patients and people with long-

term conditions. It has given GPs until the end of next February to respond.

The BMA has protested that the Government has not considered the impact of its changes on general practices, which "are already under huge workload pressure. We have real fears that [they] will result in an even greater load at the same time as forcing through a reduction in core funding".

The GP contract had enabled GPs to benefit their patients clinically and to be at the forefront of delivering care that had kept pace with technological advances, it said.

This had led to thousands of patients benefiting from early diagnosis and treatment that had saved lives. Moreover, some programs to which the Government wanted GPs to improve patient access did not exist everywhere in the country.

The BMA promised to analyse the details of these "complex proposals" and said

that it was open to "real dialogue" with the Government about their impact.

But relations between doctors and Government have been disturbed by the abrupt way in which the Government made its decision. Changes to the GP contract for doctors in Scotland (where the health system is different) were agreed in a consultative atmosphere.

But the Government walked away in October from months of negotiations with the BMA over the GP contract for England and Wales, opting instead to force the changes through.

Doctors have also been infuriated by the Government's decision to scrap a Cabinet subcommittee, promised by it in Opposition and set up by it soon after winning office, specifically to tackle major health problems such as obesity, smoking, alcohol abuse and health inequality.

The committee was intended to bring together 19 ministers responsible for 13 departments with interests – however tangential – in public health policy.

A government spokesman denied that the decision would downgrade public health, which would now "be brought into the broader domestic policy committee".

But the word around Whitehall is that the committee was a dud; it had been difficult to interest ministers from other than health portfolios and had actually convened only a few times.

"We hope that Ministers intend to engage in a meaningful discussion, and that they will listen and act on concerns that are raised, particularly where their proposals are unworkable or will lead to unintended consequences," the BMA said. "We would be extremely disappointed if this consultative process was a rubber stamping exercise for their existing plans."

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AstraZeneca takes a \$A65 million hit over Losec

The European Court of Justice – the European Union’s highest court - has upheld earlier judicial decisions that British-Swedish drug manufacturer AstraZeneca should be fined nearly \$A65 million for misusing regulatory procedures so as to delay competition from generics to its ulcer treatment omeprazole (marketed as Losec).

In 2005, the European Commission, acting on complaints from the generics industry, had fined the company \$A74.3 million after holding that AZ had made “deliberately misleading representations” about the dates when it had originally filed patents on Losec, thus extending its exclusivity for a longer period than that to which it was entitled under EU patent rules.

It had also decided that AZ had tried to deter generic rivals from launching rival (and cheaper) versions of Losec by withdrawing registration of the original precise version of the drug with various European regulators.

The effect of this was that generics manufacturers of the drug had to go through the long and expensive full regulatory approval process, rather than just having to demonstrate equivalence to Losec.

AZ appealed this decision to the European General Court – the EU’s second-highest court. But, in 2010, the General Court dismissed the appeal against the Commission’s decision, though it reduced the fine to \$A65 million because it could not find proof that AZ

had taken its anti-competitive actions in all EU countries.

The company then appealed the General Court’s decision to the Court of Justice.

The court dismissed the appeal and upheld the General Court’s fine.

It found against AZ’s case that the General Court had made errors in law, saying that it was entitled to rule that the company’s behaviour was an abuse of its dominant market position.

The company said that it was disappointed with the decision: “AZ takes compliance with all laws seriously, and has a fundamental commitment to doing business in an ethical and proper manner.”

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EU gets a new Health Commissioner

The European Parliament has approved the appointment of a replacement for former European Union Commissioner for Health and Consumer Policy John Dalli, who resigned from the position amid corruption allegations.

Maltese Foreign Minister, Dr Tonio Borg, has been appointed to replace his compatriot Mr Dalli, who quit the post last October amid allegations from the EU’s Anti-Fraud Office linking him to people accused of trying to extort money from a tobacco company in exchange for influencing draft European Commission legislation on tobacco regulation.

Mr Dalli has protested his innocence, and investigations by both EU and Maltese authorities are continuing.

Dr Borg’s own appointment was contentious and far from smooth and, though it was supported by 386 votes in the

European Parliament, 281 MEPs voted against it and 21 abstained.

In lively hearings before the vote, Socialist and Independent MEPs (who make up the second and third largest political groups in the Parliament respectively) had given Dr Borg a hard time about his record in Malta, which they said suggested an attitude on women’s and men’s health policy issues that was incompatible with the EU’s values on civil liberties and non-discrimination.

Dr Borg had felt compelled to write a formal letter to all MEPs, reaffirming his “full commitment to the [EU] Charter of Fundamental Rights in its totality and without reservation” and to combat discrimination in the particular field of health.

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US needs more primary care doctors

Family medicine researchers in the US have warned that, thanks mainly to population growth and ageing, the United States will need more than 50,000 more primary care doctors by 2025.

Using medical expenditure information from the Agency for Healthcare Research and Quality, they reckoned that nearly half of all people residing in the US who saw a doctor went to a primary care physician – a mean of 1.6 visits a year. This would rise to 1.66 a year by 2025.

They found that there was one practising primary care physician in the US for every 1,475 persons. But the ratio of primary care doctors to specialists was only about 30 per cent to 70 per cent, compared to 50-50 in most other industrialised countries, and doctors were poorly distributed to rural and other “under-served” areas.

Incentives were therefore needed to encourage medical graduates to go into primary care, the researchers said,



including increased Medicare and Medicaid payments, and greater use of the medical home approach, in which doctors delegated some tasks to team members, allowing them more time to concentrate on more complex cases.

A report by the researchers – entitled “*Projecting US Primary Care Physician Workforce Needs: 2010-2025*” – has been published in *Annals of Family Medicine*.

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate

declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

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Fiscal cliff rescue plan includes 'doc-fix'

Doctors treating patients under the United States' Medicare national health insurance program have won a reprieve from 27 per cent pay cut as part of the deal struck by Congress to prevent the country going over the "fiscal cliff".

The pay cut – mandated by the Medicare Sustainable Growth Rate (SGR) under the – was to have come into effect from 1 January.

Delaying it – a move already dubbed 'doc-fix' - will be paid for by cuts to funding for hospitals (totaling about \$30 billion) and specific health programs such as those for end-stage renal treatment (\$5 billion) and diabetes (\$0.6 billion).

American Medical Association President, Dr Jeremy Lazarus, said that the move temporarily alleviated the problem created for doctors' income by the SGR formula. But Congress' work was not complete; it had just delayed "this massive, unsustainable cut

for one year". In order to keep doctor salaries stable, it had to come up with new funds, he said.

American Hospital Association President, Rich Umbdenstock, called the move disappointing. "While fixing the physician payment formula is essential," he said, "it should not be done by jeopardising hospitals' ability to care for seniors and their communities."

'Doc-fix' does not mean that the US health system is only affected marginally by the political trench warfare that led to the fiscal cliff crisis. Under the package agreed by the Congress, deep domestic spending cuts demanded by the Republicans, who control the House of Representatives, have only been put off until March.

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Public to see how UK surgeons perform



The NHS Commissioning Board – which oversees the British health system - has ordered that hospitals caring for National Health Service patients must start publishing information on the performance of individual consultant surgeons working in 10 specialties by the northern summer.

This is one of a number of measures and incentives to improve hospital services that the Board has included in planning guidance for 2013-14. The Board's chief executive, Sir David Nicholson, said that providing the data was intended to allow

surgeons to compare performance, which in turn would in turn put pressure on them to improve.

The 10 specialties include cardiac, vascular and orthopaedic surgery.

Chair of the British Medical Association Council, Dr Mark Porter, warned that it was important that information on consultants' performance was meaningful. "Basic mortality figures alone could mislead patients," he said, "because they fail to take into account other factors that might have contributed to the death of a patient."

The Royal College of Surgeons supported the Board's objective of greater transparency. But President Professor Norman Williams insisted that RCS experts should be involved in designing and delivering the relevant outcome measures.

Measuring outcomes to provide credible data was extremely complicated, he said. "It is vital that any analysis of surgeons who take on the higher risk patients [such as those with complex health needs like diabetes and respiratory problems] is fair and reflects the complexity of these conditions, so as not deter surgeons from treating difficult cases for fear of being penalised."

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Dyslipidaemia medicines reviewed for safety

The European Medicines Agency is reviewing the safety and efficacy of cholesterol treatments following the findings of a major study into their use.

The Agency is examining the safety and effectiveness of Tredaptive, Pelzont and Trevaclyn, all produced by the pharmaceutical company Merck, Sharp & Dome (MSD) for use on adults with dyslipidaemia, particularly combined mixed dyslipidaemia and primary hypercholesterolaemia.

The Agency embarked on the review

after MSD informed it about the preliminary results of a large, long-term study it has undertaken into the clinical effects of adding these medicines to statins, compared with statin treatment alone.

Evidently, the study raises questions about the efficacy of the medicines when added to statins, as this did not reduce the risk of major vascular events compared with statin therapy alone.

In addition, in the preliminary results, there appeared to be a higher frequency

of non-fatal but serious side effects in patients taking the medicines than in patients only taking statins.

The Agency's Pharmacovigilance Risk Assessment Committee is assessing the MSD data, and will make a recommendation to the Committee on Medicinal Products for Human Use, which is expected to issue an opinion on any regulatory action required later this month.

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Indonesia asked to act on deadly drink spiking



The Australian Government has called for Indonesian authorities to crack down on the practice of spiking alcoholic drinks with methanol following a spate of deaths and injuries among Australian holidaymakers.

Foreign Affairs Minister, Senator Bob Carr, said Australian officials would ask for more action by Indonesian police and other agencies to regulate the preparation and service of alcohol, particularly at the lower end of the tourist market in holiday

spots like Bali and Lombok, where the adulteration of cocktails and other drinks with methanol is a regular occurrence – with frequently tragic consequences.

But the Minister said there were limits to what Australian diplomats could do, baulking at suggestions the Department of Foreign Affairs and Trade (DFAT) compile a list of Indonesian bars known to spike drinks.

“I don't think DFAT can end up being a consumer protection agency in Indonesia,” he said.

Senator Carr made the comments following the death of Liam Davies, 19, from Perth, who was flown to Australia from Lombok in a critical condition after drinking a methanol-laced vodka beverage at a New Year's Eve party on the Indonesian island.

His parents told the West Australian newspaper that Liam and his friends had been careful to avoid drinking the notorious Bali backyard brew arak, and he thought the drink he was consuming was made with imported vodka.

Mr Davies's death follows a series of other such incidents in which Australian tourists have been seriously harmed, or even killed, by methanol poisoning.

An 18-year-old Australian school leaver was temporarily blinded in Bali last month after drinking spiked alcohol, and in 2011 Perth-based rugby player Michael Denton died after consuming arak.

The same year Newcastle nurse Jamie Johnston suffered brain damage and renal failure after drinking a methanol-laced cocktail while in Indonesia.

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Prepare to stand by – but then what?

BY PROFESSOR STEPHEN LEEDER

Admittedly, it was Boxing Day.

I was driving home at lunchtime in Sydney along a narrow two-way street to an intersection with a one-way street. Both were well known to me, and as I prepared to turn into the one-way street I checked only for cars proceeding in the legal direction.

I do not know who was more shocked, the driver of the 4WD proceeding in the wrong direction, or me. Fortunately, we did not collide – but only just. Apologies were offered and received but the other driver claimed not to know about the one-way flow.

When I re-established normal cardiac rate and rhythm, I took a walk up the one-way street to its origin and checked the signage.

Completely inadequate was my verdict. But who do I tell? The police? The road traffic authority? The local council? Who's in charge, I wondered? I even thought of making a sign myself, and wondered how I would do it.

My problem was that so many people appeared to be in charge that I could not find one, just one, I could talk to. Meanwhile the problem remains unsolved.

A recent article in the *New England Journal of Medicine* concerned the 'bystander effect' (to view click [here](#)), the problem that occurs when so many doctors are involved in the care of a patient that no-one is sure any more as to who is in charge.

The authors, Robert Stavert and Jason Lott, two up-and-coming dermatology residents at Yale, wrote:

“The larger the group of people involved in the process of making important decisions, the more likely it is that any one person will assume that either the mantle of responsibility rests elsewhere in the group or that those responsible for taking action have already done so. The bystander effect generally increases with the size of the group and is more likely to manifest when responsibilities are not explicitly assigned.

The simple question of “Who is my doctor?” now has a longer, complex, and often unclear answer.”

Stavert and Lott speak about the increase in specialisation, and the attendant rise in the number of physicians needed to provide complex care, especially for patients with acute catastrophic and ill-defined illness. They write of one such patient:

“None of us were certain what was wrong with him, and therefore each of us continued to wait for someone else to do something. The involvement of multiple covering providers only made things worse, since each covering clinician was understandably reluctant to initiate changes absent a blessing from the primary team.

“Physician-to-physician handoffs were frequent, with more than 40 doctors participating in the patient's care during his 11-day stay in the ICU. Our inability to easily name his disease process quickly created ambiguity about “ownership” of the patient. Well-intended multidisciplinary discussions regarding his diagnosis and potential plan of care soon devolved into fragmented, narrow, and internal deliberations within each specialty.”

Stavert and Lott offer the following insight:

“Research suggests that bystanders are far more likely to intervene when they are friends with one another. Accordingly, promoting the use of mechanisms that encourage healthy and collegial interactions between specialty and primary care teams may empower individual clinicians to participate more meaningfully in the care of shared patients.”

Civility and friendship among the caring teams can make a difference – there's a New Year aspiration for you!

I ran this matter – of diffusion of decision-making and our inability to answer the question “who is my doctor?” – by a senior clinical colleague in a major hospital. He saw it as a major problem:

“Will it be solved by endless protocols and procedure manuals? Not a chance.

Do we need a collaborative and coordinated approach to ensuring clear lines of responsibility? Yes, certainly.

[We] need communication and excellent human relationships throughout our organisation. This is the key issue in my view. So that comes down to building staff morale and ensuring clear lines of communication and responsibility at all levels.”

He declined to offer a solution to the road-sign problem. Meanwhile, I shall look both ways at that intersection in future. Well, maybe I will...

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BOOK REVIEW



Developmental Origins of Health and Disease: Exposures, Outcome, Mechanisms and Interventions

Edited by M. Zygmunt, H.G. Bender and W. Kunzel

Nova Acta Leopoldina. Neue Folge, Band 112, Nummer 382, RRP \$26.99, pp119, ISBN 978-3-8047-2887-5

Reviewed by Jennifer Wang*

The Deutsche Akademie der Naturforscher Leopoldina addresses key social issues from a scientific perspective, raising public awareness and promoting further discussion on a national and international level.

One of the major concerns for Western society is the increasing prevalence of metabolic diseases, including hypertension, diabetes, obesity and cardiovascular disease.

The 2009 Leopoldina-Symposium in Greifswald, Germany, focused on intrauterine and early life influences in the development of metabolic disease.

Research presented at this meeting was published in this issue of the Nova Acta Leopoldina, one of the Academy's major journals.

This collection demonstrates how far research into the Developmental Origins of Health and Disease (DOHaD) has progressed since it was pioneered by David Barker in the 1980s.

It begins with an article by Hoffmann and Thyrian (Greifswald) introducing Barker's hypothesis that metabolic diseases originate through developmental plasticity, "in response to under-nutrition during foetal life and infancy".

Hoffmann and Thyrian assert that population-based studies are necessary to further identify risk or protective factors, and to allow the

development of preventative interventions.

The rest of the collection is structured into sections detailing intrauterine exposures, mechanisms, outcome and interventions.

Common themes include foetal programming, the effects of maternal nutrition and diabetes on foetal development, and the long-term consequences of prematurity and low birth weight.

A diverse range of studies is published from centres around the world, including review articles, animal studies and cohort studies of pre-term and low birth weight infants.

The *Developmental Origins of Health and Disease* provides compelling evidence that, to a certain extent, life trajectories are determined from even before birth.

Yet it raises hope that, through further understanding of foetal plasticity and "critical windows" of intervention, population-based interventions may finally bring metabolic disease under control.

In view of this scope, this volume would be valuable for aspiring epidemiologists, as well as any health practitioner with an interest in novel methods of disease management on a population basis.

**Jennifer Wang is a resident medical officer at the Children's Hospital at Westmead*

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Big doesn't mean better on world's most dangerous roads

BY ADRIAN ROLLINS

Hummers are big and, let's be frank, pretty ugly.

A week or so ago I was briefly stuck behind one while driving in downtown Canberra, and its presence seemed more than a little incongruous.

Thanks to generous Federal Government investment, particularly during the 1970s and 1980s, Canberra has some of the widest, best-made and quietest roads in the country. It's not the sort of territory that screams out for the closest thing to a tank that a private motorist can own.

Owning a Hummer in the nation's capital seems akin to donning a helmet and flack jacket to take part in a pillow fight.

And rising fuel prices and changes in vehicle technology make the Hummer, which first hit public roads in 1992, appear increasingly anachronistic.

At around two metres wide, and with limited visibility to the rear, it is a beast to park, and its fuel economy of about 17 litres per 100 kilometres on the open road (and a whopping 24 litres per 100 kilometres in city traffic) makes it a very expensive option for the daily commute.

General Motors finally shutdown production of the vehicle in April 2010, after numerous failed attempts to find a buyer for the brand.

Enthusiasts might argue that there is a place for the Hummer, particularly when travelling along some of the world's most dangerous roads.

And admittedly, riding in something as big and heavy as a tank might be reassuring travelling on some of Bangladesh's major roads, which are crammed with an enormous volume of trucks, coaches, local buses, vans, four wheel drives, cars, tuk tuk-style taxis (called "singees" by the locals after the compressed natural gas (CNG) they run on), scooters, bicycles, carts, cows and pedestrians.

The combination of speeding buses, trucks and cars sharing roads with slow-moving carts, pedestrians and tuk tuks is a deadly one, and more than 4000 people die every year on Bangladesh's roads.

But a Hummer might be more of a liability than an asset in many other situations.

It is always a vexed question as to what makes a road dangerous.

Putting to one side dangers stemming from armed conflict, the quality of driving, terrain, weather conditions, the quality of construction and maintenance, all play their part.

But most of the roads that make it onto lists as being among the world's most deadly usually have several features in common: they are narrow, winding, prone to rockfalls or landslides, with plenty of blind corners and few safety barriers, are major truck routes, and are mostly in mountainous regions of poorer countries.

None of which really suits a heavy and cumbersome vehicle like the Hummer.

According to CNN, the world's most dangerous road links Jalalabad to Kabul in Afghanistan.

Though it traverses territory claimed by the Taliban, it is not the civil war that accounts for most deaths.

For much of its length it clings precariously to the sides of the deep Kabul Gorge, with the combination of heavily-laden trucks, blind corners, impatient driving and precipitous drops making fatal accidents a daily occurrence.

Another that regularly makes it close to the top of "most dangerous" lists is the encouragingly-named 'Road of Death' between La Paz and Coroico in Bolivia.

Once declared by the Inter-American Development Bank to be the most dangerous road in the world, it rises 3500 metres in 65 kilometres, with dizzying drops unprotected by any sort of barrier.



The 'Road of Death', Bolivia

The busy road, plied by overloaded trucks and buses, has an annual death toll of between 200 and 300.

By comparison, Australia's deadliest road (as rated by the website *Motoring Mojo*) is the Barton Highway, linking Canberra with the Hume Highway near Yass, which recorded 110 crashes, resulting in 11 fatalities and 100 injuries, between 2001 and 2011.

Altogether, 1301 people died on the nation's roads last year, according to provisional figures collated by The Australian – a jump of almost 2 per cent from 2011.

Despite the increase, the result is a dramatic improvement from the early 1970s, when the road fatality rate was 72 per 100,000 people. Last year, the rate was at 6 per 100,000.

But Federal, State and Territory governments are falling short of their own target of cutting the toll by 3 per cent a year.

The answer, despite what some might think, is not to get more people driving Hummers and other big, heavy vehicles, but to improve the quality of the nation's roads and encourage more vehicle safety features.

Adrian Rollins is Editor, Australian Medicine

Regular motoring columnist Dr Clive Fraser is on leave and will return in the 11 February edition.

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