AUSTRALIAN

Medicine

The national news publication of the Australian Medical Association

Critical care far from anywhere

A day in the life of a Royal Flying Doctor, p15

Inside

AMA

ISSUE 25.03 - FEBRUARY 11 2013

CPD TRACKER

AUSTRALIAN
Medicine

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

Graphic Design:
Streamline Creative, Canberra

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

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

42 Macquarie St, Barton ACT 2600

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

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

IN THIS ISSUE

NEWS

SPECIAL FEATURE

REGULAR FEATURES

Doctors aren't dopes

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

It's an early contender for the most over-hyped interview of the year, but the Oprah-Lance Armstrong interview must be in strong contention.

Dragging out the content over two shows was more ambitious in prospect than dividing the Hobbit into three.

In retrospect, it made the interview slower than I would be cycling up the Col de Anything.

As someone who enjoys getting on my bicycle as many mornings as possible (no lycra), the Tour de France has had the same fascination for me that the Australian Open has for a social tennis player.

Lance Armstrong was always a hero, though it was accompanied by the uneasy feeling that when something is too good to be true, it's too good to be true.

Of course, the Oprah interview came well after the 1000-page report from the US Anti-Doping Agency last October, which concluded that Lance Armstrong was behind the "most sophisticated, professionalised and successful doping program the sport has ever seen".

So, there was little new in the interview. But as I listened my thoughts turned away from the answers and the man being interviewed to the system that lay behind him.

The doping with erythropoietin and blood transfusions was sufficiently sophisticated to escape detection for many years. It's hard to believe that this could have occurred without the team doctors being aware, complicit and even directly involved in the perversion of sporting principles.

It is easy to see how team physicians could have been sucked into a team culture of winning at all costs.

It couldn't have been just the glamour of being part of a winning team and the heady excitement that comes with it. Being on the payroll brings other pressures - financial pressure not the least of them, along with the need to be a 'team player', to embrace the winning culture and to accept the role of the 'smart guy' who can give the team an edge.

As competition intensifies and athletes with their minders strive for every bit of performance, so sport becomes more and more of a business at the high profile end, and less about sporting achievement as an end in itself.

Sports science has made a significant contribution to improving performance across many sports.

Exercise programs, diet, and input from sports psychologists, have all played a part and are seen as being natural and 'fair'.

Then there is the grey zone - for example altitude training, which is now being embraced by Australian Football League (AFL) teams, and has long been a part of preparation for big events by elite athletes.

Arguments about moral and ethical differences between endogenous and exogenous erythropoietin can be left to others.

Nevertheless, it is clearly aimed at achieving an artificial advantage through performance enhancement.

The World Medical Association has a very clear declaration on Principles of Health Care for Sports Medicine, originally adapted in 1981 with subsequent revisions - most recently in 1999.

The relevant parts states, "The physician should be aware that the use of doping practices by a physician is a violation of the WMA Declaration of Geneva…The WMA considers the problem of doping to be a threat to the health of athletes and young people in general, as well as being in conflict with the principles of medical ethics. The physician must thus oppose and refuse to administer or condone any such means or method which is not in accordance with medical ethics, and/or which might be harmful to the athlete using it, especially procedures which artificially modify blood constituents or biochemistry…"

The Medical Board of Australia, in its *Good Medical Practice: a code of conduct for doctors in Australia*, makes it clear that working in a team does not alter a doctor's personal accountability for professional conduct and the care provided.

It also points out (4.4.5) that good medical practice involves acting as a positive role model for team members. These are in addition to a doctor's underlying professional value of having a responsibility to protect and promote the health of individuals and the community.

What is clear is that medical practitioners have a higher professional duty and ethic, which is to ensure the treatments they are providing are to benefit the health of their patient and patients collectively.

In a world that is becoming increasingly corporatised there are lessons for doctors from this sad affair that go beyond the world of cycling and sport.

For doctors who are involved in the broader corporate world, the responsibility towards individual people affected by decisions and interventions remains. Once a physician, always a physician, with the ethical responsibilities that go with it.

As we have seen, these must override an alternative corporate culture and the harms that come with taking a win at all costs approach.

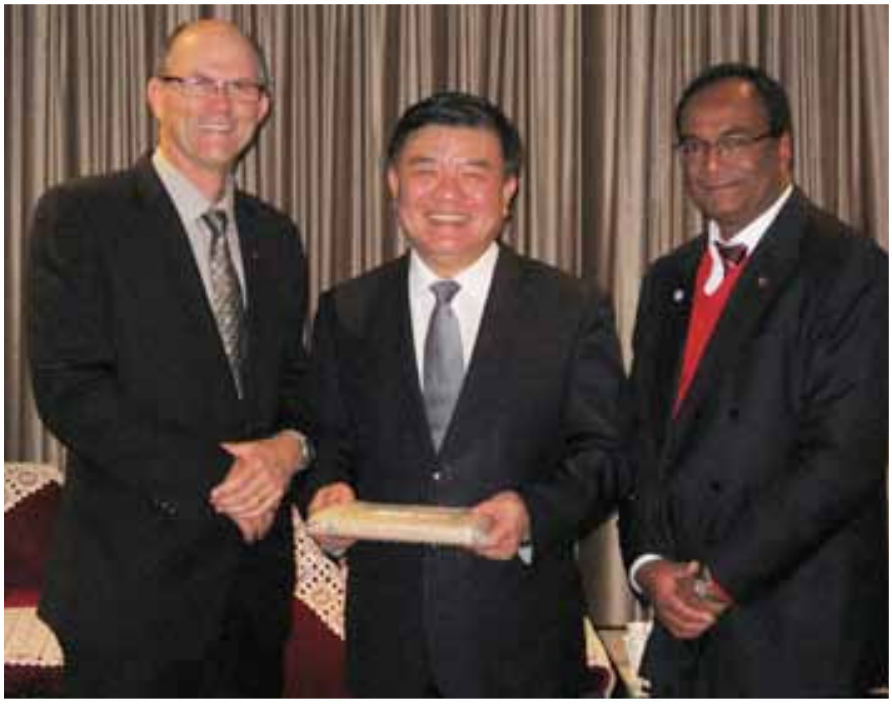
Winning may be measured in terms of profit, market share, glory or something else.

Doctors are naturally competitive, but embedded in our culture are the concepts of fairness and respect for others.

Lance Armstrong has lost so much of that he was awarded because these principles were forgotten.

TO COMMENT CLICK HERE

GPs at centre of China's health reforms



AMA President Dr Steve Hambleton, with Chinese Health Minister Chen Zhu and Chair of the World Medical Association Dr Mukesh Haikerwal

China has embarked on a massive drive to train and recruit up to 400,000 general practitioners in the next seven years as part of a far-reaching overhaul its fractured and substandard health system.

Chinese Health Minister, Dr Chen Zhu, told a World Medical Association conference in Beijing attended by AMA President, Dr Steve Hambleton, that the giant Asian country was facing a major problem from non-communicable diseases and a poorly developed primary health care system.

In a speech that Dr Hambleton said was remarkably open and frank, Dr Chen said health care in China suffered from a lack of communication and coordination between the five tiers of government (national, state, provincial, county and village), as well as a "disconnect" between primary health care and hospitals and between health prevention practices and treatment.

The Chinese Minister said the nation's hospitals were overcrowded and a severe shortage of general practitioners meant that many of the nation's 1.3 billion people suffering significant health problems were going untreated.

For example, of an estimated 200 million people who suffer hypertension, 50 per cent have never had their blood pressure tested, just 23 per cent of those where it has been diagnosed are being treated, and it is considered to be controlled in just 8 per cent of cases.

The country is also grappling with a huge upsurge in cases of diabetes. In 2000, 20 million were diagnosed as being diabetic, but by the end of the decade that had leapt to 92 million.

Dr Chen said he wanted to develop a GP-based health system as the most effective way to cope with and curb the nation's developing problem with non-communicable diseases.

"They want to make GPs one of the most important disciplines in medicine," Dr Hambleton said.

Dr Chen told the conference that treating one patient in intensive care could cost $10,000, but a GP could treat many more people at a fraction of the cost.

A pilot study involving 2000 GPs has already been set up to examine how the health care system should be structured, and the Chinese Government has set an ambitious target to rapidly build the nation's GP workforce.

By 2020, Dr Chen wants the GP-to-patient ratio to drop from around 1 per 100,000 to between two and three per 10,000, implying a recruitment target of around 390,000 doctors.

Dr Hambleton said the size of the task the Chinese Government had set itself was staggering.

"To reach that target in Beijing alone would take every GP practicing in Australia, with some left over," he said.

As part of their reform process, the Chinese Government is closely examining the structure and operation of health systems from around the world, and a delegation of Chinese officials is expected to attend the AMA's National Conference later this year.

AR

TO COMMENT CLICK HERE

Progress in closing Indigenous health gap

The AMA has called on the Federal, State and Territory governments to renew their commitment to efforts to improve the health of Aboriginal peoples and Torres Strait Islanders.

As Prime Minister Julia Gillard last week hailed a "breakthrough" in progress on reducing Indigenous disadvantage, AMA President, Dr Steve Hambleton, warned that although some improvements had been achieved, much more was still to be done.

"In 2008, COAG made a commitment to close the gap in life expectancy between Aboriginal peoples and Torres Strait Islanders and other Australians," Dr Hambleton said. "The COAG National Partnership Agreement expires later this year, and should be fully renewed to ensure momentum is not lost."

His comments came after the Prime Minister said that although there was a long way to go in reducing Indigenous disadvantage, solid gains were being made.

In presenting the Government's fifth annual *Closing the Gap* statement, Ms Gillard told Parliament on 6 February that one of the first goals under the plan when it was begun in 2008 - to deliver access to early childhood education to all four-year-olds in remote communities within five years – would be achieved this year.

"Another Closing the Gap target is now also within sight," the Prime Minister said. "In 2008 leaders pledged to halve the gap in mortality rates for Indigenous children under five within a decade. I can report that real progress is being made and, if current trends continue, our target will be met."

"In 2013, we will reach our first formal Closing the Gap target and can see two more within reach.

"These results show that the gap is not only closing but closable.

"They are proof of what we can achieve when we work together [and] end decades of chronic under-investment."

But the Prime Minister took aim at what she described as "retrograde steps" by the Northern Territory and Queensland governments to relax restrictions on alcohol in Indigenous communities.

She warned the changes could allow the "rivers of grog that wreaked such havoc among Indigenous communities" could start flowing again, and promised the Commonwealth would act on any such "irresponsible" policy change.

"Progress on Closing the Gap is hard enough without taking retrograde steps and undoing the good work that has already been accomplished," she said.

Dr Hambleton urged the nation's governments to work together to ensure that recent gains were not lost, and the momentum for change continued.

"The COAG National Partnership Agreement expires later this year, and should be fully renewed to ensure momentum is not lost," he said. "A National Aboriginal and Torres Strait Islander Health plan, which is key to closing the life expectancy gap, is currently being developed, and COAG should make a long term funding commitment to it."

Dr Hambleton said the plan needed to be "a real road map" to measure outcomes, with timelines and interim targets, and not just a statement of principles.

"Improving the health of Aboriginal people and Torres Strait Islanders is a real problem that needs practical solutions that transcend party-political differences. All political parties should make a commitment to health equality," he said.

AR

TO COMMENT CLICK HERE

Flood of foreign doctors to come under scrutiny

The Federal Government has agreed to monitor the recruitment of Resident Medical Officers from overseas following concerns raised by the AMA.

Responding to representations by AMA President, Dr Steve Hambleton, the-then Immigration Minister, Chris Bowen, last month said he was "currently considering" strengthening measures to ensure employers only recruited RMOs from overseas under the 457 visa program when they were unable to find suitably qualified local staff to fill vacant positions.

"I appreciate the AMA's concerns regarding the recruitment of RMOs using Subclass 457 visas, and the potential impact this could have on employment opportunities for Australian-trained doctors," the Minister said. "I am currently considering additional measures to strengthen [employer eligibility] requirements to enhance the integrity of the 457 visa program."

Mr Bowen's made the comments after Dr Hambleton wrote to him late last year voicing concerns that State and Territory governments were continuing to hire RMOs from overseas even as hundreds of locally-trained doctors were missing out on such positions.

The AMA President cited reports that 260 doctors had not been offered an RMO2 position in Victoria and "we understand that hundreds of RMOs in Queensland have not received an offer of a place with Queensland Health next year [2013]".

"It seems untenable that locally-trained graduates and junior doctors face potential unemployment while we continue to recruit large numbers of RMOs directly from overseas," Dr Hambleton said.

While international medical graduates made an "enormous contribution" to the health system, he said growth in the number of medical graduates meant the country was now in a position to begin moving away from its reliance on overseas doctors to fill vacancies.

Dr Hambleton said there were close to 3500 medical graduates last year and the number was expected to reach close to 4000 a year by 2016.

At the same time, the intake of RMOs from overseas was also growing.

Immigration Department figures show 1260 doctors from overseas were granted 457 visas in 2011-12, rising to more than 2000 by the end of August last year.

And the Department's most recent data, released earlier this month, show 720 GPs from overseas applied for 457 visas between July and November last year – a jump of almost 30 per cent form the same period the previous year, making it the fourth most common occupation for 457 visas, behind cooks, project managers and software programmers.

Dr Hambleton said the "vast majority" of these had been recruited directly from overseas.

"The 457 Class visa is intended to fill workforce gaps, not displace locally trained and highly skilled graduates and junior doctors who want to make a long-term contribution to the health of our nation," he said. "The current data suggests that the Visa is not being used as it was intended. The AMA believes it is time for the Government to undertake an urgent review of the recruitment of RMOs directly from overseas on the 457 Class visa, particularly within the public hospital system."

The Minister said he "appreciate[d]" the AMA's concerns and was keen to protect the integrity of the system, but he indicated he was reluctant to institute a major clampdown on the 457 visa program for RMOs.

"It is important to ensure that the overall program retains sufficient flexibility to ensure that employers with a legitimate need to employ overseas workers as RMOs are able to meet their needs," Mr Bowen said. "For this reason, I would be hesitant to remove and employer's ability to sponsor an RMO under the 457 visa program, particularly in rural Australia."

But the Minister said he would take the findings of a pending Productivity Commission inquiry into the future of the nation's health workforce into account in deciding how to manage the 457 visa program in future.

AR

TO COMMENT CLICK HERE

Practice nurse pay push may threaten jobs

"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"

Medical practices have warned they may have to freeze recruitment and cut back on nursing staff if plans by the Australian Nurses Federation to collectively negotiate on behalf of practice nurses are approved.

In witness statements presented to Fair Work Australia, doctors and practice managers working in clinics in metropolitan, regional and rural areas said any push to force them into collective negotiations with the ANF over pay and conditions for practice nurses would undermine existing collaborative and flexible work arrangements, and could lead to job cuts and hiring freezes.

In mid-2011 the ANF announced plans to negotiate a collective enterprise agreement for practice nurses covering about 900 practices nationwide, asking Fair Work Australia (FWA) to grant it a low-paid authorisation, allowing for a pay determination if no agreement was reached with employers.

The AMA, acting on behalf of around 200 practices, has vigorously opposed the claim through a series of hearings before Fair Work Australia, and final submissions on the matter were presented late last month.

A team of industrial lawyers engaged by the AMA from the firm Moray and Agnew argued that the ANF was ill-conceived and wrong.

They said that practice nurses were generally paid about 20 per cent above the award rate, so could not be considered low-paid.

In addition, they argued that pay rates that applied in hospitals should not be automatically extended to private practice because of differences in working environment and duties, and added that it was wrong to treat all private practices as the same, given the great breadth and variety in where they were located and what they did.

The AMA's arguments were supported by witness statements presented to FWA from a significant number of doctors and practice managers worried about how the ANF claim might affect their ability to operate.

Sharon Powell, practice administrator at the Lilydale Medical Centre in outer east Melbourne, warned FWA that although the ANF's claims may benefit some nurses, it could be very costly for many others.

"There will be nurses who lose their jobs because the combined effects of this log of claims, coming at a time when the Government has discontinued six nurse item numbers, will not make it financially possible to employ as many nurses," Ms Powell warned. "Our [five] nurses are all members of the ANF but do not support the ANF log of claims. They are happy with their working conditions [and] are concerned that if employers are forced to enterprise bargain, there will be nurses who lose their jobs."

Business manager of the Langpark Medical Centre in Langwarrin, Victoria, Julie Cartwright, said medical practices were coming under increasing financial strain, and would struggle to pay for significant pay increases.

"Like other small to medium businesses, we are having to cope with a poor economic climate," Ms Cartwright said. "We are faced with increasing costs, particularly energy, consumables, and wages, whilst being pressured to keep patient fees to a minimum, or to bulkbill in many circumstances.

"Whilst expenses are rising, we have had cuts to future Government funding by changes to the Practice Incentives Program.

"The ANF log of claims came without any consultation with the practice or its nurses."

Meryl Jerome, of the Benalla Church Street Surgery in Gippsland, Victoria, warned that uncertainty created by the ANF's claims had already forced the practice to delay hiring decisions.

"We would like to employ another nurse but hesitate to do so, mainly because of the impending log of claims, and the removal of nurse item numbers from Medicare schedule – the business simply could not afford to," Ms Jerome said.

FWA has reserved its decision in the case, and is expected to make a ruling within the next three months.

AR

TO COMMENT CLICK HERE

Nation 'poorly prepared' for extremes: AMA

There are "fundamental gaps" in the nation's ability to cope with health problems caused by heatwaves, bushfires, floods and other extreme weather, the AMA has warned.

As the country sizzled through a record-breaking heatwave, followed by wild storms that battered the east coast and inundated large stretches of coastal Queensland, the AMA told a parliamentary inquiry that national preparations to counter the health effects of damaging and dangerous climatic conditions were inadequate.

In its submission to the inquiry, being conducted by the Senate Standing Committee on Environment and Communications, the Association warned that extreme weather events were likely to increase in intensity, frequency and duration, increasing the stress on the health of the nation as it struggles to cope with a mounting burden of chronic disease and an ageing population.

The Bureau of Meteorology reported that January was the nation's hottest month on record, with an average mean temperature of 29.68 degrees Celsius and an average mean maximum temperature of 39.92 degrees Celsius, surpassing the previous record set in January, 1932.

"The heatwave in the first half of January was exceptional in its extent and duration," the Bureau said. "The national average maximum temperature on 7 January [40.33 degrees Celsius] was the highest on record."

Reports including the *Garnaut Climate Change Review* and the *Intergovernmental Panel on Climate Change* predict that Australians will swelter through increasingly hot summers, with the number of days above 35 degrees for major cities in southern Australia set to double by 2030.

The submission said the health implications of this were "profound", warning that the number of deaths arising from extreme heat was likely to double unless steps were taken to improve how such events are handled.

"Heatwaves have a greater impact on population health in Australia than any other natural hazard, and are associated with a significant increase in mortality and morbidity rates," it said.

As summers get hotter, so the risk of bushfires and drought mounts, adding to the stress on individual health as well as vital infrastructure, including water supplies and roads, as well as serious disruptions to food supplies.

Along with hotter weather, the nation could also face increasing incidents of damaging winds and storms, and widespread flooding, the submission warned.

The AMA said recent experience, such as the 2009 Victorian bushfires and the 2011 Queensland floods, had shown that such events can not only take a heavy physical toll on affected communities, but can be associated with long-lasting mental health problems, including depression and anxiety disorders.

AMA Vice President, Professor Geoffrey Dobb, said the health effects of such occurrences could be "profound", underlining the need for much better national preparedness.

"As we have seen recently, the health impacts of extreme weather events can reduce access to essential health services precisely where they are needed the most," Professor Dobb said.

"Australia needs to adopt a national, coordinated strategy to ensure health services can be rapidly mobilised and effectively targeted during extreme weather events, and a fundamental gap in policy leadership needs to be overcome if we are to be better prepared for the health impacts of future weather events," he said.

The AMA recommended that a national framework be developed to link health databases with real-time monitoring and assessment of weather, climate and geographical data.

It also urged there be greater investment in preventive measures and long-term planning, as well as better understanding of the scope and scale of the health effects of extreme weather – including adequate engagement of health professionals and the health sector in planning and preparing for such events - and the development of supporting regulations, legislation, standards and codes.

AR

TO COMMENT CLICK HERE

Another win for AMA ophthalmologist members

A push by optometrists to be able to prescribe medication without supervision from ophthalmologists has been knocked back following intense lobbying by the AMA.

In what AMA Vice President, Professor Geoffrey Dobb, hailed as a victory for patient safety, Pharmaceutical Benefits Advisory Committee (PBAC) has rejected a proposal from the Optometrists Association of Australia (OAA) to allow optometrists to prescribe fluoroquinolones (ciprofloxacin and ofloxacin) independently under the Pharmaceutical Benefits Scheme.

"The AMA has again successfully lobbied to ensure patients receive safe and effective treatment," said Professor Dobb, who is chair of the AMA Therapeutics Committee. "Patients with suspected bacterial keratitis will continue to be treated by optometrists under the supervision and direction of an ophthalmologist."

The PBAC announcement is another win for the AMA in representing its ophthalmologists members.

The AMA made a submission to PBAC in mid 2012 strongly opposing the removal of this restriction. The submission advised PBAC that fluoroquinolones are second-line treatments that should only be initiated by or in consultation with an ophthalmologist because the conditions for which fluoroquinolones are prescribed can be serious and sight threatening.

"Despite OAA arguments, there is no case for treating expectantly and delaying ophthalmologic review for 24 to 48 hours," Professor Dobb said.

"An ophthalmologist is available on-call, and general practitioners and ophthalmologists are equipped to see any patients needing emergency treatment."

"I encourage AMA ophthalmologist members to share the benefits of AMA membership with their non-member colleagues. It's important we have active ophthalmologist members to support ongoing lobbying on these issues."

The latest outcome follows successful submissions made by the AMA to PBAC in in 2010 and 2011 in response to OAA proposals to remove similar PBS restrictions on optometrist prescribing.

The AMA is represented on the PBAC Expert Advisory Committee on Optometric Prescribing.

GD

TO COMMENT CLICK HERE

Australia Day honours

Almost 30 AMA members have been recognised for their outstanding service to the nation through their work in medicine and contributions to community life.

Among those honoured were several state AMA Councillors, a former South Australian minister, a leading international philanthropist and several distinguished researchers.

The recipients and their citations are:

Member of the Order of Australia (AM)

Dr Brian Michael Boettcher (NSW) - For significant service to psychiatry as a clinician and educator.

Associate Professor Stuart Leigh Boland (NSW) - For significant service to medicine through leadership roles in professional organisations and as a surgeon and educator.

Associated Professor Andrew Cochrane (VIC) – AMA VIC Councillor - For significant service to adolescent and adult congenital heart disease as a clinician, researcher and educator, and through humanitarian and philanthropic contributions.

Dr Brian Leslie Cornish (SA) - For significant service to medicine as an orthopaedic surgeon, to forestry and conservation, and to the community.

Professor Stephen Misha Davis (VIC) - For significant service to medicine in the field of neurology.

Dr Alan William Duncan (WA) - For significant service to medicine in the field of paediatric intensive care as a clinician and educator.

Dr Mark Francis Ellis (VIC) - For significant service to medicine in the field of ophthalmology and to eye health in Indonesia and Timor-Leste.

The Honorable Dr Jane Diane Lomax-Smith (SA) - For significant service to the Parliament and the community of South Australia.

Associate Professor Jeno Emil Marosszeky (NSW) – For significant service to rehabilitation medicine, and through contributions to people with arthritis.

Dr Christopher Mitchell (NSW) – Past President of the RACGP - For significant service to medicine as a general practitioner through leadership roles in clinical practice, education and professional organisations.

Associate Professor Jonathan Phillips (NSW) - For significant service to mental health as a forensic psychiatrist, particularly through contributions to professional organisations.

Professor Bruce William Robinson (WA) - For significant service to medicine in the area of research into asbestos-related cancers and to the community, particularly through support to fathers.

Professor Peter Allen Silburn (QLD) - For significant service to medicine as a neurologist, particularly in the treatment of neurodegenerative diseases.

Professor David Owen Sillence (NSW) - For significant service to medicine in the field of clinical genetics.

Associate Professor Jitendra Kantilal Vohra (VIC) - For significant service to medicine in the field of cardiology.

Dr Glenda Kaye Wood (NSW) - For significant service to medicine in the field of dermatology.

Medal of the Order of Australia (OAM)

Dr Malcolm Baxter (VIC) - For service to medicine as an ear, nose and throat specialist.

Clinical Professor Graeme Leslie Beardmore (QLD) - For service to medicine in the field of dermatology.

Dr James Ernest Breheny (VIC) - For service to medical administration.

Professor Vincent Caruso (WA) - For service to medicine in the field of pathology.

Professor Bradley Scott Frankum (NSW) – AMA NSW Councillor - For service to medicine as an educator and administrator.

Dr Geoffrey Vernon Mutton (NSW) - For service to medicine in the field of orthopaedic surgery.

Dr George Christopher Peponis (NSW) - For service to the sport of rugby league football and to the community.

Professor Ajay Rane (QLD) - For service to medicine in the field of urogynaecology.

Dr John Charles Schwarz (NSW) – Founder of African AIDS Foundation with his wife, Rosalie Gae Schwarz, who also received an OAM - For service to international relations, particularly through the African AIDS Foundation.

Associate Professor Michael John Weidmann (QLD) - For service to medicine in the field of neurosurgery.

Public Service Medal

Dr Andrew Geoffrey Robertson CSC (WA) - For outstanding public service as Director, Disaster Management and Preparedness within WA Health.

Another AMA member, **Dr Peter Bilenkij**, was made Orange Citizen of the Year in recognition of his work with the Radiotherapy Alliance and Cancer Care Western NSW, and his contribution to the planning committee for the Orange Health Service.

TO COMMENT CLICK HERE

Surge in problem gambling among the young

Dramatic growth in online and mobile sports betting is driving an upsurge in problem gambling among young men, adding urgency to calls by the AMA for national leadership in protecting consumers and weaning the states and territories off gaming revenue.

In a Position Statement, *The Health Effects of Problem Gambling,* released on 7 February, the AMA warned that problem gambling had become a significant public health issue, affecting the lives of up to five million Australians.

AMA President, Dr Steve Hambleton, said young people were particularly at risk of developing problems with gambling, and called for the Federal Government to take a leadership role on the issue, and work closely with the states and territories on a coordinated approach to tackling the problem.

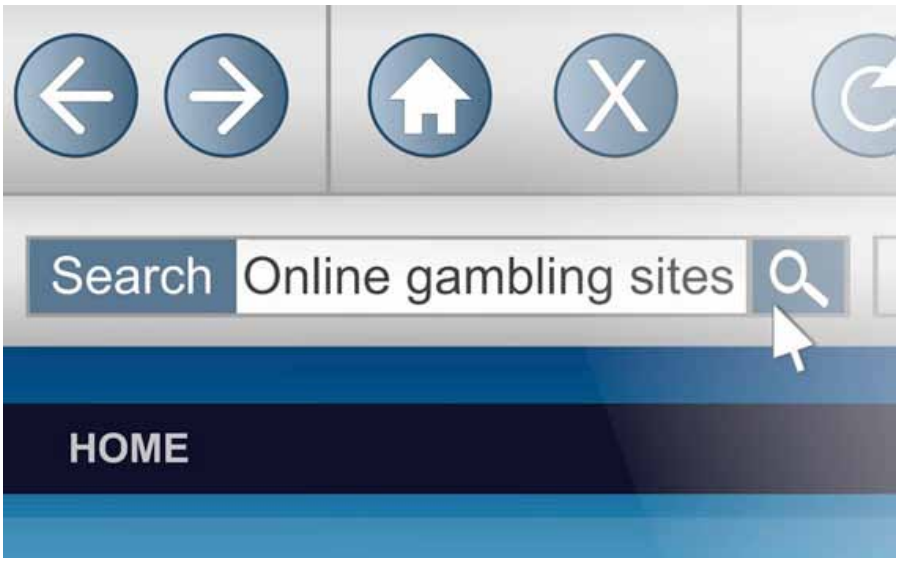
"Online sports betting is Australia's fastest growing form of gambling, and has been associated with a rapid escalation in young males seeking treatment for problem gambling," Dr Hambleton said.

The AMA President said that not only did such behaviour shatter the lives of problem gamblers themselves, but it's effects rippled out through the community.

He said that for every problem gambler, up to 10 other people – including family, friends, workmates and employers - were directly affected, in terms of strained relationships, financial problems, reduced productivity, depression and substance abuse.

Dr Hambleton said doctors witnessed such fallout in their daily practice.

"Medical practitioners see first-hand the devastating consequences of gambling," he said. "Problem gamblers see their GP more often than the average, and suffer



a range of stress-related conditions from hypertension and insomnia to stomach upsets, headaches and depression."

The Position Statement pointed out that while so far around 80 per cent of problem gambling involved poker machines, there was a concern that online and mobile betting and games could encourage and increasing number of people – particularly the young – into harmful gambling behaviour.

Dr Hambleton said the rapid growth of interactive gambling, such as online sports betting, mobile apps and gambling-themed games on social media websites, posed a significant risk, particularly the young.

"Young people are at heightened risk of developing problems with gambling, and are particularly susceptible to interactive gambling," he said.

The AMA President endorsed warnings by Australian Greens Senator Richard Di Natale that sports betting was "out of control", with people finding it increasingly difficult to know where a game of sports ends and gambling begins.

In its Position Statement, the AMA called for the Federal Government, in close cooperation with the states and territories, to establish an independent national gambling regulator to oversee the industry.

It also urged the Commonwealth to provide incentives to encourage the states and territories to reduce their reliance on gambling revenue.

AMA Vice President, Professor Geoffrey Dobb, said there had been a succession of reports and inquiries on problem gambling, and it was now time for action.

"A coordinated policy response and political leadership is needed if we are to tackle problem gambling, and curbing this behaviour among young people must be a priority.

"It's a serious problem, and unless action is taken now, it will only get worse," Professor Dobb said.

AR

TO COMMENT CLICK HERE

AMA IN THE NEWS

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

Print/Online

Daycare hygiene uproar – Banned from blowing candles, *The Adelaide Advertiser,* 6 February 2013

AMA President Dr Steve Hambleton warned that 'clean-freak' regulations placed "kids in a bubble".

School pulls together after tragedy, *Courier Mail*, 2 January 2013

AMA President Dr Steve Hambleton spoke about the importance of getting involved to strengthen the school community, following the death of a Brisbane student.

Heat linked to death toll, *The Herald Sun*, 30 January 2013

An AMA submission to a Senate inquiry into Australia's extreme weather preparedness warned more and worse flooding, bushfires, storms, droughts and temperature spikes would not only threaten lives, but lead to more depression and stress as people dealt with the loss of homes, livelihoods and loved ones.

Radio

Dr Hambleton, My Melbourne – 1377, 6 February 2013

AMA President Dr Steve Hambleton discussed new hygiene guidelines for childcare centres.

Dr Hambleton, 666 ABC Canberra, 6 February 2013

Dr Hambleton talked about the anti-acne and contraceptive pill Diane, which was suspended from sale by the French pharmaceutical watchdog after four deaths were linked to the drug.

Professor Geoffrey Dobb, ABC NewsRadio Sydney, 29 January 2013

AMA Vice President Professor Geoffrey Dobb warned Australia was not prepared to deal with the health complications of climate change.

TV

Dr Hambleton, Channel 10 News, 6 February 2013

AMA President Dr Steve Hambleton said that strict new hygiene guidelines stating that blowing candles out on a birthday cake at school could be a 'no-no' were going too far.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

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

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

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

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

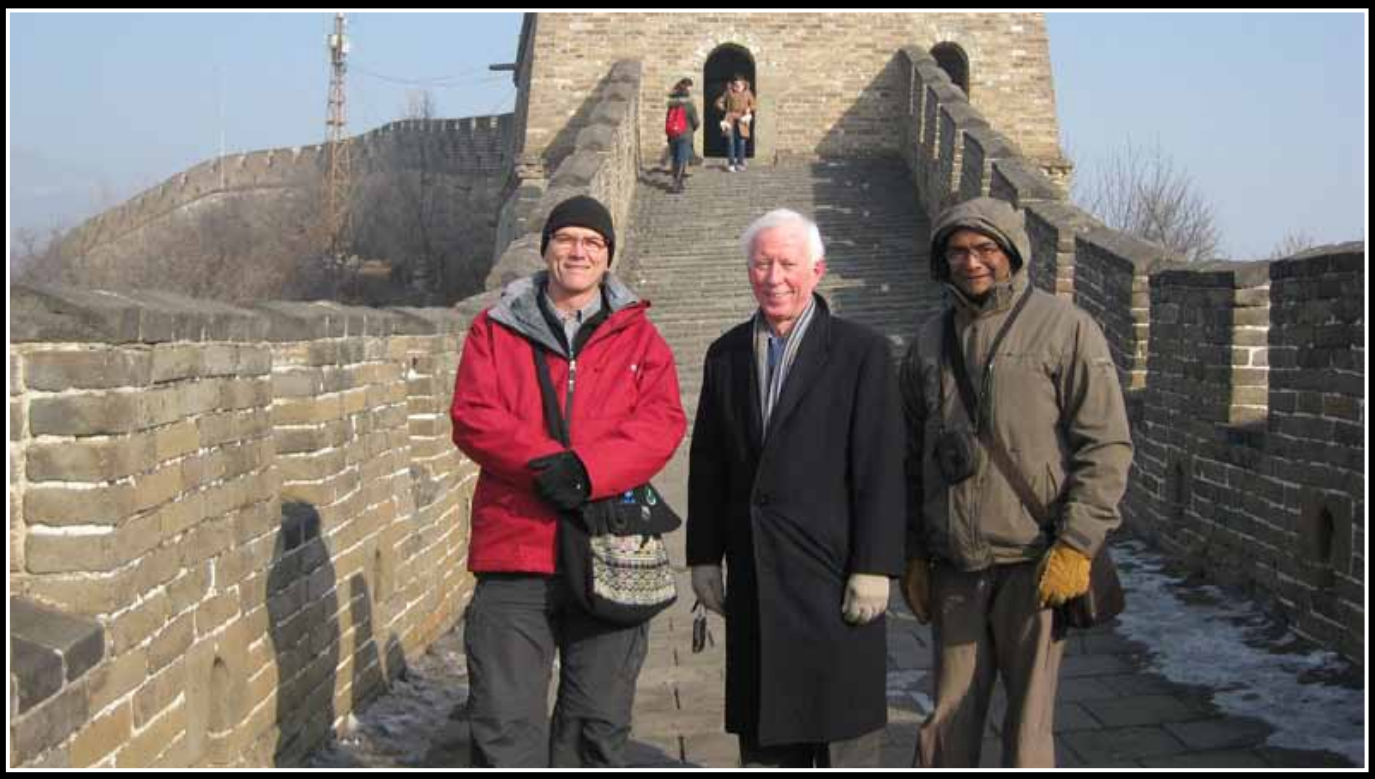
TO COMMENT CLICK HERE

AMA in action

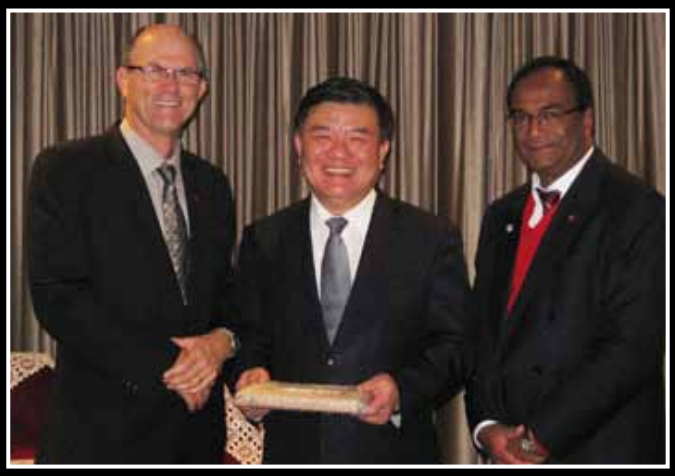
AMA President Dr Steve Hambleton has been travelling far and wide so far this year.

In the last fortnight Dr Hambleton attended the World Medical Association Conference in Beijing with former AMA President and Chair of the World Medical Association, Dr Mukesh Haikerwal. During his trip, Dr Hambleton visited the Great Wall of China and the Museum of Traditional Chinese Medicine in Beijing. Dr Hambleton returned to Australia in time for the beginning of the first sitting week of Parliament for the year. He went to Canberra, where he met with Shadow Health Minister, Peter Dutton, and Australian Greens Health Spokesperson, Senator Richard Di Natale. During this time Dr Hambleton also conducted numerous media interviews, including about changes to hygiene guidelines for childcare centres and schools.

TO COMMENT CLICK HERE



Dr Steve Hambleton with World Medical Association President Dr Cecil Wilson and Chair of the World Medical Association Dr Mukesh Haikerwal on the Great Wall of China



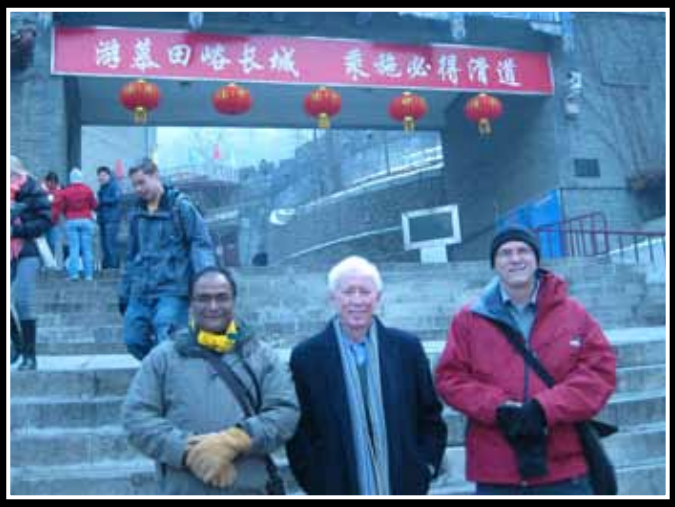
AMA President Dr Steve Hambleton, with Chinese Health Minister Chen Zhu and Chair of the World Medical Association Dr Mukesh Haikerwal

Dr Hambleton with Secretary General of the Thailand Medical Association Professor Saranatra Waikakul

AMA in action

Dr Hambleton with World Medical Association President Dr Cecil Wilson

Dr Steve Hambleton with an ancient traditional Chinese medicine teaching model displaying acupunture points.



Dr Hambleton with World Medical Association President Dr Cecil Wilson and Chair of the World Medical Association Dr Mukesh Haikerwal at the entrance to Great Wall of China

Dr Hambleton with Shadow Health Minister Peter Dutton

Dr Hambleton speaks to the media about changes to pre-school hygeine guidelines

Dr Hambleton with Australian Greens Health Spokesperson Richard Di Natale

Critical care far from anywhere

RFDS emergency service plane

It is getting to the end of a busy five-hour session at the community health centre in the remote Aboriginal community of Yalata in South Australia, and Dr Andy Killcross is waiting to see his last patient of the day

His colleague, GP registrar Ranbir Dhillon, is in the next room treating his patients, many presenting with cardiac problems and diabetes issues, but regular three-month delays in getting hospital discharge summaries makes his task difficult.

Down the corridor, mental health nurse Nigel Hines., who is studying to become a nurse practitioner, is talking to patients about their psychological problems.

While the clinicians go about their work at the centre, at the settlement's dusty airstrip nearby another patient, an elderly woman with a serious diabetic condition, has been loaded into the Royal Flying Doctor Service aircraft. She will travel with the medical team back to their home base in Port Augusta, 670 kilometres away, to receive urgent medical attention from the local hospital.

The medical team is one of many employed by the Royal Flying Doctor Service of Australia (RFDS) to provide 24-hour emergency care and essential health services, including regular clinics, to communities in remote and rural areas.

The RFDS, which was established in 1928 after Reverend John Flynn saw the struggles of people living in remote and rural Australia, has developed to now operate 21 bases across the country, with 61 aircrafts, and pilots flying the equivalent of 25 trips to the moon each year.

The RFDS doctors and flight nurses did more than 270,000 patient contacts last year, which is roughly one patient every two minutes.

The clinics delivered by the RFDS in remote and rural areas provide many communities with their only access to general practice, child and maternal health, women's health, health promotion, health screening and population health services.

Once a week, Dr Killcross and his colleagues make the trip to Yalata as part of this essential service.

The closest Central Operations base for the RFDS in the region, located at Port Augusta, schedules regular clinical services to remote and rural areas in South Australia on a fortnightly basis, though for larger communities such as Yalata this is upgraded to a weekly visit.

Australian Medicine was invited to accompany the RFDS medical team on their visit to Yalata – a flight that usually takes two hours each way.

Before boarding the aircraft at Port Augusta, Dr Killcross and his colleagues are given the medical mail for the community. At the table with the local clinical nurse they open the mail and review the information. Most of the hospital discharge summaries date back

...CONTINUED ON PAGE 16

RFDS Central Opperations command centre

One of the Yalata locals after visiting the local swimming pool

Dr Killcross at the Yalata Community Clinic

...CONTINUED FROM PAGE 15

more than three months ago. The doctor and his colleagues are still waiting for several test results for patients – they suspect the results have been lost in the system

The clinical nurse tells them that some of their patients have not gone for their specialist tests because it involves an 11-hour bus ride to Port Augusta – even longer if the specialist is in Adelaide.

The AMA believes an e-health system that connects patient information across health care settings, and which can be accessed and contributed to by treating medical practitioners, would improve safety and quality medical care in Australia. Certainty for the doctors working in Yalata an e-health system would have made their jobs a little easier.

AMA President Dr Steve Hambleton said the benefits of e-health in making the best use of existing health care services and avoiding errors, duplication and waste, were well known.

"For medical practitioners, e-health means being able to access all of the clinically relevant medical information about a patient at the time of diagnosis or treatment," Dr Hambleton said.

According to the Medical Workforce 2011 report there were 274.1 employed medical practitioners per 100,000 people working in remote or very remote areas, compared with 407.6 per 100,000 in the major cities. On average, there were 36.9 specialists per 100,000 people working in remote and rural areas compared to 148.7 in major cities.

AMA President Dr Steve Hambleton said the Medical Workforce 2011 report provided further evidence about the uneven distribution of the medical workforce around the country.

The RFDS encourages specialists to visit remote and rural communities on a regular basis, because those living in such isolation often find it hard – if not impossible - to visit their closest specialist, who might be hours away by road.

After arriving at Yalata and grabbing a quick bite to eat, Dr Killcross and his colleagues meet the clinical nurse who lives in the community. The nurse - who knows the people and their health issues intimately, and has their trust – plays a vital role assisting the RFDS team in their clinical work.

Together they go through the list of patients for the day, the nurse providing background information on their health and what treatment has been provided since the last RFDS visit.

At the Yalata clinical centre, the demand from the community for health services is high, which puts the local clinical nurse under pressure. Although the list is fairly short – only around 20 patients – many have multiple chronic diseases, making treatment time consuming and complex.

According to the Australian Institute of Health and Welfare, chronic disease attributes to 80 per cent of the mortality gap for Indigenous Australians aged between 35 to 75 years compared with the rest of the nation.

Yalata is typical of many Indigenous communities. Life expectancy in many Indigenous peoples is short in comparison to the rest of the population. The majority of Indigenous people won't make it into their 60s.*

The gap is caused by higher rates of chronic disease at younger ages, as well as increased death rates associated with chronic disease. According to the AIHW, 12 specific chronic diseases contribute to the life expectancy gap, with ischemic heart disease, diabetes and liver disease topping the list.

According to the AIHW reducing the gap in life expectancy between Indigenous and other Australians will require improvements in the prevention, treatment and management of chronic diseases.

The RFDS work with local State Governments to increase access to clinical services in remote and rural Australia. The clinical services aim to reduce chronic diseases and in turn the life expectancy gap between Indigenous and non-Indigenous Australians.

The RFDS central operations base offers:

- GP and Community Health Nurse remote clinics, (like the one in Yalata)

...CONTINUED ON PAGE 17

...CONTINUED FROM PAGE 16

Aboard the RFDS aircraft bound for Yalata

Dr Andy Gilchrist and colleagues

The Yalata Community Clinic

Inside the Yalata Community Clinic

- Rural Women's GP Service.
- Rural and Remote Mental Health Program.
- Healthy Living Program, and
- Dental program.

The return to Port Augusta was a welcome opportunity for Dr Killcross to relax. The GP had been called to an emergency on a train in outback South Australia the night before. Due to the serious nature of the patient's condition, Dr Killcross had accompanied him into the hospital in Adelaide, which meant he did not get back to the RFDS Port Augusta Base until after midnight

The Port Augusta RFDS base is the communications centre for Central Operations. All emergency calls for the area are planed and assigned, including organising all emergency evacuation and inter-hospital transfer flights, as well as after-hours back up for the Broken Hill base.

The RFDS specialises in two types of emergency air transport services; - primary response and inter-hospital transfers.

Primary responses involve the evacuation of people who are seriously ill or injured. The RFDS may fly to an isolated property, to a remote health facility or even to the site of an accident. The RFDS provides this service 24 hours a day to more than 80 per cent of the Australia.

As its name suggests, inter-hospital transfers are the aeromedical transportation of patients between hospital facilities, to higher levels of care.It usually occurs when patients with a serious illness or injury require a medical transfer to a large metropolitan hospital for higher care.

At the end of the day, Dr Killcross reflects back on the patients the team has seen. He believes he has made a difference in the lives of the people in the Yalata community, however small. He has assisted as best he could with their medical conditions.

For now, his mind is on his next flight with the RFDS tomorrow bound for yet another remote community, this one with a whole different set of health issues to treat.

The RFDS is one of the largest and most comprehensive aeromedical organisations in the world. It is a not-for-profit organisation and, while supported by Commonwealth, State and Territory governments, relies heavily on fundraising and donations from the community to purchase and medically-equip its aircraft.

If you are interested in working for the RFDS, or want to find more information, go to http://www.flyingdoctor.org.au/

* Australian Institute of Health and Welfare, (2012) *Indigenous life expectancy*. www.aihw.gov.au/indigenous-life-expectancy/

KW

TO COMMENT CLICK HERE

Preparing for the worst

BY **DR BRIAN MORTON**

"In Australia, during many types of natural and other disasters, GPs have been at the forefront of providing care and treatment and offering whatever medical support is necessary in a crisis situation"

This summer has provided its fair share of emergency situations from one end of the country to the other, and from opposing disaster categories.

From the devastating fires in Tasmania, to the consuming floods in Queensland, it is an all too familiar story, and a reminder of why GP involvement in disaster preparedness and emergency planning is essential to ensuring that, in such times, the community have ready access to medical care.

In Australia, during many types of natural and other disasters, GPs have been at the forefront of providing care and treatment and offering whatever medical support is necessary in a crisis situation.

Last year, at the instigation of the AMA Council of General Practice, the AMA released two position statements in relation to GPs and disasters.

The *Involvement of GPs in Disaster and Emergency Planning* highlights the important role that GPs play in a crisis, and advocates for recognition of the role of the GP in emergency and disaster situations, for GP involvement in disaster and emergency response planning, and for supporting GP preparedness and capacity to respond.

The second position statement, *Supporting GPs in the Immediate Aftermath of a Natural Disaster*, provides advice for GPs on pre-disaster planning. It also outlines how the AMA could assist with coordination efforts in large-scale emergencies, and urges sufficient support for GPs so they can be ready to care for the community in a disaster or emergency event.

The AMA, in its recent Federal Budget Submission, called for a National Strategy for Health and Climate Change to ensure that Australia can respond effectively to the health impacts of climate change, extreme weather events, and to people's medium and long-term recovery needs. Key elements to be incorporated in the strategy include:

- strong communication links between hospitals, major medical centers, general practitioners, and emergency response agencies to maximise efficient use of health resources in extreme weather events;
- localised disaster management plans for specific geographical regions that model potential adverse health outcomes in those areas;
- the development of effective interventions to address mental health issues arising from extreme events, including those involving mass casualties and from longer-term changes, such as drought; and
- a register of recently retired, competent medical practitioners who are willing to assist in providing medical services during a national emergency.

The AMA, through its involvement in a range of Government committees concerned with health protection, health sector resilience, and emergency response planning, works to ensure that in times of need GPs are considered and supported in their response role.

Later this month I will be attending a forum that will inform the Australian Health Protection Principal Committee, which provides overarching leadership on national policy development and implementation on emerging health threats related to infectious diseases, the environment and natural disasters. Please contact me at gpnn@ama.com.au if there are issues you think should be raised.

TO COMMENT CLICK HERE

Keeping doctors in public practice is best practice

BY **DR STEPHEN PARNIS**

In November 2012, the Commonwealth Treasury's Not-for-profit Sector Tax Concession Working Group released a consultation paper on tax concessions for the not-for-profit (NFP) sector, seeking feedback on how tax concessions for the NFP sector could be made "fairer, simpler and more effective".

In reality, we are concerned at the possibility of this group making recommendations which will undermine salary packaging – an extremely important consideration in the employment conditions for doctors working in the public health system across the nation.

The Australian Medical Association (AMA) and the Australian Salaried Medical Officers Federation (ASMOF) prepared a joint submission on the discussion paper. For the purposes of the submission, we limited our recommendations to those we believe have the potential to most significantly affect good medical care, by undermining recruitment and retention in public hospitals. Hence, the main focus was in relation to tax concessions, the benefits of which vastly outweigh their cost.

Naturally, we support a fair, efficient and equitable taxation system. The current tax concessions for the NFP sector reflect good public policy. They are designed to support the recruitment of suitably qualified staff to work in areas that would not otherwise be able to compete against the salaries offered by the private sector.

The AMA and ASMOF are not alone in urging the Working Group to consider the impact of any changes on the capacity to recruit and remunerate employees in the NFP sector.

Other interest groups have also made submissions on the issue.

One, the St Vincent de Paul Society, said, "in our experience, fringe benefits can be a valuable recruitment tool".

The Law Council of Australia noted "it is probably important here to recognise that at least some of the organisations which receive tax free benefits…are typically those which cannot remunerate employees in the same ways as the private sector".

The Association of Australian Medical Research Institutes stated "the current concessions… form an essential source of the remuneration equity between NPF and for-profit organizations".

The only possible way public hospitals can remain competitive with the private sector is by being able to provide benefits such as salary packaging. Without this benefit, doctors are much more likely to leave the sector, and not be attracted to it in the first place. States and territories struggling with diminishing health budgets cannot afford to replace this benefit with a commensurate rise in salaries.

This story is not new, nor is it unique to the medical profession.

We all know of the constant friction between the Commonwealth and the states and territories in relation to funding of public hospitals. The Rudd-Gillard health reforms promised an end to the blame game, and yet recent experience demonstrates that it has never been more acrimonious.

Tax concessions are a relatively small way in which the Commonwealth can contribute to the smooth operation of public hospitals without the impost of direct funding.

Is the net benefit of any change to tax concession arrangements really worth it?

History has shown us that health requires solid long- term strategies to remain efficient, as opposed to quick fix cost cutting. The loss of experienced staff would do immeasurable damage to the sector, which is under incredible duress.

The review needs to proceed with caution, and ensure that it thoroughly assesses the impact of potential reforms, including the downstream effects.

The AMA and ASMOF are concerned that the reforms canvassed in the paper could significantly affect the ability of public hospitals to recruit and retain staff.

This could have a devastating impact on access to a range of services, including patient care, teaching, training and research, while delivering precious little in the way of savings to Treasury.

I commend the AMA and ASMOF on their submission, which I hope will resonate with the Working Group, as it does with the thousands of public hospital doctors.

The submission can be viewed at: https://ama.com.au/policy/submissions

TO COMMENT CLICK HERE

2013: Time to fix the medical training mess

BY **CHAIR WILL MILFORD**

The beginning of a year presents a useful opportunity to reflect, both on the year just completed, and the possibilities that arrive with the year to come.

With this in mind, I reviewed the Doctors in Training columns of years past.

It was with very little surprise that the oldest column I could find concerned medical training capacity,written by Dr Andrew Perry in April 2010.

I find it more than a little disturbing that we sit here today discussing the same issue although, thanks to the AMA and its concerted advocacy, we have seen post-graduate training positions largely keep up with demand to date.

However, we have now reached the point where bottlenecks are emerging and governments must commit further resources and work more closely together to improve the planning and coordination of training places.

Beyond training capacity, the AMA's Doctors in Training Council has made good progress on a number of other fronts.

Medical training quality, as a core issue with implications for the quality and safety of health care, has become prominent.

The advocacy work the Council has conducted on this issue is beginning to coalesce and produce policy responses from organisations such as the Australian Medical Council and Health Workforce Australia. This will be a space to watch for 2013.

There have also been victories in other policy areas, including funding for teaching, training and research, and closing loopholes on domestic full-fee paying places in medical schools.

Additional advocacy work being done on a broad range of topics, engaging a number of stakeholders, should begin to bear fruit this year.

Returning to the issue of medical training capacity, it is valuable to reflect upon the events of last year.

At years end, an additional 116 intern places had been offered, in addition to the 3080 existing posts offered by the postgraduate medical councils.

With the intern year underway, I understand that only 20 of the 60 places offered and funded by the Commonwealth were accepted, reflecting the lateness with which they were offered and perhaps the quality of the posts. We still have no data on the total number of medical graduates who were unable, or chose not to, undertake an internship in Australia.

This year, 3623 medical students are expected to graduate. The Commonwealth government has already stated that last year's intervention was a 'one-off' and would not be repeated.

The issue remains on the political radar and the portents are alarming. A National Medical Intern Summit will be convened by the NSW Government later this month. What this can achieve remains to be seen, although the AMA will higlight that the Summit is only looking at the beginning of the problem.

Bottlenecks will occur in the medical training pipeline, and a real risk exists that this Summit will focus on short term, myopic fixes.

This includes the concern that previously promulgated ideas such as 'pay for your own internship' find fertile ground in state health departments desperately over-budget.

The concept that an intern should pay for the privilege of inserting an intravenous cannula at 3am, counselling a bereaved relative or completing a discharge summary remains, and always will be, ludicrous.

While internship is a stepping-stone along the training pathway to general registration and independent practice, with the financial rewards inherent in this, interns all over Australia still provide an essential service within hospitals.

An intern is not just an extraneous trainee but a foundation upon which health care delivery in public hospitals is built. Just like every other public hospital employee, they should be appropriately renumerated for the role they perform. The sooner the progenitors of these ideas realise that internship involves a serious amount of service provision and is not a free ride, the better.

As we have warned, repeatedly, for many years, this problem needs a long-term, workable solution built upon consultation and planning. Maybe the National Medical intern summit will produce this.

Regardless, the years of 'policy on the run' have not worked. The problem has not gone away. This is not about unemployed doctors. It is about the future health of Australian communities.

TO COMMENT CLICK HERE

Time to renew the commitment to better Indigenous health

BY DR STEVE HAMBLETON

On February 6 this year, Prime Minister Julia Gillard presented her annual report to Australian Parliament on the government's Closing the Gap measures to improve health and life expectancy among Aboriginal peoples and Torres Strait Islanders.

Through COAG in 2008, Australian governments undertook to establish equality in life expectancy between Aboriginal peoples and Torres Strait Islanders and other Australians, by 2030. Despite it still being early days, progress is being made, particularly in halving the mortality rate for children under five, and improved school attendance and outcomes.

However, there is a long way to go to achieve health equality, and a strong commitment needs to be maintained, especially in this federal election year.

One first significant step in this is being taken in the development of a National Aboriginal and Torres Strait Islander Health Plan.

Policies and programs must be given direction by a comprehensive strategic plan that is a real road map with measurable outcomes, timelines and targets, and not just a statement of principles.

Australian governments also need to renew their funding commitments to Closing the Gap through COAG, at a level that can fully support achievement of the National Plan.

The current funding for the COAG National Partnership Agreement on Closing the Gap finishes in 2013, and it is important that the momentum that has been built through COAG is not lost through under-resourcing.

Finally, improving the health of Aboriginal people and Torres Strait Islanders is a problem that needs practical solutions that transcend party political differences, and extend beyond the electoral cycle.

The AMA calls on political parties in the upcoming election, and subsequently, to adopt a bi-partisan approach to the issue, and to commit to working with Aboriginal peoples and Torres Strait Islanders to further the goal of health equality.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

TO COMMENT CLICK HERE

Help for doctors treating genital mutilation

"We do not know how widespread this practice is in Australia, but we know there have been instances, and anecdotal evidence suggests these are not isolated"

A free guide for doctors, nurses, midwives and other health workers on how to identify and treat women and girls suffering female genital mutilation has been developed.

Though the practice of mutilating or cutting female genitalia is banned nationwide, it is believed that ten of thousands of women arriving in the country from areas where it is practiced have suffered the procedure, and there are concerns that a small but significant number of girls are being mutilated in clandestine operations being conducted within Australia.

The ABC's *7.30 Report* estimates that around 120,000 migrant women have undergone female genital mutilation (FGM) before arriving here, and New South Wales police have arrested and charged eight people over the alleged genital mutilation of two young girls in Sydney and Wollongong in the past 20 months.

FGM can involve the partial or total removal of external female genitalia, including partial or total removal of the clitoris and the labia minora, and possibly the sewing together of the labia majora.

While many doctors may rarely, if ever, encounter a case involving FGM, Family Planning Victoria has developed a guide to help general practitioners, nurses, midwives and other primary health care workers identify and assist women who have suffered from the procedure.

Family Planning Victoria chief executive officer, Lynne Jordan, said that while most health workers would likely have heard of FGM, many would be unfamiliar with exactly what it involves, its effects on the health of women, and how to go about broaching the subject with patients.

Ms Jordan said there were "a lot of stories" about the trauma associated with FGM, but a relative paucity of practical information for doctors and other health workers.

She said that while most GPs would encounter few cases involving FGM, the guide – which includes a five-page care plan flow chart that sets out critical information in a clear and concise format – would help them identify relevant health risks and legal obligations, and how to talk about the issue with their patients.

"Women may come in with symptoms of urinary tract infection, and a vaginal examination is not normally undertaken as part of diagnosing and treating that, but women who have experienced FGM have a higher propensity to UTI," Ms Jordan said, adding that GPs armed with such knowledge will be better able to identify cases involving FGM.

She said this was important, not just in identifying as early as possible factors that could complicate childbirth, but also as a way to protect young children.

Last year Western Australia police arrested and charged a couple over allegations they took their daughter to Bali for a traditional cutting ceremony, and there are concerns that many more girls of being taken overseas to undergo FGM.

Ms Jordan said doctors and other health workers were in a unique position to identify girls at risk of being subjected to FGM.

"Women are not going to walk into a GPs office and tell them they are going to have FGM performed on their children, but if you are actually building up a patient relationship with them, you may be in a position where you can start to ask questions," she said.

Late last year Health Minister, Tanya Plibersek, announced a national summit on FGM would be held early this year to discuss ways to raise awareness of the practice and reduce its incidence.

Ms Plibersek admitted that it was not known how common the procedure was in Australia, but said the Government was committed to doing all it could to help stamp it out.

"We do not know how widespread this practice is in Australia, but we know there have been instances, and anecdotal evidence suggests these are not isolated," the Minister said.

"One such procedure performed in this country is one too many. One girl taken overseas is one too many. We must work together to help put a stop to this act from ever being performed on girls who live in this country."

Copies of the guide can be obtained by calling Family Planning Victoria on 03 9257 0100, or visiting their website: www.fpv.org.au

AR

TO COMMENT CLICK HERE

Study underlines quality of surgical care

A national audit of surgery-related deaths has found shortcomings in the care of about 100 patients.

An investigation by the Royal Australasian College of Surgeons into 10,044 cases of surgical mortality in 2011 found that in 5 per cent of cases there were grounds to criticise patient care, though there were only 100 incidents where improvements in treatment may have prevented a fatality.

The study found that the overwhelming majority of surgery-related deaths involved elderly patients suffering acute life-threatening conditions with significant co-existing illness and a pre-existing medical condition.

Of the cases audited, critical care support was deemed necessary in 56 per cent of cases, and auditors thought it was warranted in further 12 per cent of cases where it was not provided.

The College's report found that of 7567 patients who underwent surgery, 15 per cent had an unplanned return to the operating theatre because of unexpected complications.

Audit chairman, Professor Guy Maddern, said that overall, the report showed patients received high quality care from the nation's surgeons.

"There was approximately 100 cases where we thought management could have been improved and may have altered the outcome," Professor Maddern told ABC radio. "So we are talking about an extremely small number of cases that we think in hindsight could have been managed better."

But he said many of these cases involved patients with complex health problems.

"These are people who are obese, diabetic, [have] cardiovascular disease, [are] smokers, and already suffering from chronic illnesses, and in this context, as an emergency operation, you often can't get all the information you would like," Professor Maddern told the *ABC*.

"You're forced to do the procedure to try and salvage the situation, and sometimes their general health is never going to tolerate that intervention."

He said the limited number of such incidents underlined the high quality of care most patients received.

"I think the public should be reassured that the vast majority of cases get the best care."

Professor Maddern said the robustness of the audit results had been enhanced by increased participation by surgeons and hospitals.

The proportion of surgeons taking part jumped from 60 per cent in 2009 to 90 per cent by the end of 2011, while 99 per cent of all public hospitals participated and 73 per cent of private hospitals.

The College said it undertook the audits to identify systemic problems or issues in the treatment of patients, and help develop solutions.

For example, the audit has highlighted concerns regarding the transfer of patients between hospitals.

"Despite some improvement, there are still issues around transfer of patients to other hospitals," the audit found. "This is a concern, as it is essential that all clinicians involved have a complete picture of the patient's issues upon presentation."

It found insufficient clinical documentation was a problem in 15 per cent of cases examined, while transfer was judged to be inappropriate in almost 30 per cent of cases, and delayed in 35 per cent of cases.

However, the most common grounds for criticism was delay in delivering definitive treatment, which in 59 per cent of cases was attributed to the surgical team.

Nonetheless, the audit identified several improvements in the performance of surgeons since 2009, including a rise in the number of cases where no issues were identified from 71 to 77 per cent.

Against this, though, it found that "there has been an apparent increase in some post-operative complications; missing and incomplete data remains an issue; [and] fluid balance in the surgical patient is an ongoing challenge. Nine per cent of cases were perceived to have had poor management of their fluid balance".

AR

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

The Science of Immunisation

The AMA has available copies of the booklet *The Science of Immunisation: Questions and Answers,* which has been produced by the Australian Academy of Science to dispel myths and misinformation about the dangers of vaccination.

To obtain copies of the 16-page booklet, please contact 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

TO COMMENT CLICK HERE

World-first effort to gauge doctor health

Almost 50,000 doctors and medical students are being asked about feelings of depression and anxiety as part of a massive undertaking to gauge the mental health of the nation's medical workforce.

In one of the biggest such projects ever undertaken, mental health foundation *beyondblue* is sending a questionnaire to around half of the nation's 80,000 practicing doctors and about 8000 medical students seeking information about how they are coping in their work and studies, and whether they are – or would be willing to – seek assistance and support, if needed.

A recent study by *beyondblue* found that depression, anxiety disorders and self-prescribing were common in the medical profession, with the suicide rate among doctors – particularly female doctors – higher than that of the general population.

Despite this, the research found a significant proportion of doctors and medical students were reluctant to seek help.

beyondblue chief executive officer, Kate Carnell, said it was the first time that such a large proportion of the profession in one country were being surveyed regarding their mental health, and urged all doctors and students who received the questionnaire to take part.

"To ensure Australia tackles depression and anxiety as well as it can, it is vital that we ensure the mental health of our doctors is as robust as possible," Ms Carnell said. "This survey will show how Australian doctors cope in their jobs, and offer invaluable insights into how we can support their critical work. The more doctors who respond to the questionnaire, the more we can do this."

The survey was developed with the help of an advisory committee chaired by former AMA President, Dr Mukesh Haikerwal, and aims to increase awareness of the symptoms of depression and anxiety disorders, identify risk factors for both, and help encourage those experiencing problems to seek help.

Participation in the survey is voluntary and anonymous.

AR

TO COMMENT CLICK HERE

More getting SunSmart

Australians are falling out of love with the suntan in a sign that warnings about the dangers of sun exposure are hitting home.

Cancer Council research shows that a shrinking proportion of adults and adolescents desire a suntan, and far fewer are getting sunburnt now than they were a decade ago.

The study, published in the *Australian and New Zealand Journal of Public Health*, found that proportion of adults who said they wanted a tan fell from 39 per cent in 2003-04 to 32 per cent in 2006-07 and 27 per cent in 2010-11, while among adolescents the decline was from 60 per cent in 2003-04 to 51 per cent in 2006-07 and 45 per cent in 2010-11.

Just as encouragingly, the numbers who report having been sunburnt is declining, from 18 to 13 per cent among adults between 2003-04 and 2010-11, and from 25 per cent to 21 per cent among adolescents.

Chair of Cancer Council Australia's Skin Cancer Committee, Terry Slevin, said the decline was welcome, though he warned many adults and teenagers continued to engage in risky behaviour and were not taking enough precautions to protect themselves against sun damage.

"While attitudes towards tanning are improving, we are still seeing people getting too much sun," Mr Slevin said.

"Approximately 363,000 adolescents and 2 million adults are still getting sunburnt on any given weekend. Hat use has actually decreased over time, as has leg cover.

"Sun protection among adolescents and adults is still far from ideal, with only 23 per cent of adolescents and 45 per cent of adults wearing hats when outdoors."

Mr Slevin said the improvements in behaviour that had been achieved were at risk of being lost without continual campaigns and reminders about the dangers of sunburn and tanning.

He said high recall among adults and adolescents of the 'Dark Side of Tanning' advertisements showed that the campaign had an impact, but warned that "unless the Australian Government reinvests in an ongoing national campaign, we risk losing the gains we have made".

AR

TO COMMENT CLICK HERE

Claims for homeopathy junked

The British Government's chief medical adviser has dismissed homeopathy as "rubbish" and questioned public subsidies for the treatment.

As Australia's Chief Medical Officer, Dr Chris Baggoley, prepares to complete a year-long review of the eligibility of natural therapies for the Private Health Insurance Rebate, Britain's top doctor has made an outspoken condemnation of one of the therapies included in the Baggoley review.

Professor Dame Sally Davies, Britain's Chief Medical Officer, told a UK parliamentary committee that homeopathy provided no benefit for patients beyond the placebo effect, according to the *Daily Mail*.

Dame Sally, a consultant haematologist at Central Middlesex Hospital for more than 25 years, told the House of Commons' Science and Technology Committee that: "I'm very concerned when homeopathic practitioners try to peddle this way of life to prevent malaria or other infectious diseases".

Homeopathy uses very diluted forms of plants, herbs and minerals to treat ailments, and is based on the principal that illnesses can be treated by substances that produce similar symptoms.

For example, homeopathic anti-malarial tablets are made from African swamp water, rotting plants, and mosquito eggs and larvae, according to the *Daily Mail*.

Homeopathy is listed as a treatment by Britain's National Health Service, and it is estimated that British taxpayers spend about $6 million a year subsidising homeopathic treatments – a fact that befuddles Dame Sally.

"I am perpetually surprised that homeopathy is available on the NHS," she told the Committee.

In its hunt for savings, the Australian Government last year allocated $1 million to Dr Baggoley's review, with Health Minister Tanya Plibersek warning that public subsidies will be axed for all natural therapies except for those wherte there is "clear evidence they are clinically effective".

The Government expects the measure to to save about $30 million a year.

AR

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

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

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

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

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

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

TO COMMENT CLICK HERE

More kids being hospitalised for arthritis

Hospitalisation rates for children with arthritis have trebled since 2000, with girls accounting for most of the increase.

Figures compiled by the Australian Institute of Health and Welfare shown that hospitalisation for cases involving juvenile arthritis soared from 8.8 per 100,000 in 2000-01 to almost 29 per 100,000 in 2009-10.

Institute spokesman, Nigel Harding, said it was not yet clear what had driven the dramatic increase, but possible explanations included an increase in incidences of the condition, changes in hospital admission practices or treatments, and changes in the way the condition is managed.

"Living with juvenile arthritis can be challenging at any age, and its impact during adolescence may be particularly difficult," Mr Harding said. "Growth and puberty can be affected, and pain, stiffness and fatigue associated with [the condition] can lead to impaired psychological wellbeing, functional limitation and reducing participation in school and social activities."

The Institute said that, while it was not known how much in total was spent on medicines used to treat juvenile arthritis, Government subsidies paid for biologic disease-modifying anti-rheumatic drugs have increased each year since their introduction a decade ago, and reached $4.7 million in 2011.

AR

TO COMMENT CLICK HERE

Controversial measles book withdrawn from sale

The nation's largest online bookstore has withdrawn from sale a book that claims the measles can be beneficial for children.

Bookworld will no longer distribute the book *Melanie's Marvellous Measles* following an outcry from AMA President, Dr Steve Hambleton, and other health experts over its claims that contracting the deadly disease would actually make children healthier.

The book has been promoted by anti-vaccination campaigners, but has been strongly condemned by the medical community.

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," the AMA President said.

While Bookworld has ceased distributing the publication, it is still listed for sale on Amazon.

AR

TO COMMENT CLICK HERE

WIN
a 64GB iPad Mini

Australian Medicine's A Day in the Life of the AMA competition

Win an iPad Mini, with 64GB capacity and full WiFi capability, worth more than $500.

For a chance to win this great prize, simply submit up to five photos of you and/or your colleagues at work.

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

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

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

HEALTH ON THE HILL

Call to get to bottom of hospital funding crisis

The Australian Greens are pushing for a Senate inquiry into hospital financing as the Victorian hospital funding crisis deepens.

Greens health spokesman, Senator Richard Di Natale, has moved a motion calling for Senate's Finance and Public Administration Committee to launch an inquiry into the issue.

Senator Di Natale said it was "time to get to the bottom" of hospital financing, including determining the responsibility of each level of government, and the timing and impact of recent hospital funding cutbacks.

The Greens senator lamented the way governments sought to push blame for funding shortfalls onto their state or federal counterparts, and bemoaned the apparent failure of the National Health Reform Agreement to provide an effective solution.

"The community is confused about who is to blame for the recent cuts, and that's just how the state and federal governments like it," he said. "It means that they can keep pointing the finger somewhere else and take no responsibility for fixing the problem."

State and territory governments nationwide have complained of inadequate Commonwealth contributions to health funding, particularly in the face of depressed revenues from the GST.

The issue has become most politically acute in Victoria, where the State and Federal governments blame each other for a $107 million funding shortfall that has forced hospitals to axe hundreds of elective surgery procedures and close dozens of beds.

The Victorian government has accused the Commonwealth of using flawed population estimates to justify reducing its planned contribution to the state's health budget, while the Federal Government has claimed the Baillieu government has precipitated the crisis by slashing more than $600 million from its health spending.

Senator Di Natale said an inquiry was needed to get to the root of the problem.

"The blame game doesn't help someone stuck on a waiting list at the Alfred Hospital, or a family in Colac who will no longer be able to take their child to the emergency department after hours," he said. Enough is enough – it's time to get to the bottom of this issue and prevent politicians from treating it like a political football in the future."

But the Greens admit that the prospects for the inquiry do not look bright.

A spokesman for Senator Di Natale said there was unlikely to be much support in the Senate for such an investigation because it would be "quite uncomfortable" for both the major parties.

"We are not sure whether it is going to get up or not," the spokesman said.

The spokesman said the Greens were not approaching the issue with any preconceived policy ideas, but Senator Di Natale said "we have to fund a lasting solution because the public need to know who to hold accountable for this issue – it's the only way to make sure that governments will make the level of investment required for our hospitals and our broader health system".

AR TO COMMENT CLICK HERE

Superbug committee wants more time

A parliamentary committee inquiring into antibiotic resistance has sought an extension on its reporting deadline.

The Senate Finance and Public Administration References Committee, which is examining the implementation of recommendations made by a panel of experts on antibiotic resistance more than a decade ago, was due to report on 21 March.

But the Committee's deputy chair, Liberal Senator Scott Ryan, last week moved that the reporting date be moved back to 10 May.

The inquiry was established late last year following concerns raised in Parliament by Greens Senator, Dr Richard Di Natale, that most of the recommendations made by the Joint Expert Technical Advisory Committee on Antibiotic Resistance in 1999 were yet to be implemented, and that the country still lacked a regime to systematically collect data on antibiotic use and the prevalence of antibiotic resistant organisms.

The Government established an Antimicrobial Resistance Subcommittee in April last year to advise it on ways to tackle and minimise the rise of resistant infections.

AMA President, Dr Steve Hambleton, said at the time that doctors were "very concerned" about the development of antibiotic resistance.

"There are certain drugs like plain penicillin which we would reach for very quickly in the past, which we don't reach for anymore. We actually reach for stronger drugs," he told ABC radio. "And when those drugs are no longer effective, you know, we haven't got a lot of solutions."

Dr Hambleton said over-prescribing of antibiotics was a problem.

"Clearly, there are people taking antibiotics that are prescribed for these viruses where it's of simply no benefit," he said.

AR TO COMMENT CLICK HERE

...CONTINUED ON PAGE 28

HEALTH ON THE HILL

...CONTINUED FROM PAGE 27

Doctors implicated in sports doping

Some doctors are acting as a "key conduit" for the supply of performance-enhancing peptides and hormones to elite athletes, according to an Australian Crime Commission investigation.

In a finding that has reverberated through the sporting establishment, the Commission claimed there was "widespread use" of hormones and peptides in several professional sporting codes.

"Multiple players across some sporting codes, and specific clubs within those codes, are suspected of currently using or having previously used peptides, which could constitute an anti-doping rule violation," the ACC said in its report, *Organised Crime and Drugs in Sport*, released on 7 February.

"The level of suspected use of peptides varies between some sporting codes, however officials from a club have been identified as administering, via injections and intravenous drips, a variety of substances, possibly including peptides. Moreover, the substances were administered at levels which were possibly in breach of WADA anti-doping rules."

The Commission said its investigations had found some doctors supplying peptides and hormones had engaged in "lax, fraudulent and unethical" prescribing practices.

The ACC said several medical practitioners who advocated the use of peptides and hormones as anti-ageing treatments "appear to be primary prescribers of the various peptides and hormones used by elite and sub-elite athletes".

"The ACC identified doctors who have dispensed hGH directly to patients without a prescription, which is illegal, or through a pharmacy owned by these doctors," the report said. "In these instances, no prescription or record of the dispensed hGH was recorded.

"The ACC also identified lax and fraudulent prescribing practices by some doctors with links to sporting clubs and anti-ageing clinics.

"These practices include writing scripts in false names, providing prescriptions without consulting the patient and prescribing hormones without conducting the necessary blood tests normally carried out prior to the prescription of these substances. Some of these doctors are also implicated in experimenting on players, by providing them with different substances in order to determine the effects on their performance."

The release of the report came as steps were being taken to give the nation's anti-doping watchdog the power to compel athletes, doctors and sports officials to be interviewed and provide documents as part of investigations into doping in sport.

As the Australian Football League reels over claims Essendon Football Club players were injected with banned performance-enhancing drugs during the 2012 season, the Government has moved to enhance the powers of the Australian Sports Anti-Doping Authority (ASADA) to investigate violations of anti-doping rules.

Sports Minister, Senator Kate Lundy, told Parliament last week ASADA needed the extra powers if it was going to do its job properly.

Senator Lundy said that while blood and urine tests were part of the armoury of anti-doping authorities, the Lance Armstrong affair had shown that investigations and intelligence gathering were becoming an increasingly important part of efforts to expose the use of banned substances in sport.

US cyclist Lance Armstrong was last year stripped of his seven Tour de France titles after the United States Anti-Doping Agency (USADA) found that he and his US Postal Service team mates had engaged in systematic doping between 1999 and 2005.

"The United States Anti-Doping Agency was only able to establish the case against the US Postal Service team, including Lance Armstrong, because it had collected sufficient evidence through its non-analytical investigation activities," Senator Lundy said. "USADA was able to collect sworn testimony from 26 people, and the gain access to documentary evidence."

The Minister said that currently ASADA had no power to require people to submit to interview or produce documents, severely limiting its investigative capacity.

"Athletes and their support personnel under suspicion have little incentive to assist ASADA in their investigations or intelligence gathering activities," she said.

The proposed legislation, which is currently before the Senate, would give ASADA the power to compel people to attend interviews with investigators and provide information and documents relevant to inquiries.

In addition, the ASADA chief executive officer will be empowered to issue a disclosure notice requiring any specified person (not just athletes and support staff) to submit to interview and/or provide documents or any other "thing" that would assist ASADA in its work.

Refusal to comply with a disclosure notice would render someone liable to a civil penalty of up to $5100, while someone found to have contravened the terms of a disclosure notice could be fined $1020.

ASADA has also been directed to work closely with national supporting organisations to amend their rules so that all athletes and support personnel will be hit with strong penalties such prolonged suspensions if they refuse to cooperate with ASADA investigations.

"The message is clear: with these amendments, athletes and support persons who are involved in doping have a greater chance of being caught," the Sports Minister said. "People will have no option but to assist ASADA in its investigations and intelligence activities," Senator Lundy said.

AR

TO COMMENT CLICK HERE

...CONTINUED ON PAGE 29

HEALTH ON THE HILL

...CONTINUED FROM PAGE 28

Govt could force spike in private health premiums: lobby

Private health insurers have ratcheted up their campaign against planned changes to a Government rebate, warning that more than a million policyholders could be hit by big premium increases.

Private Healthcare Australia (PHA) has told a Senate committee that the Government's decision to remove the Private Health Insurance rebate from Lifetime Health Cover loadings would force the premiums some policyholders pay up by 27.5 per cent, an additional cost for some of up to $500.

The organisation warned that such a price jump would lead many to downgrade cover or cancel their insurance altogether, increasing the pressure on the public health system.

In a submission to the Senate Standing Committee on Community Affairs, PHA chief executive officer, Dr Michael Armitage, warned that "almost 1.1 million Australians will be directly, and negatively, impacted" by proposed Government changes to private health insurance arrangements.

"As at 30 September 2012, around one in seven Australians with private health cover were subjected to a Lifetime Health Cover (LHC) loading," Dr Armitage said. "If this legislation is enacted, some consumers will be confronted by an increase in their premium of up to 27.5 per cent – in addition to the annual premium adjustment [which was 5.06 per cent last year].

"This significant increase in premiums will inevitably result in many people choosing either to downgrade or terminate their cover, thereby relying more on the public hospital system for their health care needs."

Lifetime Health Cover loadings are applied at the rate of 2 per cent for every year beyond the age of 30 that a person delays taking out private health insurance.

The penalty is aimed at encouraging more young people to take out private health insurance, helping offset the higher claims made by older fund members.

In its submission to the inquiry, the Department of Health and Ageing argued that it was "incongruous for the Australian Government to pay a proportion of the LHC loading".

"The…loading is for the public policy purpose of creating an incentive to purchase private health insurance earlier in life and maintain it," the Department said.

It said that if the Government continued to subsidise a proportion of the LHC loading, the "incentive to take out hospital cover is diminished".

AR

TO COMMENT CLICK HERE

Coalition promises to 'protect' research funding

The Federal Opposition has committed to "consistent, long-term funding" of medical research if wins the 14 September federal election.

As Prime Minister, Julia Gillard, broke with political convention to announce the election date during an address to the National Press Club on 30 January, the Opposition was quick to kick off the unofficial election campaign with a promise on support for medical research.

In a joint statement, Opposition leader Tony Abbott and Shadow Health Minister Peter Dutton declared that a Coalition Government would "protect" medical research funding.

"While Budget conditions are tough, and the Coalition is committed to returning the Budget to surplus, we also recognise that funding of medical research needs to be consistent and ongoing to ensure Australia does not hollow out its capabilities in this field," the Opposition leader said.

But, while promising to "protect" medical research funding, the Coalition stopped short of nominating any specific funding amount.

Mr Abbott said Australia was a "recognised leader" in medical research, and the Coalition was determined to support this area of competitive advantage for the economy.

The Opposition leader said the Australia generated between 3 and 4 per cent of all refereed research publications in health in the world, despite having just 0.3 per cent of the global population, and the sector had produced three Nobel Prize winners in the past decade alone.

"Medical research is an essential part of the Coalition's plan to build a more diverse, world-class economy," Mr Abbott said. "In terms of cost-benefit analysis, consistent long-term funding of medical research lifts national productivity, improves quality of life and life expectancy, and takes pressure off the hospital system."

The announcement was warmly welcomed by research organisations.

Australian Academy of Science president, Professor Suzanne Cory, called on other parties to match the Coalition's promise to protect medical research funding.

"We must build on our current investment in all science education and research to take forward and develop new ideas, both for the wellbeing of Australian people and to ensure that our nation remains competitive and productive," Professor Cory said.

In its submission to the McKeon Strategic Review of Health and Medical research last year, the Academy called for a gradual increase in health and medical research funding through the next 13 years to reach 2 per cent of total national health spending.

AR

TO COMMENT CLICK HERE

...CONTINUED ON PAGE 30

HEALTH ON THE HILL

...CONTINUED FROM PAGE 29

Future Fund ponders another nail in tobacco's coffin

The Future Fund is considering excluding tobacco company stocks from its investment portfolio.

In a statement welcomed by the AMA and other health activists, the Fund revealed that it may adjust its investment strategy following widespread condemnation last year when it was revealed that it held up to $250 million worth of shares in Big Tobacco.

The Fund's managing director, Mark Burgess, said the board's governance committee has been debating and analysing the tobacco investments and was expected to make a decision in the "early part of this year".

"We have not said we are going to exclude tobacco, we are just thinking about it," he said, according to a report in The Age. "Lots of people have lots of views about what they would like to exclude. The most important thing for a long-term fund is that you have a clearly defined way you come to conclusions on that. And that is what the governance committee is designed to engage in."

The Fund, which was established to manage money set aside to cover the Commonwealth's public service superannuation liability, has until now steadfastly resisted calls to adjust its investment strategy to reflect social concerns and political policy priorities.

The fact that it is prepared to consider divesting itself from a particular investment class following pressure from politicians and public health advocates is seen as significant.

Such a move by the Future Fund would be a further blow to the tobacco companies, who have found their operations increasingly constrained.

Last year the Federal Government successfully implemented world-first laws forcing cigarettes to be marketed and sold in plain packets carrying graphic health warnings, and several other countries are considering adopting similar measures.

AR

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

PBAC nominations invited

AMA members are invited to nominate for a specialist position on the Pharmaceutical Benefits Advisory Committee (PBAC).

This is a challenging and stimulating position that provides the opportunity to contribute directly to Australia's pharmaceutical benefits policy.

PBAC is an independent expert committee that advises the Minister for Health on medicines in relation to the Pharmaceutical Benefits Scheme. PBAC is required to consider the clinical effectiveness, safety and cost effectiveness of a medication compared with existing therapies. Members must be able to interpret the comparative outcomes of therapy involving a medicine, and appraise evidence.

The AMA has been asked to nominate a range of potential candidates, particularly those with expertise in endocrinology and specialists in the field of psychiatry. The AMA's Federal Executive Council will assess nominations prior to forwarding them to the Minister for potential appointment.

PBAC meets for three, three-day meetings a year, and may occasionally hold additional one-day meetings. PBAC members currently receive an annual salary of $35,880, and all travel costs are reimbursed. Appointments are for four years.

Further information about PBAC can be found on the DoHA website at www.health.gov.au.

To nominate, please forward a curriculum vitae no longer than 2 pages (Click here [https://ama.com.au/system/files/sample_cv.pdf] for an example) to cmoylan@ama.com.au by Wednesday, 20 February 2013. If you have any questions, please contact Georgia Morris on 02 6270 5466.

TO COMMENT CLICK HERE

THE NATION

WHAT IS MAKING NEWS IN MEDICINE AROUND THE COUNTRY…

QUEENSLAND

Trouble in the North

A major Queensland health service, already reeling from the likely loss of up to 1000 jobs, has been rocked by a series of high-profile departures.

Prince Charles Hospital executive director, Jon Roberts, last week became the third senior manager to resign from his post with the Metro North Hospital and Health Service in as many months, the Courier Mail has reported.

Mr Roberts' departure came a day after the Royal Brisbane and Women's Hospital executive director, David Alcorn, announced his resignation, and follows the decision by Metro North's chief executive, Keith McNeil, to depart to take up a position as head of Cambridge University Hospitals in the United Kingdom.

The departures came as the Newman Government admitted up to 1000 jobs could go in Metro North, and warned the equivalent of 2000 full-time equivalent nursing positions across the state could be cut as part of a funding spat with the Commonwealth.

Already, Queensland Health has been at the forefront of the State Government's 10,600 job cuts.

Councils rejecting fluoride

A growing number of Queensland councils are opting out of water fluoridation programs following a cut in state funding and a relaxation of rules.

The Australian has reported that Cairns will follow Tablelands Council in withdrawing from the water fluoridation program, citing high maintenance costs and divided public opinion, and Bundaberg is due to hold a plebiscite on the issue.

The decisions have come despite compelling evidence that water fluoridation helps protect children's teeth from tooth decay, and Queensland's chief state health officer Jeanette Young urged the councils to consider the benefits of fluoridation as a safe and effective way to reduce damage to teeth.

VICTORIA

Funding war escalates

Thousands of elective surgery procedures have been cancelled and dozens of beds closed as the health funding dispute between the Federal and State governments drags on.

Doctors have warned of the danger that emergency departments are closed or their operations pared back as health services struggle to cover a multi-million dollar shortfall in funding.

The Baillieu Government blames the crisis on the Commonwealth, which has provided $107 million less than expected to Victoria because of revised population figures.

But the Federal Government said the crisis had been precipitated by a hefty $616 million cut by the Victorian Government to its own health budget.

A meeting between the Federal and State health ministers early this month failed to resolve the stand-off, which has fuelled demands for an end to the health funding "blame game" and a shift to a single-funder model of health spending.

SOUTH AUSTRALIA

Bid to speed up death

The withdrawal of feeding tubes and saline drips as a way of hastening death would be banned, under legislation proposed by an independent South Australian MP.

In an attempt to end the "hypocrisy" under which voluntary euthanasia was banned but slow and lingering death by starvation and dehydration was sanctioned, Dr Bob Such has proposed laws that would allow doctors to withdraw feeding and liquid tubes only where other life-sustaining measures, such as ventilators, were also turned off, according to a report in the Adelaide Advertiser.

Dr Such said it was "cruel" that people unable to make end-of-life decisions were essentially starved to death.

State lashed over tobacco investments

State Government agencies have been attacked for investing almost $40 million in tobacco companies while millions are spent on public health campaigns to reduce smoking, according to a report in The Australian.

Two agencies, WorkCover SA, and Funds SA, have been found to both invest – either directly or indirectly – in tobacco stocks.

It is estimated Funds SA holds about $29 million worth of tobacco company shares, while WorkCover SA's holding are estimated to be worth about $9 million.

...CONTINUED ON PAGE 32

THE NATION

WHAT IS MAKING NEWS IN MEDICINE AROUND THE COUNTRY…

...CONTINUED FROM PAGE 31

Following the revelations, incoming Health Minister Jack Snelling announced that tobacco companies would be excluded from Funds SA investment portfolios.

NEW SOUTH WALES

Firefighters resist first responder call

Firefighters and the AMA have raised concerns about plans to have fire crews to be called in as first responders to medical emergencies.

In a report, NSW Health suggested firefighters could be used to help relieve the pressure on stretched ambulance services, which have experienced a 3 per cent jump in demand for the services in the last two years.

"There is evidence to suggest that the fire service could play a role in improving emergency response times and patient outcomes through a First Responder Program," the report said.

But AMA NSW President, Dr Brian Owler, told the Sydney Morning Herald that although firefighters received first aid training, their capacity was nothing like that of fully trained paramedics.

Dr Owler said that if the ambulance service needed more officers, "then that's what they need to provide".

Black hole in health budget

New South Wales Health has denied claims of a $158 million hole in the state's health budget.

Health unions have warned that funding for critical health services has been put under pressure because of over-spending by local health districts has caused a multi-million dollar shortfall in this year's budget, according to a report in the Daily Telegraph.

But NSW Health's chief financial officer, John Roach, said that although there would be "technical adjustments" made to the budget, additional funds were likely to be allocated after 30 June, when the Commonwealth bond rate was known.

WESTERN AUSTRALIA

Hospital commitment sought

The AMA is seeking a commitment from the major political parties to fund hundreds more hospital beds to meet the state's burgeoning health demand, as the state election gets underway.

AMA WA President, Dr Richard Choong, said the next State Government needed to plan to meet the health needs of WA beyond 2020, including the provision of hundreds of extra beds at both tertiary and regional hospitals.

Doctors under threat

Alarm has been raised about escalating violence in WA hospitals, with doctors and nurses regularly threatened with guns, knives, axes, cleavers and other weapons.

Government figures show that an average of 17 staff in WA's five biggest hospitals were being threatened every day, up from 12 such daily incidents in 2009, according to a report in the Sunday Times.

WA Health Minister, Dr Kim Hames, rejected calls from the AMA for mandatory sentencing for people who physically assault doctors and hospital staff.

Dr Hames said there was "appropriate" security arrangements in place in the state's hospitals, and the rise in incidents was more a reflection on the increased demand for emergency care and increased prevalence of cases involving drug and alcohol use.

TASMANIA

Tasmania has the nation's most inefficient public hospitals, costing taxpayers more than $100 million a year, according to a report by a health policy analyst.

Analyst Martyn Goddard said Commonwealth and state data showed that a hospital procedure in Tasmania was, on average, 20 per cent more expensive than the national average, according to a report in the Hobart Mercury, and 31 per cent higher than in the nation's most efficient health system, Victoria.

Mr Goddard said that if the efficiency of Tasmania's hospitals was lifted to match the national average, they would cost $101.5 million less to run and deliver an extra 20,600 patient services.

He said bloated bureaucracy and the cost of medical supplies were major contributors to the higher running costs of Tasmanian hospitals.

AR

Blame game: cutting through the spin on Victoria's hospital funding cuts

BY **DR STEPHEN DUCKETT, DIRECTOR, HEALTH PROGRAM AT GRATTAN INSTITUTE**

This aritcle first appeared in The Conversation on 1 February, 2013, and can be viewed at: http://theconversation.edu.au/blame-game-cutting-through-the-spin-on-victorias-hospital-funding-cuts-11881

As Victorian hospitals have announced bed closures, job losses and elective surgery delaysin recent weeks, cuts to health service budgets look set to significantly affect patient care in the state.

The cuts are a result of a mid-year adjustment in health funding, costing Victoria more than $100 million in 2012-13, with significant cuts in Queensland as well. The 2012-13 Budget estimated that $16 billion would be allocated to the states for health care; this was revised down by more than $400 million in the mid-year forecast to $15.6 billion.

So who is to blame? The Victorian government would have you believe it's the Commonwealth's fault for revising its funding allocation; while the Commonwealth blames the state for passing the shortfall on to hospitals.

Current funding agreements provide that Commonwealth grants to the states for health care are adjusted based on estimates of health inflation, population change and the impact of technological change. All this is agreed.

What went wrong is that estimates of population growth (and to a lesser extent, health inflation) changed.

The source of population growth estimates is the Australian Bureau of Statistics (ABS), which changed its method of population estimation. The only accurate measure of the population occurs at the census, and even that isn't perfect. To check the census estimates, the ABS conducts a survey to verify what was reported, to check on people who have come back home after being away on census night and so on. For the 2011 census the ABS changed the way it did that, which changed the census base line.

Between censuses, the ABS makes "inter-censal" estimates by adding births, subtracting deaths and taking account of population movements. Obviously, the beginning and endpoints of the inter-censal estimates ought to reconcile with the census, but for 2011 they were 300,000 or so people out.

Some states were previously recorded as having a larger population than the new estimates (NSW 1.3% over, Victoria 1.6% over, Queensland 2.4% over), with other states being slightly under-counted.

The question then becomes, should this be reflected immediately in reduced funds to the states?

Treasurer Swan, hunting desperately for money to contribute to achieving a slither of a surplus goal, announced the $400 million hit to the budgets of the over-counted states as part of last October's *Mid-Year Economic and Fiscal Outlook*.

The affected states have cried foul. The changes have taken place mid-year, with no discussion or forewarning. It was a plot hatched in Treasury, with health experts kept in the dark.

In most states budgets had already been issued to hospitals and so, in passing on the Commonwealth hit, the political accountability was made clear. Hospitals, forced to revisit their budgets, have been required to find savings quickly and have implemented a full year of cuts over the five months after Christmas, exacerbating the impact of the Commonwealth cuts.

The Commonwealth has mounted a contemporary version of the Nuremberg defence: it is simply implementing the formula that's been agreed. It points out (correctly) that most states have squeezed their budgets, and the Commonwealth-attributed cuts are unfairly getting all the opprobrium.

The Commonwealth also points out that it is actually increasing its total contribution to health care, especially post-1 July 2014, when new growth funding arrangements kick in.

All that is moot, of course, as the Commonwealth has well and truly lost the propaganda war. The public believes the front-line hospital workers and managers who are standing up and pointing out publicly what's happening locally in terms of bed closures. And the killer punch is that they are saying 'this was our budget before the Commonwealth changes, and this is what it is now'. The dots are pretty easily connected.

The public has little patience with the blame game, and rightly so.

The Commonwealth will need some fast footwork to get out of this mess. It may be too late for it to retrieve its position, but one strategy is to offer the state a cost-neutral deferral.

In its search for significant budget savings, the Kennett government negotiated such a deal for Victoria in the early 1990s. The Keating government accepted a proposal from then Health Minister (the late) Marie Tehan whereby Victoria got an increase in funds in the first couple of years of the Commonwealth-state funding agreement, offset by reduced funding in the later years.

The Commonwealth has committed significant growth funds from 2014 onwards; it should not be beyond the wit of good-intentioned people to negotiate a way where both sides can claim victory.

But there are two main problems with this suggestion. On-again, off-again cuts are a management nightmare. And the current state of the Commonwealth-state morass may mean that good-intentioned people are now few and far between.

TO COMMENT CLICK HERE

RESEARCH

Erection problems linked to heart disease

Men with erectile dysfunction might need more assistance from their doctor than just a script for a 'little blue pill', after researchers found a link between erectile dysfunction, heart disease and early death.

Researchers followed 95,000 men aged 45 and older for two to three years. The men responded to a survey on their health and lifestyle, and the researchers also studied records of any hospital stays or deaths in the group.

Over the period of the study there were 7855 hospitalisations for cardiovascular disease and 2304 deaths.

The study is the world's largest to investigate links between erection problems and heart disease.

Lead researcher Professor Emily Banks from the Australian National University found that men with severe erectile dysfunction had a 50 to 100 per cent higher risk than men with no erection problems of ischemic heart disease, peripheral vascular disease and other cardiovascular problems.

"Men with severe erectile dysfunction have around a 60 per cent higher risk of being admitted to hospital for coronary disease then men with no erectile dysfunction," Professor Banks told *The Canberra Times*. "They're also twice as likely to die during the follow-up period".

Professor Banks said previous studies have found links between severe erection problems and heart attack and strokes, but this was the first to also include mild and moderately severe erection problems.

"The risks of future heart disease and premature death increased steadily with severity of erectile dysfunction, whether or not there was a history of cardiovascular disease," Professor Banks said.

"Rather than causing heart disease, erectile dysfunction is more likely to be a symptom or signal of underlying 'silent' heart disease and could in future become a useful marker to help doctors predict the risk of cardiovascular problem.

"This is a sensitive topic, but men shouldn't suffer in silence."

KW TO COMMENT CLICK HERE

Aspirin use linked to eye disease

Regularly using aspirin increases your risk of developing macular degeneration, a leading cause of blindness in older Australians, according to new research.

Australian researchers from the Westmead Millennium Institute for Medial research in Sydney found that regular aspirin use was linked to more than two-fold increase in the risk of developing age-related macular degeneration (AMD).

The researchers used data from the Blue Mountains Eye study, which followed more than 2000 people and they eye health over 15 years, and discovered 63 people developed neovascular AMD.

The centre's director, Professor Paul Mitchell, said 9.3 per cent of regular aspirin users in the study developed the condition after 15 years, compared with 3.7 per cent of those who did not take aspirin regularly.

"Aspirin has been put forward as something that just about everyone should take," Professor Mitchell told *The Australian*.

"It's findings like this that suggest we should be cautious about going down that path.

"Currently there is insufficient evidence to recommend changing clinical practice, except perhaps in patients with strong factors for neovascular AMD in whom it may be appropriate to raise the potentially small risk of incident neovascular AMD with long-term aspirin therapy."

Professor Mitchell said three other international studies had found similar results suggesting a link between regular aspirin use and AMD. He said more vigorous studies were needed to test the findings further.

The research was published in the journal *JAMA Internal Medicine.*

KW TO COMMENT CLICK HERE

Hope for newly infected HIV patients

Newly infected HIV patients can restore their immure systems to health if they are given antiviral therapy within the first four months of infection, according to a new study.

Researchers from the University of Texas, University of California and Monash University drew data from 468 patients followed over a 48-month period.

The study found patients with a higher CD4 + T- cells at the initiation of therapy demonstrated stronger recovery of CD4+ T- cell counts than patients who started therapy later.

Co-author of the study Professor Edwina Wright from Monash University said further clinical studies were needed to determine whether starting antiretroviral therapy earlier could enhance the chance of patients responding to future cure strategies.

"In the four months after HIV infection the immune system mounts an immune response and starts to recover naturally before it subsequently progressively declines," Associate Professor Wright said.

"This observation tells us that there may be a narrow restorative window that could be targeted for recovery through earlier initiation of potent antiretroviral therapy.

Associate Professor Wright said even a short deferral of antiretroviral therapy outside of the four-month window could compromise CD4+ T- cell recovery, irrespective of the CD4+ count at the time of treatment initiation.

The study was published in *The New England Journal of Medicine.*

KW TO COMMENT CLICK HERE

Renewed moves to ban abortions in US south

Conservative politicians in the US south are moving to ban abortions when a foetal heartbeat is detected, in a blow to efforts to protect the right of women to choose.

The Arkansas state Senate, which is controlled by Republican members, has passed the Human Heartbeat Protection Act, which would prohibit most abortions when a foetal heartbeat is detected, effectively blocking the procedure being performed as early as five weeks into pregnancy, according to a *Reuters* report.

Under the legislation, women would be required to submit to a vaginal probe to detect the heartbeat.

Before it becomes law, the Bill has to be considered by a committee of Arkansas' Republican-controlled lower House, and the state's Governor, conservative Democrat Mike Beebe, has raised concerns that the legislation could contravene federal laws and court rulings.

A succession of rulings by the US Supreme Court have prohibited attempts to ban abortions on foetuses that would not be viable out of the womb, though the window to have an abortion has narrowed from 28 to 24 weeks since the breakthrough Roe vs Wade ruling in 1973.

Murry Newbern, a lobbyist for Planned Parenthood of the Heartland, told *Reuters* that "a woman, not politicians, should make the informed decisions when it comes to her own pregnancy", and dismissed the Act as unconstitutional.

But Jerry Cox, president of the Family Council of Arkansas, said the Bill's passage through the state Senate was historic.

"There was a time when a lot of lawmakers did not even want to talk about life and abortion, much less vote on it," he said.

The move in Arkansas is the latest in a series of efforts by anti-abortion activists to have access to the procedure severely curtailed or withdrawn.

Last year, Virginia's Senate approved a law forcing women to have an ultrasound before an abortion, and pregnant women in Texas, Oklahoma and North Carolina are required to hear their doctor's verbal description of their ultrasound.

In Arizona, a law that would criminalise most abortions performed after 20 weeks is subject to legal challenge.

AR

TO COMMENT CLICK HERE

China boosts health insurance cover

The Chinese Government plans to extend public health insurance cover to almost all rural citizens as part of a strategy to boost the availability and quality of health care in the giant Asian country.

Under a targeted program, the annual government subsidy for health insurance for rural residents is set to reach 280 yuan ($46) per person this year, up almost 18 per cent from 2012.

The increase will lift the reimbursement for hospital expenses for rural residents from around 55 per cent to closer to 70 per cent.

China's Health Minister, Dr Chen Zhu, said much of the gap in coverage was due to the use of new and more expensive drugs that were not on the Government's essential drugs list.

China has developed the essential drugs list, which includes 307 categories, in an attempt to control rising medication costs and improve the access of patients to basic medical services.

In addition to increasing public health insurance cover, Dr Chen pledged a separate insurance program for serious diseases and a medical emergency aid system in rural areas to assist people with medical bills that cannot pay.

The Health Minister said the measures would be taken as work is done to boost health service governance.

"We'll improve the working mechanism and strengthen supervision to help avert unnecessary administration of drugs and examinations, to help further ease patients' economic burden," he said.

Vice Premier Li Keqiang said the steps were being taken as part of medical reforms being undertaken during the 12th Five-Year Plan period (2011-15) to enhance service quality.

"Increased financial support and innovative ways are needed to ensure that patients, doctors and hospitals all benefit from the country's medical reform," Mr Li said.

The Vice Premier said a key goal was to reduce inequalities in health care.

"Our medical reform directly targets the urban-rural gap and the regional gap," he said. "It has won strong support from the public because it started with strengthening services at grassroots levels, and favouring central and western regions, as well as rural areas," he said.

AR

TO COMMENT CLICK HERE

Taking heart from Indian progress

BY **PROFESSOR STEPHEN LEEDER**

"The rural health program is achieving other goals: there have been no reported cases of polio in India for two years"

India, with its population of 1.2 billion, is planning to build 150 new medical schools in the next five years, and at least 250 more in the following five years.

"India," as Venkat Narayan, a lean, lively and vocal Indian academic who had flown in to Delhi that morning from Emory School of Public Health in Atlanta put it, "is a place of magnificent chaos, where poverty and wealth co-exist, almost with no self-consciousness; a place where it is very difficult to get things done because of stifling bureaucracy, but a place where you can get things done because of the permissive chaos!"

No-one minds a cow slowly crossing the road or minicab drivers lining up and having a pee on the verge even in prosperous neighbourhoods.

"When I was a medical student at Bangalore in 1980, there were two medical colleges and two colleges of engineering. Now there are nine medical schools and 86 schools of engineering!" Venkat told me, with an energetic laugh. He admits that equity gets rough treatment in India.

I was visiting Delhi as a member of a review panel that has been to India 11 times in the past decade, and which reports to the Prime Minister, the Minister for Health and the Health Ministry to offer informed comment on progress with the National Rural Health Program.

The panel is headed by Jeffrey Sachs, an economist who leads the Earth Institute at Columbia University. He is a valiant warrior for global awareness of poverty. He has 'skin in the game', as more than 40 experimental development villages in Africa are being developed under the auspices of his Institute. In each, education, health and agriculture capacity building is being undertaken, though self-limited to a sustainable budget.

Sachs has strongly supported a rural health initiative in India to enlist social health workers. These are respected women in the villages who, with only days of training and no salary, assist young pregnant women to access facilities for safe delivery and neonatal care. There are now 800,000 of these women working effectively in rural India. Mobile phones and bicycles are their basic equipment. Maternal mortality rates have continued to fall. Infant mortality rates have been declining in India as a whole (more so in the cities, less so in rural areas) at 6 per cent per annum.

The rural health program is achieving other goals: there have been no reported cases of polio in India for two years. Five years ago I recall learning how the polio vaccination team, concentrated around Kolkata, numbered an astonishing 400,000.

And now India, as we have done in Australia, is actively pursuing a program of managed decentralisation of health services. Expenditure is slowly, slowly rising from 1 per cent to 2 per cent of gross domestic product. Health districts, generally much larger than ours, and working on budgets of about $40 per capita per annum, are forming.

It is interesting to see the complex tensions between federal, state and district, so familiar to us in Australia, played out at a mind-boggling scale and stupendous complexity. India gives democracy as a conversation among all citizens powerful and astonishing meaning.

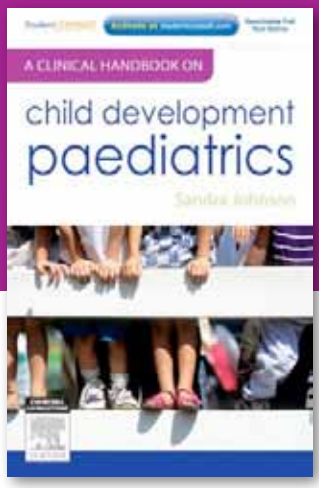
Health statistics are sparse and hard to interpret. What stats there are point upwards.

As I drove through urban slum areas all my thoughts about chronic disease prevention and primary health care were pounded by the rough surf of the social realities of that vast country.

But India is moving and progress is occurring. No shortage of work for doctors there!

TO COMMENT CLICK HERE

BOOK REVIEW



A Clinical Handbook on Child Development Paediatrics

By Sandra Johnson

Churchill Livingstone, RRP $89.95, pp320, ISBN 978-0-7295-4089-6
Reviewed by Dr Christopher Mulligan*

"Is my child normal?"

Spoken or subconscious, this one of the most common questions of all new parents. For most, the answer is yes, and that question is based on nothing more than that universal parental concern for their child to live a long, happy and healthy life.

But for others, the answer is unfortunately, no. For those kids who fall outside the scope of what society, and the medical profession, have deemed 'normal development', the consequences can be profound and lifelong.

Defining 'normal' is Dr Sandra Johnson's first task in her book *Child Development Paediatrics*, which deals with a multitude of different childhood developmental disorders. Aimed at paediatricians, paediatric registrars and general practitioners who care for children with developmental problems, Dr Johnson hopes to create a quick-reference guide to the broad field of developmental paediatrics.

The discipline covers areas from hearing and visual disorders, intellectual and learning disabilities, psychiatric and motor skill problems and many others. Her book is presented as a collection of these topics from specialist contributors, with each chapter providing an overview of a particular condition, as well as an approach to assessment and management. For any practicing clinician, the sections on some of the legal aspects of medicine and child protection are also interesting and important additions to the text.

Dr Johnson does well to cover a such wide range of pertinent fields relating to developmental paediatrics, from ophthalmology and ear, nose and throat to psychiatry and orthopaedics, but the reader is still left with the sense that in trying to cover as many relevant fields as possible, some of the depth in each of these areas is lost. Much of her information is presented in dot-point summaries and break-out boxes.

However, the book is clearly designed as a quick-reference guide rather than a definitive textbook, and has comprehensive reading lists and references for those wanting to delve a bit deeper.

Paediatrics, much like the rest of medicine in the twenty first century, is becoming more and more specialised and sub-specialised. However, Dr Johnson doesn't lose track of the 'big picture'. Despite being an inherently multi-disciplinary field, her approach remains very child-centred, highlighting the importance of a holistic approach to developmental problems, with good continuity of care navigating through the myriad of different specialists and institutions. Given the complex and chronic nature of many of these conditions, it is only fitting that the book has a strong focus on community practice, rather than acute hospital-based medicine.

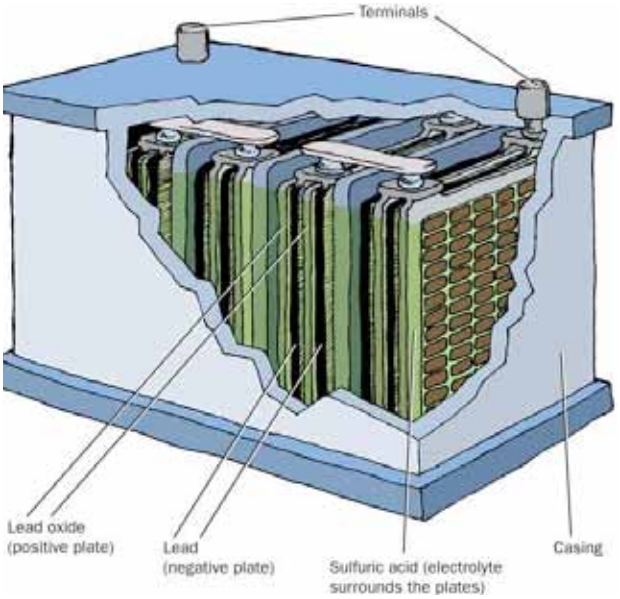
The book assumes at least a modicum of experience in clinical paediatrics and, as such, might be less appealing to a casual reader or medical student. But for those who work with children with developmental problems, and their families, *Childhood Development Paediatrics* is a useful and relevant book for clinical practice.

* Chris Mulligan is a Resident Medical Officer in New South Wales

TO COMMENT CLICK HERE

Lead-acid batteries: "Start me up!"

BY **DR CLIVE FRASER**



It is no secret that modern cars are packed with electronic gadgets.

MP3 players and satellite navigation are in our pockets, and most of us also want them in our cars.

Advances in mobile battery technology have meant that these portable devices will keep working for longer and longer, but there really hasn't been anything new in lead-acid battery technology since French physicist Gaston Planté invented the world's first rechargeable battery in 1859.

It seems that there isn't much more that science can do to enhance the chemistry of putting lead in contact with sulphuric acid.

And no matter how you do the sums, you'll never get more than 2.1 Volts from each cell.

Capable of only about 800 cycles, it's a fact of life that most lead-acid car batteries are lucky to last any more than three years.

So, with my own car only two years old, I was becoming anxious about my starter seeming a little slower to turn over. And then, with the next start, there was nothing, or at least only the faint sound of my starter motor and then nothing.

It was at that point that I discovered that my car had some artificial intelligence rivalling HAL from 2001: A Space Odyssey.

You see, one of the features of my frameless car doors is that the battery has to supply the electric windows with enough current to lower the glass a fraction of an inch to clear the door rubbers every time the doors open, and close.

Though there wasn't enough power to start my car, there was enough to bring the windows down, save for the fact that I might find myself trapped in my car and unable to exit.

The only problem was that every time I tried to turn the motor over, my windows (all four of them) kept descending.

By the time I'd given up any hope of getting home without assistance the windows were all the way down, which did make me wonder how I would have fared if it were raining, or how I would have locked my car if I had to leave it.

One other interesting epiphenomenon of having a flat battery was my car's decision to disable my airbags but, as I wasn't going anywhere anyway, did that really matter?

I was relieved to get going again with the assistance of my local motoring organization, but that pesky airbag warning light stayed on, and I still needed a visit to my local dealer to extinguish it.

The bad news here is that there really was no warning that my battery would suddenly fail and I'm not sure why any motorist should have to go back to their dealer after simply suffering a flat battery.

The good news is that my battery was covered by my new car warranty, so I didn't have to pay for the parts and labour to get mobile again.

Automotive lead-acid batteries	
For	Capable of providing huge surge currents for starting
Against	Heavy and environmentally unfriendly
This batteries would not suit	Defibrillators or pacemakers
Specifications	2.1 Volts per cell 6 cells provide 12.6 Volts Charging forces electrons from the positive plate Specific gravity falls as the battery discharges Fully charged specific gravity is 1.265 g/cm^3 Fully discharged specific gravity is 1.120 g/cm^3

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

TO COMMENT CLICK HERE

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

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

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

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

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

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

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

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

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

GREAT MEMBER DEALS

Discounts off new Volkswagen and Skoda vehicles for AMA Members*

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

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

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

*Please Note: Must be an AMA Member for minimum 3 months prior to vehicle delivery. Cannot be used in conjunction with any other offer.

Great Qantas Club Rates for AMA Members

Joining Fee: $230.00
One Year Membership: $300.00
Two Year Membership: $530.00

As a Qantas Club member you also receive complementary Qantas Frequent Flyer membership and access to dedicated Qantas Club check-in counters.

Call AMA Member Services on 1300 133 655, email memberservices@ama.com.au or login to the AMA website http://ama.com.au/memberservices-qantas to obtain an application form.

powerbuy

PowerBuy and the AMA have partnered to give Members savings on popular IT products and services. PowerBuy offers discounted deals on brands including Dell, Lenovo, HP, Fuji Xerox and NETGEAR.

For further details and to access PowerBuy's special offers for AMA Members, simply visit **www.ama.com.au/powerbuy** or phone AMA Member Services on **1300 133 655.**